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# Muslim Leaders' Understandings of Mental Health, Mental Illness, and Depression in Immigrant Women and Those Found in Consumer Health Materials: A Discourse Analysis

Selma Tobah, *The University of Western Ontario*

Supervisor: Dr. Roma Harris, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Master of Health Information Science degree in Health Information Science

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MUSLIM LEADERS' UNDERSTANDINGS OF MENTAL HEALTH, MENTAL  
ILLNESS, AND DEPRESSION IN IMMIGRANT WOMEN AND THOSE FOUND IN  
CONSUMER HEALTH MATERIALS: A DISCOURSE ANALYSIS

(Thesis format: Monograph)

by

Selma Tobah

Graduate Program in Health Information Science

A thesis submitted in partial fulfillment  
of the requirements for the degree of  
Master of Health Information Science

The School of Graduate and Postdoctoral Studies  
The University of Western Ontario  
London, Ontario, Canada

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## Abstract

The purpose of this research project was to investigate the information landscape with respect to mental health, mental illness, and depression as it might be encountered by female Muslim immigrants in London Ontario. In the study, commonalities and differences were explored in the constructions of mental health and depression as they relate to the lives of Muslim immigrants from the perspectives of local Muslim religious leaders and in publications intended for the lay public that are produced by Canadian mental health organizations. Pamphlets concerning mental health and depression, intended for the lay public, were collected from several health and social service centres. As well, semi-structured interviews were conducted with eight Muslim religious leaders about their understandings of mental health and depression, particularly as they relate to immigrants to Canada. A discourse analysis was conducted on each of the ‘texts’, the pamphlets and interview transcripts, using a pre-constructed template. Overall, the study indicates that while the pamphlets clearly reflect a primarily medicalized construction of mental illness and depression, the interviews with religious leaders conveyed a more multi-faceted understanding of these conditions. While recognizing the possible necessity for medical intervention to deal with mental health problems, the religious leaders emphasized the significance of overcoming social isolation, especially for those who are immigrants. In their construction of help or ‘treatment’ for individuals who are troubled by problems such as depression, the religious leaders emphasized the community’s responsibility, framing both the causes of and responses to mental illness within a religious discourse. The findings suggest that, as well as being a source of support to congregants, religious leaders can help to play the role of mediators, contextualizing information for mental health service providers when interacting with Muslim immigrants.

## Keywords

Consumer Health Information, Mental Health, Depression, Immigrants, Women, Islam, Mediators, Clergy

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## Chapter 1

### 1 Introduction

The purpose of this research is to explore how Muslim leaders in London, Ontario understand and construct notions of mental health, mental illness, and depression, particularly as they relate to the lives of Muslim immigrant women, and to compare these understandings with the discourses concerning mental health and depression found in consumer health information sources intended for the lay public. This comparison is intended to highlight the similarities and differences between the discourses invoked when discussing depression, demonstrating the array of messages about mental health and illness that may reach new Muslim immigrants.

This project emerged from a review of the literature which suggests that members of different cultural groups may perceive, internalize and express health-related ideas in various ways. Cultural differences in understandings of mental health conditions such as depression (see, for example, Stolovy, Levy, Doron & Melamed, 2012) may create barriers to treatment. In this research, I focused on the Muslim community. Although the Muslim population in Canada includes a diverse array of ethnic backgrounds, Muslims adhere to a similar worldview based on the Quran (a holy book considered to be divine revelation by followers of the faith) and the Sunnah (the narrated life and practices of the Prophet Muhammad) (Haque, 2004). Islam is often described not just as a religion with a particular ideology but as a complete way of life with a paradigm that influences all aspects of the life of its followers (Sayeed & Prakash, 2013), including how 'health' is understood and practiced.

Canada is home to many Muslim immigrants. In 2011, 6.8 million foreign-born individuals were living in Canada, comprising more than 20% of the population. The largest group of immigrants originated from countries on the Asian continent, including the Middle East (Statistics Canada, 2013). Of the top twenty countries of origin for permanent residents in 2010, eight are Muslim majority countries (Citizenship and Immigration Canada, 2010). In addition, the top countries of origin for government-



assisted and privately sponsored refugees from 2000 - 2010 are Muslim majority countries (Affiliation of Multicultural Societies and Services of BC, 2013). Given the size of this growing population in Canada, it is useful to understand discourses pertaining to mental health within the Muslim community.

According to Wood and Newbold (2012), there are few locally-focused studies that examine a particular city in terms of mental health services. Instead, most studies establish a generalized picture of the barriers immigrants encounter when trying to access mental health services across Canada. In this study, I focus on London, Ontario, a city that is home to a number of immigrants. The 2011 census records that over 20% of London's population is foreign born, with the most recent arrivals coming from the Middle East and Southeast Asia (City of London, 2013).

The aim of this study is to gain an understanding of the various messages that immigrant Muslims, particularly women, may encounter pertaining to depression (including symptoms, causes and treatments) within a particular culture in a specific context. A gendered approach is used in this study in order to recognize the different stressors immigrant men and women may encounter as a result of the immigration process (Amer & Hovey, 2007). Furthermore, the mental health literature indicates a difference in the prevalence and reporting of depression among men and women (Wilhelm, 2006). Focusing on immigrant women in particular enabled me to identify whether and how such differences emerge in the discourses that are the focus of this study.

In my study, I conducted a discourse analysis, informed by constructivist thought, to explore key discursive messages conveyed by Muslim community leaders within the context of research interviews, examining how notions of mental health and depression are constructed in comparison to the discourses found in the lay literature. To do so, I collected pamphlets about mental health and depression from local services frequented by immigrant populations in London. Using a discourse analysis approach, I examined the 'texts' of the interviews and the pamphlets to explore how the 'problem' of depression (or 'low mood'), particularly in women, is discursively constructed, as well as the suggested approaches to managing or remedying it. Through this comparison, I attempted

to understand more about the information landscape that Muslim women are likely to encounter when dealing with emotional challenges and mental health issues, particularly those that arise during the process of immigration and settlement.

## 1.1 Literature Review

Recently landed immigrants and refugees are often in need of mental health support as a result of trauma experienced pre- and post-migration. Relative to others in the population, immigrants are more likely to live in socioeconomic disadvantage and experience greater depression, substance abuse and anxiety (Wood & Newbold, 2012). Limited educational and economic opportunities can exacerbate feelings of alienation and can contribute to role reversals between children and parents, particularly when the latter have not adapted to local language and social customs (Wood & Newbold, 2012). Fear of stigma and further social isolation may prevent immigrants from seeking help from healthcare professionals. Despite the higher reported need for mental health services, immigrant populations often face many barriers in receiving the necessary assistance (Fawzi et al., 2009).

Mental health service providers may encounter challenges in providing services to new immigrants. In addition to possible language barriers, various cultures may express moods differently and manifest health and illness in different ways, making it difficult to diagnose particular conditions (Neale & Wand, 2013; Stolovy, Levy, Doron & Melamed, 2012). For instance, among Nigerian-born immigrant women living in the United States, depression was regarded as a sign of weakness and a source of ostracism in the Nigerian community (Ezeobele, Malecha, Landrum & Symes, 2010). As a result, symptoms were more likely to be acknowledged in somatic forms, if expressed at all. The symptoms of depression may also be confounded with forms of cultural expression. As another example, some cultures recognize suffering and death as part of spiritual contemplation, a societally encouraged process (Marecek, 2006). Because suicidal ideation is also considered to be a symptom of depression, (Diagnostic Statistic Manual of Mental Disorders, 2013), such expressions may be misunderstood by health professionals who are trying to reach a diagnosis. Such examples illustrate the need for health professionals

to maintain a broad understanding of the symptomology of anxiety and depression and their meanings in different cultures.

This study focuses on depression as a result of its conflation with ‘normal’ human emotion. Mood fluctuation can occur as a result of life occurrences, however depression is designated as a prolonged severe mood disorder (Diagnostic Statistical Manual of Mental Disorders, 2013). Furthermore, there are different understandings of the causes of depression that allow for different constructions of the condition itself (Kangas, 2001). Depending on the way in which depression is constructed and mental health is understood, different causes are attributed to the various symptoms, and the accompanying remedies are related accordingly. This project attempts to present such understandings of depression and mental health as they are described by Muslim leaders in London and to contrast these understandings with those presented in ‘mainstream’ health information pamphlets directed at the lay public.

### 1.1.1 Biomedical and Social Narratives of Depression

Within the biomedical perspective, depression, which is classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), is situated at the end of the continuum of low moods (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013). Symptoms identified as key for the diagnosis of depression include sadness or loss of interest in regular activities, a decrease in the ability to experience pleasure, loss of energy, changes in eating habits, sleep disturbances, slowing down or an increased pace of general behaviour, irritability, distortion of reality, guilt and the deterioration of social relationships (Klein & Wender, 2005). For a diagnosis of depression, several symptoms must be present for a prolonged period of time. This is thought to differentiate depression from general melancholy or mourning, which are considered natural emotional experiences (Wasserman, 2011). Most indicative of a depressive state is the disturbance of daily routines, work performance, and social capacity (Wasserman, 2011). Individuals suffering from depression may use alcohol and various drugs as a temporary form of anesthetic leading to substance abuse. Such abuse may exacerbate depressive symptoms.

The influence of the DSM's 'medicalized' view of depression extends beyond health care settings. For example, it is used in legal courts to determine competence and in schools to assess the performance of children (Kutchins & Kirk, 1997). The general social lexicon has also become medicalized with terms such as ADHD or PTSD in common use, both disorders classified in the DSM.

Although in common use, these medicalized constructions of mental disorders reflect a particular social structure that benefits some and disadvantages others. Bowker and Star (1999) encourage the examination of the organizational scaffolding and categorical structures that uphold our social systems, such as medical classification schemes, which are ubiquitous, yet largely invisible. One such system is the DSM. As Kutchins and Kirk (1997) explain, the DSM has defined what is normal and what is dysfunctional, a construction influenced by pharmaceutical companies that stand to gain through the expanding medicalizations of appropriate, everyday (or 'normal') emotional states, connecting such states to the need for pharmaceutical interventions and the need for medical monitoring (Cosgrove & Wheeler, 2013). Bowker and Star's (1999) examination of classification systems provides a useful backdrop to my research in that it suggests the importance of exploring the potential impacts of different understandings or 'classifications' of mental/emotional states, in this case, medicalized versus lay and/or religious understandings of 'low mood' or depression in a particular cultural community.

The biomedical discourse of depression focuses on biological theories about the causes of depression, as opposed to the societal conditions that may result in feelings of sadness and anxiety. Such a focus also implicates possible remedies, limiting possibilities to psychiatric and psychological options. The progression into a depressive state is thought to be either triggered by life events or produced as a result of genetically transmitted predisposition to depression (Klein & Wender, 2005). From a biological perspective, the interactions between neurotransmitters regulate moods. Without an appropriate balance, an individual is pre-disposed to depression. Life events that may trigger depression include loss of a loved one or other traumatic experiences. Both factors, that is, triggering events and chemical imbalance, may coincide to influence the mental state of an individual. In terms of treatment, when depression is deemed to be the result of a

hereditary chemical imbalance in the brain, then anti-depressant drugs are thought to be most effective. When depression is related to life circumstances, psychological treatments may be of more use, perhaps in addition to the use of anti-depressants (Klein & Wender, 2005).

The characterization of depression in biomedical discourse is also gendered. Women are more often diagnosed with depression than men. This is thought to be, at least in part, a result of the fact that women are more likely than men to verbalize symptoms of depression. Men, on the other hand, are more likely to express depression through alcohol abuse, violence, aggression, and are also less likely to discuss their emotional states. This means that the diagnostic process may differ for men and women and possibly lead to a lower incident of diagnosed depression among men than women (Wasserman, 2011). Women also experience hormonal fluctuations (premenstrual, postpartum or menopause) thought to cause depressive symptoms that may lead to diagnoses of major depression (Wasserman, 2011). This differentiation between men and women is situated in a biomedical discourse that roots depression in physiological changes and symptoms that are expressed accordingly. According to Wilhelm (2006), these factors have led to depression being characterized as a 'women's problem', creating a complex relationship between depression and gender. Notions of hysteria that were developed specifically through references to female physiology and the psychiatric discipline as a whole have been viewed by many feminist theorists as part of a patriarchal institution that encourages normative stereotypes about women's emotional behaviour (Wilhelm, 2006). In response, counter narratives have emerged in which negative or 'low' mood is seen to be a reasonable or 'healthy' response to stressors such as violence, socially constructed gender roles and economic status.

According to Amer and Hovey (2007), acculturation, the cultural change that occurs as a result of continuous interaction between two different cultural groups, can be a significant source of stress, as new immigrants are faced with learning a new language, adopting new customs, learning new laws, and experiencing incidents of perceived discrimination. Berry (1986) described different 'strategies' of acculturation, including assimilation, the adoption of the new culture while disregarding the old; integration,

accepting the new host culture while maintaining elements of the old; separation, maintaining the old culture while not accepting the new; and, marginalization, wherein the individual is marginalized by both the host and heritage cultures. The latter condition is thought to be a result of a failed attempt at assimilation and is not always the choice of the individual (Abu-Bader, Tirmazi & Ross-Sheriff, 2001). Berry's (1986) model suggests that additional stressors of the settlement process, connected to cultural adjustment, affect an immigrant's mental health. These cultural aspects intersect with socioeconomic conditions as well as dominant structural factors, such as racism, gender roles, and anti-immigrant sentiments, predisposing immigrant groups to poor mental health (Viruell-Fuentes, Miranda & Abdulrahim, 2012).

The focus within the biomedical paradigm of mental illness leaves little room for a discussion about the impact of demanding social processes, such as acculturation. However, there is some evidence of a connection between the acculturation process and mental health. Within Berry's (1986) described acculturation strategies, integration is believed to have the most positive psychological effect while marginalization is thought to be the worst (Amer & Hovey, 2007). Although researchers have attempted to validate these claims, the results have been inconsistent among various immigrant groups. For instance, Amer and Hovey (2007) studied acculturation and mental health within different groups of Arab Americans. Their findings revealed that Arab Christians responded with greater assimilation while their Muslim counterparts reported greater adherence to religious and cultural traditions. Muslims however, did not report greater acculturative stress. Instead, greater religiosity in Arab Muslims was correlated with better mental health, as assessed with standardized measures such as the SAFE Acculturation Stress Scale and the Center for Epidemiologic Studies Depression Scale (Amer & Hovey, 2007). The results were thought to be an outcome of family structures, with higher religiosity in Muslim families leading to less interfamily stress. In addition, the Christian culture of American society could lead to the better integration of Arab Christians (Amer & Hovey, 2007). Another study, conducted with Turkish and Moroccan Muslim immigrants in the Netherlands, revealed similar results, where stronger cultural adherence was associated with less acculturation distress on the part of Moroccan immigrants, but not for the Turkish participants (Fassaert et al., 2011). This study also

highlighted the sources of acculturative distress leading to potential depression, including language differences and the difficulties in developing the skills necessary to participate in the host country (Fassaert et al., 2011). These studies are important in that they demonstrate how religiosity, culture, acculturation strategies and mental health interact differently among various groups and suggest that, for some, adherence to traditional culture may have a beneficial impact on mental health.

Although not specifically identified in Berry's (1986) model, others have speculated about the role of gender in the immigrants' experience of acculturative stress. For instance, immigrant women are often the negotiators between the heritage and host cultures, particularly in their roles as mothers as they are often responsible for passing down cultural practices to their children. Many immigrant women are also likely to be tasked with both household and economic responsibilities, leading to significant overload and, possibly, higher levels of stress and depression (Amer & Hovey, 2007). The discrepancy between expected gender roles in the heritage and host cultures can also produce an additional source of stress for women, whereas less emphasis is placed on the importance of gender roles of their male counterparts (Ellis et al., 2010). Furthermore, many Muslim women wear the headscarf, standing out as identifiably Muslim, possibly making assimilation more difficult, while simultaneously becoming easy targets for discrimination (Ellis et al., 2010). As a result, Muslim immigrant women are members of multiple social identities that can affect mental health in different ways.

### 1.1.2 Depression and Islam

The Muslim scholar and author Aaidh Ibn Abdullah Al-Qarni wrote a book titled *Don't be Sad* (2005), originally published in Saudi Arabia in Arabic and has since been translated into English. Al-Qarni was included as one of 2013's Muslim 500, a list of the world's most influential Muslims compiled annually by The Royal Islamic Strategic Studies Centre. Al-Qarni's influence was cited as a result of *Don't be Sad*, which has sold over 2 million copies worldwide (The Royal Islamic Strategic Studies Centre, 2013). Although Al Quarni was accused and found guilty of plagiarism in 2010 (The Royal Islamic Strategic Studies Centre, 2013), his influence on this topic is maintained through the book's widespread distribution. The book deals with the causes of despair and how to

remedy sadness in everyday life. Al-Qarni (2005) is writing primarily from a religious perspective, using his main sources as the Quran (holy book considered to be divine revelation) and Hadith (narrated life and practices of the Prophet Muhammed) (Haque, 2004). Depression is described as an ailment that afflicts much of the world. The developed world is highlighted as the population that suffers from depression to demonstrate that wealth is not correlated with happiness. According to Al-Qarni, the causes of depression include idleness, laziness, anger, sinning and deviation from God. He also states that depression can lead to a negative outlook on life, ulcers and even suicide. Because spiritual problems are identified as potential causes of depression, not surprisingly, some of the suggested remedies for it are of a religious nature. According to Al-Qarni, reading Quran, remembering the blessings and favors of God, as well as taking comfort in relying on God will help to alleviate depression and general despondency. He cites many verses from the Quran as well as sayings of the Prophet to support his claims. Such sayings include Hadiths like “God does not send down a sickness without sending the cure” (Al-Qarni, 2005, p. 430) from which the reader is meant to take comfort in knowing that answers exist for any problems with which they are afflicted. Al-Qarni also suggests that engaging in acts of charity and helping those less fortunate will help to relieve depression. Such actions counter laziness and idle behaviour while simultaneously comforting the heart. Although Al-Qarni includes in the book a discussion about hardships causing sadness, he links it to the notion of growth and patience, i.e., that times of distress can be used to foster growth and to find strength. He draws on verses from the Quran, which indicate that hardship is followed by periods of ease.

Al-Qarni’s book, like the writings of many Muslim scholars, is focused on the state of the Muslim “believer” who is gender neutral and devoid of ethnic affiliation. The same term is used in the Quran to address anyone who is Muslim, signifying the universality of the message. In other words, Al-Qarni’s book is meant to address everyone. The only time women are specifically addressed is in terms of the possible development of depression in pregnant women (Al-Qarni, 2005).

Although Al-Qarni’s writings deviate notably from the standard biomedical perspective on the causes and treatments of depression, his work presents an understanding of



specific themes that are often repeated within an Islamic perspective which share some similarities with the cognitive therapy approach to the treatment of depression (Thomas & Ashraf, 2011). For instance, Islam emphasizes the idea of mindfulness of one's thoughts (Thomas & Ashraf, 2011). Cognitive therapy similarly encourages patients to evaluate their 'automatic' thoughts. The Islamic perspective also separates self-worth from social approval, discouraging upward social comparisons and encouraging the individual to be thankful (Thomas & Ashraf, 2011). Cognitive therapy attempts to change the patient's behaviour and levels of activity. "Behavioural activation as a technique encourages clients to gradually increase their activity levels especially focusing on activities that give them either a sense of achievement and/or pleasure. Various Islamic traditions provide similar advice advocating the continuation of beneficial activity" (Thomas & Ashraf, 2011, p. 188). This is consistent with Al-Qarni's (2005) advice for those experiencing depression to engage in acts of charity that will assist with feelings of lethargy. As a result, even though Al-Qarni's (2005) writings offer an alternative understanding of depression that significantly differs from the biomedical narrative, there are aspects of his suggestions that are consistent with the assumptions that underpin 'mainstream' psychotherapeutic counselling.

### 1.1.3 Leadership in the Muslim Community

Although Muslims come from many ethnic and national backgrounds, they adhere to a similar worldview based on the Quran and the Hadith (Haque, 2004). It is this worldview that unites Muslims in understandings of life and wellness. At a community level, Muslims who worship in a single centre are all exposed to the opinions of their religious leaders, who may further shape similar understandings within a single congregation. Some of these leaders may be consulted for help with personal counselling. The main identifiable leader is the Imam or prayer leader (Padela, Killawi, Heisler, Demonner & Fetters, 2011). In the mosque setting, this is the person who is designated to lead sermons and prayers at the mosque as well as conduct religious rituals such as marriage ceremonies and burials (Padela et al., 2011). In some institutions, the post is a paid position whereas in other mosques it is filled by a volunteer. Some religious centres share the leader's responsibilities amongst a number of individuals (Nimer, 2002). By

definition, the Imam must be a male member of the community since women cannot lead men in prayer (Padela et al., 2011). Some communities have, in addition to Imams, a number of religiously educated individuals, both men and women, whose opinions are sought about a range of personal issues. These community leaders are looked to for guidance in familial and personal issues in addition to spiritual direction and religious advice in times of crisis (Padela et al., 2011).

The weekly Friday prayers are an important religious tradition. These weekly gatherings include a sermon and, while only mandatory for Muslim men, are often attended by a wide spectrum of the community, including women and children (Padela et al., 2011). The Imam often uses these sermons as a platform to address an array of social, personal and religious issues (Padela et al., 2011). As a result, even if an individual does not specifically seek out the advice of the Imam or community leader, he/she may still be exposed to, and influenced by, their opinions.

Religious leaders in the Muslim community can be thought of as mediators of information pertaining to many aspects of the life of a Muslim congregant. Mediators are situated between the information sources and seekers (Wathen, Wyatt & Harris, 2008). Latour, (as presented in Wathen, Wyatt & Harris, 2008) differentiates between intermediaries and mediators of information. Intermediaries merely transfer information from the source to the seeker whereas mediators interpret, contextualize and transform the information. When providing information to community members, Muslim religious leaders may 'intermediate' in the sense of passing along the messages contained in traditional religious texts to their congregants or 'mediate' by interpreting and contextualizing the messages in these texts as they apply in contemporary contexts. Most Muslims in Canada have independent access to these texts and the ability to read and understand them. However, leaders are sought because of their study of, expertise, and familiarity with important texts and traditional sources, such as the previously mentioned Quran and recorded Sunnah, as well as additional scholarly interpretations of these texts. As a result of the all-encompassing nature of the Islamic faith, religious leaders often advise on matters that go beyond 'spiritual' issues, such as health (Padela et al., 2011). According to Wathen, Wyatt & Harris (2008), the preferred (inter)mediators of health

information are those who can contextualize and localize health information. Mediators can thus provide relevant information depending on an information seeker's needs and condition. It follows, then, that religious leaders may be important sources of health information in that they can contextualize health matters in a religious paradigm that is familiar to and accepted by followers.

## 1.2 Study Objectives

Among the different explanations about the causes of depression there are few, if any, explorations of constructions of depression from a religious perspective, that is, constructions that take into account the ways in which particular religious groups understand the phenomenon of depression or 'low mood'. In this study, I investigated how Muslim leaders in London, Ontario construct and project understandings of depression to the members of their religious community and compared these understandings, and related understandings of mental illness and mental health, with those found in health information sources intended for lay audiences. My review of the literature suggests that immigrant women may encounter multiple stressors resulting from the immigration process, including financial difficulties, language adaptation, and loss of social support, compounded by their roles as caregivers for other family members who may also be coping with the stress of acculturation (Amer & Hovey, 2007). Therefore, an important focus of my study is how Muslim community leaders understand gender roles as they relate to women's experience of immigration and depression, and, in particular, how these understandings inform the advice the leaders might give to congregants.

My objective in this research is to shed light on a portion of the health information landscape that Muslim immigrant women are likely to encounter in one Canadian city. By examining alternative constructs of depression from the perspective of a particular religious faith group, I hope to provide health professionals and other social service providers with a more nuanced view of the information about mental health to which members of the Muslim community, especially immigrant women, are exposed, as well as to enable those responsible for producing targeted consumer health information materials to tailor their efforts more effectively when serving the Muslim community.

## Chapter 2

### 2 Methods

In this study I conducted interviews with religious leaders in the Muslim community of London, Ontario and analyzed the interviews in terms of the discourses they reveal concerning mental health, mental illness, and depression as related to Muslim immigrant women. Using a constructivist qualitative approach, I compared the discourses expressed in the interviews with those found in materials related to mental health, and more specifically depression, that are intended for lay audiences, particularly pamphlets and handouts that are available in walk-in clinics, public libraries, as well as social service and community centres that immigrants to London may frequent. My study design was approved by the University's Non-Medical Research Ethics Board, with the signed approval form included as Appendix A.

#### 2.1 Study Participants

Muslim immigrants who settle in the London area are from both Sunni and Shia sects. The differences between these sects are largely theological with implications for religious conduct (Nimer, 2002). In this study, I recruited participants from both groups. London, Ontario has two major Sunni mosques and one major Shia mosque. In addition there is a smaller Sunni, Bosnian mosque and a community centre run by the local chapter of the Muslim Association of Canada (MAC). Within each of these institutions, a number of individuals are considered religious leaders as a result of positions that they hold and/or the knowledge they are seen to have. As a result of these qualifications, when members of the community have any concerns, they are likely to be referred to these individuals. For the purposes of this research, 'leaders' in the Muslim community are individuals who 1) hold the position of Imam and/or are chosen to conduct its duties on behalf of the mosque or 2) are teachers of a circle of religious knowledge (colloquially known as a *halaqa*) in one of the five centres. These categories of leaders were chosen to allow for both male and female participants as well as the inclusion of individuals who do not hold

the main leadership position of Imam but still have the opportunity to share their impressions and knowledge with the Muslim community.

I invited the Imams from each of the mosques<sup>1</sup>, as well as halaqa leaders in all the mosques to participate in the study. In addition, I approached the MAC Muslim community centre which, while not a Mosque and without an assigned Imam, provides services for Muslim youth, families, and the community at large. One of these services is open halaqas, specifically for women. I invited the individuals who conduct the halaqas to participate in an interview. Through this method I recruited, in total, 8 interview participants.

The interviews were semi-structured, using prepared questions and prompts (see Appendix B). Each interviewee was presented with a letter of information explaining the purpose of the study and signed the associated consent form (see Appendix C). The interviews were conducted in English and audio-recorded with the permission of the interviewee. Because Arabic is the original language of the Quran and hadith, some Arabic words and phrases were used in the interview. This was not an obstacle as I am a native Arabic speaker and I am familiar with the verses of the Quran and hadith to which the interviewees were referring. If there was any ambiguity, I was careful to ask for clarification to ensure no assumptions were being made. Furthermore, as I am a visible Muslim, I believe it would have been difficult to have a conversation with Muslim leaders entirely in a language that is different than the primary discourse of the faith.

## 2.2 Pamphlet Collection and Analysis

The constructions of mental health and depression that are revealed through the analysis of the interviews were subsequently compared to those found in lay consumer health materials concerning mental health and depression. These materials were obtained from organizations that provide service to immigrant populations in London, specifically the downtown public library, the local branch of the Canadian Mental Health Association,

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<sup>1</sup> The sampling plan excludes the Imam of the mosque in which I am member of the Board of Directors (see section on Reflexive process below).

and the Family Service Thames Valley office. A downtown, walk-in doctor's office, the Cross Cultural Learner Centre, the InterCommunity Health Centre, the office of WOTCH Community Mental Health Services, and the London-Middlesex Health Unit were also visited with the purposes of collecting pamphlets on mental health. However, the latter centres either produced duplicates of the previously obtained materials or offered no handouts on the relevant subject matter. All of these organizations offer services to immigrant populations in different capacities. Because immigrants are often dealing with unfamiliar information environments and are trying to navigate everyday information needs, there is likely to be considerable fluidity between deliberate and unconscious information practices (Caidi, Allard & Quirke, 2010). When visiting community service agencies, immigrant women who are in the process of settling in London may encounter such information pamphlets without recognizing a specific need for additional information or taking active steps to retrieve information about specific problems or issues, such as depression.

The first pamphlet chosen for this project is that produced by Seeds of Change titled *How do you feel today?*. This pamphlet was found in a number of centres across London including the downtown public library, the Cross Cultural Learner Centre and the InterCommunity Health Centre. It was the most common pamphlet found across the visited locations. Seeds of Change is a local, London-based initiative that aims to provide immigrants and refugees with information on mental health and addiction. As a result, the Seeds of Change pamphlet includes information and images intended to appeal to diverse cultural groups. For example, the cover of the pamphlet includes pictures of four individuals (2 men, and 2 women) of varying ethnic backgrounds, including a woman wearing the traditional Muslim headscarf, the hijab. The pamphlet is 8 pages long and includes sections with the subheadings 'Mental Health', 'Mental Illness', 'Addictions', 'Suicide' and 'Stigma'. The pamphlet also lists additional organizations to which the reader can reach out under the heading 'Mental Health and Addiction Services in London and Middlesex'.

Three pamphlets were collected at the Canadian Mental Health Association (CMHA), titled *Depression and Bipolar Disorder*, *Mental Illness*, and *Getting Help*. The CMHA is

a national organization with branches across Canada, including in London, that works to promote mental health through programming and advocacy activities. The organization lobbies politicians, offers community mental health services and conducts community outreach (Canadian Mental Health Association, 2013). All of the pamphlets are similar in presentation and length (8-10 pages each). None include any pictures. The first pamphlet concentrates on describing mood disorders with the subheadings 'Depression', 'Bipolar Disorder', 'Causes of Depression' and 'Bipolar Disorder', 'Treatment', 'Prevention', and 'Reach Out for Help'. The second pamphlet discusses a variety of mental illnesses including short sections on anxiety disorders, mood disorders, and eating disorders. This pamphlet includes the subheadings 'Mental Illness Affects Everyone', 'What Causes Mental Illness', 'Is There a Cure', 'How is Mental Illness Treated', 'Types of Mental Illnesses', 'Personality Disorders', 'Suicide is not a Mental Illness'. The third pamphlet describes the process of seeking help when struggling with a mental illness. The pamphlet begins with the analogy of ascending a mountain compared to the difficult periods in an individual's life. The same way a mountain climber requires support, so does someone recovering from a mental illness. This pamphlet includes the subheadings 'Finding Your Backup Team', 'Members of the Team', and 'Ready for the Peak?'. As the CMHA, is a national organization, it appears that the pamphlets are meant for the consumption of the general public across the country. The contact information specific to London, Ontario is stamped on the back of the pamphlets, a later addition that specifies the area of distribution for the particular pamphlet.

The fifth pamphlet included in the study was collected from Family Service Thames Valley. The Family Service Thames Valley is an organization that provides counselling services for individuals and families, aiming to cater to the diverse cultural and socioeconomic population in the Thames Valley area, centring in London and Middlesex with some programs available in the Oxford and Elgin counties. The organization has offices in London, Strathroy and St. Thomas. The flyer collected from the London location consists of information about group therapy as a method of improving an individual's emotional well-being. This is a one page flyer about a group called *Blues Busters*. The pamphlet includes descriptions of what an individual may be feeling to find the group useful and what a participant will learn through the group

therapy sessions. The flyer includes two images, one of a Caucasian man and the other of a Caucasian female. As this publication was only found at the Family Service Thames Valley, I assume that the intended audience is that of those who visit the centre. The Family Service Thames Valley is advertised as being able to help with feeling depressed through this Blues Busters Group. The United Way logo is placed on the pamphlet on the bottom of the page. There is no explanation of the relationship with the United Way, however it is stated on the organization's website that the United Way is a major contributor to the Family Service Thames Valley.

In order to be included in this project, the pamphlets needed to address mental health, depression, emotional wellbeing, or how to receive help for issues related to mental health. Pamphlets that only described an institution and the services offered through that institution were excluded. WOTCH Community Health Mental Health Services and the Family Service Thames Valley, and the InterCommunity Health Centre offered such pamphlets. Although beneficial in another context, these pamphlets did not provide an understanding of mental health and depression that could be included in the analysis conducted in this project.

## 2.3 Analytic Framework Questions

A discourse analysis focuses on the use of language as a form of social construction (Smith, 2007). In order to analyze the text, I used a framework of predetermined questions that incorporated both substantively focused questions and questions derived from methodological literature pertaining to deconstructing discourse. Here, the 'text' includes the transcribed interviews, as well as the mental health information pamphlets gathered from community social and health service sites. Potter and Wetherell (1995, p. 80-81) describe a discourse analysis as being "concerned with what people *do* with their talk and writing... and also with the sorts of *resources* that people draw on in the course of those practices" (as presented in Ballinger & Payne, 2000). These are the same aspects brought forward in my analysis: the words used to describe mental health, mental illness, and depression along with the resources that are called upon in the process of this description. Given that discourses both reflect and shape the contexts in which they are



produced and circulated, attention was also paid to the context in which discourses were being constructed. (Ballinger & Payne, 2000).

A common critique of discourse analysis is the position of the researcher in the process who can be seen to reinforce dominant discourses in the process of analysis instead of looking at alternative interpretations (Ballinger & Payne, 2000). One way to try and alter this possibility is through a reflexive process through which the researcher positions him or herself in relation to the analysis and the findings (Ballinger & Payne, 2000). This is also a process that I have included throughout this project as a way to demonstrate how I relate to the interviews I conducted and the results that emerged. I stopped after conducting each interview to reflect on the questions and responses. I took notes and returned to these notes as I analyzed the interviews and compared them with the pamphlet content. As there are a variety of approaches to discourse analysis, embedded in varying epistemological and theoretical perspectives, there is no single set method to conduct the analysis process (Cheek, 2004). In this study, I have chosen to use a template to apply a particular framework of questions to the analyzed texts (see Appendix D).

Understanding the setting in which the text was produced is essential to constructivist analysis (Holstein & Gubrium, 2008), therefore it is important to establish the date and place from which the text originated, as well as who, e.g., which institution(s), were involved in producing it. This line of questioning can be pursued to understand who stands to benefit from the construction described in the text.

How the text is organized is another aspect of my analysis. In the case of the pamphlets, this involved identifying the type and nature of the headings, subheadings and photos used to structure the information presented. As Bowker and Star (1999) explain, the ‘scaffolding’ provided by systems by which things and ideas are ‘classified’ or ‘ordered’, have a profound influence on how we understand, think about and behave in the worlds we inhabit. In this study, I am concerned with how ideas related to mental health, and more specifically, depression, are discussed and in relation to what other ideas. For instance, is ‘mood’ discussed by Muslim community leaders in terms of ‘health’ or is it linked to other significant concepts, and is the information presented in the pamphlets arranged according to the biomedical paradigm, e.g., in terms of ‘symptoms’, ‘causes’

and ‘treatment’ or is it set within a different structure, such as an indigenous paradigm (Stewart, 2008) which incorporates physical, emotional, spiritual and mental notions of ‘health’ or well-being?

As it was my intent to examine a part of the information landscape that is particular to Muslim immigrant women, I specifically considered references to gender in the texts of the interviews and information pamphlets. This included any mention of the ‘role(s)’ of women, especially with respect to family responsibilities, and to women’s and men’s experiences of emotional/mental problems and depression (Wasserman, 2011).

Other questions I asked in the analysis include, ‘Who has the authority to speak on issues in the settings I studied?’. This idea extends beyond the predominant voice that comes through in the text to include other sources (other people, entities, institutions, texts) that are given authority within the text itself. Analyzing authority and voice is intended to identify those who are entitled to knowledge in a particular space and who are entitled to speak in that space or context (Potter & Hepburn, 2008).

An important part of depicting a social construction is to identify the processes involved in a particular context (Gergen & Gergen, 2008). To this end, I explored what may happen when a member of the Muslim community expresses/exhibits signs of depression and my analysis also depicts the pathways through which help/support might be sought and/or offered as they are suggested through the respective texts. Here, I ask, ‘Who has the responsibility to ask for help or to act when a person is exhibiting symptoms of depression?’. ‘To what sources of help or guidance is the person likely to be referred?’, and, how is ‘help’ defined/constructed and with what expected consequences?

### 2.3.1 Analysis Process

The analysis of qualitative data occurred simultaneously with the data collection. This not only allowed for further clarification as necessary, but also permitted emerging themes to inform subsequent questioning (Bowen, 2009). Once an interview was conducted, I immediately transcribed the audio file. Only one interviewee did not consent to having the interview recorded. As a result, I took detailed notes during the interview and

included notes in the thematic analysis process. By transcribing the interviews I familiarized myself with the data before undertaking the analysis. Next, I read the transcription and identified repeated ideas that emerged throughout the text. I highlighted these repetitions into codes. I then compared the codes across all of the transcripts, combining commonalities into themes (Bowen, 2009). Once the themes had been constructed, I read through the transcripts again to identify areas in the text where the themes emerged. This allowed me to identify direct quotes from the transcripts to use when presenting my findings. For example, if an interviewee described his position in the relevant institution, I would highlight the section and label it “role of the Imam and position in the [blank] committee”. I combined all the codes that discuss the roles of the interviewees to compare and contrast across the religious leaders. This evolved into the overall theme of “Roles of religious leaders”. I conducted this process using the Word document transcripts themselves to which I added notes identifying the various codes.

The second process of analysis was the application of the a priori defined conceptual ideas for the discourse analysis as identified in Appendix D. As discourse analysis is often thought of as a particular lens rather than a method, there is no single agreed upon process (Cheek, 2004). The desired lens has been expressed through the analysis questions of Appendix D. As a result, each section of Appendix D (1, 2, 3 etc.) was collected in a separate document for each interview transcript.

I undertook the same process of analysis for the pamphlets I would collect, using the questions in Appendix D as well as looking for emerging themes. Similarly to the interview analysis, I collected the text corresponding to each section of Appendix D in a separate Word document. As both the transcripts and the pamphlets underwent the same analysis and formatting, this process allowed for a comparison across the various texts.

The thematic analysis conducted combined with the predetermined framework were both used in order to try to answer the question of trustworthiness (or credibility) (Burnard, Gill, Stewart, Treasure, & Chadwick, 2008). By using inductive and deductive reasoning between the analytic methods, I was able to consistently compare while analyzing the data. While participant validation would have been another means by which to ensure

credibility (Burnard et al., 2008), time constraints on the project did not allow me to return to participants and present them with intermediate analysis results. As a result, I tried to be thorough in the analysis process itself in order to be able to speak to the credibility of the results.

### 2.3.2 Reflexive Process

As a female Sunni Muslim I am situated within the cultural group that is the focus of the study. I have my own understandings of religious texts that I have read and I have heard various sermons and lectures throughout my life. I have come to my own conclusions with regard to my understandings of health, gender, spirituality, and the position of religious leadership from my lived experience as a Muslim. As a result, I have undertaken a reflexive process to understand how my opinions influenced the research process, particularly with respect to how I conducted and analyzed the interviews. I took notes after each interview on my thoughts and reflections on the session, as well as areas I may have left unexplored as a result of assumptions I may have made during the conversation.

In addition to my position as a Muslim conducting research about an aspect of Muslim culture, I am also heavily involved in the Muslim community in London, Ontario. I have volunteered for many years with the Muslim Association of Canada and I was a member of the Board of Directors of London Muslim Mosque when embarking on this project (hence I did not interview the Imam in my mosque as the position reports to the Board – see footnote 1). Furthermore, my family is well established and has significant ties to the community. Although I did not encounter explicit problems when recruiting participants, these relationships required delicate navigation. For example, I explained to participants that I have no intention of passing a value judgment on their responses but rather the project is exploratory with the purpose of understanding the perspective they project. I am not just a Muslim conducting research on Muslims but rather the particular Muslim community in which I am entrenched. I believe this has allowed me greater insight, but it required additional effort to ensure that I maintain ethical standards throughout all stages of the research.

## 2.4 Summary

In this research project I conducted a discourse analysis informed by a constructivist paradigm. The texts that I analyzed for this project included five pamphlets collected from various service providers across London that immigrant populations frequent as well as the interview transcripts. The 8 interview participants were religious leaders from the major Islamic institutions in the city. For the purposes of this research, a religious leader was either an Imam, the leader of a congregation, or someone who leads a halaqa (religious study circle) and is generally viewed as a knowledgeable individual in the Muslim community. A discourse analysis is underpinned by the key assumption that language is not just reflection of the way things are but contributes to the social construction of phenomena. I chose to use a predetermined list of questions that enabled me to identify how the language used in each of the sources of text constructs notions of mental health, mental illness, and depression. I specifically asked questions in order to examine the context in which the text is produced, to identify what are considered to be sources of authority in that context, as well to understand what processes are identified in reference to an individual's overall mental wellbeing.

## Chapter 3

### 3 Introduction

In this chapter, I present my findings. The chapter begins with what I found in the consumer health information materials, followed by my analysis of the transcribed interviews with the Muslim religious leaders.

#### 3.1 Analysis of Consumer Health Materials

In this section, I present the results of the analysis of the five pamphlets by first outlining the main discursive messages they contain in relation to mental health, mental illness, and depression. Through this section, I incorporate textual examples to show how these phenomena are discursively presented. I summarize this section by highlighting the features of the predominant biomedical discourse of mental illness and depression that is shaped and perpetuated through these pamphlets. In this section I chose subheadings that directly reflect biomedical language, recreating the classification system of ‘symptoms’, ‘causes’, ‘treatments’, and ‘prevention’ that was present in all the pamphlets. Through this mechanism, I am reiterating the power of classification systems as described by Bowker and Star (1999). These categorizations are often invisible and taken as natural when in fact they reflect and advance particular constructions. As this project particularly relates to Muslim immigrant women, I have also included sections in this chapter in which I examine gender constructs and references to culture and religion.

##### 3.1.1 Symptoms of Mental Illness and Depression

The symptoms of depression are outlined in the CMHA pamphlets *Mental Illness and Depression and Bipolar Disorder*. In the former, it is stated that depression “causes severe and persistent feelings of worthlessness, self-blame and sadness.” The main symptoms are feelings of worthlessness, self-blame and sadness. These feelings must be persistent and severe in order to be diagnosed as depression. The latter CMHA pamphlet lists several symptoms including:

- “Loss of interest and a lack of pleasure in activities, including sex

- Withdrawal from social situations
- Ongoing feelings of sadness, anxiety, worthlessness, hopelessness, guilt
- Changes in appetite, or an unexplained fluctuation in weight
- Lack of energy, complaints of fatigue
- Sleep disturbances (insomnia or excessive sleeping)
- Loss of focus, decreased concentration, forgetfulness
- Complaints of physical ill health with no identifiable cause
- Thoughts of suicide”

The CMHA pamphlet on mental illness grammatically differentiates between those who are experiencing the listed symptoms and those that are not. The pamphlet begins by explaining that everyone will struggle with negative emotions throughout their lives but the severe intensity of the negative emotions for some becomes overwhelming, disrupting daily life. The pronoun ‘we’ is used initially but shifts to ‘they’ when describing the second set of people. This creates two distinct groups, those struggling with mental illness and everyone else. This also has the effect of describing a state of normalcy and non-normalcy.

The *Blues Busters Group* flyer also includes a few symptoms, asking the reader, “Are you: Feeling depressed and finding it hard to cope? Having a hard time dealing with people on a daily basis? Having difficulty sleeping?” Here, the term ‘depressed’ is used as a symptom in and of itself, assuming that the reader will understand what that means, perhaps alluding to an extended period of sadness. The overarching description of ‘the blues’ includes difficulty interacting with others as well as sleep disturbances. These descriptions identify those who have ‘the blues’ and thus should reach out to the Family Service Thames Valley.

The pamphlet produced by Seeds of Change also includes a list of symptoms. This list, however, is for a variety of mental illnesses. A person experiencing any combination of the described symptoms may be struggling with a mental illness. The list of symptoms includes feeling stressed, worried, nervous, fearful, angry, aggressive, paranoid, having little energy or too much, losing interest in activities that used to be pleasurable, and

seeing or hearing things that others do not. In addition to listing the various symptoms of mental illness, this pamphlet addresses immigrants and refugees directly by stating, “feeling sad or worried are normal reactions to living in a new country. It is a good idea to ask for help if you feel this way for more than a few weeks.” This statement differentiates between the ‘normal’ feelings associated with the stresses of immigration and the ‘non-normal’ state associated with a mental illness. The focus on the length of time one experiences a symptom reiterates the difference between the normal and non-normal. In this case, “a few weeks” is deemed the cut-off point at which an individual who experiences symptoms should reach out for help.

Throughout the pamphlets, a repeated theme is the intensity and duration of mental illness which differentiates it from a ‘normal’ state. The pamphlet, *Mental Illness*, includes the following definition from the Public Health Agency of Canada (PHAC) which states that mental illness is “characterized by alterations in thinking, mood, or behaviour (or a combination), and impaired functioning over an extended period of time. The symptoms vary from mild to severe depending on the type, the individual, the family and the socio-economic environment.” Similarly the introductory CMHA pamphlet on mental health states that “for some people the unrelenting intensity of their emotions and the persistent chaotic nature of their thought patterns significantly interfere with their lives.” Within this generalized description of mental illness, the characteristics that distinguish a ‘normal’ from an ‘abnormal’ state are the intensity and the persistency of symptoms. The same assertions are made about depression. For instance, accompanying the descriptions of the symptoms of depression is the statement, “If you (or someone you know) have some of the following signs for more than several weeks, you may be experiencing a depressive illness.” Thus the symptoms must not only be present but the individual must be exhibiting the symptoms for several weeks before it can be considered depression, i.e., while many people may experience days of low mood, what differentiates the symptoms of depression as a mental illness from being just another bad day is the prolonged and intensive nature of the symptoms. The pamphlet, *Depression and Bipolar Disorder*, states “while we can all have brief periods of “highs” and “lows”, we generally do not experience extreme, extended, swings in our emotions”. The pamphlet produced by Seeds of Change similarly asserts, “everyone may experience



these changes from time to time. You need to ask for help when these feelings and behaviours begin to affect your quality of life” and “It is a good idea to ask for help if you feel this way for more than a few weeks.” Here, the reader is encouraged to ask for help when the listed symptoms have been exhibited for an extended period of time and if they are powerful enough to affect functionality in day-to-day life.

### 3.1.2 Causes of Mental Illness

In the pamphlets, the causes of depression are presented mainly as a result of chemical imbalances in the brain as well as a genetic predisposition, or a family history of depression. The CMHA *Mental Illness* pamphlet states generally about all mental illnesses that “ongoing research points to a complex combination of genetics, biological, physical and social environments as the main contributors to mental illness... Lifestyle, family environment, economic status, substance abuse stress levels and trauma can play a role in the onset, or relapse of symptoms.” Thus, there is an emphasis on the biomedical presentation of mental illness, while acknowledging that other socioeconomic conditions may be contributing factors.

The dissociation between demographic characteristics and mental illness reinforces the message that such factors do not cause mental illness. For example, the CMHA pamphlet *Mental Illness* states, “Mental health issues affect Canadians of all ages, genders, cultures, educational and income levels.” The pamphlet produced by Seeds of Change also states, “mental illness and addiction problems can happen to anyone regardless of age, gender, sexual orientation, income, education or where they were born.” The message is that mental illnesses are just like any other illness in that they can affect anyone. This message is also reinforced through the comparison with physical illness, suggesting that both types of illnesses should be seen the same way. In other words, they involve different realms of the body but are primarily internally caused and can be diagnosed, treated and prevented in the same way. The CMHA pamphlet *Mental Illness* states, “it’s time to stop treating diseases of the mind differently than diseases of the body.” The pamphlet *Depression and Bipolar Disorder* states “You would not hesitate to go to your doctor for a broken leg; seeking help for depression is no different.” Similarly, the pamphlet by Seeds of Change states, “Having a mental illness or an addiction is the

same as having any other physical illness like asthma, diabetes or heart disease. Illnesses need medical attention.” This comparison also further medicalizes the discussion of mood states.

### 3.1.3 Treatment

The most common treatments listed for all mental illnesses involve pharmaceuticals and a form of counselling. In the CMHA pamphlet, *Mental Illness*, the suggested treatments for eating disorders, mood disorders, and personality disorders all include medication, psychotherapy, and/or group therapy. The CMHA pamphlet on depression and bipolar disorder also recommends medication and psychotherapy for both illnesses while also suggesting electroshock therapy for severe cases. The pamphlet advises that individuals can independently contact a family doctor, self-refer to a psychologist and/or and approach a community organization. It is not indicated, however, how to contact a psychiatrist. The payment method for each of these options is also mentioned in the *Mental Illness* pamphlet which states that psychiatrist fees are covered by provincial health plans but psychologist fees and those charged by community organizations may not be.

An example of a community organization that can be contacted for assistance is the Family Service Thames Valley. As noted above, the *Blues Busters* pamphlet is specifically advertising a therapy group provided by the organization. As a result, the information provided is specific to that centre and the process related to that therapy group. The help process described in the pamphlet includes approaching the Thames Valley Family Service, joining the support group and learning coping mechanisms. The reader is encouraged to call to arrange a screening interview. It is not stated what the screening process accomplishes. No health care professionals are specifically listed as being involved. It is also stated that a sliding fee may apply thus a payment is part of the outlined process. The ‘sliding’ adjective indicates that the fee is based on the individual’s ability to pay. The pamphlet states that the participant will learn “how to manage those depressive feelings in a positive and supportive environment,” along with other cognitive methods that will assist in dealing with depression. The assistance that the therapy group

provides is presented as a “solution”. The word treatment is not used but it is implied that after joining the group, the participant will feel better.

It is also often stated throughout the pamphlets that familial, social and community support are all important parts of the recovery process. The CMHA pamphlet *Depression and Bipolar Disorder* states that “A supportive network of friends and family is also very helpful.” Furthermore, the CMHA pamphlet *Mental Illness* states when discussing the health care team that will assist with the treatment process that “the family is often included as part of the team because they need to give and receive support”. Friends and families can also assist in connecting an individual struggling with mental illness to the required assistance and treatment. The CMHA pamphlet on *Depression and Bipolar Disorder* repeatedly uses the phrase, “if you or someone you know...”, reiterating that loved ones can assist in the healing process. It is assumed here that family members are willing to be involved or the community has the ability to be supportive to those that need such assistance.

A biomedical understanding of mental illness is evident in the suggested treatments described in the CMHA pamphlet. Lifestyle, environment, socioeconomic factors and family life are mentioned as playing a role in the onset and intensity of symptoms but are not presented as causes. The loss of a job or financial trouble are mentioned as factors that can shake an individual, yet financial assistance is not presented as a means of helping people get back on their feet. Similarly, organizations that can help with day-to-day stresses, such as meal preparation and transportation, are suggested, but as a form of support rather than ‘treatment’. The paragraph describing these support options states that they can assist when an individual is “already feeling burdened” and are framed as relieving services. In comparison, psychiatrists are said to offer treatments that can “relieve mental disease”. Even in the context of finding help through community services, it is the individual who is urged to take action by finding out what is available and to “contact a CMHA branch near [them] to find what agencies are in [their] area”. Thus social supports are external to the discourse of health and wellness and the onus of responsibility for seeking help is on individual, emphasizing the individualistic nature of the discourse in the pamphlets.

The sentence structure used in the pamphlets while discussing treatments for mental illness reveals an understanding of the relationship between mental illness and the afflicted individual which suggests a form of externalization from the individual. For example, it is repeatedly stated that the illness is treatable, i.e., it is not the person who is treated but the illness. This differentiates the illness from the person in that they are distinct entities rather than inseparable from one another. Examples of such language in the CMHA pamphlet titled *Mental Illness* include, “Eating disorders are treated...”, “Depression responds well to medication...”. Again, it is the disorder that is to be acted upon, not the individual. This again reiterates the differentiation between the individual and the illness. The individual exhibits the symptoms of the illness but the illness is then something that can be treated, subdued, managed, or removed.

It is stated in most of the pamphlets that mental illnesses are chronic and, as a result, are lifelong conditions which can be managed to alleviate symptoms. Symptoms generally appear during adolescence and carry through adulthood. Even if a mental illness is not explicitly described as ‘chronic’, it is insinuated by the use of language such as the “management” of symptoms. This suggests that symptoms can be controlled or tamed but not completely removed. For instance, part of the treatment process is often described as the resumption of normal activities and re-integration into the community. This assumes that the individual enjoyed some semblance of normality before the onset of the mental illness and that the same normality is possible to achieve once more. The CMHA pamphlet titled *Mental Illness* also stated that treatment allows individuals to “regain their emotional footing.” The notion that emotional stability is something to be regained is analogous to losing balance momentarily and assumes that balance existed to begin with, not that the individual may have been dealing with an ever-present state of chaos. Because mental illness is assumed to be chronic, the suggested methods of treatment, i.e., pharmaceuticals and/or engaging in therapy, are presented as means of alleviating symptoms but it is implied that the illness may be dormant, perhaps to re-emerge, if triggered.

### 3.1.4 Prevention

The biomedical presentation of depression and mental illness is an individualistic one in the sense that it is the individual who is diagnosed and treated. It is also the individual who must take personal measures to prevent or mitigate the effects of mental illness. Some of the preventative measures that are suggested in the pamphlets include self-education, regular exercise, good nutrition and stress management. The CMHA pamphlet, *Depression and Bipolar Disorder*, mentions a collaborative website by CMHA, York University, Mood Disorders of Canada and Trillium Ontario dedicated to the prevention of mental illness through healthy lifestyles and encourages the reader to visit [www.mindingourbodies.ca](http://www.mindingourbodies.ca) for more information. This website is provided in addition to suggestions such as limiting caffeine and alcohol intake. Thus, taking control of personal behaviour is reiterated as an important method of illness prevention.

Self-education is commonly featured in the pamphlets. It is presented as a preventative measure and assumes that by informing individuals about the symptoms and treatments for mental illness readers can mitigate its effects. The pamphlet produced by Seeds of Change includes a subheading titled “What can you do to help yourself?” This indicates that the reader has the ability to act in such a way to prevent or mitigate the effects of mental illness. Amongst the points listed is a directive to “learn about your mental illness and/or addiction”. The CMHA pamphlet on depression and bipolar disorder describes encouraging the reader to learn about mood disorders by using library resources and community educational opportunities as “bibliotherapy”. Although the suffix ‘therapy’ is used, it is not presented as a ‘treatment’ per se but rather a preventative measure. Similarly, the CMHA pamphlet, *Getting Help*, encourages the reader to learn about mental illness by visiting the library, community health organizations as well as reputable online sites.

Although the preventative benefit of social and community activities is mentioned, the emphasis in the pamphlets is on the individual to engage such resources to prevent the onset of mental illness. Friends and loved ones can assist by looking out for the initial signs of distress and helping the person to meet health professionals, but it is stressed as the role of the individual to ask for help when needed. This can be contrasted with an

approach that would have reiterated the need to learn about mental illness in order to be able to identify warning signs in loved ones rather than in one's self. An allied preventative framework could have also called upon readers to regularly reach out to friends and family to inquire after their wellbeing rather than leaving the individual to build a social network for the sake of their own mental health. Overall, the pamphlets have the effect of 'othering' more collectivist understandings of health.

The general CMHA pamphlet on mental illness refers to the onset of mental illness in adolescence and, again, reinforces an individualistic understanding of health and illness. The pamphlet states that "the onset of these types of disorders [mood disorders] commonly occurs during adolescence and has a major economic impact on our society in terms of lost work productivity and increased health care costs." This is again consistent with an individualistic discourse, in this case that individuals have a responsibility to take measures to prevent mental illness so as not to unduly tax the health care system.

### 3.1.5 Gender

Some pamphlets do not directly address gender or gender-related issues. For instance, although the pamphlets produced by Seeds of Change and Family Service Thames Valley include photos of women they do not address these photos in the information provided. The pamphlet produced by Seeds of Change as well as the CMHA's *Mental Illness* pamphlet state that mental illness affects people from all demographic groups. The other CMHA pamphlets engage with the issue of gender differently. In the pamphlet, *Getting Help*, no direct mention of women is made, although female pronouns are used frequently when describing health care professionals who can offer help to individuals struggling with mental illness. Furthermore, roles that are socially constructed as gendered, such as housekeeping and meal preparation, are mentioned as day-to-day activities that can be overwhelming when one is struggling with mental illness. However, no mention of gender is made in relation to these activities. Childrearing is not mentioned.

The CMHA pamphlet, *Mental Illness*, describes many different types of mental illness and which disorders have a gender discrepancy. For example, eating disorders are cited as having a higher prevalence among woman than men. However, no reasons are

provided to explain this discrepancy. The pamphlet states that eating disorders “mask issues about identity, self-concept and self-esteem and are more prevalent amongst females than males.” Thus it can be assumed that women may struggle with issues of identity and self-esteem more than men do. Again though, no reasons are provided. This does not clarify if the writers believe such a difference is a reflection of biological differences or the social constructs that influence women’s behaviour.

The CMHA pamphlet that provides information about depression and bipolar disorder states that women are affected by depression twice as often as men while bipolar disorder presents in men and women equally. Among the listed types of depression is post-partum depression. This is in specific reference to women as it is directly related to women’s mental health after pregnancy. In this instance, gender is mentioned in direct relation to motherhood. The pamphlet also suggests that men express the symptomology of depression differently than women in that they are more likely to express anger or irritability rather than sadness, which, in turn, can make diagnosis difficult.

### 3.1.6 Religion and Culture

None of the pamphlets include any mention of cultural differences or any discussion of religion or its role in mental health. Faith groups and clergy members are mentioned in the capacity of offering support but not as a source of treatment per se. For instance, the pamphlet produced by Seeds of Change lists teachers, spiritual advisors and counsellors as people to whom readers can reach out if they are experiencing suicidal ideation. Similarly, the CMHA pamphlet, *Getting Help*, states “If you belong to a church, talk with a member of your clergy.” Here, religious leaders are recognized as individuals who can provide support but are not necessarily medically trained and thus whose skills are limited. This is made clear in the *Getting Help* pamphlet which outlines the skills of various healthcare workers who can assist in supporting recovery from a mental illness. Clergy members are not included in this list, neither are teachers or family members. The explicit inclusion and exclusion of different supports emphasizes the expertise of health professionals while deemphasizing the support that can be provided by spiritual advisors. In both pamphlets clergy members are positioned as potential members of an individual’s support system, as people to whom one can turn for help, but they are categorized in the

same way as friends, family, teachers or general community members. This absence of the inclusion of religion indicates that the producers of these pamphlets do not view spirituality as a factor in the presented understanding of health.

There is also no mention of the acculturation process that many immigrants and refugees experience upon resettling in a new country. This process is known to be a cause of excessive stress in the lives of new immigrants and refugees. Excessive stress related to the lives of immigrants and refugees is mentioned in the pamphlets but in the context that such stress may be an additional barrier to reaching out for help, not as contributing to the development or symptomology of mental illness. For example, the Seeds of Change pamphlet states, “immigrants and refugees may face additional stress and worries that can make it hard to ask for help.” The lack of discussion of social factors related to the lives of immigrants and the promotion of a biomedical understanding of mental illness in the pamphlets, potentially ‘others’ understandings that do not fit within this frame.

The pamphlet produced by Seeds of Change is intended to educate refugees and new immigrants about addiction and mental illness, however, some of the language used in the pamphlet, such as ‘we’ to refer to Canadians and ‘you’ to refer to newcomers, discursively divides those who are new to Canada from the existing Canadian community. Sentences such as, “Our community wants people to be healthy. We want to help people with mental illness and addiction problems” raise questions about who is actually included in ‘our community’. Claims such as, “In Canada, it is okay to ask for help when we are dealing with mental illness or addiction problems and there are many services available to you”, or “when help is offered it is to make the person feel better, not to ‘spy’ on their life” reflect cultural assumptions that may be unfounded, further differentiating between ‘real’ Canadians and newcomers.

### 3.1.7 Sources of Help and Authority

All of the pamphlets produced by the CMHA draw attention to the organization as a source of help and information on mental illness. The website [www.cmha.ca](http://www.cmha.ca) is referenced in all three pamphlets, and the reader is encouraged to visit the site or visit the local CMHA branch in person. These pamphlets also list other institutions that are



positioned as authoritative sources of information about mental illness. These institutions include the Public Health Agency of Canada, The Canadian Mental Health Association of Ontario, Mood Disorders of Canada, The Nutrition Resource Centre, and York University. These specific institutions are listed in addition to more generic sources of information, such as libraries, doctor's offices and community centres.

The pamphlet produced by Seeds of Change includes a list of services (many of which are in London, Ontario) to which people can be referred to in the event that the reader or someone the reader knows is struggling with mental illness or addiction. The listed services include:

- Addiction Services of Thames Valley
- Adult Mental Health Care Program
- Child and Adolescent Mental Health Care Program
- Canadian Mental Health Association
- Children's Mental Health Crisis Intake Team
- Daya Counselling Centre
- Drugs and Alcohol Helpline
- Family Service Thames Valley
- London District Distress Centre
- Mental Health Helpline
- Muslim Resource Centre for Social Support and Integration
- Ontario Gambling Helpline
- WOTCH Community Mental Health Services

This list includes an array of services for both mental health and addiction, as both issues are the focus of the pamphlet. Two organizations also target cultural minority groups in London. The first is Family Service Thames Valley, which specifically aims to decrease cultural or linguistic barriers to receiving adequate services. The second, The Muslim Resource Centre for Social Support and Integration (MRCSSI), offers a variety of services to new immigrants and refugees including family mediation, counselling, and food aid. There is also a significant connection between the MRCSSI and the Muslim community in London in terms of funding, support and resources. The inclusion of both

of these institutions demonstrates an understanding that different cultural minorities may need additional assistance specific to their situations. This list also serves to outline which organizations are authoritative on the issues of mental illness and addictions. By guiding readers to particular sources of help, the list potentially dictates the types of messages help-seekers are likely to receive on the topic.

### 3.1.8 Connecting Concepts

There are several connecting concepts relating to mental illness that appear in the language used in the pamphlets, serving to construct explanatory frameworks that lay out particular constructions of the reality of mental illness. For example, the pamphlet by Seeds of Change links mental illness to addiction and repeatedly uses the phrase, “mental illness and addiction”. Furthermore, it is not just a subsection that is dedicated to addiction within the overall pamphlet but the entire document is dedicated to both conditions. It is also stated that, “some people experience both mental illness and addiction problems at the same time, which can make the symptoms much worse. Professionals call this having concurrent disorders.” The CMHA pamphlet *Mental Illness* also describes the combination of conditions. However, the CMHA pamphlet does not use the term ‘addiction’ but rather describes concurrent disorders as “a condition where mental illness and a substance use problem with drugs, alcohol or gambling exist.” Despite the difference in word choice, common to both these pamphlets is medicalized terminology, such as ‘condition’, ‘illness’, and ‘symptom’, that presents the combination of addiction and mental illness as its own disorder with treatment dependent on the particular type of mental illness and substance.

Both the Seeds of Change pamphlet, as well as the CMHA pamphlet, *Mental Illness*, include a section on suicide in which it is explained that suicidal ideation is not in and of itself a mental illness, although consistent suicidal thoughts are significantly related to poor mental health. The pamphlet states, “Suicide is not a mental illness; however it can be a tragic outcome for someone who is experiencing mental health challenges as well as life events that leave them feeling hopeless, helpless and desperate”. The pamphlets urge anyone who knows someone who is struggling with suicidal ideation to talk about the

problem and, for reader who might be struggling with suicidal ideation, it is repeatedly stressed that help is available and the number for helplines is included.

The stigma associated with mental illness is also addressed in many of the pamphlets. The Seeds of Change pamphlet states: “Beliefs that lead to stigma are often not based on facts... Don't let stigma get in the way of asking for help!” The pamphlets emphasize the prevalence of mental illness as a way of reassuring the reader that he/she is not alone and that others are facing the same problem and they stress that anyone struggling with the various described symptoms should seek help from friends, family, community organizations or health professionals.

### 3.1.9 Dominant Discursive Constructions

The pamphlets all offer a similar medicalized narrative with respect to the symptoms, causes, and treatments of depression, often constructing mental illness as analogous to a physical illness. While social and environmental factors are recognized in the pamphlets as affecting an individual's mental wellbeing, genetic and physiological causes for mental illness are heavily emphasized and, relatedly, the use of pharmaceuticals combined with counselling by a health professional is described as the most effective form of treatment. Thus, the problematization of mental illness/poor mental health focuses on dysfunctional or deficient mind and body systems, which are unable to maintain health in the face of particularly stressful environmental factors. Solutions also focus on ‘fixing’ or regulating mind and body systems, thereby making an individual more capable of maintaining mental health in his or her contextual conditions. Beyond the need to address stigma, the pamphlets say little about ways of changing environments so that they promote or enable mental health. Instead, individual responsibility on the part of the person experiencing poor mental health is emphasized, such as taking preventative measures to inhibit the onset of mental illness.

Even in the pamphlet produced by Seeds of Change, which is intended for an immigrant audience, there was no direct mention of the acculturation process, only that new immigrants may feel anxious and unsettled for a few weeks after their arrival. The sources of authority mentioned in the pamphlets with respect to managing mental

illnesses reiterate a medicalized understanding as these ‘experts’ are identified as doctors, psychologists, psychiatrists, and other healthcare workers. The discourse presented in the pamphlets is also individualistic as it is the reader who is encouraged to play an active preventative role by modifying personal behaviours and learning more about mental illnesses. Furthermore, it is the individual who is repeatedly encouraged to reach out for help and ask for assistance when feeling overwhelmed, depressed, suicidal, or in need of support. While friends and family are encouraged to ask after loved ones, no mention is made of ideas of collective responsibility for mental wellbeing. This centres the focus on the individual’s role in the prevention, treatment, and management of mental illness.

## 3.2 Analysis of Interview Transcripts

Between May and August 2014 I conducted interviews with eight individuals drawn from the various Muslim religious centres in London, Ontario. The interviewees included 4 Imams, all of whom are male, and 4 halaqa leaders, three of whom are women. The interviews were conducted at locations chosen by the interviewee. Two interviewees requested that a third party be present. This was to respect Islamic behavioural conduct and ensure the comfort of the interviewee. The duration of the interviews was between 40 and 90 minutes. Only one interviewee did not consent to having the interview audio-recorded. Each of the interviews was transcribed and, subsequently, the transcriptions, along with the notes taken at the non-recorded interview, were thematically coded. In addition, the same template used to analyze the pamphlets was applied to the transcripts and interview notes in order to explore the participants’ constructions of mental health, mental illness, and depression. In this section, I present the results to allow for comparisons between the transcripts and the consumer health materials. Here, I have used section headings to organize my findings that differ slightly from the biomedical terminology of ‘symptoms’ and ‘treatments’ used above as a way to include and recognize the somewhat different perspectives of the interview respondents.

### 3.2.1 Self-Defined Role of the Community Muslim Leader

When describing their roles as religious leaders in relation to dealing with issues that were framed as mental illness, a number of the interviewees noted their lack of medical

training as a limitation in their ability to counsel or assist an individual in need of non-religious assistance. Many were wary of using the term ‘counselling’ to define their activities. These interviewees expressed what they saw as their own limitations and boundaries, while described their helping roles as not ones of ‘curing’ or identifying the causes of a person’s distress but of actively listening and finding ways to be of support to the individual requesting help. For example,

My main role in counselling is from a religious part. I do not, I’m not expert in the general counselling. So my main target will be, is to listen. (participant 1)

And for me what I, what I like to try to do is you know, help that person to, I validate what they are going through. (participant 2)

Because I’m not a professional counsellor, I’m very cautious about what kind of relationships I get involved in or what kind of advice I give. I do mentor some people. I also am a teacher. In terms of personal counselling in a professional way, it’s not something that I’m qualified to do. And do not do. (participant 7)

I guess when people come to me it's the question is um... what is what is my role. And I do believe its first a question of, you know, physician’s model, first do no harm. So I don't want to intervene in a way that's gonna make it worse. (participant 7)

Some participants indicated that their limited counselling role was a specific policy of the institution with which they are affiliated.

I don't think we can call it counselling. And we, actually the policy of the [place] is that the Imam would not be involved in counselling. (participant 6)

There are like deep issues that the general person, the Imam, who is not specialized cannot deal with except giving advice here and there and bringing people nicely together stuff like this. (participant 5)

The notion that the Imam knows everything is wrong. (participant 3)

Some interviewees extended this notion to the potential harm that an Imam could cause by engaging in unsupervised ‘counselling’, potentially having a negative impact on the wellbeing of congregants.

I think there’s a lot of harm that's done through um uh these counselling situations, violation of boundaries, um unethical behaviour, predatory behaviour, um uh, just uh you know, spiritual malpractice. (participant 7)

Thus the Imams and religious leaders carefully constructed their role as one that was not reliant on claiming the role of medical expert. Despite articulating what they viewed as their professional limitations in addressing issues of mental illness, the Imams and religious leaders reported that they do encounter individuals who may require additional assistance beyond that which they can provide, including those who are struggling with mental illness and depression.

### 3.2.2 Signs Identifying Mental Illness and Depression or When Someone is 'Not in a Good State'

The interviewees mentioned a number of indicators they perceive and have experienced as flagging potential mental health issues that required additional support beyond their own active listening and religious counselling. Many of these indicators were externally visible, obvious signs that an individual needs help. For instance,

[When] someone's standing beside you talking to another person that they think exists, that is a strong, like you can't deny something like that. (participant 2)

Usually a person who is not in a good state or in a normal state would make erratic comments or erratic decisions or maybe behave in an erratic way. It shows on the behaviour and how people talk to you. (participant 6)

The interviewees are describing behaviours that are externalized, obvious and do not require medical training to identify that an individual is in need of specialized attention. They did not speculate about what types of illnesses these behaviours may signify.

Another sign of ill health identified by the participants is when the people who approach them consistently express negative attitudes and/or lack of hope.

If person always talking about some, a lot of difficulties they.... that is going through and barely to hear from him or from her any positive statement so we start being worried. (participant 1)

I feel like for me there's indicators of bad state and what I tend to see is that they, they don't have much hope. They're not... they've become disinterested in certain things in life. They...you know the way that they're talking is almost monotone... you know detached. It's not so much about solutions anymore. Those are things that I find very concerning. (participant 2)

The notion of harm was also mentioned as an indicator of the need for external support, beyond that which the religious leader could provide. If the individuals seeking help are harming themselves or the people around them, this is seen as an indication of a serious problem.

How we figure out the cases, when we see the cases is severe. When, if someone really see that he... he or she trying to harm themselves and they see always continuously dreams and bad dreams. And when we see a person who's in the home acting abnormal so then we start being worried. (participant 1)

If the person commits something, whether physical or mental in nature, because that person may be mentally abuse another person or may inflict mental anguish on another person because of a mental condition or may inflict physical harm because of a mental condition or, you know, a combination of both. So, you know, I would look at that and say that if we see signs that this may hurt either the person, herself or himself, or another person that we should really deal with it before it gets out of control. (participant 3)

When such 'flags' are not identifiable externally, through the behaviours of the individual, there are other warning signs that can be indicators of mental illness, the most notable of which is distress in the family.

So they may not talk about it but it may be manifested in what is called domestic problems. So problems would arise between husband and wife, between children and parents. (participant 3)

Because when the mother or the father are suffering from these illnesses, depression and others, this impacts on the way they interact with their children and in their reactions to the situations of their lives. (participant 8)

A distinction made by some of the interviewees is that not every emotionally unstable state is an indication of a mental illness. For instance, a person may experience a period of sadness or hardship but this state is transient and not a sign of unhealthiness. Such emotional instability may be a result of a death or, in the case of immigrants, a new environment. As long as the disturbed mood state is temporary, it is not necessarily an indication of ill health.

Sometimes it is healthy to pour out your emotions. Just... just do what ever you want to do provided you don't hurt the people around you whether physically or emotionally. If you want to cry, if you want to, you know sometimes people go to the closet and scream. Ok, is this healthy? Maybe. (participant 3)

Not every failure to cope with such a stressor is an indication of mental illness. (participant 3)

Well if it is a prolonged state then really it needs a professional. (participant 6)

One interviewee described these states as a range: healthy, unhealthy and an in between grey area. This in between area is where the majority of individuals find themselves. The unhealthy area is clearly demonstrated as in need of assistance and treatment.

I think that the majority of people are probably in the grey. I think that if it's really clear that there's you know somebody whose going through you know, severe depression or something that's extreme then I would find it easier to say they're in a sick sort of mental state. (participant 2)

A conversation that emerged with a few interviewees about depression specifically was the difference between clinical depression and 'depression' in a colloquial sense that can be replaced by the general term 'sadness'. Consistent with the message in the medical pamphlets, one of the differences discussed was the prolonged and consistent nature of the feelings which indicates that the symptoms are those of clinical depression.

But if we see the case is depression, tension, but it can be solved. We see some smiles, we see their, we see the involvement of the person in the community, so in that case, it will not make us in a lot of worry. And we'll really try to follow up with the case and see if the person need more help. (participant 1)

It is the inconsistency here in 'depressed' behaviour that indicates a lack of worry, but still the person is monitored in case the situation changes. If it is clear that the signs or flags exhibited by the affected individual are prolonged or if the person demonstrates any of the externalized symptoms previously mentioned, including the potential for causing harm, most of the leaders told me that a professional needs to be involved, potentially to provide pharmaceutical treatment. An interesting distinction made by one interviewee was whether 'sadness' is a choice whereas 'depression' is a chronic condition that is not in the control of the afflicted individual.

Because if it was a choice then we shouldn't be depressed. You're right, we shouldn't. Like there's so much we have that we shouldn't be depressed. And you know in the Muslim belief is, even if you didn't have, you know, the fact that we have God in our lives is enough of a reason, not to be depressed, but



that's if it was a choice. And I think what we need is to educate people about is that it's not a choice it's an illness. (participant 2)

One interviewee interpreted Al-Qarni's book as referring to a general state of sadness when he discussed depression and that his assertion of using religious methods to alleviate such feelings were only meant for when someone is sad, not clinically depressed. This led to a discussion of the Islamic framework pertaining to emotion which discourages allowing any emotion, happy or sad, to overwhelm an individual.

The most important thing is not to allow an emotion to overcome you. Any emotion, even happiness. Like this is the Islamic tradition. So don't be overjoyed by what comes to you and don't be over sad, burdened or saddened by what has passed you. And the idea is to maintain stability. And that's really, you know, what I learned is that you shouldn't allow any emotion to completely overtake you. (participant 2)

This interviewee refers to the verse in the Quran that states: "In order that you do not despair over what has eluded you and not exult [in pride] over what He [God] has given you" (57:23). This attitude is meant to encourage emotional stability of the individual and the practice is cited as part of the Islamic tradition. This again, is seen as part of the choice of the individual. When emotional stability stops being a choice, then the matter is one of illness. Furthermore, when the ability to maintain emotional stability is no longer within the control of the individual, it is no longer something for which they are responsible.

If Allah takes you, takes from you, some talent or anything He does not obligate you to practically be responsible about it. (participant 5)

Overall, the interviewees described the symptoms of mental illness as obvious, prolonged, extreme, and where the behaviour of the individual is clearly differentiated from what is considered to be 'normal'. For all of the interviewees, these extreme instances are ones for which they suggest that another party should be contacted, one who is separate from the religious institution and can offer the necessary support. The external party was not specified as a medical professional but just someone external to the affiliated religious institution, such as providers of counselling and social services.

### 3.2.3 Understanding Why Mental Illness and Depression Happen

The interviewees discussed causes for mental illness and depression that include factors both internal and external to the individual. Neither of these types of causes were described as being controllable by afflicted individuals or considered to be their fault. The internal causes mentioned included chemical imbalances in the brain, reflecting a biomedical understanding on the part of the interviewees.

Mental conditions sometimes are reflections of chemical imbalance in the body which is... people cannot help. (participant 3)

In describing the nature of mental illness, some interviewees made a comparison to physical illness as a way of explaining the individual does not have control over his/her state of illness.

It's like saying you shouldn't have cancer. Well I would love not to have cancer, I would love not to be depressed, and I think that's really that's where the issue comes in. (participant 2)

The same as there may be pregnancy diabetes that has to be looked after, there may be eczema there may be other things that are physical in nature. So why should we ignore the mental conditions. (participant 3)

In the same way that a person may be diagnosed with cancer or diabetes, mental illness invokes the same understanding. This projects a biomedical understanding of mental health and depression. However, not all of the religious leaders agreed with this comparison between the mental and physical spheres.

The difference is clear [between the mental and physical]. Everything has its necessities and opinions and treatment methods and methods of dealing, depending on if the issue is a mental one or a physical, biological one. (participant 8)

If you have a headache, you know what you're gonna take, stomach ache then you know what you're gonna take. This is, this is something that it is visible to the doctors and they can, and they can diagnose what you have and they can give you the medication accordingly. But the issue with the emotional suffering or the emotional illness is something related to the personal life, personal experience. It's very difficult to get into that sometimes. (participant 1)

The interviewees who distinguished between mental and physical health often linked mental illness to external factors; environmental and societal, often relating to the

condition of immigration. For instance, they described isolation as one of the potential causes, particularly of depression. Immigrants were described as finding themselves isolated as a result of their dislocation; no longer connected to family and friends, no longer comfortable in their surroundings, and perhaps having trouble communicating in an unfamiliar language.

We have a lot of crisis because we have many people who are immigrants who moved away from all their ties and have not reestablished them.... So it gets to the point, it gets beyond the point of just every day normal um difficulty to something that is more entrenched and has escalated. (participant 7)

[We] try to explore together if it's evident that they're spending a lot of time alone. That they haven't, you know, that haven't made new connections with people. What might be stopping them from doing that is it language? Is it cultural, have they had negative encounters, is it the perception of others? (participant 7)

The conditions of migration were also cited as affecting the mental wellbeing of immigrants, particularly with respect to refugees and those who emigrated from war torn countries, possibly having witnessed trauma. Furthermore, fleeing in a state of fear was described as creating significant stress, affecting mental wellbeing as well as the ability to recover through reestablishing positive relationships in Canada.

Usually people come in and come to us and tell us, we do have, we see this, I can't sleep at night, I always see dreams, I always see the picture that I saw in Syria or in Iraq or I saw that one of my relatives, his hand was cut off or something like that. (participant 1)

I was still young. And when I left my country, I did not have more than the clothes on my back, fleeing for my life, death was coming for me, the killing. I was wearing a grey dishdash [traditional Arab clothing]. I reached a new world, scared. Everything strange and scary. ... So imagine the poor person that have nothing, that cross oceans. This is what we call fear of the unknown. (participant 8)

We have a lot of crisis because we have many people who are immigrants who moved away from all their ties and have not reestablished them, refugees who have even more, not only don't have those ties and not reestablished them but um even their own their country that they come from has completely broken their trust, police have broken their trust, authorities have broken their trust. So their ability to reestablish ties in the community is very difficult. (participant 7)

The religious leaders also referred to other beliefs that can be found in the Muslim community, such as that depression or other mental illnesses are caused by being possessed and thus can be remedied through religious practices.

His family thought that he's the jinn into him and that bad spirits went into him. And they start thinking so we have to read the Quran on him. (participant 1)

There are those who also seek it through mysticism and think it's a problem of being written about. (participant 8)

The jinn are unseen beings that are believed to live on earth that can cause humans to act erratically through possession. The interviewee is alluding to the belief that symptoms of mental illness are actually caused by jinn. These beings can only be rid of through religious processes, like reading Quran. In these comments, the interviewees are also referring to the belief that writing certain verses from the Quran or prayer on a paper has healing powers. They did not deny the existence of unseen powers, like jinn, but denied that these were a factor or had any relation to mental illness. They indicated that they do not engage in these practices and described their efforts to offer alternative methods to help troubled individuals.

But this is not, we need to really, we need to know really what is the causes of such depression or mental problem. So it might be from school, it might be from home, it might be from the street. So we need to figure out where it is and try to find ways to eliminate it or to at least minimize it. (participant 1)

Because there are some people actually who believe that mental illness is related to devil actions and they think the only thing you need to do is recite Quran and it will go away. And people like that I do advice to, I say, well I'm going to recite the Quran and make the dua (supplication to God) and all of this, but you really need to consult an expert, a physician or a psychiatrist. Someone who can really help you, because there are, these are illnesses that are, that can be healed with medications and things like that. (participant 6)

The religious leaders indicated that their response to such claims is to reiterate what they believe to be the real causes of mental illness and, in turn, point out relevant courses of action or 'solutions'.

### 3.2.4 Addressing Mental Illness and Depression

When asked directly about the use of pharmaceuticals and/or counselling to treat depression, all of the interviewees agreed that this is an appropriate treatment method. However, a few noted that, in their opinion, this approach misses other factors that can be of use to a person experiencing mental health problems. One of their concerns is whether counsellors offering professional psychological services will be sensitive to the religious practices of Muslim individuals and, perhaps, encourage behaviour or philosophical positions that are against Islamic teachings.

But a lot people have the concern that whether or not who they're going to talk to is aware of their religious and spiritual sort of um state and feeling and that's a big concern when you tell somebody [to seek counselling]. (participant 2)

Another aspect that the religious leaders think may be missing from 'mainstream' mental health treatment is encouraging socialization in order to help the recovery process. This was described as a process that cannot be provided by a therapist or a doctor.

I think that um... I think that what it lacks is a social element. I believe very very strongly in the social element um as critical to um... recovering from depression for many people. (participant 7)

Like I'd try to find specificities of their situation, and find what in the community would suit this person to help him in the way that is suitable. The Arabs had a great old saying, they're an old civilization. They would say: الطيور على اشكالها تقع (Birds of a feather will flock together). (participant 8)

This also led to comments about the role of the community in this process. In particular, some interviewees stressed that it is not just the individual who is responsible for his/her own wellbeing, but rather the community that should be of assistance where possible.

We're not just individuals. I'm a really very strong advocate of arguing that this is a, that one person is not responsible alone for their mood, that we all impact that. So at the same time we have to work collectively together on ourselves as well as on the other person. (participant 7)

Another interviewee invoked this community responsibility as a religious one, stating that it is God that encourages this behaviour.

Allah (God) wants us to help each other. There are sick people, we are responsible for them if we are healthy. There are poor people, we are responsible for them if we are rich and so on and so forth so that we live together on this earth working righteousness only, staying away from evil. (participant 5)

One of the recommendations to the general Muslim community involves providing space for individuals to give back and contribute. This suggestion was made with the explanation that individuals who do not feel they have the ability to be of use are likely to be isolated and feel depressed. Thus, as part of addressing the problem of isolation, the religious leaders suggest that Muslim centres should offer opportunities for troubled individuals to participate and contribute.

And and if I give a recommendation, you know, probably one of the most frequent recommendations I give is, I continue to talk to someone, like an immigrant woman or refugee woman, until I find what's she good at? What does she like? And then um I think about what can she contribute to the community. Uh that's I think that's the thing that's that's really missing for so many people. And of course it would make you feel depressed. (participant 7)

In addition to social and medical treatments, the interviewees also mentioned the use of religious practices such as prayer, to help the depressed individual.

And prayer itself, it's, when we bow, we prostrate to Allah (swt). We encourage people to do that. Prostrating to Allah, this is and trust there is God who will really alleviate any kind of suffering. (participant 1)

Two of the religious leaders explained the healing powers of prayer by invoking scientific studies that support its benefits.

A certain state or condition like praying at night, many of the scientists find that have found that they have benefits, or spending time in sujood (prostration in prayer) has certain secretions in the brain. I cannot say only use the psychological or medicinal treatment they can be helpful but they can have something that is missing. And that's why the doctor needs to decide with the person needing help if they are a believing Muslim, they may need help in their religion. (participant 8)

We have a halo around us, there is light around us. Like that person was bringing, that scholar the Swedish scholar, if I recollect was, was uh taking uh... pictures of those people uh... using a certain technology about the halo about them. And he found that the Muslims had more light than any other, any other... And his machine was so, was running so fast, like it was almost unable

to follow up with with uh with the light coming from that person who was praying to Allah (awj). So this means that the prayer has a real effect on our mental health. (participant 5)

A few interviewees referred to religious practices of prayer and reading Quran, not necessarily as a treatment for mental illness, but as a method of support for individuals undergoing difficult times, as well as for maintaining mental health. This was noted as part of the belief system of individuals who are requesting help. Since they are reaching out to a religious community leader, it is likely that help-seekers perceive their problem, and thus its solution, to be based in religion as well. Other than prayer services and social opportunities, the interviewees mentioned that happiness and mental wellness can be achieved through trying to achieve closeness with God and understanding one's purpose. This act of striving and religious self-development is thought to have a positive impact and is an encouraged mind frame.

Happiness it comes when you feel confidence, when you have confidence in yourself. So this confidence comes when you feel yourself, you're bettering yourself every day and every moment. So you feel confidence and that bring you happiness. We always say...el-taqwa (God consciousness) bring happiness. (participant 1)

When there is a story in the Quran, you have to understand that this story is told to you because of a purpose. You understand the purpose, you apply it and then you feel you are a better person and you, you feel you are happy. And don't think that because because you become a better person. (participant 5)

But maintaining a health mental state, you know, is helping people to achieve their goals, to realize who they are, to give them a sense of fulfillment. (participant 2)

This perspective led some interviewees to suggest how Muslim institutions can assist in the maintenance of good mental health. By providing opportunities for Muslim community members to learn and grow, the institutions support positive mental health practices. Again, the interviewees who referred to this process did not describe it as a treatment for mental illness but rather as a method of maintaining good mental health. The interviewees emphasized, however, that these practices would be insufficient to 'treat' individuals who are suffering with a mental illness.

One of the barriers that the interviewees identified to seeking and attaining care for mental illness and depression was the associated stigma. The interviewees noted their objections to such stigma and encouraged instead that these issues be properly understood.

You know let's say if a family has a member with mental illness they may just cover on that and they don't want anybody to know and they may actually run away from a neighborhood to hide because its its something that they feel embarrassed to admit so I encourage them to come out of that environment. (participant 3)

I know that there's a, there's a big, stigma around mental health in a lot of cultural and religious groups, especially things like depression. Like you shouldn't be depressed. But there, these are medical illnesses and they're conditions and I think, the way I view it too is the Islamic belief is, if there's something that, that can be treated, then we should treat it, it doesn't make sense to stigmatize people. (participant 2)

Here the interviewees are both addressing the individuals who feel stigmatized as well as the views that made them feel ashamed of being depressed or having a mental illness. As a result, they are also presenting the understanding that the associated stigma is a relevant community issue.

### 3.2.5 Gender Constructs

When asked about how gender affects the manner in which they counsel individuals or offer advice, the interviewees' responses varied. Some mentioned that their advice depended on the questions and problems that were presented, not the individual asking the question. Others believe that men and women experience different types of problems related to their mental health.

Usually the man, their problems are different then women. As I have mentioned, man maybe comes with, they have, they have problems with job or war, they're coming from war or... But mainly women come from mainly for violence issues or after they had a baby or some relatives problems. (participant 1)

Women were described as struggling with problems related to the home, whereas their male counterparts were described as succumbing to external problems, such as financial-related stresses. Marital problems were mentioned frequently as causing congregants to



seek the assistance of religious leaders. It was mentioned that a religious leader's familiarity with cultural gender norms is helpful when navigating these scenarios. For instance, the man in the family may be culturally positioned in a more authoritative role, creating a power imbalance in the household - a basis for future conflicts. Some interviewees noted that being aware of this imbalance is necessary to contextualize the problems of individuals who are asking for help.

So I would basically try to drill more of the woman what is happening and and if there is anything beyond what she is telling me. And I get also some female help along the way because there are some women who feel more comfortable confiding in a woman then in a man. So... yeah I would do it differently because I am aware of the cultural differences between men and women. (participant 3)

Furthermore, women may be less comfortable approaching a male religious leader for help, instead preferring to seek assistance from a female. Thus, in the midst of mediation, a male Muslim leader may only be aware of part of the marital conflict. A few interviewees suggested that women are more emotive than men, and thus prone to emotional crises, including depression.

On the man's side is much heavier then the anger on the women's side. This is what we see. And yet emotionally, women are more into will be more effective after a divorce, after maybe having family problems. So you can see emotionally women is more into depression more then men. (participant1)

While men are seen as more likely to react to stressful circumstances with anger, women are seen as more likely to react with depressive symptoms. The participants who mentioned it did not attempt to speculate as to the reasons for this difference. Nor did they mention that expressions of anger could be possible manifestations of depression. A few interviewees perceive women's expressions of emotion to be, at times, excessive and insincere.

But when I talk to the women, like usually they try to uh... grow emotional and then make it greater and greater, aggravate the problem until they can uh shed tears and uh I think uh...many a time um it's not honest it's not honest. It's only tears. And when I say uh please don't cry. Don't cry. Just talk about what the problem is so I can understand ok. (participant 5)

Like the man can live in a way that hides behind the expression of his gender to be stoic. And the woman can hide behind expression of tears. (participant 8)

Here, the expression of emotion is seen as getting in the way of the help a religious leader may be trying to provide, particularly in a family mediation situation.

### 3.2.6 The Use of Quran and Hadith

All of the interviewees invoked verses of the Quran and/or hadith at some point during the interview. The uses of the religious citations varied, but the Quran and hadith were often used to demonstrate a framework supported by Islamic thought that is useful to the leaders when they are assisting individuals in need.

You know the Prophet Muhammed (asws) said, the believer is a mirror to the believer. And people want to see that you, they want to see it in your face, that you feel, that you really understand how they feel. (participant 7)

In this case, the prophetic statement is used to explain how an individual seeking help should be approached, i.e., with empathy and understanding. This approach was noted as necessary if the religious leader is to be useful in times of crisis. Rather than merely regurgitating religious maxims, the leaders explained that individuals seeking help need to feel as though they are understood. Another interviewee explained the role of religion in relation to mental and emotional stability by providing a prophetic analogy.

The prophet pbuh said example of a Muslim is like a palm tree. Palm tree when a storm comes, it might little bit go right or goes left, but it will stay rooted down and it will be solid in front of the storm. Because there is a preparation for, God created it with this and the example of the believer is or should be like a palm tree. He would face all difficulties and all problems to get out of the storm, of the wind inshallah (God willing). (participant 1)

The example of the palm tree is used to set the Islamic framework of how a Muslim adherent maintains balance. By using faith as a source of strength, an individual will be able to weather the storm, like a palm tree that bends and does not break. Without the presence of a strengthening religion, an individual may be more prone to breaking, but the reason for the storm to begin with is not seen as a weakness in faith or a punishment. Everyone is described as potentially passing through difficult times, but faith can help in maintaining stability during those difficulties.

You know your destiny, you know that you'll be passing through difficulties, that this winds or the storm will pass through you, it will, you might bend a little bit as the palm tree. (participant 1)

A few of the interviewees mentioned the prophetic advice of seeking the proper treatment. In this case, religion was used for the sake of encouraging the biomedical understanding of illness, including mental illnesses in this perspective. This saying is often used to indicate that praying for relief from an illness is insufficient in and of itself but requires treatment from the necessary experts.

So, and we have a clear advice from the Prophet (asws) that if you have an illness then you seek a medication. (participant 6)

This understanding includes mental illness, framed as being similar to, or even part of, physical illness. One interviewee broke down illness as physical or spiritual, grouping both body and mind together, separating them from the spiritual aspect. In this construction, illnesses of the body and mind require help from a medical professional whereas illnesses of the soul require religious guidance.

### 3.2.7 Dominant Discursive Constructions

The interviewees presented a narrative that differs in many respects from that found in the pamphlets. Although elements of the dominant biomedical discourse, as exemplified in the analysis of the pamphlets above, were taken up within the construction of mental illness and depression conveyed by the religious leaders, the leaders' understandings included more explicit attention to environmental factors that can create overwhelming burdens which may result in a person becoming off-balanced and lead to depression. All of the interviewees agreed that the use of pharmaceuticals and counselling is an appropriate method of treating depression, however many added the qualifier that these methods were insufficient. Given the discursive expansion of causative factors to include environmental stressors, solutions offered by the religious leaders extended beyond medical treatment to address social issues.

Many interviewees noted isolation as potentially having a great effect on mental wellbeing, particularly for new immigrants who are not familiar with their physical or social surroundings. The religious leaders commented on their ability to assist with no

more than the spiritual and social aspects of congregants' mental problems, recognizing that they are not trained as counsellors, hence the need for external assistance. Most interestingly, one interviewee stated that the responsibility to assist those afflicted with mental illness is an Islamic duty of anyone who is healthy in the rest of the Muslim community. The discourses presented by the interviewees who discussed collective responsibility differed from the individualized focus that was evident in the pamphlets. Instead of emphasizing the individual's role in seeking help, the religious leaders point out that it is the healthy members of the community who must take action to ensure the wellbeing of the ill. The interviewees also discussed religiosity in the context of providing spiritual support for individuals who are experiencing difficulties, however, they did not attribute mental illness to individuals' lack of religious practice.

## Chapter 4

### 4 Discussion: Comparing Constructions of Mental Illness

My purpose in this study was to explore the information landscape relating to mental health, mental illness and, more specifically, depression as they relate to the lives of Muslim immigrants, by comparing the construction of these concepts as expressed by Muslim religious leaders in one Canadian community and in publications intended for the lay public that are produced by Canadian mental health organizations. Discourse analyses of mental health pamphlets and the text of interviews with Muslim religious leaders revealed several interesting themes. Notably, while the pamphlets clearly reflect a primarily medicalized construction of mental illness and depression, the interviews with religious leaders conveyed a more complex understanding of these conditions. While recognizing the possible necessity for medical intervention to deal with mental health problems, the religious leaders emphasized the significance of overcoming social isolation, especially for those who are new immigrants. In their construction of help or ‘treatment’ for individuals who are troubled by problems such as depression, the religious leaders emphasized the community’s responsibility, framing both the causes of and responses to mental illness within a religious discourse. The pamphlets also did not consider the specific necessities that may be required by immigrants, refugees, as well as other cultural minorities. There was no mention of the possible conditions of their lives that may make some of the assumptions in the pamphlet irrelevant. For example, the supportive role of family is reiterated in the pamphlets for those struggling with mental illness, while the immigration process may have exacerbated tensions in family relations and created physical distance from key supports. This example, as well other observations made by the interviewees, signifies that the pamphlets were not authored with this specific demographic group in mind.

#### 4.1 Understanding Classifications

In *Sorting Things Out: Classification and Its Consequences*, Bowker and Star (1999) encourage the examination of classification systems, arguing that such systems are

“artifacts embodying moral and aesthetic choices that in turn craft people’s identities, aspirations and dignity” (p. 4). Classification systems are the underlying structures that simultaneously support or make visible certain understandings of phenomena while concealing others. In the case of mental illness, standard medical classification systems such as the DSM-V, not only differentiate between various types of illnesses but also between ‘ill’ and ‘normal’ behaviour. Crowe (2000) conducted a discourse analysis to examine the DSM, stating that the diagnostic manual constructs the concept of normality through the definition and designation of various mental illnesses. He also asserted that such a classification system is built from underlying socio-cultural assumptions that need to be scrutinized in order to understand how ‘normality’ is constructed and defined. In the pamphlets I examined, depression is classified as a mental illness and differentiated from regular or ‘normal’ emotional reactions to experiences such as bereavement. The classification used in the pamphlets is consistent with the DSM-V, which lists depression, describes its symptoms, and explains how it is diagnosed and distinguished from a less intense state of ‘low mood’. The CMHA pamphlet specifically divides mental illnesses into various types, including mood disorders, anxiety disorders, eating disorders, personality disorders, and others. Here, depression is classified as a mood disorder. In contrast, the ways in which Muslim community leaders ‘classify’ mental illness was rather different. Importantly, some interviewees were reluctant to take up a medical discourse when discussing depression, yet they still acknowledged that in some instances there might be a need for medical attention.

The question that helped me to elicit how the religious leaders internally classify or make sense of depression was when I asked them to describe healthy and unhealthy emotional states. By invoking the discourse of health, I was asking interviewees how they relate moods to concepts of health and wellness. Their replies revealed that they make a distinction between unhealthy behaviours and illness in that an individual can engage in unhealthy behaviour or be in an unhealthy emotional state without being ‘ill’. The religious leaders classified individuals who sought their assistance by distinguishing between positive and negative behaviours. However, they recognize the context in which such behaviours occurred, addressing that context as a possible cause of the exhibited

behaviour. In addition, the religious leaders classified individuals depending on whether or not they could offer them assistance or if the situation required additional expertise.

## 4.2 Recognizing the Presence of Mental Illness and Depression

A medicalized understanding of depression and mental illness is evident in the classification system used to organize the information presented in the pamphlets. In particular, most of the pamphlets used the subheadings ‘causes’, ‘symptoms’, ‘treatments’ and ‘prevention’ in much the same way that information about physical illness is often presented in health materials aimed at lay audiences. In contrast, I have used more neutral terminology so as not to uphold the medical paradigm in my assumptions and to leave the discussion open to different discourses of mental health, illness and depression. Other medical terminology was also used in the pamphlets to describe individuals who struggle with both addiction and mental illness, classified as ‘concurrent disorders’. Likewise, individuals who have a developmental disability and a mental illness are deemed to have a ‘dual diagnosis’.

In contrast, many of the interviewees did not use medicalized terminology when discussing depression until it was brought up through my interview questions. For example, instead of specifically referring to doctors, they referred to ‘counsellors’, perhaps a more neutral and less medical term. Many interviewees spoke of the environmental factors that could lead an individual to feelings of prolonged ‘low mood’, mentioning isolation as a factor. They included “building confidence”, “find what in the community would suit this person” as well as “help people make connections” as ways to improve this person’s situation.

One of the key differences between the constructions of mental health found in the pamphlets and the interviews is that the interviewees emphasized externalized behaviours or attitudes that can be observed and compared to normative social behaviours. Because the Muslim leaders interact with community members in a social capacity, these external ‘symptoms’, such as erratic behaviours, are more obvious and easier to detect than the internal symptoms described in the pamphlets. In the pamphlets, various symptoms of

mental health problems were highlighted, including behavioural changes such as changes in appetite, energy levels, sleep, and the ability to focus, as well as feelings of hopelessness, stress, fear, and anxiety. Some of these symptoms were also described in the interviews, particularly a consistently negative attitude and feeling hopeless, but the religious leaders tended to emphasize more externalized or ‘visible’ symptoms, such as erratic behaviour, strange speech patterns and body movements, as well as talking with people who are not present. The interviewees also mentioned physically or psychologically harmful behaviour to one’s self or others as an indicator of a state of crisis that requires specialized care.

Although the symptoms emphasized in the pamphlets and the interviews differ, the duration and intensity of symptoms are discussed in both as indicators of when a problem requires closer examination. Specifically, both the pamphlets and the religious leaders emphasize that ‘low mood’ over a long period of time that negatively affects quality of life is not normal and is a sign that the affected individual is in need of assistance. Some of the symptoms described, such as feeling worried, stressed, fearful, angry or aggressive, are viewed as to be expected in people who are undergoing many life changes, as is the case for recent immigrants. The pamphlet produced by Seeds of Change suggests that while these feelings may be normal for an immigrant, help should be sought if these feelings persist for more than a few weeks. One of the interviewees described a similar scenario but suggested that help should be sought if the feelings persist for six months, raising an interesting question about how long it should be considered ‘normal’ for an immigrant to feel worried, stressed and fearful after settling in Canada.

### 4.3 Understanding Why Mental Illness and Depression Happen

An important difference between the pamphlets and the interviews emerged regarding the causes of mental illness, particularly depression. Overall, the religious leaders tended to focus on environmental causes whereas the pamphlets, while referring to environmental factors, focused more on biomedical causation. One interesting discrepancy between the perspectives presented in the pamphlets and the interviews was with respect to the role of families. The pamphlets describe the role of the family as a support system during the



treatment process, whereas the interviewees discussed family dynamics as a source of stress for new immigrants as well as a potential cause of depression. This significant discrepancy over the role of family as a stressor or a source of support demonstrates how some of the underlying assumptions made in the pamphlets could be problematic, particularly in understanding individuals who come from different cultural backgrounds. The pamphlets indicate that family members may be included in therapy sessions to both support someone with a mental illness and, in turn, benefit themselves from therapy. The assumption that is made in this case is that family members are willing and available to play a supportive role. The examples provided by the interviewees demonstrate why such assumptions are problematic. Indeed, many interviewees discussed domestic issues as problems for which immigrant Muslim community members would seek assistance. These observations are consistent with the writings of Carlos Sluzki (1979) who relates the migration process to family conflict. Whether the migration was forced or a matter of choice, legal or illegal, the family is severed from the usual social support networks. As a result of the migration process, the immediate environment is no longer predictable and family roles are in flux in reaction to the new host culture (Sluzki, 1979). Here, families can become a source of conflict rather than support. Many of the religious leaders cited domestic problems as either a source of personal stress that causes poor mental health, or a reflection of an individual who is struggling with mental health.

The religious leaders mentioned other stressors related to immigrant families, including cultural differences between parents and children, with the parents relating more with the culture of the country of origin while the children are more exposed to Canadian culture. The parents may feel strongly about the importance of preserving and implementing cultural and religious practices whereas their children may not. Gender roles and expectations may also differ between the home and host cultures, potentially causing friction not only between female children and their parents but also between husbands and wives. Such factors can create additional stress in the lives of Muslim immigrants and according to the interviewees, may lead to emotional instability and depression. Dion and Dion (2001) discuss how immigrant gender roles shift in the new host country with women possibly experiencing 'double burden' of taking on economic responsibilities while still managing domestic expectations. This 'double burden' was seen to negatively

affect the mental health of women. They also identify that the expectations for sons and daughters in immigrant families also differed, with greater pressures to maintain cultural customs placed on daughters, causing tensions that affect internal familial relations (Dion & Dion, 2001). These findings are consistent with some of the comments made by the religious leaders in this study about what they have observed in Muslim immigrant families.

The religious leaders' extensive commentary on the stressors related to the lives of immigrant populations was consistent with findings reported in the research literature. For example, Wood and Newbold (2012) found that a lack of language competency was a common barrier discussed by the interviewees. It not only causes difficulty in communicating and establishing social ties but can also turn what most would consider 'normal' interactions into escalated confrontations. A lack of familiarity with social customs and processes can also alienate immigrants. Simple tasks like grocery shopping or visiting a doctor's office become stressful if an individual is not comfortable with the environment and knowledgeable about social norms. These compounded issues were discussed by the interviewees as causing further isolation and contributing to low mood and depression among immigrant community members.

The religious leaders also referred to trauma experienced through the process of immigration. For instance, three interviewees mentioned that refugees might have experienced circumstances of war and violence, the residual effects of which harm their mental health. As Abu-Bader, Tirmazi & Ross-Sheriff (2001) have noted, the experience of such trauma needs to be considered in the ways that health care services are presented to immigrants and refugees. Another interviewee explained that newcomers may not feel safe in their immediate environments or have the comfort level to engage in the same level of mobility as others. These factors may have two effects on mental health – one is to isolate the individual and the second is to restrict physical movement and activity that could possibly improve the individual's mental state. According to the religious leaders, such factors may cause immigrants and refugees to suffer from multiple layers of isolation by not being able to interact with the immediate environment and this, in turn, may have a significant negative impact on their mental health and wellbeing.

It is important to note that the lack of such a discussion in the pamphlets not only indicates that immigrants are not specifically part of the target audience for these materials, but that environmental factors are not recognized in their messaging as primary causes of mental illness and depression. The pamphlet produced by Seeds of Change was the only document I examined to address stresses that affect the lives of immigrants and refugees (this is not particularly surprising since the purpose of the Seeds of Change organization is to inform immigrants and refugees about addiction and mental illness). The pamphlet states that moving to a new country can make an individual feel sad and worried and that immigrants and refugees may face barriers in accessing help. However, the Seeds of Change pamphlet did not elaborate on these stressors as a possible cause of depression or anxiety but rather contextualized them as an additional obstacle to accessing necessary services.

The interviewees suggested that spiritual practices can improve an individual's mood and be a source of support during times of difficulty. However, the interviewees did not list lack of religious adherence as a cause of mental illness or depression. I questioned all the religious leaders about Al-Qarni's book, *Don't Be Sad*, and the author's claim that low mood can be caused by a lack of religious adherence. Most of the interviewees did not agree fully with Al-Qarni's views. Some questioned whether he was using the term 'depression' in the clinical sense or as a synonym for sadness. However, Al-Qarni does directly discuss the connection between depression and suicide, perhaps indicating that he is referring to a greater issue than general sadness. Even so, by suggesting that idleness, laziness, and sinning are reasons for feeling sad, he is including religiosity in the discussion on mood fluctuation. Unlike Al-Qarni, the interviewees did not discuss failure to adhere to religious practices as a cause of poor mental health, but rather framed religious practices as a way of maintaining good mental health, in that they can provide coping mechanisms as well as cognitive supports that may help to alleviate stress and low mood. It is also noteworthy that, other than to include clergy members as potential sources of referral, none of the pamphlets I examined mentioned the role of faith in relation to depression or mental illness.

## 4.4 Addressing Mental Illness and Depression

Many of the Muslim religious leaders indicated that the problems with which they are approached by members of the community may require the intervention of a trained professional (although they didn't necessarily specify the need for a physician). In other words, without necessarily medicalizing the problem, they perceive that a more trained and qualified individual may be needed to deal with the situation. The sources of authority that the interviewees said they would call upon if someone exhibited symptoms related to depression also illustrates the way in which they classify depression. Even those who mentioned the involvement of a physician discussed the social aspects of depression, including in its treatment, suggesting perhaps that they did not find that the designation of depression as a mental illness to be mutually exclusive with its classification as a social ailment as well. If this is the case then the suggested implication is that illnesses are not solely rooted in the individual, requiring an understanding that is not solely medicalized but one which also recognizes the importance of societal involvement in the treatment and prevention of illnesses. When directly asked about a medical approach to the treatment of depression, none of the religious leaders refuted the possible necessity of the use of pharmaceuticals. However, many of them were explicit in their views that a medicalized approach to the treatment of depression alone was insufficient and that other supports are required to fully rehabilitate individuals who experience such problems.

As part of the analysis, questions of authority and voice were asked in order to determine who is the entitled in discussions about mental health and depression. With respect to treatment, the predominant authoritative figures within each text became apparent since those are the sources contacted in order to alleviate mental health concerns and thus would be considered as the most informed and able. In the pamphlets, the voices of the publishing organizations (CMHA, Seeds of Change, Family Service Thames Valley) came through as they framed themselves as sources of information. But the publications also emphasize calling upon health care professionals, particularly family doctors, psychologists, and psychiatrists. Likewise, while not every interviewee specifically mentioned medical professionals, they nevertheless recognized the authority of a

medicalized treatment approach to depression. The religious leaders were reluctant to label themselves as sources of authority on issues of mental health, stating that their knowledge was more limited to religious and spiritual support. Interestingly, many of the interviewees brought forward the unique voices, experiences, and needs of those that approach them for help rather than expressing a single narrative. This reinforced the perspective that rather than a single systematic biomedical treatment being appropriate for all cases, treatment should be dependent on the individual circumstances and environmental context experienced by the individual.

#### 4.4.1 Connecting to Sources of Support

Consistent with the messaging in the pamphlets about the role of clergy member as sources of referral, the Muslim religious leaders also described themselves as being able to connect individuals to other services that might be of use depending on the problems that were being dealt with. However, they did not limit such services solely to medical professionals and counselling services. Instead, they included services that could assist in the socialization of an individual who is feeling isolated or language support for an immigrant who is having difficulty adjusting to a new life. The interviewees also described an informal support system within the Muslim community that they had the power to call upon in order to assist someone who is struggling. Thus, they see their roles as expanding beyond merely connecting troubled people with medical and/or counselling assistance but rather reaching into broader segments of the community and doing so in a way they perceive to be central to the healing process.

The suggestions made by religious leaders mirror the recovery model of mental illness. In this model, it is more than the alleviation of symptoms that is the goal of the overall process. Instead, recovery is defined as the establishment of many social aspects of an individual's life including: relationships with friends and family, engagement in recreational activities as well as productive activities, as well as a relative degree of independence, in addition to the management of symptoms (Warner, 2009). Throughout this process, it is the empowerment of the afflicted individual that is the goal. This also becomes a long-term trajectory that can include many chronic mental illnesses. The interviewees reflected these ideas in their responses, especially in the discussion of the

importance of socialization and constructive engagement in the community. The recovery model also deviates from the medical model of mental illness in that the focus includes but is not limited to the treatment of symptoms (Warner, 2009) and, in this respect, is consistent with the comments by the religious leaders who recognize traditional ‘medical’ methods of treating mental illness while still expanding on the scope of possible ways in which to address the problems their congregants may be experiencing.

The CMHA pamphlets mentioned re-integration into the community through the assistance of various community organizations as part of the recovery process for an individual who is struggling with a mental illness. The CMHA pamphlets, which are produced for a national audience and distributed across the country, do not clearly define what the term ‘community’ refers to or how a sense of community is cultivated. While there are local services available in London, Ontario to help individuals who are struggling with mental illness, it is difficult to know if involvement with these services is sufficient to qualify as ‘community engagement’ as understood in these pamphlets. In contrast, when Imams and other Muslim religious leaders discuss the importance of community support, they are speaking as individuals attached to an institution which has regular attendees who comprise the congregation. In this context, ‘community support and participation’ implies something deeper. Some of the religious leaders spoke about introducing new immigrants to cultural groups within the congregation or to individuals who could be a source of systematic support, in the form of a ‘buddy-system’. Assisting immigrants to find support and befriend individuals in the Muslim community is a role that the religious leaders can and expect to take on, whereas, as one interviewee pointed out, these are not actions that a counsellor or a therapist could take.

The environmental stressors affecting mental health that were described by the religious leaders are consistent with a construction of depression that goes beyond that of a condition caused by biomedical factors. And the remedies the interviewees suggest similarly extended beyond individual actions to more of a community responsibility to help those who are ill to heal. In describing what they perceive to be social causes for mental disturbances, the interviewees were consistent in suggesting social practices to help alleviate the symptoms of depression. Unlike the characterizations in the pamphlets,

many of the religious leaders explained that since the individual who is experiencing symptoms may be isolated, finding social contexts into which they can be integrated would be useful. Some of the religious leaders suggested informal forms of socialization, such as introducing the isolated individual to others who may have undergone the immigration process. Some of the Muslim leaders emphasized that providing social support is the responsibility of the community rather than suggesting that the onus is on the troubled individual to seek that support. Indeed, one interviewee stated that it is part of a Muslim's religious responsibility to care for those who cannot care for themselves. This view varies significantly from the narrative presented in the pamphlets which emphasizes self-help, prevention, and behavioural modifications to deter the onset and/or treat mental illness. It also differs from the pamphlets in that it invokes a religious discourse with respect to how the community should come together to assist those struggling with illness. Here, the emphasis is not on reducing societal costs of illness but rather on the religious responsibility of the healthy to come to the aid of the ill. The use of a religious discourse to discuss issues of health and wellness creates a different message about the meaning of mental disorders than is found in the pamphlets. The idea that the onus on providing help should be on the community rather than the individual differentiates the narratives even further.

When the Muslim leaders described their own roles as 'helpers', they were wary of being described as counsellors, instead they described their capabilities in a religious and social capacity, which included reading Quran, praying with the troubled person, introducing her or him to fellow community members, and providing advice. In the pamphlets in which religious leaders were mentioned, clergy members were described as sources of support and referral to more specialized care. The interviewees did not contradict this characterization of their role, but rather expanded even further on how they could provide such support to individuals who are suffering from depression. This is a predictable difference considering that the pamphlets were not produced by religious institutions and are not focusing on the role of faith leaders in treating mental health and depression. Furthermore, an individual who approaches a religious leader for help may be looking for assistance from within a religious framework, increasing the likelihood that the support provided by a religious leader would include a spiritual dimension. In their comments, all

the interviewees accepted the value of treatments for mental illness that involve counselling and/or a medical approach, however, many of them also spoke about the healing powers of religious practices such as prayer and remembrance of God. It was help with these spiritual practices that many of the religious leaders described as their principal role in relationship to an individual in need of assistance.

The interviewees see value in trying to change an individual's mind set by using Islamic teachings, such as thankfulness (see Thomas & Ashraf, 2011), i.e., recognizing one's blessings and thereby moving away from a state of overwhelming sadness. This form of assistance was considered to be useful to both those suffering from depression as well as those experiencing temporary low mood. The interviews indicate that such an approach was commonplace in the ways in which the religious leaders advise help seekers. These practices were discussed in the context of continued support for an individual who is struggling rather than as a course of treatment. Importantly, the interviewees did not situate religious practices as an alternative to other treatment options. One interviewee went so far as to insist that it was not part of his role to state if an individual's mental anguish was related to their religiosity (or lack thereof). This cannot be a factor, he explained, that a religious leader can dictate. As a result, it cannot be part of a religious leader's role to prescribe a spiritual treatment for an illness.

#### 4.4.2 Information Mediation

I suggested in the introduction to my thesis that Muslim leaders could play the role of mediators or intermediaries by either contextualizing or simply transferring information for congregants (Wathen, Wyatt & Harris, 2008). Although I had understood the process of information mediation to be one in which religious leaders convey health information to congregants and community members, my interviews suggest that health information is more likely to move in the other direction, from the Muslim community leaders to health professionals. Many interviewees discussed their lack of medical or psychological training and their discomfort with labeling their interactions with community members as 'counselling' and they consistently mentioned at what point they would refer an individual to a more qualified professional. Many of the interviewees had established contacts with organizations or individuals that could provide assistance. In these cases,



rather than passing along medical information to congregants, the interviewees play the role of mediators by presenting the situation of the community member needing assistance to the contacted professional and describing the factors that may be involved. This could include the conditions of immigration or the individual's current financial or familial situation. One interviewee specifically mentioned that he spends time educating teachers and school administrators about the difficulties students may encounter as new immigrants.

While the interviewees constructed their roles as separate from the medical paradigm, perhaps preventing them from providing specialized health information, there is still space for religious leaders to play a mediating role for congregants. As some of the religious leaders mentioned, they have been approached by individuals who believe that mental illness is both caused by and treated through religious practices. In such cases, the leaders may have the opportunity to act as mediators by molding such beliefs in a way that understands biomedical or social narratives of mental illness. This project is also based on the premise that religious leaders have the platform to shape community members' perceptions on various issues through sermons and other open forums. As a result, religious leaders can act also as mediators to the community at large by shaping perceptions of mental illness and dispelling any associated stigma.

## 4.5 Prevention

The interviewees had little to say about prevention of mental illness. Although some of them discussed ways in which an individual could maintain positive mental health, they did not suggest that a failure to take such actions would lead to a poor mental state. These actions included religious practices as well as engaging and contributing to the community in a constructive manner (such engagement can also assist with preventing the problem of isolation). One interviewee described the ebbs and flows of life as a series of highs and lows, suggesting that an individual can prepare for the lows but not prevent them from happening altogether. This is consistent with the religious leaders' emphasis on environmental factors to explain mental health problems. As they are external to the individual, they are difficult to predict, prevent, or control. This perspective differs somewhat from that presented in the CMHA pamphlets which focus on personal

behaviours that individuals can adopt to prevent the onset of mental illness, such as physical activity, good nutrition, and self-education. The CMHA pamphlet on mental illness also mentioned the social cost of depression stating that mood disorders have an impact on health care costs and work productivity. While this statement was not made in association with preventative practices, the comment is consistent with the narrative of individual responsibility for health, so as not to burden the health care system. This differs considerably from the narrative that emerged in the interviews in which the religious leaders' discussed at length the socialization and interactive practices that can improve an individual's mental health, and their emphasis on the community's responsibility to assist those who are struggling with their health.

Through the discussion on prevention in the pamphlets, the emphasis on individualism in biomedical discourse becomes apparent. As Donnelly and Long (2003) state, "the dominant biomedical discourse produces and validates knowledge that values rationality, and this knowledge influences the discursive attitudes of health care, which favors naturalism, individualism, and objectivism, while marginalizing other ways of knowing or assessing experience" (p. 401). This means that the basis of knowledge production in the biomedical paradigm is empirical rationalism that views the human body as a series of chemical interactions. Thus in order to treat or prevent illnesses, those chemical interactions need to be addressed. The individualistic focus in the pamphlets is also evident in the emphasis on personal behaviours, a reflection of the biomedical discourse which relies on individuals to modify their behaviour in accordance (Donnelly & Long, 2003).

One of the practices recommended in the pamphlets was to limit alcohol consumption, as alcohol is a depressive substance. Addictive substances were also mentioned in the pamphlets as possibly being used as a coping mechanism for those experiencing depressive symptoms, thereby further exacerbating the problem (Wasserman, 2011). Although many of the pamphlets discussed issues of addiction and substance abuse in relation to mental illness none of the religious leaders mentioned addiction or substance abuse either in relation to mental illness or to the experience of Muslim immigrants. This may be because intoxicating substances, such as drugs and alcohol, are designated as

*haram*, or forbidden, in Islam. This does not mean, however, that Muslims do not consume such substances. The lack of mention of addiction by the interviewees could also be a result of a disassociation between substance abuse and the discourse of health, i.e., they may not ‘classify’ substance abuse as a ‘health’ issue.

The interviewees’ observations about the stressors associated with the lives of immigrants align with Berry’s theory of acculturation. According to Berry (1986), integration, accepting the new host culture while maintaining aspects of the old home culture, is the most conducive way for immigrants to achieve good mental health and prevent the onset of psychological distress caused by the acculturation process. The interviewees’ comments suggest that they agree with the integration model of Berry’s (1986) theory as religious practices were suggested as mechanisms to maintaining good mental health. When discussing the improvement of the mental health of Muslim immigrant populations, they suggested interventions that included socialization, language improvement support as well as opportunities to contribute to the community as ways of better engaging in the new host culture. As these suggestions were also discussed within the context of the involvement of the Muslim community, this further aligns the comments of the interviewees with integration as a method of maintaining good mental health for immigrant populations since the cultural context of the Muslim community is still involved as part of the method of maintaining good mental health. However, as Amer and Hovey (2007), among others, have demonstrated, the relationship between religion, culture, and acculturation is complex making it difficult to draw direct comparisons with Berry’s (1986) linear theory.

Many of the interviewees discussed the stigma often associated with mental illness, which makes it difficult to ask for assistance. The pamphlets make the same point, indicating that the association of stigma with mental illness is common and that it is a hindrance to opening up conversations about the issue. The interviewees who mentioned the stigmatization of mental illness also commented on the need to overcome this association and indicated that mental illnesses should be socially recognized as a legitimate condition without shame or negative connotation. The pamphlets imply that overcoming stigma and educating the public has a role to play in preventing mental

illness. Although the religious leaders emphasized acceptance and understanding of mental illness during the interviews, they did not position public education about mental illness as having a preventative function.

## 4.6 Gender

When asked if they advised men and women differently with respect to mental health problems most of the interviewees indicated that it depends mostly on the type of problem presented rather than the sex of the individual asking the question. However, some interviewees did indicate that they had observed differences in the types of problems that men and women approach them with, as well as in how they express themselves. Several of the leaders described women as being more emotive (demonstrating this state by crying) whereas men present with more anger. This is consistent with the description of mood disorders in the CMHA pamphlet titled *Depression and Bipolar Disorder* which states not only that the prevalence of depression is higher in women than in men, but that men may express symptoms of depression through anger rather than sadness. However, an important distinction between the discourse in the pamphlets and the interviews is that the religious leaders who discussed male anger did not view it as an alternative expression of depression and, further, some of them perceived women's ways of expressing emotion as, at times, insincere, excessive, or disruptive to their attempts to help them. This is reminiscent of Wilhelm's (2006) description of the physiological disciplines' stereotyping of extreme female emotive behaviour. Feminist theorists have responded to such negative portrayals by deconstructing their underlying physiological assumptions and, instead, championing environmental and relational understandings of emotional behaviour. While the religious leaders presented social reasons to account for the development of depression, some also described the overly emotive nature of women in their expression of distress suggesting a convergence in their biomedical and social constructions of mental illness.

Many of the interviewees also referred to cultural expectations with respect to gender that differ between home and host countries that can result in confrontations in the home, as well as affect how the Imam or community leader can provide assistance. In this case, socially constructed gender roles were regarded as the source of the problem as opposed

to the innate characteristics that are assumed by the interviewees to cause the ‘emotive’ versus ‘angry’ responses of women and men. No explanations were provided in the pamphlets about the source of the differences between men and women regarding mental health. The manner in which the interviewees discussed gender roles, specifically the roles of women as a cause of further stress and domestic tension echoes Ellis et al. (2010) who suggest that the discrepancy of gender expectations between home and host cultures specifically affects immigrant women. For instance, one of the interviewees mentioned wearing the hijab (the headscarf worn by Muslim women) as potentially making women targets for discriminatory actions that may, in turn, increase their stress levels. Overall, the interviewees emphasized the need to understand such issues from a health service provision perspective in order to be better able to care for immigrant populations.

#### 4.7 Study Limitations

For the purposes of this project, eight Muslim community leaders in one Canadian community, London, Ontario, were interviewed and their constructions of the meaning of mental illness, particularly depression, as well as its causes and treatments were compared with those presented in a small sample of pamphlets about mental health intended for a lay audience, produced by Canadian mental health organizations. While this small, limited sample allowed for a preliminary investigation, there is much room left for further inquiry. An additional limitation of this project was the conflict between my community involvement and the route of investigation. I was sitting on the board of the London Muslim Mosque at the beginning this project, restricting my access to some of the individuals who might have been called upon to participate in the interviews. Snowball sampling would have also been a useful technique to enlist more interviewees. This would also enable more discussion about who in the Muslim community is referred to as a source of authority when individuals approach with questions and various issues arise. Snowball sampling may have also led to less publicly visible Muslim leaders, i.e., those who are not Imams or halaqa leaders, who may be consulted about mental health concerns by members of the Muslim community.

## 4.8 Reflexivity

Although I think this project would have been very difficult to conduct by a researcher who is not Muslim, my role in the community brought along its own challenges. It helped that I was able to emphasize to interview participants that their anonymity would be preserved. However, it still could have been perceived that I was conducting an assessment of the leaders' performance in how they deal with congregants or the people who approach them for help. I tried to explain that my purpose was inquisitive rather than judgmental and to ask the questions in a manner that reflected that approach. However, asking individuals who had already discussed their lack of qualifications in treating depression and mental illness about the way medical professionals view the topic may have pitted the social authority of science against the self-described insecurity of the interviewees. By invoking the medical discourse I think I may have been setting the interviewees up for agreement. I do not think that the responses were disingenuous but that the question could be interpreted as a judgmental approach. Although these challenges may have arisen regardless of the identity of the interviewer, they may have been heightened by my familiarity with the faith of the participants. Regardless of the challenges, I do believe that knowledge of Islamic discourses is necessary in order to have undertaken this project. The interviewees referred to different authors, books, traditions, and holy sites that required an understanding of Islam to make sense of their responses and for me to participate in the back and forth exchanges during the interviews. The leaders also referred to Quranic verses and hadith in order to support their statements. They may have done so with liberty knowing that I was Muslim as well. Thus, a non-Muslim interviewee may have inhibited the fluidity of the conversation that was produced.

I began this investigation wondering if and how mood fluctuation, particularly depression, would be attributed to religiosity. The majority of the interviewees described religiosity as an anchor during difficult times rather than a factor in causing any mental illness. Prayer and reading from the Quran were suggested as a source of strength but not a replacement for medical treatments or other professional help. The interviewees discussed at length the stressors they believe affect the lives of immigrant Muslims and

which caused many of the problems they have experienced. Although I knew that many Muslims had emigrated from war torn countries, I had never considered how this affected their mental health, or how Islamic centres dealt with those who were struggling with the repercussions of possible trauma. I also don't think I anticipated the extent to which social factors would be emphasized as a method of assisting someone to recover from depression. This was, however, consistent with many of the interviewees' descriptions of the nature of depression itself which, although it includes a biomedical component, extends beyond a medicalized understanding. The reiteration of this perspective through a religious paradigm, while unexpected, was not surprising given that numerous religious verses and hadith refer to the building of the community and unity amongst Muslims, including helping those in need. It was interesting, however, to see this understanding invoked during a discussion on health.

## 4.9 Project Implications

This study presents important and relevant information that could better inform care for immigrant Muslims, especially women. It also highlights the gap in the literature describing the information landscape concerning mental health that is likely to be encountered by immigrant Muslims to Canada. This is an important and notable gap as, in order to better serve this population, it is important to know what understandings are pervasive and accepted within this community and how religion and religious authorities contribute to the health information landscape. While health and spirituality may not always be recognized as part of the same paradigm in the biomedical understanding of health, my research suggests that within the Muslim cultural community, it might be. Furthermore, immigrants who primarily identify with and seek help through the Islamic centres may be more accepting of a presentation of health that incorporates a religious understanding. In a future study, it would be worthwhile to investigate how Muslim immigrants seek and integrate health information with their own beliefs of health and illness as well as what contradictions may arise in these interactions and how they may react to such contradictions.

While I undertook a gendered analysis in this project, the specific needs of women with regard to their mental health did not emerge as a predominant theme in either the

interviews or the pamphlets. This may be indicative of a gap in the information landscape pertaining to the mental health needs of women in general, not just of immigrant women. It might be worthwhile in a future study to investigate whether a larger range of information sources intended for lay users specifically targets audiences by gender or refer to social roles (e.g., as homemakers or breadwinners), as well as if assumptions about gender roles transfers to educational materials about mental health intended for immigrant audiences, on a larger geographical scale.

This study also highlights the possibility for partnership between religious and social institutions that provide support for immigrant populations. While some organizations already reach out to the Muslim community in order to better understand the needs of immigrants who use their services, such relationships could be deepened to include other relevant service providers. The Muslim Resource Centre for Social Support and Integration (MRCSSI), a London based organization, was constantly mentioned by the interviewees and recognized, not only for the support it provides Islamic institutions but also for the continued possibility it offers for partnerships. While this organization provides a significant amount of relief within the Muslim community, there is a need for other organizations that provide mental health services to also extend and develop a relationship with the Muslim community to improve the provision of services.

This project also brings forward the possibility for a new model of psychological care, one that involves the community at large rather than relying primarily on the individual to seek help and recover when struggling with mental health issues. As the interviewees explained, immigrants may be trapped in isolation for a number of reasons, contributing to their poor mental health and perhaps making them more prone to depression. Furthermore, in such a state of isolation, they may not have the ability to seek help. As a result, socialization was suggested as a mechanism to assist immigrants to become more comfortable in their environments as well as to build a social support network. As this was presented even within the context of a religious responsibility, it was less the responsibility of the individual to seek help and more so the responsibility of the community to help those in need of assistance. As a result, my findings suggest not only that mental health care providers should reach out to the Muslim community to better



understand the community's perspective on mental well-being, but also to expand the opportunities for the provision of care within a paradigm that extends the understanding of health and wellness from biochemical interactions in the body to processes that can include an entire community.

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# Appendix A

## Ethics Approval Form



**Western  
Research**

Research Ethics

Use of Human Participants - Initial Ethics Approval Notice

**Principal Investigator:** Prof. Roma Harris  
**File Number:** 105127  
**Review Level:** Delegated  
**Protocol Title:** Understanding Immigrants' Experience of Depression: The Perspective of Muslim Leaders  
**Department & Institution:** Information and Media Studies/Faculty of Information & Media Studies, Western University  
**Sponsor:**  
**Ethics Approval Date:** April 08, 2014 **Expiry Date:** July 31, 2014

**Documents Reviewed & Approved & Documents Received for Information:**

Document Name	Comments	Version Date
Other	References for study rationale	2014/03/05
Other	interview questions	2014/03/10
Western University Protocol	clean version revised REB April 2, 2014	2014/04/02
Other	revised telephone script with note re: obtaining written consent	2014/04/08
Letter of Information & Consent		2014/04/08

This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above named research study on the approval date noted above.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the NMREB's periodic requests for surveillance and monitoring information.

Members of the NMREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussions related to, nor vote on, such studies when they are presented to the NMREB.

The Chair of the NMREB is Dr. Riley Hinson. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

[Redacted Signature]

Signature

Ethics Officer to Contact for Further Information

[Redacted]	[Redacted]	[Redacted]	[Redacted]
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*This is an official document. Please retain the original in your files.*

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## Appendix B

### Interview Questions

#### Introduction:

I am a Master's student at Western University and I'm conducting research under the supervision of Professor Roma Harris. The purpose of my research is to learn more about how Muslim leaders in London counsel their congregants about emotional challenges they may be facing and what resources they call upon in the process. I'm particularly interested in leaders' experiences in working with women who are recent immigrants to Canada.

Please tell me a little about your role in the X mosque and the people who make up your congregation (prompt: the demographic makeup of the congregation)

In your role as an Imam/community leader are you involved in counselling congregants?

If yes,

What are some of the common issues or problems that people in the congregation might approach you with for help or advice?

Can you describe the type of counselling you provide to assist with these issues?

If no,

What do you do if congregants approach you for help with personal problems?

When you think about a person's emotional state what distinguishes between being a 'good' or 'positive' state versus a 'bad' or 'negative' state? Prompt: when thinking about people's emotional condition, do you think of it in terms of being well or not well, 'healthy' or 'ill' in the same way as we might think of physical health? Or, from your point of view, is there a better way to describe it?

If a congregant of an immigrant background was experiencing prolonged periods in which she or he was upset, lethargic, or in a general state of low mood, how would you advise or counsel this person? [probe: would you seek out the person or would this only happen if they come to you?; do other congregants bring the problems of fellow congregants to your attention?]

What do you think might be the some of the causes of this type of behaviour or feeling?

Are there particular resources and/or texts that you might consult or use to help the person?

Are there services or resources to which you would refer the person?

How might your advice differ if it was a woman or a man you were counselling?

The symptoms that I described are common in people who are, in medical terms, described as “depressed”. Depression is considered by many to be a mental disorder for which the remedy involves psychological counselling, pharmaceuticals or both. What do you think of this approach?

A book titled "Dont Be Sad" by Aaidh Ibn Abdullah Al-Qarni is an international bestseller that discusses the causes, symptoms and remedies for melancholy, sadness and depression. He includes idleness, laziness and sinning as some of the causes and suggests reading the Quran, remembering one's blessings and to give in charity as the way to address these feelings. What are your thoughts regarding Al-Qarni's characterization of depression and his suggestions?

Women who are recent immigrants may experience significant stress related to the immigration process, taking care of the family and adjusting to a new culture. How would you suggest that such an individual should cope with stress or emotional pressure to maintain a positive or ‘healthy’ emotional state (prompt: or “good mental health”?)

Are there events or services available here at the mosque to help people achieve and/or maintain their mental health?



## Appendix C

### Letter of Information

**Project Title:** Understanding Immigrants' Experience of Depression: The Perspective of Muslim Leaders

**Principal Investigator:** Roma Harris, Ph.D., Professor, Faculty of Information and Media Studies, Western University

#### **1. Invitation to Participate**

The purpose of this study is to learn how Islamic faith leaders in the London community understand the causes of and possible remedies for emotional difficulties, such as depression, that may be experienced by members of the Muslim community, particularly those who are recent immigrants to Canada. You are being invited to participate in this study because you are a recognized religious leader within the Islamic community in London, Ontario.

#### **2. Purpose of the Letter**

The purpose of this letter is to provide you with information you require to make an informed decision regarding participation in this research.

#### **3. Purpose of this Study**

Recent immigrants and refugees to Canada from other countries may experience significant emotional distress as they adjust to life in their new communities. However, there has not been a great deal of research about how the emotional problems that immigrants might encounter, such as anxiety and depression, are understood within different religious groups. Though interviews with religious leaders from local Islamic faith and social centers in London, Ontario, we hope to gain an understanding of the information that people within the Islamic community might encounter through their interactions with faith leaders and religious texts about the causes and remedies for emotional problems. We will compare this information with that found in secular or 'mainstream' information materials intended for lay audiences, such as handouts and pamphlets about mental health, that are distributed through community organizations such as public libraries and walk-in health clinics. Our goal in this research is to learn more about the information that Muslim immigrants to the city of London may encounter about understanding and coping with emotional problems.

#### **4. Inclusion Criteria**

Adult individuals who are recognized as religious leaders within the Islamic community in London are eligible to participate in the study, specifically, Imams and halaqa leaders.

#### **5. Exclusion Criteria**

Individuals under the age of 18 are not eligible to participate in this study.

## **6. Study Procedures**

If you agree to participate in this study, you will be asked to take part in an interview that will be conducted by Ms. Selma Tobah, a student in the Master's Program in Health Information Science at Western University. She will ask you about your views on the causes, symptoms and possible remedies for emotional problems, such as stress, low mood or depression, and to comment on your experiences in assisting/advising members of your congregation who have such concerns. The interview is expected to last approximately 40-60 minutes. With your permission, the interview will be audio-recorded. If you do not wish to have the interview audio-recorded, the interviewer will not turn on the audio-recorder, but will take handwritten notes to record your answers to the interview questions.

The interview will take place in a mutually-agreed upon site that is convenient to you, such as the mosque or social center. There will be a total of approximately 10- 12 participants in the study.

## **7. Possible Risks and Harms**

There are no known or anticipated risks or discomforts associated with participating in this study.

## **8. Possible Benefits**

You may not benefit directly from participating in this study. However, we hope that by learning how emotional problems, such as depression, are understood within the Islamic community, our findings may be used by public health organizations to design more useful, culturally sensitive information resources to inform/advise people, particularly new immigrants, about mental health issues.

## **9. Compensation**

You will not be compensated for your participation in this research.

## **10. Voluntary Participation**

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time. You may withdraw your data if you withdraw your consent. Please note that if you choose not to participate or you withdraw from the study your standing in the mosque (community centre) will not be affected in any way.

## **11. Confidentiality**

All data collected in this study will remain confidential and accessible only to the investigators of this study. The audio-recording of your interview will be transcribed after which the recording will be destroyed. The transcript of your interview (or notes taken by the interviewer if the interview is not audio-recorded) will be kept in a secure, electronic file for five years after which it will be destroyed. Any reference to your name will be deleted from the transcript and, if the results of the study are published, your name will not be used. Signed letters of consent will be destroyed after five years.

**12. Contacts for Further Information**

If you require any further information regarding this research project or your participation in the study you may contact the Principal Investigator: Dr. Roma Harris, telephone number: [REDACTED] or the student Co-Investigator, Selma Tobah, telephone number: [REDACTED]

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics [REDACTED] email: [REDACTED]. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study- related records to monitor the conduct of the research

**13. Publication**

If the results of the study are published, your name will not be used. If you would like to receive a copy of any potential study results, please provide your name and contact number on a piece of paper separate from the Consent Form. **14. Consent** If you agree to participate, please read and sign the Consent Form included with this letter.

*This letter is yours to keep for future reference.*

**Consent Form Project**

**Title** Understanding Immigrants’ Experience of Depression: The Perspective of Muslim Leaders

**Study Investigators’ Names:** Roma Harris and Selma Tobah

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Participant’s Name (please print): \_\_\_\_\_

Participant’s Signature: \_\_\_\_\_

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

I consent to having my interview audio-recorded

[place a check mark in the box if you consent]

I consent to allowing the Research to use direct

quotes from my interview published reports of the study

[place a check mark in the box if you consent]

Person Obtaining Informed Consent (please print): \_\_\_\_\_

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

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

## Appendix D

### Questions for analysis

1. 'About' information
  - a. Publisher/Author
  - b. When
  - c. Intended audience
    - i. Are differences accounted for within the intended audience or is it assumed that depression = sufficient homogeneity
      1. Cultural differences within individuals experiencing depression
  - d. Descriptive: Format – headings – subheadings
2. How is depression characterized
  - a. Adjectives and synonyms that are used
  - b. What associations are being made → biological/social/spiritual
  - c. Connotation → negative or normalized
  - d. Causation
  - e. Symptoms
  - f. Remedy → if pharmaceuticals are listed, which specifically
  - g. What are the underlying assumptions/truths of this characterization
3. References to Gender
  - a. Are gender differences mentioned
    - i. How/why
  - b. If women are mentioned is it independent of their role as mothers?
4. What is the process (if any) that is undertaken when someone is recognized as depressed or has 'low mood'
  - a. Whose responsibility is it to act in the case that an individual is depressed?
    - i. Where are the verbs
    - ii. What is the responsibility of the
      1. Individual
      2. Community (general – non religious)
      3. Government (services)
      4. Imam/Muslim community leader
  - b. In what settings is this process completed?
    - i. Eg. Doctors office, Psychologist, Spiritual adviser etc
5. What is avoided or not mentioned
  - a. What is "Othered" or considered external to the used discourse
6. Who is a source of authority on this topic + what resources to they call upon
  - a. Medical professionals, religious individuals, social services

## Curriculum Vitae

**Name:** Selma Tobah

**Post-secondary Education and Degrees:** Western University  
London, Ontario, Canada  
Health Information Science, M.H.I.S.  
2012-2015

Western University  
London, Ontario, Canada  
Globalization Studies and Health Science, B.A.  
2007-2011

**Related Work Experience** Research Assistant, Dr. Lorie Donelle and Dr. Sandra Regan  
Western University  
2014-Present

Teaching Assistant, Faculty of Media & Information Studies  
Western University  
2012-2013