https://dspace.org/

Exploring the influence of Islam on the perceptions of mental illness of volunteers in a Johannesburg community-based organization.

Khan, Sumayyah

2009-09-08T08:57:57Z
http://hdl.handle.net/10539/7205

Downloaded from a DSpace repository. https://dspace.org/

Exploring the Influence of Islam on the Perceptions of Mental Illness of Volunteers in a Johannesburg community-based organization.

Sumayyah Khan

A dissertation submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in partial fulfillment of the requirements for the Degree of Master of Arts (Clinical Psychology).

June 2009

And almost everyone when age,

Disease, or sorrow strike him,

Inclines to think of God,

Or something very like Him.

-Arthur Hugh Clough

(1819-1861)

DECLARATION

I declare that this dissertation is my own unaided work. It is submitted in partial fulfillment of the requirements for the Degree of Masters of Arts (Clinical Psychology) in the Department of Psychology, University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at any other university or institution.

_____

Sumayyah Khan

30 June 2009

ABSTRACT

The understanding of mental illness is not universal. The way certain conditions are labeled in different settings, and how they are expressed in different cultures, need to be taken into consideration (Swartz, 2002). Current understandings of mental illness are rooted in Western paradigms and fail to incorporate indigenous understanding (Swartz, 2002). It is also argued that religion may play an imperative role in persistent and potentially effective methods of coping for people with mental illness (Tepper, Rogers, Coleman, & Malony, 2001). Stigma is also believed to play an intrinsic role in the perceptions that people within small communities have regarding mental illness as a whole (Mason, Carlisle, Watkins, & Whitehead, 2001). It is possible that the stigma associated with mental illness and towards those suffering from a mental illness may hinder the course of treatment.

Thus this research aims to investigate the perceptions of mental illness in a sample of volunteer counselors, from a specific Johannesburg Muslim community, who volunteer their services at the Islamic Careline. Structured interviews were conducted with 8 counsellors to determine their understanding of mental illness and to establish the role played by the religion of Islam, if any, on the perceptions of mental illness. In addition, whether or not stigma exists within this community and what affects it may, or may not, have on the understanding and treatment of mental illness was explored. Responses were analysed using thematic content analysis.

The findings of this study suggest that one's religious and cultural beliefs play an imperative role in an individual's perception of mental illness. It is also suggested that the values and beliefs held by a specific community may influence an individual's choice of treatment for a mental illness. Furthermore, it is suggested that the existence of stigma within this community towards people with mental illnesses, may also play a role in an individual's perception of mental illness and the route they choose with regards to treatment.

ACKNOWLEDGEMENTS

I would like to sincerely thank the following people:

The volunteer counselors at Islamic Careline for their willingness in being a part of this study, and for sharing their views so openly and honestly.

My supervisor Sumaya Laher for your unwavering dedication, for sharing your knowledge without hesitation, and for your continuous guidance and understanding during this process.

My parents for their patience and for always supporting me in all my endeavours in every way they can.

Mum, thanks for always setting me straight and helping me keep my feet on the ground.

Dad, thanks for always letting me follow my own path, even if you didn't always agree. I hope I've made you proud.

My family and friends for your ongoing encouragement, prayers and love. I really look forward to spending time with you all!

My colleagues, Marie, Tracey, Nicola, Fletch, and Nick, thank you for your unrelenting support and advice even while going through your own trials. I could not have survived this process without you all. Much love to you all.

TABLE OF CONTENTS

Declaration **2**

Abstract **3**

Acknowledgements **4**

Chapter 1: Literature Review **8**

1.1 Introduction 8

1.2 Definition of Mental Illness 10

1.3 Mental Illness and Culture 11

1.4 Mental Illness and Religion 12

1.5 Mental Illness in Islam 13

1.6 Stigma and Mental Illness 19

1.7 Cultural Competence 21

1.8 Volunteerism 23

1.9 Conclusion 24

Chapter 2: Methods **26**

2.1 Role of the Researcher 26

2.2 Research Rationale 27

2.3 Research Aims 28

2.4 Research Questions 28

2.5 Sample 28

2.6 Instrument 29

2.7 Ethical Considerations 31

2.8 Procedure 31

2.9 Data Analysis 32

Chapter 3: Results and Discussion 34

3.1 Understanding Mental Illness 34

3.1.1 Volunteers Perceptions 34

3.1.2 Volunteers' Clients Perceptions 36

3.1.3 Stigma 38

3.1.4 Role of Religion 44

3.2 Etiology of Mental Illness 47

3.2.1 Volunteers Perceptions 47

3.2.2 Volunteers' Clients Perceptions 50

3.2.3 Spiritual Illnesses 53

3.3 Treatment of Mental Illness 56

3.4 Conclusion 61

Chapter 4: Limitations and Recommendations 64

4.1 Limitations of the Study 64

4.1.1 Conceptual Limitations 64

4.1.2 Methodological Limitations 65

4.2 Recommendations for Future Research 67

Reference List **69**

Appendices **78**

Appendix A: Subject Information Sheet 79

Appendix B: Volunteer Counsellors Interview 80

Appendix C: Consent Form (Interview) 81

Appendix D: Consent Form (Recording) 82

Appendix E: Structured Interview Schedule 83

Appendix F: Feedback Sheet 86

Chapter 1: Literature Review

1.1 Introduction

Hayward (1999) suggested that culture shaped the way in which mental illness is expressed and consequently, an individual will manifest and express his/her psychological ailments according to what will be appropriate and allowed in their particular culture. Thus the understanding of mental illness is not universal, the way certain conditions are labelled in different settings, and how they are expressed in different cultures, need to be taken into consideration (Swartz, 2002). The beliefs of people suffering from mental illnesses are key factors in determining the most effective treatment and may influence their clinical outcome (Taylor, 2003). Religious beliefs, for instance, often provide a sense of order and help the individual in understanding what may otherwise seem overwhelming and unpredictable (Carone, Jnr. & Barone, 2001). Muslims, for example, are taught that all misgivings, calamities, hardships, illnesses, etc. occur due to the 'Will of Allah (God)' (Al-Qarni, 2002, trans. 2003).

> "Nothing shall ever happen to us except what Allah has ordained for us."
>
> (Qur'an, 9:51, trans. 2001)

It is also said that;

> "The believers, men and women, are Auliya (helpers, supporters, friends, protectors) of one another…" (Qur'an, 9:71, trans. 2001)

This implies that it is the duty of every Muslim to provide relief and aid to others (Al-Qarni, 2002, trans. 2003).

Often aid provided to others is done so in a voluntary manner and, over the decades, volunteers have proven to be a necessary part of society and play an imperative role providing much needed services to communities (Laher & Moosa, 2007). Community-based health-care facilities are frequently developed and maintained by volunteers from

the community and these organizations tend to be more convenient and accessible for community members. As a result, a majority of communities entrust their health issues in the hands of volunteer health-care workers who are often from their community. This seems to assist the community members in feeling confident in the fact that people from their community will be more understanding, or considerate, of their cultural beliefs.

Many communities appear to be creating an environment that is more educated and are acknowledging mental illnesses more openly and acceptingly at present. However; there has been an immense amount of stigma attached to being labeled as having mental illnesses, and in the past individuals' and their families treated mental illness as a 'private matter'. Historically there has also existed major marginalization based on ethnic, racial, cultural, socioeconomic and religious differences; which have adversely affected the attitudes of mental health professionals and people deserving or in need of services (Arrendondo & Toporek, 2004).

Dinos, Stevens, Serfaty, Weich, & King (2004) explain that stigma defines people according to some distinguishing characteristics and devalues people as a consequence. They go on to say that stigma may play a role in influencing how a psychiatric diagnosis is accepted, whether treatment is adhered to, and how the patient would function or interact in the world (Dinos, et al., 2004). The media has helped demystify many psychological and mental illness issues for the greater public (Borinstein, 1992) but many issues around stigma of mental illness issues still remains. This stigma surrounding mental illness is a key obstacle in providing essential treatment and care for people with mental illnesses (Satorius, 2007). Treatment of one's mental health should be dealt with the same respect and importance as any other health problem.

With this is mind; this study explores the perceptions of Muslim volunteer counselors' perceptions of mental illness. This is done with the assistance of volunteer counselors from an organization known as the Islamic Careline. The Islamic Careline is an organization that follows an Islamic ethos; however, their services are open to all within the community. Their services are focused on social issues, family difficulties; as well as,

mental illness issues. They give support, basic counseling services and referrals where necessary.

In the discussion that follows, mental illness is defined and explored in terms of its conceptualization in various cultures and within the Islamic religion. The role of stigma in understanding mental illness, and its effects on treatment are then explored. This is followed by the definition of cultural competence and the need for it when working in the mental health field is explored. Finally, the role and concept of volunteerism and the role that volunteers in the Muslim community play, is discussed.

1.2 Definition of Mental Illness

Sadock & Sadock (2003) in particular, conceptualize mental illness as being a manifestation of a behavioural, psychological or biological dysfunction in the individual. They define mental illness as a behaviour or psychological syndrome that is clinically significant and which is related to distress or disability (Sadock & Sadock, 2003).

It can be argued though that the term ‘mental illness’ has medical model implications and is perhaps not as ideologically neutral as the term ‘psychological disorder’(Millon, Grossman, & Meagher, 2004). Furthermore, mental illness traditionally connotes severe forms of psychological disorder, such as schizophrenia or mania and does not encompass less severe psychological disorders such as adjustment disorders, anxiety disorders, mild depression, and post-traumatic stress disorders (Millon, Grossman, & Meagher, 2004). However, Jorm (2000) argues that individuals’, who are not in the mental health field, often cannot recognize specific mental disorders or different forms of psychological distress. It has been argued that the understanding of the term ‘mental illness’ amongst layperson’s encompasses both severe mental disorders, as well as, the less severe psychological disorders. Furthermore from the researchers’ experience with the Muslim community in which this study was conducted, the term mental illness is more readily understood and accepted. Hence mental illness is used in this study and refers to all forms of psychological disorders.

As argued earlier, mental illness can be socially constructed and socially defined; that is, different professions, communities, societies and cultures have very different ways of conceptualizing the nature and causes, determining what mental illness is, and deciding what interventions are appropriate. All individuals are influenced in their development by various cultural and personal dimensions of identity (Arrendondo & Toporek, 2004).

1.3 Mental Illness and Culture

Culture can be defined as all the ways of life for an entire society; including, arts, beliefs, manners, dress, language, religion, rituals, and norms of behaviour of a population that are passed down from generation to generation (Sue & Sue, 2003). Furthermore, Hall and Jefferson define culture as being the way the social associations of a group are arranged and shaped; as well as, the way in which those shapes are experienced, understood and interpreted (O'Hagan, 2001). This is further acknowledged by Ruth Benedict's work, as she was one of the first key anthropological figures and whose interest was in the underlying values and ideas that existed within cultures and the relationship between these values and ideas (O'Hagan, 2001). Benedict argued that, "people's responses to situations are more likely to be determined by these underlying values and associated ideas than by any particular stimulus the situation presented" (p. 34). It is also suggested that culture shapes the expression of mental illness and; therefore, it can be argued that an individual may manifest and express their psychological illness in a way that will be fitting and allowed in that particular culture (Hayward, 1999).

Thus, one cannot ignore the role that culture plays on each of these qualities and the fact that mental illness is not restricted to separate aspects of behaviour and experience, but involves "harmonious relationships going across all areas of our functioning" – body, mind and spirit (Marsella & White, 1989, p. 366). One must keep in mind that the expression of these qualities will differ contextually and individually across cultures; however, Sturgeon (2007) argues that the basic qualities remain the same. Throughout time traditional cultures have also considered physical conditions as been related to the emotional, social, and spiritual health of an individual (Sturgeon, 2007). Religion, faith and spirituality are understood as being essential components of one's life experience and

identity (Bussema & Bussema, 2000), and individuals tend to understand and frame the experience of their illness in a more holistic way, including religion and spirituality (Daaleman, 2004).

1.4 Mental Illness and Religion

Religion and other belief systems are often integral to a culture. 'Religion' comes from the Latin *religare* meaning "to bind fast" and it is something that is featured in cultures throughout history and across societies (Boyer, 2001). Religion can be defined as, an institution which has a recognized body of followers who gather together on a regular basis for worship, and accept a set of doctrines which offer some means of relating the individual to what is accepted as the ultimate nature of reality (Boyer, 2001). Religion can also be defined as serving a unique function regarding psychological and social issues and is believed to play an imperative role in assisting with one in coping with these issues (Pargament, 2002).

According to Fallot (1999) and Sturgeon (2007), there is an increased acceptance of religion and spirituality and their potentially positive role in psychiatric rehabilitation and recovery in both clinical and research bases. La Torre (2004) discusses the importance of religious beliefs and spiritual practices in the therapeutic setting. She defines religion as "the outward form, the 'container'", which include one's acts of prayer or worship that give thanks to God. Spirituality; on the other hand, is defined as "the inward activity of growth and maturation" occurring in all of us (La Torre, 2004). These may appear to be two distinct definitions; however, they are interrelated facets that work together in one's search for enlightenment. O'Hagan (2001) clarifies this in his definition of religion, agreeing that it is a multifaceted notion; which refers to, an organized religious group (including many believers some in different religious ranks), the spiritual aspect is explained as the language and practice of one's religion that is seen as sacred, and all-in-all this relates people to their existence and their Creator.

1.5 Mental Illness in Islam

A Muslim community is determined by its religious and cultural values and beliefs because Islam has a definitive model by which its followers are expected to behave according to the Qur'anic teachings and the Sunnah; which is the examples set by their Holy Prophet Muhammad (peace be upon him) with regard to actions and conduct in day-to-day life (Husain, 1998). Every major religion has its own quest for spirituality and wellness; in general the religious quest relates to "the basic human make up, its inner weaknesses, potential qualities, and the need for a set of guiding principles for leading a meaningful life and attaining a healthy state of mind" (Husain, 1998, p. 279).

In Islamic psychology Abu Zayd al-Balkhi was the first to successfully discuss the relationship that the body and soul played with regard to illnesses (Haque, 2004). Al-Balkhi argued that man was constructed from both his soul (Ruh) and his body (Jism); therefore, one's existence could not be healthy without the interweaving of soul and body, furthermore, he felt that, if the body were sick, the *Nafs* (psyche) would lose a great deal of cognitive ability and fail to enjoy life; which could lead to certain physical and mental illnesses (Haque, 2004, Ally & Laher, 2007). Al-Balkhi traced his beliefs back to quotes from the Qur'an and other Islamic teachings; such as,

"Truly, in the body there is a morsel of flesh, and when it is corrupt the body is corrupt, and when it is sound the body is sound. Truly, it is the *qalb* [heart]."

(Sahih al-Bukhari, Kitab al-Iman quoted in Haque, 2004).

He felt that in order to understand mental illnesses one should consider psychological as well as biological factors, as an *imbalance* in either area could result in mental symptoms (Haque, 2004).

Cinnirella & Loewenthal (1999), and Lowenthal, Cinnirella, Evdoka & Murphy (2001) argue that Muslims tend to believe – more than any other religious group – in the efficacy of religious coping mechanisms for mental illness. In Islam, believers often simply refer to 'the will of Allah' and except their illness as such and not turn to professional or any

other form of help (Rack, 1989). However, The Prophet Muhammad (peace be upon him) is reported in one *hadith* to have said; “Utilize medicine O servants of God; verily God has not sent down a sickness except that a cure has also been sent down for it. He who has knowledge of it knows it; he who does not will not.” This suggests that not only is one encouraged to use known methods and medicines, but also that one should be open to all those which can and will be discovered through research and experimentation.

The religious quest of a Muslim incorporates all of the aspects stated above by Hussain (1998) and follows the literal meaning of ‘Islam’, that is, “submission to the will of God” and ‘Muslim’ meaning “one who submits” (Pargament, 1997, p. 44). Traditional psychology argues that the religious quest is an illusion and that spirituality is an expression of more fundamental psychosocial motives and desires, whereas the religious tradition has claimed that psychology has replaced the higher power with the self, and feels that by right the sacred should pave the way for directing one in life (Pargament, 1997). According to Pargament (1997), however, due to empirical studies, psychologists have begun to provide a rationale for treating spirituality as a motivator towards mental illness in its own right. According to traditional Islamic philosophies though, religion and psychology have always being integrated (Fernando, 1991). Carter & Rashidi (2003, 2004) argue that psychotherapists’ understanding and knowledge of the Muslim culture is essential for effective treatment, as a Muslim’s culture is based on Islamic teachings and it permeates their way of thinking, the way in which they interact with the world, and all their daily activities.

Scholars of Islam recognize mental illness as being caused by spiritual conditions, as well as by physiological conditions (Youssef, Youssef, & Dening, 1996). They have linguistically defined mental illness in two broad categories; “The ceasing of a person’s psyche or its corruption”, and “The overwhelming of the person’s psyche by a member of the Jinn (spirit).” Both these definitions are derived from the Arabic for ‘insanity’ or ‘mental illness’; which means “concealment or cover”, whether one’s behaviour is caused by a corrupted physiological or spiritual state the behaviour is recognized by the “concealment” or masking of the normal human psyche exhibited in a person (Youssef, et al., 1996). The belief of spiritual causes of mental illness is rooted in the form of

teachings or messages in the Holy Qur'an (the Islamic Holy Scripture/Book), and it is believed that the existence of everything that is in the Qur'an cannot be rationally disproved (Ally & Laher, 2008).

Individuals of the Islamic faith also believe that spiritual forces influence their lives and it is stated in Ally & Laher (2007) that the Qur'an states that, "I take refuge with the Lord of the daybreak from the evil of what He has created, from the evil of darkness when it gathers, from the evil of the women who blow on knots, from the evil of an envier when he envies" (p. 10). It can; therefore, be said that not only does the Qur'an acknowledge the existence of spiritual forces, but it also provides one with verses that may be used as protection against its effects. In the Islamic faith spiritual illnesses are dealt with by faith healers, the Arabic for which is moulana's, they have widespread knowledge of religious or spiritual illnesses and practice their healing from within an Islamic background (Ally & Laher, 2008).

As mentioned earlier, in Islam a person is conceptualised as being the combination of body, soul, and psyche; which are believed to interact continuously in order to maintain a harmonious equilibrium in the body. Moulana's explain that disease occurs when this equilibrium is interrupted either by natural or supernatural forces, resulting in physical, mental and/or spiritual illnesses that may impact on the individuals' functioning and abilities (Ally & Laher, 2008). Some possible symptoms that have been identified by in Islam (and other religions, and cultures) as spiritual illnesses are lethargy, illness, bad dreams, sadness, anger and voice hearing (Ally & Laher, 2008). These symptoms are similar to those found in certain diagnosis of mental illness.

Moulana's argue that mental illnesses have dualistic causes; they can manifest through natural or biological causes – similar to physical illnesses – however, mental illnesses may also be caused by unseen forces, which moulana's regard as spiritual illnesses (Ally & Laher, 2008). The description of mental illness by moulana's is similar to the definition of academic literature (Ally & Laher, 2008), specifically with regard to the description of mental illness being a demonstration of dysfunctions in one's behavioural, psychological or biological dispositions (Sadock & Sadock, 2003). However, they do

make a distinction with regard to spiritual illnesses suggesting that, although it does manifest physical and psychological symptoms similar to those of a mental illness, it spiritual illnesses differ in the sense that these symptoms cannot be explained through any medical means (Ally & Laher, 2008).

Moulana's believe that mental illnesses are a result of stress, trauma, or chemical imbalances; spiritual illnesses, however, are caused by other people intentionally wanting to make a person suffer (Ally & Laher, 2008). According to Moulana's, spiritual illnesses can be understood in two respects; jadoo (black magic) or nazr (ill will) (Ally & Laher, 2008). This is inflicted onto an individual by another through rituals and believed to be brought on primarily by jealousy. These inflictions of spiritual illnesses are described in holy texts and those people who come from a religious background tend to prescribe to these beliefs (Ally & Laher, 2008). Sufferers of spiritual illnesses turn to God and people in the service of God (Moulana's) in order to relieve their suffering.

A relatively significant body of research has shown that members of a population that regard themselves as religious have less psychological distress, more life satisfaction and greater achievement of life goals (Corrigan, et al., 2003). Recent scientific research indicates that affirming belief in God may contribute to physical and mental illness and that when people call upon faith they activate pathways for self-healing (Syed, n.d., Daaleman, 2004). Religious practices, as a means of coping with persistent mental illness, appear to be quite prevalent (Tepper, Rogers, Coleman & Malony, 2001). Mental health service providers also need to be aware of the integral role that religious practices and beliefs may play in one's ability to cope with or overcome their mental illness (Tepper, et al., 2001). In a study aimed at examining the prevalence of religious coping among psychiatric patients (Tepper, et al., 2001) it was found that 92% of patients reported using a religious activity to help them cope with their symptoms and frustrations or difficulties. Koenig, George & Peterson (1998) also found that more than half of the patients interviewed, for a similar study, reported using a religious belief or activity to cope with mental illness.

The Muslim prayer consists of contact prayer (salaah), remembrance of Allah (zikr), and recitation of the Holy Qur'an. These forms of prayer elicit a physiologic relaxation response; prayer therefore seems to serve as a buffer against adverse effects of stress. The relaxation response may result in lowered blood pressure, heart rate, breathing, and metabolic rate, which yield many long-term benefits in both physical health and mental well-being (Syed, n.d.). Religious faith may provide one with a sense of hope and positive thinking, and may result in a greater motivation to achieve and maintain a healthy mental state (Koenig, et al., 1998).

Bussema & Bussema (2000) referred to Pargament who suggested that using religion as a coping mechanism for mental illness, served five main purposes; **spiritual –** developing a closeness to God, as well as, meaning and hope; **self-development –** gaining control and feeling good; **resolve –** a sense of peace; **sharing –** connecting to one's community; and **restraint –** controlling emotions and behaviours. Religion may provide a framework for understanding mental disabilities and for adding meaning to one's life, it may also provide alternative treatment approaches that help people deal with and understand mental disabilities and may also result in safe and supportive communities where people with mental illness problems may flourish (Corrigan, et al., 2003).

Pargament (1997) also discusses the role of actions in terms of the religious acts themselves, and he cites Pruyser (1968) who stated that "millions of people stand, bend, stretch, fold their hands… per week, with the feeling that these are appropriate, necessary, or prescribed activities of religious value and relevance" (p. 37). Muslims are involved in religious actions throughout most of their day; however, a prescribed and unfaltering act amongst most practicing Muslims is that of the five daily prayers (Salaah) in which one recites the opening of the Holy Qur'an and appeals to Allah to "show us the straight path, and the path of those whom thou hast favoured, not of those who earn thine anger nor those who go astray" (Husain, 1998, p. 285). It is argued that by staying close to God through prayer, and the constant remembrance of God, will result in one's happiness and mental well-being; however, if one angers their Creator, by not engaging in prayer or disrespecting other's, it may be detrimental to their lives and their physical or mental health (Youssef, et al., 1996).

It is acknowledged that often when an individual is faced with difficulty they experience anger towards God, however, the individual usually parallels this anger by pleading with God to remove their difficulty (Bussema & Bussema, 2000). This may often be the case amongst Muslims, as they are taught to completely surrender themselves to Allah, to believe without question that all good and all misfortune that they experience is due to the will of the Almighty (Al-Qarni, 2002, trans. 2003). Muslims believe that throughout life they are tested and challenged by Allah and that one's consistent and unwavering faith will lead them to their reward, which is the gift of Junnah (Paradise) in death.

> "Peace be upon you because you have persevered in patience! Excellent indeed is the final home (Paradise)." (Qur'an, 13:24, trans. 2001)

Islamic texts argue that the event or effect of a mental illness cannot be anticipated or controlled; which would imply that an individual is not responsible for their mental illness and should therefore not be shunned or judged due to their illness, but treated equally. Islam encourages the idea of a 'universal community'; it considers everyone as equal regardless of race, colour, ancestry, or any other exclusivism (Ahmad & Ansari, 1979). Islamic values are aimed at establishing a very moral and practical attitude towards life and the Qur'an asserts that all human beings are equal in the eyes of Allah (God) - there may be differences with regard to abilities, potentials, ambitions, wealth, and so forth but it is believed that none of these can by itself establish a status of superiority (Husain, 1998). Allah recognizes and values piety and righteousness, especially concerning one's fellow man.

> "O ye who believe! Let not a group scoff at another group, it may be that the latter are better than the former… Nor defame one another, nor insult one another by nicknames." (Qur'an, 49:11, trans. 2001)

Despite this, people suffering from mental illnesses often face a great deal of discrimination, judgement, and often feel stigmatized by those in their community. This often leads to the individual feeling demoralized and results in low self-esteem as they may internalize this stigma. This may lead to the individual feeling shame about their

mental illness, which may cause them to keep their mental illness a secret, and may lead to them receiving no support or treatment (Byrne, 2000).

1.6 Stigma and Mental Illness

Stigma is defined as an attribute believed by one person or group, which causes shame to another person or group of people (Mason, Carlisle, Watkins & Whitehead, 2001). It is a negative attitude formed by prejudice and misinformation regarding a specific illness, age group, race group, etc (Satorius, 2007). Furthermore, stigma is defined as a form of prejudice based on negative stereotyping (Byrne, 2001). People experience stigmatization as a result of having a different personality, their physical appearance, illness, disability, age, gender or sexuality (Mason, et al., 2001). When an individual is seen as being different from the norm in society, they are often targeted and experience stigma by being ignored, rejected from social interactions, or they are labeled and picked on. A study by Crisp, Gelder, Rix, Meltzer & Rowlands (2000) concluded that negative attitudes towards those with mental illnesses overemphasized the sufferer's social handicaps; such as, social isolation, distress, employment difficulties, etc. that can go along with their mental illness leading to added stigmatization. It is believed that the emotional pain caused to another due to stigma is associated with their own pity, fear, disgust or disapproval of the differences between them and the person they stigmatize (Mason, et al, 2001).

There are numerous historical, religious, ethnic and cultural influences regarding stigmatization, with Western societies having always associated ideas of decency and virtue with health and rationale, which has lead to the continuation of stigma towards mental illness (Byrne, 2001). Regardless of scientific progress and the rise of the medical model, stigma is still very apparent (Byrne, 2001). The cultural definitions for stigma are often related to what is seen as acceptable or not within a specific cultural group. People suffering from a mental illness are often perceived as straying from the social norms and are viewed as inferior to the group at large (Mason, et al., 2001). They are often excluded from social activities as they are viewed as being different in a way that is unwanted by society. This presence of stigma and social exclusion often leads to the stigmatized person having lowered self-esteem and self-confidence, which - in the case of mental

illness – can often lead to relapse if in remission (Satourius, 2007). However, stigma is viewed as having a negative affect at every point of mental illness whether it is presentation, diagnosis, treatment or outcome (Byrne, 2001).

This may be due to the fact that all individuals in every culture have a pool of knowledge and attitudes used to tackle problems in their own lives, their family members, and their friends' lives that are entrenched in their upbringing (Pescosolido, 2007). These beliefs, values, and norms form a cultural atmosphere in which all those within it experience the onset of mental illness, and determine the choices they make regarding seeking advice and choosing mental illness treatment (Pescosolido, 2007). It is argued that stigmatizing attitudes are rooted very deeply in one's upbringing, making it difficult to change such complex cognitive behaviour and may have an effect on how one deals with their own mental illnesses (Mason, et al, 2001). Byrne (2000) believes that negative attitudes towards people with mental illness begin when a child is at playschool and endures into their adulthood. Research regarding this belief confirmed that the same prejudices were maintained among the same group of respondents when asked the same questions eight years later (Byrne, 2000). Other research done in a similar regard argued that, although, one's perception of mental illnesses seemed to change and they had a better understanding of the causes and forms of the illnesses, it still does not seem to change their attitudes or reduce the stigma around mental illness (Byrne, 2000).

Feeling discriminated against or stigmatized may also be why patients from traditional communities often enter into formal mental illness care as a final resort. Only after using alternative treatment courses; such as, advice from family and friends, faith healers/ hakims/ moulanas/ or the appropriate person that operates within their cultural group (Chambers, Drinkwater, & Boath, 2003).

It is argued that stigma connected to mental illness is the main hindrance to being able to provide adequate care for people suffering with a mental illness (Satorius, 2007). In order for delivery of mental illness services to be effective, they need to be sensitive and accommodating to cultural and religious values (Marsella & White, 1989, Bhui, Warfa, Edonya, Mckenzie & Bhugra, 2007), as well as, be aware of the assumptions and

generalizations that may exist within a community (Byrne, 2000, Corrigan, et al., 2003). One needs to be culturally competent to the effect that they are able to acknowledge, accept, and value the cultural and religious differences of others (Bhui, et al., 2007). Research suggests that mental health professionals who exhibit a genuine interest in their clients' cultures or behave in culturally relevant ways are perceived as more trustworthy, credible and competent by their clients (Arrendondo & Toporek, 2004).

1.7 Cultural Competence

Cultural competency is defined as one's ability to work within a community or culture different to their own, but observe a respect and understanding for that community and their cultural beliefs and practices (Bhui, et al, 2007, O' Hagan, 2001). It is believed that cultural competency is a core requirement for mental healthcare workers, who provide services to culturally diverse patient groups (Bhui, et al., 2007). Often people are not willing to engage in treatment that is foreign to their cultural upbringing and it is important for the mental healthcare workers to understand where the individual is coming from in order to help them accept alternative treatments and in order for them to be able to engage better with the patient. Sue and Sue (2003) define a culturally competent counsellor as one who works towards three integrated goals. Firstly, it is someone who is actively working towards becoming aware of their own perceptions regarding human behaviour, values, biases, etc. Second, they are actively and continuously attempting to understanding the worldview of their culturally diverse patients, and lastly, they are continuously looking for or developing new ways of treating these patients in a way that is culturally sensitive (Sue & Sue, 2003).

Occasionally beliefs and psychological defenses that may occur in the process of dealing with an overwhelming illness may be a barrier to perceiving and considering alternatives (Roberts, 2002). Therefore, cultural and religious values play an important role when one is deciding to volunteer their services to an organization or group of people. A patient and a health worker, ostensibly belonging to the same ethnic group, may actually differ in terms of social class, religious practices, languages, and cultural beliefs about illness and recovery (Bhui, et al., 2007). One's spiritual values and deeply held personal beliefs

related to their unique life experiences may also alter what is understood to be possible and acceptable for an individual (Roberts, 2002).

Many religious houses; such as, churches, mosques, synagogues, etc. offer pastoral counseling, which is counselling done by a religious leader (pastor, moulana/ imam, rabbi, etc.). This form of counselling is offered to the religious leaders' community members, and it was reported that the majority of issues addressed are severe mental illness, substance abuse, marital disputes and family problems (Young, Griffith & Williams, 2003, Ali, Milstein & Marzuk, 2005). The counseling in these cases were done individually and in groups where they discussed experiences, coping skills, and the treatment usually involves or taps into the counsellors religious understandings (Young, et al., 2003, Ali, et al., 2005). Although, the religious leaders in both these articles had little formal training they acknowledged that people preferred bringing their difficulties to them, as they feared being discriminated against by the community or professionals that they felt would not understand their backgrounds (Young, et al., 2003, Ali, et al., 2005). This supports the argument that individuals tend to turn to people who understand their cultural or religious worldviews to assist in mental illness difficulties.

Bhui, et al. (2007) argue that in order to provide culturally competent care, knowledge of cultural beliefs, values and practices is necessary otherwise it may result in inappropriate management and poor compliance. Although volunteer counsellors are not always required to be from the same community, it is often viewed beneficially if one is from the same or similar background (Kashyap, 2004). Certain cultures create systems that define what is viewed as a psychological problem or what causes mental illnesses; therefore, it is helpful to either come from the same cultural background or have an understanding of that cultures belief systems regarding mental illness (Bond, 1993). Individuals who choose to volunteer their services in the mental health field need to act according to one's authentic sense of what is good, right, and best in light of one's situation, and values (Roberts, 2002).

1.8 Volunteerism

A volunteer or lay counselor is someone who works for the community primarily because they chose to do so (Kashyap, 2004). The word volunteer comes from Latin and can be translated as, doing something out of one's own free will (Bond, 1993). Volunteering is something that can be done as part of a non-profit organization and that is often viewed as official volunteering; however, people also chose to volunteer their services in times of crisis on an individual or group basis (Kashyap, 2004). A volunteer receives no monetary or other form of compensation for their services, other then being reimbursed for money that they may have spent for the services rendered (Bond, 1993).

Volunteer services exist throughout the world; they work within communities, obtain the services of people from that community and serve the needs of that specific community (Kashyap, 2004). Volunteer counselors are trained to serve those specific needs within their community, having their services helps with the shortage resources as organizations are using people from within who are readily available and are in the community (Bond, 1993). It has been found that people find it easier to associate with or confide in people from their own community who recognize their cultural values and are aware of their diversity (O' Hagan, 2001).

The Islamic Careline is a community-based, non-profit organisation that depends largely on the services of volunteers to assist in running its telephonic and one-to-one counselling services (Laher & Moosa, 2007). This organization works within the premise that people from within the community can work towards alleviating certain mental illnesses, as they are from the same community and understand the people who utilize the services at a deeper level and are wanting to give something back to their community (Laher & Moosa, 2007).

Islamic teaching prescribe, through verses from the Holy Qur'an and by the example set by the Prophet (PBUH), that in order to appease one's own distress and hardships, that one should show kindness to others and that this will lead to one finding solace and comfort (Al-Qarni, 2002, trans. 2003). The Prophet (PBUH) stated; "give to the needy,

defend the oppressed, help those in distress, and visit the sick: you will find that happiness surrounds you from all directions" (Al-Qarni, 2002, trans. 2003, p. 37). Thus, it is an important factor in the life of a Muslim to provide assistance to those within their community that requires it.

It is therefore not surprising that a number of the volunteers at the Islamic Careline felt that counseling at the Careline was for the pleasure of the Almighty (God). Others reported counseling as a way of giving back to the community, they also reported experiencing an internal fulfillment from the work they did and felt that playing a role and having a positive impact on someone's life was worth it (Laher & Moosa, 2007). This suggests that their cultural and religious values influence their decisions for voluntarism (Roberts, 2002). It also suggests that their religious and spiritual beliefs may play a role in their interactions with and understanding of the clients they engage with and their mental illnesses. It also emphasizes that in order to provide the best care for people with mental illness that addressing religious and cultural beliefs is an imperative factor (Young, et al., 2003).

1.9 Conclusion

Perceptions of mental illness tend to differ across communities, cultures and religions. This study aims to determine whether or not one's religion plays a role in determining these perceptions of mental illness. The researcher is also looking at the role that one's cultural competence may play in assisting individuals' with accepting or understanding their mental illness and seeking out appropriate treatment. The study attempts to do this by focusing on individuals from the Muslim community, who volunteer their counselling services to the community. By so doing, the researcher hopes that the study will provide an understanding of the perceptions of mental illness within a Muslim community, through the experiences of Muslim volunteer counselors who live and work within the community. Furthermore, the researcher anticipates that the Muslim volunteer counsellor's will be able to shed some light on whether or not stigma and discrimination

towards people with mental illnesses does exist within the Muslim community. Their insight may also shed some light on the possible impact stigma may have on willingness of people from the community to seek treatment or assistance with their mental illnesses.

Chapter 2: Methods

2.1. Role of the Researcher

As a researcher one declares moral and scientific authority, using texts to function as sources of validation for an empirical discipline, showing that the world of real, lived experiences can still be taken into account (Denzin & Lincoln, 2003). Many psychological approaches require the researcher to be open about their personal viewpoint with regard to their research, which requires them to be self-reflexive and reveal their preconceptions and expectations of their research (Uzzell & Barnett, 2006). Therefore, it has to be emphasized that this research is a study about Muslim perceptions, conducted by a Muslim researcher. Acknowledging this gives rise to many queries and may instantly lead to many implications and hypotheses. However, it should be taken into consideration that if the role of the researcher, in any field of study, is that of someone in search of understanding their environment better through the use of meticulous scientific research methods, as asserted by Rosnow & Rosenthal (1996), then it can be said that this is exactly what the researcher in this study hopes to do. Not only does the researcher hope to gain a better understanding, but it is intended that the reader of this study also begins to understand and consider the various issues that will be discussed. As a Muslim, the researcher in this study could be seen as having a vested interest in the chosen topic, and although this fact cannot be ignored, it should also be remembered that as a researcher, the need to search for information and increase understanding plays an equally significant role. Although, the researcher recognizes that she may expose her own preconceptions, it is also acknowledged that it is none-the-less important in order to allow others to interpret the data and explanations that are ultimately presented (Uzzell & Barnett, 2006).

2.2 Research Rationale

Mental illness can be seen as a composite of both healthy and unhealthy elements of emotion, cognition, perception, and sensation (Schumaker, 1992). Although the major cultural groups have influenced each other over time and continue to do so, it has to be remembered that each cultural group has its own set of values and beliefs that differ from others and which also influence their particular worldview and in turn, their specific understanding of mental illness (Fernando, 1991; Swartz, 2002). This may be determined by cultural teachings, religious doctrines or social expectations. Tepper, et al., (2001) argue that religion may play an imperative role in persistent and potentially effective method of coping for people with mental illness.

The researcher hopes that this study will be beneficial at determining the role that religion may or may not play with regard to Muslim perceptions of mental illness. The study is also interested in establishing how important the ability to be culturally competent is to both the volunteer counselor's and the patients they encounter. O'Hagan (2001) argues that cultural competence should be an aspect of every health professional's training, including mental health care workers. He believes that developing the ability to respect and understand others cultural diversity enhances one's treatment capabilities (O'Hagan, 2001). Furthermore, volunteer services are an imperative part of the community and contribute greatly to healthcare, however, research into aspects of volunteerism is limited (Laher & Moosa, 2007). The experience of the volunteer counselors are, therefore, the focal point of the study, looking at and the role they play within the Muslim community, and by focusing on the way in which they perceive mental illness.

The researcher focuses on a specific volunteer-based organisation in order to gain insight into the perceptions of mental illness from people who are working within the mental health field, who are Muslim and who interact with Muslim community members. Due to their background and the community they work in, it can be argued that they have insight into the influence that Islam may or may not play on their own and their clients' perceptions of mental illness. It is also suggested that stigma and discrimination towards people with mental illnesses is rife within smaller communities (Mason, et al., 2001).

This is believed to be due to the larger community experiencing people with mental illnesses as being socially unacceptable and inferior to the rest of the community. In view of the fact that the volunteer counsellor's appear to be so closely connected to their community, the study anticipates that the volunteer counsellor's would be adept in sharing possible causes for stigma that may exist within their community regarding mental illness and towards the mentally ill.

2.3 Research Aims

The aim of this research is to investigate the perceptions of mental illness amongst a group of volunteer counsellors in a Muslim community-based organization, based in Johannesburg. It also aims to establish the role played by the religion of Islam, if any, on the perceptions of mental illness.

2.4 Research Questions

The focus of this study is based on the following questions:

1. What are the perceptions of mental illness amongst the volunteer counsellors in a Muslim community-based organisation?
2. What influence, if any, does religion play on these perceptions of mental illness?

2.5 Sample

A convenience sample of 8 female volunteer counselors was obtained. The sample was all female as this community-based organization has only female volunteer counsellors. The volunteers are also all Indian and the organization disclosed that the majority of the patients they encounter are also from an Indian background. The volunteers who participated have all received basic counseling skills training provided by the Islamic Careline. They also received training focused on marital or couples counseling, substance abuse counseling, trauma counseling, child and adolescent counseling. However, their ages, levels of education and the number of years they have participated in the field of counseling, varied as evidenced in Table 2.1. The participants' ages ranged from 29 to

52, with some having completed high school, to those who had continued studying at a tertiary level, including one who had received a Masters degree. Some participants have a background in psychology, whereas, others were trained only at the Islamic Careline. Therefore, there were participants who had volunteer counselling experience from as little as 3 years to a founding member of the organization who has been involved in volunteer counseling for over 22 years.

All counselors who were interviewed are on counseling duty at the Islamic Careline once a week for approximately four hours. Some of the participants were also full time staff who not only counselled, but also assisted in the daily running and administration of the organization. All volunteer counselors receive supervision regarding the clients they counsel, from senior staff members who include social workers and a clinical psychologist. Once a month all the volunteer counselors and staff members meet to have a group debriefing and discuss current difficulties being experienced, and to discuss solutions.

Participants	Age	Education	Years as a Volunteer Counsellor
V1	29	Matric and Computer courses	3 years
V2	52	Std. 8	14 years
V3	48	Matric, BSoc Sc (Psychology), MA Islamic Studies	22 years
V4	32	Matric	8 years
V5	33	Matric, BA (Psychology)	4 years
V6	39	Matric, Montessori Course, Psychology Courses	12 years
V7	39	Std. 8	7 years
V8	40	Matric, BA (Psychology), HR Diploma	10 years

Table 2.1

2.6 Instrument

A structured interview schedule was used in this study. This method included open and closed ended questions allowing for a greater variety of answers and more detailed responses (Stark & Roberts, 2001; Smith, 1981). This also allowed for some direction for

the respondents to follow, resulting in specific answers required for the study; as well as, giving them the opportunity to express their individual beliefs and feelings (Stark & Roberts, 2001; Neuman, 1994). The broad descriptions produced by this type of instrument also provided the readers with the ability to understand more acutely the persons and perspective being studied (Dalton, et al., 2007). In addition, this instrument provides the researcher with the opportunity to obtain clarification and elaboration from the participants to certain responses, if needed (Dalton, et al., 2007).

Furthermore, the questions were structured/formulated according to the relevant theoretical aspects that have been discussed in the literature review (Stark & Roberts, 2002; Willig, 2001). The interview looked specifically at exploring individuals' perceptions of mental illness and the possible role that their religion and beliefs may have on influencing these perceptions. Thus questions on Islamic teachings from the Qur'an with regard to the treatment of others and on the role that prayer plays in the lives of these individuals; the existence of the belief in the omnipotence of Allah (God), and whether or not the respondents believe in the psychological, as well as, the spiritual treatment of mental illness problems were included.

The questions aimed to understand and/or gain insight into the possible perceptions of the volunteer counselors at The Islamic Careline, with regard to mental illness, and to establish whether or not they feel that religion plays a role in their perceptions[1].

A pilot study was conducted, firstly with the participation of the researcher's supervisor, who is Muslim and works in the field of psychology. Secondly, three Muslim psychology students, who all live within the same Johannesburg Muslim community that the research would be conducted, volunteered their participation. The pilot study was done in order to assess the relevance of the questions chosen for the structured interview schedule. In addition, the pilot study was done to evaluate the applicability of the study within the chosen community. And furthermore, the pilot study enabled the researcher in obtaining an estimated length of time of the interviews that had been structured. It was found that the study and the questionnaire were appropriate for the chosen sample group. The findings also suggested that the interviews would be between 45 minutes to 1 hour.

2.7 Ethical Considerations

The researcher obtained ethical approval from the Human Research Ethics Committee (Non-Medical) of the University of the Witwatersrand (Protocol number, MCLIN/06/013 IH). Participation in the study by the volunteer counselors was completely voluntary. Immediately prior to the interview the participants were reminded of the purpose of the study and given the opportunity to not participate if they wished, they were also reminded that they could stop the interview or refuse to answer any questions at any time during the interview (Willig, 2001; Stark & Roberts, 2002; Mouton, 2001). The researcher then provided the participant with informed consent form; which consisted of two parts, the first was to obtain consent to participate in the interview[2], and the second was consent to have the interview audio-recorded[3] (Willig, 2001; Mouton, 2001; Smith, 1981). Before signing the forms, the participant was informed that the only people who would have access to the audio - tape would be the researcher and the researcher's supervisor.

The participant was also informed that the tapes would be destroyed after the required information was obtained and the research report was completed. The participants were assured that confidentiality would be completely maintained at all times and that no identifiable information would be included in the research report. The participants would be referred to by pseudonyms e.g. V1, V2, etc. allowing for the respondents privacy, anonymity, and confidentiality to be completely preserved (Stark & Roberts, 2002; Mouton, 2001; Smith, 1981). Once the participants agreed to the terms of the interview process, they signed the consent forms, which were returned to the researcher. The participants also received feedback in the form of a one-page summary of the research findings, once the research report was completed.

2.8 Procedure

Permission was requested, by the researcher, from the directors of the organization at which the study wished to be administered before approaching any of the potential interviewees. The researcher also obtained permission to use the name of the organization in the write up of the study. An information sheet was made available to all possible

volunteers via the internal mailing system at the organization[4]. This was used to inform the volunteer counselors of the purpose of the study and to request their assistance and participation.

The volunteer counselors that were willing to participate then left their names and contact details with the receptionist at the organization. The researcher made contact with the receptionist to obtain the information regarding the participants. The participants were contacted telephonically, and a convenient time and place was agreed upon. It was determined that the best option was to conduct the interviews at the organization itself when the relevant participant was on duty. The researcher booked an appointment for each participant via the receptionist. The interviewer explained the nature and procedure of the study to the interviewee again prior to conducting the interview. The interview was conducted as per the structured interview schedule[5]. The interviews were recorded, and later transcribed and analyzed.

2.9 Data Analysis

After the interviews were completed and transcribed, the data was organized into broader themes and relevant issues. The data was analyzed through the use of thematic content analysis, which is a well-developed and widely used method of analysis in the social sciences (Dixon-Woods, Agarwal, Jones, Young & Sutton, 2005, Mayring, 2000). Such analyses essentially produced a qualitative description of the data gathered, giving an evaluation of the content; which allowed for exploratory purposes as needed for the proposed study (Neuman, 1994). Thematic content analysis is primarily used for examining written information and identifying the themes that appear therein (Neuman, 1994). It involves the identification of prominent or recurring themes in the text, then summarizing the findings under thematic headings (Dixon-Woods, et al., 2005).

Thematic content analysis is a means of standardizing, and comparing the obtained data into understandable information and highlights relevant issues (Henning, 2004). It is a flexible means of analysis that allows significant freedom to researchers and is a way of integrating qualitative and quantitative evidence (Dixon-Woods, et al., 2005). The main

idea of the procedure is, to formulate a standard of classification, which is derived from abstract conditions and a research question, and it determines the aspects of the textual material taken into account (Mayring, 2000). Following this standard the information is worked through and categories are tentatively and gradually deduced, these categories are then revised, ultimately reduced to main categories and checked in respect to their reliability (Mayring, 2000).

The study used a five-phase analysis (Mayring, 2000); firstly, the researcher had to familiarize her self with the data; which required the researcher to repeatedly read over the data searching for meanings and patterns, and taking notes or marking ideas that would be used in the next phase. Secondly, the researcher had to go through the data identifying initial lists of ideas that seemed interesting and then organize those lists into as many meaningful groups as possible.

The third phase was to re-look at the groups organized in the previous phase and sort that information into broader levels of themes, this required analyzing the groups and fitting them into overarching themes (Mayring, 2000). The researcher had to consider the relationship between the groups and between the themes, in order to create the main themes and sub-themes. The researcher then went on to review the themes created in the previous phase and refine them into themes that have enough data to support them. The researcher also pulled together what seemed to appear as separate themes into one succinct theme. The final phase was to define and fully refine the themes that would be presented in the report. This meant determining what aspect of the data each theme captures (Mayring, 2000).

Chapter 3: Results and Discussion

The information obtained from the interview material; regarding perceptions of mental illness of volunteers in a Johannesburg Muslim community-based organization, resulted in three broad themes or categories; namely, understanding of mental illness, etiology of mental illness, and treatment of mental illness. The process also resulted in a number of sub-themes; which will be discussed in further detail below under each category.

3.1 Understanding of Mental Illness

3.1.1 Volunteers Perceptions

From the volunteer counselors who were interviewed, 80% defined mental illness as an "emotional imbalance" (V1, V2, V4, V5, V7, V8)*. V1 explained that she understood mental illness, "In terms of what we see here at the Careline, I would say its people with emotional imbalances". V4 explained her understanding by saying, "mental illness can look very, very normal and healthy… but emotionally you're not well… when you look at them they look normal, but inside they're really fighting a battle." The participants seem to hold the belief that people with mental illness may not always have symptoms that are outwardly recognizable, however, they all tend to feel that it is an emotionally overwhelming experience for the person suffering with a mental illness. Three participants also described a mental illness as being something that one "feels" and that it "cannot be seen" (V4, V7, and V8) unlike a physical illness. V7 described mental illness as, "something that is very difficult to deal with because nobody knows or sees it – you feel it." It appeared that all respondents felt that people suffering with a mental illness struggled to verbalize what they were going through.

Furthermore, the participants explained that this lack of being able to verbalize what they were experiencing due to their mental illness made it "difficult for an individual to cope"

(V6, V7) or “function normally within society” (V3, V4, V5, V8). V4 elaborated this point by saying, “diagnosed people… they have to force themselves to do things, they have to force themselves to get up in the morning.” V5 described someone with a mental illness as being, “somebody that’s not functioning to the optimum level within society” and that their illness, “stops them from reaching their full potential.” The responses suggest that many of the participants found that their clients; suffering with a mental illness, were not only ostracized by their community, but also – to a certain degree – it was self-inflicted. It appears that many of the clients at the Careline, struggled with experiencing daily negative encounters and; therefore, not only cut themselves off from social activities, but any activities outside the home. Wilson (1998) confirmed that when an individual is suffering from a mental illness and they experience emotional instability, they also lose the motivation or drive to do anything. The consequences for many people suffering from a mental illness are that they usually have damaged interpersonal, social and occupational functioning (Sadock & Sadock, 2003). This would result in the client not only suffering emotionally and socially, but financially as well.

Some participants went on to describe an individual with a mental illness as someone who displays, “uncontrollable” and “unpredictable” behaviours (V2), or that there were negative “changes in their behaviour” (V5 & V8). V2 elaborated by saying, “…you never know what the person is going to be like from day to day.” V5 felt that a mental illness becomes visible to those, “that are close to you… they’ll be able to pick up the signs… that something’s wrong.” It is a known fact that clients suffering from specific mental illnesses sometimes experience particular symptoms; which cause them to act in ways that are different to the individual’s typical way of functioning. It stands to reason that changes in someone’s usual behaviour will be detected by those the person is in daily contact with, as they are familiar with the person’s typical way of behaving. From the responses gathered it also seemed that many respondents felt that people were afraid of these changes in behaviour as they did not have any idea how to gauge what the person’s behaviour would be like on a day-to-day basis. This understanding can be linked to the definitions of mental illness discussed earlier, which include behavioural changes or dysfunctions (Taylor, 2003, Sadock & Sadock, 2003). These behavioural changes are

viewed as causing distress not only to the person experiencing them, but those close to them as well, usually due to a lack of understanding about mental illness.

3.1.2 Volunteers' Clients Perceptions

When enquiring about what the participants found were their clients understanding of mental illness, the majority of the volunteer counselors stated that a large number of their clients *deny* that they are suffering from any form of mental illness. The participants felt that the clients they encounter seem to find it easier to *blame their illnesses on others*, saying that people are j*ealous* of them. V1 stated that most of the clients she encountered, "don't want to talk about it (mental illness)" and she felt that they could be in denial of their actual problem. V2 was very honest in stating that, "there's very few (clients) that believe they have a mental illness" she went on to say, "I don't know if it's the patient's themselves or if it's their family members that are in denial." These responses seem to suggest that the clients and their family's find it difficult to acknowledge the existence of a mental illness, due to the attitudes or perceptions of their community. They seem to find it more acceptable to blame their illnesses on others, rather than admit to having a mental illness.

V3 felt that with the clients' she encountered that, "mostly it's blaming others" for their current state of mind and she felt that the role of counseling was to help the clients' take responsibility and that it was a process of them, "learning to accept their problems and try to look for solutions by themselves." In V7's experience she found that most clients, "blame it on their spouses… and they will seldom admit to having a mental illness… they are just so against even the thought of it." It appears that due to the clients' need to deny that they are suffering from a mental illness, they tend to wait until the very last, unbearable stages of their difficulties before seeking therapeutic assistance. This also suggests that the longer the client resists seeking help, the longer they can consider other explanations for their symptoms, allowing them to still feel accepted within their community.

Taylor (2003) discusses the social reaction to individuals with mental illness and believes that this reaction is vital to the way in which the individuals themselves feel about or deal with their diagnosis. He explains that often family and friends accommodate for, or even tend to deny, behaviours that may appear to be strange or problematic, and can do this for a long period time as they are reluctant to acknowledge that their partner or relative is mentally ill (Taylor, 2003). This response and denial of the individuals' illness may in turn make it more difficult for the individual themselves to acknowledge or accept a diagnosis of mental illness, as they would not be aware of their problematic behaviour as it has not been pointed out to them over time.

The researcher went on to enquire further regarding the participants' clients understanding of mental illness. The participants explained that many clients believed they were being inflicted by *spiritual illnesses* and that "often they (clients) come in stating jadoo or nazr" (V2, V3, V4, V7, V8) as their understanding of what they are experiencing. These beliefs stem from the client's feelings that people in their community were jealous of them and they felt that people used spiritual means to make them ill.

V2 stated that she had many clients who, "come in and say that someone did jadoo or nazr or something like that." It was clear from V5's response that many client's were quick to, "blame the person they are having problems with, and they claim that the person has done something to them, like put nazr or something, to make them feel that way or been upset or depressed or whatever." Jadoo and nazr are Islamic terms for types of witchcraft, usually done by people who are jealous of another and results in making their victim behave bizarrely or experience some ill health (Ally & Laher, 2008). This belief of jealously as being the motive is corroborated by V6's response that, "they talk about jadoo, jinn, you know things like that… it's usually them thinking that someone is jealous and they have done this to them."

Although many participants felt that there were some clients who truly believed and understood that their mental illness was coming from a spiritual place, this is not always the case and several participants believed that the majority of clients who claimed they were experiencing a spiritual illness were using it as an excuse in order to deny their

actual mental illness. The participants felt that instead of acknowledging that they (the clients) were experiencing a mental illness they find it easier to claim that someone else is "doing something to them" and that it is "jadoo or nazr" (V1, V2, V3, V4, V5, V6, V7, and V8). V8 states, "I mean you can't deny that this (spiritual illness) happens, it does but I think some people are more prone to using spiritual illness as a crutch instead of trying to help themselves or realizing that, or delving into the real cause of what it is. I mean some people… they just blame it on someone doing something to them, but it might really be a physical or mental ailment."

3.1.3 Stigma

Many of the participants felt that the reason the clients they encounter find it easier to claim that they are experiencing a spiritual illness or blame their illness on others; rather then admit to be suffering from a mental illness, is due to the *stigma* and discrimination that is widespread towards people with mental illness within the Muslim Indian community. Furthermore, responses from participants seem to suggest that a physical illness is more socially acceptable than a mental illness. V4 stated, "with Muslims or Indians, in general, people don't empathize as much as they do if they see a physical illness." V4 clarified this point by saying, "I think a physical illness, especially in our society, people if they can see you're sick… they can understand… mental illness is very difficult to explain to someone." The participants seemed to agree that there was a lack of understanding within their community with regard to mental illness.

From the responses received it appears that the majority of people living and working within this community feel that mental illness is not an easily accepted diagnosis. Physical illness seems to be much more easily acknowledged within the community, as most physical illnesses are one's that people are familiar with, they can recognize the illness, and they find physical illnesses easier to understand and to empathize with. They appeared to feel that the clients they interacted with faced a daily battle with regard to their ability to voice their difficulties and distress due to the negative attitudes held by people within their community. Wilson (1998) expresses how individuals, suffering from certain mental illnesses, tend to withdraw from those around them and decrease their

social interactions. In addition, he explains that one's affective expression and sensitivity are significantly altered; which results in them becoming emotionally unstable, this could work either way with the person becoming increasingly emotional or they could lack any form of emotional expression (Wilson, 1998).

When the participants were asked about the existence of stigma around the understanding of mental illness in their community 80% claimed that it was *rife* within the Muslim community. V1 was quite adamant saying, "stigma is very much still there. There's still that concept that if you're getting counseling then there's something wrong with you." She seemed to be implying that people were shunned if it was revealed that they were receiving counseling, when queried the participant agreed that this was true.

It is argued that the barriers created by discrimination and prejudice result in people feeling they have to hide their illness in order to not be socially excluded (Benjamin, 2001, Lauber, Carlos & Wulf, 2005). This in itself can add to one's mental illness, as they will constantly be experiencing stress due to the fear of being discovered as mentally ill. It is apparent from the responses that the attitude of one's community can often affect the clients' willingness to seek treatment and their ability to socially interact. The fear of being stigmatized or discriminated against may also deter individuals with symptoms of mental illness from even acknowledging that something is wrong and seeking help (Komiti, Judd & Jackson, 2006). This would explain why the majority of participants found that their clients eventually seek help when they are in the dire stages of their illness. As well as, why it takes such tremendous effort to acknowledge that they may have a mental illness.

V2 plainly expressed that, "our community, you know, they have this, uh, embarrassment and they can't come forth with their children" who are mentally or physically ill. She compared the behaviour of people from Muslim Indian communities to those from, "the European community, for example, I know we generalize, but you will see if they have a child with any sort of challenge, physical or mental, *anything*, they will… take them everywhere with them. In our community they will keep them with the maid at home!" It appears that even family members feel the brunt of social stigmatization and believe that

their relative who is suffering from a mental illness is in some way inferior or socially unacceptable.

V3 quoted statistics saying that over 90% of clients enquired vehemently about confidentiality before beginning counseling and who would be seeing them, as many of the volunteer counselors could be from the same neighbourhood as them and they may even know them personally, she added that, “they try to protect themselves… they are aware of the stigmatization so that is why they have this need to, to ensure that the service is completely confidential.” V3 explained that they often ask the individual which area they are coming from and will then advise them to come on a day when there are volunteer counselors available who are not from the same area. Some of the participants believed that many people within the community who were suffering from a mental illness masked their illness as best they could for as long as they could. It seems that there are many cases of people being negatively labeled due to their bizarre behaviours or because it was known that were receiving treatment for a mental illness. Taylor (2003) explains that when people’s behaviour does not meet the expectations of others they are often negatively labeled, usually due to ignorance.

Many of the respondents felt that people in the Muslim Indian community *lacked education* about mental illness; which resulted in them discriminating against people with mental illness, and being unable to seek appropriate help when they are experiencing problems they don’t comprehend (V2, V3, V5, V7). V2 expressed her views saying, “I think our community or society is learning to accept it (mental illness) but there’s still a lot of them in denial… Education I think, even in the Islamic perspective, education will help. People need to know and understand.” V3’s response supported this viewpoint, “I think there is a lack of understanding of mental illness within our Muslim community… and I think that if people understand that it is an illness and that people are trying to get help for themselves then there won’t be that skeptical about it, and in that way I think we’ll lessen the stigma about it and discrimination against it.”

Like V2, V5 also felt that people are becoming more open to the idea of mental illness, she felt that having organizations like the Careline in a Muslim community assisted with

making mental health treatment more accessible and acceptable, however, she did agree that it was a slow process and felt that there were still too few organizations available within communities to spread the needed knowledge about mental illness. V7 was quite candid and shared her personal experience while suffering from a mental illness, it seems that many Muslim people she encountered did not accept the existence of mental illnesses and she was often labeled as 'off her head', 'dumb' or 'crazy.' She shared that she was shunned by many of her friends and that her family battled to accept it, and that her husband was even advised to divorce her. It appears from the responses that not only does the community require education around mental illness, but that clients themselves need added support with regard to dealing with the stigma and discrimination they experience. It is believed that due to the nature of stigma, it is unlikely that clients will bring it directly to the attention of their mental health professional and that professionals should make it a routine of enquiring about any unfavorable experiences, discrimination, social support systems, etc., and integrate these issues into the treatment plan (Byrne, 2000). Most of the participants seemed to agree with this and felt that it was important to deal with the difficulties that people were facing due to seeking treatment, as well as the mental illness itself.

V7 explained how she was often blamed for causing the problem, and was told that she weak for not being able to "pull myself out of it." It seems that despite centuries of learning and understanding the brain, mental illness is still suspected as being an excessive behaviour and a sign of a weak personality. V7 experienced a lot of ignorance and discrimination from people around her and she said she now uses her own experience to help the clients she counsels, as many of them experience the same kind of stigma and intolerance. To be distinguished as 'mentally ill' carries internal consequences such as, being secretive, having lowered self-esteem and experiencing shame (Byrne, 2001, Benjamin, 2001). These were either due to or led to by external consequences of social exclusion, prejudice and discrimination. This consequence of secrecy may often result in obstructing the client from presenting their mental illness and obtaining appropriate treatment (Byrne, 2000). As evident from the responses, clients are often made to feel that they have brought this illness upon themselves and that instead of having the strength

to overcome, they are just wallowing in it. The struggle that clients experience due to their mental illness is added to by the negative attitudes of those around them; which appear to make it more difficult to seek help and deal with their mental illness.

More than half of the respondents also agreed that this stigma was due to one's *cultural* upbringing and not their religious values (V1, V2, V3, V5, V6, V7). The others were uncertain whether religion or culture was the main factor in causing stigma towards people with mental illness. Although spirituality and religion may relate to culture, this is not always the case, a religion or spiritual belief system can be shared by people from many diverse cultural groups, just as a cultural group can share many religions and spiritual communities (Dalton, et al., 2007). In this study the participants were all Indian and the majority of their client group at the Careline is also Indian. V5 explained that it was impossible for a Muslim to state that Islam teaches one to discriminate and stigmatize those that are different from them. Two of the values that Muslims are ordered to adhere to is that of 'Al-Ihsan', which declares that they must act with kindness and good intentions towards each other, and 'Al-Ukhuwwah' – brotherhood – which proclaims that amongst all Muslims their should be mutual love, respect, understanding and tolerance (Husain, 1998).

V5 asserted that "the Prophet (PBUH) was one of the first counselors, I mean all the prophets were counselors in some way." She also said later that "Muslims should have a better response to people with mental illness because we are taught that we are supposed to treat all living beings with kindness and respect, despite our differences. I think the Prophet (PBUH) and his followers all set the example for us in the way in which they treated people who were physically or mentally ill, that they treated everyone the same no matter what." The Sunnah, as mentioned earlier, are the actions of the Prophet (PBUH) and spell out principles from the Holy Qur'an that each Muslim should endeavour to live by (Husain, 1998). The principles taught by the Holy Qur'an intend to instill healthy moral attitudes with regard to one's day-to-day conduct including the way in which they treat all living creatures, in specific relation to the mentally ill it is stated,

> "Do not give your property which God assigned you to manage to the insane: but feed and cloth the insane with this property and tell splendid words to him."
>
> (Qur'an, 4:5, trans. 2001)

This quote suggests that although it may not be in the best interest of a person suffering with a mental illness to be in charge of their own, or others, financial affairs, they should be treated with the utmost kindness and well taken care of. V7 believes that "as Muslims we are not supposed to judge anybody… Because only Allah can judge." Husain (1998) confirms this statement as he says that Muslim's view treating others equally as a command from Allah, which they must earnestly adhere to. However from her own experience she added that "it's society that judges you because you are different from them, and they can't understand it." Many of the participants' remarks backed up this statement and V6 claimed that without a doubt people's negative attitudes towards understanding mental illness was a culturally based and she felt that these attitudes were created from the way in which children were brought up and the values that they were taught by their parents.

Taylor (2003) explains that a vital role regarding stigma is played by the stereotypes that taught in early childhood; which are later reinforced by external social attitudes. V1's response fully supported these feelings as she believed that "it's your upbringing, I think we were always taught while you growing up that you don't talk about your feelings, that you know, you just deal with it and get over it." Therefore, if one is not taught about mental illness and if children are not allowed to express themselves while growing up, this behaviour continues into their adulthood. If people are then exposed to others within their community who were brought up in a similar way, not only does it reinforce what they have been taught, but it also continues the cycle of ignorance.

The responses from the participants suggest that it may not be the inexplicable behaviour of someone suffering from a mental illness, that would cause negative attitudes from someone, but rather it depends on how the person understands or interprets this behaviour

based on their core values. This can be related to Ruth Benedict's argument that people react to situations based on their underlying values and ideas, rather than the actual situation (O'Hagan, 2001). Therefore, the motives behind stigmatizing attitudes and behaviour may be complex, however, they often tend to be grounded within one's sense of values and norms; which can only be understood as culturally-based prejudices (Mason, et al., 2001).

3.1.4 Role of Religion

In order to fully understand the volunteer counsellors' as well as their clients' perception of mental illness, the researcher queried their religious and cultural background and the influence that these factors may have had on them. The participants were asked if they felt that being Muslim had assisted them in understanding mental illness and their willingness to work in the mental health environment, 80% responded that undeniably *being Muslim played a vital role* them choosing to volunteer in the field of mental health and in helping them being more *tolerant* and understanding to people with mental illnesses. More then half of the respondents felt that they were doing this *as a service to Allah* or that it was *their duty as a Muslim* to help others in need, and that "it helps me feel closer to God" (V1, V2, V3, V4, V5, V8). V4 explained that, "to relieve another Muslims problems, to remove a burden from them is a great sawaab (blessing/ reward of Paradise)."

This point if further clarified by V5, "As a Muslim, you know it's one of our first priorities as a Muslim, as a Mu'min (a believer in Islam), it's one of the first few things you're going to be questioned about on the Day of Qiyamat (Judgement) – 'What did you do for mankind?' – you know, so it's every Muslim's duty to do something." This is corroborated by a statement made by the Prophet (PBUH) quoted earlier from Al-Qarni (2002, trans. 2003, p. 198). Dalton, Elias & Wandersman (2007) suggest that volunteers do so in order to fulfill a personal need, it may seem that in the case of these volunteer counsellor's their need is to do good deeds in order to be accepted and rewarded by their Creator.

Muslims believe that all humans are answerable for their deeds and righteous good deeds are seeing as the catalyst of the Holy Qur'an (Husain, 1998). The Book teaches one to establish values that are moral and practical and it urges believers to live with integrity towards themselves and others (Husain, 1998). Furthermore, Muslims follow the belief that their good deeds will be rewarded in the Hereafter, as stated in the Holy Qur'an,

> "And on the Day when the Hour will be established, that Day shall all (men) be separated… for those who believe (in Allah) and did righteous good deeds such shall be honoured and made to enjoy a luxurious life (forever) in a Garden of Delight (Paradise)." (Qur'an, 30:14-15, trans. 2001)

V8 views her role as a volunteer counselor as her duty to her Creator and states, "In a way Allah has blessed me that I can be of service to others and I don't need anyone to say thank you, it's just for the pleasure of Allah." This viewpoint is shared by V3 who said, "for me personally I think it was a calling from Allah, that you know what you need to be in this field and you need to help people help themselves. And so I take it as a very spiritual thing." V1 plainly expressed that, "it helps me feel closer to God by helping others." The Holy Qur'an affirms these perceptions,

> "Those who… do righteous deeds, hold fast to Allah, and purify their religion for Allah (by worshipping none but Allah, and doing good for Allah's sake only, not for thanks or to show off), then they will be with the believers."
>
> Qur'an, 4: 146, trans, 2001)

Frame (2003) discusses the role of God in Islam stating that He has four fundamental functions; namely, creation, sustenance, guidance, and judgement, and that Muslims are not only grateful for their blessings but choose to serve Him. They do this not only as a duty, but in order to maintain physical and emotional well-being, as well as, in the hope of ensuring eternal blessing in life after death (Frame, 2003). V2 clearly states that she feels her role as a volunteer counselor to primarily Muslim clients is, "to help them see that Allah tests us all and that we will benefit from it in the hereafter." Many of the responses suggest that the participants firmly believe in putting their faith in Allah and

that they feel responsible to help their clients have hope and to understand that God will sustain them, as clearly shown in the Holy Qur'an,

> "Who when afflicted with calamity say, 'Truly to Allah we belong and truly, to Him we shall return. They are those whom are blessed and will be forgiven by their Lord." (Qur'an 2:156-157, trans. 2001)

Furthermore,

"If Allah helps you, none can overcome you; and if He forsakes you, who is there after Him that can help you? And in Allah (alone) let believers put their trust."

(Qur'an, 3:160, trans. 2001)

Majority of the participants also said that being Muslim helped them *cope*, as they understood that "people's hardships are a test from Allah" (V2, V4, V5, V6, V7, V8). V6 thought, "Muslims have this belief in them that whatever comes it comes from Allah, so I think that gives them some ease or understanding" she felt that although Muslim clients may have moments of weakness where they question why they are suffering, "the bottom line is, you know, they have that understanding that it is from Allah, and I think it helps them accept it quicker." V8 elaborated this, " I think that your faith is deeper and also that you have a deeper understanding that whatever comes, comes from Allah and that Allah tests you in whatever way He wants to test you… as a Muslim I think it helps a person overcome because they will think you know whatever it is from Allah… Allah has His reasons for putting that person through this test."

> "And certainly we shall test you with something… but give glad tidings to the patient." (Qur'an, 2:155, trans. 2001)

V7 stated that this knowledge could result in a positive or negative attitude from the client, she explained that she has encountered clients who react negatively and, "feel that, 'I know I'm being tested and this is very difficult, and I don't why', they may be angry about it." She added that she also had clients who reacted positively, "they'll say, 'this is

a test from Allah, I will be rewarded for it and I'm going to try and work it through, and I'm going to make lots of du'a." It is acknowledged in the Holy Qur'an that there are occasions when believers will be suffering and that they will question why these afflictions are happening to them; however, they are urged to have faith in the Almighty,

"Think you that you will enter Paradise without such (trials) as come to those who passed away before you? They were afflicted with severe poverty, and ailments and were so shaken that even the Messenger (PBUH) and those who believed along with him said, 'When (will come) the help of Allah?' Yes, Certainly, the Help of Allah is near!"

(Qur'an, 2:214, trans. 2001)

The participants' responses suggest that in order for clients to understand mental illness, and to be more empathic towards those with mental illnesses, they need to be educated from an Islamic and Western perspective. In order to completely comprehend the viewpoints of the participants and their clients, it is important to be aware of what they believe the etiologies of mental illnesses are.

3.2 Etiology of Mental Illnesses

3.2.1 Volunteers Perceptions

When the participants were asked what they believed caused mental illness there were many responses; firstly, the *inability to cope with stress*, secondly, more than half the respondents also suggested that an individual who experiences *severe trauma* was susceptible to a mental illness, and, thirdly, they mentioned the existence of a *chemical imbalance* as being a cause of mental illness. V2 explained their perception of stress being a cause of mental illness by saying, "there could be a lot of stress… which can lead to a confused state of mind", V6 explained that she understood that some people were born with certain mental illnesses, however, she added, "I've also realized that to some extent, that stress plays a big part of it and that it can trigger off a mental problem that

was there but is only realized after something stressful happens." Harold Wolf's (Sadock & Sadock, 2003) research observing certain bodily functions in relation to specific emotional states suggested that a during a stressful event the client's reaction is determined by their general life circumstances and the way in which they perceive that particular event.

V5 described her understanding of what caused a mental illness by saying, "my understanding is mainly due to a type of chemical imbalances… also I think stressors in our lives can cause certain mental problems." V2 stated that although she felt trauma and stress played a role in causing mental illness she also felt that, "it's due to their chemical imbalances as well, because they can experience a trauma in their lives but some are weaker and some are stronger." These understandings can be linked to the definitions of mental illness, which discuss the importance of there being a balance in both psychological and biological factors in order to maintain a healthy mental and physical state (Haque, 2004).

It appeared that many of the participants understood that there were many etiological factors for mental illnesses, this is evident by V8's explanation as she believed that "a mental imbalance you know, it could be a trauma… And also the stress of life around you, if a person cannot handle it and it may cause certain behaviours… I really don't think it's one thing, I think it's a combination of things." Many of the participants appeared uncertain on whether there was one actual cause of mental illnesses or not, however, they seemed to have an idea of a few possible etiologies, this is viewpoint that has been substantiated over time by the many different approaches that exist with regard to understanding the etiology of mental illnesses. As mentioned earlier, these include the biological, sociological, and psychological approaches, each which have diverse perceptions of understanding mental illness; including, chemical imbalances, traumatic experiences, vulnerability to stress, and social relational problems, etc. (Taylor, 2003, Sue & Sue, 2003).

As mentioned above *trauma* was undeniably the second most common etiological factor for mental illnesses according to the volunteer counsellors. Amongst the responses

regarding this etiology were V1, who stated that, “trauma, severe trauma… in early childhood” was a cause of mental illness and that, “they don’t deal with it (the trauma) at the time, and I think as they grow up it impacts on their lives.” V2 also found in her experience as a volunteer counselor that, “there is a lot of trauma at a young age… a lot of disruption” which she felt could lead to stress and in turn weaken the individual’s ability to cope with the pressures of daily life. Another participant who accredited trauma as one of the causes of mental illness was V8 who explained that, “trauma, maybe from childhood… childhood experiences…it depends on the support and care that person has… maybe not having that support could progress into a complete mental illness.”

Taylor (2003) enlightens readers on the psychological approach to mental illness; which endeavors to understand the etiology of mental illness by looking at the client’s experiences. He elaborates that examining “the relationship between the ‘formative’ experiences of early childhood – especially traumatic experiences – and mental disorder in later life” (Taylor, 2003, p.139) has been done by many theorists and has been found to be a vital factor. There are crucial stages in the emotional development of the child and if unresolved conflicts or traumatic experiences occur, it remains in the person’s unconscious and can produce psychological problems later in one’s life (Taylor, 2003). In other words, if one experiences something problematic in their childhood it is possible that it would affect their emotional functioning, resulting in an emotional imbalance. The individual would be unable to deal with certain situations due to a lack of emotional stability and ability.

The role of trauma experienced in childhood is further acknowledged by cognitive psychologists, who argue that there are specific stages in the child’s intellectual development when they are beginning to think rationally about the world and themselves and if they experience a trauma at this point it can impede their rationalization process; which may result in distorted perceptions in their later life and cause mentally unstable behaviours (Taylor, 2003). V7’s responded that, “it’s something that comes from childhood and from a trauma of some kind… when families have experienced a trauma but then somebody doesn’t realize how much it has affected that child until a lot later on.” From this response it can be understood that it is imperative to consider the

individual's experiences as a whole when someone presents with what appears to be a trauma related mental illness, as their current state may have been the final result of an incident that may have occurred much earlier in their lives.

Participants went on to state that they also perceive f*amily* or *social problems* as likely causes of mental illness. V2 strongly believed that, "parents fighting or sibling rivalry" could lead to a mental illness. V3 thought first and foremost that, "it has to be genetic, or hormonal, secondly… I think it's life circumstances" she added that it could also be caused by, "instability in marriage and other interrelationships." V7 felt that, "it's a variety of things, I think starting from childhood if there's instability in the home, the way the child is treated by the parents… if there's a lot of fighting and arguing between the parents… if there's abuse." These perceptions of the nature and causes of mental illness by the participants appear to be corroborated by the conceptualization of mental illness in the academic literature.

This belief can be linked to Sue & Sue's definition of mental illness, which includes social problems. The impaired functioning between significant persons and can produce a great deal of stress and the individuals involved may struggle to cope or think rationally. Other academics state that mental illness has to be viewed from the psychological, physical, biological, behavioural and social contexts in order for it to be completely understood (Taylor, 2003). They also go on to say that it is important to have a holistic view and to consider the influences of external measures in triggering mental illnesses (Taylor, 2003). From the responses received it appears that unstable interpersonal relationships made up a large proportion of the clients that were encountered at the Careline. It appeared that many of the clients presented with relational problems; however, as they shared their symptoms, they often showed signs of underlying stress, anxiety and depression.

3.2.2 Volunteers' Clients Perceptions

As mentioned earlier, most participants felt that the clients they encountered did not understand the concept of mental illness and often denied the possibility of suffering

from a mental illness or they blamed it on someone having done something to them. The only common causes of mental illness that the volunteer counselors stated many of their clients acknowledged was *stress* and *family* or *social problems*. The sociological approach to understanding mental illnesses, focus on the relationships between the individual's experience of their illness, their distress and the wider patterns of social organization (Talyor, 2003). It focuses on the role of social influences with regard to causing a mental illness and finds that people in general value their close interpersonal relationships and any dissatisfaction in them could be detrimental to one's mental well-being (Taylor, 2003). This ties in with the client's viewing their illnesses as being caused by problematic social relationships.

From the participants responses it appears that hardly any of the clients encountered at Islamic Careline, perceived their illness as being a mental illness or that something is wrong with them, even when stating stress, family, or social problems the blame was always directed at someone else for causing those problems. This can be related to Seedat, et al's (2003) discussion of how traditional communities organize themselves in a way that the community functions together as a whole and that if an individual suffers, the community suffers, and it is the responsibility of the community as a whole to work together to help that individual. This could relate to the clients' perceiving their suffering as being caused by others as they feel attached to those around them and feel that their community should also take responsibility for their suffering.

This difficulty in acknowledging the existence of a mental illness has been found to exist across cultural groups. It is often argued that in most cultures mental illness has a negative connotation and is not seen as socially acceptable. Therefore, it is easier for the sufferer to lay blame on something or someone else, rather then admit to having a mental illness. As apparent from earlier responses, physical illnesses also tend to be more easily accepted then mental illnesses. It has been found that people suffering from mental illnesses; such as, depression or anxiety, often express their hardships through stating physical or somatic symptoms. The sufferer sees these symptoms as being more socially acceptable; however, in these cases physicians are unable to explain the symptoms through any medical means, which usually leads physicians to consider a possible mental

illness (Rosendal, Fink, Bro & Olesen, 2005). It's important for mental health practitioners to understand the client's reasoning behind having these types of reactions.

Therefore, the researcher queried further with regard to how the volunteer counsellor's experienced their client's understanding of the causes of mental illness. When asked whether people who sought counseling ever believed their illness to be caused by something other then medical or psychological, all the participants explained that many clients whom they encountered perceived their illnesses as being due to a *spiritual phenomenon*, stating that, "many patients believe their mental illness is caused by spiritual forces" (V1, V3, V6, V7, V8). V1 went into detail about a client she encountered who, "was convinced that he had a spiritual thing with him and he tried every avenue that he could and he was just not coming right… He was a very spiritual person, he quoted the Qur'an and the Hadith." From this statement it appears that some clients who are spiritually inclined tend to view spiritual factors as the cause for their suffering.

However, as mentioned earlier, these beliefs also seem to stem from the client's beliefs that there are people in their community jealous of them. V7 said that from her experience what typically characterized a spiritual illness was, "they say it's jealousy, blame it on a specific person who they feel must have done this to them, and they insist that it can't be an illness (mental) it must be some kind of jadoo or something, or *Jinn's* (spirit possession)." Spiritual illnesses are believed to exist within other cultural groups, and these too are viewed as mental illnesses by Western psychological approaches. Symptoms of mental illnesses in many African communities are believed to be caused by spirit possession, which are referred to as, Amamafufunyana, Zar, or Izizwe within different African cultures (Louw & Edwards, 1997). The symptoms are very similar to those described by the participants and their own clients' experiences of it; such as, *uncontrollable behaviours*, *mood fluctuations*, *etc.* and the sufferer believes that they have either been possessed or are victims of witchcraft (Louw & Edwards, 1997).

There are other views regarding the belief of spiritual illness and when V8 was asked what clients commonly believe is the cause of their mental illness, she responded that, "commonly they say black magic and jadoo, but I don't believe that, maybe to a certain

extent it's a reality that does happen, but I think a lot of people use it as an excuse." As discussed above, many participants felt that as much as people may not understand mental illnesses and their etiology, they also found it culturally unacceptable to be viewed as someone with a mental illness; this may also result in many people claiming spiritual illness, rather then acknowledging a possible mental illness. This seems to be a behaviour that is found across cultures, and are often believed by Western mental health practitioners as being due to one's fear or embarrassment of admitting to a mental illness. Simons (2001) explains that people are conscious of how they are classified by others and they will alter their behaviour in order to be more acceptable to others, even with regard to mental illnesses. From the participants responses it appears that the people within this community focus on the physical symptoms and the belief in spiritual illnesses in order to make there illness more socially acceptable.

3.2.3 Spiritual Illnesses

In order to further understand the participants' responses, the researcher queried their own beliefs regarding spiritual illness. 100% of the participants claimed that they believed in the existence of spiritual illnesses because, "It is mentioned in the Qur'an or Hadith" (V1, V3, V4, V5, V6, V7, and V8). V1 explained that, "being a Muslim I will definitely say that the existence of spiritual illnesses has been mentioned and confirmed in the Hadith and the Qur'an… Prophet Mohammed (PBUH) also experienced jadoo, so I definitely believe it exists." Furthermore V5 stated that, "I think there's lots of people that have spiritual illnesses, I think it does exist because it happened to the Prophet (PBUH), but I think there are remedies within the Qur'an and Islam has prescribed certain things for us to do in order to safeguard ourselves from these things." The Holy Qur'an states,

> "Verily, this (the Qur'an) is the Word that separates the truth from falsehood, and commands strict laws for mankind to cut the roots of evil."
>
> (Qur'an, 86:13, trans. 2001)

This suggests the existence of spiritual illnesses; however, it also suggests that within Islam there are remedies for these illnesses.

A few participants also stated having had personal experiences of witnessing a spiritual illness within their family or close friends (V1, V2, and V6). V2 shared her entire experience which appeared to have been quite traumatic for herself and all those involved, she concluded by saying, “I think that there is a lot of envy in our communities and that there people are jealous when you do well” she added that thankfully, “we are the type of people who don’t brood on things… because I think that if you let these things get to you it can drive you ‘mad’, and you can become paranoid and anxious, you’ll start believing these things are happening to you when they aren’t.” Some participants also felt that their clients struggled to admit that they were experiencing a mental illness, as it is not a diagnosis that is easily accepted within Muslim communities.

Although there are remedies for mental illness discussed in Islamic texts it appears that the stigma experienced by people suffering from mental illness, as mentioned earlier, makes it difficult for clients to seek help, and would wait until it was at the *unbearable* stage of their mental illness. (V1, V2, V3, V5, V6, V7, V8). V1 felt that “with the Muslim community, people a re not very susceptible to saying they need help, you know.” The majority of participants’ responses seem to fit V1’s point of view; which could otherwise be seen as a generalization. V2 said that in her experience, “most of the time they come when it’s very far gone and they’re already, you they’re already in the desperate stages and need help.” It materialized that in order to protect themselves against ridicule many, “people try and deal with issues themselves… I don’t blame them because I think it’s very much a cultural thing.”

Although V6 agreed that clients are “always at their worst” when they eventually seek help, she felt that it was due to their religious affiliation stating that “Allah gives people so much of sabr (patience)” which they find primarily through prayer and she added that, “they wait and wait until they reach a point when they realize that they just can’t anymore, and I think that’s when they come.” V7’s perspective totally substantiated the previous statement saying that clients arrive “at crisis point” and added that “in the

Muslim community I think the stigma is a major problem, even if they come here… they come in finally realizing that they can't do this on my own and it doesn't matter what anyone thinks I can't do it." It appears from the responses that clients truly struggle with the prospect of seeking and receiving treatment for mental illness and it is important to understand where this stems from and how clients within this community go about dealing with their mental illnesses.

3.3 Treatment of Mental Illness

When asked if the participants felt that religion played a role in determining the type of treatment clients sort, more then half felt that it did play a role and 50% felt that Muslim clients felt more at ease with treatment from a Muslim. V3 explained this point saying that, "because it is called *Islamic* Careline, a lot of people that would otherwise not go for help, will come for help, knowing that it has an Islamic ethos or a Muslim perspective… I think having a Muslim ethos has encouraged more people to use the service." V5 elaborated this point saying that from her experience of people come to Careline, "people do feel more comfortable being here, in an environment that's familiar" she added that many of her clients have at some time or another commented, "they'll say… 'I'm sure you understand what I'm saying, being a Muslim' and again it's the fact that we can relate to them and we know where they're coming from with certain things."

From these and other responses it appears that coming from the same religious background serves as a bonding factor between client and counselor. It seems that the respondents feel that it is important to be of the same cultural or religious group in order to be culturally competent when counseling a client. However, it has been argued that this is not the case and that the mental health professional needs to respect their individual clients' worldview and they should be willing to learn from as many modes of therapy and healing as possible is order to open their minds (Sue & Sue, 2003).

When the researcher asked the participants whether or not their clients would be willing to seek treatment from other Western trained mental health professionals; such as,

psychologists or psychiatrists, most of the participants stated that they would but only *as a last resort* (V1, V2, V4, V5, V8, V9). The participants also stated that clients were usually more willing to seek mental treatment from a Western trained professional, if *they were referred by a moulana or by one of the volunteer counsellor's* who they felt they could trust and who understood them (V1, V3, V6, V7). It seems that, although, some clients may be open to Western forms of treatment, the majority would still prefer receiving that treatment from someone they believed to be competent in their understanding and knowledge of their cultural background. This can be related to the earlier arguments regarding the need for mental health care workers (volunteers or professionals) to come from similar backgrounds or have an understanding of the individual's cultural beliefs and values regarding mental illness (Bond, 1993, Kashyap, 2004).

It does appear that in some cases choosing to go to a primarily Muslim organization for assistance or treatment meant that individuals are looking for Islamic remedies for their mental illnesses. V7 shared that many clients she had encountered would plead would her and, "they'll say, 'tell me what does Islam say, tell me I don't know what to do.'" Several of the participants admitted that they used Islamic teachings as a means of helping to ease their clients suffering or to assist their clients with knowledge of certain prayers and verses from the Qur'an that could help them cope. V2 said that being a Muslim she "prescribes" to her clients, the researcher asked her to elaborate and she explained that, "I encourage the reading of salaah and making zikr (meditation). I may also quote things from the Qur'an or the Hadith to help clients understand or make sense of their difficulties… I advise clients on certain sura's or du'as to read to help ease their worries. And it really helps those who believe." As discussed earlier, people tend to associate with and confide in people who they feel understand them and their belief systems (O'Hagan, 2001).

V3 felt that, "there are many counselors who together with the secular mode of counseling… suggests du'as that they can read, they will take the book on healing and the book on problems and there are many, many little ayats (verses) that many of the counselors do that, and the clients feel very satisfied with that." The respondents appear

to believe that using prayer either in the counselling session or suggesting it for outside the session can provide an influential healing source that is understandable and comforting to their clients. Research suggests that most people's attitudes, feelings, and behaviours are shaped by their religious or spiritual background and that its value should not be overlooked in the treatment of mental illness (Frame, 2003). The respondents tend to feel that both religion and therapy may be seen as ways of handling life's distress's and that it may be vital to a client's recovery to include as much as their religious values and beliefs in therapy where possible.

90% of the volunteer counselors believed that prayer played a very important role in helping their clients *cope* with the stress experienced due to their mental illness, they felt that clients found *solace* when they engaged in prayer. Prayer, in all forms, was mentioned as "helping the patients cope" (V2, V4), that it "is where patients find solace or peace" (V1, V2, V3, V5, V6, and V7). Prayer seems to be viewed as a way of "alleviating suffering" and helping clients "accept their burden" (V2, V3, V4, V6, V7, and V8). From the responses it appears that religion seems to play a vital role in assisting someone who is struggling with a mental illness. The participants seem to agree that by the clients having a relationship with God it may be uplifting and enhance their ability to cope with and accept their mental illness.

V7 encountered clients who, "have actually said that when they've really battled they've actually just gone and sat on the mussalaah (prayer mat), and I've found lots of clients who've actually just found solace in that." V3 elaborated saying that she thought, "the power of zikr is very much undermined, I think the power of du'a and prayer is very important in giving people a peace of mind that they may need." Zikr is a form of meditation during which one recites Qur'anic verses or specific Arabic words repeatedly in order to remember their Creator (Husain, 1998). The Holy Qur'an affirms,

> "Verily in the remembrance of Allah do hearts find tranquility."
>
> (Qur'an, 13:28, trans. 2001)

The participants view of the importance of zikr links with Frame's (2003) description of meditation as a form of reflection that involves concentrating on one's own breathing and opening one's self up to receive insight. Meditation has been proven to be effective in managing stress, anxiety, depression, and other health problems (Frame, 2003). It is believed that by the continuous repetition of whatever words one chooses to repeat, it eventually results in the individual becoming calmer and feeling at ease, which is related to participants findings that their clients feel calmer and find solace in making zikr. There is also a neurophysiologic basis for why the meditative process has these results, but either way it does seem to have a relaxing affect on the client. As stated by the respondent's meditation appears to help a majority of their clients cope with and accept their mental illness.

Pargament & Brant (1998) explained that religious people more frequently called upon religion as a coping mechanism in major crisis, and that drawing on an established system of beliefs may put these individuals in a better position with regard to coping with disturbing problems. Reading du'as are a way of making a plea to Allah when in distress, ill, when one desires something, or in need of forgiveness and it is believed that if it is done with true humility one's prayers will be answered (Husain, 1998). This view seems to be shared by the participants who follow the belief that everything is given from Allah and that if one turns to Him in times of need they will be taken care of.

Several studies have shown that religion and prayer is particularly helpful in moments of high levels of stress and that it can moderate the effects of stress and have a positive effect on one's life satisfaction and mental well-being (Pargament & Brant, 1998, Frame, 2003). This may be in-keeping with the Islamic teachings explained by V5 that, "Allah says if you pray five times salaah (a day) He takes care of all your hardships, you know you don't have to worry about anything 'coz everything will fall into place." As stated in the Holy Qur'an,

> "And enjoin As-Salat (the prayer) on your family, and be patient in offering them (the prayers). We ask not of you a provision (i.e. to give us something: money): We provide for you." (Qur'an, 20:132, trans. 2001)

This confirms Corrigan, McCorkle, Schell & Kidder's (2003) argument that spirituality serves an essential role in the recovery process for very religious or spiritual people who are suffering with serious mental illnesses. Prayer is believed to be the most universal and personal aspect of every religion that exists worldwide, and is a way for individuals to connect with their Creator (Frame, 2003). This connection, as apparent from some of the responses, serves as a way in which the individual can communicate with God and find some relief during difficult periods in their life. Other participants corroborate this point; for example, V3 who discussed how, "a lot of people would say that we've been to so many moulana's and I'm doing so much of du'as." V6 also stated that, "even before they come here (Careline) they would go to like a moulana or something like that to check it out." Being spiritual people it seems they feel it is their duty to go to a spiritual healer before considering other means of treatment or even other possible reasons for their current condition. As a Muslim, one has faith in Allah and believes that nothing occurs without the will of Allah, this included the state of their health (Husain, 1998). Therefore, it makes sense that they would chose to go to a healer who they feel understands their belief system.

The above statements show that clients may tend to turn to spiritual forms of treatment first as they feel this is where help lies for resolving their problems. V1 felt that coming from a Muslim background, clients were more willing to seek help from spiritual healers, "because they are brought up with it." Ally & Laher (2007) explain that faith healers, referred to as moulana's in the Muslim faith, are considered as those individuals who have widespread knowledge of religious or spiritual illnesses. Furthermore, they practice from within a specific religious or cultural perspective; which gives them the ability to effectively assist those individuals from their community who are afflicted by a spiritual illness (Ally & Laher, 2008). Moulana's are seen as the intermediary through which mental illness is dealt with in the Islamic faith, as they are considered well equipped to drive the evil spirit or the evil eye away (Ally & Laher, 2008). Ally & Laher (2007) explain the moulana's viewpoint that individuals function within an environment wherein rationally explained and natural forces as well as supernatural, unseen and inexplicable

forces exist, and that an imbalance within this environment by either natural or supernatural forces may result in either physical, mental or spiritual illnesses.

These perceptions of mental illness enhance the beliefs of the respondents that spirituality is an essential component in understanding mental illnesses within their community. The Holy Qur'an acknowledges the existence of evil spirits and the ability for people to perform black magic on another for evil gains, there are many ayats (verses) in the Scripture that are suggested to ward off evil and keep one safe from witchcraft (Ally & Laher, 2008, Pickthall, 2004). One of these prescriptions advised in Pickthall (2004) is 'Sura Muzzammil'; which he states the Prophet (PBUH) said should be read whenever someone is under distress, or sick and that Allah would help ease one's burden and the ill person shall recover. Another are the two 'Quls' (Sura Al-Falq and Sura An-Nas); which the Prophet (PBUH) is reported to have said should be read in order to safeguard against the evil of Jinn and from the evil eyes of wicked people (Pickthall, 2004). These Sura's state consecutively,

> "I seek refuge in the Lord on Daybreak. From the wrath of that which He erated. From the evil of darkness when it is intense. And from the evil of malignant witchcraft. And from the evil of the envier when he envieth"
>
> (Pickthall, 2004, p.104).

> "I seek refuge in the Lord of mankind… from the evil of the sneaking whisperer,
>
> who whispereth in the hearts of mankind, of the jinn and of the mankind."
>
> (Pickthall, 2004, p.105).

V6's response ties in with the moulana's viewpoint above as she said, " I do believe that there are spiritual forces out there and it can affect you, I think as Muslims, in our fifth or seventh Kalimah (Holy codes of faith), it's stated clearly that we have to believe in the bad and the unseen." V7 shared advice that she had been given by her grandfather, "to read the 'du'as for the contentment of the heart', and specifically the 'Manzil' because

these are for the protection from evil, and the Qur'an and Hadith speak of it so it does exist." Although all the participants believed in the existence of spiritual illnesses, many felt that they needed to be objective when seeing clients in order to give them the best form of treatment possible, suited for each individual clients' needs, and to cover all the required areas and possible diagnosis. The respondents seem to feel that no individual even within the same cultural or religious group is identical; therefore, in order to be a competent counselor they need to be open-minded. As argued by O' Hagan (2001) in order to be culturally competent, one needs to be able to form and sustain a relationship with their client, demonstrating sincerity, respect and an openness to their cultural and religious beliefs.

Scientists or non-religious individuals may ridicule the thought that God could intervene to heal the sick or provide other services to believers, true believers; however, tend to assume that God will come to their aid and they will pray for what they require (Baumeister, 2002).

3.4 Conclusion

The findings in this study acknowledge the fact that this research sample was made up of a very diverse group of people. As articulated in the literature and reiterated by the interviewees, the lay person's understanding of mental illness included all mental health issues. The interviewees' responses included everything from the less severe psychological disorders; such as, mood disorders and psycho-social stressors, to the severe mental illnesses; including, schizophrenia and other personality disorders. Mental illness was defined as people experiencing emotional imbalances, outbursts of behaviour, and that the sufferer found their symptoms extremely overwhelming. It is believed that individuals with mental illnesses find it difficult to cope with everyday life and are eventually ostracized and unable to function socially or professionally.

The findings suggests that understanding the way in which people perceive mental illness, it's definition, etiology and treatment, requires taking into account the specific

needs, beliefs, values and conditions of diverse communities. This includes their social, cultural, religious and spiritual backgrounds and what they believe about their own mental health issues. As suggested by the interviewees, many of their encounters with clients result in beliefs about mental illness being related to spiritual illnesses, and that their symptoms are due to other people having caused their illness through the use of witchcraft. As discussed in the literature many people's responses to problematic situations are generally determined by their underlying values and associated ideas than by any particular symptom.

One's Islamic background appears to play a vital role in the perception of mental illnesses amongst the interviewee's and their experiences with their clients. As discussed in the literature and reiterated by the interviewees, Islam appears to suggest the existence of spiritual forces that can affect one's physical or mental functioning. This belief seems to be largely accepted within the research sample community and appears to be an acceptable way on explaining and understanding their mental illness. Turning to God in times of crisis is also seen as the most valuable method of treatment for their difficulties and it appears the sufferers may experience a sense of guilt if they do not trust in God to heal them. They largely seem to feel that the only other alternative is to seek help from spiritual healers, who are believed to work through the assistance of God. Seeking Western medical assistance appears to be a last resort when all else fails and they are on the brink of hopelessness and are completely helpless.

The findings further imply that it is also important to be aware of the stigma and discrimination that may exist within communities regarding mental illness, as this often affects people's willingness admit to their difficulties and to seek treatment. The literature suggests that regardless of progress in the scientific and medical fields, regarding mental illness, stigma is still very evident. The findings of this study appear to concur with this suggestion, as the interviewees' responses indicate that mental health sufferers experience daily negative encounters due to their illnesses. The responses also concurred with the literature which suggested that the cultural definitions for stigma are often related to what is seen as acceptable or not within a specific cultural group. As the interviewee's indicated that many of their clients used the excuse of experiencing a

spiritual illness or being the victims of witchcraft, as these are more acceptable problems then stating one has a mental illness.

The findings tend to suggest that to a large degree traditional Islamic beliefs do still play an imperative role with regard to the way in which individuals, within a close-knit Muslim community, perceive mental illness. The research also indicates that when considering a religious or culturally-specific community, their diversity in all respects needs to be taken into consideration before any conclusions can be made.

Chapter 4: Limitations and Recommendations

This study focused on understanding the perceptions of mental illness of volunteer counselors in a Johannesburg community-based organization and the role that Islam may have played with regard to their perceptions. It can be assumed that these findings have opened opportunities for further research with regard to the association between religion, culture, and the understanding and treatment of mental illness. However, the study does present with limitations due to a number of factors, this chapter focuses on these limitations. It is followed by a discussion regarding recommendations for future research.

4.1 Limitations of the Study

4.1.1 CONCEPTUAL LIMITATIONS

This study attempted to understand the perceptions of mental illness from an Islamic viewpoint. Although there is a large amount of information available regarding Islamic understandings or law towards mental illness, the researcher struggled to obtain a sufficient quantity of this information. The research felt that the study fell short with regard to supplying definitions that were specific to the Islamic faith. Therefore, it is possible that there will be gaps in understanding the role of Islam in perceiving mental illness and the way in which aspects of the study was described and discussed; which may also have implications with regard to the conclusions that were made.

Spiritual illnesses and many other beliefs that are held not only by Islamic schools of psychology, but Asian and Hindu approaches as well, and are not considered by Western psychological approaches (Frame, 2003). Western literature does tend to be viewed as more reliable and acceptable; therefore, making it difficult to consider the reliability of illnesses or beliefs held by indigenous groups. Western approaches label these illnesses as culture-bound syndromes and view them in a similar light as mental illnesses, not

giving appropriate credit to the cultural beliefs that uphold these illnesses. This makes it difficult for the researcher to support the arguments brought forward by her respondents regarding certain cultural and religious beliefs about mental illness. This lack of information could; therefore, have limited the findings and arguments put forth in this study.

4.1.2 METHODOLOGICAL LIMITATIONS

The use of a qualitative method also entailed various disadvantages or limitations. The traditional (quantitative) viewpoint of research perceives qualitative research as being too subjective and uncontrolled to have any real value (Willig, 2001). Although, thematic content analysis allows clear identification of prominent themes, and organised and structured ways of dealing with the literature regarding these themes, it suffers from several important limitations (Dixon-Woods, et al., 2005). One of these is the argument that descriptive accounts do not necessarily comply with more than what is already assumed by the researcher (Willig, 2001; Dixon-Woods, et al., 2005). Although the information gathered in this study is substantiated, many academics argue that a qualitative study may merely be an extension of the researcher's preconceived notions regarding the topic, rather then a gathering and analysis of new information. If this were true regarding this study, it could hinder the conclusions drawn; however, all information gathered and analyzed in this study is justified.

The sample size of eight participants may be viewed as a limitation, as a larger group to obtain information from is always more useful when attempting to gain insight into a particular group or in this case particular perceptions from a specific religious and cultural group. Unfortunately, it was difficult to obtain a larger number of participants; which could have added valuable insight to the study. Many quantitative academics view a small sample size as a limitation; however, the depth of information that is possible to gather from a smaller sample group is greatly valuable (Willig, 2001). Increasing the sample size would have proved problematic in obtaining such precise and detailed information.

The participants' level of experience as volunteer counsellor's varied from 3 years to 22 years. It is possible that the lack of experience of some volunteers may have hindered their ability to provide as much reliable information about patients perceptions then maybe more experienced volunteer counselors could have provided.

Some of the participants also appeared to feel slightly intimidated by the researcher. There were often comments made about the fact that the researcher was a MA (Clin Psych) student and the participant would openly say that they didn't have degrees or weren't as educated in psychology as the researcher was and that they did not know what insight they could really offer. Although the researcher did attempt to reassure the participants on these occasions, saying that the study was interested in their perceptions as individuals, this may not have necessarily eased their insecurities and they may have held back on their responses at times, doubting their validity. This may have also resulted in the participants giving what they felt were the 'right', expected, or socially acceptable answers rather then their own perceptions. As a result, this may have influenced the conclusions that were drawn.

Being a qualitative study, the researcher's subjective preference regarding Islam and mental illness cannot be ignored, as the researcher may have focused more on certain aspects of the data than others[1]. The researcher acknowledges that some personal preconceptions may have been exposed through this study, which consequently may have effected the conclusions that were drawn.

It must also be remembered that this study focused on the perceptions of Muslim volunteer counsellor's in a specific Johannesburg community; therefore, the ability to generalize the findings in this study is limited to Muslim volunteer counselors within that community.

[1] Refer to page 26, Section 2.1

4.2 Recommendations for Future Research

Despite the limitations discussed, the findings of this study has highlighted issues that are relevant with regard to future research into the perceptions of mental illness taking into consideration specific cultural and religious groups. The South African community is made of many diverse cultures and religions, understanding these diversities will undoubtedly enable mental health care professionals to improve the service provided by offering a more open-minded attitude towards treatment and diagnosis.

A cross-cultural study comparing the beliefs and perceptions of volunteer counselors from other faiths may prove valuable. This will assist in expanding the body of knowledge regarding these perceptions and will be beneficial to improving the treatment of mental illness of people from diverse backgrounds. It may also be helpful to expand this research into the mental health field and explore the perceptions of psychiatrists and psychologists with regard to the role religion plays in the treatment of mental illness.

With this in mind the phenomenal affect of globalisation on cultures should be kept in mind, as cultures are constantly integrating with other values and beliefs that they are exposed to. Therefore, it would be valuable to have consistent cross-cultural research regarding perceptions of mental illness in order to keep constantly updated with the shifts that occur with each new generation, and the values and beliefs that impact them.

This study focused on the volunteer counselors alone, and the patients' perception of mental illness as well as the role of religion, was only understood from the participants' perspective. It would valuable and interesting to determine what the patients' and other community members' perceptions might be.

In addition, there are many gaps in our knowledge and understanding of social exclusion and stigmatization towards those suffering with mental illness. The perceptions obtained in this study were limited to those of the volunteer counselors. It would be worthwhile to explore this in a larger scale, cross-culturally to determine if these results a shared across cultures. This information would be imperative in comprehending the stigma and

discrimination that exists against those with mental illnesses and will help to create more reliable methods of educating communities about mental illness.

In conclusion, it is apparent that perceptions of mental illness in Muslim Indian communities' warrants further research, given the unique combination of religious, social and cultural factors which are the framework to this environment. Furthermore, it is suggested that by understanding the role that religion and culture play in the perceptions of mental illness in Muslim Indian communities, and acknowledging these perceptions in Western forms of treatment, will continue to be a crucial factor in improving the treatment of mental illness and encouraging Muslim Indian people to engage in all the treatments available to them.

Reference List

Ahmad, K. & Ansari, Z. I. (Eds.). (1979). *Islamic Perspectives: Studies in Honour of Mawlana Sayyid Abuk A'la Mawdudi.* Islamic Foundation, U. K: Redwood Burn Ltd. Trowbridge & Esher.

Al-Qarni, A. i. A. (2002). (Translated by: Shafeeq, F. i. M). (2003). *Don't Be Sad.* International Islamic Publishing House: Riyadh, Saudi Arabia.

Ali, O. M., Milstein, G., & Marzuk, P. M. (2005). The Imam's role in meeting the counseling needs of Muslim communities in the United States. *Psychiatry Services, 56, 202 - 205.*

Ally, Y., & Laher, S. (2008). South African Muslim Faith Healers Perceptions of Mental Illness: Understanding, Aetiology and Treatment. *Journal of Religion and Health, 47, 45-56.*

Arrendondo, P., & Toporek, R. (2004). Multicultural Counseling Competencies: Ethical Practice. *Journal of Mental Health Counseling, Vol. 26, No. 1, 44 - 56.*

Baumeister, R. F. (2002). Religion and Psychology: Introduction to the Special Issue. *Psychological Inquiry, Vol. 13, No. 3, 165 - 167.*

Benjamin, C. (2001). Aspects of Stigma Associated with Genetic Conditions. In Mason, T., Carlisle, C., Watkins, C., & Whitehead, E. (eds.). *Stigma and Social Exclusion in Health Care.* (pp. 63-75). London and New York: Routledge.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K. & Bhugra, D. (2007). Cultural Competence in Mental Health Care: A Review of Model Evaluations. *BMC Health Services Research.*

Bond, T. (1993). *Standards and Ethics for Counselling in Action.* London: Sage Publications.

Boyer, P. (2001). Religion Explained: The Evolutionary Origins of Religious Thought. *Marburg Journal of Religion: Vol. 7, No. 1.*

Borinstein, A. B. (1992). Public attitudes toward persons with mental illness [Electronic version]. *Health Affairs, Fall, 186 – 196.*

Bussema, K. E., & Bussema, E. F. (2000). Is there a balm in Gilead? The implications of faith in coping with a psychiatric disability. *Psychiatric Rehabilitation Journal, Vol. 24, No. 2, 117 - 125.*

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment, 6, 65 - 72.*

Byrne, P. (2001). Psychiatric Stigma. *The British Journal of Psychiatry, 178, 281 - 284.*

Carone, Jnr., D. A, & Barone, D. F. (2001). A social cognitive perspective on religious beliefs: their functions and impact on coping and psychotherapy. *Clinical Psychology Review, Vol. 21, No. 7, 989 - 1003.*

Carter, D. J. & Rashidi, A. (2003). Theoretical Model of Psychotherapy: Eastern-Asian Islamic Women with Mental Illness. *Healthcare Women International, Vol. 24, No. 5, 399 - 413.*

Carter, D.J. & Rashidi, A. (2004). East meets West: Integrating psychotherapy approaches for women. *Holistic Nursing Practice, Vol. 18, No. 3, 152 - 159.*

Chambers, R., Drinkwater, C., & Boath, E. (2003). *Involving Patients and the Public.* 2nd Edition. Oxford: Radcliffe Medical Press.

Cinnirella, M., & Loewenthal K. M. (1999). Religious and Ethnic Group Influences on beliefs about mental illness: A Qualitative Interview. *British Journal of Medical Psychology, Vol. 72, No. 4, 505 - 524.*

Corrigan, P., Thompson, V., Lambert, D., Sangster, Y., Noel, J.G., & Campbell, J. (2003). Perceptions of Discrimination Among Persons with Serious Mental Illness. *Psychiatric Services, 54, 1105 - 1110.*

Corrigan, P., McCorkle, B., Schell, B., & Kidder, K. (2003). Religion and Spirituality in the Lives of People with Serious Mental Illness. *Community Mental Illness Journal, 39, 487 – 494*.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatization of People with Mental Illnesses. *The British Journal of Psychiatry, 177, 4 - 16.*

Daaleman, T. P. (2004). Religion, Spirituality, and the Practice of Medicine. *Journal of American Board Family Practice, Vol. 17, No. 5, 370 - 376.*

Dalton, J. H., Elias, M. J., & Wandersman, A. (2007). *Community Psychology: Linking Individuals and Communities.* 2nd Edition. U.S.A: Thomson Wadsworth.

Denzin, N. K., & Lincoln, Y. S. (2006). *Collecting and Interpreting Qualitative Materials.* 2nd Edition. Thousand Oaks: Sage Publications.

Dinos, S., Stevens, S., Serfaty, M., Weich, S., & King, M. (2004). Stigma: The feelings and experiences of 46 people with mental illness. Qualitative Study. *British Journal of Psychiatry, 184, 176 - 181*.

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesizing Qualitative and Quantitative Evidence: A review of possible methods. *Journal of Health Services Research & Policy, Vol. 10, No. 1, 45 – 53.*

Fallot, R. D. (1999). *Spirituality and Religion in Psychiatric Rehabilitation from Mental Illness.* Retrieved 23 March 2006 from http://www.aapcho.com/

Fernando, S. (1991). *Mental illness, Race and Culture*. London: McMillan Education Ltd.

Frame, M. W. (2003). *Integrating Religion and Spirituality into Counseling: A Comprehensive Approach.* Canada: Thomson TM. Brooks/Cole.

Hayward, P. (1999). Culture and mental illness: A client centered approach. *British Journal of Psychology, 38, 103-105.*

Haque, A. (2004). Psychology from Islamic Perspective: Contributions of Early Muslim Scholars and Challenges to Contemporary Muslim Psychologists. *Journal of Religion and Health, Vol. 43, No. 4, 357 - 377.*

Husain, S. A. (1998). Religion and mental illness from the Muslim perspective. In Koenig, H. G. (Ed.). *Handbook of Religion and Mental Health* (pp. 279-290). London: Academic Press.

Henning, E. (2004). *Finding your way in qualitative research*. South Africa: Van Schaik Publishers.

Jorm, A. F. (2000). Public Knowledge and Beliefs about Mental Disorders. *The British Journal of Psychiatry, 177, 396 – 417.*

Kashyap, L. (2004). Introduction to Lay Counseling. *International Journal of Advancement of Counselling, Vol. 26, No. 4.*

Khan, M. M. & Al-Hilali, M. T. (translators.) (2001). *Interpretation of the Meanings of The Noble Qur'an: In the English Language.* Riyadh, Saudi Arabia: Darussalam Publishers and Distributors.

Koenig, H. G., George, L. K., & Peterson, B. L. (1998). Religiosity and Remission in Medically Ill older Patients. *American Journal of Psychiatry, 155, 536 - 542.*

Koenig, H. G. & Larson, D. B. (1999). *Religion and mental illness: evidence for an association.* Retrieved 23 March 2006 from www.aapcho.com/links.

Komiti, A., Judd, F., & Jackson, H. (2006). The Influence of Stigma and Attitudes on Seeking Help from a GP for Mental Health Problems. *Soc Psychiatry Epidemiology, 41, 738 – 745*.

Laher, S. & Moosa, A. (2007). Volunteer Care: Innovations in Practice. *Islamic Quarterly, 51,* 237-256.

Lauber, C., Carlos, N., & Wulf, R. (2005). Lay Beliefs About Treatments for People With Mental Illness and Their Implications. *Canadian Journal of Psychiatry, Vol. 50, No. 12, 745 - 753.*

La Torre, M. A. (2004). Prayer in Psychotherapy: An Important Consideration. *Perspectives in Psychiatric Care, Vol. 40, No. 1.*

Louw, D. A. & Edwards, D. J. A. (1997). *Psychology: An Introduction for Students in Southern Africa.* Heinemann: Johannesburg.

Lowenthal, K. M., Cinnirella, M., Evdoka, G., & Murphy P. (2001). Faith Conquers All? Beliefs about the roles of religious factors in coping with depression among different cultural-religious groups in the U.K. *British Journal of Medical Psychology, Vol. 74, No. 3, 293 - 303.*

Marsella, A. J. & White, G. M. (Eds.). (1989). *Cultural Conceptions of Mental Illness and Therapy.* Lancaster: D. Reidel Publishing Company.

Mason, T., Carlisle, C., Watkins, C., & Whitehead, E. (Eds.) (2001). *Stigma and Social Exclusion in Health Care.* London and New York: Routledge.

Mayring, P. (2000). Qualitative Content Analysis. *Forum: Qualitative Social Research, Vol. 1, No. 2.*

Maxwell, J. A. (2005). *Qualitative Research Design: An Interactive Approach (2nd ed.).* Thousand Oaks, California: Sage Publications.

Millon, T., Grossman, S. D., & Meagher, S. E. (2004). *Masters of the Mind: Exploring the story of Mental Illness from Ancient Times to the New Millennium.* Davers: John Wiley & Sons, Inc.

Mouton, J. (2001). *How to succeed in your Master's & Doctoral Studies: A South African Guide and Resource Book.* Pretoria: Van Schaik Publishers.

Neuman, W. L. (1994). *Social Research Methods: Qualitative and Quantitative Approaches.* Massachusetts: Allyn and Bacon.

O'Hagan, K. (2001). *Cultural Competence in the Caring Professions.* London and Philadelphia: Jessica Kingsley Publishers.

Pargament, K. I. (1997). *The Psychology of Religion and Coping: Theory, Research, Practice.* New York: The Guilford Press.

Pargament, K. I. (2002). Is Religion Nothing but...? Explaining Religion versus Explaining Religion Away. *Psychological Inquiry, Vol. 13, No. 3, 239 - 244.*

Pargament, K. I., & Brant, C. R. (1998). Religion and Coping. In Koenig, H. G. (Ed.). *Handbook of Religion and Mental illness* (pp. 112-128). London: Academic Press.

Pickthall, M. M. (2004). (translated by: A. S. Siddiqui). (2004). *Panjsura Shareef.* New Delhi: Saeed International (Redg).

Pescosolido, B. A. (2007). Culture, Children, and Mental Health Treatment: Special Section on the National Stigma Study-Children. *Psychiatry Services, 58, 611-612.*

Rack, P. (1982). *Race, Culture and Mental Disorders.* London: Tavistock Publications Ltd.

Roberts, L. W. (2002). Informed Consent and the Capacity for Volunteerism. *American Journal of Psychiatry, 159, 705 - 712.*

Rosendal M., Fink P., Bro F., & Olesen F. (2005). Somatization, heartsink patients, or functional somatic symptoms? Towards a clinical useful classification in primary health care. *Scandinavian Journal of Primary Health Care, Vol. 21, No. 1, 3 - 10.*

Sadock, B. J., & Sadock, V. A. (2003). *Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/ Clinical Psychiatry. (9th ed.).* Philadelphia: Lippincott Williams & Wilkins.

Satorius, N. (2007). Stigma and mental health. *The Lancet, 370, 859 - 878.*

Schumaker, J. F. (Ed.). (1992). *Religion and Mental illness*. Oxford: Oxford University Press.

Seedat, M., et al. (Eds.). (2003). *Community Psychology: Theory, Method and Practice: South African and Other Perspectives.* South Africa: Oxford University Press Southern Africa.

Simons, R. C. (2001). Introduction to Culture-Bound Syndromes. *Psychiatric Times, Vol. 18, No. 11.*

Smith, H. W. (1981). *Strategies of Social Research: The Methodological Imagination (2nd ed.).* New Jersey: Prentice-Hall, Inc.

Stark, R. & Roberts, L. (2002). *Contemporary Social Research Methods: A text using g microcase.* U. S. A: Wadsworth Group.

Sturgeon, S. (2007). Health Promotions Challenges: Promoting mental health as an essential aspect of health promotion. *Health Promotion International, 1, 36 – 42.*

Sue, D. W., & Sue, D. (2003). *Counselling the Culturally Diverse: Theory and Practice.* Davers: John Wiley & Sons, Inc.

Swartz, L. (2002). *Culture and Mental Health: A Southern African View*. Oxford: Oxford University Press.

Syed, I. B. (n.d.). *Spiritual medicine in the history of Islamic medicine*. Retrieved 23 March 2006 from www.IRFI.org/articles.

Taylor, S. (2003). Mental Disorders. In Taylor, S. & Field, D. (Eds.). *Sociology of Health & Health Care (3rd ed).* (pp. 137-154). Oxford: Blackwell Publishing.

Tepper, L., Rogers, S. A., Coleman, E. M., & Malony, H. N. (2001). The Prevalence of Religious Coping Among Persons With Persistent Mental Illness. *Psychiatric Services, 52, 660 - 665.*

Uzzell, D., & Barnett, J. (2006). Ethonographic and Action Research. In Breakwell, G. M., Hammond, S., Fife-Schaw, C., & Smith, J. A. (Eds.). *Research Methods in Psychology*. (pp.300 - 320) 3rd Edition. London: Sage Publications.

Ward, C. A. (Ed.). (1989). Altered States of Consciousness and Mental illness: A cross-cultural perspectives. Newbury Park: Sage Publications.

Welman, J. C. & Kruger, S. J. (1994). *Research Methodology: for the Business and Administrative Sciences (2nd ed).* South Africa: Oxford University Press.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in the theory and method.* London: Sage Publications.

Wilson, P. W. (1998). Religion and Psychoses. In Koenig, H. G. (Ed.). *Handbook of Religion and Mental Health* (pp. 161-173). London: Academic Press.

Yinger, J. M. (1957). *Religion, Society and the Individual: An Introduction to the Sociology of Religion.* New York: McMillan Company.

Young, J. L., Griffith, E. E. H., & Williams, D. R. (2003). The Integral Role of Pastoral Counseling by African-American Clergy in Community Mental Health. *Psychiatric Services, 54, 688 - 692.*

Youssef, H. A., Youssef, F. A., & Dening, T. R. (1996). Evidence for the existence of schizophrenia in medieval Islamic society. *History of Psychiatry, 7, 55 - 62.*

APPENDICES

Appendix A: Subject Information Sheet

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4500 Fax: (011) 717-4559

As-salaam-u-aleikum,

My name is Sumayyah Khan and I am a Master's student at the University of Witwatersrand. As part of my course I have to complete a research project. My research is interested in trying to understand what the perceptions of mental illness are of the volunteer mental healthcare workers in the Mayfair Muslim community. I would also like to explore whether or not the volunteer mental healthcare workers feels that religion plays a role in these perceptions. I would like to invite you to participate in this study.

Participation is completely voluntary and you may decline or withdraw at any time and there will be no negative consequences. I assure you that all information gathered will be dealt with in a strictly confidential manner. No identifiable information will be included in the research report. The interview materials (tapes and transcripts) will not be seen by anyone other than my supervisor and myself. The interview incorporates a range of questions dealing with the above-mentioned issues. Your participation would consist of a 45min – 1hr one-on-one interview with me where you will be asked these questions. Although it would be appreciated if you could answer all of the questions to the best of your ability, you are free to omit questions if you wish.

If you choose to participate, you may leave your contact details with Anisa Moosa who will forward them to me. I will contact you as soon as possible to arrange a time, date, and place that is at your convenience to conduct the interview. If required, feedback will be available approximately 6 months after the interview. Feedback will be in the form of a one-page summary of the study and its results. If you require any further information, please contact me on 072 2122 503 or e-mail me at sumayyahkhan1@gmail.com. You may also contact my supervisor, Sumaya Laher on 011-717 4532 or e-mail her at sumaya.laher@wits.ac.za.

Your participation in this study will be greatly appreciated.

Sumayyah Khan

Appendix B: Volunteer Counsellors Interview

As-salaam-u-aleikum,

I would like to thank you for agreeing to participate in my study. Before beginning with the interview I would like to assure you that everything you say during this interview will be kept strictly confidential, and only my supervisor and I have access to the tapes. The tapes and transcripts will be destroyed after the relevant information has been obtained. Although I know who you are, confidentiality will be maintained by not disclosing any information that is of a personal nature in the report. Assigning a pseudonym to your information in the report, for example, Ms/ Mrs. X, will maintain confidentiality. Any information that you may reveal regarding your clients will also be kept confidential.

I would like to remind you that you maintain the right to withdraw from the interview, or withdraw information provided at any time during the interview. You also have the right to refuse to answer questions if you wish to do so. A feedback in the form of a one-page summary of the study and its findings will be provided to you, if you request it. The feedback will be available approximately 6 months after the collection of the data.

My contact details were on the information sheet provided (See Appendix A) when requesting your participation. I do have some available if you are no longer in possession of the information sheet. Before beginning the interview I will need you to complete these two consent forms (See Appendix C & D).

Thank you. If you are ready we can begin the interview.

Appendix C: Consent Form (Interview)

I, _____ give my consent to being interviewed by Sumayyah Khan, for her study exploring the perceptions of mental illness of Muslim volunteer mental healthcare workers. I acknowledge that:

- Participation in this study is voluntary.
- I may refuse to answer any questions without justification.
- I may withdraw information from the study at any time.
- I may withdraw my participation from the study at any time.
- There are no risks or benefits associated with this study.
- No identifiable information of me or my clients or me will be included in the research reports.
- All information provided will remain confidential.

Signed: _____

Date: _____

Appendix D: Consent Form (Recording)

I, _____ give my consent for my interview with Sumayyah Khan to be recorded for her study exploring the perceptions of mental illness of Muslim volunteer mental healthcare workers. I acknowledge that:

- The tapes and transcripts will not be seen or heard by anyone other than the researcher and her supervisor.
- The tapes and transcripts will be kept in a safe place for the duration of the study and will be destroyed after the relevant information has been obtained from them.
- No identifying information will be used in the transcripts or the research report.
- Although, direct quotes may be used in the research report from my interview, I will be referred to by a pseudonym.

Signed: _____

Date: _____

Appendix E: Structured Interview Schedule

Information Observed: Gender

Communication with the organization confirmed that all the volunteer counselors are Muslim.

I would like to begin the interview by asking you a few questions that will help me get to know you better, all the questions are relative to the research and, as said before, you may choose to not answer any questions at any time.

1a. How old are you?

1b. What is your highest level of education? (Secondary and Tertiary)

1c. What counseling training have you been involved in? (Prompt with; counseling courses, other volunteer programs, Childline, Lifeline, etc.)

1d. How many years in total have you been involved in counseling? And how many years have you been counseling at Islamic Careline?

1e. Does Islamic Careline cater specifically for the needs of Muslims or is anyone welcome?

2. How would you describe mental illness?

3. How do you think a mental illness differs from a physical illness?

4. How do you think mental illness manifests or shows up in a client?

5. How does a mental illness differ from everyday problems?

6a. What type of cases do you generally see at the careline? (Prompt with trauma, hijacking, robbery, domestic violence, marital problems, etc)

6b. How often would you encounter these type of cases? Are the cases generally long-term or short-term?

6c. How do you think these cases impact on your life? (Prompt with; does it affect your personal life, do you find it difficult to disconnect, etc.)

7. At what stage in one's struggle with mental illness do people tend to seek the assistance of Islamic Careline?

8. Do the people who come to see you, first seek medical help, before they seek your assistance?

9. In your understanding, what are the causes of mental illness?

10. At the Islamic Careline, what do people commonly believe is the cause of their mental illness?

11. What role do you feel you, as a volunteer counselor, play with regard to mental illness?

12. Do you feel that being a Muslim has assisted you in your understanding of mental illness and willingness to work in this field? Please elaborate.

13. In your opinion, what role do you feel Islam plays in helping Muslims understand mental illness?

14. In your opinion, does salaah play a role in assisting someone who is suffering with a mental illness? Please elaborate.

15. To your knowledge, do you find that people tend to spend more time dedicated to prayer in times of stress then on a normal basis? Please elaborate.

16. In your experience, does stigma exist around the understanding of mental illness in the Muslim communities?

17. Do you feel that stigma does/doesn't exist in the Muslim communities due to religious or cultural values? Please elaborate.

18. Do you think that Muslims have a different understanding of mental illness then people from other religious groups? Please elaborate.

19. Do you believe that one's religion or culture is a key factor in determining their choice of treatment for mental illness?

20. Do the people who seek counseling, believe their problems to be caused by forces other then medical or psychological? (Prompt with; for example, spiritual forces, etc.)

21. What typically characterizes a spiritual illness (prompt with like jaadoo or nazr)?

22. Can it be said, that there is a distinction between mental illness and spiritual illness?

23. What are your personal beliefs regarding spiritual illness? (Prompt with; do they exist, in what form do they exist, what are the symptoms, what experiences have you had with them, etc.)

24. How do you counsel clients who believe their illnesses are caused by spiritual forces? What do you say to them?

25. How do you feel about other Western forms of mental illness treatment, i.e. Psychologists, Psychiatrists, etc? Would you refer someone who seeks your help to one of these professionals?

26. How do you feel about other spiritual forms of mental illness treatment, i.e. moulana's, faith healers, etc? Would you refer someone who seeks your help to one of these professionals?

27. In your experience, what response have people who have sought your assistance had with regard to Western forms of treatment?

28. In your experience, what response have people who have sought your assistance had with regard to spiritual forms of treatment?

29. In your experience, have people; who believe their illness to be caused by a spiritual misgiving, being open to seeking assistance from Western professionals?

30. In your opinion, do you believe it is possible for Western and spiritual forms of treatment to work collaboratively?

31. Do you have any further comments or would like to add any other information that you feel we have not discussed? If yes, please elaborate.

Shukran for your time.

Appendix F: Feedback Sheet

The understanding of mental illness is not universal. The way certain conditions are labeled in different settings, and how they are expressed in different cultures, need to be taken into consideration. Incorporating indigenous understandings and religious views towards mental illness in Western paradigms will help mental health providers offer the best and most appropriate means of treatment for people across cultures. Stigma is also believed to play an intrinsic role in the perceptions of mental illness and it is possible that this stigma may hinder the course of treatment for those suffering with a mental illness.

Thus this research investigated the perceptions of mental illness in a sample of 8 volunteer counselors, from a specific Johannesburg community, who volunteer their services at the Islamic Careline. Structured interviews were conducted with the counselors to determine their understanding of mental illness and to establish the role played by the religion of Islam, if any, on these perceptions. In addition, whether or not stigma exists within this community and what affects it may, or may not, have on the understanding and treatment of mental illness.

Based on the information obtained from the interview material, three broad themes or categories emerged; namely, understanding mental illness, etiology of mental illness, and treatment of mental illness. The process resulted in a number of sub-themes in each category. The first category is divided into four sub-themes; namely, volunteers perceptions, volunteers' clients' perceptions, stigma, and role of religion. The second category also included volunteers perceptions and volunteers' clients perceptions; as well as, spiritual illnesses. The third category included the importance of cultural competence amongst mental health providers, prayer as a coping mechanism, and the assistance of spiritual healers. The findings of the study suggests that understanding the way in which people perceive mental illness, its definition, etiology and treatment, requires taking into consideration the specific needs, beliefs, values and conditions of diverse communities. This includes their social, cultural, religious and spiritual backgrounds and their personal beliefs about mental illness.