Doctoral Thesis

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Acknowledging the unseen: Muslim practitioners' understandings and processes of alleviating emotional distress with British Muslims

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Word Count Statement

Thesis Section	Text	Title page, abstract, tables and figures, references, footnotes and appendices	Total
Abstract	300	-	300
Literature Review	7979	4182	12161
Research Paper	7591	5530	13121
Critical Appraisal	3867	482	4349
Ethics	4660	-	4660
Totals	**24,397**	**10,194**	**34,591**

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Abstract

This document comprises a literature review, in the form of a meta-ethnography, a research paper, using Grounded Theory methodology and a Critical Appraisal of the research process. Muslims may be considered to hold a unique worldview, with regards to the existence of the physical and metaphysical world. It was of interest to explore this epistemology within the context of therapy, specifically in relation to practitioners' conceptualisations of, and processes used to alleviate emotional distress experienced by Muslims.

Section one, the meta-ethnography considers Muslim practitioners' conceptualisations of emotional distress including both spiritual and non-spiritual explanatory models of emotional distress. Six papers were included for the review. Three themes emerged from the analysis: *spiritual causes*, *non-spiritual causes* and the *impact on clinical work*. Findings are presented with supporting first-order quotations and are discussed in terms of the clinical implications and limitations of the literature reviews. Suggestions for further research are made.

Section two presents a Grounded Theory which shows and explains processes used by Muslim practitioners, in alleviating emotional distress of British Muslims, outside mainstream mental health services. 14 interviews took place with nine participants, who identified as holding a role in alleviating emotional distress within the British Muslim community. Three key components of the model are presented, *practitioners' conceptualisation of Islam and wellbeing*, *engaging a diverse range of British Muslim individuals* and *therapeutic processes* used to alleviate emotional distress. Findings are discussed in terms of the clinical implications of the model with an acknowledgement of the limitations of the research findings. Suggestions for future research are made.

The third and final section, the Critical Appraisal, summarises the findings of the previous sections. Strengths and weaknesses of the overall paper are acknowledged, and the researcher offers a personal reflection upon the influence of their epistemic position on the conduct of the research.

Declaration

The thesis presents work undertaken as part of the Doctorate in Clinical Psychology at the University of Lancaster, Division of Health Research. The research took place between October 2017 and December 2018. The work presented is the author's own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere

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Signed: *Sana Gill*

Date: 17.03.19

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Section One:

Exploring Muslim practitioners' conceptualisations of emotional distress

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[1] Please note this manuscript was prepared in line with author guidelines for the *Journal of Religion and Health* (See Chapter 4). Where these guidelines have not been followed, Lancaster University thesis guidelines have been followed. The word count is also in line with University not *Journal* guidance.

Abstract

The acknowledgement of conceptualisations of emotional distress (ED), which may contrast with scientific and largely positivist explanatory models of the modern 'West' are important for psychologists to consider when aiming to improve cultural competency. For Muslim communities, religious and cultural conceptualisations of ED may include spiritual attributions to such experiences.

One way to inform cultural competency in work with Muslim communities is to learn from those who are currently effective in engaging with this population. This meta-ethnography considers the conceptualisations held by Muslim practitioners, including those with professional qualifications and those who adopt the role of a traditional or faith healer. Six papers were included for review.

The analysis showed three main themes of *Spiritual causes* and *Non-spiritual causes* of ED and considered *The impact of conceptualisations on clinical work* of Muslim practitioners. Clinical implications include developing ways of working collaboratively with faith healers, being mindful of potentially conflicting epistemic views with regards to existence of the metaphysical and consequent conceptualisation of ED. Limitations of the paper are considered, and suggestions made for future research.

Keywords: mental health, Muslim, metaphysical, spiritual, conceptualisations

CONCEPTUALISATIONS OF EMOTIONAL DISTRESS

Experiences of emotional distress (ED) are reported to be influenced by sociocultural and religious contexts (Molsa, Hjelde & Tilikainen, 2010). Vygotsky's sociocultural theory suggests that emotional experiences are likely to be both understood and expressed within the parameters deemed permissible by the sociocultural contexts within which individuals develop (Schaffer, 2009). Consequently, a diverse range of mental health or emotional difficulties exists among individuals, and a number of explanatory models have been offered for such experiences. The conceptualisation of one's difficulties is likely to influence the interaction of an individual seeking support for such experiences (Hernandez, Nesman, Mowery, Acevedo-Polakovich & Callejas, 2009).

Widely accepted understandings of ED are rooted in largely scientific, positivist paradigms (Swartz, 2002), forming the basis of universal diagnostic systems such as the DSM-V (APA, 2013) and the ICD-10 (WHO, 1992). These paradigms of the modern 'West' are based upon empirical findings, endorsing the idea that knowledge and truth are largely observable, tangible and therefore testable. These paradigms stand in contrast to many religious belief systems, for instance, some religious groups attribute ED to spiritual and supernatural causes, including the wrath of God (as either a blessing or a punishment), curses or evil spirits (Choudhry, Mani, Ming, Khan, 2016; Hayward, 1999; Molsa et al, 2010).

It has been argued that if practitioners use scientific paradigms alone, to formulate psychological experiences and needs of individuals holding alternative or additional cultural and religious conceptualisations of their difficulties, this can result in negative consequences such as misdiagnosis and inappropriate therapeutic approaches (McConnochie, Ranzijn, Hodgson, Nolan & Samson, 2012; Mkhize, 2004; Teuton, Bentall & Dowrick, 2007).

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Acknowledging also, the presence of diverse emotional experiences, it has been suggested that broadening the aetiological perceptions held by mental health practitioners is necessary, particularly in recognising non-Western conceptualisations of mental health difficulties (MHD) (APA, 2000; Dinh, Groleau, Kirmayer, Rodriguez & Bibeau, 2012; Laher, 2014), enhancing cultural competency in working with the increasingly diverse populations.

The organisational cultural competence of mental health services has been described as the "degree of compatibility" between services and the community context and cultural characteristics of the local population that it serves (Hernandez et al, 2009). It has also been suggested that, further to outreach work with marginalised communities, engaging in learning exchanges between mental health services and the communities they support may be beneficial to achieve cultural competence (Hernandez et al, 2009; Laher, 2014; Molsa et al, 2010). It is hoped that this approach may support practitioners in their understanding of client experience and tailoring of appropriate interventions through the acknowledgement of religious and cultural contexts, known to influence client conceptualisations and experiences of emotional difficulties.

There is a particular tension between the dominant, scientific perspective of the modern 'West' and Islamic spiritual explanatory models of ED. Possession by Jinn (spirits), persecutory processes such as Black Magic (witchcraft/sorcery) and Nazr (evil eye), are examples of spiritual conceptualisations, reported by some Muslims, to explain the manifestation of their ED (Ally & Laher, 2008; Haque, 2004; Islam & Campbell, 2014; Weatherhead & Daiches, 2010; Abdussalam-Bali, 2004). It is important to note that whilst these are reported trends among Muslims, this does not necessarily reflect the attribution style of all Muslims.

Global demographics, as reported by the Pew Research Centre (PRC, 2010), indicate that there are 1.6 billion Muslims across the world. The latest statistics reported in 2010, by the PRC,

indicate that 62% of the global Muslim population reside in Asia-Pacific, 20% in the Middle East and North Africa and 16% in Sub-Saharan Africa. Just 3% of the global Muslim population reside in Europe and 0.2% in North America. Muslims are reported to be the majority population in 49 countries, the country with the largest population reported to be Indonesia, where 87.2% of the population identify as being Muslim and the second largest being India (*Table 1*).

Specific spiritual attributions as the cause of emotional experiences, such as hallucinations, delusions, anxiety, anorexia, post-partum depression and neurological difficulties, are reported by Muslim clients, treated within mainstream services, across the globe (Dein, 2003; Ghubash & Valsamma, 2009; Gurma & Tesfaye, 2011; Lim, Hoek & Blom, 2015; Lim, Hoek, Ghane, Deen & Blom, 2018; Mullick, Khalifa, Nahar & Walker, 2013; Razali, Khan & Hasanah, 1996). Similarly, individuals who work to alleviate ED, including nurses and psychologists in Saudi Arabia (Tayeb, Khayat, Milyani, Alsawwaf, Alzaben & Koenig, 2018) and health workers in India (Joel, Sathyaseelan, Jayakaran, Vijayakumar, Muthurathman & Jacob, 2003; Urvais, 2017), attributed the cause of ED to black magic, evil eye and Jinn possession.

Of the spiritual attributions given as the cause of ED, by both practitioners and clients, the most commonly reported is possession by Jinn or spirit. The root of the word Jinn is 'j-n-n' in the Arabic language, translated to mean "concealed", "secluded" or "remote" (Ameen, 2005; Omar, 2003) and described, by Quranic text to be created by God, out of "smokeless fire" (Al-Ashqar, 2005; Lim et al, 2018).

Some Muslims believe that, although invisible to the human eye, Jinn are capable of making themselves visible (Lim et al, 2018) and can take the form of an animal or another human being (Ameen, 2005; Dein, Alexander & Napier, 2008; Lebling, 2010). References

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within the Quran[2] and Hadith[3] describe Jinn to be intelligent beings with a sense of agency, enabling them to cause interference in the lives of humans (Dein et al, 2008; Islam & Campbell, 2014; Lim et al, 2018). Jinn are said to possess or attack individuals who are weak of will, lacking in confidence or faith or experiencing a significant transition in their life such as marriage, childbirth or puberty (Deine & Illaiee, 2013; Hussain & Cochrane, 2002). Jinn are reported to cause physical, emotional and social distress in the lives of humans (Abdussalam-Bali, 2004).

A further attributed cause of ED is 'black magic' which refers to the conduct of 'witchcraft' or 'sorcery'. Some Muslims describe Black Magic as the deliberate calling upon Jinn or demons from the spirit world to inflict physical, social or psychological harm on other individuals. It is believed, by some, that only individuals with specific skills, sometimes described as *Sihr* in Islamic texts can conduct such affairs (Laher, 2014). It is thought that misfortune may be inflicted using direct methods, such as using products of plants to inflict symptoms of rashes, vomiting, fever, miscarriage and hallucinations as well as negative emotional experiences such as agitation, terror, helplessness and despair (Dein, 2003).

A third spiritual attribution, is reported to be the 'evil eye' referred to in some cultures as 'nazr'. Nazr is attributed, by some Muslims to explain their ED and is considered to be inflicted upon another individual without intention, as a reaction to negative emotions such as jealousy or envy (Stein, 2000).

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[2] Quran – Holy scripture of the Islamic religion

[3] Hadith – term used to describe the actions, sayings and guidance of the Prophet Muhammed, the main figurehead of Islam

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These spiritual or supernatural attributions as ED are reported to be held by Muslims, in both Islamic and non-Islamic countries (Ally & Laher, 2008; Al-Habeeb, 2004; Dein, Alexander & Napier, 2008; Endrawes, O'Brien & Wikes, 2007; Haque, 2004; Islam & Campbell, 2014; Khalifa, Hardie, Latif, Jamil & Walker, 2011). Such findings suggest that psychologists may encounter Muslim clients who hold spiritual attributions to their ED.

The number of Muslims accessing British mental health services is relatively low in comparison to the majority population (Aloud & Rathur, 2009). Despite 5.2% of the population being Muslim (ONS, 2018), just 2.3% of referrals to Improving Access to Psychological Therapies (IAPT) Services in Britain, between 2016 and 2017 were Muslim. Moreover, Muslims were reported to be the least likely religious group to experience reliable improvement from services, with just 39% of Muslim clients reported to have reached recovery (Baker, 2018). Social stigma, mistrust of mental health services and a lack of religious or spiritual aspects to the conceptualisation and treatment of emotional difficulties are described as pertinent factors which may influence the low presentation of Muslims to services (Aloud & Rathur, 2009; Sarfraz & Castle, 2002; Weatherhead & Daiches, 2010).

Research suggests that Muslims, across the globe, are more likely to seek support from friends and members of their religious community including imams[4] and faith healers[5] (Al-

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[4] Imam - Leader of the Muslim congregation

[5] Faith healer - individuals who have a comprehensive understanding of a religious or cultural viewpoint, often recognised by their local community as being competent to alleviate physical and emotional malaise (Al-Habeeb, 2004).

Krenawi & Graham, 2000; Ali, Milstein & Marzuk, 2005), as a first point of contact for mental health concerns (Chong & Mohamad, 2013; Gurma & Tesfaye, 2011; Leavey, 2008; Razali & Tahir, 2018; Uwake & Orakpor, 2014). Khalifa et al (2011) report 64% of adult British Muslims believed that when their emotional difficulties had a spiritual cause, a religious figure should be consulted rather than a doctor, suggesting that conceptualisations of ED may influence an individual's choice in the source of emotional support.

For many Muslims, globally, Imams and faith healers are reported to be the first point of contact for mental health concerns before they seek support at mainstream mental health services.

Islamic faith or traditional healers, described as 'Moulana' or 'Matawaa', are considered, by Muslims, as alleviating ED through the expulsion of evil spirits (Al-Habeeb, 2004; Syed, 2003) and recognised as individuals who hold a comprehensive understanding of Islam. Healing practices are reported to include the recitation of specific verses from the Quran, while holy water is splashed upon, or offered as a drink to the individual to alleviate their distress (Khan & Sanober, 2016; Lim et al, 2015). Abdullah, Saini, Sharip & Shaharom (2017) described Muslim faith healers as pious individuals who use prayers in treating mental and physical ailments of their local community, who may be experiencing psychological difficulties as a result of spiritual infliction by Jinn, black magic or the evil eye (Al-Habeeb, 2004).

Individuals who play a role in the alleviation of ED, in a formal or professional role, including faith healers, imams and those working within mainstream mental health services may be considered, collectively, as Muslim practitioners. It may be suggested that Muslim practitioners acknowledge Islamic, spiritual understandings of ED in addition to common, Western conceptualisations of MHD, including biopsychosocial factors, pertinent to the client

(Choudhry et al, 2016). Alternatively, a belief in spiritual causes may be viewed as a cultural explanation or religious context of the manifestation of clients' ED. For example, a client who reports to have been possessed by a Jinn, may be considered to be expressing a MHD, within the parameters governed, and deemed permissible by, their cultural context. Conversely, from the perspective that spiritual illnesses exist as separate entities, a client may be described as experiencing a spiritual illness. Practitioners who adopt this conceptualisation are likely to acknowledge clients as existing within both a natural environment and a supernatural one, within which intangible or unseen forces, such as spirits, may function (Laher, 2014). Consequently, practitioners' conceptualisations of ED may determine whether a client receives a diagnosis of psychosis, to use an example, or a spiritual illness. Furthermore, this may influence the intervention suggested to the client and potentially client conceptualisation of their experiences, acknowledging power differences between client and practitioner (Khalifa & Hardie, 2005).

It is important to understand Muslim practitioners' conceptualisations of ED to inform potential ways of joint working with mainstream mental health services in the hope of improving organisational cultural competence (Hernandez et al, 2009). Acknowledging religious, cultural and professional training influences, it is of particular interest to understand how Muslim practitioners, working in both formal and informal contexts, may make sense of potentially conflicting explanatory paradigms of ED. Several qualitative studies have explored the conceptualisations held by Muslim practitioners, reporting both spiritual and non-spiritual attributions to the cause of ED.

To date, however, there are no syntheses which consider the conceptualisations of ED held by Muslim practitioners who work, both formally and informally, to alleviate ED. The aim of this paper is therefore, to create a synthesised understanding of such conceptualisations to

inform a broader recognition, by mainstream mental health professionals, of the aetiological

perspectives of ED, which may be held by Muslim clients.

Methods

Search strategy

A systematic search of five electronic databases: Medline, CINAHL, SocINDEX, Scopus and PsycINFO was conducted to identify qualitative papers considering Muslim practitioners' conceptualisations of ED. Whilst it is acknowledged that the use of Western databases may be limited by positivist conceptualisations of MHDs, these databases were deemed appropriate for use. It was established that there were no alternative databases which could provide an adequate platform for such a systematic search strategy required for this piece of academic research.

A scoping search informed the relative specificity of the search terms, selected to be broad enough to capture relevant papers and specific enough to ensure that relevant papers were not excluded. Search terms, including thesaurus terms of each specific database were combined using Boolean logic operators (*Appendix, 1-A*).

Papers were requested from the British Library if they were not retrievable electronically. In addition to electronic database searches, papers were hand searched to identify any further papers which may have been relevant for inclusion to the review. Handsearching did not reveal any additional papers, indicating that the search strategy was suitably efficient.

Database search results were imported to EndNote. Duplicates were identified by hand in addition to the use of electronic software. All titles and abstracts were screened to establish suitability of papers for inclusion to the review. Where relevance of the paper was unclear from the title, abstracts were retrieved. Finally, if further clarification was required, full-texts were obtained (Figure 1).

[Figure 1]

Inclusion and exclusion criteria

Papers considering the conceptualisation of MHD by Muslim practitioners including faith healers, persons of religious authority (e.g. Imams or recognised members of the community) and mental health professionals (e.g. psychologists, counsellors and psychiatrists) were selected for inclusion. A large number of papers were screened, considering first the titles of papers (Diagram 1).

Papers exploring mental health conceptualisations of a mixed sample group, were included if it was transparent, in the results section, which direct quotes reflected the views of Muslim practitioners. If it was difficult to identify the views of the target population, papers were excluded, to ensure the robustness of the synthesis.

Quantitative studies were excluded, as well as papers which did not explicitly mention Islamic or Muslim perspectives of MHD. Papers which reported Muslim community members' conceptualisations of MHD were not included for review. For example, if a paper was conducted in a Muslim country, but it was not explicitly stated that participants were Muslim, the paper was excluded.

Papers included for review

Six papers were included for review, which considered practitioners' conceptualisations of MHD. Most of these papers considered conceptualisations of MHD in general, one considered conceptualisations of psychosis and one considered the conceptualisations of Schizophrenia, Depression, Obsessive Compulsive Disorder (OCD) and Psychosis. Studies reported conceptualisations of 47 participants including 22 faith healers, 10 traditional healers, eight

volunteer counsellors and seven psychiatrists. Gender was reported for 40 participants, male

(n=25) and female (n=15). Studies took place in South Africa (n=3), United Arab Emirates

(UAE), *n=1*, Malaysia (n=1) and United Kingdom (UK), *n=1* (Table 2).

Dominant narratives of included papers

Careful attention was given to ensure that the search strategy limited bias towards

Eurocentric terminology used to describe MHDs or experiences of ED. The presence of

Eurocentric, medical and diagnostic narratives was however, noted among the included papers.

For example, many of the papers used diagnostic frameworks to describe the experiences of the

participants, the impact of such reporting styles on the review findings is acknowledged. It may

be argued that the review is therefore limited in its ability to capture conceptualisations of

Muslim practitioners who may ascribe to an alternative framework to explain ED.

[Table 2]

Quality appraisal of studies

While quality appraisal of papers for inclusion in a quantitative systematic review is

considered integral to the process, controversy exists with regards to the meaningfulness of this

appraisal as part of qualitative syntheses (Britten, Campbell, Pope, Donovan, Morgan & Pill,

2002; Caroll & Booth, 2014). In addition, there is limited consensus on what constitutes the

quality criteria for this appraisal (Campbell et al, 2011; Dixon-Woods et al, 2007; Spencer,

Ritchie, Lewis & Dillon, 2003).

It is acknowledged that both the methodological rigour and depth and breadth of findings

reported is important in assessing the value of the paper in its contribution to the field of

research. Evaluation tools for qualitative papers may be considered counterproductive however, because they can result in reducing a rich amount of qualitative data to a checklist of more technical aspects of the reported form of the research, which may not necessarily reflect the credibility of the paper (Sandelowski & Barroso, 2003). Furthermore, it may be argued that, because qualitative studies require application of an academic framework to authors' interpretations of qualitative data, the process may influence the form of the presentation of data, but may not reduce its perceived credibility (Barbour, 2001).

Despite acknowledging the presented drawbacks, quality appraisal ensures the necessary reliability and accuracy of reports, by authors, on the primary data collected. The researcher therefore, included a brief structured assessment tool the Qualitative CASP Checklist from the Critical Appraisal Skills Programme (CASP, 2017 [Public Resource Unit, 2006]) to prompt judgements about the quality of papers included for review (Masood, Thaliath, Bower & Newton, 2010). The CASP considers three main questions when assessing the quality of the paper: Are the results of the study valid? What are the main results reported? What are the implications of the findings? This assessment tool is suggested to prompt researchers in their judgements of papers (Dixon-Woods et al, 2007). In light of the suggested controversy, this tool was used to prompt the researcher to consider the quality of the papers to support the qualification of the reliability and validity of their interpretation of reports.

Despite previous papers formulating a numerical score based on the CASP (Feder, Hutson, Ramsay & Taket, 2006), the researcher was reluctant to exclude a paper on the basis of reporting quality alone, as it was considered that the paper may still add meaningful data to the review (Dixon-Woods et al, 2007; Garside, 2014). A comparative appraisal was conducted, where key elements of the CASP were considered in relation to the papers included for review

(*Appendix 1-B*). A numerical score was not allocated however, and the CASP was not used as a basis for the inclusion criteria of papers for the review.

Analysis

A metasynthesis is an interpretative analysis of qualitative data, grounded in empirical data (Shaw, 2012). This metasynthesis is conducted from a social constructionist stance, acknowledging that the themes created are a reflection of the author's construction of participants' conceptualisations of ED (Creswell & Miller, 2000).

A meta-ethnography is one of the most developed methods for synthesising qualitative data and its origins lie within the interpretative paradigm (Bondas & Hall, 2007; Britten et al, 2002). This method was considered to meet the aims of synthesising findings reported by papers included in the review. The meta-ethnographic method allows for analysis of findings to be considered as higher-order themes, expressing conclusions about the way papers relate to one another (Noblit & Hare, 1988 p. 10-11), whilst preserving interpretations of individual participant conceptualisations.

This is achieved by expressing an overall summary and interpretation of the second order constructs reported by authors of the papers (Britten et al, 2002). In this review, 'second order constructs' refer to the authors' interpretations of practitioners' conceptualisations of MHD. The direct reports of the participants themselves are described as first order constructs.

Noblit and Hare's (1988) meta-ethnographic methodology consists of seven stages. Stages one and two included the identification of a research question and the completion of literature searches, as described above. Stage three included a close reading of the papers

included for review, extracting contextual information (see Table 2). Analysis of papers, in chronological order considering how the papers relate to one another, as stage four, where major themes or concepts were noted and entered into an Excel spreadsheet. First-order constructs (*Appendix 1-C*) were extracted and included in the tabular representation of the studies (*Appendix 1-D*).

Stages five and six included the translation of studies into one another, creating a synthesis of these. Attention was paid to any common or recurring concepts and any nuances in the comparisons were noted and captured in the fieldnotes made by the author. During repeated readings of the papers, concepts were printed on separate pieces of paper and organised to reflect the emerging themes noticed by the author.

Using Mindjet MindManager 2017 software, visual maps were created alongside final reads of papers. Development of fieldnotes captured third order constructs[6] (*Appendices 1-E*). This facilitated the establishment of higher order themes, summarising the findings of the papers, preserving significant concepts highlighted within individual papers (Table 3). These are described in the findings section, stage seven of the methodology (Noblit and Hare, 1988).

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[6] Third-order constructs are defined as the researcher's interpretation and analysis of the authors' interpretations, reported in the findings of the papers included for review (second-order constructs), of the data collected from study participants. In this case, second-order constructs would be the conceptualisations of MHD reported by Muslims who work to alleviate ED (*Appendix C*).

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All papers included for review presented broadly similar themes, including spiritual and non-spiritual conceptualisations of ED held by Muslim practitioners. A reciprocal translation was therefore chosen for this review, this involved an expression of points of connection and similarity of the included papers (Britten et al, 2002; Noblit & Hare, 1988 p. 38) as opposed to a refutational synthesis, more appropriate for papers presenting opposing conceptualisations of ED (Noblit & Hare, 1988 p.47).

[Table 3]

Findings

Seven second-order constructs emerged from the reciprocal translation. These fell into three, third-order constructs, as summarised in Table 3: *Spiritual causes*, *Non-spiritual causes* and *The impact of conceptualisations on clinical work.*

All but two papers, reported participants' attribution of both spiritual and non-spiritual causes to ED. One paper, considering the perceptions of South African psychiatrists, reported non-spiritual causes exclusively. Whilst they acknowledged the concept of spiritual causes among the local Muslim population, participants did not work clinically from this epistemic framework (Bulbulia & Laher, 2013). It is of note, however, that this paper did not include participant quotations, which may have influenced the nature of the inferences made by the researcher.

A second paper, considering the perceptions of Malaysian faith healers reported solely spiritual causes of ED (Sa'ad, Razali, Sanip & Rani, 2017). It may nevertheless be inferred from presented quotes, from faith healers, describing processes used to distinguish spiritual and non-spiritual illnesses, that practitioners did in fact, acknowledge non-spiritual causes of ED.

Spiritual causes

Spiritual causes of ED, fell into two categories of; *Jinn possession* and *persecutory processes* of spiritual illness.

Jinn possession.

Jinn possession as a cause of ED seemed to imply that the origins of 'madness' lay within the spiritual world and that humans existing within a natural environment, also exist within a supernatural environment. At times of disharmony in the spirit world, Jinn were reported to

interfere with the human world, and consequently, the lives of humans. (Ally & Laher, 2008; Rashid, Copello & Birchwood, 2012; Sa'ad et al, 2017; Thomas, Al-Qarni & Furber, 2015).

Ally & Laher (2008) report that Indian faith healers in South Africa described Jinn possession as a cause of emotional and physical malaise, including the inability to comprehend logical reasoning, hallucinations, deluded thinking and disturbance to sleep and eating patterns. Faith healers described spiritual illness to be "…some unseen force that can't be diagnosed by any mechanical means or via any instruments of such".

Spiritual presentations of ED were compared, by faith healers, to widely held conceptualisations of mental health diagnoses such as depression or psychosis. Thomas et al, 2015 report similar comparisons to symptoms of psychosis, by UAE faith healers. One faith healer described Jinn possession as a process which can:

> …harm him in some way, which either causes him to become ill or generally high fever, and sometimes in Jinn possession the person displays strength which is not normal… he might start speaking funny, like speaking in a strange language, or giving information which people cannot generally… you know attain by just looking around…

Moreover, faith healers described the actions of the possessed individuals as a reflection of the actions of the Jinn itself and compared these experiences to those considered as psychosis, "we'll always say like they use in your people's terminology you see a split personality" (Ally & Laher, 2008).

Similarly, British faith healers were reported to interpret case vignettes describing symptoms of psychosis, including the hearing of voices, as jinn possession. The faith healers reported that the voices are likely to be the voices of the Jinn which have possessed the individual's body (Rashid et al, 2012).

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Thomas et al. (2015) reported UAE faith healers' descriptions of Jinn possession. These healers used the term 'Jinn interference', rather than possession, to describe the interaction of the spiritual and non-spiritual world. Faith healers described two forms of Jinn interference, 'malbus' meaning 'worn', described Jinn possession and 'malmus', translated to mean 'touched' (with sexual connotations), described to have less severe effects than 'malbus'.

Instances which may result in Jinn possession were reported, by British faith healers, to include Jinn falling in love with a human (Rashid et al, 2012). Contrastingly, faith healers also reported Jinn possession on account of revenge, if the Jinn believed that a human had acquired their territory (Rashid et al, 2012).

Factors which left an individual vulnerable to such possession were also reported, by Malaysian faith healers.

the reason why mentally ill patients seem to suffer from depression and psychosis is because of Jinn disturbance, it may initially have been rooted in a psychological cause, but when a person is weak, it is a gateway for Jinn to enter the patient's body… (Sa'ad et al, 2017),

This suggests a belief that the emotional weakness of an individual may increase their vulnerability to Jinn possession. This was, similarly, reported by Emirati faith healers, "Some people are just vulnerable to the Jinn and need to do extra ibādah (worship), some people become vulnerable in times of emotional distress" (Thomas et al, 2015).

A spiritual deficit was also reported as an alternative factor in an individual's vulnerability to Jinn possession, referenced in three papers (Rashid et al, 2012; Thomas as et al, 2015; Sa'ad et al, 2017), "The main cause is distance from the Qur'an. The problem is reduced if people stay close to the Qur'an and perform Adhkār (remembrance)" (Thomas et al, 2015).

Furthermore, authors report that some participants endorsed religiosity as a protective factor, reducing an individual's vulnerability to Jinn possession,

>…it is exactly the same as any disease, some people can easily catch colds, other people have good resistance to colds, some people can easily be harmed by Jinn, other people have good resistance to Jinn…However, there are things that a Muslim should do to protect themselves. These things are our Iman[7], our Salat[8], our Dhikr[9].. (Rashid et al, 2012).

A Malaysian faith healer, held the view that psychological explanations cannot be attributed to Schizophrenia and Obsessive Compulsive Disorder (OCD), as they "…are caused by Jinn disturbance, the symptoms of OCD have nothing to do with psychology" (Sa'ad et al, 2017) but this did not reflect the view of all Malaysian faith healers, who acknowledged the existence of both spiritual and non-spiritual illnesses as separate entities, "It is difficult to differentiate the symptoms because when patients visit us for treatment, they manifest both types of ailments" (Sa'ad et al, 2017).

Persecutory processes.

Persecutory processes, in which "madness" was cast upon one human being by another through an interaction with the spiritual world, was also considered as a spiritual cause of ED. Witchcraft, sorcery and black magic were terms used interchangeably to describe the process of

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[7] Iman – Arabic term meaning 'faith'

[8] Salat – Arabic term meaning 'prayer'

[9] Dhikr – Arabic term meaning 'remembrance of God'

individuals who may or may not have supernatural powers, inflicting intentional harm upon another human being, through the communication of, or mastery of spiritual entities such as Jinn (Thomas et al, 2015). Cultural nomenclature such as 'jadoo' by participants who lived in South Africa (Ally & Laher, 2008; Laher & Khan, 2011) and 'Sihr' by faith healers who lived in the UAE (Thomas et al, 2015) as well as British Asian faith healers (Rashid et al, 2012), was also used to describe these processes.

It was reported that both physical illness and ED may be caused by witchcraft (Ally & Laher, 2008; Laher & Khan, 2011; Rashid et al, 2012), "…Prophet Muhammed (peace be upon him) also experienced jadoo, so I definitely believe it exists" (Laher & Khan, 2011).

Ally & Laher (2007) report the belief among faith healers in Johannesburg that black magic can be achieved using plants or through the help of a Jinn, to cause disharmony or upset in another person's life which could be seen as an intentional cause of harm to another individual.

Three papers described the evil eye as looking at someone with jealousy or envy, as resulting in the radiation of evil. Reports indicated that any human being could be capable of inflicting this kind of distress on another person, without intention.

If he is somebody of a jealous nature, he will radiate evil. If he is a good-hearted person, he will radiate good, so by him looking jealously at somebody, it can just make him sick, maybe you know, and he…err he might not even realise that he is doing it… (Ally & Laher, 2008).

Cultural nomenclature including 'nazr', by Indian faith healers and South African counsellors and 'ain' or 'hasad' by UAE faith healers also used to describe this phenomenon. Admiring glances were reported to cause symptoms including loss of appetite, disturbed sleep patterns, bad luck and misfortune. Such experiences were reported to present similarly to that of

a psychological difficulty. Participants reported that this made it difficult to distinguish between the two (Ally & Laher, 2008).

While all papers reported a widespread belief in spiritual causes of MHD, Indian counsellors in South Africa did not always accept this as an exclusive cause of distress, "commonly, they (clients) say black magic and jadoo, but I don't believe that, maybe to a certain extent it's a reality that does happen, but I think a lot of people use it as an excuse" (Laher & Khan, 2011). Similarly, authors reported that a faith healer from the UAE estimated that around 20% of those who consult them have difficulties arising from spiritual causes and that the remainder are more suited to seeing a psychologist or a psychiatrist and claimed that "some clients fake it for attention and perhaps have psychological problems like Munchhausen syndrome or personality disorders" (Thomas et al, 2015). Such reports may suggest that practitioners' conceptualisations of ED may contrast to those held by clients. This may be indicative of practitioners' more sophisticated understanding of ED, perhaps acknowledging that spiritual causes are not an exclusive explanation for distress. On the other hand, this may indicate a lack of acknowledgement, among practitioners, of clients' conceptualisations of ED.

Non-spiritual causes

Non-spiritual conceptualisations of ED were reported by practitioners, acknowledging client existence within the tangible and physical world. Such factors were considered, by participants, to exist in addition to causes which were considered to have origins in the supernatural world, "like physical illnesses can be brought on in a natural way, mental illness can also be brought on in a natural way" (Ally & Laher, 2008).

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A range of biological, cognitive, cultural, economic, political and systemic factors were ascribed as causes of ED, by Muslim faith healers, counsellors and psychiatrists working in South Africa, Somalia, UK and Malaysia, as contributory factors to the manifestation of ED (Ally & Laher, 2008; Rashid et al, 2012; Thomas et al, 2015; Sa'ad et al, 2017).

> …a mental imbalance you know, it could be trauma…and also the stress of life around you, if a person cannot handle it and it may cause certain behaviours…I really don't think it's one thing, I think it's a combination of things, (Laher & Khan, 2011)

Biological factors including genetic predisposition (Laher & Khan, 2011; Thomas et al, 2015), brain chemical imbalance (Ally & Laher, 2008; Bulbulia & Laher, 2013; Laher & Khan, 2011) and brain dysfunction (Bulbulia & Laher, 2013) were attributed as causes of ED. These were particularly emphasised by Muslim psychiatrists (Bulbulia & Laher, 2013). In addition, UAE faith healers acknowledged idiosyncratic cognitive styles as contributing to the manifestation of ED (Thomas et al, 2015).

Childhood trauma was also reported as a causal factor in the development of ED (Ally & Laher, 2008; Laher & Khan, 2011; Rashid et al, 2012). Acculturative factors were reported as social stressors, particularly between different generations of a family (Laher & Khan, 2011; Rashid et al, 2012) and conflict between parental and child wishes regarding a choice of life partner were identified as particular areas of contention.

Navigating such boundaries within the context of Britain, a relatively liberal society, encouraging individualism and freedom of choice, may be a struggle for newer generations of Muslims. British faith healers report that navigating a 'dual' lifestyle may result in the presentation of a 'split personality', compared to the presentation of psychosis,

The reason (for psychosis) is that before the age of eighteen you've kept his (client)

desires under control and as a consequence he's saying things like this, so he starts to

have a split personality because he is been repressed and controlled... the majority of

women become hysteria patients or develop a psychological problem, the reason is that

they have become forced to do everything by their parents, like you must marry from our

choice… (Rashid et al, 2012).

The impact of conceptualisations on clinical work

Analysis of the included papers revealed that all participants shared the view that spiritual

illness exists as a separate entity to those which are described in Western, scientific paradigms as

MHD. While symptomology of a spiritual illness was reported, by participants, as similar to

those described as MHD, the causation of such experiences may be as a result of spiritual

inflictions, such as Jinn possession, black magic or evil eye, or as a result of biopsychosocial

factors. Some participants acknowledged that there may be some instances where a client may be

experiencing ED because of a combination of both spiritual infliction and biopsychosocial

factors, giving rise to the issue of differential diagnosis and consequently, a number of treatment

options.

Some participants were reported to use strategies to distinguish between spiritual

illnesses and non-spiritual illnesses to inform their clinical practice. Participants who believed a

client's distress as having a spiritual cause, would not expect the client to respond to non-

spiritual interventions and vice versa (Ally & Laher, 2008; Sa'ad et al, 2017).

I will use Ruqyah[10] to ensure that there is no interference from the Jinn. I will see the reaction exhibited by the patients - whether they feel any vibrations, discomfort, or no difference, during the process itself. We do not know about the unseen which is why we tend to pay extra attention to the way patients act. If the patient were to be diagnosed as experiencing a disturbance by Jinn instead of actually having a mental health problem, we will treat the former first (Sa'ad et al, 2017).

South African psychiatrists and Indian counsellors, reported that while they acknowledged the beliefs of their own (Laher & Khan, 2011) and of the local community (Bulbulia & Laher, 2013), in the spiritual causation of distress, they were careful to keep their religious beliefs separate from clinical work, adopting the explanatory model endorsed by their professional body. The authors of the Bulbulia & Laher (2013) described this choice of South African psychiatrists as a "conflict…that was evident between the psychiatrists' personal position and beliefs and their need to conform to the dominant Western paradigms within which they were trained".

British and Emirati faith healers report that human nature cannot be conceptualised by science alone, acknowledging spiritual aspects to an individual's being in the formulation of clients' difficulties (Rashid et al, 2012; Thomas et al, 2015).

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[10] Ruqyah is an Islamic term which describes the recitation of Qur'an or seeking of refuge through remembrance of God and supplication, used as a means of treating a range of problems including physical and emotional distress.

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If someone seeks medical advice we say that the treatment you're receiving should also be alongside spirituality; then both methods will come together, so just because one is working, it doesn't mean to say that you drop the other method, both can be done at the same time... (Rashid et al, 2012).

Authors described this approach as a biopsychosociospiritual model, considering the interplay of both spiritual and non-spiritual cause or explanations for distress.

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Discussion

This synthesis of six papers summarised Muslim practitioners' conceptualisations of ED to include both spiritual and non-spiritual attributions. These practitioners included counsellors, psychiatrists and faith or traditional healers.

The majority of papers report participants' acknowledgment of the existence of two forms of ED, one which has a spiritual cause, including the possession by Jinn, or persecutory processes such as black magic or the evil eye and the second, caused by non-spiritual factors, in line with the widely accepted explanatory model of MHD.

It is acknowledged that the attribution of spiritual causes to ED would not be considered as an anthropological or cultural explanation for a MHD from the perspective of practitioners, contrary to suggestions by previous literature (Khalifa & Hardie, 2005) rather, advocating that two causes of ED exist. In contrast, a single paper considering the conceptualisations of South African, Muslim Psychiatrists held the epistemic view of the scientific, understanding of MHD. These psychiatrists acknowledged the perspective of their local community, in the attribution of spiritual causes to their ED, as a cultural explanation of a MHD (Bulbulia & Laher, 2013).

Recognising the critical importance of various factors which may influence the conceptualisations of ED of Muslim practitioners, including personal religious beliefs, cultural values, professional training and epistemic views, this discussion aims to explore the clinical implications of these findings.

The findings of the synthesis indicate that Muslim practitioners consider clients from an Islamic epistemology, as existing within the human, tangible, natural world whilst acknowledging the supernatural environment. Practitioners, generally believed that potential interference by spiritual entities in the physical world may cause ED. Viewing the context of a

client's experience in this way may be seen as conflicting with the largely scientific view of Western, mainstream mental health services in Britain.

Practitioners navigated varied and apparently conflicting epistemic positions within clinical work, in relation to conceptualisations of ED held by clients and the services within which they practise. In some cases, practitioners' conceptualisations of ED contrasted with those held by their professional body, resulting in various strategies to navigate such ways of working, particularly with regards to differential diagnosis.

For some practitioners, spiritual strategies were employed to differentiate between ED which had a spiritual cause and distress with a non-spiritual cause. When a distinction was not possible, spiritual and non-spiritual interventions were used to address client distress (Ally & Laher, 2008; Rashid et al, 2012; Sa'ad, 2017). British and UAE faith healers, on the other hand, integrated spiritual conceptualisations of ED into an existing biopsychosocial model, acknowledging that ED could be caused simultaneously, by a combination of spiritual or non-spiritual factors, (Rashid et al, 2012; Thomas et al, 2015).

For psychiatrists and counsellors working in South Africa, it appeared that, although they may hold spiritual conceptualisations of ED, or be aware that others may hold this epistemic position, these conceptualisations were held separate from clinical practice. Moreover, clinical practice was consistent with the widely held, scientific, explanatory model of MHD (Bulbulia & Laher, 2013; Laher & Khan, 2011). This may suggest that those who are trained in largely Western scientific models of MHD are more likely to subscribe to such ways of working. Alternatively, it may be argued that more spiritually informed explanations of ED are silenced within the context of a more dominant, scientific model of MHD.

It may be further argued that, given its strong scientific underpinning philosophy, the context and framework of Western training, in approaches to MHD does not always facilitate exploration of religious or cultural explanatory models of ED. Counsellors and psychologists report feeling spiritually challenged during training and others, spiritually stunted, throughout their training experience (Blair, 2015).

Clinical Implications

The synthesis shows that Muslims who work to alleviate ED across cultures, particularly those in the role of a faith healer, attribute causal explanations to ED which contrasts to that of mental health services. Acknowledging the variation found in the consideration of metaphysical causes of ED, by Muslim practitioners, may have implications for Muslim clients who may encounter faith healers or mainstream services in their pursuit of support for their experiences of ED.

If a client holds a belief that their ED has a metaphysical cause, it is understandable that they may not engage in mainstream services, which are largely placed within a framework governed by the parameters of the diagnostic criteria of the DSM-V (APA, 2013) and ICD-10 (WHO, 1992). Conversely, if a client holding a non-spiritual conceptualisation of their ED was referred for support to a faith healer on account of friends' and family's perceptions of their difficulties, this would also result in negative outcomes. This discrepancy in conceptualisations between a client and their friends and family was reported by Deine et al. (2008).

In addition, if a client did choose to engage in mainstream services, it may be detrimental to their wellbeing if a method of intervention was employed, without consideration of alternative conceptualisations of their experiences.

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To address this issue of possible incompatibility of service provision for some Muslim clients, a faith healer may be considered as having an instrumental role in the referral pathway for Muslim clients who hold a spiritual conceptualisation of their distress. This role may include working collaboratively with the client to distinguish the cause of their distress between a spiritual or biopsychosocial cause, validating the beliefs held by the client, encouraging their engagement in either a mainstream service or an intervention delivered by the faith healer themselves. Whilst it may be acknowledged that individuals are currently seeking faith healers as a first point of contact (Chong & Mohamad, 2013; Gurma & Tesfaye, 2011; Leavey, 2008; Razali & Tahir, 2018; Uwake & Orakpor, 2014), it may be beneficial to formalise and incorporate faith healers in the referral pathway to mainstream services.

For those clients who do engage in mainstream mental health services, there are several implications of the synthesis findings for therapeutic work with Muslims. Whilst assumptions should not be made for all Muslim clients, it is important for mental health practitioners, within mainstream services, to acknowledge a broader aetiological belief system that may be held by some Muslims (Deine & Illaiee, 2013; Laher, 2014). Specifically, questions about the conceptualisations of difficulties held by the client, should be included within an initial assessment session. This may be facilitated by the more recent addition to the DSM-V (APA, 2013), a guide to a Cultural Formulation Interview (CFI), which may serve as a guide to prompt an assessment of clients' idiosyncratic conceptualisations of their emotional difficulties.

Practitioners should be mindful to take a validating approach to metaphysical conceptualisations of distress, recognised as an important factor to underpin therapeutic effectiveness of several modalities of therapy and identified as an important aspect of client experience of therapy (Linehan, 1997; Paulson & Worth, 2011). In addition, where clients hold a

belief in a metaphysical cause of their distress, it is likely that an external locus of control may be held, particularly if they express the cause to be as a result of black magic or evil eye. Moreover, it is likely that such conceptualisations could be accompanied by high levels of anxiety or hypervigilance to threat or, if a Muslim holds the belief that their distress is as a direct communication from God, this could have associated emotional consequences of guilt, anger and injustice. Such psychological and emotional consequences should be considered in the client formulation.

Limitations

A relatively ambitious and novel review was attempted through the conduct of this synthesis. While the findings may reflect the conceptualisations of Muslim individuals who work to alleviate ED, the synthesis has a number of limitations which should be taken into consideration.

Most prominently, it is noted that a very small number of papers consider Muslim practitioners' conceptualisations of ED. Furthermore, the small number of participants, in comparison to the global population of Muslims (*Table 1*), poses limitations to the extent that robust conclusions can be made from the results of this review. In addition, many papers were excluded from synthesis such as those which explored conceptualisations of a mixed sample group, comprising of more than Muslim practitioners (e.g. community members and/or those who identified with other religious affiliations). This meant that conceptualisations of some Muslim practitioners were omitted from this synthesis.

Just six papers were eligible for inclusion to the review, conducted in four countries including and reported conceptualisations of faith healers, counsellors and psychiatrists who

identified with seven ethnic minorities. Given the range of cultural contexts, professional roles and ethnic minorities, it is difficult to draw robust conclusions based on the outcomes of the synthesis alone. Further research within specific cultural contexts, specific professional roles and ethnic minorities may improve the validity and reliability of conclusions that may be made, acknowledging the role of cultural and professional training influences upon Muslim practitioners' conceptualisations of ED.

In addition, there was a notably low number of papers, included for review, which consider the conceptualisations of Muslim mental health practitioners who had undergone Western training. Whilst this reduces the generalisability of findings to other professionals such as psychologists and psychiatrists or counsellors, working within other cultural contexts to South Africa, it may also indicate a lack of literature which considers the mental health conceptualisations of healthcare professionals who hold Islamic values. On the other hand, it should not be assumed that all Muslims hold beliefs in supernatural causes of MHD.

It may be suggested that bias may influence the nature of research papers published which consider mental health conceptualisations of Muslims. Papers which find significant differences in the conceptualisations of ED may be more likely to be published than those which report findings which align with more mainstream, biopsychosocial causes of MHD.

In addition, the quality appraisal of the studies (*Appendix 1-B*) highlighted that authors, of all papers, did not consider their position in relation to the participants who took part in the study which may give rise to further bias in data collection and thus findings reported. Adopting an a priori approach, where the scientific and widely accepted explanations of ED underpins the researchers' epistemic position, may restrict the exploration of non-spiritual conceptualisations of MHD. Viewing the Muslim population, particularly faith healers as 'other' and as holding

more 'alien' perspectives on MHD may lead to bias in the focus on data collection in relation to spiritual causes of distress. Pejorative reporting of Malaysian faith healers' conceptualisations of MHD was noted in the Sa'ad et al, 2017 paper, raising further, the question of potential bias in the data collection reported by studies. For example, authors described Malaysian faith healers as having "limited knowledge and understanding of mental illness. They only have a general idea of mental illness despite their tertiary level of education". It may be inferred that this style of writing communicates the epistemic view of the authors as believing that 'other' conceptualisations of ED may be subordinate to those held by the majority, but may also result in the overemphasis on data collection about spiritual conceptualisations of distress, held by Muslim practitioners, rather than perhaps highlighting the similarities between this minority group and the majority of populations (Sa'ad, 2017).

Conclusion

In considering papers from a number of countries, this review shows that Muslim practitioners, across formal and informal settings, report an acknowledgement of both spiritual and non-spiritual causes of ED. In the light of the limited number of papers produced and included for review, it is difficult to make robust conclusions. It may be suggested, however, that faith healers across cultures were more likely to adhere to spiritual attributions to the cause of ED when compared with professional practitioners, including counsellors and psychiatrists, in their clinical practice. Whilst reliable conclusions may not be drawn, it may be suggested that professional training influenced the conceptualisations of Muslim practitioners. It may further be suggested that practitioners keep personal religious beliefs separate to their work within mainstream services, conforming to explanatory models endorsed by their professional body. Clinical implications of the findings are discussed, including the potential collaboration with faith healers.

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Figures and Tables

Figure 1.

PRISMA flow diagram

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Table 1.

A table to illustrate countries with the largest Muslim populations

 (Pew Reserach Centre, 2010).

10 Countries With the Largest Muslim Populations, 2010 and 2050

	2010 MUSLIM POPULATION	% OF WORLD'S MUSLIM POPULATION IN 2010		2050 MUSLIM POPULATION	% OF WORLD'S MUSLIM POPULATION IN 2050
1 Indonesia	209,120,000	13.1%	1 India	310,660,000	11.2%
2 India	176,200,000	11.0	2 Pakistan	273,110,000	9.9
3 Pakistan	167,410,000	10.5	3 Indonesia	256,820,000	9.3
4 Bangladesh	134,430,000	8.4	4 Nigeria	230,700,000	8.4
5 Nigeria	77,300,000	4.8	5 Bangladesh	182,360,000	6.6
6 Egypt	76,990,000	4.8	6 Egypt	119,530,000	4.3
7 Iran	73,570,000	4.6	7 Turkey	89,320,000	3.2
8 Turkey	71,330,000	4.5	8 Iran	86,190,000	3.1
9 Algeria	34,730,000	2.2	9 Iraq	80,190,000	2.9
10 Morocco	31,930,000	2.0	10 Afghanistan	72,190,000	2.6
Subtotal	1,053,010,000	65.8	Subtotal	1,701,070,000	61.6
Subtotal for Rest of World	546,700,000	34.2	Subtotal for Rest of World	1,060,410,000	38.4
World Total	1,599,700,000	100.0	World Total	2,761,480,000	100.0

Source: The Future of World Religions: Population Growth Projections, 2010-2050. Population estimates are rounded to the nearest 10,000. Percentages are calculated from unrounded numbers.

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Table 2. Study characteristics of papers included in the synthesis

	Source paper (n=6)	Country setting	Ethnicity of participants	Role of participants	Sample N, age and gender (if stated)	Method of Data Collection	General/specific mental health difficulties considered
1	Ally & Laher (2008)	South Africa	Indian	Faith Healers	N = 6/6, 4 were Moulana	Semi-structured interviews	General
2	Laher & Khan (2011)	South Africa	Indian	Counsellors	N = 8, 8 females, 29-52 years	Semi-structured interviews	General
3	Rashid, Copello & Birchwood (2012)	UK	3 Indian, 1 Afghani, 3 Pakistani, 1 Egyptian	Faith Healers	N= 8, 7 males, 1 female, 29-55 years	Semi-structured interviews	Psychosis and substance misuse
4	Bulbulia & Laher (2013)	South Africa	South African	Psychiatrists	N = 7, 3 males, 4 females.	Semi-structured interviews	General
5	Thomas, Al-Qarni & Furber (2015)	United Arab Emirates	Abu Dhabi, Dubai	Traditional Healers	N = 10, 10 males, 24-57 years	Telephone semi-structured interviews	General
6	Saad, Razali, Sanip & Rani (2017)	Malaysia	Malaysian	Faith Healers	N = 7, 5 males, 2 females,	Semi-structured interviews	Schizophrenia, depression, psychosis and obsessive compulsive disorder (OCD).

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Table 3. Summary of second and third order constructs

Third order constructs	Ally & Laher (2008)	Laher & Khan (2011)	Rashid & Birchwood (2012)	Bulbulia & Laher (2013)	Thomas, Al-Qarni & Furber (2015)	Saad, Razali, Sanip & Rani (2017)
Mental health difficulties located in the spiritual world *(Possession by spirits)*	Jinn possession	-	Jinn possession	-	Jinn possession	Jinn possession
Persecutory processes initiated by the human world *(Black magic, evil eye, witchcraft)*	"Ill will", Islamic witchcraft (jadoo), proximity to the devil (sihr), evil eye (nazr)	Evil eye (nazr), black magic (jadoo)	Magic, sorcery/witchcraft (sihr)	-	Envy (hasad), evil eye (ayn), sorcery/witchcraft (sihr)	-
Non-spiritual causes						
Biopsychosocial factors	Behavioural, psychological or biological dysfunction, disharmony	All counsellors understood mental illness as traditionally	Psychological problems, acculturalisation, family and systemic factors	Significant focus on biological dysfunction and	Biopsychosocial models of mental illness considered adverse life events, genetics	-

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	within the four parts of the (Islamic) self	defined in Western psychology models	can cause psychosis	chemical imbalances	and idiosyncratic cognitive styles	
The impact of conceptualisations on clinical work.	Symptoms of spiritual illness can be present in psychological or physical form but are distinct entities	Counsellors agreed that spiritual illnesses exist and can mimic the symptoms of mental illness, viewed as distinct entities.	Faith healers viewed spiritual illness as distinct from other illnesses with a non-spiritual cause. Science which relies heavily on facts and figures is an incomplete picture of human nature.	Although spiritual illnesses were acknowledged by the Psychiatrists, this was kept very separate from interactions with their clients. Efforts were made not to impose Islamic views within their clinical work	Faith healers described to hold a bio-psycho-social-spiritual perspective on mental health difficulties. Distinction made between spiritual illnesses and other mental health difficulties.	Faith healers viewed mental illness symptoms as either being a mental condition or a presentation of a Jinn, as two distinct entities rather than a cultural explanation of the same thing

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*Studies are included in the metasynthesis.

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Appendices

Appendix 1-A: Example of search strategy

		Results
S39	Limit to: Journal articles/Peer reviewed articles	
S38	Limit to: English	
S37	S14 AND S21 AND S36	
S36	S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35	
S35	TI reflection* OR AB reflection*	
S34	TI position* OR AB position*	
S33	TI idea* OR AB idea*	
S32	TI belie* OR AB belie*	
S31	TI view* OR AB view*	
S30	TI stance* OR AB stance*	
S29	TI opinion* OR AB opinion*	
S28	TI appraisal* OR AB appraisal*	
S27	TI attitude* OR AB attitude*	
S26	TI perception* OR AB perception*	
S25	TI explan* OR AB explan*	
S24	TI concept* OR AB concept*	

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S23	DE "Community Attitudes" OR de "Implicit Attitudes" OR DE "Attribution"	
S22	DE "Concepts"	
S21	S15 OR S16 OR S17 OR S18 OR S19 OR S20	
S20	TI spiritual* OR AB spiritual*	
S19	TI religo* OR AB religio*	
S18	TI islam* OR AB islam*	
S17	TI muslim* OR AB muslim*	
S16	DE "Spirituality"	
S15	DE "Religious Beliefs" OR DE "Religious Affiliation" OR DE "Religion"	
S14	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13	
S13	TI psychologic* N4 problem* OR AB psychologic* N4 problem*	
S12	TI psychologic* N4 disorder* OR AB psychologic* N4 disorder*	
S11	TI psychologic* N4 difficult* OR AB psychologic* N4 difficult*	
S10	TI "psychiatric disorder*" OR AB "psychiatric disorder*"	

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S9	TI "psychiatric illness*" OR AB "psychiatric illness*"	
S8	TI "mental disorder*" OR AB "mental disorder*"	
S7	TI "mental illness*" OR AB "mental illness*"	
S6	TI "mental health" OR AB "mental health"	
S5	TI emotion* n4 distress OR AB emotion* n4 distress	
S4	DE "Mental Disorders" OR DE "Chronic Mental Illness" OR DE "Psychiatric Patients" OR DE "Psychiatric Symptoms"	
S3	DE "Mental Illness (Attitudes Toward)"	
S2	DE "Psychopathology" OR DE "Abnormal Psychology" OR DE "Mental Disorders" OR DE "Psychiatric Symptoms"	
S1	DE "Emotional Instability"	

Appendices 1-B: Illustration of quality appraisal, using the CASP tool as a guide (CASP, 2017)

	Saad, Razali, Sanip & Rani 2017	Thomas, Al-Qarni & Furber 2015	Bulbulia & Laher 2013	Rashid & Birchwood 2012	Laher & Khan 2011	Ally & Laher 2008
Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes
Is a qualitative method appropriate?	Yes	Yes	Yes	Yes	Yes	Yes
Is the research design appropriate to address the aims of the research?	Justification of using semi-structured interviews face to face. Highlighted reasosn as to why family and relatives were not interviewed as part of the study. No justification for choice of analysis method though	Yes	Identified semi-structured interviews. No justification given in the paper as to why this method was chosen however or why the method of analysis.	Yes. Justification of research methods is stated. Justified the use of grounded theory approach and also the use of vignettes in the interview schedule as well. Also justified recruitment methods.	Justification of research method is not detailed	Yes it was appropriate but not detailed in the paper as to why it was chosen.
Was the recruitment strategy appropriate to the aims of the research?	Only respondents registered under the GAPPIMA took part in the research study. Purposive sampling took place followed by snowball sampling because the sample size was relatively small. Does not give a justification as to why this was chosen. Seems appropriate but does not capture the perspectives of non-registered faith healers	Recruitment was conducted online using search engines but also through personal communication links. I think this was an adequate way to recruit because those who werent advertised online would hopefully be contacted through word of mouth and those who were online would avoid the limitations posed by just interviewing people who you know on a couple of degrees of separation.	A convenience sample was interviewed. It should be noted that the pool of Muslim psychiatrists in Johannesburg is not big. 14 psychiatrists were approached, only 7 consented to be interviewed.	Explained that participants were recruited from diverse cities of the UK, specifically in areas with a varied ethnic group. Enligish, Urdu and Punjabi speaking participants because the researcher was fluent in these languages. Group was chosen for reasons: their knowledge of Islam and unique perspective on the cause of such disordersm given that they would make reference to the Quran in their interpretation and due to the likelihood of them being consulted by members of the community when presented with an ailment. Purposive sampling was implemented. 3 people refused to take part due to suspicion of Western research.	No description given about the recruitment strategy. Unclear as to how participants were recruited or why they were chosen in this manner. No discussion around people not wanting to take part or how many people were approached.	Didn't talk about why these participants were selected. Stated that the participation was voluntary and that the sample were identified using the information provided by community members about faith healer in and around Johannesburg. Faith healers contacted telephonically to request their assistance.
Was the data collected in a way that addressed the research issue?	Did not justify the setting for data collection. Clear details given about the interviews being face to face in nature, length of interviews were given. Does seem an appropriate use of data collection.	Telephone interviews were conducted, has its limitations but would say that on the whole, yes, it was collected in a way that addressed the research issue	Did not justify mehtod of semi-structured interviews. Doesn't say how they were conducted or whether the interviews were piloted beforehand. No mention of audio recording. Saturation was not discussed.	Interviews were conducted at a mosque or in the healers home. Provided justification for including vignettes in the interview questions. Vignettes were piloted on four clinical psychologists, three individuals of Islamic faith and a postgraduate student. The feedback did not lead to significant modification. Interview schedule was also piloted. Saturation was reached.	Interviews were piloted and questions were changed according to the feedback which was obtained. No details about whether interviews were recorded. No mention of saturation.	Semi-structured interviews but no justification for the use of this method. Interviews were audio recorded.
Has the relationship between researcher and participants been adequately considered?	Researchers position in relation to the study was not acknowledged	No mention of the relationship between the researcher and participants	No	No	No	no
Have ethical issues been taken into consideration?	Ethical approval was sought. No details about the description of the study given to the participants. Issue of consent of family and friends of the participant was gained. Details were given with regards to maintaining participantconfidentiality noted	Each participant had the aims of the study explained to him over the telephone, and in the Emirati dialect of Arabic. Study information sheet was emailed to participants ahead of the scheduled interview dates. Verbal consent was obtained. Institutional ethical approval was given for the study	Ethical clearance was obtained from the Human Research Ethics Committee of the University of the Witwatersrand. No mention of consent or confidentiality.	If participants expressed an interest in taking part then informal telephone contact was made, where they were encouraged to ask any questions about the study, subsequently a date and time was arranged for the interviews.	Ethical clearance was otained from the Human Research Ethics Committee at the Unveristy of Witwatersrand.	b
Was the data analysis sufficiently rigorous? If there is an in-depth description of the analysis process	Not very much detail about the analysis process. Described as being transcribed and thematic content analysis was carried out	yes	Thematic content analysis was conducted as per the steps outlined by Braun and Clarke. No further details were given.	Yes	No in depth description of the analysis process. The interviews were recorded, transcribed and analysed using thematic content analysis as described by Mayring (2000)	Theamtic analysis using the process of selective reduction. Focus on specific words/patterns that were indicative of the research question (Henning, 2004). Broader themes and relevant issues were then highlighted.
If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data	No detail about how the themes have been reached	Yes, detail is given about the thematic analysis process and how the emergent themes were developed from the raw ata itself		Grounded theory approach was taken	No details given	

• Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process	No details given	No evidence of this	No details given	No details given	No details given		It does indicate that they took aspects of the data in relation to the research question but not really explicit detail of how the jump was made from the whole dataset to the specifically presented aspects of the data.
• If sufficient data are presented to support the findings	No details given	Examples were given from the transcripts to support each theme and sub theme which were discussed	I would have liked to have seen more quotes included in the results section but there was at least one quote per theme that was discussed	No	No data was presented	Relevant quotes/extracts from the interviews were highlighted to support research findings	Relevant quotes/extracts from the interviews were highlighted to support research findings
• To what extent contradictory data are taken into account	No details given	Contradictory data was taken into account. Adequate detail was given, numbers of participants were given if relevant. Difficult to say whether there was additional contradictions which were not described however.	Sufficiently, both biopsychosocial conceptualisations as well as the more islamic based conceptualisations were taken into account and documented. This concept is considered in the introduction of the paper and again in the Discussion	Difficult to say	Reported adequately	Contradictory findings were reported. Less critical analysis around this, not very much room for considering alternative interpretations of the data however.	Not really addressed. Usually just the authors interpretation of the findings
• Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation	No details given	No details given	No details given	No details given	No details given	No details given	no
Is there a clear statement of findings? If the findings are explicit • If there is adequate discussion of the evidence both for and against the researcher's arguments • If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst) • If the findings are discussed in relation to the original research question	Findings are explicit. Not clear if there was adequate discussion for and against researcher's arguments. Researchers did not discuss the credibility of the findings. There was a mention of more than one researcher but the role that they had in the analysis of the interview analysis is unclear. Findinfs are discussed in relation to the original research question		Findings are explicit and discussed in reation to the research question but I don't think the findings were clear. My interpretation of this paper is that actually the counsellors showed a mix of western as well as islamic understanings of the causation of mental health difficulties. Perhaps indicating an interplay of both cultural, religious and western training perspectives. It was also something difficult to understand exactly what the authors mean here because they would say contradictory things like - counsellors believed that clients were in denial but would then go on to cosnider the topic of nazr and jadoo. All counsellors were aligned to both the psychological understandings of mental health difficulties but also saw a place for the consideration of spiritual illnesses. They viewed these illnesses as being different from one another though, despite them appearing to be similar in nature. This was not expressed clearly in the findings section in my opinion	Clear statement of findings. No real discussion for and against the authors arguments. No mention of additional researchers cross-referencing the analysis to avoid bias. Findings are discussed in relation to the original research question.	Yes, findinfs are explicit. Discussion for and against researchers arguments. Triangulation not considered - unclear as to how many analysts there were who took part in the study conduct. Findings are discussed in relation to the original research question.		Clear statement of findings. No comment about triangulation as a limitation despite only one researcher carrying out the analysis. Findings were discussed in relation to the original research question
How valuable is the research? If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used	Future recommendations for research are provided. Does give some clinical implications but did sound rather bias in the interpretation of results. Gave considerations for the ways in which future research should be carried out.		Recognises the limiations of the study and highlights that future studies should attempt to simultaneously explore the views of the UAE's mainstream health-care professionals (psychologists and psychiatrists) with regards to the possible metaphysical aetiology of mental health problems. No further detail is given about this however. The paper does also consider the impact on clinical working ivthin the UAE and calls for the consideratioon of a more integrated approach to serving the UAE nations with both spiritual as well as biopsychosical conceptualisations of mental health difficulties	Some references to other studies were made. No mention of future research. References were made about the clinical implications of the study.No mention of how these results may relate to other populations.	Discusses the contribution to existing knowledge in relation to current practice and in light of previous research. Future research was detailed. Related to the socio-political environment of the UK.	Mentions the implications of the findings in relation to clinical practice but also ackowledges that they may not be generalisable to other contexts. Makes reference to other, relevant literature.	Findings were described in relation to existing research and also in relation to practice but not in much detail. No mention about future research. Did relate to the wider population

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Appendices 1-C: Working definitions of 1ˢᵗ, 2ⁿᵈ and 3ʳᵈ order constructs. Diagram adapted from Malpass et al, (2009).

First order constructs	Muslim practitioners' views, accounts and conceptualisations of the cause of emotional distress	Interpretations of experience
Second order constructs	Authors' views and interpretations (expressed in terms of themes and concepts) of Muslim practitioners' conceptualisations of emotional distress	Interpretations of interpretations of experience
Third order constructs	The views and interpretations of the researcher, conducting the synthesis, (expressed in terms of themes and key concepts)	Interpretations of interpretations of interpretations of experience

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Appendix 1-D: Example of initial extraction of first order constructs, tabular form.

Saad, Razali, Sanip & Rani	Thomas, Al-Qarni & Furber	Bulbulia & Laher	Rashid & Birchwood	Laher & Khan	Ally & Laher
Most respondent had a limited understanding of the aetiology of psychiatric illness. Believed that most illness was associated with jinn disturbance.	Consensus among the healers that four key metaphysical factors can occasionally explain the presence of abnormal emotional of behavioural states - hasad (envy), ayn (evil eye), sihr (sorcery) and jinn (unseen beings)	Psychiatrists perceived mental illness in a way which was congruent with the definition of mental illness provided by the DSM-IV-TR and ICD-10. Although participants did not include all aspects of the seminal texts in their definition	Healers often cited psychological problems as the cause of psychosis. They acknowledged psychosocical issues such as an abusive childhood or due to a major life event that acted as a trigger.	All counsellors understood mental illness as traditionally defined in psychology. On the whole, counsellors ascribed a number of different factors which could lead to mental health difficulties such as childhood trauma, inability to cope with stress, genetic predisposition, chemical/hormonal imbalances and family/social problems.	Disease occurs when the balance between the four interacting parts of the mind, body, self and soul/spirit is interrupted
"Schizophrenia and obsessive compulsive disorder (OCD) are caused by jinn disturbance. The symptoms of OCD have nothing to do with psychology"	Traditional healers appear to hold a relatively holistic conceptualisation of health, which makes little distinction between the metnal and physical aspects, seen to be interconnected	Strong emphasis on biological factors such as organis dysfunction or chemical imbalances on participant responses - congruent with the psychaitrsit training in the biomedical model.	play a part in the causation of psychosis "The reason is that before the age of eighteen you've kept his desires under control and as a consequence he's saying things like this, so he starts to have a split personality because he is been repressed and controlled... the majority of women become hysteria	"Stress plays a big part of it and that it can trigger off a mental problem that was there but is only realised after something stressful happens"	can be brought on in a natural way, mental illness can also be brought on in a natural way" in agreement with th DSM IV description of mental illness being a manifestation of a behavioural, psychological or biological dysfunction in the individual
"The reason why mentally ill patients seem to suffer from depression and psychosis is because of jinn disturbance, it may initially have been rooted in a psychological cause, but when a preson is weak, it is a gateway for jinn to enter the patients body. For OCD patients who take ablution for hours, I have classified them as being under the disturbance of jinn, given that based on my experience, such patients become normal after the recitation of ruqyah"	Factor given most attention and emphasised most by traditional healers was the jinn. Described as something that is inaccessible to the senses, something unseen or veiled. Described as sentient creatures that, although typically concealed to human senses, are saif to coexist alongside mankind."	Less reference made to environmental and socio-cultural aspects and even less to religious aspects of mental health difficulties.	Western framework is used to understand the cause of the disorder, evident in the Freudian terminology. The cause of the disorder was attributed to external factors, being parents repressive way of controllling their children, up to the point of adulthood when they are faced with the predicament of having to accept an unwanted arranged marriage.	A mental imbalance you know, it could be trauma... and also the stress of life around you, if a person cannot handel it and it may cause certain behaviours... I really don't think its one thing, I think it's a combination of things.	Faith healers also report spiritual illnesses which have physical and psychological symptoms - characteristic of mental illness." Some unseen force, that can't be diagnosed by any mechanical means or via any instruments of such" and "presenting various physical symptoms of unexplained aches and pains and in very rare circumstances, unexplained abnormal behaviours"
	Proposed that kinn occasionally interfere in the lives of humans, and this can lead to abnormal states and behaviours that the western medical tradition typically associates with psychiatric morbidity	Believe that islam acknowledges the presence of mental health difficulties	Religious factors were also believed to play a role in the development of the disorder, in particular the possession of a jinn. In some instances, healers used this as their causal explanation, suggesting that there are overlaps with psychosis symptoms and the possessions of a jinn.	Allah." "Muslims have this belief in them that whatever comes, it comes from Allah, so I think that gives them some ease or understanding" reports that Muslim clients may have moments of weakness where they question why they are suffering. "The bottom line is, you know, they have that understanding that it is from Allah, and I think it helps them accept it quicker"	Medical conditions present themselves as a result of black magic
Two levels of jinn interference were talked about - malmus (touched) and malbus (worn) - similar to possesion. Malmus (touched) can have sexual connotations - arguably less severe than being possessed.		Participoants emphasised the role of spiritual aspects when commenting on Islamic definitions of mental illness. Being possessed by jinns - mentioned by all participants. Being bewitched or having being affected by nazr are common beliefs among patients from the Muslim community.	The healers believed the vignette described a person possessed by a jinn, they gave instances of their past clients who displayed similar symptoms, such as hearing voices and something whispering to them.	illnesses exist and that the symptoms mimic those of mental illness. All counsellors indicated that they themselves subscribe to the belief in the existence of spiritual illnesses. "Being a Muslim, I will definitely say that the existence of spiritual illnesses has been mentioned and confirmed in the Hadith and the Quran.. prophet muhammed also experienced jadoo,	"the inability to handle pressures and stress of everyday life" were also identified as causes of mental health difficulties

CONCEPTUALISATIONS OF EMOTIONAL DISTRESS

Appendix 1-E: Visual mind maps, using Mindjet MindManager 2017 to illustrate

the development of emerging third-order constructs.

Section Two:

Therapeutic processes used by Muslim practitioners to alleviate emotional distress,

among British Muslims

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[1] Please note this manuscript was prepared in line with author guidelines for the *Journal of Religion and Health* (See Chapter 4). Where these guidelines have not been followed, Lancaster University thesis guidelines have been followed. The word count is also in line with University not *Journal* guidance.

Abstract

A Grounded Theory (GT) is presented, showing therapeutic processes used by Muslim practitioners, outside mainstream mental health services in alleviating emotional distress (ED) of British Muslims. A total of 14 interviews were conducted with nine participants, including recognised members of the Muslim community (an Imam, faith healer and youth group leader) and Muslim mental health professionals (a CBT therapist, community outreach worker, person-centred therapist, counsellor and two clinical psychologists).

Three key concepts are presented: *Practitioners' conceptualisations of Islam and wellbeing, Engaging a diverse range of British Muslim individuals* and *Therapeutic processes.* The GT shows that therapeutic processes used to alleviate ED are seen to be an amalgamation of the clinical applications of psychological theory, encouraging an insight into the self and religious philosophy, encouraging an openness to God's wisdom and submission to His plan. Limitations of using each of the processes exclusively are acknowledged and it was concluded that employing a combination of the two processes in synergy was considered to be best practice. Such processes were used across both formal and informal settings, by Muslims of professional and non-professional backgrounds. Clinical implications of the findings are considered within the context of limitations of the study methodology and sample. Future suggestions for research are made.

Keywords: mental health, Muslim, metaphysical, spiritual, therapeutic processes

Individuals who hold a religious or spiritual (R/S) belief report less psychological distress, more life satisfaction and greater achievement of life goals (Corrigan, Thompson, Lambert, Sangster, Noel & Campbell, 2003), associated with positive mental health (Koenig, McCulloch & Larson, 2001; Koenig, 2008; Moreira-Almeida et al, 2006; Syed, 2003). While some psychological therapies have roots in R/S traditions, more recently, an increasing interest has been seen in the explicit inclusion of R/S, with specific faith groups including Islam.

Literature suggests that R/S therapy may be as effective as secular therapies (Anderson, Heywood-Everett, Siddiqui, Wright, Meredith & McMillan, 2015; Hook, Worthington, Davis, Jennings, Garmer & Hook, 2009; Post & Wade, 2009). Whilst such literature may endorse inclusion of R/S within therapy across faith groups, R/S therapy itself remains undefined. Furthermore, relatively little is known about specific components or processes in such interventions, for Muslims (Abu Raiya & Pargament, 2010; Hook et al, 2009) or how psychologists working in mainstream services may achieve competence to provide "culturally sensitive" assessments and interventions for Muslims, as stipulated by national guidance (NICE, 2010).

The term emotional distress (ED) will be used to describe difficult emotional experiences, including mental health difficulties. This term is used to incorporate cross-cultural experiences of emotional, psychological and mental health difficulties, broadening the parameters within which such experiences may exist. Furthermore, these parameters are not restricted to conventional, largely Western and biomedical definitions of mental health difficulties.

Contributory factors to the rise in emotional distress (ED) experienced by British Muslims (Abu-Ras & Abu-Bader, 2009; Schmitt, Branscombe, Postmes & Garcia, 2014)

include greater deprivation and social exclusion (Muslim Council of Britain, 2015), marginalisation, racism and negative portrayal by the media (Ameli, Mohammed, Marandi, Ahmed, Kara & Merali, 2007; Rippy & Newman, 2006; Atta, Randall, Charalambou & Rose, 2018).

Despite increased mental health difficulties (MHD) reported among British Muslims (Chew-Graham, Bashir, Chantler, Burman & Basteer, 2002), use of mainstream mental health services by this group is relatively low (Rethink, 2007). Several factors have been identified which may dissuade Muslims from using mainstream mental health services. Of particular note are differences in R/S perspectives of clients and practitioners (Aloud & Rathur, 2009; Anand & Cochrane, 2005; Gilbert, Gilbert & Sanghera, 2007; Keynejad, 2008; Fassaert, Tuinebreijer, Knipscheer, Verhoeff, Beekman & Dekker, 2011; Pilkington, Msetfi & Watson, 2012; Weatherhead & Daiches, 2010) and the perception that interventions may not incorporate R/S considerations (Amri & Bemak, 2013).

Muslims accessing services, report reduced confidence in raising R/S issues (Ankrah, 2002). The Muslim community has responded to this discrepancy, providing alternative avenues of support. Imams are reported to be the first point of contact for ED (Wang, Berglund & Kessler, 2003), their role has been seen to evolve from offering spiritual and marital guidance, to offering emotional support (Ali, Milstein & Marzuk, 2005). Additionally, the rise of Muslim charitable and third-sector organisations have appeared to play a role in alleviating ED of this community (Oppedal, Røysamb, & Sam, 2004).

Discrepancies between Islamic philosophy and mainstream services

R/S therapy is suggested as improving experiences and outcomes of British Muslims (Arip, Sharip & Rosli, 2018; Hamjah, Akhir, Ismail, Ismail & Arib, 2015; Rosli, Sharip & Ismail, 2018). The incongruence of a Muslim's R/S beliefs and their R/S practice is reported

to contribute to the manifestation of ED (Keshavarzi & Haque, 2013). An important role of a therapist working with Muslims, is argued to be in supporting a client's journey towards self-actualisation and introspection, to attain congruency of their R/S beliefs and practices (Keshavarzi & Haque, 2013).

Widely used psychology models, endorsed by mainstream services, are largely based on principles of philosophy (rational principles) and science (empirical data), leaving little room for metaphysical, supra-rational considerations (knowledge source transcending rational and empirical data). Consequently, ED is broadly understood as an outcome of interactions between clients and their physical, tangible environment. Psychological processes include an encouragement of self-awareness and promotion of independent agency to alleviate ED. It may be argued, that the absence of metaphysical considerations may not, naturally, present an opportunity for exploration of such congruence.

Whilst some modern psychological approaches, such as mindfulness and Acceptance and Commitment Therapies (ACT) are based upon religious ideology, widely accepted psychological models are generally based upon principles of individualism (Badri, 1979; Triandis, 1989), a reductionist medical model and a dualistic model of the mind and body (Mehta, 2011). Such paradigms may be perceived as conflicting with Islamic epistemic positions, with regards to wellbeing and lifestyle.

A traditional Islamic way of life is viewed as collectivist in nature, emphasising the needs of the extended family and community above those of an individual (Al-Mateen & Afzal, 2004; Carter & Rashidi, 2003; Weatherhead & Daiches, 2015). Complete dependency is reserved for God.

Contrasting the dualistic model of mind and body, Islamic philosophy describes the 'self' as a holistic entity of mind (Aql), body and soul (Ruh); where spiritual and worldly

experiences are inseparable (Keshavarzi & Haque, 2013; Malik, 2018). Islamic philosophy, acknowledging the interaction between a client and physical environment, also considers the influence of the client's relationship with the divine (God) on their emotional experiences (Yusuf, 2018). Muslim philosophers, Ibn-Hazm and Abu Hamid Mohammed Al-Ghazali (10th/11th century), defined ED as distance from God, attributing the degree of physical and mental health as a function of one's proximity to Him (Ghazali, 1853, 1986). Ghazali further claimed that good character, achieved through emulation of the ways and being of the prophet Muhammed, are indicators of positive mental health. A central concept within Islamic philosophy is the seeking of an eternal after-life, viewing life on earth as temporary, a concept which continues to form the basis of Muslim practice until the present day. Acknowledging that many Muslims follow the teachings and writings of Islamic philosophers, this epistemological view is suggested as central to ensuring effective therapy with Muslims (Ad-Dab'bagh, 2009).

Acknowledging that experiences of ED are influenced by cultural and R/S contexts (Hayward, 1999; Laher & Khan, 2011; Molsa, Hjelde & Tilikainen, 2010), Muslims living in Britain are likely to be influenced to varying degrees, by western, non-western, secular and non-secular conceptualisations and experiences of ED, possibly complicated by processes of acculturation (Simich, Maiter, Moorlag & Ochocka, 2009; Sirin, Gupta, Ryce, Katsiaficas, Suarez-Orozco & Rogers-Sirin, 2013). Consequently, a heterogenous population of Muslims with varied mental health needs (Al-Mateen & Afzal, 2004; Eltaiba & Harries, 2015; Hedayat, 2006; Rasool, 2000; Springer, Abbott & Reisbig, 2009), which may not be fully addressed by mainstream services.

Theoretical positions

Attempting to address discrepancies highlighted between philosophical underpinnings of Islamic values and those of models of psychology, three dominant epistemic positions offer responses to the daunting task of integrating Islamic concepts and values into modern psychology (Haque, Khan, Keshavarzi & Rothman, 216).

One position endorses the view of Western models through an Islamic lens (Badri, 1967), involving little change to psychological models, staying mindful of religious orientation as contextual factors within the delivery of therapy (Ad-Dab'bagh, 2017; Ali, Liu & Humedian, 2004; Weatherhead & Daiches, 2015). This approach claims that Western models, applied in an idiosyncratic manner, can be effective with Muslim clients. It has been suggested, however, that such models may be unsuitable for particularly religious Muslims (Beshai, Clark & Dobson, 2013).

A second position suggests that widely used psychological models such as CBT, adapted to incorporate Islamic values and practice, could meet the needs of the British Muslim population. Taking an a priori, Eurocentric approach, therapeutic models incorporating Islamic ideology with British Muslims, report efficacious results (Arip et al, 2018; Husain & Hodge, 2016; Mir, Meer, Cottrell, Kanter, McMillan & House, 2016; Naz & Khalily, 2015; Rosli et al, 2018; Vasegh, 2014).

A third epistemic position asserts that theological principles cannot be subjected to empiricism (Haque et al, 2016), calling for a separate model built upon Islamic philosophy, viewed by some as distinct from those which underpin widely used psychology models (Yusuf, 2018). While a consensus around the definition of the emerging field of 'Islamic Psychology' remains unclear (Kaplick & Skinner, 2017; Skinner, 2018), focus upon the Islamic concept of the 'self' is central to its ideology (Haque et al, 2016). Several theoretical models have been put forward (Abu-Raiya, 2015; Inayat, 2005a, b; Khalid, 2007; Skinner

2010; Yaqoob, 2003) but limited studies present condition-specific interventions, using an

Islamic approach (Abudullah et al, 2013). While general approaches to interventions are

considered (Haque & Keshavari, 2014), studies considering components of such interventions

are scarce.

Collectively, the literature presents an academic, intellectual response to highlighted

discrepancies. Limited reflection of the models in relation to Muslims' lived experiences,

conceptualisations of their ED (Weatherhead & Daiches, 2015) or indeed clinical practice, is

considered. In order to address the needs of the diverse British Muslim population, a call for a

model which accommodates different Islamic affiliations and levels of religiosity has been

made (Haque et al, 2016).

Current practice within the British Muslim community

Clinicians may enhance their ability to work effectively with Muslims by learning

from those who already do. However, the nature of formal and informal emotional support

currently accessed by British Muslims outside mainstream services, is unclear.

Globally, Muslims are reported to seek emotional support from friends and family, in

addition to seeking support from Imams and third sector organisations (Al-Krenawi, Graham,

Dean & Eltaiba, 2004; Aloud & Rathur, 2009). A similar pattern of help-seeking is reported

in Britain (Furnham & Malik, 1994; Netto, Gaag, Thabki, Bondi & Mumro, 2001). Few

clergy are reported to hold psychology or counselling qualifications in America (Ali et al,

2005; Ali, 2016), it is unclear whether this is the case within Britain. Moreover, limited

professional qualifications of clergy may not necessarily invalidate their capability in

alleviating ED. It is therefore of interest to explore the nature and provision of emotional

support available to British Muslims.

An IPA study explored British Imams' delivery of emotional support. Authors report that Imams' relationship and closeness to God was important in their therapeutic interventions with Muslims (Watts, Murray & Pilkington, 2013). Imams expressed that this relationship enabled a relinquishing of control to God, offering hope to clients. The curative nature of God's power was believed to be central process in their practice. Belief in the metaphysical, that everything good and bad comes from God, helped Imams and clients to alleviate their burdens, developing a dependent agency upon God's power. Ruqyah[2] was also employed as a therapeutic approach. Imams also encouraged independent agency of clients in taking responsibility for change in their life.

In support of the focus on inclusivity in UK health and social policy (Department of Health, 2013), it is hoped that learning from processes actively used with British Muslims to alleviate distress, may inform ways of meeting the ethical obligation (APA, 2017; BPS, 2018) of psychologists to provide appropriate and accessible mental health services to British Muslims. This study aims to create a theoretical model, illustrating and explaining the nature of therapeutic processes used by practitioners, outside mainstream mental health services, alleviating ED of this group.

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[2] Ruqyah is an Arabic term used to describe the recitation of the Quran to seek refuge in, and to promote, the remembrance of God to alleviate distress (physical, psychological or social). It is the belief of Muslims that there is no benefit in the recitation of the Quran itself but that the benefits come from God.

The Researcher

Holding a critical realist epistemology (Archer et al, 2016), acknowledging ontological realism at its heart, I endorse that much of reality exists and operates independently of our awareness and knowledge of it. Attempting to explain and interpret current practice of British Muslim practitioners, outside mainstream services, my research is informed by belief that knowledge about reality is often historically, socially and culturally situated. As a Trainee Clinical Psychologist, recognising my Islamic values and as a third-generation South Asian woman, I adopt a position of curiosity in the exploration of the processes involved in alleviating ED.

Methodology

Design

It was of interest to develop a theoretical model illustrating the processes of alleviating ED, used by Muslim practitioners. A grounded theory (GT) methodology was chosen because, in comparison with other qualitative methods, it places emphasis on theory development, providing an iterative approach to the exploration of meaning and potential for explanation of these processes (Kolb, 2012; Strauss & Corbin, 1990).

Rather than being restricted by previously established theoretical positions, GT encourages exploration and development of theory, grounded in the data collected (Groen, Simmons & McNair, 2017; Hallberg, 2009). This research design lends itself well to the focus of this research topic, which has not previously been addressed.

Given the evolving and heterogenous nature of the British Muslim population, a constructivist GT methodology approach (Charmaz, 2006; 2014) was used. Rather than offering a finite perspective of reality, this approach allowed for interpretation of current therapeutic processes, at a given time. This approach also acknowledges that realities captured are likely to be constructed through the interactions and interpretations of both the researcher and participants involved in the research (Pidgeon & Henwood, 1997).

Ethical Approval

Ethical approval was obtained from the Lancaster University Research Ethics committee (*Appendix 2-A*).

Recruitment, data collection and analysis

Following the iterative and constant comparison processes of the GT model, three cycles of participant recruitment, data collection and analysis took place. The method of constant comparison meant that, in subsequent cycles, each stage of analysis informed recruitment, using theoretical sampling to reinforce theory development (Glaser 1992; Glaser & Strauss, 1967). 14 semi-structured, 45-90 minute (average 60 minutes) interviews were completed between October 2017 and August 2018. Following receipt of participant information (*Appendix 2-B*), written consent was obtained for 12 face to face interviews. Verbal consent was recorded for a further two interviews via skype and telephone.

The first cycle included participants who responded to a recruitment poster (*Appendix 2-C*), circulated on social media (WhatsApp, Facebook, Twitter), in mosques, community centres and third sector organisations within NW England and London. Given that a diverse sample is suggested to contribute to richer theory and understanding of processes involved (Glaser & Strauss, 1967), initial sampling targeted a range of British individuals who self-selected as holding a role in alleviating ED of Muslims, outside mainstream services. 15 participants responded to the recruitment poster. Eight participants did continue with participation and all remaining seven participants were interviewed from the 15 who responded to initial recruitment (Table 1).

[Table 1]

An interview schedule was developed through discussion with two academic supervisors. The first cycle included broad, open questions exploring participants' perspectives of their therapeutic role. Questions also explored participants' approach to formulating, conceptualising and alleviating ED. Responses were transcribed and analysed by the researcher, seeking supervision to ensure adherence to GT methodology. Active codes (gerunds) were attributed to specific segments of the interview (Charmaz, 2006, p.42) as part

of the initial coding of the analysis (*Appendix 2-D*) and entered into an Excel spreadsheet (*Appendix 2-E*). Initial codes were analysed and categorised (*Appendix 2-F*) and emerging phenomena noted through comparison and observed relationships between codes (see Field notes for further detail). A mind map facilitated data analysis (*Appendix 2-G)*. A visual model of the GT was also created, depicting emerging categories (*Appendix 2-H*).

Informed by analysis outcomes, theoretical sampling (Glaser & Strauss, 1967) was used in the second cycle of recruitment. Participants were chosen for interview where it appeared that analysis of additional data could further develop and explore emerging categories (Charmaz, 2006). Following academic supervision, additional interviews with some of the participants from cycle 1 were conducted to further explore specific processes involved in alleviating ED (Table 2). A further objective of the second round of interviews was to 'test' the initial model (*Appendix 2-H*) to ensure that it was grounded in the data.

Adapted interview prompts were used until data collected did not contribute any new information, indicating theoretical sufficiency. Following completion of five interviews, these were transcribed, analysed and focused coding undertaken. This involved coding of selected data, considered to add detail and development of emergent theoretical categories (Drawucker, Martsolf, Ross & Russ, 2007). The visual model evolved as part of the process of constant comparison (Glaser & Strauss, 1967).

Theoretical sampling informed recruitment, of Muslim Clinical Psychologists working outside mainstream services, for the final cycle of the GT process. Discussion with academic supervisors, suggested that this would add depth and clarity to the existing theoretical categories addressing complex concepts relating to both Islam and the practice of psychology (Table 2). In addition, it was hoped that interviews with Clinical Psychologists would 'test' the model for its relevance to the professional field.

Two Clinical Psychologists were interviewed. As with the second cycle, focused coding took place. Outcomes of the analysis were amalgamated with previous findings, contributing to further development of the visual model (*Appendices 2-I* and *2-J*).

[Table 2]

Consultation with the literature

To avoid contamination of data interpretation during the development of a GT, researchers have been advised against consultation with existing literature (Glaser & Strauss, 1967). It is also noted, however, that remaining unfamiliar with the literature base is somewhat unrealistic (Giles, King and de Lacey, 2013; Pidgeon & Henwood, 1997). Acknowledging this controversy, brief consultation with the literature was considered necessary to complete an ethics proposal and formulate the initial query. The researcher remained relatively naïve to the literature however, until data analysis was complete (Dey, 1999; Ramalho, Adams, Huggard & Hoare, 2015).

Fieldnotes

Written prose and visual diagrams captured key ideas from supervisory discussions, focused codes and theoretical categories (*Appendix 2-K)*. These were consulted to inform decision making around recruitment strategy, theoretical sampling and development of the GT.

Findings

A theoretical model is presented, illustrating processes used by Muslim practitioners outside mainstream services, to alleviate ED of British Muslims. Three key elements of the model, *practitioners' conceptualisation of Islam and wellbeing, engaging a diverse range of British Muslim individuals* and *therapeutic processes* are presented.

An Islamic epistemology was central to participants' approach to alleviating ED. Islam was referenced explicitly at times and at others, Islamic principles were held in mind by practitioners. The decision to use Islam explicitly within therapy was influenced by practitioners' personal conceptualisation of Islam, its relevance to emotional wellbeing and a consideration for individual differences in the R/S orientation of clients.

Two processes are shown in practitioner approaches to alleviating ED. In the first, Islam is used as a framework to encourage the clients' insight to the self, promoting independent agency, or control over client wellbeing, similar to processes within widely used paradigms of psychology. The second process, encourages an openness and closeness to God and His wisdom, described as encouraging dependence upon God's power in the alleviation of distress.

The process of gaining insight into the self lead to an insight into God's wisdom. These processes are viewed as occurring simultaneously in a cyclical, synergistic manner. Moreover, as the client increased their closeness to God, an insight into the self was facilitated, encouraging in turn, an insight, openness and closeness to God. Although acknowledged by participants as being unobtainable due to human limitations, this cycle of processes was described to be infinite in nature, continuing with the ultimate goal of submission to God's wisdom and complete awareness of the self.

Following an assessment and formulation of clients' idiosyncratic needs and acknowledging the benefits of activating the synergy of the two processes, therapeutic work focused on achieving a balance between the two. Key components of the model are considered below, to be read in conjunction with the visual (Model 1).

[Model 1]

Practitioners' conceptualisation of Islam and wellbeing

Practitioners referenced Islamic resources including Hadith[3] and excerpts from the Quran[4], Islamic values and practice to inform their understanding of wellness. Belief and closeness to God and Islamic practice were equated to wellbeing,

> I think every concept of wellbeing and wellness starts with your faith in God…and it will always end with that as well…I don't think that there is any part of the Islamic faith that will deny (your wellbeing)...(P7).

Practitioners, who had completed mental health professional training, viewed Islamic values as complementary to their existing knowledge,

> ...like any other therapist that has a spiritual or faith background, it gives them…a practitioner, (they) have more arrows to their bow, to help their client. Doesn't

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[3] Hadith – an Arabic term used to describe a collection of sayings, actions, habits and intentions of the Prophet Muhammed. Hadith are often used to offer a narrative of the Prophet's life, to provide a human example for Muslims to follow.

[4] Quran – The sacred text of Islam, considered by Muslims to be the direct word of God which was revealed directly to the Prophet Muhammed

necessarily mean that you are using them all, they may not be appropriate, but it just means that you have more depth…(P4).

Participants considered the influence of the heart, in the formulation of clients' difficulties. Interventions were delivered on both humanistic and spiritual levels. A combination of both processes was considered by participants, to be best practice.

Therapy opens up the client to their own guidance…open to what God sends us… our Fitrah[5] is contained by the heart…an important concept, based on a primordial witnessing of God…every human being has within themselves a memory of the existence of…Allah (P8).

Whilst acknowledging that interventions take place on humanistic and spiritual levels, all practitioners believed that God has ultimate control over the emotional wellness of clients and therefore, allowed space for God within therapy. "As Muslims, we believe that Allah created everything, and He knows everything…it's up to Allah…to accept (our prayers) and help people in the way that He thinks best…" (P6)

Engaging a diverse range of British Muslim individuals

Practitioners appeared to take a non-judgemental stance with regard to the current R/S position of clients, acknowledging further that God is the ultimate judge. Consequently, adopting a collaborative stance, practitioners would only incorporate religious concepts and practice if the client indicated a desire to "…psychologically, spiritually… (you need to ask yourself) does that person have the spiritual openness to explore…" (P5), clients were

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[5] Fitrah – An Arabic term which has no true English translation but has been translated as a instinctual, primordial human nature

considered as being on an individual, complex and ever-evolving R/S journey, "I suppose it (Islam) touches people in different ways…" (P7).

Acknowledging the R/S journey of each client, practitioners referenced the Quranic verse, "there is no compulsion in religion" (2:256). Practitioners were mindful to keep personal Islamic opinions separate from work with clients,

> …it's not for me to launch into that just because they are Muslim. I have to respect
> where they are… I am Muslim but if they wanted to approach me with that
> (Islam)…that would have to come from them (P4)

Therapeutic processes

Processes which encourage an insight into the self.

It was considered essential by participants, that insight to the self should be at the core of any intervention, "…without knowledge or understanding, or even presence of mind, it isn't going to (heal your heart) … because you are not present…unless you are actually connected…" (P4).

Encouraging insight into the self, using Islam, was considered by participants, to empower clients to take independent agency in their wellbeing, "You define your life as you wish… that again is a fundamental principle in Islam, that we are given a choice, given opportunity and it is for us to choose our own path…" (P5).

Whilst acknowledging that ultimate control and healing comes from God, practitioners placed importance on the concept of 'free will' to engage clients in finding their independent agency, "…God has given you free will to do whatever you want, Allah is not controlling you… He has given you free will…" (P6), encouraging the client to take action,

> Islam is an active religion… Allah has given us humans movement, freedom,
>
> capacity, opportunities…He wants us to go into different things …you have to do
>
> something… (P4).

Practitioners acknowledged a common community narrative that ED is due to a R/S deficit. Islamic stories, metaphors and parables from the Quran and Hadith[6] were used to encourage clients to compare their personal experiences with those reported of the prophets, to alleviate any associated guilt.

> …often, they think that (they are) a bad person or…bad Muslim…I will say well
>
> actually, did you know that such and such a Sahaba[7] had an experience like this or our
>
> prophet (pbuh)? (P4)

Prophetic stories offered guidance in responding to distress and facilitated a process of normalising client experiences, reassuring clients that ED is not due to punishment for deficits in R/S, "An example I would give is…think about…the best of mankind, the prophets…all of the prophets experienced distress at some point in their lives, they were unhappy…hurt…grieving… and they were the best of us!" (P4).

Limits to alleviating emotional distress through insight to the self.

Participants acknowledged limitations to encouraging insight to the self exclusively. Incorporating reflection upon spiritual aspects of clients' identity, cultivating dependent

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[6] Accounts of the Prophet Muhammed's advice, sayings and actions which often take the form of short verses or stories to illustrate a concept or life guidance.

[7] Sahaba is the most common, Arabic term to describe a companion of the Prophet Muhammed

agency through God consciousness and openness to His power was reported to enhance the alleviation of ED.

> There are always going to be things which are outside our knowledge and understanding…when you just have to say that…it was just Allah's will and that is one of those times when you have to put a stone on your heart and say Allah knows best… that's where your faith is important… (P4).

Such limitations could be interpreted as participants' endorsement of the need to acknowledge God's power in the alleviation of ED.

> …for example, panic attacks…CBT can help to explore how the thinking is overtaking on this, but it may be useful to consider why Allah has given this person panic attacks…it can be about letting go…to experience something like an annihilation of oneself…being open to that and…(submitting to God's plan). (P8)

Processes which encourage an openness to God.

Remembrance of God.

A second therapeutic process involved the encouragement of clients to embrace an openness to God's wisdom. Practitioners expressed a belief that God's presence within therapy contributed to the alleviation of clients' distress, "I see Islam in everything that I do you know…I see myself very much as someone who is an instrument of Allah's work…any ease, well-being, anything that is good…comes from Allah". (P9).

The act of 'Dhikr'[8], translated as 'the remembrance of God', was reported to enhance an openness to God's wisdom, alleviating ED. Dhikr involved reciting and chanting God's names[9], interpreted by some participants as a mindfulness exercise, and by others as an act of the divine and His healing qualities. "…(dhikr) can bring calmness, it can bring contentment, it can bring clarity of mind, protection…I suppose it's like calling on God…it's calling on God's protection…" (P7).

Participants encouraged clients' openness to God, hopeful that relinquishing their control to a higher being would bring a sense of relief. The alleviation of distress by this process was interpreted, by some participants, as extending clients' perceived locus of control and by others, as the work of the divine. "It's when we forget Him, and we think that we are everything…we think that we control everything…we get into a mess…when you realise actually, I don't control everything…it's quite liberating…" (P4).

Hadiths and Quranic parables were used to illustrate ways in which the prophets' openness to God's wisdom alleviated their ED,

At one point the prophet Muhammed was almost suicidal…he wanted to throw himself from the mountain…he himself needed consolation…which came through the (divine) revelation…we use it a lot of times today…we explain it to them (clients)… (P5).

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[8] Dhikr, a form of devotion, in which the worshipper (Muslim) is absorbed in the rhythmic repetition of the name of God or His attributes

[9] Muslims believe that there are 99 names of God. As written in the Quran, each name describes one of God's attributes

Acknowledging God as the ultimate power was also reported as helping clients find meaning to their distress, "He wants you to experience something, He wants you to see what or when you are going to turn to Him…sometimes you need to step away…to get yourself back together and for you to feel stronger". (P4).

Finding meaning in one's distress may be considered synonymous with the process of gaining insight to the self and as example of the bi-directional therapeutic processes illustrated by the visual model (Model 1), where processes of gaining insight to the self, are seen to be inextricable from processes which encourage an insight or openness to God's wisdom "…you talk about somebody being tested…God never tests anyone more than they can handle at any one time…He tests you because He loves you, but He is also testing to bring out a quality in you that maybe you didn't know…" (P7).

Prayer and supplication.

Some practitioners described using prayer[10] and supplication[11] both within and outside the therapy room when they felt 'stuck' with how to proceed with clients,

I pray…when I am stuck on how to support a family or when…I don't necessarily

share that with the family because I don't know how it's going to land with them, it's

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[10] Prayers – Muslims believe that there are five obligatory, daily prayers and are considered, by Muslims, to be one of the most important obligations of the Islamic faith (prayer is one of the five fundamental pillars of Islam).

[11] Supplication –Synonym to "Duaa". Following the ritualistic prayer, Muslims may offer supplication to God. Although there are some set supplications which can be recited for certain requests of God, these may also be personalised.

hard to know how they might experience that. I mean obviously if they ask me to pray for them then I will (share that)…(P9).

Some practitioners encouraged clients to engage in ritualistic, daily prayers themselves: "…some people don't know how to pray, so we teach them how to pray, how to make a duaa" (P6)

Benefits of prayer were perceived by participants, to be numerous, both non-spiritually and spiritually. By some, prayer was compared to mindfulness exercises,

> …it does relate…you meditate…chant the words …over and over…I'm always sort of relating it back…you can achieve the same goals when you are praying…the same sort of soothing…clearing your mind, allowing thoughts to come in and out…that's the whole power of prayer (P3)

Regular, daily prayers were also regarded to facilitate a daily structure, for example, as part of a behavioural activation plan, within a cognitive behavioural framework, "…I would mix it all in…pleasurable activities, achievable activities that would reward and nourish…I would ask if they want to include prayer…whatever their targets are" (P4).

From a spiritual perspective, prayer was considered to enhance clients' openness to God's wisdom. Following prayer, Muslims make personal supplications to God. Participants worked with clients to identify specific supplications, acknowledging His power to alleviate ED, "…Part of the art of therapy is to get down to…(a specific duaa) to be free of hating my father for example, or distilling down specific duaas about anxiety that you wish to be relieved from…" (RS, p17).

Participants acknowledged, that a client's willingness to be open to God is a personal decision and was therefore gently encouraged, following the client's lead.

…it can feel a little overwhelming, particularly if they already feel like they are

failing in their spiritual connection….If they do feel more spiritually connected, I just

think bingo…because at the end of the day that's the aim…as a Muslim and as a

therapist, that's a bonus (P4).

Submission to God.

Encouragement of openness to and dependence upon God's power, was sometimes

extended to encouragement of submission to God's plan.

Transmission (from God)…is crucial to us in Islam…things are coming to us all the

time and thus submission is when we are open to what we see…so in therapy, the

therapist is in the state that they are open to (God)…therefore you receive inspiration

that is evoked by your clients need…(P8).

Participants acknowledged that total submission, "although…basic principles of faith,

these are high-level concepts to mentally achieve" (P7), but that life itself involves striving to

achieve this. If clients communicated a readiness to explore this powerful notion, and

considered it useful, practitioners encouraged clients to reach a place of acceptance with a

situation, by reminding them that this life is a test or trial[12], in preparation for their ultimate

goal, the afterlife.

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[12] It is a common belief, among Muslims, that the more that an individual is tested within this

'temporary' life, the more that they will be rewarded in the next life (the afterlife). This belief is based

upon a number of references in the Quran, which indicate that God tests those He loves the most, in

order for their best reward (in the afterlife) to be granted.

…submitting to His plan and recognising that no matter what…He knows what is happening and even if you don't get your contentment, if you don't have your sound state of mental wellbeing in this world, you will be given it in the hereafter…. (P7).

Some practitioners reported using this reminder in exceptional circumstances, where processes which encouraged insight to the self were considered inadequate, "…she was so distraught that I felt the only way to console her was by using the idea of God and Islam and bigger things...for this woman to be trusting in". (P3)

Therapeutic limitations to gaining an insight into God's wisdom.

Clients who were not ready to embrace an openness to God, these processes were considered to have little positive impact and indeed, could potentially exacerbate experiences of ED. Moreover, the possibility of dismissing clients' emotional experiences was highlighted as a limitation to using this process alone,

 …although…you can talk about God's plan and submit to it…you still have all the emotions there, you still have the feelings of loss…bereavement and…not being able to cope…as much as you trust in God, you still have that human element…they may need to work through a lot of emotions (before) they come to that place of acceptance….(P3).

Participants expressed great concern, that an exclusive focus on the belief that everything happens because of God, may perpetuate deprecating thoughts about ED being a punishment from God,

Yeah, I think it's really damaging…every one of the prophets experienced distress at some point in their lives…they were the best of us…are you telling me that their faith was weak, or they didn't adhere to religious principles enough? I do not believe that… (P4).

Directing a client towards prayer and supplication without an intellectual awareness of its benefit was also reported to be unhelpful, "…I find it destructive to tell someone to go and pray when they have no connection to prayer…". (P3).

Additionally, practitioners described that exclusive use of processes encouraging trust in God's power may lead to clients' passive attitudes towards their wellbeing and potentially exacerbating their difficulties. Therefore, participants endorsed a balance of encouraging independent agency as well as dependence or openness to God, "You can of course pray that there be a cure discovered or that it goes away but at the same time you have to be doing things as well…so have faith, but tie your camel[13]… there has to be a balance you know?" (P9).

Participants endorsed clients' intellectual engagement in processes which encourage openness, and ultimately submission to, God's wisdom: "A lot of the time, before connecting with Allah, it's about connecting with themselves…" (P5).

> I do feel that insight (to the self) comes first, I think it's more important within the therapy, insight to the self is more important than where we sit with God…your overall aim is to help that person gain insight into themselves and religion could be used as a sort of thread as part of that process. (P3).

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[13] Tie your camel – taken from a Hadith: A companion of the Prophet Muhammed asked: "O Messenger of Allah, should I tie my camel and trust in Allah, or should I untie her and trust in Allah?" The Messenger of Allah, peace and blessings be upon him, said, "Tie her and trust in Allah". This hadith is reported by Imām al-Termezī/Tirmidhī. The message of this hadith is to highlight the guidance given on the balance required between trusting in God, His wisdom and your pre-determined destiny; with that of exercising your autonomy and free will.

Achieving a balance.

Acknowledging limitations of exclusive focus on processes which encourage an insight to the self, or those encouraging a closeness or insight into God's wisdom, participants highlighted the benefits of establishing balance and synergy of these processes. Participants also acknowledged that drawing upon aspects of both processes may be required at different points in a client's life, or indeed therapy, acknowledging the holistic entity of the client in mind, body and soul.

> I think you need a balance of (the) approaches because Islam is a practice, physical practice… as well as a refinement of the soul and they both come together and they both develop one another… I think there are points where you may concentrate on one more than the other… one is feeding into the other and I think it can work either way… (P7).

Discussion

The GT shows therapeutic processes used with British Muslims, including the explicit or implicit use of Islamic concepts, values and practices. Therapeutic processes used to alleviate ED are seen to be an amalgamation of clinical applications of psychological theory, encouraging insight into the self, and religious philosophy, encouraging openness to God's wisdom and submission to His plan. These processes were used in both formal and informal settings, by Muslims of professional and non-professional backgrounds, outside mainstream mental health services.

Interpretation of the GT

A central construct considered within modern psychology of religion, describes religious orientation across spectrums of Intrinsic Religious Orientation (IRO) and Extrinsic Religious Orientation (ERO) (Allport & Ross, 1967). Individuals with greater IRO are likely to view religion as a framework for life (Masters, 2013), and those with greater ERO may use religion to achieve a sense of personal wellbeing by gaining a greater sense of peace, protection and happiness through faith. Individuals who have greater ERO may also use religion to derive social outcomes, such as a sense of belonging and an opportunity to connect with family and spouses (Ghorbani, Watson, Zarehi & Shamohammadi, 2010).

Variation in religious orientation is acknowledged by the GT, allowing a flexible and fluid approach to working with Muslims, holding varying degrees of IRO and ERO. In order to achieve collaborative therapeutic goals, Muslim clients may require individually tailored approaches relating to the extent and combination of both therapeutic processes highlighted by the GT.

The GT shows the use of processes which draw upon the curative nature of God's power, while promoting the independent agency of clients, reflecting findings reported in an IPA study with British Imams (Watts et al, 2013). Optimum emotional wellbeing of Muslims is considered, by practitioners, to be achieved by enabling the synergy of processes which encourage insight to the self and an openness to God, His wisdom and His power.

Muslim Experiential Religiousness (MER) has been shown to correlate positively with measures of both ERO and IRO (Ghorbani et al, 2010), including the central spiritual idea of submission to God. Ghorbani, Watson, Geranmayeour & Chen (2014) operationalised the act of submission as a dynamic of three spiritual constructs of love, closeness and submission to God. These constructs are described to be self-perpetuating, where an individual submits to God through an act of love and, in doing so, feels closeness and love in return, reinforcing the act of submission. This concept may support the explanation of the second therapeutic process of the GT, where Islamic concepts are used to encourage an insight into God's wisdom, encouraging an openness to His power.

The GT model in relation to existing theoretical literature

The discrepancy between widely used psychological models (Mehta, 2011) and those acknowledging the metaphysical, representing a closer orientation to Islam (Badri, 1979; Haque et al, 2016; Skinner, 2018) is acknowledged. Addressing the apparent juxtaposition of these philosophies, the GT presents a cohesive framework in which these may be combined.

The framework allows practitioners to pursue therapeutic processes encouraging both independent and dependent agency. Muslim practitioners consider clients within the context of the physical world and their relationship with the divine. As suggested, this synergy may illustrate processes through which a practitioner may support clients in achieving congruence between their R/S beliefs and actions (Keshavari & Haque, 2013).

Similar to Islamically adapted psychological models, the GT shows that using Islamic parables and values may guide a client, within the human context of their existence, to a greater insight to themselves. For example, excerpts from the Quran or Hadith facilitate relaxation techniques (Arip et al, 2018; Naz & Khalily, 2015; Rosli et al, 2018), thought challenging or restructuring (Husain & Hodge, 2016; Mir et al, 2016; Naz & Khalily, 2015; Vasegh et al, 2014) and psychoeducation (Arip et al, 2018; Rosli et al, 2018, Vasegh, 2014).

It may be argued that adapted models reflect one process of the GT, which encourages an insight into the self. Furthermore, while the use of Islam in adapted models allows for a common 'language', effective in engaging British Muslims in therapy, such approaches are likely to remain, broadly, within an a priori, humanistic paradigm. However, in contrast to adapted models, which may be suitable for Muslims of greater ERO, the GT further acknowledges the role of a practitioner in facilitating an openness to God. Moreover, the GT does not ascribe to an a priori humanist model, offering an option for Muslim practitioners to meet the needs of Muslims who may have greater IRO or indeed, those of varying religious orientations.

The GT may also be considered to reflect theoretical perspectives of 'Islamic Psychology'. This perspective considers the heart or 'Qalb' as central to an individual's emotional wellbeing, reported to be influenced by, the mind or 'Aql' (Keshavarzi & Haque, 2013; Skinner, 2010; Weatherhead & Daiches, 2015). Keshavarzi & Haque (2013) describe the 'Aql' as the centre of cognition including logic, reasoning, thoughts and beliefs.

The processes highlighted in the GT may reflect concepts of the 'Aql' and the 'Qalb', where an exclusive focus on the 'Aql' is similar to encouraging an insight to the self, supporting clients in the understanding their distress further, from an intellectual perspective.

Similarly, an exclusive focus on the 'Qalb', indicating a distance from God (Keshavarzi & Haque, 2016), employs interventions which may be considered as encouraging an openness to God. These practices include the remembrance of God (Dhikr), recitation of specific Quranic verses and prayers (Abdullah, Abidin, Hissan, Kechil, Razali & Zin, 2013; Farooqi, 2006; Watts et al, 2013). This approach may be considered to reflect the processes and practices highlighted in the GT.

Clinical Implications

Combined with processes encouraging an insight to the self, the GT indicates the use of practitioners' personal connection with God and Islamic perspectives on existence (Ghazali, 1853, 1986), in the delivery of therapeutic processes which encourage an openness to God's wisdom and power, in alleviating ED of British Muslims. These findings indicate that acknowledging the metaphysical, is central to therapy conducted with Muslims outside mainstream services. This presents a number of clinical implications.

Acknowledging the largely humanistic and positivist framework of mainstream services and the psychological models it endorses, the inclusion of metaphysical processes within therapy presents significant challenges. It may be argued that practitioners who are not Muslim, or indeed R/S themselves may struggle to include all aspects of the GT in their work.

Mental health practitioners are reported to be less religious and more spiritual than the general population (Delaney, Miller & Bisono, 2007; Neeleman & King, 1993; Whitely, 2012). While some non-religious practitioners report feeling comfortable to address R/S aspects within therapy (Mir et al, 2016) and positive learning experiences from clients' spiritual beliefs (Blair, 2015), others reported feeling uncomfortable raising spiritual issues. Practitioners were feared patronising clients and some report R/S discussions ending in conflict (Magaldi-Dopman, Park-Taylor & Ponterotto, 2011; Mir et al, 2016).

Furthermore, psychology training courses are reported to lack opportunities for R/S exploration both personally and clinically (Blair, 2015; Hage, Hopson, Siegel, Payton & DeFanti, 2006; Mir et al, 2016; Schafer, Handal & Brawer, 2011). The lack of diversity of clinical psychologists highlights further limitations. While it may be argued that an increase in Muslim psychologists may increase numbers of practitioners who feel able to incorporate processes shown in the GT, it must be considered that subjecting metaphysical therapeutic

processes to empiricism presents significant challenges to the already established working system of mainstream services.

Existing literature provides guidance for mainstream practitioners in their work with Muslims, including the awareness of practitioners' R/S (Wiggins, 2006), inclusion R/S assessments, consideration of clients' conceptualisation of the 'self' and most importantly, conveying an openness to speak about R/S issues (Abu-Raiya & Pargament, 2010; Knox, Catlin, Casper & Schlosser, 2005; Weatherhead & Daiches, 2015). It is unlikely, however, that such recommendations can equip mainstream practitioners to incorporate all aspects of the GT within therapy. It may be further argued that such efforts may facilitate engagement of religious clients in therapy, providing a common 'language' to enter the world of Muslim clients (Vasegh, 2014) but there is limited scope to encourage an openness to God within therapy.

Acknowledging a number of barriers to delivering therapy including the processes shown in the GT, a pragmatic solution may be to work collaboratively with Muslim practitioners currently working outside mainstream services. The GT may instead, act as guiding principles for mainstream practitioners, and Muslim clients who may have limited awareness of the therapeutic approaches available to them, thus enabling clients to make informed choices about the care they receive.

For clients, particularly those with a high IRO, it may be more appropriate for liaison or referral to a Muslim practitioner working outside mainstream services who may be better able to meet the needs of Muslims who would benefit from therapy which includes the synergy of processes shown in the GT. It should be considered, however, that some Muslims may choose mental health support from mainstream services to actively avoid discussion

around their R/S identity and therefore, assumptions should not be made that all Muslims will benefit from models including R/S components.

In addition, acknowledging the lack of consensus in the definition of Islamic Psychology (Skinner, 2018), the GT may provide a working framework for Muslim practitioners, forming a cohesive approach to therapy models which may serve Muslims occupying varying orientations of religiosity (Allport & Ross, 1967).

Limitations and future research

While the GT shows the processes used by Muslim practitioners to alleviate ED of Muslims outside mainstream services, the efficacy of such processes remains unknown.

Additionally, acknowledging the use of a constructivist GT methodology, the perspectives and epistemic position of the researcher will have inevitably influenced the outcome of the model produced (Elliot, Fischer & Rennie, 1999). Although supervision was sought to minimise bias, the GT is based upon the researcher's interpretation of the data collected. The influence of the researcher's epistemological position in relation to the research is further discussed in Section Three.

There were several strengths of the sample population, including both professional and non-professional practitioners, across a range of socioeconomic boroughs within Britain. The sample, however, was not representative of the British population of Muslim practitioners. All but one practitioners identified as South Asian in ethnicity and the remaining one worked predominantly with South Asians. Additionally, no participants from the third sector were recruited. The GT may therefore, not be applicable to practitioners of other ethnicities or third sector contexts, until future research provides clarification. Furthermore, given that all practitioners were Muslim, it may also be of interest to test the GT within other R/S populations.

Conclusion

This GT shows that the inclusion of metaphysical processes is central to therapeutic work with British Muslims outside mainstream services. Whilst these findings highlight that achieving this, within mainstream services, poses significant challenges, working collaboratively with Muslim practitioners outside mainstream services may be the most pragmatic solution to meeting the varied needs of British Muslims. Whilst the clinical efficacy of the model cannot be quantified within the scope of this paper, it nevertheless offers a systematic and qualitative insight into the nature of support sought by Muslims, grounded in the perspectives of Muslim practitioners.

Tables and Figures

Table 1.

Participant Characteristics

Participant Number		Participant Characteristics	Interview Block(s)
P1	F	Community out-reach worker	1
P2	F	Trained counsellor, lead sister at the mosque	1
P3	F	Trained in person-centred therapy, CBT qualification	1,2
P4	F	Trained CBT therapist, IAPT practitioner	1,2
P5	M	Imam	1,2
P6	M	Community faith healer	1,2
P7	F	Muslim Youth Group Leader, qualified teacher	1,2
P8	M	Consultant Clinical Psychologist	3
P9	F	Clinical Psychologist	3

Table 2.

A table to highlight key decision making throughout the recruitment process

Key points for decision making regarding recruitment throughout the GT process	Detail of decisions making process through consultation with academic supervisors
Completion of first cycle of interviews and recruitment for second cycle of interviews	• Analysis of first cycle interviews indicated that a community approach to alleviating emotional distress was mainly preventative in nature. Approaches to alleviating significant experiences of emotional distress was conducted on an individual level in both formal and non-formal settings. Whilst initial categories indicated the general framework of alleviating emotional, the researcher was curious to understand this in more detail. • A decision was therefore made to conduct additional interviews with participants from the first cycle to obtain further detail about specific processes and perspectives involved in therapeutic work with British Muslim individuals to alleviate emotional distress.
Recruitment during the second cycle of interviews	• Following the completion of second interviews with three participants from round one, a decision was made to adapt the model to reflect a more cyclical process of alleviating emotional distress rather than having two distinct categories of: insight into God and insight to the self • A decision was also made to contact a participant from the first round of interviews who was initially considered to be an anomaly in relation to the other participants. A position of curiosity was taken to see whether the adaptation to the model would allow for the incorporation of his data • The content of interviews was raising questions, from the researcher, which required an increased level of psychological knowledge from participants. A decision was made to direct recruitment towards individuals who had undergone psychological training or who had an appropriate level of psychological understanding which would contribute to the develop of the model. Recruitment was therefore conducted using social media platforms for Muslim psychologists.

Model 1.

Visual representation of the GT

Practitioners' Conceptualisation of Islam and Wellbeing

- Drawing upon Islamic principles to inform theoretical perspectives in therapy such as hadith, Quran, consultation with scholars
- A focus on the holistic wellbeing of clients to include the heart, mind, body and spiritual aspects of the self
- Drawing upon personal religious identity/interpretation of Islamic principles to inform therapeutic approach
- God's will encapsulates theoretical and practical elements of therapy

Engaging a Variety of British Muslims

- Acknowledging individual differences and preferences in spiritual journey
- There is no compulsion in religion
- Implicit use of Islamic principles
- Collaborative approach
- Formulation based on the need for insight into the self/insight into God

Complete self-awareness

Total submission to God's decree

INSIGHT TO THE SELF

INSIGHT INTO GODS WISDOM

Limits to gaining insight into the self

Limits to gaining insight into God

Limits to gaining insight into the self

Limits to gaining insight into God

Therapeutic processes

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Appendices

Appendix 2-A: Letter confirming ethical approval of the study

Lancaster University

Applicant: Sana Gill
Supervisor: Suzanne Hodge
Department: Health Research
FHMREC Reference: FHMREC17003

17 October 2017

Dear Sana,

Re: Exploring processes of alleviating emotional distress within British Muslim communities

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;

- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);

- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 592838
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Dr Diane Hopkins
Research Integrity and Governance Officer, Secretary to FHMREC.

Appendix 2-B: Participant Information Sheet

Doctorate in Clinical Psychology | Lancaster University

Exploring Processes of Alleviating Emotional Distress Within British Muslim Communities

Thank you for showing an interest in this study. My name is Sana, I am a Trainee Clinical Psychologist, in my final year of a Doctorate at the University of Lancaster. This study forms part of my thesis submission for my degree (like a PhD).

Why am I conducting this research?
- I am interested in exploring the types of emotional support which exists within the Muslim community.
- This may include formal support such as Muslim Helplines, Rukkiyah, Muslim Counselling as well as informal support which may be given by people within the community such as Imams, Community Leaders, Charities and Youth Group Leaders (and many more!).

Background
There is evidence to suggest that mental health and emotional difficulties are increasing among Muslim populations, especially since the rise of islamophobia and negative media portrayal of Muslims. This has been particularly noticeable since events such as 9/11 and the growing incidence of terror attacks which are often associated with Muslims. There is evidence to suggest that Muslims do not access mainstream mental health services as much as the rest of the population and if they do, it's usually at a much later stage when mental health difficulties may be more severe.

I am therefore interested in understanding the support that exists within the Muslim community itself. I would like to know some more about the kinds of problems that you may help with and how you go about this. I have been training in Clinical Psychology principles and would be really interested to see if any of the work that we do is similar and to see what might be different. I would like to know what you have found to be useful in your work supporting Muslims and about some of the difficulties that you may have faced and areas of development for the future.

How can you help?
You are being invited to take part in this study because you offer support to members of the Muslim community for emotional difficulties. I would be really interested in hearing about the work that you carry out and to learn more about the nature of this work.
- I would like to interview you for around 60 minutes – this can be over the phone or face to face.

- Our conversation will be recorded, to help with my memory of what has been discussed but also so that I can analyse are conversations after our conversation has ended.
- At the end of the study I hope to produce a document of all the different kinds of support which exist for Muslims within the UK.

My English is not very good!

Please let me know which language you would prefer to speak in. I will do my best to find an interpreter who speaks your language of choice and will request funding for this. Please note that funding may not always be available, but every best effort will be made.

Do I have to take part?

You do not have to take part in the research if you do not want to. You are free to stop the conversation at any point and if you change your mind about taking part afterwards you may ask me to delete our audio recording up to seven days after our conversation.

Will our conversation remain private?

- What we talk about will remain between us but if I am worried about the safety of either yourself or the people that we speak about then I will need to my supervisor about this. This is so I can arrange support for either yourself or your client. I will try to speak to you about this before I do this.
- When I write up my research, I may use some quotes from our conversation but I will use a fake name to make sure that your identity is protected.
- All data will be anonymised, by removing your name or details of your organisation from the write up. Readers of the article will not know that you have taken part in this research.
- Any audio recordings will be kept on a secure university server and will be destroyed once I have handed in my thesis
- Files on the computer will be encrypted so only I will be able to see the information

What will happen to the results?

- The results will be summarised and reported as part of a university assignment and may be submitted for publication in an academic or professional journal.
- I would like to make the results of the project as public as possible using the media, social media and perhaps leaflets so that members of the Muslim community are aware of the kinds of support available
- I hope that mainstream, NHS services may start to understand some of the kinds of things that are happening within our community as well. This is help the Muslim community provide adequate emotional support for its members.

Are there any risks?

ALLEVIATING EMOTIONAL DISTRESS AMONG BRITISH MUSLIMS

There are no risks anticipated with participating in this study. If you feel sad or distressed during or after our conversation, please let me know. We can stop the conversation at any time and you are free to leave if you don't feel like continuing.

Are there any benefits to taking part?
Although you may find participating interesting, there are no direct benefits in taking part. It is a chance to have your feelings and opinions heard however, we would like to make sure that members of the British Muslim community feel supported during times of emotional distress.

Who has reviewed the project?
This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at the University of Lancaster.

Please Note
It may feel relevant to talk about some of the people that you have been supporting. It is important that their identity remains anonymous so please refrain from using their real name or giving any personal information about the person unless you have had permission from them to do so.

Where can I obtain further information about the study if I need it?
You can contact myself (**Sana Gill**) at
s.gill1@lancaster.ac.uk or 07508 374 663

You may also like to speak with my research supervisors:
Anna Daiches (Clinical Director)
a.daiches@lancaster.ac.uk or 01524 594406

Suzanne Hodge (Lecturer in Health Research)
s.hodge@lancaster.ac.uk or 01524 592712

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Bill Sellwood
01524 593 998 or b.sellwood@lancaster.ac.uk
Health Research, Furness College, Lancaster University, Lancaster, LA1 4YG

If you wish to speak to someone **outside** of the Clinical Psychology Doctorate Programme, you may contact:

Professor Roger Pickup
01524 593746 or r.pickup@lancaster.ac.uk
Faculty of Health and Medicine, (Division of Biomedical and Life Sciences), Lancaster, University of Lancaster, LA1 4YG

If you are feel distressed or upset after our interview, please contact:

Sakoon – Peace of Mind Islamic Counselling service 07943 561 561 info@sakoon.com www.sakoon.co.uk	Muslim Women's Network 0800 999 5786 www.mwnhelpline.co.uk
Muslim Community Helpline 0208 904 8193/0208 908 6715 www.muslimcommunityhelpline.org.uk Mon-Fri 10am – 1pm	Muslim Youth Helpline 0808 808 2008 www.myh.org.uk

Appendix 2-C: Recruitment poster

بِسْمِ اللهِ الرَّحْمٰنِ الرَّحِيْمِ

Do you support Muslims with their emotional difficulties or mental health?

Do Muslims come to you with emotional problems?

☐ If you are an Imam, Counsellor, a Youth Group leader, or a leading member of the Muslim community you may offer emotional support to Muslims

☐ As part of my doctorate degree (PhD) at the University of Lancaster, I am carrying out some research and would like to understand the emotional support available in our community. I would like to ask you some questions about the kind of work that you do.

☐ If you offer give emotional support to others in either a formal or informal way which is not NHS based and would like to take part or find out some more information, please contact Sr Sana Gill

E: s.gill1@lancaster.ac.uk   M: 07508 375 663

Doctorate in Clinical Psychology | Lancaster University

Please note: Your participation will remain anonymous if you would like this to be the case

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Appendix 2-D: An example of initial coding, attributing gerunds to interview transcript

Maintaining self-awareness Experiencing a conflict of values	P: It's like ok so young Muslim girls are doing this, like this is not even like having a boyfriend and you really loved him and you were going away. No, this is just completely … I just need to get pregnant
Identifying vulnerabilities of Muslim girls	Desperation
	P: Desperation. So there's there's that going on
	Mmm so is that the majority of your work then? That kind of stuff?
Recognising the impact of restrictions on young Muslims	P: Yeah yeah with that, I have come across that erm which then leads parents to be even more strict and say right my daughters are not going to college, you're not doing this, because of this and then all this about exploitation and all that about Pakistani men who are exploiting women and they are hearing this and they are saying that they want to keep our daughters safe. Erm yeah that exploitation was mainly with predominantly they said white,
Feeling saddened at the experiences of Muslims	young you know females who are vulnerable and it's not good and I'm not saying that there are a lot of people that do that but there is a lot of that that goes on. I actually see that and I know and I have been told. And it is, a lot of them Pakistani, Muslim and men
Identifying difficulties with depression and suicidality	And and so you described some of the emotional difficulties that come with those awful things.. things like depression and low mood… anything else that you come across?
	P: Depression, low mood, some can be suicidal… it can come to that stage where people have nothing left to live for
Identifying drug and alcohol abuse among Muslims as a coping mechanism	Yeah
Understanding drug and alcohol abuse as a way of managing anxiety	P: Because you know, if you've not got family or nothing then it's like well what can we do? What's the point? Er drinking, drugs. Erm I've known some girls turn to that, it's just to get rid of those anxieties. Erm And all those difficult feelings that they are going through. Yeah all those feelings they are going through because once you go down that road… it's it's trying to get back out. A lot of them are on anti-depressants. Or on medication, you know the doctors are helping with the. So ok they will be on medication but then at the same time medication is just
Criticising the use of medication	supressing. Those, it doesn't solve the… it doesn't make them feel any better all it does is I feel that it just supresses certain nerves and what that does is it slows them down anyway

Appendix 2-E: An example of initial coding process following the first round of interviews

Collectivist Views							
Collectivist approach to bringing up children	3						
Believing that safeguarding should be done as a community	29						
Identifying a religious family as a need for mental wellbeing		28					
Placing more importance on religious community leader than the family itself		28					
Supporting people to support others within the community		33					
Valuing community spirit				19			
Needing a network of support				20			
Wanting to improve the community				21			
Valuing collectivism				21			
Valuing human connection				21			
We are all human				21			
Advocating for a supportive community				21			
Believing that communities should be self-sufficient				22			39
Valuing togetherness				21			39
Adopting a collectivist approach to community wellbeing	29			21			
Valuing a supportive community				68			
Wanting to increase the sense of community connection within the mosque						8	
Valuing a good friendship group							
Perceiving that no one has time to listen							
Considering the whole system rather than just the individual		20					
Considering family opinion on the account of the individual		20					

Appendix 2-F: An example of focused coding category after all interviews were complete

2-F1: Focused coding of 'Insight into God and the self as a simultaneous process'

Dual process: Insight into the self/Insight into God					
Insight into God and the self is a simultaneous process					
Highlighting need for both insight into the self and God	20	14, 16		5	
Merging insight into the self with insight into God		7, 11, 14, 15, 16	10, 12	3, 5,13	1, 9. 17
Gaining insight to the self must also bring insight into God			13		
Gaining insight into the self by gaining insight into God		7			
Merging a human experience of emotion with insight into God		8			
Separating insight into self from insight into God		8			
Viewing insight into God as being a part of the self		9			
Understanding insight into the self as part of the process of understanding God		16			
Balancing insight into the self with the insight into God		17			
Believing that God wants you to gain insight into yourself as well as him	11				
Drawing upon islamic guidance to illustrate the dual process of gaining insight into the self as well as God				14	
Encouraging the client to find meaning to distress while trusting in Allah				3	
Gaining closeness to God/submitting to God encourages the client to find meaning in their ditress, gaining insight into the self				6	
Encouraging thoughts and explanation through insight into the self				7	
Finding a balance					5
Balancing the needs of this world with the hereafter					5

2-F2: Focused coding of the category 'Practitioners understanding/relationship with Islamic terms of wellbeing'

Practitioners understanding/relationship with Islamic terms of wellbeing					
Viewing islam as having all the answers to wellbeing				6	
Holding islam as framework for intervention				6	
Believing that by abiding by islamic principles will bring you emotional contentment				6	
Incorporating spirituality as part of the intervention		15			
Drawing upon islam to inform understanding of wellness		15			
Believing that islam is an active and empowering religion		18			
Drawing upon interpretation of Islam to direct therapy		18			
Understanding of wellness - an islamic influence		1			
Using islam as a framework for diagnosis/formulation					5
Submitting to Allah's will in personal life		7			
Trusting in Gods plan		7			
Submitting to Gods plan alleviates emotional distress		8			
Believing that God alleviates distress				8	
Viewing practitioners as vehicles of God's work				8	
Believing in the power of the rituals				16	
Believing in the power of dhikr				16	
Gaining insight into God improves wellbeing		1			
Identifying a need to consider spiritual paradigms					4
Drawing upon advice/knowledge from scholars in islam				5, 11	
Using dreams/interpretation as part of the formulation					6

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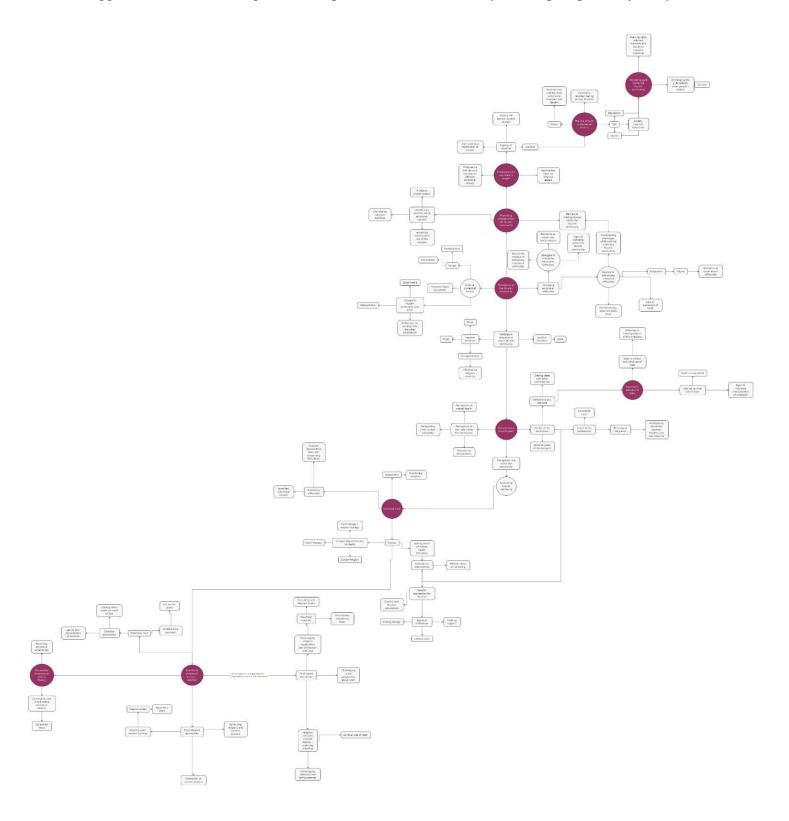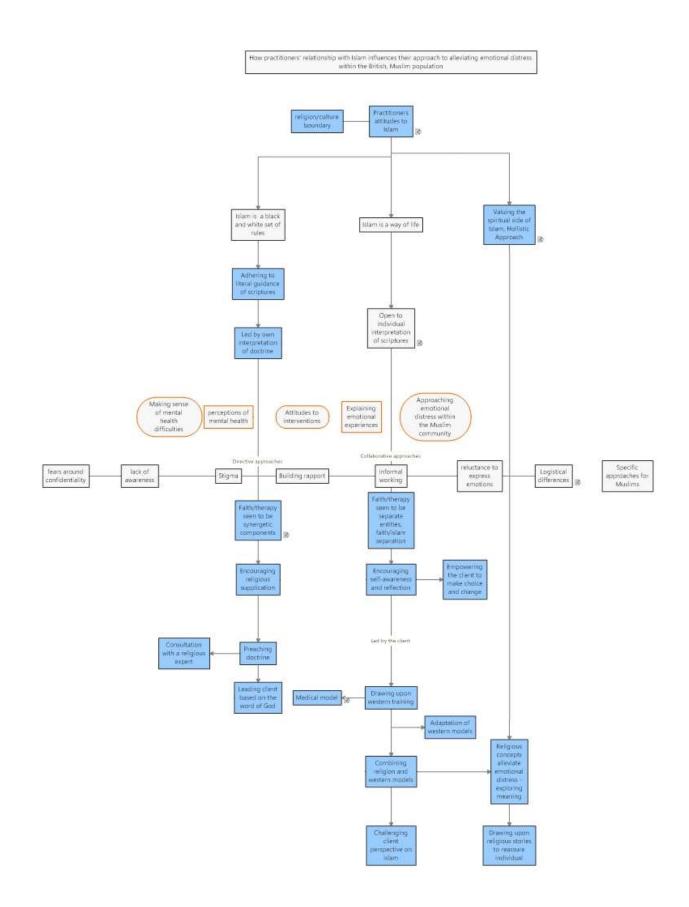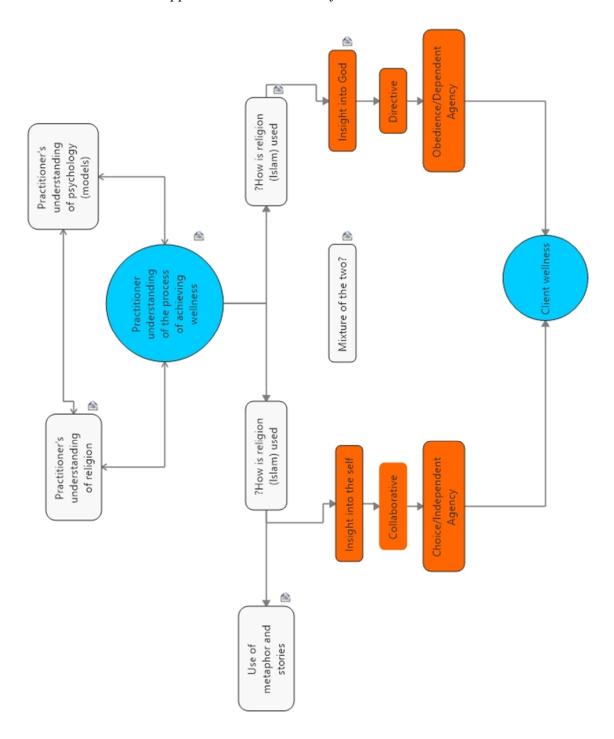*Appendix 2-G: A mindmap illustrating initial themes obtained following stage one of analysis*

Appendix 2-H: Phase one of the visual model
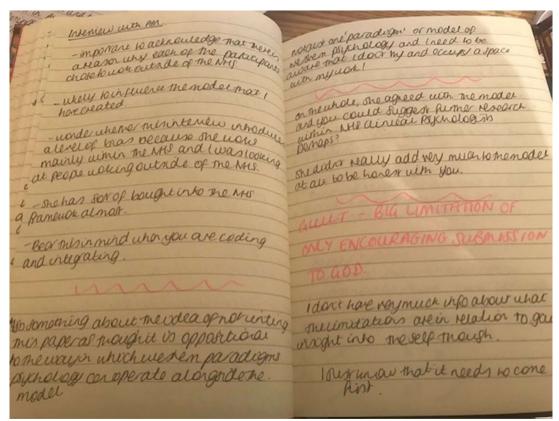
Appendix 2-I: Phase two of the visual model

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Appendix 2-J: Phase four of the visual model

Practitioner's understanding of psychology models

- Recognition of parallels which exist within Islamic guidance and clinical models of psychology (Badri)
- Emotional content of distress is seen as separately addressed (more likely to be from a Western model) to encouragement of submission to Allah
- Islam is seen as an additional dimension of the therapeutic tool
- Drawing upon theoretical evidence base

Acknowledging individual differences

- Individual journey of connectedness with God
- Varying levels of spiritual based practice
- Formulation based on need for insight to self/insight to God

Holistic Approach

Practitioner understanding of the process involved to achieve wellness

Submission to Gods plan

Practitioner's understanding of religion

- Using Islamic principles to inform therapeutic approach
- Drawing upon personal religious identity/interpretation of Islamic principles to inform therapeutic approach
- Believing in the power of God (or acknowledging this concept is important for the client) —encapsulates the therapeutic relationship, sets the context
- Believing that everything happens because of God
- Drawing upon the work of Islamic scholars

Finding a way in

- Ways to engage clients based on current position
- Implicit use of Islamic principles
- Assessment of client preference for Islamic content of therapy

Insight into the self

Promoting independent agency, using concepts, hadith, parables from Islamic scriptures

Limit to gaining insight into the self

Gaining insight into God

Promoting dependent agency, through rituals, dhikr, rukiyah, duaa, acceptance of Allah's will

Limits to gaining insight into God

Encouraging the client to 'let go' to God's plan

Processes used within therapy with the client to alleviate emotional distress

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Appendix 2-K: Excerpts from the fieldnotes of the researcher

[Handwritten journal/notebook pages]

Left page (top image):

...where I would like to know more detail about what it is specifically which is required for Muslims during therapy.

24/02/18 - memos
Coding NY interview
· seems to be an importance of identity
· self awareness
· boundaries between culture, religious ideology, doctrine, faith, spirituality wellness, use of religion as a control

· being really aware of what is going on in the room
· so walpurtice wanting to change the community to be more in their galaxe and assimilating all the qualities that we have been blessed with

...mething about navigating between western techniques and drawing upon knowledge of Islam.
Building a bridge
...ent to be occasions where she contradicts self but on the whole I think she provides

Right page (top image):

...an existence of multiple identities which inform her therapeutic relationships

...in contrast to AC - seems really fixed on her training as an impt anchor as the 'correct' way to do things and makes adaptations to suit client culture / religious needs.

· doesn't wait for the client to bring this into the room
...make a conscious effort not to preach about Islam but NY explores function / relationship with Islamic ideology
- AC really medical I felt

- BE on the other hand, very faith-based and led by God
- AC showed some belief in the view of mental health difficulties being as a result of a religious deficit
↳ she really amalgamates faith-based practice and literature based.

Left page (bottom image):

...that he talks about eg practices are just reminders of Allah that is similar to what he was saying about reminding himself that one is doing it for God.
...the whole life is a submission - everything one desires to Allah ultimately.
If you push enough that worldly spiritual barrier, you are likely to bring that into your work with clients

| implicitly | explicitly |

- is another dimension to explore
- would use it in their work with non Muslim clients as well
- to use as a different model here?

Again, themes of engagement and finding a way in were also very present within the interview with BE.

...mething about therapeutic relationship and finding a way in.

Right page (bottom image):

...given the ultimate aim for all is to alleviate emotional distress.

mainly through gaining insight into themself and then, if possible, to gain insight into God because there seems to be this understanding that insight into the self can...

| help to build a connection | Many view Islam as a voluntary thing. You need to actively participate in your religious commitment |

As you know God and his creation, you get to know your mind as you, and it feeds your self-awareness

independent agency and to demonstrate agency because we all have free will.

· sometimes the spiritual connection / awareness that you do not have it is...

Section Three:

Critical Appraisal

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The Critical Appraisal will present a summary of findings of both Section 1, Literature Review (LR) and Section 2, Empirical Paper (EP), followed by a discussion of the relative strengths and weaknesses of the papers. A reflection upon the researcher's epistemological position in relation to the design and conduct of the research will then be presented. Finally, the influence of the research process on the professional development of the researcher is discussed, together with dissemination and potential utility of the GT produced.

Summary of findings

Both papers reflect the central Islamic belief in the co-existence of both the physical and metaphysical world. The EP concerned the development of a grounded theory to articulate the processes used in alleviating emotional distress (ED) by Muslim practitioners, outside mainstream mental health services. Participants included both prominent members of the Muslim community, (an Imam, faith healer and youth group leader) and Muslim mental health professionals (a CBT therapist, community outreach worker, person-centred therapist, counsellor and two clinical psychologists).

The model developed, as part of the research (Model 1), shows that a metaphysical belief system is central to therapeutic processes used by Muslim practitioners, outside mainstream services. This belief system is central, not only to processes which encourage an insight into God's power and wisdom, but also to processes used to encourage an insight to the self which consider the influence of the tangible environment upon an individual's emotional wellbeing.

Overall, belief in the existence of God and in a metaphysical world was shown to influence the practitioner's epistemic approach to their formulation of clients' difficulties, and to intervention and specific techniques they used. Clients were considered to exist within both a physical and a metaphysical context, with this world being viewed as a temporary

existence, in the hope of attaining reward in the afterlife. Belief in the co-existence of metaphysical and physical worlds is central to the Islamic faith and therefore held by many Muslims. Careful consideration was given by the practitioners to ensure that their personal religious beliefs were not imposed upon clients, tailoring intervention to those who may present with varying religious orientations.

Practical techniques used within therapeutic interactions to alleviate ED with Muslim clients included drawing upon faith, prayer and submission to God's power. Stories/parables of the prophet Muhammed and from the Quran were also used to illustrate and support psychological processes, including acceptance and normalisation. Such processes were considered key in promoting independent agency, whilst maintaining an insight into God's wisdom, in acknowledgement of His ultimate control and power over human experience. These processes were employed within a flexible framework, in order to meet individual needs. In the event that a client indicated that they were not comfortable in exploring their relationship with God, or indeed, contemplation of their religious or spiritual orientation, the model shows how practitioners, without explicit mention of God's existence or power, encouraged an insight to the self (Model 1).

The LR considered conceptualisations held by Muslim practitioners from Britain, UAE, Malaysia and South Africa, the majority of whom identified as faith healers. Some of these practitioners identified with an ethnic heritage which differed from the country within which they practised, including conceptualisations of ED held by Indian faith healers in South Africa (Ally & Laher (2008). Conceptualisations held by mental health professionals, including psychiatrists and counsellors, were also considered as part of the review.

The LR showed that faith healers, in particular, hold a belief in the existence of two forms of ED. In line with the widely held view of western, largely positivist, explanatory

models of mental health difficulties (MHD), the first form is one caused by biopsychosocial factors. The second, reported to present as similar in symptomology to those caused by biopsychosocial factors, is believed to be caused by metaphysical processes of the supernatural world, including jinn possession and persecutory spiritual processes of black magic and the evil eye.

It is acknowledged that these findings may not be representative of all Muslim practitioners. In two papers included in the LR, practitioners who had undergone professional training in counselling and psychiatry acknowledged beliefs in the existence of spiritual illnesses, but kept these explanatory models separate to their clinical work. This may suggest that Muslim practitioners trained in a 'western' or 'secular' practice may hold varying degrees of spiritual conceptualisation. On the other hand, it may reflect how these practitioners make sense of their religious beliefs within the context of clinical practice. Conversely, in the EP, spiritual causes of ED were not mentioned by any of the participants. Furthermore, there was no indication that the use of metaphysical processes in interventions represented a response to ED believed to be caused by a spiritual entity. Acknowledgement of the metaphysical was central to the processes of alleviating ED, but not in the attribution of cause of distress.

Such diversity in epistemic viewpoints, highlighted within the EP and LR, may be considered to be the product of a complex interplay of factors including practitioners' professional or therapeutic identity, possibly further influenced by historical, cultural and religious factors. There were differences, in terms of professional identity, between the participants included in the LR, and those interviewed as part of the EP and development of the GT. Practitioners considered in the LR were mainly faith healers, whereas those considered by the EP were mainly Muslim professionals who had undertaken professional training, or those who held an additional professional role to their community commitments

in alleviating ED. The LR briefly highlights ways in which practitioners may make sense of their conceptualisations of ED, positioned within the context of a predominantly modern scientific model of MHDs.

It is also acknowledged that cultural and religious contexts may influence practitioners' conceptualisations of ED. While the EP may show how Muslim practitioners of South Asian origin, working with South Asian Muslim clients, use therapeutic processes to alleviate ED, the LR did not present an opportunity to make such conclusions.

Acknowledging several influencing factors including acculturalisation, professional training, religious and cultural contexts, upon the conceptualisations of Muslim practitioners, the broad cultural variation of a relatively small number of practitioners considered by the LR meant it was difficult to make generalisable conclusions. For example, just one paper considered the conceptualisations held by British faith healers (Rashid, Copello & Birchwood, 2012). Without further research to support them, such findings, based upon eight British faith healers, may not be generalisable to other British faith healers.

The LR highlights the influence of a number of factors including professional training, cultural context and religious beliefs, on the conceptualisations held by Muslim practitioners who alleviate ED. This complexity presented challenges in interpreting the LR, but also in considering implications of the LR findings for clinical services and therapeutic practice in clinical psychology.

As can be evidenced by the demographics of participants from the LR, most of the existing research considering conceptualisations of ED by Muslims working with mental health issues has been conducted with religious or traditional healers. In addition, the number of qualitative papers which consider conceptualisations of ED by this population group is relatively low. The lack of research resulted in the inclusion of papers from different

countries with potentially marked different cultures, making them difficult to compare or reflect upon in relation to the EP which focusses, in detail, on the practice of British Muslims, with British Muslims.

Papers included in the LR were written, mostly, from an a priori perspective, whereby the widely held understanding of MHDs was accepted as truth, stipulated by psychiatric models of the DSM-V (APA, 2013) and ICD-10 (WHO, 1993). The perspective of most authors of the papers reviewed, was that Muslim practitioners may conceptualise the causes of emotional difficulties within the realms of acceptable cultural and religious parameters, suggesting that authors viewed participants' understandings of ED in cultural terms.

Taking this epistemic position may present a publication bias in the nature of the papers produced, whereby research that highlights culturally diverse views of ED are more likely to be published than those that highlight Muslim perspectives which align with the widely accepted model of ED. Consequently, there are likely to be more papers which consider the conceptualisations of Muslims who hold a non-dominant perspective, rather than those who share similar ideologies to the mainstream conceptualisations of MHDs. It may be further argued that there are Muslim practitioners, both within the UK and around the globe, who hold similar conceptualisations of ED to those endorsed by the western mental health model.

Several strengths are acknowledged in the conduct of the empirical research and the production of the GT. In line with GT guidance, a broad range of individuals were interviewed as part of the initial cycles of data collection and analysis. Theoretical sufficiency was reached, and the theory is confidently grounded within the data collected through methods of constant comparison. The paper contributes to an evidently limited literature base which considers the processes of alleviating ED within the British Muslim population and

highlights the potential for exploring metaphysical considerations within therapy. It is hoped that the findings of this paper may be disseminated within the Muslim community to increase awareness of the variety of therapies available, with reference to the epistemic base of the models. In addition, it hoped that the model may increase mainstream practitioners' awareness of the nature of the processes involved in alleviating ED within the Muslim community.

Although the GT shows the current practice of Muslim practitioners within Britain, this research cannot provide insights into the effectiveness of the processes utilised with this population group and further research is required to assess the efficacy of such working models.

The influence of the researcher's epistemological perspective

Acknowledging the diversity of epistemological positions which may exist among the population of Muslim practitioners, I have taken the opportunity to reflect upon my own position in relation to the research and the influence that this may have had on the development of the GT (Model 1).

I acknowledge my position as a third-year trainee clinical psychologist and the influence that my epistemological position may have had on the conduct, analysis and report of the research. I also acknowledge that while my understanding of Islamic values played an important role in gaining permission from, and access, to the world of therapy conducted by Muslim practitioners outside of mainstream services, my understanding was relatively limited, in terms of how these values related to my personal epistemological position, both personally and as a trainee psychologist. Consequently, I adopted a position of curiosity in conducting the research. I believed that widely held scientific explanations of MHDs may not offer the only approach to conceptualising an individual's distress. I adopted this position and

will continue to adopt this position with clients that I work with, irrespective of their religious or cultural affiliation. As such, I did not hold any pre-conceived ideas about what form the nature of therapy would take within this community, when I embarked upon the research. Moreover, I did not ascribe to a religious, or Islamic epistemic position as I separated my religious orientation from my professional conduct.

In fact, it was my hope prior to the conduct of this research to discover ways of working with British Muslims in mainstream services, by learning from those who are successful in engaging Muslims in therapeutic interventions. As a Muslim, on clinical training, I refuted the view that working with Muslims required something 'additional' or 'different' from mainstream approaches to therapy, as conveyed by my clinical training. My belief, at this point, was that if psychological models are tailored effectively and collaboratively with Muslim clients, it was possible to work effectively with this population. I acknowledge the influence of my personal identity on this perspective, viewing myself as a part of the Muslim community. It was a challenge for me to accept that Muslims would require something 'additional' or that their worldviews were significantly different to those endorsed by the largely scientific paradigms underpinning mainstream mental health services. Whilst I was aware of particular barriers, to the access of services by British Muslims (Keynejad, 2008) I believed that such barriers were as a result of socio-political factors including the presence of a strong social stigma, institutionalised racism, growing mistrust of services and a general lack of awareness, amongst the Muslim community, about mental health support or provision (Amri & Bernak, 2013; Atta, Randall, Charalambou & Rose, 2018; Weatherhead & Daiches, 2010). My assumption, therefore, was that difficulty in engaging Muslims in therapy was the challenge, rather than the existence of fundamental differences in the processes involved in alleviating ED.

I acknowledge that my position, regarding Muslims as individuals who experience ED, irrespective of their religious position, may have influenced my approach to the research. It may be further argued that if I took the position of a faith healer, similar to those included in the LR, that I would have approached the research from a different perspective. I sought to highlight the commonalities between mainstream perceptions of MHD and Islamic understandings of ED. Holding the epistemic position of a faith healer, my aim may perhaps have been to highlight the differences and possible incompatibilities between mainstream working and models of Islamic Psychology.

Recruitment.

During recruitment, particularly of cycle 1 of the GT, I was mindful to avoid being led by 'Western' parameters which define the roles of those who alleviate ED as those holding professional qualifications. In line with the guidance of GT methodology (Glaser & Strauss, 1967), recruitment therefore, took a broad and open approach to individuals who self-selected as adopting a role in alleviating ED of British Muslims, outside of mainstream services. Interestingly, while I was trying to value the position of community leaders such as Imams or youth group leaders working with Muslims, the participants themselves expressed the view that they were 'no expert' and looked to those who had professional qualifications. It may be argued that some of the participants viewed their religious roles as subordinate to that of individuals trained within a particular profession, this perception may have influenced the nature of participant responses. In addition, participants may have been mindful to inhibit responses which they considered as conflicting with a research project perceived to endorse 'western' ideas. This led me to consider the influence of the western narratives around mental health difficulties (MHD) within the context of the scientific dominance in the modern 'west'.

Following the age of enlightenment, scientific revolution in the West, a move towards a reason-orientated way of thinking began to counter the dominance of religion that existed previously (Argyle, 2000; Bhugra,1996; Rhi, 2001). This lead to a divergence in the epistemic positions of science and religion. Esmail (1996) argues that,

> …as a result of the post-industrial revolution, the 'West' has brought its own assumptions about the self and about the individual and its relations with family and community, contrary to those obtaining in Muslim cultures conscious of their formative traditions.

Despite perceiving myself as equal to or perhaps even less knowledgeable than an Imam who played a role in the alleviation of distress in Muslims, I became aware of my position of perceived power from Muslim practitioners. I wondered if the participants taking part in the research were those who assimilated their epistemic views with those widely held by the 'west', perhaps explaining some of the discrepancies in the findings of the EP and LR.

Data Collection and Development of GT

Across the three cycles of data collection, I started to become aware of the differences in epistemologies held by Muslim practitioners. I became further aware of the apparent disconnect between the practitioners operating within the same geographical area and started to question the cohesion and consistency of practitioners within the NW of England. Participants expressed the need for a network of Muslim practitioners, in order to share good practice and ways of working. I started to question my assumptions about the processes of alleviating ED being similar within and outside mainstream mental health services. This view developed further as data collection progressed.

This questioning was particularly apparent during the visual model development, during the earlier stages (*Appendix 2-I*), where emerging themes from the analysis indicated a

dichotomy in the processes of gaining insight into God and insight to the self. This was particularly challenging to me, as a Muslim trainee clinical psychologist, as I started to reflect upon aspects of my identity which may represent opposing epistemic world views. I was able to identify as someone who was close to God, but also as someone who valued the insight to their 'self' and did experience these processes as dichotomous.

I became aware of the field of Islamic Psychology, as a separate entity to those who work with Islamically adapted psychological models, a poorly or undefined field which appeared to be in a period of recent resurgence. Of particular note, was the definition of the 'self' from an Islamic perspective to include the mind, body, soul and heart. This was a particular area of contention for me, as this was not something I had considered in relation to my professional identity. It provided an opportunity to reflect on what it meant to be a trainee psychologist, holding Islamic values.

Navigating the philosophical underpinnings of psychological therapy, within a Western paradigm, which considers the dualistic model of the mind and body and tends to focus on treatment at an individual level, sat well with my personal values. Asserting independent agency and increasing self-awareness are principles which have been formative in my development as an individual.

It became a little more challenging however, when I started to explore the philosophical underpinnings of Islamic principles, particularly those within 'Islamic Psychology'. Such principles include the adherence to religious values and practice to maintain emotional wellbeing, in addition to the conceptualisation of the self as being a holistic entity of the mind, body and soul. Assertions of this paradigm which assert the remembrance of God and the epistemic view on life as being temporary, challenged my original view on the world as a trainee.

Throughout my clinical training, I have not felt a need to question the compatibility of my religious values and the models of psychology that I use with clients. Prior to this research, I understood/believed that psychology models can be applied to individuals of varying cultural and religious backgrounds, provided that they are delivered in a personalised manner. Aside from asking individuals about their religious beliefs and whether this played a part in their coping with ED, I hadn't really considered the role of religious identity in relation to an individual's perception of their existence and the significance that this perception might have on the formulation of their difficulties. I feel that this research has shaped me, both personally and as a clinician.

Professional Development

In light of the research process, I will be mindful in the future to consider individual differences in the conceptualisations held by clients, particularly with reference to religious and spiritual perspectives on existence. I will consider particularly, the influence that this may have on their understanding, and the manifestation of their difficulties. This will be a consideration within my work, not only with those who are Muslim or of any other religious or spiritual (R/S) orientation, but with all clients.

Specifically, I will take care to consider the impact that such conceptualisations may have on a client's willingness to engage with therapy as well as the impact of the context within which the therapy takes place. Moreover, if a client is accessing mainstream services, I will be mindful of the expectations that the individual may have from a clinician within such a context and perhaps explore this in more detail before proceeding with therapy. With clients who identify as Muslim or with any other spiritual or religious framework, I will hold the GT in mind to consider ways in which I can acknowledge their personal, metaphysical beliefs within my approach to formulation and intervention. I will also be mindful of potential

collaboration, with faith healers or Imams, assessing the compatibility of their conceptualisations of ED in relation to that of the client.

Most importantly, I think the concept of choice and informed consent is paramount and I will endeavour to raise awareness of the content and the range of types of therapy, available to the British Muslim community. As noted by Blanch (2007), "There is also great variability between individual religious personalities, and the right match is critical, so developing a pool of known referral possibilities is a good strategy" (p258). I will therefore take opportunities to raise awareness and educate practitioners both from within and outside mainstream services about issues of epistemology and the impact that this may have on the compatibility of therapeutic approaches for British Muslims.

Gaps in knowledge

Several gaps in knowledge are highlighted between the findings of the LR and the EP which may be addressed by further research. For example, an exploratory study of the processes used in therapeutic approaches by individuals who use the title of 'faith healer' or 'traditional healer' may give clarity to any differences in approach of this population group, compared to the community members considered by the EP.

Discussions which led to the development of the GT did not indicate that practitioners understood ED within a supernatural framework. It may not be appropriate to assume that those who took part in this research did not hold such conceptualisations, however. Furthermore, acknowledging that my epistemic position, which did not hold spiritual causes for ED in mind at the time of recruitment or data collection, may have influenced the development of the GT. In order to confirm such assumptions, research exploring the conceptualisations of ED held by British Muslims, who identify as having a role in alleviating ED, outside mainstream services is required.

Conclusion

Findings of both the LR and the EP highlight the complexities of integrating metaphysical or religious epistemic positions within the largely scientific paradigms of western mental health services. While these world views seem initially juxtaposed, this may not necessarily be the case. This accords with the view of American philosopher and psychologist William James (1902, cited in Blanch, 2007), who argued that the value of religious experience in therapy should be determined by the client's individual and subjective evaluation of its effect. Furthermore, he argued that the religious orientation of the practitioner should not have an impact on the way that they work with their client and that it is the client experience, which is of most value.

With regards to finding a pragmatic solution to managing apparently juxtaposing philosophical positions, James also states that,

> Wisdom lies, not in forcing the consideration of the more metaphysical aspects of human consciousness upon them (practitioners) but, on the contrary, in carefully rescuing these aspects from their hands, and handing them over to those of the specialists in philosophy, where the metaphysical aspects are already allowed to belong (James 1892/1983)

In light of James' perspective, and further to the discussion of Section Two, a realistic solution in the further development of appropriate emotional support for this population, may be found in the collaboration with "specialists in philosophy" including Muslim practitioners, drawing on their expertise and knowledge of Islamic perspectives.

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Section Four:

Ethics Documents

Sana Gill

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

e: s.gill1@lancaster.ac.uk   t: 07710614838

Participant Consent Form

Doctorate in Clinical Psychology | Lancaster University

Exploring Processes Involved in Alleviating Emotional Distress Within the British Muslim Communities

We are asking if you would like to take part in a research project to understand the processes involved in alleviating emotional distress within British Muslim communities.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Sana Gill

Please initial each statement

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study

2. I confirm that I have had the opportunity to ask any questions and to have th

3. I understand that my interview will be audio recorded and then made into an anonymised written transcript.

4. I understand that audio recordings will be kept until the research project has been examined.

5. I understand that my participation is voluntary and that I am free to withdraw from the study up until seven days after the interview.

6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.

7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published

8. I consent to information and quotations from my interview being used in reports, conferences and training events.

9. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with her research supervisor.

10. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.

11. I consent to take part in the above study.

Name of Participant_____ Signature_____ Date _____

Name of Researcher _____ Signature _____Date _____

Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

Application for Ethical Approval for Research

Guidance on completing this form is also available as a word document

Title of Project: Exploring processes of alleviating emotional distress within British Muslim communities

Name of applicant/researcher: Sana Gill

ACP ID number (if applicable)*:   **Funding source (if applicable)**

Grant code (if applicable):

*If your project has _not_ been costed on ACP, you will also need to complete the Governance Checklist [link].

Type of study

▯ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, _two_ and four of this form**

☒ Includes _direct_ involvement by human subjects. **Complete sections one, _three_ and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM   Trainee Clinical Psychologist, DClinPsy

2. Contact information for applicant:
E-mail: s.gill1@lancaster.ac.uk **Telephone**: 07710614838 (please give a number on which you can be contacted at short notice)

Address: 45A Handforth Road, Wilmslow, Cheshire, SK9 2LX

3. **Names and appointments of all members of the research team (including degree where applicable)**

Sana Gill (Trainee Clinical Psychologist), Anna Daiches (Course Director) and Suzanne Hodge (Lecturer in Health Research)

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3. **If this is a student project, please indicate what type of project** by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

May 2017

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant: Suzanne Hodge (Lecturer in Health Research), Anna Daiches (Course Director of DClinPsy)

5. Appointment held by supervisor(s) and institution(s) where based (if applicable): Suzanne Hodge (Lecturer in Health Research), Anna Daiches (Course Director of DClinPsy) at the University of Lancaster

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' n o

4c. If yes, where relevant has permission / agreement been secured from the website moderator? n o

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? n o

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with the Data Protection Act 1998.

6a. Is the secondary data you will be using in the public domain? n o

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE
Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

Since 9/11, there has been an increase in the reports of mental health difficulties among British Muslims. Despite this, there is a significantly low proportion of Muslims seeking support from mainstream mental health services. Literature suggests that Muslims may turn to their own communities in search of ways to alleviate emotional distress, little is known about the nature of this distress or how this may be addressed within the Muslim community of Britain. This research project will explore what these processes look like. This study will take a Grounded Theory approach using a sample size of approximately 15 people in three 'blocks' of interviews using purposive sampling followed by theoretical sampling. The first round of interviews will consider individuals who self-classify as providers of emotional support for members of the Muslim community.

2. **Anticipated project dates (month and year only)**

Start date: October 2017   End date: June 2018

Data Collection and Management
For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The inclusion and exclusion criteria of the participants will ultimately be guided by the research itself (theoretical sampling based on the findings of previous interviews) following a Grounded Theory approach. The initial group of participants (purposive sample) will be individuals who classify themselves as aiming to alleviate emotional distress for members of the Muslim community, outside of the NHS. Participants wil be male and female, over the age of 18 - there will be no maximum age limit stipulated for this study. Further interview groups will remain flexible and open to guidance through findings from comparative analysis. I hope to interview a minimum of 9 and a maximum of 15 people for this study, in 2 or 3 interview blocks due to time allowance as part of a doctoral thesis.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

 Advertisements in the form of a poster (hard copy and electornic version) will be distributed in mosques (advertised in the newsletter, placed on the noticeboard), community centres, halal meat shops, muslim schools as well social media (twitter, facebook,instagram; personal accounts will not be used), email and instant messenger. Third sector charities and personal contacts will also be contacted by telephone or email explaining the purpose of the study.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

A grounded theory approach will be taken given the limited amount of research undertaken on the processes involved in alleviating emotional distress within the Muslim community. Semi-structured interviews will take place with participants exploring the processes of support offered to British Muslims to allevaite emotional distress. Topics such as the referral process, identifying distress, intervention and evaluation of intervention will be discussed as well as strengths and weaknessess of the kind of support the participant is offering to their clients. Interviews will be conducted face to face where possible e.g. the participants place of work, their home or a public meeting place. Telephone/skype interviews will also be considered, participants will be informed that these calls are not secure, to create ease with recruitment and to suit participant needs. Interviews will be audio-recorded. Questions will remain as open as possible in order to capture a wide range of responses and to consider conceptualisation of emotional distress which may not fit with pre-conceived ideas from the principal investigator who is a Muslim and a trainee psychologist.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with the Data Protection Act 1998.

During data collection, audio recordings on a dictaphone will be transferred following completion of an interview and stored on a password protected laptop, transferred to a secure university server and transcribed at the earliest time available - ommitting any identifiable information. Once transcribed and analysis completed, the audio recordings will be destroyed. At the end of the study the transcripted data will be sent to the DClinPsy programme Research Coordinator using an electronically secure method of data transfer and stored in a password-protected file space on the university server or Box. Scanned in consent forms will be stored separately for ten years. Paper copies of any consent forms will be destroyed at th point. Paper copies of the transcriptions will be destroyed at the point of assingment submission. It will be the responsibility of the programme Research Coordinator (under the direction of the DClinPsy Programme or Research Director) to delete the data after this time.

7. Will audio or video recording take place? ☐ no ☒ audio ☐ video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data. Identifiable data such as audio recordings will be stored on the university server until thesis hand in. File names will be coded to protect identifiable data. Electronic copies of the consent forms will also be stored on the university network in a separate file so that the audio recordings are not associated with personal details. If a hard copy of a consent form is obtained, this will be scanned and the paper copy destroyed. In the event that data will need to be transferred between work stations, an encrypted USB stick will be used.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Audio recordings will be stored on the univeristy server once an interview has been completed (taken off the dictaphone). Audio recordings will be destroyed at the time of thesis hand in.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE? Lancaster University use PURE as a data repositiry, access to the data here will be available to those with the necessary licensing to access information.

8b. Are there any restrictions on sharing your data ?

Due to the detail of personal information shared in the interviews, it is not deemed appropriate to share the data from the study.

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

Once participants have read and understood the Participant Information Sheet, a 24 hour period is recommended for participants to cosnider and ask questions before consent is taken. Participants will sign the consent form before the interview begins. In the event that interviews are conducted over Skype or telephone, the information sheet and consent forms will be emailed to the participant and verbal consent will be obtained. In the event that the particiapant does not have an email address, the contents of the consent form will be read over the phone. A record of verbal consent will be made and stored as a separate audio recording, stored on the University server; separate to the interview.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

In the event that the participants becomes distressed or upset during the study, the interview will be stopped. The participant will be given time to recover and will be given the option to either continue with the interview or terminate the interview. Details of additional support can be found on the bottom of the participant information sheet.

There may also be cautiousness due to shame and stigma around mental health of this population that individuals may want to withdraw from the study. Participants will be given one week post interview to withdraw from the study if they wish to due to the nature of the analysis, future interviews will be dependent upon analysis of previous interviews and so a longer period of notice may mean delays for the research timescale. Details of available support can be found on the bottom of the participant information sheet. These will be re-iterated at the end of the interview with any participants who may experience distress when taking part in the study.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

In the event that the principal investigator will need to conduct on interview at a participant's home or place of work the Lone Worker Policy of University of Lancaster will be adhered to. The investigator will inform their line manager of the times and dates of scheduled interviews. This will specifiy a location, omitting any personal details such as 'home visit', 'community centre'. Details of the investigators car registration number will also be given to their line manager. A buddy system will also be in operation on the actual day of the interview where colleagues of the investigator will be given the address and location of the participant on the day of the interview. If there is no contact made following an interview at the time that the buddy is expecting, they will inform the management team who will also attempt to contact the invesigator. Police will be notified if deemed appropriate.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There may be no direct benefit to taking part in the study but the participants may find it a positive experience to reflect and think about the work that they engage with in the muslim community.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:
n/a

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Personal information of the participants will be kept separately to the interview recordings and transcripts. These will be kept in a locked cabinet and given to the University to be kept securely. Pseudonyms will be used in the

write up of the research paper. Other identifiable information such as the location of the interviews will not be mentioned explicitly within the write up of the research paper. In the event that the principal investigator has concerns about the safety of the participants or of the people discussed during the interview, confidentiality will be broken in this instance. This is detailed on the participant information sheet.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

One Muslim lady who works within social care but provides informal support additionally outside of work, advised on the nature of the advertisement. Feedback was given in relation to the poster and this was amended accordingly. A second Muslim lady who is a Muslim counsellor also advised on the poster an gave recommendations for recruitment being through word of mouth which has been taken in to consideration. A third Muslim lady was one of the Muslim community who commented on her level of comprehension of the advert material. A male member of the Muslim community also gave feedback on the supporting documentation for the study.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

Thesis submission, leaflets produced for members of the Muslim community as well as those working within mainstream services detailing available resources in the community (this will be dependent upon the nature of the findings of the study), publication in a resaerch journal. If deemed appropriate, the media and press will also be contacted to promote dissemination of the findings as well as social media handles.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

I do not anticipate any harm to come to participants who take part in the study, there may be some low level of distress which may be uncovered when speaking about some of the struggles which exist to provide adequate emotional support within the Muslim community but it is hoped that participating in the study will be seen as a positive step to improving the nature of support available for this community. The principle investigator should take care when working alone but the University Lone Working Policy will be adhered to closely as detailed above. Careful consideration will be taken to protect the confidentiality of any individuals discussed during the interviews and this will be detailed in the supporting documentation as well as being discussed verbally with participants.

SECTION FOUR: signature

Applicant electronic signature: Sana Gill   Date 18/08/17

Student applicants: please tick to confirm that you have discussed this application with your supervisor, and that they are happy for the application to proceed to ethical review ☒

Project Supervisor name (if applicable): Suzanne Hodge   Date application discussed [   ]

Submission Guidance

1. Submit your FHMREC application <u>by email</u> to Diane Hopkins (d.hopkins@lancaster.ac.uk) as two separate documents:

   i. **FHMREC application form.**
   Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*

   ii. **Supporting materials.**
   Collate the following materials for your study, if relevant, into a single word document:

      a. Your full research proposal (background, literature review, methodology/methods, ethical considerations).
      b. Advertising materials (posters, e-mails)
      c. Letters/emails of invitation to participate
      d. Participant information sheets
      e. Consent forms
      f. Questionnaires, surveys, demographic sheets
      g. Interview schedules, interview question guides, focus group scripts
      h. Debriefing sheets, resource lists

   Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:

   i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Diane Hopkins **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the [FHMREC website.](#) Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

   ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:

      a. existing documents/data only;
      b. the evaluation of an existing project with no direct contact with human participants;
      c. service evaluations.

3. <u>**You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**</u>

Author guidelines for target journal

Target Journal: Journal of Religion and Health

Impact Factor: 1.061

MANUSCRIPT SUBMISSION

Manuscripts, in English, should be submitted to the Editor-in-Chief via the journal's web-based online manuscript submission and peer-review system:
http://jorh.edmgr.com
Inquiries regarding journal policy, manuscript preparation, and other such general topics should be sent to the Editor-in-Chief:
Curtis W. Hart, M.Div.
Editor-in-Chief, Journal of Religion and Health
e-mail: cuh9001@med.cornell.edu
Tel.: (347) 752-7421
The online system offers easy straightforward log-in and submission; supports a wide range of submission file formats [such as Word, WordPerfect, RTF, TXT, and LaTeX for manuscripts; TIFF, GIF, JPEG, EPS, PPT, and Postscript for figures (artwork)]; eliminates the need to submit manuscripts as hard-copy printouts, disks, and/or e-mail attachments; enables real-time tracking of manuscript status by author; and provides help should authors experience any submission difficulties.
Manuscripts should be checked for content and style (correct spelling, punctuation, and grammar; accuracy and consistency in citation of figures, tables, and references; stylistic uniformity of entries in the References section; etc.), as the typesetter is instructed to follow (accepted) manuscripts as presented. Page proofs are sent to the designated author for proofreading and checking. Typographical errors are corrected; authors' alterations are not allowed.
Books for review and inquiries about book reviews should be sent to the Editor-in-Chief at the above address.

- www.jorh.edmgr.com

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MANUSCRIPT STYLE

Type double-spaced using generous margins on all sides, The entire manuscript, including quotations, references, figure-caption list, and tables, should be double-spaced. Manuscript length, except under unusual circumstances, should not exceed 25 double-spaced pages. Number all pages consecutively with Arabic numerals, with the title page being 1. In order to facilitate masked (previously termed "double-blind") review, leave all identifying information off the manuscript, including the title page and the electronic file name. Appropriate identifying information is attached automatically to the electronic file. Upon initial submission, the title page should include only the title of the article.

An additional title page is to be uploaded as a separate submission item and should include the title of the article, author's name (with degree), and author's affiliation. Academic affiliations of all authors should be included. The affiliation should comprise the department, institution (usually university or company), city, and state (or nation) and should be typed as a footnote to the author's name. The title page should also include the complete mailing address, telephone number, fax number, and e-mail address of the one author designated to review proofs. A brief autobiographical paragraph, preferably no longer than 100 words, that includes highest degree, academic affiliation, expertise, projects, etc. (in that order) should be included on the title page.

An abstract is to be provided, preferably no longer than 100 words.

The names, institutional affiliations, and e-mail addresses of three (or more) suggested potential reviewers should be included on the additional title page.

A list of 3–5 key words is to be provided directly below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

CONFIDENTIAL MATERIAL

If your article contains any reference to material obtained under the HIPPA regulations regarding the use of Protected Health Information(PHI), to guarantee the privacy and confidentiality of this information, the author is required to do the following to be in compliance with HIPPA regulations:

1. Obtain from the subject(s) a signed and dated Release of Information Form which states explicitly that the subject(s) is giving his/her informed consent to have his/her Protected Health Information published in the Journal of Religion and Health. This form should include the title of the article to be published and should contain the original signature of the subject(s) and it should remain securely contained in the author's possession in perpetuity.

2. Submit to the Editor-in-Chief of the Journal of Religion and Health an Authorization Form to be obtained from the Editor-in-Chief with the original signature of the author, indicating that the author has the permission of the subject(s) to publish his/her material and authorizing the Journal of Religion and Health to publish the article in compliance with HIPPA regulations regarding Protected Health Information. This form will also be signed by the Editor-in-Chief of the Journal of Religion and Health and the original form will be placed in a locked file under the auspices of the Editor-in-Chief in perpetuity. A copy of this form will be mailed to the author for his/her files in an envelope marked: "Personal and Confidential" .

3. The author will make every effort to protect the identity of the subject by using pseudonyms, and changing any information that might make it possible for the reader to identify the subject. This would include any illustrations, including photographs, that might reveal the subject's identity.

ILLUSTRATIONS

Illustrations (photographs, drawings, diagrams, and charts) are to be numbered in one consecutive series of Arabic numerals and cited in numerical order in the text. Photographs should be high-contrast and drawings should be dark, sharp, and clear. Artwork for each figure should be provided on a separate page. Each figure should have an accompanying caption. The captions for illustrations should be listed on a separate page.

Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table should be typed on a separate page. Center the title above the table, and type explanatory footnotes (indicated by superscript lowercase letters) below the table.

REFERENCES

List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. References should include (in this order): last names and initials of all authors, year published, title of article, name of publication, volume number, and inclusive pages. The style and punctuation of the references should conform to strict APA style–illustrated by the following examples:
Journal Article

Plante, T. G., & Aldridge, A. (2005). Psychological patterns among Roman Catholic clergy accused of sexual misconduct. Pastoral Psychology, 54, 73–80.
Book
Levin, J. (2002). God, faith and health: Exploring the spirituality–healing connection. New York: Wiley.
Contribution to a Book
Cutler, D. L., Bigelow, D., Collins, V., Jackson, C., & Field, G. (2002). Why are severely mentally ill persons in jail and prison? In P. Backlar & D. L. Cutler (Eds.), Ethics in community mental health care: Commonplace concerns (pp. 137–154). New York: Kluwer Academic/Plenum Publishers.

FOOTNOTES

Footnotes should be avoided. When their use is absolutely necessary, footnotes should be numbered consecutively using Arabic numerals and should be typed at the bottom
of the page to which they refer. Place a line above the footnote, so that it is set off from the text. Use the appropriate superscript numeral for citation in the text.
In general, the journal follows the recommendations of the 2009 Publication Manual of the American Psychological Association (Sixth Edition), and it is suggested that contributors refer to this publication.