**EXPLORING SERVICE PROVIDERS’ PERSPECTIVES ON MENTAL HEALTH- MUSLIM UNIVERSITY STUDENTS**

**EXPLORING SERVICE PROVIDERS’ PERSPECTIVES ON MENTAL HEALTH- MUSLIM UNIVERSITY STUDENTS**

**By**

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# Abstract

 This study examines the perspectives of seven mental health professionals who work with Muslim university students. The study specifically examines the experiences, struggles, and needs of Muslim university students in accessing mental health services from the perspective of mental health providers. Additionally, this study presents recommendations for service providers to consider when working with Muslim university students. It has been observed that almost all theories and data related to contemporary psychology have come from Western populations (Basit & Hamid, 2010). Hence this study attempts to fill a void in current knowledge.

 A qualitative research study (Mason, 2000) utilizing a critical social science approach as well as principles related to Grounded Theory were applied to this study. Individual interviews were carried out with seven participants. The data analysis revealed various themes: understandings of well-being, factors impacting Muslim students’ well being, existing needs, and a proposed model when working with Muslim Students. The paper concludes with a brief set of recommendations for practice and limitations.

# Acknowledgements

‏ ‏‏ مَنْ لاَ يَشْكُرِ النَّاسَ لاَ يَشْكُرِ اللَّهَ

“*Whoever is not grateful to people is not grateful to Allah” (Ahmad, Tirmidhi)*

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# Introduction

 I reflect on the days prior to the completion of my undergraduate degree at McMaster University, before a Master Social Work (MSW) was on the horizon. I had one goal: working with others to improve their lives, particularly their health and well-being. As I discovered and entered into the field of Social Work, I hoped that the skills that I would one day develop could be used to benefit the particular needs of the Muslim community, a community that has consistently given to me, raised me, provided for me, and nurtured my identity. Thus, I intended for my professional pursuits to aid their efforts and assist in any area I may be of benefit to.

As an insider and outsider in the Muslim community, I have a strong hold and understanding of the community’s biggest strengths as well as weakness and limitations, and above all, areas that require resources and improvement. I would consider mental health to be an area that is in need of discussion, support, resources, and time from individuals trained in the field.

From as early as December 2011, I have had an interest in conducting research on the unique needs, conceptions, troubles, and barriers that Muslims appear to experience in accessing mental health services. It was not until I began this thesis that the population group was narrowed down to university students. This largely stemmed from the literature available on Muslim mental health, very little of which focuses exclusively on the experiences of Muslim university students.

Initially, I was not certain that the MSW would be an appropriate avenue to explore the experiences of Muslim university students. At times I felt that my personal identity and professional and academic interests would become too intricately connected, or that it would be seen as commonplace amongst my peers and educators that I, a Muslim female student, would naturally choose my own community to study in my thesis. Additionally, I was not sure if my proposed topic was a needed area of research, given that I was not familiar with the literature. I initially believed I was pursuing my interests, motivated by curiosity, as opposed to fulfilling a particular need. Both motivations are not mutually exclusive, however, and I hoped to join the two in my thesis.

As I became well versed in the literature, I was exposed to a variety of topics concerning Muslim mental health, as many of the major methods and techniques developed in the West are not always suitable and effective for Muslim individuals (Basit & Hamid, 2010). Additionally, research concerning the mental health needs of particular groups, such as American Muslims, and mental health stigma in the Muslim community (Ciftci, Jones & Corrigan, 2013) emerged from the literature and provided a platform for other areas that required research. These included cultural considerations for social services agencies to consider when working with Muslim clients (Graham et al., 2010) as well as studies regarding risky behaviours among Muslim college students (Ahmed et al., 2014). This literature, in addition to the gaps I have observed in the Muslim community, informed my literature review and research approach. The following chapter will be a discussion on the literature I reviewed for this study.

# Chapter 1: Literature Review

 The following section provides a critical review of the literature. This was guided by a number of key questions, including how people conceptualize Muslim mental health, gaps in existing research, and how my research question would aid in bridging these gaps. To provide context to this discussion, I will begin by briefly highlighting my proposed research topic and the various questions I intend to explore.

 In answering my primary research question, I explored service providers’ perspectives on the concept of human well-being and available treatments in relation to the mental health of Muslim university students. The rationale behind choosing this topic and exploring related questions was largely generated from the existing discourse on this field, and the scant research available. A more thorough and in-depth discussion regarding how my research topic will build on, complement and contrast the existing work will be presented later in the paper. The following paragraphs summarize the existing research that is most relevant to my research topic.

## 1.1 Existing Knowledge

 Literature concerning the provision of mental health services for Muslim university students is beginning to surface. Examples include an Islamic model of strengths perspective (Abdullah, 2015) and a text on Muslim Mental Health (Humeidan, 2012). Cultural considerations for working with Muslims, Islamic models of well-being, current treatment responses, barriers to treatments, and recommendations for clinical consideration are topics that have not been widely explored in the literature. However, in recent years, academics and practitioners have begun publishing noteworthy articles and books that specifically address these topics. Among these prominent individuals is Graham et al. (2010), who elaborates on these considerations, and notes that social work is just beginning to adapt its knowledge base to operate in a culturally diverse world (p. 337). The article titled, “Cultural Considerations for Social Service Agencies Working with Muslim Clients” offers insight into the issues faced by agencies that work with Muslim clients and how agencies and practitioners can modify their approaches to ensure their clients receive care that addresses their unique diversity. Graham et al., (2010) make a key point in highlighting the need for social work agencies to localize, namely to adapt knowledge to local circumstances of culture, community, and values. In this sense, they encourage practitioners to enhance their cultural understandings and offer services that “address the specific needs of individual Muslim clients rather than services that are offered on the basis of an essentialist conception of what it means to be Muslim in North America” (p. 338). These findings strongly inform my proposed research topic because they highlight specific aspects of Muslim cultural values including faith, spirituality, family, and perceptions of service seeking, and how these are related to service delivery and agency responses. Finally, this section discusses the myriad of inherent differences between and within the Muslim community, which originates from one’s family, ethnicity, religious interpretation, and so forth. Thus, this neatly aligns with my research questions, as it prevents the pitfall of creating services that further homogenizes a group simply based on their shared religious affiliation.

 Similarly, Ahmed and Reddy’s (2007) article titled “Understanding the Mental Health Needs of American Muslims: Recommendations and Considerations for Practice” offers service providers an understanding of the mental health needs of American Muslims. Although this article is situated in an American context, it provides insight into the areas that require more research in a Canadian university setting. The authors point to the need for increased mental health services for American Muslims. This is largely attributed to increased feelings of anxiety, fear, and rejection that Muslims experience as a result of religious harassment and racial profiling post-9/11 (Ahmed & Reddy, 2007). As such, American Muslims have higher rates of posttraumatic stress disorders (PTSD) than the general population in the United States (Ahmed & Reddy, 2007). It also raises questions around how current services are structured in order to meet the needs of Muslim clients. Moreover, in relation to my proposed topic, the authors note that the emergence of empirically-based interventions has provided some guidelines on implementing interventions for specific disorders, including anxiety and depression, largely in university-based training facilities. However, these “training facilities” are not clearly defined, and the transportability and efficacy of these interventions in culturally and spiritually diverse communities has not been established (Ahmed & Reddy, 2007).

 Moreover, Basit and Hamid (2010), discuss the growing body of literature that examines how best to tailor social work as a field to the specific needs of American Muslims. The article titled “Mental Health Issues of Muslim Americans”(2010) discusses the underpinning of various schools of thought in the mental health field, which largely represent the religio-cultural traditions and narratives of Western society. This work informs my proposed research topic as it discusses the types of emotional and psychiatric concerns that are most prevalent in Muslim American populations. Additionally, it provides insight into the various therapeutic approaches mental health professionals employ that have been found to be effective in psychosocial treatment with Muslims Americans (Basit & Hamid, 2010).

 Similarly, Humeidan (2012) takes the discussion of effective treatments a step further by providing a set of recommendations for culturally sensitive counselling with Muslims in the context of university-based counselling centers. The knowledge presented in the book titled “Counselling Muslims: Handbook of Mental Health Issues and Interventions” was authored by a number of key informants in the United States with varying educational and occupational backgrounds. Humeidan (2012) provides a strong point of entry for the questions. Humeidan continued by noting that counsellors at university counselling centers and clinicians working with university-aged students are in the unique position to facilitate counselling accessibility for Muslim clients. As such, she encourages those with an interest in facilitating cultural sensitivity to examine her 15 recommendations, which range from counsellors examining their attitudes and biases, to counsellors assessing and integrating the multiple social identities of a client in providing care (Humeidan, 2012). Humeidan’s research has been a resource that continues to fuel my interest in Muslim mental health and has significantly contributed to my proposed research topic and thesis question.

 Joshanloo’s (2012) articled titled “A Comparison of Western and Islamic Conceptions of Happiness” offers an in depth assessment on the conceptualization of happiness and human well-being across dominant schools of Islamic thought and discusses the contemporary impact this has on Muslims. Joshanloo also notes that despite there being some differences in the behavioural expression of happiness and well-being within Islam, the various scholars of different sects are in agreement on the segments that contribute to the notion of happiness. This lends to a number of potential commonalities and considerations for clinicians to recognize when addressing a Muslim students’ concerns of well-being. Moreover, Joshanloo (2012) provides a historical understanding of happiness within Islam and undertakes an analysis of Western psychological literature, allowing him to identify differences and similarities between the two paradigms. This comparison also influenced the rationale for my method in interviewing service providers from both Islamic and non-Islamic backgrounds.

 In addition, Keshavarzi and Haque (2013) provide an alternative perspective of health and psychopathology in offering a framework of the theoretical underpinnings of spiritually-oriented psychotherapy, as well as suggest intervention strategies when working with Muslim clients. These perspectives provide a strong foundation for discussing mental illness in Muslim cultures, theological perspectives on human well-being and the self, and Muslim attitudes toward mental illness. All of this existing knowledge contributes to and informs my research questions, which I intend to purposefully integrate into the existing and growing body of research on Muslim mental health.

 Similar to Islamic conceptions of human well being, Bagasra and Mackinem (2014) explore how Muslim Americans interpret mental illness. The authors found that how Muslim Americans’ interpret mental illness largely depends on the symptoms and context of the illness. “An Exploratory Study of American Muslim Conceptions of Mental Illness” (2014) calls for an in depth assessment of how the beliefs of Muslim Americans affect attitudes toward therapies and mental health services. It also influences clinicians’ exposure to Muslim students and the types of troubles they present with.

 Ciftci et al.’s (2013) article titled Mental Health Stigma in the Muslim Community, focuses on intersectional stigma and the complex relationship between race/ethnicity, gender, religion, and health status, all with the aim of gaining a deeper understanding of stigma in the Muslim community. This dimension is one of the most significant factors that inhibit individuals from seeking formal treatments. The authors outline several considerations that concern stigma in this community, which is a necessary step to ensuring treatment is both accessible and culturally appropriate. Additionally, Abdullah’s (2015) article titled “An Islamic Perspective for Strengthens-Based Social Work with Muslim Clients” provides a very innovative and unique analysis of Islamic concepts in relation to mainstream strengthen perspective. More specifically, Abdullah briefly explores the concept of *fitra* or “original purity” in relation to strengths perspective to determine a religious as well as culturally appropriate equivalent for working with Muslim clients within the broader context of multicultural practice. Abdullah (2015) continues by noting that fitra or “original purity” is examined as an inner human impulse that can support hope and resilience amongst Muslim clients as well as a basis to guide social and welfare service provision to them. The practical implications of fitra in relation to an individual’s wellbeing are not further examined in the paper. However, the focus of the conversation is hardly an Islamic theological debate about fitra where different religious views exist about its essential character as an intrinsic human impulse. On the contrary, the intent is to propose the use of the concept as a conceptual and practical focus for strengths-based change with Muslim clients (Abdullah, 2015). This article has contributed to and influenced my analysis of the discussions I conducted with key informants, who note the importance of cultural sensitivity that is uniquely tailored to the specific experiences and needs of Muslim clients. Indeed, Abdullah’s (2015) work is timely and the first of its kind to juxtapose both Islamic and Western concepts, which will act as a basis to guide social and welfare service provision to Muslim clients

 Additionally, concepts related to Muslim youth acculturation and integration concerns were discussed by Graham et al., (2010). The authors discuss the degree of diversity that is present within and between Muslim communities. As such, a variety of approaches are needed when working with Muslim clients (Graham et al., 2010). Moreover, according to the authors, one’s diversity is based on a number of factors, including geographic location and background, one’s level of acculturation in North America, religious sect, socioeconomic status, as well as gender (Graham et al., 2010). These factors are significant and contribute to the study as the participants were prompted to discuss a host of factors that potentially impact a Muslim students’ well-being, many of the which were reflected in the Graham et al., (2010) study. Similarly, Basit and Hamid (2010) note that hardly any data exists to determine whether religious and socio-cultural factors have been major impediments to integration and acculturation, and why some individuals develop chronic ethnic-identity problems and others do not. This study looked at culture and the potential factors that contribute to a university student’s mental health.

 For the purposes of this study, the terms acculturation and assimilation are important to define. According to Berry (2005), a prolific author on the subject of acculturation, this term is characterized as a dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members. Groups of people and their individual members engage in intercultural contact, which produces a potential for conflict and the need for negotiation in order to achieve outcomes that are adaptive for both parties. On the same token, Berry (2005) notes that assimilation is one of the ways that individuals or groups go about acculturating, where assimilation is usually a process characterized by intermediate levels of stress. This stress, termed acculturative stress, is attributed to the changes which take place within one individually as well as within their family and social circle in regards to language and geographical setting (Berry et all, 1997). Interestingly however, Berry (2005) describes assimilation as a processes by which people “go about” and “pursue”. This suggests that assimilation is intentionally desired and perhaps even sought after in particular groups and individuals.

 Furthermore, assimilation refers to a specific type of structural assimilation as originally defined by Gordon in 1964 as noted in the paper by Chiswick and Houseworth (2008). Assimilation is the process by which the foreign born individuals acquire human capital specific to the host country (Chiswick and Houseworth, 2008). A signal of one’s structural assimilation and acquiring of human capital is an individual’s economic status such as education, earnings, or occupation (Chiswick and Houseworth, 2008). Barry and Houseworh (2008) note an empirical indicator towards one’s level of assimilation is intermarriage. Similarly, tied to education and intermarriage are the findings that favourable labour market outcomes are a noteworthy indicator of assimilation, which assists one in pursing post secondary education and subsequently increased chances of getting married. Additionally Chiswick and Houseworth (2008) note the expected findings that one’s English language ability corresponds to a higher level of assimilation. Notions of assimilation that are prevalent within the counsellor-counselee relationship throughout treatment as well as within dominant western society are explored more deeply in the findings sections of the study.

 Lastly, Al- Krenawi and Graham’s (2000) article titled “Culturally Sensitive Social Work Practice with Arab Clients in Mental Health Settings” provides insight for working with a culturally specific group who experience mental health concerns. This article inadvertently informed my research topic, as it highlights the areas that require more research, including the Canadian and youth population. This paper discusses key considerations when working with a client who identifies as ethnically Arab, as well as the role of the social worker in undertaking treatments with individuals whose identities are closely related to their ethnicity.

 Additionally, the topic of Muslim mental health is truly be a niche topic that is comprised of a subset of clinicians who are attuned and devoted to the particular social, cultural and religious traits that may influence a large majority of observant Muslim students. These clinicians are pioneers in this area of research and have made tremendous strides in their published works. These clinicians including Dr. Alean Al-Krenawi, mentioned above, Dr. Omar Mahmood, Dr. Rania Awaad, and Hooman Keshavarzi. These clinicians’ work will be briefly outlined in this literature review.

## 1.2 Conceptual Themes

Despite the limited research available on mental health in the Muslim community, a number of key themes and contentions emerged throughout the literature. The following paragraphs highlight these major themes.

**Western approaches to treatment.** Graham et al. (2010), Basit and Hamid (2010), as well as Ahmed and Reddy (2007) explicitly discuss the predominance of Western thought on helping professions. The authors note that current techniques developed in the West may not always be suitable and effective for Muslim Americans (Basit & Hamid, 2010). This theme is widespread throughout the literature and substantiated by the continued call for cultural consideration and religious sensitivity (Graham et al. 2010). Based on this reoccurring theme as well as recommendations for future research, I have included research questions that seek to assess the benefits as well as limitations of the Western model of mental health treatment when working with Muslim youth**.**

### Cultural sensitivity. Although there is a continued call for practitioners to enhance their cultural understanding and “offer services that address the specific needs of individual Muslims” (Graham et al. 2010, p. 338), this statement is seldom followed by measurable steps aimed at instilling this sensitivity and awareness. With the exception of Humeidan (2012), the call for cultural sensitivity is largely the extent of the alternatives provided in lieu of or in conjunction with Western approaches to treatment

 Similarly, in “Islamophobia and the therapeutic dialogue: Some reflections”, Inayat (2007) discusses the importance of culturally sensitive care in light of the atmosphere of fear and controversy that presently surrounds Muslims. Inayat (2007) provides clear recommendations to clinicians who are committed to providing culturally appropriate care. Among these recommendations is a thorough discussion on Islamophobia, what constitutes Islamophobia, and the impact this has on counsellor-counselee therapeutic relationship.

 **Human well-being and conception of illness.** The concept of well-being and mental health within Islam is an important and reoccurring theme throughout the articles and book I reviewed. Joshanloo (2012) and Bagasra and Mackinem (2014) elaborate on this theme in observing that an inherent distinction exists between an Islamic worldview and a Western conceptualization of well-being. This is because an Islamic understanding of well-being goes beyond this world and incorporates mystical experiences and believes practicing religious duties are essential to a Muslim’s conception of happiness and the good life. Similar to the concept of human well-being, illness or a lack of well-being within Islam can also be conceptualized very differently from a secular understanding of illness. This is due to the belief that illness could be associated with drawing nearer to one’s lord as opposed to a punishment or personal trial (Bagasra and Mackinem, 2014). The findings section of this dissertation will speak directly to the notion of human well-being from Islamic versus Western understanding of human well-being and the influence this has on treatment.

 **Accessing treatments**. Another major theme seen throughout the articles reviewed is the rampant stigma associated with mental health as a whole. Citfti et al. (2013), Bagasra and Mackinem (2014), Al- Krenawi and Graham (2000), and Joshanloo (2013) all address the stigma associated with accessing mental health treatments, as it is often seen as the result of an individual’s moral failure. In addition, Keshavarzi and Haque (2013) note in“A Psychotherapeutic Model for Muslims” that individuals from Africa, the Middle East, and Asia who are spiritually or religiously oriented have generally not accepted psychotherapy, and more generally counselling. This research suggests that there is a stigma attached to seeking mental health care among ethnically diverse individuals (Keshavarzi and Haque, 2013, p. 231). Moreover, Graham et al. (2010) found stigma to be the primary hindrance in service seeking, arguing that “this was due to strong prohibition against exposing personal and familial issues to outsiders” (p. 342). As such, the concept of community and the role they play in service seeking is a major theme throughout my proposed research topic.

 Similarly, Inayat (2007) specifically discussed and examined barriers to the use of mental health services by Muslim clients and highlighted six factors that contribute to their underutilization. These factors include a) mistrust of service providers, b) fear of treatment, c) fear of racism and discrimination, d) language barriers, e) differences in communication and e) issues of culture/religion. These factors are indicated as being major impediments to Muslim clients accessing mental health treatments, although it is not specified to university-aged students.

## 1.3 Gaps in Literature

 The discussion on cultural sensitivity is often ambiguous and lacks both direction and depth, and as a result, has largely become a symbolic rational for all research studies conducted in the area of Muslim mental health. It is imperative to our work as clinicians and researchers to make a genuine effort to learn and engage with the lived experiences of Muslims facing mental health concerns and not merely aspire towards an all-encompassing notion of “cultural sensitivity”. The experiences of individuals are a precursor to the need for cultural sensitivity, the former of which is often rooted in oppression and experiences of exclusion.

 Among the authors who specifically speak to cultural sensitivity are Al- Krenawi and Graham (2000). They highlight the experiences of racism and exclusion in a post-9/11 era faced by Arab Americans. However, these experiences are framed as being unique to Arab Americans and were published in a research study over 15 years ago. As a result, it has minimal application to a current Canadian university context.

 Additionally, my research topic intends to assess the role of community and the part they play in creating, maintaining and advocating for well-tailored and accessible treatments for Muslim university students. “Community” itself is a fluid concept and is not well defined throughout the literature, nor is its role or benefits substantively discussed. This is somewhat contradictory given that the Muslim community experiences increasingly high rates of stigma surrounding mental health diagnoses, particularly when accessing formal treatment (Ciftci et al., 2013). Thus, it was imperative for me to discuss the role of the community with key informants and the part it plays in the perpetuation of stigma as well as service seeking.

 In addition, my research intends to shed light on mental health in the Muslim community from a Canadian context. All of the articles, with the exception of Graham et al., (2013), were published in the United States, which calls for the need for context-specific research. In addition, my sample of key informants mimics the research that is coming from the United States, as three out of the seven of my participants were American residents.

 Moreover, research concerning Muslim university students experiencing mental health issues is entirely missing from the literature. There is no research that specifically concerns Muslim university students, the distinct problems they present with, and how specific treatment can be modified to meet their distinct needs. My research aims to provide an initial starting point for research to begin to flourish in order to truly understand the distinct concerns, needs, and barriers that Muslims university students experience when accessing mental health services.

 As noted by Ahmed and Reddy (2007), university-based training facilities have provided some guidelines on implementing interventions for specific disorders. However, this is associated with a number of concerns including a lack of reporting regarding efficacy of treatments with culturally diverse clients and the accessibility of such treatments. As such, in order to address the lack of analysis regarding existing university-based interventions, my research directly intended to assess the treatments available to university students. This is relevant to my research, as it suggests that there may be unique challenges or troubles that Muslim youth are confronted with. Additionally, my research looked at the specific mental health concerns presented by Muslim university students, and the degree to which the treatment responses actually address the well-being of Muslim clients. Although specific ethnic groups within the Muslim community have been the focus of published works, Muslim university students are an increasingly underserved and under-researched population who are at increased need of mental health supports.

 The literature reviewed led to the development of SC, which served to anchor the current study (Bowen, 2006, Glaser 1978, Blumer, 1954). These concepts are the following: well being, and straddling two cultures. Additionally, the following section highlights the research questions explored in this study, which were specifically influenced by sensitizing concept. These SC emphasize important features of social interaction that emerged from the literature review, thus providing a strong starting point for the development of the research questions.

**Overarching Research Question**

 “An Exploratory Study of American Muslim Conceptions of Mental Illness” (2014) calls for an in depth assessment of how the beliefs of Muslim Americans affect attitudes toward therapies and mental health services. This is relevant to my research questions as the attitude students hold towards therapies affects students’ willingness to access formal treatments and university-counselling centers.

As noted in research presented on Muslim mental health as well as arose from this study, there is a gap in what is occurring in direct practice and students’ existing needs. In order to determine what these tensions and needs are, it became necessary to explore what tensions arise from Western understandings of well-being versus Muslims understandings of well-being.

 “Exploring Service Providers’ Perspectives on Mental Health; Muslim University Students” is the title of this study. This title encompasses various dimensions of the study: the population group interviewed for the study (mental health service providers), the exploration topic (Muslim university-aged students), and the area of discussion (mental health). Furthermore, due to the exploratory nature of this study and the Muslim clinicians who were interviewed, I emphasized the conceptualization of a Muslim model of well-being and psychotherapy in my research.

 In addition, in order to build on the call for cultural sensitivity and compliment existing work, I have included a question that seeks to understand how collaborative working between clinical and religious approaches to treatment can be achieved. Additionally, my research questions seek to address and assess current responses to university students seeking mental health services in relation to instances of discrimination and racism. My research also explores what ‘help rooted in social justice’ would look like for a Muslim university student, and provides the platform for narratives to emerge that center around oppression, lived experiences of inclusion and exclusion, as well as racism and Islamophobia.

 The research question for this study intended to highlight conceptions of human well-being from the perspectives of service providers working with Muslim university students in relation to their mental health. This question looks at what tensions emerge when working with Muslim students. Mental health encompasses a range of topics that were explored in this study, including well-being, factors contributing to the troubles Muslim university students experience, and a proposed set of recommendations for clinicians striving to be more culturally sensitive with their clients. These recommendations stem from the belief that there is a pervasive lack of training among mental health professionals when serving Muslim students.

 The following chapter provides the reader with an in depth look at the methodology utilized to explore the research questions emerging from the literature review - particularly in regards to the theoretical approach, sensitizing concepts (well-being and straddling two cultures,), participants, interviewing process, and data analysis.

#

# Chapter 2: Methodology

## 2.1 Overview of Methodological Approach

 A qualitative research approach (Mason, 2000) was utilized in this study in order to explore service providers’ perspectives on mental health, specifically considering the perspectives of Muslim university students. In addition to interviewing service providers from various backgrounds, I located myself within the research and explored my views as an insider and outsider within the study. Moreover, I shared my perspectives as a graduate student, researcher, and a Muslim woman. Furthermore, I included a lengthy section on the methodological, theoretical, and epistemological approaches that I applied to this research in order to provide context and rationale for my interpretation of the data and the analysis of the transcripts.

## 2.2 Theoretical Approach

 Neuman’s (1997) “The Meaning of Methodology” describes a critical theoretical framework as “aprocess of inquiry that goes beyond surface illusions to uncover the real structures in the material world in order to help people change conditions and build a better world for themselves”(Neuman, 1997, p. 59). I believe this accurately describes my research study, as I hope my research will contribute to dramatic improvements in and spark further research into existing mental health treatments for Muslim university students. Moreover, my theoretical perspective informs my data analysis, as I intend to provide a critique that reveals current conditions of mental health services and helps service providers view and shape treatments and discourses around services in a more holistic and client-centered fashion (Neuman, 1997).

In addition, a critical researcher conducts a study to critique and transform social relations. I believe that I have attempted to achieve this in the questions posed in my interview guide and the manner in which they were framed, which allows for the uncovering of myths, reveals hidden truths and helps people change the world (Neuman, 1997), or more specifically, their experiences when accessing mental health treatments. This is evident in the questions I posed to participants such as, “how can existing treatments be modified to meet the needs of Muslim clients?”. This question is one example of the personification of the critical approach to social science research. It highlights the fundamental nature of social reality from this theoretical approach because it assumes that social reality always changes and the change is rooted in the tensions, conflicts or contradictions of social institutions (Neuman, 1997). The tensions, conflicts and contradictions of social institutions are evident in my research study, as it calls for changes and modifications of existing treatment methods. Moreover, my research study enabled key informants to discuss current tensions in practice, the contradictions and struggles within existing treatment responses, and the challenges associated with delivering alternative treatment responses to Muslim students.

Furthermore, I find that the Critical Social Science (CSS) approach to research strongly aligned with my research study, as this approach is action oriented. Throughout the literature review I conducted, the observations I made, and my discussions with others, I was dissatisfied with the current mental health services offered to students, as well as the lack of sensitivity and awareness documented amongst service providers working with diverse clients. Due to this dissatisfaction, a critical approach to research suggests that I as a researcher am using this forum to seek improvements and shed light on the inconsistencies and the areas requiring improvement (Neuman, 1997). Moreover, as a critical researcher, I am privy to asking uncomfortable questions, exposing hypocrisy, and investigating conditions in order to encourage dramatic grassroots action (Neuman, 1997). As such, a critical approach to research upholds the notion that “learning is reducing illusion and ignorance” (Neuman, 1997), which I aspire to achieving in my research study.

## 2.3 Methodology

A grounded methodological principles were applied to this research study. In addition to grounded theory, I utilized an inductive approach to reasoning, where the researcher develops theoretical propositions or explanations out of the data in a process that is commonly seen as moving from the particular to general (Mason, 2002). In this approach, I did not pay particular attention to any concept; rather I would began my analysis with only a few vague concepts which were used in the interview guide (Neuman & Kreuger, 2006).

As will be demonstrated throughout my analysis of the transcripts as well as the description of the dimensions, features and qualities of methodology, grounded theory and inductive reasoning are highly complementary. Mason (2002) notes that inductive reasoning is traditionally associated with “grounded theorizing”, whereby explanations and theories are fashioned directly from the emerging analysis of the data. The following paragraphs will expand on critical social science, but more specifically grounded theory in the context of inductive reasoning. In addition, the following section will highlight the dimensions, features, qualities, and characteristics that these perspectives would typically pay attention to.

### Grounded Theory and Inductive reasoning

 *“The best way to do grounded theory, is to just do it” – Glaser (2004)*

Grounded theory is widely used in qualitative research. It purposes the notion that theory develops during the data collection process. This inductive approach to data analysis and reasoning suggests that theory is built from data or grounded in the data (Neuman & Kreuger, 2006). As such, a striking feature of grounded theory is the creation of theory that is faithful to the evidence and data collected. This suggests that grounded theory neatly compliments my utilization of a critical approach to social science, as I utilized this theory to analyze specific events and stories presented in my interviews in order to gain insight and draw connection between students’ experiences and larger societal factors (Neuman & Kreuger, 2006). This includes the discussion of Muslim students who may experience stigma, religious or ethnic discrimination, as well as mental health concerns, all of which are circumstances that are connected to larger societal dynamics.

###  Sensitizing concepts. Social researchers tend to view sensitizing concepts as interpretive devices; a starting point for a qualitative study. These concepts draw attention to important features of social interaction and provide guidelines for research in specific settings (Bowen, 2006). Quite interestingly, Bowen (2006) notes that research usually begin with such concepts, whether a researcher states this or not and whether they are aware of them or not, the latter of which was the case for this study. Upon further exploration, it was evident that three sensitizing concepts were developed from the literature review, as they provided the starting point for the development of the research question, interview guide and building analysis.

The use of sensitizing concepts (SC) was appropriate for this study as they helped form the conceptual theory and framework (Bowen, 2006). For the purposes of this study, a conceptual framework can be defined as linking various concepts that serve as an impetus for the formulation of theory (Bowen, 2006). The concepts were derived from the review of the literature on well being in relation to Muslim students. Others were added as they emerged from the data gathering through in-depth semi-structured interviews. These concepts appeared to underpin the discussion on mental health and Muslim students’ access to treatments, and it is evident that these concepts contained theoretical ideas that would help set the context and direction for my study (Bowen, 2006).

As stated at the end of the literature review on page 15, two SC emerged. These were: well-being, and straddling two cultures. Three more SC emerged in the data analysis hence added to the original two. These were: human well-being from a Muslim perspective, and existing needs and proposed model, and cultural competence. However, the concept of well-being from a western perspective was integrated into the SC on human well being from a Muslim perspective thus only four SC are mentioned below. This is presented in much more depth in the discussion chapter. The following paragraphs looks at various definitions and explorations of the SC that emerged in this study.

**Well-being from a Muslim perspective**. From a western perspective, well-being is conceptualized as an imbalance in one’s Maslow’s Hierarchy of Needs. Muslim clinicians however often took what can be referred to as a “holistic” approach whereby discussions of a students’ spiritual, physical, psychological well being were all discussed in unison; whereby a harmony and balance between the three aspects was sought after.

**Straddling two cultures**. This term highlights an importance phenomenon that university students may experience. This predicament is characterised by a conflict which can arise between one’s religious or personal values, and the beliefs espoused by one’s community.

**Existing needs and proposed model.** This concept emerged in the data analysis as an important aspect in the life of Muslim students. It refers to the existing mental health needs of Muslim students as well as a holistic model of working with them that includes community.

**Cultural competence**. The final sensitizing concept that emerged from the interviews was cultural competence. The participants weaved together various examples of culturally competent care when working with Muslim university students. The topic of cultural competence was often prompted by discussions of what help rooted in a social justice paradigm would look like.

## 2.4 Participants

In order to discuss the sample of participants in my research, I believe it is of greater importance to first discuss my sampling practice, the recruitment process, and who was sought and why, as each participant's contribution to the research study was vital both individually and to the collective findings of the study. Mason (2002) suggests that it is helpful to see qualitative sampling as an *organic* practice, a practice that grows and develops throughout the research process “in ways that are crucially related to the emerging shape of the research project (Mason, 2002, p. 127).

 **Demographics.** A total of seven participants agreed to join the study, all of whom are professionals with master and doctoral degrees in mental health, who teach mental health related courses at universities or training institutions, or/and have a clinical practice (counsellors, psychologists, psychotherapists, psychiatrists, chaplains). Given that the intent of the research study was to assess mental health service providers’ perspectives on Muslim university students’ mental health, access to treatments, human well-being and so forth, it was important that at least half of the participants were individuals who a) identified as being Muslim, b) had a willingness to bring this Islamic understanding to treatments with clients and incorporate it within existing methods, c) worked with university-aged students, and d) were trained in Western therapeutic methods.

 Four of the seven participants identified as female and three identified as male. The age of participants ranged from thirty to late sixties. Similarly, participants have been in practice for as little as three years and the more senior participants have been in practice for nineteen and twenty seven years! Additionally, all of the participants work with university students, but their speciality or the frequency with which they encounter university students varied, particularly between participants who were employed by a university versus those who worked out of an agency. The participants employed a host of treatment modalities- many expressed having a preference for cognitive behavioural treatments, mindfulness, commitment and acceptance therapy, dialectical behavioural therapy, and psychodynamic therapy. The usage of these treatments largely differs depending on the needs of the client.

 **Occupation**. Two of the participants were chaplains in Canada. Of the Muslims practitioners, three were male and one was female. Of these four participants, there was one Chaplain, two Clinical Psychologists, and one Psychiatrist. In addition to their secular training, all of the Muslim participants had spent time abroad in Muslim-majority countries attaining traditional Islamic knowledge in areas such as jurisprudence, creed, Islamic sciences more generally, and memorization of the Quran. Additionally, three of the four Muslims participants live and practice in the United States.

The other three participants were mental health providers who worked within an academic setting. These individuals are often the first or second line of contact when students are experiencing a mental health crisis. The office and job title of individuals will not be shared in order to preserve the anonymity of the individuals, as this is a niche community and individuals can easily be identified. The presence of two groups of participants was intended to allow for a comparative analysis of service providers’ perceptions, experiences and approaches to treatment.

Social workers were not specifically sought out as participants, as the reality is that we may not be the first line of contact when university students are wishing to speak to a mental health provider on campus. This is true for individuals who are both Western and Islamically trained, as none of the participants held a degree in social work. This limitation is accounted for given the niche group of individuals working in the field of Muslim mental health to begin with. Additionally, the occupations of the service providers themselves were not necessarily a significant factor. Rather, the service provider’s approach to treatment, awareness of the needs of Muslim students, experience working with students of various backgrounds and articulation of their philosophy of practice was of greater importance. Similarly, the knowledge base of social work itself borrows from a number of disciplines including psychology and sociology, and as such. The participants, despite their distinct backgrounds, often presented very similar theoretical ideas (Trevithick, 2008)

**Recruitment**. On April 14, 2015, I sent my first six set of recruitment emails from my McMaster email to potential key informants. I believe my most significant advantage – being an insider and as a result, having access to interviewing participants and disseminating the information within my community – was also be my greatest obstacle. Struggling with this positionality is important. I was acquainted with these potential participants in both personal and professional capacities. The first email sent was delivered to a clinician I had made connections with at a conference I attended for my thesis in Dearborn, Michigan between March 26 – 29, 2015 titled the 7th Annual Muslim Mental Health Conference – Faith and Healing: Moving from Trauma to Empowerment. I sent three subsequent recruitment emails to clinicians I had networked with at this conference, two of whom agreed to be interviewed and are among the seven participants of this study. Additionally, another prominent Social Work professor, director, and practitioner I met at the conference agreed to participate, signed the consent form and began the interview with me. However, five minutes through the interview, the participant found that as a director of a program and someone who has been out of direct practice for some time, it would not be appropriate for them to be a part of the study.

Yakushko et al. (2001) note that for some of us, a pursuit of advanced Western degrees in psychology may leave one feeling that they have “left their communities”, and by extension may not be attuned to what truly *needed* to be researched, that is, the needs of the community. In an attempt to avoid this outcome, I requested to meet with one of my participants for a preliminary discussion in January 2015, where I presented much of the existing literature on Muslim university students who are experiencing mental health concerns. I asked the participant to share some of the concerns that he most commonly encounters in his practice that he believed would be important to address in the span of this study. This meeting served two purposes. The first is that it kept me connected to needs of the community and grounded in the concerns that they face on a daily basis. Secondly, it enabled me to acknowledge these concerns in shaping the interview protocol, which had a direct impact on the questions I asked and the answers I received from participants.

## 2.5 Interviewing

The first interview took place on April 21, 2015 at 9:30 AM at McMaster University. For the next seven weeks, I conducted an interview each week. Three interviews were conducted at the service provider’s office and one interview, a personal contact of mine, took place in their home. Participants were notified of our commitment to confidentiality as they each signed and were given a copy of the Information and Consent Form (see Appendix 2). Thus participants were able to select a location for the interview to take place that was most convenient and appropriate for them while ensuring that confidentiality was maintained. This was clearly outlined in a subsequent email once they confirmed their willingness to participate.

The interviews lasted between 40 minutes to approximately an hour and 45 minutes. Semi-structured interviews were conducted with the participants using an interview protocol (see Appendix 3). As noted, interviews for 1W, 2W, 3W and 4M took place in person at offices and the home of the respective participants. The remainder of the interviews took place telephone, where the participant received a phone call on their cell or office telephone numbers due to their distant locations. All interviews were audio recorded using Garage Band on a MacBook Pro. In addition, I took handwritten notes throughout each interview. I sought consent from all participants prior to any data collection or the use of recording devices.

Each interview was transcribed prior to conducting the next interview. This was done with the intent of learning from the previous interview, take note my style of interviewing, the way in which I framed questions and how I might improve my delivery, based on my observations as well as the recommendations of participants.

As Mason (2002) notes, qualitative interviews require a great deal of planning. In retrospect, it would have been helpful for me to develop my style and demeanour for conducting interviews, especially given it was my first time conducting qualitative interviews myself. Working out how to ask questions (in other words, how to phrase them) and what words to use (Mason, 2002, p. 67) was often a limitation I experienced. This was particularly evident with the question “what does just help look like?” given that more than one participant asked for clarification and rewording. Additionally, every participant asked me to clarify and reword at least one question throughout the interview as they did not understand the intent behind it. This leads to my next limitation when it came to interviewing: achieving a good balance between talking and listening (Mason, 2002, p. 75). Upon asking for clarification, I found myself on a tangent where I was explaining the context for a question, the reason for asking this specific question as opposed to others, and remarking on the thoughtful additions made by the participant. In the moment, this was done to assist in the flow of the interview, where the conversation seemed purposeful as opposed to an awkward or a one-way dialogue (Mason, 2002, p. 74). In addition, I felt that this explanation was needed as often times the questions appeared repetitive given my positioning, and this voiced by a few participants. Thus the explanation served as an explanation of the importance and relevance of each question.

Similarly, I found myself keeping an eye on my watch to ensure that I was respecting the time the participant allocated for the interview, as well as keeping tabs on the audio recording and ensuring it was working. A number of technical difficulties occurred, including the loud ticking of a clock next to my recording, which made it extremely difficult to hear the participant and transcribe the interaction. Similarly, because three of the seven interviews were conducted via telephone and the participants had exceedingly busy schedules, two of the calls began on one day, and commenced approximately two weeks later. One of the participants had a total of four calls with me to complete the interview, as the participant conducted the calls while travelling from city to city and often had obligations that required the participant to end the interview prematurely. This often resulted in frustration on my part. I distinctly remember one occasion, I was at my in-laws home and it was a long weekend. I received an email from one participant asking if I could call as they had a 10-minute time-slot available. I feel as though participants were not always aware of the time it took to set up the call, the computer, find a quiet location, and so forth, in order for my to collect data that I could work with.

## 2.6 Writing

For the sake of safeguarding the confidentiality and anonymity of the participants, I have referred to all the participants as a number between one and seven based on the order in which they were interviewed, followed by a W or a M behind the number to signify with the participants’ Western or Muslim background. This “background” refers to their clinical training and religious denomination and not their ethnicity. I have major reservations about identifying participants this way, as it risks generalizing and homogenizing the beliefs and perspectives of all “Western” and “Muslim” participants and could potentially paint each respective group with the beliefs presented in this study. It also suggests that the two groups are mutually exclusive and practice on opposite ends of the “cultural sensitivity” spectrum. I caution readers against reaching these simplified conclusions and urge them to acknowledge the infinite degree of nuance and differences of thought and approaches between each participants, irrespective of their religious domination and approach to treatment. However, I have used this classification method because it is the simplest and clearest way of informing readers of the theoretical and religious paradigm with which participants approach their work, thus providing context for the reader.

## 2.7 Locating Myself in the Research

**Insider and outsider.** I feel as though my insider and outsider roles were so entrenched in me that it required a prompt to trigger my awareness and reflection. As a Muslim woman born and raised in Canada to Middle Eastern parents, I have experienced many barriers and instances of prejudice and Islamophobia that other Muslim university students encounter. I share many theological, communal, familial, and societal norms as the individuals this study focuses on. And yet, I am not among them. I am in a research position. I am privy to interviewing service providers, having them be open and willing to share the experiences and instances of these students, and experience a great deal of privilege both personally and on professional fronts. Additionally, I have been shielded from instances of war, famine, migration, and trauma that many Muslim university students have encountered and that very likely shapes their university experience. These dimensions automatically place me in a privileged outsider role, despite the very traits that make me an insider and have given me the “in” to several participants that I interviewed.

Despite my outsider position on many fronts, I have a deep desire to contribute to my community. Yakushko et al. (2011, p. 279) describes how this commitment may stem from a realization that we have gained a privileged position vis-a-vis our education and training that we have an obligation to bring our knowledge back to those we consider our “family”. Producing meaningful research on a vastly underserved community strengthened my resolve to spend my research opportunity in service of the Muslim community. This resolve was motivated by a sense of obligation and duty, as well as a desire to increase my own knowledge in Muslim mental health. Similarly, Yakushko et al. (2001, p. 279) note that “we may also realize that Western researchers and practitioners lack information about our communities or countries”, which was among the greatest motivating factors for this research study.

The benefits of being an “insider” was that I could make a number of very quick connections to the experiences that the participants shared and spoke of (Watt, 2005, p. 23). Therefore, during the interview process, particularly with the Muslim practitioners, I consciously clarified their answers, tried to ask the same question in a different way by using prompts that were common between us and would capture the nature of the question more accurately (Watt, 2005, p. 23). This often enabled me to develop a greater sense of comfort and an effective communication style and I felt as though many of the Muslim participants were sharing insights that they might not have shared with a researcher they did not connect with on so many levels. The interviews with the participants, particularly those who identified as Muslim, were very enjoyable. Indeed, the similarities in both our racial, religious, cultural, and professional identities and experiences enabled us to create a sense of connectedness and rapport. Whereas I met all the Western participants during working hours in their office, the Muslim participants often conducted their interviews very early in the morning, late in the day (due to the time difference), or in their place of residence.

## 2.8 Data Analysis

 Based on my utilization of grounded theory (GT) principles, the questions generated from the data invariably differed had I been using a different theory. Charmaz (2012) notes the central analytic strategies of grounded theory consists of line-by-line coding of data from the start of data collection, using comparative methods such as comparing data with coding, writing memos, and theoretical sampling, which will be discussed below. Moreover, in using GT principles, particular attention to the coding, categorization of statements, actions, and meanings of the data and participants was needed. This allowed me to draw connections between the data and ask key questions concerning the data such as: “What is this data a study of?”, “What does the data suggest?”, “When, how, and with what consequences are participants acting”? (Charmaz, 2012, p. 5). Therefore, these questions shaped the analysis of my own data.

**Coding**. Similarly, an important quality of grounded theory is the notion of drawing connections between micro level events and situations and larger social forces for the purpose of restructuring the theory and informing social action (Neuman & Kreuger, 2006). An open coding to grounded theory was employed whereby events, actions, and interactions are compared with others for similarities and differences and are given conceptual labels. This process allows a researcher to group these categories and subcategories and clearly describe them in term of their properties and dimensions (Baker-Collins, 2015). As noted, Charmaz (2012) highlights the importance of line-by-line coding of the data from the start of data collection. In line with Mason (2002, p. 149), the first three out of the seven transcripts were read once for a literal reading, in order to familiarize myself with the words and language used and the form and structure of the dialogue. However, for the final four transcripts, I found this literal reading to be quite the opposite of “literal”, as purely literal readings or objective descriptions are not possible; the transcripts, and by extension the social world, is shaped by how we see it (Mason, 2002, p. 149). Similarly, because I conducted and transcribed the interviews myself, I had developed a strong understanding of the words and language used and the literal content of the transcripts that I felt this first step to be quite repetitive.

 For the remainder of the transcripts, I conducted a line-by-line coding as I read the transcripts for the first time. The first three transcripts provided a foundation for the initial basic set of categories, and concepts about the troubles university students experience, the needs of Muslim university students, and the role of the Muslim community to name a few. The final four transcripts were also inductively analyzed as the concept, categories and ultimately the theories emerged from the transcripts (Neuman & Kreuger, 2006) To my surprise and delight, a number of similar terminologies, concepts, and themes began to emerge across the transcripts, which necessitated the development of a document table where the coding could be found in a centralized location. The table began with a specific concept to general categories and themes and allowed me to note connections between the participants. This process allowed for a much more seamless analysis of the data as the connections that had been made as I was transcribing were already noted in a centralized document.

In addition, a striking dimension of theory is that it is an interactive method. A particularly important characteristic of grounded theory is its emphasis on data analysis. Taking this a step further, a constructivist approach to grounded theory pays specific attention to studying phenomena and sees both data analysis as created from shared experiences and relationships with participants (Gubrium et al., 2012). In this view, grounded theorists study how participants construct meanings and actions from as close to the insides of the experience as possible (Gubrium et al., 2012). Interviewing service providers allowed for a breadth of experiences, situations, and narratives to emerge in order for themes and patterns to form.

Moreover, a grounded theorist locates their data analysis to the time, place, culture, and context of the data collection, all while reflecting one’s social, epistemological, and research location (Gubrium et al., 2012). This interactive as well as reflective approach to analyzing data resonates with my approach to research, as it seeks to accurately highlight the experiences of Muslim university students by assessing their experiences as closely as possible, as well as simultaneously considering the university setting, and the culture within which service providers practice. This culture may include a Western paradigm to service but can also encompass the organizational culture, time constraints, and neoliberal pressures on a treatment agency and university wellness centre.

Due to the brevity of my thesis, I will be limited in my capacity to authentically utilize grounded theory. Instead, I adopted the features and characteristics that most logically and appropriately match the trajectory of my research due to the capacities and time constraints in place. An example of a dimension of grounded theory that cannot be fulfilled in this thesis is the notion of “theoretical sampling”. In this process, the researcher continues to collect, code, and analyze data and decides what data to collect next and where to find this data in order to develop the theory as it emerges. Thus the process of data collection is controlled by the emerging theory (Gaser, 2004). Due to the nature of the thesis and the limited time available for its completion, the notion of collecting relevant data in hopes of creating a theory exceeds the bounds of this thesis. The following chapter presents the findings of the study. The findings related to understanding human well-being, factors impacting Muslim university students’ well being, as well as a proposed model when working with Muslim students are all discussed below.

# Chapter 3: Findings

 The following section will present key findings, terms, shared concepts, insightful remarks, and consistent themes across the seven interviews that are relevant to the initial research question. Despite the diversity amongst the participants, a very rich and engaging dialogue emerged from each interview. Due to the depth and detail of the conversations, I have structured the headings of the following sections to mimic the structure of the interview protocol that was used for the seven interviews. The protocol is divided into the three main sections and themes that emerged from the literature, with questions stemming from the overarching themes. These sections include: understanding of well-being, factors impacting Muslim students’ well being, and existing needs and proposed model when Working with Muslim Students. Many of the findings will be presented in a manner that allows for similarities and differences to be discussed amongst the participants who are trained solely from a Western perspective as well as the participants with an Islamic approach to treatment.

## 3.1 Human Well-being from a Muslim Perspective

 The topic of human well-being and “what it looks like” in university students brought about a range of various and intriguing responses. *Holistic* approaches to well-being were described by participants across the interviews, but their definitions differed from one clinician to the next. 1W and 3W discussed the importance of looking at Maslow’s Hierarchy of Needs in relation to assessing a client’s well being. Participant1W stated:

If we look at Maslow’s Hierarchy of Needs, that those things are sorted out, food, shelter, the basics and I sometimes see students here, we have a benevolent fund, there’s some students who don’t have those basic needs met. So the person would have basic needs met, have a sense that they can explore. (p. 1)

Similarly, the third participant interviewed offered a complementary insight to that of the first participant:

The more difficult the imbalances are, the more your well-being is out of whack. Maslow’s Hierarchy of Needs, even though it's way too rigid I think when we don’t have our basic needs met then its very hard to function and do other things...think about it from a practical place, you know having a place to live and food and having shelter, these sort of important things, when these things are out of whack then all these other things take a second place. (p. 2)

Additionally, human well-being was similarly conceptualized, by 4M, 6M and 7M. 4M referred to well-being “as a sense of *balance*”,which was described as the following:

That internal ability to bring balance to all of these external and internal factors. There's all of these internal and external factors that contribute to our own state and having well-being is being able to balance of all that. And being able to deal with all of that that’s productive and purposeful. (p. 2)

In another case, 7M described well-being from an Islamic perspective whereby:

Human well-being is when a human being is in obedience to their lord, so understands all the signs of God around them and is able to live in this world in *harmony* and *peace* with all of the creation around them including themselves (p. 1)

A participant, 7M directly described balance in regard to a specific challenge that university students may experience:

*Balance* being when you’re going from whatever bubble they were in before in terms of high school and into...having to deal with things themselves, there’s a lot of adjustments. (p. 2)

 Another participant also used similar examples to balance, but used terms and phrases such as “calmness”, “content with the inability of knowing everything”, “comfort with where you are and your place in the world, world as natural order” (6M, p. 3).

The aforementioned conceptions of human well-being provide insight into how “holistic” well-being is characterized from an Islamic perspective. Similarly, a striking feature among Muslim clinicians was that they always described human well-being from an Islamic perspective, and psychological and Islamic perspectives were automatically linked, as two necessary halves of the whole individual. Participant 4M eloquently described the distinction between the psychological perspective of well-being versus an Islamic understanding:

From a psychological perspective, the primary area of study for someone in psychology is the mind, and even looking at the mind as a biological organ. From the Islamic perspective, it’s more than just that. *It’s the relationship of the state of one’s mind and also including the state of one’s heart.* And the two are interconnected, there’s an overlap. The Islamic understanding of human being is actually that the heart and the spirit is of greater importance than just the mind alone. That s a very intangible aspect that could be missed if just looked from a psychological perspective. (p. 2)

The overlap that 4M described is potentially vital to understanding a Muslim clients’ notion of their well-being, as the Islamic perspective is very deeply tied to theological understandings of the divine and so forth. It also “relates to bigger questions like ‘what’s the meaning of life, what’s the direction that I’m going in, what’s my purpose in this world, how do I understand trauma, how do I understand difficulty’. (4M, p. 2) As such, the internal sense of balance 4M speaks of is synonymous with the harmony and peace described by 7M.

###  Multi-pronged approach: Additionally, 5M describes an increasingly significant perspective of well-being that was distinctly unique in relation to the other perspectives. This perspective is a three-pronged approach, all three of which are rooted in faith and used as a measuring guide against which clients’ well-being is assessed. 5M notes:

I have my own model that I conceptualize well-being with. And I take into consideration three different factors. One is the self...like the physical well-being and mental health related to the self. The second is God, looking at religiosity...understanding of the person if something [negative] happens. And the third element is the other. With their family, community, work, etc. So those three elements in my opinion make up human well-being per se, you know self, God, and other. (5M, p. 3)

 It is seems that this approach, although not currently noted in any form of literature apart from theological studies, is useful as it clearly incorporates various aspects of therapy that can shape one’s analysis on a situation depending on the needs of the client at that time. Participant 5M notes:

If you look at it from different perspectives, humanistic, or self-psychology, or behaviourism, all those kinds are included in this model and it does end up helping. (p. 4)

###  Well-being on a continuum. What is even more striking is how a lack of well-being is characterized by the participants in this study. Many of the participants discussed the nuance and complexity in determining the well-being of a client. 6M describes the spiritual, psychological, and emotional states that comprise one’s overall well-being. However, despite considering these dimensions, there still remains a great deal of variation in the manifestation of one’s well-being.

Participant 2W notes:

It can be extremely varied. There’s probably a continuum there because as I’m saying this I’m realizing that some students may say “I have a sense of well being, but I have an issue in my life and I want to work through it”, so another student might say I do not have a sense of well being and these are the contributing factors. (p.3)

As such, it is evident that the mechanisms used to assess well-being are incredibly complex, varied, and nuanced, which results in an “inability to cope with different pressures” (4M, p. 2). The discussion of the various pressures and troubles that Muslim students experience will be highlighted in the following paragraphs.

A participant in this study known as 6M noted this fluctuation in a person’s well-being and psychological state. They highlight the importance in recognizing that ups and downs in one’s perceived and observed well-being is a regular occurrence and again, can vary on a continuum.

There’s a certain amount of ups and downs and disturbances that are normal...I would contend even if someone is going through a tough time or particularly struck by the duration they could overall you know they could be healthy. (p. 4)

## 3.2 Factors Impacting Muslim Students’ Well-Being

A number of concepts and categories consistently emerged across the interviews with regard to the pressures that Muslim university students experience. The participants noted these factors as they most usually are the reasons which lead students to seek assistance. I will discuss the most significant and frequently mentioned categories. As an entry point to this discussion, one of the participants shared a striking insight. Upon being asked a subset of the question “what special problems are Muslim students confronted with?”, 4M noted, “I think it's not necessarily special problems but I think Muslims are looking for different solutions” (p. 7). This statement shifted how I interpret the “troubles” of Muslim university students, as the troubles may manifest in similar ways and yet, it is more about dealing with questions such as “how am I going to deal with that, what’s the solution?...that’s where there would be a difference” (4M, p. 7)

The following headings are overarching themes representing the most commonly mentioned troubles that are experienced by Muslim university students as noted by the participants in this study. These troubles were noted by participants as creating varying levels of disturbances in the lives of students, yet all equally concerning for students.

**Multiple expectations: parental, cultural, and academic**: A concern that was mentioned across interviews was the notion of expectations. 1W, 4M, 5M and 6M specifically referred to the expectations that students are pressured to meet and are burdened by, which are often instigated and fuelled by one’s parents with regard to culture and academic achievements. 6M notes, “I usually ask the client to explain their understanding [of being] Muslim, or to fulfill their parents expectations, have them describe it in their words” (p. 16). This lends to the prevalence of this concern, as well as the need for clients to identify their concerns and take the expert role in explaining their troubles.

When discussing concerns about the experiences of Muslim university, parents were mentioned as a consistent challenge. Although the context varied, it only varied slightly. Parents were mentioned in the context of expectations, relationships, education, culture, and various sub-themes, which will be noted in the following sections. 5M noted:

I would say parents are number one...like difficulty with dealing with expectations that parents have, and that’s an issue that comes up a lot. It’s very common and it ends up leading to other problems. I try to empower them and they should be making their own decisions and what that means for them and how respect and love for parents is different from following every command. (p. 4)

As such, it evident that parents are a source of pressure among Muslim university students. This concern also encompasses an additional dimension, which involves sensitivity in respecting and not defying parents’ wishes. 2W notes this dichotomy that students often find themselves in, “…[feeling] very torn, between you know, not wanting to disrespect the parents or the family or also feeling a real sense of loyalty and affiliation with her family”(p. 4). This example was in the context of a student living two lives, one she felt was in-line with the values espoused by her parents, and the other in-line with the student’s own enjoyment and sense of fulfilment.

Similarly, as a Western clinician employed within an academic setting, 1W touched upon a striking insight regarding expectations. Firstly, she identified that parental and familial expectations are a major concern for students. Participant 1W commented on number of “differences” and benefits for students working with a clinician that is separate from their own community. The first one is in relation to expectations:

From the conversation that I have had, the person was going to an Imam, there would be certain expectations about the person’s behaviour or constancy in terms of participation, the kind of prayer life of the community. I would not be imposing any expectation at all...I mean I could certainly listen but I wouldn’t be saying, “you should do this” or “your community expects this”, or anything like that. (p. 4)

1W continues by noting that by working with someone separate from her own community, she is able to “Give people a little bit of an oasis, its part of what some students need...simply giving the space to sit in quiet for bit, it changes the tenor things. We move away from expectation and pushing to being, just being” (p. 5)

###  Academic anxiety. An additional issue that was mentioned across the interviews was the student’s pressure to succeed. Particularly at larger prestigious institutions, which all but one participant were affiliated with, academic pressure is a significant concern among not only Muslim students, but students more generally. It is evident that this pressure to succeed extends beyond academics and spills into other aspects of one’s overall understanding of success. 4M notes “Especially at a place like here, academic stress, you know this pressure to succeed, you know this anxiety around, ‘even when I get out of here, am I going to find a job’” (p.4).

Moreover, 7M speaks about the pressures at a large university and the anxiety associated with academics and test taking, which are often triggers for students to seeking assistance. 7M observed, “I’m a in big university where students are very much high achievers...so there is a lot of anxiety around academics and around test taking and around balance” (p. 4).

Many of these academic pressures are associated with adjustment concerns, as noted by 7M. Participant 7M also touched upon subsequent troubles that are associated with and the result of various academic troubles that were completely missing from the narratives of other participants. She noted three troubles that apply to Muslims in observing that “A good bit of addiction...where what might just have been experimental before or social use of whatever has now become, because of all they’re feeling, has now become an actual addiction...the academics, adjustment and addiction all apply to Muslims” (p. 2).

It is important to note these concerns as they impact Muslim students, regardless of the Muslim community’s hesitation and taboo when discussing the use and abuse of alcohol and drugs.

###  Prejudice and racism. Prejudice and racism in the context of Muslim university students’ mental health was a recurring and prominent theme in the interviews, particularly how these unfortunate experiences impact or exacerbate students’ existing mental health concerns. Various participants noted that if an existing diagnosis or symptoms were present, students would experience an exacerbation of their pre-existing concerns as a result of the negative experiences of prejudice and racism. A participant noted that this pattern is not unique to Muslim students alone, rather “Many students who wear a symbol of their faith, be it hijab, or kippa or whatever, do experience some targeting or racism or Islamophobia” (1W, p. 5).

Interestingly, 2W was firm in her belief that “absolutely for sure” prejudice and racism do in fact impact mental health. This participant also made a comparison between racism and bullying, where the latter is consistently given attention via social media campaigns and the former is viewed exclusively as a hate crime or a isolated incident. 2W notes that”

 In rudimentary terms, its sort of like a form of bullying so there’s definite connections between bullying and lots of things. For sure, it might be racism that’s experienced here or it might be racism that’s experienced elsewhere (p. 4)

Additionally, 4M noted the impact of prejudice on the lives of Muslim individuals. He discussed the repercussions that institutional racism has the mental health of individuals and the perverseness of prejudice onto various other aspects of one’s life:

For a student who already might be prone to anxiety or stress, the added difficulty of experiencing prejudice and racism definitely exacerbates…prejudice, particularly institutional prejudice weighs very heavily, like there is stress when you’re travelling. There’s stress when you dress a certain way, that’s because of all those assumptions that can be attached to that. So I would say definitely it impacts mental health directly. And if and when it becomes institutionalized its even worse because you can impact an entire generation…so I think it even goes beyond just the individual and it definitely has mental health consequences…its very stressful. (p. 8)

 Participants like 4M and 5M discussed the impact of mental health in exacerbating existing concerns. However, it was clear throughout the interviews that the majority of Muslim practitioners made a stronger connection between prejudice and institutional or systemic racism, as opposed to the Western practitioners who often generalized situations as isolated cases or concerns that those from all faith groups experience. Institutional and systemic racism and prejudice was discussed in relation to current political circumstances, which trickles down to the individual level, with impacts being felt by university students. Similarly, 7M reflects on this point where it was noted, “With all the media focusing its attention on ISIS and all the different issues happening in the Middle East there has been quite a bit of Islamophobia that Muslim students specifically are experiencing because they’re on a college campus” (p. 12).

The participant continues by noting that in essence, college campus are less safe for Muslim students:

In college you’re sort of free and encouraged to speak your mind and explore new things and challenge old ideas so there’s some how less protection in college then maybe a work place setting where you have a limited number of people you’re working with…In college there’s tones of people around you and the possibility of some harassing you based on your faith is very high, I mean we saw that with Chapel Hill. (p. 5)

Participant 7M is making a connection to the Chapel Hill shooting, where on February 10, 2015, three young Muslim students were shot dead by their neighbour in their home in a quiet neighbourhood near the University of North Carolina. This incident took place after the victims expressed to their families that their killer, Hick, frequently confronted them. 7M is correlating such unfortunate events to one’s outward religious identity, and the racism and prejudice Muslims experience. Additionally, the same participant even noted that the racism and prejudice is so pervasive, particularly in light of the media attention on Muslims, that experiences of racism this year surpasses that of the 9/11 attacks:

I'm really struck by this specifically by the Islamophobia piece that’s out there and really evident, really evident…it’s day in and day out…it’s also at the youth groups, even at the school level the amount of bulling that’s gone up an amount of teasing and poking and isolating you know, its just horrendous. I mean there’s definitely a spike in that, I think to I would say even more than where after 9/11. (7M, p. 7)

###  “Straddling two cultures”: While culture is difficult to define in this context, it is important to make the distinction between culture and religion. A participant of the study, 4M spoke about this tendency to conflate these terms by noting:

I’m actually really cautious of using the word culture, because in Canada, being a multicultural society, being Muslim can almost be viewed as a cultural practice, when in reality, its a religious practice that people with vastly different cultures and background ascribe to. (p. 4)

Culture in the context of religion, neoliberal and Eurocentric ideologies were highlighted in the interviews. However, cultural and religious challenges are often fluid and interrelated. A participant expanded upon this point by providing an example of this in stating that “Usually, what you get is the culture becomes the dominant authority in terms of what their parents want...we are told through our culture that we are supposed to follow whatever the parents say...sometimes parents have ridiculous expectations!” (5M, p. 5).

More specifically, speaking to the point that troubles that are shaped by culture and are unique to Muslim students, 3W referred to the phrase “straddling two cultures” in the interview:

Straddling two cultures is very challenging and that becomes a focal point...like who do I want to be and how to navigate this and “how do I balance these two different parts of what my belief system is and my values.” Its unique to anyone straddling two cultures or two beliefs systems or belief systems.” (3W, p. 5)

This passage highlights two important points. The first is that conflict can arise between one’s religious or personal values, and the beliefs espoused by one’s community. Secondly, this conflict is not exclusive to individuals who are Muslim, but rather is experienced by anyone attempting to straddle two cultures that are often contrast, although complementary in many instances as well. An example of straddling two cultures is wanting to respect one’s religion and parents versus wanting to date or drink, which is prohibited in the Islamic faith (3W, p. 6). It is clear in this instance how one’s desire to fulfill parental expectations as well as uphold one’s own values and beliefs can cause tension and troubles for students who are attempting to seamlessly navigate these various ways of being.

 Similarly, 5M noted that Muslim individuals significantly struggle with religion and culture, “which can sometimes be two different things” (p.6). They noted:

Being acculturated into American society and religion and sometimes the two of those are pointing in two different directions and that kind of confusion that takes place, especially looking at the age group between 12 and 20, the identity development is happening. (5M, p. 7)

According to 5M (p. 7), this often leads to a number of subsequent outcomes for this age group that is at the pinnacle of identity development. The first a) complete assimilation into American or Western culture, b) complete marginalization of one’s own culture and American culture and may become radicalized and rebel, c) integration of all three of them into a unique identity that he[she] has (5M). As such it is clear that navigating two, occasionally opposing cultures, is an area of concern and trouble for many Muslim students, and more generally, students with two belief systems. Moving forward, it is necessary to define the term assimilation.

**Limitations of Western understandings of troubles.** A limitation that was noted by both Western as well as Muslim service providers was the tendency for Western clinicians to promote and encourage students to individuate from their families, friend circles and community. 2W notes:

A limitation might be the bias that exists in a Western culture towards things like individuation, individuality, separating from the family, whereas that’s not the fit maybe for some people. (p.5)

This concern is connected to a multitude of various considerations and barriers such as “feelings or worry on the part of the students around being understood or misunderstood by the person they’re talking to, the individual, by the system, by the larger community” (2W, p. 5).

Furthermore, 7M noted a number of relevant and related limitations that arise from a Western model when working with Muslim youth. The participant gave an example of a typical concern for university-aged students regarding “parents driving her nuts”. According to 7M, a typical Western response would be, “Well, you need to individuate, you need to kind of become your own person, even if that includes severing the ties, cutting this off” (7M, p.3). Moreover, the participant continues by using a metaphor to describe how parents perceive Western concepts of individuation, comparing it to a “Festering wound, like a gangrenous foot that needs to be chopped off so you can grow and move on. In our tradition [as Muslims] that’s really problematic” (p.3). These excerpts highlight the various limitations which are inherent in the recommendations provided by clinicians when the cultures and paradigms of the client are not taken into consideration.

 Additionally, 7M carries on by stating that despite Western solutions being very effective and helpful for many students, they often create many more subsequent problems for students who ascribe to the Islamic faith:

By and large we come from a very collectivist society and understanding of human interaction, whereas here in the West, there’s a lot more emphasis on the individual, individualism as opposed to collectivism. So when you tell a person embedded within a Muslim household of Muslim culture to just individuate and take off, that causes ten times more problems than it would for somebody who isn’t Muslim. And that might be the simplest of all examples. (p.3)

Thus, 7M clearly suggests that there are definite limitations to a Western model of therapy and treatment when working with Muslim students, further observing that “If you don’t see things that are specific to the Islamic belief system, [clinicians] are going to be missing the point, missing the mark when working with Muslims” (p. 3).

Additionally, the suggestions by Western clinicians to individuate appear to suggest a push for clients to assimilate into Western culture. Similarly, it is evident that pressures manifesting themselves in the shape of parental, cultural and academic, are also a push towards assimilation. Although it is not clear whether this is an intentional practice, the clinicians who I interviewed highlighted that the Western responses to students troubles, more often then not, result in a great degree of anxiety for students and their families as it conflicts with their cultural and religious value systems. Equally important to note is that despite a number of limitations of a Western model when working with Muslim students, existing treatments continue to be beneficial for students and are not rejected from an Islamic paradigm. Indeed, 5M notes that “One thing we have to understand is that Islam doesn’t negate or reject any of the western model” (p.5), while 4M clarified that “there are values in the west that are completely aligned with Islam, it’s not like its one or the other” (p. 18)

The following paragraphs will in fact highlight the main differences, based on the participants’ perspectives, between how the concerns of students can be reconciled from an Islamic versus Western approach to treatments.

## 3.3 Existing Needs and Proposed Model when Working with Muslim Students

 An important theme that emerged from the research is the particular needs of Muslim university students experiencing mental health concerns as noted by the mental health care providers who were interviewed. Each participant offered unique and practical examples of some of the needs they have identified, based on their own social location and interactions with students.

 One of the participants, 7M noted that among the most pressing needs for Muslim students, is the ability to “Seek treatment without fear or ridicule and feeling inadequate to the community’s response” (p. 14). Similarly, 6M echoed these sentiments by noting that in addition to seeking fear without ridicule, particular clinicians are also needed to guide this treatment in observing “The need for more Muslim mental health professionals who they feel they can talk to or the need for the concept to be more accepted in their community because they’re basically quite alone in that sense” (p. 14).

Similarly, 5M discussed a simple yet profound concern regarding the availability of services for Muslim students, and this being a specific need regarding treatment:

 I would say availability of services and I would also say that the colleges and universities employ somebody…who is Muslim or you have a Muslim student, offer them…like hey we’ll pay for your therapy, you can go to this person and see them so they don’t have to worry about it because a lot of college students will go to their wellness centre and seek counselling there and a lot of Muslim students might be looking for a Muslim therapist and being able to provide that to them. So availability of services is probably the most important [need]. (p. 9)

These suggestions shed light on limitations that exist at post-secondary institutions in addressing Muslim students’ mental health needs, including the limited options that university students have in seeking Islamically-oriented service providers. Comparably, 5M makes an alternative suggestion of how students might go about seeking services from clinicians outside of the university setting – a step 5M believes reflects university’s commitment to better the service that students receive.

Additionally, 6M discusses the possibility of peer mentorship and coaching:

One of the needs that can help if fulfilled is just meeting other Muslims who have similar issues! And it provides a sort of like group therapy situation where you don’t feel that you’re the weird one out where it validates it for you, it normalizes what you’re going through, it can be incredible, such a great source of relief for some people. (p. 14)

A suggestion from 4M for Muslim youth experiencing mental health concerns that emerged from the dialogue was that “A little bit of face-time...like actually face-time. People don’t have really heartfelt conversation. They also feel like they have stuff to do. The stakes are really high and this sort of obsession with success puts a lot of stress on people’s shoulders” (4M, p. 15).

Moreover, 7M discusses the pressing and emerging needs for Muslim students:

“…a place to facilitate needs. [Muslim students] need help transitioning from high school to college or from being home with family to being alone or with roommates on campus so there’s lots of adjustments [and] transition so they’ll need help with that. Also, a lot of Muslim students, when they come to college, this is really the first time they have new found freedom, and this is the first time to do okay with that not fail horribly with this new found freedom, so the need to balance that out with making proper decisions and being happy with this freedom and making proper decisions” (p. 9).

 One of the participants, 4M, discussed their understanding of the perceived benefits of an Islamic ideology that would assist in many of the day-to-day anxieties and stressors Muslim university students experience if this knowledge were acquired. 4M noted that “Values, nature, spirituality, thikr (remembrance of God), worship, you have so much...your value is your soul. I think if we adopted “an Islamic paradigm” it would solve so many mental health issues” (p. 18).

Additionally, 7M noted an Islamic mental health model is possible if approached in a particular manner. Such a model could then be called *Islamic psychotherapy.* An Islamic psychotherapy model requires one to use the teachings of the Prophet (peace be upon him) as the measuring stick against which everything else is considered. This approach would be reinforced by one’s learning about Islamic. From here, an Islamic model of psychotherapy can be developed and used in treatments, alongside Western models. This participant continued by noting how an Islamic psychotherapy model could be developed:

There’s so much fantastic research that’s happened obviously in the Western world and modern times that needs to be bridged back to what *our* predecessors have said and talked about so if you start there and then you take all the good benefits that’s come from Western models and research and take of it what’s good and fits with our model and get rid of what doesn't (7M, p. 3).

This approach to an Islamic model of mental health differs from merely adapting existing treatments, which was noted by two participants as being an ineffective and inauthentic way of “Islamicizing” existing treatments. 7M noted, “Some of the models that have started to come out [are] taking the western model that’s already in place and just trying to “Islamicize” it or put some Muslim term or Islamic term, “Islamicize” each CBT term and call it Muslim CBT” (p. 3).

It is evident that a Muslim model of mental health links back to conceptions of well-being and lack of well-being, happiness and values, and ways in which well-being and happiness can be achieved in drawing on examples from the prophetic tradition, as well as prayer and remembrance of one’s lord. All of these can be developed and incorporated into existing treatment methodologies. Indeed, the two are not inherently contradictory, with each lending and gaining wisdom from one another.

**Collaborative working**. A question that was posed to all participants concerned the idea of a “collaborative working” relationship, whereby an approach to therapy would be organized such that a client could have both their clinical and religious needs met. All of the participants expressed openness to working alongside different but complementary service providers in striving to fulfill a client’s the needs. Indeed, several participants encouraged and noted the importance of recognizing when it is necessary to refer to another clinician, thus remaining competent in one’s practice. This is a key point that will be discussed following this section.

 A participant known as 2W provided a recommendation on how a collaborative working relationship might be actualized in a given context, noting that one way may be “If [Muslim students] had a counsellor who had an Islamic background and was also trained in the spiritual therapeutic aspects” (p. 13).

Similarly, more than one participant noted the desire of wanting to learn from the client themselves, thus creating an alternative meaning for a “collaborative working” relationship. In this definition, it is between the clinician and the client themselves:

I would want to learn from the client, how that was impacting what we’re working on and help me understand how we can integrate the two together because maybe I'm giving divergent messages from what they’re getting…it’s a constant conversation, does that fit for you, lets find another way to make that happen. (3W, p. 12)

 Moreover, 3W continued by noting that one may find help in a number of different places, and not simply within the confines of one therapeutic relationship, although 3W qualified this insight:

We get help in lots of different places and we need to hear many perspectives in order to make up our minds about something are going to work for us. So it doesn’t make sense to me at all to say, ‘well, if you’re seeing that person then you can’t see me’. Though we do not encourage people to see different counsellors. That’s not helpful. But…different providers, different types of providers are no problem. (p. 13)

 Clinicians or clients themselves often suggest collaborative working, due to a particular understanding of one’s owns concerns. Referring to the niche psychological service offered by the agency that they work at, 6M noted, “A lot of the people who come to us come to us for that reason: because they’re seeking that understanding of human psychology but also incorporating Islamic ideas into it as well or even stems from Islam itself and not from the western models” (p. 5).

###  Competence in professional practice: A striking finding that emerged throughout the interviews was participants’ emphasis on upholding a social work value, namely, competence in professional practice. Competence is a cornerstone of a professional social work relationship, as well as any and all therapeutic relationships. This value is of utmost importance because individuals, communities, and other professionals place their trust and confidence in the competence of the professional with whom they are working. This confidence is rooted in the clinician’s professional proficiency, their continued striving towards professional development and skill building, as well as having the awareness of when it is appropriate and necessary to seek consultation.

 One of the participants of this study. 4M noted the importance of not only being competent in one’s practice, but also consulting with others in order to provide one’s clients with the highest level of service: “God says: ‘Give trusts to its proper people”, and being really clear on what you offer people” (p. 6).

This insight is profound given that it speaks to three major points: competence in practice, proper allocation of services, as well as transparency with the client, all of which are important traits to embody and uphold as a clinician. An example of this was seen in the dialogue with 2W, where the participant noted:

This student whose questions were largely spiritual, I think my ability to be helpful to her were fairly limited and that’s where kind of trying to hook her up with more appropriate resources was an important part so there would be things I could help her with but larger spiritual questions I wouldn’t be able to help her with. (p. 13)

This situation suggests that self-awareness of one’s social location promotes cultural sensitivity and competence, enabling a practitioner to assess the degree of fit between the client’s needs and the treatment options available. A participant, 7M speaks to a similar instance of competence in practice where he emphasizes the importance of consulting with individuals who are knowledgeable and skilled in one’s line of work and clientele. They noted:

Ask the people who *do* know, get consultation. So there’s this whole idea of professional consultation, even though you’re the professional and you have the degree and have the license, it does not mean that you have all the answers. There’s such a thing called “cultural consultation” or a “religious consultation”. So that might mean that you reach out to another clinician...who’s more versed working with that group of people or when you asked the client “so whose important to you”…that’s a really important and key thing that clinicians, its an extra step but it makes you that much better of a clinician if you do it.” (p.6)

The emphasis on professional competence across all the interviews, regardless of a participant’s training and specializations, was a encouraging finding. This suggests that this practice is at the forefront of those who work with students with culturally and religiously diverse backgrounds.

Similarly, 7M discussed the importance of cultural competence courses that are usually offered in all faculties as an elective. She noted:

Culture and religion – people tend to blow these courses off like ‘yeah, that’s not heavy duty work.’ The thing is, those courses are actually and of course I'm biased because I teach one, but they’re really important because if you take what’s being taught seriously, then you realize that who you’re working with comes with their own standard and you’re not there to judge or put your feelings onto it. I think every therapist should start in understanding their client…start with the person. (p.12)

 **Cultural sensitivity.** Throughout the interviews, the participants weaved together various examples of culturally competent care when working with Muslim university students. This was often prompted by discussions of what help rooted in a social justice paradigm would look like. The following section will highlight the findings that arose from the conversations that were most pertinent to the discussion of culturally competent care.

Participants highlighted the importance of discussing a Muslim student’s religiosity and the role of Islam in his or her life in an intake session. This will impact an individual’s course of treatment, the help they seek, potential referrals and consultations that need to be made and so forth. As noted by 6M, “Try to figure out what their identity is, they’re kind of lost and floating in terms of their religiosity and trying to figure out what they’re comfortable with in terms of how they express their faith” (p. 6). This is tied to the notion of providing care that is catered to the specific needs of the client in question, as service providers are “not dealing with one standard understanding” (6M, p. 8). As such, 7M noted that if a client seeks care and specifically asks or seems interested in speaking about spiritual therapy, there are a host of questions that are asked in order to specifically cater to the client’s needs and expectations, which includes “asking what their interpretation of religion or spirituality means to them” (p. 9) in order to get a sense of where they are coming from.

**Gender**. The topic of gender and its relevance when working with Muslim clients was a reoccurring theme throughout many of the interviews. Two of the participants of this study1W and 4M spoke about the importance of following the cues of the client, and allowing them to determine the nature of the interaction. Participant 1W observed, “I mean I would certainly be sensitive to things like not reaching out for a handshake, or to make sure that the blinds were open or someone else was here” (1W, p. 11). Additionally, 1W made a recommendation the context of gender and a therapeutic relationship: “Some helpful reminders about what would make the student more comfortable, especially I think of, about working with male students. You know if you’re female, the comfort level there. Because I sometimes, I have to be conscious, its just that natural tendency to shake hands” (1W, p. 11). Additionally, both 1W and 4M validated the confusion that clinicians can experience when attempting to provide culturally sensitive care, given the multitude of different clients, comfort levels, and preferences:

Like within one culture, it’s rude for men and women not to shake hands and in Islamic sort of practice and how Islamic culture are, its rude to extend your hand, so how do you navigate that? And to make things more confusing, you have a lot of Muslim who do shake hands! It’s very confusing, and a lot of people don’t know the basis for that. (4M, p. 10)

 They continued by providing more direct recommendations to clinicians, which he received from his educators:

When I was at the seminary, this was the rule they taught people because they had all kinds of people. So they were like, ‘Listen, when you’re dealing with a Muslim, don’t extend your hand unless they extend it first’, but if they extend their hand then you can shake hands. You’re not going to offend them. (p. 11)

The participant continued by noting that in the context of help that is rooted in social justice, a sensitivity based on gender is essential:

 That is a big one. I think generally its safe to assume that a Muslim woman would probably be more comfortable being counselled by a woman and Muslim man would be comfortable with a man…even if that’s not the case, just recognizing that there’s certain boundaries that Muslims might be aware of. For example, if it’s a setting in which the counsellor and the counselee are two different genders that they’re not in seclusion. (p. 11).

 Moreover, 6M pointedly noted how:

 Religiosity should not be assumed by such outward expressions such as beards for men or hijab for women. This outward expression should not be assumed to mirror one’s level of religiosity, rather, a woman in hijab enters your office and you immediately assume all these theological assumptions of who she is and you ignore her Canadian identity. You need to be able to incorporate all the facets of whoever this person feels they are in their own eyes and have some literacy and fluency in the concepts of Islamic faith. (p. 12)

This point links to the comments made by 1W and being aware of the different sensitivities that may be present among Muslim students.

**Role of the Muslim community.** Participants were asked to share their perspectives on the role of the Muslim community with regard to the mental health of Muslim university students. The overwhelming majority of participants noted the single most important role of the Muslim community is to educate themselves and others about the topic of Muslim mental health. This theme may have been mentioned for a number of reasons, among them: the perceived lack of knowledge surrounding mental health, a limited number of culturally sensitive practitioners or religious leaders, potentially the stigma surrounding mental health, or perhaps all three. Again, participants referred to education as whole, and did not specify or cater to particular groups of people. As noted by 2W, “Education would be important, making sure people understand, I mean there’s so many educational campaign rights now, hopefully it’s affecting every community, not just the Muslim community” (p. 8).

A participant specifies their recommendations by noting the people who would be involved in educating and how one might go about disseminating knowledge:

People who are in the field have to do more foot work, letting different people know about what mental health is and what are the different issues that Muslims are facing, raise awareness and educate people of the community because it will lead to more people having a better understanding and being more open to seeking counselling right away instead of waiting. (5M, p. 6)

Additionally, the topic of education was taken a step further when 6M discussed the “community-wide responsibility” of creating open, safe and supportive environment:

 Creating an environment that is safe and supportive so that the youth can come and express whatever kind of issues they’re dealing with and feel, that they won’t be judged…a community responsibility is to have general education on psychological concepts, for everybody so that everybody is involved, even if you are a community member who is not directly effected by some psychological issue. There should be basic knowledge out there so people can identify basic symptoms and signs of psychological distress, particularly in young people. (p. 10)

In addition to this discussion, 6M noted that mental health should also be encouraged as a field of education. He eloquently stated:

It’s going to be harder if people outside our community are always treating our community. I think encouraging the field of mental health in general as an accept field of study, as a career choice. If we can encourage young Muslims to go into that field, basically develop a larger pool of Muslim mental health professionals. (p. 10)

7M noted practical ways in which psycho-education can take place on university campuses. 7M noted that weekly circles of knowledge organized by the Muslim Students’ Association could be focused on mental health awareness, and a trained professional facilitating would not be a necessity:

It doesn’t even have to be a mental health provider that speaks about it as long as the person speaking is psychologically minded. It could be a mental health provider speaking about it or you could have somebody who’s from the faith side who’s careful in how they speak about this issue. (p. 12)

The participant continued by noting two benefits of educating university students themselves on mental illnesses, particularly in Muslim communities:

If we educate early, a) it could be immediately effective because of the age trajectory of things [certain illnesses], b) you’re building life long skills that when into the real world and they see mental illness all around them, but they won’t recognize it until they have a name for it. (p. 8)

Finally, 4M noted the importance of Muslim communities not being “an insular community”. He calls for a “calculated integration” whereby Muslim practitioners reach out to institutions, whether its churches, hospitals, or high schools and give presentations on “what Islam is actually about and the reason why it’s important for university students” (p. 9). He continued by noting that when students have a strong sense of confidence in their faith and it assists them in dealing with their troubles, this builds a sense of resilience. Thus, “The Muslim community, through confidence and through education internally, would build resilience in Muslim youth, and I think that’s a really important thing” (4M, p. 9).

 This chapter highlighted findings in regards to understanding of well-being, factors impacting Muslim students’ well being, and existing Needs and Proposed Model when Working with Muslim Students. The findings were presented in a manner that allowed for similarities and differences to be discussed amongst the participants who are trained solely from a Western perspective as well as the participants with an Islamic approach to treatment. The following section will discuss the depth, parallels, and contradictions of these findings in relation to existing literature on the topic of Muslim.

# Chapter 4: Discussion

The experiences of the mental health service providers interviewed in this study echoed, challenged, and contributed to many of the themes in the existing literature. The following section will provide brief insight into the contributions, contradictions, and depth of my research. Finally, I will conclude with limitations of this study.

 This study contributes to the existing literature because it is situated in a Canadian context as opposed to an American context, and speaks to an older age demographic of late teens and young adults. Moreover, this study discussed many more specific troubles that Muslims university students experience, including parents, academic anxiety, and faith-based concerns. Humeidan (2012) cites Benton et al. (2003) in echoing these findings and notes that “clients at university counselling centers are most likely to seek counselling for issues related to relationships, anxiety, family issues, educational concerns, depression, and situational issues” (p. 218).

 Additionally, as explored throughout the research, the troubles presented by university students are quite frequently impacted by experiences of racism and prejudice. One of the participants even discussed how this year has been particularly troubling given the plethora of hate crimes and negative media attention. Therefore, such findings are warranted given that many Muslims have experienced some form of racism and negative experiences associated with negative biases and racism. Such experiences are not uncommon for Muslims in North America-, and as such, internalized racism should be examined among ethnic/racial, and religious minorities. The participants contributed to this dialogue as they provided insights for a Canadian context as well as a spoke about a university demographic specifically.

This research study discussed at length human well-being and how well-being or a lack thereof can be characterized from both a faith-based and a secular paradigm. As noted by Joshanloo (2012), this line of research has focused almost entirely on Western populations and largely neglected people from other regions (p.1857). Thus a particular focus of this research was to assess human notions of well-being. This statement contributes to the findings that arose from this study, as all three of the Western-oriented clinicians (1W, 2W, 3W) referred to Maslow’s Hierarchy of Needs when assessing a client’s well-being. This highlights the prevalence of the use of more secular measurements to assess the state of one’s well-being.

 Particularly important and unique to this study is the model that arose from this study, and that is how one understands human well being from a Muslim perspective. Key informants shared their understandings of human well-being from an Islamic perspective and how these understandings can practically impact a clinician’s conceptualizations of the troubles experienced by Muslim students. Differing studies including the work by Joshanloo (2012) provide an in-depth assessment of a Muslim understanding of a good life and happiness, and specified a general notion of mental well-being; this differs in regards to the holistic well being discussed in this paper. Well-being was never characterized by participants of this study as happiness or a good life, rather words such as balance, purposefulness, productivity, positive perceptions of self, others and God, were all exclusive to this study in regards to the population group and context. The various understandings of well-being that arose from the interviews rings very true to clinicians and ultimately will assist clinicians, both Muslim and clinicians from alternative backgrounds. A more thorough discussion of holistic well being in regards to Muslim students is beyond this current research. Further research is needed to assess and compare the existing understandings of well-being and the implication this has on practice if coupled with recommendations for cultural sensitivity.

 Additionally, the findings of this study contribute to the literature and dominant discussions on happiness that Western psychology offers. The emphasis from service providers and generated from findings highlights Western treatments places emphasis on individuation and fulfilling one’s personal goals and desires as opposed to one’s family or community can cause many more problems for the client than they initially began with. This provides a sense of depth to the sentiments shared by Joshanloo (2012). He notes that the dominant version of happiness that Western psychology offers is where “well-being is conceived of as identical to subjective well-being, which is dependant on the pleasure experiences of the individual over a certain period of time” (p. 1859). Many of the participants in the study offered insights on well-being that was much more linked to a collectivist and communal understanding of well-being and happiness. This finding lends to existing literature while adding a dimension of depth. It finds that university students also derive their sense of well-being from maintaining balance in their life, a balance that is linked to their familial, religious, and spiritual positionality. The analysis presented in the above section and in the findings suggests that there are inherent differences and similarities between the Western and the Islamic conceptualization of human well-being

**4.1 Recommendations for Practice**

 **Cultural sensitivity.** Participants of this study felt that culturally sensitive care is needed to meet the needs of Muslim university students. In addition as generated from the findings, it is necessary for clinicians to supplement their academic training and enrol in courses that discuss culture, power and privilege, the existing literature, although sparsely, points to similar trends. The participants echoed Humeidan (2012)’s points, as she emphasizes the importance of providing culturally sensitive care to cater to the increasing Muslim students present in university settings. Humeidan (2012) notes that those whose religion is more salient to others or outwardly visible via Islamic clothing may have a different experience on university campuses. However, as confirmed by some participants, religiosity should not be assumed by such outward expressions such as beards for men or hijab for women. This outward expression should not be assumed to mirror one’s level of religiosity, rather, as noted by 6M on page 56, the role of religion in one’s life should be assessed in therapy.

 Similarly, Basit and Hamid (2010) discussed a number of the most prevalent emotional and psychiatric concerns among Muslim Americans. The authors found that the most prevalent concern for American Muslims with a mean age of 14.9 was their difficulty trying to resolve conflicting value systems (Basit & Hamid, 2010). This finding was certainly echoed by participants in this study. Participant 1W highlighted the difficulties experienced by individuals who possess two values systems and 2W noted the particularly significant troubles for those who straddle two cultures. This finding also highlights the importance of cultural sensitivity training noted by 7M in order for clinicians to supplement their training and cater to the needs of their clients.

Although this is just one of the many examples where participants have called for a rich, in depth and holistic assessment of clients, it strengthens the recommendations shared by Humeidan (2012). She notes the importance of counsellors expressing “interest in learning about Muslim clients and their culture, while being attuned to the client as an individual and not as a representative of his/her larger community” (p. 223). This ties to an additional dimension that was noted by at least half of the participants, and that is the importance of distinguishing between a client’s religion and culture, and asking those of knowledge through a cultural consultationif deemed necessary by the client or the clinician. Basit and Hamid (2010) note, “It is imperative to have a clear understanding of religio-culture difference and social customs and values when conducting and assessment, [particularly] within minority communities” (p. 107). This insight, along with the recommendations made by participants such as 7M, lends to the call for increased cultural competence training, education both within the Muslim community and the larger community, as well as a willingness amongst practitioners to seek out the opportunities for vulnerabilities and ask those who are more knowledgeable, both fellow clinicians and clients.

### Limitations

Among the major limitations of this study was the sample size. With only seven mental health providers interviewed, the findings as well as the discussion that followed the findings were limited. As a result, it was challenging to draw substantive conclusions. Similarly, of the seven individuals who were interviewed, three of the participants live in the United States, and their clientele are American University students. While the participants offered very rich and valuable insights that were relevant to this research study, it potentially weakened its applicability to a Canadian context. Additionally, none of the participants who were interviewed were social workers by profession. This was noted in the method section and is not a major limitation. However, given that this is a Master of Social Work dissertation, I feel it necessary to make note of this point.

### Implications

As opposed to concluding this study with formal remarks regarding the summary of the findings, it is perhaps more appropriate to discuss the various of implications presented form the rich discussion presented in this study. This study generated a number of implications for various avenues, including education and practice. The concept of education was at the forefront of the discussion of the role of the Muslim community. Participants of this study overwhelming identified education as the single most important role of the Muslim community- to educate themselves and others about the topic of Muslim mental health. Additionally, participants noted education to be a community wide responsibility, of creating open, safe, and supportive environments for individuals to discuss how they’re feeling.

Upon the most noteworthy comments presented throughout the study was a call for different solutions that Muslim clients are seeking. This comment came as a reaction to the question of “special problems” confronted by Muslim students. This highlights the needs for wide spread education among community members and clinicians to be able to identify and work alongside Muslim clients as they seek out different solutions. Similarly, it displaces the blame from Muslims students, as it may often appear that Muslims inherently possess “special” “negative” or “disruptive” problems and situations.

As such, a implication of this study is for Muslim communities, Muslim mental health practitioners, as well as practitioners as a whole, to work as allies, both internally and externally to create education platforms, events, workshops, café education nights, mosque forums, and other avenues, in hopes of building resilience in Muslim youth and wide spread awareness amongst service providers and community members.

 Similarly, implications for practice are important to note. Equally tied to education are the findings generated of service providers seeking out education in order to transform the treatment experience for their clients. This includes educating oneself about a Muslim identity, conceptions of human well-being, as well as seeking out educational courses related to culturally competent care during the course of their formal training. These courses would pay particular attention to culture, power, and privilege. These implications emerged and were presented in hopes of bettering the services and experiences of Muslim individuals experiencing mental health concerns.

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DATE: Monday April 6, 2015

# APPENDIX 1

# LETTER OF INFORMATION / CONSENT

**A Study Exploring Service Providers’ Perspectives on Mental Health;**

**Muslim University Students**

**Principal Investigator:**

Hager Rostom

School of Social Work

McMaster University

Hamilton, Ontario, Canada

**(416) 294- 9816**

E-mail: rostomh@mcmaster.ca

**As part of the interview process I will ask that the professionals abide by their professional code of ethics. I will also reiterate that I am interested in common themes and that practitioners not reveal any confidential information and compromise their professional values**

**Purpose of the Study**

 You are invited to take part in this study on the mental health experiences of Muslim university students, which I am conducting for my Masters of Social Work thesis. I am hoping to assess service providers’ perspectives on the existing barriers and distinct troubles that university students of the Islamic faith face when accessing mental health treatments. I also hope to find out how mental health service providers respond to Muslim students, as well as the skills and treatments they utilize. Moreover, I would like to explore if existing treatments are meeting the needs of Muslim students and how modifications can be made in order to allow for greater cultural sensitivity.

**What will happen during the study?**

This study began with a brief literature review on necessary areas of research, and to provide context for the interview questions. Approximately 6-10 mental health providers who are key informants will be interviewed for this study. One interview with you, as well as with other participants, will likely be an hour to and hour and a half in length. With your permission handwritten notes will be taken, supplemented by an audio recording for transcribing and analyzing the interview findings. The interviews will take place at a location that is most convenient for you. Moreover, if you currently live outside of Ontario or in the United States, the interview will take place electronically via VSEE and will also be audio recorded. VSEE is a secure, confidential alternative to Skype<http://vsee.com/>. The comprehensive interview questions can be found at appendix 3, however a list of sample questions is below:

· Demographic and background information such as age and education

· What is a Muslim understanding of well-being?

· What would help look like?

· How might mental health be conceptualized from an Islamic perspective?

· If needed, how might existing treatments be modified to meet the needs of Muslim clients?

**Are there any risks to doing this study?**

The risks involved in participating in this study are minimal. You may feel uncomfortable with disclosing information regarding your experiences of working with Muslim students. You may find it stressful to answer the range of question. In addition, this research study seeks non-identifiable patient and treatment information, and may be more than the average “minimal” risks. Moreover, you do not need to answer questions that you do not want to answer or that make you feel uncomfortable. I describe below the steps I am taking to protect your privacy.

**Are there any benefits to doing this study?**

 The study has a number of potential benefits to the community, the clients, as well as to your practice when working with this population and others. It will allow you as a mental health provider, to contribute to the scarce body of literature on this underserved population. Moreover, it enables you to assess existing and underlying barriers to the mental health of Muslim students, as well as comment on their distinct troubles, both of which are missing in scholarly literature. In addition, it allows service providers to be more competent in their work and effective in their treatments.

**Confidentiality**

 Every possible measure will be taken to ensure your information is kept private and anonymous. The interview notes and recordings will not be shared with anyone other than my supervising professor and myself. The information you provide will be kept in a password-locked computer where only I will have access to it. Once the study has been completed, the data will be destroyed. Moreover, I will not use your name or any information that would allow you or your clients/community to be identified. As such, pseudonyms will be used throughout the research and write-up process of the research.

**What if I change my mind about being in the study?**

 Your participation in this study is voluntary, thus it is your choice to be part of the study or not. If you decide to be part of the study, you can withdraw from the interview for whatever reason, even after signing the consent form or part-way through the study or up until approximately May, 2015. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

**How do I find out what was learned in this study?**

 I expect to have this study completed by approximately August 2015*.* If you would like a brief summary of the results, please let me know how you would like it sent to you.

**Questions about the Study:**

If you have questions or need more information about the study itself, please contact me at:

|  |
| --- |
| Email: rostomh@mcmaster.caTelephone: (416) 294- 9816 |

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

 McMaster Research Ethics Secretariat

 Telephone: (905) 525-9140 ext. 23142

 C/o Research Office for Administrative Development and Support

 E-mail: ethicsoffice@mcmaster.ca

**CONSENT**

* I have read the information presented in the information letter about a study being conducted by Hager Rostom of McMaster University.
* I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

· I understand that the research data will be kept for a time period of five years, as this research may be used as the basis for future doctoral research that the researchers intends to pursue.

* I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until approximately ***May 31th, 2015.***
* I have been given a copy of this form.
* I agree to participate in the study.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Participant (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please answer the following three questions:***

1. I agree that the interview can be audio recorded.

· Yes.

· No.

2. I agree for hand-written notes to be taken throughout the interview.

· Yes

· No

3. I would like to receive a summary of the study’s results.

· Yes

· No

Please send them to me at this email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or to this mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. I agree to be contacted about a follow-up interview, and understand that I can always decline the request.

· Yes. Please contact me at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

· No.

# APPENDIX 2

# Interview Questions

**Masters Candidate in Social Work**

**Exploring Service Providers’ Perspectives on Mental Health;**

**Muslim University Students**

**Information about these interview questions**: This gives you an idea what I would like to learn in this study.. Sometimes I will use other short questions to make sure I understand what you told me or if I need more information when we are talking such as: “*So, you are saying that …?*), to get more information (“*Please tell me more?”),* or to learn what you think or feel about something (“*Why do you think that is…?”).*

**As part of the interview process I will ask that the professionals abide by their professional code of ethics. I will also reiterate that I am interested in common themes and that practitioners not reveal any confidential information and compromise their professional values**

1. Demographic of participant (implication of practitioner qualities)

· Length of practice*.( I.e. number of years in practice*)

· Gender

· Age

· Scope of practice. (*I.e. who are the clients, presenting concerns)*

· Occupational characteristics. (*I.e., education, specialized training, credentials)*

**Well-Being**

2. What does human well being look like?

3. For students who are not experiencing well being, what does that look like?

4. What does the trouble that Muslim students come to you with look like? (i.e. does culture shape how complaints are made?)

5. What are some, if any, of the limitations of the western model when working with Muslim youth?

· What does a Muslim model of well being offer?

**Response to Students- Treatment**

6. What are examples of the challenges or trouble that Muslim youth come to you with?

è What special problems are Muslims confronted with?

è Have you observed that prejudice or racism impacts mental health? Is there a relationship between prejudice, and mental health struggles?

7. What is the role of the Muslim community?

8. What would just help look like?

9. How do service providers respond to the struggle of well-being?

10. Does the treatment response actually address the well being of their clients?

**Barriers**

12. What are the needs of Muslim youth experiencing mental health concerns?

13. How might one of these concerns be approached differently from an Islamic paradigm vs. a Western approach?

14. How might these gaps be reconciled?

 à How might collaborative working be developed? (I.e. a client wishes to pursue a clinical and religious approach simultaneously)

15. How can existing treatments/treatments be modified to meet the needs of Muslim clients?

16. What dimensions of ill-being do you respond to in the service that you provide

17. Provide recommendations for clinicians to consider when working with Muslims clients.

18. Is there something that’s important that you would like to add?

**END**

Appendix 3

Email Recruitment Script

 Hager Rostom BA, BSW

Masters Candidate in Social Work

Exploring Service Providers’ Perspectives on Mental Health;

Muslim University Students

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Subject line: McMaster Study Participation Request – Exploring Service Providers’ Perspectives on Mental Health; Muslim University Students

Hello, I hope you are doing well. My name is Hager and I currently a Masters of Social Work (MSW) Candidate at McMaster University in Hamilton, Ontario.

I am inviting you to participate in a research study I am conducting as part of my MSW thesis. I am hoping to assess service providers’ perspectives on the existing barriers and distinct troubles that Muslim university students face when accessing mental health treatments. I also hope to find out how mental health service providers respond to Muslim students, as well as the skills and treatments they utilize. Moreover, I would like to explore if existing treatments are meeting the needs of Muslim students and how modifications can be made in order to allow for greater cultural sensitivity.

I obtained your email from name individual/agency, due to your experience working with [Muslim] university aged students in providing them with mental health services.

In addition, it is incumbent upon me to outline possible risks associated with this study. Given that your identity as well the information you provide will be confidential, the risks are minimal. You may feel uncomfortable with disclosing information regarding your experiences of working with Muslim students. You may also find it stressful to answer the range of questions. As such, you may choose to skip any interview questions that you do no want to answer. You can also withdraw from this study any time during the interview and afterwards up to May 2015.

I have attached a copy of a letter of information about the study that gives you full details. This study has been reviewed and cleared by the McMaster Research Ethics Board. If you any have concerns or questions about your rights as a participant or about the way the study is being conducted you can contact:

 The McMaster Research Ethics Board Secretariat

 Telephone: (905) 525-9140 ext. 23142

 c/o Research Office for Administration, Development and Support (ROADS)

 E-mail: ethicsoffice@mcmaster.ca

We would like to thank you in advance for your time and consideration. After a week, we will send you a one-time follow-up reminder.

Hager Rostom, BA, BSW

Masters Candidate in Social Work

School of Social Work

McMaster University, Hamilton Ontario

Tel: 416.294.9816

Rostomh@mcmaster.ca

# Appendix 4: MREB Clearance Certificate https://ethics.mcmaster.ca/mreb/print\_approval\_brian.cfm?ID=3534



|  |
| --- |
| McMaster University Research Ethics Board(MREB)c/o Research Office for Administrative Development and Support, MREB Secretariat, GH-305, e-mail: ethicsoffice@mcmaster.ca CERTIFICATE OF ETHICS CLEARANCE TOINVOLVE HUMAN PARTICIPANTS IN RESEARCH |
| Application Status: New Addendum Project Number:  |
| TITLE OF RESEARCH PROJECT: |
|  |
|  | Faculty Investigator(s)/ Supervisor(s) | Dept./Address | Phone | E-Mail |  |
|  | Social Work | 23789 |  |
| StudentInvestigator(s) | Dept./Address | Phone | E-Mail |
|  | Social Work |  | rostomh@mcmaster.ca |
| The application in support of the above research project has been reviewed by the MREB to ensure compliance with the Tri-Council Policy Statement and the McMaster University Policies and Guidelines for Research Involving Human Participants. The following ethics certification is provided by the MREB: The application protocol is cleared as presented without questions or requests for modification.  The application protocol is cleared as revised without questions or requests for modification. The application protocol is cleared subject to clarification and/or modification as appended or identified below: |
| COMMENTS AND CONDITIONS: Ongoing clearance is contingent on completing the annual completed/status report. A "Change Request" or amendment must be made and cleared before any alterations are made to the research. |
|  |
| Reporting Frequency: | Annual:  | Other: |
| Date: Chair, Dr. B. Detlor  |

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