

REPRESENTATIONS OF PSYCHOLOGICAL DISTRESS AMONG CANADIAN
MUSLIMS OF SOUTH ASIAN ORIGIN:
A QUALITATIVE STUDY USING THE SELF-REGULATORY MODEL

by

Humair Yusuf

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Representations of Psychological Distress Among Canadian Muslims of South Asian Origin:

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Department of Applied Psychology and Human Development
Ontario Institute for Studies in Education
University of Toronto

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Abstract

This study sought to gain insight into representations of distress among Canadian Muslims of South Asian origin. It sought to examine whether representations of distress among this population are influenced by Islamic, scientific, and Western representations, the extent to which they differ from those assumed in the prevailing literature on Islamic healing, counselling, psychotherapy, and psychiatry with Muslim populations, and whether individuals attempt to incorporate multiple influences into a single coherent representation, or they construct multiple representations simultaneously. The Self-Regulatory Model of Illness Representation (Leventhal, Brissette & Leventhal, 2003) was utilized to understand how the participants made sense of, emotionally responded to, and coped with their experiences of distress.

The findings of this study indicated that a common theme among the participants was the belief that their distress was a form of punishment from God due to lack of faith or piety, thereby suggesting a significant religious aspect to their representations of distress. Paradoxically, the participants attempted to cope with their distress through counselling and psychotherapy or pharmacotherapy, which implies an equally strong biomedical aspect to their representations of distress. Reasons for

this dual and possibly contradictory nature of participants' representations of distress are discussed along with the implications of the findings for counselling and psychotherapy.

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Table of Contents

Abstract	ii
Acknowledgements	iv
List of Figures	xii
List of Appendices	xiii
Chapter 1 Introduction	1
1.1. Background and Context	1
1.2. Research Question	9
1.3. Rationale for This Study	11
Chapter 2 Literature Review	15
2.1. Representations of Illness	15
2.1.1. Representations of Illness in Coping and Healing	16
2.1.2. Representations of Illness in Counselling and Psychotherapy	19
2.2. Models of Illness Representations	20
2.2.1. The Medical Model.....	20
2.2.2. The Health Belief Model.....	22
2.2.3. The Theory of Planned Behaviour	23
2.2.4. The Self-Regulatory Model.....	24
2.2.5. The Ethno Biopsychosocial Model.....	29

2.2.6. Comparison of Illness Representation Models.....	30
2.3. Culture and Representations of Illness	31
2.4. Representations of Illness in Islamic Contexts	35
2.4.1. Identity	36
2.4.2. Causation.....	37
2.4.3. Consequences	39
2.4.4. Cures.....	41
Chapter 3 Research Methodology	48
3.1. Rationale for the Research Methodology	49
3.1.1. Rationale for Qualitative Methodology.....	49
3.1.2. Rationale for Phenomenological Methodology.....	50
3.1.3. Rationale for Interpretive Phenomenological Analysis	53
3.1.4. Rationale for Qualitative Interviewing	55
3.2. Ethical Issues	57
3.2.1. Risks and Safeguards	57
3.2.1.1. Regulation of distress	58
3.2.1.2. Confidentiality and anonymity	58
3.2.1.3. Informed consent	59
3.2.2. Possible benefits.....	60
3.3. Study Design.....	61
3.3.1. Participants.....	62
3.3.1.1. Selection of participants.....	62

3.3.1.2. Recruitment of participants	63
3.3.1.3. Description of sample.....	64
3.3.2. Instrument.....	65
3.3.3. Procedure	66
3.3.4. Data Analysis	67
3.3.4.1. Reflection	67
3.3.4.2. Transcription	68
3.3.4.3. Coding.....	68
3.3.4.4. Connections.....	69
3.4. Methodological Limitations.....	70
3.4.1. Researcher Background.....	70
3.4.2. Interviewing.....	71
3.4.3. Sample	72
3.4.4. Generalizability of Results	74
Chapter 4 Results.....	76
4.1. Context of Distress	78
4.1.1. Social Context.....	79
4.1.1.1. Family: “stress, pressure, burden...no support at all”	81
4.1.1.1.1. Parents: “They made me miserable, absolutely miserable”	81
4.1.1.1.2. Spouses: “Conflict took over my life”	84
4.1.1.2. Community: “Constant pressure, constant confusion”	86
4.1.1.2.1. Friends and acquaintances: “Feeling inferior was like feeling nauseous”	87

4.1.1.2.2. Local Muslim community: “Never-ending judgment”	88
4.1.1.2.3. Canadian society: “Do I really belong?”	90
4.1.2. Economic Context	92
4.1.2.1. Income: “The stress of not having enough money crushed me”	93
4.1.2.2. Social status: “The shame was like being suffocated”	96
4.1.3. Religious Context.....	97
4.1.3.1. Lack of faith: “I doubted God so of course I was going to suffer”	98
4.1.3.2. Lack of piety: “I’m being punished for my sins”	100
4.2. Experience of Distress	103
4.2.1. Physical Experience	105
4.2.1.1. Chronic pain: “I hurt all over... I didn’t know whether to scream or cry.”	106
4.2.1.2. Gastrointestinal disorders: “...brought my life to a standstill”	108
4.2.1.3. Fatigue: “It felt as if life had been sucked out of me”	111
4.2.1.4. Disrupted sleep: “My life was turned upside down”	112
4.2.2. Emotional Experience.....	114
4.2.2.1. Hopelessness: “I’d reached the end”	115
4.2.2.2. Helplessness: “Everything I did felt futile. My life was pure futility”	118
4.2.2.3. Feeling overwhelmed: “I was constantly drowning”	119
4.2.2.4. Confusion: “I couldn’t think. Nothing made sense”	122
4.2.2.5. Guilt	124
4.2.1.5.1. Familial guilt: “My parents shouldn’t have suffered so much due to me”	124

4.2.2.5.2. Religious guilt: “I deserved to suffer”	126
4.2.2.6. Anger	128
4.2.2.6.1. Familial anger: “I’d be boiling inside, on the verge of blowing up”	129
4.2.2.6.2. Religious anger: “This idea of a petty and vengeful God makes me furious”	131
4.2.3. Behavioural Experience	133
4.2.3.1. Numbing and avoidance.....	134
4.2.3.1.1. Substance abuse: “Vodka was my crutch”	134
4.2.3.1.2. Social withdrawal: “One by one I deleted everyone from my life”	136
4.2.3.2. Neglect of responsibilities	138
4.2.3.2.1. Familial responsibilities: “I was too depleted to be a mother”	138
4.2.3.2.2. Religious responsibilities: “My faith became a burden”	140
4.3. Coping with Distress	143
4.3.1. Social Coping	145
4.3.1.1.1. Empathy and support: “Just being listened to made all the difference”	147
4.3.1.1.2. Lowered expectations: “I simply stopped caring”	149
4.3.1.2. Community	151
4.3.1.2.1. Local Muslim community: “They kept me alive”	152
4.3.1.2.2. Canadian society: “I could finally become the person I wanted to be”	153
4.3.2. Religious Coping	155

4.3.2.1. Trust in God’s plan: “It was God’s will”	156
4.3.2.2. Connection with God: “I brought God back into my life”	158
4.3.2.3. Exemptions from religious obligations: “I gave myself a break”	160
4.3.2.4. Rejection of religious beliefs: “What didn’t feel right, I simply dropped”	162
4.3.3. Psychological Coping	163
4.3.3.1. Counselling and psychotherapy: “Little in my life changed, but I coped better”	164
4.3.3.2. Psychiatry: “It was not just in my head, I was sick for real.”	167
Chapter 5 Discussion	172
Chapter 6 Conclusion	205
6.1. Unique Contributions	206
6.2. Implications for Counselling and Psychotherapy	207
6.3. Limitations.....	215
6.4. Recommendations for Future Research.....	218
References.....	224
Appendix A Recruitment Poster	288
Appendix B Information Letter	289
Appendix C Consent Form	292
Appendix D Interview Guide.....	293

Appendix E Participant Demographic Information.....295

Appendix F Participant Biographies296

List of Figures

Figure 1. Organization of Results.....	77
Figure 2. Context of Distress.....	78
Figure 3. Social Context.....	80
Figure 4. Economic Context.....	93
Figure 5. Religious Context.....	98
Figure 6. Experience of Distress.....	104
Figure 7. Physical Experience.....	106
Figure 8. Emotional Experience.....	115
Figure 9. Behavioural Experience.....	134
Figure 10. Coping with Distress.....	144
Figure 11. Social Coping.....	146
Figure 12. Religious Coping.....	156
Figure 13. Psychological Coping.....	164

List of Appendices

Appendix A Recruitment Poster	288
Appendix B Information Letter.....	289
Appendix C Consent Form	292
Appendix D Interview Guide.....	293
Appendix E Participant Demographic Information.....	295
Appendix F Participant Biographies.....	296

Chapter 1

Introduction

1.1. Background and Context

Despite the current emphasis on cross-cultural counselling and multicultural competence, counselling and psychotherapy are based on Western concepts of health, illness, emotional distress, and healing. In the context of arguments by Bhugra and Bhui (1998) and Rathod (2017) that cultures shape emotional experiences and determine the criteria for illness, and by Good and Good (1982, in Moodley, 2014) that the meaning of illness for individuals is rooted in the network of meanings that an illness has in a particular culture, it is not surprising that counselling and psychotherapy with individuals from diverse cultural, racial, and ethnic groups can be challenging and problematic.

The differing worldviews of counsellors and psychotherapists, along with a lack of knowledge regarding the beliefs, values, and behaviours of clients from diverse cultural groups in addition to their historical, political, religious, and social contexts are likely to compromise the relevance and efficacy of counselling and psychotherapy for such clients. Moodley (1999) draws attention to the difficulty of incorporating non-Western clients' narratives and cultural metaphors into Western psychotherapy, and Bojuwoye and Sodi (2010) are critical of its lack of sensitivity to individuals' worldviews, the power dynamics that shape their social realities and its inability to integrate these realities into the healing process. Vontress (2005), meanwhile, points out that the distinctions between psychological, physiological, social, and spiritual realms that are standard in Western psychotherapy are alien to many non-Western cultures and traditions. In contrast to the emphasis on curing or

eliminating symptoms in counselling and psychotherapy, Waldram (2013) describes how other traditions of healing can offer relief and possibly even healing without necessarily providing a cure. Research by Elias and Munirah (2017) has provided empirical evidence of the benefits of incorporating spirituality in the treatment of mood disorders, and Bezanson, Foster, and James (2005) maintain that, compared to healing processes influenced by religion and spirituality, psychotherapy is less likely to enable individuals to make meaning of distress and suffering and validate its significance. Harris, Randolph, and Gordon (2016), however, highlight the complexity of individuals' spiritual needs and the wide range of expectations, preferences, and desires regarding the role of spirituality in coping and healing.

Moreover, in the context of the ethnocentric nature of counselling and psychotherapy suggested by Sue and Sue (2003), the culturally and racially oppressive practices documented by Howitt, Owusu-Bempah, and Owusu-Bempah (1994) and Richards (2012), and the underlying racism directed at clients from racial and ethnic minorities explained by Littlewood (1992) are far more troubling. In a similar vein, a study by Al-Roubaiy, Owen-Pugh, and Wheeler (2017) draws attention to racism and cultural insensitivity in counselling and psychotherapy provided to Muslim clients in the West. Moodley (2005) draws attention to the danger of projections of such 'otherness' on clients, which can result in factors such as race and culture "constructing themselves as the source of the problem... cultures that are different become cultures that are problematic, pathological and inferior" (Moodley, 2005, p. 323).

While Koslofsky and Domenech Rodríguez (2017) have documented the extensive evidence supporting the importance of cultural sensitivity to healing, Bojuwoye and Sodi (2010) highlight how Western counselling and psychotherapy are

ineffective for clients from non-Western cultures. In this context, Moller, Burgess, and Jogiyat (2016) have provided evidence of how ethnicity and religious identity can constitute barriers to seeking counselling for psychological distress, and Richardson and Bradbury (2012) have documented the limited success of counselling and psychotherapy in Western countries for clients from other cultures of origin.

The high rates of mood and anxiety disorders among Muslims in North America (Amer, 2014) coupled with the exceptionally low utilization of mental health services among this population (Hodge, 2005) could therefore suggest that Western psychotherapy is not adequately meeting the mental health needs of the Muslim diaspora. Similar reasons could underlie the prevalence of Islamic traditional healing among Muslims in the United States (Goforth, Pham, Chun, Castro-Olivo, & Yosai, 2016), Canada (Gadalla, 2010), the United Kingdom (Dein, Alexander, & Napier, 2008), and continental Europe (Missinne & Bracke, 2012). Meanwhile, Haque, Khan, Keshavarzi, and Rothman (2016) describe the current interest and ongoing research into integrating Islamic traditions into counselling and psychotherapy as a reaction to the prevailing Eurocentric narratives in psychology.

This increasing recourse to Islamic traditional healing by Muslims in the West can be understood in the context of arguments by Moodley and Sutherland (2010) and Vontress (2001) that healing practices rooted in a particular culture are more likely to resonate with the subjective representations of illness of individuals who belong to that culture and are therefore more likely to engender an appropriate and beneficial healing process. This notion is supported by considerable empirical evidence for the importance of concordance between individuals' subjective representations of illness and healers' explanatory models and healing strategies in different cultures (e.g., Callan & Littlewood, 1998; Elias & Munirah, 2017; Koslofsky & Domenech

Rodríguez, 2017; Rathod et al., 2018). The prevalence of Islamic traditional healing among Muslims in the West, including Canada, therefore indicates that their representations of illness are likely to differ from those assumed and expected by the scientific and medical model that underlie contemporary Western healing modalities such as counselling, psychotherapy, and psychiatry.

Leventhal, Meyer, and Nerenz (1980) describe how individuals actively develop representations of illness in response to symptoms or diagnoses, which determine how individuals subjectively experience, understand, and express their illness and are based on personal knowledge, social, and cultural contexts and the resources available to manage the illness (Diefenbach & Leventhal, 1996; Leventhal, Brissette & Leventhal, 2003; Leventhal & Ian, 2012; Leventhal, Phillips & Burns, 2016). These representations are important because they influence individuals' emotional responses along with how they adapt, cope, and manage the illness (Petrie & Weinman, 2006). Moreover, research by Folkman and Lazarus (1998) indicates that coping is a mediator of emotion, and because coping strategies are based on representations of illness, they are likely to play a critical role in the distress experienced by individuals. Conversely, Ali, Kohli, and Yadav (2017) suggest that perceptions or expectations of distress determine coping strategies.

While a number of models of representations of illness exist, Moodley (2000) cites research by Lau and Hartman (1983), Leventhal et al. (1980), Leventhal and Diefenbach (1991), Leventhal, Nerenz, and Steele (1984), and Scharloo et al. (1998) to suggest that the following five dimensions are common to most models: the identity or label given the illness and its symptoms; beliefs about what caused the illness; physical, psychological, social, and economic consequences of the illness; expected duration of the illness; and the degree to which the illness can be managed

or cured. A sixth dimension, illness coherence, that considers whether individuals think about their illness in a coherent manner, has also been discussed by Hagger, Koch, Chatzisarantis, and Orbell (2017), Lowe and Norman (2016), and Weinman and Petrie (1986). Consistent with the description of illness as being rooted in the network of meanings that an illness has in a particular culture (Good & Good, 1982, in Moodley, 2014), these representations are not uniform but vary across cultures, societies, and circumstances (Baumann, 2003; Landrine & Klonoff, 2001).

There is extensive literature on the need for counsellors and therapists to understand how individuals subjectively represent and present mental illness and then to incorporate these representations in the healing process (Bhui & Bhugra, 2002; Cooper, 1998; McAndrew et al., 2017; Rathod, 2017). Antoniadou, Mazza, and Brijnath, (2017), Jones, Smith, and Llewellyn (2016), and McAndrew et al. (2008) suggest that understanding representations of illness, in particular beliefs regarding management, control, and cures, can lead to insights into potential interventions and strategies for healing. Meanwhile, not acknowledging and addressing how clients from diverse cultures represent mental illness can lead to them being held responsible for representations of distress differing from those perceived as universal (Littlewood, 2002), ultimately resulting in clients' representations and presentations being "marginalized and rendered invisible, and with the client feeling oppressed through this experience" (Moodley, 2003, p. 120).

The literature on Islamic traditional healers and healing practices (e.g., Al-Krenawi & Graham, 1999; Dein et al., 2008; Dwairy, 2009; Hodge, 2005; Irfan, Saeed, Awan, Gul, Aslam, & Naeem, 2017; Rassool, 2015) has resulted in an implicit

conceptualization of illness in terms of God's¹ will. Hodge (2005) describes how Muslims believe in an omnipotent God who is personally involved in worldly affairs. This omnipotence and personal involvement means that whatever happens to an individual is because it has been willed by God. Psychological distress is thus understood as the result of a distant or defective relationship with God or even punishment imposed by God for not following His instructions (Al-Krenawi & Graham, 1999). Meanwhile, relief or cures are believed to come solely from God (Rassool, 2015).

Examining and understanding representations of illness, however, present considerable challenges (Stiles, 2003) and require not just the elicitation of individuals' representations and presentations of illness but also observations of what these individuals actually do in practice (Dein, 2003). Abu-Raiya, Pargament, Stein, and Mahoney (2007) highlight the paucity of systematic and rigorous psychological research on Muslims. Few recent exceptions have been published since then, such as a study on the experiences of British Muslims in psychotherapy by Tarabi, Loulopoulou, and Henton (2018) that raised questions regarding the relationship between psychotherapy and Islam. Moreover, there has been no empirical investigation into the authenticity and accuracy of the representations of illness

¹ Based on the APA Style Manual (APA, 2010), God, Quran, Hadith, Heaven and Hell have been capitalized when they are used as proper nouns and do not take a definite or indefinite article. When they are used generically as common nouns with an article they are not capitalized.

Since there are no clear guidelines regarding the capitalization of pronouns such as He or Him when God is the antecedent they have been capitalized following the conventions of the literature cited in this study (e.g., Al-Krenawi & Graham, 2000; Hodge, 2005).

among Muslims described by Al-Krenawi and Graham (1999), Dein et al. (2008), Dwairy (2009), Hodge (2005), Irfan et al. (2017), and Rassool (2015). In addition, Abu-Raiya and Pargament (2011) argue that the majority of such studies are based on “theological speculation, clinical observations, and anthropological methods” (p. 93) and Johada (2016) criticizes them for “a high level of abstraction” and “a striking lack of consistency” (p.169). It can also be argued that they lack an appreciation of the complexity of the role of religion and spirituality in coping and healing described by Harris et al. (2016). Finally, they rely primarily on perceptions, assumptions, and generalizations by healers and practitioners, which, as Yalom (2002) and Elliot and Williams (2003) point out, are often different from those of clients.

The enduring traditions and current prevalence of Islamic healing could be considered an indication of the accuracy of the representations of illness conceptualized by Al-Krenawi and Graham (1999), Dein et al. (2008), Dwairy (2009), Hodge (2005), Irfan et al. (2017), and Rassool (2015). However, arguments by Selby (2016) that studies on Muslims “emphasize the most pious... over-privilege the most committed practitioners... narrowly depict ‘Muslimness’... [and] erase Muslim multiplicity” (p.72), along with research by Bhui et al. (2008) that draws attention to how representations of mental illness among Muslims vary by culture and ethnic origin, suggest that it is not known to what extent the representations of illness among Muslims that are prevalent in the literature are applicable to Canadian Muslims of South Asian origin, and how, or in which aspects they differ. Further, since representations of illness are dynamic and constantly changing in response to changes in individuals’ perceptions and ideas regarding their illness based on a range of social, cultural, and personal factors (Petrie & Weinman, 2006), the ones described above are unlikely to adequately capture how Canadian Muslims’ representations of illness have

mutated and evolved through the experience of migration, interaction with other cultures, establishment of post-9/11 diasporic identities as Muslims in the West, and exposure to and participation in the scientific and medical model of illness (Rassool, 2015; Selby 2018). Finally, Moodley and Sutherland (2010) point out that individuals often engage in traditional healing in conjunction with Western counselling, psychotherapy, or psychiatry, thereby suggesting multiple and simultaneous representations of illness. There are, however, no studies that have examined whether Canadian Muslims incorporate multiple and possibly incompatible representations into a single coherent representation or simultaneously sustain complementary or even contradictory representations of illness.

This lack of empirical knowledge increases the likelihood that the treatment provided to Canadian Muslims of South Asian origin is not relevant to their needs, ineffective, and possibly marginalizing, thereby contributing to barriers to seeking counselling and psychotherapy (Moller, et al., 2016) and the lack of utilization of mental health services (Hodge, 2005) despite the acute need for it among this population (Islam, Multani, Hynie, Shakya, & McKenzie, 2017). Moreover, there are several causes for concern: the recent trend towards the integration of Islamic traditional healing into Western counselling and psychotherapy (e.g., Hamdan, 2008; Husain & Hodge, 2016; Husain, et al., 2017; Rüschoff & Kaplick, 2018) notwithstanding evidence of limited success (Richardson & Bradbury, 2012), the complexities of such a process due to differing and possibly conflicting values and belief systems (Hwang, 2011), and an acknowledgement that this is an emerging area in counselling and psychotherapy that requires further research (Naeemm, et al., 2015). Accompanied by the focus on the association of religious coping with well-being (e.g., Abu-Ras, Gheith, & Cournos, 2008; Aguilar-Vafaie & Abiari, 2007; Ai,

Peterson, & Huang, 2003; Elias & Munirah, 2017; Khawaja 2008), it also risks the inappropriate and irresponsible use of religion in healing processes to engender unproductive feelings of shame, guilt, obligation, fatalism, and intellectual resistance (Harris et al., 2016; Smith & Richards, 2005) and potentially reinforces negative religious coping methods that ultimately contribute to distress (Aflakseir & Coleman, 2009; Berzengi, Berzenji, Kadim, Mustafa, & Jobson, 2017; Khan & Watson, 2006) but are largely ignored in the literature.

1.2. Research Question

Due to contested notions of illness (e.g., Good & Good, 1982, in Moodley, 2014) and controversies regarding diagnoses (e.g., Gornall, 2013) this study focused on psychological distress rather than illness or mental illness. The concept of psychological distress was used to refer to emotions, patterns of behaviour, interpersonal difficulties, and somatic symptoms that resulted in significant impairment and compromised individuals' functioning (Drapeau, Marchand & Beaulieu-Prévost, 2012; Walker & Avant, 1995). This study did, however, refer to and build on existing research that discusses illness and mental illness with its various meanings and connotations.

The primary purpose of this study was to examine representations of psychological distress among Canadian Muslims of Indian, Pakistani, and Bangladeshi origin using the Self-Regulatory Model of Illness Representation (Diefenbach & Leventhal, 1996; Leventhal, Brissette, & Leventhal, 2003; Leventhal & Ian, 2012; Leventhal, Phillips, & Burns, 2016). It sought to gain insight into the influence of Islamic, scientific, and Western traditions and worldviews on these representations, whether they are consistent with those assumed in the prevailing literature on Islamic healing, counselling, psychotherapy, and psychiatry with Muslim

populations, and if not, the ways in which they differ. It also aimed to understand whether Canadian Muslims of South Asian origin attempt to incorporate multiple influences into a single representation or whether they simultaneously construct multiple representations. These goals can be encapsulated into the following research question: How do Canadian Muslims of South Asian origin represent psychological distress?

In order to answer this research question, the following secondary research questions were also addressed:

1. How do Canadian Muslims of South Asian origin experience psychological distress?
2. How do Canadian Muslims of South Asian origin make sense of psychological distress?
3. How do Canadian Muslims of South Asian origin respond to psychological distress?

Qualitative and specifically phenomenological methodology, namely Interpretive Phenomenological Analysis (IPA, Smith, 1996; Smith & Osborn, 2004), was employed to provide rich and nuanced descriptions of the lived experiences of Canadian Muslims of South Asian origin who had suffered from psychological distress. The participants of this study were 15 individuals who identified as Canadian; Muslim; of Indian, Pakistani, or Bangladeshi cultures of origin; and resided in the Greater Toronto Area, Canada. They included, but were not limited to, individuals who had received a DSM diagnosis (American Psychiatric Association, 2013) for a mental health disorder, along with those who had sought counselling, psychotherapy, or pharmacotherapy, had engaged in traditional Islamic healing, as well as those who sought no treatment to cope with their psychological distress.

This study thus endeavored to provide empirical evidence regarding representations of psychological distress among Canadian Muslims of South Asian origin, thereby contributing to the existing literature on representations of psychological distress as well as traditional and spiritual healing, counselling, psychotherapy, and psychiatry with Muslim populations. Consequently, it also aimed to impact clinical practice by engendering relevant and effective treatment for Canadian Muslims as well as Muslims in general, and ultimately to increase the utilization of mental health services among this population.

1.3. Rationale for This Study

The rationale for this study is based on the importance of understanding representations of psychological distress in counselling and psychotherapy (Bhui & Bhugra, 2002; Cooper, 1998; McAndrew et al., 2017) in the absence of research and empirical evidence on such representations among Muslim populations (Abu-Raiya et al., 2007). This lack of research is particularly acute for Canadian Muslims and specifically Canadian Muslims of South Asian origin, whose representations of distress are likely to be different from those of Muslims of other cultures of origin due to the considerable variance of such representations among Muslims by culture and ethnicity (Bhui et al., 2008). Moreover, although this paucity of research is problematic, the assumptions, perceptions, and generalizations highlighted by Abu-Raiya and Pargament (2011) that pervade the existing literature on counselling and psychotherapy with Muslim populations can result in adverse consequences for Muslim clients. Specifically, this study is concerned with and focuses on the implicit conceptualizations of representations of psychological distress in primarily Islamic terms (e.g., Al-Krenawi & Graham, 1999; Dein et al., 2008; Dwairy, 2009; Hodge, 2005; Irfan et al., 2017; Rassool, 2015). This could result in well-intentioned and

culturally sensitive counsellors and psychotherapists incorporating these conceptualizations into their clinical practice, because they uncritically accept these assumptions. The end result is potentially adopting approaches that are not only inappropriate, irresponsible, and unproductive, but also marginalizing and distressing.

By investigating subjective representations and presentations of psychological distress among Canadian Muslims of South Asian origin, this study aimed to provide empirical evidence that critically questions as well as supplements the current knowledge in the area. Specifically, it aimed to examine the extent to which representations of psychological distress among Canadian Muslims of South Asian origin differ from those assumed by counselling, psychotherapy, and psychiatry, or Islamic traditional healing, and the extent to which Canadian Muslims subscribe to scientific and Western representations of distress, Islamic ones, attempt to construct a single coherent representation that incorporates multiple influences, or simultaneously sustain multiple representations of distress. The goal of this study was therefore to provide a nuanced and comprehensive understanding of representations of distress among this population.

The increasing salience of Islamic worldviews among Muslims in the West (Kelly, Aridi, & Bakhtiar, 1996) and the centrality of Islam to Muslims' lives (Abu-Raiya & Pargament, 2011) suggests that representations of distress influenced by Islamic traditions may be part of Canadian Muslims' attempts to create personal, social and cultural frameworks to manage and give meaning to their realities. However, although an understanding of such representations of distress is important in a social and cultural context, it is crucial for addressing the prevalence of psychological distress and the low utilization of mental health services among Canadian Muslims.

By focusing on the actual individuals who suffered from psychological distress, this study also aimed to address concerns along the lines of those raised by Yalom (2002) and Elliot and Williams (2003) that the current knowledge of representations of distress is based on the perceptions and interpretations of practitioners rather than clients. In addition, since this study aimed to include participants who sought counselling, psychotherapy, or psychiatry, alternative or traditional healing, or no treatment at all, a greater appreciation of how different healing processes influence representations of distress could be a significant contribution of this study. Other potential insights include the relationship between representations of distress and faith, both in terms of how religious beliefs may shape representations of distress and how evolving representations of distress may strengthen, sustain, or weaken individual faith.

While this study ultimately aimed to provide a better understanding of representations of psychological distress among Canadian Muslims of South Asian origin, thereby improving the relevance, suitability, and efficacy of mental health services for this population and increasing their utilization of these services, the qualitative nature of the research, however, meant that its immediate aim was to examine in detail and interpret the lived experiences, perceptions, and meanings of psychological distress for the group studied rather than make general claims for larger populations. Nevertheless, the detailed descriptions yielded by this study were contextualized within existing scholarship and thus have implications for counselling and psychotherapy by connecting them to clinical practice. This study also offers suggestions for future research into specific aspects of representations of distress, leading to studies conducted on other groups as well as studies employing different

research methodologies that enable more generalized claims to be made not just for Canadian Muslims of South Asian origin but also for other populations.

The overall aim of this study was to use the Self-Regulatory Model of Illness Representation (Diefenbach & Leventhal, 1996; Leventhal, Brissette, & Leventhal, 2003; Leventhal & Jan, 2012; Leventhal, Phillips, & Burns, 2016) to gain insights into how Canadian Muslims of South Asian origin experience, make sense of, and respond to psychological distress. This chapter has provided the background and context for this study, its underlying rationale, and the research questions that will be addressed. The next chapter, the literature review, discusses the existing literature on representations of illness, models of illness representations, the influence of culture on representations of illness, and representations of illness in Islamic contexts, thereby establishing the theoretical framework for this study. It is followed by the chapter on research methodology, in which the rationale for selecting qualitative and phenomenological methodology is provided, the recruitment and selection of participants along with the interview process and data analysis are described, and ethical issues and methodological limitations are discussed. In the results chapter, the findings generated by this study are presented in the form of themes of context of distress, coping with distress, and experiences of distress. These themes are organized into subthemes, which are examined through participants' own words by presenting excerpts from the interviews. The discussion chapter situates the findings of this study in the context of other research and scholarly writing and also explores underlying reasons that explain the findings. Finally, the conclusion details the unique contributions of this study, its limitations, its implications for counselling and psychotherapy, suggestions for future research, and a summary of the study's findings and conclusions.

Chapter 2

Literature Review

This chapter provides an overview of the literature on representations of illness and representations of illness in Islamic contexts. It is organized into four sections: the first section introduces the concept of illness representations and discusses their role in coping and healing and their importance in counselling and psychotherapy; the second section reviews commonly used models of illness representations; the third section discusses the relationship between culture and representations of illness; and the fourth section describes representations of mental illness or psychological distress in Islamic contexts in terms of the labels, causes, consequences, and cures implicit in these representations.

2.1. Representations of Illness

Studies by Leventhal, Meyer, and Nerenz (1980) and Leventhal, Nerenz, and Steele (1984) indicate that when individuals are confronted by health threats such as new symptoms or diagnoses, they react by developing an organized pattern of beliefs or representations of illness to make sense of and emotionally respond to their condition. Lowe and Norman (2016) describe this process as automatic and spontaneous and according to Leventhal et al. (1997) the need for such representations is so strong that individuals experiencing symptoms tend to look for diagnoses or labels to make sense of their symptoms, whereas those who receive diagnoses look for relevant symptoms to confirm the diagnoses even when the illness may be asymptomatic. Research by Ghio et al. (2018) indicate that beliefs regarding symptoms and the label or identity given to them are prioritized over other aspects of

illness representations, and Ali et al. (2017) report that identity and causality of illness can overlap in certain cases. Clare, Quinn, Jones, and Wood (2016), however, discuss findings that individuals who receive diagnoses, and thus assign a label or identity to their illness, report greater awareness of their illness and anticipate its consequences more accurately, but also experience lower mood compared to those who did not receive diagnoses.

Representations of illness are necessarily subjective and integrate individuals' existing beliefs or schemata regarding illness along with their previous personal experiences of illness and healing, observations of family and friends suffering from illness, media and other social or environmental images, and linguistic and cultural notions of health and illness (Diefenbach & Leventhal, 1996; Leventhal et al. 2003; Leventhal & Ian, 2012; Leventhal et al. 2016). Although these representations are coherent (Hagger, Koch, Chatzisarantis, & Orbell, 2017; Lowe & Norman, 2016; Weinman & Petrie, 1986), they are also dynamic and constantly being revised to accommodate changes in individuals' perceptions and ideas regarding their illness based on symptoms, diagnoses, and treatment along with social, cultural, and other external sources (Petrie & Weinman, 2006). The wide range of factors that contribute to and influence subjective representations of illness mean that the same diagnosis can evoke different physical and psychological responses among individuals.

2.1.1. Representations of Illness in Coping and Healing

Subjective representations of illness are important because they influence individuals' emotional responses to their illness, which, according to Achstetter, Schultz, Faller, and Schuler (2016), are linked to recovery and healing. Research by Folkman and Lazarus (1998) suggests that since coping mediates emotional responses, representations of illness are likely to play a critical role in the distress

experienced by individuals, because it is these representations that determine coping strategies. However, according to Ali et al. (2017), it is the perception and expectation of distress that determines which coping strategies are selected by individuals, and Hagger et al. (2017) link these emotional responses to the extent to which the coping strategies are employed.

Representations of illness can shape behaviours such as seeking and adhering to treatment (Cameron & Leventhal, 2003; Dunn et al., 2017; Petrie & Weinman, 2006) and delays in seeking treatment (Attari, Ozgoli, Solhi, & Majd, 2016). Mo, Lau, and Wu (2018) describe how they can underlie depression and suicide ideation, and Broadbent (2010) presents evidence associating representations of illness with avoidance, hypervigilance, cognitive reappraisal, seeking reassurance, and the expression or suppression of emotions to manage the anxiety and distress associated with the illness.

Findings by Wilski and Tasiemski (2016) suggest that beliefs about controllability are more salient for coping and healing than those regarding other aspects of illness. These findings are consistent with studies that have shown that strong beliefs regarding the management or controllability of illness can engender productive coping strategies; regular reappraisal of symptoms; and improved physical, social, and psychological functioning (e.g., Glattacker, Giesler, Klindtworth, & Nebe, 2018; Langston, Edwards, Lyvers, & Stapleton, 2017; Oexle, Ajdacic-Gross, Müller, Rodgers, Rössler, & Rüschi, 2015; Scharloo et al., 1998), as well as studies that have related low perceived controllability to poor recovery (e.g., Achstetter et al., 2016; Chan & Mak, 2016).

Research on the impact of beliefs regarding the consequences of illness has produced differing results. Glattacker et al. (2018) report that the anticipation of

severe consequences result in greater treatment adherence and thus better recovery. In contrast, findings by Achstetter et al. (2016) and Scharloo et al. (1998) indicate that perceptions of severe consequences are related to poor recovery, and Chan and Mak (2016) and Dunn et al. (2017) describe how real or perceived consequences of stigma represent barriers to treatment and recovery.

The importance of identity in illness representations is highlighted by Langston et al. (2017) and Scharloo et al. (1998), who describe how beliefs regarding identity can result in avoidance and denial and lead to poorer physical, social, and psychological functioning and thus compromise recovery. Ali et al. (2017), meanwhile, argue that establishing an identity or attaching a label to the illness is a necessary first step towards developing and implementing strategies for coping and healing. A different perspective on the impact of identity is provided by Clare et al. (2016) who report improved cognitions regarding illness and more practical approaches to dealing with its consequences but lower mood among individuals who use diagnostic labels to represent their illness.

Given the significance of illness representations to coping and healing, Bhui and Bhurgra (2002) argue that exploring and understanding subjective representations of illness can help promote collaboration between mental health practitioners and clients or patients, thereby improving adherence to treatment, clinical outcomes, and overall satisfaction. Achstetter et al. (2016) emphasize the importance of assessing illness beliefs at the beginning of treatment to identify individuals with lower probabilities of positive outcomes, and to thus modify interventions accordingly. Meanwhile, Cooper (1998) takes a stronger stance, claiming that the connections between subjective representations of illness and outcomes are so compelling that it is essential to the healing process for practitioners to consider individual representations

of illness, which is supported by empirical evidence provided by Brzoska (2018), Cooper, Jackson, Weinman, and Horne (2005) Dimova, Ward, Swanson, and Evans (2017), Dunn et al. (2017), Heid, Pruchno, and Wilson-Genderson (2018), Langston et al. (2017), Shiyabola et al. (2018), Stockford, Turner, and Cooper (2007) and Webster, Norman, Goodacre, Thompson, and McEachan (2014).

2.1.2. Representations of Illness in Counselling and Psychotherapy

McAndrew et al. (2017) highlight the lack of research on illness representations for mental health problems compared to physical health problems and argue that they are equally significant in the treatment of mental health. Evidence for the importance of subjective representations of illness in counselling and psychotherapy is described in several studies. Callan and Littlewood (1998) and McCabe and Priebe (2004), for example, report that satisfaction with treatment and positive outcomes are most likely when there is concordance between practitioners' explanatory models and individuals' subjective representations of illness. King, Beehler, Vest, Donnelly, and Wray (2018) emphasize the importance of communication in this regard. Similarly, Moodley (2000) cites research that suggests that the consequences of not adequately acknowledging and addressing subjective representations of illness in counselling and psychotherapy include dissatisfaction and disenchantment among clients (Littlewood, 1990), differences between therapists and clients (Brimrose & Bayne, 1995), poor working alliances (Kareem, 1992), and stereotyping (Bhugra & Bhui, 1998).

In this context, McAndrew et al. (2008) advocate using these representations to develop interventions and treatment plans. Petrie and Weinman (2012) and Leventhal, Phillips, and Burns (2016) argue that interventions designed to change representations of illness can improve adherence to treatment as well as out outcomes.

Their arguments are supported by studies conducted by Antoniadou et al. (2017), Broadbent, Ellis, Thomas, Gamble, and Petrie (2009), Chan and Mak (2016), Corbett, Groarke, Walsh, and McGuire (2016), Petrie, Cameron, Ellis, Buick, and Weinman (2002), and Richardson, Schüz, Sanderson, Scott, and Schüz (2017), which suggest that interventions designed to communicate and alter representations of illness can facilitate recovery and thus advocate for the development of interventions for coping- and healing-based individual representations of illness. Meanwhile, Jones et al. (2016) provide evidence for the greater efficacy of interventions that focus on beliefs and perceptions regarding cures and controllability, which is consistent with the findings of Wilski and Tasiemski (2016) that beliefs about controllability are more salient than those regarding other aspects of illness representations.

2.2. Models of Illness Representations

This section reviews the main models used to study health and illness behaviours. It describes the Medical Model (Clare, 1980), the Health Belief Model (Becker, 1974, in Strecher & Rosenstock, 1997), the Theory of Planned Behaviour (Ajzen, 1985, in Manstead & Parker, 1995), the Self-Regulatory Model (Leventhal et al., 2003), and the Ethno Biopsychosocial Model (Alladin, 1993). The strengths and limitations of each model are discussed and the section concludes by arguing that the Self-Regulatory Model is the most appropriate for the purposes of this study.

2.2.1. The Medical Model

The medical model, as defined by Clare (1980), involves observation, description, and differentiation and requires practitioners to recognize symptoms, develop aetiologies, and treat disease. According to Shah and Mountain (2007), this definition can result in reductionist and pathologizing conceptualizations of illness or

disease that assume a mechanistic view of the body and understand illness in terms of causation and remediation or treatment. Meanwhile, Stojanov, Korf, Jonge, and Popov (2011) highlight the weaknesses of the medical model in the context of mental health: because classification systems are scientifically non-falsifiable, cerebral processes are nondeterministic and possibly chaotic, the relationship between therapeutic approaches and suspected pathology are vague, and diagnostic tools are inadequate compared to other areas of medicine.

Tallis (2004) defends the medical model on the basis of its historical success in treating disease and reducing fear, superstition, and stigma, and Shah and Mountain (2007) attempt to circumvent ideological criticism by redefining the medical model in terms of treatment based on empirical evidence. Conversely, critics of the medical model (e.g., Blackwell, 1992; Bracken & Thomas, 2001; Kleinman, 1987; Littlewood, 1996) maintain that it treats individuals as passive recipients of treatment instead of active participants in the healing process. More importantly, these critics argue that it does not distinguish between disease, which they describe as a biological condition, and illness, which they characterize as a set of symptoms and a social definition of that particular set of symptoms respectively. The medical model thus disregards the social, cultural, and psychological aspects of individuals' experience of disease. In the medical model, as a result, differences in representations of illness across cultures may be ascribed to limited intelligence and a lack of knowledge of mental illness (Summerfield, 1999).

Notwithstanding the considerable criticism it has received and the development of psychosocial approaches that claim to be empowering, humane, and holistic (Shah & Mountain, 2007), the medical model has been evolving since the eighteenth century and remains the dominant paradigm for studying health and illness

in Western societies. Research showing how childhood sexual abuse (e.g., Hart & Rubia, 2012), personality traits (e.g., Joyce et al., 2006) and psychotherapy (e.g., Cozolino, 2017; Schore, 2012) are associated with changes in neurological structure and function have demonstrated the strength of the medical model to incorporate social and psychological aspects of illness as well as biological. Finally, Bracken et al. (2012) argue that treatments rooted in the medical model do not obviate engagement with relationships, meanings, and values, and Badenoch (2008), Siegel (2010), and Wilkinson (2010) suggest that the biological and medical model underlies many ostensibly humanistic and psychosocial approaches.

2.2.2. The Health Belief Model

The Health Belief Model (Becker, 1974, in Strecher & Rosenstock, 1997) proposes that health, illness, and related behaviours can be explained and predicted by four factors: perceived susceptibility, i.e., an individual's sense of vulnerability regarding an illness; perceived severity, i.e., symptoms, social and economic consequences; perceived costs, benefits, and barriers, i.e., an individual's belief that a recommended behaviour is possible and its benefits outweigh its costs and inconveniences; and a precipitating event such as a distressing symptom, the illness of a friend or family member, or media images and health campaigns (Champion & Skinner, 2008). Thus, unlike the medical model, the Health Belief Model is based on individual cognitions and self-efficacy while allowing for social, cultural, and personal factors.

Janz and Becker (1984) list 29 studies that empirically support this model and Henshaw and Freedman-Doan (2009) argue that it is especially suitable for research on mental illness. Their study, which used the Health Belief Model to examine factors that might encourage or inhibit individuals from utilizing mental health services,

suggests its applicability to developing and evaluating programs aimed at increasing mental health awareness and utilization of services.

While Diefenbach and Leventhal (1996) object to this model at a fundamental level by arguing that individuals do not think about health and illness in probabilistic terms, it can be argued that even if probabilistic thinking does play a role, it is simplistic and even reductionist to assume that such thinking by itself can determine health- and illness-related behaviours in their entirety. Moreover, the predictive and explanatory power of the Health Behaviour Model has been questioned by studies conducted by Harrison, Mullen, and Green (1992) and Hyman, Baker, Eprahim, Moadel, and Philip (1994).

2.2.3. The Theory of Planned Behaviour

Developed by Ajzen (1985, in Manstead & Parker, 1995), the Theory of Planned Behaviour was initially used to explain and predict health-related behaviours in terms of intentions based on personal or attitudinal, along with social or normative, factors. Later perceived control or self-efficacy was added as a third variable. By acknowledging the importance of social or normative factors, this model allows for cultural influences in understanding health and illness (Montaño & Kasprzyk, 2008). Although the Theory of Planned Behaviour was not specifically designed for understanding health and illness, it has been used in health-related fields. For example, it was employed in a study by Conner, Kirk, Cade, and Barrett (2003) to examine the factors underlying motivations to use dietary supplements, which suggested that strong beliefs about the health benefits of dietary supplements, rather than actual need for the supplements, was the most powerful influence regarding their usage. Moreover the study indicated that media images played a greater role in shaping health-related beliefs than personal experiences or observations.

The Theory of Planned Behaviour differs from the medical model by emphasizing personal and social factors over biological ones. In addition, by explaining health-related behaviours in terms of intentions based on these factors, it avoids the excessive simplicity of the Health Behaviour Model. However, it gives equal weight to both personal and social factors, whereas studies by Brubaker and Wikersham (1990) and Armitage and Conner (2001) suggest that personal factors are a far more important component of intentionality than social ones. In addition, the usefulness of this model is limited by not identifying which personal factors, such as specific values or beliefs, are important in subjective representations of illness.

2.2.4. The Self-Regulatory Model

The origins of the Self-Regulatory Model (Diefenbach & Leventhal, 1996; Leventhal et al., 2003; Leventhal & Ian, 2012) can be traced to the behavioural Fear-Drive Model (Dollard & Miller, 1950) in which fear is defined as a motivational state and it is through a process of learning and reinforcement that individuals are able to reduce or eliminate fear. The findings of Leventhal's research into how fear messages might lead to health-related behaviours—that different types of information influence attitudes and actions—resulted in the development of the parallel process model (Leventhal, 1970, in Leventhal et al., 2003) in which health threats are represented both cognitively and emotionally and result in parallel processes of representing the threat, coping with it, and appraising the success or failure of the coping strategies. Leventhal, Nerenz, and Steele (1984) proposed that representations of illness are based on individuals' ideas or beliefs regarding the identity, cause, duration, and consequences, which determine how individuals manage and cope with their illness. Research by Lau and Hartman (1983) and Lau, Bernard, and Hartman (1989)

indicated that beliefs regarding the cure and controllability of the illness are also an important element of illness representations.

According to the Self-Regulatory Model, the five components of illness representations are identity, cause, timeline, consequences, and curability or controllability. The identity component refers to the label given to the illness, the nature of the illness (such as associated symptoms), and the links between the label and the symptoms. Leventhal et al. (1997) describe how identity is symmetric: individuals who experience symptoms desire labels for their illness, whereas those who have a label (e.g., through a diagnosis) look for symptoms and are likely to interpret diverse and possibly unrelated symptoms as evidence for the label. The causal component reflects individual beliefs regarding the perceived cause or causes of the illness. Ideas regarding causation are shaped by personal experiences and social and cultural influences, and need not be limited to biological or medical factors. The timeline component is concerned with perceptions regarding the duration of the illness, i.e., whether the illness is acute, episodic, cyclical, or chronic, and is more likely than other components to be reevaluated over the passage of time. The consequences component focuses on how the illness is likely to affect individuals' functioning and the perceived physical, emotional, social, and economic impact of the illness. Hale, Treharne, and Kitas (2007) point out that beliefs regarding consequences are often unrealistic initially but modified over time. The cure or controllability component indicates the extent to which individuals believe that the illness can be cured or controlled, as well as individuals' self-efficacy and role in achieving desired or possible outcomes.

This model implies that representations of illness are dynamic and changing (Shiloh, 2006) and although the components are distinct, they are not necessarily

independent and are linked to each other in complex and evolving ways (Leventhal & Crouch, 1997; Weinman, Petrie, Moss-Morris, & Horne, 1996). Moreover, following Leventhal's parallel processing model (1970), this model also assumes that representations are both cognitive and emotional and are processed in parallel.

Leventhal, Leventhal, and Contrada (1998) and Keller, Leventhal, Prohaska and Leventhal (1989) emphasize that these cognitive and emotional representations are shaped by personal, social, and cultural contexts. Personal contexts include memories of prior illness and healing processes, ongoing somatic experiences that may be continuously compared with each other, and personality traits that include patterns of thinking and emotional regulation. Social and cultural contexts influence which symptoms are emphasized and incorporated into illness representations while others are disregarded and excluded, thereby shaping expectations, treatment, and strategies for healing (Deifenbach & Leventhal, 1996; Kleinman, 1980). Unlike the medical model, therefore, the Self-Regulatory Model incorporates social and psychological aspects of illness and does so in a more nuanced and sophisticated manner than the Health Belief Model or the Theory of Planned Behaviour.

Studies using the Self-Regulatory Model to examine representations of illness (e.g., Leventhal, 1970; Leventhal & Nerenz, 1985; Leventhal et al., 1997) initially utilized extensive, in-depth, semi-structured interviews in which the researchers focused on individuals' perceptions and experiences in order to elicit and understand their representations of illness. Quantitative methods involving the use of questionnaires were subsequently used by Prohaska, Leventhal, Leventhal, and Keller (1985) and Lacroix (1991), whereas Lau and Hartman (1983) and Lau et al. (1989) used extended longitudinal studies to examine and develop the Self-Regulatory Model of illness representations.

Current measures to study representations of illness include the Illness Perception Questionnaire (IPQ) developed by Weinman et al. (1996), which utilizes components of identity, causation, consequences, timeline, and controllability from the Self-Regulatory Model (Diefenbach & Leventhal, 1996; Leventhal et al., 1997; Leventhal et al., 2003). A revised and updated version was proposed by Moss-Morris, Weinman, Petrie, Horne, Cameron, and Buick (2010) that included additional subscales to assess timeline perceptions, illness coherence, and emotional representations. Bhui and Bhugra (2002) are critical of this approach, because it assumes that the variables being investigated are generally known and are familiar to individuals from different linguistic and cultural groups. Instead, they propose the Explanatory Model Interview Catalogue (EMIC), developed by Weiss (1997), or the Short Explanatory Model Interview (SEMI), developed by Lloyd, Jacob, and Patel (1998). The EMIC involves an extended and time-consuming interview that explores several areas: what names are given to the illness, whether it is an illness at all, what causes it, what is evident about it, and what can be done about it, both by the individual and others who can provide help. Thereafter follow standardized steps to manage and analyse the data. Napier et al. (2014) and Nichter (2008) have described its use to study the relationships between cultural perceptions, social representations, and health. The SEMI, in contrast, utilizes a semi-structured interview format to explore individual representations of illness that can then be categorized, although there is no standard system of data analysis. It has been used in studies to examine indigenous beliefs about mental illness that differ significantly from the biomedical models (e.g., Joel et al., 2003). Bhui and Bhugra (2002) argue that the EMIC and the SEMI are sufficiently flexible to be used together to overcome shortcomings of both qualitative and quantitative approaches.

There is considerable empirical support for the Self-Regulatory Model of illness representation (e.g., Petrie & Weinman, 1997; Lau & Hartman, 1983; and Lau et al., 1989). In particular, a meta-analysis of 45 empirical studies by Hagger and Orbell (2003) supported the construct and discriminant validity of this model across illness types. Moreover, Weinman and Petrie (1997) have described the applicability of the Self-Regulatory Model to a range of medical conditions, including diabetes, rheumatic disease, cancer, chronic fatigue syndrome, myocardial infarction, and mental illness. In addition, it has proved to be particularly useful in studying complex and interrelated conditions with multiple underlying factors. For example, a study by Detweiler-Bedell, Friedman, Leventhal, Miller, and Leventhal (2008) used the Self-Regulatory Model to examine the relationship between depression and chronic illness. Prior studies (e.g., Anderson, Freedland, Clouse, & Lustman, 2001; Dickens, McGowan, Clark-Carter, & Creed, 2002) have shown that treatments for depression among individuals suffering from chronic physical illness do not improve illness outcomes, and chronic illness management programs have a similarly limited impact on mood. Detweiler-Bedell et al., (2008) explain these findings in terms of excessive demands on the self-regulation system, resulting in competing representations of illness and the inability to develop adequate strategies for coping and healing. In other words, because chronic illness and depression are treated as separate and distinct, individuals are unable to form a coherent representation of their illness. Moreover, strong beliefs regarding identity and consequences for both conditions accompanied by vague ideas regarding their management or controllability result in poor physical and psychological functioning as described by Scharloo et al. (1998).

2.2.5. The Ethno Biopsychosocial Model

Similar to, and in many ways an expansion of, the Self-Regulatory Model (Diefenbach & Leventhal, 1996), Alladin (1993; 1999) proposes a nine-dimensional Ethno Biopsychosocial Model that includes biological, psychological, social, and spiritual dimensions within the context of individuals' ethnic and cultural identities, which he argues are central to individuals' representations of illness and processes of healing. The nine dimensions of illness representation are sickness conception, body function beliefs, well-being criteria, causal and healing beliefs, health practice efficacy beliefs, recognition of health needs, reliance on self-treatment, acceptance of suggestions for health care, and cooperation with health advice.

This model is based on an earlier model proposed by Ahmed and Fraser (1979) that focused mainly on medical needs. It has been adapted by Alladin (1993) for counselling and psychotherapy and empirically validated in a study by Alladin and Ullah (1990). By positing ethnic and cultural identities as central to individuals' representations of illness, this model can be considered to be particularly suited to research on counselling and therapy with clients from ethnic minority groups and has been used by Collins and Arthur (2010) as the basis for a model for developing multicultural competence. Similarly, Duan et al. (2011) have highlighted its usefulness in challenging assumptions in North American approaches to counselling psychology that may limit its transferability to other cultures, and a study by El Rhermoul, Naeem, Kingdon, Hansen, and Toufiq (2018) has documented expectations of such an approach for the management of illness among Moroccans suffering from depression. It can be argued, however, that this model does not provide any information not already available through the Self-Regulatory Model and that its

nine dimensions of illness representation are implicitly included in the Self-Regulatory Model's five components.

2.2.6. Comparison of Illness Representation Models

All the models of representations of illness described above are supported by empirical evidence, have been used extensively to study health- and illness-related behaviours, and, with the exception of extreme and reductionist versions of the medical model, acknowledge the influence of personal, social, and cultural factors on representations of illness. For the purposes of this study, however, the Self-Regulatory Model has a number of advantages over the other models. First, unlike the medical model, the Health Belief Model and the Theory of Planned Behaviour, the Self-Regulatory Model considers representations of illness to be central to individuals' cognitive and emotional responses to illness rather than a corollary or incidental factor. Second, it suggests a fluid and dynamic process in which representations of illness evolve to accommodate changes in individuals' perceptions and ideas regarding their illness. Third, after the medical model there is more empirical support for the Self-Regulatory Model than any of the other models and it has been used widely to study a range of physiological and psychological conditions. Finally, although the Ethno Biopsychosocial Model also emphasizes representations of illness and their dynamic nature, the five components of illness representation in the Self-Regulatory Model provide a more practical and manageable framework to gather and analyze data compared to the Ethno Biopsychosocial Model's nine dimensions.

2.3. Culture and Representations of Illness

Bhugra and Bhui (2006) and Rathod (2017) describe how normative standards of behaviour and cognitive and emotional experience are constructed in and defined by cultural contexts: when individuals deviate from those norms, they are considered, both by themselves and other members of the group, to be suffering from illness, resulting in a primarily cultural evaluation and categorization. Similarly, Moodley (2000) adds that specific behaviours or expressions are often necessary to determine or validate illness in particular cultural contexts, and Diefenbach and Leventhal (1996) argue that cultural contexts determine which symptoms are acceptable and therefore reported, emphasized, and incorporated into subjective representations of illness, and those that are unacceptable are ignored, disregarded, and excluded. Representations of illness constructed by a culturally influenced process of evaluating and incorporating information are therefore rooted in the network of meanings that an illness has in a particular culture (Good & Good, 1982, in Moodley, 2014). Moreover, it follows that expectations and resources for treatment along with ensuing strategies for coping and healing are also shaped by cultural factors to provide relief from these culturally defined, selected, and emphasized symptoms (Deifenbach & Leventhal, 1996; Kleinman, 1980; Moodley, 2000). Although there is considerable literature on the influence of culture on illness representations, recent studies on Sri Lankans and Australians (Antoniades, Mazza, & Brijnath, 2017), Turks (Brzoska, 2018), Ugandans (Sarkar et al., 2018), Germans and Iranis (Reichardt et al. 2018), and African-Americans (Shiyanbola, Ward, & Brown, 2018) have provided empirical evidence of different cultural contexts resulting in differing representations of illness.

Rathod et al. (2018) describe the increasing recognition and acceptance of the need for treatment plans to incorporate cultural factors, and Koslofsky and Domenech

Rodríguez (2017) cite extensive literature that provides evidence of the efficacy of culturally adapted interventions to address differences in representations of illness due to cultural factors (e.g., Barrerra, Castro, Strycker, & Toobert, 2013; Benish, Quintana, & Wampold, 2011; Chavez-Korell et al., 2012; Chowdhary et al., 2014; Griner & Smith, 2006). Conversely, according to Pelto and Pelto (1997), social, cultural, political, and economic factors often determine the treatment choices for individuals, who then construct representations of illness around available resources for coping and healing.

This notion of culturally influenced representations of illness underlies research by Landrine and Klonoff (2001) that suggests that European and North American egocentric cultures distinguish between physical, psychological, social, and spiritual dimensions and tend to embrace biomedical representations of illness. In contrast, they describe how Asian, African, Latin American, and Aboriginal, and Native American sociocentric cultures are less likely to make such distinctions and tend to incorporate physical, psychological, social, and spiritual elements into their representations of illness. Baumann (2003) adds that cultures linked by ancestry, heritage, language, and socio-political circumstances tend to share similar representations of illness: mental illness is considered to be the result of fate in Latin America, with individuals having little control over outcomes; manifested in somatic symptoms in Southeast Asia; and believed to have spiritual causes in Africa. Cultural contexts also determine the manner in which individuals present or communicate their representations of illness. For example, North Americans and Europeans focus on the intensity, frequency, and duration of symptoms (Baumann, 2003); Indians, Pakistanis, and Bangladeshis refer to the biological heart or liver (Dein, Cook, Powell, & Egger, 2010; Inayat, 2005; Patel, Musara, Butau, Maramba, & Fuyane, 1995); Moroccans

emphasize impatience, anger, and social difficulties (El Rhermoul et al., 2018); South Africans present illness in terms of concentric layers representing physiological, psychological, and spiritual functioning that shape interaction with the environment (Laher, 2014); Chinese, even those who live North America, talk about somatic symptoms and physical pain throughout the body (Li & Browne, 2009; Mechanic, 1995); Sri Lankans describe burning sensations (Patel & Sunathipala, 2001); Pacific Islanders construct life histories that examine definitions of the self and interpersonal relationships (Kagawa-Singer & Chung, 1994); and Aboriginal and Native Americans invoke dreams and sacred symbols that represent life, cycles of time, the earth, and the universe (Fleming, 1992).

Variations in the somatisation of depression illustrate how culture, religion, geography, and the options for treatment can shape representations of illness. Mechanic (1995) describes how symptoms consistent with DSM (American Psychiatric Association, 2000) and ICD-10 (World Health Organization, 1992) criteria for depression are presented by individuals and diagnosed by mental health professionals as neurasthenia in China. Moreover, he adds that, although symptoms such as fatigue, headache, and neuralgia are emphasized over sadness, anxiety, or hopelessness, individuals tend to not be interested in treatment for these symptoms but in the social meaning of neurasthenia, which provides a culturally acceptable reason to distance themselves from distressing situations. Mechanic (1995) explains this in terms of the stigma associated with mental illness in China along with the lack of resources to treat it, resulting in somatic expressions of distress being incorporated into representations of illness both at an abstract and concrete level.

Symptoms consistent with depression are also expressed in terms of physical pain and somatic symptoms among South Asian Muslims, whose beliefs and practices

are typically influenced by Sufi traditions (Inayat, 2005). In Sufi spirituality, the heart is an essential element of the human psyche and where interplay between psychological and spiritual factors is located. Distance from God and deviation from his guidance can thus lead to an “incongruent heart” (Inayat, 2005, p. 198), which is experienced and expressed as physical pain. In the Middle East and Africa, where Islamic practices tend to be influenced by sub-Saharan beliefs to a greater extent than by Sufism, depression is also somatized but often ascribed to the evil eye or to possession by evil spirits known as jinn (El Rhermoul et al., 2018). Similar to South Asian traditions, in Arab cultures possession is believed to be a punishment for sin² and distance from God and provide an example of an individual’s guilt at misbehaving with his mother being interpreted as sinning against God and resulting in possession by a jinn and searing pain throughout his body (Al-Kenawi & Graham, 1999). Along with physical pain, symptoms include social withdrawal, isolation, disorientation, and incoherence, plus deviant or erratic behaviour such as aggression, infidelity, and dishonesty (Al-Kenawi & Graham, 1999; El Rhermoul et al., 2018). Since there is considerable stigma attached to mental illness in Muslims cultures (Ciftci, Jones, & Corrigan, 2013), by shifting the cause of dysfunctional behaviour to outside forces, individuals are not held personally and morally accountable, and thus considered deserving of sympathy by their families and extended communities. In the same way, somatic symptoms such as insomnia, loss of appetite, and diminished energy are emphasized in Asian cultures such as Malaysia (Razali & Khalib, 2012), although according to Razak (2017), cultural constructions of mental illness in

² The concepts of sin and sinful behavior are used to refer to intentional actions that go against God’s commandments as set out in the Quran and the Hadith (Fleet et al., 2017).

Malaysia differentiate emotional distress from when there is a known organic etiology, such as epilepsy, which shape treatment approaches as well as social responses.

2.4. Representations of Illness in Islamic Contexts

The Quran, which is believed by Muslims to be the unchanged words of God revealed to the Prophet Muhammad, instructs Muslims to “feed and clothe the insane... and tell splendid words to him” (4:5). The Quran also declares that God “cares for all creatures” (2:268) and that those who follow God’s guidance “need have no fear and neither shall they grieve” (2:111). There are also numerous references in the Quran to it being a book of healing: “O mankind, there has come unto you a guidance from your Lord and a healing for the diseases in your hearts” (10:57) and “We have sent down in the Quran such things that have healing and mercy for the believers” (17:82). Meanwhile, Al-Krenawi and Graham (1999) draw on Islamic history to describe how the Prophet Muhammad treated people for mental illness and that his companions and followers learned his methods and eventually developed a unique healing tradition.

Youssef and Youssef (1996) examine the management of schizophrenia in medieval Islamic society, and Haque (2004) provides an overview of the contributions of early Islamic scholars to psychology. These include, among others, Al-Balkhi, who, in the 9th century studied anxiety, aggression, obsessions, and depression; Ibn-Sina or Avicenna, who, in the 11th century put forward physiological and psychological theories for hallucinations, insomnia, depression, and mania; and Al-Tarabi, who in the 9th century advocated the need for counselling in a manner recognizable to contemporary therapists and counsellors. Meanwhile, Moodley (2000) draws attention to research by Murphy (1986) and Said (1993) that describes how it

was Ibn Khaldun in the 14th century who first suggested a connection between culture and mental illness in an attempt to explain the experiences of Bedouin who had given up their traditional nomadic existence in favour of an sedentary urban lifestyle.

Contemporary conceptualizations of representations of illness in Islamic contexts are based on Quranic principles and the writings of early Muslim scholars but also reflect the current social, cultural, and political idioms of Islamic societies. This section uses the Self-Regulatory Model (Diefenbach & Leventhal, 1996; Leventhal et al., 1997; Leventhal et al., 2003) and in particular the dimensions of identity, causation, consequences, and cures as a framework to provide an overview of the literature on illness representation in Islamic contexts.

2.4.1. Identity

Symptoms such as chronic pain throughout the body, feelings of anxiety, sadness and hopelessness, social withdrawal, isolation, disorientation, and incoherence, plus deviant or erratic behaviour such as aggression, infidelity, and dishonesty, are traditionally presented as and ascribed to possession by evil spirits in Islamic contexts but are likely to be considered evidence of mental illness in Western societies (Al-Kenawi & Graham, 1999; El Rhermoul et al., 2018; Razak 2017). Dein, Alexander, and Napier (2008) describe how it is often the sudden appearance of the symptoms, rather than the symptoms themselves, that is attributed to possession. These spirits, known as jinn, are believed to follow Iblis, the Islamic counterpart of the Biblical Devil, who was expelled from the Garden of Eden. Jinn are said to be imperceptible to perception, composed of fire, more powerful than human beings but less than angels, and intelligent, with a sense of agency comparable to that of humans that makes them accountable for their actions (Al-Krenawi, 1999; Al-Krenawi & Graham, 1997). It is believed that they occupy dark and polluted places, graveyards,

rubbish dumps, and even toilets, and are able to move instantaneously from place to place, fly through the air, take the form of animals, and move heavy objects (Al-Krenawi, 1999; Al-Krenawi & Graham, 1997). According to Dein et al. (2008), those in impure or transitional states, in which boundaries are vague and shifting, for instance during menstruation, pregnancy, or after the birth of a child, are considered most vulnerable to possession.

In South Asia, where Islamic beliefs and practices have been influenced by Sufism (Irfan et al., 2017), distress is often labelled or described in terms of a “sinking heart” (Fenton & Sadiq, 1993; Karuse, 1989, in Moodley, 2014, p.257) or an “incongruent heart” (Inayat, 2005, p. 198). In Sufi spirituality the heart is an essential element of the human psyche and where interplay between psychological and spiritual factors is located. This notion is consistent with numerous references to diseased hearts and healing of the heart in the Quran, such as “In their hearts there is a disease” (2:10) or “In the remembrance of God do hearts find rest” (13:28), alongside observations by Al-Krenwai (2005), Bhui et al. (2008), Dein et al. (2008), Hodge (2005), Irfan et al. (2017), Razak (2017), and Razali and Khalib (2012) that distress is expressed in terms of physical pain and somatic symptoms.

2.4.2. Causation

Hodge (2005) says Muslims believe in a God who is both omnipotent and intimately involved in the affairs of humankind. As a result, Husain (1998) argues, they believe that God is directly responsible for their distress or well-being. According to Al-Krenawi and Graham (1999), “[B]oth health and illness are caused by Allah, through the natural and supernatural powers created by Him” (p. 55) and mental illness or distress is therefore the result of a distant or defective relationship with God, or it is a punishment for not adhering to what has been decreed.

Notwithstanding the emphasis on God's mercy and compassion throughout the Quran, Kirkwood (2002) points out that fear is an important factor in many individuals' relationship with God. Those who do not sufficiently fear God are likely to neglect their religious obligations and eventually face consequences, whereas those with excessive fear are likely to suffer anxiety and depression. Underlying the lack of either obedience or fear is the absence of a positive and meaningful relationship with God, which is likely to result in distress (Haque, 2001). Bhui et al. (2008) report incidents of Muslims attributing symptoms of distress to irreligious feelings such as greed, jealousy, and envy, or sinful behaviours such as not praying enough or being remiss regarding duties and obligations prescribed in the Quran or the Hadith, which are the sayings and traditions of the Prophet Muhammad.

There is considerable literature reinforcing the notion that in traditional Islamic belief systems, psychological distress is considered God's punishment for sinful behaviour or the lack of faith and piety (e.g., Abu Raiya & Pargament, 2010; Al-Krenawi & Graham, 1999; Sabry & Vohra, 2013). Empirical evidence for this notion along with its prevalence throughout Muslim cultures and communities has also been extensively documented (e.g., Al-Krenawi, 1999; Bhui et al., 2008; Hamdan, 2008; Khan, 2014; Swami et al., 2009; Weatherhead & Daiches, 2010).

Beliefs in sorcery, black magic, the evil eye, and especially possession by jinn are also common (e.g., Al-Krenawi & Graham, 1999; Dein & Sembhi, 2001; El Rhermoul et al., 2017; Razak, 2017; Weatherhead & Daiches, 2015). According to Al-Juhri (1991, cited by Al-Krenawi & Graham, 1999, p. 55) jinn "seduce mankind as punishment for their sins." Meanwhile, in Sufi traditions, distress is the result of stagnation or interruption of the process of developing qualities of mercy, compassion, and self-discipline, transcending material and physical desires and

ultimately moving closer to God. In particular, lack of control of the ego, manifested through attitudes such as arrogance and selfishness, can also result in mental unrest. Inayat (2005) draws attention to the Quranic instruction regarding the ego: “Successful is one who keeps it pure and ruined is one who corrupts it” (91:9). Inayat (2007) points out that the etymological origin of term *jihad* is from the word *jahada*, which means to strive or struggle, and traditionally referred to a struggle against an individual’s ego, particularly attitudes such as selfishness that prevent individuals from doing good and living in accordance with God’s laws and instructions. She also quotes a Hadith, attributed to the Prophet Muhammad after a return from a military victory, whereby he says, “[W]e go now from the lesser *jihad* to a greater one,” suggesting that personal striving to control one’s ego and better oneself is more important than military campaigns (Inayat, 2007, p. 291). The need to control the ego may underlie the individual’s relationship to the community in many Islamic societies in which the community provides protection and empowerment (Jafari, 1993), and values such as cohesion, harmony, interdependence, consensus, and the overall development of the community take precedence over individualism, self-actualization, and personal autonomy (Kelly et al., 1996).

2.4.3. Consequences

Studies by Al-Krenawi (2005), Ciftci et al. (2013), and Naeem, Ayub, Kingdon, and Gobbi (2012) have documented considerable stigma associated with mental illness among Muslims in the Middle East and South Asia. These studies go on to describe how real and perceived stigma can lead to interpersonal conflict, deny potential support from family and community, and exacerbate an individual’s distress, which are consistent with findings of social problems (El Rhermoual et al., 2017) and loneliness (Elias & Munirah, 2017) accompanying depression among this population.

However, Sadruddin (2007) argues that this stigma also results in delays between the onset of mental illness and contact with mental health professionals, and research by Khan and Raza (1998) describes extensive self-medication, especially the common use of benzodiazepines, and treatment being limited to those who have attempted suicide, overdosed on opiates or psychotropic medication, or are suffering severe mental illness such as schizophrenia. In addition, Khan, Islam, and Kundi (1996) report infrequent follow-up visits or premature termination accompanied by either abrupt discontinuation or extended self-administration of prescribed medication. Khan and Raza (1998) also point out that South Asia is unique in the higher incidence of married individuals seeking psychological help as compared to those who are single, possibly because merely the suggestion of mental illness could have severe consequences for a family's reputation and consequently the individual's marriage prospects.

In a study on attitudes towards mental illness, Zaman (1997) explicitly links its expression in terms of physical pain and somatic symptoms among Muslims to the considerable stigma associated with it. Moreover, in their research on possession by jinn, Pirani et al. (2008) argue that giving mental illness the label of possession helps diminish the stigma experienced by individuals because, by shifting the cause of dysfunctional behaviour to external forces, they are not held personally and morally accountable and are instead considered deserving of sympathy, care, and encouragement. Razak (2017) has reported similar findings: in Malay culture, for instance, distress is differentiated on the basis of emotional and organic causes, with the former resulting in reduced stigma.

In addition to social consequences such as stigmatization, the belief that mental illness is God's punishment for sinful behaviour can result in feelings of

fatalism (Littlewood & Dein, 2013) and interpersonal religious conflict (Koenig & Al Shohaib, 2014). There is also evidence of Islam beliefs regarding causation and social attitudes exacerbating distress, leading to undesirable outcomes such as feelings of shame, guilt, and anger, and ultimately negative coping (Abu-Raiya & Pargament, 2015; Abu-Raiya, Exline, Pargament, & Agbaria, 2015; Aflakseir & Coleman, 2009).

2.4.4. Cures

Notwithstanding the notion that illness is caused by the will of God and believers should accept their fate with patience and fortitude, Dein et al. (2008) and Rassool (2015) emphasize that this does not imply that individuals should not seek help. They refer to the belief that “there is no sickness for which Allah does not provide a cure” (Dein et al., 2008, p. 41). The process of healing is typically manifested in bringing the individual closer to God by improving the relationship with Him or “regaining connection and intimacy with Allah” (Inayat, 2005, p. 199). A crucial aspect of healing in Islamic contexts is that “cures come solely from Allah” (Rassool, 2015, p. ix) and healing can occur only through “the direct influence of Allah” (Dein et al., 2008, p. 44) or “rigorous assertion of Allah’s authority” (Dein et al., 2008, p. 49). Even when faith healers or religious figures such as pirs, sheikhs, moalj, or imams are involved in the process, they are “merely tools in God’s hands” (Al-Krenawi & Graham, 1999, p. 60) who mediate between individuals and God by advising and instructing regarding religious practices.

This process of healing through improving the relationship with God typically involves prayer and reading the Quran (Armstrong & Munro, 2018). All Muslims are expected to pray five times a day, which, according to El Azayem and Hedayat-Diba (1994) can reinforce the connection between faith in God and everyday life. Bhui et al. (2008) and Majid (2003) report that prayer helps individuals clear their minds, gain

perspective on their problems, develop a sense of hope and generally feel good. In addition, Henry (2015) describes how Islamic prayers can produce spiritual energy that may “yield many psychological benefits, such as amelioration of stress and improvement in subjective well-being, interpersonal sensitivity, and mastery” (p. 387). In a study on the effects of prayer on depression, significant improvement was reported for individuals saying special late night prayers compared to those who continued with their normal prayer routine (Majid, 2003). Since the Quran refers to itself as “guidance from your Lord and a healing for the diseases in your hearts” (10:57), individuals often read or recite or even listen to audio recordings of specific passages. According to Bhui et al. (2008), turning to the Quran in this manner has a similar effect to prayer. Prayer, and for many Muslims, handling the Quran, is preceded by a symbolic physical cleansing, which Inayat (2005) describes as providing “outer purity” to complement the “inner purity” provided by praying or reading the Quran (p. 202). Abdullah (2015) argues that such purity can lead to strength, resilience, and growth. In addition to praying and reading the Quran, Muslims attempt to please and move closer to God by distancing themselves from irreligious feelings such as discontent, greed, and jealousy, being helpful, hospitable, and respectful to other people, not making an issue of their distress, and accepting their difficulties as God’s will (Bhui et al., 2008). Hamjah and Akhir (2014) argue that such strategies for healing and coping are based on concepts of *aqidah* (faith), *ibadah* (devotion to God), and *akhlaq* (moral conduct). Empirical evidence for the prevalence of Islamic references, rituals, interventions, and ethics in healing and coping among Muslims has been provided by Zakaria and Akhir (2017), and a study by Hamjah, Akhir, Ismail, Ismail, and Arib (2017) suggests that *ibadah* (devotion to God) plays a central role in healing.

Individuals in distress often supplement their attempts to improve their relationship with God by turning to healers known as *pirs*, *sheikhs*, or *moalj bel-Quran*. *Pirs* are prevalent in South Asia and typically claim to be descended from generations of healers and may even trace their lineage to Sufi saints (Dein et al., 2008). Pirani et al. (2008) describe their treatment as being based on “ritualistic communication with the spiritual world... based on dialogue with the spirits” (p. 382). Interventions can include prayer, recitation of the Quran or the 99 names of Allah, singing, dancing, playing music, blowing over the patient, appeals to saints for assistance, making the patient drink water that has been poured over the Quran for cleansing of sins and purification, and the use of charms or amulets containing verses of the Quran for protection (Dein et al., 2008; Inayat, 2005). According to Dein et al. (2008), many of these practices “blur the boundaries between magic, herbal, and Islamic healing” (p. 42) and since saints and magic are often invoked, which implies that the healing was not the result of God’s will and the assertion of his authority, many imams and religious scholars dismiss such practices as unrelated to Islam, sinful, and even heresy (Al-Daramdash, 1991; Dein et al., 2008). In the Middle East, where stricter interpretations of Islam are prevalent, individuals turn to *sheikhs* or *moalj bel-Quran* healers, who work within the framework of Islamic healing. According to Al-Krenawi and Graham (1999), they are expected to have strong faith, exemplary characters, extensive knowledge of the Quran and to administer only those treatments that are derived directly from the Quran and the Hadith. Interventions include providing patients with a greater understanding of God’s power and guiding them to obey God’s commandments. Political developments since the 1980s have resulted in *sheikhs* or *moalj bel-Quran* asserting themselves and developing a following among South Asian Muslims (Armstrong, 2000).

If the illness or distress is attributed to possession by jinn, then *pirs*, *sheikhs*, or *moalj bel-Quran* may resort to an exorcism to drive out the evil spirits. The process is described by Al-Krenawi and Graham (1999) as comprising of ritual cleansing, addressing the jinn directly to find out why they have entered the individual's body, and reading specific verses of the Quran to agitate the jinn and persuade them to leave. Al-Krenawi and Graham (1999) point out that the exorcism of jinn relies on the individual's confidence and belief in the healer's expertise, which can instil hope and raise expectations of success. Moreover, they add that such rituals often involve family members, thereby activating a support network that is likely to be beneficial to the client.

Instead of seeking help from particular healers, many individuals throughout the Muslim world visit shrines for healing and relief from illness and distress. In South Asia these shrines are associated with Sufi saints, whereas in the Middle East they are the graves of sheikhs and the practice is known as "sheikh visiting" (Pirani, et al., 2008, p. 377). These Sufis and sheikhs are believed to have close relationships with God due to their piety and services to humanity during their lifetimes, which has given them healing powers and the abilities to mediate between God and ordinary individuals to provide relief from distress and misfortune. Devotion to these Sufis and sheikhs range from paying respect to them in the hope that they will mediate with God on their behalf to alleviate their suffering to actually praying to them to use their healing powers to cure afflicted individuals (Gadit & Khalid, 2002). According to Priani (2008), individuals living at shrines often experience the saint or sheikh as communicating with them in their dreams or presleep stages to give instructions regarding rituals, usually the distribution of food or money, that will result in a cure. Al-Daramdash (1991) argues that since the healing being sought in such contexts is

not the result of God's will and the assertion of his authority, such practices cannot be considered consistent with mainstream Islamic traditions.

Individuals visit shrines both of their own volition and due to family pressure, and may make single or repeated visits or remain at the shrine for an unlimited period of time. While at the shrine individuals believe themselves to be under the Sufi's or the sheikh's protection and less vulnerable to jinn and black magic. Pirani et al. (2008) point out that remaining at the shrine provides individuals respite from stressful and problematic situations in their daily lives that are likely to be contributing to their distress. Moreover, they tend to live together in a therapeutic community in which they are accepted; have the opportunity to share their problems and express their emotions without judgment, criticism, or other adverse consequences; and provide each other with support and empathy.

In the context of studies that have demonstrated positive associations between religion and spirituality and mental health and well-being (e.g., Koenig, 2008; Koenig, McCullough, & Larson, 2001; Ross, Kennedy & Macnab, 2015; Utz, 2013), there have been numerous attempts to incorporate Islamic beliefs and healing strategies into Western psychological approaches such as counselling and psychotherapy. Haque, Khan, Keshavarzi, and Rothman (2016) describe these attempts as ranging from the unification of Western psychological models with Islamic beliefs and practices to the development of theoretical models and frameworks within Islamic psychology.

Examples of a unification between Western psychological models and Islamic beliefs are provided by Hamdan (2008), Hussain and Hodge (2016), Habib, Dawood, Kingdon, and Naeem (2015), Irfan et al. (2017), and Naeem et al. (2015), who describe various versions of cognitive restructuring models based on conventional

Cognitive Behavioural Therapy (e.g., Beck, 1979), in which maladaptive thoughts, such as religious ones deriving from Islamic notions of sin and punishment, are challenged by concepts such as forgiveness and redemption taken from the Quran and Hadith. Similarly, Rüschoff, and Kaplick (2018) and Armstrong and Munro (2018) have proposed models of integrating Islamic concepts into psychodynamic and narrative therapy, and Henry (2015) has delineated strategies for incorporating Islamic prayers into conventional psychotherapy.

Hamjah and Akhir (2014) provide an example of the development of theoretical models and frameworks within Islamic psychology by suggesting a counselling process based on faith, worship, devotion to God, and moral conduct, and Zakaria and Akhir (2017) describe strategies for healing and coping derived primarily from faith. Others models of counselling and psychotherapy that utilize Islamic beliefs emphasize personal and social change (Zayed, 2017), strength and resilience stemming from *fitra* (purity) (Abdullah, 2015), and concepts of human behaviour, pathology, health, and spirituality within the context of the psychology of Islam (Keshavarzi & Haque, 2013).

There is considerable empirical evidence for the efficacy of such religious coping strategies in counselling and psychotherapy with Muslims (e.g., Abu-Ras, Ghieth, & Cournos, 2008; Aflakseir & Coleman, 2009; Aguilar-Vafaie & Abiari, 2007; Ai, Peterson, & Huang, 2003; Habib et al., 2015; Hussain & Cochrane, 2002; Khan & Watson, 2006; Khawaja, 2008; Naeem et al., 2015). However, a study by Richardson and Bradbury (2012) showed little improvement and other studies indicated that, while devout Muslims receiving counselling and psychotherapy that incorporated Islamic beliefs and coping strategies showed rapid improvement compared to control groups of non-religious clients who received standard treatments,

the differences were not significant after six months (Azhar &Varma 1995; Razali, Aminah, & Khan, 2002).

This chapter has provided an overview of the literature on representations of illness, their role in coping and healing, and their importance in counselling and psychotherapy. After reviewing the main models used to study illness representations, I argued that the Self-Regulatory Model is the most appropriate for the purposes of this study. Literature on the relationship between culture and representations of illness was also discussed, followed by an overview of mental illness in Islam and, using the framework of the Self-Regulatory Model, representations of mental illness in Islamic contexts. It is important to note, however, that the studies that formed the basis of the discussion did not endeavour to examine representations of mental illness directly but were concerned with theories of healing in Sufism and Islam, Islamic traditional healers, and healing practices. Moreover, the participants in the studies were based in South Asia, the Middle East, and the United Kingdom and were selected on the basis of having engaged in Islamic traditional healing, which suggests distinctly Islamic representations of illness. A search of the PsychInfo and ERIC databases yielded no studies that specifically examined representations of illness among Muslims in Canada or those who did not actively seek Islamic traditional healing for their distress. It is these gaps in the literature that this study aims to address.

Chapter 3

Research Methodology

The purpose of this study was to gain insight into the representations of distress among Canadian Muslims of South Asian origin. It sought to examine the subjective nature of these representations, the various influences that shaped them, and whether they were consistent with or contradicted the prevailing literature on Islamic healing, counselling, psychotherapy, and psychiatry with Muslims. In order to gain a detailed and thorough understanding of participants' representations of distress, this study used the Self-Regulatory Model of Illness Representation (Diefenbach & Leventhal, 1996; Leventhal et al., 1997; Leventhal et al., 2003) and aimed to explore participants' lived experiences of their distress, specifically the physical and emotional aspects of their distress, what they believed caused it, how it affected their lives, how they tried to cope with it and what they found helpful and unhelpful.

This chapter endeavors to describe the qualitative and phenomenological approach utilized for this study and to present a rationale for selecting this approach. It addresses ethical considerations for conducting research with individuals who have experienced distress, such as potential benefits and risks for participants and measures taken to mitigate the risks. It also provides an overview of the inclusion criteria and recruitment of participants along with basic demographic information about them, followed by interview processes and procedures, and data analysis. Finally, it discusses issues of trustworthiness, credibility, dependability, confirmability, transferability, researcher background and assumptions, and the limitations of this methodology.

3.1. Rationale for the Research Methodology

3.1.1. Rationale for Qualitative Methodology

Qualitative methodology was considered suitable for this study due to its roots in social constructivism, in which individuals seek to understand their experiences and assign meaning to them within a framework constructed through social, cultural, and historical contexts (Creswell, 2013; Flick, 2014). From a research perspective, this entails gaining rich, nuanced, and appropriately contextualized insights into individuals' narratives, experiences, associated meanings, and ultimately, their subjective realities (Polit & Beck, 2010).

Ratner (2002) describes qualitative methodology as means of attempting to comprehend individual and subjective psychological phenomena, while Stiles (1993) highlights its focus on participants' experiences from their own perspectives, and Sandelowski (2000) draws attention to its emphasis on staying close to the data. These are all aspects of qualitative methodology that correspond to this study's goals of seeking to understand representations of distress among Canadian Muslims of South Asian origin. Moreover, given the politically fraught nature of Muslim identity in Western and secular environments, along with the social stigma associated with mental illness in this population (e.g., Basit & Hamid, 2010; Ciftci, et al., 2013), it would not be unreasonable to consider Canadian Muslims of Indian, Pakistani, and Bangladeshi origin to be a "hard-to-reach" population (Penrod, Preston, Cain, & Starks, 2003, p. 100), with concerns of confidentiality and fear of exposure, and therefore best researched through qualitative methodology (Heckathorn 1997; Penrod et al., 2003). In a similar vein, Lee and Renzetti (1993) describe the challenges of researching sensitive topics such as psychological distress and advocate the use of qualitative methodology for this purpose. Finally, Atieno (2009) provides the most

compelling case for using qualitative methodology: a pre-emptive reduction of data can be avoided by qualitative approaches that do not attempt to “define exactly which elements are important and crucial and should be considered to the exclusion of others” and are consequently suited to “managing data without destroying complexity and context” (p. 13).

3.1.2. Rationale for Phenomenological Methodology

Phenomenological research, according to Husserl (2014, cited by van Manen, 2017), aims to explore individuals’ lived experiences and to produce a description of the essence of those experiences rather than develop an objective theory to explain them. According to van Manen (2017), Husserl aspired to “capture experience in its primordial origin or essence, without interpreting, explaining, or theorizing” (p. 814). Moustakas (1994) emphasizes descriptions of the nature of the experiences, for example, what was experienced and how it was experienced, while van Manen (1990) allows for reflection and interpretation by the researcher about the meanings of experiences for individuals but without attempting to explain or analyze the experiences themselves. Phenomenological research entails the suspension of judgments and presuppositions and, in contrast to positivist approaches, locates the reality of objects or phenomena to individuals’ consciousness of them (Stewart & Mikunas, 1990).

Phenomenological methods are appropriate for a study on the construction of subjective representations of psychological distress because such a study entails focusing on actual client perceptions and experiences rather than theoretical perspectives. Chessick (1995) points out the dangers of projecting theoretically influenced assumptions on clients and advocates the use of phenomenology to facilitate the disclosure and exploration of subjective experiences without the

imposition of preconceived ideas. Further, Mattaini and Kirk (1993) suggest that such an approach is particularly suited to studies involving religious beliefs, which often depend on depth and richness of description. Their arguments are supported by Franklin and Jordan (1995), who draw attention to the holistic, open-ended, and ideographic nature of phenomenological methodology.

Patton (2002) describes the term “phenomenology” as being used in a number of different contexts in philosophy, social science, and research methodology, but points out that in all contexts the emphasis is on understanding how individuals experience phenomena and then make sense of the experience. According to Patton (2002), this requires conducting detailed interviews to explore associated perceptions, emotions, cognitions, judgments, and how individuals describe the experience and share it with others. This process is necessarily a subjective one, and the aim of phenomenological research is to clarify and gain insight into the subjectivity of individual experience rather than eliminate or minimize subjectivity as required by positivist and postpositivist approaches towards their goal of objectivity (Giorgi, 2002).

When studying the perceptions and experiences of individuals, the advantages of phenomenological approaches over efficiency and effectiveness studies that utilize surveys and questionnaires to gather data are articulated by Gallegos (2005) in terms of “discovery” rather than “verification,” which implies an approach shaped by preconceived notions. Abandoning such structural formats in favour of clients’ own language and descriptions makes the research less likely to be constrained by theoretical biases or preconceptions as well as to yield richer, more comprehensive and accurate data regarding individual perceptions and experiences.

Further support for using a phenomenological approach is provided by Robbins (2006), who points out the smaller sample size required in comparison with quantitative studies and the greater analytical—as opposed to statistical or generalized—insights gained. More importantly, especially regarding clients' perceptions and experiences, which may be vague and ambiguous to the individuals themselves, a phenomenological approach allows for the gradual emergence of explicit themes. This notion of emergence suggests that the researcher is not a passive observer of an objective reality but an intrinsic part of the process. While a positivist perspective would suggest that this is a flaw in the methodology, Robbins (2006) argues that this provides an entry into a necessarily subjective realm.

In the same vein as Giorgi (2002) and Robbins (2006), Denzin and Lincoln (2000) argue that phenomenological research provides an alternative perspective on the issue of validity, in which validity refers to the unique descriptions of individual experiences and perceptions, and whether the resulting explanations fit the descriptions. Thus, a phenomenological approach rejects the notion of a single objective perspective in favour of multiple interpretations of individual experiences and perceptions. Moreover, Gubrium and Holstein (2000) maintain that such an approach is the only way to protect the subjectivity of individuals from being rejected in favour of a supposedly generalizable and objective reality created by a detached observer who does not reflect their lived experiences.

Writing from a feminist and multicultural perspective Goodman et al. (2005) suggest that phenomenological approaches to research allow the sharing and amplification of individual experiences. Not only does this provide a richer description of the phenomena, but it also reduces the power differential between researchers and the individuals whose perceptions and experiences are being studied.

Given the real or perceived marginalization of Muslims in Canada, the issue of power differentials is likely to be an important factor in the interview and the process of gathering data, and in the context of the arguments made by Goodman et al. (2005), a phenomenological approach should help in negotiating these power differentials.

3.1.3. Rationale for Interpretive Phenomenological Analysis

Within phenomenological research traditions there are a number of distinct approaches, for example transcendental or empirical phenomenology (Moustakas, 1994; Girogi 1995) and hermeneutic phenomenology (van Manen, 1990). Interpretive Phenomenological Analysis (IPA), which can be located within the broader hermeneutic tradition, is particularly suited to this study, because it was initially proposed as a methodology to examine issues in the psychology of illness (Smith, 1996).

IPA, which assumes connections between experiences, cognitions, and verbal accounts, has proved to be an effective methodology to study counselling, psychology, and cross-cultural issues. For example, it has been used in studies on the experience of depression (Rhodes & Smith, 2010), alcohol addiction (Shinebourne & Smith, 2009), self-harm (Wadman et al., 2017), counsellor and psychotherapist experiences in therapy (Akhtar, 2016), client experiences in therapy (Tarabi, Loulopoulou, & Henton, 2018), and client perceptions regarding the effectiveness of counselling and psychotherapy (Macleod, Crauford, & Booth, 2002). It has also been employed in studies on representations of illness (Harman & Clare, 2006), the experience of empathy in counselling and psychotherapy among clients from different cultural and linguistic backgrounds (Pugh & Vetere, 2009), the perspectives of Chinese clients on counselling and psychotherapy (Jim & Pistrang, 2007), health beliefs among Ultra-Orthodox Jews (Coleman, 2007), and the experience of

emotional distress among African Caribbean clients in the United Kingdom (Sisley, Hutton, Goodbody, & Brown, 2011).

In addition, IPA has been used extensively in conjunction with Leventhal's Self-Regulatory Model to examine representations of illness for a variety of conditions (e.g., Goodman, Morrissey, Graham, & Bossingham, 2005; Harman & Clare 2006; Snelgrove & Lioffi, 2009). Of particular relevance to this study is the use of IPA to analyse interview transcripts in studies that employed Leventhal's Self-Regulatory Model to examine illness representations and participant experiences in psychological contexts such as anger and meaning-making (Eatough & Smith, 2006), psychological change (Higginson & Mansell, 2008), narcissism (Morf & Rhodewalt, 2001) and intellectual disabilities (Dysch, Chung, & Fox, 2012).

Smith (1996) describes IPA as having roots in phenomenology and symbolic interactionism. IPA is phenomenological in that it is concerned with individuals' personal perceptions of experiences, while the influence of symbolic interactionism can be seen in the emphasis on the personal, social, and cultural meanings constructed by individuals and ascribed to those experiences (Smith, Flowers, & Osborn, 1997). Chapman and Smith (2002) argue that IPA is comparable to discourse analysis (Potter & Wetherell, 1987, cited by Chapman & Smith, 2002) because of the importance it places on the actual language employed by individuals and use of verbal accounts to elicit their perceptions of experiences and the meanings ascribed to them. Unlike discourse analysis, however, Chapman and Smith (2002) maintain that IPA is concerned with the thoughts, beliefs, and ultimately the meanings associated with individual's discourse rather than the interactive tasks embedded in it. Moreover, IPA posits a complex relationship between individuals' linguistic, affective, and cognitive

processes, and therefore these meanings are not necessarily evident in individuals' verbal accounts and need to be interpreted by the researcher (Smith & Osborn, 2009).

Thus, following the hermeneutic approach of van Manen (1990), IPA is not merely descriptive, and individuals' accounts of experiences should be critically interrogated and interpreted by researchers (Smith, 2004). Textual analysis, according to Smith (2004) and Smith and Osborn (2009), needs to be supplemented by an examination for intentional, unintentional, and unconscious processes contextualized in personal, interpersonal, social, cultural, and theoretical frameworks.

In addition, IPA recognizes that the process of engaging with and interpreting individual perceptions is dependent on researchers and influenced as well as complicated by their conceptions and interpretive frameworks. Smith and Osborn (2009) describe this as a "double hermeneutic" in which "participants are trying to make sense of their world; the researcher is trying to make sense of participants trying to make sense of their world" (p. 53). IPA can also be characterized as combining an empathic hermeneutic with a questioning hermeneutic (Smith & Eatough, 2006), resulting in a range of possible interpretations. Such multilayered inquiry, incorporating individuals' personal accounts and researchers' conceptions followed by interpretive inquiry, lead to what Smith and Osborn (2004) maintain is a richer analysis that respects and does justice to individuals in their totality.

3.1.4. Rationale for Qualitative Interviewing

Following the recommendations of Smith (2004) and Chapman and Smith (2002) for conducting IPA research, this study relied on semi-structured interviews of Canadian Muslims of Indian, Pakistani, and Bangladeshi origin for the collection of data. Qualitative interviewing was considered appropriate for this study because it aims to "describe and clarify people's experiential life as it is lived, felt, undergone,

made sense of and accomplished by human beings” (Schwandt, 2001, in Schultze & Avital, 2011, p. 1) and thus facilitates the understanding of participants’ experiences and the meanings ascribed to them from their perspectives (Kvale & Brinkmann, 2009). Further, by allowing the interviewer to delve deeply into participants’ lived experiences along with providing the flexibility to digress (DiCicco-Bloom & Crabtree, 2006) and ask probing questions for clarity (Bloomberg & Volpe, 2008), qualitative interviewing can provide the rich, nuanced, and appropriately contextualized insights into individuals’ narratives, experiences, associated meanings, and subjective realities to which qualitative research aspires (Polit & Beck, 2010). Moreover, since there is considerable literature on representations of distress among Muslims (e.g., Al-Krenawi & Graham, 1999; Dein et al., 2008; Hodge, 2005) and one of the goals of this study was to examine the extent to which participants’ representations of distress were similar to or differed from those described or assumed in those studies, a qualitative approach to interviewing was necessary, because interviews had to be conducive to new and unexpected narratives and new ways of understanding and interpreting them (Atieno, 2009; Bloomberg & Volpe, 2008).

Qualitative interviewing is essential for IPA’s goal of allowing participants to “express themselves and their ‘lived experience’ stories the way they see fit without any distortion or prosecution” (Alase, 2017, p. 9). By allowing participants’ own words, phrases, and descriptions to be recorded and analyzed, interviewing provides a more detailed and exact picture of individuals’ perceptions and experiences than the use of questionnaires and surveys (Creswell, 2007). In addition, according to Wandschneider (2007), interviewing participants allows for their facial expressions, body language, and other non-verbal behaviour to also be documented. Finally, Hodge (2001) points out that due to discrepancies in education levels among

participants, the often difficult language and sophisticated vocabulary of questionnaires can result in incorrect responses, which can be clarified and corrected in a conversational format.

3.2. Ethical Issues

While there is extensive literature on the protection of participants in psychological research (e.g., Berg, 2004; Sales & Folkman, 2000), ethical considerations were especially important for this study given its focus on participants' experiences of distress. Since the interviews aimed to explore personal and sensitive matters such as participants' physical and emotional experiences of distress, their beliefs regarding what caused it, its impact on their lives, and the strategies they employed to cope with it, potential risks to participants were identified and safeguards were put in place for their protection in line with guidelines set out in the Canadian Code of Ethics for Psychologists (CPA, 2000). Approval was also secured from the University of Toronto Research Ethics Board prior to beginning this study.

3.2.1. Risks and Safeguards

Based on the overarching guidelines set out in the Canadian Code of Ethics for Psychologists (CPA, 2000) and ethical issues specific to studies of this nature as discussed by Berg (2004) and Sales and Folkman (2000), areas for concern regarding the protection of the participants of this study were identified and addressed. These included the following: causing distress to participants during interviews, ensuring confidentiality and anonymity in the collection and storage of data, and eliminating the possibility of their feeling coerced or obligated by securing informed consent, which included repeated emphasis on the voluntary nature of the study and

participants' right to withdraw at any stage. These concerns and the measures taken to mitigate them are discussed in detail in this section.

3.2.1.1. Regulation of distress

Given that talking about previous experiences of distress risked triggering additional distress in the participants of this study, care was taken to be empathic during the interview process and to ensure that the participants did not feel pressured into revealing details that they were not comfortable discussing. Probing questions were posed gently, and at all times participants were free to choose which aspects of their experiences they wished to share. During the informed consent process and throughout the interview, participants were encouraged to take as many breaks as they required and made aware of their right to refuse to answer questions or engage in discussions on topics without providing a reason.

Since the sample for this study was not considered to be a vulnerable population or to face any significant risk as a result of taking part in this study, the presence of a registered psychologist was not required during the interviews. Participants who experienced distress were provided empathy, support, and if necessary, taken through a process of grounding (Najavits, 2002) and abdominal breathing (Bay, 2000). Basic information on counselling and psychotherapy, crisis services, online and community resources, referrals, and written materials such as self-help books were made available to participants who expressed the need or desire for such help.

3.2.1.2. Confidentiality and anonymity

All information provided by the participants of this study was considered confidential and all possible efforts were made to protect their confidentiality and

anonymity unless they explicitly stated a desire to be identified and receive credit for their contributions. Participants were not identified by name in this thesis and will not be in any other publication resulting from this study. Participants were informed that interviews will be audio taped and transcribed. Interviews were conducted in English to rule out the need for a translator. During the course of the study, audio tapes and transcripts were stored under double lock-and-key in the research office of the Centre for Diversity in Counselling and Psychotherapy at the Ontario Institute for Studies in Education at the University of Toronto. I, as the sole researcher and transcriber, was the only person who had access to the recordings and transcripts, which were retained for a period of three years. After three years, paper documents were shredded and CDs were broken. Participants were not required to share their names with the researcher and no information that may be used to identify them was included in the transcripts, which used arbitrarily assigned pseudonyms. Participants were also given the opportunity to review transcripts of their interviews to ensure that they contained no information that might reveal their identity.

3.2.1.3. Informed consent

Informed consent as required by the Canadian Code of Ethics for Psychologists (CPA, 2000) and the University of Toronto Research Ethics Board was sought from each participant: they were informed of the purpose of the study and its voluntary nature, potential risks and benefits, the limits of confidentiality. In addition, their rights as participants were explained, including their right to refuse to answer questions or engage in discussion on topic without providing a reason, to request clarifications, to take a break during the interview, and especially their right to withdraw from the study at any time. In particular, the voluntary nature of the study and the right to withdraw at any stage were emphasized at each stage of the

recruitment process and before the actual interview. A voluntary-participation form was initialled by each participant after they had demonstrated sufficient understanding to provide consent and all concerns had been addressed (see Appendix C). This form was stored under double lock-and-key on the premises of the Ontario Institute for Studies in Education at the University of Toronto, with all other materials pertaining to this study.

3.2.2. Possible Benefits

Discussing their experiences of distress during interviews enabled participants to reflect on their emotions and to organize, explicate, make sense of, and often assign meaning to them. While not all participants went through such a process, and the nature and intensity of the process among those who did go through it varied considerably (for instance, many experienced the interview as the beginning of a process that they may or may not have continued), it mirrored the principles of emotional awareness and transformation that underlie Emotion-Focused Therapy (e.g., Greenberg, 2004). Similarly, describing their experiences of distress, and in particular their means of coping with it, can be seen in terms of participants developing narratives that highlighted their resilience and reframed their experiences in a meaningful way that is reminiscent of narrative therapy (e.g., White, White, Wijaya, & Epston, 1990).

Ultimately, while the interview was not meant to be a therapeutic experience, by giving participants an opportunity to explore their distress in an accepting and non-judgmental environment, it provided some of them with a sense of the potential benefits of therapy and may have motivated them to seek professional counselling or psychotherapy. It was, however, not within the scope of this study to follow-up whether they actually engaged in counselling or psychotherapy, and if they did,

whether they found it beneficial and persisted with it.

3.3. Study Design

This study employed IPA methodology (Chapman & Smith, 2002; Smith, 2004), which required detailed analysis of interview transcripts towards a goal of examining perceptions of experiences and ascribing meanings among a specific group of individuals rather than making generalized claims for larger populations.

Purposeful, instead of random or representative, sampling was therefore employed to recruit a well-defined and homogeneous sample of participants for whom the issues being examined were of significant relevance or importance.

Data were collected through semi-structured interviews conducted by me in the fall of 2011 and winter of 2012. These interviews were audiotaped and then transcribed verbatim by me. While researchers typically begin with some basic predetermined questions and areas of inquiry, this format was flexible and allowed me the freedom to diverge from it as participants engaged in a dialogue. Subsequent questions were adapted by me during the course of the interview to probe areas of particular interest and importance and to allow unanticipated themes to emerge and be examined.

Repeated readings of each transcript, accompanied by annotations regarding key phrases, concepts or processes, constituted the first stage of the analysis. In the next stage, these notes were condensed into themes and connections were established with other themes in the same transcript in an attempt at a coherent and thematic organization of each individual case. Only after saturation or closure was reached for each case was each one compared with other cases for connections, commonalities, and shared themes, resulting in a superordinate set of themes for this group of participants. At the same time, attention was paid to variations and divergence among

cases to get a sense of the complexity of the issues being examined. To ensure fidelity to participants' verbal accounts, these superordinate themes were linked with initial annotations and extracts from the interview transcripts. Finally, the superordinate themes were integrated into a narrative that attempted to depict the essence of the perceptions, experiences, and meanings for the particular group of participants. This entire process, starting with the selection and recruitment of participants and concluding with the data analysis, is described in detail in this section.

3.3.1. Participants

3.3.1.1. Selection of participants

IPA requires a well-defined and homogeneous sample of participants, and Bhui et al. (2008) draw attention to how representations of psychological distress and religious coping strategies vary by culture and ethnic origin among Muslim populations. Therefore, men and women between the ages of 18 and 65, from Pakistani, Indian, or Bangladeshi families of origin residing in the Greater Toronto Area who self-identified as being Muslim were recruited. In addition to the above demographic requirements, participants must have had experiences of emotional or psychological distress, such as feelings of anxiety, agitation, hopelessness, worthlessness, or excessive guilt; symptoms such as pain, fatigue, or digestive problems unrelated to a physical illness; a lack of interest or pleasure in most activities; diminished ability to concentrate; difficulty making decisions; or changes in appetite, sleep or other patterns of behaviour that had significant impact on their daily lives. Participants may have sought counselling, psychotherapy, or psychiatry. Participants who sought alternative or traditional healing, or specifically Islamic traditional healing, were also considered eligible for this study, as were those who

sought no treatment at all. Since psychological distress in geriatric populations and coping with the process of aging is a separate area of research (Aréan & Reynolds, 2005), men and women above the age of 65 were excluded.

Once potential participants self-identified as being Muslim, factors such as worldviews, intensity of belief, fulfilment of religious obligations, centrality of faith to everyday life and membership of religious organizations were not considered. To prevent the possibilities of affecting or influencing the healing process, only those who had concluded treatment or described themselves as having overcome their distress and healed were considered eligible to participate. In addition, to ensure accurate recollections of their representations of distress prior to seeking help and of the healing process itself, participants must have concluded their experience of distress and subsequent treatment or healing process within the last two years. Notwithstanding the apparently broad and flexible criteria for inclusion, self-identifying as Muslim and having experienced distressing feelings, physical symptoms, or changes in patterns of behaviour are consistent with purposeful recruitment and theory-based sampling (Patton, 2002), because participants were selected on the basis of their potential representation of theoretical notions, in this case representations of psychological distress within Islamic frameworks. Moreover, the selection criteria were sufficient to result in a well-defined and homogeneous sample of participants as required by IPA (Chapman & Smith, 2002; Smith, 2004).

3.3.1.2. Recruitment of participants

Participants were recruited through advertisements posted on bulletin boards and fliers and handouts available in public areas of mosques, universities, and community centres (see Appendix A). The requirement that participants have

concluded treatment ruled out the risk of healers influencing or pressuring individuals about the study, or of individuals perceiving such influence or pressure.

Potential participants who contacted the researcher were provided additional information regarding inclusion criteria and details of participation (see Appendix B). They were asked to review the information and contact the researcher within two to three days to ask questions, discuss concerns, and request clarifications. Once they had indicated a willingness to participate, a brief interview was conducted to ensure that they meet inclusion criteria. Selected participants were offered an opportunity to meet with the researcher in person to discuss the study before interviews were scheduled.

To avoid concerns regarding accuracy of translation and the need for a translator, participants required a working knowledge of English. Given that the Indians, Pakistanis, and Bangladeshis are well established in Toronto, it was reasonable to expect a working knowledge of English among members of these communities. Moreover, excluding individuals who are unable to communicate effectively did not compromise the sample or represent a limitation of the study, because they were not likely to be representative of Canadian Muslims of South Asian origin. Although there was no remuneration for taking part in this study, transportation costs were reimbursed.

3.3.1.3. Description of sample

The participants were 9 men and 6 women who self-identified as Muslim and as coming from an Indian, Pakistani, or Bangladeshi culture of origin. They ranged between 25 and 66 years of age. All of them were residents of the Greater Toronto Area. (See Appendix E for an overview of participants' demographic information and Appenndix F for biographies).

3.3.2. Instrument

Following the recommendations of Smith (2004) and Smith et al. (1999) for conducting IPA research, this study relied on semi-structured interviews for the collection of data. As described by Creswell (2007), because it allowed participants' own words, phrases, and descriptions to be recorded and analyzed, interviewing provided a more detailed picture of individuals' perceptions and experiences than the use of questionnaires and surveys. In addition, according to Wandschneider (2007), interviewing participants allowed for their facial expressions, body language, and other non-verbal behaviour to also be documented. Moreover, Hodge (2001) points out that due to discrepancies in education levels among participants, the often difficult language and sophisticated vocabulary of questionnaires can result in incorrect responses, which can be clarified and corrected in a conversational format.

As required by IPA, a semi-structured rather than open-ended interview format ensured that the conversation remained focused on the participants' perceptions and experiences. An interview schedule (see Appendix D) based on guidelines developed by Smith (1995) and ensuing IPA studies on representations of illness (Harman & Clare, 2006) and clients' perceptions of counselling and psychology (Macleod, Crauford, & Booth, 2002; Schoenberg & Shiloh, 2002) was used as a loose guide, and topics were covered differently and in a different order for each participant. Moreover, interviews occasionally diverged, with some questions being modified from the schedule and new ones being introduced to probe areas of particular significance. This allowed unanticipated themes to emerge and be examined.

During the course of the interview, participants were engaged in a dialogue to explore in as much detail as possible the personal meanings ascribed to their

perceptions and experiences. Areas explored included symptoms of the participants' experiences of distress, what they believed caused it, how long it lasted and how it affected their lives, aspects of the healing process that they found helpful and unhelpful, and how it may have changed the way they now comprehend their experience.

The interviews began with participants being invited to describe what their experience of distressing feelings, physical symptoms, or changes in patterns of behaviour were like. Subsequent questions and their order were determined by the participants' narratives. Questions were posed in an open-ended and conversational manner and participants were encouraged to communicate naturally and directly. During the course of the interviews, clarifications were requested by both the researcher and participant, and responses were summarized frequently to ensure that the researcher's understanding of them was correct. The interviews took between 90 and 120 minutes to complete.

3.3.3. Procedure

Once potential participants agreed to take part in this study, a mutually convenient time for an interview was scheduled. All interviews were conducted in a research office at the Ontario Institute for Studies in Education at the University of Toronto.

Prior to starting interviews, the main objectives of the study and measures to protect participants' anonymity and confidentiality were outlined, participants were given an opportunity to ask questions, and informed consent, as described earlier in this chapter, was secured (see Appendices B and C). Participants were also asked to provide basic personal and demographic information such as age, place of residence, culture of origin, and the number of years that had passed since their experience of

distress. Whenever possible, an effort was made to segue as seamlessly as possible from the collection of personal and demographic information to the semi-structured interview (see Appendix D).

After the conclusion of each interview, participants were given time to compose themselves if necessary. They were also asked if they were feeling distressed and wished to be taken through a grounding exercise; wanted information on crisis services, online, and community resources; or needed counselling and psychotherapy. None of the participants reported feeling sufficiently distressed to require either grounding or information on resources for coping with their distress. Finally, permission was sought to get in touch with participants to request clarifications during transcription and also for them to review the data analysis for accuracy, provide feedback, make corrections, or elaborate on themes they felt had not been adequately explored. Contact information and their preferred means of contact, either email or telephone, were also confirmed. All of the participants agreed to be contacted.

3.3.4. Data Analysis

Data collected from the interviews were analysed according to the guidelines for IPA as described by Smith et al. (1999). It entailed four distinct steps: reflection, transcription, coding, and finding connections. These are described separately in this section.

3.3.4.1. Reflection

I wrote a brief reflection at the conclusion of each interview. This reflection included the following points: the ease or difficulty with which participants were able to engage in a dialogue, topics that they found particularly challenging, aspects of the

interview that might not be evident when reading the transcripts at a later stage (e.g., facial expressions, body language, and non-verbal behaviours), and overall impressions, tentative interpretations, and emergent themes.

Writing these reflections or notes right after interviews enabled first impressions and other salient points to be recorded for future reference. They thereby enabled the analysis to stay close to the data in its entirety and not include only participants' words. This in turn provided a more detailed and nuanced description of participants' experiences as required by IPA without being influenced by prior interviews or influencing subsequent ones. This process of writing reflections is comparable to reflective journaling to ensure quality and validity in interpretative phenomenological analysis described by Vicary, Young, and Hicks (2017).

3.3.4.2. Transcription

Interviews were transcribed verbatim as soon as possible after each one was concluded. Transcribing interviews took between 12 and 20 hours per interview. To avoid previous interviews or the transcription process influencing future interviews, attempts were made not to schedule or conduct additional interviews until the transcription of the last one was complete. Ideas and themes that emerged during the transcription process were added to the reflections or notes mentioned above.

3.3.4.3. Coding

Individual interview transcripts were read repeatedly and notes regarding key phrases, concepts, or processes made on the physical transcripts. These notes focused on segments that both appeared to pertain directly to the research questions and those that did not but nevertheless seemed important to participants. The latter allowed for the emergence of new and unanticipated themes that might not have been considered

previously. Next, using Microsoft Excel (Microsoft Office, Version 14.0, 2011), these notes were condensed into themes that attempted to encapsulate the essence of each participant's perceptions and experiences of distress. Themes were coded using participants' actual words to stay as close to the data as possible and to minimize interpretation. Once no additional themes could be found and saturation was reached, connections were established with other themes in the same transcript. Domains such as "background of distress," "experience of distress," "coping and healing" and "reflections on experience" were used towards a coherent and thematic organization of the data. After a suitable interval, this process was repeated and the entire transcript was read and coded again to ensure that no themes had been overlooked or incorrectly coded. At this stage, participants who had consented during the recruitment and informed consent process to review the analysis for accuracy were sent copies and requested to provide feedback, make corrections or elaborate on themes they feel had not been adequately explored. Most of the participants reported being satisfied with the analysis, but only two supplemented the information provided during the interviews and one corrected an error.

3.3.4.4. Connections

After the initial coding for all individual transcripts was complete, they were compared with each other for connections, commonalities, and shared themes. As described by Smith et al. (1999), certain themes clustered together and others appeared to contradict them or suggest superordinate categories. In order to move towards the goals of this study, these themes were then compared continuously with interview transcripts to confirm fidelity to the primary data while developing a comprehensive and nuanced description of participants' representations of distress.

This process of comparison entailed the following steps: relating coded segments from the interviews to emergent themes while simultaneously relating these themes to interview data, compiling conceptually similar codes and themes into inclusive categories or superordinate themes, delineating these superordinate themes in terms of specific attributes and distinct characteristics, and scrutinizing contradictory data. The result was the creation of a superordinate set of themes common to all cases, along with underlying subordinate themes for variations and divergence within themes to get a sense of the complexity of the issues being examined. These superordinate and subordinate themes were linked with extracts from the interview transcripts and notes to ensure they remained as close as possible to participants' verbal accounts. Finally, while ensuring consistency with the data, the superordinate and subordinate themes were integrated into a narrative that depicts the essence of the representations, perceptions, experiences, and meanings of distress for this group of participants.

3.4. Methodological Limitations

The methodology selected for this study is subject to a number of limitations. While many of these limitations are shared by IPA and qualitative research in general, others are unique to this study and only became apparent after the data collection and analysis were completed. This section discusses the limitations that stem from its qualitative and phenomenological nature and the steps taken to address them. Limitations that were unique to this study are covered in the Conclusion chapter.

3.4.1. Researcher Background

I, the researcher, am a male doctoral student enrolled at the Ontario Institute of Studies in Education at the University of Toronto who possesses a graduate degree in

counselling psychology. When I started this study I was 38 years old and had four years' experience as a counsellor and psychotherapist using Western psychotherapy methods but no experience in Islamic traditional healing. I come from a Pakistani and Muslim culture of origin but do not hold strong religious or spiritual beliefs and do not observe traditional Muslim practices.

While this background can provide significant insights into the social, cultural, and religious contexts of the participants of this study, it can also result in considerable biases in design of this study and the interpretation of its findings. IPA (Smith, 2004; Smith et al., 1999) acknowledges the influence of researchers' conceptions and interpretive frameworks in eliciting and interpreting participants' perceptions of experiences and the meanings ascribed to them. These conceptions are likely to play a role in what researchers attend to, find significant, and prioritize during the analysis, and to what extent certain concepts or processes are critically interrogated. Smith et al. (1999) therefore suggest a continuous and ongoing process of critical self-reflection in terms of researcher background, interview questions, impressions, and interpretations. Although not explicitly required in IPA, an awareness of these conceptions and interpretive frameworks can be compared to bracketing" preconceived notions as described by Giorgi (1985, cited by Golsworthy & Coyle, 2001). While I attempted to engage in the requisite self-reflection and bracketing, I also relied on participants' reviews and feedback of the data analysis to highlight and mitigate possible distortions due to researcher bias.

3.4.2. Interviewing

While the advantages of interviewing, including the ability to document participants' own words and phrases along with their non-verbal behaviour, and to accommodate linguistic abilities and discrepancies in education levels, have been

discussed previously in this section, it is important to acknowledge the limitations it imposes. Specifically, Bloomberg and Volpe (2008) and Charmaz (2006) point out that there are considerable differences in how individuals respond to interviews, and that these differences are exacerbated by the context of the interview and respective personalities and backgrounds of both the interview and the participants.

For this particular study, these limitations are likely to be manifested in participants' discomfort in being interviewed along with nervousness or reluctance to talk about what is essentially a very personal experience. In this context, Hussain and Cochrane (2003) have described a tendency among Muslims to not make an issue of their distress. A lack of verbal orientation or inability to articulate their lived experiences could also pose similar problems.

Moreover, participants may respond to their shared heritage with me, the researcher, by being circumspect in the information they choose to divulge or by providing responses that they believe I am seeking. Following the suggestions of Charmaz (2006), Smith et al. (1999), and Stiles (1993), these challenges were addressed by engaging with participants in a conversational rather than formal or pedantic manner, being open and honest, attempting to establish participants' trust and build a rapport, using a semi-structured format with probing questions, and including their possible reactions to my personality and background. The context of each interview was also taken into consideration in the process of critical self-reflection or bracketing described in the previous section.

3.4.3. Sample

Participants were selected based on the following: self-identifying as Muslim and of Indian, Pakistani, and Bangladeshi origin, having experienced psychological distress within the last two years, and describing themselves as having healed or

overcome their distress. This selection criteria is consistent with IPA methodology, which requires a well-defined and homogeneous sample. It could, however, be argued that this sample was not sufficiently homogenous because it ignored the differences between the many branches and schools of Islam. For example, Armstrong (2000) and Esposito (2004) describe traditional Sunni and Shia branches of Islam, multiple Sufi orders, numerous schools of theology, later movements such as the Nation of Islam, and the Ahmediyya and the Gülen. Further, Bhui et al. (2008) point out that even among Muslim populations, experiences of distress and religious coping strategies vary by culture and ethnicity and could thus differ not just among Indians, Pakistanis, and Bangladeshis, but also among the many ethnic groups within these countries, such as Indian Muslims in Assam, Bihar, Gujarat, Kashmir, Jharkhand, Karnataka, Kerala, Maharashtra, Rajasthan, Uttar Pradesh, and West Bengal (Varshney, 2003); Pakistani Muslims in Balochistan, Khyber Pakhtunkhwa, Punjab, Sindh, Azad Kashmir, and Gilgit-Baltistan (Talbot, 2012); and Bangladeshi Muslims in Barishal, Chittagong, Dhaka, Khulna, Mymensingh, Rajshahi, Rangpur, and Sylhet (Shelly & Rahman, 2007).

According to Schimmel (1980) and Singh (2016), the overwhelming majority of Muslims in India, Pakistan, and Bangladesh follow the Sunni branch of Islam, and in particular the Hanfi school of theology. Followers of Shia Islam constitute a small minority, members of the Ahmediyya and Sufi orders are negligible as a percentage of the Muslim population in South Asia, and the Nation of Islam and the Gülen are nonexistent in the region. Moreover, there is considerable literature to suggest that the differences between these various schools of Islam pertain primarily to issues of jurisprudence, such as inheritance, evidence, and punishment regarding criminal conduct, commerce, and trade (e.g., Hodaee, 2013; Kayadibi, 2017; Sadr, 2003).

Significantly, the basic principles of Islam, such as faith in God, prayer, fasting, and charity, which are derived directly from the Quran with minimal interpretation, are shared by all branches and schools (Armstrong, 2000; Esposito, 2004), resulting in comparable belief systems, religious practices, and worldviews. Similarly, a review of accounts of Islam in India, Pakistan, and Bangladesh (e.g., Bigelow, 2010; Hasan, 2002; Robinson, 1998; Schimmel, 1980; Singh, 2016) suggest sufficient commonalities to consider selecting participants on the basis of self-identifying as Muslim and of Indian, Pakistani, and Bangladeshi origin as an adequately well-defined and homogeneous sample as required by IPA. Meanwhile, it is likely that restricting the sample to specific ethnic groups or schools of Islam would have had minimal impact on the findings but made recruitment considerably more difficult.

3.4.4. Generalizability of Results

The issue of generalizability of the results could also be considered a limitation of this study. However, the choice of qualitative and phenomenological methodology meant that generalizability beyond the immediate sample was not a goal of the study, which instead endeavoured to provide rich and detailed descriptions of participants' representations of distress. These descriptions can be contextualized within existing scholarship, connected to personal and professional experiences, and have broader implications by informing the practice of counselling and psychotherapy and by providing recommendations for future research, which are discussed in the conclusion.

This chapter endeavoured to describe the qualitative phenomenological methodology, i.e., IPA, utilized for this study and to provide a rationale for its selection. It also discussed ethical issues such as informed consent, possible risks and benefits of participation, and the protection of participants' anonymity and

confidentially. The design of this study, which included the selection and recruitment of participants, the use of a semi-structured interview, and data analysis were outlined, and possible methodological limitations discussed. These aspects of the study are relevant to its findings and will be acknowledged throughout the next chapter, which examines the results.

Chapter 4

Results

This study aimed to examine representations of psychological distress among Canadian Muslims of Indian, Pakistani, and Bangladeshi origin. Qualitative, semi-structured interviews were conducted with 15 participants and transcripts were analysed using Interpretive Phenomenological Analysis (IPA). The emergent themes of this analysis are presented in this chapter.

In an attempt to capture the content of the interviews, the complexity of participants' experiences, and their understanding of those experiences, the results of this study have been organized into domains of context, experience, and coping with psychological distress, which are further divided into superordinate themes and subthemes (see Figure 1). As required by IPA, the analysis emphasizes the exact words, phrases, and descriptions used by the participants to provide insight into the cognitive, emotional, and meaning-making processes that were implicit in the participants' progression of becoming distressed, experiencing and engaging with their distress, and ultimately coping with, adapting to, and managing their distress. Each domain is presented in a separate section in this chapter, along with the superordinate themes and subthemes that constitute it.

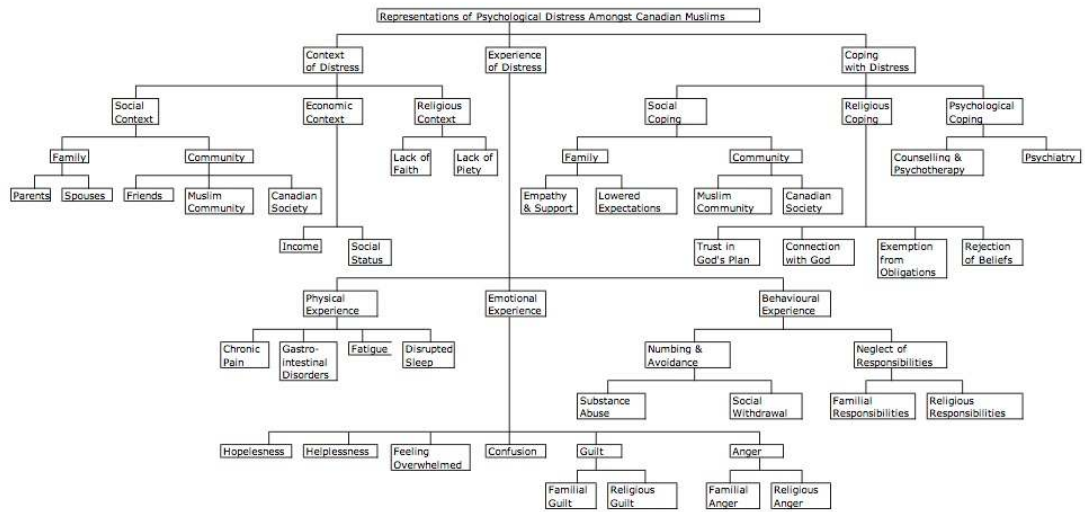


Figure 1. Organization of Results

4.1. Context of Distress

During their interviews, all participants in this study addressed what happened in their lives before they became distressed. While some described their circumstances prior to their experience of distress in considerable detail, other participants merely alluded to them without ascribing any particular significance to them. There was also variation in the degree to which participants considered that their circumstances at the time had contributed to their distress, ranging from believing them to be incidental or unrelated, to considering them directly responsible for their subsequent experiences. In a number of instances, probing questions regarding the cause of their distress resulted in participants making connections and ascribing causality that they had previously not considered, or at least not articulated.

This section aims to capture participants' reflections on the circumstances preceding and possibly contributing to or even directly causing their experience of psychological distress that followed. It therefore endeavours to provide a context and background for the subsequent sections that focus on participants' lived experiences of distress and coping with distress. The domain of context of distress is organized into themes of social, economic, and religious contexts (see Figure 2).

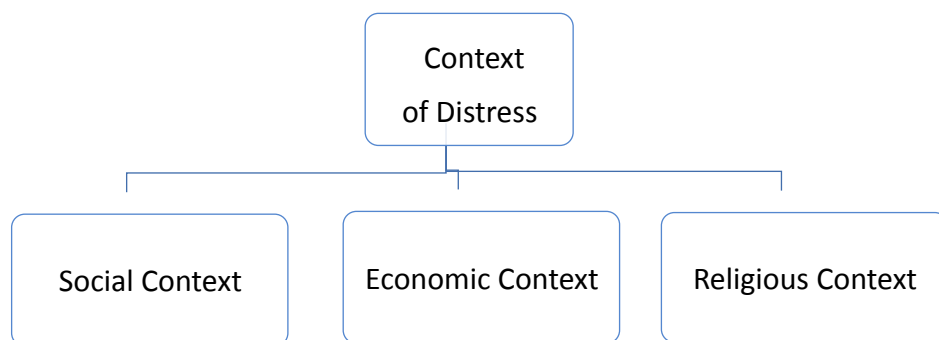


Figure 2. Context of Distress

The social context includes subthemes for participants' relationships with family members, especially parents and spouses, and their perceived place in and interaction with the broader community in which they lived. Participants' experiences as individuals within their immediate circle of friends and acquaintances, as members of a diasporic Muslim community, and as Muslims living in post-9/11 Canada are described separately.

The economic context of participants' distress examines participants' struggles to secure and sustain employment or establish themselves in careers in Canada and the ensuing financial insecurity and psychological toll of these struggles. Among those participants who were financially secure, notions of wealth, status, and family expectations are discussed, in particular the pressure to sustain lifestyles and standards of living comparable to friends and acquaintances in Canada, those that they had previously enjoyed in their countries of origin, or those that were currently being enjoyed by their extended families or contemporaries in their countries of origin.

The religious context of participants' psychological distress is explored through the subthemes Lack of Faith and Lack of Piety. The former focuses on concerns and conflicts regarding participants' belief in, and relationship with, God, whereas the latter examines the extent to which they were able to fulfill religious obligations (e.g., prayer, fasting, modest dress, abstinence from alcohol and extramarital sex) and the consequences of perceived lapses or noncompliance with Islamic beliefs and values.

4.1.1. Social Context

Reflecting on the period before they became distressed, most participants recalled strained or conflictual family relationships, especially with parents and spouses. In particular, participants described parents who made them feel "that I

didn't matter... that I was nothing," made their lives "miserable," or considered them "a servant who doesn't get a salary." In a similar vein, participants described spouses who treated them with "indifference" and "contempt" and "hated" them and would have been "perfectly happy if [they] left... or even better, died." Equally salient in participants' accounts was anxiety and uncertainty regarding their cultural identities as Muslims, members of a visible minority, and as Canadians, which they described in terms of feeling "confused" and "insecure" and "belonging ... [but] sometimes not sure about really belonging."

In order to describe the complexity of the social context of participants' psychological distress, this theme is explored through the emergent subthemes Family and Community. Parental and spousal relationships are discussed separately in the subtheme Family, while the subtheme Community is organized into participants' relationships and interactions with personal friends and acquaintances, the local Muslim community, and Canadian society in general (see Figure 3).

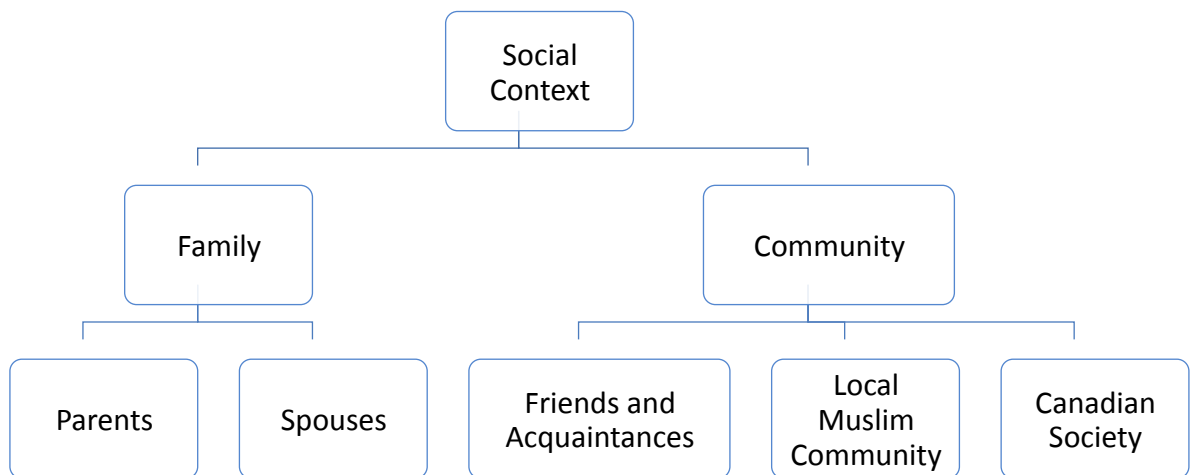


Figure 3. Social Context

4.1.1.1. Family: “stress, pressure, burden...no support at all”

Many of the participants in this study were part of large, extended families in which multiple generations resided in the same house or apartment and shared the same living space, household responsibilities, and financial burdens, which resulted in a lack of privacy and independence that one participant described as “never being on my own” and “treated like a child... despite being over forty years old.” After adult children moved out and established their own homes and families, parents, siblings, children, grandchildren, cousins, and in-laws typically remained intimately involved in their lives. Although participants recalled feeling “constantly harassed” and that there was always “someone to tell us how we *should* be living... what we *should* be doing...,” it was their relationships with their parents and spouses that they considered especially relevant and emphasized in the context of the psychological distress that was the subject of this study.

4.1.1.1.1. Parents: “They made me miserable, absolutely miserable”

There was considerable variation in participants’ descriptions of their relationships with their parents and how these relationships influenced or contributed to their experience of psychological distress. While some participants invoked childhood experiences and described how their parents had “damaged” them and “ruined” their lives, others focused on relationships with aging parents during adulthood and described how either feeling like a “burden” on their parents or the “unfair burden” of taking care of their parents that had been placed on them resulted in considerable distress.

Zehra (pseudonym) provides an example of how participants’ childhood experiences resulted in depression experienced as an adult:

For as long as I can remember my father was more interested in my brothers than he was in me... he was really proud of them, he talked about them all the time. He never talked about me to anyone. He never talked *to* me... I didn't realize it at the time, but he really made me feel inferior. I've felt inferior since I was a little girl...

Zehra refers explicitly to her father's gender bias and the impact it had on her without making any allowance for a cultural context in which sons are typically valued more than daughters. Zehra was unique among the participants of this study in explicitly linking her childhood experiences of being ignored and devalued to her subsequent distress and holding her father responsible without making any excuses for him or attempting to justify his actions.

Yasin (pseudonym) recalled being caught up in the ongoing tension and conflict between his parents. He described "yelling and screaming and fights all the time," how his parents would "do all kinds of things to hurt each other" and then how he was "the one who had to sort things out between them," which took a considerable toll on him.

I was always worried about their next fight and scared that either my father would leave my mother or she would throw him out... I remember worrying that they would get divorced... what I was really worried about was that their lives would fall apart... and that I wouldn't be able to do anything about it... It was an unfair burden to place on me. At the time I don't think I realized how much I resented it... I was just so overwhelmed...

Thus despite struggling to cope with the responsibility and accompanying anxiety of keeping his parents' marriage intact while resenting them for the burden

they had placed on him, Yasin continued to play the role of mediator, even though it caused him considerable distress.

Hashmi's (pseudonym) relationship with his father was characterized by disparagement and humiliation: "My father was always irritable when I was around. He was irritated at me... He didn't hide how much trouble I caused him... and how much he resented me... he made me feel like a burden... completely useless..."

While Hashmi acknowledged the distress his father's attitude caused him, he blamed himself for being a "disappointment" and a "failure" because he could not sustain employment and therefore remained financially dependent on his parents. According to Hashmi, his father used these reasons to justify his hostility towards his son. Hashmi was similarly articulate about the verbal and physical abuse his father inflicted on him.

... he was always ready to shout at me, to hit me. I remember trying to study for tests when I was in school—maths, physics, subjects he forced me to take even though I was no good at them—and not understanding anything and then crying because I knew I would fail and then he would be furious and beat me... I was so scared of him... I was always scared... But I was disobedient... [and] disruptive, that's why he beat me...

Despite vivid memories of his father's beatings along with living in constant fear of them, Hashmi defended his father's actions by recalling that he had required such excessive discipline.

Similarly, Rubina recalled a childhood in which her father had been abusive and violent towards his wife and children: "He once attacked me with a screwdriver... and my mother with a kitchen knife," she said. But in his fifties, unemployed and with his health failing, he was dependent on Rubina not just for money but also to look

after him. Unlike Hashmi, however, Rubina was able to express her anger and hatred towards her father.

Sometimes I get so angry that I fantasize about him having a stroke and being paralyzed and helpless... I wish he would die... But nothing ever changes and I have to keep looking after him... I wish I would die.

Although Rubina was aware of the injustice of her situation—“Parents are supposed to take care of their children. What has my father ever done for me except make me miserable?”—she was also resigned to it and continued to do everything she could to take care of him, regardless of how distressing the effort was for her.

Participants’ childhood experiences of neglect, criticism, and abuse by their parents set the stage for their experience of psychological distress in adulthood. Moreover, relationships between adult children and ageing parents were characterized by a sense of responsibility and resentment, which further complicated and contributed to their distress.

4.1.1.1.2. Spouses: “Conflict took over my life”

For most of the married participants in this study, relationships with spouses were central to their well-being and conflict between husbands and wives was a source of considerable distress. Marital discord elicited a range of emotions among participants, ranging from feeling “lonely” and “isolated” to “as if I had been locked in a cupboard for years.” Others described how strained relationships and marital conflict felt “not very different from betrayal” and were “almost as bad as being unfaithful.”

Aalia (pseudonym), for example, recalled reacting with shock and disbelief at being forced to confront the truth about her marriage of fifteen years.

I thought I was in a happy marriage with a great husband who loved me, even if he was grumpy and critical most of the time. And then all of a sudden I realized that he didn't love me. It was hard to believe. I could tell he resented me. Perhaps he hated me? I was completely lost. I felt alone. I didn't know who I was anymore.

Aalia's reaction thus conveyed a range of emotions that included loneliness, confusion, self-doubt, and the loss of her sense of self once she realized that she was not in a happy marriage.

Unlike Aalia, Chandni (pseudonym) was clear about the impact of her husband's mistreatment of her and her reaction to it: "I felt worthless... worse than worthless. I was so angry with my husband... I wanted to hurt him for making me feel that way. I wanted him to suffer... to be in pain..."

Chandni thus blamed her husband for her diminished self-esteem and described extreme anger and a desire to exact revenge.

Omar (pseudonym), in contrast, described conflicting emotions regarding his marriage and relationship with his wife.

I wanted it [my marriage] to be over... being around my wife was unpleasant... [and] stressful... I just wanted her to leave... I was afraid of making a mistake that I would regret later... I was also worried about my wife and felt guilty for abandoning her... ruining her life... and my parents, how they would deal with me being divorced... Most of all I felt helpless and resentful.

Omar, therefore, found his wife's presence distressing and wanted to end his marriage. However, doubt, anxiety, guilt, and fear of the consequences for himself,

his wife, and his parents prevented him from taking any action in this regard and resulted in increased suffering due to his lack of agency and the accompanying anger.

Participants' experiences of distant or conflictual spousal relationships were therefore distressing for them not only because of the ensuing loneliness and isolation, but also because of feelings of worthlessness and a loss of their sense of themselves, especially among the female participants of this study. Moreover, the doubt, confusion, anxiety, anger, guilt, and sense of being trapped that accompanied participants' feelings of worthlessness and the loss of sense of self further intensified their distress.

4.1.1.2. Community: "Constant pressure, constant confusion"

During the course of their interviews, participants discussed how their bicultural identities and simultaneous membership of distinct but overlapping communities was stressful and distressing for them. While comparisons with their immediate circle of friends and acquaintances resulted in feelings of "failure" and "despair," the notion of being a Muslim in Canada was especially problematic for participants. Self-identifying as a Muslim raised questions and tensions regarding their belonging to and personal relationship with the Muslim community, while being identified as part of the Muslim diaspora in broader Canadian context triggered anxieties regarding stereotyping, suspicion, discrimination, and intolerance. A number of participants resented having to "pander to fanatics" and expressed a desire to engage with the Muslim community "as a moderate Muslim... without becoming a kaffir [unbeliever] in their eyes." Others feared that by living in Canada they could not "be a Muslim... without hiding... and without being considered a fundamentalist... or a terrorist." The role of participants' relationships with their

friends and acquaintances, their membership of local Muslim communities and of Canadian society in general are discussed separately.

4.1.1.2.1. Friends and acquaintances: “Feeling inferior was like feeling nauseous”

Among the participants in this study, those who had suffered setbacks in life or not been as successful as they had expected, especially in comparison with their friends and acquaintances, described these setbacks as a source of distress.

Participants recalled how “painful it was to compare my life with my friends’ lives” and subsequently felt “jealous” and “ashamed of being jealous.”

Faraz (pseudonym), for example, explained how he reacted to his friends’ career advancement and success: “It really hurt to see them [my friends] getting high-profile jobs and getting promoted... while I was bogged down just getting an entry-level job and keeping it... It felt unfair.”

Faraz’s friends’ relative success and achievements compared to him were further accompanied by a feeling of being wronged, which therefore played a significant role in his distress. In the same way, feelings of inferiority in comparison to his friends and classmates were the source of Qassim’s (pseudonym) distress. Qassim had been unable to complete his college education and recalled that he began to “shun” his classmates once they received degrees and secured jobs because being among them would “bring me down.” He also described a cycle of repeatedly setting himself up for failure in his attempts to compensate for these feelings of inferiority, thereby worsening his situation and exacerbating his distress.

...once you mess up that big, you try and fix it by doing something spectacular. But of course you can’t, and you keep messing up again and

again. I messed up royally... I kept letting the mess pile up... and getting more and more overwhelmed.

A similarly extreme reaction was described by Bayat (pseudonym), who was in his late fifties when he realized that his peers were more successful and affluent than him. While Bayat claimed not to share his friends' material aspirations—"I'm not interested in fancy cars and big houses and business class travel... or even just money for its own sake"—he was nevertheless distressed when he realized that he was not going to "be as rich or successful as my friends... not in my lifetime."

It was a shock. It was worse than that. For years I had taken it for granted that I would do the best in our group. I felt cheated. It was as if someone had hit me. I couldn't think straight.

Thus Bayat found his friends' greater successes and accomplishments distressing not because of the lifestyles they were able to afford or even the respect they enjoyed, but because of the consequences for his own sense of self and the feeling of being left behind.

Participants primarily experienced feelings of distress when they compared themselves to their friends and acquaintances. It was the contrast between their lives and those of their friends that triggered their feelings of failure and inferiority.

4.1.1.2.2. Local Muslim community: "Never-ending judgment"

A number of the participants of this study described their relationship with the local Muslim community as characterized by being "constantly judged... by everyone and about everything" and the perpetual threat of being "rejected" for not conforming to the community's expectations.

Rubina (pseudonym), for example, who was in her early twenties and forced to interact with the community by her parents, felt negatively judged even though she believed that she complied with most Islamic values.

I don't drink [alcohol], I dress modestly, I don't have a boyfriend. What more do they want? That I cover my head? Go into full niqab [face-covering veil]? ... it's so frustrating... sometimes I get so angry that I wish I wasn't a Muslim... and then I feel bad for thinking such thoughts.

Rubina's sense of being judged thus led to feelings of frustration, anger, and then guilt about what she considered irreligious thoughts. For Saira (pseudonym), who was not as compliant a Muslim as Rubina but nevertheless wished to remain connected to the community, judgment and exclusion by the Muslim community was a foregone conclusion:

For them I'm a slut and a heathen and that's that... they've already decided that and excluded me... It really hurts the way they've condemned me and rejected me... mostly I'm just mad... It's not fair... Who the hell are they to reject me? What gives them the right?

Saira's sense of being judged and excluded by the Muslim community resulted in a cascade of negative emotions that included feelings of hurt, rejection, indignation, and rage. Similarly, Zehra's interactions with them were also characterized by judgment and criticism since her way to relating to God differed from conventional Islamic practice:

My faith is very strong. I turn to God on a regular basis. What I do not like is organized religion... the wordiness, the rituals... They [the Muslim community] criticize me, lecture me... tell me that I'm not a Muslim, that I'm going to Hell. It's really upsetting even if I don't actually believe it...

While Zehra found her local Muslim community's judgments distressing, staying away from them in order to avoid their judgments resulted in even more distress:

I'm scared of their reaction so I just stay away... Nobody understands how alone I feel. My family [in India] thinks I should have hundreds of friends here and blames me for my loneliness. I feel really alone in Toronto, really isolated. It gets very depressing.

Ultimately, the anticipation of being judged by the local Muslim community resulted in Zehra feeling afraid, isolated, lonely, and depressed, and, in addition, negatively judged by her family in Pakistan for her distress. For many participants in this study, therefore, local Muslim communities were a source of distress because of pressure to conform to their values and of negative judgments for not conforming. Both the fear of being judged and rejected, along with actual judgments or rejection, resulted in distress among participants, which was exacerbated by a range of accompanying emotions that included frustration, anger, guilt, loneliness, and isolation.

4.1.1.2.3. Canadian society: "Do I really belong?"

Most of the participants of this study reported a sense of assimilation into Canadian society, describing a sense of "comfort" and "belonging," with only a few feeling "insecure" and "excluded." Underlying the distress experienced by participants were questions regarding the extent to which they were able to practice their faith and still be accepted into and interact with Canadian society.

Mehreen (pseudonym), for example, believed that she was accepted as a Muslim "as long as she was not too Muslim." She was frightened of the consequences of wearing a hijab [headscarf], which she believed to be obligatory for her as a

Muslim woman. She feared the outcomes of following this practice in both her social life and employment as a resident of Toronto:

What will people think? ... I don't want people to label me a fundo [fundamentalist]. I want to look nice... I want to be normal. I'm scared that if I start covering my head I won't be able to make friends, I won't be able to find a job... I'll only be able to hang out with other Muslims... I feel guilty all the time but I'm stuck and I don't know what else I can do... It makes me angry and bitter. I wish I didn't have this problem and could be like everyone else.

Due to her fear of being socially and professionally excluded from Canadian society and relegated to only interacting with other Muslims, Mehreen felt she had no choice but to disregard her obligation to cover her head in public. Consequently, she felt trapped by her lack of options and experienced constant feelings of guilt. Moreover, she felt resentful about her guilt and overall distress. Similarly, Tapal (pseudonym) would have liked to fulfill his religious obligations to pray five times a day but decided against it:

Everything was fine, but I knew that if I started praying at work it would all change. I'd become "the Muslim." They'd [my co-workers] give me strange looks, wouldn't relax with me or want to hang out with me. I suppose I was insecure. So I stopped praying... I was cut off from God. I was scared that God would punish me. I was scared all the time.

Due to his insecurity about practicing and faith and fear of being labelled a Muslim and thus excluded socially, Tapal felt compelled to not pray at his place of work in order to fit in. As a result, however, he felt disconnected from his faith and constantly afraid of being punished for failing to fulfill his religious obligations.

Unlike Mehreen and Tapal, Omar's feelings of exclusion were based on a sense of being an outsider in Canada rather than his inability to fulfill religious obligations:

I've been here [in Toronto] for most of my life but I'll always be a Muslim. I drink, I don't eat halal, I don't pray or fast, but I have a Muslim name and so I'm stuck being "a Muslim"... I'm tired of waiting to become a real Canadian, a full Canadian. It's futile. I've given up waiting... I've given up hoping...

Omar's sense of being trapped in his Muslim identity and distress at not being a part of Canadian society despite living in Toronto for the majority of his life was therefore compounded by feelings of exhaustion, futility, resignation and hopelessness regarding his continued feelings of alienation and exclusion.

The prospect of being excluded by Canadian society was ascribed by most participants to a sense of being foreign as well as the practice of their faith. The anticipation of being judged, labelled, and ultimately excluded socially engendered feelings of insecurity among participants and resulted in many of them desisting from visibly Islamic practices such as observing hijab or praying. This resulted in distress not just due to failing to fulfill religious obligations, but also due to accompanying feelings of guilt, anger, and fear.

4.1.2. Economic Context

A number of the participants in this study recalled economic concerns preceding their experience of psychological distress. For many participants, difficulties in securing employment and earning money to meet expenses resulted in them feeling "insecure," being "stressed about every dollar I spent," and "feeling like a failure... for not being able to find a job." Others described "intense pressure" to maintain standards of living comparable to those in their countries of origin, which

some participants felt were “unreasonable” and “ridiculous... for Canada.” Even participants who earned steady incomes and were financially secure reported feelings of distress, in particular stemming from the perceived loss of status due to working jobs they felt were not commensurate with their education and professional experience, a situation they described as “demeaning” and “humiliating.”

The economic context of participants’ psychological distress is described through the subthemes Income and Social Status (see Figure 4).

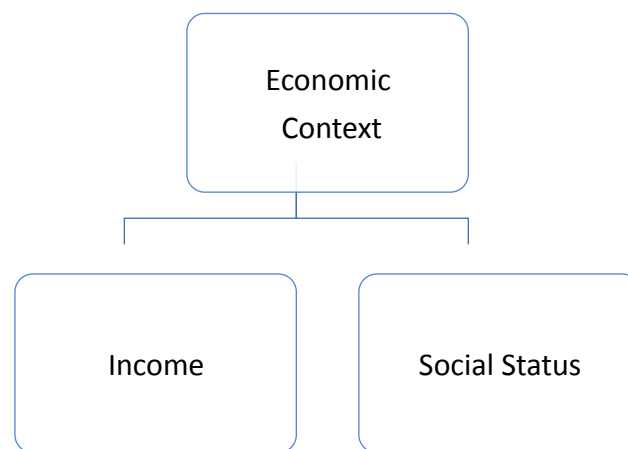


Figure 4. Economic Context

4.1.2.1. Income: “The stress of not having enough money crushed me”

Participants whose distress was linked to earning a steady income to meet expenses included both those who were employed and those who were unemployed and struggling to find jobs. Those who were employed described being “constantly worried” about meeting expenses along with the considerable “strain” of having to “anticipate a crisis” and “plan for the future.” In contrast, all of the participants in this study who were unemployed were supported financially by their families, and therefore their distress resulted from feeling “humiliated” and a “burden” for being financially dependent on parents and siblings, and “frustrated” and “helpless” for not being able to secure a job.

Kardar, for example, stated that he was employed and had a regular income but was nevertheless concerned about not being able to manage if faced with a crisis:

I was making enough money, enough for myself at least... But I was constantly worried that something would happen... my mother would get sick and I'd have to send money for her treatment and then I'd run out and have nothing left... I suppose I was really worried about being helpless.

Kardar's (pseudonym) anxiety was therefore based on anticipated expenses for events or circumstances that were possible but not certain, whereas Hashmi, who lived with his ageing parents and was financially dependent on them, was concerned about a more likely eventuality:

My parent's are getting old and I don't know what will happen to me once they aren't there. Maybe my sister will support me? I don't know... I try not to think about it but I'm constantly worried about what will happen to me... I feel very insecure... very scared.

Like Kardar, Hashmi's uncertainty, insecurity, and fear about how his financial needs would be met once his parents were no longer around or able to support him were based on his anticipation of the future rather than his circumstances at the time. In contrast, Qassim, who described himself as "getting by... barely... only just" recalled the stress of meeting day-to-day expenses:

Every cup of coffee, every burger, I had to ask myself, 'Do I really need this? Can I do without it?'... I was stressed all the time. I was stressed about every dollar I spent... It was a huge stress... it was a never-ending stress...

Qassim's description of continuous pressure from trying to manage within limited means was echoed by Zehra, although she described additional distress because her mother was supporting her: "I cut back wherever I could because I had to

account for all my expenses... I had to justify everything... It was humiliating to have to keep asking her for money... I felt really guilty about spending her money.”

Thus while Zehra was also under pressure to keep her daily expenses to a minimum, her distress was compounded by the guilt and shame of not being able to support herself and instead relying on her mother. Similarly, Faraz, who “felt like a burden on his parents” because he was financially dependent on them, described his distress at not being able to find a job:

It was really frustrating to be called in for interviews and then not get the job... [and then to] find out that people less qualified than me had been hired. It made me really angry... I felt really helpless... I felt like a failure... I’d be so ashamed every time I had to tell my parents that I hadn’t got yet another job... that was the worst part.

Faraz’s inability to support himself and thus remain financially dependent on his parents was especially distressing for him. Consequently he reported feelings of shame, frustration, anger, and a lack of agency, along with harsh and critical judgments of himself.

Concerns about the lack of money or absence of a steady income therefore contributed to participants’ experience of psychological distress in a number of different ways. While earning money to meet expenses was a common source of stress and anxiety among the participants in this study, the accompanying feelings of uncertainty, insecurity, guilt, shame, helplessness, and failure, plus dependency on their parents added to their distress, and in a number of cases, were more distressing than concrete and immediate financial concerns.

4.1.2.2. Social status: “The shame was like being suffocated”

Notions of social status were of considerable importance to many participants, and, in a number of instances, described as being one of the underlying causes of their distress. The perception of reduced social status, primarily due to working in areas such as retail or security, which participants felt did not reflect their education, professional experience, and social class in their countries of origin, was especially distressing and a source of “shame” and “humiliation.” Meanwhile, participants who were able to maintain their social status in Canada described it as a “struggle” that took a considerable toll on them.

Ishaq (pseudonym), for example, felt it was humiliating to work as a security guard. Ishaq’s distress was exacerbated by two factors: the disappointment of not being able to work in his chosen field in which he had a university degree from the United States, and the comparison with his father, who was a successful and prominent industrialist in his country of origin:

It was extremely disappointing... I didn’t go to the States and study business management for four years and then emigrate to Canada to work as a security guard—my father was a industrialist in Pakistan ... nothing in my life has been as demeaning as putting on a uniform and going off to a blue collar job every day...

Similarly Qassim recalled the shame he felt due to his job as an attendant at a gas station:

I was pumping gas six, eight, ten hours a day. It wasn’t too bad but the shame was unbearable. Of course I didn’t tell anyone but I was so ashamed that I completely stopped meeting my friends... Now that I think about it, the loneliness was even worse than the shame.

Qasim's feelings of shame led to him isolating himself, which resulted in him experiencing intense loneliness. In contrast to Ishaq and Qassim, Bayat was able to maintain his social status from India, although he described struggling to cope both physically and financially in the process. Moreover, while he considered it unnecessary to continue the lifestyle that he had enjoyed in India since he was living in Canada, he felt that reduced social standing was not an option for him or his family, and was therefore compelled to meet social expectations regardless of the consequences for him:

We lived as if we were still in India... I couldn't afford it at all... it was ridiculous to live like that in Canada but I didn't have a choice... I had no control. I felt I was heading for disaster but couldn't do anything about it... I was stressed about money all the time and ashamed to be stressed about money... The stress and the shame left me exhausted all the time.

The compulsion to maintain his social status resulted not just in financial worries for Bayat, but also in feelings of anxiety and loss of agency. Participants' perceptions of their social status were therefore especially important to them, and consequently distressing, although the nature of the distress was very different. For some participants the perceived loss of social status led to disappointment, shame and humiliation, which for others the pressure to maintain the social status from their countries of origin triggered feelings of anxiety and helplessness.

4.1.3. Religious Context

Consistent with traditional Islamic beliefs that suffering is the result of moving away from God or not following His instructions, there was a strong sense among the participants in this study that their distress was a form of "punishment by God." Participants believed themselves to be deserving of punishment for a variety of

transgressions, ranging from “doubt” and “lack of trust” in God to “disobeying [God’s] instructions” and “sinning... even though I knew exactly what I was doing.” Examples of the sins that participants described themselves as having committed ranged from “missing prayers” and “not covering my head” to “drinking alcohol” and “watching pornography.”

In order to understand the irreligious thoughts and behaviours for which participants believed they were being punished, and which therefore resulted in their subsequent experiences of distress, the religious context of participants’ distress is examined through the subthemes Lack of Faith and Lack of Piety (see Figure 5).

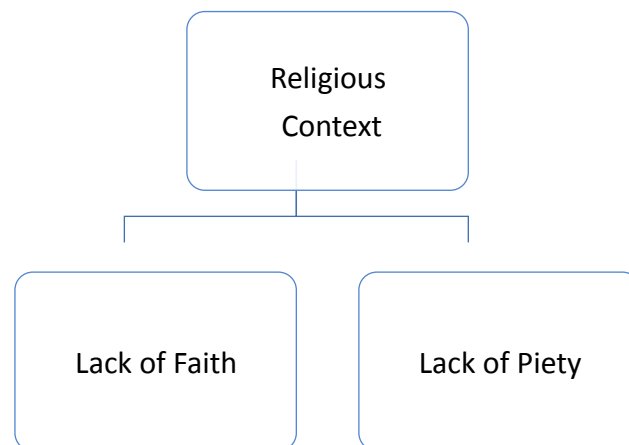


Figure 5. Religious Context

4.1.3.1. Lack of faith: “I doubted God so of course I was going to suffer”

A number of participants felt that insufficient devotion to God or an imperfect relationship with Him was the reason for their punishment through psychological distress. Some participants recalled that before their experience of distress, they “didn’t feel the need” for God in their lives, causing them to believe they deserved punishment. For others, “wavering... rather than blind faith” in God and “questioning God” instead of “accepting His plan” indicated a lack of faith that constituted sufficient reason for punishment.

Omar, for example, reported a distant and one-sided relationship with God, along with the eventual consequences of not being sufficiently devout:

My relationship with God was very casual. God wasn't part of my life. I had pushed my faith into the background... I only turned to God when things were bad and there was nobody there for me... This [distress] was my punishment.

While Omar maintained that he had "always had faith in God," Aalia, described wanting, but not being able to, have complete faith and trust in God:

I wanted to believe that everything that's happened has happened because it was part of God's plan... [but] I didn't trust God completely... and now I am being punished for it. I feel lost and confused and alone and hopeless.

Ultimately, Aalia believed that her experience of distress was punishment for her weak conviction and inability to rely on God without reservation or doubt. In the same vein, Kardar also described struggling unsuccessfully with his lack of faith in God, the accompanying fear of retribution, and his sense of being held accountable for his doubts: "I had promised myself that I would never doubt my faith in God. However I couldn't stop. I continued doubting.... I was constantly scared of being punished. My suffering was my punishment."

A number of the participants of this study believed that as Muslims it was essential for them to have absolute and unwavering faith in God. Those who doubted or questioned their belief systems, especially their belief in a conventional Islamic God, considered themselves to be lacking in faith and consequently deserving of their punishment, which took the form of psychological distress.

4.1.3.2. Lack of piety: “I’m being punished for my sins”

Participants who did not describe any doubts regarding their faith in God nevertheless admitted to being lax about religious obligations such as prayer and fasting. A number of them also reported disregarding Quranic instructions against sinful behaviours such as drinking alcohol or engaging in extramarital sex. For these participants the psychological distress that they experienced was therefore believed to be punishment for what they considered to be sinful acts.

There was a great deal of variation in the nature of sins for which participants believed they were being punished. These included attitudes such as “hubris” and “lacking humility,” neglecting to pray regularly, “my career...[and] what other people would think” being a “higher priority than my responsibilities as a Muslim,” and relationships with members of the other sex that were “immoral” and “forbidden.” Moreover, while most participants explicitly connected their wrongdoings with their punishment in the form of psychological distress, others recalled wondering “What have I done to deserve this? Why am I suffering?” and then searching for reasons for which they were being punished.

For example, while Mehreen was convinced that her distress was a punishment, she had trouble identifying a specific transgression that merited her suffering: “I must have done something if God is making me suffer. I must have done something wrong that I’m being punished for.”

Unlike Mehreen’s speculations, Saira had no doubts regarding the underlying cause and purpose of her experience of distress:

... a sense of arrogance, a sense of entitlement, the sense that I could pull off things that other people feel too scared or too humble to pull off... What I

went through was a form of punishment... God's way of telling me that I shouldn't step out of my bounds... to stick to my limits.

Tapal was also able to identify a specific reason for his distress, although in his case it was failing to pray five times a day as required in Islam, rather than an inappropriate attitude or worldview: "I stopped praying because it was stressful and inconvenient... God taught me a lesson."

Thus Tapal believed his distress was punishment for not fulfilling his religious obligations. Ishaq, meanwhile, attributed his suffering to behaviour that he believed to be explicitly forbidden in Islam and therefore deserving of punishment: "I had started drinking alcohol and going out with women... I had a girlfriend... we would go out on dates and all that stuff... we made out... that was the reason for what I went through... it was my fault."

While Ishaq's acceptance of responsibility for his actions and the distress that he suffered as a result was straightforward, Chandni explained her extramarital affair with another man as an attempt to seek the affection and companionship that was "denied to me by my husband" and to meet her "physical and emotional needs." Despite feeling that her relationship was justified by her husband's inattention to her, she was nevertheless clear that it was sinful and merited punishment and that her suffering was a reasonable and expected consequence: "I had an affair with another man. I disobeyed God's instructions... of course I suffered... I deserved to suffer. I deserved to be punished."

The participants of this study, therefore, had a strong sense of their distress or suffering being a form of punishment by God. In addition, they were willing to ascribe their suffering to punishment for sinful behaviour, even when the offence for which they believed they were being punished was not immediately obvious. The

transgressions that were considered sinful and worthy of punishment ranged from inappropriate attitudes to neglect of religious obligations and disobeying God's instructions regarding forbidden activities.

During their interviews, participants described the circumstances and causes of their subsequent experience of distress along with the ensuing emotional consequences. They reflected on specific relationships, economic and social factors, and aspects of their faith that they believed were responsible for their distress. The excerpts in this section, therefore, provide a context and set the stage for the next sections on participants' coping and experience with distress.

This section revealed how family and religious faith, which participants typically needed for support, contributed to their distress instead. For instance, a number of participants described how childhood experiences of parental neglect, criticism, and abuse resulted in psychological distress in adulthood, while relationships between adult children and ageing parents were distressing because of feelings of responsibility, resentment, dependency, and being a burden. Similarly, for many of the participants of this study, the notion that they had not been sufficiently faithful or pious led to the belief that they were being punished for their lack of faith and piety, and moreover, that they deserved to be punished.

In addition, for some of the participants in this study, social factors that others turned to for support and coping, such as friends, acquaintances, and local Muslim communities, were sources of distress. Comparisons with the lives of friends and acquaintances led to feelings of failure and insecurity, and participants reported pressure from local Muslim communities to conform. If they didn't conform, they experienced criticism, judgment, and rejection. Meanwhile, Canadian society in a broader context triggered anxieties of being labelled, stereotyped, and excluded

socially for practicing their faith, and therefore being unable to, or choosing not to, practice their faith. The following sections explore how these themes influenced and manifested themselves in participants' experience and coping with psychological distress.

4.2. Experience of Distress

For the most part, the participants in this study had vivid and extensive recollections of their experiences of psychological distress, which they were able to describe at length during their interviews. Whereas probing questions were required to help participants explore possible causes and contexts for their distress, as described in the previous section, the participants in this study, with few exceptions, found it relatively easy to describe their experiences of distress and consequently the use of probing questions was comparably limited and restricted to eliciting detail, evoking images, and intensifying emotional responses. In most instances, participants' discussions of their experience of distress constituted the major portion of their interviews.

This section sets out to investigate participants' lived experiences of distress. It therefore builds on the previous section, in which the contexts that contributed to or caused participants' psychological distress are described, and then segues into the next section that examines participants' strategies for coping with and managing their distress. To fully capture the content of this domain, participants' recollections of their experiences of distress are clustered into themes of physical, emotional, and behavioural experiences of distress (see Figure 6).

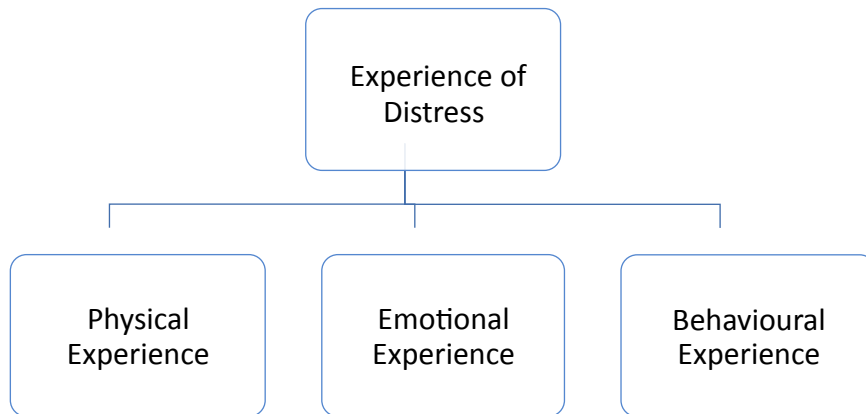


Figure 6. Experience of Distress

The theme of participants’ physical experience of distress is explored through the subthemes Chronic Pain, Gastrointestinal Disorders, Fatigue, Insomnia, and Disrupted Sleep. The physical manifestations of participants’ distress are described, along with ensuing disruptions to their lives and the impact on their overall functioning.

Participants’ emotional experience of psychological distress is examined through the subthemes Hopelessness, Helplessness, Feeling Overwhelmed, Confusion, Anger, and Guilt. Feelings of helplessness were linked to strained or conflictual familial relationships for most participants, whereas feelings of hopelessness were due to a sense of being trapped in a difficult circumstance with no apparent resolution. Participants who felt overwhelmed described being burdened by excessive demands and obligations, and those who recalled confusion reported not being able to think clearly or make sense of their difficulties, along with internal conflict, uncertainty and indecision. Anger among the participants of this study was due to mistreatment or excessive demands by family members and the notion that their distress was punishment for sinful behaviour and could be alleviated by praying to God and seeking forgiveness. Similarly, participants’ guilt towards their families, in particular their parents, derived from the distress participants believed that they had

caused them, while their guilt towards God was based on actions they considered impious or sinful.

The behavioural experience of distress includes the subthemes Numbing and Avoidance and Neglect of Responsibilities. Participants' substance abuse, hyperactivity, and social withdrawal constitute the subtheme Numbing and Avoidance, and their neglect of social and religious obligations are examined separately in the subtheme Neglect of Responsibilities. The consequences of participants' behaviours for their relationships, careers, health, and well-being are also discussed in this subtheme.

4.2.1. Physical Experience

Physical symptoms experienced by participants included chronic pain, gastrointestinal disorders, fatigue and disrupted sleep. The chronic pain described by participants was either "localized" or "diffused throughout" their bodies and varied in intensity from "soreness" and "general aches and pains" to "torture." In contrast, the gastrointestinal disorders and fatigue that participants recalled was consistently "severe" to the point of being "debilitating" and left participants feeling "imprisoned" or "paralyzed by my exhaustion." Many participants also reported disrupted sleep, and although most of them were not particularly distressed by their hypersomnia, which was even welcomed as an "easy way to avoid everything," insomnia caused anxiety, frustration, loneliness, and difficulties at work that rendered participants "desperate" and "unable to function" to the extent that they felt that they "might as well have been dead." The subthemes Chronic Pain, Gastrointestinal Disorders, Fatigue, and Disrupted Sleep are used to describe participants' physical experience of distress (see Figure 7).

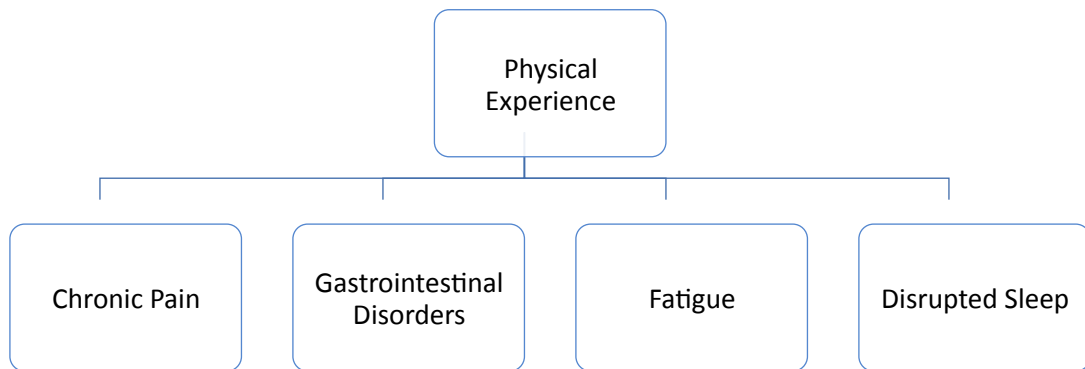


Figure 7. Physical Experience

4.2.1.1. Chronic pain: “I hurt all over... I didn’t know whether to scream or cry.”

Chronic pain was a common feature of participants’ experience of distress. For some participants it was “mild... really more discomfort than pain” or “irritating ... [and] inconvenient,” whereas for others it was “excruciating” and “hellish.” Similarly, participants described their pain as being localized to “around my temples and above my eyes” or in their “shoulders and neck” or being “everywhere... all over my body.” There was also considerable variation in participants’ responses to their pain, which ranged from “ignoring it and hoping it would go away” to “stress” and “anxiety” with resulted in them seeking medical attention and needing to have “all kinds of tests and scans.”

Like many of the participants in this study, Qassim recalled experiencing physical symptoms during his period of distress, but was only able to describe them in vague terms:

... a sinking feeling in my stomach... a stomach ache, but not a very bad one. More like a really heavy feeling as if something was weighing me down... It was as if the tension throughout my body had manifested itself as a weight.

Notwithstanding his hazy memories and the relatively mild nature of his physical symptoms, Qassim nevertheless linked them to his overall experience of psychological distress. Similarly, Faraz recalled “dull, throbbing, stress headaches” due to the “stress of not being able to find a job.” While he described the headaches themselves as “tolerable... irritating more than really painful,” they were a source of considerable anxiety for him and compounded his stress of being unemployed and not being able to find a job:

I was constantly scared of getting a headache during a job interview and just zoning out... I was under enough stress trying to find a job and being rejected again and again, and the anxiety of getting a headache during an interview just made it worse for me... I probably blew a bunch of interviews because I was so anxious...

Faraz’s physical experience of distress was therefore characterized by mild pain but significant anxiety regarding experiencing the pain. The latter impacted his ability to function almost as adversely as the pain itself and considerably amplified his overall experience of distress.

Saira, in contrast, suffered from far more acute symptoms and was able to describe her experience of physical pain in much greater detail:

Shooting pain in my right arm, painful twitch in my eye, awful stomach cramps ... I would wake up in pain in the middle of the night ... I was sore all over, as if I had been beaten up... It was really intense... I had to get medical help... that’s how I ended up in therapy.

Saira considered her physical experience of pain to be unrelated to her psychological experience of distress and therefore turned to her general physician, who in turn referred her to a psychotherapist. Chandni’s reaction was similar to

Saira's and she sought medical help for her incapacitating headaches, which were among the most severe physical symptoms described by the participants in this study, and which resulted in a referral to a specialist followed by extensive medical investigations:

I would get terrible headaches. I can't describe how bad they were. It was like someone was squeezing my head, but at the same time my brain was exploding from the inside... I couldn't speak, I couldn't think, I couldn't do anything... I was terrified I might have a brain tumour... eventually I ended up with a neurologist who ordered an EEG, an MRI and a bunch of other tests...

Like Faraz, the anxiety associated with the physical pain and its possible causes was an additional source of distress for Chandni. The participants in this study thus differed greatly in the severity of their pain, their reaction to it, and the extent to which it affected their lives and shaped their experience. The pain described by them ranged from being incidental to debilitating. Moreover, although physical pain resulted in some participants eventually addressing their psychological distress, for others the anxiety and stress associated with their pain significantly exacerbated their experience of psychological distress.

4.2.1.2. Gastrointestinal disorders: "...brought my life to a standstill"

Many participants in this study recalled suffering from gastrointestinal problems of varying intensity. These included bloating, which was described as "constantly feeling as if I had overeaten," hyperacidity and oesophageal reflux leading to feelings such as "there was a monster inside me" and abdominal pain that was so painful that "it felt as if someone had stabbed me with a dagger." Most distressing for participants, however, was persistent diarrhoea, which prevented them from "living a

normal life.” The physical discomfort and inconvenience experienced by participants who suffered from diarrhoea were accompanied by a range of feelings that included anxiety, isolation, uncleanliness, frustration, embarrassment, and shame and thus compounded their distress.

For example, Tapal, who continued to work and sustain a social life throughout his experience of psychological distress, recalled his persistent diarrhoea as being a source of inconvenience and shame:

I spent a lot of my time in public washrooms. In my office, in restaurants, in malls, in cinemas, in subway stations. It was really embarrassing, so I would make up stories about where I was going or just wander off without telling anyone... because I was constantly using public washrooms, I never felt clean—clean enough to pray, that is, which bothered me a lot.

While Tapal attempted to mitigate his feelings of shame by lying or making excuses for his repeated disappearances, frequenting public washrooms meant that he was unable to perform the ablutions required for him to pray five times a day, which resulted in additional distress for him. In contrast to Tapal, who, notwithstanding his distress and the difficulties he faced, managed to continue with his daily routine for the most part, Yasin’s life was considerably curtailed by his hyperacidity and oesophageal reflux:

Apart from water, pretty much everything I ate or drank made me feel sick. It was as if my chest was on fire. Or I might vomit every time I swallowed... I had an endoscopy and the doctors said it was just stress, as if that made it okay... I dreaded eating and drinking. And because most socializing involved eating or drinking I ended up cancelling plans... .. It was like being in a strange kind of jail.

Therefore, in addition to the physical symptoms of hyperacidity and oesophageal reflux, the ensuing anxiety experienced by Yasin compelled him to restrict his activities and limit his interaction with friends and family, ultimately leading to feelings of isolation. His physicians' diagnosis of stress and inability to alleviate his distress, moreover, resulted in feelings of frustration. While Bayat described a similar experience of suffering from diarrhoea, the consequences for him were much more severe and included absenteeism at work accompanied by social withdrawal and isolation:

I couldn't go anywhere. I don't know how many days of work I missed. My social life finished. It was extremely frustrating... I got desperate enough to resort to adult diapers... It was too humiliating to use them. I tried them once or twice and then gave up and just stayed at home.

Bayat's diarrhoea and his inability to control it was therefore especially distressing not only because it prevented him from fulfilling his professional and social obligations, but also because of the accompanying frustration, desperation, and humiliation that characterized the experience.

For the participants in this study, therefore, the experience and consequences of gastrointestinal disorders, in particular persistent diarrhoea, extended far beyond the physical symptoms. Diarrhoea triggered a range of distressing emotions and compromised participants' ability to work and socialize, leaving them feeling lonely and isolated. Moreover, most participants did not consider their gastrointestinal distress to be a manifestation of their overall experience of psychological distress, but a separate and distinct ailment that caused additional suffering.

4.2.1.3. Fatigue: “It felt as if life had been sucked out of me”

Nearly all of the participants in this study described feelings of lethargy and tiredness during their experience of psychological distress. They recalled a “lack of energy, lack of initiative... difficulty in getting anything done” along with feeling “run down” and “depleted.” Participants differed considerably, however, in the extent to which their fatigue impacted their functioning and contributed to their distress. While a number of participants described being “frustrated” by their lack of energy that made “getting through each day a struggle,” they were nevertheless able to continue to meet their professional, familial, and social obligations. In most cases, therefore, tiredness was not an especially salient feature of their experience of distress. For others, however, unrelenting fatigue and lack of energy were incapacitating and among the primary sources of their distress.

Aalia’s fatigue, for instance, resulted in her significantly curtailing her activities, withdrawing from her social life, and struggling with her duties as a mother:

From the minute I woke up every morning I was exhausted. I felt more tired when I woke up than when I went to sleep. I stopped going out, meeting people... [I] was barely able to get my children to school in the mornings... I became desperate... after looking at a couple of websites I became convinced that I was suffering from chronic fatigue syndrome and went to see a doctor who told me I needed to see a therapist.

Aalia’s fatigue, accompanied by feelings of despair, was thus acute enough to meet the diagnostic criteria of chronic fatigue syndrome according to health information websites on the internet. It therefore prompted her to seek medical attention, thereby highlighting her psychological distress and resulting in her being

referred for psychotherapy. Notwithstanding her fatigue and the ensuing difficulties with her mood and ability to function, Aalia was able to meet basic family responsibilities. Due to his lack of energy, Kardar, in contrast, was unable to fulfill his academic obligations, with far more severe consequences:

I had no energy. I was completely unproductive. I couldn't do anything at all...

I stopped attending classes, turning in assignments... eventually I had to withdraw from college... Sometimes I felt frustrated but mostly I just felt hopeless and defeated.

Kardar's lack of energy was therefore debilitating, and along with the adverse effect on his education and academic record, triggered feelings of frustration, despondency, and failure.

Although almost all the participants in this study experienced a lack of energy and fatigue to some extent, most of them were able to cope with it and did not recall it as being a noteworthy aspect of their distress. For others, however, the severity of their fatigue was sufficient to compromise their functioning, engender negative emotions, and contribute significantly to their experience of distress. At the same time, however, the fatigue experienced by participants led to awareness of their accompanying psychological distress followed by measures to alleviate it.

4.2.1.4. Disrupted sleep: "My life was turned upside down"

Disrupted sleep was a feature of many participants' experience of psychological distress. In most instances, participants reported "sleeping at odd hours," "sleeping too much... sleeping all the time," and "sleeping even when I wasn't tired." For some participants, hypersomnia was preceded by insomnia and they recalled "tossing and turning for hours" before they could sleep or "being desperate to fall asleep and going crazy" because they continued to remain awake, followed by

sleeping through the day and then waking up “just when everybody else was getting ready for bed.”

Disruptions to regular patterns of sleep were not recalled as especially troubling for those participants who experienced only hypersomnia and were even considered an “escape... a timeout” by some of them. On the other hand, the combination of hypersomnia and insomnia, which resulted in participants’ sleep cycles being “reversed” and them feeling that they were “living in a different time zone from everyone else” was a source of considerable distress.

For example, while Saira recalled hypersomnia as one of the principal features of her experience of psychological distress, she did not describe it as contributing significantly to her suffering: “I slept a lot. I slept excessively...endless endless sleeping... I’d sleep in, I’d wake up... I’d go back to sleep. I’d take naps in the afternoon...”

Hypersomnia was also a feature of Ishaq’s experience of distress, and like Saira, he did not recall it as a source of stress or anxiety. In fact, for Ishaq, sleeping excessively was a way of coping with his despair: “I slept more and more... I would just sleep... and hope that everything will go away... that was my way of dealing... You can say I was trying to avoid everything.”

In contrast to Ishaq, for whom hypersomnia was a means of escape and avoidance, Zehra’s insomnia, followed by the inability to wake up, resulted in considerable anxiety and distress”

I’d be up all night, getting more and more agitated... [The next morning] I’d really have a hard time waking up... I’d sleep late, until lunchtime, till the evening if nobody woke me up... because of my messed up sleep I couldn’t work, I couldn’t study... I was miserable.

Zehra's distress was therefore due both to the anxiety of not being able to sleep at night and her compromised productivity and inability to function the next day because of her disrupted sleep cycle. Bayat's experience was similar to Zehra's but far more distressing for him due to the severity of his insomnia:

I just couldn't fall asleep despite all the pills the doctors gave me. I even combined them with whiskey and vodka... It was bloody frustrating... I'd go entire nights without sleeping and then sleep through the whole day... I can't tell you how lonely I felt when I was awake and the rest of the family was asleep... I barely saw my children. I was cut off from everyone.

For Bayat, insomnia resulted not just in frustration stemming from not sleeping at night, but also feelings of isolation because he was unable interact with his family due to their disparate hours of sleep and wakefulness.

While the participants did not describe excessive sleeping as being particularly distressing, the combination of being unable to fall asleep at night and then sleeping through the following day were the cause of significant distress. In addition to the frustration and anxiety due to disruptions to regular patterns of sleep, the ensuing diminished productivity and functioning, along with the loneliness and isolation resulting from reduced interpersonal contact, increased participants' experience of distress.

4.2.2. Emotional Experience

Participants' experience of distress was characterized by a range of emotions that varied considerably in nature and intensity. These included feelings of hopelessness or "perpetual darkness" due to enduring financial problems and conflictual relationships with family members, accompanied by a sense of "helplessness" because of difficulties in functioning due to anxiety or depression or

the inability to “take charge... [and] sort things out.” Participants also described feeling “overwhelmed” and “unable to cope” with their responsibilities and obligations, along with being “confused” and “unable to think clearly... to take decisions rationally so that I wouldn’t regret them later.” Anger resulted from “constant criticism,” being “held to impossible standards,” and the “pressure” of being expected to endorse and engage in Islamic traditions and rituals. Meanwhile, participants who believed that they had “let down” their parents, lacked “complete faith and trust” in God, had “not followed His instructions” by engaging in behaviour that was prohibited in Islam and therefore sinful, recalled feelings of guilt.

Participants’ emotional experience of distress is discussed through themes of hopelessness, helplessness, feeling overwhelmed, confusion, anger, and guilt. The themes of anger and guilt are both examined through sub-themes of family and religion (see Figure 8).

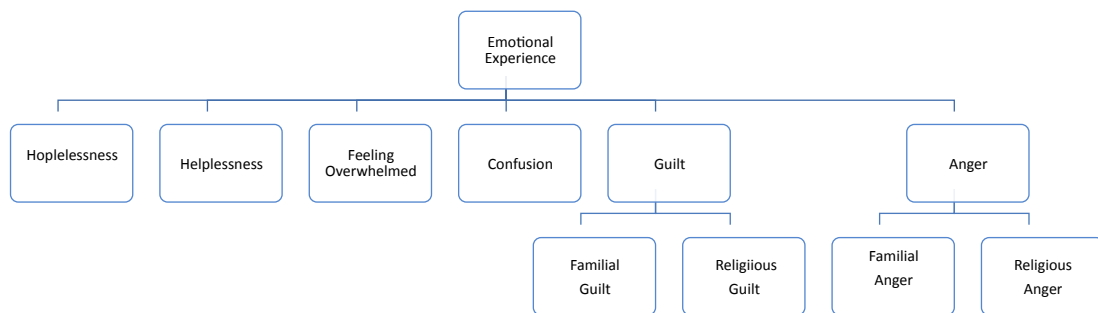


Figure 8. Emotional Experience

4.2.2.1. Hopelessness: “I’d reached the end”

All the participants in this study recalled feelings of hopelessness of varying duration and intensity. For some participants the sense of hopelessness was temporary and linked to individuals or relationships, “any interaction with my father would completely drain the hope out of me,” particular circumstances such as financial

difficulties “when I thought about work and money, that’s when just I wanted to quit and give up” or specific triggers such as being told that their distress “was God’s will” and they should “have faith in God and pray and then things will work out.” For other participants hopelessness was the most salient part of their experience of distress and characterized by a pervasive sense of their being “trapped” and with “no way out” and having “nothing left... no options at all.”

Rubina’s hopelessness, for example, was due to her responsibility to look after her father despite his violent and abusive nature and his ongoing conflict with her and her mother. In particular, it was the repeated failure of her numerous attempts to reduce the atmosphere of “constant tension and hostility... [and] hatred” that pervaded their home through interventions by family members and mental health professionals such as counsellors, therapists and psychiatrists that left her despondent:

I used to be full of hope... I would tell my self, “Now things are going to be all right. Now I am going to be happy.” But things only got worse and worse. I lost all hope... I would just wait for each day to pass.

Unlike Rubina whose distress felt never-ending, Qasim’s despair after he had dropped out of college, had no source of income and had alienated himself from his friends and family, was characterized by a sense of finality:

It was the end of the road for me... There was nothing I could do, nobody I could turn to. I couldn’t even turn to God because turning to God for help would be a great slap on his face because I’d ignored Him for so long.

While Rubina and Qasim were resigned to their hopelessness and did not believe they had any means of alleviating it and therefore no option but to endure it, Yasin was unique among the participants in this study for thinking about ways that he might escape the circumstances underlying his despair:

I felt trapped... by my work, by my family, by everything in my life. There was no way to break free... I would fantasize about disappearing and starting a new life with a new name somewhere far away. I would fantasize about becoming somebody else. And when I would think about how impossible that was, I would fantasize about crashing into the car ahead of me while driving and ending everything in a second. But of course I knew that was out of the question... and I'd feel worse afterwards because I knew it was just a fantasy. One of many fantasies.

Yasin's sense of hopelessness was due to his inability to conceive of any change in his circumstances along with any escape from them. The extent of his despair can be gauged from his suicidal thoughts, and while he ruled them out and dismissed as them as "fantasies," not even having the option of escape by taking his own life heightened his sense of feeling trapped and hopeless.

Unlike Rubina, Qasim and Yasin, whose sense of despair built up over time, Mehreen described a sudden onset of hopelessness based on the realization that her enduring health concerns, marital problems and financial difficulties would "go on and on ... probably forever" or were at least unlikely to be resolved soon:

All those years, I waited for a miracle... I knew that it would take a miracle for my life to get better. Then I realized there will never be a miracle. It's never going to happen. It's never going to come. It was as if a light had been switched off. Everything became dark. My life became dark.

Participants' sense of hopelessness therefore derived from a number of different factors and varied in onset and degree. Common to their experiences of hopelessness, however, was a sense of being caught up in an enduring and difficult set of circumstances with no obvious solution or way out.

4.2.2.2. Helplessness: “Everything I did felt futile. My life was pure futility”

While feelings of helplessness were reported by a number of participants in this study, there were notable differences in how they were experienced and described. Most participants recalled feeling helpless when confronted by or embroiled in situations over which they had “no control” or “no influence whatsoever,” especially if family members were involved and they “could only watch like a spectator” as people they loved or cared about suffered. In such instances helplessness was central to their experience of psychological distress. For others, however, feelings of helplessness were secondary to other manifestations of distress such as extreme anxiety or depression that rendered them “incapable of functioning... like a normal person” and therefore part of a broader spectrum of distressing emotions that constituted and exacerbated their experience.

Hashmi’s sense of helplessness, for example, was based on debilitating anxiety that prevented him from interacting with other people, holding a job and supporting himself, ultimately leaving him reliant on his parents for financial support: “I couldn’t work. I couldn’t meet people. I couldn’t even look after myself. I was completely useless. I depended on my parents for everything. It was humiliating.”

Thus Hashmi’s helplessness was one of many ramifications of his anxiety which, along with the accompanying isolation and humiliation, was incorporated into his overall experience of psychological distress. Omar, in contrast, who said of his divorce that “when it finally happened it was a huge relief” nevertheless recalled feelings of helplessness due to his parents’ and daughter’s distress as they went through divorce proceedings and custody arrangements as the predominant feature of his emotional distress: “What really hurt was to see my parents in pain and my

daughter in pain and not be able to do anything about it... Being totally powerless was unbearable.”

Omar’s distress was therefore result of him being unable to mitigate his parents’ and daughter’s suffering. Like Omar, Aalia equated her experience of distress with her helplessness to resolve the ongoing discord and conflict that characterized her family’s relationships with each other. The main difference between their relationships was that while Omar had no choice but to wait while the legal process took its course, Aalia tried continuously to mediate between family members but to no avail:

My mother, my father, my husband and my son were fighting all the time. I was caught in the middle but nothing I did made any difference... Most of all I felt helpless... Sometimes I would go and sit in my car and just cry.

Unlike the helplessness described by Hashmi and Omar, who were unable to take any action to alleviate the distress experienced by them or their loved ones, Aalia’s feelings of helplessness were based on the inefficacy and futility of her attempts to resolve the multiple conflicts between her family members.

For the participants of this study, therefore, feelings of helplessness were linked primarily to familial circumstances or relationships that they were unable control or change. For some participants these feelings were integral to or even constituted the entirety of their experience of distress, while for others they were one of many emotions that contributed to it.

4.2.2.3. Feeling overwhelmed: “I was constantly drowning”

A sense of being “overwhelmed” and “unable to cope” with everyday responsibilities and routine matters was a common theme among the participants of

this study. Participants reported feeling “swamped” and “inundated” by “little things” that “should have been manageable but just added up and became too much” accompanied by “urgency... panic... [and] fear for no real reason.” Such feelings were typically ascribed to “too many competing demands, obligations, deadlines” or believed to be the result of confronting “forces larger than anything I could manage.” In addition to struggling with day-to-day demands and obligations, participants’ distress due to feeling unable to cope was often compounded by a vague notion that they had “missed something... [or] forgotten something.”

Saira, like many other participants, recalled the pressure of having numerous obligations and responsibilities:

There was just too much to do... What bothered me most of all was that there was this sense of something to be done... that I urgently needed to sort out... but the whole thing was eluding me... I constantly felt overwhelmed but I couldn’t figure out by what... I felt directionless... a sense of time running out.

While Saira described being overwhelmed by her obligations and responsibilities, she was especially distressed by anxiety regarding unspecified or unknown matters that she felt required her attention. In contrast to Saira, who attempted to meet all her commitments, Chandni’s instinct when she felt overwhelmed and unable to cope with everyday matters was to withdraw and avoid all her responsibilities and obligations: “I was so overwhelmed by everyone and everything that I just wanted to lock myself in a cupboard and never come out... I would hide in my bedroom for days.”

Chandni thus attempted to cope with her feelings of being overwhelmed through escape and avoidance, which resulted in isolation. Escape, however, was not

an option for Tapal, who felt swamped by the demands of his career and his family and like Saira, tried to fulfill his responsibilities and obligations despite struggling to do so:

Everyone had expectations of me... it was a huge burden. I felt buried under... Sometimes it was as if I couldn't breathe... as if I was being suffocated... I needed constant reassurance that I could cope. Every few minutes I needed somebody to tell me that everything would be okay... I became so annoying for my friends that one by one they all ditched me.

Tapal therefore felt overwhelmed by the expectations that other people had of him. Moreover, his abiding need to allay his doubts and fears about being able to cope resulted in him alienating his friends. A similar experience of feeling overwhelmed was described by Bayat, but unlike Tapal, who turned to his friends for support, his was a far more solitary and isolation one:

I had reached the point that whenever my phone rang I wanted to smash it... The demands were never-ending... The thought of somebody wanting something from me, even if it was just a few minutes to talk, to say hello, drove me crazy... I was totally overcommitted [and] overburdened... Anytime a friend suggested we get together, I'd want to give him two slaps... It was a chore to meet anyone so I hardly did... I felt lonely, of course, but I had no choice.

The pressure to meet other people's demands of him and his commitments to them resulted in Bayat feeling overwhelmed. In addition, he experienced considerable anger and avoided social interaction, consequently sequestering himself, which in turn resulted in feelings of loneliness.

Participants' experience of distress thus included a sense of being overwhelmed and unable to cope with their obligations and responsibilities, which they attempted to mitigate through avoidance or turning to others for support. Moreover, ensuing feelings of anxiety, isolation and anger exacerbated their distress.

4.2.2.4. Confusion: "I couldn't think. Nothing made sense"

A number of the participants of this study recalled their experience of psychological distress as being characterized by feelings of confusion and being "disoriented... as if I had jet lag that just went on and on and never ended." While some participants described experiencing a general sense of "disorder" and "commotion" in their lives, others linked feeling "dazed... [and] unclear about what to do" when faced with distressing events or circumstances. Triggers for such feelings included setbacks and difficulties in their careers that participants were unable to "understand... [and] couldn't have even imagined," strained relationships that resulted in participants struggling with "doubt" and "indecision," and crises of faith that left participants in a "state of upheaval."

For example, Faraz's distress at not being able to find a job and establish himself in a career was accompanied by considerable confusion regarding the reasons for his difficulties:

I kept wondering how I was different from everybody else. It was so easy for them. What was the difference between us? What had I done that they hadn't? ... Why weren't things working out for me? Why was I the one who had to suffer? I just couldn't understand... I was so baffled... It just didn't make any sense.

Faraz reacted with puzzlement and incomprehension at not being able to find a job despite feeling that he was as qualified and capable as other people who had been

successful in securing employment. While Faraz struggled to understand his current situation, Omar's confusion was primarily about a future course of action, namely proceeding with a divorce and the impact it would have on his family:

Between my parents my wife and my daughter I felt as if I was being pulled in different directions at the same time. Everything was entangled... I couldn't think straight... I was very confused. I was unsure of myself, unsure of everything. I didn't know what to do.

Omar's experience of confusion entailed conflicting loyalties to his parents, his wife and his daughter, a lack of clarity, a sense of uncertainty, indecision and a lack of confidence in himself. Kardar, meanwhile, was confused about whether he believed in the Islamic notion of suffering as punishment:

I had trouble believing that God was punishing me by making me suffer. It didn't seem rational. But I was scared that if I didn't believe then I would be punished even more and my suffering would get worse... My thoughts were muddled... I wished I could pick one [point of view] or the other and be clear [about my belief]... The indecision drove me mad... I was in constant turmoil.

Kardar's confusion was similar to Omar's as it was characterized by internal conflict, uncertainty, indecision and the inability to think clearly. There was, however, a significant difference in their experiences as Omar was confused about whether to seek a divorce from his wife and concerned about the consequences of his decision for his family, whereas Kardar's confusion regarding his belief was the primary source of his distress.

Feelings of confusion, therefore, influenced participants' experiences of distress in a variety of ways. For some participants confusion accompanied their distress due to strained relationships or career difficulties and exacerbated their

suffering, while for others it was their confusion and inability to think clearly and decisively that was the source of their distress.

4.2.2.5. Guilt

Guilt was a common theme among participants' experience of distress. Descriptions of participants' experiences ranged from feeling that they "deserved to suffer" to being "weighed down" by guilt. Their feelings of guilt are examined through two further subthemes: Familial Guilt, based on participants' sense of "disappointing" their parents and "letting them down," and Religious Guilt, which resulted from them having "ignored God," "challenged God," or "disobeyed His instructions."

4.2.1.5.1. Familial guilt: "My parents shouldn't have suffered so much due to me"

Participants in this study who felt that they had "not been there" for their parents or had been negligent of their "duty to take care of them" recalled their experience of distress as being characterized by strong feelings of guilt. These feelings derived from a range of factors that included "turning [their] back on" their parents by emigrating to Canada, causing them "stress" and "tension," as well as being "dependent" on them and therefore a "burden that wasn't fair... [and] that they didn't deserve."

For instance, Omar's feelings of guilt were due to being divorced and single at the age of thirty-six, which he considered to be a source of considerable stress for his parents:

It really upsets my parents that I'm divorced. I don't mind being single, but I really feel guilty about how much it bothers my mother... and I know it's not rational but then I end up feeling responsible, as if it was all my fault.

Omar, therefore, did not feel guilty about any transgression or neglect on his part, but due to the distress his circumstances caused his parents. In particular, his mother's aspirations that he be married and settled, and the personal responsibility she took for them not being realised, contributed significantly to his guilt.

Similarly, Faraz's distress at his extended unemployment was based primarily on his sense of letting his father down and the anxiety that he caused him:

He [my father] worked so hard to send me to college and I hadn't been able to get a job despite having two Masters degrees ... most of all I felt guilty for disappointing him. I knew I'd manage somehow, but I felt awful about how much he worried about me.

Faraz, like Omar, felt guilty about not meeting his parents' expectations and for the distress that they had caused them, rather than anything he had done or had any control over. In contrast, Zehra, for example, described feelings of guilt for having emigrated to Canada while her mother continued to live by herself in India:

It was my decision to come to Canada and I don't regret it... [but] I feel I've abandoned my mother by coming here... It's not right for her to be alone at this age. She should have her children around to look after her... [but] I can't do anything about it. My guilt is part of the price I have to pay for all that I have gained by coming to Canada.

While Zehra acknowledged that her guilt stemmed from something she had consciously done, namely relocate to Canada, she did not believe remedying the situation or alleviating her guilt were possible, and therefore accepted her guilt and

reconciled herself to continuing to feel guilty. Hashmi's feelings of guilt were much greater because his parents had looked after him through repeated depressive episodes, followed by periods of hospitalization and recovery, and continued to look after him due to his recurrent anxiety and depression:

I brought them [my parents] nothing but trouble ... Looking after me was a huge strain... Although my father took care of expenses my mother took care of me in every other way... I never let her rest even though she was not well herself ... I felt so guilty that I tried to stay out of their way as much as I could. I would just stay in my room and listen to music.

Despite suffering from severe anxiety and depression, which prevented Hashmi from being self-sufficient and living independently, he blamed himself for being dependent on his parents and consequently felt guilty for being a burden on them. Due to the intensity of his guilt Hashmi felt unable to face his parents and tried to avoid them as much as he possibly could, thereby withdrawing from them and isolating himself.

The participants of this study, therefore, felt guilty about the distress they caused their parents not only due to decisions and actions that they had taken, but also due to personal difficulties and setbacks over which they had limited or no control. Moreover, the latter guilt experienced by the participants often outweighed their own distress due to misfortunes such as unemployment and a failed marriage.

4.2.2.5.2. Religious guilt: "I deserved to suffer"

Notions of being "guilty in front of God" among the participants in this study were intrinsically linked with the belief that they were being punished for their sins. Many, although not all, of the participants who attributed their distress to punishment

for lack of faith or irreligious behaviour also described feelings of guilt that “never go away... will always there” for the same or related transgressions.

Merely the experience of psychological distress also engendered feelings of guilt because participants reasoned that they must have done something to merit such punishment from God, and thus felt guilty for what they had done that displeased Him.

Mehreen, for example, believed that her suffering was punishment for a misdeed or lapse in her adherence to Islam and accepted her guilt despite not knowing the nature of her offence: “God is making me suffer... he’s not forgiving me... I must be guilty of something really bad and I will have to live with my guilt.”

Mehreen thus reasoned that if she was suffering she must be guilty, and having concluded that she was guilty, experienced feelings of guilt even though she was unable to provide any grounds for her feelings.

Unlike Mehreen, who accepted what she believed God had decided for her despite not knowing the underlying reasons, Aalia’s feelings of guilt stemmed from her inability to accept God’s will with equanimity:

I didn’t accept my fate... I resented so many things that happened even though I know that they happened because they were meant to happen. They happened because God meant them to happen... I feel so guilty that I challenged God but I couldn’t help it.

Aalia’s feelings were the result of her belief that her fate was willed by God and consequently to be accepted unquestioningly. Resenting or being angry about her fate was therefore tantamount to resisting or disputing God, which she considered to be irreligious and contradictory to her faith, and was thus the source of her guilt.

Chandni felt guilty for cheating on her husband and having an extramarital relationship with another man: “I am guilty of breaking God’s laws. ... I don’t deserve to be forgiven because I haven’t repented for what I did.”

Chandni’s feelings of guilt were therefore based on behaviour that she believed to be sinful and wholeheartedly accepted her guilt. Meanwhile Hashmi, like the other participants, both accepted his guilt and was resigned to it:

I could have prayed to God and asked for forgiveness but I didn’t... Maybe it was because I thought it would be wrong to ask for forgiveness when I knew that I was guilty of so many things that were wrong and immoral? I don’t know...

Hashmi was unwilling to seek God’s forgiveness to alleviate his feelings of guilt. He was unsure about the reasons for his reluctance, but speculated that the nature of his transgressions and his firmly held belief regarding his guilt obviated the possibility of forgiveness and relief.

Islamic beliefs regarding morality, distress as a form of punishment, and the need to accept God’s will were therefore central to participants’ experience of guilt. Moreover, these beliefs resulted in participants accepting and resigning themselves to their guilt rather than seeking to atone or make amends.

4.2.2.6. Anger

The participants of this study described feelings of anger that ranged from “irritability” to “indignation” and “rage.” Provocations included traffic, the weather, politics, bosses, co-workers, financial pressures, friends and even inanimate objects, especially laptop computers and mobile phones, which participants recalled wanting to “smash with a brick” and being “tempted to hurl out of a window” respectively. For the majority of participants, however, the most significant sources of anger were their

families and their religion. Participants described how they “resented” family members who placed what they considered to be “unreasonable demands” on them, along with being “furious” with those who they felt had mistreated them. The notion that their distress was punishment for sinful behaviour resulted in anger among those participants who believed that they “didn’t deserve to suffer,” as well as those who “struggled” with the Islamic conceptualization of a punitive God. These two sources of anger are discussed separately.

4.2.2.6.1. Familial anger: “I’d be boiling inside, on the verge of blowing up”

Participants’ experience of distress included intense anger towards family members, in particular parents and spouses. Their anger was based a sense of being “criticized... day in, day out, for years and years” and as well as being “taken for granted” or treated “like a servant.” While participants described feelings of “bitter” and “blinding” rage, there was considerable variation in their management and expression of it. Participants ways of dealing with their anger included “keeping it in” to prevent “making things worse,” avoiding family members with whom they were angry “in case they lost control” and “lashing out” because they “didn’t care anymore.”

Mehreen’s anger towards her husband, for example, was due to having to support him financially while simultaneously pretending to conform to traditional gender roles:

My husband behaved as if he was this big shot and wanted me to be a submissive and obedient wife... for a while it was okay. But he was unemployed for ages and we lived on my savings... completely wiped them out. He even used my money to help out his parents... I was furious with him

but couldn't say anything because if I did his pride would be hurt and he'd throw a tantrum with me... that made me even angrier.

Although Mehreen was not particularly bothered by her husband's demands for respect at first, once she concluded that he had also taken advantage of her, she felt considerable anger towards him. Moreover, her inability to discuss financial matters with him or express her anger because of his likely reaction further aggravated her feelings.

Bayat's anger was based on feelings of being denigrated by his wife and held to standards he considered unreasonable:

Throughout our marriage my wife criticized me and compared me to her good-for-nothing brothers who spent their lives living off their father's inheritance and cheating their sisters out of their share... For years I put up with it but after a point I'd had enough... I used to control my temper but then I couldn't anymore... When she criticized me I'd let her have it, I wouldn't hold back... I'd really explode with rage... I wanted to hurt her the way she had hurt me for so many years.

Bayat described initially suppressing his anger like Mehreen, but over time began to express it to his wife aggressively and destructively with the explicit aim of avenging the pain he believed that his wife had inflicted on him. Qassim, in contrast, deliberately avoided his father because he was concerned about not being able to control his anger towards him:

As long as I can remember my father bullied us... He was a real tyrant... We were all terrified of him. But he never held a job for very long... he relied on my mother to support the family and pay the bills... It drives me crazy to think how badly he treated us while contributing absolutely nothing... I'd like to

beat the shit out of him... I have stay away from him in case I actually do...

I'm mad at my mother for letting him treat us like that. And I'm mad at myself for taking all his shit for so long...

Qassim's anger was therefore directed primarily at his father for mistreating and terrorizing his family and failing to fulfill his responsibilities to them. In addition he described feelings of anger towards his mother and also himself for not standing up to his father and allowing the abusive behaviour to continue.

The participants' of this study therefore described how they initially indulged, tolerated and feared family members' mistreatment of them, which subsequently resulted in intense anger. There was considerable variation in participants' expression of their anger, with some restraining themselves or avoiding those family members against whom they harboured strong feelings of anger, to expressing their rage with the explicit intention of causing pain and suffering.

4.2.2.6.2. Religious anger: "This idea of a petty and vengeful God makes me furious"

Islamic beliefs, practices and the expectation to conform to them resulted in significant feelings of anger among a number of the participants of this study. Underlying participants' anger was the notion their psychological distress was "punishment" and "the will of God" and that "God was making [them] suffer" because they had "disobeyed His instructions." Participants who accepted the notion of distress as punishment recalled feeling angry because they believed their suffering to be unjustified and consequently asked God "Why me? Why do I have to suffer?" For other participants, the notion of a punitive God which they described as being "foisted" on them, along with the expectation that they should seek to alleviate their

distress by “praying for forgiveness” and accepting their fate because “things will work out the way they are meant to work out” was a source of anger.

For example Ishaq, who subscribed to the notion of psychological distress as punishment by God, described feelings of anger because he felt that he had not done anything that warranted his suffering: “Sometimes when I was angry... I’d question God in my prayers. Why? What have I done to deserve this? When I try and do everything right why does crap still fall in my lap? It’s not fair.”

Ishaq’s anger thus derived from a sense that his distress was an unjustified or unfairly imposed punishment, and he expressed his anger by questioning God’s reasons for punishing him.

Saira, in contrast, recalled her experience of distress as being characterized by considerable feelings of anger based on Islamic beliefs and practices:

... being told that you should have faith in God and pray and things will work out was totally unhelpful and frustrating... being told to let fate or God sort out the problem... was really bloody annoying... I was irritated and impatient with the idea and irritated and impatient with people who suggested it.

Saira therefore resented being advised by people around her to rely on God for relief and was also angered by the thought of depending passively on God to mitigate her distress. Similarly, Yasin was indignant at the conceptualization of a punitive God implicit in the idea of psychological distress as punishment imposed by God:

The idea of God as a petty bureaucrat, sitting with a checklist, waiting to catch every little thing I forgot or did wrong struck me as ridiculous... It made me mad... It made me mad that people believed it and even madder that I was supposed to believe it, and probably did, to some extent.

Yasin's anger, like Saira's, stemmed both from the idea that his distress was God's way of punishing him for his lapses and wrongdoings, as well as the fact that people with whom he interacted believed in this idea and also expected him to believe in it.

Participants therefore experienced anger based on the notion of psychological distress as form of punishment by God due to a number of different reasons. These included feelings among participants that they did not deserve such punishment, their inability to accept the idea that God was making them suffer to punish them and that they should seek relief by trusting God and praying for forgiveness, other people's belief in this idea, and the expectation that they should also believe in it and conform to it.

4.2.3. Behavioural Experience

Participants' descriptions of their experience of psychological distress included significant changes to their behaviour. These changes included a variety of strategies to avoid and get relief from their distress and "have a moment's peace... a break" and "just forget ... feel good about myself ... or at least not feel like crap" as well as "get away from everyone and everything." In addition, participants recalled neglecting their responsibilities to their families and described feelings of not being "around for my children" and being "useless as a parent." Many participants also felt that they had been remiss in fulfilling the duties and responsibilities incumbent on them as Muslims, which they attributed to reasons ranging from being "anxious and overwhelmed" to a "weakening of faith."

The behavioural aspect of participants' experience of psychological distress is discussed through themes of numbing and avoidance and neglect of responsibilities.

The theme Numbing and Avoidance includes the subthemes Substance Abuse and

Social Withdrawal. The theme Neglect of Responsibilities is organized into the subthemes Neglect of Familial Responsibilities and Neglect of Religious Responsibilities (see Figure 9).

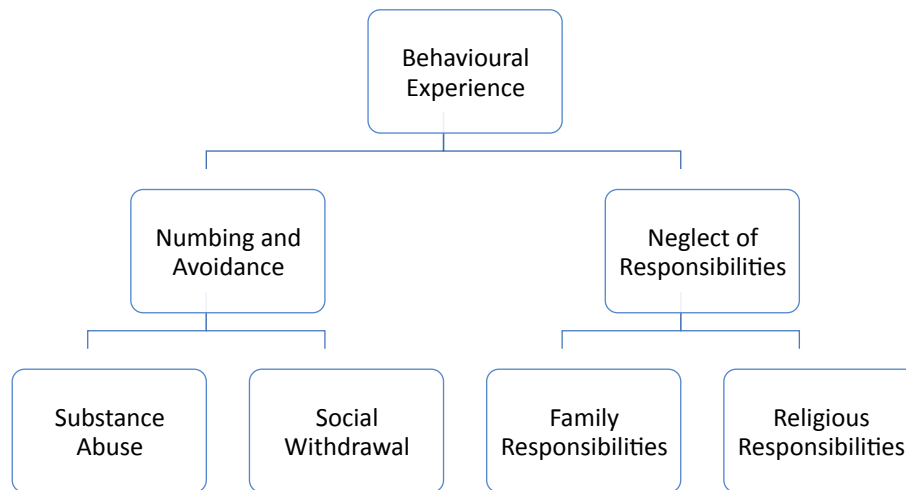


Figure 9. Behavioural Experience

4.2.3.1. Numbing and avoidance

Participants engaged in a number of behaviours in an attempt to “numb” or “distract” themselves so they could cope with their psychological distress. Examples of such behaviours include the excessive consumption of alcohol, described by participants as “a companion,” and the use of benzodiazepines without proper prescriptions, which were recalled by one participant as being “as good as alcohol” with the added advantage of “not being against Islam.” Participants also attempted to “simplify their lives” and “reduce unnecessary stress” by withdrawing from their family and social lives and “not going anywhere... not meeting anyone.” Such behaviours and coping strategies employed by the participants of this study are discussed under the subthemes Substance Abuse and Social Withdrawal.

4.2.3.1.1. Substance abuse: “Vodka was my crutch”

Notwithstanding the strict prohibition on the consumption of alcohol in Islam, accompanied by considerable social and cultural stigma against drinking in most

Muslim communities, a number of participants nevertheless reported that alcohol abuse was a significant feature of their experience of psychological distress. Participants who considered themselves observant Muslims regarding other aspects of their faith recalled disregarding the injunctions against alcohol in Islam for reasons such as “they don’t apply to me because I don’t really get drunk.” Participants would then end up “drinking too much... much more than I knew I should” and drinking simply “to get through the day.” For those participants who were uncomfortable about resorting to alcohol, benzodiazepines provided an alternative. They described “using them to get through difficult situations” and taking them as if they were “like candy, or at least like vitamins.”

For example, Chandni used benzodiazepines when she felt overwhelmed and unable to cope with the conflict with her husband and mother-in-law:

Whenever things with them [Chandni’s husband and mother-in-law] got too much for me I’d take a few pills—two, three, four—I’d keep taking them until I was completely knocked out... I would sleep for days. I wouldn’t leave my bed for days... The pills were my only escape...

Benzodiazepines thus provided Chandni with an escape from interpersonal conflict and a tense environment. She continued to use benzodiazepines despite being “rushed to hospital to get my stomach pumped” on two separate occasions because her family thought she had “overdosed and was trying to commit suicide” and the judgment and criticism she had to endure as a result. Yasin, meanwhile, recalled resorting to alcohol in order to manage daily responsibilities and obligations:

I drank to numb myself to get through business meetings. I had to numb myself with vodka to survive socializing. I needed a couple of drinks to get through evenings at home... I drank to turn off my mind and stop thinking

about all my problems... Sometimes I would carry vodka in a hipflask and mix it into Sprite or Seven Up so nobody would know.

Despite using alcohol excessively as a means of numbing and avoidance regarding unpleasant, stressful and anxiety provoking situations or thoughts, Yasin struggled to reconcile his drinking with being a Muslim:

I'm a good person, I'm honest, I'm generous, I treat people well and when I drink I don't gamble away my family's savings or visit prostitutes or beat my wife... What's the harm? Why should God object? ... I do plenty of good things, the one bad thing I do should be overlooked.

For the participants of this study, therefore, the excessive use of prescription medication and alcohol provided a means of escape, numbing, and avoidance. Moreover, they persisted with their substance abuse despite it being contrary to their religious beliefs, while simultaneously facing the prospect of disapproval and stigmatization, as well as risking their health and even their lives.

4.2.3.1.2. Social withdrawal: "One by one I deleted everyone from my life"

Many of the participants in this study described how they found interacting with friends and family "no longer enjoyable," "stressful," and "unpleasant" during their experience of psychological distress. Consequently, they kept to themselves by "staying at home... staying out of everyone's way and making sure everyone stayed away" from them. Participants recalled that, although this social withdrawal resulted in their feeling "calmer" and that their lives were "simpler...[and] less cluttered," they also felt "cooped up" and "alone."

Hashmi, for example, found being among other people to be upsetting and anxiety provoking. He therefore tried to avoid people altogether and if compelled to meet anyone would try and keep his interaction to a minimum:

If I was around people I'd get agitated ... [and] impatient to get away immediately... I totally stopped meeting people and if anyone came over to our house I'd stay in my room until they left... I became used to being alone and didn't mind it at all.

Whereas Hashmi recalled being anxious when interacting with other people, Rubina described a different basis to her stress: she would have to report back to her father after meeting with her friends and justify going out and spending time with them:

Meeting my friends was extremely stressful. I'd be anxious all the time... all I could think about was getting home and having to explain to my father why I went out, who I met, how much money I spent... I was better off staying at home and not going anywhere.

In contrast to Hashmi and Rubina, who were content to remain at home and restrict or even eliminate their interaction with other people, Aalia felt overwhelmed by keeping up with her friends and therefore stopped going out with them. She reported feeling isolated as a result:

Going out was such a hassle that it just wasn't worth it... chasing down friends, coordinating plans, figuring out what to do about each other's children, it was just too overwhelming... I was lonely... often I felt cut off from everyone, but what could I do?

Thus, while Aalia described being unable to cope with the demands of her social circle and felt compelled to withdraw from it, she had to contend with the additional distress of loneliness and isolation.

Social withdrawal among the participants of this study was therefore motivated by feelings of anxiety, stress, and being overwhelmed and unable to cope. While some participants were content with their ensuing isolation and found it a relief not to have to meet and interact with people, others felt lonely and distressed.

4.2.3.2. Neglect of responsibilities

Many of the participants of this study described “neglecting” and “failing to fulfil” their responsibilities during their experience of psychological distress, which they attributed to “struggling to cope” with their distress. By neglecting their responsibilities, however, participants ultimately exacerbated their distress due to feelings of “guilt” and “conflict.” While participants described neglecting a range of responsibilities that included parental, spousal, social, economic, academic, moral, and religious responsibilities, it was the neglect of their responsibilities to their children, spouses, and parents, and of their responsibilities to God that were especially significant to their experience of distress. The subthemes Neglect of Familial and Religious Responsibilities are discussed in detail below.

4.2.3.2.1. Familial responsibilities: “I was too depleted to be a mother”

Reflecting on their behaviour during their experience of psychological distress, many of the participants of this study recalled being so “preoccupied” or “focused” on their distress that they neglected their responsibilities to their families. In most cases, participants described adverse and enduring consequences due to this neglect, ranging from feelings of resentment against them to relationships with other

family members being “changed forever” and “ruined.” While some participants believed their family members should have been “considerate” and “sympathetic,” others considered their reactions to be justified and felt guilty for neglecting their parents, spouses, or children.

Saira, for instance, recalled that coping with her distress left her depleted and unable to give time to her husband, which strained their relationship: “Sorting myself out took all my time and energy. I was completely drained. I had nothing left for my husband... He should have understood but years afterwards he held it against me.”

While Saira accepted that she had neglected her husband during her experience of distress, she felt he should have been more accommodating. In contrast, Bayat, who described similar difficulties in coping with his distress, acknowledged that his neglect of his responsibilities to his family placed a considerable burden on his son, and consequently did not consider his son’s resentment against him to be unjustified:

Getting though each day took a lot out of me... I left my son in charge of the business, the family, everything... he was still a child but had to become head of the family and pay the bills and run the household... it must have been traumatic for him. He still resents me for it.

Like Saira and Bayat, Kardar described how his distress resulted in him being unable to fulfill his responsibilities to his mother:

My mother was all alone and I should have been looking after her... organizing things so that she would never have to worry about money... I was so caught up with my own problems that I ignored her... I did nothing at all for her. It was very selfish and irresponsible of me.

Kardar's experience of distress, however, was different from that of Saira and Bayat because his neglect of his mother did not adversely affect his relationship with her. Instead, Kardar was critical of his own behaviour and felt he had been thoughtless and unduly focused on his own needs. Chandni was similarly critical of herself and regretted neglecting her children during her experience of distress: "I was so obsessed with myself that I barely thought about my children... they were more or less abandoned... My relationship with them never recovered. I feel terrible about not being there for them."

Chandni's distress was therefore compounded by her regret at neglecting her children and the negative impact her neglect had on her relationship with them.

Coping with their own distress thus resulted in many of the participants of this study neglecting their responsibilities to their families. This neglect exacerbated participants' experience due to the strain it placed on relationships with other family members, along with feelings of guilt and regret at their behaviour.

4.2.3.2.2. Religious responsibilities: "My faith became a burden"

Many participants reported that during their experience of distress they had neglected religious responsibilities that all Muslims are expected to fulfill such as praying five times a day. They described themselves as having been "lax about praying" and while some of the participants attributed the neglect of their religious responsibilities to a "lack of will power," feelings of anxiety that made it "impossible" to pray, as well as a sense that religious responsibilities such as prayer were "rituals to comfort oneself" that would make "no difference" to participants' experience of distress, others offered no reasons for their behaviour.

For example, Hashmi, who believed that it was his "duty and responsibility" to fast during Ramzan and pray five times a day, was unable to explain why he neither

prayed nor fasted: “I didn’t pray at all. I don’t know why... [but] I asked my mother to say special prayers for me and read the Quran on my behalf.”

Although Hashmi completely neglected his religious responsibilities, he did consider them sufficiently important to request his mother to pray for him. Similarly, Faraz, ascribed similar significance to prayer but felt that given his anger at his distress and his refusal to submit to God’s will, it would have been inappropriate for him to pray to God: “I just couldn’t accept my fate as I was supposed to... I was so angry about what I was going through that it wouldn’t have been right to pray. I wanted to, but it would have been disrespectful.”

Faraz therefore took a conscious decision not to pray. Tapal also wanted to say his prayers regularly, but unlike Faraz, Tapal’s perfectionism regarding praying made it severely anxiety provoking and ultimately impossible for him:

Everything had to be perfect... the way I pressed my hands on the floor, the way I said each Arabic word. If I didn’t get it right I’d start again from the beginning... I became obsessive... Praying became too stressful. I couldn’t keep it up.

In contrast to participants such as Faraz and Tapal who described wanting to pray, Mehreen recalled no such desire or inclination during her experience of distress: “I would not even say my prayers... What was the point? ... I wasn’t going to get an answer back. I’d be throwing questions in the air.”

Despite considering prayer to be futile and frustrating, Mehreen nevertheless felt uncomfortable about not praying. This discomfort was inconsistent with the futility and frustration that she associated with prayer, and thus resulted in internal conflict which was additionally troubling for her.

The participants of this study therefore neglected their religious responsibilities because they were either unable to fulfill them due to factors such as anxiety, or were unwilling to because of a sense of impropriety or lack of conviction. While some participants had a clear understanding of their behaviour, its causes, and its consequences, for others the experience was characterized by conflict and contradiction.

The first section of this chapter focused on the circumstances and causes of participants' experience of distress. It provided the context for this section, which explores participants' experience of distress and leads to the final section of the results chapter of this study, which covers how the participants coped with their distress.

The various themes of participants' experience of distress which they highlighted during their interviews included those that accompanied, exacerbated, and ultimately constituted their experience of distress. For example, participants described a variety of physical experiences such as chronic pain, gastrointestinal disorders, fatigue, and disrupted sleep that ranged from being secondary to their experience of distress to being intrinsic to it. For many participants it was the adverse impact on their productivity, functioning, and lives, and the ensuing frustration, loneliness, and isolation, rather than the physical discomfort, that they emphasized in their recollections of their experience of distress.

In contrast, for almost all the participants of this study, the emotional aspect of their distress was central to their overall experience. Feelings of being overwhelmed, hopeless, helpless, confused, guilty, and angry were especially distressing and debilitating and what participants remembered most vividly. Moreover, many of these emotions were interconnected and triggered by and reinforced by each other. For

some participants, they compounded their experience of distress by leading to additional negative emotions such as loneliness and anxiety.

The participants of this study described their behavioural experience of distress in terms of numbing and avoidance through substance abuse and social withdrawal and the neglect of their familial and religious responsibilities. Like the other themes of participants' experiences, these were distressing both for the own sake as well as for the associated distress that resulted from feelings of shame, isolation, guilt, interpersonal and intrapersonal conflict. The examination of participants' physical, emotional, and behavioural experiences of distress in this section forms a basis for the next section, which covers the strategies they used to cope with their distress.

4.3. Coping with Distress

The participants of this study employed a variety of strategies to cope with their psychological distress. Given that participants had resorted to these strategies towards the end of their experience of distress, their recollections of them were relatively recent and accessible compared to participants' memories of the context and experience of their distress. Participants utilized these strategies long after their distress had diminished, with many continuing to utilize them when interviewed for this study even though they were not experiencing any significant psychological distress at the time. This made it easier for them to describe the use and efficacy of these strategies in detail. Moreover, since these strategies had resulted in relief from their distress, most participants were enthusiastic about discussing them and recommending them to other people facing similar difficulties.

This section examines how participants coped with or managed their psychological distress. It therefore acts as a conclusion to the previous sections that

established the context and explored the lived experience of participants' distress. The domain of coping with psychological distress is organized into distinct themes of social coping, religious coping, and psychological coping (see Figure 10).

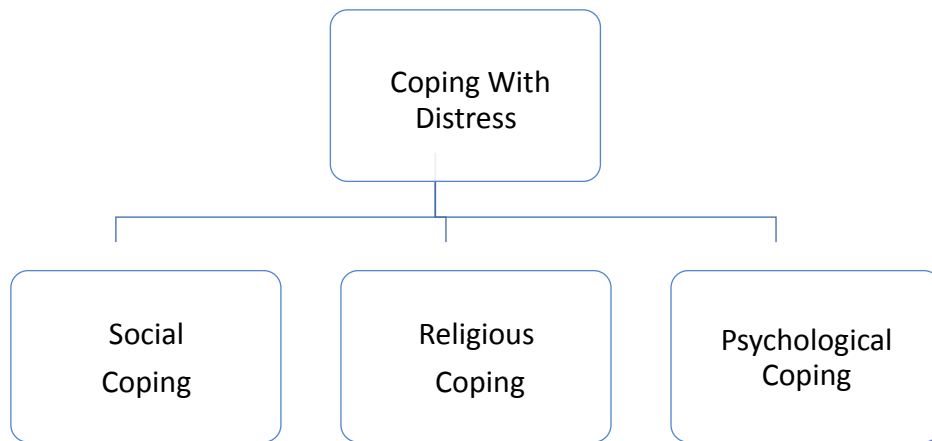


Figure 10. Coping with Distress

The theme of social coping includes the subthemes Family and Community. The subtheme Family examines the role of participants' families in their experience of relief. It describes how a number of participants were able to turn to parents, siblings, and spouses for empathy and support, and how those whose family relationships were characterized by anxiety, disappointment, and hurt were able to cope with their distress by lowering the expectations of their relationships with other family members. The subtheme Community explores the different ways that participants' membership in their local Muslim communities and in Canadian society in a broader context enabled them to alleviate their distress through a sense of connection and belonging, or freedom, autonomy, and privacy.

The theme Religious Strategies is organized into the subthemes Trust in God's Plan, Connection With God, and Reevaluation of Religious Obligations. The subtheme Trust in God's Plan focuses on how participants alleviated their distress by reconceptualizing their experience of distress as part of God's plan. The subtheme Connection With God examines how participants experienced relief by attempting to

move close to God, and the subtheme Reevaluation of Religious Obligations describes how participants who felt overwhelmed or resentful of their religious obligations mitigated their distress by reducing the burden that these obligations placed on them.

The theme Psychological Coping describes how psychological interventions by mental health professionals provided participants with relief from their distress. The subtheme Counseling and Psychotherapy examines the roles played by empathy, expressing and exploring emotions; and how participants' awareness, understanding, and acceptance of themselves and their needs during the process of counseling and psychotherapy enabled them to manage and cope with their distress. Meanwhile, the subtheme Psychiatry focuses on how receiving a diagnosis, seeing their distress as illness, and then taking medication often resulted in prompt relief for participants without the embarrassment, vulnerability, and effort that they believed psychotherapy entailed.

4.3.1. Social Coping

Social strategies for coping with distress involving relationships with participants' families and the communities in which they lived played an important role in participants' experience of relief from their distress. For those participants who enjoyed close and healthy relationships with their families, knowing that their parents, siblings, spouses, and children were "there for them" or that they could "turn to them for support" played a significant role in their coping. The support extended by family members ranged from "simply listening" and allowing participants to "to vent, to unload... to lose it without worrying about the consequences," to providing financial support and even "taking charge" and helping to "get my life back on track" by sorting out problems pertaining to their education, careers, marriages, and other aspects of their lives. In contrast, for those participants for whom strained or

conflictual family relationships were the cause of their distress, relief was the result of “creating a safe distance” between them and members of their family or “lowering expectations” of other family members and their relationships with them to “minimize the disappointment” or become “immune... so that I wouldn’t be hurt.”

Correspondingly, the local Muslim communities to which participants belonged played an important role in participants “keeping in touch” with their cultural roots and identities and not “losing themselves” and thus feeling “alienated and isolated.” At the same time, exposure to Canadian attitudes and the freedom provided by Canadian society allowed participants to “pick and choose” which aspects of their cultures of origin, especially in terms of relationships with family members, they wished to adopt and which ones they found “suffocating” or “demeaning” and therefore wanted “to ditch... [and] to make clear to everyone... that they no longer applied to me.” Participants’ recollections of the role of family relationship and the communities that they inhabited in coping with their distress are clustered into the subthemes Family and Community (see Figure 11).

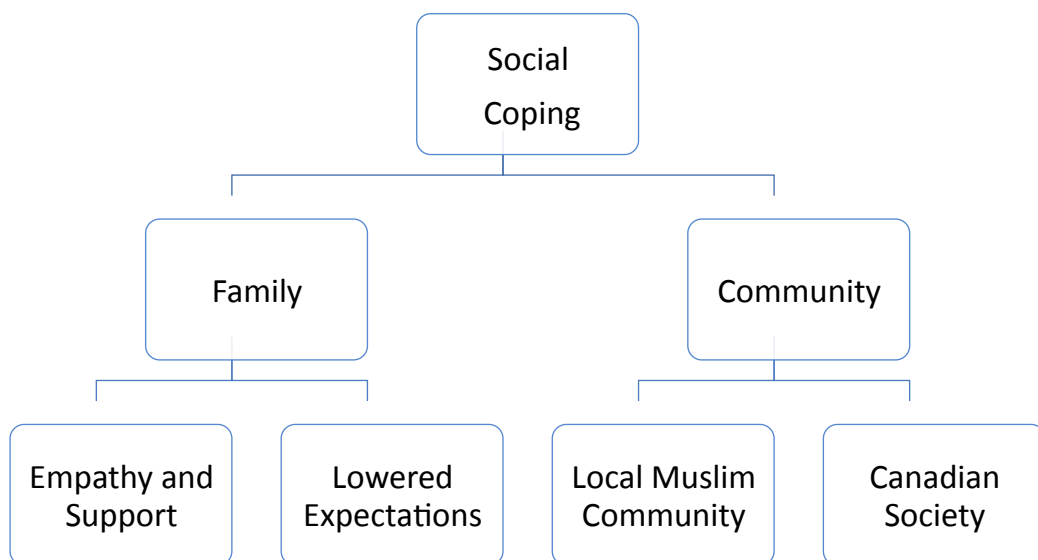


Figure 11. Social Coping

4.3.1.1. Family

Relationships and interactions with family members had a significant influence on participants' coping with psychological distress. Participants who enjoyed healthy relationships with their immediate and extended families benefited from "just being able to talk about my problems" and receiving support towards resolving academic, financial, professional, and immigration issues, or generally "sorting my life out." For participants whose psychological distress was rooted in relationships that were "toxic" and characterized by "hurt" and "disappointment," coping entailed "questioning" and in most instances "lowering" or "rejecting" the expectations of the relationship. Empathy and support from participants' families and lowered expectations of relationships are discussed separately.

4.3.1.1.1. Empathy and support: "Just being listened to made all the difference"

Participants recalled how being listened to by family members as they described their distress resulted in considerable relief. The empathy provided by parents, siblings, spouses, and even aunts and uncles enabled participants to feel "understood" and therefore not like a "crazy... an alien from outer space." It also afforded them an opportunity to "unravel" their distress and "put it into words," which made it less "daunting" and "something I felt I could deal with." In addition to empathy, the "real... concrete" support extended to participants assisted them in "regaining control" of their lives, thereby alleviating distress. This type of support ranged from financial assistance in the form of "hard cash" to organizational and logistical help, such as "making appointments for me... and then driving me there to make sure I didn't miss them."

For example, Saira described how sharing her stresses and concerns with her family played a role in diminishing her distress: “They helped me clarify my thinking... I actually had that feeling of getting something off my chest... I found it extremely helpful.”

Thus, Saira’s relief was due to unburdening herself to her family along with examining and deconstructing her understanding of her distress. Qassim, in contrast, required far more active and involved support from his family:

They got me out of the mess I was in... got me a lawyer, paid her fees, found me a place to stay... That they cared enough to help despite all I had done was huge... It made a really big difference that I wasn’t on my own anymore.

It was therefore not only the legal, financial, and organizational support extended by Qassim’s family, but also the sense of validation and belonging that he derived from it, that enabled him to cope with his distress. Kardar reported a similar experience, in which talking to his extended family about the issues underlying his distress led to him finding a resolution. This also increased his sense of agency:

Sitting down with my uncles and going over my problems made everything feel manageable... Mostly they just listened, they didn’t say much, they didn’t lecture me as I had feared... by the end I had worked out what needed to be done... I didn’t feel so helpless afterwards.

Kardar, like Saira and Qasim, thus benefitted from his extended family’s empathy and understanding, which allowed them to reflect on his distress and consider ways of addressing it.

The empathy extended by family members was therefore instrumental in participants’ experience of relief by enabling them to feel understood, and by providing an opportunity to reflect on, articulate, deconstruct, and address the causes

of their distress, thereby making it more manageable. In addition, family support facilitated coping with distress by making resources for solving participants' problems available to them, while the fact of being the recipient of such support made participants feel cared for and reduced their alienation.

4.3.1.1.2. Lowered expectations: "I simply stopped caring"

Many of the participants of this study recalled how lowering their expectations of themselves with regard to their parents, spouses, and children; their expectations of other family members; and family members' expectations of them helped them cope with their distress. Participants described how their expectations of being a "dutiful son," a "good, if not perfect, parent," being in a "happy marriage" and being "loved completely... unconditionally" were "questioned" and "disputed" and then "lowered" or even "discarded." Lowering expectations, according to participants, often "made no real difference" to their interaction with other family members, but made it "easier to cope with" the "insensitivity" and "hostility" that characterized their relationships.

For example, challenging his parents' expectations of him to be successful and established in his career resulted in relief for Faraz:

... there was more to my life than making my parents proud and providing them with accomplishments to boast about... I felt that a tremendous burden had been lifted... I became immune to their criticism... I didn't feel like a failure anymore.

Even though Faraz remained unemployed and continued to be criticized by his parents for not being able to find a job, no longer feeling compelled to please them took considerable pressure off him. It enabled him to deflect their criticism and ultimately feel better about himself. Whereas Faraz was able to cope with his distress

by challenging his parents' expectations of him, Aalia's relief resulted from lowering her expectations of herself as a parent:

... it just wasn't possible for me to watch out for him [my son] every second as if he was still a child... Once I accepted that, it was liberating to not worry constantly about him... and not feel guilty about not worrying.

Although there was no tangible difference in Aalia's relationship with her son, by absolving herself of the burden of being constantly vigilant about his well-being, her anxiety diminished and she also no longer felt obligated to be anxious, which resulted in a sense of freedom and relief. In contrast, Rubina's experience of relief also stemmed from discarding her expectations of her father:

I no longer expected my father to be a father to me. For me he was a sick man... helpless... depressed... It didn't bother me when he treated me badly because I didn't expect him to love me or look after me.

Rubina was able to tolerate her father's mistreatment because she did not expect any affection or support from him and was therefore neither hurt nor disappointed when she did not receive it. Similarly, by discarding all expectations of her husband, Chandni was able to eliminate the anxiety and fear that characterized her marriage:

I made peace with the fact that we would never have a normal husband-wife relationship... I stopped considering him a companion, or even wanting him to be a companion... I stopped caring if he was upset with me... it became easy to ignore his temper outbursts and bullying.

Not being constrained by the expectations of a relationship with her husband made Aalia less vulnerable to his displeasure and intimidatory behaviour, and thus helped her cope with her distress.

Participants were thus able to cope with their distress by lowering their expectations of their family relationships, which included both their roles in the relationships and those of their parents, children, and spouses. By challenging, lowering, or even discarding expectations, participants were able to experience relief despite there being no change in their family members' behaviour and interaction with them.

4.3.1.2. Community

Simultaneously being members of their local Muslim communities and broader Canadian society helped the participants of this study cope with their distress in different ways. Local Muslim communities, which were often “cultural communities... Muslim in name only,” played an important role in preventing participants from feeling “rootless” and “lonely” and offered them connections to their culture of origin, thereby allowing them to “hold on my identity.” Through companionship and social activities, these communities also served as a base for participants to “rebuild” lives that had been “unsettled” by immigration, relocation within Canada, and children growing up and leaving the home. These local communities also provided access to individuals knowledgeable about Islam who were able to mentor participants through their religious crises.

Meanwhile, being part of Canadian society and thus a culture and environment that “valued” and “emphasized” individualism provided participants “freedom that would have been unimaginable” in their cultures of origin. Moreover, the relative privacy and anonymity of Canadian society enabled participants to exercise these freedoms, especially regarding “how I want to live my life... [and] how much I want my parents to be involved in it.”

Thus, whereas local Muslim communities promoted affinity and belonging, Canadian society allowed participants personal independence and the establishment of boundaries. The distinct roles played by local Muslim communities and Canadian society in helping the participants of this study cope with their distress are discussed separately.

4.3.1.2.1. Local Muslim community: "They kept me alive"

The participants of this study turned to their local Muslim community for companionship, a sense of "belonging," and "connection." Although community activities generally "revolved around the mosque," they were "not always about religion" and were often "charitable, social... sometimes even athletic," featuring "very competitive cricket matches." While many participants' involvement with their local communities was focused on worship, for others it was "primarily social" and a way of getting to know other people from similar cultural backgrounds. Regular interaction with other Muslims from South Asia helped alleviate participants' loneliness and isolation, and their distress due to feelings of being "uprooted... [and] dislocated" from their cultures and identities.

Omar, for example, described how the local Muslim community enabled him to cope with his anxieties of assimilation into Canadian culture:

Going to the mosque and being part of the congregation, not just on Fridays but whenever I could, was a way of holding on to my identity... It was comforting... as if I had brought a part of home with me to Canada. I belonged somewhere. I no longer felt cut off... I didn't feel so lost anymore.

Visiting his local mosque thus helped Omar remain connected to his culture and maintain his identity as a Canadian Muslim with South Asian roots. Similarly,

Bayat relied on his local Muslim community for companionship and to stay socially active:

My children had grown up and had their own lives. My wife and I had drifted apart... My brothers and sisters couldn't get visas to come to Canada. I was very lonely... My friends were my family. They kept the loneliness at bay, kept it from killing me. I only survived because of them.

For Bayat, therefore, the friends he made in the Muslim community replaced his family and helped him cope with feeling isolated and distant from his children and siblings.

While Muslim communities to which the participants of this study belonged tended to congregate in mosques and emphasized prayer and other faith-based activities, the benefits that participants availed from them were not primarily religious in nature. Instead, the experience of relief reported by participants derived from the social interaction, companionship, connection to cultural roots, and sense of identity that they provided.

4.3.1.2.2. Canadian society: "I could finally become the person I wanted to be"

While feelings of insecurity and exclusion from Canadian society resulted in considerable distress for many participants in this study, others described enjoying the "privacy" it provided and how it helped them cope with their distress. Exposure to Canadian attitudes towards family relationships enabled participants to realize that they "had a choice" regarding how close and connected they wished to remain with their families and "how much of their parents' interference I was willing to tolerate." Similarly, examples provided by friends and co-workers resulted in participants

concluding that “living my own life did not mean I was betraying my parents” and led them increasingly to seek “independent” and “self-sufficient” lives.

Participants also recalled how they “thrived” from being “irrelevant” and “unknown” in Canadian society, which absolved them of the “burden” of “family reputation[s] going back generations.” In particular, feeling “anonymous” allowed them freedom that would have been inconceivable in their countries of origin.

Ishaq, for instance, described how living in Canada relieved the pressure of being from a prominent Pakistani family:

It was a blessing to just be myself and not have to worry being somebody’s son and grandson and great-grandson... I loved that nobody cared about my family... that I wasn’t worth gossiping about... I could live my life on my own terms in a way would have been impossible back home. I felt free. At last I could breathe.

Due to the anonymity provided by Canadian society, Ishaq did not have to contend with the anxiety of being compared unfavourably with other family members or be careful not to be a source of disappointment or embarrassment to his family. Moreover, because he did not have to live up to standards established by previous generations, he was free to make his own lifestyle choices. Similarly, Canadian society gave Zehra the opportunity to abandon a way of life that did not appeal to her and adopt one that did:

After I moved out of my parents’ house, they couldn’t run my life anymore, they couldn’t interfere... I no longer had to explain or justify everything I did. It was liberating. Sometimes I would imagine that being released from jail would feel like this... I could finally live like an adult. I could finally start living my life. I was finally really alive.

Zehra was therefore able to establish boundaries between herself and her family that protected her privacy and independence. As a result, she felt freer and less constrained by her family and their values and could therefore focus on her own ambitions and self-actualization.

Being members of Canadian society and availing of the anonymity and privacy afforded by it thus provided the participants of this study relief from the distress caused by family expectations and constraints. As a result, participants were able to establish boundaries with their families, assert their independence and autonomy, and make their own lifestyle choices.

4.3.2. Religious Coping

Since the belief that they were being “punished by God” played an important role in the distress experienced by many of the participants of this study, coping strategies entailed “try[ing] to get close to God” by “connecting” or “reaching out” to Him through prayer or in “my own way” and “seeking forgiveness... asking for it, pleading for it.” A number of participants also coped with their distress by “reaffirming...[their] blind faith” in God and consequently “placing complete trust” in Him and accepting that their suffering had meaning because it was “part of a larger scheme of things” and “God’s will” and therefore “for the best.” Participants also experienced relief by taking advantage of exemptions from religious obligations applicable to them based on Islamic tenets or “within the limits of what was allowed.” For other participants, sharing and exploring their reservations and difficulties regarding their faith with individuals who had a similarly problematic relationship with Islam led to “personally reinterpreting... [and] being sensible,” or even challenging and “rejecting” traditional Islamic notions of punishment and thus provided considerable relief. The details of participants’ religious coping with their

distress are examined through the subthemes Trust in God’s Plan, Connection With God, Exemption From Religious Obligations, and Rejection of Religious Beliefs (see Figure 12).

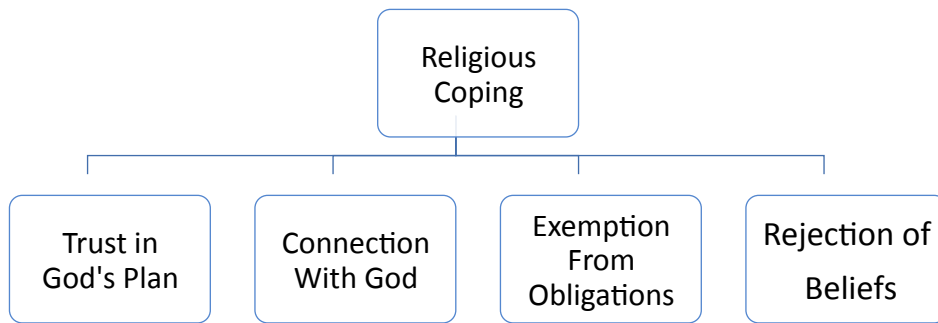


Figure 12. Religious Coping

4.3.2.1. Trust in God’s plan: “It was God’s will”

To cope with their psychological distress, many participants in this study ascribed meaning to their experience by interpreting it as “part of God’s plan” and “part of a larger scheme of things.” Participants’ belief in “meaning and structure in the background” and that the “universe is too beautifully balanced not to be structured” enabled them to “trust God completely... absolutely” and therefore accept that their distress was not “random” or “incidental” but “willed by God” and “therefore for the best.” There was, however, considerable variation in participants’ understanding of their own role in the process, with some relying passively on God to “sort things out” for them while others were of the opinion that God would only help if they “did all they could.”

Faraz, for example, reached the conclusion that once he had made a sincere effort to resolve his problems, he could then leave the outcome to God:

I understood that as long as I was doing my best, what happened was in God's hand. I left it up to God... that gave me peace.... If things didn't go my way I wouldn't get as angry and frustrated as I used to before.

Trusting God with his fate provided Faraz relief from the pressure to succeed and helped him to cope with setbacks and disappointments. Similarly, discussion with other Muslims at his mosque led to a change in Omar's perspective. By accepting that God had willed his circumstances and that his suffering "wasn't just about me, all alone, by myself," Omar could cope with his distress: "Seeing myself as part of a larger scheme of things... a cog in the wheel... helped to give meaning to everything that happened... I was able to accept it because it was God's will and therefore for the best."

Omar's relief was therefore based on ascribing meaning to his distress by seeing it as part of God's plan and trusting that whatever God had willed for him as part of this plan was optimal for him. Unlike Faraz, Omar did not consider an effort on his part to be a precondition for relying on God. Aalia was similarly content to trust in God's plans for her:

I believe that I can only see a small section of a bigger picture. I believe that things happen for a reason... because they are meant to happen, because God means them to happen... Whatever happens will be for the best because it is part of God's plan.

Aalia's coping with her distress was therefore based on her conviction that God had a plan for her, that His plan was beyond her comprehension and there was therefore no point in trying to understand it or make sense of it. Moreover, she believed that since her distress was God's will and part of His plan for her, it was thus in her best interest to be accepted with equanimity.

Participants' belief that their experience of was part of God's plan and willed by Him gave their suffering meaning and significance and helped them cope with their distress. In addition, participants' trust in God was a source of relief because it encouraged acceptance of His will and consequently their experience of psychological distress.

4.3.2.2. Connection with God: "I brought God back into my life"

Feeling "connected" to God provided many of the participants of this study relief from their experience of psychological distress. Those participants who felt that God was "involved" or "present" in their lives and that they could "turn to God" described feeling "safe," "content," and "at peace," and were therefore able to cope with their distress. Others sought to move "close to God" and then endeavored, primarily through prayer, to "request Him... beg Him" for forgiveness and protection, which resulted in feelings of "calm and satisfaction." Although most participants attempted to connect with God through prayer and reading the Quran, a few of them felt that the "ritual got in the way" and reached out to Him in their "own way."

Zehra, for example, described how reaching out to God resulted in relief from her distress:

I would turn to God... I would pray... in my own language, my first language, which is English...no ritual, nothing formal, just a call from the heart.... There have been times of great distress for me and it gave me comfort...

Although Zehra's relationship with God was devoid of conventional Islamic practices such as prayer and reading the Quran, it was nevertheless meaningful to her and a source of solace and support. Similarly, Ishaq described a close and engaged relationship with God that was based on informal dialogue and not just prayer and reading the Quran:

I have a very active God in my life... He keeps an eye on me... waking me up every now and then. "You have been getting a little bit off track... remember we had a deal, let's just stick to it..." And I'd say, "Look, let's sit down and resolve this like two gentlemen ... let's talk about what's going on here"... He does answer... it takes my stress away... I have a sense that things will work out...

Like Zehra, Ishaq described a meaningful connection with God that did not involve conventional Islamic practices but nevertheless provided him with a sense of protection and relief from his distress. Hashmi, meanwhile, coped with his distress by reaching out to God through a specific prayer:

Whenever I would recite the prayer for healing that I'd been taught, my agitation would go away... even if my mother would recite it for me I would feel peace and contentment...

Hashmi's connection to God and the comfort and relief that it afforded him was therefore based on Islamic practices that are common and expected among Muslims. While Zehra, Ishaq, and Hashmi were secure in their relationship with God, Mehreen's distress was based at least partly on the belief that she was being punished for sins she had committed even though she had no idea what they might be. By reaching out to an aunt who had a thorough understanding of Islamic texts, she was able to cope by seeking God's forgiveness:

She [her aunt] showed me that everywhere in the Quran it says that whatever sin you commit, if you ask for forgiveness, you will be forgiven... for two days in a row I said my prayers like I'd been told and cried like anything and just asked God for forgiveness... I felt more composed... I felt really content... that things would go right for me...

Unlike many participants who drew comfort from reciting the Quran and praying in Arabic without necessarily understanding the content, Mehreen experienced relief from her distress by seeking help from a religiously knowledgeable individual, studying and understanding the notion of forgiveness in Islam, and then asking for forgiveness based on what she had learned.

Participants' relationship with God and their sense of being able to connect with Him therefore played an important role in their coping with distress. There was considerable variation in the manner in which participants reached out to God, with some relying on prayer and reading the Quran and others developing ways of their own that felt more personal and meaningful to them. Moreover, those who followed conventional Islamic practices differed in the extent to which they sought to study and understand the underlying tenets or merely follow instructions regarding Islamic obligations and practices.

4.3.2.3. Exemptions from religious obligations: "I gave myself a break"

Religious obligations were a source of distress for a number of the participants of this study. They were ultimately able to cope by "reevaluating" these obligations through discussions with family members and other individuals who had appropriate knowledge of Islamic practices, whereby they learned that they were exempt from them. For many participants, their distress was due to feeling "overwhelmed" by the "pressure" of obligations such as praying five times a day, along with feeling "guilty" for not being able to fulfill them. Once these participants understood that they could "be practical" and "do what they could" and trust that "God will understand" they typically experienced significant relief.

For example, Tapal was able to manage with his anxiety and guilt once he received a diagnosis of Obsessive Compulsive Disorder which meant that the

accommodations extended in Islam to those who are sick and unable to fulfill their religious obligations applied to him as well:

Because of my obsessiveness it had become impossible for me to pray... the anxiety was too much... I constantly felt answerable to God... After I was diagnosed [with OCD] and it was clear that I was sick I stopped praying because prayers aren't obligatory during sickness and I didn't feel guilty... It was a huge relief. I felt better right away.

Tapal thus needed a religious authority to confirm that he was not expected to pray regularly and would not be punished for failing to fulfill his religious obligations. In contrast, Bayat's relief from the pressure of his religious obligations was the result of personally reevaluating his religious obligations and responsibilities and the extent to which he was willing and able to fulfill them:

... the obligations became unbearable... too much for me. I resented being a Muslim. Eventually I had to draw a line... this was how much I was willing to do and not more... pray occasionally instead of regularly, things like that. Drink alcohol but not eat pork.... Not bother about halal. It all became easier then. Being a Muslim didn't feel like such a burden... I wasn't so angry all the time. I was more relaxed and happy.

Bayat's coping was therefore based on diverging from a strict interpretation of Islam that allows no flexibility regarding the observance of religious duties and instead reaching a personal compromise between the demands of his faith and his willingness and ability to conform to them. Participants were thus able to cope with the pressure of religious obligations and the ensuing distress by reevaluating their religious obligations, modifying their observance, and if necessary, exempting themselves from fulfilling them.

4.3.2.4. Rejection of religious beliefs: “What didn’t feel right, I simply dropped”

For a number of participants in this study, the notion that their suffering was punishment for sinful behaviour caused them to feel “blamed” for their “basic urges and wants and needs.” As a result, they found it difficult to seek forgiveness from God or rely on their faith in God and to trust that “things will work out the way they are meant to work out,” which made them feel “helpless” or “impatient and irritated” by the “passivity” and “fatalistic” attitudes. They thus coped by “pushing all that aside and trying to take control” of their lives.

For example, Saira, who was frustrated by the idea that her suffering was a punishment for sins she had committed and that she should pray for forgiveness and wait for her distress to diminish, experienced relief by dismissing the idea and attempting to take control of her life.

Being told to have faith in God and pray and things will work out... that I should just let things take the course they were meant to... was totally unhelpful and frustrating... being trapped into thinking that I deserve this added to feelings of hopelessness and frustration... I forgot about it... was more proactive and aggressively tackled my issues... I took control of my life and once I took control things began to fall into place pretty quickly.

Unlike the participants in the previous section, who coped with their distress by reevaluating their religious obligations within a framework of Islamic beliefs and practices, Saira’s experience of relief resulted from a rejection of a particular set of beliefs. Similarly, Yasin coped by moving away from the idea that his distress was punishment for sinful behaviour.

Over time I reasoned that God made me the way I am so it wouldn't make sense for Him to punish me for the things I did, and in any case, it wasn't as if I had killed anyone. And once I stopped thinking in terms of sin and guilt and punishment, everything became better. The stress and tension went away, I felt lighter, more optimistic...

Like Saira, therefore, Yasin's coping strategies entailed rejecting a particular Islamic belief. Neither Saira nor Yasin renounced Islam in its entirety, only certain traditional and commonly held beliefs. They continued, however, to identify as Muslim.

4.3.3. Psychological Coping

Counselling, psychotherapy, and psychiatry played a significant role in helping nearly all of the participants of this study cope with their distress. Participants recalled that "being in the hands of an expert" made them feel "safe," and the treatment or process resulted in their feeling "stronger" and "hopeful." For a number of participants receiving a diagnosis and "knowing that they suffered a condition that other people also suffered from... and that there was a treatment for it" brought considerable relief. Others described how "making an appointment was the first step" towards getting better and being able to cope with their distress. It made them feel "lighter... buoyant" even before they met a psychologist, psychiatrist, or psychotherapist. Participants' recollections of their psychological coping are organized into the subthemes Counselling and Psychotherapy and Psychiatry (see Figure 13).

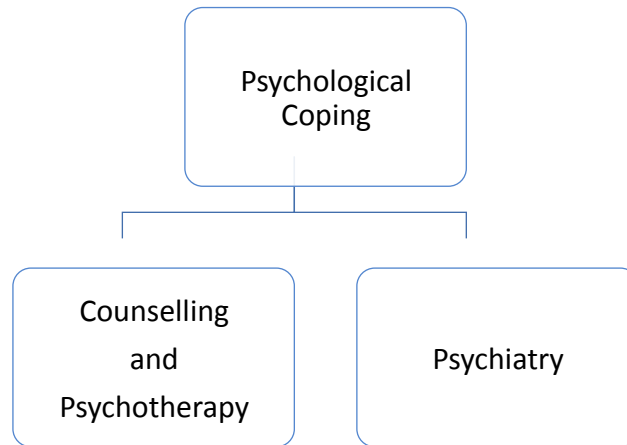


Figure 13. Psychological Coping

4.3.3.1. Counselling and psychotherapy: “Little in my life changed, but I coped better”

Counselling and psychotherapy helped many of the participants of this study cope with their psychological distress. Participants either obtained referrals to psychotherapists from general physicians and psychiatrists, scheduled appointments after friends and family members either “pleaded” with them or “insisted,” or sought professional help on their own because they had reached “the end” and “couldn’t manage anymore.” Participants’ relief was often attributed to psychotherapists encouraging and enabling them to “talk about things that I was too ashamed to talk to anyone else about” or to “articulate the way my head was working and why things were happening for me,” and then accepting and ultimately validating their distress. There was considerable variation in participants’ individual experiences. A number of participants recalled how therapy enabled them to “figure out what was important and what I needed to do” and thereby “take control of my life.” Others described how “putting emotions into words...took my anxiety out... took my stress out” or “being listened to... and not being told everything was my fault... made me feel less worthless.”

For Rubina, the value of counselling and psychotherapy lay primarily in mitigating her loneliness: “I felt my therapist was the only person who cared about me... He understood what I was going through... I didn’t feel so alone ... I would feel hopeful after every session.”

By resonating with her experience and empathically affirming her experience, Rubina’s therapist was able to establish a therapeutic relationship in which she felt heard, understood, cared for, valued, and supported, and thus experienced relief from her distress. Mehreen, meanwhile, described how expressing her emotions during therapy was empowering for her and helped alleviate her distress:

I was able to express myself to my therapist... He mostly listened and asked a few questions but I felt a burden had been lifted off me... I could think clearly, make plans... I came up with ideas that would never have occurred to me before... I felt that if wanted to do something... I’d make sure that I do it... I’d be successful... I felt a lot better...

By articulating and reflecting on her emotions with her therapist, Mehreen was able to unburden herself and feel lighter, which in turn allowed her to clarify her thinking and explore new options and possibilities. Consequently she described a greater sense of personal agency along with feeling hopeful and optimistic. Mehreen’s therapist, therefore, helped her cope with her distress through emotional exploration and reflection. Aalia’s therapist, in contrast, changed her understanding of the causes underlying her suffering:

I felt that something was wrong with me, there was something that needed to be fixed and through therapy I realized nothing needed to be fixed and everything just needed to be managed... I blamed myself and once she [my

therapist] made me realize that it [my depression] wasn't my fault... I was able to handle it much better.

Aalia's therapist was thus instrumental in her challenging and then rejecting the sense of defectiveness and inferiority that caused or at least contributed to her depression, along with the notion that she was somehow responsible for being depressed. Once Aalia ceased to believe that her distress was due to personal shortcomings or limitations and absolved herself of blame for it, her ability to cope improved considerably.

Similarly, Saira, described how her therapist helped her to achieve particular goals that had been eluding her:

I had a very clear sense of what I wanted out of therapy and I expressed it... [to the therapist] and she respected those desires and then worked with me on a very focused basis... to bring about what it was that I wanted.

Thus Saira stated a specific objective at the onset of therapy and the relief she experienced was based on identifying and taking concrete steps towards achieving it. In contrast, while Kardar was vague about the exact nature of his distress and how he might address it, his therapist enabled him to cope by helping him tease apart his distress and be precise about his particular sources of anxiety, which made them feel more manageable:

Talking about the things that were bothering me made a big difference. By being specific... separating all my worries and stresses so they weren't all mixed up with each other made them not so overwhelming... afterwards I felt much more confident...

Kardar's experience of relief, aided by his therapist, was the result of exploring, deconstructing, and validating his distress. Like Kardar, to whom therapy

provided greater understanding and acceptance of himself and his emotions, Chandni's experience of relief was based on an appreciation of unmet needs, emotions identified, and validation received during the therapeutic process:

Therapy helped me understand that I had an affair with another man to fulfill my needs to be loved and desired... for intimacy... and that those needs were not wrong or abnormal... It made it easier for me to accept that I had had an affair... I didn't feel so guilty even though I still believed that I had committed a terrible sin.

Chandni's belief that her extramarital relationship with another man was wrong and immoral played a significant role in her distress. Thus, by making her aware of her need for emotional and psychological intimacy, and by legitimizing and validating those needs, therapy enabled Chandni to accept her behaviour and consequently decrease her feelings of guilt and the accompanying distress.

Participants thus described how psychotherapy provided them relief from their distress in a number of different ways. These included formulating concrete goals and enabling participants to achieve them, empowering participants through expressing and exploring emotions, and increasing participants' awareness and understanding of themselves and their needs, followed by validation and acceptance of them. In addition to such active interventions, participants recalled how empathic attunement fostered a sense of understanding and support that helped them cope with their distress.

4.3.3.2. Psychiatry: "It was not just in my head, I was sick for real."

Many participants reported benefitting from psychiatric treatment, in particular receiving a formal diagnosis followed by medication to alleviate their symptoms of distress. Some participants initially consulted physicians or therapists

and “progressed” to psychiatrists when they did not experience relief or their distress worsened, whereas others, for example, those who had been hospitalized due to the severity of their symptoms, were initially treated by psychiatrists and then referred to psychotherapists once their condition had “stabilized.” Whereas some participants described medication as enabling them to “function normally,” others reported how receiving a diagnosis made their distress “real” and “confirmed that I was sick,” and enabled them to begin the process of healing. Moreover, while most participants sought treatment from psychiatrists as well as counsellors and therapists, some preferred to work with psychiatrists, because they “didn’t have the patience” for therapy or felt “awkward” at the prospect of “talking about my problems for an entire hour” and because there was “less hassle involved in popping pills than going for weekly therapy sessions.”

For instance, Zehra described feeling considerable relief when she was diagnosed with major depressive disorder by a psychiatrist:

Being told that I was sick made all the difference. It meant I wasn’t lazy or irresponsible or disorganized. I felt better immediately... I was on medication for a while but didn’t stick with it for very long because everything began to fall in place.

Zehra thus credited her diagnosis of major depressive disorder rather than the treatment that followed for enabling her to cope with her distress. Specifically, for Zehra, being afflicted with an illness enabled her to challenge the negative labels and judgments that contributed to her distress. Faraz described a similar process catalysed by a diagnosis of bipolar disorder:

The pressure was off. I didn’t feel like such failure anymore. I could get treatment and take time out to get better. And I knew that because it [bipolar

disorder] was a chronic condition, the same standards wouldn't apply to me anymore. It was easy to take control of my life after that.

In contrast, Hashmi credited the medication prescribed by his psychiatrist for his recovery:

I needed the medicines my psychiatrist gave me to clear my mind... without them I wasn't able to tell what was real and what I was imagining... I was paranoid and scared all the time... It was only after I had been on medication for a while, when the fear was under control, that I felt stable and was able to start therapy...

Once Hashmi's condition had stabilized under his psychiatrist's care, he began to see a psychotherapist as well in order to manage his distress. Yasin was also treated by both a psychiatrist and a psychotherapist, but preferred benzodiazepines prescribed by his psychiatrist to manage his anxiety:

When my chest was pounding and I couldn't think straight, it was ridiculous to expect me to meditate and breathe from my stomach as my therapist had taught me... only a Xanax would calm me right away. I'd feel normal... I could function normally.

Although Yasin was familiar with techniques such as meditation and diaphragmatic breathing to manage his anxiety, he felt that benzodiazepines reduced his anxiety faster and more effectively. Bayat was similarly dismissive of therapy and relied on medication to continue functioning.

I didn't need any advice on what to do and what not to do... the antidepressants my psychiatrist gave me made a big difference ... the effects didn't last long, I needed more and more pills, different pills, but at least I was able to sleep and wake up at regular times and go back to work. I wasn't so

miserable... I stopped feeling like I was dying all the time... I could live my life.

While medication provided Bayat significant relief from his distress, its effects soon wore off and he frequently required new prescriptions from his psychiatrist. Despite the temporary nature of the relief provided by medication, Bayat did not consider psychotherapy for long-term coping strategies.

While some participants reported that merely receiving a diagnosis provided relief because it negated the negative labels and judgments that were a significant part of their distress, others felt that the medication prescribed by their psychiatrists provided relief through management of symptoms and improved functioning. A number of participants, moreover, persisted with medication even when its effects were not long lasting, and their use of medication was not always under the supervision of a psychiatrist. Reliance on medication also resulted in some participants devaluing and disregarding other forms of coping such as psychotherapy.

The first two sections of this chapter examined the context and experience of participants' distress and thus lead to this section, the third and final section of the results of this study, which covers how participants coped with their distress. This section therefore provides a conclusion to the previous sections and participants' journey through their distress.

The emergent themes in this section reveal a range of strategies employed by participants to cope with their distress and experience relief from their suffering. In some instances such as family relationships, they included both turning to their families for empathy and support, and turning away from them, especially emotionally, and lowering expectations. Similarly, participants were able to use the

multiple and overlapping communities of which they were members to establish a sense of belonging and rootedness and privacy and autonomy for self-actualization.

Participants' religious coping was also varied in nature. Some participants reported reaffirming their faith in Islamic beliefs and worldviews, becoming more observant of their religious obligations, and generally intensifying their overall religiosity. Others, in contrast, described a process of reinterpretation and reevaluation of Islam that made their faith acceptable, meaningful, and a source of support rather than distress.

Finally, counselling, psychotherapy, and psychiatry played a significant role in most participants' coping and experience of relief. Counselling and psychotherapy facilitated participants' emotional awareness and sense of agency, but most of all, it validated their experience. Participants also found considerable benefits in psychiatry, not just from the medication that they were prescribed, but also through the process of receiving a diagnosis, which provided their distress with a specific label and course of treatment.

Chapter 5

Discussion

This study aimed to examine the representations of distress among Canadian Muslims of South Asian origin. It sought to gain insight into how they are influenced by Islamic, scientific, and Western representations; the extent to which they differ from those assumed in the prevailing literature on Islamic healing, counselling, psychotherapy, and psychiatry with Muslim populations; and whether individuals attempt to incorporate multiple influences into a single coherent representation or construct multiple representations simultaneously. The Self-Regulatory Model of Illness Representation (Diefenbach & Leventhal, 1996; Leventhal et al., 1997; Leventhal et al., 2003) was utilized to understand how the participants made sense of, emotionally responded to, and coped with their experiences of distress. The concept of distress was used to refer to distressing emotions, patterns of behaviour, interpersonal difficulties, and somatic symptoms that resulted in significant impairment and compromised individuals' functioning. The participants of this study included, but were not limited to, individuals who had received a DSM diagnosis (American Psychiatric Association, 2013) for a mental health disorder, along with those who had sought counselling, psychotherapy, or pharmacotherapy, or had engaged in traditional Islamic healing to cope with their distress.

The Self-Regulatory Model was used to design a semi-structured interview that focused on the five components of illness representations, namely identity, causation, duration, consequences, and coping (Leventhal et al., 2003). Data were gathered through interviews with 15 participants who identified as Canadian, Muslim,

and of Indian, Pakistani, or Bangladeshi origin, and who resided in the Greater Toronto Area. As required by Interpretive Phenomenological Analysis (Smith, 2004; Smith & Osborn, 2008), the results highlighted the exact words, phrases, and descriptions used by the participants.

In the results chapter, participants' recollections and reflections of their experiences were organized into domains of context, experience, and coping with distress. In contrast, the discussion chapter aims to move beyond verbatim recollections and examine the various aspects of participants' distress within the context of the Self-Regulatory Model and situate them within current research and scholarship.

While reviewing the results of the study within the framework of the Self-Regulatory Model and its components of identity, causation, duration, consequences, and coping (Leventhal et al., 2003), it became evident that the identity predominantly assigned by the participants to their psychological distress was punishment by God for their lack of faith or lack of piety. Beliefs regarding causation associated with and underlying this identity of punishment included doubting or questioning their belief in a conventional Islamic God, neglecting religious obligations, disobeying God's instructions, or engaging in behaviour considered sinful in Islam. In this regard, the findings of this study are therefore in agreement with the literature on Islamic conceptualizations of psychological distress in terms of punishment (e.g., Al-Krenawi & Graham, 1999; Dein et al., 2008; Dwairy, 2009; Hodge, 2005; Irfan et al., 2017; Rassool, 2015).

While the religious causes underlying their distress were especially salient for the participants, the results also drew attention to social and economic causation. The social causes described by participants, especially regarding the impact of familial

relationships, are broadly consistent with the existing literature. For instance, participants' accounts of distress due to distant or conflictual marriages correspond to findings linking marital discord to psychological distress, both among the South Asian diaspora (e.g., Anand & Cochrane, 2005; Patel, Rajpathak, & Karasz, 2012) and other populations (e.g., Beach, Katz, Kim, & Brody, 2003; Choi & Marks, 2008; Whisman, 2001). Furthermore, many participants believed that childhood experiences of neglect, criticism, and abuse resulted in their experience of psychological distress as adults. The role of emotional maltreatment of children by parents in subsequent mental health problems during adulthood has been documented extensively (e.g. Rizvi & Najam, 2014; Taillieu, Brownridge, Sareen, & Afifi, 2016). Research on South Asian diasporic families by Baptiste (2005) has highlighted how notions of parental authority, expectations of respect and deference, and the use of guilt and shame to create a sense of familial obligation can result in distress as indicated by the participants of this study. In addition, the feelings of inadequacy and failure due to the inability to fulfill parental expectations described by participants are similar to the findings of Kim, Coletti, Williams, and Hepler (1995). Moreover, participants' relationships with ageing parents were characterized by feelings of responsibility, obligation, and resentment, which match the findings of Neal and Hammer (2017), while the sense of being a burden or a disappointment among participants who were financially supported by their parents has also been reported by Ingersoll-Dayton, Neal, and Hammer (2001) and Merz, Consedine, Schulze, and Schuengel, (2009).

Social causes of participants' distress also included their relationships with their extended communities. Participants' negative self-evaluations based on comparing themselves to their friends and acquaintances fit with the current understanding of the damaging nature of social comparisons and their association

with mental health problems (e.g., Swallow & Kuiper, 1988; Van Deurzen, Van Ingen, & Van Oorschot, 2015). Similarly, their fears of being judged, labelled, and excluded from Canadian society due to their faith are not unexpected. Surveys conducted by the Angus Reid Institute (2017) and the Canadians for Justice and Peace in the Middle East and the Canadian Muslim Forum (2018) suggest that Canadians are less tolerant of Muslims than of followers of other religions. Moreover, these fears are likely to have been complicated by the politicization of Islamic narratives in Canada, which have resulted in Muslims feeling the need to apologize for and explain the difference between their faith and radical Islam (Jamil & Rousseau, 2012), their implicit sense of complicity and guilt regarding the violence inspired by radical Islam (Patel, 2012), and concerns that piety among Muslims is associated with support for radicalism and extremism (Fair, 2015). However, in contrast to findings by Inman, Howard, Beaumont, and Walker (2007) and Akram-Pall and Moodley (2016) that ethnic and religious communities are a source of support for Canadians of Indian, Pakistani, and Bangladeshi origin, many of the participants of this study found their local Muslim communities to have rigid expectations of conformity and to be judgmental and exclusionary, thereby resulting in feelings of rejection, loneliness, and isolation and ultimately exacerbating participants' distress.

Regarding the economic causes of participants' distress, namely financial stress and real or perceived loss of status due to economic factors, there is considerable research on the adverse impact of financial stresses on health and well-being (e.g., Friedland & Price, 2003; McKee-Ryan, Song, Wanberg, & Kinicki, 2005; Vinokur, Price, & Caplan, 1996) along with the greater vulnerability of immigrant and diasporic communities in this regard (e.g., Hovey, 2000; Hwang & Ting, 2008; Mui & Kang, 2006; Noh & Avison, 1996). Participants' understanding on the role of

financial stress causing their distress are compatible with this research. Perceived loss of social status, however, was a more significant cause of distress to the participants of this study. This is consistent with several studies: Tiffin, Pearce, and Parker (2005) indicate that loss of social status is associated with psychological distress, and Alcántara, Chen, and Alegría (2014) and Nicklett and Burgard (2009) report that this association is particularly acute among diasporic communities. These findings regarding the importance of social status can also be linked to notions of shame and honour that are prevalent in the literature on acculturation, family, and mental health and among South Asian and Muslim diasporas (e.g., Ayyub, 2000; Ahmad, Riaz, Barata, & Stewart, 2004; Das & Kemp, 1997; Foner, 2012; Mathews, 2000; Werbner, 2007).

The participants of this study faced a range of consequences due to their psychological distress. Physical consequences included chronic pain, gastrointestinal disorders, fatigue, and insomnia. Although such somatic symptoms are common in mood and anxiety disorders (e.g., Kapfhammer, 2006), Baumann (2003), Dein et al. (2010), and Inayat (2005) argue that these are especially likely to be manifested by Muslims of South Asian cultures of origin. Furthermore, a number of studies (e.g., Burr & Chapman, 2004; Mumford et al., 1991; Lauber & Rössler, 2007; Williams, Eley, Hunt, & Bhatt, 1997) have provided empirical evidence for the propensity towards somatisation of distress among this population.

Similarly, consequences such as avoidance, social withdrawal and neglect of responsibilities described by the participants are typical of psychological distress and have been documented extensively (e.g., Harris, 2014; Kamimura et al., 2015; Ottenbreit & Dobson, 2004; Orzechowska, Zajączkowska, Talarowska, & Gałeczki, 2013). A search of relevant psychological databases did not highlight any studies on

these aspects that focused on Muslim or South Asian populations. In contrast, consequences such as numbing through the excessive use of alcohol, drugs, and prescription medication reported by some of the participants of this study have been the subject of a growing body of research on Muslim populations. Although there is a school of thought that Islamic beliefs regarding the prohibition of any form of intoxicants have helped mitigate substance abuse among Muslims (e.g., Marican & Ab Rahman, 2015), others such as Arfken and Ahmed (2016) have drawn attention to the prevalence of substance use among Muslims, and Hasan et al. (2009), Mohamad (2009), and Khan and Raza (1998) have provided details of alcohol, drug, and benzodiazepine abuse among specific Muslim populations.

For most of the participants, however, the emotional consequences of hopelessness, helplessness, feeling overwhelmed, confusion, guilt, and anger were of primary significance and dominated their recollections of being distressed. While the lack of empirical research on experiences of psychological distress among Muslims was a primary rationale for this study, there have been numerous studies on psychological distress among other populations (e.g., Kahlon, Neal, & Patterson, 2014; Krumm, Checchia, Koesters, Kilian, & Becker, 2017; O'Mahony, 2015; Ratcliffe, 2014; Rhodes & Smith 2010; Smith & Rhodes, 2015) that have reported emotional responses similar to the consequences described by the participants of this study. The findings of this study did, however, differ from the existing research regarding participants' guilt and anger directed at their families, their religious beliefs, and backgrounds. While the latter can be framed in terms of research on the role of religion in triggering negative emotions (e.g., Pargament et al., 2003; Smith & Richards, 2005), factors such as diminished parenting self-efficacy (Ali, 2008), cultural value conflicts between parents and children (Varghese & Jenkins, 2009;

Walsh, 2007) due to the diasporic experience along with the use of guilt and shame to create a sense of obligation among South Asian parents (Baptiste, 2005) can provide a context to understand the former.

Participants' coping with distress was examined through themes of social, religious, and psychological coping. Given the significance of the family among both Muslim and South Asian diasporas (e.g., Ali, Liu, & Humedian, 2004; Carolan, Bagherinia, Juhari, Himelright, & Mouton-Sanders, 2000; Shariff, 2009), it is not surprising that participants' families were important to their social coping. Moreover, the roles of empathy and management of familial expectations in alleviating distress among participants have been researched and documented extensively (e.g., Carr, 2009; Negash & Sahin, 2011; Fincham, Paleari, & Regalia, 2002; Paleari, Regalia, & Fincham, 2005; Worthington, 1998). Unlike findings reported by Hodge (2005) and Walsh (2010), however, the results of this study did not indicate that religion and spirituality in any way served to mitigate participants' distress stemming from familial relationships or conflicts.

In addition to family, community was a crucial aspect of participants' social coping. Notwithstanding the experiences of judgment and rejection by local ethnic and Muslim communities that many of participants of this study described as contributing to their distress, some of them were able to turn successfully to these communities for social interaction and companionship and to provide a sense of identity and belonging. This relief provided by local communities corresponds to the findings of Inman et al. (2007) and Akram-Pall and Moodley (2016). Conversely, the relief participants experienced due to the privacy and autonomy Canadian society provided can be seen in terms of the resolution of cultural value conflicts described by Varghese and Jenkins (2009) and Walsh (2007) and of the expression of participants'

evolving Canadian and bicultural identities (Downie, 2013; Ng & Northcott, 2010). However, no studies explicitly exploring these phenomena among Canadian Muslims of South Asian cultures of origin were found in commonly used psychological and other databases.

The results of this study indicated that, similar to social coping, participants' religious coping took distinct and diametrically opposed forms. Some participants found relief in turning to God, reaching out to Him through prayer, reading the Quran, accepting that their psychological distress had been willed by Him, and trusting in His plan for them. Such approaches to coping with psychological distress among Muslim populations have been discussed in detail (e.g., Abdullah, 2015; Armstrong & Munro, 2018; Bhui et al., 2008; El Azayem & Hedayat-Diba, 1994; Hamjah & Akhir, 2014; Hamjah et al., 2017; Inayat, 2005; Majid, 2003; Zakaria & Akhir, 2017). In contrast, other participants coped by reevaluating their religious beliefs to make faith more relevant and meaningful to them or by rejecting Islam altogether. Cottee (2015) and Miller (2012) are examples of the few studies that have been carried out in this area.

Participants' psychological coping entailed counselling, psychotherapy, and psychiatry. The benefits described by participants, such as normalization of distress, emotional awareness, validation, acceptance, empowerment, increased agency, symptom relief, and improved functionality are consistent with the literature (e.g., Ahn & Wampold, 2001; Burns, 2015; Cooper, 2008; Feltham, 2002; Wampold & Imel, 2015) and highlight participants' comfort and familiarity with the biomedical model of illness (Clare, 1980; Shah & Mountain, 2007). Significantly, none of the participants engaged in or expressed a preference for culturally modified approaches

such as those proposed by Hamdan (2008) or Husain and Hodge (2016) that integrated Islamic principles into counselling and psychotherapy.

Although the researcher's choice to use a semi-structured interview allowed him to explicitly inquire about the duration of participants' psychological distress and ask follow-up probing questions in this regard, participants had limited recollections or reflections on this component of their representations of distress. Brown III (2002) and Hale, Treharne, and Kitas (2007) provide a possible reason for this reticence: they conceptualize this aspect of the Self-Regulatory Model as concerning predictive beliefs about how long the illness or distress is going to last and whether it will be acute or chronic. Thus, the potential duration of participants' representations of distress is likely to be relevant at the onset of illness or distress and not to feature in representations described by participants who have concluded treatment or consider themselves healed. Because having overcome psychological distress was part the selection criteria in order to rule out the possibility of the interview adversely influencing participants' treatment or healing, the absence of this component in this study is not unexpected.

This overview of the results within the framework of the Self-Regulatory Model highlights a discrepancy or inherent contradiction in the representations of psychological distress described by the participants of this study. Specifically, the results indicated that all the participants, including those who were not especially religious, those who did not subscribe to conventional Islamic beliefs and worldviews, and even those who identified as 'culturally Muslim' but were antagonistic to conventional Islamic beliefs and worldviews, believed that their distress was a form of punishment for their lack of faith or piety, thereby suggesting a significant religious aspect to their representation of distress. Such beliefs regarding identity and

causation would entail turning to God, seeking forgiveness through prayer, reading the Quran, and other Islamic healing traditions, which did provide relief to some of the participants of this study. Paradoxically, however, the primary approach to coping for all of the participants of this study, even those who were highly religious and described their faith as being central to their lives and worldviews, was counselling and psychotherapy or pharmacotherapy, which imply an equally strong biomedical aspect to their representations of distress and thus a mismatch between identity and causation on the one hand and coping on the other.

Moreover, while participants did report social and economic causes as contributing to their distress and the resolution of these causes as resulting in relief, especially in response to probing questions, they did not consider these causes to be particularly significant to their distress nor did they credit their resolution with any meaningful or enduring relief. Further testament to the preponderance of the religious and biomedical aspects of participants' representations is provided by the fact that all of them without exception turned to biomedical interventions in the form of counselling, psychotherapy, and pharmacotherapy. While a few of them did look towards religious figures for help, none of them sought social or economic interventions that focused on families, relationships, cultural differences, financial pressures, or social inequalities.

The Islamic worldviews underlying the religious aspects of participants' representations of distress that led them to believe that their suffering was a form of punishment have been studied and documented extensively. Consistent with the participants of this study, Abu Raiya and Pargament (2010), Al-Krenawi and Graham (1999), Sabry and Vohra (2013), and Weatherhead and Daiches (2015), among others, have described how in Islamic belief systems psychological distress is considered

God's punishment for disobeying His instructions, engaging in sinful behaviours, or not being sufficiently faithful and pious. Moreover, samples of Bedouin and other Arab Muslims (Al-Krenawi, 1999; El Rhermoul et al., 2018; Hamdan, 2008), Bangladeshi Muslims (Bhui et al., 2008), and British, Egyptian, Indonesian, Iranian, Malawian, Pakistani, Sudanese, and Turkish Muslims (Weatherhead & Daiches, 2010) have provided empirical evidence for this notion and indicated that the belief that individuals' suffering is punishment for lack of faith or piety is prevalent across Muslim cultures and communities. Thus, from a religious or Islamic perspective, in representations of distress constructed within the framework of the Self-Regulatory Model, distress is believed to be caused by sinful behaviour, lack of faith and piety, and is assigned the identity of punishment.

All of the participants of this study without exception described similar beliefs regarding the causes of their psychological distress, ascribing it to not being sufficiently devoted to God, having wavering faith or doubting His existence, being arrogant and hubristic, not praying regularly, consuming alcohol, and engaging in adultery. The notion of psychological distress as punishment was so prevalent and powerful among the participants of this study that even participants who could not recall any impious or sinful behaviour were nevertheless convinced that the fact of their suffering meant that they must have committed a transgression that merited punishment. Moreover, participants who rejected literal interpretations of Islam and disavowed its punitive aspects, and those who believed their distress to be caused by biological and environmental factors, could not completely set aside the notion that their suffering was a form of punishment and, despite their attempts to rationalize and challenge such thoughts, continued to entertain them and ultimately reported being frustrated with themselves for failing to dismiss them. In this regard, the findings of

this study therefore conform to those of Al-Krenawi (1999), Bhui et al. (2008), El Rhermoul et al. (2018), Hamdan (2008), and Weatherhead and Daiches (2010) and unambiguously answer one of the questions posed by this study, namely that the representations of distress among the participants, Canadian Muslims of South Asian origin, are strongly influenced by traditional Islamic beliefs and are broadly consistent with the existing literature on the topic. Moreover, this tendency to ascribe distress to religious or spiritual causes rather than biomedical ones is not limited to Muslim populations but has been reported among diverse visible minorities of African, Asian, and Latino cultures of origin (Jimenez, Bartels, Cardenas, Daliwal, & Alegría, 2012).

Most participants' belief that their suffering was a form punishment resulted in their experience of distress being characterized by feelings of guilt, even when they were unable to identify the reasons for their culpability, which led to feelings of defectiveness and shame. Comparable negative religious coping has been described by Hood Jr (1992), Pargament et al. (2003), and Smith and Richards (2005).

Moreover, such participants were therefore unable to seek forgiveness or atone for their conduct as prescribed in Islam and were consequently resigned to their guilt with no hope of relief. Participants whose guilt was based on behaviours such as drinking alcohol or adultery, which are proscribed in Islam but are routine or acceptable in Canadian society, described similar resignation. Since they lacked sufficient remorse, were unwilling to repent, and intended to continue such behaviours, they therefore felt that they could not seek forgiveness and, moreover, they felt they did not deserve to be forgiven. This triggered additional feelings of shame and defectiveness and ultimately compounded their distress.

These findings are therefore consistent with studies (e.g., Hood Jr, 1992; Pargament et al., 2003; Smith & Richards, 2005) that describe how religious beliefs

can lead to unproductive feelings of shame, guilt, and fatalism. In the same vein, the role of religious struggles in exacerbating distress has been documented in a number of studies (e.g., Ano & Vasconcelles, 2005; McConnell, Pargament, Ellison, & Flannelly, 2006; Weber & Pargament, 2014) and arguments by Koenig and Shohaib (2014), and that religious struggles among Muslims can lead to negative emotions are particularly relevant to the findings of this study.

Conjectural or not completely warranted but nevertheless pervasive feelings of guilt also resulted in resentment and anger among the participants. In this study, participants' resentment was based on their sense of being punished for relatively minor transgressions despite attempting to be good Muslims and follow God's instructions. Their anger, meanwhile, was directed primarily at the concept of a punitive god with which they did not agree but to which they nevertheless subscribed. Similar responses to punitive conceptualizations of God have been documented by Ellison and Lee (2010), who describe how individuals feel anger towards God for punishing them through challenges, crises, or distress. Thus, in terms of the overall aims of this study, its findings were broadly consistent with those of Al-Krenawi (1999), Bhui et al. (2008), Hamdan (2008), and others regarding how traditional Islamic beliefs shaped their representations of distress. However, by highlighting participants' religious struggles and ensuing feelings of guilt, resentment, and anger, the findings provided additional insights and a more nuanced view than the existing literature on Islamic influences and the consequences of these influences, on representations of distress among Canadian Muslims of South Asian origins.

Participants' feelings of guilt accompanied by resentment and anger can ultimately be understood in terms of a conflict between the traditional Islamic conceptualization of a God who had to be literally and unquestioningly obeyed and

their desire for a moderate and merciful God who felt more relevant to their lives. Wright (2010) describes how the harsh God of the Old Testament in the Bible has evolved into a comparably tolerant and accepting God in many Christian and Jewish communities in North America and Europe. Canadian Muslims of Indian, Pakistani, and Bangladeshi origin are likely to have been exposed to and influenced by this process, yet are unable to implement it in their own faith due to their internalization of a punitive and uncompromising notion of God and the complete absence of any discourse regarding the traditional Islamic conceptualization of a God.

Instead, Aslan (2011) describes how Wahabi and Salafi versions of Islam, based on the 18th movement led by Muhammad ibn Abdul Wahhab, which emphasize literal interpretations of Islam, disapprove of innovation and advocate the purging of all external influences, are currently gaining in prominence and influence. Consequently, many Muslims implicitly feel they face a choice between leaving their faith altogether or sticking to a belief system with which they are not entirely comfortable. Moreover, they are required to accept many aspects of Islam that they may be inclined to reject. Given the anticipated stigma and the adverse implications for well-being associated with rejecting faith and embracing atheism (Abbott, 2017), along with extreme fear of apostasy and its consequences in Islam (Cottee, 2015; Opal, 2014), most opt for the latter, which results in feelings of conflict, guilt, resentment, and anger such as those described by the participants of this study. This fear even prevailed among those participants who were explicitly resentful and hostile towards Islamic beliefs and articulated a desire to renounce their faith.

Some participants were able to cope with these feelings by reevaluating their religious obligations and modifying their observance of them. By justifying potentially sinful behaviour like not praying regularly and drinking alcohol in terms

of being practical, realistic, doing their best, and trusting in God to understand, they were able to reach a compromise between the demands of their faith and their willingness to fulfill religious obligations without renouncing their belief in Islam. Significantly, participants who rejected Islamic beliefs that they felt contributed to their distress emphasized that they were only rejecting specific attitudes or beliefs and not Islam in its entirety, which is consistent with the fear of apostasy described by Cottee (2015) and Opal (2014). The findings of this study, that justifying un-Islamic behaviours, reevaluating obligations, and rejecting specific Islamic beliefs resulted in relief for participants, thus contradict studies that portray Islam as a source of only positive coping (Abu Raiya & Pargament, 2010), advocate Islamic healing strategies (Keshavarzi & Haque, 2013), and emphasize faith, worship, and moral conduct as a means of healing (Hamjah & Akhir, 2014). Consequently, the findings indicate representations of distress that are not exclusively or wholeheartedly shaped by Islamic beliefs and are ultimately different from those assumed in the prevailing literature on Islamic healing.

Other participants, in contrast, found relief through moving closer to God, primarily through conventional Islamic practices such as prayer and reading the Quran. Underlying their actions was the belief that reaching out to God, establishing or re-establishing a connection with Him, and trusting in His plan for them would result in forgiveness for their lack of faith or sinful behaviour and thereby mitigate their punishment and alleviate their distress. The role of faith in alleviating distress among Muslims has been extensively researched, for example, by Abu Raiya and Pargament (2010), Keshavarzi and Haque (2013), Hamjah and Akhir (2014), and Koenig and Shohaib (2014). In this context, the findings of this study are consistent with the existing the literature on the topic.

The participants of this study thus reported myriad coping strategies, indicating a range of attitudes towards Islam and Islamic beliefs, which in turn suggest that although their representations of distress were undeniably and significantly influenced by Islam, there was considerable variation in the nature of this influence. By drawing attention to the disparate and at times contradictory nature of participants' representations of distress, the findings of this study provide insight into the complexity of participants' representations and reinforce claims of the fluidity of such representations (e.g., Leventhal et al., 2003) along with the diversity of representations of distress among Muslims as described by Bhui et al. (2008), even among a purposefully sampled and relatively homogenous group such as the participants of this study.

It is noteworthy, however, that the notion of psychological distress as punishment for lack of faith or piety, which was the most significant Islamic influence on participants' representations of distress regardless of the nature or intensity of their religiosity, is not mentioned or even alluded to in the Quran, the Hadith, or the traditions of Islamic jurisprudence and scholarship. The Quran provides vivid details of the punishments of Hell awaiting those who have chosen not to believe in God, describing them as “companions of Fire in which they will live forever” (2:39) and “As soon as the fire destroys their skins, We will give them new skins so that they may suffer more of the torment” (4:56). Meanwhile, those who rejected His guidance will be “bound in chains, with garments of pitch and faces covered by fire” (14:48-50), forced to “drink boiling water” (14:16-17), and eat the tree of Zaqquq which “will be like molten brass, which will boil in their bellies like water” (44:43-50).

Quranic punishments during this life for sinful behaviour and rejecting God also do not involve psychological distress and instead recall the Old Testament of the

Bible and take the form of drought and plagues suffered by the Egyptian Pharaohs, the many humiliations of Nimrod culminating in his brain being gnawed by insects, the destruction of the Sodom by an earthquake, and the great flood that destroyed Noah's people. Esposito (2002) further highlights the absence of psychological distress as punishment in Islamic traditions by describing how Islamic jurisprudence provides extensive details of categories of crimes, separating those whose punishments are predetermined, such as theft, prohibited sexual intercourse, false accusation, drinking alcohol, and gambling, from those in which judges have discretion to impose punishment and those in which compensation can be paid to victims or their heirs. Requirements for conviction and the means, duration, and intensity of the punishments such as flogging, exile, or execution are also explicitly set out, thereby obviating ambiguity or the need for interpretation.

The notion of psychological distress as punishment for lack of faith or piety that pervades representations of distress among the participants' of this study is also absent from the psychological studies of early Muslim scholars, making its origin and prevalence even more puzzling. Haque (2004), for example, describes how in the 11th century Avicenna used Aristotelian concepts to move away from notions of mental illness being caused by divine or supernatural factors and posited a significant link between the mind and the body, enabling him to study conditions such as memory loss, delirium, and hallucinations from a medical perspective and develop rudimentary therapies that would be recognizable to contemporary psychologists. Others, such as Al-Razi in the 10th century devised behavioural interventions for emotional distress, Al-Tabari in the 9th century described the merits of counselling and a healthy rapport between physicians and patients, and Al-Balkhi in the 9th century emphasised healthy thoughts to treat depression in what might be described as a cognitive approach

towards well-being, thereby indicating a tradition focused on physiological, social, behavioural, and cognitive explanations for distress rather than religious and punitive ones.

Given the specificity with which the Quran, Hadith, and Fiqh list prohibited behaviours and their corresponding punishments, coupled with the absence of any reference to psychological distress as punishment, which pervaded and was central to representations of distress among participants, the notion of psychological distress appears problematic within the framework of Islamic beliefs. It thus questions the religious aspects of participants' representations of distress, specifically the nature and influence of Islam because, in the traditional Islamic framework, the consequences of rejecting God or disobeying His instructions are straightforward—being denied entry into Heaven and condemned to Hell—and although the prospect of Hell might result in psychological distress, the experience of distress in itself does not constitute punishment.

Meanwhile, although the concept of *Tawakkul* (trusting and relying on God) is emphasized repeatedly in the Quran (8:2; 9:51; 65:38:2; 67:1-2), and Hamdan (2008) argues that it can be beneficial in providing relief from distress, there is no punishment prescribed for those who lack this trust and are unable to rely completely on God. Nevertheless a number of the participants in this study explicitly ascribed their distress to punishment for the lack of such trust. Similarly, according to the Fiqh, consuming alcohol or engaging in adultery, for which some participants felt their distress was punishment, come under the category of *Hudud* punishments which are specified in the Quran and entail flogging and exile (Esposito, 2002) rather than psychological distress. Ultimately, it would not be unexpected for individuals to experience distress in the form of guilt for their transgressions or fear if they were

actually facing Hudud punishments, which, of course, was not the case for the participants of this study.

In the absence of an obvious Islamic tradition or framework, participants' tendency to interpret their psychological distress as punishment by God can be understood in terms of an attempt to provide meaning and purpose to their experience. Hamdan (2008) refers to the idea that suffering in this world constitutes atonement for sins and cites the following Hadith of the Prophet Muhammad:

No fatigue, nor disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were that the prick he receives from a thorn, but that Allah expiates some of his sins for that. (University of Southern California—Muslim Student Association [USC-MSA], n.d., vol 7, book 70, #545 as cited in Hamdan, 2008, p. 106)

This Hadith does not necessarily provide a source or explanation for the belief held by the participants of this study—that their psychological distress was punishment for their lack of faith and piety. It does, however, provide a context to link distress with punishment, in which psychological distress is not simply punishment but instead serves to redeem an individual's sins and thus precludes punishment in the afterlife, thereby providing meaning and purpose to participants' distress and simultaneously validating the significance of their suffering. Ahmed (2012), Dwairy (2009), Hedayat-Diba (2014), and Mehraby (2003) suggest that Islamic belief systems and worldviews enable such meaning-making, which is closely associated with emotional regulation (Lloyd, 2018), and thus can serve to facilitate healing and coping with distress without necessarily seeking to cure or eliminate it. In a broader sense, Boehnlein (2000) and Bezanson et al. (2005) describe a comparable process of meaning-making and validation through spirituality and religion. As a contrast to that,

Brinkman (2016) describes how psychological distress is pathologized in contemporary Western society and interpreted in terms of psychiatric diagnosis, resulting in “diagnostic cultures” that are devoid of meaning (p.7).

In terms of seeking to understand representations of distress among Canadian Muslims of South Asian origin and to understand the nature and extent of Islamic influences on these representations, it can be argued that the religious aspect of participants’ representations, specifically the notion of distress as punishment, derives from the importance of meaning-making (Lloyd, 2018) and Islam provides a means and a context for fulfilling this need that cannot be satisfactorily met in contemporary Western society (Brinkman, 2016). The findings of this study thus suggest a more nuanced view of how and why Islamic beliefs shape representations of distress compared to the existing literature on this topic, which tends to assume uncomplicated Islamic representations based on faith as religiosity as an established fact.

The notion of psychological distress as punishment that prevailed among the participants of this study and dominated their representations of distress can also be seen as derived from the belief among Muslims in an “omnipotent God... personally involved with His creation” (Hodge, 2005, p. 164). This omnipotent and personal nature of God implies, according to Husain (1998), that nothing happens to individuals apart from what God wills and causes. Thus, as Al-Krenawi and Graham (1999) argue, in Islamic belief systems, “both health and illness are caused by Allah, through the natural and supernatural powers created by Him” (Al-Krenawi & Graham, 1999, p. 55), and it follows that Muslims are bound to believe that their psychological distress has been caused by God. The conceptualization of a god disposed to impose punishment in the form of psychological distress and suffering is explained by Armstrong (2001), who traces the evolution of the God in the Quran and the Old

Testament to Yaweh, initially a god of war who delivered the Israelites from slavery during the time of Moses and ultimately supplanted all other gods worshipped at the time. Such origins suggest violence, ruthlessness, and vengefulness, at least in initial incarnations, which are now manifested in the punitive nature of the God of the Torah, the Bible, and the Quran and thus account for a God who would punish those with whom He is displeased for not being sufficiently faithful or adhering to what has been decreed by Him.

Given the extensive literature on the shortcomings of medical and biological models of illness (e.g., Blackwell, 1992; Bracken & Thomas 2001; Kleinman, 1987; Littlewood, 1996), it would not have been surprising if participants' representations of distress were Islamic in all aspects, not just causation. Summerfield (1999) in particular highlights the implications of such models for individuals from different cultures whose representations of illness and distress are likely to be shaped by their cultural backgrounds. The participants of this study, however, not only incorporated but actively sustained and acted on aspects of their representations of distress based on medical and biological models of illness, especially in regard to coping with their distress. These findings are consistent with those of El Rhermoul et al. (2018), who describe how Moroccans suffering from depression believed their distress to be caused by the evil eye but sought treatment from psychiatrists rather than traditional healers. However, they contradict the findings of Rogers-Sirin, Yanar, Yüksekbaş, Senturk, and Sirin (2017) that religiosity was associated with negative attitudes towards psychological services, and those of Farver, Bhadha, and Narang (2002), Inman et al. (2007), Akram-Pall and Moodley (2016), and Williams (1988), which indicate that Canadians of Indian, Pakistani, and Bangladeshi origin are likely to be

significantly religious, invested in their traditional cultures, and turn to their religious beliefs and worldviews in times of distress and vulnerability.

Rassool (2015) points out that seeking treatment for psychological distress does not conflict with seeking help from God, and Youssef and Youssef (1996) and Haque (2004) have described how historically Islamic societies utilized contemporary knowledge and available resources for the treatment of illness. However, Zayed (2017) asserts that Islamic approaches to psychological health and well-being are primarily preventive rather than curative. In this sense, taking advantage of current scientific advances and embracing biological and medical representations of distress for coping and healing is consistent with Islamic traditions.

The differences between the findings of this study and the existing literature (e.g., Farver et al., 2002; Inman et al., 2007; Akram-Pall & Moodley, 2016) can be understood in the context of arguments by Selby (2016) that research on Muslims in Canada focuses on the most pious and committed members of this population and thus emphasizes their beliefs, practices, and worldviews. The participants of this study, in contrast, included Muslims who were not especially devout and whose relationships with their faith were ambivalent, conflictual, and even hostile, resulting in representations of distress that were not exclusively Islamic but that incorporated other influences in a complex and at times contradictory manner.

Another possible explanation for participants' inclination towards the biomedical aspects of their representations of distress is provided by Ng and Northcott (2010), who have documented how immigrants who arrived in Canada at an early age were more likely to develop a Canadian or bicultural identity than those who arrived at a later age, who were more likely to retain their ethnic identity. Thus, unlike the participants of studies by Farver et al. (2002), Inman et al. (2007), Akram-Pall and

Moodley (2016), and Williams (1988), who were likely to be susceptible to migration stresses (Jacob & Jacob, 2017; Al-Roubaiy et al., 2017) and likely to identify strongly with traditional Islamic as well as Indian, Pakistani, or Bangladeshi culture and values, the participants of this study had spent sufficient time in Canada resulting in greater integration into Canadian society and identification with its culture and values.

It could therefore be argued that, although participants' worldviews evolved during the process of acculturation, assimilation into Canadian society, and eventual development of a bicultural identity, Islamic beliefs and practices not only failed to evolve in tandem but due the literalist, rigid and puritanical Wahabi and Salafi influences that rejected any innovation in religious thought (Aslan, 2011), made them less relevant and meaningful for the participants and ultimately less likely to play a prominent role in participants' coping with distress. In this context, it is possible that traditional Islamic beliefs and practices were perceived as superstitious and regressive, making biomedical treatments and ultimately biomedical aspects of participants' representations of distress more attractive, a process described by Tallis (2004).

While the evolution of Canadian or bicultural identities may be responsible for the diminished significance of Islam in the everyday lives of participants, the politicisation of Islam by Muslims in the West and the ensuing development of their collective identities (Rassool, 2015) may have resulted in a more active process of participants distancing themselves from Islamic beliefs and practices without necessarily rejecting their faith in its entirety. For instance, Jamil and Rousseau (2012) report how Muslims in Canada felt personally responsible for apologizing for and explaining the difference between themselves and those Muslims who engaged in terrorism or violence inspired by supposedly Islamic ideologies, regardless of whether

they had actually been associated with terrorists or were themselves victims of discrimination. Even more distressing for Canadian Muslims, according to Patel (2012), was an implicit yet baseless sense of complicity with the terrorism and violence, which engendered feelings of guilt and prevented them from grieving along with the rest of Canadian society for the actual victims. Further, concerns examined by Fair (2015) that piety among Muslims is connected to support for terrorism and sectarian violence are accompanied by findings by Downie (2013) that many Muslims in Canada negotiated this prevailing political narrative by moving away from explicit and visible Islamic practices. These included traditional strategies for coping with distress based on Islamic representations and can therefore explain participants' inclination towards strategies rooted in biomedical representations of distress.

A number of the participants did, however, describe interacting with their local Muslim communities as beneficial, which is consistent with the findings of Inman et al. (2007) and Akram-Pall and Moodley (2016), who describe how Canadian Muslims of South Asian origin are inclined to turn to and connect with their local communities when experiencing distress. Yet these interactions were primarily social, with little or no bearing on participants' belief that their distress was the result of punishment for sinful behaviour. In Islamic representations of distress, healing would entail a process of turning to God, seeking forgiveness through prayer, and reading the Quran, which imply detachment and solitude, something participants are likely to have found isolating. The adverse impact of isolation has been documented extensively, and because isolation is a significant component of distress (e.g., Cacioppo & Cacioppo, 2014; Lynch, 1977; Peplau & Goldston, 1984), participants' lack of enthusiasm for a process that risked further isolation can be understood in this context. In contrast, Currie (2011) argues that promoting social inclusion is central to

healing in biomedical representations of distress and incorporated into counselling, psychotherapy, and psychiatry and might therefore explain participants' preference for incorporating biomedical elements into their representations of distress, especially regarding coping.

Similarly, the adverse impact on participants' sense of self due to their belief of having sinned may have played a role in their construction of representations of distress with a strong biomedical rather than religious nature. For instance, according to Hood Jr. (1992), feelings of guilt based on sinful behaviour can compromise self-esteem, and Pargament et al. (2003) describe how they can impair the ability to cope. Moreover, Corrigan (2004) suggests that internalizing such negative notions can lead to "self-stigma." The impact of stigma on mental health and well-being have been researched extensively (e.g., Bharadwaj, Pai, & Suziedelyte, 2017; Link & Phelan, 2001; Sartorius, 2007) and include feelings of defectiveness, diminished self-esteem, self-efficacy, and outlook for the future. In addition, findings by Achstetter et al. (2016) explicitly link illness representations that result in self-stigma to poor recovery. Thus, if feelings of guilt based on sinful behaviour underlie self-stigma among the participants, turning to biomedical representations of distress instead of religious ones could help them reduce the stigma and cope with its consequences.

Since all the participants believed that they had sinned, some degree of self-stigma was unavoidable. However, healing processes within exclusively Islamic representations of distress would have entailed embracing not just that they had sinned, a notion that was vague and problematic for many participants, but also the accompanying feelings of guilt, shame, and defectiveness, thereby reinforcing participants' self-stigma. Although it has been argued that biomedical representations can be stigmatizing (e.g., Byrne, 2001; Cooper, Corrigan, & Watson, 2003; Read &

Law, 1999), for the participants of this study, the biomedical aspects of their representations were in all likelihood less stigmatizing than Islamic ones, and possibly even mitigated the Islamic aspects which exacerbated their distress, especially concerning self-stigma. Ultimately, incorporating biomedical elements into their representations of distress therefore presented a viable and attractive alternative to exclusively Islamic representations as participants sought relief.

While perceptions of isolation and stigma inherent in purely Islamic representations of distress may have inclined participants towards incorporating biomedical aspects, perhaps the most significant appeal of biomedical aspects was the sense of empowerment they provided in comparison to exclusively Islamic representations. The biomedical model of illness and its associated representations of distress have been accused of being disempowering and requiring passivity (e.g., Akoul, 1998; Street Jr, Gordon, Ward, Krupat, & Kravitz, 2005). Other researchers (e.g., Kaba, & Sooriakumaran, 2007; Mountain & Shah, 2008; Tallis, 2004) dispute this and argue that contemporary relationships with healthcare providers are based on active participation and engagement. In this context, Bohart and Tallman (1999) describe clients or patients as “drivers of change” (p.3), and Berzins (2006) argues that healthcare providers now promote personal responsibility among clients or patients who are expected to take an active role in their healing, which includes goal-setting and self-management during treatment.

In contrast, coping and healing strategies in exclusively Islamic representations of distress are predicated on complete submission to God followed by accepting His judgment with equanimity and without question (Al-Krenawi & Graham, 1999; Hodge 2005). Hamjah et al. (2017), for example, equate worship with submission and claim that it underlies all Islamic healing. According to Hamdan

(2008), such approaches can be seen as derived from the broader concept of Tawakkul, which is emphasized in the Quran (8:2; 9:51; 65:38:2; 67:1-2) and entails trusting and relying completely on God. Not only did a number of participants explicitly describe this concept as reminiscent of the feelings of helplessness and lack of control that characterized their experience of distress, but they also claimed it resulted in feelings of frustration and ultimately increased their distress. Even for participants who did not articulate such adverse reactions, the lack of agency and empowerment implicit in such a concept is unlikely to resonate with the personal individualism, autonomy, and self-reliance that are fundamental Western values and would have been incorporated, to varying extents, into the Canadian or bicultural identities developed by the participants as described by Ng and Northcott (2010), and thus biased, or at least inclined participants towards including biomedical elements in their representations of distress.

Encouragement for participants to incorporate biomedical elements into their representations of distress is also likely to have been provided by their healthcare providers' beliefs in the medical model and their ongoing participation in it. The influence of healthcare providers' beliefs on patients' expectations and behaviours has been documented extensively (e.g., DiMatteo, Sherbourne, Hays, Ordway, & Kravitz, 1993; Osterberg & Blaschke, 2005; Street, Makoul, Arora, & Epstein, 2009) along with the prevalence of their belief that medication is the most effective form of treatment (Ahn, Proctor, & Flanagan, 2009). It is therefore not unexpected that participants who, as residents of the Greater Toronto Area, would have had regular interactions with doctors and clinicians, would believe pharmacotherapy to provide the best chances of relief from their distress. Consequently, this belief is likely to be incorporated into their representation of distress in that same way that the participants

of the study by El Rhermoul et al. (2018) believed their depression to be caused by the evil eye but turned to psychiatry for healing.

Moreover, the participants' social and economic backgrounds both in Canada and their countries of origin meant that they were familiar with the biomedical approach of focusing on disease aetiologies, diagnosing and treating symptoms, and modifying treatment plans based on results (Shah & Mountain, 2007). Specifically, the methodology and goals of concrete and measurable symptomatic relief characteristic of biomedical treatment (Clare, 1980) would have inspired confidence in this approach and thereby influenced the inclusion of biomedical aspects of representations of distress, even if they were not necessarily applicable to participants' experiences. In addition, the 'consumer-driven' paradigm of the medical model (Paul, Sanson-Fisher, & Carey, 2013) and associated representations of distress, in which patients and clients are considered consumers of healthcare and have the authority to measure and judge their well-being or distress, is likely to have been more palatable to the participants compared to Islamic approaches and representations which entail submitting to God, placing absolute trust in Him, and then accepting His decision without question (Al Krenawi & Graham, 1999; Hodge 2005).

With some exceptions, the nature of participants' representations of distress and the processes through which these representations were constructed were broadly consistent with the literature on the Self-Regulatory Model (e.g., Diefenbach & Leventhal, 1996; Leventhal et al., 1997; Leventhal et al., 2003), most significantly regarding the role of social and cultural factors. It was evident from the findings of this study that participants' representations were influenced to a considerable extent by social and cultural factors, such as their religious faith and their bicultural

identities as Muslims and Canadians of Indian, Pakistani, or Bangladeshi heritage. Moreover, participants' emphasis on their incompatible and possibly contradictory beliefs that their distress was the result of punishment for their lack of faith and piety and that counseling, psychotherapy, and psychiatry offered the best chances of coping and relief, accompanied by the exclusion of economic, relational, and societal factors in their representations of distress, have been anticipated in the literature. For example, Deifenbach and Leventhal (1996) and Kellinman (1980) argue that the interplay between the multiple social and cultural factors shape representations of distress and illness and determine which factors are incorporated into participants' representations and which ones are disregarded and excluded.

In a similar vein, the dual religious and biomedical nature of participants' representations of distress can be understood in the context of studies by Shiloh (2006), who suggests that representations of distress and illness are dynamic and fluid. Similarly, Leventhal and Crouch (1997) and Weinman et al. (1996) describe constantly evolving, complex, and possibly unpredictable interactions between the multiple factors that influence and constitute representations of distress and illness. Specifically, the apparently incompatible aspects of participants' representations of distress can be seen as manifestations of their occasionally problematic relationship with Islamic beliefs and worldviews. These Islamic beliefs and worldviews resulted in religious struggles and crises, emotional responses of guilt, shame, resentment, and anger, and led to participants distancing themselves from certain aspects of Islam and local Muslim communities. However, they continued to identify as Muslims and remained within a belief system in which they were neither entirely comfortable nor committed.

Leventhal (1970), Leventhal et al. (1998), and Keller et al. (1989) provide a possible explanation for participants' ostensibly problematic attachment to the Islamic aspects of their representations of distress, particularly regarding causation, by proposing that representations of distress and illness are constructed emotionally and cognitively. The belief that their distress was the result of punishment for sinful behaviour may have social and cultural roots and participants remained wedded to it even when it was incompatible with their worldviews and other aspects of their representations of distress. It could be argued that this belief was sustained because it fulfilled a strong emotional need by providing a sense of purpose and meaning to their distress and validating its significance, as highlighted by Ahmed (2012), Dwairy (2009), and Mehraby (2003), while ensuring benefits for emotional regulation as described by Lloyd (2018). Biomedical representations of distress and illness, in contrast, are severely lacking in this respect, due to their focus on symptoms, aetiologies, and treatment (Clare, 1980) and the ensuing reductionist, pathologizing, and mechanistic view of illness (Shah & Mountain, 2007) that is devoid of meaning and part of a broader context of diagnostic cultures described by Brinkman (2016).

This emotional aspect of representations of distress, which provided purpose, meaning, and validation to participants in this study, coupled with the concept of symmetry, might explain the curious finding that a number of them believed that their distress was punishment for sinful behaviour even though they struggled to identify the sins that they had committed. According to Leventhal et al. (1997), representations of distress can be symmetric in the sense that individuals experiencing symptoms desire labels for their illness, whereas those who have a label (typically through a diagnosis) look for symptoms and are likely to interpret unrelated symptoms as evidence for the label. Thus, having accepted the label of punishment as

part of their representation of distress due to social and cultural factors, and the emotional benefits it provided, participants tried to find sins for which they were being punished in the same way that Leventhal et al. (1997) describe individuals who have a label for their illness look to symptoms to justify that label.

Participants' emphasis on coping and the importance given to it compared to other aspects of representations of distress or illness in the Self-Regulatory Model, for example, identity, cause, duration, and consequences (e.g., Leventhal et al., 2003), echo many research studies but also raise questions regarding the findings of this study within the framework of the Self-Regulatory Model. The significance of participants' preference for biomedical coping strategies in shaping their overall representations of distress can be understood within the context of research by Lau, Bernard, and Hartman (1989) and Wilski and Tasiemski (2016), who highlight the relative importance of beliefs regarding coping because of their implications for individuals' self-efficacy and role in coping and healing. Moreover, Glattacker et al. (2018), Langston et al. (2017), and Scharloo et al. (1998) describe how strong beliefs regarding coping result in productive and effective coping strategies. Folkman and Lazarus (1998) maintain that beliefs regarding coping and the ensuing coping strategies underlie individual's emotional responses, and Mountain and Shah (2008) emphasize how the medical model and related representations of distress foster hope and optimism. Thus, while the findings of this study are consistent with those of Lau et al. (1989), Scharloo et al. (1998), Folkman and Lazarus (1998), Mountain and Shah (2008), and Wilski and Tasiemski (2016), they raise the question of whether, and to what extent, coping strategies are determined by representations of distress and illness. It could be argued, for instance, that individuals select coping strategies based on those that they believe have the greatest likelihood of desirable outcomes and then

construct representations of distress around those strategies. Alternatively, coping strategies and representations of distress and illness could evolve in parallel through a process of mutual influence and reinforcement.

These questions are even more problematic when, as in this study, beliefs regarding causation and strategies for coping appear to be incompatible or even conflicting. The Self-Regulatory Model assumes coherent representations of distress and illness (Hagger et al., 2017; Lowe & Norman, 2016; Weinman & Petrie, 1986) with Hagger and Orbell (2003) providing evidence for the benefits of specific and well-defined representations and Detweiler-Bedell et al. (2008) arguing that the inability to form coherent representations of distress severely compromises coping and healing. The findings of this study appear to contradict those of Hagger and Orbell (2003) and Detweiler-Bedell et al. (2008), because all of the participants reported coping successfully and ultimately overcoming their distress despite significant divergence in their beliefs regarding causation and strategies for coping. The successful coping described by the participants despite the lack of coherence in their representations of distress could be indicative of a parallel postformal dialectical process in which contradictory positions are integrated (Lemieux, 2012). Berg (2008) highlights how such postformal processes are particularly useful for the reconciliation of reason and emotion, which are relevant to the findings of this study since it has been argued that rational analysis and emotional needs could underlie the inherent contradictions in participants' representations of distress. The findings are, moreover, consistent with arguments by Clare et al. (2016) regarding the disadvantages of coherent representations of illness and the benefits of focusing on selective aspects of illness representations that facilitate coping and healing. Ultimately, the results of this study lead to a number of questions regarding representations of distress and illness,

such as individuals' awareness and understanding of them, whether accuracy is necessary or beneficial in this regard, the importance of coherence in representations of distress, whether multiple and mutually exclusive representations can be sustained by individuals without being reconciled into a coherent whole, and how such representations might impact coping and healing.

Chapter 6

Conclusion

The findings of this study, which sought to examine representations of distress among Canadian Muslims of Indian, Pakistani, and Bangladeshi cultures of origin, have been presented in the previous chapters. Using Interpretive Phenomenal Analysis (Smith, 2004; Smith & Osborn, 2008), participants' words, phrases, and descriptions were used to gain insight into their recollections, reflections, and understandings of their experiences of distress. In the results chapter, these were organized into domains of context, experience, and coping to provide a nuanced and comprehensive overview of their representations of distress. The discussion chapter proceeded to explore the simultaneous and apparently contradictory religious and biomedical nature of participants' representations of distress. Specifically, it focused on participants' beliefs that their distress was punishment for sinful behaviour or for not being sufficiently faithful, coupled with their recourse to counselling, psychotherapy, and psychiatry to cope with their distress. The discussion chapter then expanded on and explored possible reasons underlying these distinct and incompatible aspects of participants' representations of distress in the context of existing research and literature. It also highlighted other studies that were consistent with, contradicted, or provided additional insights into the findings of this study.

This chapter discusses the unique contributions of this study, its implications for understanding representations of distress among Canadian Muslims of Indian, Pakistani, and Bangladeshi cultures of origin and Muslims in a broader context, and consequently their implications for counselling, psychotherapy, and psychiatry, both with this population and also more generally. Finally, it acknowledges the limitations of this study and provides recommendations for future research.

6.1. Unique Contributions

The main rationale for this study was that the current literature on Islamic healing, counselling, psychotherapy, and psychiatry with Muslim populations assumes representations of distress based on traditional Islamic beliefs and values, and that these assumptions are made by researchers, traditional healers, and mental health professionals. Consequently, the most significant contribution of this study is to provide empirical knowledge of representations of distress among Canadian Muslims from Indian, Pakistani, and Bangladeshi cultures of origin based on the actual experiences and understandings of individuals who suffered from psychological distress, which referred to distressing emotions, interpersonal difficulties, somatic symptoms, and behaviours that compromised functioning.

The findings of this study also indicate that the participants' representations of distress differed from those assumed in the existing literature in a number of ways. Specifically, they incorporated myriad Western and scientific beliefs, such as the medical model of health and illness and need for agency and autonomy, along with Islamic beliefs, such as distress being punishment for sinful behaviour and the need for submission to God for forgiveness and relief. Moreover, while many of these Western and Islamic beliefs can be considered inconsistent and inherently contradictory, they were nevertheless held simultaneously.

In addition, this study documented the considerable variation in the influence of Islamic values and beliefs on representations of distress and, more significantly, highlighted certain problematic aspects of these influences, thereby challenging the existing literature, which overwhelmingly portrays faith as fostering greater well-being and alleviating distress among Muslim populations. Although the belief among

Muslims that distress is a form of punishment has been researched and described extensively, the findings of this study highlight the potentially insidious and damaging manifestations of this belief, which can include feelings of resentment, anger, helplessness, shame, guilt, fatalism, defectiveness, and diminished self-esteem.

The salience and relevance of Islamic beliefs, values, and worldviews to Canadian Muslims of Indian, Pakistani, and Bangladeshi origin are also questioned by the findings of this study. Once again, while the existing literature tends to describe this population as being significantly religious and turning to their faith and communities during times of distress, the participants of this study revealed a more complex and at times problematic relationship to their faith and communities, thereby suggesting that the evolution of bicultural or Canadian identities, the increasingly puritanical nature of Islam, and reactions to the prevailing political narrative of Islam in Canada have had a significant impact on the beliefs, values, and worldviews of the participants, and consequently on their representations of distress.

Ultimately, this study provides empirically based insights into representations of distress among Canadian Muslims of Indian, Pakistani, and Bangladeshi cultures of origin. It not only challenges prevailing assumptions in the existing literature but also suggests a nuanced and complex understanding of representations of distress among this population that merits further study.

6.2. Implications for Counselling and Psychotherapy

While the qualitative and phenomenological nature of this study precludes the statistical generalization of its results to other populations allowed by quantitative methods, they can still have implications in a broader context by connecting them to personal and professional experiences and practices. Consequently, the findings of

this study are relevant to and can thus inform the practice of counselling and psychotherapy for Muslims and the general population in a number of ways.

The incompatible and occasionally conflicting aspects of the representations of distress described among the participants of this study, for example, have implications for our understanding of representations of distress and their role in counselling and psychotherapy. While the Self-Regulatory Model of Illness Representation (e.g., Leventhal et al. 1997) describes representations of distress as being influenced by multiple and diverse factors and as being fluid and constantly evolving, it nevertheless assumes an underlying coherence in individual representations. Moreover, as discussed in the previous chapter, coherent, specific, and well-defined representations of distress are considered beneficial (Hagger & Orbell, 2003), whereas the lack of, or inability to construct, such representations can compromise coping and healing (Detweiler-Bedell et al. 2008). In this context it would not be unreasonable for counsellors and psychotherapists to consider inconsistent and contradictory representations of distress problematic, and to challenge them in therapy and help their clients develop coherent, specific, and well-defined representations in order to encourage their healing.

The findings of this study, however, call into question the coherent nature of representations of distress implicit in the Self-Regulatory Model and the related literature (e.g., Diefenbach & Leventhal, 1996; Leventhal et al., 1997; Leventhal et al., 2003), and the likely inclination among counsellors and psychotherapists to aspire towards such coherence with their clients. Not only did the participants describe representations of distress that incorporated religious and biomedical aspects that were at odds with each other, it can be argued that these divergent aspects facilitated coping and healing. For instance, while the religious aspects of participants'

representations of distress, namely that their distress was punishment for sinful behaviour, provided meaning and validation to their suffering and could thus serve to improve emotional regulation (Lloyd, 2018), the biomedical aspects, which entailed counselling, psychotherapy, or psychiatry, provided a sense of agency, empowerment, and the prospect and means of coping. On their own, meanwhile, purely religious representations were likely to result in unaddressed feelings of helplessness, shame, guilt, and defectiveness, and purely biomedical ones likely to feel reductionist and pathologizing. Therefore, rather than emphasize coherent, specific, and well-defined representations of distress as implied by Hagger and Orbell (2003) or Detweiler-Bedell et al. (2008), the results of this study suggest that it would be in clients' interests for counsellors and psychotherapists to instead focus selectively on adaptive and functional aspects of representations of distress that are conducive to coping and healing as described by Clare et al. (2016). This approach would be especially useful if these adaptive and functional aspects can serve to mitigate the damaging aspects of concomitant representations, regardless of whether they might appear to be divergent and contradictory.

Another significant implication of this study pertains to the salience of Islam in individual Muslims' lives, their relationship with their faith, and the consequences for counselling and psychotherapy. While it was acknowledged from the onset that representations of distress among Muslims vary by culture and ethnic origin (e.g., Bhui et al. 2008), the findings of this study highlight the extent to which they vary even among a purposefully sampled and relatively homogenous group such as the participants of this study. This variation was apparent not only in the degree of religiosity and intensity of belief but also, and more significantly, in the nature of

their relationships with Islam. These relationships ranged from being conducive to healing to exacerbating or even causing participants' distress.

It is imperative, therefore, for counsellors and psychotherapists not to presume that Muslim clients have an unambiguously straightforward and healthy relationship with Islam that can provide a basis for healing, as is almost universally assumed in the literature (e.g., Al-Krenawi, 1999; Hamdan, 2007), which, according to Selby (2016), emphasizes the beliefs, practices, and worldviews of especially pious and committed Muslims. Instead they need to be sensitive to the possibility of a problematic relationship that may need to be explored and addressed in therapy to enable healing and coping. Moreover, while religious struggles and conflicts can be resolved in therapy within conventional Islamic frameworks as described by Hamdan (2008) and Hussain and Hodge (2016), counsellors and psychotherapists also need to be open to the prospect of moving beyond Islamic frameworks to address their clients' needs.

In this context, for example, approaches to counselling and psychotherapy that incorporate Islamic beliefs and healing strategies such as those proposed by Armstrong and Munro (2018), Hamdan (2008), Hussain and Hodge (2016), Habib et al. (2015), Irfan et al. (2017), Naeem et al. (2015), and Rüschoff and Kaplick (2018) may be employed with Muslim clients who believe that their distress is punishment by God for sinful behaviour. However, Muslims who have trouble with Islamic beliefs such as the punitive nature of Islam may require counsellors and therapists to help them articulate and explore their internal religious conflicts. The findings of this study also suggest that the goal of therapy should not necessarily be to reconcile these conflicts but to help manage feelings such as guilt, shame or anger that might be triggered by them and, if required, to enable clients to confront conventional Islamic beliefs that they may have internalized but which nevertheless run counter to their

values and worldviews. This process may entail reevaluating Islamic beliefs and obligations in order to make clients' faith more meaningful and relevant to them in their everyday lives, thereby mirroring, on a personal level, the evolution of the doctrinaire faith of the Old Testament into the comparatively milder versions of Judaism and Christianity generally practiced today (Wright, 2010) but which is unthinkable in contemporary Islam (Aslan, 2005). It could also lead to clients rejecting their faith and leaving Islam altogether, in which case counsellors and psychotherapists would need to be prepared support clients as they face the considerable challenges of social stigma, ostracism, and moral condemnation (Abbott, 2017; Cottee, 2015), especially in the context of the extreme attitudes towards apostasy prevalent in Islam communities and societies (Opal, 2014).

Given the role of Islam in providing meaning to distress and validating its significance, as suggested by the findings of this study, which were also consistent with the literature on this topic (e.g., Ahmed, 2012; Dwairy, 2009; Mehraby 2003), counsellors and psychotherapists would also need to ensure that clients have a comparable locus of meaning in their lives. While it would not be unreasonable to expect that individuals who wish to reject Islam do not rely on it to provide meaning and purpose, the complex and contradictory nature of representations of distress highlighted in this study raise the possibility that individuals who find the beliefs, practices, and worldviews of Islam unacceptable and distressing may nevertheless rely on it for an underlying sense of purpose of meaning without being aware of it. Counsellors and psychotherapists would therefore need to be especially careful in helping their clients decide whether they wish to abandon or merely reevaluate and modify their faith. In the case of the former, they would need to help manage the social stigma, ostracism, and moral condemnation that they are likely to encounter,

but also be certain that they are not left devoid of a sense of meaning and purpose, which could have adverse consequences for emotional regulation (Lloyd, 2018) and leave them vulnerable to the pathologization that is characteristic of diagnostic cultures (Brinkmann, 2016). Notwithstanding participants' inclination towards counselling, psychotherapy and psychiatry, the findings of this study draw attention to the importance of their faith for making meaning of distress, and thus highlight the potential usefulness of dual interventions as described by Moodley and Sutherland (2010). Such interventions would entail the use of traditional Islamic healing in conjunction with counselling and psychotherapy in a manner that could provide the benefits of both traditions.

In the same way that this study highlighted the need for counsellors and psychotherapists to be wary of presuming that Muslim clients' faith had a positive and uncomplicated impact on their representations of distress, it indicates a similar need for caution regarding their clients' relationships to Muslim communities in the North American and European diaspora. While previous research (e.g., Farver et al., 2002; Inman et al. 2007; Akram-Pall & Moodley, 2016) reports local Muslim communities as being a source of solace and comfort for Muslims, especially during periods of distress, the findings of this study suggest that not all Muslims find them to be supportive, with some describing experiences of judgment, exclusion, and ostracism, thereby compounding their feelings of isolation and ultimately their distress. Thus, rather than simply assuming that Muslim communities can serve as support networks for Muslim clients, counsellors and psychotherapists need to assess whether interacting with local Muslim communities is likely to be beneficial to clients, to explore clients' previous and ongoing interactions with these communities, and to be able to help them develop alternative support networks if required.

While the conflicts between Islamic and Western values have been discussed exhaustively from theological, cultural, political, and other perspectives, in the everyday lives of the Muslim diaspora living in Europe and North America they tend to manifest themselves in issues such as the consumption of alcohol, headscarves and veils worn by women, relationships between the sexes, sexual orientation, and deference to elders. Consequently counsellors and psychotherapists who aspire towards multicultural competence are likely to be mindful of such issues and have strategies for dealing with them in therapy. The findings of this study, however, draw attention to a more fundamental conflict between Western values such as personal individualism, autonomy, and self-reliance, and the Islamic concept of Tawakkul, which entails trusting and relying completely on God, submitting completely to Him, and unquestioningly accepting His judgment (Al-Krenawi & Graham, 1999; Hamdan 2008). This conflict broadly resonates with the complexities of addressing cultural differences in counselling and psychotherapy described by Hwang (2011). As revealed by the participants of this study, individuals are unlikely to articulate or even be aware of this conflict, yet it can be intrinsic to their representations of distress, especially with regard to their coping and healing. Cultural competency would therefore require counsellors and psychotherapists to be aware of the prospect of this underlying conflict, to be able to discern whether it is indeed contributing to clients' distress or hindering their healing, and to help clients develop strategies to manage, if not resolve, it.

Similarly, the challenges of acculturation among South Asians, issues of belonging and identity, and the implications of both factors for mental health and well-being have been documented in a number of studies (e.g., Khan & Watson, 2005; Jibeen & Khalid, 2010), and counsellors and psychotherapists working with

this population are likely to be familiar with them. For the most part, however, the participants of this study had spent sufficient time in Canada and had established and grown comfortable with their Canadian and bicultural identities. And while racism and discrimination were concerns, the findings of this study suggest that the politicization of Islam and the accompanying political narrative, especially regarding extremism and terrorism, were more likely to be problematic, underlie the tension in participants' relationships with their faith, shape their representations of distress, and ultimately impact their strategies for coping with distress. This study, therefore, stresses the importance for counsellors and psychotherapists to be able to move beyond issues of acculturation, belonging, identity, racism, and discrimination, and to support their Muslim clients as they negotiate the broader political narrative of Islam regardless of whether they have been directly affected by the issues at stake. Finally, given the prevalence of feelings of guilt and shame among the participants, it also highlights the importance of knowledge regarding the adaptiveness of guilt and shame (e.g., Konstam, Chernoff & Deveney, 2001; Tangney & Dearing, 2003; Tignor & Colvin, 2017) along with the ability to address these emotions in therapy in a manner that is not simplistic or reductionist but is sensitive to the unique cultural and religious complexities that underlie them.

The overall implications of this study can therefore be encapsulated in terms of counsellors and psychotherapists refraining from making assumptions regarding clients' representations of distress and their relationships with Islam, being mindful of nuances, complexities, and contradictions in this regard, and being open to new ways of approaching these issues and engaging with clients. In concrete terms, these implications would mean taking a critical view of the prevailing literature on counselling and psychotherapy with Muslims. In professional and clinical contexts,

such a critical approach might entail not challenging and possibly even encouraging inherently contradictory aspects of representations of distress, being comfortable exploring clients' religious conflicts, being willing and able to embark on a process of engaging with these conflicts, even if it leads to the reevaluation or rejection of clients' faith. It would also include sensitivity to the problematic nature of clients' social, cultural, and political realities, and providing appropriate support even if it goes against conventional and generally accepted strategies and worldviews.

6.3. Limitations

Many of this study's limitations were typical of qualitative and phenomenological research and expected. Others, however, were unique to this study and became evident only after the data were collected and analyzed. While the expected limitations were covered in the methodology chapter, along with the steps taken to address them, this section discusses the unexpected ones and their implications on the results and the conclusions drawn from them.

In particular, the sample of participants was a possible limitation of this study for a number of reasons. Participants were selected on the basis of self-identifying as Muslim and of Indian, Pakistani, and Bangladeshi origin, having experienced psychological distress within the last two years, and describing themselves as having healed or overcome their distress. Attempts were made to recruit participants from throughout the Greater Toronto Area (GTA), Canada, through advertisements placed on bulletin boards in public areas of mosques, universities, and community centres. Most of the participants, however, lived in or near Downtown Toronto, which could be explained by the decision to conduct interviews at the Ontario Institute of Studies in Education, which is easily accessible by bus, subway, or streetcar from nearby neighbourhoods but comparably difficult to reach by car or public transit from other

parts of the GTA, such as York, Halton, Peel, and Durham Regions. In addition, my own residence in this vicinity along with my familiarity with it resulted in my efforts at recruitment being largely focused in this area. Consequently, there was comparatively less representation from areas such as Mississauga, Scarborough, Brampton, and Markham, where there are large, concentrated, and cohesive communities of Muslims from Indian, Pakistani, and Bangladeshi cultures of origin, with potentially different social and economic backgrounds and worldviews, and with different relationships to Islam, their cultures of origin, local Muslim communities, and Canadian society. It is conceivable that if there had been more participants from these areas, additional and varied themes would have emerged from the interviews, and that the findings of this study might have been markedly different.

Other aspects of the selection and recruitment of participants for this study that may have had a similar impact on its findings were education and command of English. All of the participants were college graduates with at least a bachelor's degree, with many of them possessed or were working towards advanced degrees. Similarly, they were all able to express themselves easily and articulately in English, and for many it was their preferred language. While it would not be unreasonable to expect Indians, Pakistanis, and Bangladeshis living in Toronto to have a working knowledge of English, the participants' fluency in English was comparable to the majority of Canadians who are native speakers of the language. This combination of post-secondary education and English proficiency could therefore correlate to a sample biased towards participants who are well-integrated into Canadian society and able to take advantage of the benefits it provides. It would thus exclude Canadian Muslims of Indian, Pakistani, and Bangladeshi cultures of origin whose inadequate education and language skills could result in diminished

economic prospects, lack of acceptance into Canadian society, and feelings of alienation, exclusion, and rejection. These economic and social differences are likely to shape their worldviews, values, and belief systems, and Islam's role in their everyday lives. Again, as in the case of participants from concentrated and cohesive South Asian Muslim communities, including such participants in this study could have resulted in different emergent themes and conclusions regarding representations of distress.

While the homogeneity of the sample can be considered a limitation of this study, it could also be argued that the participants were not sufficiently homogenous. IPA (Smith, 2004; Smith et al., 1999) requires a well-defined and homogenous sample of participants, and purposeful sampling was used to recruit participants who had experienced psychological distress within the last two years and self-identified as Muslim and of Indian, Pakistani, or Bangladeshi origin. The methodology chapter delineated the arguments for not recruiting participants from particular ethnic groups of Muslims of Indian, Pakistani, or Bangladeshi origin or from different branches and schools of Islam and thus considering the sample sufficiently well-defined and homogenous. However, participants' degrees of religiosity, the intensity of their faith, its salience and centrality to their everyday lives, their ensuing worldviews, perceptions, and interactions with contemporary society, and the nature of their relationship with Islam were not considered during the selection and recruitment of participants. The results of this study, however, highlighted how these factors, which had significant influence over participants' representations of distress, varied within the sample. Had factors such as religiosity, intensity of faith, salience, and centrality to participants' lives and the nature of their relationship with Islam, particularly whether it was a healthy relationship that was conducive to healing or an antagonistic

or unhealthy one that caused or exacerbated distress, been delineated in advance and included the selection criteria, the emergent themes might have been more focused and yielded richer descriptions of participants' representations of distress with greater detail.

6.4. Recommendations for Future Research

The findings of this study, which challenged prevailing assumptions of representations of distress among Muslims of Indian, Pakistani, and Bangladeshi origin and provided an insight into the complex nature of these representations, also suggest a number of issues for further study. These primarily focus on our understanding of representations of distress and their role in counselling and psychotherapy, the need for a more nuanced conception of how Islamic beliefs and values impact these representations, and the broader implications of individuals' relationships with Islam, especially in Western and diasporic Muslim communities.

First of all, the notion of inconsistent and inherently contradictory aspects of representations of distress merits detailed examination. While the Self-Regulatory Model of Illness Representation (e.g., Leventhal et al., 2003) acknowledges the mutable and evolving nature of representations of distress, it does assume overall coherence in individual representations, which is challenged by the results of this study. Further research is therefore required to explore the possibility and prevalence of such inconsistencies and contradictions and their implications for counsellors and psychotherapists. For instance, it would be worthwhile to examine whether they are detrimental to individuals and need to be corrected as argued by Hagger and Orbell (2003) and Betweiler-Bedell et al. (2008) or whether they are adaptive and should be selectively encouraged to facilitate coping and healing as suggested by the findings of this study.

The main goal of this study, to develop a sophisticated and comprehensive understanding of representations of distress among Canadian Muslims of South Asian cultures of origin, could be furthered by conducting iterations of this study with more rigorous selection criteria. For instance, multiple studies along the lines of this one with purposefully sampled, well-defined, and homogeneous groups based not just on self-identification as Muslim and of Indian, Pakistani, or Bangladeshi origin, but also on the basis of religiosity or lack thereof, intensity of faith, relevance of Islam to everyday life, nature of relationship with Islam, extent of integration into Canadian society, development of Canadian or bicultural identities, social and economic status, worldviews, and membership of or alliance to different branches, schools of jurisprudence, and ideologies of Islam would yield richer and more detailed descriptions and thus provide greater insights into the representations of distress among this population.

Many of the differences between the findings of this study and previous ones by Farver et al. (2002), Inman et al. (2007), and Akram-Pall and Moodley (2016) have been explained on the basis of participants' development of Canadian and bicultural identities as described by Ng and Northcott (2010). More research on the process of identity formation in the context of religiosity, relationships with their faith, interaction with Muslim and Canadian communities, and overall worldviews, especially those focusing on the differences in this regard between immigrants and subsequent generations who have grown up in Canada, could shed more light on the Canadian and bicultural identities among Canadian Muslims of Indian, Pakistani, and Bangladeshi origin and their influence on representations of distress.

Similarly, research into the conflicts between Islamic and Western beliefs and values and their manifestations in the subjective, lived experiences of Canadian

Muslims of Indian, Pakistani, and Bangladeshi could provide a better understanding into representations of distress among this population and have important implications for counselling and psychotherapy. Such research could entail studies into the conflicts between Western notions of individualism, self-reliance, and autonomy versus Islamic ones of relying completely on God and submitting to His judgment without question, as was indicated by this study, and the negotiation of troubling political narratives as described by Downie (2013), Jamil and Rousseau (2012), and Patel (2011).

Perhaps the most important topics for future research are internal conflicts and problematic relationships with Islam among Muslims. While studies have shown that religious beliefs can result in feelings of shame, guilt, helplessness, and fatalism (e.g., Meisenhelder & Marcum, 2004; Pargament et al., 2003; Smith & Richards, 2005), there is a severe lack of research specifically on Islamic beliefs in this regard, possibly due to emphasis on pious and committed Muslims and their beliefs, practices, and worldviews highlighted by Selby (2016), that urgently needs to be addressed by studies that acknowledge Muslim diversity and examine how Islamic beliefs and values can cause or exacerbate distress.

Armstrong and Munro (2018), Habib et al. (2015), Hamdan (2008), Hussain and Hodge (2016), Irfan et al. (2017), Naeem et al. (2015), and Rüschoff and Kaplick (2018) have proposed strategies to address psychological distress and resolve religious conflicts through counselling and psychotherapy within Islamic frameworks. In contrast, moving beyond conventional Islamic frameworks to reevaluate individual faith and making Islam more relevant and meaningful has not been the subject of any research studies and neither has rejecting Islam altogether. While finding subjects for such studies is likely to be difficult for the reasons highlighted by Opal (2014) and

Cottee (2015), members of groups such as Salaam Canada, which aims to support individuals who identify as both Muslim and queer or trans, or Ex-Muslims of North America, an advocacy and community building organization for individuals who have left Islam, are likely to provide access to subjects whose experiences could lead to important insights into these topics and serve as starting points for further research.

Finally, given the significance of the punitive nature of Islam to the participants and their representations of distress, it could be interesting to situate the findings of this study in a broader context of punishment in anthropology, sociology, evolutionary psychology, and biology. For example, suggestions by Hoffman (2014) that humans possess an innate punitive instinct, and by Boyd, Gintis, Bowles, and Richerson (2003) that the concept of punishment was necessitated by the evolution of society could form the basis of studies in a variety of disciplines to examine whether the punitive nature of Islam and other religions can be understood as a manifestation of biological and sociological imperatives.

This study used the Self-Regulatory Model of Illness Representation (Diefenbach & Leventhal, 1996; Leventhal et al., 1997; Leventhal et al., 2003) to provide empirical evidence on representations of psychological distress among Canadian Muslims of Indian, Pakistani, and Bangladeshi cultures of origin. It focused on how participants experienced, made sense of, and responded to their distress, and by using qualitative and phenomenological methodology, it sought to provide rich, nuanced, and appropriately contextualized descriptions of participants' narratives and the meanings that they assigned to them. It differed from the existing literature by focusing on participants' experiences rather than adopting clinical, theological, or anthropological perspectives.

The results of this study revealed that participants' believed that their psychological distress was a form of punishment for their lack of faith or piety, indicating a religious aspect to their representations of distress. However, rather than engage in traditional Islamic healing practices, such as turning to God, praying for forgiveness, or reading the Quran, participants sought to cope with their distress by seeking help from counsellors, psychotherapists, and psychiatrists, suggesting a simultaneous biomedical aspect to their representations that was shaped by Western and scientific influences.

The religious aspects of participants' representations of distress were understood as a source of meaning, purpose, and validation. Meanwhile, the biomedical aspects were explained in terms of participants' bicultural identities, internal religious conflicts, feelings of isolation, stigmatization and disempowerment, discomfort with the politicization of Islam, experience and comfort with the medical model and traditional Islamic practices, and worldviews losing their resonance for participants.

The results of this study thus challenged the prevailing assumptions in the existing literature regarding representations of distress among Muslims. Significantly, they drew attention to the need for counsellors and psychotherapists to be open to the possibility of clients constructing inherently contradictory representations and to focus on functional aspects of these representations rather than coherence. The results also emphasized the importance of counsellors and psychotherapists not making assumptions regarding clients' representations of distress due to the considerable variance in the salience of Islam to participants' lives and the complexity of their relationships to their faith. The need for counsellors and psychotherapists to be open to clients confronting, reevaluating, and abandoning aspects of their personal faith that

are problematic for them were also discussed, along with the prospect of clients leaving Islam altogether.

Finally, a number of areas for future research were highlighted by the findings of this study. These included representations of distress with incompatible aspects; representations of distress among participants purposefully sampled on the basis of religiosity and intensity of faith; the impact of acculturation and integration into Canadian society on representations of distress, internal conflicts, and problematic relationships with Islam among Muslims; and healing by moving beyond conventional Islamic frameworks in counselling and psychotherapy.

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Appendix A

Recruitment Poster



Adult Muslim men and women of South Asian origin are invited to participate in a study on feelings of agitation, hopelessness or guilt; pain, fatigue or digestive problems unrelated to a physical illness; a lack of interest or pleasure in most activities, diminished ability to concentrate and difficulty making decisions; or changes in appetite, sleep or other patterns of behaviour that had significant impact on their lives.

Purpose of Study: To study the experiences of distressing emotions, symptoms such as pain, fatigue or digestive problems unrelated to a physical illness, a lack of interest or pleasure in most activities, diminished ability to concentrate, difficulty making decisions, or changes in appetite, sleep or other patterns of behaviour that had significant impact on the daily lives of Canadian Muslims of South Asian origin.

Researcher: Humair Yusuf

Faculty Supervisor: Dr. Roy Moodley

Location of Study: Department of Adult Education & Counselling Psychology
Ontario Institute for Studies in Education
University of Toronto
252 Bloor Street West
Toronto, Ontario M5S 1V6

Participation: One interview lasting 1-1/2 to 2 hours

For Further Details Please Contact:

Humair Yusuf
416-827-8804

humair.yusuf@utoronto.ca

Appendix B

Information Letter

Researcher Information

This study will be conducted by Humair Yusuf, a graduate student at the Ontario Institute for Studies in Education, University of Toronto, and will be supervised by Roy Moodley, Ph.D., who is a faculty member and Associate Professor in the Department of Adult Education and Counselling Psychology.

Details of the Study

This study aims to explore the experiences of distressing emotions, symptoms such as pain, fatigue or digestive problems unrelated to a physical illness, a lack of interest or pleasure in most activities, diminished ability to concentrate, difficulty making decisions, or changes in appetite, sleep or other patterns of behaviour that had significant impact on the daily lives of Canadian Muslims of South Asian origin. Specifically it is concerned with *what this experience was like* for Canadian Muslims of South Asian origin—not just the causes and symptoms of the distress, but also the accompanying thoughts and feelings. In addition, this study is interested in the kinds of help that individuals sought to manage their feelings, physical symptoms or changes in patterns of behaviour, and whether it was helpful or unhelpful. It is hoped that the findings of this study will lead to the development of recommendations and resources for counsellors and other professionals to provide appropriate help to individuals facing similar experiences.

Recruitment of Participants

This study is looking for adult men and women who are Muslim, of Pakistani, Indian or Bangaldeshi origin, currently resident in Canada, and during the last two years suffered from emotional or psychological distress, symptoms such as pain, fatigue or digestive problems unrelated to a physical illness, a lack of interest or pleasure in most activities, diminished ability to concentrate, difficulty making decisions, or changes in appetite, sleep or other patterns of behaviour that had significant impact on their daily lives. Approximately 12-15 people will be interviewed for this study.

Nature of Participation

Participants will be asked to be available for one audio-taped interview that will last between 1-1/2 and 2 hours at a suitable time and place. In the interview, they will be asked to talk about the feelings, physical symptoms or changes in patterns of behaviour experienced by them. Participants may request to see in advance a list of the topics that they will be asked to discuss. After the interview participants will be sent a copy of the transcript of their interview, accompanied by a written discussion containing the researcher's interpretations and comments about the information

provided. They will have the opportunity to review the transcript and discussion, and to provide suggestions, corrections, and comments. This feedback would be appreciated, but is optional.

Participation in this study is entirely voluntary. Participants may refuse to participate at any time, decline to answer any question, or withdraw during the course of the interview, without any negative consequences.

Risks of Participating

During the course of the interview, participants *may* choose to share sensitive information regarding a difficult time in their lives. This has the potential to be upsetting, which is the only foreseeable risk associated with participation in this research. If, at any point, participants wish to take a break, change topics, or stop the interview, they may do so without any negative consequences. They will have the opportunity, once the interview is finished, to discuss the process. If participants feel they require additional help, they will be provided information about resources for counselling and psychotherapy.

Benefits of Participating

The results of this research may be used to develop materials or recommendations for counsellors and other professionals to provide appropriate help to individuals, especially Canadian Muslims of South Asian origin, who are experiencing similar feelings, physical symptoms or changes in patterns of behaviour.

People sometimes find that sharing their previous experiences of emotional or psychological distress can lead to personal insights, understanding, growth, and development.

Confidentiality of Information

The information provided by participants will remain strictly confidential, and they will be invited to choose a pseudonym so that nobody can identify them. In addition, the information provided will be carefully edited to remove or disguise personal details which may even remotely identify participants. The data collected for this research may be used for publication in journals, books or presentations, but participants' identities will *not* be revealed. The interview recordings and transcripts will be retained for a period of three years, and will be kept in a locked cabinet in an office at the Ontario Institute for Studies in Education which is also kept locked. The researcher is the only person who will have access to the recordings and transcripts. After three years, paper documents will be shredded and CDs will be broken.

Participants may also change their mind about participating after the interview, and can still contact the researcher to withdraw from the study. However, once the information from individual participant's interviews has been fully analysed and combined with other participants' information, they will no longer have the option to

withdraw. Participants will be informed of this deadline in advance.

Participants may also indicate if they wish to be sent the results of this research once they become available.

Any participants who have questions regarding their rights as a participant may contact University of Toronto's Research Ethics Review Office by e-mail (ethics.review@utoronto.ca) or phone (416-946-3273). They may also contact Dr. Roy Moodley, who is supervising this study, at roy.moodley@utoronto.ca.

Individuals who would like to participate in this study, or have any questions regarding it, may contact Humair Yusuf at humair.yusuf@utoronto.ca or 416-827-8804.

Thank you for considering participation in this research.

Humair Yusuf, M.A., M.Ed., Ed.D. Candidate

Ontario Institute for Studies in Education
University of Toronto
252 Bloor Street West
Toronto, ON M5S 1V6

Appendix C

Consent Form

If there is anything you do not understand about the information letter or this consent form, or if you wish to ask any questions, please speak to the researcher.

I have been given a written explanation of the study by the researcher, which includes full details of any potential psychological risks and what participation entails. I have also been given the opportunity to ask questions regarding the study.

I understand that if I share any information that suggests I may be at risk of harming myself or others, or if I share any information regarding a child who is currently being abused or may potentially be abused, then the researcher is legally required to report this information. This is the only instance in which my identity would be revealed.

I have read through and understood the information letter and this consent form, am satisfied that my questions have been addressed, and have had enough time to think about the study.

My decision to participate is completely voluntary and has been taken without any pressure.

I agree that I will participate in this study in the manner described.

Name: _____

Signature: _____

Date: _____

Declaration by Researcher

I confirm that I have explained the nature of the study and have supplied the participant with all the necessary information regarding the nature of this study in terms that, in my judgment, are suited to their understanding.

Name: _____

Signature: _____

Date: _____

Appendix D

Interview Guide

You have identified yourself as a Muslim of South Asian origin who experienced distressing emotions, symptoms such as pain, fatigue or digestive problems unrelated to a physical illness, a lack of interest or pleasure in most activities, diminished ability to concentrate, difficulty making decisions, or changes in appetite, sleep, or other patterns of behaviour. I would like to hear *what this experience was like for you*. I am interested in both physical and emotional aspects of your experience, what you believe caused it, how it lasted, and how it affected your life, how you tried to cope with your distress, and what you found helpful and unhelpful.

1. When were you first aware of your feelings/ physical symptoms/ changes in patterns of behaviour?

Probe: How did you feel physically at the time? Do you recall any symptoms?

Probe: How did you feel emotionally at the time? Do you recall specific moods or feelings?

Probe: Where there any specific changes in your behaviour?

Probe: Where there any specific changes in your level of activity?

Probe: Where there any specific changes in your professional life?

Probe: Where there any specific changes in your relationships?

2. What do you believe were the reasons for your feelings/ physical symptoms/ changes in patterns of behaviour?

Probe: Why do you think these factors caused your feelings/ physical symptoms/ changes in patterns of behaviour?

3. How did you cope with your feelings/ physical symptoms/ changes in patterns of behaviour?

Probe: What did you do to make yourself feel better?

Probe: Did you share your feelings with other people? If so, with whom and what was it like to talk about your experience?

Probe: Did you seek professional help? What prompted you to seek help?

Probe: From whom did you seek help? What prompted you to seek help from this person or organization?

Probe: What was the experience of seeking help like?

Probe: What was helpful in coping with your distress?

Probe: What was unhelpful in coping with your distress?

4. How long did your feelings/ physical symptoms/ changes in patterns of behaviour last?

Probe: In retrospect, was there anything you could have done to make yourself feel better faster?

5. How did your feelings/ physical symptoms/ changes in patterns of behaviour affect your life?

Probe: How did it affect your relationships with friends and family?

Probe: How did it affect your professional life?

Probe: Did it have any other consequences?

6. How did your moods, feelings, or physical symptoms change during the course of the experience?

7. How do you feel about the experience now?

Probe: Did being a Muslim have any impact on your experience?

8. What advice would you give to other people experiencing similar feelings/ physical symptoms/ changes in patterns of behaviour?

Appendix E

Participant Demographic Information

Name (Pseudonym)	Gender	Age at Time of Interview	Self-Identified Culture of Origin
Aalia	Female	42	Bangladeshi
Bayat	Male	66	Indian
Chandni	Female	51	Pakistani
Faraz	Male	27	Bangladeshi
Hashmi	Male	41	Indian
Ishaq	Male	32	Pakistani
Kardar	Male	45	Pakistani
Mehreen	Female	30	Pakistani
Omar	Male	32	Indian
Qassim	Male	27	Bangladeshi
Rubina	Female	25	Pakistani
Saira	Female	30	Indian
Tapal	Male	37	Pakistani
Yasin	Male	38	Indian
Zehra	Female	29	Indian

Appendix F

Participant Biographies

1. Aalia is an artist who supplements her income by teaching painting and working in a custom framing store. She is married and has two children but is in a strained relationship with her husband of 15 years. For a brief period, she saw a counsellor at a not-for-profit, provincially accredited counselling agency.
2. Bayat is a retired entrepreneur who has handed his business over to his son. He has suffered from depression for most of his life and been treated with medication by a number of psychiatrists. He has also been admitted into residential alcohol rehabilitation facilities on multiple occasions and undergone medically assisted withdrawal detoxification but then relapsed repeatedly.
3. Chandni is a mother of three children and lives with her husband and his parents. Her relationship with her husband is characterized by conflict, which she blames primarily on her mother-in-law. She has been hospitalized for attempted suicide and benzodiazepine abuse and regularly sees a psychotherapist and a psychiatrist.
4. Faraz has a master's degree in engineering but has been unable to find a job and receives financial support from his parents. He has been diagnosed with bipolar disorder, which he has managed through medication prescribed by a psychiatrist.
5. Hashmi has degrees in economics and accounting but has been unable to sustain a steady job due to a range of mood disorders that have

afflicted him since his late teens. Although he lives with and receives financial support from his parents, he has worked occasionally for a local music store. His treatment has been managed primarily by psychiatrists but he has also briefly seen a psychotherapist.

6. Ishaq trained for a career in the hospitality industry but has been unable to find a suitable job and currently works as a security guard. He is married and has a two-year-old daughter and is under considerable financial strain.
7. Kardar is an architect employed at the Toronto office of a global architect and design firm. He financially supports and maintains close ties with his mother in Pakistan, who has no other children. He sought psychotherapy to cope with stress and anxiety.
8. Mehreen is married and has two children. She works two jobs in retail in order to support the family, because her husband is unemployed. She suffers from chronic health problems and turned to a not-for-profit, provincially accredited counselling agency when she felt overwhelmed and unable to cope.
9. Omar is a real estate professional who is financially independent and successful. His experience of distress corresponded with the breakup of his marriage and the subsequent divorce and child custody proceedings.
10. Qassim left university without completing his degree and works at a gas station. He temporarily cut off all contact with his family and struggles with legal and financial issues.

11. Rubina is a healthcare professional who is the primary caregiver to her ageing and abusive father. She is in a committed but long-distance relationship with a man in the United Kingdom. She saw a psychotherapist to help cope with her personal and professional stress.
12. Saira is an established journalist who has been married for less than a year. She was referred for stress management to a psychotherapist by her general physician.
13. Tapal is a banker and mortgage broker who has been diagnosed with Obsessive Compulsive Disorder. He regularly sees a psychotherapist and was also treated briefly with medication by a psychiatrist.
14. Yasin is a senior manager in a logistics company. He is married and, along with his wife, lives with his parents, whom he supports financially. He suffers from anxiety and has sought treatment from both a psychotherapist and a psychiatrist.
15. Zehra is single, works part-time in early childhood education, and relies on her family for financial support while she looks for full-time employment. She has been diagnosed with major depressive disorder and is on medication prescribed by a psychiatrist. Zehra had previously been seeing a psychotherapist for weekly sessions but now schedules sessions occasionally.