



**Exploring senior phase educators' perceptions of learner mental health in
Kwazulu-Natal's Muslim schools**

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Declaration

I, Muhammad Coovadia (Student number: 224078747), declare that:

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Abstract

Adolescent mental health is an escalating global concern, with approximately one in seven individuals aged 10 to 19 experiencing a mental health condition, many of which remain undiagnosed and untreated. Educators, serving as mental health gatekeepers, play a pivotal role in addressing this crisis, making their views influential. However, a void persists in understanding educators' perspectives on learner mental health, especially in South African Muslim schools.

This study aimed to explore senior phase educators' perceptions of learner mental health in KwaZulu-Natal's Muslim schools, employing a transcendental phenomenological approach grounded in ecological systems theory. Eight senior phase educators from three Muslim schools were purposively selected, with data collected via once-off online semi-structured interviews and analysed using reflective thematic analysis.

The five emergent themes were (1) a spectrum of perspectives on mental health and illness, anchored in socioemotional functioning and a spiritual foundation; (2) the influence of cultural barriers, such as supernatural beliefs, entrenched stigma, and confidentiality concerns, which impede mental health access; (3) the identity conflict stemming from navigating dichotomous worldviews; (4) the crucible pressure cooker environment shaped by layered expectations and religious demands; and (5) the multifaceted intervention strategies adopted despite areas of improvement, reflecting existing progress and gaps.

The study's qualitative design and limited racial diversity among participants limit the findings by providing contextually grounded insights into an under-researched context. Nonetheless, the findings illuminate distinct challenges and opportunities, and contribute to the literature on Muslim mental health and mental health in schools. It is recommended that future research expand to diverse Muslim schooling contexts and that targeted mental health

training be developed for various members of the ecosystem to strengthen early identification and support strategies.

Keywords: adolescent mental health; culture; Islamic schools; Muslim mental health; religion; senior phase learners; South Africa

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Abbreviations

ADHD	Attention Deficit/Hyperactivity Disorder
AMS	Association of Muslim Schools
BEd	Bachelor of Education
DBE	Department of Basic Education
EST	Ecological Systems Theory
FET	Further Education and Training
GPs	General Practitioners
HPCSA	Health Professions Council of South Africa
HSSREC	Humanities and Social Sciences Research Ethics Committee
IC	Islamic Careline
IIRM	Islamically Integrated Resiliency Model
KZN	KwaZulu-Natal
P	Participant
PGCE	Post Graduate Certificate in Education
RTA	Reflective Thematic Analysis
SA	South Africa
SACE	South African Council for Educators
SADAG	South African Depression and Anxiety Group
TA	Thematic Analysis
TRREE	Training and Resources in Research Ethics Evaluation
UK	United Kingdom
UKZN	University of KwaZulu-Natal
WHO	World Health Organization

Chapter One: Introduction

The World Health Organization (WHO) reported that one in seven individuals aged between 10 and 19 experiences a mental health disorder, with adolescent mental health an escalating global concern (WHO, 2021). Adolescence is a pivotal developmental stage marked by a surge in mental health concerns driven by biological, cognitive, psychological, and social changes (Jörns-Presentati et al., 2021; Mælan et al., 2018; Sibanda et al., 2022). If left untreated, these can have a deleterious impact, potentially leading to substance use, developing physical health issues, diminished school attendance and academic success, increased interpersonal conflict, overall reduced life expectancy, and death by suicide (Harris et al., 2022; Soares et al., 2014).

While adolescent mental health is a global concern, South Africa (SA) is not immune to it (Ajele et al., 2025). Ajele et al. (2025) demonstrated that high school students in SA encounter a multitude of stressors, including academic pressures and identity formation, impacting their mental health. This constitutes a pivotal concern as adolescent mental health problems also pose a public health threat (Jacobs & Lekganyane, 2024).

To combat this endemic, Weist et al. (2023) argued that mental health support for youth should be delivered where they are. This is supported by WHO's (2021) identification of schools as central settings for addressing mental health. Teachers are well-positioned to observe their learners' emotions and behaviours, given the extended time they spend with them (Graham et al., 2011; Sibanda et al., 2022; Soares et al., 2014). They often also serve as the initial mental health contact point for parents and students (Shelemy et al., 2019). This has led to teachers being termed "mental health gatekeepers" due to their role as primary referral sources for paediatric mental health (Fazel et al., 2014; Splett et al., 2018).

Despite the vital role schools and educators play in addressing mental health, challenges in tackling it within this context persist. This includes, but is not limited to, a lack

of formal mental health training among educators, a limited understanding of mental health within school settings, restricted resources, and concerns about increased workload (Bryer & Signorini, 2011; Mellin et al., 2010). Importantly, studies indicate that educators are committed to supporting their learners' mental health needs when provided with appropriate resources relevant to their context (Edwards, 2020; Kamel et al., 2020). This accentuates the need to develop relevant resources relevant to their contexts to aid educators in addressing learner mental health.

The success of addressing mental health in schools is dependent on teachers' attitudes and perceptions of mental health literacy (Sibanda et al., 2022). Interestingly, teachers in private schools have been found to be more aware and to have better attitudes towards students with mental health conditions than teachers in public schools (Kamel et al., 2020). This underscores the importance of context in understanding teachers' perspectives.

Crucially, understandings of mental health are not universal. Rather, they are shaped by one's environment, with cultural and religious beliefs significantly impacting them (Alqasir & Ohtsuka, 2023; Baloyi, 2020). These environments influence how people understand mental health disorder symptoms and shape their attitudes toward mental health treatment (Alqasir & Ohtsuka, 2023). This illustrates the importance of exploring mental health from cultural and religious frameworks, especially in the multicultural South African context.

While culturally sensitive mental health approaches are constitutionally warranted in SA (Baloyi, 2020), a gap endures in the literature regarding cultural and religious understandings of mental health in SA, especially among South African Muslims. Mohamed-Kaloo and Laher (2014) underscored this, concluding that qualitative research is needed to unpack the role culture and religion play in understanding mental health in SA.

Although research on Muslim adolescents is increasing internationally, it remains in its nascent stages (Ahmed & Hashem, 2016). Studies conducted abroad, such as in the United Kingdom (UK), indicate that in countries where mental health services are easily accessible, Muslim youth underutilise them due to stigma and a reluctance to share personal problems with strangers (Randhawa & Stein, 2007). This results in Muslim youth relying on family, friends, and/or spiritual healers to help them cope with mental health concerns (Al-Krenawi & Graham, 2011; Haroun et al., 2011). Importantly, these studies are over 10 years old, with their relevance questionable. However, a lack of recent literature is palpable.

Notably, research also demonstrates the potential protective role of Islamic religiosity. Studies suggest that increased religiosity serves as a buffer against depression and anxiety and has a positive relationship to happiness and well-being in Muslim youth (Vasegh & Mohammadi, 2007; Yapici & Bilican, 2014). A UK-based study found that Muslim youth had the lowest levels of psychological distress when compared to other faith groups, a finding attributed to the strong social cohesion within minority religious communities (Dabbagh et al., 2012). However, the applicability of these studies to Muslims living in SA remains uncertain.

Critically, in the South African Muslim context, Laher and Ismail (2012) posited that a paucity of research focusing on mental health among Muslims exists, attributing this gap in part to their status as a minority group. More recently, and focusing specifically on Muslim youth, Ahmed and Hashem (2016) observed that information on Muslim youth in African countries remains limited.

Although these assertions were made over five years ago, upon perusal of current literature, it remained evident that a knowledge gap persists regarding the cultural and religious dimensions of mental health, specifically within the South African Muslim school context and in relation to adolescent mental health. In relation to the general South African

adolescent population, Ajele et al. (2025) recently contended that despite the urgency of mental health among South African youth, studies conducted in South African high schools remain scarce. Furthermore, limited research has examined teachers' insights into learner mental health (Skinner et al., 2019).

Therefore, this study addressed this lacuna by investigating senior phase educators' perceptions of learner mental health in Muslim schools in KwaZulu-Natal (KZN). After examining the literature, no studies exploring educators' perceptions of learners' mental health in South African Muslim schools were found, underscoring the novel and valuable contribution of this study.

1.1. Problem Statement

Adolescent mental health is an escalating global concern, with a substantial proportion of young people experiencing mental health disorders during the ages in which schooling remains a primary developmental context (WHO, 2021). If unaddressed, such difficulties may contribute to impaired academic functioning, interpersonal difficulties, substance use, and elevated risk trajectories across the lifespan (Harris et al., 2022; Soares et al., 2014). Within South Africa, adolescent mental health concerns are similarly urgent, with learners exposed to layered academic and psychosocial stressors that may compromise wellbeing and functioning (Ajele et al., 2025; Jacobs & Lekganyane, 2024).

Schools have therefore been increasingly positioned as key sites for early identification, prevention, and support, with evidence indicating that schools are central settings for adolescent mental health promotion (WHO, 2021; Weist et al., 2023). Educators, in particular, are frequently framed as mental health gatekeepers because they spend sustained time with learners, observe behaviour and emotional changes, and are often the first point of contact for parents and learners when concerns arise (Fazel et al., 2014; Graham et al., 2011; Shelemy et al., 2019; Splett et al., 2018).

However, school-based mental health efforts are shaped by educators' perceptions and mental health literacy, which vary across contexts and may be constrained by limited formal training, uncertainty regarding roles, and concerns about workload and competence (Bryer & Signorini, 2011; Ekornes et al., 2012; Mellin et al., 2010; Nash et al., 2016). As a result, how educators conceptualise mental health and mental illness has direct implications for identification, referral pathways, and the quality of support learners receive (Ekornes et al., 2012; Sibanda et al., 2022).

Crucially, understandings of mental health are not culturally neutral. Cultural and religious frameworks influence how distress is interpreted, what is considered normative, and what forms of support are perceived as legitimate (Alqasir & Ohtsuka, 2023). Despite calls for culturally responsive mental health approaches in South Africa, research remains limited regarding the cultural and religious dimensions of mental health, particularly within South African Muslim communities (Mohamed-Kaloo & Laher, 2014) and Muslim youth in African contexts (Ahmed & Hashem, 2016). In addition, broader South African school-based mental health research remains scarce, and limited work has explored educators' insights into learner mental health (Ajele et al., 2025; Skinner et al., 2019). Consequently, there is insufficient empirical grounding regarding how senior phase educators perceive learner mental health and how religion and culture shape these perceptions. This study addresses this gap by exploring senior phase educators' perceptions of learner mental health in Muslim schools in KwaZulu-Natal.

1.2. Aims and Objectives

This study aimed to explore the perceptions that senior phase educators at Muslim schools in KZN have about learner mental health. Specifically, it sought to understand the influence that religion and culture have on their perceptions. The objectives of the study were:

1. To explore the viewpoints of senior phase educators in KZN's Muslim schools regarding mental health and mental illness.
2. To establish the influence religion and culture have on the attitudes of KZN's senior phase educators in Muslim schools regarding learner mental health.
3. To determine the common mental health concerns challenging senior phase learners in KZN's Muslim schools as identified by their educators.
4. To ascertain the intervention strategies that senior phase educators in KZN's Muslim schools implement to support learner mental health.

1.3. Research Questions

The study's research questions were:

1. What viewpoints do KZN's senior phase educators in Muslim schools have regarding mental health and mental illness?
2. What roles do religion and culture play in shaping the attitudes of senior-phase educators in KZN's Muslim schools to learner mental health?
3. What are common mental health concerns that senior phase educators in KZN's Muslim schools identify their learners to be challenged with?
4. What intervention strategies do senior phase educators in KZN's Muslim schools implement to support learner mental health?

1.4. Significance of the Study

This study is significant because it provides context-specific evidence on how learner mental health is understood and responded to within a relatively under-researched schooling context: Muslim schools in KwaZulu-Natal. Educators have been described as frontline agents in school-based mental health support and referral processes (Fazel et al., 2014; Shelemy et al., 2019; Splett et al., 2018). Given that educator perceptions shape identification and help-seeking pathways (Ekornes et al., 2012; Sibanda et al., 2022), empirical insight into

these perceptions will help strengthen responsive mental health promotion and intervention within Muslim schools.

The findings may benefit multiple stakeholders. Senior phase educators may benefit from a clearer understanding of how mental health and mental illness are conceptualised in their schooling context, which may inform targeted mental health literacy initiatives, early identification practices, and appropriate referral pathways. School leadership and governing structures may benefit by using the findings to refine school-level policies and procedures related to confidentiality, mental health support structures, and collaboration with external support services. Learners may benefit indirectly through improved responsiveness and coherence in school-based support, particularly where educators' understandings influence whether distress is recognised, validated, or escalated for further assistance. Parents and caregivers may benefit because educators are often approached for guidance when concerns arise, and strengthened school family collaboration is central to effective support pathways (Shelemy et al., 2019; Soares et al., 2014).

In addition, mental health practitioners and community-based organisations may benefit by gaining contextual insight to support the development of culturally and religiously congruent school-linked interventions and collaboration models, consistent with calls for intersectoral approaches to youth mental health (Shelemy et al., 2019; Soares et al., 2014). Finally, researchers and policy stakeholders may benefit because the study addresses identified gaps in the South African literature on adolescent mental health in schools and teacher perspectives (Ajele et al., 2025; Skinner et al., 2019), while contributing to the limited body of work on Muslim mental health in South Africa and African contexts (Ahmed & Hashem, 2016; Laher & Ismail, 2012). In doing so, the study provides an empirical basis for future research, training, and policy development to strengthen support for learner mental health.

1.5. Operational Definitions

To ensure clarity in this study, the operational definitions of key terms used are provided below, in alphabetical order.

1.5.1. Educator

For this study, an educator was defined as a person registered with the South African Council for Educators (SACE) as such. Individuals imparting knowledge at a school who were not registered with SACE were not regarded as educators in this study.

1.5.2. Islamic/Muslim School

An Islamic or Muslim school is one that offers a dual curriculum that includes religious education, such as Islamic jurisprudence and prophetic traditions, as well as secular subjects like mathematics and history (Davids & Waghid, 2021). While these schools operate independently of the state, they must be registered with the Department of Basic Education (DBE) and Umalusi, the national quality assurance body. Although not directly accountable to the DBE, they adhere to its regulations. The school's governance is thus managed by school boards that are composed of founders, funders, religious trusts, or family members (Pilo et al., 2024). In this study, the terms Islamic school and Muslim school were used interchangeably. Furthermore, to be classified as an Islamic school in this study, the school had to also be a member of the Association of Muslim Schools (AMS) to ensure consistency and commonality.

1.5.3. Mental Health

Consistent with this study's interpretivist approach, as will be further elaborated in Chapter Three, the study conceptualised mental health as a social construct. Therefore, instead of imposing a predefined definition, the study was designed to explore the meanings that participants ascribed to mental health and mental illness within their respective contexts.

However, to provide a clear framework for the study and to avoid perpetuating confusion, this study was guided by the widely cited WHO definition of mental health. This definition was selected as it is framed in social constructionism, as identified by John-Langba et al. (2022). WHO defined mental health as "a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community" (WHO, 2022, para. 1). This understanding provided the foundational lens for the study, while allowing for an exploration of the subjective meanings that participants associated with the term without imposing definitions.

1.5.4. Senior Phase

In SA, the term senior phase refers to grades seven to nine, with learners in this phase typically aged 13 to 15 (Du Toit, 2016). As this phase includes adolescence, it was selected as the focus of this study.

1.6. Structure of the Dissertation

This dissertation is divided into five chapters. The current chapter, Chapter One, highlights the importance of adolescent mental health and the critical role educators and their perspectives play in addressing mental health. The gaps in current literature were highlighted, and the rationale for the study was established. Thereafter, the study's aims, objectives, and questions were stated, along with operational definitions of key terms.

In Chapter Two, current literature on the topic is reviewed. Moreover, Bronfenbrenner's Ecological Systems Theory (EST) and its rationale for adoption as a theoretical framework are discussed.

Chapter Three outlines the study's methodology and explains the rationale for each research decision. Thereafter, the research process, including the data analysis process and ethical considerations, is described in detail.

Chapter Four begins with an overview of the research participants, providing key information about the sample. Next, the chapter presents and discusses the research findings, integrating them with current research and reflecting on their implications.

Chapter Five, the thesis's final chapter, summarises the study's key findings, reflects on its limitations, and offers theoretical, practice, and policy recommendations.

Chapter Two: Literature Review

2.1. Introduction

This chapter synthesises literature pertinent to the research study under various subtopics. Firstly, the search strategy adopted is explained. Next, an understanding of mental health and mental illness will be provided, with definitions and a focus on the importance of context. Thereafter, an understanding of mental health from an Islamic lens will be advanced. To move beyond mere definitions, the concept of adolescence will be explored, focusing on developmental perspectives and the importance of mental health during this stage. Subsequently, attention will be given to the role that educators play in addressing mental health. Next, the challenges educators face in addressing learner mental health will be presented, underscoring the need for research on this topic. Lastly, the theoretical framework underpinning this study will be explained, and its applicability justified.

2.2. Search Strategy

The literature review was compiled using a structured search strategy. An updated consolidated search was conducted and finalised in August 2025 to ensure that the literature included in this dissertation reflects the most relevant and current evidence base at the time of submission. Searches were conducted using PsycINFO, ERIC, Scopus, Web of Science, PubMed, Sabinet African Journals, and Africa-Wide Information, with Google Scholar also used to identify additional multidisciplinary and grey literature. Where relevant, ProQuest Dissertations and Theses was consulted to identify pertinent postgraduate research. The inclusion of grey literature and the search beyond these databases were critical, as valuable articles on Islamic psychology and Muslim mental health were found in these sources.

Search terms were organised around four conceptual clusters: (a) learner and adolescent mental health, (b) educator perceptions and school based mental health support, (c) religion, religiosity, and spirituality in relation to mental health, and (d) Muslim or Islamic

schooling contexts. Keywords and synonyms included combinations of: mental health, mental illness, psychological distress, wellbeing, anxiety, depression; adolescent, youth, learner, senior phase; teacher, educator, mental health literacy, perception, attitude, belief, help seeking, referral; and Muslim, Islam, Islamic school, Muslim school, faith based school, religion, religiosity, and spirituality. Geographic terms such as South Africa and Africa were included where relevant to refine searches for context-specific literature.

Boolean operators were also used. Examples of search strings included:

1. (“mental health” or “mental illness” or “wellbeing” or “psychological distress”) and (“adolescent” or “youth” or “learner”) and (“teacher” or “educator” or “school staff” or “mental health literacy” or “perception” or “attitude”)
2. (“Muslim” or “Islam” or “Islamic school” or “Muslim school” or “faith-based school”) and (“mental health” or “wellbeing” or “mental illness”) and (“adolescent” or “learner”)
3. (“religion” or “religiosity” or “spirituality” or “faith”) and (“mental health” or “wellbeing” or “help seeking”) and (“adolescent” or “school”)
4. (“South Africa” or “KwaZulu-Natal” or “KZN” or “sub-Saharan Africa”) and (“teacher” or “educator”) and (“mental health” or “wellbeing”)

Where database functionality permitted, filters were applied to prioritise relevance, including English language and publication dates between 2015 and 2025 to capture contemporary scholarship. Only English literature was consulted, possibly limiting the review's scope as alternative languages are dominant in Muslim countries. Seminal sources outside this date range were included selectively where they were foundational to key concepts or theoretical framing. In addition to database searches, backward citation searching via reviewing reference lists was used to locate additional relevant literature.

2.3. What is Mental Health and Mental Illness?

John-Langba et al. (2022) conducted a landmark systematic review examining definitions of mental health, finding that mental health was defined in diverse ways across the reviewed studies. This ranged from detailed prescriptions to broad descriptions, with some studies adopting an apophatic description, defining mental health by stating what it is not (John-Langba et al., 2022).

The challenge of defining mental health is not novel, with literature dating back to the 1950s documenting this and its subsequent implications (Galderisi et al., 2015). Significantly, Jahoda (1958) attested that there is no psychological term vaguer and more equivocal than mental health. While this assertion was documented in 1958, the challenge of defining mental health remains (Gautam et al., 2024).

Notably, an individual's theoretical orientation shapes their understanding of mental health and its definition. Due to his theoretical beliefs, Freud contended that mental health is an ideal notion that is unattainable (John-Langba et al., 2022). Conversely, Menninger (1947) defined mental health as achieving both effectiveness and happiness in one's interactions with the surrounding world.

The medical model of mental health, a perspective that remains one of the dominant approaches in the field, defines mental health in terms of the presence or absence of disease (John-Langba et al., 2022). However, authors have critiqued this understanding, contending that mental health should be understood as a positive occurrence rather than the mere absence of a condition (Westerhof & Keyes, 2010). Consequently, contemporary definitions of mental health and mental illness have included psychosocial factors, acknowledging the critical role of social and psychological elements in conjunction with biological factors (Gautam et al., 2024).

Due to the post-positivist movement, a shift towards understanding and defining mental health in a social constructivist framework has been witnessed (John-Langba et al., 2022). Within this perspective, mental health is not an objective, universal state but rather a social construct whose meaning and expression are explicated by social, political, and economic factors (Galderisi et al., 2015; Gautam et al., 2024). This understanding is critical, as it aligns with the study's theoretical framework and the underpinning paradigms of EST and interpretivism, respectively. However, this understanding has also been problematised for being unduly prescriptive and for having limited practical implementation (Manwell et al., 2015).

WHO's definition of mental health remains dominant in the literature (Ekornes et al., 2012). WHO (2001) defined good mental health as a condition of overall well-being in which one can realise their abilities, manage normal life stressors, work productively, and contribute to their community. Conspicuously, WHO's definition is also framed in social constructivism (John-Langba et al., 2022). Furthermore, Wren-Lewis and Alexandrova (2021) critiqued this definition for being incredibly demanding, describing a life of self-actualisation that most people fail to achieve.

In parallel, other scholars argue that definitions should move beyond abstract ideals of well-being toward clearer conceptual components. For example, Galderisi et al. (2015) propose mental health as a dynamic state of internal equilibrium that supports adaptive functioning, including cognitive and social skills and the ability to manage emotions. This aligns with critiques that overly idealised definitions risk becoming aspirational benchmarks rather than workable conceptual tools.

Another term that remains challenging to define and is often conflated with mental health is mental illness. Jahoda (1958) critiqued those who equate mental health and mental illness, advocating that they are separate constructs. John-Langba et al. (2022) uncovered that

the issue of coalescing the two constructs is especially noticeable in legislative pieces, such as mental health acts, wherein mental illness is defined instead of mental health. This is concerning, as mental health encompasses more than the absence of mental illness (Galderisi et al., 2015; Mælan et al., 2018) and includes the presence of positive well-being (Mælan et al., 2018).

Mental health and mental illness are not mutually exclusive, yet distinctive (Westerhof & Keyes, 2010). The significant difference between the two concepts is that mental health exists on a continuum that every individual possesses at every moment to some degree, even when a mental illness is present or absent (Galderisi et al., 2015). Keyes' continuum model further argues that individuals may be flourishing, moderate, or languishing regardless of whether a diagnosable disorder is present, highlighting the limits of equating no disorder with good mental health (Keyes, 2002).

Importantly, the lack of clear definitions of both mental health and mental illness has created challenges and opportunities, with Jackson and Haslam (2022) arguing that if expansive definitions of mental illness are adopted, it may increase help-seeking attitudes but also increase the population's vulnerability to stressful experiences. From a social constructionist standpoint, what a society labels as illness is shaped by cultural meanings, norms, and power relations, with direct implications for how mental distress is interpreted and responded to (Conrad & Barker, 2010).

John-Langba et al. (2022) argued that mental health policies and programmes at national and communal levels in SA should reflect broader understandings of mental health, and that intersectoral collaboration is required. Given that mental health is regarded as socially constructed and encompasses more than the absence of disease, I propose that understanding how each society constructs mental health is critical, especially for effective

strategies to be developed. Hence, investigating how senior phase educators in Muslim schools conceptualise mental health and mental illness is regarded to be valuable.

This section has established definitions and conceptualisations of mental health and mental illness. Subsequent sections of this literature review will examine how these concepts manifest in the lives of individuals, particularly adolescents, to ensure that the thesis goes beyond theoretical definitions and offers practical illustrations.

2.4. Culture as a Compass for Mental Health

Modern psychology focuses on a biomedical model of behaviour (Bulbulia & Laher, 2013), ignoring human beings' spiritual nature and resulting in an epistemological deficiency (Iqbal & Skinner, 2021). Soares et al. (2014) noted this when they stated that health encompasses a person's concurrent physical, mental, and spiritual well-being. Owing to the omission of spiritual understandings of these concepts, concerns have been raised regarding the medicalisation of normative human emotional reactions, such as sadness or anger, in Western models of mental health (Edwards, 2020).

Psychology studies human behaviours, and hence it must be inclusive of human diversity (Baloyi, 2020; Woodbridge, 2007). While this is a global challenge, it is critical in SA given the heterogeneous societies that its citizens coexist within (Johnston, 2015; Laher, 2014). Adopting a universalistic perspective in mental health fails to adequately explain culturally driven presentations of psychological distress (Laher, 2014; Matoane, 2012). Truter (2022) contended that this universalistic approach to mental health is a central driver of the high levels of non-adherence to Western treatment regimens in SA.

Regrettably, post-colonial SA has not yet incorporated spiritual dimensions into the psychological healing process. Despite the country's constitutional guarantee of the rights of cultural, religious, and linguistic communities, the field of psychology remains entrenched in colonial frameworks (Baloyi, 2020). The Health Professions Council of South Africa

(HPCSA) called for a cultural shift in psychology that incorporates spirituality in the early 2000s, yet meaningful reform has not taken place (Mkhize et al., 2014; Pillay et al., 2013).

Internationally, efforts are being made to explore the intersection of religion and mental health. However, despite the expanding body of work on religion and mental health, most research uses samples from Christian populations (Abdel-Khalek, 2011; Utz, 2012). Furthermore, those focusing on Muslim populations tend to concentrate on Muslims living in the Arab world or Muslim Asian countries like Malaysia, with less attention paid to Muslims living outside these contexts (Abdel-Khalek, 2011). While these assertions were noted over a decade ago, recent work suggests the trend persists, with many studies conducted in Christian congregational contexts (e.g., Hlongwane & Juby, 2023; Village & Francis, 2025) and Muslim-focused research still commonly emerging from Middle Eastern and Malaysian settings (e.g., Elshamy et al., 2023; Saged et al., 2022).

Importantly, from an Islamic perspective, mental health and illness are not distinct from physical health, with both being assigned by God (Mehraiki & Gholami, 2017; Utz, 2012). Furthermore, both are conceptualised to stem from biological, psychological, environmental, spiritual, and/or supernatural sources (Utz, 2012). Hence, each of these elements should be considered when offering definitions of these terms grounded in Islamic theory.

Attempting to define mental health from an Islamic perspective, Mehraiki and Gholami (2017) stated that it encompasses facilitating individual and social development, the prevention of mental disorders, and the provision of suitable treatment and rehabilitation. Exigently, misconstruing mental health within the Muslim community can lead to individuals being undiagnosed and untreated (Razak, 2020).

While understanding a client's culture is imperative, caution must be exercised in assuming uniformity of beliefs among adherents. Hence, the perspectives of the individual

being consulted must be acknowledged (Rothman, 2018). This statement correlates with the previously discussed notion that mental health is socially constructed. Given the literature presented thus far, exploring the mental health perceptions of educators in Muslim schools was essential, as their religious and occupational contexts were deemed likely to influence their understandings. Notably, no studies on this topic were identified in a literature review, underscoring the current knowledge gap.

Furthermore, to fully grasp mental health within a specific context, it is imperative to also consider how developmental stages intersect with these cultural understandings, particularly the period of adolescence, where mental health concerns are prominent.

2.5. A Developmental Perspective on Adolescence

Rooted in the notion that mental health is socially constructed and shaped by contexts such as age, as highlighted through the inclusion of the chronosystem in EST, it is imperative to delve into specific developmental stages during which mental health becomes salient.

Adolescence is a crucial developmental stage that is marked by a transition from childhood to adulthood (Jaworska & MacQueen, 2015; Newman & Newman, 2020; WHO, 2021). While traditional definitions of adolescence state that it spans from puberty to adulthood, there is a lack of clear demarcations between these polarities (Newman & Newman, 2020).

WHO states that adolescence spans ages 10 to 19 (WHO, 2021). However, contemporary research indicates that the development of the prefrontal cortex, the brain region related to decision-making and impulse control, continues into the mid-20s (Newman & Newman, 2020). This calls for adopting a more inclusive definition of adolescence that encompasses individuals aged 10 to 24 years (Jaworska & MacQueen, 2015; Newman & Newman, 2020).

While these comments denote the time frame of adolescence, this developmental stage has multiple key features (Newman & Newman, 2020). Adolescence involves profound changes across developmental domains, including physical, neurocognitive, psychological, and social domains (Ajele et al., 2025). Biologically, adolescence is heralded by puberty, a process involving neuroendocrine changes such as adrenarche and gonadarche, which drive physical maturation, including growth spurts and hormonal fluctuations (Bonnie & Backes, 2019).

Cognitively, advancements in abstract thinking and metacognition are observed, with the prefrontal cortex, which is responsible for executive functioning, developing during this phase (Bonnie & Backes, 2019). According to Piaget (1971), this stage is called the formal operational stage, as it marks a shift from reasoning about concrete, visible events to abstract thinking.

Adolescence is also a period of increased neurodevelopmental plasticity, making it a unique window for intervention and positive change, but also rendering adolescents more vulnerable to engaging in risk behaviours and developing psychopathology (Bonnie & Backes, 2019; Rudolph et al., 2017). Although this plasticity makes adolescents malleable, it is not synonymous with passivity. Instead, they are increasingly active agents in their own developmental process. Yet, as they navigate these changes, they require scaffolding and support from their environments (Bonnie & Backes, 2019).

From a psychosocial perspective, central to adolescence is the development of identity, in which an individual begins to understand themselves, their place in the world, and their ability to influence it (Bonnie & Backes, 2019). Erikson's (1968) seminal theory argues that identity formation is critical during this stage, and it involves integrating diverse experiences, culminating in a more stable and coherent sense of self through exploration. During this period, social identities, such as culture and religion, profoundly influence

psychosocial outcomes and experiences of inclusion or exclusion (Russell & Fish, 2017; Umaña-Taylor et al., 2014). This reinforces the rationale for the current study, which explores the influence of religious and cultural factors on learner mental health.

2.6. Adolescence from an Islamic Perspective

Importantly, adolescence is a social construct, with biological, legal, social-cultural, and religious factors shaping how it is defined and perceived (Newman & Newman, 2020). Islam's conceptualisation of development presents an alternative framework from approaches framed in logical positivism (Shehu, 2015). Shehu (2015) categorised human development from birth to old age into nine stages based on Islamic scripture and scholarly sources. The fourth and fifth stages are relevant to the current study.

The fourth stage, *Sinnul-Murahaqah*, encompasses individuals aged 10 to 15. According to Islamic doctrine, while cognitive development begins to mature during this stage, a person continues to operate within a childhood mentality and is therefore not morally accountable for their actions (Shehu, 2015). This distinction in accountability may influence the social expectations placed upon learners during this period, although empirical research in this domain is required to explore this possibility.

The fifth stage, *Sinnul-Bulugh*, involves individuals aged 15 to 33 years. During this period, an individual is considered cognitively mature and assumes full moral and religious responsibility for their actions (*takleef*). This stage is triggered by puberty, and Islamic doctrine demarcates its onset based on physiological changes (Shehu, 2015). The attainment of puberty is a transitional moment as it represents an individual's readiness to assume moral and religious responsibilities (Sulaiman et al., 2014).

Sulaiman et al. (2014) also attempted to categorise development based on cognitive growth, drawing from Islamic sources. Their classification mirrored that of Shehu (2015), with them titling the ages from seven to 15 as the *tamyiz* stage, a period in which children

begin to distinguish between right and wrong and develop a sense of moral and ethical behaviour (Sulaiman et al., 2014).

The Islamic conceptualisation of development, particularly regarding *takleef* (religious obligation), provides an alternative lens through which to examine the psychosocial pressures adolescents experience in Muslim schools and how these might be interpreted by their educators. However, scientific studies are required to analyse this view.

2.7. The Mental Health Epidemic During Adolescence: A Perilous Stage

After conceptualising adolescence, it is imperative to examine the prevalence of mental health challenges during this stage. Mental health concerns are recognised to increase during adolescence (Jörns-Presentati et al., 2021; Mælan et al., 2018), with many postulated to have an onset during adolescence (Eriksson et al., 2018; Sibanda et al., 2022). WHO (2021) propounded that adolescent mental health is a global rising concern, with one in seven individuals aged between 10 and 19 experiencing a mental health disorder. Alternative statistics indicate that 10% to 20% of adolescents internationally meet the criteria of a diagnosable mental health condition (Jones et al., 2021; Jörns-Presentati et al., 2021).

SA is not immune to this adolescent mental health endemic (Ajele et al., 2025). In fact, SA's unique challenges may exacerbate this issue. Ajele et al. (2025) found that high school students in SA encounter a multitude of stressors, including academic pressures and identity formation, which profoundly impact their mental health. Furthermore, in sub-Saharan Africa, the burden of common mental health disorders has doubled among adolescents over the past 30 years (Sibanda et al., 2022).

Anxiety and depression rates amongst adolescents are particularly concerning (Melton et al., 2014; WHO, 2021). Additionally, adolescents are susceptible to engaging in risk-taking behaviours, such as substance use and unsafe sexual practices, which could lead to mental health disorders (WHO, 2021). The number of adolescents dying by suicide and self-harming

is a further concern (Harris et al., 2022; Quarshie et al., 2020). Crucially, some of these assertions were made before the COVID-19 pandemic.

The detrimental impact of the COVID-19 pandemic on children and adolescents, and its lifelong negative implications, is well established in the research (Gittings et al., 2021; Weist et al., 2023). The sudden lifestyle changes that included social distancing, school closures or switching to distance education methods, and an increase in stress and mental illnesses amongst primary caregivers and the general population, adversely affected children (Benton et al., 2021; Bryant et al., 2020; Fegert et al., 2020). This has predisposed them to increased rates of anxiety and other mental health challenges (Benton et al., 2021; Fegert et al., 2020; Imran et al., 2020).

A meta-analysis by Racine et al. (2021) examined the global prevalence of clinically elevated child and adolescent anxiety and depression symptoms during COVID-19. This review, encompassing 29 studies and 80,879 youth, found prevalence estimates of clinically significant depression and anxiety symptoms to be markedly higher than the estimates reported prior to the pandemic's onset.

Given the global adolescent mental health crisis, early identification, prevention, and intervention of mental health concerns amongst adolescents are critical (Reinke et al., 2018). Early intervention is more effective than addressing these impediments later in life (Kato et al., 2015). Overall, mental health challenges are less intense, shorter in duration, and less likely to recur when addressed early (Bryer & Signorini, 2011; Yates, 2017). This, coupled with the increase in mental health concerns during adolescence, highlights the importance of research focusing on adolescent mental health.

Mælan et al. (2018) asserted that the bidirectional relationship between mental health and academic achievement is well documented. If mental health concerns are not addressed adequately within educational settings, it can result in lower educational achievements,

violence, substance use, and an overall reduction in life satisfaction (Splett et al., 2018; Yates, 2017). Young people impacted by mental illness also have a higher risk of decreased social interactions, higher school dropout, teenage pregnancy, and juvenile delinquency (Soares et al., 2014).

2.8. The Unique Mental Health Needs of Muslim Adolescents

Given their religious beliefs and societal norms, Muslim adolescents may face idiosyncratic challenges and opportunities. They are reported to experience decreased levels of mental health literacy, increased mental health stigma, and limited access to care, with all of these hampering their ability to address arising mental health issues (Essau et al., 2012; Raja, 2004). These challenges are exacerbated by the rampage of Islamophobia, with discrimination and social exclusion adding to the psychological burden of Muslim youth (Abu Khalaf, 2023; Kishi, 2017; Samari et al., 2018).

These discriminatory experiences have been identified as a risk factor associated with adverse mental health outcomes such as depression and negative self-esteem in Muslim adolescents across developed countries (Kayrouz et al., 2022; Priest et al., 2021). However, caution should be exercised when generalising these results, given that they were conducted in Muslim-majority or Western Muslim-minority countries. Hence, they may not reflect the reality of Muslim adolescents residing in SA.

Another challenge witnessed by Muslim adolescents in Muslim minority countries is acculturative stress and trauma from socio-political conflicts (Stuart & Ward, 2018). This is important as the recent socio-political conflicts, such as the Hamas-Israel-Iran war in the Middle East, may have further negative implications on the mental health of Muslim adolescents.

Anxiety and depression are prevalent among Muslim adolescents, a phenomenon not exclusive to Muslim adolescents, as previously highlighted. Nonetheless, these concerns are often underreported due to cultural challenges and a reliance on non-professional support systems such as spiritual healers and family (Al-Krenawi & Graham, 2011; Haroun et al., 2011).

Intriguingly, research by Kayrouz et al. (2022) captured the risk of clinically elevated difficulties among Muslim adolescents in Australia. Their findings suggest that Muslim males aged 11 to 17 and Muslim females aged 16 to 17 were not at a higher risk when compared to their peers in the general adolescent population in Australia. However, Muslim females aged 11 to 15 appeared to be at greater risk for developing clinically significant emotional and conduct-related problems than non-Muslim females in the same age group. Additionally, Muslim females aged 11 to 17 demonstrated a higher likelihood of experiencing conduct problems, emotional symptoms, and hyperactivity-inattention difficulties than their male Muslim counterparts (Kayrouz et al., 2022). Their findings underscore the importance of disaggregated data and highlight potential gendered differences in mental health experiences within the Muslim adolescent population that warrant further investigation.

Furthermore, although some guidance has emerged for working with Muslim youth in psychotherapy, such as adopting an ecological approach and consulting religious figures when appropriate (Ahmed & Amer, 2012; Bragazzi & del Puente, 2012; Kennedy et al., 2010), the empirical foundation for such interventions remains sparse. Relevant to the current study, these non-professional support systems may include educators, although a lack of research on the mental health role educators play to Muslim adolescents is perceptible.

Positively, studies suggest that the sense of belonging provided by their religious community may serve as a protective factor against psychological distress for Muslim

adolescents (Stuart & Ward, 2018). Increased religiosity has also been linked to lower rates of depression and anxiety, as well as positive associations with happiness and well-being among Muslim youth (Abdel-Khalek, 2007; Abu-Rayya et al., 2016; Vasegh & Mohammadi, 2007; Yapici & Bilican, 2014). A UK-based study even found that Muslim youth had the lowest psychological distress among various faith groups, with it being attributed to strong social cohesion within the religious minority (Dabbagh et al., 2012).

Ahmed and Hashem (2016) found that despite an increase in global research on Muslim adolescents, a gap remains, particularly concerning how Muslim youth perceive and address mental health. This is especially notable in sub-Saharan African countries and other Muslim minority contexts (Ahmed & Hashem, 2016), underscoring the importance of the current study. Notably, while this assertion is over five years old, upon perusal of recent literature, it was evident that it persists.

2.9. The Climacteric Role Teachers Play in Addressing Mental Health

Shelemy et al. (2019) highlighted that intersectoral collaboration with wider communities is required to support young people's mental health. Over the past decade, an increased need for mental health support in schools has been observed (Imran et al., 2020). This is further testified by WHO's (2021) assertion that developing supportive familial and school environments is critical to effectively address adolescent mental health.

Educators have been identified as key front-line professionals who promote mental health (Ekornes et al., 2012; Graham et al., 2011; Soares et al., 2014). The extended quantity of time teachers spend with students allows them to notice signs and symptoms of depression, anxiety, learning disorders, and other mental health concerns (Graham et al., 2011; Harris et al., 2011; Sibanda et al., 2022; Soares et al., 2014). Teachers are well-positioned to assess their learners' weaknesses and are also well-situated to determine their strengths (Yates, 2017).

Teachers also educate learners about mental health, providing a preventive and educational role (Mælan et al., 2018; Samdal et al., 2017; Soares et al., 2014). Furthermore, they guide parents in supporting their child's mental health (Soares et al., 2014). When parents identify that their child is exhibiting behavioural problems that are caused by an underlying mental health concern, they frequently approach educators for guidance (Shelemy et al., 2019; Yates, 2017). As a result, teachers are typically the first point of contact for parents and students concerned about their mental health (Shelemy et al., 2019). These insights can be understood from an ecological lens, the study's theoretical framework, as educators are firmly situated within the microsystem and mesosystem. In this role, they directly interact with learners and engage with their caregivers.

Teachers have thus been called gatekeepers to mental health services, as they refer learners to them (Fazel et al., 2014; Splett et al., 2018; Stiffman et al., 2010). Stiffman et al. (2010) explained a mental health gatekeeper as a non-mental health professional who initiates or directs access to treatment. Children, unlike adults, do not refer themselves to therapy or counselling. Rather, access to services is generally initiated by their parents or educators (Loades & Mastroiannopoulou, 2010). However, these referrals are based on their parents' or teachers' perceptions of mental health (Yates, 2017), making their perspectives pivotal.

Weare (2010) found that in the school context, mental health is confined to pupils with a defined diagnosis or condition. Ekornes et al. (2012) further established that of their 1575 survey respondents, 62% strongly agreed that the term is linked to illness and diagnosis, while Soares et al. (2014) found that 41.9% of their study's 31 participants defined mental health as being free from disorders that result in emotional imbalance. Mental health is thus an uncommon term and is imbued with negative connotations in schools (Ekornes et al., 2012).

Notably, Kamel et al. (2020) reported that educators had a favourable disposition towards students with mental health issues. Critically, teachers in private schools were found to be more aware and to have better attitudes towards students with mental health issues compared to teachers in public schools (Kamel et al., 2020). These findings underscore the importance of understanding the contextual factors central to the current study in shaping educators' receptiveness to mental health.

Overall, schools are the most logical setting for mental health support (Minahan, 2022; Weist et al., 2023). However, the success of such measures is dependent on teachers' attitudes and perceptions of mental health (Sibanda et al., 2022). Furthermore, collaboration between mental health practitioners and schools is necessary to ensure that school-based mental health promotion and support are tailored to meet the requirements of all school community members (Soares et al., 2014), highlighting the need for the current study.

2.10. The Challenges Encountered by Teachers When Addressing Mental Health

Despite the critical role that educators play in addressing mental health, many were not provided with any formal mental health training (Bryer & Signorini, 2011; Nash et al., 2016). This has led them to have a limited understanding of the concept (Nash et al., 2016). While this has changed in certain areas, with some younger teachers focusing slightly more on mental health during their training than older teachers, it remains a concern (Bryer & Signorini, 2011). However, these findings are from studies conducted several years ago and therefore may not reflect the current reality.

Psychologists and educators typically have varied understandings of mental health, creating challenges (Bryer & Signorini, 2011; Mellin et al., 2010). How mental health is understood has significant practical implications for policy within school systems and for the multidisciplinary collaboration required for optimal support (Ekornes et al., 2012). Ekornes et al. (2012) highlighted that if mental health is restricted to mental illness, then it will most

likely be seen by educators as an area beyond their competency and a burden upon them. This is also reflected in the findings of Mælan et al. (2018), wherein they found that educators were scared to intervene in mental health concerns and deemed it to be a burden as they feared making matters worse.

Notably, the findings of Mælan et al. (2018) contradict those of Graham et al. (2011), who reported that educators were confident in their ability to address mental health concerns when asked in a quantitative self-report. However, interestingly, in Graham et al.'s (2011) qualitative findings, educators noted that balancing roles and meeting expectations were exacting.

Teachers have also identified mental health promotion as an additional task to their already heavy workload (Ekornes et al., 2012; Graham et al., 2011). Several American studies indicate that educators feel unprepared to assist learners with their mental health concerns, lack confidence when discussing mental health, and are insecure about making appropriate referrals (Bryer & Signorini, 2011).

Splett et al. (2018) found that while educators may be able to identify learners with severe externalising and internalising problems, they were less accurate in identifying students with moderate or subclinical signs or symptoms that require intervention. Moreover, Yates (2017) stated that educators tend to internalise challenges rather than externalise them, as externalising concerns interferes with classroom functioning. This is concerning given that internalising behaviours result in more severe consequences if left unattended, such as interpersonal conflicts and death by suicide (Splett et al., 2018).

Given the lack of training and the importance of mental health, educators have shown interest in learning more about the topic (Soares et al., 2014). Reinke et al.'s (2011) study found that the majority of the 292 teachers who participated believed schools were environments where mental health should be addressed. Studies also indicate that educators

are committed to supporting the mental health needs of their learners and are interested in additional mental health training when provided with the appropriate resources that address their needs and are relevant to their context (Edwards, 2020; Graham et al., 2011).

Hence, understanding the common mental health concerns educators identify their learners as being challenged by, and their current intervention strategies, was conceptualised to aid in providing support recommendations and guiding the development of training geared towards equipping educators with the required skills. However, this had to be done while keeping their context in mind. Hence, the next section will explore the study's theoretical framework, which was envisioned to assist in exploring the context of Muslim school educators.

2.11. Theoretical Framework: Urie Bronfenbrenner's Ecological Systems Theory (EST)

A theoretical framework provides an organised set of concepts and premises to conceptualise a study (Varpio et al., 2019). It serves as its blueprint (Grant & Osanloo, 2014), and is based on one or more theories (Abend, 2008). By clearly defining a study's theoretical framework, a logical connection is established throughout the research (Varpio et al., 2019). This study used Urie Bronfenbrenner's EST as its framework.

EST is a widely cited framework in human development and educational psychology (Tong & An, 2023). It posits that human development and behaviour are shaped by various interconnected environmental systems (Hayes et al., 2022). Bronfenbrenner (1981) described ecology as the interrelationships between individuals and their environments for the evolution and survival of individuals.

Evolving over four decades, the theory progressed from the ecology of human development to ecological systems theory, and eventually to bioecological theory (Navarro et al., 2022; Tudge, 2017). The final iteration introduced the concept of proximal processes, formalised as the Process-Person-Context-Time (PPCT) model to guide research (Navarro &

Tudge, 2022). This model identified five systems that influence individuals, namely, (1) the microsystem, (2) the mesosystem, (3) the exosystem, (4) the macrosystem, and (5) the chronosystem (Hayes et al., 2022).

The microsystem incorporates an individual's immediate environment, comprising one's family, peers, colleagues, and others with whom one has direct contact. It plays a key role in shaping attitudes and behaviours through a symbiotic influence, with a person impacting and being impacted by their environment (Hayes et al., 2022). Therefore, in this study, educators' perceptions of learner mental health were seen as shaped by and shaping the ecologies they are a part of.

The mesosystem refers to the interconnectedness between different microsystems, such as the relationship between a child's parents and their school (Tong & An, 2023). These interactions are critical as they can support or hinder a person's development. The exosystem, on the other hand, includes external environments that an individual may not directly engage with but that still influence them. This encompasses societal institutions such as the media and community organisations (Hayes et al., 2022).

The macrosystem comprises an individual's broader historical, cultural, and societal context, including aspects such as race and cultural norms. Lastly, the chronosystem denotes the time transitions within one's lifespan, reflecting that development is ever-changing (Hayes et al., 2022).

EST was appropriate for this study because it considered the interactions among various systemic influences, including cultural and religious contexts. EST is a holistic theory (Christensen, 2016), making it a suitable framework, as Islamic theories of mental health also adopt a comprehensive approach, as explained previously. Its suitability is further strengthened by Eriksson et al.'s (2018) argument that mental health must be analysed and promoted holistically.

2.12. Conclusion

This chapter presented a synthesis of current literature relevant to the topic. It began by highlighting that literature underscores that mental health is not merely a fixed, universal concept but a contested, socially constructed notion. The ambiguity in its definition is evident since Jahoda's (1958) early critiques and was reiterated in John-Langba et al.'s (2022) systematic review. Furthermore, the literature reveals an epistemological deficiency in Western-centric biomedical models, which perpetuate the marginalisation of spiritual dimensions central to many religions, including Islam (Iqbal & Skinner, 2021; Laher, 2014). This calls into question the efficacy of interventions when the very construct of mental health is ill-defined or misunderstood, demanding that the current study explore educators' perceptions of mental health, especially within the specific cultural and religious context of SA's Muslim schools.

Moving beyond cultural and religious understandings, the review next explored age and the chronosystem's impact on mental health. The consulted literature established adolescence as a stage of increased mental health vulnerability. This period of heightened neurodevelopmental plasticity, while offering immense potential, simultaneously renders adolescents susceptible to mental health challenges (Bonnie & Backes, 2019). This highlights the importance of addressing mental health during this formative stage, as it is a zero-sum moment, where intervention can lead to positive outcomes, but inaction typically results in significant negative consequences.

Compounding this, the intersection of Islam with this developmental epoch creates idiosyncratic complexities for Muslim adolescents (Kayrouz et al., 2022). While their religion may also have protective factor layers, like a strong community belonging, the literature

exposes a research void concerning Muslim adolescent mental health, particularly in Muslim minority contexts like sub-Saharan Africa (Ahmed & Hashem, 2016).

To address the escalating adolescent mental health crisis and effectively harness this developmental stage's potential, the review uncovers the paradoxical and often untenable position of educators as mental health gatekeepers. Teachers, embedded within the learners' microsystem, are ideally positioned to identify mental health concerns and make appropriate referrals (Shelemy et al., 2019; Splett et al., 2018). Yet, the literature exposes a deficit in mental health training and a tendency to conflate mental health with mental illness among educators (Ekornes et al., 2012; Nash et al., 2016).

These insights underscore the need for mental health interventions that move beyond generic, universalistic approaches when addressing mental health among Muslim adolescents in KZN's Muslim schools. These interventions must be culturally congruent and sensitive to the idiosyncratic pressures of Muslim adolescents and the needs of their educators. These findings shaped the study's aim of exploring educators' perceptions of learner mental health in KZN's Muslim schools. While this literature review establishes the value of investigating the study's research questions, the next chapter will detail the methodological approach employed to explore them.

Chapter Three: Research Methodology

3.1. Introduction

This chapter outlines the study's methodology. The study explored the learner mental health perceptions of senior phase educators at Muslim schools in KZN. A detailed description of the research process adopted to investigate the research questions will be provided, along with the rationale for each step. The validation and rigour applied to ensure a high-quality qualitative study are also discussed in this chapter. Lastly, the ethical considerations adhered to are described.

3.2. Paradigmatic Underpinning

A research paradigm provides a lens through which a researcher views and perceives the world. Researchers conduct their study within a paradigm, which guides every action and helps them select methods to explore the research questions (Bertram & Christiansen, 2014). This study applied a social constructivism paradigm.

Social constructivism underscores society and culture's role in developing understanding and knowledge (Bikner-Ahsbabs et al., 2015). According to the theory, knowledge is subjective. Hence, it is conceived as existing independently and as co-constructed by the researcher and participants (Howitt, 2019). This paradigm suited the study, given that senior phase educators' perceptions of learner mental health were subjective.

The theory asserts that participants are deemed experts in their lived experience and are best suited to develop subjective meanings from it (Bikner-Ahsbabs et al., 2015; Creswell & Poth, 2018). Hence, participants were envisioned to best understand mental health in the context of KZN's Muslim schools, the common mental health concerns their learners face, and intervention strategies suitable to the specific contexts in which they are positioned, making social constructivism an appropriate paradigm.

3.3. Research Design

A qualitative phenomenological study was used to explore the research questions. Qualitative research stems from the argument that there are various versions of reality, each connected to the context in which it transpires (Clarke & Braun, 2013). Qualitative studies assess the subjective meanings that groups or individuals assign to social experiences and challenges (Camic, 2021). The perceptions that educators in Muslim schools had regarding mental health were subjective and could not be quantified. Thus, a qualitative approach was sensible. Furthermore, the qualitative design complemented the study's paradigmatic undermining of interpretivism, as it helped the researcher understand learners' mental health from educators' perspectives.

A phenomenological study explores the common meanings a group of individuals assigns to a shared lived experience or phenomenon, describing the phenomenon's universal essence (Creswell & Poth, 2018). This approach suited the study, as the common perceptions of learner mental health among senior phase educators in KZN's Muslim schools were explored, with the group of individuals being senior phase educators and the shared phenomenon being their perceptions of learner mental health.

Specifically, a transcendental phenomenological approach was adopted. This requires the investigator to bracket their experiences to gain a fresh perspective on the phenomenon (Creswell & Poth, 2018). Originating from Edmund Husserl's work, transcendental phenomenology is a descriptive analysis of human experience (Wertz et al., 2011). In this approach, the researcher develops a textural description, which describes what participants experienced, and a structural description, which explores how they experienced the phenomenon based on the context (Creswell & Poth, 2018). This design was suitable because it helped convey a universal essence of the studied phenomenon and mitigated any biases I

may have had, an element that was especially important given that I have worked in a school setting and identify as a Muslim.

3.4. Sampling

Sampling is the process by which research participants are selected from the target population and involves decisions about which individuals to observe, including their settings and characteristics (Terre Blanche et al., 2006). Nonprobability sampling, specifically purposive sampling, was used to select participants. Nonprobability sampling chooses participants based on predetermined characteristics, while purposive sampling determines potential participants based on a set of inclusion criteria (Babbie, 2020; Neuman, 2014). Purposive sampling was appropriate, given that the study required individuals who met specific selection criteria.

Originally, nine participants were intended to be selected from three Muslim schools based in KZN. Three senior phase educators were to be selected from each school, ensuring diverse experiences. However, recruitment challenges necessitated reducing the number to eight participants. Nevertheless, the data from the eight participants were expected to provide sufficient information to answer the research questions; hence, it was decided to proceed with them. Participants were selected on a first-come, first-served basis, preventing researcher bias.

In qualitative research, a guiding principle is that the sample should be sufficiently large and varied to address the research objectives, as Patton (2015) emphasises. Malterud et al. (2015) further stated that six to ten participants with varied experiences are generally sufficient to meet the research aims of qualitative studies. Furthermore, Boddy (2016) noted that although there is no strict guideline for sample sizes in qualitative research, a range of around ten is commonly effective.

Beyond numeric guidance, the sample's adequacy was strengthened by its heterogeneity in professional experience and teaching responsibilities. While subject specialisation and specific senior phase grades were not used as exclusion criteria, the resulting sample nevertheless reflected diversity across subjects (e.g., English, Mathematics, Life Orientation, Islamic Studies, Social Science, and Technology) and grades (seven to nine), which strengthened the adequacy of the sample.

Specifically, in phenomenological research, Bartholomew et al. (2021) argued that large samples can diminish the depth of individual voices. They asserted that a stipulated sample size is contrary to phenomenology's theoretical foundation, which prioritises answering the research question over the number of participants (Bartholomew et al., 2021). Thus, the sample of eight participants was carefully selected to elicit comprehensive responses that addressed the research question while respecting phenomenology's emphasis on capturing the essence of individual experiences and avoiding diminishing their views.

Participants were selected based on the following inclusion criteria: senior phase educators who were registered as educators with SACE, identified as Muslims, were currently teaching at one of the three selected schools, having taught for a minimum of three years at a Muslim school, and were proficient in both written and spoken English of any socioeconomic status, age, race, gender, relationship status, or ethnicity.

Any educator who identified as a Muslim met the inclusion criteria, with no consideration given to the sect of Islam they conformed to. A minimum of three years of teaching experience at a Muslim school was required to gain a more in-depth exploration. Only individuals well-versed in written and spoken English were selected to ensure that informed consent was obtained in understandable language and that participants' accounts were not distorted by translation. Furthermore, no consideration was given to the subjects or grades the educators taught, if they were senior-phase educators. No age limitations were

placed, given that the mental health training levels of younger and older educators may differ, as highlighted in the literature review.

Exclusion criteria included educators who taught only in the foundation, intermediate, and/or Further Education and Training (FET) phases, but not in the senior phase.

Furthermore, educators employed at a non-Muslim school or a Muslim school besides the three identified schools did not qualify for participation. Individuals who may have engaged with senior phase learners at the three identified schools but were not registered as educators with SACE did not meet the participation requirement. Lastly, educators with less than three years of experience at a Muslim school were not eligible to participate.

3.5. Data Collection Procedure

Data was gathered after obtaining gatekeepers' permission from the identified schools and receiving ethical clearance from the University of KwaZulu-Natal's Humanities and Social Sciences Research Ethics Committee (HSSREC) (HSSREC/00007751/2024). Gatekeepers' permission letters have not been included to maintain school and participant confidentiality, while the HSSREC ethical approval letter is located under Appendix A.

The researcher designed a research advertisement that the participating schools shared with their educators upon HSSREC's approval. This advert, detailing the study's aims, objectives, researcher information, inclusion criteria, and participation requirements, is in Appendix B. Once a participant reached out to the researcher and expressed a willingness to participate, the information sheet and informed consent form (Appendix C) were shared, and a date and time for the interview were mutually agreed upon.

Interviews were conducted virtually due to the researcher's and participants' geographic locations. Whilst some limitations of online interviews exist, such as the possibility of decontextualising participants, they also have benefits (Knott et al., 2022; Thunberg & Arnell, 2021). For example, online interviews offer flexibility in scheduling and

time (Knott et al., 2022), an element particularly beneficial given participants' occupations. Moreover, online interviews may mitigate discomfort experienced during interviews (Knott et al., 2022; Thunberg & Arnell, 2021), an important consideration given the religion of the study's participants, as will be expounded on in the ethical considerations section of this thesis.

Online interviews took place on Zoom. Interviews lasted approximately 60 to 90 minutes and were conducted in English only, without a translator. At the start of the interview, participants were provided with an overview of the study and an opportunity to ask any questions or clarify any concerns. Moreover, time was allocated at the end for participants to reflect on the interview, clarify any concerns, and receive contact details for debriefing services.

The interview questions, as indicated in Appendix D, were designed based on the aims and objectives of the current study and on the study by Mohamed-Kaloo and Laher (2014). Mohamed-Kaloo and Laher (2014) established the perceptions of Muslim General Practitioners (GPs) regarding mental health using a qualitative approach and collected data employing semi-structured interviews. Given that their study also explored the perceptions of mental health amongst a group of Muslims, some of their interview questions were valuable for the current study.

One pre-test interview was conducted with an individual who met the inclusion criteria to assess the appropriateness, clarity, and sequencing of the semi-structured interview schedule, thereby strengthening the quality of the data collection instrument (Malmqvist et al., 2019). The participant was informed that the interview formed part of the pre-testing process, and the transcript was reviewed by the researcher and supervisor prior to commencing full-scale data collection. Following this review, minor amendments were made to the wording and ordering of questions to enhance clarity and flow. No questions were

added or removed, and the data generated during the pre-test interview were not included in the study's results.

Interviews were recorded using Zoom's built-in recording feature, enabling transcription and ensuring the data was not misrepresented. Express consent for the recording was sought in the consent form. The recordings were stored on the researcher's password-protected laptop for up to 72 hours before being transferred to a protected Google Drive. Verbatim transcriptions were produced using Whisper AI, an encrypted artificial intelligence programme that has demonstrated high accuracy in transcribing interviews (Wollin-Giering et al., 2024), with all identifying information removed. The researcher verified and edited transcripts manually to ensure no errors occurred. Verbatim transcriptions help solidify the validation and rigour of the research, a mandate of good qualitative studies (Gill et al., 2008). The digital transcriptions of all consent forms and other documents were stored in Google Drive and accessible only to the researcher and his supervisor.

All personal information was processed in accordance with the Protection of Personal Information Act 4 of 2013 (POPIA). Only information necessary for the study's aims was collected. Zoom was selected due to the researcher's and participants' geographic locations and the practical benefits of flexible scheduling. However, the potential privacy and confidentiality risks associated with online interviewing were explained at the start of each interview, along with the steps taken to mitigate these risks.

Once the interviews were transcribed, the recordings were deleted from the Google Drive. Furthermore, transcriptions were stored on a password-protected Google Drive, accessible only to the researcher and his supervisor, and will be retained for a minimum of 5 years. All physical data collected was securely stored in a safe at the researcher's private residence and made available to the supervisor upon request. Physical data will be stored for a minimum of five years and then destroyed in an environmentally friendly manner. Lastly,

participants were allowed to share their email addresses with the researcher for an infographic highlighting the research findings, which will be shared with them after the study is completed.

3.6. Data Collection Method

Semi-structured, one-off online interviews were used to collect data. Interviews allow a researcher to pose open-ended questions for a personal understanding of participants' experiences (Creswell & Poth, 2018). Since social constructivism acknowledges that participants are best positioned to understand their experiences and ascribe meaning to them, interviews were sensible. Furthermore, interviews are valuable when there is limited knowledge regarding the phenomenon being studied (Gill et al., 2008), making it a suitable technique. Interviews are also a suitable data collection method for phenomenological studies (Creswell & Poth, 2018).

Semi-structured interviews combine structured and unstructured questions, facilitating clarified and detailed responses (Du Plooy-Cilliers et al., 2022). It allows participants to explore areas related to the research topic that the researcher did not previously consider (Gill et al., 2008). Given the lack of existing research, a semi-structured approach was ideal and aligned with the study's aim of providing a detailed understanding of educators' perceptions.

3.7. Data Analysis

The data gathered was analysed using Thematic Analysis (TA). TA is a systematic method of recognising, identifying, and communicating patterns that emerge from the data and align with the objectives of a study. In TA, these patterns are referred to as themes (Braun & Clarke, 2006). TA provides a rich, detailed account of the data (Braun & Clarke, 2006; Guest et al., 2012). Since a detailed and rich description of senior phase educators' perceptions was sought, TA was appropriate. Furthermore, it complemented the study's paradigm, as both TA and social constructivism seek to understand reality through

participants' lenses (Braun & Clarke, 2006). Additionally, it is a flexible method that can be used with numerous theoretical frameworks (Braun & Clarke, 2020; Herzog et al., 2019).

Specifically, Reflexive Thematic Analysis (RTA) was adopted. In RTA, an inductive approach is adopted, in which the researcher allows codes and themes to emerge from the data. The researcher actively and critically reflects on their biases and assumptions, contemplating how these may influence their interpretations of the data (Braun & Clarke, 2019). RTA was a suitable technique for the study, as it helped remove any personal biases I may have had and provided a rich, descriptive analysis of the data. As determined by Clarke and Braun (2013), the researcher records assumptions before and during analysis, noting suppositions about the topic and how their life experiences may influence data interpretation. This was critical given that a transcendental phenomenological approach was adopted, with RTA useful for bracketing my biases.

There are six phases in RTA, namely, (1) familiarising oneself with the data, (2) developing initial codes, (3) finding themes, (4) appraising the themes, (5) defining and naming the identified themes, and (6) producing the report (Braun & Clarke, 2006). Familiarisation entails the researcher gaining an overview of the data by reading through it and noting observations (Braun & Clarke, 2006; Herzog et al., 2019). The researcher read and re-read the transcripts and listened to the interview recordings to verify and become familiar with them.

Wordings are highlighted during the development phase to ensure distinct codes are recorded (Braun & Clarke, 2006). The researcher coded the entire data set during this stage. In the third phase, overarching themes are recorded, whilst peripheral codes are repudiated (Braun & Clarke, 2006). A researcher must actively interpret the data whilst ensuring that their biases do not influence the process, as themes do not emerge naturally (Herzog et al., 2019). To enhance this, the number of initially identified themes and the selection process for

key themes were documented. Additionally, coding and theme identification were performed manually by the researcher without the aid of software programmes.

Both semantic and latent themes, which refer to explicit and implicit meanings, respectively, were identified (Maguire & Delahunt, 2017). Given the transcendental phenomenological approach, both textural and structural themes were identified. Braun and Clarke (2020) advised that a researcher must reflect on their assumptions during this stage and determine how they influence their coding, which I did.

Thereafter, each theme was scrutinised to verify that it correctly reflected the data and to determine whether any additional codes had been overlooked (Braun & Clarke, 2006). Each theme must be checked during this stage to ensure it is clear and distinct from others (Herzog et al., 2019). During this stage, I checked to ensure the themes represented the entire data set. Furthermore, themes were assessed to determine if they align with the research questions (Maguire & Delahunt, 2017).

Once confirmed, themes were defined and given names that comprehensively captured their contents. Concise yet catchy names were selected, with a third party consulted for their comments on the proposed names, as advised by Herzog et al. (2019).

Lastly, each theme, with an explanation and examples from the transcriptions that support it, was presented in the results and discussion section of this research report (Braun & Clarke, 2006). During the write-up, themes were contextualised within current literature as recommended by Braun and Clarke (2013). Furthermore, Herzog et al. (2019) asserted that researchers using RTA must meticulously document the research process to allow for transparency and reflexivity. Therefore, a detailed description of the research process is provided in this write-up.

3.8. Validation and Rigour

Creswell and Poth (2018) noted that validation and rigour must be considered in qualitative research, with validation evaluating the accuracy of the results and rigour affirming the analysis's integrity. Rohleder and Lyons (2014) determined that a thorough qualitative study has four measures that can be applied to assess the trustworthiness of qualitative findings, namely, (1) credibility, (2) transferability, (3) dependability, and (4) confirmability.

3.8.1. Credibility

Credibility is achieved when the researcher conveys accurate evidence (Johnson et al., 2020). To ensure credibility, I transcribed the interviews verbatim and thereafter cross-checked the de-identified transcriptions for errors. Furthermore, credibility was ensured through the provision of thick, detailed descriptions of the data, allowing the reader to judge the congruence between the data excerpts and the researcher's interpretations. Shenton (2004) asserted that steps must be taken to ensure that participants provide honest data, guaranteeing that the data truly represent the studied phenomenon. To facilitate this, participants were alerted that they could abstain from answering discomforting questions.

3.8.2. Transferability

Transferability mandates that the researcher furnishes in-depth information about the study, allowing readers to assess if the results apply to their or other situations (Johnson et al., 2020). Contextual information was provided in this report to enhance transferability. This included aggregated demographic data on participants' age ranges, gender distribution, and years of experience. Instead of revealing individual details, these summary descriptions were presented to maintain confidentiality. Furthermore, detailed information about the sampling strategy and data collection method was also provided to enhance transferability.

3.8.3. Dependability

Dependability stipulates that the researcher provides ample detail about the study process so that the research may be replicated (Johnson et al., 2020). A pre-test interview was conducted to augment dependability as recommended by Malmqvist et al. (2019). Furthermore, detailed information about the study's aims, objectives, questions, and methodology was provided in this thesis to strengthen the study's dependability.

3.8.4. Confirmability

Confirmability warrants that the findings are based on data collected from participants rather than the researcher's bias (Johnson et al., 2020). Crystallisation, referring to the regular introspection by researchers on biases, assists in establishing conformability (Ellingson, 2008). To uphold this, I kept a research journal, and any personal triggers were discussed with my psychologist whilst ensuring confidentiality. The adoption of a transcendental phenomenological methodology, including practices such as epoché, also reduced researcher bias, guiding me to set aside my personal experiences and remain open to participants' perspectives.

3.9. Ethical Considerations

Maintaining the highest ethical standards is crucial when conducting research (Babbie, 2020). To achieve this, data collection began only after HSSREC approved the study, with a research supervisor moderating all activities. Additionally, my supervisor and I completed the Training and Resources in Research Ethics Evaluation (TRREE) course to equip us with the required ethics skills. Furthermore, the eight-ethical-principles framework of Emanuel et al. (2008) was adhered to in the study, as described below.

3.9.1. Collaborative Partnership

A collaborative partnership requires mutual respect for the host community's values and practices, incorporating them into the study's design (Wassenaar & Mamotte, 2012). This

was achieved by taking into account the community's religious values. In Islam, intermingling between the opposite sexes is frowned upon (Hazim & Nazari, 2023). Some female participants might have felt uncomfortable being interviewed by a male. This is particularly relevant as females outnumber males in teaching (Davids & Waghid, 2020). To mitigate discomfort, participants were informed of the researcher's gender beforehand, and online interviews were selected.

Fair benefits should be derived from the research's results for the community, and their contributions should be credited (Emanuel et al., 2008). To ensure this, I will disseminate the study's results to the community via each school's management. Additionally, recognition of all contributors, while maintaining confidentiality, was provided in the acknowledgements section. The same will apply to any resulting publications and conference presentations.

3.9.2. Social Value

Research must lead to improvements in health and to the addressing of issues of value to the community (Emanuel et al., 2008). The current study is envisioned to enhance learners' mental health by raising awareness of the topic amongst teachers and catalysing further research and interventions. Furthermore, Wassenaar and Mamotte (2012) asserted that a study's social value can be enhanced by disseminating its findings to appropriate members of the community. Hence, the findings will be shared with the AMS for dissemination to their constituencies, should they wish.

3.9.3. Scientific Validity

Scientific validity is ensured when the study's methodology is rigorous, and it is hypothesised that the study answers the research questions (Emanuel et al., 2008). The scientific validity of the study was maintained by carefully selecting and reviewing all methodological decisions, ensuring they aligned with the research objectives and current

research standards. Lastly, the researcher completed a research methodology module to ensure current scientific knowledge.

3.9.4. Fair Participant Selection

The participants selected should be suitable to address the research question or questions (Emanuel et al., 2008). Furthermore, the selected population should have an equal opportunity to participate (Wassenaar & Mamotte, 2012). To ensure this, the researcher identified three Muslim schools in KZN via a Google search and contacted each to request liaison details and to send participation invitation letters. When selecting educators from the school, the researcher sent out an advert via the school's management, and the first three individuals who contacted the researcher and met the inclusion criteria were selected for participation.

3.9.5. Favourable Risk-Benefit Ratio

Nonmaleficence, which requires no harm, and beneficence, which requires safeguarding participants, were upheld (Kumpf, 2013). The researcher acknowledged the participants' humanity and their vulnerability, recognising that the interviews may have solicited negative emotions. To protect participants, they were provided with contact details for Islamic Careline (IC) for debriefing services. Given that identifying as Muslim was an inclusion criterion, culturally appropriate debriefing services were acquired, as Muslim counselling needs often differ (Rothman, 2018). A letter confirming IC's agreement to facilitate the debriefing services can be found in Appendix E. Contact details for the South African Depression and Anxiety Group (SADAG) were also provided.

Beneficence was realised as participants were projected to benefit from the engagement in the form of being provided a platform to reflect on their perceptions of learner mental health. Other benefits included providing insights to guide mental health training for

educators, assisting in developing support systems for them, and contributing to addressing a knowledge gap in the literature.

The risk of conflict of interest or dual roles was minimised by selecting only Muslim schools where I was not previously employed. Furthermore, only individuals with whom I had no pre-existing relationship were included, assisting in mitigating involuntary participation or coercion.

3.9.6. Independent Review

All research should be scrutinised by an independent ethical review committee before data collection commences (Emanuel et al., 2008). The study commenced only after it was reviewed and approved by HSSREC. Furthermore, two independent lecturers from the University of KwaZulu-Natal's (UKZN) psychology department reviewed the research proposal and provided feedback before submission for ethical approval.

3.9.7. Informed Consent

Participants must be informed in comprehensible language about the study's risks and benefits (Emanuel et al., 2008). In SA, the right to autonomy is a constitutional mandate that guarantees all individuals the right to free choice. Therefore, researchers must seek informed consent (Dhai & McQuoid-Mason, 2010). Before conducting an interview, participants read and completed the participant information sheet and informed consent form, written in understandable, unambiguous language. This document explains the purpose and procedures of the study, the potential consequences of participation, the right to refuse participation, confidentiality, and the contact details of my supervisor and me. Furthermore, it explicitly stipulated that participants would not be financially compensated.

Only English-speaking participants were included in the study to ensure that participants understood the consent process and could clarify any concerns. Bhandari (2021) states that a participant's right to freedom of choice encompasses the respect for their

diversity. Given the study's context, I sought to foster an environment that was attuned to cultural differences during interviews. For example, I was mindful of Islamic and cultural beliefs regarding opposite-sex engagements and eye contact.

3.9.8. Ongoing Respect for Participants and Study Community

Participants must be respected during and after the study (Emanuel et al., 2008). This can be done by providing participants with the opportunity to withdraw from the study and by respecting their anonymity and confidentiality (Wassenaar & Mamotte, 2012). Due to the semi-structured interview design, participant anonymity could not be guaranteed (Bhandari, 2021). However, confidentiality was maintained.

This was achieved by assigning a unique number to each participant during transcription and de-identifying the transcribed data. Furthermore, I conducted the online interviews at my private residence, using earphones to prevent third parties from hearing the discussion. However, unauthorised listening could not be guaranteed on the participants' side, as a third party might overhear the conversation. Participants were notified about this possibility during the initial interview engagements.

3.10. Conclusion

Chapter three detailed the study's methodology, emphasising the rationale for each step. A qualitative, transcendental-phenomenological approach was adopted, with data collected through once-off, online semi-structured interviews. Purposive sampling was used to select eight senior phase educators from three Muslim schools in KZN, based on predefined inclusion and exclusion criteria. The obtained data were transcribed verbatim before being analysed using RTA. Lastly, ethical and scientific standards were upheld, with ethical approval from an ethics committee, to ensure the quality of the research.

Chapter Four: Findings and Discussion

4.1. Introduction

Adopting Bronfenbrenner's EST, this study explored the perceptions that senior phase educators working at Muslim schools in KZN have about learner mental health. Specifically, the research aimed to understand their viewpoints regarding mental health and mental illness, to establish the influence of religion and culture on their attitudes towards learner mental health, to identify the common mental health concerns challenging senior phase learners as observed by their educators, and to ascertain the intervention strategies educators implement to provide mental health support.

This chapter presents and discusses the research findings. It begins with a brief description of the participants, followed by an overview of the identified themes. Each theme and subtheme is then discussed in detail, with excerpts from the transcriptions used to substantiate the findings.

4.2. Participant Information

The study engaged eight participants from three Muslim schools in KZN. The sample had equal numbers of males ($n=4$) and females ($n=4$). While this suggests an even split between male and female participants, it must be examined within the context of the SA teaching profession, where females constitute the majority. Wills and Böhmer (2023) found that in 2021, 70% of educators in SA were female. Additionally, Davids and Waghid (2020) found that 85.1% of students entering the Bachelor of Education (BEd) and Postgraduate Certificate in Education (PGCE) programmes at a university in SA between 2016 and 2020 were female, indicating the field's growing feminisation. Notably, the demographics of teachers within Muslim schools are undocumented; thus, it remains unknown if the sample reflects the population's gender composition.

The age of participants ranged from 27 to 70 years, with a mean of 57.57 (SD=14.34) and a median of 63. This allowed diverse perspectives to emerge. However, the higher median shows that the sample predominantly comprised older educators. This was noteworthy during data analysis, given potential generational differences in how younger and older educators understand mental health. For example, Ekornes et al. (2012) found that younger teachers placed greater emphasis on mental health during their educational training than their older counterparts.

Regarding years of professional experience, participants had a considerable collective tenure, with a mean of 24.57 years (SD=13.89) and a median of 23 years. The range of experience, from 3 to 45 years, included both novice and seasoned educators. However, the high median indicates that more experienced educators participated.

Participants taught a range of subjects within the senior phase across the various grades. The subjects taught included English, Mathematics, Life Orientation, Islamic Studies, Social Science, and Technology, while the grades encompassed grades seven, eight, and nine.

Participants' educational backgrounds also varied. Three participants reported having completed traditional Islamic studies beyond their secular education. This dual qualification provided additional insights into how religious factors influence mental health. One participant also acknowledged having an undergraduate degree in social work in addition to a PGCE. The remaining participants held formal qualifications solely within the education sector.

Lastly, all participants were Indians, limiting the racial representation of the sample. In KZN, Indians make up 82.43% of Muslims, with other racial groupings also existing (Vahed, 2020). All these characteristics, including gender, age, years of experience, and race, were critically engaged with throughout the data analysis phase to contextualise the findings. Table 01 summarises the above-mentioned information for ease of reference.

Table 01 *Summary of participant demographics*

Characteristic	Details
Gender	Male: 4 (50%) Female: 4 (50%)
Age (years)	Range: 27–70 Mean: 57.57 SD: 14.34 Median: 63
Years of teaching experience	Range: 3–45 Mean: 24.57 SD: 13.89 Median: 23
Subjects Taught	English, Mathematics, Life Orientation, Islamic Studies, Social Science, Technology
Grades taught	Grade seven, grade eight, grade nine
Educational background	• 3 participants held Islamic studies and education qualifications • 1 held a social work degree and a PGCE • 4 held education-related qualifications only
Race	Indian: 8 (100%)

4.3. Summary of Themes

Through RTA, five themes emerged that addressed the research questions. These were as follows: (1) a spectrum of perspectives on mental health and illness; (2) navigating cultural barriers despite a religious emphasis; (3) the modern Muslim learner's identity tug-of-war; (4) surviving the crucible pressure cooker; and (5) the multifaceted intervention strategies adopted by educators despite areas of improvement. An overview of these themes, including their subthemes, is presented in Table 02. Each verbatim quote used to substantiate a theme or subtheme is followed by the participant's assigned number in parentheses (e.g., P1 for Participant 1).

Table 02 *Themes identified from the interviews during data analysis*

Main themes	Subthemes (if applicable)
-------------	---------------------------

1. A spectrum of perspectives on mental health and illness	1.1 An emphasis on socioemotional functioning 1.2 A spiritual foundation to mental health
2. Navigating cultural barriers despite a religious emphasis	2.1 The shadow of supernatural beliefs 2.2 The entrenched cultural stigma 2.3 The complexities of confidentiality in a close-knit community
3. The modern Muslim learner's identity tug-of-war	---
4. Surviving the crucible pressure cooker	4.1 The weight of expectations 4.2 The compounding effect of religious and academic demands
5. The multifaceted intervention strategies adopted by educators despite areas of improvement	5.1 Enhancing the role of faith leaders in learner mental health support 5.2 Addressing gendered support

4.4. Theme One: A Spectrum of Perspectives on Mental Health and Illness

Theme one addressed research question one: what viewpoints do KZN's senior phase educators in Muslim schools have regarding mental health and mental illness?

When prompted to define mental health and mental illness, 50% of participants (n=4) expressed challenges, stating that these concepts are too broad and can be viewed from multiple perspectives. Participant two stated:

"It's (mental health) a difficult question to actually define because there's so many ways in which one can do that." (P2)

Participant eight echoed similar sentiments, emphasising the broadness of defining mental health:

"Okay, so it's a very, I would say, it's a very broad question to to ask. Like, how do we define mental health itself?" (P8)

This finding resonates with the sentiments of John-Langba et al. (2022), who identified that mental health and mental illness are historically and contemporarily elusive and

challenging constructs to define. Notably, within the school setting, Edwards (2020) similarly found that their participants expressed concerns about the ambiguous nature of the term mental health. This is also evident in South African mainstream high schools, with research noting teachers' difficulty in providing definitions of mental health, describing it as complex and vague (Abreu, 2023). These converging findings suggest that the ambiguity in understanding mental health and mental illness may not be unique to senior phase educators in KZN's Muslim schools.

This further suggests that the ambiguity may stem from the macrosystem, where official bodies fail to provide clear, consistent definitions of mental health and mental illness, leading to varied ground-level understandings. John-Langba et al.'s (2022) finding that legislation is particularly guilty of failing to define these terms supports this.

Nonetheless, despite these challenges, all educators provided descriptions of mental health and illness. Upon analysis of their thoughts, it became apparent that despite their varied understandings of mental health and mental illness, participants highlighted the centrality of a child's socioemotional functioning to mental health and illness, and the role spiritual well-being plays. This led to the two identified subthemes discussed below.

4.4.1. An Emphasis on Socioemotional Functioning

When speaking about mental health, participants highlighted the importance of socioemotional functioning. Participant three offered a comprehensive perspective on mental health, encompassing emotional regulation, social engagement, and adherence to social norms. They stated:

“Maybe, uhmm, the child's emotional state. Ahh, the sense of mental well-being, uhm, how they're feeling, how they're coping, how easy it is for them to socialise, how easy it is for them to take instructions, to work within a group, ahh, those kind of things.” (P3)

Significantly, this explanation introduces a potentially problematic conflation of equating social conformity with mental health. Participant seven shared similar sentiments to participant three, indicating how a person's interactions with others indicate their mental state.

“Hmm, so I think, I would, so that it's like, you know, how someone's feeling, their emotions, and how they're doing with other people. The way a person engages and acts with other people is a sign of how a person is doing mentally.” (P7)

This statement of participant seven risks pathologising individuals who may struggle with social engagement for reasons unrelated to mental illness, such as cultural differences. Jackson and Haslam (2022) noted that a lack of clarity when defining mental health can lead to unintended consequences. Furthermore, adopting expansive definitions of mental illness, while potentially increasing help-seeking, might inadvertently increase a population's vulnerability to stressful experiences by broadening the scope of what is considered abnormal (Jackson & Haslam, 2022).

In the school context, Weare (2010) discovered that teachers are influenced by the strong medical connotations of the term mental health, associating it with a defined condition or diagnosis. Ekornes et al. (2012) further asserted that mental health is a negatively loaded term in schools. In contrast to these findings, the current study revealed that participants held more positive views of mental health and mental illness. Rather than viewing mental health through a purely biological lens, participants associated it more with emotional and social functioning.

This shift toward a more positive conceptualisation of mental health holds important implications for mental health promotion. Ekornes et al. (2012) concluded that when educators view mental health more positively, as an element encompassing social and emotional well-being, they are better positioned to engage in mental health promotion.

However, it should also be borne in mind that, as previously highlighted, participants viewed a learner's ability to abide by societal norms as an indicator of their mental health. This is further evidenced by participant one's illustration of how non-compliance with social rules indicates a child's mental health status.

“This would give me an idea of the extent to which you can relate to our society, like how we built up rules in our society. So, if the rule says that you must sit, you must. Ahhh well, in our culture, it is you must sit and eat. That if I see a child walking, standing and walking and eating, he's not, not with the rule. He's not with the rule of society.” (P1)

This point regarding the pathologisation of non-compliance with societal and school norms, exemplified by participant one's interpretation of a child eating while standing as a sign of poor mental health, has considerable applications. This perspective aligns with the findings of Yao et al. (2021), who reported that within the collectivist culture of Eastern China, teachers interpret students' failure to adhere to school rules as evidence of underlying mental health conditions. Yao et al. (2021) further argued that the labelling of nonconformist adolescent behaviour as pathological reflects a broader process of medicalisation.

Similar patterns were observed in this study. Participant two, an educator who also holds a social work degree, highlighted that educators confuse discipline-related issues that stem from inadequate classroom management as an indication of mental health concerns.

“Uhhh, very often they confused, uhm, discipline issues, you know, where there was a lack of discipline in the classroom, they confused those issues with a need for counselling.” (P2)

This underscores a lack of differentiation between behavioural issues due to inadequate classroom management and mental health concerns. This highlights that while the participants' focus on socioemotional functioning compared to biological determinants may

have positives, pathologising nonconformist behaviour may also be present, an element that is imbued with negatives.

4.4.2. A Spiritual Foundation to Mental Health

All participants indicated that there is a spiritual foundation to mental health, emphasising its positive impact on learner mental health. This aligns with a burgeoning body of literature that establishes a positive correlation between spirituality and mental health within general populations (Koenig et al., 2020; Lucchetti et al., 2021; Vitorino et al., 2018) and among adolescents (Alqasir & Ohtsuka, 2023; Cotton et al., 2006).

Participant seven captured the importance of spirituality on mental health, stating:

“Spirituality is key for mental health in Islam. If you're spiritually healthy, you'll be mentally healthy too, you know.” (P7)

This demonstrates the perceived inextricable link between spirituality and mental health. Further elaborating on this, participant eight, a religious scholar and religious studies educator, provided an in-depth analysis of mental health rooted in Islamic theology. Referencing religious scripture, they explained the divine importance of mental health. This finding resonates with the research of Bulbulia and Laher (2013), who reported that all Muslim psychiatrists in their Johannesburg-based study believed that Islam recognises mental illness. Importantly, this study records a reported relationship between mental health and religion as well, not only mental illness.

Building on the relationship between spirituality and mental health, several participants offered examples of how specific Islamic rituals influence learners' mental health. Salaah, which is an act of worship performed by Muslims five times a day (Nazish & Kalra, 2018), was highlighted as a positive contributor to mental health. Participant seven acknowledged:

“Salaah, and your other spiritual acts, are all very important when it comes to mental health.” (P7)

Expanding on this, participant five described the observable changes found in students after performing Salaah during stressful situations.

“It happens; you see it. You can actually, you, you see those children come off the musallah (prayer mat) and they are so different from the child that went on to the musallah (prayer mat).” (P5)

This anecdotal observation aligns with the findings of Laher and Khan (2011), who also documented positive changes in clients following prayer.

Similarly, the recitation of the Quran, the holy scripture of Muslims, was identified by participants as a practice promoting mental health. Participant six affirmed:

“We must read the Quran, it's good for the mind, it's good for your heart, it's good to keep you calm.” (P6)

Beyond this, some participants provided instances of how particular actions improve mental health in specific situations. For instance, participant five expressed that reciting scripture before examinations assists with test anxiety. They described:

“You know that the time before we begin a paper, any exam, and we read the Yasin (a chapter of the Quran), that sukoon (tranquillity) that comes over them. There's that moment that they find in the reading, in resorting to the scripture, to, uhm, as a support it offers them. That, that psychological crutch.” (P5)

This perspective on how spirituality positively influences mental health is supported by the findings of Mohamed-Kaloo and Laher (2014), who found that Muslim GPs in Johannesburg recognised the benefits of religious practices such as Salaah and supplication for mental health. Laher and Khan (2011) reported similar findings among counsellors at an Islamic counselling centre in Johannesburg, who highlighted the value of prayer in coping with mental illness.

While these findings are from qualitative studies, quantitative research has similarly established the impact of Salaah and other religious actions on mental health. Emerging neurobiological research shows that Salaah reduces frontal brain activity and increases blood flow to the caudate nucleus, a section of the brain's reward centre, thereby positively influencing mental health (Rahman, 2025). Furthermore, the narrative review by Nazish and Kalra (2018) concluded that Salaah offers mental health benefits.

The systematic review by Owens et al. (2023) further corroborates these findings, indicating that Salaah, supplications, and reading, memorising, and listening to the Quran reduce anxiety, depression, and stress, and increase one's quality of life and coping abilities. Furthermore, Rozali et al. (2022) concluded from their systematic review that reciting, listening to, or memorising the Quran positively impacts depression, anxiety, and other domains of one's mental health. Finally, Ijaz et al.'s (2017) study among 174 students from two universities in Pakistan found that regular mindful prayer is associated with better mental health outcomes. However, Alqasir and Ohtsuka (2023) critically highlighted that, while the psychological benefits of spiritual practices are well documented, there is a potential misinterpretation within some communities, where these practices are misconstrued as the exclusive source of cure for all life's challenges.

4.5. Theme Two: Navigating Cultural Barriers Despite a Religious Emphasis

This theme speaks to research question two: what roles do religion and culture play in shaping the attitudes of senior-phase educators in KZN's Muslim schools of learner mental health?

While the previous theme highlighted how Islamic teachings emphasise the importance of mental health, this theme explores how religious interpretations and culture shape educators' attitudes towards learner mental health, creating opportunities and barriers. This is consistent with the conclusions of Koenig et al. (2020), which posits that while religion

serves as a powerful resource for individuals experiencing mental health challenges, it can paradoxically impede treatment.

Participants acknowledged that specific cultural beliefs and practices shape learner mental health attitudes, with it manifesting in the form of supernatural beliefs, pervasive stigma, and confidentiality concerns, which are explored in the subthemes below.

4.5.1. The Shadow of Supernatural Beliefs

An impediment that shapes attitudes about mental health is the pervasive influence of supernatural beliefs, particularly concerning spiritual possession (*jinn*) and black magic (*jadu*). Participants voiced concerns that the tendency to attribute mental health symptoms to these phenomena, rather than acknowledging mental health concerns, acts as a barrier to help-seeking behaviours. In fact, participant two noted that some Muslims have a complete disbelief in mental health and prefer to interpret behavioural changes as manifestations of spiritual possession or divine retribution. They revealed:

“...a disbelief in mental health that no such thing exists, and uhmm, that you're probably possessed...or that you may not be leading a deeny (spiritual) life, and that's why you are going through whatever it is that you are going through.” (P2)

This was corroborated by participant eight, an Islamic scholar, whose acknowledgement of the diagnostic challenges posed by the symptomatic overlap between mental health conditions and spiritual possession is salient. Given that individuals with knowledge of religious or spiritual illnesses, such as Moulanas (Islamic scholars), are approached to intervene in supernatural health conditions (Ally & Laher, 2008), this scholar's recognition of the ambiguity highlights a potential misdiagnosis. This further aligns with the findings of Laher and Khan (2011), who reported that their participants agreed that spiritual illnesses exist and that their symptoms mimic those of mental illness.

Participants eight articulated the negative implications this has, asserting a preference by parents for attributing distress to demonic possession rather than admitting a mental health disorder. They stated:

“You find that what was interesting for me is, like, there's a very fine line between schizophrenia and jinn possession, for example, right? We would rather acknowledge in our communities, or we would rather accept that my child or myself, is possessed by a jinn, but I'm not willing to say that I have a mental health issue.” (P8)

This preference may stem from the stigma associated with mental health within the Indian Muslim community, making supernatural explanations, however inaccurate, a more socially acceptable attribution, an aspect that will be explored further under sub-theme two. Furthermore, participant eight also illustrated how the attribution of mental health issues to black magic can serve as a mechanism for externalising responsibility.

“Sometimes we look for something to blame for our own issues. A man has, he has some anger issues, and he beats his wife, Allah forbid. And then he turns around and says, no, somebody made jadu (black magic) on me. That's why I beat my wife. So sometimes we also use it as a scapegoat. You know, we would rather choose to deny mental health issues, right, and pass the buck onto something else.” (P8)

This aspect of passing on the buck is supported by Laher and Khan's (2011) finding that spiritual illnesses are more culturally acceptable than mental health conditions, demonstrating the stigma of mental health and subsequent denial of it. An example of this in a Muslim school setting was provided by participant one, who described a parental consultation where academic decline was attributed solely to black magic. They illustrated:

“There's one example I heard of a child, his academic progress went down. During a parent's consultation day, the mother came to me, and she said: My child got a problem. I

know the last two terms' marks been going down and so on, and we know there's a problem. But the problem is, we think it's black magic...." (P1)

Contextualising these findings within the Islamic understanding of mental health is crucial, as it acknowledges multiple aetiological factors, including biological, psychological, spiritual, and/or supernatural domains (Bulbulia & Laher, 2013; Utz, 2012). Importantly, these assertions indicate that while Islam recognises spiritual and supernatural causes of mental health, it does not deny other aetiologies. However, the current study's participants' accounts suggest a cultural preference for supernatural explanations, despite it not being the sole cause of mental health conditions.

This spiritual preference may not be an exclusive phenomenon to Muslim schools but rather a wider macrosystem occurrence in SA, with Abreu (2023) noting that teachers in their South African study also believed that a lot of cultures attribute mental illness to being cursed. Furthermore, this may be linked to stigma, another critical impediment reported by participants.

4.5.2. The Entrenched Cultural Stigma

Building on the preceding subtheme, cultural stigma emerged as an element that shapes attitudes and serves as a barrier to addressing mental health concerns within the KZN Muslim school setting. Participants observed a tendency to downplay the severity of mental health problems. Participant four noted:

"Culturally, I think, uh, mental health issues are seen as minor, like not a big deal... People give time for other types of health like physical health and other things, but when it comes to mental health, it is still not seen in our school as a major thing in the parents and learners and that." (P4)

This attitude may be due to cultural values that prioritise visible, physical ailments over less tangible emotional or psychological struggles. This reluctance to acknowledge mental

health needs was further evidenced by participant five, who simply stated, *"We don't talk about what troubles us."* (P5)

The impact of stigma extends to the classroom environment, where a misunderstanding of mental health conditions, such as Attention Deficit/Hyperactivity Disorder (ADHD), was observed. Participant two, a Life Orientation teacher who acknowledged the importance of mental health, asserted:

"Then we have another issue where we have learners who are disruptive in class. Some of them has to do with maybe an ADHD issue. But I personally say to them that that's nonsense. You know, if you tell yourself to not to fidget and you don't fidget, I always tell them, I said, who's the boss here? You know, is it your mind? Your mind must be the boss. Your brain is the boss here." (P2)

This educator's statement demonstrates limited insight into the neurological basis of ADHD, attributing it to a lack of willpower. This illustrates stigma in action, denying the condition's biological reality and placing blame on the learner. Furthermore, it may reflect an attitude, shaped by cultural misunderstandings, that mental health conditions are a matter of willpower rather than a biological fact. This resonates with Minahan's (2022) assertion that deficient understandings about mental health disorders create inaccurate perceptions about them and hinder interventions, and Kern et al.'s (2015) finding of teachers' reduced familiarity with ADHD in mainstream schools in SA.

Participants observed that learners internalise the devaluation of mental health, as evidenced by participant one's observation that mental health is not a priority to them. They observed:

"Number two, the child doesn't look at mental health issues as a priority." (P1)

This reluctance to seek help is compounded by the fear of social labelling, including being labelled by teachers, as noted by participant seven.

"But sometimes they don't want to talk about their problems because they're scared of being labelled. Teachers or even learners might label them, and that makes them hesitant to speak out." (P7)

This aligns with Abreu's (2023) findings that the fear of stigmatisation and social discrimination creates secrecy and prevents learners from seeking mental health support. Specifically, Essau et al. (2012) reported that Muslim adolescents experience increased mental health stigma. This corresponds to participant six's lament that stigma was particularly pronounced within the Indian Muslim community.

"You see, unfortunately, unfortunately, especially amongst the Indian community, amongst the Indian community, we are Muslims, right? And what I find, and which I'm now beginning to even believe, that as Muslims, we don't focus so much on mental health." (P6)

They further elaborated on the misconception surrounding mental health treatment, equating seeking mental health support with "madness".

"Now, because as Muslims, we believe, or not we believe, we think, sorry, we think that if somebody is going to a psychologist or a psychiatrist or a social worker, they mad. And because of that, we shy away. And because we shy away, we have a problem." (P6)

This aligns with Mohamed-Kaloo and Laher's (2014) findings within the Muslim community of Lenasia, where mental illness was commonly stigmatised, and patients concealed their diagnoses as seeking support was equated with madness. Alqasir and Ohtsuka (2023) further found that Muslims may approach religious healers instead of mental health practitioners to avoid this shame.

The tragic consequences of this stigma were highlighted by participant eight, who reported an instance of a youngster dying by suicide within the Muslim community due to untreated depression. They relayed:

"Muslim people have committed suicide, and it was because of severe depression and refusal, ahh, because of stigma to get any help, mental health support, or any mental health support from whether it's doctors or psychiatrists. And it's a very, very sad state of affairs for our communities. And we've lost, we've lost many, many youngsters in this way." (P8)

This accentuates the urgent need to address the stigma surrounding mental health within the Muslim community. Despite these challenges, participant eight acknowledged the school's efforts in providing mental health support, stating:

"I would honestly, I would honestly say that the schools have supported the idea...So, I don't think the school as itself is a, is a problem. I think the problems could more stem from the community, rather than from the school." (P8)

This suggests that while the school is making efforts to provide mental health services, community-level stigma remains an obstacle. Participant three supported this idea with their sentiments, stating:

"Unfortunately, parents tend not to want to come to these (mental health) programs...so I don't know if the community itself realises the value of mental health at that way." (P3)

This aligns with Graham et al.'s (2011) and Shelemy et al.'s (2019) findings that teachers feel unsupported by parents. Yates (2017) further corroborated the issue of stigma as a major barrier preventing children from accessing needed mental health services. Abreu (2023) noted similar cultural barriers within Afrikaans and African communities in SA, where negative mindsets towards mental illness were prevalent, and Padayachee and Laher (2014) discovered that stigma was a reported barrier to mental health support in the Indian Hindu community. These findings indicate that stigma is not an idiosyncratic challenge to KZN Muslim schools but may rather be prevalent in SA's general population.

Interestingly, Abreu (2023) highlighted that adopting a biologically oriented understanding of mental illness can paradoxically lead to increased stigma. However, this was not directly present in the current study, given the participants' emphasis on socio-emotional functioning. Moreover, Yao et al. (2021) found that teachers may be reluctant to make referrals due to students' stigmatisation, which underscores this cultural barrier's impact. This is noteworthy given that teachers are gatekeepers to mental health services, as highlighted in the literature review.

4.5.3. The Complexities of Confidentiality in a Close-Knit Community

One of the cultural aspects that shaped the attitudes of educators and posed a challenge to accessing mental health services, identified by participants, was the complex issue of confidentiality within the close-knit Muslim school community. Participant one articulated this concern, highlighting the tension between a learner's need for support and their deep-seated fear of information dissemination, stating:

"You seem to go and make an appointment with the counsellor to sit there after school, talk to this person, worry about confidentiality, to worry where that problem is going to go. Maybe this counsellor will come home and talk about, and this child's got the whole thing, and he actually puts him off." (P1)

This encapsulates the vulnerability learners feel when contemplating seeking help, burdened by the fear that their lives might become communal knowledge. This was amplified by the participant's inability to guarantee confidentiality. Participant one stated:

"But I can't guarantee the child that confidentiality when he's dealing with the counsellor." (P1)

This demonstrates how the educator's awareness of the community's interconnectedness shapes their attitude towards confidentiality, leading them to hesitate to guarantee learners' privacy. Participant one elaborated on how the community's

interconnectedness is a threat, as mental health professionals might have a pre-existing relationship with the learner's family. Participant three expounded on this by highlighting how their Muslim school's communal nature exacerbates this issue, explaining:

"So, our school tends to, because everyone knows everyone in the community, so they tend to keep dirty laundry very close to their heart." (P3)

This metaphor of "keeping dirty laundry very close to their heart" conveys the reluctance to disclose personal problems within a community where social connections are prevalent, and information may be circulated. This not only prevents learners from accessing necessary support but also deters educators from referring learners to mental health support, as they fear stigma post-public disclosure, linking back to the previously discussed subtheme.

This aligns with Mohamed-Kaloo and Laher's (2014) study, which identified concerns over confidentiality as a factor that prevents patients from seeking mental health help within the general Muslim population. Similarly, Padayachee and Laher's (2014) research suggested that concerns about privacy deterred Hindu clients from seeking help. While the contexts differ, apprehension about personal information spreading within close-knit communities was a common theme across the current study and these studies. Additionally, Padayachee and Laher's (2014) findings in the Indian Hindu context suggest that this phenomenon is common across Indian communities, not solely in Muslim communities. This is critical given that all participants in the current study were Indian.

4.6. Theme Three: The Modern Muslim Learner's Identity Tug-of-War

This theme is linked to research question three: what are common mental health concerns that senior phase educators in KZN's Muslim schools identify their learners to be challenged with?

Participants identified an identity crisis among senior phase Muslim learners, which they perceived as a driver of anxiety and alienation, impacting learner mental health. This

crisis was attributed to the tension between adherence to Islamic social norms and the pressures of assimilating into a broader, contrasting culture.

This finding aligns with current literature. Adrian (2024), using Erikson's (1968) theory as a framework, contended that religion plays a central role in shaping personal and social identity, providing moral guidance and emotional support. However, in a globalised society, religious identity has become complex and fluid, creating challenges (Adrian, 2024). Notably, research consistently exhibits that religious identity is the most salient feature of a Muslim youth's identity (Ahmed & Hashem, 2016; Awad & Sultan, 2025). The religious identity of Muslim youth helps them navigate their environment, although further research is required to fully understand its behavioural implications (Ahmed & Hashem, 2016).

The duality of Islamic beliefs and the globalised society leads to an internal identity conflict, as participant six stated. They contended:

"You see, Muslim learners are now presenting the identity crisis that they don't know now what to do." (P6)

This clash between distinct cultural systems reflects a challenge originating from the macrosystem level, where broader societal norms differ from the cultural and religious norms advocated within the Muslim community. The tension between these overarching cultural blueprints creates a complex ecology for identity formation.

Participant seven's statement encapsulates the core of this struggle, wherein they stated:

"And then also the trying to fit in. They find themselves at crossroads with their religious identities and then just trying to fit in with other people." (P7)

This shows the difficulty Muslim adolescents experience when trying to integrate with other communities while maintaining their religious identity, with participants observing that this leads to isolation. The reason why this occurs during adolescence can be explained by Erik Erikson's psychosocial model, particularly the fifth developmental stage. It is described

as identity versus role confusion, a phase wherein adolescents are shaping their identity, with this navigation having severe psychological implications (Halevy & Gross, 2023).

Participant one elaborated on this identity crisis, emphasising the need to "marry the two worlds" and the critical role of Islamic scholars in doing so. They stated:

"Because the problems most of our children are having is related to two worlds. One is the Western world that he's living in, and the other one, the spiritual path which we all trying to draw him towards. He's got to marry the two, and the best person for that is a scholar who is linked to both worlds." (P1)

Research documents the clash between Islamic values and Western culture. Ali and Bagley (2014) established that in the Canadian context, Muslim students are taught to see themselves as distinct from Westerners and are discouraged from adopting their culture. Ramadan (2004) advanced that this leads to feelings of unease and inferiority, resulting in students concealing their religious identity or even rebelling against both Islamic and Western cultures.

Participant five, an English teacher, recounted an incident where Muslim learners participating in a debate at a non-Islamic school encountered ideologies contradicting their religious beliefs. They stressed how these occurrences confuse learners, especially when left unattended to post-event. They narrated:

"Our children, fortunately, they have me....and I will speak to them about it. I will because there's a real world out there. And I will tell them what the Quran says, what we believe, what we have to live by, and what the world is saying and doing...they didn't sit there with their mouths open." (P5)

This example shows how, when Muslim learners are exposed to differing worldviews, it can create confusion and uncertainty if not addressed properly. The proactive pedagogical

stance adopted by participant five, in which they addressed ideologies that contradict Islamic beliefs, underscores the important role educators play in navigating these contradictions.

The educational context has been identified as pivotal in the identity development of Muslim youth (Ahmed & Hashem, 2016). This underscores the vital role of schools and educators within the microsystem of Muslim youth in tackling macrosystem challenges, where daily interactions can facilitate the negotiation of their identity.

However, as Shah (2018) noted in the UK state school context, educators' preparedness to assist learners in navigating these terrains is concerning. While participant five demonstrated awareness of the contradiction and attempted to intervene, it remains unknown if all Muslim school educators adopt a similar approach, and their competence in doing so is open to question. Furthermore, Ramadan (2004) critiqued how Islamic education itself can inadvertently foster a sense of difference and inferiority when educators contrast Muslim identity with a Western other.

Marcia's (1966) theory of identity, which posits that adolescents actively navigate identity formation through exploration and commitment, offers insights into the mental health impact of identity confusion on Muslim learners. Muslim learners who are attempting to harmonise their religious identity with the pressures of a globalised culture may experience periods of identity diffusion or moratorium, characterised by heightened uncertainty and anxiety. This anxiety may be exacerbated by Islamophobia, which subjects Muslim youth to discrimination and social exclusion (Abu Khalaf, 2023; Samari et al., 2018).

The desire to negotiate their identity while living in a society that holds pernicious stereotypes about their faith can lead to feelings of marginalisation and ultimately create pressure to downplay their Muslim identity to avoid hostile interactions. This is supported by research conducted in Western countries, which highlights pressures to assimilate and the

feelings of marginalisation experienced when religious values clash with secular norms (Ali & Bagley, 2014).

While theories of identity development (Erikson, 1968; Marcia, 1966) and social identity theory (Tajfel & Turner, 1979) provide frameworks for understanding the identity crisis experienced by adolescents in KZN's Muslim schools, their application to the specific socio-cultural context of these schools warrants investigation. As Halevy and Gross (2023) noted, religious identity formation remains an under-researched area.

Critically, the Islamically Integrated Resiliency Model (IIRM) asserts the importance of a strong Islamic identity among children for positive mental health (Awad & Sultan, 2025). Awad and Sultan (2025) argued that a secure Islamic identity can foster resilience in Muslim youth, aiding them to navigate discrimination and marginalisation. This reinforces the significance of the identified identity conflict experienced by learners in KZN's Muslim schools on their mental health.

Fostering a strong Islamic identity may thus serve as a protective factor against mental health challenges for these learners, with microsystem elements such as educators and Islamic scholars potentially playing a role in harnessing this. Mahmud et al. (2023) specifically contended that religious identity development can be fostered in educational contexts by accepting learners unconditionally, fostering an atmosphere in which they feel unjudged, and increasing empathetic interactions.

4.7. Theme Four: Surviving the Crucible Pressure Cooker

This theme also addressed research question three: what are common mental health concerns that senior phase educators in KZN's Muslim schools identify their learners to be challenged with?

It emerged that participants identified the stress experienced by Muslim learners as a major mental health concern. Participants highlighted a confluence of factors, including

school pressures, parental expectations, comparisons between siblings and family members, and the idiosyncratic demands of Islamic education, that contributed to overwhelming stress.

Participant five summarised the issue of pressure, encapsulating the greatest mental health concern faced by senior phase Muslim school learners in KZN as:

"Stress (pause), stress (pause), stress (pause), I'll say it again, (pause) stress, and I'll say it again, (pause) stress". (P5)

This finding corresponds to existing scholarship, with Edwards (2020) establishing that numerous studies have proven how school-related stress results in exacerbated anxiety in children. Considering the origins of this stress and pressure, two subthemes emerged, with each discussed below.

4.7.1. The Weight of Expectations

The pressure-cooker environment experienced by senior phase Muslim school learners was identified as fuelled by parental and teacher expectations and by the practice of comparisons. Participants highlighted that these expectations function more as deterrents than as encouragements. Participant three observed the impact of hypercritical mothers and sibling comparisons, noting:

"Where they feel that the mums are hyper critical. Uhhh, the mums don't have time for them, they are compared to the other siblings..." (P3)

This comparison of learners to their higher-achieving siblings was not only evident among parents but also among teachers. Participant three testified:

"So, we may have the youngest one (sibling) with us currently, but we've had the older brother and sister, maybe they've came out in the top 10. So, automatically, teachers also may say something, inadvertently, you may say something, and then the child brings up something that it is already an issue. You know at home that they do, I am compared to my sibling, or I am, uhm, feeling not so worthy as they are." (P3)

Research indicates that academic factors are a major source of stress for adolescents globally. Adolescence is recognised as a stage of academic achievement, with stress arising from high expectations to perform well, stemming from students, parents, teachers, and society at large (Sham, 2015). Hence, the impact of these expectations from parents and teachers may not be unique to Muslim schools, as Abreu (2023) also discovered that teachers in SA believed that learner anxiety was caused by stress due to the expectations from their schools and parents. However, the scope of comparison was further broadened in the current study, encompassing peers and even cousins at different schools. Participant six described this, stating:

"You see, the common problem is pressure, right?....when you come to the school, the teachers are all putting pressure on them...then you get peer pressure, like these two cousins in the same class or two cousins, possibly in different provinces or different cities. So, I find the negative pressure and the negative competition is affecting children big time." (P6)

This multi-layered pressure environment, where parental, school management, teachers and peer expectations converge, may be distinct to Muslim schools given their collectivistic nature, creating an overwhelming burden for learners.

Furthermore, these expectations were deemed to be disconnected from individual capabilities, as described by participant six.

"You see, for example, now a parent will say, you know what, I want 70%, I want 80%, I want 90%, I want, and that poor child is not academically inclined, you know. So, then it will impact on them that they try to cheat, they try to copy, you know, they try to play sick, you know, my stomach is paining or this is paining." (P6)

These mismatched expectations can lead to maladaptive coping mechanisms such as cheating. Additionally, this, combined with the cultural stigma surrounding mental health, as discussed previously under theme two, may result in somatisation of concerns as highlighted

by participant six. The findings of Mohamed-Kaloo and Laher (2014) in the South African Muslim context corroborate this, as they highlighted how emotional distress caused by factors like stress manifests physically through pain-related complaints, as seeking help for physical issues is more socially accepted.

From a mental health perspective, participant four described how the unrealistic expectations create heightened anxiety in children. They noted:

“Ahh, also, heightened anxiety from, uhh, unrealistic expectations. There are a lot of expectations placed on children, and this then has an impact on the children.” (P4)

Participant five alarmingly stated that the school’s academic expectations are killing children, warning:

“(School name) wants academic excellence. They’re finishing our children...” (P5)

While the statement is hyperbolic, it conveys the school’s academic focus. This finding is consistent with other research that established the negative impact of academic and exam pressure on youth mental health (Edwards, 2020). This suggests that the issue of pressure is not exclusive to the Muslim school context. However, it remains unknown if it is worse in Muslim schools, especially given the collectivistic beliefs of their members as highlighted in this study, with learners' academic performance compared to extended family members as well.

4.7.2. The Compounding Effect of Religious and Academic Demands

Participants revealed that the academic pressures faced by Muslim learners are compounded by their religious commitments. This intersects with the identity-related challenges discussed in theme three, exposing that religious obligations not only contribute to identity-related challenges among Muslim learners, but also impose academic pressures.

Participant eight articulated this by stating:

"You see, as opposed to going to a, ahh, a normal school, a government school, or even just a private school that's not run on an Islamic ethos, right? You don't have Islamic studies as a component. That's an added workload for you.....so Muslim children are very, very, very busy children." (P8)

This stresses the additional academic layer of Islamic studies and extracurricular religious activities that Muslim school learners navigate alongside their other academic curriculum. Participant five highlighted the time constraints learners face due to these layers, noting the need to juggle tasks. They stated:

"... the extracurricular, their religious commitments, the, the tuition that they require. Its time demands and then of course the digital demands, so there's a lot of things that they're having to juggle in terms of time." (P5)

This paints a picture of how Muslim learners must juggle these responsibilities. The sacrifices learners make to manage this were described by participant five, wherein they commented:

"...where they have got to a point where they realised, okay, this has got to be dumped off my schedule. I can't play netball; I can't play soccer. I love it, it's my passion, but I'm going to give it up for now." (P5)

This demonstrates the emotional toll of prioritising academic and religious commitments over personal passions and recreational activities. Furthermore, participant five was concerned about the resultant lack of joy and fun in their school's learners' lives due to these demands, stating:

"I think that yes, um you know, um we have these co-curricular demands on the children. Bring some into their lives, moments, bring fun yeah, let them be children. Let them live, let them be children....I want to hear the children laugh. Which they don't do (pause), they don't do (pause), you don't hear children laugh anymore." (P5)

This shows the detrimental impact of the pressure placed on Muslim school learners due to these competing demands. The absence of laughter, as highlighted by the participant, is concerning and suggests the cost of these demanding schedules, which require recreational activities to be omitted.

This finding offers a novel insight into the experiences of senior phase learners in Muslim schools in KZN, as no previous research in this regard was located. While research acknowledges that sociocultural factors such as religion and family shape leisure behaviours and can act as constraints on leisure activities (Agans et al., 2023), this study highlights the nature of religious obligations as an academic workload within the KZN Muslim school context. Unlike students in other government or private schools in SA, this study showed that Muslim learners are required to engage in additional religious studies and activities.

Importantly, Agans et al.'s (2023) study found that while religion can limit leisure choices and time, university students often negotiate or adjust their leisure activities to align with religious or family expectations rather than abandoning them entirely. However, these findings refer to university students, not younger learners. Furthermore, in the university contexts, there was no formal integration of religious studies as an academic demand, as is the case in Muslim schools. Hence, the impact of religious obligations on learner mental health in Muslim schools remains underexplored, making the current finding novel and in need of further investigation.

4.8. Theme Five: The Multifaceted Intervention Strategies Adopted by Educators Despite Areas of Improvement

This theme is tied to research question four: what intervention strategies do senior phase educators in KZN's Muslim schools implement to support learner mental health?

Participants expressed that they and the Muslim schools they are working in are committed to addressing the mental health needs of their learners. They affirmed this,

providing evidence of the implementation of various support mechanisms. For example, six participants disclosed that their Muslim schools have a dedicated mental health professional to whom they refer learners. Additionally, participant eight emphatically stated:

"I would honestly, I would honestly say that the schools have supported the idea. I can tell you that that's why they have a counsellor in the school. If they didn't support the idea of mental health, then they wouldn't have a counsellor in school." (P8)

In addition to in-house counsellors or mental health professionals, some participants highlighted alternative strategies that educators adopted. Participant four described how they and their school refer learners to off-site counselling services and even get external speakers for mental health talks and seminars. They disclosed:

"Ahh, yeah, there are things like off-site counselling and, ahh, talks and seminars. The school does arrange for counselling with external people when needed, and they have talks on it." (P4)

Moreover, participants acknowledged their role in addressing mental health, with some disclosing that they offer informal mental health support to learners by providing them with guidance and advice. Participant one detailed how educators extend their support beyond academic matters, describing how the school communicated to learners that they can approach specific teachers, with one being them, should they wish to speak to someone. They described:

"People have noticed that when children have a problem, they come, when they have a problem, they usually open up to me or talk to me whenever they have a problem regarding academic matters. So, they said, let us extend it and if the child has got personal problems or social problems or whatever, he can come up to you and talk about it." (P1)

This finding about an increased awareness of mental health among Muslim schools aligns with the assertion of Weist et al. (2023) that research indicates a growing global

awareness of the importance of mental health support in educational settings. This suggests it may not be an idiosyncratic phenomenon among Muslim educators and schools.

Critically, participant three offered a counter view. They argued that even though their school embraced and made provision for mental health, a gap remains. They disclosed that a single counsellor is expected to address the mental health needs of the entire school, which ultimately leaves some individuals without services.

“So, unfortunately, to have a school counsellor is something very big, but the school counsellor is literally dealing with all 1000 learners and teachers and their issues. So, it's like really very difficult for the school counsellor to touch base with everyone...” (P3)

Research on mental health in South African schools, especially in under-resourced settings, highlights the shortage of mental health professionals and the strain on existing support systems (Mampane, 2023; Setlhare et al., 2016). The current theme's findings corroborate these studies, highlighting that areas of growth in learner mental health support among Muslim schools remain despite substantial progress.

In particular, regarding areas for improvement, participants raised two notable suggestions, leading to two subthemes, as discussed below.

4.8.1. Enhancing the Role of Faith Leaders in Learner Mental Health Support

Three participants recognised the critical role that Islamic scholars (*Moulanas/Apas*) can play in supporting learner mental health. Participant one highlighted the advantage Muslim school learners have due to the role of Islamic scholars in the school.

"But the advantage that the child has in our school is that he has access to, to Islamic scholars like our Moulanas and so on....that influence, I feel, in a Muslim school is a very, very important one." (P1)

Participant one further acknowledged the existing relationship and trust that learners hold for their religious leaders in the school environment. This contrasts with the trust

hesitancy they have for mental health professionals, as previously identified, positioning Islamic scholars as key sources of support. Studies in the UK reinforce this by indicating that in countries where mental health services are easily accessible, underutilisation has been witnessed by Muslim youth due to stigma and a reluctance to share personal problems with strangers (Ahmed & Hashem, 2016). This results in Muslim youth relying on family and spiritual healers to help them cope with mental health concerns (Ahmed & Hashem, 2016; Al-Krenawi & Graham, 2011; Haroun et al., 2011). Further corroborating this, Alqasir and Ohtsuka (2023) found that many Muslims in their study preferred seeking help from religious healers to avoid societal shame (Alqasir & Ohtsuka, 2023).

To fully leverage religious leaders in aiding learner mental health, participant one advocated for a more structured and accessible integration of faith leaders into the school's mental health support system. They argued:

"You don't have Moulana sitting in the office, and I can go and sit and talk to him. So, I feel a Muslim school can make our Islamic scholars more accessible on a personal level...The Moulana, whoever is doing that type of this thing, must be more accessible. You must have an actual timetable where people can just go and see him at any time, right?" (P1)

However, participant two offered a critical counterpoint, cautioning that faith leaders may inadvertently mishandle mental health concerns due to a lack of training or a judgmental approach. They concerningly said:

"...so sometimes with the, with the, with the Moulanas or the Muallimahs, or the scholars here, the way they deal sometimes with an issue can be problematic... sometimes the manner that it's dealt with is dealt with in an intolerant manner and in a manner of judgement. You know, there's judging, it's judgmental, it's intolerant, and it is unsympathetic. (pause) Yeah, and, and so, and very dismissive." (P2)

This observation underscores the need to provide appropriate training and resources to faith leaders, should collaboration occur, so they can effectively address mental health concerns. Without this, their interventions, while well-intentioned, could inadvertently exacerbate the distress of learners seeking help. This highlights the need to balance leveraging trust in faith leaders with ensuring they possess the necessary skills and understanding to provide appropriate support.

Notably, participant eight, a younger Islamic scholar, expressed a personal interest in pursuing further studies in mental health, showing that Islamic scholars may be willing to engage in this training. They requested:

"Make dua (prayer), in sha Allah (if God permits), I take this route and begin to study it again and begin to pursue it." (P8)

This proactive stance also demonstrates a potential awareness of the importance of integrating mental health and Islamic practice, and a desire to do so among Islamic scholars, although further research in this area is required.

This eagerness to learn Western psychotherapy methods and combine them with Islamic tradition for effective treatment among *Imams* (religious leaders) is documented in research, even within the South African context (Razak, 2020). This suggests a willingness within the macrosystem of Islamic leadership to bridge traditional and Western approaches to mental health, which could positively impact the microsystem of the school.

The integration of complementary and alternative care providers, such as traditional or faith healers, is recommended in SA (Moshabela et al., 2016; Truter, 2022). However, while numerous researchers advocate for syntheses between Western and alternative care providers to address mental health in SA (Laher, 2014; Van der Watt et al., 2017), caution against their inclusion has also been documented. Notable concerns include their questionable ability to effectively deal with more severe mental illnesses like psychotic disorders (Truter, 2022).

Nonetheless, this theme resonates with other literature on integrating religious resources into mental health support. Religious houses, including mosques, regularly provide pastoral counselling to their communities, addressing a range of issues, including substance use and family problems (Laher & Khan, 2011). A scoping review by Perez et al. (2025) examining faith community-mental health partnerships, including those involving Muslim communities, found that faith leaders are indispensable partners in providing mental health services. Furthermore, faith community-mental health partnerships may lead to reaching individuals and groups who might otherwise not seek psychiatric services due to stigma or cultural preferences (Hankerson et al., 2025). This is imperative, given the prevailing mental health stigma found in Muslim schools as identified earlier.

Furthermore, although previous research highlights the role of pastoral counselling in the general population, this study demonstrated its potential in Muslim schools when implemented effectively. However, as Hankerson et al. (2025) also argued, further research on this phenomenon is required for effective integration.

4.8.2. Addressing Gendered Support

Participants identified Islamic gender roles and the barriers these create for learners seeking help as an area of growth. Islamic scripture emphasises the separation of genders in social contexts, particularly in interactions that involve personal or emotional disclosure (Attum et al., 2019). Participants explained how this can lead to learners' reluctance to seek support from educators or mental health practitioners whose gender differs from theirs.

Participant one, for example, observed that female learners are typically reluctant to discuss their problems with male teachers. They noted:

"Girls won't really generally come up to male teachers and talk about their problems." (P1)

Participant eight noted how navigating these gender regulations is acutely challenging when addressing learner mental health, given the lack of male counsellors in Muslim schools.

"Because I do think we have, we have a lot of female, uh, counsellors, but we don't have male counsellors....so, I think also to encourage our students, uhmm, obviously we can't be very short-sighted, to encourage our males also to, to become psychologists and psychiatrists because they can, they can have, they can be a very big asset to the Islamic and the Muslim communities, especially the Islamic schools." (P8)

This suggests a need for a more diverse pool of mental health professionals to accommodate the gender preferences of Muslim learners, ensuring they feel comfortable seeking support from professionals of their preferred gender.

The concept of seeking out a gender matching therapist is debated in the literature on gender matching. Seidler et al. (2021) found that while many men reported no preference regarding a therapist's gender, younger men and those endorsing more traditional masculine norms preferred male therapists. Importantly, their study also concluded that seeing a therapist who matches one's gender preference increases satisfaction with psychotherapy (Seidler et al., 2021).

In terms of females, Landes et al. (2013) found that women overwhelmingly prefer female therapists, especially when discussing emotionally sensitive topics. This aligns with the behaviour of female learners as reported by educators in the current study, who reputedly avoid disclosing emotional problems to male educators. Critically, while previous literature from alternative populations indicates that gender-matching is advantageous, the current study inferred that within the Muslim school setting, it may carry increased importance given religious rulings around gender interactions.

From a cultural-religious perspective, Attum et al. (2019) stressed the importance of gender matching in Muslim healthcare contexts, recommending that gender be considered

when assigning providers to patients. This aligns with the current study's participants' call for more male mental health professionals in Muslim schools. Hence, this theme indicated that Islamic teachings on gender interactions serve as a barrier to mental health help-seeking behaviours, with gender matching mental health support recommended to combat this. Additionally, collaborating with Islamic scholars of different genders, as indicated in the first subtheme of this theme, could further address the gender gaps in interventions.

4.9. Conclusion

Chapter four provided a description of the themes that emerged and a detailed discussion of the participants' extracts, contextualising them within current literature. It highlighted the perceptions held by educators about mental health and dominant views within the Muslim community. Thereafter, specific challenges prevalent among senior phase Muslim school learners were outlined, followed by an examination of current support and areas for growth.

Chapter Five: Concluding Summation

5.1. Introduction

This transcendental phenomenological study, guided by Urie Bronfenbrenner's EST, investigated the perceptions of senior phase educators in KZN's Muslim schools regarding learner mental health, addressing a gap in an under-researched topic. This chapter provides a summary of the study's findings, reflects on its limitations, and offers recommendations and implications.

5.2. Summary of Key Findings

Five themes were identified that addressed the research questions. A summary of them is presented below, organised by research question.

5.2.1. Research Question 1: What viewpoints do KwaZulu-Natal's senior phase educators in Muslim schools have regarding mental health and mental illness?

The findings reveal that participants grappled with articulating definitions of mental health and mental illness, a difficulty that is historically and contemporarily present (Abreu, 2023; John-Langba et al., 2022). This suggests that the ambiguity in defining mental health may stem from a macrosystem issue, in which professional and authoritative bodies fail to provide clear, consistent definitions. John-Langba et al.'s (2022) findings support this, noting that legal literature particularly fails to distinguish between mental health and mental illness.

Despite this ambiguity, participants offered a spectrum of views on mental health. A focus on socioemotional functioning and the perceived spiritual foundation of mental health was central to these perspectives. Notably, unlike some studies that found educators hold negative, purely medicalised views of mental health (e.g., Weare, 2010), participants in this study viewed mental health in a more positive light, as a state of well-being rather than merely the absence of illness.

While an emphasis on socioemotional functioning may indicate a more holistic view of mental health than a purely biomedical one (Ekornes et al., 2012), it also carries the risk of pathologising non-conformist behaviours or disciplinary issues by equating social adherence with mental illness (Yao et al., 2021). This suggests that in a collectivistic culture, a focus on social rules can lead to a misunderstanding of a child's behaviours and a misattribution of them to mental illness. The school, as a microsystem, may hence pathologise behaviours in accordance with its own set of social norms and rules. This offers insight into a potential misunderstanding that arises from the intersection of faith and mental health in Muslim school settings.

Regarding the perceived spiritual foundation, participants viewed Islam as a positive contributor to mental health, aligning with the literature on spirituality's benefits for mental health (Koenig et al., 2020; Lucchetti et al., 2021). This reflects the role religion, which can be found in the macrosystem and exosystem, has on perceptions of mental health among participants. At the macrosystem level, religion acts as a framework that shapes beliefs about mental health and illness. Furthermore, its influence at the exosystem level stems from institutional structures, such as religious institutions and community leadership, which indirectly impact these perceptions. However, the implications of these understandings are complex, as research question two highlights some of their intricacies.

5.2.2. Research Question 2: What roles do religion and culture play in shaping the attitudes of senior-phase educators in KwaZulu-Natal's Muslim schools to learner mental health?

Participants observed how religious and cultural interpretations shape their attitudes towards learner mental health, creating opportunities and barriers. While Islamic teachings acknowledge mental health and create positive attributions to it, participants identified the

impact that cultural norms and misinterpretations of Islamic teachings have. This finding aligns with the research of Koenig et al. (2020), which posits that while religion serves as a powerful resource, it can paradoxically impede treatment. This is expressed via supernatural beliefs, entrenched stigma, and confidentiality concerns in KZN's Muslim schools.

A cultural preference for attributing mental health symptoms to supernatural phenomena like *jinn* or *jadu* (black magic) was noted. This aligns with other research on Muslim mental health in SA (Ally & Laher, 2008; Laher & Khan, 2011), reflecting a potential macrosystemic influence where culture impacts educators' perspectives. This cultural explanation of supernatural causes, while acknowledged as an aetiology within an Islamic mental health framework (Bulbulia & Laher, 2013), becomes a barrier when it is conceptualised as the sole explanation of mental health concerns, thereby denying biological or psychosocial aetiological factors. This suggests that the macrosystem of Islamic teachings supports a comprehensive view of mental health. However, cultural beliefs within the microsystem, such as those held by educators, and influences from the exosystem, such as the broader Muslim or Indian community, may override this understanding.

Participants also highlighted that cultural stigma is an impediment. They observed that within their community, mental health is downplayed or ignored, with senior phase learners internalising this view. This stigma manifests as a fear of social labelling and a misconception that conditions like ADHD are a matter of willpower. This fear of stigma and social discrimination, documented in other studies as well (e.g., Abreu, 2023; Essau et al., 2012; Mohamed-Kaloo & Laher, 2014), leads to secrecy and prevents individuals from seeking help. Furthermore, its tragic consequences on mental health, such as leading to death by suicide, were observed by participants.

Stigma is understood to be prevalent across the various ecological systems. Within the microsystem, a misunderstanding of conditions like ADHD was identified among participants. During parent-teacher meetings, stigma of mental health in the form of denying its presence was observed, showing its impact at the mesosystem level. At the exosystem level, participants pointed to community narratives that equate mental illness with weakness or personal failure, discouraging families from acknowledging difficulties or seeking care.

Another cultural barrier identified is the issue of confidentiality in a close-knit community. Participants noted that due to the school community's interconnectedness, learners fear that personal information shared with mental health practitioners will be leaked. This fear, exemplified by an educator's inability to guarantee learners' confidentiality, deters help-seeking. Participants' views regarding the complexities of confidentiality within a close-knit Muslim community align with current literature (Mohamed-Kalou & Laher, 2014; Padayachee & Laher, 2014). Furthermore, it highlights how the mesosystem, the interaction between the school and the community, creates a friction where cultural norms of interconnectedness clash with the need for confidentiality when seeking mental health services.

While some of these challenges may not be exclusive to the Muslim school context, this study illuminates their ecological interplay within the Muslim school environment, creating multifaceted barriers. Understanding and addressing these barriers is critical to effectively support Muslim learners' mental health.

5.2.3. Research Question 3: What are common mental health concerns that senior phase educators in KwaZulu-Natal's Muslim schools identify their learners to be challenged with?

Participants identified two primary mental health concerns challenging senior phase Muslim learners: an identity tug-of-war and the crucible weight of expectations. The first arises from the tension between adhering to Islamic teachings and assimilation into a Western, contrasting culture, leading to feelings of anxiety and alienation. This conflict can be understood as originating from the macrosystem level, where societal norms clash with the religious principles advocated within Muslim communities. Erikson's (1968) psychosocial model explains the psychological implications of this during adolescence by identifying identity formation as a core task during this phase. This underscores the significance of the chronosystem, showing how an identity crisis caused by macrosystem influence coincides with a critical stage of development.

The school and its educators can play a key role in helping Muslim learners navigate this domain, with their influence resting in the microsystem. Their role in developing a stable integrated identity is essential, as a secure Islamic identity is linked to positive mental health and resilience (Awad & Sultan, 2025). However, previous studies questioned the preparedness of all educators to handle this task (Shah, 2018). Research also contends that the educational context can create feelings of inferiority when educators contrast Muslim identity with a "Western other" (Ramadan, 2004).

The second mental health concern identified stems from the academic weight imposed by school pressures, parental expectations, family comparisons, and the demands of Islamic education, creating overwhelming stress and a lack of joy in senior phase learners' lives. This aligns with research indicating that academic pressures are a serious source of adolescent stress (Abreu, 2023; Edwards, 2020). However, this study highlighted a potentially idiosyncratic element in Muslim schools due to their collectivist nature, with learners compared to even extended family members. This multi-layered pressure leads to

maladaptive coping mechanisms such as the somatisation of distress, an element consistent with previous research (Mohamed-Kaloo & Laher, 2014).

Furthermore, another source of stress is the additional academic layer of Islamic studies and extracurricular religious activities. Muslim learners are reportedly required to juggle these responsibilities, leading to time constraints and forcing them to sacrifice personal passions and recreational activities. While research acknowledges that religion influences leisure choices (Agans et al., 2023), this study highlighted how religious obligations as an academic demand may limit leisure activities and contribute to stress.

These concerns, as perceived by their educators, highlight the distinct pressures faced by senior phase learners in KZN's Muslim schools. This emphasises the need for targeted support that is appropriate to the context and effectively addresses these concerns.

5.2.4. Research Question 4: What intervention strategies do senior phase educators in KwaZulu-Natal's Muslim schools implement to support learner mental health?

Participants reported educators' and Muslim schools' commitment to addressing learners' mental health, with educators supporting learners in myriad ways. This includes having dedicated in-house mental health professionals and collaborating with external service providers for individualised and communal support. Critically, some educators also provide informal mental health support, serving as approachable figures for students to discuss their challenges and offering guidance. This commitment to mental health aligns with a growing global awareness of the importance of school-based mental health support (Weist et al., 2023). However, participants indicated that support limitations exist, with a service gap due to a high learner-to-counsellor ratio identified, a finding consistent with other research on under-resourced South African schools (Mampane, 2023).

Participants noted the importance of leveraging faith leaders as a source of mental health support for increased learner wellbeing. Learners have a pre-existing trust in Islamic scholars, which can overcome the stigma and reluctance to seek help from formal mental health professionals. This aligns with literature that documents how Muslim youth often rely on spiritual healers for mental health support (Alqasir & Ohtsuka, 2023).

However, the findings also showed that without proper training, faith leaders could inadvertently do more harm due to a lack of knowledge or a judgmental approach. This underscores the need for a collaborative approach that equips faith leaders with the resources to intervene effectively. Furthermore, it shows how creating support within the school microsystem through faith leaders could help provide Muslim learners with the support they need.

The study also uncovered the importance of addressing gendered mental health support. Due to religious beliefs and cultural norms, learners may be reluctant to engage with a mental health practitioner of the opposite gender to them. This finding aligns with literature on the benefits of gender-matching in therapy (Seidler et al., 2021), and can be explained through EST. At the macrosystem level, religious injunctions around gender interaction and cultural expectations shape attitudes toward help-seeking. Furthermore, at the exosystem level, the availability of gender-matched practitioners in the healthcare system further impacts learners' access to support.

The inclusion of faith leaders and gender-sensitive support to bolster mental health in Muslim schools is a key finding. This further emphasises the need for targeted, context-specific strategies that address the multiple ecological level challenges.

5.3. Limitations of the Study

There were several limitations to the study. Researcher bias is a potential limitation despite the application of RTA and a transcendental phenomenological approach, as my background as a Muslim and my experience working in a school setting could have influenced data interpretation. While efforts were made to bracket personal biases, it remains possible that my pre-existing beliefs influenced the data interpretation, leading to an overemphasis on certain themes or a subconscious filtering of other information.

Secondly, the study relied on self-reported data, which may have introduced social desirability bias or inaccurate recall. Hence, the findings may not accurately reflect participants' beliefs and practices. Thirdly, the purposive sampling technique may have led to only educators interested in the topic of mental health participating, with those having negative views of mental health not being encapsulated in the findings. Furthermore, the sample also primarily comprised older, Indian educators, potentially overlooking the perspectives of younger teachers or those from other racial backgrounds, despite the research design accommodating other racial and age demographics.

Lastly, as a qualitative inquiry rooted in a transcendental phenomenological approach was adopted, the findings are contextual. The geographical location was limited to KZN, and the context was restricted to senior phase educators in Muslim schools. This constrains the study's transferability, meaning the findings may not be directly applicable to other Muslim schools in SA, to educational contexts beyond Muslim schools, or to educators from the foundation, intermediate, or FET phases at the participating schools. To minimise this limitation, a rich description of the study was provided in this write-up to allow the reader to discern if the findings may be applicable to their context.

5.4. Recommendations

Based on the study's findings, a few recommendations are proffered. These are divided into practice, research, and policy recommendations.

5.4.1. *Practice Recommendations*

Mental health workshops that are suitable for the Muslim school context should be developed for educators and the school community to address the cultural and religious beliefs that influence perceptions of mental health. These programmes should be co-developed with input from mental health professionals, Islamic scholars, and educators to ensure appropriateness. Specifically, these interventions should address stigma, confidentiality, supernatural phenomena, and the difference between mental health and social non-adherent behaviours, equipping educators to differentiate between mental health and other concerns. This recommendation is informed by Theme Two, which highlighted supernatural explanatory frameworks, entrenched stigma, and confidentiality concerns, alongside Theme One's indication that educators held varied and sometimes unclear understandings of mental health and mental illness.

Furthermore, psychoeducational workshops for parents and teachers on the mental health impacts of pressure and comparisons should be facilitated. This should include educating them on the distinction between healthy encouragement and hypercritical expectations. This recommendation is grounded in Theme Four, which showed that learner stress was fuelled by parental and teacher expectations and pervasive comparisons within learners' social networks. This also aligns with EST, strengthening the microsystem influence of educators and parents and the mesosystem of their relationship.

All these interventions should include a component that clarifies the concepts of mental health and mental illness, grounded in an Islamic understanding. This is essential given the

lack of a clear understanding among participants, as highlighted in this study. The participants' existing perspectives on the importance of socioemotional functioning and the spiritual foundation of mental health should be validated in accordance with their beliefs, while also identifying the other understandings and aetiological factors of mental health and illness.

Individualised mental health access should also be increased in Muslim schools by offering support based on gender preferences. Furthermore, the study showed that collaboration with faith leaders may be valuable as they can provide basic mental health support and refer learners appropriately. However, this must be done with caution, and appropriate training and resources must be provided to effectively address the gap. Additionally, this support should be offered in a structured manner, such as having dedicated consultation times. This recommendation is informed by Theme Five, which identified the value of faith leaders in support pathways and highlighted the importance of gendered preferences in help-seeking.

School counsellors and mental health practitioners should also consider identity and the stressors identified in this study when engaging with senior phase Muslim school learners. This can be done by normalising the identity struggles experienced by these learners, viewing them as part of a developmental trajectory as understood by Erikson (1968). Secondly, the IIRM, as advocated by Awad and Sultan (2025), can serve as a reference point for developing a strong identity in this context. This recommendation is derived from Theme Three, which showed an identity tug-of-war experienced by learners, perceived by educators as contributing to anxiety and alienation.

For the stress concerns, mental health practitioners engaging with these learners could provide psychoeducation on time management strategies and stress coping mechanisms, such

as grounding techniques or mindfulness. Furthermore, identifying leisure activities that are Islamically appropriate and feasible given these learners' time constraints may help increase pleasurable activities and reduce stress. Including these leisure activities and hobbies may also help validate the learner's self-worth beyond grades and academic achievements. This recommendation is grounded in Theme Four, where participants repeatedly identified stress as a central concern linked to academic, parental, peer, and Islamic education demands.

Additionally, it might be valuable for mental health practitioners to address cultural barriers to therapy, such as stigma and confidentiality, at the onset of interventions for enhanced engagement. To address the stigma, this can be done by normalising the learner's experience of it and explaining, from an ecological model, how it impacts them in a developmentally appropriate manner. Additionally, their beliefs regarding mental health could be explored, recognising that these views result from their distinct ecological context. To address confidentiality concerns, it may be valuable to explicitly discuss any specific concerns the learner may have, such as sharing information with parents. Contracting with the learner and obtaining their written assent may assist in this process. This recommendation arises from Theme Two, which showed that stigma and fears about confidentiality within a close-knit community can deter both disclosure and referrals to support.

Furthermore, it is encouraged for Muslim schools to address learner mental health from an ecological model, as demonstrated above, for more effective intervention. This corresponds to the assertion by Ahmed and Hashem (2016) and can be achieved by implementing strategies that target multiple levels of EST. For example, open communication and collaboration between parents and the school should be fostered to strengthen the mesosystem; local community organisations and faith leaders should be engaged to target the exosystem; and policies that support culturally relevant mental health services should be advocated for to enact a macrosystem change.

5.4.2. Research Recommendations

Research on Muslim adolescents has increased, though critical gaps remain (Ahmed & Hashem, 2016). While this assertion is nearly 10 years old, a similar observation was noted upon perusal of current literature. Based on this study, research should be conducted with larger, more diverse samples to evaluate its findings. Exploring the perspectives of students themselves, parents, school management, school governing bodies, and Islamic scholars within Muslim schools would assist in gaining a deeper understanding of learner mental health.

Research could also prioritise racial diversity and gender differences within mental health amongst Muslim adolescents. Employing mixed methods designs, incorporating quantitative data to assess the prevalence of mental health concerns and qualitative data to provide an in-depth understanding, might offer meaningful contributions.

Studies exploring the effectiveness of different interventions and support systems in promoting learner mental health in schools are recommended. This can include longitudinal research to understand the long-term impact of mental health interventions on learner mental health and academic success, thereby including the chronosystem. Lastly, research examining how Muslim adolescents compare to other adolescents in their mental health and presenting mental health concerns may yield important insights.

5.4.3. Policy Recommendations

The findings highlight the need for a policy that acknowledges and addresses the mental health needs of Muslims, especially Muslim learners. Policy should emphasise the importance of considering the influence of cultural and religious factors when addressing mental health and mental illness. This must include contextually appropriate understandings of these concepts, given their socially constructed nature. Furthermore, a policy promoting

intersectoral collaboration among mental health practitioners, schools, and religious leaders may enhance support for adolescents. This recommendation is informed by Theme One and Theme Two, which showed variability in conceptualisations of mental health alongside culturally mediated barriers (stigma, supernatural beliefs, confidentiality), and by Theme Five's emphasis on collaboration with faith leaders as part of support pathways.

Devising and implementing clear policies regarding confidentiality in the Muslim school setting for mental health practitioners may be crucial. Lastly, policy should advocate for the integration of mental health literacy modules into teacher training programmes and ongoing professional development for educators, with Muslim school educators specifically receiving guidance on culturally and religiously informed responses to mental health challenges in Muslim contexts. This recommendation follows from Theme Two's findings on confidentiality anxieties within close-knit communities and Theme One's indication of definitional ambiguity, which together highlight the need for formalised guidance and educator capacity-building

To assist in implementing these recommendations, Table 03 provides a summary of the recommendations and a timeline for implementation, broken down into short-term, medium-term, and long-term goals. Furthermore, responsible actors who can champion these changes are also noted.

Table 03 *Recommendations summary and implementation prioritisation*

Time horizon	Recommendation (summary)	Responsible actor(s)	Traceability to findings
Short term	Clarify confidentiality boundaries and referral pathways, including written assent where appropriate	School leadership and mental health practitioners	Theme Two
	Parent and educator psychoeducation on pressure, comparisons, and stress	AMS, school leadership, educators, faith leaders,	Theme Four

		and mental health practitioners	
	Practitioner guidance to normalise identity struggles and incorporate identity-informed framing	Mental health practitioners	Theme Three
Medium term	Develop contextual mental health literacy workshops that are co-developed	AMS, school leadership, mental health practitioners and faith leaders	Themes One and Two
	Structured collaboration model with faith leaders for learner support	AMS, school leadership, faith leaders, and mental health practitioners	Theme Five
	Gender-sensitive access pathways	School leadership, mental health practitioners, and faith leaders	Theme Five
Long term	Integrate mental health literacy into teacher development and Muslim-school specific guidance	DBE, teacher training institutions, and AMS	Themes One and Two
	Advocate for culturally and religiously responsive adolescent mental health policy and intersectoral collaboration	DBE, AMS, HPCSA, mental health practitioners, and faith leaders	Themes One, Two, Five

5.5. Conclusions of the Study

This study contributed to understanding mental health within the context of Muslim schools in KZN, where a knowledge gap exists. The study found that cultural and religious factors play a complex role in shaping attitudes towards mental health, with interventions targeting the barriers to mental health required.

Notably, it highlighted the tension between the recognised importance of mental health in Islamic teachings and the persistent cultural barriers that impede access to care. The study showed that Muslim learners face idiosyncratic challenges related to identity formation,

school pressures, parental expectations, sibling comparisons, and Islamic education demands that further emphasise the need for targeted interventions.

While Muslim schools and their educators have grown in their dedication to supporting learner mental health, the study found that it can be enhanced by equipping Islamic scholars to provide basic mental health support and refer appropriately, thereby strengthening intersectoral collaboration. However, this must be done with caution and training. Additionally, addressing gendered support could prove beneficial.

This study, born from literature establishing the burgeoning mental health crisis among adolescents and the critical role educators play in addressing it, serves as a catalyst for understanding and addressing mental health within the KZN Muslim school context. The echoes of this research call for a paradigm shift, urging intersectional collaboration across the ecological system to provide effective support that moves beyond generic approaches, especially for the potentially distinct challenges faced by senior-phase Muslim school learners. The implications extend to policy and practice, demanding a revaluation of how mental health is conceptualised and how support is delivered.

References

- Abdel-Khalek, A. M. (2007). Religiosity, happiness, health, and psychopathology in a probability sample of Muslim adolescents. *Mental Health, Religion & Culture*, 10(6), 571-583. <http://doi.org/10.1080/13674670601034547>
- Abdel-Khalek, A. M. (2011). Islam and mental health: A few speculations. *Mental Health Religion & Culture*, 14(2), 87–92. <https://doi.org/10.1080/13674676.2010.544867>
- Abend, G. (2008). The meaning of ‘theory.’ *Sociological Theory*, 26(2), 173–199. <https://doi.org/10.1111/j.1467-9558.2008.00324.x>
- Abreu, L. I. (2023). *The mental health needs of South African mainstream high school learners: Teachers’ experiences and perceptions* [MA thesis, University of the Witwatersrand]. <https://wiredspace.wits.ac.za/bitstreams/8e8f1434-3010-4b3e-8f7a-658f1bdee318/download>
- Abu Khalaf, N., Woolweaver, A. B., Marmolejos, R. R., Little, G. A., Burnett, K., & Espelage, D. L. (2023). The impact of Islamophobia on Muslim students: A systematic review of the literature. *School Psychology Review*, 52(5), 206–223. <https://doi.org/10.1080/2372966X.2022.2075710>
- Abu- Rayya, M. H., & Abu- Rayya, H. M. (2009). Ethnic identification, religious identity, and psychological well-being among Muslim and Christian Palestinians in Israel. *Mental Health, Religion & Culture*, 12, 147- 155. <http://doi.org/10.1080/13674670802387330>
- Adrian, T. (2024). The role of religion in the formation of personal and social identity. *New Trends in Psychology*, 6(2), 51–55. <https://dj.univ-danubius.ro/index.php/NTP/article/view/3099>

- Agans, J. P., Son, J. S., Powers, S., Hanna, S., & Weybright, E. H. (2023). College students' healthy leisure: Latent profile analyses of constraints and negotiation strategies. *Leisure Sciences*, 1–22. <https://doi.org/10.1080/01490400.2023.2252434>
- Ahmed, S., & Amer, M. M. (Eds.). (2012). *Counseling Muslims: Handbook of mental health issues and interventions*. Routledge/Taylor & Francis Group.
- Ahmed, S., & Hashem, H. (2016). A decade of Muslim youth: Global trends in research. *Journal of Muslim Mental Health*, 10(1), 25–49. <https://doi.org/10.3998/jmmh.10381607.0010.104>
- Ajele, K. W., Ramadie, K. J., Idemudia, E. S., & Ugwu, L. E. (2025). Mental health among high school students in South Africa: Roles of childhood adversity, bullying behaviour, peer pressure, and self-esteem. *Journal of Psychology in Africa*, 34(6), 629–636. <https://doi.org/10.1080/14330237.2024.2369754>
- Ali, F., & Bagley, C. (2014). Islamic education and multiculturalism: Engaging with the Canadian experience. *Journal of Contemporary Issues in Education*, 8(2). <https://doi.org/10.20355/c50p4q>
- Al-Krenawi, A., & Graham, J. R. (2011). Mental health help-seeking among Arab university students in Israel, differentiated by religion. *Mental Health Religion & Culture*, 14(2), 157–167. <https://doi.org/10.1080/13674670903454229>
- Ally, Y., & Laher, S. (2008). South African Muslim faith healers' perceptions of mental illness: Understanding, aetiology and treatment. *Journal of religion and health*, 47(1), 45–56. <https://doi.org/10.1007/s10943-007-9133-2>
- 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>

- Attum, B., Hafiz, S., Malik, A., & Shamoon, Z. (2019). Cultural competence in the care of Muslim patients and their families. *StatPearls*.
<https://europepmc.org/article/MED/29763108>
- Awad, N., & Sultan, S. (2025). *Raising resilient Muslim youth: Strategies for building a strong Muslim identity in children*. Yaqeen Institute.
<https://yaqeeninstitute.org/read/paper/raising-resilient-muslim-youth-strategies-for-building-a-strong-muslim-identity-in-children>
- Babbie, E. R. (2020). *The practice of social research*. Cengage.
- Baloyi, L. (2020). From teaching psychology in conqueror South Africa to teaching African swa moya in the psychology curriculum: Critical reflections and experiences in a Masters Clinical Psychology programme. *South African Journal of Psychology*, 51(3), 453–463. <https://doi.org/10.1177/0081246320954308>
- Bartholomew, T. T., Joy, E. E., Kang, E., & Brown, J. (2021). A choir or cacophony? Sample sizes and quality of conveying participants' voices in phenomenological research. *Methodological Innovations*, 14(2). <https://doi.org/10.1177/20597991211040063>
- Benton, T. D., Boyd, R. C., & Njoroge, W. F. M. (2021). Addressing the global crisis of child and adolescent mental health. *JAMA Pediatrics*, 175(11), 1108–1110.
<https://doi.org/10.1001/jamapediatrics.2021.2479>
- Bertram, C., & Christiansen, I. M. (2014). *Understanding research: An introduction to reading research*. Van Schaik.
- Bikner-Ahsbabs, A., Knipping, C., & Presmeg, N. (2015). *Approaches to qualitative research in mathematics education: Examples of methodology and methods*. Springer.
- Bhandari, P. (2023). *Ethical considerations in research | Types & examples*. Scribbr.
<https://www.scribbr.com/methodology/research-ethics/>

- Boddy, C. R. (2016). Sample size for qualitative research. *Qualitative Market Research: An International Journal*, 19(4), 426–432. <https://doi.org/10.1108/QMR-06-2016-0053>
- Bonnie, R. J., & Backes, E. P. (2019). Fulfilling the promise of adolescence: Realizing opportunity for all youth. In *Journal of Adolescent Health* (Issue 4, pp. 440–442). The National Academies Press. <https://doi.org/10.17226/25388>
- Bragazzi, N. L., & del Puente, G. (2012). Panic attacks and possession by djinns: Lessons from ethnopsychiatry. *Psychology Research & Behavior Management*, 5, 185–90. <http://dx.doi.org/10.2147/PRBM.S37714>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE.
- Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589–597. <https://doi.org/10.1080/2159676x.2019.1628806>
- Braun, V., & Clarke, V. (2020). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, 21(1), 37–47. <https://doi.org/10.1002/capr.12360>
- Bronfenbrenner, U. (1981). *The ecology of human development: Experiments by nature and design*. Harvard University Press.
- Bryant, D. J., Oo, M., & Damian, A. J. (2020). The rise of adverse childhood experiences during the COVID-19 pandemic. *Psychological Trauma Theory Research Practice and Policy*, 12(S1), S193–S194. <https://doi.org/10.1037/tra0000711>

- Bryer, F. K., & Signorini, J. A. (2011). Primary pre-service teachers' understanding of students' internalising problems of mental health and wellbeing. *Issues in Educational Research*, 21(3), 233–258. <https://eric.ed.gov/?id=EJ955140>
- Bulbulia, T., & Laher, S. (2013). Exploring the role of Islam in perceptions of mental illness in a sample of Muslim psychiatrists based in Johannesburg. *South African Journal of Psychiatry*, 19(2), a396. <https://doi.org/10.4102/sajpsychiatry.v19i2.396>
- Camic, P. M. (2021). *Qualitative research in psychology: Expanding perspectives in methodology and design*. American Psychological Association.
- Christensen, J. (2016). A critical reflection of Bronfenbrenner's development ecology model. *Problems of Education in the 21st Century*, 69(1), 22–28. <https://doi.org/10.33225/pec/16.69.22>
- Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, 26(2). <https://share.google/S247m2UwFKzynCesD>
- Conrad, P., & Barker, K. K. (2010). The social construction of illness: key insights and policy implications. *Journal of Health and Social Behaviour*, 51 (S67–S79). <https://doi.org/10.1177/0022146510383495>
- Cotton, S., Zebracki, K., Rosenthal, S. L., Tsevat, J., & Drotar, D. (2006). Religion/spirituality and adolescent health outcomes: A review. *The Journal of Adolescent Health*, 38(4), 472–480. <https://doi.org/10.1016/j.jadohealth.2005.10.005>
- Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE Publications.
- Dabbagh, N., Johnson, S., King, M., & Blizzard, R. (2011). Muslim adolescent mental health in the UK: An exploratory cross-sectional school survey. *International Journal of*

Culture and Mental Health, 5(3), 202–218.

<https://doi.org/10.1080/17542863.2011.594246>

Davids, N., & Waghid, Y. (2020). Gender under-representation in teaching: A casualty of the feminisation of teaching? *South African Journal of Higher Education*, 34(3).

<https://doi.org/10.20853/34-3-4045>

Dhai, A., & McQuoid-Mason, D. J. (2010). *Bioethics, human rights and law, principles and practice*. Juta Academic.

Du Toit, A. (2016). Foundations in the South African senior phase curriculum for entrepreneurship education in consumer studies. *Journal of Family Ecology and Consumer Sciences*, 44, 11-20.

<https://www.ajol.info/index.php/jfec/article/view/143699/133413>

Du Plooy-Cilliers, F., Davis, C., & Bezuidenhout, R. (2022). *Research matters* (2nd ed.). Juta Academic.

Edwards, A. (2020). *Primary school teachers' views on their role in child mental health prevention* [PhD, University of East London]. <https://doi.org/10.15123/uel.88812>

Ekornes, S., Hauge, T. E., & Lund, I. (2012). Teachers as mental health promoters: A study of teachers' understanding of the concept of mental health. *International Journal of Mental Health Promotion*, 14(5), 289–310.

<https://doi.org/10.1080/14623730.2013.798534>

Ellingson, L. L. (2008). *Engaging crystallization in qualitative research: An introduction* (1st ed.). SAGE Publications.

Elshamy, F., Hamadeh, A., Billings, J., & Alyafei, A. (2023). Mental illness and help-seeking behaviours among Middle Eastern cultures: A systematic review and meta-synthesis of qualitative data. *PloS one*, 18(10), e0293525.

<https://doi.org/10.1371/journal.pone.0293525>

- Emanuel, E. J., Wendler, D., & Grady, C. (2008). An ethical framework for biomedical research. In E. J. Emanuel, C. Grady, R. A. Crouch, R. K. Lie, F. G. Miller, & D. Wendler (Eds.), *The Oxford textbook of clinical research ethics* (pp. 122–133). Oxford University Press.
- Erikson, E.H. (1968). *Identity: Youth and crisis*. Norton & Co.
- Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: What is their value for guiding public mental health policy and practice? *Social Theory & Health*, 16(4), 414–433. <https://doi.org/10.1057/s41285-018-0065-6>
- Essau, C. A., Olaya, B., Pasha, G., O'Callaghan, J., & Bray, D. (2012). The structure of anxiety symptoms among adolescents in Iran: A confirmatory factor analytic study of the Spence Children's Anxiety Scale. *Journal of Anxiety Disorders*, 26, 871–878. <https://doi.org/10.1016/j.janxdis.2012.08.001>
- Fazel, M., Patel, V., Thomas, S., & Tol, W. A. (2014). Mental health interventions in schools in low-income and middle-income countries. *Lancet Psychiatry*, 1(5), 388–398. [https://doi.org/10.1016/s2215-0366\(14\)70357-8](https://doi.org/10.1016/s2215-0366(14)70357-8)
- Fegert, J. M., Vitiello, B., Plener, P. L., & Clemens, V. (2020). Challenges and burden of the Coronavirus 2019 (COVID-19) pandemic for child and adolescent mental health: A narrative review to highlight clinical and research needs in the acute phase and the long return to normality. *Child and Adolescent Psychiatry and Mental Health*, 14, 20. <https://doi.org/10.1186/s13034-020-00329-3>
- Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry*, 14(2), 231–233. <https://doi.org/10.1002/wps.20231>

- Gautam, S., Jain, A., Chaudhary, J., Gautam, M., Gaur, M., & Grover, S. (2024). Concept of mental health and mental well-being, it's determinants and coping strategies. *Indian Journal of Psychiatry*, 66(2), S231–S244.
https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_707_23
- Gill, P., Stewart, K., Treasure, E., & Chadwick, B. L. (2008). Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal*, 204(6), 291–295. <https://doi.org/10.1038/bdj.2008.192>
- Gittings, L., Toska, E., Medley, S., Cluve, L., Logie, C. H., Ralayo, N., Chen, J., & Mbithi-Dikgole, J. (2021). ‘Now my life is stuck!’: Experiences of adolescents and young people during COVID-19 lockdown in South Africa. *Global Public Health*, 16(9), 947–963. <https://doi.org/10.1080/17441692.2021.1899262>
- Graham, A., Phelps, R., Maddison, C., & Fitzgerald, R. M. (2011). Supporting children's mental health in schools: teacher views. *Teachers and Teaching*, 17(4), 479–496.
<https://doi.org/10.1080/13540602.2011.580525>
- Grant, C., & Osanloo, A. (2014). Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your “house”. *Administrative Issues Journal*, 4, 12-26. <https://share.google/oGxtlRJjLBFhkQ2en>
- Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. SAGE.
- Halevy, G., & Gross, Z. (2023). Toward an integrative theory of identity formation: Three components of the religious identity formation process. *Pastoral Psychology*, 73(2), 253–270. <https://doi.org/10.1007/s11089-023-01100-z>
- Hankerson, S. H., Squirewell, C. T., & Flowers, M. (2025). Evaluating partnerships between faith communities and the mental health sector. *Psychiatric Services*, 76(1), 1–1.
<https://doi.org/10.1176/appi.ps.25076002>

- Haroun, Z., Bokhari, A., Marko-Holguin, M., Blomeke, K., Goenka, A., Fogel, J., & Van Voorhees, B. W. (2011). Attitudes toward depression among a sample of Muslim adolescents in the Midwestern United States. *International Journal of Adolescent Medicine and Health*, 23(3), 293–301. <https://doi.org/10.1515/ijamh.2011.058>
- Harris, L. M., Huang, X., Funsch, K. M., Fox, K. R., & Ribeiro, J. D. (2022). Efficacy of interventions for suicide and self-injury in children and adolescents: A meta-analysis. *Scientific Reports*, 12, 12313. <https://doi.org/10.1038/s41598-022-16567-8>
- Harris, R., Rendall, S., & Nashat, S. (2011). *Engaging with complexity: Child & adolescent mental health and education*. Routledge.
- Hayes, N., O'Toole, L., & Halpenny, A. M. (2022). *Introducing Bronfenbrenner: A guide for practitioners and students in early years education*. Routledge.
- Hazim, M., & Nazari, A. M. (2023). The negative consequences of gender mixing and its rulings in Islamic Shariah. *Integrated Journal for Research in Arts and Humanities*, 3(4), 6–19. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4503566
- Herzog, C., Handke, C., & Hitters, E. (2019). Analyzing talk and text II: Thematic analysis. In *The Palgrave Handbook of Methods for Media Policy Research*. Palgrave Macmillan.
- Hlongwane, N., & Juby, V. (2023). Knowledge, attitudes, and help-seeking behaviour for mental illness in a Christian community. *South African Journal of Psychiatry*, 29, 2139. <https://doi.org/10.4102/sajpsychiatry.v29i0.2139>
- Howitt, D. (2019). *Introduction to qualitative research methods in psychology: Putting theory into practice*. Pearson.
- Ijaz, S., Khalily, M. T., & Ahmad, I. (2017). Mindfulness in Salah Prayer and its association with mental health. *Journal of Religion and Health*, 56(6), 2297–2307. <https://doi.org/10.1007/s10943-017-0413-1>

- Imran, N., Aamer, I., Sharif, M. I., Bodla, Z. H., & Naveed, S. (2020). Psychological burden of quarantine in children and adolescents: A rapid systematic review and proposed solutions. *Pakistan journal of medical sciences*, 36(5), 1106–1116.
<https://doi.org/10.12669/pjms.36.5.3088>
- Iqbal, N., & Skinner, R. (2021). Islamic psychology: Emergence and current challenges. *Archive for the Psychology of Religion*, 43(1), 65–77.
<https://doi.org/10.1177/0084672420983496>
- Jackson, H. J., & Haslam, N. (2022). Ill-defined: Concepts of mental health and illness are becoming broader, looser, and more benign. *Australasian Psychiatry*, 30(4), 490–493.
<https://doi.org/10.1177/10398562221077898>
- Jacobs, C. L., & Lekganyane, M. R. (2024). Opinions of social workers regarding mental health-related challenges encountered with children and adolescents in South African child and youth care centres. *Social Work/Maatskaplike Werk*, 60(4), 690–713.
<https://doi.org/10.15270/60-4-1395>
- Jahoda, M. (1958). *Current concepts of positive mental health*. Basic Books/Hachette Book Group. <https://doi.org/10.1037/11258-000>
- Jaworska, N., & MacQueen, G. (2015). Adolescence as a unique developmental period. *Journal of Psychiatry and Neuroscience*, 40(5), 291–293.
<https://doi.org/10.1503/jpn.150268>
- John-Langba, J., Matsela, M., & John-Langba, V. N. (2022). A review study of the concept of mental health. *Journal of Human Ecology*, 79(1), 1–12.
<https://doi.org/10.31901/24566608.2022/79.1-3.3340>
- Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A review of the quality indicators of rigor in qualitative research. *American Journal of Pharmaceutical Education*, 84(1), 7120.
<https://doi.org/10.5688/ajpe7120>

- Johnston, E. R. (2015). South African clinical psychology's response to cultural diversity, globalisation and multiculturalism: A review. *South African Journal of Psychology*, 45(3), 374–385. <https://doi.org/10.1177/0081246315575648>
- Jones, E. A., Mitra, A. K., & Bhuiyan, A. R. (2021). Impact of COVID-19 on mental health in adolescents: A systematic review. *International Journal of Environmental Research and Public Health*, 18(5), 2470. <https://doi.org/10.3390/ijerph18052470>
- Jörns-Presentati, A., Napp, A., Dessauvagie, A., Stein, D. J., Jonker, D., Breet, E., Charles, W., Swart, R. L., Lahti, M., Suliman, S., Jansen, R., Van Den Heuvel, L. L., Seedat, S., & Groen, G. (2021). The prevalence of mental health problems in sub-Saharan adolescents: A systematic review. *PloS One*, 16(5), e0251689. <https://doi.org/10.1371/journal.pone.0251689>
- Kamel, A., Haridi, H. K., Alblowi, T. M., Albasher, A. S., & Alnazhah, N. A. (2020). Beliefs about students' mental health issues among teachers at elementary and high schools, Hail Governorate, Saudi Arabia. *Middle East Current Psychiatry*, 27(1), 30. <https://doi.org/10.1186/s43045-020-00039-8>
- Kato, N., Yanagawa, T., Fujiwara, T., & Morawska, A. (2015). Prevalence of children's mental health problems and the effectiveness of population-level family interventions. *J Epidemiol*, 25(8), 507–516. <https://doi.org/10.2188/jea.JE20140198>
- Kayrouz, R., Karin, E., Ghanem, C., Choudhury, N., & Malas, A. (2022). Muslim adolescent mental health in Australia: A cross-cultural comparison of the risk of developing clinically significant psychological problems. *Journal of Child and Family Studies*, 31(10), 2837–2848. <https://doi.org/10.1007/s10826-022-02257-6>
- Kennedy, K. S., Godlas, A., Gale, J., & Parker, M. L. (2010). Building bridges: Cross-disciplinary collaboration between family therapy and Islamic Studies. *Journal of Muslim Mental Health*, 5, 350–367. <http://doi.org/10.1080/15564908.2010.551289>

- Kern, A., Amod, Z., Seabi, J., & Vorster, A. (2015). South African foundation phase teachers' perceptions of ADHD at private and public schools. *International Journal of Environmental Research and Public Health*, 12(3), 3042–3059.
<https://doi.org/10.3390/ijerph120303042>
- Keyes, C. L. M. (2002). The mental health continuum: from languishing to flourishing in life. *Journal of Health and Social Behavior*, 43(2), 207. <https://doi.org/10.2307/3090197>
- Kishi, K. (2017). *Assaults against Muslims in U.S. surpass 2001 level*. Pew Research Center.
<https://www.pewresearch.org/fact-tank/2017/11/15/assaults-against-muslims-in-u-s-surpass-2001-level/>
- Knott, E., Rao, A. H., Summers, K., & Teeger, C. (2022). Interviews in the social sciences. *Nature Reviews Methods Primers*, 2(1), 73. <https://doi.org/10.1038/s43586-022-00150-6>
- Koenig, H. G., Al-Zaben, F., & VanderWeele, T. J. (2020). Religion and psychiatry: Recent developments in research. *BJPsych Advances*, 26(5), 262–272.
<https://doi.org/10.1192/bja.2019.81>
- Kumpf, C. I. (2013). Frameworks and models in ethical decision-making. In C. M. Jungers & J. Gregoire (Eds.), *Counselling ethics: Philosophical and professional foundations* (pp. 47–70). Springer Publishing.
- Laher, S. (2014). An overview of illness conceptualizations in African, Hindu, and Islamic traditions: Towards cultural competence. *South African Journal of Psychology*, 44(2), 191–204. <https://doi.org/10.1177/0081246314528149>
- Laher, S., & Ismail, A. (2012). South African Muslim psychologists' perceptions of mental illness. *Journal of Psychology in Africa*, 22(4), 667–669.
<https://doi.org/10.1080/14330237.2012.10820585>

- Laher, S., & Khan, S. (2011). Exploring the influence of Islam on the perceptions of mental illness of volunteers in a Johannesburg community-based organisation. *Psychology and Developing Societies*, 23(1), 63–84.
<https://doi.org/10.1177/097133361002300103>
- Landes, S. L., Burton, J. R., King, K. M., & Sullivan, B. F. (2013). Women's preference of therapist based on sex of therapist and presenting problem: An analogue study. *Counselling Psychology Quarterly*, 18(26), 330–342.
<https://doi.org/10.1080/09515070.2013.819795>
- Loades, M. E., & Mastroyannopoulou, K. (2010). Teachers' recognition of children's mental health problems. *Child and Adolescent Mental Health*, 15(3), 150–156.
<https://doi.org/10.1111/j.1475-3588.2009.00551.x>
- Lucchetti, G., Koenig, H. G., & Lucchetti, A. L. G. (2021). Spirituality, religiousness, and mental health: A review of the current scientific evidence. *World Journal of Clinical Cases*, 9(26), 7620–7631. <https://doi.org/10.12998/wjcc.v9.i26.7620>
- Mælan, E. N., Tjomsland, H. E., Baklien, B., Samdal, O., & Thurston, M. (2018). Supporting pupils' mental health through everyday practices: A qualitative study of teachers and head teachers. *Pastoral Care in Education*, 36(1), 16–28.
<https://doi.org/10.1080/02643944.2017.1422005>
- Mahmud, S., Mohsin, M., Dewan, N., & Muyeed, A. (2023). The global prevalence of depression, anxiety, stress, and insomnia among general population during COVID-19 pandemic: A systematic review and meta-analysis. *Trends in Psychology*, 31, 143–170. <https://doi.org/10.1007/s43076-021-00116-9>
- Maguire, M., & Delahunt, B. (2017). Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *All Ireland Journal of Higher Education*, 9(3). <https://ojs.aishe.org/index.php/aishe-j/article/view/335>

- Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, 26(13), 1753–1760. <https://doi.org/10.1177/1049732315617444>
- Malmqvist, J., Hellberg, K., Möllås, G., Rose, R., & Shevlin, M. (2019). Conducting the pilot study: A neglected part of the research process? Methodological findings supporting the importance of piloting in qualitative research studies. *International Journal of Qualitative Methods*, 18(1), 1-11. <https://doi.org/10.1177/1609406919878341>
- Mampane, M. R. (2023). The contribution of educational psychology to South African preservice teacher training and learner support. *Education Sciences*, 13(10), 1047. <https://doi.org/10.3390/educsci13101047>
- Manwell, L. A., Barbic, S. P., Roberts, K., Durisko, Z., Lee, C., Ware, E., & McKenzie, K. (2015). What is mental health? Evidence towards a new definition from a mixed methods multidisciplinary international survey. *BMJ Open*, 5(6), e007079. <https://doi.org/10.1136/bmjopen-2014-007079>
- Marcia, J. E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology*, 3(5), 551–558. <https://doi.org/10.1037/h0023281>
- Matoane, M. (2012). Locating context in counselling: The development of indigenous psychology in South Africa. *Psychotherapy and Politics International*, 10(2), 105–115. <https://doi.org/10.1002/ppi.1263>
- Mehraki, B., & Gholami, A. (2017). Physical and mental health in Islam. *World Family Medicine*, 15(9), 142–148. <https://doi.org/10.5742/MEWFM.2017.93114>
- Mellin, E. A., Bronstein, L. R., Anderson-Butcher, D., Amorose, A. J., Ball, A., & Green, J. (2010). Measuring interprofessional team collaboration in expanded school mental health: Model refinement and scale development. *Journal of Interprofessional Care*, 24(5), 514–523. <https://doi.org/10.3109/13561821003624622>

- Melton, T., Croarkin, P., Strawn, J., & Mcclintok, S. (2014). Comorbid anxiety and depressive symptoms in children and adolescents: A systematic review and analysis. *Journal of Psychiatric Practice*, 22(2), 84–98.
<https://doi.org/10.1097/PRA.0000000000000132>
- Menninger, K. A. (1947). Psychology and psychiatry. *American Psychologist*, 2(4), 139–140.
<https://doi.org/10.1037/h0056668>
- Minahan, J. (2022). *A qualitative study of teachers' knowledge of anxiety and their feelings of preparedness to support students with anxiety* [PhD, Lesley University].
https://digitalcommons.lesley.edu/cgi/viewcontent.cgi?article=1207&context=education_dissertations
- Mkhize, N., Madlala, N. M., & Chitindingu, E. (2014). Democratising access and success: IsiZulu terminology development and bilingual instruction in psychology at the University of KwaZulu-Natal. *Interdisciplinary Journal for the Study of the Arts and Humanities in Southern Africa*, 13, 128–154.
<https://doi.org/10.1177/0081246320954308>
- Mohamed-Kaloo, Z., & Laher, S. (2014). Perceptions of mental illness among Muslim general practitioners in South Africa. *South African Medical Journal*, 104(5), 350.
<https://doi.org/10.7196/samj.7863>
- Moshabela, M., Zuma, T., & Gaede, B. (2016). Bridging the gap between biomedical and traditional health practitioners in South Africa. *South African Health Review*, 2016(1), 83–92. <https://www.cabidigitallibrary.org/doi/full/10.5555/20163194040>
- Nash, P., Schlösser, A., & Scarr, T. (2016). Teachers' perceptions of disruptive behaviour in schools: A psychological perspective. *Emotional and Behavioural Difficulties*, 21(2), 167–180. <https://doi.org/10.1080/13632752.2015.1054670>

- Navarro, J. L., & Tudge, J. R. H. (2022). Technologizing Bronfenbrenner: Neo-ecological Theory. *Current Psychology*, 42(22), 19338–19354. <https://doi.org/10.1007/s12144-022-02738-3>
- Nazish, N., & Kalra, N. (2018). Muslim prayer- a new form of physical activity: A narrative review. *International Journal of Health Sciences and Research*, 8(7), 337–344. http://www.ijhsr.org/IJHSR_Vol.8_Issue.7_July2018/43.pdf
- Neuman, W. L. (2014). *Social research methods: Qualitative and quantitative approaches* (7th ed.). Pearson.
- Newman, B. M., & Newman, P. R. (2020). *Theories of adolescent Development*. Academic Press.
- Owens, J., Rassool, G. H., Bernstein, J., Latif, S., & Aboul-Enein, B. H. (2023). Interventions using the Qur'an to promote mental health: A systematic scoping review. *Journal of Mental Health*, 32(4), 842–862. <https://doi.org/10.1080/09638237.2023.2232449>
- Padayachee, P., & Laher, S. (2014). South African Hindu psychologists' perceptions of mental illness. *Journal of Religion and Health*, 53(2), 424–437. <https://doi.org/10.1007/s10943-012-9646-1>
- Patton, M. Q. (2015). *Qualitative evaluation and research methods*. Sage.
- Perez, L. G., Cardenas, C., Blagg, T., & Wong, E. C. (2025). Partnerships between faith communities and the mental health sector: A scoping review. *Psychiatric Service*, 76(1), 61–81. <https://doi.org/10.1176/appi.ps.20240077>
- Piaget, J. (1971). The theory of stages in cognitive development. In D. R. Green, M. P. Ford, & G. B. Flamer, *Measurement and Piaget*. McGraw-Hill.
- Pillay, A. L., Ahmed, R., & Bawa, U. (2013). Clinical psychology training in South Africa: A call to action. *South African Journal of Psychology*, 43(1), 46–58. <https://doi.org/10.1177/0081246312474411>

- Pilo, A. S., Van Jaarsveld, L., & Challens, B. (2024). School principalship leadership and management in integrated Muslim schools in South Africa: An investigation. *Leadership and Policy in Schools*, 1–18.
<https://doi.org/10.1080/15700763.2024.2324019>
- Priest, N., Doery, K., Truong, M., Guo, S., Perry, R., Trenerry, B., Karlsen, S., Kelly, Y., & Paradies, Y. (2021). Updated systematic review and meta-analysis of studies examining the relationship between reported racism and health and well-being for children and youth: A protocol. *BMJ open*, 11(6), e043722.
<https://doi.org/10.1136/bmjopen-2020-043722>
- Quarshie, E. N., Waterman, M. G., & House, A. O. (2020). Self-harm with suicidal and non-suicidal intent in young people in sub-Saharan Africa: A systematic review. *BMC Psychiatry*, 20, 234. <https://doi.org/10.1186/s12888-020-02587-z>
- Racine, N., McArthur, B. A., Cooke, J. E., Eirich, R., Zhu, J., & Madigan, S. (2021). Global prevalence of depressive and anxiety symptoms in children and adolescents during COVID-19: A meta-analysis. *JAMA pediatrics*, 175(11), 1142–1150.
<https://doi.org/10.1001/jamapediatrics.2021.2482>
- Rahman, L. (2025). Contributions of Islamic belief and spiritual well-being and mental health on Muslim adolescents: A literature review. *International Journal of Psychiatry*
International Journal of Psychiatry, 10(1), 01–04.
<https://doi.org/10.33140/IJP.10.01.04>
- Raja, R. A. (2004). *Attitude of Pakistani American Muslim men towards seeking psychotherapy* [PhD dissertation, The Chicago School of Professional Psychology].
<https://www.proquest.com/docview/305054464?pq-origsite=gscholar&fromopenview=true&sourcetype=Dissertations%20&%20Theses>
- Ramadan, T. (2004). *Islam, the West and the challenges of modernity*. Islamic Foundation

- Randhawa, G., & Stein, S. (2007). An exploratory study examining attitudes toward mental health and mental health services among young South Asians in the United Kingdom. *Journal of Muslim Mental Health*, 2(1), 21–37.
<https://doi.org/10.1080/15564900701238518>
- Razak, T. (2020). *A qualitative study understanding how mental health is viewed amongst South African middle-adult Muslim males* [Honours Research Report, The Independent Institute of Education]. <https://iiespace.iie.ac.za/bitstreams/b3dfd581-31eb-46c4-b963-b8ceb256a108/download>
- Reinke, W. M., Herman, K. C., & Dong, N. (2018). The incredible years teacher classroom management program: Outcomes from a group randomized trial. *Prevention Science (Print)*, 19(8), 1043–1054. <https://doi.org/10.1007/s11121-018-0932-3>
- Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly*, 26(1), 1–13. <https://doi.org/10.1037/a0022714>
- Rohleder, P., & Lyons, A. (2014). *Qualitative research in clinical and health psychology* (5th ed.). Red Globe Press.
- Rothman, A. (2018). An Islamic theoretical orientation to psychotherapy. In C. Y. Al-Karam (Ed.), *Islamically integrated psychotherapy: Uniting faith and professional practice* (pp. 25–56). Templeton Press.
- Rozali, W. N. a. C. W. M., Ishak, I., Ludin, A. F. M., Ibrahim, F. W., Warif, N. M. A., & Roos, N. a. C. (2022). The impact of listening to, reciting, or memorizing the Quran on physical and mental health of Muslims: Evidence from systematic review. *International Journal of Public Health*, 67, 1604998.
<https://doi.org/10.3389/ijph.2022.1604998>

- Rudolph, M. D., Miranda-Domínguez, O., Cohen, A. O., Breiner, K., Steinberg, L., Bonnie, R. J., Scott, E. S., Taylor-Thompson, K., Chein, J., Fettiich, K. C., Richeson, J. A., Dellarco, D. V., Galván, A., Casey, B., & Fair, D. A. (2017). At risk of being risky: The relationship between “brain age” under emotional states and risk preference. *Developmental Cognitive Neuroscience, 24*, 93–106.
<https://doi.org/10.1016/j.dcn.2017.01.010>
- Russell, S. T., & Fish, J. N. (2017). Mental health in lesbian, gay, bisexual, and transgender (LGBT) youth. *Annual Review of Clinical Psychology, 12*, 465–487.
<https://doi.org/10.1146/annurev-clinpsy-021815-093153>
- Saged, A. a. G., Sa’ari, C. Z., Abdullah, M. B., Al-Rahmi, W. M., Ismail, W. M., Zain, M. I. A., & alShehri, N. B. a. B. M. (2022). The effect of an Islamic-Based intervention on Depression and Anxiety in Malaysia. *Journal of Religion and Health, 61*(1), 79–92.
<https://doi.org/10.1007/s10943-021-01484-3>
- Samari, G., Alcalá, H. E., & Sharif, M. Z. (2018). Islamophobia, health, and public health: A systematic literature review. *American Journal of Public Health, 108*(6), e1–e9.
<https://doi.org/10.2105/AJPH.2018.304402>
- Samdal, G. B., Eide, G. E., Barth, T. F. W., Williams, G., & Meland, E. (2017). Effective behaviour change techniques for physical activity and healthy eating in overweight and obese adults; Systematic review and meta-regression analyses. *The International Journal of Behavioural Nutrition and Physical Activity, 14*(1), 42.
<https://doi.org/10.1186/s12966-017-0494-y>
- Seidler, Z. E., Wilson, M. J., Kealy, D., Oliffe, J. L., Ogrodniczuk, J. S., & Rice, S. M. (2021). Men’s preferences for therapist gender: Predictors and impact on satisfaction with therapy. *Counselling Psychology Quarterly, 35*(1), 173–189.
<https://doi.org/10.1080/09515070.2021.1940866>

- Setlhare, R., Wood, L., & Meyer, L. (2016). Collaborated understandings of context-specific psychosocial challenges facing South African school learners: A participatory approach. *Educational Research for Social Change*, 5(2), 18–34.
<https://doi.org/10.17159/2221-4070/2016/v5i2a2>
- Shah, S. (2018). “I am a Muslim first . . .” Challenges of Muslimness and the UK state schools. *Leadership and Policy in Schools*, 18(3), 341–356.
<https://doi.org/10.1080/15700763.2017.1398335>
- Sham, F. M. (2015). Stress symptoms among adolescent: A study from an Islamic perspective. *Journal of Religion and Health*, 54(4), 1278–1285.
<https://doi.org/10.1007/s10943-014-9866-7>
- Shehu, S. (2015). A study of the Islamic perspective of cognitive development and its implications in education in the Muslim world. *Revelation and Science*, 5(1), 1–9.
<https://journals.iium.edu.my/revival/index.php/revival/article/download/125/135>
- Shelemy, L., Harvey, K., & Waite, P. (2019). Supporting students’ mental health in schools: What do teachers want and need? *Emotional and Behavioural Difficulties*, 24(2), 100–116. <https://doi.org/10.1080/13632752.2019.1582742>
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2), 63–75. <https://doi.org/10.3233/efi-2004-22201>
- Sibanda, T., Sifelani, I., Kwembeya, M., Matsikure, M., & Songo, S. (2022). Attitudes and perceptions of teachers toward mental health literacy: A case of Odzi High School, Mutare District, Zimbabwe. *Frontiers in Psychology*, 13, 1-9.
<https://doi.org/10.3389/fpsyg.2022.1003115>
- Skinner, D., Sharp, C., Marais, L., Serekoane, M., & Lenka, M. (2019). A qualitative study on teachers’ perceptions of their learners’ mental health problems in a disadvantaged

community in South Africa. *Curationis*, 42(1) a1903.

<https://doi.org/10.4102/curationis.v42i1.1903>

Soares, A. G. S., Estanislau, G., Brietzke, E., Lefèvre, F., & Bressan, R. A. (2014). Public school teachers' perceptions about mental health. *Rev Saúde Pública*, 48(6), 940–948.

<https://doi.org/10.1590/s0034-8910.2014048004696>

Splett, J. W., Garzona, M. E., Gibson, N., Wojtalewicz, D., Raborn, A., & Reinke, W. M. (2018). Teacher recognition, concern, and referral of children's internalizing and externalizing behavior problems. *School Mental Health*, 11(2), 228–239.

<https://doi.org/10.1007/s12310-018-09303-z>

Stiffman, A. R., Stelk, W., Horwitz, S. M., Evans, M., Outlaw, F. H., & Atkins, M. S. (2010).

A public health approach to children's mental health services: Possible solutions to current service inadequacies. *Administration and Policy in Mental Health*, 37, 120–

124. <https://doi.org/10.1007/s10488-009-0259-2>

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

<https://doi.org/10.1080/13674676.2018.1462781>

Sulaiman, A., Jamsari, E. A., & Noh, N. C. (2014). Islamic environment in child

development according to the views of Imam Al-Ghazali. *Mediterranean Journal of Social Sciences*, 5(29), 33-39. <https://doi.org/10.5901/mjss.2014.v5n29p33>

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G.

Austin, & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33-37). Brooks/Cole.

Terr Blanche, M., Durrheim, K., & Painter, D. (2006). *Research in practice: Applied methods for the social sciences* (2nd ed.). UCT Press.

- Thunberg, S., & Arnell, L. (2021). Pioneering the use of technologies in qualitative research – A research review of the use of digital interviews. *International Journal of Social Research Methodology*, 25(6), 757–768.
<https://doi.org/10.1080/13645579.2021.1935565>
- Tong, P., & An, I. S. (2023). Review of studies applying Bronfenbrenner’s bioecological theory in international and intercultural education research. *Frontiers in Psychology*, 14, 1233925. <https://doi.org/10.3389/fpsyg.2023.1233925>
- Truter, Z. M. (2022). Collaborative care for mental health in South Africa: A qualitative systematic review. *South African Journal of Psychology*, 53(1), 18–31.
<https://doi.org/10.1177/00812463221093525>
- Tudge, J. R. H., Merçon-Vargas, E. A., Liang, Y., & Payir, A. (2017). The importance of Urie Bronfenbrenner’s bioecological theory for early childhood educators and early childhood education. In L. Cohen & S. Stupiansky (Eds.), *Theories of early childhood education: Developmental, behaviorist, and critical* (45–57). Routledge.
<https://doi.org/10.4324/9781315641560>
- Umaña-Taylor, A. J., Quintana, S. M., Lee, R. M., Cross, W. J., Rivas-Drake, D., & Schwartz, S. J. (2014). Ethnic and racial identity during adolescence and into young adulthood: An integrated conceptualization. *Child Development*, 85(1), 21–39.
<https://doi.org/10.1111/cdev.12196>
- Utz, A. (2012). Conceptualizations of mental health, illness, and healing. In S. Ahmed & M. M. Amer (Eds.), *Counselling muslims: Handbook of mental health issues and interventions* (1st ed., pp. 15–31). Routledge.
- Vahed, G. (2020). Muslims in post-apartheid South Africa: Race, community, and identity. *Social Identities*, 27(1), 44–58. <https://doi.org/10.1080/13504630.2020.1814724>

- Van der Watt, A. S. J., Nortje, G., Kola, L., Appiah-Poku, J., Othieno, C., Harris, B., Oladeji, B. D., Esan, O., Makanjuola, V., Price, L. N., Seedat, S., & Gureje, O. (2017). Collaboration between biomedical and complementary and alternative care providers: Barriers and pathways. *Qualitative Health Research*, 27(14), 2177–2188. <https://doi.org/10.1177/1049732317729342>
- Varpio, L., Paradis, E., Uijtdehaage, S., & Young, M. (2019). The distinctions between theory, theoretical framework, and conceptual framework. *Academic Medicine*, 95(7), 989–994. <https://doi.org/10.1097/acm.0000000000003075>
- Vasegh, S., & Mohammadi, M. (2007). Religiosity, anxiety, and depression among a sample of Iranian medical students. *The International Journal of Psychiatry in Medicine*, 37(2), 213–227. <https://doi.org/10.2190/j3v5-l316-0u13-7000>
- Village, A., & Francis, L. J. (2025). Psychological and Spiritual Well-Being Among Church of England Clergy and Laity three years After the COVID-19 Lockdowns. *Journal of Religion and Health*, 64(6), 5125–5146. <https://doi.org/10.1007/s10943-025-02412-5>
- Vitorino, L. M., Lucchetti, G., Leão, F. C., Vallada, H., & Peres, M. F. P. (2018). The association between spirituality and religiousness and mental health. *Scientific Reports*, 8(1), 17233. <https://doi.org/10.1038/s41598-018-35380-w>
- Wassenaar, D. R., & Mamotte, N. (2012). Ethical issues and ethics reviews in social science research. In A. Ferrero, Y. Korkut, M. M. Leach, G. Lindsay, & M. J. Stevens (Eds.), *The Oxford handbook of international psychological ethics* (pp. 268–282). Oxford University Press.
- Weare, K. (2010). Mental health and social and emotional learning: Evidence, principles, tensions, balances. *Advances in School Mental Health Promotion*, 3(1), 5–17. <https://doi.org/10.1080/1754730x.2010.9715670>

- Weist, M. D., Hoover, S. A., Daly, B. P., Short, K. H., & Bruns, E. J. (2023). Propelling the global advancement of school mental health. *Clinical Child and Family Psychology Review*, 26(1), 851–864. <https://doi.org/10.1007/s10567-023-00434-7>
- Wertz, F. J., Charmaz, K., McMullen, L. M., Josselson, R., Anderson, R., & McSpadden, E. (2011). *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry*. The Guilford Press.
- Westerhof, G. J., & Keyes, C. L. (2010). Mental illness and mental health: The two continua model across the lifespan. *Journal of Adult Development*, 17(2), 110–119. <https://doi.org/10.1007/s10804-009-9082-y>
- Wills, G., & Böhmer, B. (2023). *Male managers, female teachers: The South African case of gender imbalances in school leadership and management*. Research on Socio-Economic Policy. [https://tdd.sun.ac.za/downloads/notes/Note%2012%20-%20Male%20Managers,%20Female%20Teachers%20\(TDD%2010%20July%202023\).pdf](https://tdd.sun.ac.za/downloads/notes/Note%2012%20-%20Male%20Managers,%20Female%20Teachers%20(TDD%2010%20July%202023).pdf)
- Wollin-Giering, S., Hoffmann, M., Höfting, J., & Ventzke, C. (2024). Automatic transcription of English and German qualitative interviews. *Forum: Qualitative Social Research*, 25(1), 1-37. <https://doi.org/10.17169/fqs-25.1.4129>
- Woodbridge, N. B. (2007). Psychotherapy: science or religion? Some implications for today's church. *The Journal of The South African Theological Seminary*, 4(9), 83–95. https://hdl.handle.net/10520/AJA19968167_23
- World Health Organization. (2001). *The World Health report 2001: Mental health: New understanding, new hope*. <https://iris.who.int/handle/10665/42390>
- World Health Organization. (2021). *Mental health of adolescents*. <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>

- World Health Organization: WHO. (2022). *Mental health*. <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>
- Wren-Lewis, S., & Alexandrova, A. (2021). Mental health without well-being. *The Journal of Medicine and Philosophy*, 46(6), 684–703. <https://doi.org/10.1093/jmp/jhab032>
- Yao, M., Kadetz, P. I., Sidibe, A. M., Wu, Y., Li, J., Lyu, J., Ma, C., & Hesketh, T. (2021). Teachers' perceptions of student mental health in Eastern China: A qualitative study. *International Journal of Environmental Research and Public Health*, 18(14), 7271. <https://doi.org/10.3390/ijerph18147271>
- Yapici, A., & Bilican, F. I. (2014). Depression severity and hopelessness among Turkish university students according to various aspects of religiosity. *Archiv für Religionspsychologie /Archive for the Psychology of Religion*, 36(1), 53–69. <https://doi.org/10.1163/15736121-12341277>
- Yates, N. (2017). *A case study exploration of teachers' perspectives on children's mental health service needs in title I elementary schools* [PhD, Walden University]. <https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=4958&context=dissertations>

Appendix A: Ethical Approval Letter



04 November 2024

Muhammad Coovadia (224078747)
School of Applied Human Sc
Pietermaritzburg Campus

Dear M Coovadia,

Protocol reference number: HSSREC/00007751/2024

Project title: Exploring the perceptions of senior phase educators in KwaZulu-Natal's Muslim schools regarding learner mental health

Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 25 September 2024 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

Incidents of adverse events and serious adverse events (AEs and SAEs) should be reported in writing to HSSREC, the study sponsors, and any regulatory authority (where appropriate), within 7 working days of the occurrence for local sites and 14 days for all other South African sites.

This approval is valid until 04 November 2025.

To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

HSSREC is registered with the South African National Health Research Ethics Council (REC-040414-040).

Yours sincerely,



Professor Dipane Hlalele (Chair)
/nng

Humanities and Social Sciences Research Ethics Committee

Postal Address: Private Bag X54001, Durban, 4000, South Africa

Telephone: +27 (0)31 260 8350/4557/3587 Email: hssrec@ukzn.ac.za Website: <http://research.ukzn.ac.za/Research-Ethics>

Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

INSPIRING GREATNESS

Appendix B: Research Advert

Exploring the Perceptions of Senior Phase Educators in KwaZulu-Natal's Muslim Schools Regarding Learner Mental Health

What Is the research about?

The study aims to explore the perceptions that educators working in Muslim schools in KwaZulu-Natal have about learner mental health.

What is expected of participants?

Participants will be required to participate in a 60-90 minute online interview via Zoom as per agreement with the researcher. The date and time of the interview is flexible.

Participation

Should you wish to participate in the research study, please contact the researcher:

Muhammad Coovadia- 42 [REDACTED]

or alternatively email mcoovie@gmail.com

CALLING SENIOR PHASE EDUCATORS TO PARTICIPATE IN A RESEARCH INTERVIEW

Do you meet the following criteria?

- Senior phase educator registered with SACE
- Proficient in written and spoken English
- Taught at a Muslim school for a minimum of three years

Who is conducting the study?

The research will be conducted by Muhammad Coovadia as a requirement for a Master of Social Science in Counselling Psychology degree at the University of KwaZulu-Natal (UKZN), Pietermaritzburg campus.

Ethical considerations

- This research has been approved by UKZN's Humanities and Social Sciences Research Ethics Committee.
- Information will be kept confidential in the write up of the thesis, with no identifying information being disclosed.
- Participation in this research is voluntary.

Questions

Should you have any questions, feel free to contact the researcher for clarity. Additionally, you can contact the researcher's supervisor on the following email: MatoaneM@ukzn.ac.za



Appendix C: Information Sheet and Informed Consent

Information Sheet and Consent to Participate in Research

Date:

Dear Participant,

My name is Muhammad Coovadia from the University of KwaZulu-Natal, Pietermaritzburg campus. I am currently completing a Master of Social Science in Counselling Psychology and conducting a research study under the guidance of Prof Matshepo Catherine Matoane from the Discipline of Psychology at UKZN Pietermaritzburg (MatoaneM@ukzn.ac.za).

You are being invited to consider participating in a study that explores the perceptions of senior phase educators in KwaZulu-Natal's Muslim schools regarding learner mental health. The aim of the research is to explore the perceptions that senior phase educators working in Muslim schools in KwaZulu-Natal have about learner mental health. If you choose to enroll and remain in the study, you will be required to participate in a once of in-depth semi-structured interview that will be conducted on Zoom. The interview is expected to last between 60 to 90 minutes with participants not required to show their faces. Participants may be reimbursed for their data and the study is self-funded.

The study may involve asking sensitive questions concerning learner mental health. Whilst the study will not provide any direct benefits to participants, it is anticipated that the findings will fill the current knowledge gap on the topic and may inform intervention strategies to better support educators.

Whilst the research involves no foreseeable risk to participants, it is possible that the questions may make you feel uncomfortable. Details for free psychological services will be provided during the interview to participants to help them cope with risks that may arise from taking part in the research.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number to be inserted).

In the event of any problems or concerns/questions you may contact the researcher at [REDACTED] or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Participation is voluntary and participants may withdraw participation at any point before the final thesis is submitted. In the event of refusal or withdrawal of participation, participants will not incur a penalty or a loss of treatment or other benefits to which they are normally entitled. During the research participants can communicate to the researcher that they wish to be removed from the study and the researcher will not ask or question the participant's decision. The researcher will be respectful and always seek to dignify the participants.

No costs will be incurred by participants as a result of participation in the study besides data costs. In the event of participants requiring data for the interview, a maximum of 500 megabytes will be provided to the participants.

Participants will be informed about the purpose and motives of the study both orally and in writing. Confidentiality regarding private information from the participants will be kept between the researcher, his supervisor, and the participant. In addition, participants will be assured that their identities will not be exposed in research reports or any other form of publication. Information will be kept for a period of five and then destroyed. Participation in the study is voluntary and participants can withdraw from the study anytime without being penalised. Participants will be given an informed consent form which they would have to sign and returned.

----- CONSENT

I (Name) _____ - have been informed about the study entitled Exploring the Perceptions of Senior Phase Educators in KwaZulu-Natal's Muslim Schools Regarding Learner Mental Health by Mr Muhammad Coovadia.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at + [REDACTED] or [REDACTED]

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

I hereby provide consent to:

Audio-record my interview
Video-record my interview

YES / NO
YES / NO

Signature of Participant

Date

Signature of Witness
(Where applicable)

Date

Appendix D: Interview Schedule

Below is the proposed interview schedule. Given that a semi-structured interview technique will be adopted, additional questions may be added as required. The interview will be split into six sections, beginning with an introduction that will gather background information about the participant before the topic is addressed.

Section 1: Introduction

- 1.1. Thank you for agreeing to participate in the research study. I will ask you a few questions regarding your perceptions as a senior phase educator at a Muslim school in KwaZulu-Natal regarding mental health. If you prefer to abstain from answering any question, please inform me and we will proceed to the next question. Do you have any questions about the interview process?
- 1.2. Can you please share an overall background of your journey as a teacher including your educational background and work experience?
- 1.3. How long have you been working at a Muslim school?
- 1.4. Which grades and subjects are you currently teaching?
- 1.5. Do you currently hold any management positions at your school? If so, please could you provide the relevant details?
- 1.6. Kindly provide me with your age.

Section 2: Unpacking Mental Health and Mental Illness

- 2.1. As an educator, what is your definition of mental health?
- 2.2. Do you feel mental health and mental illness refer to the same concept or different concepts? Kindly explain your thoughts.
- 2.3. In specific reference to a Muslim school setting, what are the key elements of learner mental health?

Section 3: Religious and Cultural Influences on Mental Health Perceptions

- 3.1. Please describe how you feel Islam conceptualises mental health and mental illness.
- 3.2. Do you think Islam's conceptualisation of mental health is similar to other religions/cultures? Please elaborate on your understanding.
- 3.3. Have you experienced any conflicts or differences between your understanding of mental health and that of your religion? If so, how do you generally navigate this?
- 3.4. What religious or cultural norms within the school positively influence mental health and mental illness?
- 3.5. What are some religious or cultural norms in the school that you feel negatively impact mental health and mental illness?
- 3.6. Can it be said that there is a distinction between mental health and spiritual well-being? Please elaborate.

Section 4: Common Learner Mental Health Concerns

4.1. What are some mental health concerns that senior phase learners at (insert name of school) experience?

4.2. Please describe how these mental health concerns manifest in senior-phase students.

4.3. What are common signs and symptoms that these learners present with?

4.4. Do you notice any gender differences in learners' mental health concerns or their manifestation? Please elaborate on your answer.

Section 5: Intervention Strategies

5.1. Do you assist learners when they require mental health support? If so, how do you achieve this?

5.2. Discuss any resources or specific intervention strategies you found effective when supporting learner mental health.

5.3. What initiatives has the school implemented to support learner mental health amongst senior phase learners?

5.4. Have you encountered any challenges when addressing learner mental health? If so, please describe them.

5.5. Do you know of any guidelines or teachings in Islam about addressing mental health? If yes, do you implement any of these techniques?

Section 6: Closing Comments

6.1. Would you like to provide me with any additional information that may benefit my research study?

Appendix E: Confirmation of Debriefing Services from Islamic Careline




Confidential Counselling Service
 008-834 NPO
 P.O. Box 42863 Fordsburg 2033
 32 Dolly Rathebe Road Fordsburg 2092
 Tel: 011 373 8080 Fax: 011 373 8099
 Email: careline@islamsa.org.za

19/04/2024

Ref: Islamic Careline Debriefing Request

Dear Muhammad Coovadia

As Salaam Alykum

Thank you for your letter, dated 15 April 2024, to request Debriefing Services as a support to your referenced research study.

Islamic Careline is pleased to be a part of this initiative and will provide the debriefing services for your participants as required.

We wish you the best for this study and are looking forward to this journey with you

Please feel free to contact us for any further assistance

Shukran
 Was Salaam Alykum

Shuhaida Adam
 Social Worker

Indeed the Almighty responds to the call of the servant as long as a servant is in the service of fellow human beings. (Hadith)

Appendix F: Turnitin Report

Muhammad Coovadia Thesis Submission.docx

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