Bridging Faith and Psychological Well-Being:

Understanding Mental Health Perceptions Among Muslim Communities

by

Ingi Elakary

A Capstone submitted in partial fulfillment

of the requirements for the degree of

Master of Counselling (MC)

City University of Canada

Alberta Virtual Campus, Canada site

December 07, 2025

APPROVED BY

Dr. Carmen Almarza, PhD., CCC (CCPA) Capstone Instructor

Dr. Peter Hall, PhD RP, Weekend Cohort Stream Coordinator and Capstone Coordinator, Virtual Campus-Master of Counselling Program

Dr. Renee J. Schmidt, PhD, Academic Program Director, Virtual Campus-Master of Counselling Program

Abstract

Faith and mental health have often been viewed as separate. Through my own learning and work in the field, I have come to see that healing feels incomplete when we ignore the spiritual part of people's lives. Faith can bring hope, strength, and meaning during difficult times, qualities that are deeply connected to mental well-being. When spirituality and psychology are treated as unrelated, clients are left trying to heal without a full sense of balance.

Antoniou and Kalogeropoulos (2024) in a recent report found that while faith often helps people cope, many still face stigma or discomfort when mental health care overlooks their spiritual beliefs. Within Muslim communities, this gap can lead to silent suffering and hesitation to seek help. This capstone explores how Islamic faith, culture, and stigma shape mental health experiences and help-seeking among Muslims in Canada.

Keywords: Islamic mental health, stigma, cultural influence, religious coping, intersectionality

Acknowledgments

This journey would not have been possible without the guidance of my faith, which has been my true source of strength, clarity, and direction through every step of this program.

To my three amazing children, thank you for your patience, love, and understanding. You have been my greatest motivation and the reason I kept going, even on the hardest days.

To my parents and my brother, I am deeply grateful for your constant love and encouragement. Knowing that you are always there for me gave me the courage to keep moving forward.

My sincere thanks to my Capstone professor, Dr. Almarza, whose support, insight, and encouragement have meant so much throughout the writing process. Your guidance allowed me to write a successful, unique capstone.

I also want to thank my close dear friends who encouraged me to pursue this master's program, believed in me when I doubted myself, and reminded me of my own strength. Your faith in me made all the difference.

This achievement reflects not only my effort but also the love, faith, and support of everyone who walked beside me along the way.

Table of Contents

Chapter 1: Introduction

Canada's Muslim population is growing and diverse. From 2001 to 2021, the number of Muslims in the Canadian population more than doubled, rising from 2.096 to 4.996 (Statistics Canada, 2025). This includes individuals from different parts of the world, such as North and South Asia, the Middle East, North and East Africa, and Southeast Asia, among other countries (Statistics Canada, 2024). Despite this growth and the visibility of the Muslim community, Muslims often face significant barriers to mental health care. Zia et al. (2022) examined mental health service utilization and help-seeking preferences among Canadian Muslims and found that while 65% of participants reported moderate to high levels of psychological distress and 60.1% perceived a need for professional mental health support in 2021, less than half had ever sought help from a mental health professional (48.7%) or a general practitioner (44.7%), and only 21.4% reported seeking psychological help from an imam. The findings of the study illustrated that Muslim community members often underutilize professional mental health services and that these research participants, who experience mental health concerns, do not seek professional help due to several barriers such as structural issues (e.g., cost of services), attitudinal factors (e.g., stigma), and community-specific challenges like Islamophobia and cultural mistrust of Western mental health systems (Zia et al., 2022).

Overview of the Topic

Muslims report that they turn to religious coping strategies such as prayer, Qur'an recitation, and attending the mosque more often (Al-Krenawi, 2019). These practices are deeply rooted in spiritual and cultural traditions, and some community members perceive them as the primary path to healing. Religious coping skills are not problematic; for many they provide strength and meaning (Ahad et al., 2023). Tensions arise when clients entirely depend on

spirituality and do not seek proper mental health support, either viewing mental health care as only spiritual or there is stigmatization where professional interventions are delayed or completely avoided (Ahad et al., 2023). This is critical, especially with cases of anxiety, depression, or trauma; honouring faith while incorporating therapeutic techniques is necessary.

Despite the growing body of literature on mental health, limited research explores its intersection with Islamic beliefs. Existing studies highlight stigma barriers to care and the influence of religious interpretations on help-seeking among Muslims (Ahad et al., 2023; Al-Krenawi, 2019; Alqasir & Ohtsuka, 2023; Bagasra, 2023; Basri et al., 2022; Muse, 2024). However, there remains a notable gap in developing interventions that integrate Islamic faith with mental health needs. In Canada specifically, the mental health needs of Muslim communities remain under-researched and insufficiently addressed within mainstream services, where stigma, perceived incompatibility between Islamic values and Western psychological models, and fear of discrimination contribute to underutilization of care (Alqasir & Ohtsuka, 2023).

In some Muslim communities, mental illness is often perceived as a sign of weak faith or a failed spiritual test. However, Islamic teachings encourage reaching out to qualified experts when facing challenges. For instance, the Qur'an, Surah An-Nahl (16:43), states, "Ask those who possess knowledge if you do not know," which is interpreted as a directive to consult professionals. Ibn Kathir (1372/2003) explains this verse as an instruction to consult specialists of various disciplines not limited to theology. In the context of mental health, this can be seen as a call to seek trained professionals alongside religious guidance. Furthermore, the Qur'an affirms both spiritual and practical responses to distress: "And We send down of the Qur'an that which is healing and mercy for the believers" (Qur'an 17:82), which classical scholars such as Al-Tabari

(2000) and Al-Qurtubi (2007) interpret as referring to both spiritual and psychological healing, a reminder that spiritual recitation can soothe the heart but does not preclude other forms of treatment. Most significantly, Allah says, “Say, O My servants who have transgressed against themselves, do not despair of the mercy of Allah. Indeed, Allah forgives all sins” (Qur’an 39:53). This verse, often cited in mental health khutbahs and spiritual care, addresses the despair and shame that accompany depression and trauma, offering reassurance that divine mercy surpasses human failure or emotional struggle (Al-Tabari, 2000; Al-Qurtubi, 2007).

A study by Al-Krenawi (2019) highlighted that Muslims do prefer religious-based support over psychological support; in many communities, imams and faith leaders serve as the main and sometimes only support for emotional distress. While imams can provide valuable support, they may not be trained in proper mental health interventions. Also, the stigma around mental health illness can result in silence, avoidance of proper treatments, or spiritualizing the psychological disorders (Al-Krenawi, 2019).

Purpose Statement

The purpose of this study is to explore how Islamic beliefs and cultural norms shape mental health perceptions, coping mechanisms, and treatment-seeking behaviours among Muslims in Canada. By exploring barriers to mental health, including stigma, religious misinterpretations, and systemic challenges, the study aims to uncover reasons that prevent Muslims from accessing professional mental health care. It also includes evaluating the effectiveness of cultural and faith-based interventions that align with the teachings and values of Islam in improving accessibility and treatment outcomes.

The significance of this study offers insight on how cultural and religious beliefs influence the challenges Muslims face when seeking mental health care. It looks to incorporate

Islamic perspectives to promote a better understanding of how mental health care can be approached in ways that resonate with the Muslim community. The study offers insights for mental health professionals, religious leaders, and policymakers to help develop culturally competent interventions tailored to Muslim communities. Additionally, the research aims to promote mental health awareness, reduce stigma, and provide evidence-based recommendations that integrate both psychological and spiritual well-being for better mental health outcomes among Muslims. The research question to guide this capstone project asks, how do cultural influences and religious beliefs impact mental health perceptions and help-seeking behaviours among Muslims in Canada? A secondary research focus includes the exploration of culturally integrated interventions that can improve mental health support.

Theoretical Framework

This research is guided by three complementary frameworks: religious coping theory, intersectionality theory, and cultural humility. These perspectives provide a culturally responsive lens to explore how faith and identity shape mental health experiences among Muslims and how clinical and spiritual resources can be integrated. Religious coping theory offers an understanding of how spirituality and religious practices can serve as both protective and avoidant mechanisms in response to psychological distress. Proposed by Pargament (1997), this theory emphasizes that religious coping is not homogeneous; rather, it can manifest as positive coping when seeking spiritual support or reframing difficulties through faith or as negative coping when feeling punished by God or experiencing spiritual disconnection (Javaid et al., 2024). Through Islamic resources such as the Qur'an, the prophetic model of Prophet Muhammad, and the principles of *Usul al-fiqh*, among others, these enable Muslims to negotiate

the issues of life. Research in Muslim contexts confirms that religious coping is fundamental to understanding perceptions of wellness and approaches to distress (Javaid et al., 2024).

Intersectionality theory, introduced by Kimberlé Crenshaw in 1989, highlights how overlapping identities, such as religion, gender, immigration status, and ethnicity, can all shape the experience of accessing resources as well as marginalization (Finnegan, 2022). Ahmed and Mao (2024) stated that Muslims, especially women, often navigate complex sociocultural dynamics that influence their decisions on whether to seek mental health care. Holding cultural humility does not assume a fixed understanding of culture and faith. Cultural humility encourages an ongoing, reflexive approach to understand what an individual's expressions and needs are. Introduced by Tervalon and Murray-García (1998), this approach is beneficial in a mental health setting, as it has been shown to reduce perceived judgment and increase trust while working with racialized or religious communities (Tanhan, 2019).

These three frameworks together offer a strong foundation for examining the research question. Religious coping theory helps explain how Islamic beliefs shape the ways Muslims understand and respond to mental health challenges. Intersectionality theory highlights how overlapping identities such as religion, gender, ethnicity, and immigration status together can influence perceptions of mental health and access to care. Integrating cultural humility also adds a clinical lens by emphasizing the importance of non-judgmental, culturally responsive practice when working with Muslim clients. Together, these frameworks support a deeper understanding of how faith, identity, and cultural context shape mental health perceptions and help-seeking behaviours among Muslims in Canada. These frameworks support a respectful and critical exploration of how faith and identity shape responses to mental health challenges and how Muslim individuals negotiate between spiritual resources and mental health clinical support.

Methodology

This study is based on a comprehensive literature review. The research process involved identifying peer-reviewed articles, books, and research studies that explored the intersectionality between Islamic beliefs and mental health care among Muslim-identifying individuals. Sources were selected based on their relevance, credibility, and publication within the last five years, with a focus on recent studies from Canadian or Western contexts. Literature was selected based on emerging themes, including stigma, religious coping, barriers, and cultural competence. The literature review approach facilitated a critical synthesis of diverse perspectives and identified gaps in current research. A total of 24 articles were initially identified through the database and search engine queries. After screening titles and abstracts and applying the inclusion and exclusion criteria, 17 articles remained to inform the thematic analysis. The table summarizing the selected articles provides an overview of the scope, focus, and relevance of the studies included in this review (see Appendix A).

Literature Search Process

A systematic literature review was conducted to gather relevant articles for the thematic analysis. Primary databases were utilized, including City University and Cambridge University Library. Additionally, Research Gate, PubMed, and PsycNet were used to maximize the number of available articles. The following key terms and phrases were searched: mental health, Islam, Islam and mental health, Islamic culture, coping, coping strategies, stigma, barriers, mental health stigma, Islamic teachings, intersectionality, cultural interventions, spiritual beliefs, Muslims, Muslim communities, support systems for the Muslim community, mosque, and Imam.

The inclusion criteria for this research project required sources to be published within the last five years, be available in English, and have a focus on mental health perceptions, coping

mechanisms, treatment-seeking behaviours, or barriers to accessing mental health care in Muslim populations. Research sources that did not directly address the experiences or perspectives of Muslims regarding mental health were excluded. Additional exclusion criteria included scoping reviews, theoretical commentaries, and opinion pieces, studies focusing on the development or validation of psychological measurement tools without exploring lived experiences or beliefs, articles addressing general mental health without specifically exploring religious, cultural, or faith-based aspects related to Muslim populations, and studies focused solely on populations not relevant to the Muslim faith or cultural context, such as non-Muslim immigrant groups or general public health populations. To maintain the focus on culturally relevant themes, studies were also excluded if they examined mental health only in the context of forced migration, refugee status, or war trauma without connecting these experiences to religious or cultural interpretations of mental health. Additionally, dissertations and theses were excluded to ensure that only peer-reviewed, published literature informed the analysis.

Contribution to the Field

This capstone focuses on the intersection of Islamic belief systems and mental health services among Canadian Muslims, addressing a gap in the field of counselling. The study is addressing the complex relationship between faith, culture, and mental health within the Muslim community to understand the stigma, religious misinterpretations, and barriers that often prevent Muslims from seeking mental health support. The study explores how these factors shape mental health perceptions and care-seeking behaviours. By identifying faith-based and culturally integrated interventions, the research has the potential to offer mental health practitioners, policymakers, and religious leaders ways to provide accessible and effective mental health care for Muslims. Additionally, this study contributes to existing literature by bridging the gap

between mental health care and religious beliefs, challenging misconceptions, and advocating for more inclusive, culturally sensitive therapeutic approaches. Understanding these influences is crucial for reducing stigma, improving mental health literacy, and promoting interventions that align with both psychological and spiritual well-being.

Reflexivity and Positionality Statement

As a Muslim-identifying woman, the intersectionality between mental health and Islamic beliefs has been a stressing issue for me. I have seen people struggle with mental health but refuse to admit it or seek professional help. Instead, they turned to religious practices, which raised questions for me, especially considering how easily people seek medical attention for physical issues without hesitation or shame.

The idea of this capstone emerged from a deeply personal and reflective experience. During the years, I have seen many issues raised due to mistreated mental health. In 2009, I lost my childhood friend when her dad woke up one day and took his life along with his wife and children. This was my first exposure to the idea of mistreated mental health issues due to the fear of stigma; this incident left me devastated for years, trying to make sense of how someone as sweet and kind as her father could flip one day and wake up and kill the people he loves the most. Before dying at the hospital, he did confirm that he was protecting his family from danger by sending them to heaven. After I moved to Canada, I heard about an incident where a man, also with untreated mental health issues, killed his wife. His family members knew about his condition but agreed with him not to receive treatment because they were worried about the stigma and that the family would be known as people who carry mental health sickness. I remember being in shock. How can families watch someone mentally struggling to the point of destroying his family because of stigma?

Last year, while attending Friday prayer at a mosque in London, Ontario, the imam delivered a khutbah that highlighted the importance of mental health and emphasized the need for seeking professional support (Rajeh, 2024). He drew a powerful analogy comparing how people urgently seek medical health support when they break a limb yet often suffer in silence when faced with psychological distress. Rajeh acknowledged the value and importance of prayer and faith but stressed that spiritual practices should complement, not replace, professional mental health care. This message deeply resonated with me and reflected on the conflict I had observed within community members; it affirmed the concern surrounding mental health and stigma and the misconception that faith alone is sufficient to heal psychological suffering, although this is against the Islamic teachings that stress the importance of seeking the proper treatment for every disease to stay healthy and strong. That khutbah was a turning point that stressed my desire to explore that topic academically and professionally.

While my own experiences brought me to this topic, they also influence how I read and understand the research. Having seen the impact of untreated mental health in Muslim communities, it would be easy for me to assume that every study should point in the same direction or confirm what I have witnessed. Because of that, I paid close attention to moments when my emotions or expectations surfaced, reminding myself to focus on what the researchers were actually saying. I also included studies that offered different perspectives, for example, showing positive religious coping, strong community support, or helpful collaborations between faith and mental health. Being mindful of these influences helped me stay grounded in the evidence rather than my assumptions and allowed me to approach the literature with greater balance and honesty.

Definition of Terms

Cultural Humility

A lifelong, reflective practice where professionals recognize their cultural limitations and strive to understand the identities, values, and needs of others. It emphasizes openness, empathy, and the reduction of power imbalances in therapeutic relationships, particularly with culturally diverse populations (Tanhan, 2019).

Faith-Based Interventions

Supportive strategies or programs that incorporate spiritual or religious elements to promote well-being. Among Muslims, this may include Qur'anic counselling, imam-led support, or integration of Islamic teachings with psychological approaches (Hassan et al., 2021).

Help-Seeking Behavior

The process by which individuals recognize distress and seek support through formal (e.g., therapy) or informal (e.g., religious leaders, family) means. In Muslim communities, help-seeking is shaped by stigma, cultural norms, and religious values (McLaughlin et al., 2022).

Imam

A religious leader in the Muslim community who leads prayers, provides religious guidance, and is often turned to for emotional or spiritual support. While imams may offer comfort, they may not be trained in evidence-based mental health interventions (Al-Krenawi, 2019).

Islamophobia

Prejudice, discrimination, or hostility directed toward Islam or Muslims. Islamophobia has been shown to negatively impact the mental well-being of Muslims and discourage their engagement with healthcare systems (Zia & Mackenzie, 2022).

Khutbah

A formal sermon delivered during the Friday (Jumu'ah) congregational prayer in Islam. The khutbah provides religious guidance and is increasingly used to address community issues, including mental health, by encouraging help-seeking and reducing stigma.

Mental Health Stigma

Negative beliefs or attitudes about mental illness that result in shame, denial, or avoidance of treatment. In Muslim communities, stigma may be tied to perceptions of weak faith, spiritual failure, or fear of social exclusion (Ahad et al., 2023).

Prayer (Salat/Du'a)

Key practices in Islam. Salat refers to the five daily ritual prayers, while du'a refers to informal personal supplications. Both are often employed as religious coping strategies during times of distress (Javaid et al., 2024).

Religious Coping

Strategies that individuals use to manage distress through their religious beliefs and practices. Religious coping can be either positive (e.g., trusting in God, praying) or negative (e.g., spiritual guilt, feeling punished by God). Among Muslims, religious coping is a typical first response to psychological distress (Javaid et al., 2024).

Spiritualization of Mental Illness

Believing that mental health issues are solely spiritual, often leading to the avoidance of psychological interventions. This can result in delayed treatment or increased suffering (Al-Krenawi, 2019).

Stigma

A mark of shame or disapproval associated with a particular condition or identity. In the context of mental health, stigma discourages open discussion, disclosure, and timely treatment—especially in communities where mental illness is seen as taboo or a sign of personal weakness (Ahad et al., 2023).

Usul al-Fiqh

The foundational principles of Islamic jurisprudence that guide legal and ethical decision-making. These principles support seeking knowledge and treatment and can be used to promote mental health care as a religiously permissible and encouraged act (Javaid et al., 2024).

Outline of Capstone Chapters

This capstone is organized into three chapters. Chapter 1 introduced the research topic and background, and outlined the purpose, research question, theoretical framework, and definitions of key terms. Chapter 2 offers an in-depth, thematic analysis of existing literature related to Islamic beliefs and mental health, particularly within the Canadian Muslim context. The chapter is structured around key themes that are directly relevant to the research question, including mental health stigma, religious coping, cultural and structural barriers to care, and the role of religious leadership. Each theme is explored by synthesizing current peer-reviewed research, identifying both areas of agreement and divergence in the literature. The chapter emphasizes analysis over description by drawing connections between studies, critiquing methodologies and underlying assumptions, and identifying theoretical and practical gaps, particularly regarding faith-informed interventions.

Chapter 3 provides a critical discussion and interpretation of the findings from the literature review and connects them to practical applications in the field of mental health and

culturally responsive care. This chapter revisits the research purpose and question, explores structural limitations in the current literature, including the dominance of Western psychological frameworks, and proposes culturally aligned practices such as therapeutic frameworks, collaborations with religious leaders, and psychoeducational initiatives. The study will conclude with a personal reflection on the learning process, revisiting my positionality and highlighting any shifts in understanding, as well as professional growth and implications for future clinical and community work.

Chapter 2: Literature Review

This chapter reviews what recent research says about how Islamic beliefs, cultural values, and lived experiences shape the way Muslims understand mental health and decide whether to seek help. While mental health stigma, religious coping, and systemic barriers have been widely explored, much of the research lacks a culturally responsive integration of Islamic teachings. Although studies mention Islamic beliefs or cultural influences, they are often discussed briefly without fully exploring how faith, identity, and social context intersect in lived experiences. To discuss and review these patterns, this chapter is grounded in three key frameworks: religious coping theory (Pargament, 1997), intersectionality theory (Finnegan, 2022), and cultural humility (Tervalon & Murray-García, 1998). Together, these frameworks help understand of how faith, culture, and mental health are deeply connected and influence one another in complex ways.

This chapter is organized in themes that arose from the findings. The literature themes are stigma and misconception influences on mental health, effects of coping mechanisms and faith-based responses on help-seeking, and the barriers to mental health care and culturally responsive interventions. As the review unfolds, I also points out the gaps within the literature, such as the lack of Canadian-focused studies, limited attention to intersectional experiences, and the need for more culturally responsive therapeutic models.

Stigma and Misconceptions about Mental Health in Muslim Communities

Stigma remains one of the significant obstacles when it comes to accessing mental health care in many Muslim communities (Rajeh, 2024). Mental health struggles are often misunderstood, sometimes seen as a sign of weak faith or not being spiritually devoted enough, or even explained through supernatural beliefs like jinn possession or the evil eye (Ahad et al., 2023). These misconceptions may contribute to shame, silence, and a reluctance to seek

professional help, with many individuals turning to informal support or religious practices instead of mental health services (Fekih-Romdhane et al., 2023). Feelings of shame, pressure from the community, and personal self-judgment may contribute to the belief that mental health struggles should be kept private or dealt with by becoming more religious instead of seeking help from a therapist or mental health professional (York & Awan, 2023).

Religious Interpretations and Spiritualization of Mental Illness

For Muslims, mental health challenges are often viewed through a religious lens, seen as a sign of spiritual weakness, a form of divine punishment, or even the result of supernatural forces like possession (Al Krenawi, 2019; Alqasir & Ohtsuka, 2023; Bagasra, 2023). While rooted in cultural traditions, these beliefs may delay or prevent professional intervention. Alqasir and Ohtsuka (2023) conducted a qualitative study to explore how religious and cultural beliefs and superstitions shape Muslims' understanding of mental disorders and preferred treatment approaches. The researchers interviewed 12 Arab Muslim participants from Egypt, Saudi Arabia, and Sudan, all residing in Melbourne, Australia, and found that most attributed mental illness to supernatural causes such as jinn possession, the evil eye, magic, or divine punishment. These beliefs and misinterpretation of Islamic texts, as well as cultural teachings, often led participants to seek help from religious or traditional healers rather than professional mental health services. Mental wellness was frequently associated with a strong relationship with God. Despite consistent religious practice, many participants refrained from identifying as highly religious, a finding attributed to cultural and religious modesty norms.

The study found that many participants had serious misunderstandings about mental health. For instance, some confused schizophrenia with dissociative identity disorder, while others were unfamiliar with conditions like post-traumatic stress disorder. Instead of turning to

mental health professionals or trusted resources, most relied on Islamic websites or religious texts to make sense of what they or others were going through. Stigma was a salient issue; participants described fear of being labelled crazy or bringing shame to their families, which discouraged help-seeking. Interestingly, the single participant with mental health field experience demonstrated better understanding, suggesting that psychoeducation and mental health knowledge can shift people's attitude towards mental health (Alqasir & Ohtsuka, 2023).

While the study offers important insights into how cultural practices and misinterpretation of Islamic teachings influence mental health beliefs and behaviours, it is limited by a small, geographically specific sample. It does not explore the experiences of diverse Muslim groups. Furthermore, it does not examine culturally integrated interventions or the influence of acculturation and formal education. Further research on how culturally and religiously informed psychoeducational strategies can support Muslim communities is needed.

Bagasra (2023) employed a mixed-methods approach to examine how religious interpretations influence the conceptualization of mental illness and help-seeking behaviours among Muslims in North America. The study gathered responses from 255 participants and looked at their answers to open-ended survey questions. It focused on how they view mental illness through an Islamic spiritual lens and how their religious beliefs shape their experiences with mental health support. The findings of the study showed that participants held both protective and obstructive theological beliefs, with some reporting viewing mental illness as a test from God and that they need to show resilience, while others interpreted mental health as punishment for a sin they committed, fostering shame and stigma. These views influenced participants' willingness to seek professional mental health support (Bagasra, 2023). The study pointed to several key barriers that keep many Muslims from accessing mental health care. These

included fear of being misunderstood or judged by providers, limited knowledge about mental health, stigma, and discomfort with Western approaches to treatment. Islamophobia also played a role, particularly for immigrants and refugees, adding to feelings of exclusion and emotional strain (Bagasra, 2023).

While Bagasra emphasized how valuable it is to integrate Islamic teachings into therapy and align services with clients' faith, the study did not explore how differences in religiosity or cultural background might affect the way people relate to their faith or interpret mental health. Even so, the results align with evidence of underutilization among Muslim Americans (Zia & Mackenzie, 2022). The study also reinforces calls for spiritually integrated care and affirms the growing availability of resources and training for culturally responsive practice (Saherwala et al., 2021). Further research should address distinctions in religiosity, cultural heritage, and migration background to tailor mental health interventions for diverse groups. This aligns directly with the research questions proposed in this capstone, understanding the impact of cultural influences on mental health perceptions and help-seeking behaviours among Muslims in Canada.

Social and Cultural Dimensions of Stigma

Stigma is consistently identified as a major reason why many Muslims hesitate to seek mental health support. In particular, when stigma becomes internalized, it often leads to more negative attitudes about getting help (Ahad et al., 2023; Fekih-Romdhane et al., 2023; Khanthavudh et al., 2025). Ahad et al. (2023), in a literature review study, found that mental health within Muslim communities is usually stigmatized, which may lead to reluctance to seek help. Stigma produces poor health outcomes, increased morbidity, and reduced the quality of life for people with mental health conditions. The study posited that stigma is shaped by societal norms, values, and beliefs, and it can differ by demographic factors such as gender.

The study highlighted the ripple effect of stigma among Muslim individuals, families, and healthcare providers, suggesting different strategies such as public awareness campaigns, cultural competency training, peer support programs, and community-based services, stressing how clinicians' cultural sensitivity is critical in reducing stigma and improving early diagnosis and treatment (Ahad et al., 2023). Although the study offers a valuable cross-cultural perspective, it remains general, draws on no empirical data, and focuses on Muslims in Canada. These gaps point to the need for research that looks more closely at how stigma connects with cultural influences and religious beliefs in shaping mental health perceptions and help-seeking.

Fekih Romdhane et al. (2023) conducted a large-scale quantitative study with 9,782 Muslim participants to examine the moderating role of mental illness stigma in the relationship between religiosity and help-seeking attitudes. Using validated Arabic instruments, the researchers found that religiosity was generally associated with more favourable help-seeking attitudes but only when stigma levels were low to moderate. Among individuals with high stigma, religiosity was negatively associated with help-seeking (Fekih-Romdhane et al., 2023). These findings challenge the idea that being religious always stops Muslims from seeking help. In fact, when stigma is reduced, religiosity can actually encourage people to reach out for support. Despite the study’s large sample, limitations include its cross-sectional design, overrepresentation of female participants, and lack of self-stigma data. Longitudinal, cross-cultural research including non-Arab Muslim samples is needed to test culturally informed anti-stigma interventions.

Building on the idea that help-seeking is shaped by more than individual attitudes, Basri et al. (2022), in a qualitative study, explored how South Asian Muslim American college students navigate cultural expectations and personal mental health needs. Participants reported

pressure to meet family or community expectations, and many avoided therapy out of fear of being judged or facing social backlash (Basri et al., 2022). While the study offers meaningful insight, it mainly reflects the experiences of young, educated individuals, so it does not necessarily speak for the wider Muslim community. It also did not explore how things like religious education or involvement in mosque life might shape people's views on mental health.

When the two studies by Fekih Romdhane et al. (2023) and Basri et al. (2022) are considered together, they show that both cultural pressures and religious beliefs shape help-seeking, but in different ways depending on how stigma operates within a person's environment. This reinforces the need to examine these dynamics among Muslims in Canada, where migration experiences, community structures, and diverse cultural backgrounds may influence how stigma, culture, and religion come together. This is exactly what the research question in this capstone seeks to explore.

Taha (2021), in a qualitative study focusing on Canadian Muslims' counselling experiences, reported that stigma was not limited to internal or cultural sources but was often reinforced inside counselling spaces themselves. Participants recounted incidents where counsellors made Islamophobic comments, showed little understanding of Islamic practices such as hijab (head scarf), prayer, or fasting, and even invalidated clients' faith-based coping strategies. These experiences created feelings of being stereotyped and marginalized, which discouraged participants from returning to therapy. Some participants reported a sense of cultural unsafety in treatment, where they felt they had to educate the counsellor about Islam or downplay their faith to be understood. Such dynamics amplified self-stigma and reinforced community fears that seeking therapy might expose one to judgment or bias. Importantly, participants noted that the lack of Muslim or culturally competent counsellors meant that stigma

was compounded by a sense of isolation and invisibility within the Canadian mental health system (Taha, 2021). While the study provides valuable insights, it has several limitations. Participants were Canadian-born Muslims or early-age immigrants, excluding newcomers and refugees with diverse counselling experiences. The sample was also focused on young and highly educated individuals, narrowing its relevance for older adults or those with less formal schooling. Requiring English fluency may have led to excluding older immigrants or recent arrivals who may have needed translation. These limitations point to the need for further research on how cultural and religious factors shape mental health perceptions and help-seeking among Muslims in Canada, which is the main focus of this capstone.

Zia and Mackenzie (2022) conducted a quantitative study exploring how internalized stigma influences help-seeking attitudes among Canadian Muslims. They tested the internalized stigma model with 238 participants recruited through community channels and confirmed a serial mediation pathway: public stigma → self-stigma → negative attitudes → diminished help-seeking intentions. Neither acculturation nor enculturation moderated these links, indicating that internalized stigma is a barrier regardless of cultural adaptation. Strengths include diverse sampling and statistical controls; limitations involve reliance on self-report and limited power to detect subtle effects. The authors urge larger studies examining systemic barriers and culturally tailored anti-stigma interventions (Zia & Mackenzie, 2022).

Coping Mechanisms and Faith-Based Responses to Mental Health

Faith plays an important role in the way Muslims perceive and respond to psychological distress; some rely on spiritual coping strategies such as prayer, reading the Qur'an, seeking guidance from religious leaders, and placing trust in God's will, rather than immediately turning to clinical interventions. These practices may offer comfort, meaning, and resilience in the face

of adversity, especially among those who have experienced trauma, displacement, or discrimination (Kanu & Nosike, 2025; Rutledge, 2025). However, while faith-based coping can promote psychological well-being and post-traumatic growth, certain maladaptive forms, such as viewing suffering as divine punishment or suppressing emotions in the name of piety, can delay treatment and intensify distress (Kanu & Nosike, 2025). This theme explores the dual nature of religious coping and the concept of integrating faith-based strengths into culturally sensitive therapeutic models.

Positive Religious Coping

Religious coping theory posits that faith can offer comfort and meaning during psychological distress (Pargament, 1997). Albatnuni and Koszycki (2020) examined how Muslim prayer contributes to subjective well-being among Canadian Muslims. Using a sample of 155 participants recruited online, the authors tested a parallel multiple mediator model to explore how the frequency and duration of both obligatory and voluntary prayers influenced well-being through four mediators: optimism, spirituality, mindfulness, and social support. Albatnuni and Koszycki (2020) revealed that spirituality and optimism have a significant effect on the relationship between prayer and well-being, while mindfulness and social support, though correlated with prayer, did not have any effect. Spirituality was linked to prayer frequency and duration, underscoring its central role in the connection between prayer and well-being (Albatnuni & Koszycki, 2020).

The strengths of the study lie in its culturally sensitive design, robust statistical modelling, and the differentiation between prayer types. However, limitations such as cross-sectional design, overrepresentation of women participants (78.7%), reliance on self-reporting, and the absence of a state mindfulness measure, which may have better captured intentional

awareness during prayer. Future longitudinal and experimental work with gender-balanced samples and explicit intrinsic versus extrinsic religiosity measures may clarify mechanisms unique to Muslim populations. The findings support inclusion of spiritually integrated practices in mental health interventions for Muslims, especially refugees and immigrants who frequently engage in religious coping. This study highlights how spiritual beliefs and religious practices shape mental health perceptions and coping among Muslims, demonstrating why it is essential to examine how these factors influence help-seeking in the Canadian context.

Alsubaei et al. (2021), in another study, investigated how religious coping promotes post-traumatic growth in forcibly displaced, trauma-exposed Muslims and whether this is conditioned by perceived discrimination. Using a global MTurk sample and the Muslim Religious Coping Modified scale, the authors confirmed that more frequent religious coping predicted higher post-traumatic growth, replicating positive associations reported in Muslim refugee studies and in broader trauma samples (Alsubaie et al., 2021; Jehangir et al., 2024). Although the overall interaction with discrimination was non-significant, simple slope probes showed the coping → post-traumatic growth path strengthened at moderate to high discrimination levels, echoing the rejection identification model may intensify in-group religious identification (Alsubaie et al., 2021). Post-analyses revealed that social and social behavioural coping items, such as attending mosque events, were the principal drivers of growth, underscoring Pargament's (1997) contention that religion furnishes meaning, communal support, and life transformation.

The study highlights that religious coping plays an important role in how Muslims make sense of trauma and move toward growth. This connects to the research question because it demonstrates how religious beliefs and culturally rooted coping strategies shape the way mental health is understood, as well as how these factors may influence whether someone feels able or

willing to seek support. For Muslims in Canada, many of whom experience discrimination, the finding that religious coping may become even more influential underscores the importance of understanding how cultural and spiritual factors shape help-seeking behaviours.

Building on these foundations, Javaid et al. (2024) explored religious coping and mental health wellbeing within Muslim university students. The findings of the study stressed that positive religious coping, such as Qur'anic recitation, prayer, and seeking comfort and meaning through faith, was consistently linked to lower stress, higher emotional resilience, and greater life satisfaction. Negative coping, including guilt, self-blame, and doubt, was associated with heightened distress and anxiety. The review emphasized that faith-based coping should be understood within its cultural and developmental context, recommending that mental health interventions for Muslim students integrate spirituality and cultural sensitivity to strengthen adaptive coping and resilience. This study adds valuable contemporary evidence supporting the protective role of religion in mental health and reinforces the need for faith-integrated, culturally responsive counselling approaches (Javaid et al., 2024).

However, the study focused on university students from South Asia and the Middle East, limiting generalizability to Muslims in Western minority contexts such as Canada. Samples were largely homogeneous, young, educated, and moderately to highly religious. The study excluded newcomers, refugees, and less religious individuals. In addition, the study primarily used quantitative self-report measures, offering little insight into how faith is experienced in everyday life across different cultures. Addressing these gaps would deepen the understanding of how Muslim individuals draw upon faith as a resource for psychological well-being and resilience. These gaps highlight why the present research question is important, as it seeks to understand how cultural influences and religious beliefs shape mental health perceptions and help-seeking

behaviours among Muslims in Canada, whose lived experiences may differ substantially from those represented in this study.

Negative Religious Coping and Delayed Treatment

While turning to faith can bring comfort and strength during difficult times, it is not helpful in every form. Some people experience what is called negative religious coping, like feeling abandoned or believing they are being punished, which is associated with heightened distress and reduce help-seeking (Kanu & Nosike, 2025). Bagasra (2023) points out that such beliefs, including spiritual guilt and viewing struggles as divine punishment, are strongly linked to delayed treatment. Within a Muslim immigrant sample, "spiritual bypass," which is defined by avoiding psychological distress under religious pretexts, was strongly linked to increased self-stigma and negative help-seeking attitudes (Ahmad et al., 2023, p. 45). The study indicates that negative religious coping is consistently correlated with psychological symptoms across diverse trauma-exposed groups. These findings implicate that negative coping styles, such as feeling abandoned or punished by God, are barriers to mental well-being and accessing timely treatment (Bagasra, 2023).

Despite identifying these harmful patterns, there is a gap in the current research in evaluating practical solutions for reframing negative religious beliefs, as few interventions have been developed to counteract religious guilt or divine punishment perceptions. This gap highlights the need for culturally and spiritually sensitive therapeutic frameworks. For instance, integrating spiritually informed cognitive reframing may help reframe punitive divine beliefs into more compassionate understandings of religious teachings such as divine mercy and unconditional forgiveness. Encouraging participation in supportive faith communities could also mitigate spiritual guilt and promote timely help-seeking.

Role of Imams and Religious Leaders

Imams and religious leaders play a key role in shaping how mental health is understood and approached in many Muslim communities. Because they are trusted and respected, people often turn to them first when struggling emotionally, especially in places where mental illness is still misunderstood or carries stigma (Humam et al., 2023). Recent research suggests that faith leaders can do more than offer spiritual support; they can also help guide people toward professional mental health services by offering referrals and education in a way that feels culturally and religiously safe (Humam et al., 2023). Involving imams in mental health efforts could be a meaningful way to connect spiritual care with emotional well-being. This highlights how cultural and religious factors, specifically the influence of trusted faith leaders, can shape how Muslims understand mental health and where they turn for help, which directly affects help-seeking behaviours within the Muslim community.

Muse (2024) also found that imams are often the first people Muslims reach out to during emotional distress but noted that most do not have the training to deal with mental health issues. While Muse suggested building stronger partnerships between therapists and religious leaders, the study neglected to include evidence to show how well that approach works in practice. Muse (2024) highlights the mental health challenges and barriers faced by the Muslim communities, such as Islamophobia and cultural stigma, emphasizing the need for culturally competent therapists who understand Islam and Muslim culture, as well as integrating mental health services into community spaces like mosques. Muse (2024) also recommends training religious leaders to offer essential support; since Muslims often have access to Muslim leaders and imams, training them to offer essential support would help the community with mental health care and reduce the stigma around mental health. Some barriers mentioned to be addressed were fair

salaries, professional development, and policies addressing systemic barriers such as poverty, lack of insurance, and immigration status, which could make mental health care less accessible to people. The study provides practical tips for finding a culturally competent therapist who understands and respects the unique needs of Muslim clients, understands Islamic principles and practices, and has cultural sensitivity and empathy. The study stresses the importance of finding the right fit and reminds individuals that they are not alone, with many resources available to support them (Muse, 2024). These insights relate directly to the research question, as they illustrate how cultural influences, religious beliefs, and structural barriers shape mental health perceptions and help-seeking behaviours among Muslims. These issues are particularly relevant in the Canadian context.

Zia et al. (2022) found that engagement with imams with regard to mental health concerns was notably low among Muslims in some cities in Canada despite their cultural prominence. The study suggested that this underutilization may be due to a lack of perceived competence or training among religious leaders to handle psychological issues (Zia et al., 2022). Zia et al. suggested training imams and religious leaders; however, how imams could be systematically incorporated into therapeutic frameworks was not investigated, leaving a gap in translating trust into intervention. In contrast, Ahmed and Mao (2024) explored the mental health beliefs of Muslim immigrant women in Canada. They found that participants trust religious leaders more than unfamiliar Western-trained therapists. This finding indicates a clear opportunity to leverage imams as bridges between communities and formal mental health services. Ahmed and Mao suggested religious figures such as imams could act as cultural mediators to reframe psychological distress in religious terms as well as facilitate referrals to culturally competent care (Ahmed & Mao, 2024). While rich in depth and cultural insight,

Ahmed and Mao's qualitative methodology limits the generalizability of their findings. Their study was also primarily focused on women, leaving the question of whether similar trust patterns exist among Muslim men or across different sectarian lines (e.g., Sunni vs. Shia communities). These findings connect directly to the research question, as they demonstrate how cultural and religious influences, particularly the strong trust placed in imams, shape how Muslim immigrants in Canada understand mental health and decide whether to seek professional help.

Barriers to Mental Health Care and Culturally Responsive Interventions

Minority Muslim communities in Western countries encounter a range of intersecting barriers to accessing mental health care, including stigma, cultural misconceptions, language challenges, and a dearth of culturally competent providers. Religiosity can simultaneously obstruct and facilitate engagement with services depending on prevailing stigma (Ghuloum et al., 2024). Culturally responsive interventions, such as training providers in Islamic health principles, partnering with community and religious leaders, and delivering psychoeducation grounded in Islamic values, are gaining traction as strategies to close the mental health gap (Fekih-Romdhane et al., 2023).

Structural and Systemic Barriers

McLaughlin and colleagues (2022) researched why Muslims, especially in Western countries, hold back from getting mental health support through a mixed-methods study with 350 participants. The findings show a combination of external pressures, such as Islamophobia, fear of being misunderstood, concerns about cultural mismatch, and internal struggles of stigma and worry about being judged. These pressures affect how community members feel about stress and whether they would consider therapy. One of the strengths of McLaughlin et al. study is the use

of both quantitative data and open-ended responses, allowing for the capture not only of statistical patterns but also of the lived language and concerns that Muslims voiced around therapy. The study also used validated measures and a clear theoretical model to examine how Islamophobia and self-stigma may influence attitudes toward help-seeking, which added depth. Additionally, the large and diverse sample strengthened the credibility of the findings, and the inclusion of questions about therapist preferences and faith-based support made the study directly relevant for clinicians and service providers working with Muslim communities.

Despite these contributions, the study had several challenges and limitations. Recruitment was online, which may exclude older Muslims, those less connected, or those not comfortable completing surveys in English, limiting the extent to which the results can be generalized. The use of short written responses rather than interviews or focus groups somewhat limited the depth of participants' experiences. Another challenge is that the study focused mainly on identifying barriers, rather than on what could actually help. Nothing was tested or tried in practice, so we are left knowing the problem but not the pathways forward. Although the authors highlighted important issues of stigma, trust, and cultural misunderstanding, they did not offer concrete, evidence-based strategies to address them, especially when working with imams or other community leaders. Lastly, the cross-sectional method means we cannot conclude that Islamophobia causes higher stigma or reduced help-seeking. Future research should explore approaches, such as community-based programs or faith-integrated supports, to determine what actually improves help-seeking and strengthens the relationship between Muslims and mental health services.

Reich et al. (2024) looked at how young immigrant Muslim women in Quebec experience mental health care, especially as they navigate the challenges of culture, gender, and systemic

barriers. Many of the women in the study said they were unhappy with the support they received, pointing to issues like language barriers, a lack of cultural understanding, and therapists who did not seem to get their religious values. Some felt judged or misunderstood when they talked about things like modesty, family expectations, or their faith, and this disconnect often led them to stop therapy early or not come back at all (Reich et al., 2024). Reich et al. (2024) did highlight the need for more culturally sensitive care in a detailed way, yet the study did not go beyond observing the problems. It did not test out solutions or offer clear steps for how services could better support Muslim immigrant women, which is an important gap. Future research should prioritize implementing and assessing culturally adapted models such as therapist training in religious literacy, use of culturally matched providers, or faith-informed psychoeducation to address the unmet needs identified in this study.

Taha (2021) suggested that the barriers Canadian Muslims face are not just cultural or personal; some of these barriers are rooted in systemic inequities and Islamophobia. Through semi-structured interviews conducted with six participants, aged 22–30 years old, participants described how their hesitation to seek counselling was tied to a broader social climate marked by anti-Muslim hate crimes, discriminatory policies, and the surveillance of Muslim organizations. These experiences created feelings of hypervisibility and mistrust, which often carried into the counselling room. Some clients worried that what they shared could be misunderstood or judged through a racialized or securitized lens, making them less willing to be fully open in therapy. Others spoke about the lack of institutional support for Muslim counsellors and the absence of services that acknowledged Islamic worldviews, which deepened perceptions that mainstream counselling was not designed for them. Taha's findings emphasize that mental health stigma among Muslims cannot be fully understood without situating it in the Canadian socio-political

context, where structural Islamophobia and systemic discrimination intersect with cultural stigma to shape help-seeking behaviours. Addressing these barriers, therefore, requires cultural competence at the clinical level and systemic reforms that build trust and demonstrate accountability to Muslim communities (Taha, 2021). The study directly supports the research question, as it shows that Muslim help-seeking in Canada is shaped by more than cultural or personal beliefs; the wider social and political environment also influences it.

AlHarbi et al. (2023) examined mental health beliefs in Muslim communities and cognitive behavioural therapy acceptability. Their study highlights that Muslims have the lowest mental health recovery rate among other religious groups, pointing to significant barriers that affect recovery. These barriers exist at four levels: individual, cultural, provider, and management. Individually, when mental health struggles are attributed to religious causes like jinn possession or weak faith, it reinforces stigma. Language barriers, gender norms, and family reputation concerns also limit access. At the provider level, Muslims often present with physical symptoms rather than seeking mental health care directly. The study emphasizes the need for culturally sensitive therapy, faith-integrated approaches, collaboration with religious leaders, and therapist training on Islamic perspectives to improve mental health accessibility and effectiveness (AlHarbi et al., 2023).

Although the AlHarbi et al. study provides valuable insight, it lacks recommendations for clinician training; the findings may not be transferable across all Muslim communities, as it only includes publications in English or Arabic, excluding research in other languages. It focuses on adult Muslims with and without cognitive behaviour therapy treatment experience and only considers published studies, which could raise concerns about publication bias. The study does not differentiate between various Muslim communities and sects, which makes generalization of

the findings difficult. Research on practical training modules for therapists working with Muslim clients would be needed. The findings of the study illustrate how cultural influences and religious beliefs shape mental health perceptions and help-seeking behaviours among Muslims, which is directly related to the research question. Additionally, the study's emphasis on the need for faith-integrated therapeutic approaches, collaboration with religious leaders, and the importance of adapting culturally informed interventions that directly connects to the secondary focus of this capstone, on exploring culturally adapted interventions that can enhance mental health support.

The Need for Culturally and Religiously Integrated Therapy

Ahmed and Mao (2024) employed an intersectional approach to examine beliefs and attitudes toward mental health issues among Muslim immigrant women in Canada using four focus groups of 21 participants in Ottawa, Canada. The study focused on three main themes: stressors, mental health care seeking, and utilizing coping strategies. The survey data emphasized that for many Muslim women in Canada, culturally sensitive therapy must account for modesty norms, gender roles, and trust in religious authorities. Their qualitative findings suggest that therapeutic rapport is harder to establish when clients feel the therapist lacks familiarity with Islamic values. This disconnect could lead the clients to feel misunderstood or judged, as well as discourage them from continuing therapy (Ahmed & Mao, 2024).

Ahmed and Mao (2024) highlight how religious leaders are often seen as more trustworthy sources of support than unfamiliar mental health professionals. The study stressed the importance of integrating spiritual and cultural considerations into clinical practice. This highlights the importance of culturally and religiously integrated therapy models that align with clients' culture and values. The small sample size of the study and the lack of outcome data limit

the study's generalizability. The findings of the study connect closely to the focus of the capstone, as it shows how cultural expectations and religious beliefs affect the way Muslims understand mental health and decide whether to seek help. The participants reported that they often prefer approaching imams rather than therapists, which reflects how trust, familiarity with Islamic values, and cultural beliefs influence help-seeking behaviours. These findings offer insight to why some Muslims may hesitate to approach therapists despite experiencing significant mental health challenges and stress. The study also highlights the need for therapists to work in ways that respect modesty norms and religious frameworks, areas directly related to this capstone's interest in culturally and spiritually integrated approaches. While the sample size is small and limited to women, the study still offers meaningful perspectives on the kinds of barriers. It supports shaping mental health experiences for Muslims living in Canada.

Muse (2024) provided practical recommendations for finding culturally competent therapists, including seeking providers familiar with Islamic principles, community-based mental health initiatives, and collaborative models involving mosques. The study underscored the need for the support to train therapists and understand broader barriers such as poverty and immigration status, which affect Muslim communities. While the study offers helpful, real-world advice and highlights important systemic needs, it remains more advocacy-oriented and lacks empirical validation of its suggestions (Muse, 2024). With similar results, Ibrahim and Whitley (2020), in a narrative review, advocated for faith-integrated therapy models, stressing the lack of large-scale empirical studies demonstrating improved outcomes. The review suggests that while these models are conceptually compelling, they still need testing and stronger evidence before they can be widely implemented within mainstream mental health systems. This highlights a

significant research gap: the need for data-driven approaches to culturally and religiously integrated care (Ibrahim & Whitley, 2020).

Hassan et al. (2021) explored whether a spiritually adapted psychoeducational program could reduce addiction-related stigma and encourage help-seeking among Muslims in Canada. The program was delivered in mosque settings with the aim to make mental health education more accessible and acceptable by rooting it in Islamic values. The study found that participants not only gained accurate knowledge about addiction but also showed reduced stigma and increased willingness to seek professional help (Hassan et al., 2021). This study underscores how faith-based approaches that are held in trusted spaces can bridge the gap between communities and care systems. Hassan et al.'s use of a community-based participatory research model involved Muslim community members in the design process to ensure cultural resonance. A mixed-methods approach with pre- and post-program surveys along with qualitative interviews captured both measurable and personal outcomes. Ninety-three Muslim adults participated across nine mosques in Toronto. While promising, the study had limitations, including a small sample size, absence of a control group, and short follow-up period. Hassan et al. (2021) also recommend scaling up such efforts with more diverse samples and evaluating long-term outcomes. This work supports a growing movement in the mental health field from one-size-fits-all interventions to approaches that meet communities where they are. Ultimately, it shows how mosque-based outreach and faith-integrated models can play a powerful role in reducing stigma and encouraging mental health service use among Muslim populations.

Compared to broader studies like AlHarbi et al. (2023), which focus on barriers such as stigma and somatic presentation of symptoms, Hassan et al.'s work offers a tangible, community-driven model for reducing stigma and improving access. It challenges the idea that

secular interventions alone are enough, showing how culturally embedded programs can make mental health support more approachable and effective. The study opens doors for adapting this model to other mental health issues such as anxiety, depression, or trauma. The study proves how culturally and religiously informed interventions can influence mental health perceptions and help-seeking behaviours among Muslims. When mental health support reflects Islamic values, respects cultural norms, and is delivered through trusted community spaces, stigma decreases and engagement with services improves (Hassan et al., 2021). This supports the secondary question of this capstone, which is to explore culturally integrated approaches that strengthen mental health support for Muslims in Canada. By showing that secular models alone may not be sufficient, the study highlights why culturally tailored programs may be more effective, reinforcing the central argument that cultural and religious contexts play a significant role in how mental health is understood and accessed.

Community-Based and Preventative Approaches

Community initiatives try to meet Muslims where they already gather and feel safe, such as mosques, khutbahs, student clubs, helplines, and other grassroots spaces to provide prevention, early identification, and stigma reduction before a crisis requires formal clinical care (Abu-Ras et al., 2024). These programs share three core elements: familiar venues (e.g., Friday sermons, mosque seminars, peer groups) that lower the psychological cost of showing up), faith-framed content that speaks the language of Islamic values while normalizing professional help-seeking, and a collective impact, in which community members, imams, and clinicians co-design or deliver the intervention, strengthening trust and sustainability.

A recent qualitative study by Faruk et al. (2025) focused on the experiences of Muslims with mental health services and providers across Ontario using a community-based participatory

action research approach with focus groups. The study uncovered deep-rooted mistrust of Eurocentric mental health models, widespread cultural stigma, and a critical shortage of care aligned with Islamic values. Participants emphasized the need for religious models, such as integrating faith-informed counselling and training, involving imams in psychospiritual support roles, and delivering services through mosques or Muslim-led organizations. The authors proposed strengthening the engagement with Muslim communities, stressing that therapeutic models should incorporate Islamic coping strategies and spirituality to reduce barriers and help build trust (Faruk et al., 2025). This study reflects the research question by showing how cultural and religious expectations shape help-seeking and by identifying community-preferred, faith-informed interventions that can strengthen mental health support.

Hassan et al. (2021), in a mixed-methods evaluation, followed 93 adult congregants across nine Toronto mosques who attended a 90-minute addiction-stigma seminar delivered by Muslim mental-health professionals. Quantitative pre/post surveys showed significant gains in mental health literacy and a marked drop in agreement with shame-based statements about addiction. The interviews one month later suggested participants felt permission to approach imams or family physicians for help. However, the study tracked neither behavioural follow-through (i.e., treatment uptake) nor long-term retention of stigma gains, leaving questions about durability and scalability (Hassan et al., 2021)**.**

Rajeh's (2024) khutbahs with mental-health messaging delivered psycho-educational segments on stress, depression, and the prophetic model of seeking counsel during Friday khutbah in a mosque in London, Ontario. The content analysis confirmed that messages consistently paired spiritual coping (such as *tawakkul*, or trust in God) with encouragement to seek professional mental health support (Rajeh, 2024). The approach is highly cost-effective; one

sermon can reach hundreds of attendees in a single week and leverages the authority and trust already placed in religious leaders. This model is similar to efforts such as the Australian National Imams Council's (ANIC) 2019 Take Time for Mental Health campaign**,** which developed and distributed khutbah templates to imams across Australia. These sermons included practical examples, Quranic and prophetic references to emotional distress, and explicit reminders that seeking professional help is not a sign of weak faith. ANIC also provided imams with fact sheets and links to local mental health services to share with congregants (ANIC, 2019). While the campaign was widely praised for reducing silence around mental health in Australian mosques, it lacked empirical follow-up, highlighting a broader research gap around measuring the impact of religious-based public education on actual help-seeking behaviour.

Similarly, Abu-Ras et al. (2024), in a scoping review of mosque-based health interventions, covered 14 empirical studies that used mosques as intervention venues, eight of which targeted mental health or addiction outcomes. Across the literature, mosque programs generally improved knowledge and self-reported help-seeking intentions**,** but only a minority embedded behaviour-change theory or measured clinical outcomes. Abu-Ras et al. (2024) call for theory-driven designs, stronger evaluation frameworks, and partnerships that clarify the imam's role (i.e., educator, gatekeeper, or counsellor). Muse (2024), in a community-centred thesis on cultural proficiency, highlights the importance of delivering mental health services in familiar and trusted environments. Muse finds that access to mental health care for Muslim communities depends on offering care in familiar spaces. Recommendations include training providers in both Islamic literacy and cultural humility (Muse, 2024). Promising community-based initiatives include mobile counselling clinics at Islamic centres and wellness weeks organized by Muslim Student Associations on university campuses that offer a practical roadmap

for institutional support through funding streams and chaplaincy partnerships (Muse, 2024). However, as an advocacy-oriented thesis, it lacks empirical testing of these proposed models, leaving questions about their scalability and effectiveness. There is converging evidence that mosque-based and sermon-based outreach can shift community knowledge and attitudes toward mental health. Yet significant implementation gaps remain. Few studies track whether increased awareness leads to actual therapy uptake, and even fewer use control groups or long-term follow-ups. Imams are often open to collaboration but report limited training in mental health, echoing calls by Abu-Ras et al. (2024) for clearer, theory-informed frameworks defining the role of religious leaders in mental health support. Additionally, underrepresented groups such as youth, reverts, refugees, and Muslims in rural areas are rarely included in program evaluations. Emerging digital initiatives (e.g., the Naseeha helpline) show promise anecdotally, but peer-reviewed evidence remains limited. Future research on rigorous designs such as randomized controlled trials or stepped-wedge evaluations, combined with community-based participatory methods, to ensure that interventions remain both scientifically robust and culturally resonant.

The research shows many different barriers Muslims in Canada face when it comes to mental health. These barriers show up in many ways through experiences of Islamophobia, language issues, stigma, modesty expectations, and worries about whether a therapist will understand their values. Across the research, these factors shape how people made sense of their mental health and whether they felt comfortable reaching out for support. Several studies, including McLaughlin et al. (2022), Reich et al. (2024), Taha (2021), and Ahmed and Mao (2024), find that when therapists are not familiar with Islamic beliefs or cultural norms, clients often pull back or stop treatment altogether because they do not feel understood.

The research also shows effective approaches for many Muslims. Studies like AlHarbi et al. (2023) and Hassan et al. (2021), along with mosque-based and khutbah programs, show that engagement is stronger when support is offered in familiar community spaces, includes Islamic language or teachings, or involves trusted religious leaders. These findings connect directly to the research question because they show how cultural backgrounds and religious beliefs shape the way Muslims view mental health and help-seeking behaviour. They also support the secondary focus of this capstone, showing that culturally and spiritually grounded approaches may better align with what many Muslim clients are seeking.

Chapter Conclusion

This chapter presented a comprehensive thematic analysis of recent literature on Islamic beliefs and cultural norms that influence mental health perceptions and help-seeking behaviours among Muslim communities, particularly in Canada. Through the lenses of religious coping theory, intersectionality theory, and cultural humility, the review synthesized 17 peer-reviewed studies across three central themes: stigma and misconceptions, coping mechanisms and faith-based responses, and barriers to mental health care and culturally responsive interventions. The theme of stigma and misconceptions within the literature shows the role of religious interpretations and cultural stigma in shaping how mental illness is perceived and experienced. Misconceptions, such as attributing mental illness to jinn possession or weak spirituality, contribute to silence, shame, and reluctance to engage with clinical care. Social and communal pressures often reinforce these beliefs, especially when religious identity is deeply tied to family honour and reputation. Coping mechanisms highlighted across the literature illustrate the dual nature of religious coping. While positive religious coping (e.g., prayer, trust in God, community support) can foster resilience and well-being, negative religious coping (e.g., feelings of divine

punishment or spiritual guilt) can delay treatment and intensify emotional suffering. These findings emphasize the importance of integrating spiritual strengths while addressing harmful misinterpretations through culturally sensitive therapeutic approaches. Barriers found across the literature focused on systemic and structural barriers such as Islamophobia, lack of culturally competent providers, and the marginalization of imams in clinical partnerships, as well as emerging models of culturally and religiously integrated therapy. Studies within this theme also highlighted the potential of community-based and preventative approaches, such as mosque-based psychoeducation, khutbah messaging, and collaborative care frameworks that meet Muslims in trusted, familiar spaces. While these initiatives show promise in reducing stigma and increasing access, they are often limited by small sample sizes, lack of long-term follow-up, and minimal empirical testing.

Together, these themes point to several important insights. First, culturally embedded understandings of mental illness require more than translation; they require deep listening, community engagement, and therapeutic models that affirm both faith and psychological well-being. Second, interventions should include underrepresented voices, such as youth, reverts, and rural or newly immigrated Muslims, and be tested for long-term impact. Third, practitioners would benefit from support through training in Islamic perspectives, religious literacy, and cultural humility to provide care that is both clinically effective and spiritually congruent. These findings lay the foundation for Chapter 3, which interprets the implications of this literature review and translates them into applied practices. The next chapter will revisit the project's core questions and propose actionable recommendations such as frameworks for culturally integrated therapy, faith-informed psychoeducation, or imam-clinician collaborations. It will also offer personal reflections on the research journey and professional learning that has emerged

throughout this capstone. In doing so, Chapter 3 will bridge the gap between research and real-world application, offering strategies to better support Muslim clients in mental health settings with respect, compassion, and cultural atonement.

Chapter 3: Discussion and Applied Practices

The primary aim of this capstone is to explore how cultural influences and Islamic religious beliefs can impact mental health care perceptions and help-seeking behaviours among Muslims in Canada. It utilizes the frameworks of religious coping theory (Pargament, 1997), intersectionality theory (Finnegan, 2022), and cultural humility (Tervalon & Murray-García, 1998). The research question guiding this capstone examines: How do cultural influences and religious beliefs impact mental health perceptions and help-seeking behaviours among Muslims in Canada, and what culturally integrated interventions can improve mental health support? This question was informed by observations and personal experiences within a community that continues to face stigma, systemic neglect, and cultural dissonance when accessing mental health services.

This capstone aims to bridge the gap between clinical and lived experiences of Muslim individuals living in Canada, navigating mental distress within complex sociocultural landscapes. Chapter 3 builds on this foundation by interpreting the findings from the literature review and examining how these themes intersect with broader social, religious, and systemic contexts. Chapter 3 examines the implications of the themes that arose in the literature review through the lenses of religious coping theory and intersectionality, drawing out implications for culturally responsive mental health care. This chapter interprets the key findings from the literature review, focusing on implications, theoretical insights, limitations, and structural issues that perpetuate existing inequities in mental health care for Muslims in Canada.

Discussion

The findings from Chapter 2 show that reduced help-seeking does not arise from a single cause but from the interaction of stigma, religious meaning-making, systemic inequities, and

cultural context. Findings also show that cultural humility must be prioritized over cultural competence; cultural humility emphasizes an ongoing, reflective, and rational process where clients are viewed as experts in their own identity (Reich et al., 2024; Taha, 2021; Zia & Mackenzie, 2022). Mental health care for Muslims should be faith-informed, not faith-replacing, to integrate, rather than override, spiritual frameworks. Findings show mental health services must validate positive religious coping while offering tools to address maladaptive interpretations (Albatnuni & Koszycki, 2020; Bagasra, 2023; Ahmed & Mao, 2024; Alqasir & Ohtsuka, 2023). A community-centred delivery of effective interventions often emerge within, or are endorsed by, trusted community institutions such as mosques, schools, or family networks (Basri et al., 2022; Fekih et al., 2023; Hassan et al., 2021; Muse 2024). Collaborative ecosystems with therapists, imams, educators, and public health professionals should be formed instead of isolated systems (Hassan et al., 2021; Mclaughlin et al., 2022; Muse, 2024; Zia & Mackenzie, 2022). These findings highlight why the research question remains relevant, as mental health experiences cannot be separated from the spiritual, cultural, and social experiences that shape the Muslim community in Canada.

Understanding the Impact of Stigma Through Intersectionality

Stigma, especially internalized and community stigma, was one of the most prevalent and damaging barriers identified across the literature. For Muslims, especially women, youth, and immigrants, stigma has been experienced on multiple levels and layers. For example, some Muslim women reported struggling with mental health while also dealing with Islamophobia at school or work, as well as the gendered and cultural expectations to support their families and children (Ahmed & Mao, 2024; Fekih-Romdhane et al., 2023; Taha, 2021). Muslim women's experiences with stigma is compounded by Islamophobia, level of silence, and gender-based

expectations (Taha, 2021). Such findings suggest that stigmas related to religion, gender, ethnicity, and immigrant identity overlap. These kinds of experiences limit autonomy and reinforce the idea that psychological pain is either a spiritual failure or an issue to be hidden, as there are other priorities in life that need to be focused on first. By understanding how these factors intersect, mental health professionals can begin to dismantle the myth of neutral care and instead recognize how power, privilege, and structural exclusion may manifest within therapeutic spaces.

By recognizing these intersecting pressures, it becomes clear how stigma is reinforced both socially and structurally. The idea of neutral care and the assumption that therapy can be delivered without acknowledging identity and context overlooks how power and privilege operate within therapeutic places (Gafford et al., 2019). In my opinion, care is never neutral; rather it is shaped by cultural values, policies, and societal expectations. When stigma intersects with systemic inequities, Muslim clients may perceive therapy as unsafe, biased, or dismissive of clients' lived realities. Expanding on this connection makes clear that dismantling the myth of neutral care requires acknowledging stigma as an expression of broader structural exclusion.

The Impact of Religious Beliefs, Misinterpretations, and Religious Leaders

Religious beliefs were shown to play both protective and obstructive roles throughout the literature. Positive religious coping, such as prayer, trust in divine will (*Twakol*), community support, and belonging is consistently associated with resilience, posttraumatic growth, and improved well-being (Albatnuni & Koszycki, 2020; Alsubaei et al., 2021). However, negative religious coping, including feelings of divine punishment, guilt, or shame, contributed to delayed help seeking and more profound emotional suffering (Bagasra, 2023). Many Muslims rely on faith as their first method of coping. Although this is often beneficial, the literature indicates that

misinterpretations, such as viewing mental illness as punishment from God or possession by jinn, can perpetuate avoidance and drive individuals away from evidence-based treatments. These misinterpretations are frequently passed down through generations or inherited in the culture, especially when accessing services that fail to engage religious views (Al-Krenawi, 2019; Alqasir & Ohtuska, 2023).

Islam itself does not oppose mental health treatment; the Qur'an encourages seeking knowledge and help from qualified experts, as Allah states in the Qur'an, "Ask those who possess knowledge if you do not know" (Qur'an 16:43). This verse encourages people to seek guidance from those with knowledge; it can serve as an entry point for reframing mental health care within Islamic ethics and promoting therapeutic care as a religiously encouraged act. This connects to the research question, as it shows that beliefs about God, faith, or spiritual causes directly shape how Muslim clients view their distress and whether they feel comfortable seeking mental health support. Believing that symptoms are a test from God, a punishment, or something they should handle privately through prayer, therapy may not feel like an option. For counsellors, understanding how symptoms are viewed is crucial because some Muslim clients may bring their faith into the room either as a source of strength or as something that makes them hesitate to seek support. When counsellors are aware of both sides, they can respond in ways that respect the client's beliefs, support the client's sense of autonomy, and help them make sense of their symptoms. This also helps counsellors avoid unintentionally dismissing or pathologizing the client's faith, which can quickly break trust. Creating sensitivity and openness may help clients feel they have a safe space to express both their emotional and spiritual concerns, making them more likely to stay engaged in therapy.

In truth, Islamic teachings emphasize mercy, healing, and the importance of seeking support. Islam encourages believers not to suffer in silence but to care for both the heart and the mind. One well-known Hadith (prophetic teaching) affirms this balance: "Make use of medical treatment, for Allah has not made a disease without appointing a remedy for it, except one disease, namely old age" (Sunan Abi Dawood 3855). This narration reflects a foundational Islamic principle that seeking treatment is encouraged as part of a holistic view of wellness. When such compassionate teachings are misapplied or overshadowed by stigma, they can unintentionally create barriers to care. For this reason, it is essential for clinicians to understand the dual role of religion as both a source of healing and, at times, a misunderstood obstacle and to hold space for the complex spiritual narratives that shape Muslim clients' experiences.

Imams and religious leaders hold a pivotal role in shaping the community's mental health narrative. There is growing advocacy for training imams to function as mental health educators. However, some studies showed that, while many Muslims trust their imams, only a small portion seek mental health guidance through them. This reflects a structural limitation; Imams are accessible and respected but are often untrained in mental health and may lack referral networks or trauma informed knowledge (Muse, 2024; Zia et al., 2022). Muslims frequently turn to imams during distress as imams are more than religious leaders, they are trusted community figures who often provide emotional support when people are struggling before approaching a therapist, especially when the distress is tied to family, faith, or life's meaning. However, despite this trust, many imams are unequipped to respond to mental health concerns beyond spiritual guidance. As Zia et al. (2022) and Muse (2024) find that most imams in North America receive little to no

formal training in trauma-informed care; there is a lack of integration into mental health systems, which hinders referrals to appropriate services.

When counsellors understand the imam's influence, they are better able to appreciate why some Muslim clients might arrive with strong spiritual interpretations of their symptoms or a hesitation toward clinical services. There is value for practitioners to build relationships with religious leaders, as collaboration can increase referrals, strengthen continuity of care, and help clients feel that therapy does not conflict with their faith. Recognizing the role of imams for Muslim clients is crucial for the counselling field, as it encourages more culturally responsive interventions and supports the development of community-based partnerships that can reduce stigma and improve access to care for the Muslim community. Programs like mosque-based psychoeducation and messages during Friday khutbah have shown potential in reducing stigma and promoting professional care by opening conversations, reducing stigma, and encouraging help-seeking. It is important to create a long-term sustainable model, working on developing relationships between mental health professionals and faith leaders, offering capacity building for imams, and making room for faith-based healing to work alongside clinical support. More empirical data is needed to assess the long-term efficacy of these models and to explore variations across sects, generations, and geographic contexts, as well as genders.

Systemic and Structural Challenges

Beyond individual and communal factors, structural power dynamics continue to reproduce inequities for mental health care among Muslims. Islamophobia, racial profiling, language barriers, and socioeconomic instability are all factors that contribute to the feeling that accessing mental health treatment is unsafe or exclusionary (McLaughlin et al., 2022; Reich et al., 2024). For many Muslims, therapy becomes another domain where they must educate the

providers, defend their identities, or be forced to hide part of themselves to avoid judgment. Equally concerning are the systemic and structural barriers that marginalize Muslim clients within Canadian mental health systems. This is caused by the lack of culturally competent practitioners, Islamophobia, language barriers, and clinical models that are often incompatible with faith-based worldviews. Muslim clients often experience clinical spaces as sites of cultural dissonance where they are either forced to suppress their faith identity or become educators for their therapists; these experiences affect therapeutic trust and efficiency.

The need for cultural humility rather than presumed cultural competence is critical. Therapists must engage in ongoing reflection, co-learning, and relationship building to genuinely meet clients where they are and honour each client's unique story and experience. Counsellors need to be aware of these structural experiences that directly shape how safe, open, and trusting Muslim clients feel in the counselling space. When counsellors overlook the impact of Islamophobia or systemic discrimination, clients may perceive therapy as another setting where they must protect themselves or downplay who they are. Recognizing and understanding these experiences allows counsellors to create a safe and inclusive space while also supporting clients in showing up fully without fear of judgment or misunderstanding (Lin, 2023).

Studies also highlighted that despite good intentions, many therapists lack religious understanding or fail to adopt cultural humility practice, which would lead to rupture rather than rapport, especially when clients feel their values are misunderstood (Gafford et al., 2019; Reich et al., 2024). This is important for the counselling field because when practitioners overlook clients' cultural or spiritual frameworks, the therapeutic space can feel unsafe or invalidating, increasing the likelihood of early disengagement. Mental health systems must consider this gap,

beginning with diversifying the workforce, reforming training, and offering supervision models that integrate cultural complexity and spiritual factors.

Community-Based Models of Support

Building on these insights, Reich et al. (2024) carried out a qualitative study in Quebec that focused on the therapeutic journey of young immigrant women navigating mental health services. During the interviews, the participants described facing persistent stigma and misunderstanding from family and community members, along with feeling discouraged from the clinical experiences where cultural and religious contexts were overlooked. They also reported how their faith and trust in God helped them stay grounded and hopeful during recovery. When clinicians acknowledged the spiritual aspect, participants reported that it gave their treatment process a sense of meaning, structure, and resilience (Reich et al., 2024). These stories underscore how culturally responsive care can support healing by viewing faith as a source of strength rather than a barrier. Cultural and religious values shape clients' comfort with therapy and identify the importance of spiritually attuned care for improving engagement (Reich et al., 2024).

Taha (2021) observed that wellness for Muslim communities in Canada needs to be redefined not as turning away from faith to embrace clinical authority, but as creating space where faith, culture, and emotional healing are deeply intertwined. Her study calls for a paradigm that welcomes both distress and devotion, where Muslim clients no longer feel the need to choose between spiritual authenticity and psychological care. Integrating such approaches means moving beyond cultural competence to participating in cultural humility, faith literacy, and community-based collaboration principles that form the foundation of a genuinely inclusive, ethical, and practical mental health framework (Taha, 2021). These findings show how

spiritual beliefs influence mental health perceptions by emphasizing the need for culturally and spiritually responsive practices in therapeutic settings.

The need for future research to explore integrated religious-clinical care models is important. For example, creating training programs to help imams build basic mental health knowledge and learn how to refer people to the right services could make a big difference. At the same time, building stronger partnerships between mosques and mental health professionals would help bridge the gap between spiritual and clinical care. To understand how well these efforts work, it would be important to study them over time using both numbers and personal stories to see if they improve people's well-being and help reduce stigma in different Muslim communities. Future research should explore how migration, acculturation, and intergenerational dynamics shape the relationship between religiosity and mental health.

Limitations of the Existing Literature

While the literature offers rich insights, there are also significant limitations for generalizability, including cross-sectional and relying on self-reported data, small sample sizes, over-presentation of one gender, exclusion of non-Arab Muslims (Albatnuni & Koszycki 2020; Fekih Romdhane et al., 2023; Javaid et al., 2024; McLaughlin et al., 2022; Zia & Mackenzie, 2022). There is a lack of large-sample-size longitudinal studies that track the impact of culturally adapted interventions over time within the literature. Moreover, the lack of understanding of how to define and measure cultural competence or faith integration in therapy results in inconsistent application across services. Another limitation is the absence of youth voices, reverts, and Muslims living in rural, underserved areas. These groups face unique barriers that are not addressed. Future research must centre on their experiences to ensure more inclusive mental health practices.

It is important to acknowledge that recommended strategies and findings may not be universally applicable. Muslim communities are diverse and sectarian. Language and generational differences may affect how these approaches may be received. For example, reverts to Islam, second-generation youth, or Muslims from marginalized racial groups may have different needs and expectations from therapy than the older immigrant population (Cavdar et al., 2021). Furthermore, not all Muslims desire faith integration in therapy; some may view religious discussions as outside the therapist's role. The emphasis must always remain on informed consent, client autonomy, collaborative goal setting, and the client's unique personal experience.

Applied Practices

The findings of this capstone highlight an urgent need for culturally and spiritually integrated mental health practices that meet the needs of Muslims seeking mental health care in Canada. The limitations of the Western models combined with systemic exclusion and culturally specific stigma underscore the necessity of rethinking how services are delivered and by whom. These challenges stress that while many Muslims rely on faith, community, and cultural values when coping with distress, the supports available in mainstream mental health settings often do not reflect or accommodate the Muslim community's needs. Studies such as Ahmed and Mao (2024), McLaughlin et al. (2022), and Taha (2021) show that when clients do not feel understood spiritually or culturally, they are less likely to remain in therapy or to seek help in the first place. Because of these gaps, there is a growing need for an approach that brings together clinical practice with the faith-based and community-driven supports that Muslim clients already turn to. In light of this, the next section outlines a faith-integrated mental health framework that responds directly to the barriers and offers practical ways to strengthen care for Muslim communities in Canada. This comprehensive faith-integrated mental health framework

can be adopted by mental health professionals, policymakers, and community leaders to improve cultural alignment and therapeutic efficiency among Muslim populations. The faith-integrated mental health framework is structured around three pillars and is designed to be flexible and adaptable to various clinical, educational, or community-based settings.

Pillar 1: Clinician Training in Islamic Religious Literacy and Cultural Humility

Muslim clients often terminate therapy because they feel misunderstood, spiritually dismissed, or culturally misjudged. Studies show that clinicians frequently avoid religious conversations, misinterpret culturally embedded expressions of faith, or pathologize spiritual coping mechanisms (Ahmed & Mao, 2024; Reich et al., 2024). This pillar addresses those gaps through structured training and reflection.

Training modules should include basic Islamic principles such as *Tawakkul* (trust in God), *Sabr* (patience), gratitude, and supplication. Modules should differentiate culture and religious practices, with emphasis on religious coping and mental health, and the common spiritual interpretations of mental illness. Training should also include reflective supervision models that focus on transference and countertransference involving faith-based content, along with case consultations with Muslim-identified practitioners and interfaith supervisors. Clinical training should include culturally adapted assessment tools such as intake forms. Intake forms should inquire about religious identity and cultural background using two different sections on the form, and ask for client-preferred terminology and desire to integrate spirituality through the sessions. Religious literacy and cultural humility training should also provide ways to include tools for clients to incorporate practices such as *Dhikr* (remembrance of God), Quranic journaling, and gratitude reflections that are rooted in Islamic teachings. Gratitude programs and

continuing education platforms are encouraged to include these modules to reduce any areas overlooked by the clinician and promote trust and strong therapeutic relationships.

Integrating this kind of training meet the recommendation with the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2017). Counsellors are expected to practice cultural humility, respect the client's worldview, and avoid causing harm. These responsibilities are challenging to meet without understanding how faith and culture shape a client's experience. Having even a basic understanding of Islamic beliefs, along with using ongoing reflective practice, can help counsellors avoid misreading a client's spiritual coping and better support the client's sense of autonomy. This training helps create a space where clients feel they can talk openly without worrying about being dismissed or misunderstood. The College of Registered Psychotherapists of Ontario (CRPO) points to these responsibilities by emphasizing culturally responsive care, respecting clients' belief systems, and the importance of avoiding practices that might unintentionally cause harm or limit a client's autonomy (2022).

Pillar 2: Imam-Clinician Collaboration Protocols

Imams are often the first point of contact for Muslims in emotional or spiritual crisis. However, their role is undefined and unsupported in most mental health systems. Imams are not trained to support mental health patients properly. Proper training and collaboration protocols would establish clear pathways for shared care. Mental health trainings for imams can be delivered through Islamic counsellors or university partnerships to focus on recognizing symptoms of common disorders, understanding trauma, and ethical referral policies. Collaboration can be established through referral pathways by establishing protocols between mosques and mental health clinics. Collaboration can be facilitated through quarterly meetings between clinicians and religious leaders to discuss community needs. This may aid the transition

between spiritual and clinical care. In this collaboration framework, with client consent, imams may be included in treatment planning, where appropriate. However, structural implementation barriers, such as overburdened community leaders or resistance from traditional religious scholars may delay or hinder the rollout of proposed initiatives (Hassan et al., 2021; Zia & Mackenzie, 2022). Any intervention must be co-designed with community members and continually evaluated for impact and inclusivity.

This approach mirrors collaborative care models in Indigenous communities where cultural leaders and clinicians work together. A shift from individualized, Western-based approaches to a more holistic, culturally rooted system where Indigenous cultural leaders and Western clinicians collaborate, share knowledge, and integrate practices, provides culturally safe, community-led, comprehensive mental health support and leads to positive treatment experiences (Montesanti et al., 2022). Similarly, among Arab and Arabic-speaking refugee populations, a scoping review by Berry et al. (2025) identified systemic barriers to mental health care that mirror the concerns addressed in this framework. Despite having health insurance, many refugees underutilize psychological services due to a lack of culturally and linguistically appropriate care, inadequate support systems, and stigma surrounding mental illness. These challenges, especially when compounded by gender and socioeconomic status, have been linked to psychosomatic symptoms and low self-rated health. The authors call for more culturally integrated interventions, including partnerships between formal health systems and community-based networks. This underscores the necessity of establishing collaborative protocols between clinicians and Imams, trusted leaders who can bridge spiritual care with therapeutic support.

Pillar 3: Mosque-Based Psychoeducation and Community Outreach

Mosques are trusted spiritual safe places that can act as key sites for stigma reduction and early mental health interventions. Several studies affirm the efficiency of mosque-based psychoeducation. Hassan et al. (2021) found that seminars held in mosques led to improved mental health literacy and destigmatization. Rajeh (2024), through live experience, was able to reach a big part of the community by talking about the importance of seeking mental health care and its relevance to Islamic teachings, as it is a must to seek the right treatment when needed. Rajah highlighted how Friday sermons can normalize help-seeking behaviour. Ahmed et al. (2024), through the Canadian Muslim Addictions Program, showed that digital outreach rooted in Islamic values increased treatment engagement among youth and families. This approach builds on the successful models piloted in Australia (ANIC, 2019) and Toronto (Hassan et al., 2021), with the recommendation of partnering with research institutions to study long-term outcomes.

From an ethical standpoint, community-based outreach supports the counsellor's responsibility to reduce barriers to care and make mental health services more accessible, which also helps counsellors meet clients in settings that already feel culturally safe, lowers stigma, and encourages informed decisions about seeking help. Research by Hassan et al. (2021), Muse (2024), and McLaughlin et al. (2022) shows that these kinds of partnerships are not only effective but also reflect ethical commitments within counselling to promote equity, honour cultural context, and work alongside communities rather than separately from them. This approach is consistent with the CRPO *Professional Practice Standards*, which emphasize culturally safe, client-centred, and context-informed services (CRPO, 2022).

Recommended strategies for mosque-based psychoeducation and community outreach include implementing quarterly mental health seminars delivered by Muslim therapists or culturally trained practitioners to discuss topics like anxiety, trauma, parenting, and addiction. It is recommended to integrate Quranic verses and prophetic traditions that support emotional resilience and the importance of seeking help. Integrating Friday khutbah by developing templates that address mental health topics and messages that can emphasize spiritual and clinical care as complementary, not contradictory. Resource corners can be included in mosques, with brochures and information for competent Muslim therapists or sharing a national digital hub, through video resources, psychoeducational materials, and therapist locators tailored for Canadian Muslims. This community-centred approach would help reduce the psychological burden of seeking help and bridge the gap between spiritual and clinical domains.

Additional Recommendations

Beyond the above-mentioned pillars, several supplemental strategies can be implemented to strengthen mental health care accessibility and impact. These recommendations include building a national directory of Muslim therapists that is searchable by gender, language, sect, and region; utilizing culturally adaptive cognitive behaviour therapy that incorporates Quranic themes of reframing, accountability, and resilience with Islamic metaphors to explain core therapeutic concepts; encouraging Islamic-integrated mental health practice at home through prayers or gratitude journaling, compassion practices inspired by *Hadith* (Prophetic teachings), and the Qur'an; and building mobile clinics for underserved communities through partnerships with mosques to provide mental health services in rural or immigrant-dense neighbourhoods.

Taken together, the three pillars speak directly to the gaps raised earlier in this capstone. This faith-integrated mental health framework provides practical ways to respond to the cultural,

spiritual, and structural factors that shape how Muslims in Canada make sense of their mental health and whether they feel comfortable seeking support. The need for this kind of approach is reflected in the literature and shows how mistrust and cultural disconnection affect help-seeking (Ahmed & Mao, 2024; Reich et al., 2024), while demonstrating the value of community-based, faith-sensitive outreach (Hassan et al., 2021). By focusing on clinician training, collaboration with religious leaders, and outreach through familiar community spaces, the framework ties back to the central research question and supports how cultural influences and religious beliefs can better address mental health perceptions and help-seeking behaviours among Muslims in Canada. These recommendations also show how culturally integrated interventions can improve mental health support by offering counsellors practical and ethical ways to create safer, more respectful, and accessible support for Muslim clients. To build on this work, future research could examine how intersectional factors such as gender, generational status, or visibility of religious identity interact with stigma to shape help-seeking behaviour.

Reflection on Personal Learning

This capstone began as an inspiration on a Friday khutbah at the mosque but quickly became a personal journey of reconciliation. As a Muslim woman, I have observed fear from many community members to reach for mental health support. With the rise of Islamophobia, many Muslim individuals are increasingly struggling with mental health. Rather than risk stigma or shame, many choose to suffer in silence. Others fear working with therapists who may not understand their cultural or religious background, with some reporting that they eventually quit therapy because they felt judged or misunderstood. Learning about spiritually integrated interventions affirmed that therapy that excludes faith cannot fully meet the needs of those whose

identities are shaped by religion. Remembrance of Allah, prayers, and Quranic verses have been a source of tranquillity for many Muslims and cannot be separated.

This made me reflect on all the people who struggle, hide their grief, and feel isolated. When we decontextualize mental health or remove a human being from the context of their lived experiences and the society they are embedded within, our work as counsellors may lend itself to perpetuating the very injustices that we aim to eliminate. Challenges such as Islamophobia have a significant impact on how Muslim clients experience counselling. Therefore, such systemic challenges must be challenged by counsellors and the wider community in research, practice, and policy. Counsellors and academics in this field need to advocate against structural biases that unfavourably disadvantage Muslim individuals (Taha, 2021).

This capstone has shifted my professional goals. I want to advocate for culturally responsive care, educate therapists about Islamic frameworks, and contribute to creating spaces where my community feels both respected and supported. The stories I hear from community members, the gaps I found through the research, and the hope I saw in emerging interventions reaffirmed that culturally responsive therapy is not a luxury; it is a necessity.

Conclusion

This capstone has explored the complex interplay between Islamic faith, cultural identity, and mental health care among the Muslim community in Canada. It sought to identify culturally and spiritually integrated interventions that improve access to care. To guide this exploration, the capstone centred on the following research question: How do cultural influences and religious beliefs affect perceptions of mental health and help-seeking behaviours among Muslims in Canada? A secondary focus examined what culturally integrated interventions may help improve mental health support. Grounded in religious coping theory (Pargament, 1997), intersectionality

theory (Finnegan, 2022), and cultural humility (Tervalon & Murray-García, 1998), the study revealed how faith-based values, stigma, cultural pressures, and systemic inequities intersect to shape help-seeking patterns and therapeutic outcomes.

Across the literature, what stood out most was how many different factors come together to influence how Muslims understand their mental health. People often made sense of distress through their faith, family expectations, cultural background, and experiences in the broader society. Collectively, the literature emphasized that faith plays a complicated role in how Muslims make sense of their mental health. For many, turning to prayer, reading the Qur'an, or relying on their community brought much comfort and gave them something steady to hold onto. Others were unsure if seeking therapy was even allowed, and a few spoke of feeling guilty for seeking help outside prayer. Another complication was the worry that a therapist might not understand their beliefs or would judge them.

Spiritual coping was identified repeatedly as a factor that could help some to feel stronger and calmer when they connected with their faith. For others spiritual coping created a pressure to rely only on prayer or religious advice, often creating a sense of shame if their mental health did not get better. These kinds of experiences shaped an understanding of how therapy is viewed in the Muslim community in Canada and whether seeking support outside religious practices is acceptable. These mixed experiences matter because they shape how someone interprets their symptoms, how they cope, and whether therapy feels like an acceptable or safe option.

Numerous studies also pointed to more significant systemic issues that make it harder for Muslims to get the kind of support they need. These findings highlight that access to mental health care is shaped by broader structural and cultural factors. Limited availability of therapists who can work respectfully with faith, minimal collaboration between mental health services and

religious leaders, and the lack of services in trusted community settings can all create barriers to care. Together, structural and cultural factors influence whether Muslim individuals feel able to seek support and remain engaged in therapy over time. In response to these challenges, the faith-integrated mental health framework presented in the recommendations offers an approach that focuses on clinician training, collaboration between imams and mental health professionals, and community-based outreach within familiar and trusted settings.

Altogether, the studies lend support to creating a mental health system that considers culture, faith, lived experience, and the wider challenges Muslims face. When these pieces are missing, people often come away feeling misunderstood or not fully helped. My hope is that this capstone adds to the conversations already happening and encourages clinicians, educators, and policymakers to build services where Muslim clients feel safe, respected, and able to ask for support without feeling they must put their faith aside. Mental health care that honours the wholeness of identity including spirituality is not optional; it is essential for justice, inclusion, and meaningful healing.

References

Abu-Ras, W., Aboul-Enein, B. H., Almoayad, F., Benajiba, N., & Dodge, E. (2024). Mosques and public health promotion: A scoping review of faith-driven health interventions. *Health Education Behavior*, *51*(5), 677–690. https://doi.org/10.1177/10901981241252800

Ahad, A. A., Sanchez-Gonzalez, M., & Junquera, P. (2023). Understanding and addressing mental health stigma across cultures for improving psychiatric care: A narrative review. *Cureus*, *15*(5). https://doi.org/10.7759/cureus.39549

Ahmed, F., Ragheb, H., Isgandarova, N., Khokhar, J., Azab, M., Ali, A., Twakkal, A. A., & Hassan, A. N. (2024). Developing a faith-based virtual psychoeducation program to enhance addiction services for Canadian Muslims: C-MAP. *Canadian Journal of Community Mental Health*, *43*(1), 97–101. https://doi.org/10.7870/cjcmh-2024-007

Ahmed, R., & Mao, Y. (2024). An intersectional approach to understanding beliefs and attitudes toward mental health issues among Muslim immigrant women in Canada. *Health Communication, 39*(10), 2014–2025. https://doi.org/10.1080/10410236.2023.2252644

Ahmad, S. S., McLaughlin, M. M., & Weisman de Mamani, A. (2023). Validation and test–retest reliability of the Spiritual Bypass Scale in Muslims and implications for psychological help-seeking attitudes and self-stigma. *Spirituality in Clinical Practice*, *10*(1), 45–45. https://doi.org/10.1037/scp0000300

Albatnuni, M., & Koszycki, D. (2020). Prayer and well-being in Muslim Canadians: exploring the mediating role of spirituality, mindfulness, optimism, and social support. *Mental Health, Religion & Culture*, *23*(10), 912–927. https://doi.org/10.1080/13674676.2020.1844175

AlHarbi, H., Farrand, P., & Laidlaw, K. (2023). Understanding the beliefs and attitudes towards mental health problems held by Muslim communities and acceptability of cognitive

behavioral therapy as a treatment: Systematic review and thematic synthesis. *Discover Mental Health*, *3*(1). https://doi.org/10.1007/s44192-023-00053-2

Alqasir, A., & Ohtsuka, K. (2023). The impact of religio-cultural beliefs and superstitions in shaping the understanding of mental disorders and mental health treatment among Arab Muslims. *Journal of Spirituality in Mental Health*, *26*(3), 279–302. https://doi.org/10.1080/19349637.2023.2224778

Alsubaie, M. K., Dolezal, M., Sheikh, I. S., Rosencrans, P., Walker, R. S., Zoellner, L. A., & Bentley, J. (2021). Religious coping, perceived discrimination, and posttraumatic growth in an international sample of forcibly displaced Muslims. *Mental Health, Religion & Culture*, *24*(9), 976–992. https://doi.org/10.1080/13674676.2021.1973978

Antoniou, N., & Kalogeropoulos, D. (2024). Exploring the intersection of faith and mental health in religious clients. *Journal of Assessment and Research in Applied Counseling*, *6*(3), 226–235. https://doi.org/10.61838/kman.jarac.6.3.25

Australian National Imams Council. (2019, October 9). ANIC national khutbah (sermon) "take time for mental health". https://anic.org.au/wp-content/uploads/2024/12/ANIC-National-Khutbah-Sermon-Take-time-for-Mental-Health.pdf

Al-Krenawi, A. (2019). The impact of cultural beliefs on mental health diagnosis and treatment. In M. Zangeneh & A. Al-Krenawi (Eds.), *Culture, diversity and mental health: Enhancing clinical practice* (pp. 149–165). Springer Nature Switzerland

Al-Qurtubi. (2007). *Al-Jami' li-Ahkam al-Qur'an* [The Compendium of Legal Rulings of the Qur'an]. Cairo: Dar al-Kutub al-Misriyya.

Al-Tabari. (2000). *Tafsir al-Tabari: Jamiʿ al-Bayan ʿan Taʾwil al-Qur'an*. Beirut: Mu'assasat al-Risalah.

Bagasra, A. (2023). Religious interpretations of mental illness and help-seeking experiences among Muslim Americans: Implications for clinical practice. *Spirituality in Clinical Practice, 10*(1), 20–31. https://doi.org/10.1037/scp0000299

Basri, T., Radhakrishnan, K., & Rolin, D. (2022). Barriers to and facilitators of mental health help-seeking behaviors among South Asian American college students. *Journal of Psychosocial Nursing and Mental Health Services, 60*(7), 32–38. https://doi.org/10.3928/02793695-20211215-01

Berry, Y., Khan, S., Smadi, R., Rehman, S., Hanania, J., Alabdalrazzak, M., Sbei, O., & Al Achkar, M. (2025). Mental health challenges and barriers to care among Arab refugees: A scoping review of US and Canadian studies. *PRiMER*, *9*. https://doi.org/10.22454/primer.2025.330739

Canadian Psychological Association. (2017). Canadian code of ethics for psychologists, 4th ed. https://cpa.ca/aboutcpa/committees/ethics/codeofethics/

Cavdar, D., McKeown, S., & Rose, J. (2021). Mental health outcomes of ethnic identity and acculturation among British-born children of immigrants from Turkey. *New Directions for Child and Adolescent Development, 2021*(176), 141–161. https://doi.org/10.1002/cad.20402

College of Registered Psychotherapists of Ontario. (2022). *Standards & regulations for registered psychotherapists.* https://crpo.ca/practice-standards/

Faruk, S., Asadullah, M., & Tsang, A. K. (2025). Religious-tailoring of mental health services in Ontario: A qualitative study exploring service user and provider recommendations. *Journal of Community Psychology*, *53*(7). https://doi.org/10.1002/jcop.70036

Fekih-Romdhane, F., Daher-Nashif, S., Stambouli, M., Alhuwailah, A., Helmy, M., Shuwiekh, H. A., Mohamed Lemine, C. M., Radwan, E., Saquib, J., Saquib, N., Fawaz, M., Zarrouq, B., Naser, A. Y., Obeid, S., Saleh, M., Haider, S., Miloud, L., Badrasawi, M., Hamdan-Mansour, A., … Hallit, S. (2023). Mental illness stigma as a moderator in the relationship between religiosity and help-seeking attitudes among Muslims from 16 Arab countries. *BMC Public Health*, *23*(1). https://doi.org/10.1186/s12889-023-16622-7

Finnegan, E. (2022). Using intersectionality to understand abuse against elders: A conceptual examination. In J. Healy, & B. Colliver (Eds.), *Contemporary Intersectional Criminology in the UK* (pp. 187–203). https://doi.org/10.1332/policypress/9781529215946.003.0012

Gafford, J., Raines, T. C., Sinha, S., DeBlaere, C., Davis, D. E., Hook, J. N., & Owen, J. (2019). Cultural humility as a spiritually focused intervention in correctional settings: The role of therapists' multicultural orientation. *Journal of Psychology and Theology*, *47*(3), 187–201. https://doi.org/10.1177/0091647119847540

Ghuloum, S., Al-Thani, H. A., & Al-Amin, H. (2024). Religion and mental health: An Eastern Mediterranean region perspective. *Frontiers in Psychology*, *15*. https://doi.org/10.3389/fpsyg.2024.1441560

Hassan, A. N., Ragheb, H., Malick, A., Abdullah, Z., Ahmad, Y., Sunderji, N., & Islam, F. (2021). Inspiring Muslim minds: Evaluating a spiritually adapted psycho-educational program on addiction to overcome stigma in Canadian Muslim communities. *Community Mental Health Journal*, *57*(4), 644–654. https://doi.org/10.1007/s10597-020-00699-0

Humam, F., McBryde-Redzovic, A., Mahoui, I., Ali, S., Abolaban, H., Zia, B., & Awaad, R. (2023). The role of Muslim religious leaders in mental health: A community-based

participatory research study in the San Francisco Bay Area. *Pastoral Psychology*, *72*(4), 539–556. https://doi.org/10.1007/s11089-023-01077-9

Ibn Kathir. (2003/1372 CE). *Tafsir Ibn Kathir (Abridged)* (A. Al-Mehri, Trans.). Darussalam.

Ibrahim, A., & Whitley, R. (2020). Religion and mental health: a narrative review with a focus on Muslims in English-speaking countries. *BJPsych Bulletin*, *45*(3), 170–174. https://doi.org/10.1192/bjb.2020.34

Javaid, Z. K., Naeem, S., Haroon, S. S., & Mobeen, S. (2024). Religious coping and mental well-being: A systematic review on Muslim university students. *International Journal of Islamic Studies and Culture, 4*(2). http://ijisc.com.pk/index.php/IJISC/issue/view/192

Jehangir, Z., Usama Bin Zubair, Syed Azhar Ali Kazmi, Anam Haider, Aroosa Burki, & Anam Jamil Butt. (2024). Association of post-traumatic growth with the use of religion and spirituality as a coping strategy among refugees of Azad Jammu and Kashmir. *Journal of Ayub Medical College Abbottabad*, *36*(4). https://doi.org/10.55519/jamc-04-13407

Kanu, R., & Nosike, C. J. O. (2025). The impact of religious beliefs on mental health and well-being. *International Journal of IGBO Scholars Forum for Socio-Cultural Advancement, 18*(2). https://acjol.org/index.php/igboscholars/article/view/7028

Khanthavudh, C., Grealish, A., Tzouvara, V., & Leamy, M. (2025). Supporting healthcare in rural communities in Thailand: An exploratory qualitative study to understand the role and current mental health practices of village health volunteers. *PLOS ONE*, *20*(3). https://doi.org/10.1371/journal.pone.0320559

Lin S. L. (2023). Inequities in mental health care facing racialized immigrant older adults with mental disorders despite universal coverage: A population-based study in

Canada. *Psychological Sciences and Social Sciences, 78*(9), 1555–1571. https://doi.org/10.1093/geronb/gbad036

McLaughlin, M. M., Ahmad, S. S., & Weisman de Mamani, A. (2022). A mixed-methods approach to psychological help-seeking in Muslims: Islamophobia, self-stigma, and therapeutic preferences. *Journal of Consulting and Clinical Psychology, 90*(7), 568–581. https://doi.org/10.1037/ccp0000746

Montesanti, S., Fitzpatrick, K., Fayant, B., & Pritchard, C. (2022). Identifying priorities, directions and a vision for Indigenous mental health using a collaborative and consensus-based facilitation approach. *BMC Health Services Research*, *22*(1). https://doi.org/10.1186/s12913-022-07682-3

Muse, R. (2024). *Breaking the barriers: Enhancing mental health care for Muslim communities through cultural proficiency and community awareness* [Bachelor thesis, Portland State University]. https://doi.org/10.15760/honors.1568

Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, practice.* American Psychological Association. https://psycnet.apa.org/record/1997-08957-000

Qur'an (M. A. S. Abdel Haleem, Trans.). (2005). Oxford University Press. (Original work published ca. 610–632 C.E.)

Rajeh, A. (2024). *Mental health and Islam: Friday khutbah Jummah Prayer: London Muslim Survey* [Video]. YouTube. https://www.youtube.com/live/eCE8q3VXa7o?si=6o9KRHSJQqbm7yt6

Reich, M., Jarvis, G. E., & Whitley, R. (2024). Examining recovery and mental health service satisfaction among young immigrant Muslim women with mental distress in Quebec. *BMC Psychiatry*, *24*(1), 483. https://doi.org/10.1186/s12888-024-05940-8

Rutledge, K. (2025). Rethinking pathways to well-being: The function of faith practice in distress alleviation among displaced Muslim women affected by war. *Frontiers in Psychiatry*, *16*. https://doi.org/10.3389/fpsyt.2025.1335640

Saherwala, Z., Bashir, S., & Gainer, D. (2021). Providing culturally competent mental health care for Muslim women. *Innovations in Clinical Neuroscience, 18*(4–6), 33–39. https://pmc.ncbi.nlm.nih.gov/articles/PMC8667712/

Statistics Canada. (2024, December 16). *The Muslim population in Canada.* Government of Canada. https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2024058-eng.htm

Statistics Canada. (2025, January 23). *A snapshot of the Muslim population in Canada*. Government of Canada. https://www.statcan.gc.ca/o1/en/plus/7639-snapshot-muslim-population-canada

Taha, W. (2021). "Counselling Made Me a Better Muslim": The counselling experiences of Muslim clients in Western Canada [Master thesis, University of Calgary]. http://hdl.handle.net/1880/113947

Tanhan, A. (2019). Acceptance and commitment therapy with ecological systems theory: Addressing Muslim mental health issues and wellbeing. *Journal of Positive Psychology and Wellbeing, 3*(2), 197–219. http://journalppw.com/index.php/JPPW/article/view/172

York, C. M., & Awan, H. (2023). Introduction to the special issue on Islamic spirituality in clinical contexts. *Spirituality in Clinical Practice*, *10*(1), 1–3. https://doi.org/10.1037/scp0000316

Zia, B., Abdulrazaq, S., & Mackenzie, C. S. (2022). Mental health service utilization and psychological help-seeking preferences among Canadian Muslims. *Canadian Journal of Community Mental Health*, *41*(1), 35–45. https://doi.org/10.7870/cjcmh-2022-003

Appendix

List of Articles Included for Analysis

Author	Year	Title	Source	Type
Ahad et al.	2023	Understanding and Addressing Mental Health Stigma Across Cultures for Improving Psychiatric Care	PubMed	Narrative Review
Ahmed & Mao	2024	An Intersectional Approach to Understanding Beliefs and Attitudes Towards Mental Health Issues Among Muslim Immigrant Women in Canada	PubMed	Qualitative
Albatnuni & Koszycki	2020	Prayer and Well-Being in Muslim Canadians: Exploring the Mediating Role of Spirituality, Mindfulness, Optimism, and Social Support	City U library	Quantitative
Alharbi et al.	2023	Understanding the Beliefs and Attitudes Towards Mental Health Problems Held by Muslim Communities and Acceptability of Cognitive Behavioral Therapy as a Treatment	Research Gate	Systematic review, thematic synthesis
Alqasir & Ohtsuka	2023	The Impact of Religio-Cultural Beliefs and Superstitions in Shaping the Understanding of Mental Disorders and Mental Health Treatment Among Arab Muslims	City U library	Qualitative
Alsubaei et al.	2021	Religious Coping, Perceived Discrimination, and Posttraumatic Growth in an International Sample of Forcibly Displaced Muslims	City U library	Quantitative
Bagasra	2023	Religious Interpretations of Mental Illness and Help-Seeking Experiences Among	Research Gate	Mixed Method

Author	Year	Title	Source	Type
		Muslim Americans: Implications for Clinical Practice		
Fekih-Romdhane et al.	2023	Mental Illness Stigma as a Moderator in the Relationship Between Religiosity and Help-Seeking Attitudes Among Muslims from 16 Arab Countries	City U library	Narrative review
Hassan et al.	2021	Inspiring Muslim Minds: Evaluating a Spiritually Adapted Psycho-Educational Program on Addiction to Overcome Stigma in Canadian Muslim Communities	PsycNet	Mixed method
Ibrahim & Whitley	2020	Religion and Mental Health: A Narrative Review With a Focus on Muslims in English-Speaking Countries	Cambridge U.	Narrative review
Javaid et al.	2024	Religious Coping and Mental Well-Being: A Systematic Review on Muslim University Students	Research Gate	Systematic review
McLaughlin et al.	2022	A Mixed-Methods Approach to Psychological Help-Seeking in Muslims: Islamophobia, Self-Stigma, and Therapeutic Preferences	PsycNet	Mixed methods
Muse	2024	Breaking the Barriers: Enhancing Mental Health Care for Muslim Communities Through Cultural Proficiency and Community Awareness.	Portland State U	Literature review
Basri et al.	2022	Barriers to and Facilitators of Mental Health Help-Seeking Behaviors Among South Asian American College Students	Research Gate	Qualitative
Reich et al.	2024	Examining Recovery and Mental Health Service Satisfaction Among Young Immigrant Muslim Women With Mental Distress in Quebec	PubMed	Qualitative

Author	Year	Title	Source	Type
Taha	2021	Examining the Counselling Experiences of Muslim Clients in Western Canada	Calgary U	Qualitative
Zia & Mackenzie	2022	Internalized Stigma Negatively Affects Attitudes and Intentions to Seek Psychological Help Among Western Muslims: Testing a Moderated Serial Mediation Model	Research Gate	Quantitative