REACH

COMMUNITY HEALTH PROJECT

Mental Health Issues amongst Muslim Women Residing in South East Glasgow Community Health and Care Partnership Boundary: A Study of Their Beliefs, Knowledge and Service Access Issues

A Research Report by REACH Community Health

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Project

REACH Community Health Project is an innovative National Voluntary Organisation whose aim is to improve the health of Black and Minority Ethnic (BME) communities living in Scotland.

The project is also committed to facilitate change within mainstream health services to better address the health needs of this particular community. To achieve these aims REACH has developed a triangulated formula in the form of a Services Unit, Policy and Research Unit and a Cultural Diversity Training Health Unit.

Our ***vision*** is a multi-cultural society in which all people have equal access to appropriate health services and our mission is to empower BME communities by ensuring that their health needs are fully met.

REACH Community Health Project have three key objectives as working principles which helps us to implement our policies into practice thereby achieving our aims. The objectives are as follows;

1. To provide a range of good quality, culturally-sensitive preventative health services.

2. To influence mainstream policy and undertake innovative research so as to identify and remove barriers to health for BME communities.

3. To provide cultural diversity training for mainstream, voluntary and private sector organisations working with BME communities.

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Abstract

This study was conducted to understand and document the mental health knowledge and beliefs held by Muslim women in Glasgow and to address issues surrounding accessing mental health services.

Mental ill health is a contentious health issue, often loaded with negative perceptions largely as a result of misunderstanding mental health problems, some of which includes the causes of mental distress, the effect of these mental health problems on the individual, their family and society at large and the treatment options available. Misrepresentation and sensationalising of severe mental illness cases by the media perpetuate and encourage in upholding such prevailing stereotypes of mental health sufferers. As a result of these factors, the stigma attached to mental ill health has been noted to restrict and hinder individuals from seeking support and help for their mental health problems.

There are reams of research studies and publications into various mental health problems such as depression and anxiety, eating disorders and severe and enduring mental illnesses such as schizophrenia and psychosis. Much of the research available on mental health, particularly amongst Black and Minority Ethnic communities, highlights the high prevalence of mental health problems amongst women in these communities. Despite studies looking into mental health of BME communities, there is a lack of research looking at mental health in Muslim women. This research study attempts to address the gap by studying the belief and knowledge Muslim women hold about mental health and factors important to them when accessing support for mental health problems.

1. Introduction

Glasgow is a thriving multicultural city, consisting of diverse ethnic, racial and religious groups. The Muslim population of Glasgow, despite composing 3.8% of the city's population (General Register for Scotland, 2001), are an under represented, under-resourced and under-studied minority. Existing health research has focused on the needs of various segments of BME communities recognised to be particularly vulnerable, such as South Asian and Black women (Bhui & Bhugra, 2002) however, no studies that exclusively look at the mental health needs of Muslim women independent of their ethnic background and race exist for the UK. The recent rise in numbers of asylum seekers choosing to settle in Glasgow are not included in population census. The asylum seekers population compromises of a wide mix of various backgrounds, countries and ethnic groups. For the city of Glasgow the large numbers of Somalian, Iraqi and Kurdish groups make up the overall asylum seeker and refugee population, with a significant number being women and Muslim. The consensus statistics do not take into account these figures and therefore actual Muslim population of the city may be higher.

Census statistics report the Muslim community to be amongst one of the most deprived and socially excluded communities in the UK. Low levels of employment, poverty, poor health and low educational achievement have been documented. Within these findings, Muslim women report poorer physical and mental health than their male counterparts (Office for National Statistics, 2001). However, due to under-reporting and method of data collection these findings may be an under-representation of the true scale of

health problems, particularly mental health problems encountered by Muslim women (Sonuga-Barke, Mistry, & Qureshi, 1998; Cochrane & Fazi, 2003).

While South Asian groups predominate within Muslims in Britain, there is a danger in essentialising Muslims in Britain to wholly be of South Asian background and their views/opinions are representative of Muslims within the UK (Rex and Modood 1994; Nielsen 2000). Pakistanis and Bangladeshis may be almost entirely Muslim, but Islam is pan-ethnic and there are Muslims in Britain of Turkish, Arab, Albanian, Bosnian, Iranian, Kosovan, Nigerian and Somali descent. Owing to the diverse nature of Muslims within the UK, it is essential to ensure research reflects the diversity of views held by these various ethnic groups and adequately addresses their needs accordingly.

The meaning of being mentally healthy is subject to many interpretations rooted in value judgments, which may vary across cultures. Mental health should not be seen as the absence of illness, but more to do with a form of subjective well being, when individuals feel that they are coping, fairly in control of their lives, able to face challenges, and take on responsibility. Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity specific to the individual's culture (The World Federation For Mental Health, 2006).

1.1 Prevalence of Mental Health Problems in Black and Minority Ethnic (BME) Women

Research highlights prevalence rates of psychological morbidity for South Asian women to be greater compared to the indigenous population (Anand & Cochrane, 2003), particularly in certain domains such as depression, anxiety,

suicide, self-harm and eating disorders (Bhugra & Bhui, 2003; Fazil & Cochrane, 2003). The South Asian population consists of those individuals who identify themselves as having cultural origins in the Indian subcontinent – Pakistani, Indian and Bangladesh being the predominant countries of origin. As an ethnic group, the South Asian population is culturally diverse and heterogeneous, compromising of subgroups, each having wide variations in traditions, language, customs and religions respectively.

Classification of all subgroups under the category of South Asian risks giving rise to and reinforcing of cultural stereotypes and distorts overall clinical picture. The importance of distinguishing between subgroups was highlighted by Nazroo (1997) in his large-scale community survey looking at mental health in minority ethnic groups. Findings indicated all subgroups to report comparatively lower rates of depression and anxiety than their white counterparts. However, further analyses on South Asian subgroups yielded Pakistani women to have higher rates of depression and anxiety whilst Indian and Bengali women showed the lowest rates. A similar longitudinal study by Hitch (1981) found similar results, where high rates of depression amongst Pakistani women and low rates in Indian women were noted.

Community studies indicate Muslim women of Pakistani origin as being particularly vulnerable to depression and anxiety (Creed et al., 1999; Sonuga-Barke & Mistry, 2000; Fazil & Cochrane, 2003). Sonuga-Barke & Mistry (2000) found depression and anxiety levels to be more pronounced in Pakistani Muslim women in comparison to Indian Hindu women. In another study by Creed et al., (1999) prevalence rates of depression and anxiety in a sample of British South Asian women, of Sikh, Hindu and Muslim religious

background were compared with a sister sample living in India and found Muslim women to obtain higher scores for depression and anxiety than their counterparts. Despite the results of these studies, there has been little research conducted whereby the mental health needs of Muslim women have been investigated independent of their ethnic background.

Furthermore, studies which have investigated the mental health of South Asian women often consist of studying small samples which may obscure participants' regional origins or religion. Obscuring religion in studies looking at mental health of women from a shared cultural and ethnic background affects obtaining a clearer and accurate understanding of the prevalence of mental health problems in certain groups and subsequent help seeking behaviours. Stereotyping South Asian culture as "repressive" in comparison to the "liberated" West can be readily incorporated into "pseudo scientific explanations" of mental illness and come to be regarded as "fact" for legitimate use in explaining and treating mental health illness among women in this minority group (Burr, 2002). Similar stereotyping for Muslim cultures is also possible and therefore detrimental to the understanding and subsequent treatment of Muslim women with mental health problems.

Research into the African-Caribbean and Black population points to the over-representation of Black patients sectioned under the Mental Health Act. Mental Health Act admission rates are higher for African–Caribbean than for comparable samples of White and other ethnic groups (Bagley, 1971; Bebbington et al, 1991; Moodley & Perkins, 1991). There is also a greater likelihood of black patients being detained in hospital compulsorily (Harrison et al. 1989; Davies et al. 1996; Commander et al. 1997a) and are more likely

to have the diagnosis of schizophrenia and other forms of psychosis (Department of Health, 1992). There is little research into Black, Black African or African-Caribbean women of Muslim faith or background within the UK, despite compromising a large number of the population.

The mental health needs of other ethnic groups, such as Arabs have not been documented on the same scale as South Asian. The problem with identifying the population of Arab individuals or those of Arab descent is due to the nature of consensus data collection. "Arab" as an ethnic group ceased to be recorded since 1991; instead statistics are based on country of origin. Due to the obscure census of data collection, "Arab" ethnic groups are not as easily identifiable as other groups. This lack of identification as a group means that they are an under-represented and an under-researched group. As a result major future planning and development issues do not include this group. These issues include, for example, planning of health needs, including mental health.

1.2. Understanding of Mental Health amongst the Muslim Population

Stigma and negative perceptions of mental health problems are prevalent within BME communities and whilst research reflects this, there is scarce information regarding barriers faced by Muslim women. For the majority of Muslims Islam is a way of life, a complete belief system by which all spheres, personal, social, occupational and familial, are adhered to, impacted, influenced and inspired by the teachings of the Qur'an and Sunnah. [6]

The role of beliefs in the understanding of mental health issues is pertinent among Muslim women. Mental health problems such as depression and anxiety may be interpreted as a sign of a weak nafs (soul) and feelings of

suicide or suicidal ideation may be met with conflict and guilt as Islam prohibits the act of suicide. Another example is the Islamic notion of spirits (jinn), which may affect attitudes towards certain mental illnesses such as schizophrenia and psychosis.

Whittaker, Hardy, Lewis & Buchan (2005) found mental health beliefs amongst a sample of Somalian women to be influenced by religious and cultural understandings. Conflicts and convergence between religious and traditional beliefs were noted where Somali beliefs about zar possession were interwoven and fused with Islamic beliefs of jinns.

Understanding mental distress has often been shown to be strongly related to wider cultural beliefs (Helman, 1990), with religion arguably to be a significant predictor of attitudes towards seeking help (Kleinman, 1987). Sheikh and Furnham (2000) found religion to be a significant predictor of attitudes towards seeking help. Causal beliefs about mental distress predicted positive attitudes to seeking help among the British South Asian and Pakistani groups. Muslims were the least likely, and those with no religious affiliation the most likely, to have a positive attitude to seeking help from a mental health professional.

1.3. Religion and Coping

A common emergence from various research studies points to the utilisation of prayer in coping and maintaining positive mental health. Prayer is perceived as a means of gaining better knowledge of oneself and acts as a form of self-administered therapy and maintains feelings of control and self-efficacy. Prayers have also been seen as less inhibiting than communicating problems to friends, family and / or professionals due to it's private nature,

with near to none or non existent scope of being stigmatised. Other cited reasons suggest cognitive factors, particularly religious faith and prayer to be pertinent, as found by Loewenthal (1993) in a study looking at Pakistani women and coping techniques for depression. These studies confirm the value of Islamic prayer in attitudes towards seeking help for mental illness (Beliappa, 1991)

Religious practices and beliefs could play a useful role in treatment for mental health problems, in combination with Western medicine / medication (Cinnirella & Loewenthal, 1999; Whittaker et al., 2005). The use of traditional or spiritual healers, known as "pirs" "shaykhs" or "moalj bel-Quran, who offer culture specific approaches to mental illness and treatment is common practice for various sections of the Muslim community, particularly those from a South Asian or African background (Hussain & Cochrane, 2003). Malik (1998) suggests that one reason for visiting traditional healers is that 'the healer is part of a community, with shared belief systems and world view, who has an understanding of the rules of that community and whose role is understood and respected by that community' (p. 14).

Although the prevalence and use of these traditional and spiritual healers is unclear (Ineichen 1987; Webb-Johnson, 1995), the use of traditional healers is often made alongside rather than in place of western medical intervention (Cochrane & Sashidharan, 1996; Greenwood et al., 2000). However, cross generational and trans-cultural differences persist for the use of these traditional healers and so generalisation of the use of traditional healers by all or most sections of the Muslim community, in explaining the under utilisation of mental health services, is an inadequate and oversimplified assumption.

1.4. Accessing provisions for mental ill health

Language barriers have long been recognised as one factor hindering and preventing the delivery of satisfactory health care provision (Hussain & Cochrane, 2002). However language for some women is not a barrier when seeking help from mental health services, but rather other factors contribute to overall dissatisfaction with provisions from services.

As presentation and reporting of psychological symptoms is "culturally grounded" (Fernando, 1990), "evidence" of mental illness in one culture can vary substantially from another. Some have related the occurrence of mental illness to vary between cultures due to the acceptability of behaviours in the West that would otherwise be deemed inappropriate in some other cultures (Whittaker et al., 2004). However, where host culture is dominated by one particular ethnic group and views of this group is largely accommodated by services, views of other ethnic groups and method of relating symptoms may be discredited or misinterpreted.

1.5. Stigma

An important factor hindering seeking support and intervention from health professionals is that of community stigma. The act of being labelled with a mental health problem can serve to make life difficult for the individual and families as maintaining family and individual reputations within the community is often a key consideration. Some concerns surround the notion of being "doubly stigmatized" by one's own ethnic / religious group, for being mentally ill and by the indigenous white population, for being non-white.

Some families have also referred to the discrediting of their value system by mental health professionals as a deterrent in opening up for fear of their value system to be reinterpreted as "a belief based on neurotic obsessional needs" (Weiselberg, 1992). These fears of community stigma in turn may reduce the likelihood of individuals from such ethnic and religious groups to turn to other community members for help and advice.

1.6. GP

Anxieties about confidentiality have often emerged as a barrier in seeking help from a GP, particularly where the GP is of same ethnic background or known to the family in a shared socio-cultural context (Gilbert et al., 2004; Newhan Study). Such fears however are not unsubstantiated as demonstrated in the case studies conducted by Newham Asian Women's Project into the suicide / attempted suicide by young girls from a South Asian background. Some of the participants related incidents whereby GPs broke confidentiality and informed the parents and / or guardians of issues discussed during appointments.

1.7. Ethnic Preference

Referral rates for mental health problems are reported to be low among Pakistanis in Britain in comparison to other groups (Ball, 1995). Suggestions for this trend had often included fear of social stigma as a result of seeking help and the effectiveness of support within the Muslim community.

The issue of ethnic and religious matching of therapist and patient is central as one of the formulations in the provision of culturally sensitive mental health

services. Cinnirella & Loewenthal (1999) conducted a comprehensive study of religious and ethnic group influences on beliefs about mental illness.

There was felt to be more of a risk with a person 'from a different culture' to give advice which would be against a service user's cultural and religious beliefs and values. They reported Muslim respondents to prefer health professionals of the same religion or race in relation to seeking treatment for depression and schizophrenia on the grounds of shared cultural understanding and common identity. An example of this was the more possible suggestions by a Muslim health professional in ways which religious practices may aid in coping, such as readings from religious texts.

On the other hand, it has been proposed not all individuals prefer to see health professionals from their own cultural background (Messant, 1992) due to issues of confidentiality, community discovering their plight thus tarnishing their and their family's reputation.

1.8. Cultural factors

Ingrained notions of family honour (izzat), shame and role fulfilment as studied by Gilbert et al (2004) are significant factors influencing seeking professional help for mental health issues. Experiences of physical entrapment within the constraints of traditional cultural values (such as role fulfilment, obligation to duties and maintenance / upholding family honour) were found to be contributory factors to the development of mental health difficulties and help seeking behaviours and so may explain discrepancies in help seeking behaviours by Muslim women.

Feeling restricted in the amount of information they can provide in apprehension of being judged as being a "bad Muslim" or seen as "letting the

community down" may also be a contributory factor in low uptake of services (Cinnirella & Loewenthal, 1999). Familial involvement in health care provision may not be wanted by individuals and so family therapy practices that invite extended family to assessment and subsequent meetings may be inappropriate. Also, if accessing services are viewed as the possible abandonment of a relative, such as accessing residential care then help seeking and service uptake are reduced. Having the choice of health care practitioner and other health professionals involved in health care provision may aid in the engagement of services by Muslim women.

2. Methodology

Triangulated Qualitative research was employed for this research study. Triangulation is conventionally defined as the purposive gathering of multiple sources of data and the use of these data sources in the reporting of results (Babbie, 1989; Neuman, 2003).

The most common application of triangulation in social research is in the use of multiple measures – for example, focus groups, interviews and observation – to gain a more complete picture of a phenomenon, all fully reported on and compared. Triangulated qualitative research employs well-established and well defined methods of data collection such as focus groups and interviews alongside other techniques, to obtain a more complete understanding of the issue (Guba and Lincoln, 2000). In essence, triangulated studies help with the confirmation and completeness of the research findings, where different methods and approaches are used to obtain a set of results, to obtain a more

complete picture that using one method alone may miss out or not be achieved.

The first stage of research involved conducting an extensive review of the literature available on Muslim women and mental health. The literature review supported the scarcity of research studies that looked at mental health amongst Muslim women and so added further weight into the importance of addressing this research gap.

The second stage involved active verbal data collection which was obtained via two ways; by conducting semi-structured interviews and by holding focus groups.

The third stage in triangulated qualitative research refers to the content and narrative analysis of the data. Themes from the data were analysed based on discussion of the transcripts and analysis of the patter and patterns which emerged. Sequences of core phrases, views, opinions and ideas were taken as indicators of themes. Content analysis on themes allowed for comparison, understanding and insight into the themes alongside comparing and linking other related themes accordingly.

2.1. Measures

Semi structure interviews allow a degree of flexibility for participants in relating and explaining in greater detail and depth without the confines of being rigid and succinct in their responses. This allows participants to elaborate on aspects or views which they subscribe importance to or wish to make pertinent. The use of these semi-structured interviews in the research study generated data rich in individual experiences, understanding and concepts of mental health.

The focus group generated discussion on the topic of mental health, by sharing, understanding and exploring the divergent views, beliefs and opinions held by the participants. In order to generate a good dialogue and allow participants to be involved fully in the discussion the focus groups were kept to 3 individual groups and made up of small numbers of participants.

2.2. Participants

Participants were Muslim women who resided under the South East Glasgow Community Care and Health Partnership (CHCP) boundary area. The sample size for the semi-structured interviews was a total 15 participants and there were 9 participants in total for the 3 focus groups.

2.3. Recruitment

Participants were service users of community resources and organisations that fell under the South East Glasgow CHCP area and were approached to partake in the research study. Participants were provided with information on the research project and gave their consent to voluntarily participate in the interviews and focus groups.

3. Discussion

3.1. Mental health

Mental health was a term which the respondents found difficult to conceptualise outside and in isolation of illness. Mental health was predominantly understood to be associated with and in the context of difficulties or problems. The importance of mental health was very much seen to refer to the absence of illness and the majority of understanding pertaining

to the term "mental health" was almost always in reference to or linked to difficulties or problems with mental health.

> Mental health means somebody has something wrong with his mentality. (p8)

Despite finding it a hard term to conceptualise, mental health was seen to be very important for the individuals overall well-being, with an emphasis on taking a holistic approach whereby the mind with the body are seen to be one entity but consisting of two components that affect one another.

> Related to mental status. Response to environment, your motivational level, emotional, feelings, behaviour and attitude. Everything is related to my mental health, my emotional behaviour. It is the backbone of everything, it affects my physical, my work life, home life everything. Backbone to life (p10)

> Mental feelings, about how you are feeling, your thoughts and emotions....We all have mental health; there is a difference between mental health and mental ill health (p14)

> Someone's psycho-social well-being. How a person is feeling, mentally, psychologically and how they interact with other people, their surroundings and environment. Everything that affects you, if you are not well psychologically then it would affect your physical health. (p15)

3.1.1 Understanding mental health

The understanding of mental health was very much related to the inner state of the individual, with common reference of mental health being an unseen aspect of health, very much not apparent or obvious to others and was demonstrated by comparison using examples of physical ill health.

> Well being of your internal state. How you perceive life, deal with things, good or bad. How content you are with yourself. Psychological is embedded; it influences how you deal with things in life as well. (p3).

> Well-being related to feeling. Like physical health is usually attributed to a physical cause, like a sore head a sore leg. Mental health is what you feel inside – happy, sad (p4).

> It's easy if you have a broken arm to go into hospital and they can see it, but with a mental health issue there is a part of you that's broken, but its not visible (p9).

Emotions, such as happiness and sadness and feelings were markers and indicators of good mental health. A change or fluctuation of these emotions was seen as signs of possible mental ill health.

> Feelings, being sad and withdrawn from others. Has to do with emotions and how you are feeling (p11)

> When you are not angry, be happy and have no sadness. No stress or problems to deal with. Function normal with everything and everybody (p12)

> Mental feelings, about how you are feeling, your thoughts and emotions. Maybe there is an imbalance in their emotions, they may feel very sad at one point and then incredibly ecstatic or manic at other times, so there isn't that healthy balance (p14)

As a result of emotions and feelings playing a pertinent role in overall mental well-being, good mental health was also understood to contribute towards and sustain relationships, performance, coping with stress and quality of life and social interaction.

> When you are happy and normal, have good behaviour and treat people properly. How you are with other people, relate to other people and cope with problems (p5).

> Relations with people, the way how people....psychologically how somebody reacts to things, to other people, to themselves (p7).

> How you cope with people and things, your reaction to stress and perhaps responsibilities (p13).

3.1.2 Understanding and awareness of mental ill health

Mental ill health however was seen to be a state or condition whereby the functioning level of the individual was not deemed normal or healthy for them

> Anything that takes you out of the norm, the individual's norm, what is normally considered ok or normal for them. (p14)

and resulted in changes in performance, particularly of daily tasks and chores that would otherwise be within their capacity to carry out.

> That has something to do with the mental performance of the person .:. Sometimes the person he feels that he is very down, he can't do anything (p8)

> Mental health is when it affects your mood and your everyday life so badly that you cannot focus on your personal care, your daily chore, going out to work, or even talking. (p2FG2)

The potential for mental ill health to manifest physically was recognised

> ....what comes under you mentally as opposed to physically although it can manifest itself in physical form eventually. (p14)

However it was noted that the definition or standard of what is considered normal was subjective and open to interpretation depending on culture and society.

> An altered state of mind from what would be considered healthy, not normal, as your norm may be considered mentally ill (p1)

> Anything that takes you out of the norm, the individual's norm, what is normally considered ok or normal for them (p14)

3.2. Causes of mental health problems

3.2.1 Relationship problems and abuse

Relationship problems, particularly those involving marital relations including divorce were seen to be one of the catalysts in developing mental health problems.

> Some kind of relationship problems, with family members or other relatives.(p12)

> Marriage, relationship problems, domestic issues. (p9)

> Family problems for Asians, as they are very family orientated. If things go bad or you don't like them it can cause problems. If you are not happy with your husband, have relationship problems of break ups. (p15)

In addition, abuse in its various forms and facets, particularly the long lasting cyclical effect were also very much thought to contribute towards mental ill health.

> Abuse, including domestic abuse and other forms such as physical, emotional, mental, sexual and verbal were seen to be significant in contributing to mental ill health, with the cycle of abuse occurring throughout an individual's lifespan and possibly becoming perpetrators of abuse themselves(p12)

> Experiences in life as well, such as those who have been abused and then go on to abuse other people, they have some sort of mental issues and have gone and done it to someone else (p3)

> ....and mental abuse usually hurts your feelings and emotions. Mental, verbal and physical abuse. (p4)

3.2.2 Racism and discrimination

Racism was a pertinent issue amongst the women in the study. Many of the women had experienced racism or did not feel safe when out and about

> Racism, I am afraid to go out after dark because of name calling. The TV coverage on Muslims and link to terrorism makes you scared to go out and do things; you feel victimised (p5)

> Racism as well, I work with this woman who is a refugee and she witnessed some horrific crimes in her home country, on top of which now that she is here she is a victim of racism and is taunted in the streets. So she stays indoors for fear of being attacked, which doesn't help her mental state at all. (p14)

Owing to the visibility of Muslim women by way of attire, in particular the headscarf that some Muslim women wear was seen to be misunderstood, discriminated against and victims of racism purely on the grounds of their faith.

> It affects how we are viewed and treated, if you are wearing the hijaab it can restrict...not because it's a faith issue, but how people perceive you as a result of the bad image of Muslims perpetrated by the media (p11)

> As a group of Muslims we are in a country which is not ours, and because of the political things, either the 7th of July or September, although we have nothing to do with it we are under pressure because of our scarf. (p8)

Much of the discrimination and stigma was felt to be increased due to political events and images perpetuated by the media. And had the capacity to have serious and real effects on the mental health of Muslim women

> So I feel the media has a big role to play in this, people in society feed on that and don't look behind the newspapers. Sometimes it only takes verbal abuse, due to maybe your religious attire, beliefs, colour of skin or your ethnic background to instil that fear which can lead to isolation, withdrawal and mental health problems. (p14)

3.2.3 Unemployment

Unemployment generally was expressed to be one of the potential events that can cause or contribute to the onset of mental health problems. However, unemployment was deemed to be a more pertinent issue afflicting men due to the increased social status for men in employment and their expected role as breadwinner and provider for the family

> Men are meant to be braver and show no emotion, meant to be protectors, so not being to work due to mental health problems or lack of work leading onto mental health problems. Not being able to fulfil role of provider may exacerbate problems or be the cause of mental health problems (pp3)

> In Asian culture, unemployment is more of an issue for men. Since they are meant to be breadwinners, sometimes they are compared to other people who can affect their ego (p15)

And also in terms of achievement and a marker of success in comparison to the individuals peer group

> Unemployment also, you can become depressed when friends are well established, sometimes you don't feel like mingling with them because they are of a different social standing than yourself (p15)

As a result, unemployment by the participants in this study was seen to be less significant and had less of an impact for women. However this was viewed and understood in the context of gender roles. Therefore the impact and effect of unemployment on women varied accordingly across and between groups of women

> Girls are not too big a deal if they are unemployed, socially they won't feel those kinds of pressures from everybody for not having a job, although personally they may feel a bit inadequate or being a failure if you are independent or career minded (p15)

3.2.4 Financial

Financial constraints owing to debt and its association with poverty and poor housing were seen one of the factors out of the myriad other compounding factors that can proceed and exacerbate the potential to developing mental health problems due to fewer opportunities available

> Just because you are poor doesn't meant you are more likely to have mental health problems. But it may be related to not being able to get a job, and seeing other people around you moving on in life, so maybe it may have an impact (p3)

3.2.5 Physical health

Physical impairments, such as physical health problems, disability or degenerative conditions, were thought to have an effect on mental health due to being unable to engage in a lifestyle of the individuals choosing, the discrimination they face and because of the lack of opportunities available to them

> May also be related to physical form, such as being disabled, scarred or having multiple sclerosis, it may in some way affect mental health as you are not ideal or "normal" in the eyes of society (p1)

> Physical impairment can lead to mental health problems, you might feel inadequate, useless, different and a bit alien since you cannot integrate fully – you don't belong to the mainstream society because you feel unable to fully participate in community events and life (p15)

Organic disorders were also noted to lead onto problems with mental health within a cognitive capacity, but this was seen to be an effect of the condition and not the cause of the problem

> If this person is having something else, like a geriatric condition or something like that...that is out of their control. If the person has Alzheimer's he doesn't know what he is doing, so it depends on the disease. (p8)

> The nature / nurture debate, such as in the case of dementia, it may cause mental health problems but it is not a mental illness but a medical disorder. So medical disorders may affect you mentally but are not pure, specific mental disorders. (p1)

3.3. Cultural differences and generation gap

The cultural clash between adopting Western lifestyle and compromising Islamic beliefs were seen to be a significant contributor to the development of mental health problems

> Teenagers who grow up in this kind of environment, a clash of cultures whereby this culture and lifestyle is seen as normal but islamically it is not permissible just end up rebelling. (p4)

> Sometimes when your children grow up and... and are teenagers and are living in a country like that, we have our own specific values and if the children are not going according to that can cause [you and them] mental health problems (FG3)

Instilling fear into individuals in order to encourage them to comply with religious practises or believe in religion was seen to be a method of control, which increased the gap in generation and fuelled culture clashes.

> That sector of the community that feels they need to put the fear of God into individuals to teach them the basics of their religion. (p9)

Causes of pressure and stress were loosely recognised to differ between generations. The generation gap between parents and children and stresses for each party was seen to be down to different expectations and goals.

3.3.1 Parents

Parents were seen to be focused on their children, and often their own goals revolved around having their children settled in terms of marriage

> If you split it up into two generations, like older generation and the younger generation....Maybe something to do with the pressure of children, especially if you have teenage children, maybe of making sure they are on the right path, that they are on the straight and narrow. Or maybe if they are at that age where parents are looking to getting them married off. I think with Asian parents there is a lot to do with the family honour and respect that is a major thing. (p1fg1)

3.3.2 Young Individuals

For younger individuals there were different goals and ambitions which involved academia, building of career and attaining success within those spheres

> With younger people, or people my age, there is a lot of pressure or depression, a lot to do with career things, even when you are at university and you are working towards a good degree and a career and a good job. There is a lot of pressure there as well (p1FG1)

3.3.3 Priorities and Expectations

The desire for a career amongst young women was seen to over-ride and replace the expected life events, whereby the appeal or desire to go into marriage is over-shadowed with being independent and financially secure

> Difference now is they are more interested in pursuing their own careers, so once they have a job and are earning money. Because they are earning money they have the freedom to do a little more of what they like than girls did in my age. We were not encouraged to work, we were encouraged to get a degree but then go into marriage, whereas now the argument is the girls are educated, they have their degrees they work and think "why am I going to go into a marriage when I am able to work and provide for myself" it is not as attractive finding a partner as it was when I was younger.(p2FG1)

However, it was argued that this scenario does not apply for all young women where many do wish to marry and so tailor their careers around married life, some of the employment being a result of ambition or to ease the burden on the family or themselves

> ...yes some girls getting into their careers and earning for themselves, but there are some who look for a career that would suit a lifestyle if they were married, so they would want maybe a job that would suit them working and being at home, with the in-laws or something (p1Fg1)

It is economical as well. Back then if you were newly married and want to buy a house, if it was just the husband working he was capable enough of paying the mortgage whereas things have changed so much now. With regards to things, such as if you want a car, or to pay the mortgage, it is necessary for both people to work. (P1Fg1)

Many issues attributed to religion where pointed out to be cultural factors presented as religion, much of where the generation gap and conflict between parents and children occurred.

Mostly its cultural, its culture that becomes like a religion.....In the sense that if other people, like family are giving you hassle because of faith, "that this is because of faith" when its not really its culture....They get under pressure they get depression forget upset and get hassled by the parents by saying this is faith.... (p1Fg3)

3.4. Vulnerability to mental health problems

3.4.1 Women

Women were seen to be more vulnerable towards having mental health problems. Much of this was related to responsibilities and expectations of them and the performance of roles and the duties associated with those roles.

Women – so many things to do, more stress to take care of family, husband, school and the house. More responsibilities, more pressure

to take care of others. Sometimes when you are tired you feel upset and shout at others or lose temper. (p5)

I think women more than men. There is more expected from women. No matter what they say, they say that there is equality in society between men and women, but they are not. (p6)

Some these expectations were felt to be non-malleable or non-transferable to other members of their family, particularly those expectations related to and involving family.

Take care of the husband, the children and as part of the family sometimes she is a working woman, and has to do the housework. A lot of responsibilities - are very high on the woman. (p8)

Women's vulnerable position with regards to expectations and fulfilment of roles was seen to be added to further by salient cultural factors

Women are usually more restricted, and play second fiddle to the men, are more confined and there is no freedom. And if there are problems in marriages, then the emphasis on solving problems or reason for breakdown is put on the woman, that it was probably her fault. (p4)

Women are more prone, because of the low social status associated to women in the Asian culture; you have to sacrifice things, a lot more so

than men. If things go wrong then she is to blame and the support system in place for him is not available to her. (p15)

There's this patriarchal expectations on women, so there's this expectation on women to fulfil their roles in everything which has been put on them by men (p6)

Inconsistencies in terms of expectations of men and women on top of the inequality in rights and status and other cultural issues were seen to be an additional factor in causing distress. Behaviours exhibited by women were seen to be less socially acceptable and weighed heavily with stigma and ostracized by family, friends and the community

For some behaviours or actions, if men do it then it is frowned upon but forgotten about. But if women do it, its very different, its not tolerated or accepted at all, like adultery. So she suffers more, by not being able to talk about it due to the social binding. There is that inequality of power and status (p15)

3.4.2 Men

Despite pressures on women, mental health problems amongst men were also admitted to be prevalent although admittance on part of the men and subsequent help seeking behaviours were viewed as being relatively low

> Men may be more prone to mental health problems because they are less likely to talk about their problems.... But men bottle it up more. The statistics on men committing suicide; rates are higher (p4)

Much of the mental health problems for men were thought to be related to unemployment or financial issues and were directly derived from the loss of role as provider and its associated status in the community

> But it [mental health problems] could be like men as well because of the expectations put upon them. Not being the breadwinner (p6)

> If the husband has no job, then he could become depressed because he cannot provide for this family, and his children are asking him to buy them things like toys, but he cannot (p13)

3.4.3 Teenagers

Teenagers were seen to be more vulnerable to developing mental health problems as a result of the transitional life stages and the pressures put on them to achieve and succeed.

> Teenagers because of the transitions they are going through in their thinking and the reality, they want to make a balance most of the time but they struggle (p10)

Manifestation of mental health problems amongst teenagers could manifest in their behaviour or actions which are unacceptable according to societal norms

.... sometimes their mental health problems manifest in socially unacceptable forms, such as antisocial behaviour.. (p1)

3.4.4 Children

Being in an environment which was not stable or consisted of family members who had mental health problems was thought to have an effect on children's mental well-being or make them more vulnerable to developing mental health problems in the future

> Children who are exposed to family problems or family members who have mental health problems may also develop problems or be less resilient to stress than those who perhaps have no history or exposure to metal health problems. (p4)

Not recognising mental health problems amongst children or misinterpreting the signs and symptoms may account for lack of understanding or seeking further help or support

> But also I think even as a child and they are misbehaving, out of control it could be a mental health problem as well. They are behaving that way for attention, but is misinterpreted thinking it is just misbehaviour (p6)

3.5. Supporting Individuals with Mental Health Problems

Cases where friends or family members had mental health problems, relationships were noted to be strained. Some of the relationship problems

were a result of feeling unable to support the person during the periods where their mental health problems were intense and felt helpless

> She would turn on people when withdrawn, would not want any social interaction with anyone. And so people have learnt to leave her alone when she is in that withdrawn state, although I do not like leaving her like that, there is nothing I can do (p4)
>
> They were a little bit unsure of what to do, so I think there was that shock and guilt in not knowing how to help, or if they were trying to help was that help useful or not. (p9)
>
> It was extremely difficult for the family members and distressing, as they felt helpless and sometimes were impatient through lack of understanding. (p14)

At other occasions the potential longevity and constant exposure to the individual's mental health problems were deemed to be out of friends and family ability to cope with

> As a friend, it was difficult as you have a certain amount of sympathy, patience and tolerance. Personally I wouldn't have the patience for that, since it is a long term thing to help someone with. And it's difficult to understand the person. (p3)

3.6. Coping with Mental Health Problems

3.6.1 Support

Having supportive family and friends was seen to be key in dealing with stress and alleviating any pressures entailed, and so having a social network to rely on in times of distress was considered important

> To have the support of your family and friends, it is very important. You need close family and friends to motivate you, encourage you to go out and meet people, interacting. And to identify the problem to get rid of it. (p4)

Support in motivating the individual to engage and interact others:

> Go out and enjoy yourself, have social support, friends you can talk to abut problems. (p5)

> to help in their recovery and distress, and to resolve their problems, alongside, practical support were all seen to be important types of support that friends and family should provide:

> Take on some of their responsibilities; give them practical support....So to remove them from the house and that environment. (p8)

> Supporting them from the closest person, like family and friends because they are always there and interacting with them. Emotional and practical support, both. (p10)

Having someone to talk to, to share their problems with or to seek advice from was something that women felt they needed from their friends and family

> Support from friends and family, have someone to talk to, some nice Muslim women who can help you even if they don't share culture or language (p11)

3.6.2 Religion and spirituality

Religion was a form of self-administered therapy, with a lot of women finding solace and tranquillity in performance of the appointed prayers and engaging in other religious duties and tasks. Prayer in particular, was sought out to be a form of personal time, as it required leaving tasks and chores to dedicate attention and concentration to their prayers

> It helps alleviates a lot of stresses in life, for example if I wasn't getting anywhere in my job hunt and was being racially motivated against I would think ok Allah will help me. And for me personally, I do istikharah (guidance prayer) at every turn and it alleviates a lot of stress in my life. It can help you, if you really have and practise it. (p3)

Alleviation of stress was considered to be important in the maintenance of good mental health, and religion was one of the methods frequently employed to reduce anxiety and promote well-being.

> If I didn't have religion my life would be a lot harder, I use my religion a lot to fall back on and to gain some support from (p3)

Religious beliefs and spirituality were viewed to have a positive influence on mental well-being.

> Religious practises could help some people, things like preaching. Its like meditation, they might find peace because they are converting their feelings and all those things in one direction. (p10)

Religion and religious practises allowed problems and stresses experienced to be put into perspective, and were seen to be a minute part of the larger picture. Personal difficulties and problems were believed to be known by God, and that they were tests of patience and gratitude. Entailing these hardships have a greater benefit and would ultimately be rewarded

> As Muslims we believe God is the Shafi (The Healer), the Quran is.....He is the shifa (Cure/Healing). But still I think as Muslims we are tested for our patience, and sometimes this is one of the ways we are tested if we are mentally speaking not normal. (p8)

> If you believe in faith then it can help, but you need to have that belief and have a strong belief in it. To think God can and will help you and all will be fine requires a strong faith in God, that life is a test and events that occur are trials and tribulations that make you more firm

> and stronger. But if you don't have it, then it doesn't help or alleviate problems. (p15)

However becoming frustrated with your situation and problems with this understanding or perspective was expressed to be a frequent occurrence

> If you feel anything and everything belongs to Allah, and life is a test then you don't feel as bad, but when you become angry then also become angry with Allah for making you go through that. (p5)

For one participant who had suffered from mental health problems, engaging in prayers or becoming more in touch with religion was viewed to be a sign of mental ill health

> When I fell ill I was practising my faith but I was distanced from it, I didn't have the in depth knowledge that I have now and I started reading the Quran and doing my prayers was seen to be part of the illness. Whereas that was my therapy, that was my way of coping. (p9)

The private nature of prayer was viewed favourably; particularly the reduced potential for problems becoming public and being judged should they confide in family members, or friends.

> If you tell someone, if someone has belief in Quran, I say God doesn't' like people to stay upset, He knows about your problems and life is a

trust, everybody's life is. It is different and knows that you are going through. Praying is the best thing you can do; when I help...I don't like other people knowing about things, so just tell it to God (p12)

The benefits of religious practises were voiced by many of the participants, who seen it as reducing anxiety and providing hope. Engaging in religious practises was seen to provide and renew hope of alleviating stresses and problems, referring to taking the examples contained within the Islamic texts.

But if she can, if she can read the Quran and pray...there is so many verdict in the Quran-e-Kareem that can help her....I feel like it will be good for her and graceful. I think it should help her. If she reads the Quran, she will see that so many of the Prophets had so many difficult times, after every pressure... where there is asr there is yusr, wherever there is difficult there is farij you know what I mean (p13)

Religious practises and duties were not seen to be obligatory for those suffering from mental health problems and so encouragement to engage in prayers was seen with the view of providing a medium for respite.

If they can, I should think with the depressed person his / her performance, she is not patient enough to do whatever she has to do. I'm afraid one of this is religious practise....They can't do prayers like a normal person...they can't I'm afraid. (p13)

3.6.3 Medical Intervention

Medical treatment was not seen as being necessary for all mental health problems. It was dependent on the severity and type of the problem

> Treatment – for extreme situations then yes medical intervention may be necessary, but not for mild, short term of sustainable problems. (p15)

Generally however, medical intervention was proposed to be a viable but last option for the treatment of mental health problems. Much of the attitudes surrounding medical intervention focused on the severity of mental health problem and its effect on the individual physically

> ...., I don't think medical input can help that. When you are suffering only mentally then medical input can't help. When it begins to affect you physically then yes, maybe it can help. (p15)

The low favourability and reluctance for medication was due to concerns about becoming addicted or developing dependency on the medication

> Temporarily I suppose anti-depressants, although personally I wouldn't go down that road, or I don't think I would if I was in that state. I would avoid it like the plague but a lot of people would go for that. I think they're a little bit addictive, so I would avoid them (p1fg2).

The use of medication in combination and alongside other interventions was considered the ideal way of treating mental health problems. Maintaining a good balance between medication, social inclusion and support was strongly emphasised

> What it is when you are on medication you depend on it, but there are some that say they aren't addictive. So in some ways it can help you, but in other ways if you just depend on the medication that's not good. There should be something along side it. it works at the symptoms not the cause, if you do it all together, have medication and friends family that's better (p1fg3)

3.6.4 Counselling and talking treatments

Counselling was seen to be a useful medium to utilise for the alleviation of stress and in the treatment of mental health problems. Accessing counselling at the early stages of mental health problems was seen to act as a preventative tool in the further deterioration of mental health

> People should go for counselling at the first opportunity they can. When they realise and suspect there to be problems or the potential to become worse, they should talk to someone, a professional who can help them. Utilise these services. (p4)

> Counselling, yes for the depression it is one of the treatment....Because these people they have these things, and if they talk about it and get if off their chest they will be much better (p8)

However, the concept of counselling was felt not to be understood by some, and so would not be able to fully utilise the service

> I think Asian people don't grasp what counselling actually is. If their first language isn't English, you wouldn't really know what counselling is. If you tried to explain it, or translate it "you talk to someone about it" they wouldn't think much of it. Those who understand what counselling is would use that facility. They don't know the benefit of counselling. (p1fg1)

Having the support of family, friends and peers was seen to be an informal type of counselling, but the benefit was great.

> Yeah but even having a social chat with somebody outside of the family really does help, you're taking out all of the stress. Maybe it's like counselling but its not a service you're using if it's a close friend. Just sort of get things off your chest (p2fg2)

Counselling was seen in a positive light as it allowed individuals to talk through their problems, to alleviate stresses and to be able to voice their thoughts and concerns to someone.

> Counselling is useful, as sometimes you can't speak openly to a family member of loved ones, you hold back. Need someone impartial; even if

they don't advise you, just a listening ear can help. But that depends on the person's problems and issues, sometimes they may be able to approach a family member or friend, sometimes they may not. (p14)

3.7. Barriers

3.7.1 Stigma

Stigma which was mostly due to misunderstanding and lack of awareness was an important factor hindering individuals from admitting or realising they had problems or difficulties and in accessing support or information.

The likelihood or potential for the individuals' mental health problems or emerging mental health problems to be discovered by the community was seen to be increased if they attempted to access support or help. Much of the possible negative reaction which could be encountered was seen to come from members of the community as opposed to family members.

> Lack of understanding, [that's] where most of these kinds of attitudes come from, and ignorance or fear...fear of the unknown, think they should be put away because they are afraid they'll catch it or something. Family may be supportive and not think that way, but community are less supportive (p14)

Owing to the family and community orientated culture amongst most of the participants, the family was seen to be a supportive unit, and would be expected to care and support the individual during and after difficulties. The

community was considered to be a substantial support and resource that individuals could access. This support would compromise a number of social networks and associations, which would have been built up over the years through generations working, participating and contributing towards strengthening the community and in establishing themselves, individually as families and collectively as a community.

> Community ostracism is not helpful at all, because you may in the past have sought their help or support, but when it comes to a mental health problem, they don't want to know. If they stigmatise you, where do you go? They share your language, your peer group, your culture and traditions. So if that is removed, that support ceases then you become alienated and so would make your mental health problems a lot worse. (p14)

However, the close knit nature of the community despite being an advantage could also harvest the potential to cause harm through this familiarity and easy accessibility. Maintaining family honour and reputation is inextricably linked with strength, resilience and sustenance. Families which were able to exhibit and display these qualities would be seen as more desirable and able to contribute much better and more refined than other counterparts.

As a result, expectations were placed on the family to support the individual, with the knowledge of the possible effect it would have on them and at the detriment of them being seen in a negative light through association with the

individual. Mental health problems in or amongst a family member would affect the rest of the family negatively as the mental illness would be perceived as being hereditary, therefore considerably reducing the desirability or the capacity which the family could contribute or participate towards the community.

3.7.2 Religious and cultural sensitivities.

Lack of information or awareness on Muslims and fulfilling of their needs and religious sensitivities by both staff and other patients was viewed to be a factor that could affect accessing mental health services.

> There was a young Asian girl that was in the other ward and because of the media and the stigma attached to..... The stigma people have attached to the Muslim religion she was quite discriminated against, not by staff but my other patients. Because the first thing they seen was this young girl wear this hijaab and they immediately linked that to that. And people when they are really unwell can be really cruel (p9)

Lack of provision for Muslims in hospital or medical settings to practise their faith or to engage in religious practises was seen to be one of the factors important in meeting cultural and religious needs

> Staff should be sensitive to cultural and religious needs, for example if you are in your bed with no hijaab on, to have porters of visitors walking by without notifying you so you can fix yourself is not nice (p11)

3.7.3 Complicated terminology

Having information related to the patient in simple terms, explaining the diagnosis, the mental health problem and its effect and prognosis of the condition was held to be important.

> If the issue isn't a language barrier, then it is medical jargon that's confusing. So you want the advice and information simplified. (p14)

3.7.4. Confidentiality

Having personal information shared with a health professional kept confident was seen to be important for Muslim women. Owing to the misunderstanding and stigma attached around mental health, being able to share and relate problems to the health professional knowing it to be in the strictest confidence contributed towards building up trust and being re-assured in family members or the community not discovering the illness

> Confidentiality was a huge thing, especially coming down to a cultural, religious thing. Because the first GP was a family friend.....My current doctor, is a chap, is Muslim he knows members, he knows of my family. Whereby my last GP they could phone up and get information from him, whereas with this one he says "I can only speak to you if she says so", there is a line. Because of that I'm a lot more open to him. (p9)

> Confidentiality is important...You need confidence to talk about your problem, and to go to a doctor who will keep your details private. I know of a friend who's husband is a GP and she usually knows of what patients he has seen and their problems because he tells her. (p4)

3.7.5 Gender of health professional

Most of the participants preferred seeing a female health professional as they felt they would be more comfortable and would be able to relate their problem better.

> Should be a female doctor, because we are not used to that kind of environment. Some women keep worrying and are embarrassed thinking about how I can relay my problem to them (p2)

> ..... Easier for Muslim women to talk better and more openly with a female. Maybe she feels shame and not talks about the problem, like my mother, if she is comfortable with someone then she will talk. And also because women have more problems, so another woman can understand it better than a man (p12)

For some having a female health professional was a cultural and religious need, which they applied across all health services they accessed and so would like for it to be the same case when accessing and utilising mental health services.

3.7. 6 Ethnic or religious background of health professional

Some of the participants favoured seeing a mental health professional of the same background, both ethnically and religiously as they perceived the level of understanding to be better and it would be easier to relate issues that within

a cultural or religious framework would be comprehended easier by someone of a shared ethnic and religious background.

> if you are Muslim or Asian it would be helpful to get help from the same community, so of the same background. So would help us the most, same religious. Because the understanding level will differ, because we have some values that the white people don't understand at all. And even if they understand by having a course or reading, then they should deal but of the same background they know so communication would be better. (p10)

However, a health professional of shared background for some could pose a problem as they felt people perhaps could be judged and shared culture may hinder or impinge on the therapeutic relationship.

> Background of the doctor may be an issue, they might bring cultural aspects into the treatment which you may very well want, or that might hinder or make you hesitant in being open with them (p14)

> Sometimes the background of the individual may be a preference for some people, they may feel more comfortable and understood if they had someone of the same background, but then again others may feel they are being judged and so would feel more embarrassed to be open. (p15)

3.7.7 Familiarity

Consistency and familiarity with health professionals was preferred for a number of reasons. Not having to repeat medical history or personal information related to issues was the most commonly mentioned reason.

> It should be someone you feel comfortable enough to go to. At my GP practise there are several GPs there, but I always see the one doctor because of familiarity and continuity, then he knows me and my medical history better so I don't have to repeat myself or go over things again (p14)

Familiarity with the health professional allowed individuals to build trust, rapport towards a therapeutic relationship, which was important for some. However potential dependency on the health professional was seen to be quite negative and should be avoided by supplementing professional support with support from friends and family

> For counselling I think it is very important to build a relationship with the health professional, but it may cause problems if that person leaves and a replacement is put in place, it may set the individuals progress back. But if they have a sufficient support system outside and in addition to the counselling then they probably won't mind or feel the need to build up a therapeutic relationship. If support is not available then yes it may be important. (p15)

3.7.8 Availability

The GP being accessible and available when his / her intervention or support was required was critical in influencing the likelihood of accessing mental health services in the future

> Timely availability. Because sometimes you just pluck up the courage to go to the GP but the GP is not available so you may not bother going back at all (p3)

Being approachable and having a good style of interaction was also preferred as it allowed the individual to be comfortable enough to relay their problem and feel they were being listened to and took seriously, without fear of being ridiculed or confidentiality being compromised

> I have a superb relationship. I can phone up and say "I need a 5minute appointment" and they know I have to see him right away..... and I say if I'm feeling alright, then there's no point in me coming to see you and he knows I'm not the type of person who'd come for the sake of nothing. But he says just come, sit down, to look at you and say that you're ok. (p9)

> To listen to you, give you time, understand and to accept these feelings or the way you feel is "real" and not something to ignore or disregard as being petty or something you will "get over". (p1)

Waiting period for being seen by a special was thought to be too long, where the individual's mental health could deteriorate within the waiting period for seeing a mental health professional or the waiting itself could exacerbate matters.

> Sometimes if the GP is sending to a special or a private where she has to be there for a long time, and it doesn't help. All mental cases should be taken as emergency, since most of the time by the time they can be seen it has deteriorated. (p8)

3.7.9 Language

Language presented a significant barrier in seeking help or information. Not being able to obtain information in own language and not being aware of who to speak to or what services they could offer due to these language barriers made seeking help and support more difficult.

> If somebody has a mental health problem and wants to go to the doctor, the first time she enquires she has an interpreter who maybe doesn't understand what she is talking about – because she needs the interpreter because she doesn't know the language (p12)

Not having language support in place when in crisis was thought to exacerbate problems

> I can see from the prospect of somebody who didn't have my ability to communicate due to language. That could be a problem. For someone who's just coming to this country. To put it into words. If I couldn't speak the language I'd think how am I going to get across to them how I'm feeling? (p9)

3.7.10 Mixed Wards

Majority of the women felt having segregated and single sex wards were very important for Muslim women in hospital when receiving treatment. Nursing staff as well as health professionals were also preferred to be all female. However making single sex wards, with all female staff available and a reality was recognised to be difficult to achieve

> Single sex wards would be preferable but not feasible as they always say there is a shortage of beds, so to have an entire female only ward may not be a possibility in reality to achieve. (p1)

3.7.11 Education and Awareness in the Community

Misunderstanding of Islam and its treatment of women as a result of media coverage and the visibility of Muslim women in society was also thought to lead to religion being attributed or seen as a contributor of the mental health problems women may experience.

> Some hold a false belief or have the wrong impression which is perpetuated by the media of Muslim women being meek, oppressed creatures, who do not have a say or any independence, which is down

> to a lack of information and quite a lot of ignorance. And [so] think religion is the cause of any mental health problems they may have (p4)

Community education and raising awareness of mental health problems was emphasised to be the way to move forward and to remove the stigma and misunderstanding prevalent amongst various factions of society and the community.

The lack of awareness and education about mental health and mental health issues was seen to be generic and applicable to all facets of the community, across different ethnic backgrounds and religious faiths.

> There is a lot of ignorance in the Muslim society because most of the time we are not educated enough. Even here, there is lot of ignorance and misunderstanding.... even here in the UK and Europe if she is depressed and she is talking about her depression they feel she is abnormal. This will affect...make her condition worse. (p8)

Tailoring the method and approach of raising awareness for specific communities, such as addressing cultural issues and targeting specific attitudes and misconceptions could be related to better by members of the community and therefore would be more effective.

4. Conclusions

The understanding of mental health amongst Muslim women was, on a large scale, linked to and in relation to illness. Mental health was seen in the context of fulfilling relationships and the ability to cope with life stressors, alongside the quality of interaction with others. Mental ill health demonstrated difficulties and heightened emotional behaviour and was understood by comparison of performance in tasks, daily chores, and quality of relationships when in good health that were otherwise the norm and within the individuals capacity to cope subsequently created difficulties and showed marked deterioration in.

The causes or events which can contribute to mental health problems were vast and were seen to differ between individuals. Relationship problems, between the husband and wife, or with the children and in some cases living in the extended family were seen to cause a lot of stress and increase responsibilities. Domestic abuse and violence, including physical, verbal and emotional abuse were all seen to significantly contribute towards causing mental health problems. Women were viewed to be more vulnerable or more likely to have mental health problems, largely due to their responsibilities and also of their un-equal status in society.

Salient cultural factors in causes of mental health were also abound, particularly those linked to patriarchal components of some cultures that were mistakenly attributed to faith or religion. These were apparent in conflicts between parents and youth as a result of cultural differences and generation

gap. The different set of ideals and expectations for each group were thought to add increased pressure to conform and fulfil those expectations or otherwise rebel.

The role of men as breadwinners was seen to be affected by unemployment as it contributed a lot more to the social status, worth and value of men in society as understood by the participants in this study. Unemployed men are seen to entail pressures from a multitude of sources such as from within themselves for not fulfilling or being able to fulfil the role of breadwinner and therefore provide the family with a certain quality of life and from society for not being able to fulfil his responsibilities. Women to a certain extent if unemployed were not felt to feel the same pressures or stresses, although the potential for this to become the case was real and evolving due to the focus on building a successful career and fulfilling ambitions and aspirations.

Racism and discrimination had a fundamental effect on Muslim women. Much of the racism encountered was linked to political events and the negative image portrayed by the media of Muslims. It was felt that the instability of the world and the use of political events were sensationalised and influencing the way society at large perceived them and perpetuated prevailing stereotypes and misconceptions. For Muslim women who were asylum seekers and refugees, there was the triple barrelled negativity and they felt the treatment they have received or could potentially receive prevented them from attaining or desiring the quality of life they wanted. As a result, the women felt curtailed

and restricted in being able to fully contribute and participate in the community due to limited opportunities and fear of discrimination.

Various coping methods were thought to help individuals with mental health problems; the most emphasised one was support. The support of family, friends and peers was felt to be crucial not only in the alleviation of daily stresses and pressures but in encouraging the individual in interacting with others and preventing withdrawal. Much of the support beneficial in coping was social, emotional and practical support. Although caring for someone with mental health problems or being a pillar of support was strenuous at times, as they felt helpless and relatively unequipped to help the individual.

Medical intervention was viewed differently amongst the participants. Some were concerned regarding long term dependency on medication and therefore seen it as a valid option but would be considered if health or situation deteriorated or was not improving. For others, medication was seen to be an intervention best employed alongside other additional inputs such as having a good social network, counselling or aid in addressing the issue causing distress.

Talking treatments were viewed positively, with great value placed on the benefits of talking and seeking advice from others. Social support was seen as an informal type of counselling and was viewed from this perspective however impartial advice from a professional trained in counselling skills suited some individuals due to the unfamiliarity and impersonal nature.

Counselling from professionals allowed individuals to speak openly about problems without fear of being judged, which could be an issue when speaking to friends or family, particularly if the problems occurring were caused or involved those within their immediate social circle.

Engaging in religious practises and turning to religion were frequently employed coping mechanisms, as it was felt to serve the purpose of being a form of self-administered therapy. Prayer in particular was utilised to alleviate stress and enforced a sense of personal time reserved for the individual to focus on themselves and to distract them from their problems. Due to the private nature of prayer and the seeking of sustenance from religious texts, these practises encouraged individuals to view their problems differently and in perspective in terms of the purpose of life and their life goals. Much of this refocusing and reprioritising of life events and situations as inspired or led by their religious beliefs was felt to contribute towards sustaining good mental health.

Accessing support for mental health involved a number of factors for Muslim women. Language barrier was raised as an issue for women who may not be well versed in the English language or who could not speak English. The language barrier was not limited only to problems with verbal communication but also to the unavailability of written material on mental health in their own language.

Having a female health professional was a preference amongst most of the participants, as it allowed them to feel more comfortable in discussing details of a personal nature and feel more at ease. Where there was a choice available, most women opted to have a female health professional. However, for some it was not a preference, but rather they looked to the health professional being skilled and approachable to give a good quality of service. Some participants preferred the health professional to also be of the same ethnic background as the service user, and if possible to share the same faith. This was thought to facilitate a better level of understanding and comprehension of moral values, way of life and cultural factors that a health professional from a different ethnic or religious background could not relate to or understand. However, issues surrounding confidentiality, prejudice and feeling being judged by professionals who were of shared ethnic background and faith was recognised to have the potential to limit, hinder and make the service user hesitant in fully utilising and benefiting from the treatment they offer.

Familiarity with the health professional was preferred for those engaged in long term treatment, particularly with a GP, counsellor or a support worker as it aided in establishing of trust and rapport with the individual. Repeating medical history or personal problems to different health professionals was thought to become tiresome and could lead to a relapse, worsening of symptoms or reluctance to access support. However, too much familiarity or the need for the same health professional at appointments was also thought to perhaps encourage dependency and could cause problems if the health

professional was unavailable or there were long gaps between appointments. As a result, an additional support system, such as a social network was thought to be necessary and should exist concurrently with treatment from health professionals.

Mixed wards were seen to be problematic and lacking the privacy or security that single sex wards would provide and therefore was considered an important and preferred choice. In addition to the wards being single sex, the staffs on the ward including the health professionals, nurses and porters were also preferred to be female.

5. Recommendations

Findings from the research project point to a number of recommendations and plans of actions that can be applied in addressing and facilitating the understanding of mental health and accessing mental health services for Muslim women.

Recommendations are as follows:

- Raise awareness of mental health and mental health problems amongst the community to dispel misunderstanding and eradicate misconceptions of mental health thus reducing stigma by tailoring methods according to the group or faction of the community, to adequately address cultural and religious factors that may prevail within that section of the community.

- Educate Muslim women on the importance of mental well-being and promote mental well-being by way of mental health promotions and mental health initiatives.

- Encourage existing organisations, health centres, GP surgeries and local community resources to become involved in raising awareness, through means possible for them, such as distribution of reading material in the forms of leaflets, displaying posters on mental health campaigns and information on contacts for organisations and help lines for mental health.

- Make mental health material, such as information leaflets, publications and events related to mental health accessible to all sectors of the community by having material in various languages and formats.

- Involve community organisations and stakeholders in the promotion of mental well-being.

- Make mental health services and service providers aware of the cultural and religious needs of Muslim women.

- Address the needs of Muslim women when accessing treatment or support from health service providers.

6. Limitations to study

Owing to the nature of the study, attempts to encompass a diverse population of Muslim women including ages, ethnic backgrounds and status were compounded by limitations. The south east of Glasgow compromises of a large South East Asian population of Muslims inhabiting the area. Therefore, Muslims of other backgrounds, such as those from Arab, African-Caribbean or Black African groups were difficult to recruit. Although various pockets of areas within this boundary include a large population of asylum seekers and refugees, they were a hard group to recruit and follow up in terms of participation. The research however did attempt to stratify the sample population by ensuring it was a true reflection of the area in which the research was being carried out.

7. Future Plan

It would be beneficial and advantageous to follow up this research on Muslim women and mental health in an attempt to address the research gap for this sector of the population.

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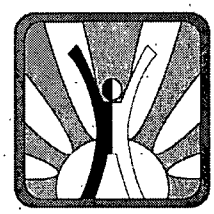


REACH

COMMUNITY HEALTH PROJECT

Me Myself and I

Women's Mental Health Project

January 2011

Funded by

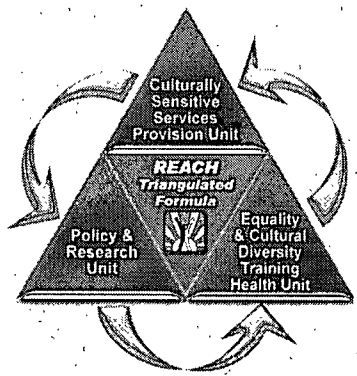
see me...

Contents Pages

1. Background

REACH Community Health Project, established almost a decade ago in Glasgow, has since evolved into a national third sector organisation with a key strategic role in improving the health & wellbeing of Black and Minority Ethnic (BME) Communities, particularly those living in Scotland. REACH has units engaged in culturally sensitive Service Provision, Policy and Research and Training and Development. These areas of expertise act to mutually reinforce one another, and this Triangulated Formula makes REACH uniquely placed to tackle health inequalities and service barriers faced by BME communities.

Our *vision* is a multi-cultural society in which all people have equal access to appropriate health & wellbeing services and our *mission* is to empower communities, (particularly ethnic minorities) by ensuring that their health needs are fully met.



REACH achieves this through its Triangulated Formula, which encompasses three units: Preventative Culturally Sensitive Service Provision, Policy and Research and Training and Development.

1.1 Project Aims

This innovative project was aimed at challenging the high levels of stigma and discrimination around mental health issues within BME communities. By facilitating

discussion and learning it leads to the breaking down of barriers to accessing support services and open up life chances for those with mental health issues.

The project, funded by SEE ME focused upon BME women due to their influential role within family and community settings, as a pilot project it is hoped this will provide evidence of good practice that can be replicated elsewhere.

The project saw Sessional educators with lived experience of mental health issues, utilise their experiences to open up issues of stereotyping, stigma and discrimination. The attendees of the sessions were predominantly from a BME background having suffered from mental health issues either primarily or through a secondary experience by being a carer for family members who suffer from mental health problems. Having come from BME backgrounds, facing barriers in recognising mental health on its own the stigma and challenges the attendees face have shown to be more complex than ignorance or lack of awareness.

One of the aims of the project was to educate women that mental health issues are very real and not personality issues, which are what many of the attendees, had been raised to believe. The wide spread problems at grass root levels within BME communities lead REACH to undertake such a project to effectively and measurably improve the lives and mental well being of women in the community.

1.2 Key Topics

During the course of the sessions there were key topics covered by the educators given by the project worker. Out with this the attendees were also given the opportunity to request their choice of topic to be discussed in future sessions.

The main topics given to educators were:

- What is mental health?
- Confidence

- Self Esteem
- Depression / anxiety
- Post Natal Depression
- Bi Polar disorder
- The stigma around mental health
- Challenges faced with in the family home and in the community

Outside of these topics, at the end of every session the participants were asked if they would like to cover anything specific in the next session, be it to continue on the same topic but more in depth or to learn about another mental health condition. The educator would then come back to the project worker who would put together another pack for the next session covering the requested topics.

2. Methodology

As mental health is still considered a taboo subject in many cultures, recruitment and promotion of the project had to be handled in a very delicate manner. Understanding the mentality of the attendees first and foremost lead to the educators being recruited from different areas with in Glasgow so there was little or no chance of familiarity with the attendees. The reason for this was so the attendees were not hindered or hesitant to speak in the case that the educator would know them outside in their personal lives.

2.1 Recruitment

The recruitment was carried out in a discreet manner; although posters and leaflets were distributed possible attendees were given one contact number to call should they wish to attend and also given the date, time and venue of sessions if they preferred to attend anonymously.
Once the educators had been established promotional material was distributed to the local area in:

- Shops
- Gyms
- Women's centres
- Libraries
- Health centres
- Doctors surgeries
- Youth Centres
- Online via social networking

Many attendees used the telephone number given to call to ask about the project and determine if it was right for them. Upon discovering the nature of the project, this lead to a great rise in the levels of demand quicker than anticipated.

The biggest concern for many if not all participants was that of confidentiality. As this was an anticipated concern all attendees and educators were given confidentiality agreements to sign. See Figure 1.1

2.2 Educators

Educators were selected on the basis of past experience, qualifications and ability to communicate effectively as well as listen actively. Initially three Sessional educators were recruited to conduct the mental health sessions. The educators were of different age ranges and had different personal experiences with mental health. They were given training, information packs and background information on the project prior to any sessions starting.

With in the packs the educators were briefed on the importance of confidentiality first and foremost. It was imperative that this was reinforced during sessions to increase attendees confidence.

A presentation on mental health conditions, stigma, and challenges was given to the educators prior to commencing the sessions. See Figure 1.2

The project drew in approximately 64 possible attendees for the classes however we were unable to facilitate such a large number and of the 64 possible attendees 16 participants were chosen to attend the initial sessions.

The participants were split into 2 groups in accordance to age and educator relevance. The women were put into the group where the rest of the participants were of a similar age, background and could also relate to the educator.

2.3 Group Session

In the initial session women were given a formal introduction to the project by both the educator and the project worker. They were given a questionnaire to complete prior to the presentation and discussion to ascertain their current levels of knowledge. See Figure 1.3

3. Results

The results of the initial questionnaire were as follows:

3.1 Describe what mental health means to you?

The questionnaire was completed collectively as not only was there a language barrier but there was also a literacy barrier. Many of the women could not read English or write English to a legible degree thus by completing the questionnaire collectively the educator could help them put their thoughts on paper as an answer.

Although the answers were in their own words the general understanding of mental health was:

"Your thinking / mind being affected by various things such as bereavement, loss, hardship and the inability to cope with pressures." – Client 04

3.2 What mental illnesses are you aware of?

The women who answered this question all answered with depression and worry.

3.3 Give examples of stigma you or someone you know with a mental health issue has experienced

Every participant that answered this question answered saying they felt they were considered as mad by family and the community around them. They felt people do not have an understanding of depression or mental health in a general sense so considered anyone with depression or anxiety as "mental" / "mad".

3.4 Do you or anyone in your friends / family suffer from any mental illness?

All participants answered yes to this.

3.5 On a scale of 1 – 10 (1 being very easy and 10 being very difficult) how would you rate the following:

1. Access to information on mental health issues? **Average score 6**

2. Access to services to help cope with a mental illness? **Average score 7**

3. Access to speak to a professional / counsellor? **Average score 7**

4. Access to support services? **Average score 7**

3.6 If given the opportunity, would you like to have a confidential one to one session with a counsellor?

- 62% of participants answered yes
- 20% of participants answered no
- 18% declined to answer

4. Conclusion

Although there has been much demand for this service and in the long term REACH would be happy to facilitate more sessions. Due to the nature of the project it is currently short term we did not evaluate the difference the project has made after 6 months, which would be helpful for REACH to understand further.

We intend to invite women back to REACH not just those who participated in this project but also those who showed interest to participate and ascertain their levels of knowledge after two mental health sessions. To those who did not have the opportunity to participate we would like to explore how they could be helped further.

5. Appendix

5.1 Figure 1.1

Me Myself and I

Gateway to positive health: BME women's project

Confidentiality Agreement

IT IS AGREED AS FOLLOWS:

1. In consideration of each of the parties disclosing to the other Confidential Information for the Purpose the parties hereby undertake that they shall:

i. Not communicate, disclose or make available all or any part of the Confidential Information to any third party;

ii. Not directly or indirectly use, or permit others to use, the Confidential Information other than for the Purpose.

iii. Not make any announcement or disclosure in connection with the Confidential Information or the Purpose without the prior written consent of the other party.

Anybody found in breach of this agreement will be excluded from the session and not be allowed to return, it may also hinder further involvement in future projects.

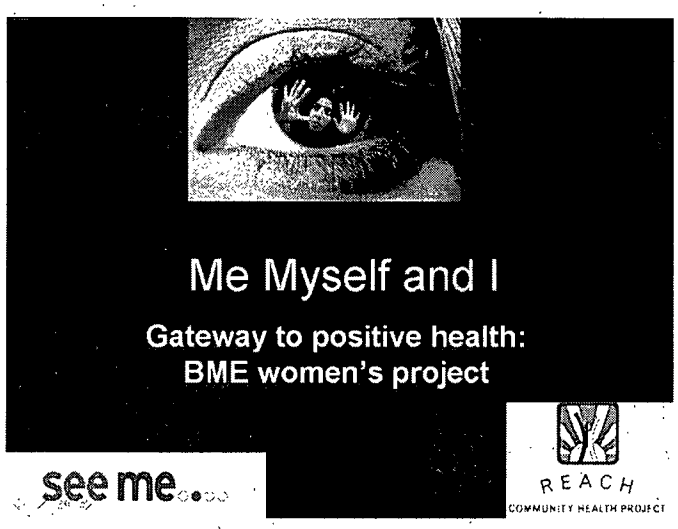
PRINT NAME:.....

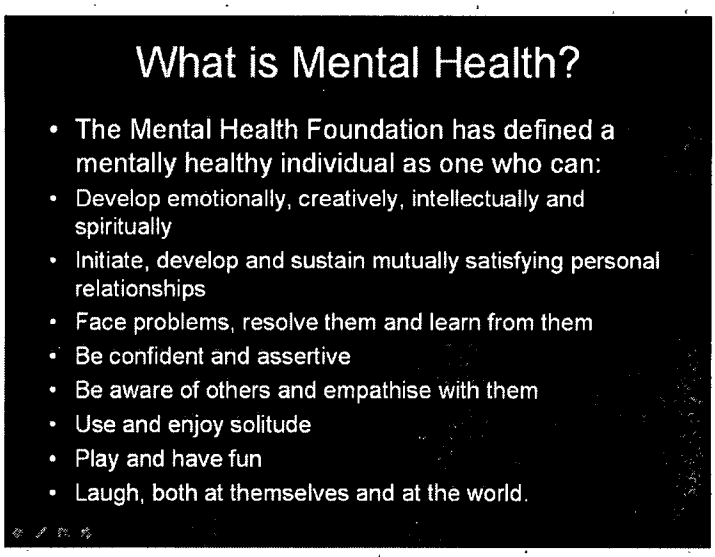
SIGNATURE:.....

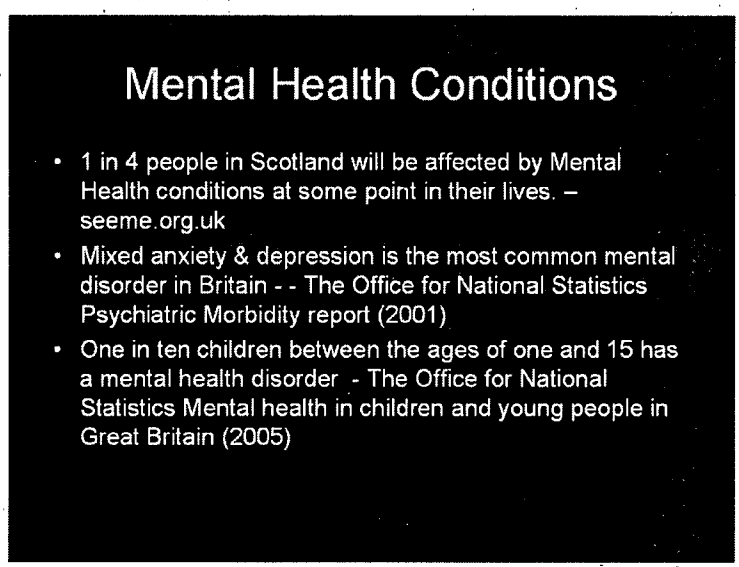
DATE:.....

Back

5.2 Figure 1.2







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5.3 Figure 1.3

REACH

COMMUNITY HEALTH PROJECT

Me Myself and I

Gateway to positive health: BME women's project

Session 1

1. Introductions
2. Confidentiality
3. Questionnaire on mental health
4. Presentation / discussion on mental illness
5. Discussion on personal experiences
6. Evaluation on benefit of session
7. Conclusion / next session teaser

see me...

Me Myself and I

Gateway to positive health: BME women's project

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PRINT NAME:.....

SIGNATURE:.....

DATE:.....

Me Myself and I

Gateway to positive health: BME women's project

Describe what mental health means to you?

What mental illnesses are you aware of?

Give examples of stigma you or someone you know with a mental health issue has experienced

Do you or anyone in your friends/family suffer from any mental illness?

☐ YES ☐ NO

On a scale of 1 – 10 (1 being very easy and 10 being very difficult) how would you rate the following:

5. Access to information on mental health issues?

6. Access to services to help cope with a mental illness?

7. Access to speak to a professional / counsellor?

8. Access to support services?

If given the opportunity, would you like to have a confidential one to one session with a counsellor?

☐ YES ☐ NO