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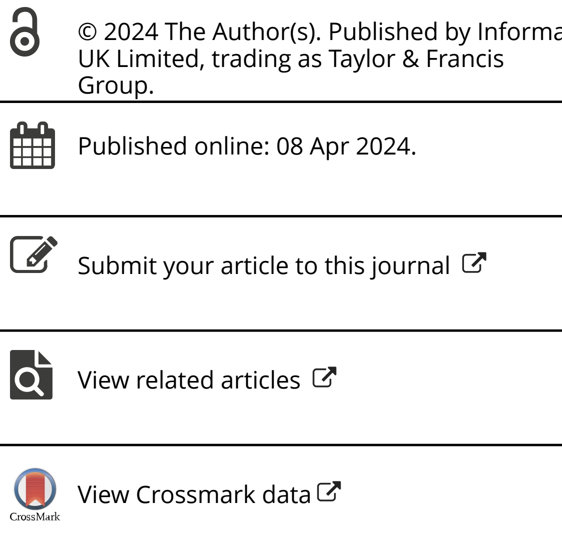

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ORIGINAL ARTICLE

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Perceptions of mental health and illness amongst Australian Ismaili Muslim youth

Karim Mitha[a,b,c], Shelina Adatia[d] and Mariam Tarik[e]

[a]Usher Institute, University of Edinburgh, Edinburgh, UK; [b]Department of Sociology, University of Glasgow, Glasgow, UK; [c]Public Health, Royal Free London NHS Foundation Trust, London, UK; [d]Faculty of Education, University of Ottawa, Ottawa, ON, Canada; [e]Adult Mental Health Service, Oxleas NHS Foundation Trust, Kent, UK

ABSTRACT

Objective: Extant research on mental health within Muslim communities reveals inequalities, with religio-cultural beliefs viewed as influencing experience, access to care, and treatment outcomes. Additionally, religious affiliation is a prominent marker of social identity amongst Muslim migrant communities. This study examined whether acculturative approaches and identity influence perceptions of mental ill health within a Muslim migrant community.
Method: Semi-structured interviews were conducted with 11 Australian Muslim youth – six of whom were recent immigrants and five who were Australian-born/raised. Data was analysed using reflexive thematic analysis.
Results: Two main themes were identified: 1) making sense of mental health, and 2) the influence of social representations. Sub-themes included: 1a) defining mental health, 1b) perceived determinants, 2a) "emotional" vs "factual", and 2b) education through experience: personal encounters with mental illness.
Conclusion: Overall, faith and religion played an important role in conceptualisations of mental health for young Australian Muslims – alluding to the necessity of faith-sensitive mental health services for ethnic and religious minority communities.

ARTICLE HISTORY

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KEYWORDS

Australia; culture; mental health; Muslim; religion; youth

KEY POINTS

What is already known about this topic:

(1) Cultural beliefs influence mental health understandings, access to care, and treatment for Muslims.
(2) For Muslims, conceptualisations of mental ill health are often based on cultural and pre-Islamic influences (e.g., the role of supernatural spirits).
(3) Cultural context affects access to, and experiences of, mental health services.

What this topic adds:

(1) Muslim youth feel that faith and religion are vital for mental well-being and self-efficacy, highlighting the importance of adapting therapeutic modalities within a faith-sensitive paradigm.
(2) For recent immigrants, the influence of the supernatural on mental health is not necessarily negative.
(3) Personal experience impacts perceptions of mental illness and may play a role in reducing stigma.

Introduction

It is increasingly important mental health services meet the needs of youth. Young adulthood is marked by several changes in life and social circumstances, and the ability to cope with those changes can have an impact on psychological well-being (Collins & Mowbray, 2005; Miething et al., 2016). Patel et al. (2007) note that most mental health conditions have their genesis in youth and they outline risks and protective factors during this period which influence the subsequent development of mental health conditions. In Australia estimates from the Australian National Study for Health and Wellbeing noted that nearly 40% of youth aged 16–24 experienced a mental health disorder in the preceding year– 40% of females and 24% of males experienced anxiety while 17% of females and 10% of males experienced an affective disorder (Australian Bureau of Statistics [ABS], 2022a). The same survey found that 45% of those experiencing a mental health disorder sought help (ABS, 2022a).

CONTACT Karim Mitha karim.mitha@ed.ac.uk

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These statistics point to increased demand and unmet needs for mental health services. Indeed, Jorm and Kitchener (2020) note that despite changes in service provision, such as "Better Access" and Headspace schemes, there has been no concomitant improvement in young people's mental health and wellbeing.

The necessity to adapt mental health service provision becomes increasingly obvious when considering the diversity of Australia's population. The Australian Bureau of Statistics notes that approximately 28% of the Australian population was born abroad, and that 20% identify as other than White British/Irish/Australian (ABS, 2022b). It is therefore imperative to pay close attention to the experiences of ethnic minorities and the factors impacting their mental health. For example, Dickson et al. (2019) note substantial mental health needs amongst Australian Aboriginal youth – a consequence of marginalisation and wider socio-economic circumstances. In light of these inequalities, Wright et al. (2020) argue that mental health services should be culturally sensitive and those services targeting youth should be co-designed in order to effectively meet their needs.

Culture and mental health

Understanding the cultural frameworks of ethnic minority youth is particularly important in addressing mental health inequalities. Several theories have sought to understand why ethnic minority youth experience greater levels of mental health challenges. Minority stress theory (Valentín-Cortés et al., 2020), for instance, posits that individuals in minoritised social positions experience discrimination and adverse social circumstances due to their marginalised status and that these stressors compound to adversely affect mental health. Similarly, acculturative stress (Maiya et al., 2021) suggests that adaptation to a new cultural context, along with changes in socio-economic circumstances and values, can lead to feelings of powerlessness and isolation, negatively impacting mental health (Ahmed & Reddy, 2007; Bhugra, 2004; Bhugra & Bhui, 2003). In effect, the challenges that come with being an ethnic minority youth can influence psychological wellbeing.

Cultural psychology recognises that cultural context informs belief systems and receptivity to care whilst contextualising experience, coping strategies, and discourses of mental illness. This distinction is significant, as the inability to view mental health conditions through a particular cultural lens could impede early intervention. As Cauce et al. (2002) note, the cultural background of ethnic minority youth informs their experiences of mental ill health – from problem recognition, to the decision to seek help, to the type of help sought (e.g., informal networks, traditional healers, allopathic services, etc.). Understanding and interpreting mental health, even whether a specific mental ill health experience could be considered an "illness", thus occurs within a specific cultural framework informed by wider socio-cultural processes. Common examples would be cultural or psycho-spiritual frameworks attributing mental ill health experiences to Divine or supernatural causes (Bairami et al., 2021; Bagasra & Mackinem, 2014; Bhugra & Bhui, 2018; Dein et al., 2008; Marsella & White, 1982). If the frameworks employed by youth to understand their experiences don't align with those of clinical practitioners, there is a risk of misdiagnosis. Indeed, Liang et al. (2016) observed an overdiagnosis in certain mental health conditions (e.g., conduct disorder, behavioural disorders, and psychosis) amongst ethnic minority youth in the United States. These occurrences are equally prevalent in the UK (Bansal et al., 2022), Canada (Beiser & Hou, 2016), and New Zealand (Baxter et al., 2006), whereby ethnic minority youth experience greater delays in accessing treatment, inferior quality of treatment, and a greater burden of disease.

Acculturation and mental health

Berry and Hou (2017) propose a relationship between acculturation and mental wellbeing, suggesting that the acculturative strategies adopted by ethnic minority youth within a new cultural context can promote or impede psychological wellbeing. Berry's (1992) acculturation framework has frequently been used as a model for understanding acculturation amongst migrant communities. His strategies, guided by factors of cultural maintenance and cultural contact/participation, include integration, assimilation, marginalisation, and separation. Integration is considered most beneficial for psychological wellbeing, whereas those who are marginalised, experience poorer mental health (Amer, 2005; Banting & Kymlicka, 2010; Bhui et al., 2005; Choy et al., 2021; Goforth et al., 2014). The applicability of the framework to youth's psychological wellbeing has been shown cross-culturally, whereby integrationist approaches are linked with better resilience and psychological wellbeing (Wu et al., 2018).

With the increased public discourse regarding mental health, particularly within Australia, it is imperative to understand whether acculturation plays a role in perceptions of mental health and illness amongst minority youth. Although Do et al.'s (2014) study was

amongst adults over 25, they identified a difference in the understanding of mental health between Vietnamese Americans and Vietnamese nationals in Vietnam suggesting that while mental health awareness remained low in both groups with no differences in stigma, acculturation played a role in conceptualisations of mental illness with Vietnamese Americans less likely to note traditional, cultural views. Conversely, a study amongst Somali migrants in Minnesota showed that traditional beliefs continued to inform understandings and attitudes towards mental health despite long periods of settlement (Pratt et al., 2016). As the Somali population is largely Muslim, there may be an attenuating factor of religion in relation to cultural beliefs of mental health. Ali et al.'s (2022) study amongst Muslim women in the United States noted that higher cultural and religious beliefs were associated with greater rejection of mainstream mental health services. Within the Australian context, Bairami et al. (2021) noted that amongst Muslim Australians, conceptualisations of mental health and illness varied, with some respondents denoting environmental and biological bases of mental illness although cultural and supernatural explanations remained prominent, echoing the work of Bagasra and Mackinem (2014) amongst American Muslims. Nevertheless, that study was conducted with older adults and it is unclear to what extent these views may hold amongst Australian Muslim youth and the impact of acculturation on these views. This study thus examines youth in a Muslim migrant community perceived as largely espousing an integrationist acculturation strategy to ascertain the influence of acculturation/integration on conceptualisations of mental health and illness. This would have implications in responding to mental health needs amongst ethnic minority youth and culturally adapting existing interventions.

Muslim mental health

Extant work examining Muslim mental health has primarily focused on the UK (McClelland et al., 2014; Pilkington et al., 2012), and United States (Ali et al., 2022; Khan et al., 2019), with some work in Australia (Khawaja, 2007; Mitha & Adatia, 2016) and New Zealand (Adam & Ward, 2016; Stuart & Ward, 2018). Research amongst South Asian Muslims in the UK in particular has noted the under-utilisation of mainstream mental health services (Bansal et al., 2014; Pilkington et al., 2012), though there has been no examination as to generational status (i.e., youth-specific studies). Contributing factors include cultural understandings, lack of cultural competency/sensitivity by clinical practitioners, and stigma (Haque, 2004; Khan et al., 2019; Neale et al., 2009; Pilkington et al., 2012).

Research on mental health amongst Muslims has outlined two distinct models of how mental health is conceptualised. One approach considers efforts to promote an Islamic-based psychology (Farooqi, 2006; Rothman & Coyle, 2018, 2020; Skinner, 2019) which Younis (2021) describes as debates within the Muslim community as to whether one should "Islam-icise" psychology or "psycholog-ise" Islam. These debates largely lie in the realm of mental health practitioners and theologians. The second approach is that of the "everyday"-lay conceptualisations held by Muslims, which may be an amalgam of religious and cultural syncretic traditions. Through this lens, mental illness is conceptualised as divine retribution, *nazar* ("evil eye"), or supernatural spirits (*djinns*) (Dein et al., 2008; Haque, 2004; Laird et al., 2007; Mitha, 2020). Lim et al.'s (2015) systematic search showed that beliefs in supernatural spirits/*djinns* were a common explanatory framework amongst Muslims experiencing mental health disorders, wherein treatment would involve seeking help from a faith healer and the use of *taweez* (amulets), *ruqyah* (exorcism), fasting, etc (Al-Adawi et al., 2002; Dein et al., 2008; Gunson et al., 2019; Rassool, 2015). Additionally, research amongst British and American Muslims suggests that Muslims may view mental ill health as a consequence of lack of faith, failure to pray, or as a test from God; treatment would thus include reading scripture (the Qur'an), performing *dhikr* (recitation), or ritualistic fasting (Beliappa, 1991; Chaudhury, 2011; Cinnirella & Loewenthal, 1999; Pratt et al., 2016; Weatherhead & Daiches, 2010). It is important to note, however, that many of these studies did not include respondents' generational status or religious denomination. Additionally, many of the respondents were older adults, raising questions regarding the presence of similar findings amongst younger Muslims and the influence of acculturation on conceptualisations.

There have been conflicting findings concerning the link between acculturation and mental health in Muslim migrant communities. Asvat and Malcarne's (2008) work amongst Muslim university students in Canada found that individuals noting greater mainstream versus heritage culture identification reported greater depressive symptoms, whereas Khawaja's (2007) work on Muslim migrants in Brisbane showed greater separation from the mainstream society predicted greater psychological distress. Contrary to findings from acculturation theory, Amer and Hovey (2007) found that for Muslims adults in America, an integrationist approach did not lead to better psychological

wellbeing and a separation approach was associated with lower levels of depression. Goforth et al.'s (2014) study with Arab American Muslim adolescents noted that acculturation and acculturative stress were associated with psychological distress, but a strong religious/ethnic identity mitigated experiences of distress. This finding was echoed by Adam and Ward's (2016) work amongst Muslim adults in New Zealand. Mussap's (2009) work with adult Muslim women in Australia suggests an assimilationist approach is associated with disordered eating. Conversely, Bhui et al.'s (2005) work amongst Bangladeshi Muslim adolescents in East London found an integrationist approach was associated with lower levels of mental health problems. Bagasra and Mackinem (2014) examined the influence of acculturation on conceptualisations of mental illness amongst American Muslims, identifying a general adherence to "Western, bio-medical" paradigms of mental illness while non-immigrant American Muslims showed greater adherence towards religio-cultural based paradigms, in which worldviews are a syncretic mix between religious tradition and local cultural beliefs. Bairami et al. (2021) noted that amongst adult Muslim Australians, while some respondents denoted environmental and biological bases of mental illness, cultural and supernatural explanations remained prominent. Scholars have suggested that the acculturative strategy and Muslim denomination may play a role. Khuwaja et al.'s (2007) work amongst Pakistani Ismaili Muslim female youth in the United States noted greater acculturation was associated with lower levels of psychological distress. Damani-Khoja's (2018) comparison of adults of different Muslim denominations in the United States found that Sunni Muslims endorsed more traditional cultural beliefs though both Sunnis and Ismailis noted receptivity of accessing formal avenues of support. There is thus evidence to suggest that understanding the acculturative process of Muslim migrant communities is central to understanding the frameworks they employ in relation to mental health and illness.

Australian Muslims

There are approximately 815,000 Muslims in Australia, comprising roughly 3% of Australia's population (ABS, 2022c), with 66% under the age of 35 (ABS, 2022c) and nearly 40% Australian-born (Abu-Rayya et al., 2016). Nearly half of Australian Muslims are of Lebanese or Turkish descent (Khawaja & Khawaja, 2016), and consequently most research on Australian Muslims has focused on these ethnic groups, with limited work on other ethnicities (e.g., Asghari-Fard & Hossain, 2017; Patton, 2014).

The Australian Ismaili Muslim community comprises an even smaller subset of the Australian Muslim community. With a self-estimated population of 5000, Australian Ismailis comprise a minority amongst Australian Muslims and the global Ismaili Muslim community. The Australian Ismaili Muslim community is demographically young, with a substantive proportion under the age of 25. It is ethno-culturally distinct, as its adherents are predominantly of East African and South Asian heritage. The community also differs from other Muslim denominations – theologically, as adherents to the Shia tradition of Islam and affirm spiritual allegiance to Aga Khan IV, and liturgically with distinct syncretic religious practices.

In contrast to other Muslim minority migrant communities, migrant Ismaili Muslim communities have adopted an integrationist acculturative strategy whereby visible markers of Muslim religious identity (e.g., hijabs and beards) are generally not worn, the community's *lingua franca* is largely English (followed by the language of the host country), and men and women are encouraged to participate in the mainstream labour market (Bolander, 2016; Steinberg, 2011; Versi, 2010). In sum, in line with the integrationist acculturation strategy Ismaili Muslim migrants adopt mainstream culture in public spaces, with matters of cultural heritage relegated to cultural community events and places of worship (Mukadam & Mawani, 2006, 2009). Due to the community's relative integration and economic success within their host countries, there is a perception of the community as progressive, liberal, and integrated (Bhimani, 2019; Mukadam & Mawani, 2009; Versi, 2010). Yet, perhaps consequentially, the community draws criticisms from more orthodox adherents of Islam regarding their "Muslim"-ness and continues to experience religious persecution by virtue of being a Muslim minority denomination (Amnesty International, 2015; Asani, 2010; Merchant, 2016; Mitha et al., 2020). There has been little published work pertaining to health and wellbeing within the Ismaili Muslim community, with only three studies examining the relationship between acculturation and health: Kassam-Khamis et al.'s (2000) work with British Muslims of different denominations examining diet, Khuwaja et al.'s (2007) work with Pakistani female Ismaili Muslim youth in Texas noting greater acculturation was associated with lower levels of psychological distress, and Damani-Khoja's (2018) work with adult Muslims of different denominations in the United States in which Sunni Muslims were found to endorse more traditional cultural beliefs though both Sunnis and Ismailis noted receptivity of accessing formal avenues of support.

Aims and objectives

This study is the first to examine the influence of integration and acculturation on perceptions of mental health amongst Ismaili Muslims. It considers how community members frame notions of mental health and illness and the extent to which their views are influenced by traditional, cultural, or bio-medical paradigms. It aims to build upon extant research in Muslim mental health by researching a Muslim community portrayed as integrationist. Moreover, this study aims to contribute to debates concerning mental health service delivery for minority communities by identifying factors other than integration which may influence formulations of mental illness.

Methods

Study design

According to Creswell (2013), a qualitative design is used when a problem or issue requires a complex and detailed understanding. Given the lack of research in mental health amongst the Ismaili Muslim community, and the contradictory findings amongst Muslim migrant communities more broadly, a qualitative approach was deemed most appropriate for understanding participant perspectives. As perceptions themselves are a variable lending itself to an interpretivist paradigm, they require hearing directly from the participants themselves to capture the richness and nuance of their stories – particularly, when researching religio-culturally sensitive topics. A qualitative design was thus deemed necessary for this study. The study was guided by Berry's (1992) acculturative theory, applying it at the community rather than individual level. Thus, we do not make claims on any *individual* participant's acculturative strategy but rather, examine how their views may reflect a *community's* broader acculturation.

Participants and recruitment

Eleven participants (seven men and four women) between the ages of 18–25 were recruited via purposive and convenience sampling from local mosques within two Australian cities with the largest Muslim populations. Five participants were born and raised in Australia. Six were born in India or Pakistan and immigrated to Australia after the age of 16 for study/employment. Respondents' immigration status was noted as "recent immigrant" if they resided in Australia for less than 5 years. Respondents were also reflective of the larger Ismaili community, in that they comprised of ethnic East African and South Asian individuals. Due to the exploratory nature of the study and its qualitative approach, there were no pre-set inclusion/exclusion criteria other than respondents having to be over 18, identifying as Ismaili Muslim, and legally residing in Australia. Individuals who were not of East African or South Asian ancestry, with uncertain immigration status and/or refugees/asylum seekers were excluded. As per the reflexive thematic analysis approach, there was no *a priori* determination of sample size and neither was the concept of "saturation" used (Braun and Clarke 2019). Rather, the focus was on the depth of the interviews and obtaining rich insights from understanding the experiences of a minority and under-researched community.

Ethics

Ethical approval was obtained by the Graduate Review Board at the Institute of Ismaili Studies in London, where the first author was based during the time of data collection. As this study was not clinical health research, and used a community-based sample, the Board deemed institutional ethical approval to be sufficient. The Institute of Ismaili Studies does not record formal ethical approval numbers for its research. Informed consent was obtained prior to individual semi-structured interviews.

Data collection

Individual semi-structured interviews were conducted with respondents. A broad topic guide was used during conversation, based on the following areas:

- participants' demographic/cultural history (e.g., their parents' country of origin, their experiences growing up),
- the role of mainstream/heritage culture in their worldviews,
- their experiences as young Ismaili Muslims in Australia,
- avenues through which they have heard about mental health and wellbeing,
- personal understandings of mental health and mental illness,
- personal encounters with people experiencing mental ill health,
- awareness of and receptivity to avenues of social support if experiencing mental health difficulties, and
- their views on particular mental health needs amongst the Ismaili and wider Muslim community in Australia.

Interviews were conducted by the first author and ranged from 30 minutes to three hours. Interviews were held in a location convenient to participants, with many choosing a private area within the local mosque. Interviews were conducted in English and audio-recorded and transcribed *verbatim* by the first author. Transcripts were reviewed by the authors, as well as colleagues noted in the acknowledgements, to ensure credibility and appropriate interpretation.

Analytic approach and procedure

Data was analysed using reflexive thematic analysis, "a method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79), following the step-wise approach outlined in Jaspal (2020) and Braun and Clarke (2006, 2019, 2021) – specifically, familiarisation with the data; generation of initial codes; searching for themes; reviewing themes; defining and naming the themes; and finally, writing the article. Aligned with the reflexive thematic analysis approach (Braun & Clarke, 2019, 2021), we have acknowledged our own positionality and subjectivity as a resource in the analysis through discussion in the reflexivity section. The reflexive approach also recognises that the development of themes and codes is iterative, interpreted through the lens of the researchers, with themes generated inductively from codes. Analysis was iterative and all authors were involved in the coding process. Transcripts were read repeatedly by the first author for familiarity with the dataset and then uploaded into NVivo 10.0, a qualitative software package which facilitated the cross-comparison of responses to organise coding. Preliminary impressions and interpretations were coded inductively and independently from passages, words, and sentences by the first and second authors. These codes were grouped together into broader observations, or "themes". Themes were rigorously reviewed against the data for compatibility and interview extracts listed against corresponding themes. Themes observed via cross-comparison between respondents enabled the generation of supraordinate themes. These supraordinate themes are presented herein. Extracts that were considered vivid, compelling, and representative of the themes were selected for inclusion. In respondent quotations, ellipses indicate omission and square brackets signify clarification. Pseudonyms have been used for anonymity.

Reflexivity

It is important to state that the first and second authors were from a similar ethno-cultural background as respondents, which aided in facilitating access and in interpreting cultural idioms of distress. From a reflexive thematic analysis approach, we recognise how this broader ingroup status has facilitated the interpretation of participants' narratives and the development of themes (Braun & Clarke, 2019). Additionally, none of the authors were from the Australian context, which may have aided in trust as mental health issues are heavily stigmatised within Muslim communities globally and there is often reluctance to disclose particularly sensitive information to perceived members of the same social ingroup (Ciftci et al., 2013; Davis et al., 2009).

The decision for the first author to be the sole interviewer was based on the premise that while there is often a segregation of the sexes within Muslim contexts, this is not the case amongst Ismaili Muslims. Ismaili women tend not to wear a *hijab* and, given the community's broader acculturation strategies, strict sex segregation is unusual. Nevertheless, it appeared that gender dynamics may have indeed played a role given the low number of female respondents, suggesting continued cultural considerations of gender with regards to sensitive topics. Still, there was a willingness by female respondents to speak to the first author. This willingness may reflect greater levels of acculturation and data would thus need to be interpreted in that light. The perspective of the second author, a female Muslim, was therefore crucial in being able to interpret the views of all respondents. The iterative data analysis process and communication between the authors, a mixed-gender team, as well as other academics noted in the acknowledgements, ensured robustness in the data and minimised any potential biases.

Results

The study sought to examine how Ismaili Muslim youth conceptualised notions of mental health and illness, specifically, to what extent their views are influenced by traditional, cultural, or bio-medical paradigms. As the Ismaili Muslim community is said to employ an integrationist acculturative strategy, it sought to investigate to what extent this approach was reflected in the mental health paradigms of youth and to identify factors which may influence formulations of mental health and illness amongst Muslim youth more broadly. Two major themes were identified: 1) making sense of mental health – which comprised of two sub-themes, 1a) defining mental health, and 1b) perceived determinants, and 2) influence of social representations – which also comprised of two sub-themes, 2a) "emotional" vs

"factual" and 2b) education through experience: personal encounters with mental illness. The results section will discuss each of these themes and sub-themes in sequence.

Making sense of mental health

This theme considers how respondents understood concepts of mental health and illness ("defining mental health") and what they felt to be causative factors ("perceived determinants"). Differences were visible by migration status, with recent immigrants linking mental illness to not being "normal" and lacking identity/self-efficacy. While respondents noted the influence of biological/environmental factors, recent immigrants were more likely to endorse supernatural explanations for mental illness, rejecting biological explanations compared to Australian-born/raised youth. Both groups, however, noted the importance of religion in maintaining mental wellbeing. These findings are discussed below.

Defining mental health

This section examines how youth understood and framed concepts of mental health and mental illness. Australian-born/raised youth linked mental health to *"your overall well-being"* (Sabrina, Australian-born/raised), and *"everything that encompasses your health that is not physical"* (Baber, Australian-born/raised). Recent immigrants appeared more likely to interpret mental health as mental illness, as they contrasted experiencing "mental health" to "normal" functioning.

> Mental health is depression … . being really emotional – Amaar, recent immigrant

> something going in your mind which disturbs you all the time through which you can't do your things properly. – Ahmed, recent immigrant

Amaar's quote denotes a view that depression is due to an inability to regulate one's emotional state rather than psychological or biological causes. This was echoed by others:

> What is mental illness? All what a normal person is not … if you are not able to perform any activity the way it should be or a way it efficiently should be performed … not being able to perform to your own efficiency. – Salman, recent immigrant

These views suggest a juxtaposition of those who suffer from mental ill health against *"normal"* individuals, implicitly construing the former as abnormal. Respondents alluded to the importance of self-efficacy, suggesting when *"efficiency"* is compromised mental health issues may arise. There was a discernible link between self-efficacy, identity, and mental health:

> Mental illness is obviously opposite to mental satisfaction … not knowing your identity or faith or all sorts of medical things that … relate to … not [being] in the right state of mind … bipolar … stuff like that – Afzal, recent immigrant

Although Afzal differentiates between mental health and mental illness, he links identity to mental health, whereby one must "know" one's identity for *"mental satisfaction"*. Afzal's suggestion of a triad of identity, faith, and biological factors (*"medical things")* as comprising *"mental satisfaction"* implies that an imbalance of any three could lead to mental illness. Thus, while Australian-born/raised youth interpreted mental health in relation to wellbeing, recent immigrants believed mental health meant a distinction and separation from identity, efficiency, and self-efficacy, alluding to a negative, culturally-informed connotation of the term.

Perceived determinants of mental illness

This section considers what respondents deemed to be factors influencing mental health and illness. Participants attributed mental distress to factors such as *"loneliness/lack of support"*, *"not living a balanced life"*, *"lack of confidence"*, *"stress*", and *"family/personal problems*", in addition to *"genetics"* and *"substance abuse"*. Recent immigrants, however, generally eschewed biological explanations, instead favouring religious and cultural-based belief models:

> Supernatural powers …. some people have a gifted … ability … , means they can observe things … the [mental] illness, they cannot get them … I remember … when I was in secondary school one of the guys, his eyesight is very very good, there is a … stone and he can see what is on the back of the stone. – Omar, recent immigrant

> Genetics … I don't think it has any effect … if someone is depressed and comes to *jamaatkhana* (house of worship) and does their *bandagi* (meditation) and. their *du'a* (prayers) on time … and thinks of the *Imam* (spiritual leader) … it will make them relaxed. – Amaar, recent immigrant

As these extracts demonstrate, recent immigrants appeared to reject biological explanations of mental illness, instead favouring psychospiritual ones. Indeed, Omar argued that "supernatural powers" may offer protection from mental illness, whereas Amaar suggested that religious activity could aid in overcoming mental ill health.

Conversely, Australian-born/raised youth echoed bio-medical frameworks of mental health as prevalent in Australian society:

> I'm not … a scientist but I assume there is some [chemical basis] … for example people who … go through depression take tablets … which would change their serotonin levels … in the brain which change the way you feel. I don't know if that is … part of the cause [of mental illness] … lifestyle … issues, isolation, those sorts of things … probably … bring it on more than anything else and whether there is any biological factors that make people predisposed to mental illness … – Baber, Australian-born/raised

This quotation underscores an awareness of a multifactorial cause of mental illness, involving social and "*biological factors*". Still, like recent immigrants, Australian-born/raised respondents also alluded to the role of religion and religious identity in psychological wellbeing:

> "spirituality" and religion does play a huge role … it probably gives you a[n] … open awareness and medium to discuss your issues and … somewhere to sort of relax … – Sabrina, Australian-born/raised

> [religion] plays quite a big role [in mental health] actually …… balance between the two lives [religious and secular] … does affect you … mentally – Shoaib, Australian-born/raised

Thus, despite the difference seen in the influence of biological versus supernatural influences of mental illness amongst the two groups, both noted a clear importance of the influence of religion in maintaining mental wellbeing. Within the Ismaili Muslim tradition, there is an emphasis on balance of *din* (religious) and *dunya* (worldly), hence, it wasn't surprising to hear that echoed amongst respondents – where they felt having such a balance was important and not having this balance could lead to mental health difficulties. Regardless of the role of cultural influences, it was clear that religious factors were critical in maintaining a coherent identity and promoting mental health.

Sources of social representation of mental illness

Respondents appeared to suggest that the avenue of information related to mental health and mental illness influenced their understanding. They contrasted "factual"-based information as presented in schools to sensationalised approaches seen in the media. Recent immigrants suggested there was no discussion of mental illness in their countries of origin, showcasing different cultural approaches to discussing mental health. Both groups felt there was a role to play in their religious community in relation to mental health awareness and coping. More importantly, respondents noted that their own views had changed upon personal encounters with someone experiencing mental illness – suggesting a reframing based on a compassion-focused perspective was helpful. These themes are elaborated upon below.

"Emotional" vs "factual"

This section examines how respondents interpreted discourse about mental health within "emotional" or "factual" frameworks. Respondents claimed to have heard about mental health issues from a variety of sources, including media and personal networks. Afzal, a recent immigrant, contrasts the level of information between the Australian and Pakistani contexts, noting: *"Over there, [Pakistan] you can't imagine such a thing … if someone is disabled or mentally ill … that's it*", thus implying that in Pakistan there is neither the discourse nor support services available for mental ill health. Australian-born/raised respondents mentioned hearing about mental health:

> Everywhere [laughs] … on TV … the news … , in school. Not so much in *[jamaat]khane* … but you hear about it everywhere … . you look somewhere and you've got a billboard with "Do you have depression?" – Sabrina, Australian-born/raised

Though respondents noted various information sources, their interpretation of the veracity of information varied:

> On TV, movies and Internet [it] is all about the facts, whereas home and school … is about emotions … . I would get most of my information from the Internet because it's a lot more … reliable to some extent – Shoaib, Australian-born/raised

Sabrina noted how mental health is discussed at university and in the media:

> [mental health issues] are actually discussed in [uni]… [at a] more academic level and the whys and hows and how to figure [it] out and if you look at the media and whatnot, it sort of makes a play of mental illnesses … behaving "retardedly"

There is a distinct contrast between the *"academic"* manner in which mental health issues are discussed at university and the sensationalism of media portrayal. Sabrina, for instance, alludes to behaviours of celebrities with poor mental health charicaturised in the media, referring to: *"Lindsay Lohan – an example of people with mental issues. Emo people"*. This has implications for how youth construe notions of mental health and illness.

Some recent immigrants reported hearing about mental health at schools but had a different interpretation of its validity:

> At school there is a lot of information .... but ... not much of discussion. In movies it is the same thing. It's all hyped up, you know? They show too much entertainment ... [the] Internet is more ... real, I guess. They explain it to you in much [more] detail than ... in school – Salman, recent immigrant

Youth thus distinguish between "factual" information as presented in academic contexts versus "emotional" as in feelings, experiences, and sensationalism. This has implications on mental health promotion efforts, particularly for recent immigrants, as the information they see in the media and schools may be their only source of mental health information. Although it may help to destigmatise a culturally taboo topic, it is also important for youth to know how to distil the right information.

The influence of religion was also mentioned when discussing the "emotional" aspects of mental health, particularly by recent immigrant respondents who alluded to the importance of health information disseminated within the mosque/*jamaatkhana*. Amaar states:

> in *jamaatkhana*...there was ... a huge article ... saying ... If you're going through a tough time ... depressed, stressed ... make sure you come to *jamaati mukhisaheb* (community leader) and ... talk to Council people first. They'll help you save money and help you take care of things and solve problems ... in an Ismaili way than if you go up to a professional and they're like "you know I think you've got a problem with your religion" and that kind of sticks in your head for the rest of your life.

This articulates the tension Muslim youth may face in engaging in mainstream mental health services – a fear of their religion being marginalised, dismissed, or seen as the problem. Amaar, here, noted there may be *"an Ismaili way"* to discuss mental health issues, suggesting a religiously-informed/sensitive approach to mental health issues would be favourable. For Muslim youth, having a distinct *religious* way to address mental health issues is paramount. Respondents spoke of the social benefit of their religious community, alluding to the importance of belongingness and social support, for example, by getting involved in their religious community and seeking support from religious leaders. This suggests that Muslim youth believe it is crucial that their faith be acknowledged and understood in mental health services.

Education through experience: personal encounters with mental illness

This sub-theme discusses the influence of personal experience with mental illness on respondents' own frameworks and understanding of mental health and illness. Respondents were forthright about their experience and encounters with mental health issues within their personal networks, whether through close friends, peer networks, colleagues, or members within their community:

> I do know someone [with a mental illness] ... [I have become] more comfortable ... able to accept it more. If I didn't know someone I'd be like, "that is kinda weird", "why are you thinking like that?" Whereas if you are put into situations with someone you ... know, it makes you ... warm to it ... you understand what they are going through ... . [your opinion] does change – Amira, Australian-born/raised

Amira's extract suggests that although someone experiencing mental ill health may initially be characterised as "weird", that view can be reframed upon personal encounters – resulting in greater empathy and understanding. Some recent immigrants also agreed with this viewpoint:

> Definitely [people's views would change]. Don't ask me what changes. I think that some people [if they] haven't met someone who has a mental illness ... they think that probably it is dangerous to go to that person ... if you are in touch with someone [who has a mental illness] ... sometimes you feel sympathy for them, you feel like taking care of them. – Salman

Again, we see how someone with mental ill health may initially be considered *"dangerous"* but personal connection, leading to sympathy and pastoral care, can change one's view. Here, respondents suggested that direct or indirect personal encounters with someone experiencing a mental illness engendered feelings of empathy whereas solely theoretical knowledge gleaned from external sources made them feel distant and disconnected. Here, personal encounters were suggestive of playing an important role in countering dominant socio-cultural discourse of stigma and shame in relation to mental illness (Ciftci et al., 2013). This showcases the importance of "humanising" and developing empathy through personal encounters, which can transform existing views of mental health and illness.

Discussion

This qualitative study examined conceptualisations of mental health and illness amongst Australian-born/raised and recent immigrant Ismaili Muslim

youth. Broader work with Muslim migrant communities (e.g., Bagasra & Mackinem, 2014; Pratt et al., 2016) found that American Muslims generally viewed mental illness through a confluence of bio-medical, fatalistic, and traditional religio-cultural paradigms, whilst in the Australian context, Bairami et al. (2021) noted cultural and supernatural explanations remained prominent amongst their respondents. Although the Ismaili community has been purported as the most integrated and acculturated Muslim denomination (Versi, 2010), only two studies have examined the impact of acculturation on mental health within the community – Khuwaja et al.'s (2007) work with Pakistani female teenagers in Texas noting greater acculturation led to lower levels of psychological distress, and Damani-Khoja's (2018) work comparing adults across Muslim denominations in the United States noting Sunnis endorsed more traditional cultural models of mental health whilst both Sunnis and Ismailis noted receptivity of accessing formal avenues of support. This study sought to examine whether the Ismaili community's purported integrationist acculturative approach was seen in conceptualisations of mental health and illness, comparing recent immigrants with Australian-born/raised youth.

The study's findings suggest that whilst Australian-born/raised youth saw mental health as multifactorial, recent immigrant youth juxtaposed it against a sense of "normalcy" and maintaining self-efficacy, demonstrating the psychological significance of self-efficacy highlighted by Bandura (1977, 1997) and Breakwell (1986, 1993) and the *cultural* significance of self-efficacy as a societal value (Solberg & Viliarreal, 1997).

A potentially novel finding of this research was that although recent immigrants in this study discussed the role of supernatural powers influencing mental health, consistent with previous research amongst Muslim communities (e.g., Bagasra & Mackinem, 2014; Walpole et al., 2012), they construed it differently. Rather than noting the influence of the supernatural elements such as *djinns* and *nazar* as causes of mental illness (Bagasra & Mackinem, 2014; Bairami et al., 2021; Dein et al., 2008), respondents suggested religious-based supernatural elements could act as mental health *promoters*. This line of interpretation resonates with work by Abu-Raiya and Pargament (2015) and Abu-Raiya et al. (2019), noting that religion can be used as a positive form of coping amongst Muslims when facing psychological distress. Additionally, the findings that Australian-born/raised youth noted a biological and environmental basis of mental illness contrasts with other work amongst wider Muslim youth suggesting traditional cultural belief models still hold (Bagasra & Mackinem, 2014; Bairami et al., 2021).

This finding is significant given Ismailis are perceived to be a more acculturated Muslim community (Versi, 2010) and thus may be expected to hold "Western" biological conceptualisations of mental illness. Thus, recent immigrants explaining mental illness within a cultural paradigm may be a result of the desire for cultural continuity in a new context. Additionally, both groups of respondents suggested that the loss of faith had mental health implications. In fact, respondents were keen to emphasise the role religion played in maintaining *well-being*. The importance of religion and faith identity amongst Muslim communities has been well documented in the literature (e.g., Aly, 2007; Haque, 2004; Modood et al., 1997).

In light of increased public discourse regarding mental health, respondents were asked about where they may have heard about mental health. Recent immigrants suggested only hearing of these issues once in Australia, whereas Australian-born raised youth noted hearing discourse of this within domestic and educational spheres. This suggests cultural constructs in relation to stigma/taboo of mental ill health still play a role in cultural discourse regarding mental health (Syed et al., 2007), and thus an avenue for acculturation is exposure to the "mainstreaming" of mental health and illness.

Interestingly, both groups of respondents noted differences between the way mental health was discussed in schools versus the media. Westad (2015) suggests that a "top-down" "transmission" model of mental illness information may be ineffective, as it negates individual experience and reflexivity. In this case, respondents noted their own views changing through personal encounters with those with lived experience. Alexander and Link (2003) noted contact with people with mental health conditions plays a role in reducing stigma, referring to this process as "contact hypothesis" and this study showed how this may play a role in changing attitudes towards mental ill health.

Unlike the work by Burr and Chapman (2004) and Gilbert et al. (2004), who noted that South Asian Muslim women tended to not see psychological symptoms as "real" and viewed only physical distress as requiring professional support, respondents here appeared to acknowledge the realities and challenges of mental illness – a novel finding compared to similar populations. For Australian Ismaili Muslim youth, concepts of "care" and "understanding" towards others with mental health issues seem to take primacy in

contrast with notions of "shame" and "stigma", often seen amongst wider Muslim communities (Abu Raiya & Pargament, 2010).

Limitations

Although this study focused on a small and distinct Muslim community, thereby limiting generalisability, it adds to the literature regarding Muslim mental health. It is recognised that the nature of the sample selection, recruitment via attendees at mosques, may have resulted in bias in that respondents would naturally be expected to be religiously-minded as regular attendees of places of worship. Further work could therefore examine differences between "religious" vs "cultural" Muslims or those who may not attend Islamic places of worship. Furthermore, quantitative methods may elucidate wider spread views through use of standardised questionnaires and measuring associations between religious coping, worldviews, and psychological distress (e.g., Bairami et al., 2021). Additional work could build on that of Damani-Khoja (2018) to outline whether denominational differences, as seen in her work in the United States, hold within the Australian context. Further work could investigate how mental health discourse on social media may influence views of mental health amongst minority communities. This study has further clinical implications in that it outlines that the relationship between acculturation and mental health constructs is nuanced and it may be reductive for practitioners to assume that all Muslim groups hold traditional cultural views towards mental illness. Respondents denoted a willingness and receptivity for further information regarding mental health, which suggests an important role of psycho-education and cultural adaptability, bearing in mind the importance respondents denote to religion in maintaining personal mental well-being.

Conclusion

This study examined recent immigrant and Australian-born/raised Ismaili Muslim youth. It found that youth often conflated notions of mental health and mental illness, interpreting concepts of "mental illness" as "mental health", reflecting lay discourse surrounding mental illness. Recent immigrants seemed less likely to indicate a biological basis of mental illness, stating supernatural powers as a factor influencing mental health. Although this echoes the literature to an extent (e.g., Bagasara & Mackinem, 2014; Bairami et al., 2021; Haque, 2004), it is an unanticipated finding for Ismailis given that they distinguish themselves *vis-à-vis* other Muslim communities as more acculturated. This study's findings also contradict those of Bagasra and Mackinem (2014) who noted that it was more settled immigrant Muslim communities who held traditional religio-cultural views of mental illness, suggesting that in this case of Ismaili Muslims, "cultural fossilization", as experienced by other Muslim migrant communities (Ghaffar-Kucher, 2015), may not apply.

Although this study is exploratory, it identified several interesting findings. Namely, both recent immigrant and Australian-born/raised Ismaili Muslim youth seemed aware, to some extent, of common mental disorders. Nevertheless, the strong attachment respondents placed in their faith regarding coping with mental health issues denotes the importance for clinical practitioners working with Muslims to engage with issues of religion and its impact on one's understanding of their mental health. The increased movement of "Islamic counselling" and "Islamic psychology" amongst Muslim migrant communities (e.g., Mitha, 2020; Rothman & Coyle, 2020) could be read as a reaction of Muslims turning to therapeutic models which incorporate religio-cultural discourse. Indeed, Husain et al. (2017) have described how culturally adapted forms of psycho-education, using culturally-appropriate terminology and religious teachings have improved knowledge and attitudes towards mental health amongst Muslims. This study further adds to the body of literature denoting the importance of cultural adaptations in mental health services in order to meet the demands of an increasingly diverse population who may have different models and constructs of mental health. This work has additional implications in addressing the needs of ethnic minority migrant youth, particularly in responding to addressing mental health needs whilst being cognisant of different conceptualisations of mental illness which may be employed. This is particularly important given the increased prevalence of mental health conditions amongst youth, as well as increasingly diverse youth populations in many Western countries.

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ORCID

Karim Mitha http://orcid.org/0000-0003-2538-5130
Shelina Adatia http://orcid.org/0000-0003-2606-1699

Data availability statement

Due to the fact that the research employs a small sample size and discusses religio-culturally sensitive issues, data cannot be made publicly available to respect respondent confidentiality and anonymity.

References

Abu Raiya, H., & Pargament, K. I. (2010). Religiously integrated psychotherapy with Muslim clients: From research to practice. *Professional Psychology: Research and Practice*, *41*(2), 181–188. https://doi.org/10.1037/a0017988

Abu-Raiya, H., & Pargament, K. I. (2015). Religious coping among diverse religions: Commonalities and divergences. *Psychology of Religion and Spirituality*, *7*(1), 24–33. https://doi.org/10.1037/a0037652

Abu-Rayya, M. H., Walker, R., White, F. A., & Abu-Rayya, H. M. (2016). Cultural identification and religious identification contribute differentially to the adaptation of Australian adolescent Muslims. *International Journal of Intercultural Relations*, *54*, 21–33. https://doi.org/10.1016/j.ijintrel.2016.07.002

Abu-Raiya, H., Ayten, A., Tekke, M., & Agbaria, Q. (2019). On the links between positive religious coping, satisfaction with life and depressive symptoms among a multinational sample of Muslims. *International Journal of Psychology*, *54*(5), 678–686. https://doi.org/10.1002/ijop.12521

Adam, Z., & Ward, C. (2016). Stress, religious coping and wellbeing in acculturating Muslims. *Journal of Muslim Mental Health*, *10*(2). https://doi.org/10.3998/jmmh.10381607.0010.201

Ahmed, S., & Reddy, L. A. (2007). Understanding the mental health needs of American Muslims: Recommendations and considerations for practice. *Journal of Multicultural Counseling and Development*, *35*(4), 207–218. https://doi.org/10.1002/j.2161-1912.2007.tb00061.x

Al-Adawi, S., Dorvlo, A. S., Al-Ismaily, S. S., Al-Ghafry, D. A., Al-Noobi, B. Z., Al-Salmi, A., Burke, D. T., Shah, M. K., Ghassany, H., & Chand, S. P. (2002). Perception of and attitude towards mental illness in Oman. *International Journal of Social Psychiatry*, *48*(4), 305–317. https://doi.org/10.1177/002076402128783334

Alexander, L., & Link, B. (2003). The impact of contact on stigmatizing attitudes towards people with mental illness. *Journal of Mental Health*, *12*(3), 271–289. https://doi.org/10.1080/0963823031000118267

Ali, S., Elsayed, D., Elahi, S., Zia, B., & Awaad, R. (2022). Predicting rejection attitudes toward utilizing formal mental health services in Muslim women in the US: Results from the Muslims' perceptions and attitudes to mental health study. *International Journal of Social Psychiatry*, *68*(3), 662–669. https://doi.org/10.1177/00207640211001084

Aly, A. (2007). Australian Muslim responses to the discourse on terrorism in the Australian popular media. *Australian Journal of Social Issues*, *42*(1), 27–38. https://doi.org/10.1002/j.1839-4655.2007.tb00037.x

Amer, M. M. (2005). *Arab American mental health in the post September 11 era: Acculturation, stress, and coping* [Doctoral dissertation, University of Toledo].

Amer, M. M., & Hovey, J. D. (2007). Socio-demographic differences in acculturation and mental health for a sample of 2nd generation/early immigrant Arab Americans. *Journal of Immigrant and Minority Health*, *9*(4), 335–347. https://doi.org/10.1007/s10903-007-9045-y

Amnesty International. (2015, May 13). *Pakistan: Attack on Ismaili Shi'a Muslims in Karachi is a product of "climate of impugnity"*. https://www.amnesty.org/en/latest/news/2015/05/pakistan-attack-on-ismaili-shia-muslims-in-karachi-is-product-of-climate-of-impunity/

Asani, A. (2010). From Satpanthi to Ismaili Muslim: The articulation of Ismaili Khoja identity in South Asia. In F. Daftary (Ed.), *A modern history of the Ismailis: Continuity and change in a Muslim community* (pp. 95–128). Bloomsbury Publishing.

Asghari-Fard, M., & Hossain, S. Z. (2017). Identity construction of second-generation Iranians in Australia: Influences and perspectives. *Social Identities*, *23*(2), 126–145. https://doi.org/10.1080/13504630.2016.1207515

Asvat, Y., & Malcarne, V. (2008). Acculturation and depressive symptoms in Muslim university students: Personal-family acculturation match. *International Journal of Psychology*, *43*(2), 114–124. https://doi.org/10.1080/00207590601126668

Australian Bureau of Statistics. (2022a, July 22). *National study of health and wellbeing*. https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release

Australian Bureau of Statistics. (2022b, September 20). *Cultural diversity of Australia*. https://www.abs.gov.au/articles/cultural-diversity-australia

Australian Bureau of Statistics. (2022c, June 28). *2021 census shows changes in Australia's religious diversity*. https://www.abs.gov.au/media-centre/media-releases/2021-census-shows-changes-australias-religious-diversity

Bagasra, A., & Mackinem, M. (2014). An exploratory study of American Muslim conceptions of mental illness. *Journal of Muslim Mental Health*, *8*(1). https://doi.org/10.3998/jmmh.10381607.0008.104

Bairami, K., Spivak, B. L., Burke, L. M., & Shepherd, S. M. (2021). Exploring mental illness attributions and treatment-seeking beliefs in a diverse Muslim-Australian sample. *Clinical Psychologist*, *25*(1), 44–54. https://doi.org/10.1080/13284207.2021.1929143

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*(2), 191–215. https://doi.org/10.1037/0033-295X.84.2.191

Bandura, A. (1997). *Self-efficacy: The exercise of self control*. Freeman.

Bansal, N., Bhopal, R., Netto, G., Lyons, D., Steiner, M. F., & Sashidharan, S. P. (2014). Disparate patterns of hospitalisation reflect unmet needs and persistent ethnic inequalities in mental health care: The Scottish health and ethnicity linkage study. *Ethnicity & Health*, *19*(2), 217–239. https://doi.org/10.1080/13557858.2013.814764

Bansal, N., Karlsen, S., Sashidharan, S. P., Cohen, R., Chew-Graham, C. A., & Malpass, A. (2022). Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography. *PLoS Medicine*, *19*(12), e1004139. https://doi.org/10.1371/journal.pmed.1004139

Banting, K., & Kymlicka, W. (2010). Canadian multiculturalism: Global anxieties and local debates. *British Journal of Canadian Studies*, *23*(1), 43–72. https://doi.org/10.3828/bjcs.2010.3

Baxter, J., Kingi, T. K., Tapsell, R., Durie, M., & Mcgee, M. A. (2006). Prevalence of mental disorders among Māori in Te Rau Hinengaro: The New Zealand mental health survey. *Australian and New Zealand Journal of Psychiatry*, *40*(10), 914–923. https://doi.org/10.1080/j.1440-1614.2006.01911.x

Beiser, M., & Hou, F. (2016). Mental health effects of premigration trauma and postmigration discrimination on refugee youth in Canada. *The Journal of Nervous and Mental Disease*, *204*(6), 464–470. https://doi.org/10.1097/NMD.0000000000000516

Beliappa, J. (1991). *Illness or distress? Alternative models of mental health*. Peterson.

Berry, J. W. (1992). Cultural transformation and psychological acculturation. In J. Burnet, D. Juteau, E. Padolsky, A. Rasporich, & A. Sirois (Eds.), *Migration and the transformation of cultures* (pp. 23–54). Multicultural History Society of Toronto.

Berry, J. W., & Hou, F. (2017). Acculturation, discrimination and wellbeing among second generation of immigrants in Canada. *International Journal of Intercultural Relations*, *61*, 29–39. https://doi.org/10.1016/j.ijintrel.2017.08.003

Bhimani, S. (2019). The spacialization of modern, liberal Muslims with the Canadian nation: An animation of Ismaili Muslim exceptionality. *Social Identities*, *25*(2), 224–239. https://doi.org/10.1080/13504630.2017.1414593

Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica*, *109*(4), 243–258. https://doi.org/10.1046/j.0001-690X.2003.00246.x

Bhugra, D., & Bhui, K. (2003). Eating disorders in teenagers in East London: A survey. *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association*, *11*(1), 46–57. https://doi.org/10.1002/erv.486

Bhugra, D., & Bhui, K. (Eds.). (2018). *Textbook of cultural psychiatry* (2nd ed.). Cambridge University Press.

Bhui, K., Stansfeld, S., Head, J., Haines, M., Hillier, S., Taylor, S., Viner, R., & Booy, R. (2005). Cultural identity, acculturation, and mental health among adolescents in east London's multiethnic community. *Journal of Epidemiology & Community Health*, *59*(4), 296–302. https://doi.org/10.1136/jech.2003.014456

Bolander, B. (2016). English and the transnational Ismaili Muslim community: Identity, the Aga Khan, and infrastructure. *Language in Society*, *45*(4), 583–604. https://doi.org/10.1017/S0047404516000439

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise, and Health*, *13*(2), 201–216. https://doi.org/10.1080/2159676X.2019.1704846

Breakwell, G. M. (1986). *Coping with threatened identities*. Methuen.

Breakwell, G. M. (1993). Social representations and social identity. *Papers on Social Representation*, *2*(3), 1–19.

Burr, J., & Chapman, T. (2004). Contextualising experiences of depression in women from South Asian communities: A discursive approach. *Sociology of Health & Illness*, *26*(4), 433–452. https://doi.org/10.1111/j.0141-9889.2004.00398.x

Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, *70*(1), 44–55. https://doi.org/10.1037/0022-006X.70.1.44

Chaudhury, S. R. (2011). *Attitudes towards the diagnosis and treatment of depression among South Asian Muslim Americans* [Unpublished doctoral dissertation]. Columbia University.

Choy, B., Arunachalam, K., Gupta, S., Taylor, M., & Lee, A. (2021). Systematic review: Acculturation strategies and their impact on the mental health of migrant populations. *Public Health in Practice*, *2*, 100069. https://doi.org/10.1016/j.puhip.2020.100069

Ciftci, A., Jones, N., & Corrigan, P. W. (2013). Mental health stigma in the Muslim community. *Journal of Muslim Mental Health*, *7*(1). https://doi.org/10.3998/jmmh.10381607.0007.102

Cinnirella, M., & Loewenthal, K. M. (1999). Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. *British Journal of Medical Psychology*, *72*(4), 505–524. https://doi.org/10.1348/000711299160202

Collins, M. E., & Mowbray, C. T. (2005). Higher education and psychiatric disabilities: National survey of campus disability services. *American Journal of Orthopsychiatry*, *75*(2), 304–315. https://doi.org/10.1037/0002-9432.75.2.304

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Sage.

Damani-Khoja, N. (2018). *Mental health help-seeking in South Asian American Muslims: The role of cultural beliefs, attitudes, and knowledge* [Doctoral dissertation, University of Houston].

Davis, R. E., Couper, M. P., Janz, N. K., Caldwell, C. H., & Resnicow, K. (2009). Interviewer effects in public health surveys. *Health Education Research*, *25*(1), 14–26. https://doi.org/10.1093/her/cyp046

Dein, S., Alexander, M., & Napier, A. D. (2008). Jinn, psychiatry and contested notions of misfortune among east London Bangladeshis. *Transcultural Psychiatry*, *45*(1), 31–55. https://doi.org/10.1177/1363461507087997

Dickson, J. N. N. M., Cruise, K., McCall, C. A., & Taylor, P. J. (2019). A systematic review of the antecedents and prevalence of suicide, self-harm and suicide ideation in

Australian Aboriginal and Torres Strait Islander youth. *International Journal of Environmental Research and Public Health*, *16*(17), 3154. https://doi.org/10.3390/ijerph16173154

Do, M., Pham, N. N. K., Wallick, S., & Nastasi, B. K. (2014). Perceptions of mental illness and related stigma among Vietnamese populations: Findings from a mixed method study. *Journal of Immigrant and Minority Health*, *16*(6), 1294–1298. https://doi.org/10.1007/s10903-014-0018-7

Farooqi, Y. N. (2006). Understanding Islamic perspective of mental health and psychotherapy. *Journal of Psychology in Africa*, *16*(1), 101–111. https://doi.org/10.1080/14330237.2006.10820109

Ghaffar-Kucher, A. (2015). 'Narrow-minded and oppressive'or a 'superior culture'? Implications of divergent representations of Islam for Pakistani-American youth. *Race Ethnicity and Education*, *18*(2), 202–224. https://doi.org/10.1080/13613324.2014.889111

Gilbert, P., Gilbert, J., & Sanghera, J. (2004). A focus group exploration on the impact of izzat, shame, subordination and entrapment on mental health service and use in South Asian women living in Derby. *Mental Health, Religion, & Culture*, *7*(2), 109–130. https://doi.org/10.1080/13674670310001602418

Goforth, A. N., Oka, E. R., Leong, F. T., & Denis, D. J. (2014). Acculturation, acculturative stress, religiosity and psychological adjustment among Muslim Arab American adolescents. *Journal of Muslim Mental Health*, *8*(2). https://doi.org/10.3998/jmmh.10381607.0008.202

Gunson, D., Nuttall, L., Akhtar, S., Khan, A., Avian, G., & Thomas, L. (2019). *Spiritual beliefs and mental health: A study of Muslim women in Glasgow*. UWS-Oxfam Partnership. https://oxfampartnership.uws.ac.uk/wp-content/uploads/2021/10/Spiritual-Beliefs-and-Mental-Health-Final-Report.pdf

Haque, A. (2004). Religion and mental health: The case of American Muslims. *Journal of Religion and Health*, *43*(1), 45–58. https://doi.org/10.1023/B:JORH.0000009755.25256.71

Husain, M. I., Chaudhry, I. B., Rahman, R. R., Hamirani, M. M., Mehmood, N., Haddad, P. M., Hodsoll, J., Young, A. H., Naeem, F., & Husain, N. (2017). Pilot study of a culturally adapted psychoeducation (CaPE) intervention for bipolar disorder in Pakistan. *International Journal of Bipolar Disorders*, *5*(1), 1–9. https://doi.org/10.1186/s40345-017-0074-8

Jaspal, R. (2020). Content analysis, thematic analysis and discourse analysis. In G. M. Breakwell, D. B. Wright, & J. Barnett (Eds.), *Research methods in psychology* (5th ed., pp. 285–312). Sage.

Jorm, A., & Kitchener, B. A. (2020). Increases in youth mental health services in Australia: Have they had an impact on youth population mental health? *Australian and New Zealand Journal of Psychiatry*, *55*(5), 476–484. https://doi.org/10.1177/0004867420976861

Kassam-Khamis, T., Judd, P. A., & Thomas, J. E. (2000). Frequency of consumption and nutrient composition of composite dishes commonly consumed in the UK by South Asian Muslims originating from Bangladesh, Pakistan and East Africa (Ismailis). *Journal of Human Nutrition and Dietetics*, *13*(3), 185–196. https://doi.org/10.1046/j.1365-277x.2000.00230.x

Khan, F., Khan, M., Soyege, H. O., Maklad, S., & Center, K. (2019). Evaluation of factors affecting attitudes of Muslim Americans toward seeking and using formal mental health services. *Journal of Muslim Mental Health*, *13*(2). https://doi.org/10.3998/jmmh.10381607.0013.201

Khawaja, N. G. (2007). The predictors of psychological distress among Muslim migrants in Australia. *Journal of Muslim Mental Health*, *2*(1), 39–56. https://doi.org/10.1080/15564900701238526

Khawaja, N. G., & Khawaja, S. (2016). Acculturative issues of Muslims in Australia. *Journal of Muslim Mental Health*, *10*(2), 43–53. https://doi.org/10.3998/jmmh.10381607.0010.203

Khuwaja, S. A., Selwyn, B. J., Kapadia, A., McCurdy, S., & Khuwaja, A. (2007). Pakistani Ismaili Muslim adolescent females living in the United States of America: Stresses associated with the process of adaptation to US culture. *Journal of Immigrant and Minority Health*, *9*(1), 35–42. https://doi.org/10.1007/s10903-006-9013-y

Laird, L. D., De Marrais, J., & Barnes, L. L. (2007). Portraying Islam and Muslims in MEDLINE: A content analysis. *Social Science & Medicine*, *65*(12), 2425–2439. https://doi.org/10.1016/j.socscimed.2007.07.029

Liang, J., Matheson, B. E., & Douglas, J. M. (2016). Mental health diagnostic considerations in racial/ethnic minority youth. *Journal of Child and Family Studies*, *25*(6), 1926–1940. https://doi.org/10.1007/s10826-015-0351-z

Lim, A., Hoek, H. W., & Blom, J. D. (2015). The attribution of psychotic symptoms to jinn in Islamic patients. *Transcultural Psychiatry*, *52*(1), 18–32. https://doi.org/10.1177/1363461514543146

Maiya, S., Killoren, S. E., Monk, J. K., Kline, G. C., & Chavez, F. L. C. (2021). Latino/a young adults' experiences of acculturative stress, depressive symptoms, and romantic relationship commitment: Ethnic identity as protective. *Journal of Social and Personal Relationships*, *38*(5), 1738–1749. https://doi.org/10.1177/0265407521996472

Marsella, A., & White, G. (1982). *Cultural conceptions of mental health and therapy*. D. Reidel Publishing Company.

McClelland, A., Khanam, S., & Furnham, A. (2014). Cultural and age differences in beliefs about depression: British Bangladeshis vs. British Whites. *Mental Health, Religion & Culture*, *17*(3), 225–238. https://doi.org/10.1080/13674676.2013.785710

Merchant, N. H. (2016). Between a rock and a hard place: Shia Ismaili Muslim girls negotiate Islam in the classroom. *Diaspora, Indigenous, and Minority Education*, *10*(2), 98–111. https://doi.org/10.1080/15595692.2015.1084918

Miething, A., Almquist, Y. B., Östberg, V., Rostila, M., Edling, C., & Rydgren, J. (2016). Friendship networks and psychological well-being from late adolescence to young adulthood: A gender-specific structural equation modeling approach. *BMC Psychology*, *4*(1), 34. https://doi.org/10.1186/s40359-016-0143-2

Mitha, K. (2020). Conceptualising and addressing mental disorders amongst Muslim communities: Approaches from the Islamic golden age. *Transcultural Psychiatry*, *57*(6), 763–774. https://doi.org/10.1177/1363461520962603

Mitha, K., & Adatia, S. (2016). The faith community and mental health resilience amongst Australian Ismaili Muslim youth. *Mental Health, Religion & Culture*, *19*(2), 192–207. https://doi.org/10.1080/13674676.2016.1144732

Mitha, K., Adatia, S., & Jaspal, R. (2020). The construction of national and religious identities amongst Australian Isma'ili Muslims. *Social Identities*, *26*(6), 791–810. https://doi.org/10.1080/13504630.2020.1814718

Modood, T., Berthoud, R., Lakey, J., Nazroo, J., Smith, P., Virdee, S., & Beishon, S. (1997). *Ethnic minorities in Britain: Diversity and disadvantage*. Policy Studies Institute.

Mukadam, A., & Mawani, S. (2006). Post-diasporic Indian communities: A new generation. In S. Coleman & P. Collins (Eds.), *Locating the field: Metaphors of space, place and context in anthropology* (pp. 195–210). Berg.

Mukadam, A., & Mawani, S. (2009). Excess baggage or precious gems? The migrations of cultural commodities. In R. Gale & P. Hopkins (Eds.), *Muslims in Britain: Race, place, and identities* (pp. 150–168). Edinburgh University Press.

Mussap, A. J. (2009). Acculturation, body image, and eating behaviours in Muslim-Australian women. *Health & Place*, *15*(2), 532–539. https://doi.org/10.1016/j.healthplace.2008.08.008

Neale, J., Worrell, M., & Randhawa, G. (2009). Breaking down barriers to accessing mental health support services-a qualitative study among young South Asian and African-Caribbean communities in Luton. *Journal of Public Mental Health*, *8*(2), 15–25. https://doi.org/10.1108/17465729200900010

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *The Lancet*, *369*(9569), 1302–1313. https://doi.org/10.1016/S0140-6736(07)60368-7

Patton, C. (2014). Multicultural citizenship and religiosity: Young Australian Muslims forging a sense of belonging after 9/11. *Journal of Intercultural Studies*, *35*(1), 107–122. https://doi.org/10.1080/07256868.2013.864626

Pilkington, A., Msetfi, R. M., & Watson, R. (2012). Factors affecting intention to access psychological services amongst British Muslims of South Asian origin. *Mental Health, Religion & Culture*, *15*(1), 1–22. https://doi.org/10.1080/13674676.2010.545947

Pratt, R., Fadumo, A., Hang, M., Osman, S., & Raymond, N. (2016). Perceptions of mental illness in the Somali community in Minnesota. *International Journal of Migration, Health and Social Care*, *12*(1), 16–25. https://doi.org/10.1108/IJMHSC-04-2014-0011

Rassool, G. H. (2015). Cultural competence in counseling the Muslim patient: Implications for mental health. *Archives of Psychiatric Nursing*, *29*(5), 321–325. https://doi.org/10.1016/j.apnu.2015.05.009

Rothman, A., & Coyle, A. (2018). Toward a framework for Islamic psychology and psychotherapy: An Islamic model of the soul. *Journal of Religion and Health*, *57*(5), 1731–1744. https://doi.org/10.1007/s10943-018-0651-x

Rothman, A., & Coyle, A. (2020). Conceptualizing an Islamic psychotherapy: A grounded theory study. *Spirituality in Clinical Practice*, *7*(3), 197. https://doi.org/10.1037/scp0000219

Skinner, R. (2019). Traditions, paradigms and basic concepts in Islamic psychology. *Journal of Religion and Health*, *58*(4), 1087–1094. https://doi.org/10.1007/s10943-018-0595-1

Solberg, V. S., & Viliarreal, P. (1997). Examination of self-efficacy, social support, and stress as predictors of psychological and physical distress among Hispanic college students. *Hispanic Journal of Behavioral Sciences*, *19*(2), 182–201. https://doi.org/10.1177/07399863970192006

Steinberg, J. (2011). *Isma'ili modern: Globalization and identity in a Muslim community*. Univ of North Carolina Press.

Stuart, J., & Ward, C. (2018). The relationships between religiosity, stress, and mental health for Muslim immigrant youth. *Mental Health, Religion & Culture*, *21*(3), 246–261. https://doi.org/10.1080/13674676.2018.1462781

Syed, E. U., Hussain, S. A., & Yousafzai, A. W. (2007). Developing services with limited resources: Establishing a CAMH in Pakistan. *Child and Adolescent Mental Health*, *12*(3), 121–124. https://doi.org/10.1111/j.1475-3588.2006.00429.x

Valentín-Cortés, M., Benavides, Q., Bryce, R., Rabinowitz, E., Rion, R., Lopez, W. D., & Fleming, P. J. (2020). Application of the minority stress theory: Understanding the mental health of undocumented latinx immigrants. *American Journal of Community Psychology*, *66*(3–4), 325–336. https://doi.org/10.1002/ajcp.12455

Versi, S. (2010). *Make this your home: The impact of religion on acculturation: The case of the Canadian Khoja Nizari Ismailis from East Africa* [Master's thesis, Queen's University]. QSpace: Queen's Scholarship & Digital Collections. https://bit.ly/2U3wI9v

Walpole, S. C., McMillan, D., House, A., Cottrell, D., & Mir, G. (2012). Interventions for treating depression in Muslim patients: A systematic review. *Journal of Affective Disorders*, *145*(1), 11–20. https://doi.org/10.1016/j.jad.2012.06.035

Weatherhead, S., & Daiches, A. (2010). Muslim views on mental health and psychotherapy. *Psychology & Psychotherapy: Theory, Research & Practice*, *83*(1), 75–89. https://doi.org/10.1348/147608309X467807

Westad, K. (2015). The silent epidemic. *UVic Knowledge*, *15*(4). https://bit.ly/2ROWtti

Wright, M., Crisp, N., Newnham, E., Flavell, H., & Lin, A. (2020). Addressing mental health in aboriginal young people in Australia. *The Lancet Psychiatry*, *7*(10), 826–827. https://doi.org/10.1016/S2215-0366(19)30515-2

Wu, Q., Ge, T., Emond, A., Foster, K., Gatt, J. M., Hadfield, K., Mason-Jones, A. J., Reid, S., Theron, L., Ungar, M., & Wouldes, T. A. (2018). Acculturation, resilience, and the mental health of migrant youth: A cross-country comparative study. *Public Health*, *162*, 63–70. https://doi.org/10.1016/j.puhe.2018.05.006

Younis, T. (2021). Politicizing Muslim mental health toward a decolonial framework. *Journal of Muslim Mental Health*, *15*(1), 1–18. https://doi.org/10.3998/jmmh.143