The Broader Social Context
of Help-Seeking Behaviours
Including a Research Study Pertaining to
Imams and the Muslim Community

Ohinor Choudhury

Thesis submitted in fulfilment of the requirements for the award
of Professional Doctorate in Counselling Psychology (DPsych)

City University London
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Bismillahirrahmanirrahim
‘In the Name of Allah, the Most Gracious, the Most Merciful’

‘Verily, with hardship, there is relief’ (Al-Qur’an, 94:6). By the mercy of Allah Subhanahu Wa Ta’ala it has been possible to realise the completion of this doctoral thesis; after much hardship I have certainly experienced relief. I would like to express Shukr (gratitude) to my Creator, to Whom one day I will return.

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Finally, I would like to thank my Father. By the decree of Allah Subhanahu Wa Ta’ala it was not ordained for you to share this moment with me, but this is for you. Your strength, tolerance and resilience taught me to be fearless like a Bengal tiger, embrace the adversities of life and to never lose hope; my achievements are yours, Abba.
DECLARATION

I grant powers of discretion to the University Librarian to allow this Doctorate Portfolio to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.
<table>
<thead>
<tr>
<th>Islamic Terminology</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alhamdulillah</td>
<td>‘All praise is due to Allah’</td>
</tr>
<tr>
<td>Al-ishara</td>
<td>‘Sign’ or ‘signal’</td>
</tr>
<tr>
<td>Bismillahirrahmanirrahim</td>
<td>‘In the Name of Allah, the Most Gracious, the Most Merciful’</td>
</tr>
<tr>
<td>Deen</td>
<td>Observing the religion of Islam</td>
</tr>
<tr>
<td>Duaa</td>
<td>Prayer</td>
</tr>
<tr>
<td>Fatwa</td>
<td>An Islamic legal pronouncement issued by an expert in the religious law of Islam</td>
</tr>
<tr>
<td>Hadith</td>
<td>A collection of the narrations of Prophet Mohammed (PBUH)</td>
</tr>
<tr>
<td>Halaal</td>
<td>Permissible for the Muslim</td>
</tr>
<tr>
<td>Haraam</td>
<td>Not permissible/ forbidden for the Muslim</td>
</tr>
<tr>
<td>Imaan</td>
<td>Faith</td>
</tr>
<tr>
<td>Inshaa Allah</td>
<td>‘If Allah Wills’/’ God Willing’</td>
</tr>
<tr>
<td>Jummah</td>
<td>The congregation prayer of Muslims taking place each Friday. This is usually held in the mosque</td>
</tr>
<tr>
<td>Khutba</td>
<td>The delivery of the Muslim sermon by an Imam or appointed religious person. This takes place at the mosque every Friday following the afternoon prayer</td>
</tr>
<tr>
<td>Madrasa</td>
<td>Islamic educational institution</td>
</tr>
<tr>
<td>Masjid/Mosque</td>
<td>Muslim place of worship</td>
</tr>
<tr>
<td>Mashaa Allah</td>
<td>‘As God has Willed’. The context in which this phase is used can vary, however it is commonly used in acknowledgement that all things good come from God and are blessings from the Divine. Many Muslims use this phrase in admiration or praise of something or someone</td>
</tr>
<tr>
<td>Muezzin</td>
<td>This is the official title of the individual who pronounces the call to Muslim prayer from the minaret of a mosque</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Qiyas</td>
<td>Studying of the Qur’an and Hadith in order to apply an injunction within Islamic jurisprudence. This is achieved through a process of deductive analogy by making comparisons between the Qur’an and Hadith to address circumstances, queries and questions.</td>
</tr>
<tr>
<td>Rukiya</td>
<td>This term refers to recitation of specific verses in the Qur’an and repeating supplications narrated and taught by Prophet Mohammed (PBUH) to alleviate human sickness/illness. Rukiya is also performed for the exorcism of Jinn possession.</td>
</tr>
<tr>
<td>Sadaqah</td>
<td>‘Sincerity’. The giving of charity which is not obligatory.</td>
</tr>
<tr>
<td>Sahaba Radiyallah</td>
<td>The companions of the Prophet Mohammed (PBUH)</td>
</tr>
<tr>
<td>Shifa</td>
<td>‘Healing’/’Curing’</td>
</tr>
<tr>
<td>Sunnah</td>
<td>‘Path’/’way’. According to Islamic jurisprudence Sunnah is regarded as the derivation of rulings based on the practices of Prophet Mohammed (PBUH).</td>
</tr>
<tr>
<td>Surah Al-Bakarah</td>
<td>‘The Cow’. The name of the second and longest chapter of the Qur’an</td>
</tr>
<tr>
<td>Tawid</td>
<td>‘Unification’/’Oneness’. The doctrine and Oneness of God. This is the term used to define monotheism in Islam.</td>
</tr>
<tr>
<td>Umrah</td>
<td>This term is used to describe the non-mandatory pilgrimage to Mecca. Muslims can make this journey at any time of year. It is sometimes referred to as the ‘mini Hajj’.</td>
</tr>
</tbody>
</table>

1 The glossary was constructed by the author from personal experience and understanding as a follower of Islam from birth, and compared to a cross section of contemporary internet language and dialogue used by the Muslim community to check for accuracy. However the author does not claim authenticity for the definition of terms described.
PART A: PREFACE

1. INTRODUCTION

This doctoral portfolio entails three pieces of written work completed during the course of my training as a Counselling Psychologist. The predominant theme in this portfolio relates to the prerogative of the evolving Counselling Psychologist; exploring topical issues in a contemporary world. These pieces of work represent my desire, as both a reflexive and scientist practitioner, to comprehend the broader social context of my role in the discipline of Counselling Psychology.

Part B of this portfolio is a novel piece of qualitative research investigating the Imam’s experience of managing the mental health needs of the Muslim community, Part C is a client study detailing my therapeutic work with an adult survivor of childhood sexual abuse (CSA) and the portfolio draws to a close with Part D, a journal article of the present research that is intended for submission to the Psychology journal psychology and psychotherapy: theory, research and practice, Wiley online library publication. I will provide a summary for each individual piece of work and how they interrelate to the overarching theme in this portfolio.

2. PART B: DOCTORAL RESEARCH

Part B of this portfolio consists of a piece of qualitative research entitled ‘The Imam’s experience of managing the mental health needs of the Muslim community’. A proliferation of cross-cultural studies has highlighted the fragmented relationship between the Muslim community and mental health services in the UK and internationally. The ideological belief systems of the Muslim community and mistrust towards healthcare professionals are among
the factors which have resulted in low referral rates to mental health services, and an ever expanding gap in meeting the mental health needs of this diverse Black and Ethnic Minority (BME) group (Inayat, 2007; Weatherhead & Daiches, 2010). Earlier research have called for mental health professionals to consider seeking the views of formal religious leaders/Imams in the Muslim community (Amri & Bemak, 2013) who are often the first port of call for Muslims experiencing emotional distress, and become informal primary mental health providers (Ali, Milstein & Marzuk, 2005). The focus of the study was to explore the role of Imams within this context.

A qualitative research strategy was employed using Interpretative Phenomenological Analysis (Smith et al., 2009) in the form of six face to face semi-structured interviews with Imams. Interviews were transcribed and an IPA thematic analysis as described by Landridge (2004) was applied to the research data, revealing three main themes representing the shared aspects of the Imams’ experiences in responding to psychological distress of the Muslim community. The themes and the research findings are further considered in line with relevant literature and implications for professional practice for the discipline of Counselling Psychology.

In the current socio-political climate Islam has been given negative and unprecedented attention globally (Kaplan, 2006) and in the UK (Ameli et al., 2007) which does not align with Islamic doctrine and practice (Williams, 2005). With the emergence of ‘Islamophobia’ following the aftermath of September 11, 2001 Muslims have contended with fear and controversy, further fuelled by anti-Muslim racism (Pynting & Mason, 2007). Efforts to demystify Islam and provide a reasonable justification against the case of Islamophobia (Tahir, 2005; Gottschalk & Greenberg, 2007) have been to modest avail and the perceived mental health of Muslims remains fragile (Sheridan, 2006).
Throughout my training as a Counselling Psychologist belonging to this minority group, I have become increasingly curious to explore whether a flaw in the system has alienated Muslims from accessing public sector mental health services, and whether the Islamic population use alternative means of managing psychological distress. If so, how are these needs managed and met? What is the role of the Imam, and is there any possibility of co-working between Imams and health providers to make available a seamless service for Muslims requiring mental health attention? This has given rise to my identity as a scientist practitioner.

The Muslim community remain an enigma to government initiatives aiming to develop mutually inclusive mental health services for BME groups in Britain (Department of Health, 2005; 2014). The government's drive to promote equality in accessing service provision appear under-utilised by this growing population that are becoming increasingly segregated from attempts to close the widening gap in mental healthcare. It is hoped this organic research may be one of the first steps towards promoting active change, inform community practitioners, public sector services and health providers wishing to improve access to mental health services for the Muslim community. A further hope is for this research to make a valuable contribution to a Counselling Psychology perspective, for the promotion of social justice and equity in the provisions of public sector healthcare.
3. PART C: CLIENT STUDY

As a budding Counselling Psychologist I have been drawn towards clinical settings with client groups that are ‘hard to reach’ or particularly vulnerable, due to the social stigma associated with the nature of their problem. One may question what constitutes social stigma since mental health itself can certainly fall under this broad category. Specifically, I am referring to those client groups that have not only experienced stigma under the label of mental health difficulties, however also relative to wider societal issues. Part C of this portfolio discusses a client study outlining therapeutic work with an adult survivor of childhood sexual abuse (CSA) using a Cognitive Behavioural Therapy (CBT) integration approach, detailing the various stages of the therapy process. CSA is serious problem and statistics have indicated the prevalence of CSA as one out of three or four children (Briere & Elliot, 2003), and the majority of CSA survivors only receive therapeutic treatment after the age of 18 due to sexual abuse not being reported during childhood (Alaggia, 2005).

Survivors of CSA have been found to develop complex needs in adulthood including trauma, anxiety, depression, substance misuse, sexual dysfunction, affect regulation difficulties, personality and dissociative disorders (Ross & O’Carroll, 2004) in addition to an increased risk of committing suicide (Sachs-Ericsson et al., 2009). Notably, CSA is further complicated by the taboo of ‘speaking up’ and survivors may not benefit from public health provision due to the challenges they may experience with help-seeking. In writing this client study I went through a process of truly understanding myself as a reflexive practitioner who is concerned with taboo subjects, and reminded about the realities of psychological and emotional trauma which are not always neatly defined by pragmatic theory.
The aforementioned research in Part B of this portfolio explores the experiences of Imams with addressing the mental health concerns of Muslims following the growth of Islamaphobia and the rise of anti-Muslim racism; a very current issue faced by the Muslim community in the UK and internationally. The client study in Part C continues the theme of this portfolio concerned with the broader social context of help-seeking behaviours. The research in Part B and the client study in Part C both relate to my dual role as a researcher and practitioner working with specific social groups in the community; the former group is associated with experiencing difficulty reporting help-seeking, and the latter group appear more sensitive to help-seeking, therefore not benefiting from full access to mental health services as the rest of the population.

4. PART D: JOURNAL ARTICLE

The portfolio concludes with a journal article in Part D, illustrating a summation of the research described in Part B, which is intended for submission to the Psychology journal psychology and psychotherapy: theory, research and practice, Wiley online library publication.
REFERENCES FOR THE PREFACE


PART B: DOCTORAL RESEARCH

The Imam’s experience of managing the mental health needs of the Muslim community

ABSTRACT

Background: This research endeavoured to explore the Imam’s experience of managing the mental health needs of the Muslim community given the contemporary issues faced by the Islamic population, including stigma of accessing mental health services (Inayat, 2007) exacerbated by political demonisation (Tahir, 2005; Sheridan, 2006; Gottschalk & Greenberg, 2007; Ameli et al., 2007). Recommendations were made for mental health professionals to consider the views of formal religious leaders to; understand the help-seeking behaviours of the Muslim community including clarity for the implication of religious methods of coping (Mullick et al., 2013) and; reduce stigma of accessing mental health services by establishing communication pathways with local mosques (Amri & Bemak, 2013).

Method: A qualitative methodological approach was employed in the form of Interpretative Phenomenological Analysis (Smith et al., 2009). A compilation of transcripts from six semi-structured interviews with male Imams were subjected to an IPA thematic analysis as described by Landridge (2004). This was achieved by a process of ‘coding’ the individual accounts of participants.
Results: Three main themes emerged entitled ‘Mending the broken bridge’; ‘Alleviating distress’; ‘Role identity’. The Imams attempted to restore psychological wellbeing using a range of consultation extending beyond the sphere of religion and spirituality. However limited direct collaboration between public health providers and mosques resulted in Imams signposting Muslim clients to either their GP, or to seek support from allied health professionals. While the Imams expressed openness to refer directly onto formal services they were uncertain how to proceed with this.

Conclusion: Imams held a relational landscape when connecting to others on a humanistic level by drawing on their binary skills of an Islamic minister and a learned-resourceful individual in the heart of the community. However there remains a need to establish a direct referral pathway between Imams and health providers to 'catch' Muslim individuals who fall through the gap with help-seeking for mental health problems, as it was apparent from the findings of the study. This may necessitate a transparent dialogue between all parties for understanding of one another’s roles, in line with the multi-modal considerations of the Muslim client framework developed by the researcher.
CHAPTER ONE:

INTRODUCTION

1. Overview

The introduction to the research comprises of two main parts; a general introduction to Islamic beliefs, practices and model of faith and an eclectic literature review. As the present research has not been investigated in the UK at the time of writing this thesis, the supportive introductory material and eclectic literature review are intended to assist a holistic understanding of the overall literature discussing Islam and the Islamic population. In view of this, the present research is also concerned with the broader social context of help-seeking behaviours of the Islamic population pertaining to mental health difficulties, and to identify a need for specific research in this domain.

1.1 The religion of Islam

A brief summation of terminology is presented here to provide contextual knowledge of ‘Islam’ and ‘Muslims’ as featured throughout this research. Muslims predominantly refer to ‘Allah’ which is the Arabic word for God. It is important to distinguish that Allah simply refers to the Arabic translation of God which is not exclusive to Muslims, since it is commonly used by Arabic-speaking Christians. A great proportion of Muslims append the Arabic words ‘Subhanahu Wa Ta’ala’ after saying Allah, meaning ‘the Most Glorified, the Most High’ as a marker for reverence in the highest regard. From this point forward every mention of Allah will be followed by Subhanahu Wa Ta’ala.
Islam originates from the Arabic term ‘Aslama’ or ‘submission;’ however the words peace and safety can also derive from this. Islam embodies religion and the follower of Islam is called a Muslim defined as ‘one who submits to the Will of Allah Subhanahu Wa Ta’ala’. While there exist different sects of Muslims from diverse cultural backgrounds and origins around the world, all references to Muslims in this research is intended as a general identifier of those who follow Islam. It is the duty of the Muslim to submit to the commandments of Allah Subhanahu Wa Ta’ala and follow the basic tenets of Islam constituting five pillars; these will be discussed later in this chapter.

1.2 History of Islam

The naissance of Islam dates back to 7th Century Arabia upon the revelation of the Holy Qur’an to Mohammed Ibn Abdullah, the Prophet of Islam. When the name of the Prophet of Islam is spoken or written by a Muslim, they commonly affix ‘PBUH’ the acronym for ‘peace be upon him’ as a symbol of respect. Similarly the acronym ‘SAW’ is also widely used to represent the original Arabic transliteration ‘Sallallahu Alaihi Wa Sallam’ translated most closely in the English language to ‘may the peace and blessings of Allah be upon him’.

Mohammed (PBUH) was an Arab trader who lived in the city of Mecca in Saudi Arabia, and each year he invariably practiced meditation unaccompanied inside a secluded cave in the Mountain of Hira during an allocated time. In the course of this twelve-monthly meditation Mohammed (PBUH) would habitually observe the fast, pray and give alms to the population who suffered from economic hardship.

Islamic historians (Esposito, 1998; Haykal, 1976) stipulated that Mohammad (PBUH) was concerned by the wide-spread polytheist religious practice and the ill treatment of the elderly, poor and women in Arabian society. Mohammed (PBUH) was also perturbed by the attitudes of tribal leaders who did not take responsibility to attend to all members of society, especially
neglecting those who were marginalised (Armstrong, 2000). This instigated Mohammed (PBUH) to annually segregate himself from a civilisation that did not align with his moral and ethical beliefs, and meditated on matters related to restoring social justice and egalitarianism (Lippman, 1995). While meditating in Mount Hira on the 17th day of the Muslim holy month of Ramadan 610 A.D., the Arch Angel Gabriel also identified as ‘Jibra’il’ in Arabic, brought the first Wahi (revelation) to Mohammed (PBUH) by the decree of Allah Subhanahu Wa Ta’ala which consisted of 6,340 verses of the Qur’an. The subsequent 22 years ensued with Arch Angel Jibra’il continuing to deliver the message of Allah Subhanahu Wa Ta’ala to Mohammed (PBUH) in Mount Hira; this was disseminated to the Arabian population until his death in 632 A.D.

1.3 The Holy Qur’an in Islam

The word ‘Qur’an’ is a verbal noun in Arabic deriving from the verb ‘qara’a’ meaning ‘recitation’. The Holy Qur’an is the scared scripture of Muslims and believed to be the word of Allah Subhanahu Wa Ta’ala as revealed to Mohammed (PBUH) by Arch Angel Jibra’il. The Qur’an itself features 114 individual units called ‘Surahs’ that are arranged from the most lengthy to the shortest, and selected Surahs are recited by Muslims during the ritual of Salah (prayers) and to seek Istikhara (spiritual guidance) from Allah Subhanahu Wa Ta’ala. Some verses indentified in selected Surahs are deemed to provide answers to specific questions and dilemmas (Armstrong, 2000). The Surahs explicate all matters of human existence including guidelines for following religious doctrine, jurisprudence according to Islam and details on the subject of order in the world. The Qur’an is separate from the ‘Hadith’ which is a compilation of the sayings and proverbs of Prophet Mohammed (PBUH), and ‘Sunnah’ referring to his teachings. Within the Qur’an exists the five fundamental pillars of Islam which lay the concrete foundation for the religion of Muslims (Esposito, 1998; Lippman, 1995).
1.4 The five pillars of Islam

In view of the multiple origins of Muslims globally, individual regional customs also influence Islamic practice, although the fundamental tenets of Islam constituting five basic pillars (figure 1) are universally agreed upon and adhered to by all Muslims (Esposito, 1998). The first and most prominent pillar of Islam is the ‘Shahada’ the declaration of faith in Arabic ‘La ilaha illa-llah, Muhammadu-rasulu-llah’ (there is no god but Allah and Mohammed is the messenger of Allah). The recitation of the Shahada itself is the only requirement for one to revert to Islam as it is regarded as the foundation of the Muslim faith.
Additionally the Shahada symbolises a socio-political testimony for one God for the whole of humanity (Lang, 1996). The second pillar of Islam is ‘Salah’ (prayer) as stipulated by the Qur’an ‘O you who believe, remember Allah, remembering Him frequently and glorifying Him morning and evening. He it is Who sends His blessings on you, and so do His angels, that He may bring you forth out of utter darkness into the light and He is merciful to the believers [Prayer is better than sleep’ (33:41-43). Salah involves a combination of Arabic recitations selected from the Qur’an and a sequence of prostrations. It is obligatory for all Muslims to complete Salah east-facing towards the direction of ‘Kaaba’ (Muslim holy shrine in Mecca, Saudi Arabia) five appointed times each day; these may be performed individually in the home or within a congregation. The Salah times are outlined as follows;

i) Fajr (before sunrise)
ii) Zuhr (early afternoon)
iii) Asr (mid-late afternoon)
iv) Maghrib (just after sunset)
v) Isha (during the evening before midnight; although Islamic scholars are not able to provide a universal ruling and some may choose to pray into the night before Fajr).

The giving of ‘Zakat’ (alms tax/compulsory charity) is the third pillar of Islam and an obligation for every financially stable Muslim. The meaning of the Arabic word Zakat translates to ‘purification’ and parting oneself from wealth is deemed to purify the heart from greed. Zakat is considered as an expression of worship and gratitude to God similar to that of Salah; however it also encompasses social equality since the proceeds of Zakat are distributed to those in society who are in need (Esposito, 1998). The contribution for Zakat is
made annually and calculated as 2.5 percent of the total earnings, assets and wealth of the Muslim.

‘Sawm’ (fasting) the fourth pillar of Islam is prescribed during the month of Ramadan for Muslims who are physically and psychologically able. Ramadan typically lasts for a period of up to 30 days and is the 9th month of the lunar calendar. Children are not required to fast until they reach the age of puberty. During Ramadan one must abstain from drinking any form of liquid, and the consumption of food and physical intimacy are also strictly prohibited from the entire duration between sunrise and sunset. Muslims usually continue their daily obligations of going to work, attending to their families and any other necessary activities whilst setting aside time for self-reflection, additional prayer and spiritual steadfastness to increase compassion for those in poverty and less fortunate (Esposito, 1998).

The fifth and final pillar of Islam is ‘Hajj’ the holy pilgrimage to Mecca in Saudi Arabia. This pillar is only obligatory for Muslims who are physically and financially able to make the journey, and must be performed at least once in a lifetime. Hajj incorporates a number of rituals and performed in complex stages honouring the teachings of Prophet Abraham (PBUH) who built the Kaaba with his son Ishmael (PBUH) as a place of worship to Allah Subhanahu Wa Ta’ala. The Hajj takes place once a year on the 10th day of ‘Zul-Hajjah’ which falls on the 10th month of the lunar calendar.

1.5 Obligatory practices in Islam

Set aside from the religious practices that Muslims are required to perform as their duty to God and their responsibility towards fellow humans, a number of compulsory norms are also decreed in Islam. Given the multiplicity of spiritual practice which varies among Muslims from
diverse cultural backgrounds (Lippman, 1995), the areas covered pertain to the global Muslim community. Concerning dietary practice, Islam strictly prohibits the consumption of any meat from a pig as instructed in the Qur’an ‘forbidden to you (for food) are: dead meat, blood, the flesh of swine, and that on which hath been invoked the name of other than Allah’ (5:3). It is notable to observe that the Bible also declared this ruling in the book of Leviticus; ‘and the swine, though he divide the hoof, and be cloven footed, yet he cheweth not the cud; he is unclean to you’ (11:7); ‘of their flesh shall ye not eat, and their carcass shall ye not touch, they are unclean to you’ (11:8). This also reappeared in the Bible in the book of Deuteronomy; ‘and the swine, because it divideth the hoof, yet cheweth not the cud, it is unclean unto you. Ye shall not eat of their flesh, nor touch their dead carcass’ (14:8).

While the Qur’an and the Bible do not precisely define the ruling for this restriction, Muslim scholars contend this is related to the natural tendency of the pig as an unhygienic scavenger in the ecosystem. Alcohol is also prohibited in Islam and referenced under the umbrella of ‘intoxicants’ in the Qur’an; ‘you who believe, intoxicants, and gambling, and the altars of idols, and the games of chance are abominations of the devil; you shall avoid them, that you may succeed’ (5:90). The Qur’an does not permit ingestion of any intoxicants into the body which covers a wider range of substances. Falling under the label of intoxicants are both alcohol and illicit drugs not otherwise prescribed for medicinal purposes, due to the harmful consequences on the body.

The topic of gender roles raises contention and dispute concerning the treatment, rights and responsibilities of women within the Muslim community (Haddad & Esposito, 1998). This is further complicated by the ethnic and cultural variations of Islamic practice world-wide which shape conduct towards Muslim women. The scope of this subject is far too intricate to adequately explore here; further comprehensive writings on Muslim women are available for
review (Esposito & DeLong-Bas, 2002; Haddad & Esposito, 1998; Hasan, 2002; Wadud, 1999). Islam prescribes a modest dress code for men and women to only wear loosely fitted and unrevealing clothing. For Muslim women in particular this can vary to greater and lesser degrees, given that some Islamic states deem the burqa (full body covering) mandatory, while others may hold a liberal approach to modesty as a matter of interpretation (Haddad & Lumis, 1987). The Muslim female who observes the Hijab (traditional head covering) is easily identifiable as a follower of Islam, however many Muslim women also choose not to wear a head covering.

2. Eclectic literature review

When considering the cultural needs of the Muslim community sincere attempts have been made to grasp the diverse differences that exist between Muslim faith groups, acknowledging cultural variations and interpretation of religious doctrine (Shafi, 1998). Such endeavours have provided invaluable guidelines for Western therapists to empower the therapeutic relationship with their Muslim client within diverse multicultural settings (Shafi, 1998). Aspects of culture such as language, acculturation, family dynamics and community networks within the Muslim community have been evaluated for appropriate adaptations of psychological treatments (Gater et al., 2010; Rahman, 2007; Rahman et al., 2008; Rathod & Kingdon, 2009). Faith-sensitive interventions have also been found to improve both depression (Townsend et al., 2002) and quality of life (Lee et al., 2010) and the religious identity of Muslim populations has given rise to spiritually-focused therapy aimed at providing meaning (Gerwood, 2005), and a sense of wellbeing (Hawkins et al., 1999). Moreover, the development of the first accredited training programme in the UK for Islamic counselling (http://www.islamiccounselling.info/) is dedicated to providing guidance and promoting good practice for counsellors.
Conversely, a proliferation of cross-cultural studies point towards the fragmented relationship between the Muslim community and mental health services in the UK and internationally, despite advances in sensitive adaptations for psychologically informed treatments available to the Islamic population. The ideological belief systems of the Muslim community and mistrust in healthcare professionals are among factors that have contributed to low referral rates to mental health services, and an ever expanding gap in meeting the mental health needs of this diverse Black and Ethnic Minority (BME) group (Inayat, 2007; Weatherhead & Daiches, 2010). Some of these factors are discussed in line with the eclectic literature, and how they capture the organic nature of the research phenomena.

2.1 Attitudes with accessing psychological treatment among the Muslim community

The concept of shame/izzat surrounding mental health amongst Muslims is a predictor for accessing primary care mental health services; beliefs related to preserving reputation and honour appear influential in the decision making process since the act of seeking help from mental health services is a perceived weakness (Pilkington, Msetfi & Watson, 2012). When faced with mental health difficulties Muslims are more likely to practice religious coping through prayer and recitation of the Qur’an as religiosity is believed to alleviate mental distress, and Muslim women are found more likely to seek guidance from relatives and formal religious leaders (Abu-Ras & Abu-Bader, 2008).

Moreover, religious coping mechanisms in Islam such as prayer, recitation of the Qur’an, asking for forgiveness from Allah Subhanahu Wa Ta’ala and non-obligatory fasting outside the month of Ramadan are examples that have been found to relieve negative mental states (Hussain, 1998). In particular, prayer is considered effective in treating depression (Loewenthal & Cinnirella, 1999) strengthened by the spiritual, psychological, physical, and
moral roles that avert consciousness from focusing on distress, embodied within the concentration of mind and changes in posture during Islamic ritual prayers (Hussain, 1998).

While higher levels of religiosity show better mental health among religious Muslims when compared to non-religious Muslims (Abdel-Khalek, 2007; 2008), clarity is required to distinguish whether the stigma of reporting poor religiosity among religious Muslims were accounted for. Analogous to other religions (Pargament, 1997) negative religious coping and struggle can also be found in Islam; poorer religious coping has been associated with negative outcomes in terms of physical health and emotional distress (Pargament et al., 2000; Sherman et al., 2005), and greater religious struggle has been found to negatively impact the psychological wellbeing of Muslims consistently (Abu Raiya et al., 2008; Aflakseir & Coleman, 2009; Khan & Watson, 2006). Elsewhere mental health difficulties experienced by Muslims are associated with an unsound relationship with God or punishment for disobedience (Al-Krenawi & Graham, 2000) and psychological issues are believed to derive from a ‘weak spiritual heart’ or an absence of religious practice (Weatherhead & Daiches, 2010).

The exception to these views can be deciphered by the type of psychological distress being experienced; psychosis is more widely accepted as an organic disorder thus reducing reluctance to present within mental health services albeit at a later stage with a higher rate of psychiatric sectioning (Weatherhead & Daiches, 2010). Even with the exception of psychosis being an ‘acceptable’ form of psychological distress further contention remains between orthodox medicine and religiosity in managing the mental health needs of Muslims. Muslim clients may choose to use religious coping strategies to manage their disorder and decline medication without informing their doctor (Cinnirella & Loewenthal, 2001). This is thought to
be exacerbated by a lack of trust in psychiatrists understanding of the significance of religious coping (Aloud & Rathur, 2009).

2.2 Jinn possession, black magic and mental health

Another divide between mental health services and the Muslim community can be drawn from the Muslim understanding of Jinn, black magic and the evil eye. Islam stipulates there to be three separate and parallel worlds which co-exist; these are divided by the existing and seen world of mankind, the unseen world of Jinns and the unseen world of Angels (Al-Ashqar, 2003). In line with Islamic teaching Jinns are described as the unseen inhabitants of the human world; they can take on various shapes, forms and they have the ability to see us however we cannot see them unless they choose to make themselves visible. Jinns are also believed to live and behave similarly to people; they have free-will to choose between ‘good’ and ‘bad’ deeds/acts, eat, drink, work, pro-create and have a natural timeline for death while Angels do not have free-will and they are conditioned to follow the instructions of God (Al-Ashqar, 2003).

There is widespread and common acceptance among British Muslims that Jinns are at large responsible for causing human suffering; Jinns cause physical and psychological harm through possession by entering the body of a Muslim and controlling their responses as the strength of the Jinn supersedes that of humans (Khalifa & Hardie, 2005). Various Islamic literature have discussed the role of black magic and evil eye; black magic refers to the ability for humans to inflict pain and suffering on others by winning the favour and joining forces with Jinns, and evil eye refers to the human ability to cause mental or physical harm with a wicked or malevolent stare (Dein et al., 2008).
In the Arab Peninsula where the major population comprises of Muslims it is also widely accepted that Jinns are the root cause of mental illness, and those who identify themselves as possessed by Jinn often display symptoms concurrent with mental health difficulties such as lethargy, tiredness, headaches, difficulty concentrating, memory loss and anxiety (El-Islam, 1995). Upon further diagnostic and medical examinations those proclaiming Jinn possession were also presenting with one or more psychiatric disorder or a physical health problem (Bayer & Shunaigat, 2002), and those reporting such symptomology were mostly males with lower levels of education. Muslims in India belonging to a ‘higher caste’ understood psychological distress as independent from spiritual matters, and postgraduate Nigerian migrants in the United States were more likely to explain marital difficulties and psychosis as natural occurring phenomena, while those with lower levels of education showed greater belief in supernatural causation (Olusesi, 2008).

British Muslims with higher educational attainment explained mental health difficulties as a natural causation from a reaction to difficult life events rather than the intervention of Jinns, (Dein et al., 2008) black magic or evil eye (Mullick et al., 2013) therefore the beliefs among Muslims concerning Jinn can be understood from the viewpoint of education. However the religious leader of the Muslim community, the Imam, is often approached primarily to treat mental health problems irrespective of educational attainment and belief in Jinn possession through spiritual healing of the body and soul using their learned knowledge of the Qur’an (Mullick et al., 2013).

2.3 The role of Imams

A study by Ali, Milstein and Marzuk (2005) sought to investigate how Imams met the counselling needs of the Muslim community in the United States, following the increased discrimination experienced by Muslims after the events of September 11, 2001. It was not
apparent whether there was a greater need for the utilisation of mental health services and what provisions were made available for the Islamic population. As described by Ali, Milstein and Marzuk (2005) Islam is central as a way of life for the Muslim individual and their family, and when personal or familial problems occur the Imam is often consulted to address difficulties with reference to the Qur’an and Hadith.

The Mosque in America study by Bagby, Perl and Foehle (2001) which explicated the functioning of mosques and the roles undertaken by the mosque leaders/Imams, discovered 74 per cent of the mosques delivered marital and systemic counselling services to their congregants. Although it was not known whether the Imams were suitably qualified to provide psychotherapeutic services, if they possessed the range of knowledge and skills required to address such difficulties and whether they referred onto psychiatric services when necessary. In response to this, Ali, Milstein and Marzuk (2005) set out to investigate the extent of counselling needs sought from the Muslim community, and the training and experience of the Imams with delivering a counselling service to their respective congregations. They conducted a nationwide cross-sectional survey of Imams throughout the United States, using the North American Muslim Resource Guide (Nimer, 2002) which contained the addresses of 1,118 mosques. Anonymous self-report questionnaires were mailed to Imams of 730 mosques which were selected at random from the aforementioned guide. The questionnaire itself included a 79-item scale, a vignette, multiple Likert scales and open-ended questions developed by Ali, Milstein and Marzuk (2005) adapted from former research (Milstein et al., 2000).

62 of the 730 questionnaires were completed and returned, or which no participants reported to having a degree in psychiatry, 5 per cent reported having a degree in psychology, 9 per cent in social work and 7 per cent in counselling. When responding to a list of various
counselling training experiences, 13 per cent of participants reported having undergone formal clinical pastoral education, 21 per cent reported having completed a course on counselling provided by an Islamic organisation and 25 per cent reported having undergone consultation or received supervision from a mental health professional. When reporting time spent on counselling activities weekly, 55 per cent of Imams reported spending one to five hours, 30 per cent reported six to ten hours and 5 per cent reported that they did not spend any time counselling. The study found there to be an increased need for counselling relating to issues of discrimination since September 11, 2001 and the help-seeking behaviours of the Muslim community extended to social needs, family problems and psychiatric symptoms alongside religious and spiritual concerns. Please see ‘appendix N’ for the table of the survey results demonstrating the full range of reported reasons for which congregants sought counselling from Imams.

The study also discovered that Imams were less likely to undergo formal psychotherapeutic training that may help them to effectively address the demands of managing the multifaceted needs of the Muslim community, in comparison to clergy of the two other Abrahamic faiths of Judaism and Christianity. The study identified this to be significant in view of the socio-political climate in the United States at the time of publication, the need for further research to expand on their results and to investigate the degree to which Imams utilised community mental health resources in the absence of formal psychotherapeutic training.

The study also recognised the need to cultivate communication and a trusting working relationship between Imams and mental health professionals to improve access to psychologically informed services, which are sensitive and responsive to the religious and cultural needs of the Islamic population. The relevance of these findings present an opportunity to construct further research as a step towards exploring whether these needs
also apply to the Islamic population in the UK with regards to any potential impact of the events of September 11, 2001, and any potential need to enhance the provision of mental healthcare made available. Moreover, it bears relevance to explore whether Imams in the UK have completely different experiences and opinions concerning the mental healthcare system, and the potential for bridging communication between these two parties should this be warranted.

2.4 The socio-political context

The concept of ‘Jihad’ is vast and comprehensive although it is commonly misunderstood by those who are not familiar with Islamic terminology. The word Jihad originates from the Arabic root word ‘Jahada’ meaning to ‘strive’ or ‘struggle’ by an exertion of some nature. When contextualised in the purest form Jihad denotes to an individual and inner trial within oneself and obstacles which conflict with submission to Allah Subhanahu Wa Ta’ala. This may manifest as ethical decision making between right and wrong, one’s moral compass and any personal dilemmas one may face which interfere with the practice of one’s beliefs and values in all aspects of life. Jihad also materialises collectively as follows;

i) Intellectual Jihad; difficulty with transmitting the message of God to mankind and resisting social evils

ii) Economic Jihad; this correlates with Zakat by adhering to economic guidelines for the distribution of wealth to improve the lives of those in poverty

iii) Physical Jihad; this concerns self-defence against subjugation and threat.
The ‘physical Jihad’ can also be used to describe a ‘just cause’ as seen in a political and military context; however the term is often mistranslated to ‘holy war’ in the West. Moreover ‘Harb-u-Muqadasah’ is the Arabic equivalent of ‘Holy War’ which is not featured anywhere in the Qur’an, and no known record of authentic Islamic sources permit Muslims to invoke terror or war against non-Muslims on the grounds of them not being a follower of Islam.

Given the plural representations of Arabic words when translated into the English language, the meaning of ‘just cause’ has become a product of interpretation and distorted by some extremist Islamic groups to conduct themselves and apply Jihad in circumstances that are not deemed ‘just’ by Muslims and non-Muslims alike.

Close examination of the Qur’an has revealed that the term Jihad only features on four occasions within a military description, of which none directly reference to struggle in combat (9:24; 22:78; 25:52; 60:1). It is important to highlight that the concept of holy Islamic war is only made permissible as a last resort, and can only be acted upon after meeting very specific conditions outlined in the Qur’an for the purpose of freedom and safeguarding faith.

As instructed in the Qur’an ‘to those against whom war is made, permission is given [to fight], because they are wronged; and verily, Allah is most powerful for their aid; [They are] those who have been expelled from their homes in defiance of right; [for no cause] except that they say, “our Lord is Allah”. Did not Allah check one set of people by means of another, there would surely have been pulled down monasteries, churches, synagogues, and mosques, in which the name of Allah is commemorated in abundant measure…’ (22:39-40). Furthermore the Qur’an states ‘why should ye not fight in the cause of God and of those who, being weak, are ill-treated [and oppressed]? Men, women and children, whose cry is: “Our Lord! Rescue us from this town, whose people are oppressors; and raise for us from thee one who will protect; and raise for us from thee one who will help!”’ (4:75).
The conditions of physical Jihad are unequivocally defined in the Qur’an, and the passages provided correlate to specific historical events during the period of Qur’anic revelation to Mohammed (PBUH) that cannot be replicated in society today. Moreover, physical Jihad cannot be imposed to coerce non-Muslims to embrace Islam as cited in the Qur’an ‘let there be no compulsion in religion’ (2:256); ‘if it had been thy Lord’s will, they would all have believed, all who are on earth! Wilt thou then compel mankind, against their will, to believe’ (10:99). Jihad is an all-encompassing term directed towards betterment of self and society which does not condone tyranny and the massacre of innocent people; in this sense the use of the term Jihad synonymous with terrorism does not assimilate with the teachings of Islam.

The actions of some extremist Islamic groups who have conducted themselves and applied Jihad in circumstances that are not deemed acceptable nor appropriate according to Islamic ruling, as outlined above, have created an atmosphere of fear and controversy for Muslim communities in Britain that may feel unable to voice their distress openly (Hussain & Bagguley, 2013). Furthermore, media narratives in the UK have featured Islam in a derogatory manner which has served to invoke public fear (Afshar, 2008; Carland, 2011) and a religion which threatens British cultural values (Khiabany & Williamson, 2008), thus promoting prejudice against the Muslim community at large (Williamson & Khiabany, 2010).

The relevance of understanding the socio-political context informs the line of this research when considering the help-seeking behaviours of the Islamic population, since Muslims may be feeling particularly vulnerable in the current political climate in Britain (Williams, 2005). The reporting of world news pertaining to Islam has created negative global publicity that are discordant with the values held by Muslims (Williams, 2005); this may emphasise the sense of vulnerability for the Muslim individual seeking mental health support. Williams (2005) proposes therapists working with Muslim clients are to remain mindful of false assumptions.
concerning Islamic beliefs advocated by the mass media (Williams, 2005). Similar to the tone of the study completed by Ali, Milstein and Marzuk (2005), it also bears relevance to consider the psychological impact of unfavourable media narratives depicting the Islamic population in the UK, and to better understand the potential need for the provision of mental healthcare. This also creates an opening to explore whether Imams in the UK have engaged with this sensitive topic in their interactions with congregation members, and how, if at all, this has informed any guidance they have provided; religious, spiritual, therapeutic or otherwise.

3. Rationale for the current research

Islam is the fastest growing religion in UK and the second largest after Christianity with approximately 2.7 million Muslims who comprise 4.8 per cent of the population (Office of National Statistics, 2011). Despite the steady rise of this BME group, demographic data suggest South Asian Muslims who equate 68 per cent of the Muslim population (Office of National Statistics, 2011) are among those that are less likely than other BME groups and the indigenous White population to access mental health services (Sheikh & Furnham, 2000) as well as the Muslim population as a whole (Patel et al., 2000). This raises curiosity to explore whether a flaw in the system has alienated Muslims from accessing public sector mental health services, and whether the Islamic population use alternative means of managing psychological distress. If so, how are these needs managed and met? From a research standpoint this merits further inquire.

Earlier studies suggest Muslims experience better mental wellbeing compared to other BME groups therefore not requiring access to mental health services (Cochrane & Stopes-Roe, 1977; Nazroo, 1997) while more recent research indicates a high rate of psychological morbidity (Fazil & Cochrane, 2003). What is the case for Muslims living in the UK and why
are there contradictory explanations? With the emergence of ‘Islamophobia’ following the aftermath of September 11, 2001 Muslims have contended with fear and controversy. This has been fuelled by anti-Muslim racism (Pynting & Mason, 2007) and derogatory terms such as ‘xenophobia’ which refers to a fear of strangers; this appears paradoxical given that Muslims have settled in Britain for over a century. In the current socio-political climate Islam has been given negative and unprecedented attention both internationally (Kaplan, 2006) and in the UK (Ameli et al., 2007) which is not indicative of Islamic doctrine and practice (Williams 2005). Efforts to demystify Islam and provide a reasonable justification against the case of Islamophobia (Tahir, 2005; Gottschalk & Greenberg, 2007) have been to modest avail and the perceived mental health of Muslims remains fragile (Sheridan, 2006).

The Muslim community are an enigma to government bodies aiming to develop mutually inclusive mental health services for BME groups in Britain (Department of Health, 2005). The government’s drive to promote equality in accessing service provision appear under-utilised by this growing population that are becoming increasingly segregated from attempts to close the widening gap in mental healthcare. Muslims appear underrepresented in voluntary accessed primary care mental health services (Weatherhead & Daiches, 2010), and resistance to accessing services at an early stage have resulted in misdiagnosis and an overrepresentation of BME groups within in-patient psychiatric settings (Weatherhead & Daiches, 2010). This is further compounded by barriers to access for BME groups including limitation of healthcare professionals from diverse minority backgrounds and fear of institutionalised racism (Fernando, 2005).

4. **Relevance of the current research to the discipline of Counselling Psychology**

Research to date have focused on barriers to accessing mental health services, Islamic approaches to mental health, Muslim views on mental health, religious influences on beliefs
about mental illnesses, the concept of Islamophobia and factors affecting intention to access psychological services. All of these are incredibly invaluable and have contributed greatly towards understanding Muslim perspectives, Islamic ideologies and moving towards culturally sensitive practice in the context of mental health. For example, cultural commonalities that exist among Western narratives such as ‘individualism’, ‘self-determination’, and ‘egalitarian gender roles’ have also been identified for Islamic narratives with cultural values embedded in ‘community consensus’, ‘self-control’ and ‘complementary gender roles’ (Hodge & Nadir, 2008). These conceptualisations of culture have provided crucial and pragmatic heuristics for therapists to remain mindful and respectful of cultural considerations in their therapeutic work with Muslim clients. Carter and Rashidi (2003) recommend four principle considerations in line with culturally sensitive psychotherapy practice with the Islamic population:

i) Prayer schedule; flexibility with appointments to accommodate obligatory religious practices

ii) Eye contact; averting one’s eyes downward conveys respect in the Islamic tradition, as opposed to a direct gaze

iii) Gender considerations; providing the option of a female therapist for female Muslim clients, or discuss other suitable arrangements if only a male therapist is available

iv) Physical contact; cultural norms may stipulate the male therapist is to refrain from any type of physical contact with the female client, including common practices in therapeutic encounters such as the shaking of hands. Male therapists are to also refrain from walking behind a female Muslim client where possible.
It has been suggested that mental health professionals should consider seeking the views of formal religious leaders that may unveil the help-seeking behaviours of Muslims, provide clarity for the significance of religious methods of coping (Mullick et al., 2013) and reduce stigma of accessing mental health services by opening clear communication pathways with local mosques (Amri & Bemak, 2013). This will draw upon the preference for Muslims to seek psychological therapy from mental health professionals with an understanding of Islam (Weatherhead & Daiches, 2010), facilitated by the implications for and the perspective that Counselling Psychology might bring to this process. However, research is yet to focus on the role of the gatekeeper and religious leader at the heart of the Muslim community widely referred to as ‘Imam’, ‘Mulvi’ or ‘Maulana’. For the purpose of continuity throughout this research I will be referring to the Muslim religious leader as ‘Imam’.

Inayat (2007) highlighted areas which impact on the underutilisation of mental health services in Muslim clients including; mistrust of service providers; fear of treatment; fear of racism and discrimination; language barriers; differences in communication and issues of culture. Counselling Psychologists can combat some of these barriers by gaining knowledge about Islam and its impact on Muslim expression of distress. A number of key issues have already been identified as deterring access to psychological therapy, including the ‘Eurocentric’ knowledge base which underpins therapeutic treatments (Hasley & Patel, 2003). Opportunity to learn and gather information from Imams in relation to the needs of the Muslim community will raise awareness of the availability of services, and address barriers to access which remains a contentious issue.
Wider thinking related to the application of cultural competence when working therapeutically with BME communities have explored the model of acculturation to guide a person’s cultural integration (Berry, 1997), and how this may affect assessment and treatment. Campinha-Bacote (2007b) provides five key constructs that outline the process of cultural competence in healthcare;

i) Cultural awareness; examine biases towards other cultures from an individual and professional stance

ii) Cultural knowledge; process of seeking/developing an information base in connection with other groups

iii) Cultural skill; ability to conduct a culturally sensitive assessment

iv) Cultural desire; stimulation of energy in the professional to ‘want to’ engage in the process of cultural competence.

Taking into account relevant issues for individuals presenting from BME groups has contributed markedly towards identifying issues pertaining to gender differences, economic/social disadvantage, lack of knowledge of services, intergenerational issues, post migration and long-term effects of migration, stigma, language barriers, family environment and faith to recognise the complexity of people’s lives (Chahal and Ullah, 2004) when understanding the impact of cultural values on mental health. This has also raised awareness of the influence of religious beliefs, expectations and acceptability of treatment and individual differences that exist between BME communities (Pieper & Van Uden, 2005). Moreover, the influence of the social environment shaped by distal influences (politics, economics), proximal influences (education, employment situation, personal relationships) and the person (beliefs systems, interpretation of bodily sensations) are further contributions towards providing culturally sensitive psychotherapy (Hagan & Smail, 1997a).
The implications of the cultural components outlined seem particularly relevant to the current research and to the discipline of Counselling Psychology. This seems pertinent when considering positive mental health promotion by a process of strengthening individuals, strengthening communities and reducing structural barriers to mental health. By strengthening the individual allows for increased emotional resilience by promoting coping skills and allowing them to develop a positive cultural identity in building their confidence and self-esteem, with the incorporation of their cultural values in the structure of their mental health treatment. Arguably the most demanding would be in reducing structural barriers to mental health by challenging stereotypes and reducing the political, social and economic barriers that dissuade the participation of the Muslim community. However taking into account relevant issues for individuals presenting from the Muslim community is a positive first step towards overcoming barriers by considering a wide range of concerns, including the limited knowledge of services, stigma, potential language barriers and faith to recognise the intricacies of people’s lives and how this shapes their expectations and outlook of accessing psychologically informed services.

5. **Aim of the current research**

The aim of this research is to investigate how Imams experience the mental health needs of the minority Muslim community. This is a novel area which has not been previously researched in the UK, at the time of writing this thesis. The Department of Health in England have continued to examine mental health related inequalities experienced by BME communities in their Mental Health Strategy ‘No health without mental health’ (DoH, 2011), and how this should be addressed.
More recently, the Department of Health’s ‘Closing the Gap’ report identified 25 ‘priorities for change’ that focused on strategies for improving the quality of life experienced by those living with mental illness. Number 4 of the 25 priorities related specifically to adult BME communities;

‘4. Simply making services available is not enough. We are also looking at ways to overcome inequalities around service usage - and around the outcomes those services achieve. For example, evidence shows that people from black and minority ethnic (BME) communities have to date been less likely to use psychological therapies. We are working with the Race Equality Foundation and other stakeholders to try and understand why this is the case and to understand inequalities around access to other services. NHS England are also working with BME community leaders to encourage more people to use psychological therapies’ (Department of Health 2014, p.13).

The Department of Health (2014) recognises the inequalities experienced by those from BME communities, and the need to work more closely with ‘BME community leaders’ for better understanding on tackling poor mental health outcomes and encouraging access to psychological services. In line with this, the limited collaboration between statutory mental health services and Imams in the Muslim community merits attention to foster communication, a trusting relationship and to comprehend the help seeking behaviours of the Islamic population. For this reason, a qualitative research approach was deemed suitable to listen to the individuals who are yet to be given a voice. It is hoped this research may promote active change and inform practitioners, public sector services and health providers wishing to improve access to mental health services for the Muslim community from a broader approach of inquire.
Imams are often the first port of call for Muslims experiencing emotional distress and become informal primary mental health providers by default (Ali, Milstein & Marzuk, 2005). While Imams are invaluable to the Muslim community many have not undergone psychotherapeutic training (Haque, 2004; Ali, Milestein & Marzuk, 2005) and do not refer Muslims onto formal services due to a lack of knowledge and experience in using conventional referral pathways (Budman, Lipson & Meleis, 1992). This raises concern for vulnerable Muslim clients who are unlikely to receive adequate psychological assessments and treatment at early onset of mental health difficulties that may become progressively worse.

Reflecting on the cultural competency considerations as described by Chahal and Ullah (2004) and Pieper and Van Uden (2005), people experiencing mental health problems belonging to a Muslim community will benefit tremendously from living in a environment that understands, values, supports and empowers them. With this in mind, apart from seeking input from Imams alternative mental health support is also available; these are largely independent providers in the private and third sectors offering specialist psychotherapy services to the Islamic population. For example, a number of Islamic counselling services advertised through various websites (http://www.islamiccounselling.co.uk/; http://www.sakoon.co.uk/; http://www.barefootinstitute.com/; http://myf.org.uk/ ) provide culturally sensitive mental health support to Muslims in Britain using an Islamic counselling framework, or the option of conventional psychotherapy with the choice of discussing Islamic concepts with Muslim therapists. The ethos of these specialist services aspire to break down barriers and openly tackle taboo subjects that may discourage Muslims from accessing help via mainstream avenues.
The actual figure for the uptake of Islamic counselling services remains unknown, therefore connecting with local culturally sensitive access points such as the mosque can provide a vital link in supporting Muslims who represent a diverse minority community, by providing counselling to individuals presenting with unique needs. Emphasis on the effectiveness of mental health promotion can be better achieved by involving Imams to facilitate the early detection of mental health problems and reducing the fear and stigma associated with mental illness. This in turn may promote social inclusion of the Muslim community by facilitating tolerance and participation and reducing anxiety associated with accessing statutory mental health services.

The present research will seek to explore the experiences of the Imam in managing the mental health needs of the Muslim community; an organic phenomenon which may also unveil the degree to which statutory mental health services are involved in this process according to their views and narratives. Given that the Department of Health (2014) is seeking to work ‘with BME community leaders to encourage more people to use psychological therapies’ (p.13) the research positions itself at a time when such inquiry appears topical.
1. Research design and rationale for qualitative methodology

The Imam is a central figure in the Muslim community and consulted for advice and support for a range of spiritual and emotional difficulties. The present study wished to explore the Imam’s experience of managing the mental health needs of the Muslim community. As described by Smith et al. (2009) the ethos behind qualitative research in the field of psychology is concerned with an in-depth exploration, descriptive and interpretative account of an individual’s meaning making derived from their subjective experiences. The spirit of qualitative research is engaged with understanding the complex intricacies of human experience which comparatively differs from quantitative methods that focus on deriving a single truth or phenomena; this is expressed by Nelson and Quintana (2005) who ascribe quantitative research being achieved by ‘confirmation’ while qualitative research through ‘discovery’.

To date there remains the absence of psychological research which employs a qualitative standpoint to understand the experience of formal religious leaders in the Muslim community, and how they respond to the help-seeking behaviours of Muslims living in the UK. This paucity of research may indicate the challenge of embarking on such inquiry and the social, political and religious barriers which may prevent researchers from gaining access to this group of participants in such an intimate manner. A quantitative study by Ali, Milstein and Marzuk (2005) explored how Imams met the counselling needs of the Muslim community in the United States following the increased discrimination subjected to Muslims after the events of September 11, 2001; however the prime focus of the research was to
understand the Imam's experience of delivering a counselling service to their respective congregations without formal psychotherapeutic training.

While the research findings generated useful information about the help-seeking behaviours of the Muslim community in the United States, the potential to explore the meanings that Imams ascribed to their experiences of dealing with the multiple distresses of their congregation was overlooked, and more importantly how this shaped decision-making in their professional work. This novel area has remained unearthed until this point in time of writing this thesis; therefore a holistic approach to analysis using qualitative research handled data with sensitivity while allowing for the richness and complexity accompanying the experience to unveil in a natural manner. This is in contrast to quantitative research which reduces complex phenomena into numeric figures with little room for flexibility.

Qualitative research methodology has made a marked contribution to our understanding of human experiences and a range of phenomena, not otherwise afforded by the objective and statistically driven data of quantitative methods (Bryman, 1992). Moreover, qualitative research processes are deemed the most effective when attempting to understand human experiences and social phenomenon (Morrow, 2007) enabling the researcher to gather information in greater depth, whilst simultaneously gathering a deeper understanding of psychotherapeutic processes in contrast to the positivist, objective process associated with quantitative methods (Hill, 2005).

The exploratory nature of qualitative procedures encourages the inquisitive mind of the researcher to employ the use of open ended questions, gathering rich data in the process and bringing to light potential new information to a topic otherwise more difficult to discover
using alternative research procedures (Morrow, 2007). Furthermore, the narrative format in which qualitative data is presented creates accessibility and receptiveness to a wider audience outside of the research community (Creswell, 1998). The unique ingredient of the researcher’s own perceptions, assumptions and motivations generate a degree of trustworthiness when conducting qualitative research, thus contributing to transparency and research integrity (Morrow, 2005). This is further substantiated by the mandatory self-reflective process stipulated for qualitative research and openly commenting on issues of subjectivity.

The use of qualitative methods have been applied to other areas of health and social psychology enabling a greater understanding when assessing people’s responses to treatment, and the connection between experiences and specific behavioural patterns (Mays & Pope, 2000; Murphy et al., 1998). Qualitative research methods exhibit great potential in discovering issues that are otherwise overlooked with quantitative design methods particularly when considering psychotherapeutic processes in Counselling Psychology (Morrow, 2007). Practicing qualitative methods of research in Counselling Psychology contributes to the maturation of credibility facilitated by its methodological diversification and expansion to psychology (Ponterotto, 2005).

Given that the research was curious to explore the personal experience of the Imam, an emerging phenomenon with no former position in psychological literature, the use of qualitative research methodology appeared well placed when attending to the research question being investigated. In line with this Smith et al. (2009) postulate the use of semi-structured interviews invite the participant to share their account which is reflective of their status as the ‘experiential expert’, unearthing meanings and drawing upon the richness from individual experiences, which may unveil unforeseen categories of meanings in the process
(Willig, 2008). The use of rigorous, qualitative methodology governed by an exploratory frame lead to a rich understanding of the Imam’s experience of managing the mental health needs of the Muslim community.

2. Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was selected for the methodological approach; this is a qualitative research strategy which seeks to understand the subjective experiences of individuals and their interpretation of the phenomena being explored (Smith, 2004). IPA extends beyond the interpretation of subjective experience; it seeks to examine the underlying meanings which are embedded in the specific experience itself, that are shaped by the personal and social world of the individual in their relationship with events or occurrences they have interacted with (Smith & Osborn, 2003). IPA was originally developed by Jonathon Smith and is now becoming widely used in the field of psychological research, rooted in phenomenology and hermeneutics (Smith, 2004) and drawing upon a multi-faceted paradigm of psychological, interpretative and ideographic compositions (Biggerstaff & Thompson, 2008; Smith et al., 2009).

Traditionally IPA requires a small research sample in which individual analysis of transcripts are produced; the sample size is premeditated in this way as participants are selected from a homogenous category to share a detailed account of the phenomena under investigation (Smith et al., 2009). This method aligns with an idiographic approach differing from the nomothetic underpinning found in quantitative methods that identify sequences of outcome measurements from large samples, and provide chance claims about individuals from this information (Smith & Osborn, 2003).
Careful consideration was given when selecting the appropriate qualitative method for the study, taking into account the focus of meaning making and capturing an idiographic insight into the participant’s subjective experiences. Discourse analysis (DA) was explored as a potential qualitative method since it is concerned with the relationship of psychological processes and language to convey meaning, and how discourse is applied in the construction of meaning (Phillips & Jorgensen, 2002). In this approach language is described to actively influence and mould the individual’s social reality; therefore psychological experiences are shaped by the use of discourse and consolidated by social interactions (Willig, 2008). A key difference between IPA and DA is how language is examined to reach the actual construction of meaning; DA investigates the role of language when an individual is describing their experience while IPA searches for the ascribed meaning to the experience (Smith et al., 1999). As such IPA can be seen to be engaged with the intrinsic meanings that participants attach to their reality in contrast to DA where meaning is created and conceptualised through a manifestation of discursive materials.

In view of the above IPA is concerned with how individuals make sense of their experiences in their symbolic interaction with the world, forming an essential part of the meanings shared through their narrative. This compares significantly to discursive psychology where language itself is believed to construct a version of an ‘inner world’ (Potter & Wetherell, 1987) which may not consider wider societal and cultural influences in the formation of interpretation. Moreover IPA seeks to uncover the internal processes which individuals themselves may not have a conscious awareness of (Lyons, 2007). Given that the present study was concerned with inquiry, a desire to understand the experiences of Imams with managing the mental health needs of Muslims as opposed to the use of discourse in shaping these, IPA was chosen as the preferred method.
3. Ontological and epistemological considerations

3.1 Phenomenology and IPA

IPA stems from a phenomenological standpoint which asserts that knowledge is derived through the symbolic interactions between individuals, how they understand the world and the objects surrounding it. The concept of phenomenology was initiated by the philosophical tradition of Edmund Husserl, who stipulated that the conscious meaning of an individual’s subjective experience with other people and objects in the world forms the basis of the experience which is informed by perception. Husserl referred to this as “intentionality” which can be understood as an individual’s direct consciousness to an object or event, and as such, reality is shaped by the conscious meaning of an object or event that can shift according to the individual’s perception. This can be shaped by the individual’s experience of thought, emotion, memory and imagination and within the realm of phenomenology exist the potential for a number of different and fluid realities.

The phenomenological perspective arose from opposition to the positivist paradigm which postulated that the world can be objectively measured and a universal reality can be discovered independent of subjective human interaction. The idea that reality is changeable based on subjective perceptions creates a doorway for the IPA researcher to engage with the participant in an inductive and dynamic manner to understand the phenomena being discovered. As described by Larkin et al. (2006) the phenomenological undertone in IPA provides access to an individual’s unique point of reference to the world in the context of their experiences and how phenomena has been understood by them; thus individuals are ‘persons in context’ who are inextricably connected with their physical environment and phenomena within a psychological framework.
This process can be observed in IPA where the researcher seeks to gain access to the individual’s relatedness and engagement with phenomenon in order to comprehend the ‘phenomena at hand’ and develop a ‘renewed insight’ (Larkin et al., 2006). This is further substantiated by Willig (2008); the role of the researcher is to actively engage with, and decipher the raw data provided by the participant in the form of their account of the phenomena being explored. IPA is deeply connected to phenomenology with emphasis on the individual’s experiential and subjective world that is not merged into a wider objective reality. While Husserl’s development of descriptive phenomenology asserted that individual experience related to consciousness while preconceived suppositions were ‘bracketed’, or set-aside, this also directed the researcher to bracket any preconceived opinions they may have in order to gain authentic access to the phenomenon (Dahlberg et al., 2008). However the IPA researcher’s attempt to understand the participant’s world presents a dual process whereby access to the phenomena is both partial and complex (Smith, 1996), and the extent to which the researcher can bracket their own beliefs in their analysis of the phenomena has been disputed.

The work of Heidegger (1962) extended itself to hermeneutics which is understood as the philosophy of interpretation (Creswell, 1994). Traditional phenomenology which identified closely with the naturalistic paradigm arose in protest of the positivist paradigm to offer a ‘voice’ to the individual, although it remained fixed into its descriptive nature. This lead to the dissatisfaction of researchers with traditional phenomenology who felt restricted in their engagement with phenomenological data and moved towards a ‘hermeneutic’ or interpretative manifestation of descriptive phenomenology, whereby the researcher was permitted to bring an interpretative element to the research analysis (Landridge, 2004).
3.2 Interpretative Phenomenology and IPA

As reported by Larkin et al. (2006) IPA positions itself as an interpretative analytical perspective which takes into consideration the descriptive implications of phenomenology, whilst simultaneously providing a conceptual interpretation of the participant’s ‘sense-making’ of their subjective reality. This type of interpretative analysis equips the IPA researcher to approach the phenomenological data with flexibility to examine how participants expressed specific feelings, made certain claims or shared insight in the context of a particular situation. Interpretative phenomenology affords the researcher the freedom to apply their own interpretation in IPA research since the very exploration of the participant’s subjective account is entwined with the researcher’s own perspectives to a certain degree (Willig, 2008).

IPA embodies a phenomenological stance with the aim to capture the idiographic world view of the participant narrated through their experiences, while simultaneously harnessing an interpretative element in the evaluations made by the researcher that are informed by their own world-view; the analysis itself remains an interpretation through this process rather than presented as empirical truth (Mcleod, 2001). Discoveries made are a product of the relationship between the participant and the IPA researcher as mutually inclusive in the emerging ‘reality’ reached through a combination of the ‘intellectual construction’ of the subject matter being explored (Larkin et al., 2006).

The IPA researcher is inevitably restricted from uncovering the ‘whole truth’ although drawing upon a Heideggerian and hermeneutic approach to phenomenology acknowledges a sensitivity and responsiveness found in IPA. While the goal of interpretative phenomenology ascribed by Heidegger (1962) aims to reveal any object of our attention in a manner which is not tainted by preconceived suppositions, in order for the subject-matter to
reveal itself in its true form, coming back to this idea of ‘person in context’ reminds us that this position belongs to both the participant and the researcher in how the world is observed; this is inspired by Heideggerian phenomenology when considering relatedness to meaningful context. The sensitive approach in IPA prepares the researcher to ‘bracket’ and adjust any suppositions they may have accordingly when investigating the subject-matter despite the epistemological and methodological limitation, and a realisation that it might not be possible to reveal the ‘whole’ authentic experience of the participant.

Since the researcher is also a ‘person in context’ it does not make it unachievable to access the participant’s ‘life-world’. This interpretative feature of IPA evolved from the philosophical tradition of the ‘double hermeneutic’ process described by Heidegger (1962), that is, interpretation can be applied when understanding experience. In view of IPA this interpretative process is seen as the researcher being involved in a dual interpretative process with attempting to make sense of the participant making sense of their life-world (Smith et al., 2009; Smith & Osbourn, 2003). IPA seeks to engage purposefully with the ‘person in context’, and in doing so, attempting to understand how an individual relates to, and provides meaning to objects and events in their experiential claims.

The IPA researcher dedicates themselves in a manner which is responsive to investigating, portraying and interpreting how participants identify with their experiences. This position has been referred to as ‘contextualism’ (Madill et al., 2000) which aligns with the belief that we respond towards things according to the symbolic meaning ascribed to them. Revelations made from the phenomenological data is only made ‘real’ by the participant allowing themselves to relate to things in a meaningful way when distressed, concerned, involved or affected by them.
Interpretative phenomenology in the Heideggerian tradition is not concerned with the pure internal experience of an individual, rather, an acknowledgement of the ‘person in context’ through their narrative and personal engagement with the world by embracing a hermeneutic stance when considering the individual’s relatedness to the subject-matter. In this sense IPA extends beyond a pure description as observed in traditional Husserlian phenomenology, explained in the following extract by Tappan (1997):

Hermeneutic approaches [. . .] do not subscribe to a ‘correspondence theory of truth’, which assumes that the truth of a particular theoretical statement is determined by the degree to which it corresponds to the hard and fast ‘facts’ of reality, and thus which understands that the ultimate goal of any science is to provide accurate (or, at the very least, ‘falsifiable’) descriptions and explanations of an independent reality. Rather, hermeneutic approaches view the knower and the known as fundamentally interrelated, and thus assume that any interpretation necessarily involves an essential circularity of understanding—a hermeneutic circle in which the interpreter’s perspective and understanding initially shapes his [sic] interpretation of a given phenomenon, and yet that interpretation, as it interacts with the phenomenon in question, is open to revision and elaboration, as the perspective and understanding of the interpreter, including his biases and blind spots, are revealed and evaluated (p.651).

IPA emerged from a descriptive phenomenological tradition and evolved into an interpretative framework inspire in part by Heidegger’s philosophy, demonstrating the difference between ‘phenomenology’ and ‘interpretation’. In this very context the IPA researcher can use their toolkit of the ‘interpretative range’ to surpass the participant’s own conceptualisations by making discursive inferences that the participant themselves may not have a conscious awareness of (Smith, 2004). This level of dexterity provides strength to the phenomenological account since there is no single truth as to how knowledge is attained which has contributed to the popular growth of IPA in the field of qualitative psychological research (Reid et al., 2005).

While the main focus of IPA is concerned with exploring people’s lived experiences and the meanings attached to those experiences, it also takes into consideration ‘that socio-cultural
and historical processes are central to how we experience and understand our lives, including the stories we tell about these lives’ (Eatough & Smith, 2008, p.184). IPA can be seen to incorporate aspects of both descriptive phenomenology and discursive traditions; attention to the experiential nature of subjective accounts of the life-world lean towards phenomenology while the discursive element draws upon the use of language in the form of social action to create meaning in the social world (Reicher, 2000).

Multiplicities of epistemological positions are embedded within qualitative methods (Willig, 2008) and ‘they have different philosophical roots, they have different theoretical assumptions and they ask different types of questions’ (Reicher, 2000, p.4). Distinct differences and commonalities between qualitative perspectives can appear complicated in the first instance (Landridge, 2004; Lyons, 2007; Smith et al., 2009) however the theoretical approaches can be categorised into two groups; those that pay attention to meaning for participants and those that emphasise the role of language (Landridge, 2004). The characterisation between various qualitative approaches can be observed along a range from experiential to discursive and from empiricist to constructionist (Lyons, 2007; Willig, 2008).

IPA initially emerged from the divide between quantitative social cognitive approaches and discursive approaches to health psychology in order for researchers to ‘unravel the meanings contained in... accounts through a process of interpretative engagement with the texts’ (Smith, 1997, p.189). The perceived similarity in the systematic analysis of the data-set to derive a cluster of themes and categories echoes with grounded theory (Willig, 2008) and the explicit process of establishing meaning through interpretation relates to cognition as found in narrative analysis (Crossley, 2007; Smith et al., 2009). Eatough and Smith (2006) recognise that ‘IPA shares some common ground with Foucauldian discourse analysis,
which examines how the people’s worlds are discursively constructed and how these are implicated in the experiences of the individual’ (p.118-9).

IPA recognises the significance of language, how individuals construct meaning and make sense of the world although its phenomenological grounding advocates that human experience extends beyond the construction of language as people are embodied beings with agency (Ashworth, 2000). IPA can be seen to assume a social constructionist approach in relation to discourse analysis, as explained by Smith et al. (2009) ‘while IPA studies provide a detailed experiential account of the person’s involvement in the context, FDA offers a critical analysis of the structure of the context itself and thus touches on the resources available to the individual in making sense of their experience’ (p.196). Given that IPA does not position itself with a specific epistemological position makes it a further appealing research option.

Landridge (2004) notes how IPA resembles a standard thematic analysis as an alternative to traditional quantitative methods in how ‘phenomenological approaches offer a psychology that truly captures the rich lived experience of people engaged in life in its many different forms’ (p.289). Landridge (2004) also asserts ‘that IPA actually bears even more similarity to a standard thematic analysis...psychologists working within this perspective will therefore have less need to justify their work than psychologists from other qualitative perspectives, for many of the arguments in favour of this work have already been made and need not be remade every time one produces new work’ (p.291). Braun and Clarke (2013) offer further weight by stating that ‘IPA is both a thematic approach and concerned with the specifics of individual experiences...IPA studies tend to focus on significant life experiences that often have implications for our identities, as they unfold in particular contexts’ (p.181).
Braun and Clarke (2013) provide further reflections of ‘thematic’ coding commonly employed in qualitative research first established by Merton (1975), without openly referring to the practice as thematic analysis which has hidden its wide use in the field. To address this oversight thematic analysis has been given recognition as a theoretical method of analysis with distinct procedures providing a systematic framework for analysing, identifying and reporting identifiable patterns/themes across phenomenological data (Braun & Clarke, 2006) and now correctly identified and discussed as being a method in its own right (Whittacker, 2009; Howitt, 2010; Howitt & Cramer, 2008; Joffe, 2011; Stainton-Rogers, 2011). Subsequently thematic analysis has been used with a wide range of research topics investigating the experience of different phenomenon (Frith & Gleeson, 2004; 2008; Hussain & Griffiths, 2009).

Furthermore the unique strength of thematic analysis can be found with its flexibility to approach qualitative data without a predetermined method of data collection, theoretical orientation, epistemological or ontological position as it classifies itself as a mode of data analysis and not a methodological approach to qualitative research (Braun & Clarke, 2013). The systematic procedure of thematic analysis can be applied to answer and analyse any type of qualitative research question and data with the exception of those that concentrate on language use (Braun & Clarke, 2013). For this reason I anticipate the interviews transcribed will be compatible with an IPA thematic analysis as described by Landridge (2004), while the methodological approach followed the theoretical orientation of IPA in order to remain compliant with epistemological and ontological considerations, which were deemed essential for the embodiment of this qualitative research.
3.3 Epistemological Reflexivity

As explored earlier in this chapter within qualitative research models exist a body of ontological and epistemological standpoints; the task of the qualitative researcher is to make clear their positioning in view of their research (Madill et al., 2000). Ontology refers to the nature of reality (Hudson & Ozanne, 1988) while epistemology describes the relationship between the researcher and reality (Carson et al., 2001). This research allies with the ontological position of ‘social constructionism’ which lends itself to making sense of the world by viewing knowledge as something which is socially constructed from human experiences and the perception of these experiences. Therefore social constructionism aims to understand the nature of reality and the variety of constructions made from reality in the world that is being observed (Murphy et al., 1998). Social constructionism is a relativist stance (Hammersley, 1992) that explores human experience and social practice as pluralist, that is, the same phenomenon can be described in various ways without claiming an absolute truth. The present study required an approach towards participants with openness to their reality from social constructs that were likely to derive from religion and culture in their management of these, contrary to the reality of mental health services.

The epistemological position was identified in this research as ‘contextualist constructivism’ which asserts that all knowledge can be understood from different perspectives of the same phenomenon (Madill et al., 2000). It would be unrealistic to claim, as a researcher, that the realities of participants were fully captured since my own perceptions have been shaped by my individual experiences of the world. However contextualist constructivism accommodated the observation of my own beliefs while undergoing research for a comparison of experiences to reflect upon (Madill et al., 2000).
Furthermore, consideration was given to emic-etic issues while undergoing the process of data collection concerning human behaviour and belief systems. An ‘emic’ account is a description of behaviour/belief regarded as meaningful whether this is conscious or unconscious from the person within the culture, sometimes referred to as the ‘actor’. By its very nature anything from within a culture can provide an emic account. An etic account differs in that it provides a description of a behaviour/belief by an observer in terms that can be applied across cultures with exclusivity; therefore an etic account seeks to remain culturally neutral (Pike, 1967). This was of particular importance to my role as the researcher; to interpret the data gathered from the Imam from their meaning-making using their emic frame that arose from a spiritual/religious perspective, and my translating this rich material from an etic approach and applying this to inform Counselling Psychology practice.

4. Participants

It has been debated that the provenance of Imams outside of the UK who have either migrated, or invited to lead congregations in British mosques whereby pastoral services are not delivered in English have created uncertainty in their linguistic and cultural skills to connect with Muslims in the UK (Lewis, 2001). Taking this into consideration all participants were English-speaking male Imams over the age of 18. Presently women are not ordained as Imams within UK Islamic clergy therefore non-English speaking Imams and females formed the exclusion criteria.

It is customary to recruit a ‘homogenous’ sample of participants in IPA research who are able to relate to the topic of investigation in a meaningful way during their idiographic accounts (Smith et al., 2009). Homogenous participants are clustered according to specific requirements that are sought in IPA research which can vary from socio-demographic factors of occupational background, sex and age to key aspects pertaining to experience. In
the present study participants were recruited according to their professional position as an Islamic minister in charge of leading a Muslim congregation within a registered mosque in the UK. Participants were identified from the online UK Muslim Directory http://www.muslimdirectory.co.uk/ from mosques which advertised an ‘advice and counselling’ service to the Muslim community.

The type of ‘advice and counselling’ provided by the Imams remained ambiguous since it was not specified whether this was religious, spiritual, cultural or therapeutic counselling and formal training qualifications were not stated. Nonetheless, the intention of the research was to inquire about the individual experience of Imams in managing the mental health needs of the Muslim community rather than their expertise in delivering ‘therapy’ whether religious or psychological. As noted by Madge (1975) ‘interviewees may be selected because he (sic) is in a position of authority; or because he possesses special knowledge about other people or things; or because he is one of a class of people in whom the scientist is interested’ (p.145).

4.1 Recruitment

The participants were recruited voluntarily using the online UK Muslim directory website http://www.muslimdirectory.co.uk/ which identified mosques that offered an ‘advice and counselling’ service, and guidelines provided by the BPS (2013) for ethical practice in psychological research online were observed. To take into account the dispersed geographical nature of the recruitment process I gained entry into the field by using a script for telephone recruitment [appendix A] and did not engage with ‘cold calling’. Rather, I inquired with the administration member(s)/gatekeeper of each mosque as to the availability of the Imam and requested a telephone meeting to explain the research aim.
Once a telephone meeting with the Imam was agreed I verbally outlined the aims of the research following the telephone recruitment script [appendix A]; at this stage it was established whether the Imam provisionally wished to take part in the research and a date, time and location for the face to face interview was agreed. Following this the participant information sheet [appendix E] and participant consent form [appendix F] were sent via email to either the personal email account of the Imam or to the global email address of the mosque which detailed the agreed date, time and location of interview. A further electronic script [appendix B] was also sent via e-mail to mosques across the UK with email accounts identified in the online UK Muslim directory and responses followed up by both email and telephone.

4.2 Procedure

Purposeful criterion sampling was used in line with the participant selection and recruitment process described above. A sample of six participants took part in the study of which one participant was selected as a pilot (please see section ‘4.4 piloting’ on p.64 for more details). According to the guidelines provided for IPA it is common to use a small sample of either five or six participants (Eatough & Smith, 2006; Smith & Osborn, 2007) who meet the homogenous category since the methodological approach is concerned with the specifics of individual experience. The procedure section in qualitative research is examined for trustworthiness (Yardley, 2000) with emphasis placed on providing a thorough description of the procedure as this evidences validity and rigour (Silverman, 2005). Procedural validity can be accomplished by detailing the research process undertaken in a transparent way with a clear description of each step.
The setting of the research interview took place at the community mosque where the participant provided a pastoral service to their congregation, with the exception of one participant where the research was held in the multi-faith room of a general hospital following their sermon of the Friday prayer. The strategy employed here was to honour the interpretative and naturalist approach whereby qualitative researchers attempt to make sense of phenomena and the meanings people bring to them in their natural setting (Deniz & Lincoln, 1994). In addition the social context in which the participants were met ‘on their territory’ was grounded in the method of data generation being sensitive to the ‘real life’ of the participant and extracting rich and contextual data (Mason, 1996), rather than removing the participant from their natural setting and creating an experimental paradigm by following a rigid structure of booking a standard meeting room in an unrelated place.

The services provided by Imams are highly sought after and they are often under time pressures in meeting the demand of the Muslim community, therefore gaining access in the first instance was challenging. Arranging to attend the community mosque where the Imam was based contributed to their willingness to participate in the research, as they were not inconvenienced to travel. Upon considered research supervision discussing safety an agreement was reached whereby an email was sent to the research supervisor of the location, date and time of each research interview on the day of, before and after each interview was held to confirm no harm had occurred to me in the research process.

4.3 Remuneration

In the field of medical and quantitative social research providing financial inducements to participants have been widely practiced and the detrimental implications for research considered regarding ethics and exploitation of vulnerable participant groups (Russell et al., 2000; Sandel, 2003). Recognition has also been given to the positive implications of financial
compensation to participants as a means of increasing response rates (Singer & Kulka, 2002) and equalising power differentials in the researcher-participant dyad (Thompson, 1996). There remains a paucity of guidance which discuss the implications of monetary payments to participants in qualitative research, other than standardised guidelines on conducting psychological research provided by the BPS (2001) stating ‘the payment of participants must not be used to induce them to risk harm beyond that which they risk without payment in their normal lifestyle’ (p.10). After careful consideration and reflection on potential ethical issues that may have arisen, the decision was made to offer a financial donation of £20.00 to the mosque which the participant was affiliated with, or to a charity of their choice as an acknowledgement of their involvement with the research.

Deciding the level of donation at £20.00 was guided by practical reasons in line with the research budget and the participants were given £20.00 cash in a sealed envelope at the end of each research interview. It is commonplace for members of the Muslim community to offer donations to the mosque similar to that of a church, temple or gurdwara; it is not invariably the case that congregation members offer monetary payment however this is deemed appropriate as a fair exchange of the Imam imparting their knowledge, advice and counsel free of charge and a contribution aiding maintenance of the mosque.

While explicit guidelines do not exist which recommend the amount congregation members may donate, often the mosque is involved with initiatives aimed at improving facilities, developing community events or raising funds for charitable causes both in the UK and abroad. In line with this offering a donation both as a researcher and a Muslim member of the community wishing to support the mosque felt fitting, as opposed to framing this as recompense to the Imam with the risk of causing offence. Further reflection on this topic can
be found in the ‘further discussion and conclusion’ chapter under ‘further researcher reflexivity’.

4.4 Piloting

In order to investigate whether Imams were willing to openly discuss their experiences in the management of the mental health needs of the Muslim community, a pilot study was conducted with one participant. The participant was selected as per the recruitment guidelines discussed and the semi-structured interview schedule for the research was followed [appendix C]. The initial pilot was very useful with ‘testing’ the research questions as the participant appeared to understand the concepts discussed and did not display any difficulty with providing a response; therefore further amendments were not required. The main rationale with conducting the pilot was to establish any identified needs to refine the research questions, for example the Imam not relating to the concept of ‘mental health’ in which case the question may have required formatting. The outcome of the pilot study was included in the final data.

During the telephone recruitment stage of conducting the pilot, the administration member(s)/gatekeeper of the mosque in charge of setting up the meeting with the Imam inquired whether I was a journalist under the guise of a University researcher followed by a series of ‘screening’ questions. It quickly came to light when introducing myself on the phone, the most effective approach was to clarify my position as a researcher affiliated with a University, that the research had passed an ethical clearance process and provide the option of forwarding the research supervisor’s details prior to sending details of the research, while also informing them that all the relevant information will be included in the participant information sheet. This level of transparency assured the administration member(s)/gatekeeper and the Imam who were satisfied with being sent the participant
information sheet [appendix E], without requesting to speak with the research supervisor in the first instance. Further reflection on this topic can be found in the ‘further discussion and conclusion’ chapter under ‘further researcher reflexivity’.

5. Data collection and interview procedure

Semi-structured interviews were conducted to collect the research data. The particulars of the interview were provisionally arranged during the telephone recruitment stage [appendix A] followed by an email confirmation which included an attachment of the participant information sheet [appendix E] and consent form [appendix F]. The interviews took place on an individual face to face format and the majority were conducted at the location of the mosque where the Imam lead their congregation, with the exception of one interview which was held at the multi-faith room of a general hospital.

A signed consent form [appendix F] was collected from each participant detailing the objective of the study, their agreement to partake in the study and to be audio recorded including a verbal summary of the consent form to check their understanding. Upon completion of the interview participants were given the option of fifteen minutes for debrief, provided a plain envelope with the donation of £20.00 and a participant support sheet [appendix G] detailing counselling services participants could access if they felt the need to. All hard copies of documents have been stored in a locked safe at my home and will be shredded after the completed thesis is uploaded in the City University library, where it will remain for ten years as per the University policy. Audio recordings have been kept on my personal laptop and only accessible via an encrypted password for additional protection and security.
The format of the semi-structured interview schedule [appendix C] was designed as an invitation for the participants to discuss topics in as much depth as they felt relevant (Arskey & Knight, 1999) and different Imams spent different time spans in answering questions, which gave rise to the flexibility in altering questions when appropriate and exploring unexpected topics (Smith & Osborn, 2003) that were related to the overall theme discussed. The first eight questions were designed to be open-ended to encourage participants to talk about relevant issues pertaining to their experience of managing the mental health needs of the Muslim community. The latter four questions were more focussed in order to gauge the role of wider societal agencies, and how, if it all, this interacted with the experience of participants and their management of mental health issues brought to their attention by the Muslim community.

At the beginning of each interview the Imam was greeted with the Arabic phrase ‘Asallamu Alaikum’ which translates to ‘may peace be upon you’; this is commonly practiced by Muslims around the world and fundamental in the context of the research interview with establishing rapport and demonstrating respect to the Imam. Throughout the interviews I made the conscious decision to use various Islamic terms in order to strengthen rapport and build a working relationship with the Imams in their disclosure of experiences. Please see ‘glossary of Islamic terminology’ for the full list of terms used and their definitions.

Throughout the course of the interviews I became more confident in my questioning style and gently introduced prompts when more detail was needed to either clarify certain discussion points or draw out more information; I found this worked exceptionally well as the participants responded to this as ‘mind tags’ and revealed various approaches they drew upon ranging from practical advice giving, liaising with other professionals in the public sector and within their own networking streams. As I became more assured in my
interviewing techniques I found that I was asking the research questions in a fluid manner without the need to follow the interview schedule in a regimented way; this opportunity was maximised to develop a rapport with the participant during the interview while simultaneously collecting rich contextual data.

There were periods when participants incorporated unrelated topics into the interview schedule which affected the flow of discussion pertaining to the research inquiry. During these instances I sensitively and tactfully addressed this by assimilating the voluntary topic(s) into the interview schedule; I felt it was important to synthesise in order to demonstrate that I had acknowledged the contribution made by the participant and maintained rapport. This was a fine balance of listening, remaining engaged with something that was not linked to the interview schedule and manoeuvring the dialogue back to the research topic which was challenging in places. While I had a framework in my mind as to the areas I wished to touch upon with the Imams, it was also necessary to allow flexibility for the Imams themselves to share accounts that they deemed relevant in sharing their experiences and my task was to somehow find a way of making a connection.

During one particular interview the battery of the Olympus audio recorder had finished approximately seven to eight minutes of reaching the end, therefore I swiftly changed the battery and offered an apology to the participant for the interruption. While the participant appeared undeterred by this happening and continued engagement with the research interview, it may have impacted the data gathered and the experience of the participant in the research. The participant responded to this glitch by offering reassurance and compassion to my flustered apology. I felt embarrassed by my failure to ensure the apparatus were adequate for the duration of the interview and the dynamic of the interview shifted as I was no longer a researcher; I had become an anxious congregation member.
who the Imam was comforting reflective of their common practice in offering support. I was not aware of this shift until the interview had terminated while reviewing the incident on the train home, however I concluded that it was appropriate to include the remaining minutes in the final data, as what I felt did not interfere with the process since the participant was not affected and the flow of the research interview remained unchanged.

It was interesting to observe the various ways I was permitted to enter the mosque given that male and female congregation members had separate entrances and segregated sections of the building where men and women occupied. My role as the Muslim female researcher undergoing doctoral training permitted access to the Imam that may not have been readily available to the general Muslim female congregation members attending the mosque, as the Imam is predominantly present in the male section of the mosque. Please see ‘personal reflexivity’ for further insight.

5.1 Transcription

Each interview was converted in an orthographic transcription of words spoken by myself in order to conduct an IPA thematic analysis; this was a very time-consuming activity due to the level of concentration and focus required when listening to the audio recordings. However the process of transcription developed ‘closeness’ to the data (Riessman, 1993) which Bird (2005) believes to be ‘a key phase of data analysis within interpretative qualitative methodology’ (p.227) and referred to as an interpretative course of action whereby meaning takes shape. The meticulous attention to the transcribing of data facilitates the interpretative skills desired at the data analysis stage (Lapadat & Lindsay, 1999). Given that transcription forms the initial stage of analysis and not simply a ‘mechanical process’ for organising qualitative data, memos were also made with reflections about the interviews as part of the
data analysis strategy which provided a valuable contribution during the coding and categorising phase.

Various systems exist which provide guidelines for transcribing audio data into text (Edwards & Lampert, 1993; Lapadat & Lindsay, 1999), although the guidelines recommended for thematic analysis do not demand intricate detail as the language itself is not subject to investigation, rather, the interpretations drawn from the language used. An orthographic transcription of words spoken is recognised as sufficient for providing information suitable for data analysis and the inclusion of non-verbal and non-semantic sounds such as coughing laughter, pauses, silences and repetition are not mandatory (Braun & Clarke, 2006; Braun & Clarke; 2013). Subsequently transcriptions were not highly detailed with pros, lengths of pauses and any additional non-verbal utterances and noises were not included. In order to protect anonymity all identifying details in the transcriptions have been replaced with ‘XXX’. Please see ‘ethical considerations’ for more details.

5.2 Data analysis strategy

A qualitative research strategy was employed using Interpretative Phenomenological Analysis (Smith et al., 2009) in the form of six face to face semi-structured interviews with Imams. Interviews were transcribed and an IPA thematic analysis as described by Landridge (2004) was applied to the research data; this involved a process of ‘coding’ the individual accounts of the participants. This was found to be compatible with the phenomenological nature of IPA that provides a ‘voice’ to participants (Larkin et al, 2006). Landridge (2004) describes an IPA thematic analysis involving three levels of codes grouped as first, second and third level codes which are formatted according to the different level of interpretation applied to the text.
The first level of coding was identified as ‘initial codes’ that involved reading and re-reading the data at a descriptive level where the textual data was categorised by the process of assigning codes to chunks of words, phrases and sentences that emerged from the text. While minimum interpretation was required at this level the assignment of codes was a lengthy procedure as initial codes were revised, some of which were combined while proceeding through the transcript in order to accurately encompass the meaning in the text without unnecessary overlapping.

The second level of coding was identified as ‘organising themes’ which required active interpretation of the data from the first level of coding and creating ‘super-ordinate’ constellations that encapsulated the overarching meanings of descriptive codes into specific themes that were identified. The third and final level of coding was identified as ‘main themes’ which demanded a highly meticulous examination and interpretation of the codes from the super-ordinate constellations, and grouped according to the overall meaning identified from the initial descriptive and interpretative codes. The third level coding formed the major concepts of phenomena derived from the data. Please see ‘appendix H’, ‘appendix I’ and ‘appendix J’ for table of coding in the three stages and the ‘synthesis of analysis and discussion’ chapter for further review of concepts identified.

According to Landridge (2004) there is no set way of developing themes when using an IPA thematic analysis although it is recommended for the researcher to follow the same analytical framework across all transcripts to maintain consistency and rigour with data analysis. The three levels of coding can also be understood to begin with an inductive approach when identifying themes and merging into a deductive approach when creating master themes. Emphasis was placed on reading and re-reading the transcripts and taking notes of thematic words as they appeared; since the research hoped to address the
experience of participants the data was transformed into an interpretation through the words spoken (Braun & Clarke, 2013). This in turn captured the main characteristics that portrayed the participants’ experience which were changed into a language discourse and an epistemological standpoint which was phenomenological.

While an IPA thematic analysis (Landridge, 2004) was conducted on the interpretation of experience, the main focus aligned with a two-stepped hermeneutic process in the analysis of phenomena. To explain this further there is a need to establish the difference between hermeneutics and context when considering the hermeneutic circle; to understand the part of the whole we are required to understand the whole without discriminating between them, to utilise and acknowledge with discipline. Further, Braun and Clarke (2013) stipulate:

For IPA, procedures for pattern generation are very clear ...once all data items have been examined, superordinate themes are compared across the whole dataset, to determine the final (master) themes that will be presented in the overall analysis...emergent themes are developed from the original data item (e.g. interview transcript) and the exploratory comments...emergent themes aim to capture elements that appear to be crucial for the developing analysis; they reflect a mix of staying close to the participant’s experience, and the analyst’s developing interpretation. They sit somewhere between codes and themes in a TA approach (p.237).

Data analysis in IPA outlined by Smith et al. (2009) involves the dataset being broken down into stages, initially beginning with reading and re-reading the detailed descriptions of the text and forming general notes, identifying ‘label themes’ from individual sessions, forming ‘cluster themes’ derived from shared meanings across texts and producing ‘principal themes’ identified emerging across all participants sits very closely to the procedure recommended for thematic analysis. Given that a thematic analysis ‘is relatively unique among qualitative analytic methods in that it only provides a method for data analysis...TA can be applied to data in different ways, from experiential to critical’ (Braun & Clarke, 2013, p.178) and it served as a crucial tool when exploring the phenomenological data.
5.3 Personal reflexivity

IPA acknowledges that the researcher is also a 'person in context' whose world-view will interact with the interpretations made of participants’ experiences (Smith et al., 2009); in line with this qualitative research demands the researcher to engage with personal reflexivity and transparency in their involvement with research (Yardley, 2000). Here I would like to step aside as a researcher and explain why I chose this research topic from a personal account. Given that I am a British Muslim the choice of research topic is certainly close to my heart as the concepts discussed are those that are very familiar territory. I have been raised in a practicing Muslim household where Allah Subhanahu Wa Ta’ala is believed to remedy any type of illness psychological or physiological through prayer and ‘Imaan’, the Arabic word for faith.

With the message that ‘faith conquers all’ interwoven in my psyche I would be disloyal to my own belief system if I am not honest about my position. I do believe Allah Subhanahu Wa Ta’ala has the authority to alleviate human suffering of any nature while I contend that prayer and Imaan alone are neither capable nor sufficient of remediying difficulties. There is a fundamental difference I would like to clarify here; I am of the opinion that Allah Subhanahu Wa Ta’ala does respond to prayer and Imaan strengthens this process however I also consider individuals responsible to source appropriate help in the observed world and not depend entirely on Divine intervention.

My relationship with the research was both personal and professional; being a Muslim and a practitioner-researcher in the field of Counselling Psychology. I anticipated the process of recruiting participants as the most challenging task considering one major static factor; being a Muslim female wishing to interview Imams that were exclusively male, and who, in my understanding, maintained strict boundaries relating to conduct with women as stipulated in
Islamic law. At the preliminary stages of the research I felt very apprehensive about approaching Imams due to the uncertainty of their response to my request for interview, how likely if at all, they were prepared to answer the questions I had proposed and whether they deemed participation worthwhile. Moreover, I was preoccupied with Islamic regulations and rejection on the grounds of being a female entering a religious institution dominated by men. I felt it was necessary to mentally prepare myself to encounter, what I perceived to be a dominant and religious patriarchal culture that held strong views about religious help-seeking, with the message that Islam had all the answers with no room for psychology. I underwent a period of apprehension driven by the idea of not being taken seriously when approaching the Imams.

As I began the process of telephone recruitment and conversed with the administration member(s)/gatekeeper of the mosque when requesting a meeting with the Imam I encountered a very different obstacle which caught me off guard; I was repeatedly asked whether I was an under-cover journalist wanting to report ‘bad things’ about Islam and my identity as a legitimate researcher questioned. In hindsight it appeared very logical for the research request to arouse suspicion given the unfavourable coverage on Islam and Islamaphobia as explored in the eclectic literature review, and I found myself grappling with the very contentious issues I had written about. This experiential encounter which I had not foreseen acted as the trigger I needed to demonstrate my sincerity and passion for the much needed research. After reassurance was offered and the details of the University affiliated with the research provided, the hurdle of setting up the research interviews was a far smoother process than predicted.
When the location of the research interview was agreed to take place in a private room/office at the mosque, the ‘issue’ of my being a female Muslim conducting a one to one interview with the Imam was not raised at any point, and admittedly, I had not inquired about this either in case I shot myself in the foot. I came to learn that, my status as a doctoral researcher and the intention to produce a piece of research aimed at helping the Muslim community had bypassed all the barriers that may have otherwise affected the research going ahead. The fact that I was a Muslim female with exclusive access to the Imams was quite extraordinary and my beliefs about the patriarchal system of the religious setting were positively challenged. It would be naive to suggest such would be the case for all Muslim females since I was granted ‘special permission’ based on my academic background, however I felt privileged and honoured to be granted the opportunity to interview the Imams, learn about their experiences and confront my own misconceptions. Moreover, the Imams were very welcoming, warm and engaged with discourse that was not dominated by Islam. Please see ‘synthesis of analysis and discussion’ chapter for further details.

A further dilemma concerned dress code; for the purpose of entering the mosque I observed the traditional Islamic female attire of the Hijaab. There remains an expectation for a Muslim woman to observe the Hijab when attending a mosque or in the presence of an Islamic institution. While I do not observe the Hijab in my personal life, as a sign of respect to the Imams and the parameters stipulated by Islam as appropriate dress code for the Muslim woman, I adorned the Hijab during face to face interviews with Imams. There were times when I felt like a fraud battling with my authentic self to remain genuine, honest and true as deception is not a trait I wished to assume. I willingly accepted my ‘under cover’ position not as a journalist, however as a researcher seeking knowledge and wishing to contribute something of value to the field of Counselling Psychology in the service of the Muslim community, which was the very driving force behind this research. I worked through feelings of guilt and deception as I held my intention to be virtuous. While effectively ‘undercover’ as I
was not displaying my true self since I do not ordinarily wear a Hijab, I believed this to be a necessary measure in the spirit research.

Moreover, conceptually and contextually I perceived my role as an ‘embodied bridge’ of the research, given that the core of the study related to the Islamic population in the UK with regards to their utilisation and access to mental health services, through the experiences of the gatekeeper to the Muslim community. Given that I belong to both the community of mental health professionals and the Islamic population, with access to the Imams that have the knowledge and power to navigate the relationship, Counselling Psychologists can be positioned to communicate in the centre. This may support better and lucid communication between the three groups of mental healthcare, the Islamic population and Imams. My position as both a practitioner working in a setting which provides mental healthcare provision whilst also belonging to the Muslim community strengthens my position as an ‘informed messenger’. I can see the potential for improvement of the communication pathway between mental healthcare services and Imams; therefore I anticipate some of my interpretations may be influenced by these facts.

6. Ethical Considerations

The research was granted ethical approval from the City University Ethics Committee and School of Social Sciences [appendix D]. Given my role as a scientist practitioner the following ethical guidelines for research stipulated in the BPS (2011) were also observed throughout the process;
i) Respect for the autonomy and dignity of persons

ii) Scientific value

iii) Social responsibility

iv) Maximising benefits and minimising harm

Special attention was given to the guidelines provided by the HCPC (2012) to ensure the research was conducted in a manner which the governing body deemed suitable, in addition to guidance provided by the BPS (2013) for ethical practice in psychological research online. The following ethical guidelines were also observed concerning participant rights; information relating to the purpose of the research provided to participants [appendix E], informed consent form [appendix F] to allow interviews to be audio-recorded, right to terminate the research interview at any given time without an explanation, right to debrief not affected by early termination, right to anonymity and right to withdraw any data provided. All participants provided written consent for publication indicated on the informed consent form [appendix F].

During the interviews participants either identified themselves by declaring their name, the names of their colleagues, public institutions, community services, the name of the mosque which they were affiliated with and specific geographical locations. To protect anonymity of the participants and those who were named in the interviews, throughout the transcripts identifiable information have been replaced with ‘XXX’ for the purpose of ethical consideration. The same system was also followed when identifiable information was stated by myself during interviews. The confidential dataset gathered has been stored in a secure format and only accessible by myself; signed material and all hard documentation have been stored in a locked safe at my home and audio recordings have been protected with an encrypted password on my personal laptop. All names and other identifying information
have been anonymised to protect the participants’ identities, including the labels provided to the audio recordings whereby participants have been allocated numbers only.

At the beginning of each interview participants were informed of their right not to answer all of the questions, and were reminded of their right to terminate the interview at any stage if they wished not to proceed or if they felt distressed or uncomfortable. The participants were given the right to withdraw their consent from the research itself at any stage, as outlined in the participant consent form [appendix F]. It was not anticipated that any harm would come to the participants as a result of the research however all were provided the option of up to fifteen minutes debrief at the end of each interview, followed by a list of independent support agencies in addition to my contact details and the research supervisor should they require any assistance or support in future [appendix G].

In line with the integrity of the qualitative researcher during all modes of communication including email, telephone and face to face with participants and those associated with participants from the recruitment stage right the way through to interview and debrief, I held in mind that ‘qualitative researchers are guests in the private spaces of the world; their manners should be good and their code of ethics strict’ (Stake, 2000, p. 447). I felt this was amplified in my role as a researcher entering the highly private world of the highest ranking member of the Muslim community. Integrity, honesty and respect were attributes that were significant in my role as a researcher in the presence of the Imam, which were supported by my therapeutic skills as a Counselling Psychologist.
CHAPTER THREE:

SYNTHESIS OF ANALYSIS AND DISCUSSION

1. Introduction to synthesis of analysis and discussion

Three dominant themes which were categorised as main themes formed the foundation of the analysis. These were identified as frequently recurrent themes throughout the rigorous process of data analysis. This chapter outlines the synthesis of analysis and discussion of the identified three main themes and their constituent organising themes; these demonstrate the key features of the Imam’s experience of managing the mental health needs of the Muslim community. In order to illustrate the findings, each main theme and their associated organising themes are described with sample extracts from the original transcripts completed during the research interview stage. Extracts were selected according to their representation of encapsulating something significant about the theme or depicted the theme as a whole (Smith et al., 2009).

An orthographic transcription with the exclusion of non-verbal and non-semantic sounds was deemed suitable for the thematic analysis of the data, which also excluded pros, lengths of pauses and any additional non-verbal utterances and noises (Braun & Clarke, 2006; Braun & Clarke; 2013). In order to preserve anonymity all identifying details in the extracts have been replaced with ‘XXX’ and explanatory notes have been included in square brackets [ ] to provide contextual information; otherwise, the extracts included are the exact spoken words of the participants during the research interview. In addition, grammatical errors were not corrected to avoid manipulation of the data and to maintain authenticity of the collected accounts of participants.
Extracts are tagged with the participant research number which is also the same as the transcript number that the data was gleaned from, followed by the page and line numbers. An example would be ‘Participant 1; L33-45’. This procedure is followed for all extracts, some of which may correspond with the table of code generation [appendix J].

The decision to synthesise the analysis with the body of discussion granted an opportunity to reflect upon the development of analysis, inform the reader with more explanation about the transcript and the process of becoming ‘close’ to the data. It also afforded flexibility to include details about the practitioner experience, the relationship with the themes derived and relevant literature pertaining to both the analysis and discussion.

2. Synthesis of analysis and discussion

As described in the methodology chapter, purposeful criterion sampling was used to recruit six participants who took part in the study, of which one participant was selected as a pilot to gauge whether Imams were willing to openly discuss their experiences of managing the mental health needs of the Muslim community. The initial pilot was very useful with ‘testing’ the research questions as the participant appeared to understand the concepts discussed and did not display any difficulty with providing a response; therefore further amendments were not required and their data was included. The setting of the research interview took place at the community mosque where the participant provided a pastoral service to their congregation, with the exception of one participant where the research was held in the multi-faith room of a general hospital following their sermon of the Friday prayer.
A summary of the research methodology is explicated here as a reminder of the research process, how this developed into the analysis and assimilated with the discussion. Face to face semi-structured interviews were conducted to collect the research data; these were provisionally arranged during the telephone recruitment stage [appendix A] followed by an email confirmation which included an attachment of the participant information sheet [appendix E] and consent form [appendix F]. Upon completion of the interview participants were given the option of fifteen minutes for debrief, provided a plain envelope which enclosed a donation of £20.00 and the participant support sheet [appendix G] detailing counselling services participants could access if they felt the need to. An orthographic transcription of words spoken from the interviews developed ‘closeness’ to the data (Riessman, 1993) which were later analysed thematically.

A qualitative research strategy was employed using Interpretative Phenomenological Analysis (Smith et al., 2009) in the form of six face to face semi-structured interviews with Imams. Interviews were transcribed and an IPA thematic analysis as described by Landridge (2004) was applied to the research data; this involved a process of ‘coding’ the individual accounts of the participants. This was found to be compatible with the phenomenological nature of IPA that provides a ‘voice’ to participants (Larkin et al, 2006). Landridge (2004) describes an IPA thematic analysis involving three levels of codes grouped as first, second and third level codes which are formatted according to the different level of interpretation applied to the text.

The three levels of coding began with an inductive approach when identifying initial codes and merged into a deductive approach when creating the organising and main themes (Landridge, 2004). All six transcripts were only read in the first instance to become ‘close’ to the data, following which, each transcript was read for a second time whereby the first level
of descriptive coding was applied, with emphasis on reading and re-reading the transcripts line by line to create codes for the data through a process of operationalisation (Marks & Yardley, 2004). During the second and third deductive stages the organising and main themes emerged through a constellation coding system of sentences and paragraphs in the transcripts in order to explore the ‘nuances’ of recurrent themes with more precision (Huberman & Miles, 1994).

To ensure rigour in the data analysis the organising and main themes were reviewed at each stage; as themes emerged they were systematically checked against the data set and the preliminary themes identified (Fereday & Muir-Cochrane, 2006). This type of investigation aligns itself with the semantics of textual analysis whilst also promoting researcher reflexivity. Development of the themes was an iterative and reflexive process, from the initial stage of analysis until the final stage when the organising and main themes were determined. During the analysis, initial codes in the inductive stage were merged to correspond with the organising themes where appropriate; this decision was made to foster ‘internal homogeneity and external heterogeneity’ (Braun & Clarke, 2006, p.91). Furthermore, as the main themes were established, the intention was to categorise them in accordance to the narratives provided by participants, without simply ‘paraphrasing the content of the data extracts’ (Braun & Clarke, 2006, p.2).

Finally, the strategy adopted to analyse and present the results of the IPA thematic analysis follows a theoretical mapping process; this will involve three steps intended as a combined approach for the presentation of the results which assimilate into relevant discussion points. The first step will focus on an initial descriptive mapping of the accounts provided to illuminate common themes around this group of participants, and therefore each organising theme will be presented by illustrating extracts from the original orthographic transcriptions.
This will follow onto the second step of an interpretative mapping of the analysis with interpretative claims of phenomena identified by the researcher encapsulated within the synthesis of the analysis and discussion towards the end of each main theme, as the final step, supported by the relevant literature that localises the overall experiential accounts of the participants. This strategy is followed when reviewing each of the three main themes from the beginning to the end.

2.1 Diagrammatical illustration of main themes and organising themes

Figure 2: Demonstration of main themes and constituent organising themes

3. Main theme one: mending the ‘broken’ bridge

This theme is related to the Imams’ relationships with professionals in the wider field of allied health and social care spheres and public services; when referring to ‘professionals’ this is what is intended here unless otherwise specified. When discussing their involvement, or lack
of, with professionals, the Imams appeared to either signpost, recommend or encourage members of their congregation to seek support from professionals with the mind-set that they will be provided with the help that is required. The Imams themselves demonstrated an anticipation and/or expectation that professionals would provide the necessary provision for the Muslim community, and effectively ‘mending the broken bridge’ for the Muslim community in their recommendations.

In the first organising theme, ‘dependence on other professionals for facilitating meaningful change’, the Imams described the roles and expectations of professionals to be adequately equipped with providing the required support for Muslim individuals; in doing so the Imams themselves maintained a level of trust in professionals to appropriately address difficulties that are presented to them. In the second organising theme ‘ambivalent relationship with other professionals; frustration and positivity’, the Imams reflected upon their personal experiences, encounters and outcomes as a result of either direct or indirect involvement with professionals.

### 3.1 Organising theme one: dependence on other professionals for facilitating meaningful change

The Imams frequently described the multimodal needs of the Muslim community, and saw these needs to be attended to by professionals as continuing support. As a result the Imams deemed the role of other professionals as appropriate avenues, and indeed, a resource which should be accessed when the need arose. Participant one commented on their views and their interaction with professionals:

‘If you read all NHS schemes, it is their duty to help and support.’ (Participant 1; L14-15).
‘They [Muslim individuals] are living in British society and if they have any cultural problems or any emotional problems, they can go to Imam first, their first choice. Second to their GP to share, and then get some care from GP.’ (Participant 1; L14-15).

‘XXX mental issue department [secondary mental health community service], they are also coming forward to help and support us with their many methods, and their equipment, including their many posters and flyers [advertising mental health services and initiatives] and so on and so forth.’ (Participant 1; L225-227).

Participant one made a general statement that ‘all NHS schemes’ have a duty of care, and they perceived their role to be aligned with GPs and community mental health services in providing a merged system of support to the Muslim community. Here, the Imam encouraged interaction and co-working with professionals to enhance the support provided. Participant two also echoed similar experiences:

‘So when people are coming to me also, if, I think people are having, physical problem, as in any disease, so I motivate them and request them to go visit their GP, and if problem is more severe, so they should ask GP to referral towards the consultant.’ (Participant 2; L23-25).

‘We know what kind of sources are available, what kind of jobs, doctors, expertise, they are available around us, so, we try our best according to our knowledge, according to our employers, we try to guide them, and if we go through proper channel, and get treatment, and get the problem sorted out.’ (Participant 2; L100-103).
‘With the other aspect of treatment is, you know, one thing is the psychological effects, so when a patient is going and visiting a doctor, so, he or she is thinking now, they are in front of doctor and doctor will give them advice and medicine, and then they will be ok.’ (Participant 2; L27-29).

Here, the Imam made reference to both physical and psychological difficulties and suggested the GP to be the port of call and medicine as a treatment approach. The Imam displayed a strong conviction for the ‘sources that are available’ to ultimately ‘get the problem sorted out’. This particular Imam is also a qualified physician, and their approach to resolving physical and mental health related difficulties are presumably influenced by conventional medicine. Their position is unique here in both their religious and medical training, and their knowledge of ‘what kind of sources are available’ and following the ‘proper channel’ to ‘get treatment’ characterised the belief that professionals are competent in the service they provide. This conviction and belief was also evident in the account provided by participant three:

‘When people who might be suffering, or have been, made aware of, you know, the importance of gaining help, of getting help, then obviously, then we assume that, GPs will take appropriate measures, and then, you know, forward their respective patients to, respective agencies, where they can get additional help.’ (Participant 3; L239-242).

‘In the community, for example, I personally, because we haven’t, we haven’t been involved in the mental health, institutions, at most, we have, like I said, referring the matter to the GP, and for them to get involved, and take responsibility. (Participant 3; L239-242).
Participant three acknowledged ‘the importance of gaining help, of getting help’ from GPs and ‘assume that, GPs will take appropriate measures’ with the hope that they will ‘forward their respective patients to, respective agencies’ where the appropriate attention will be provided. Here, the Imam also designated the GP to ‘take responsibility’ when matters of mental health were recognised. This concept of responsibly and the role of professionals as suitably placed to take charge is also shared by participant four:

‘So, there is always space, to contact people [professionals] who are above, there is always space for people with more experience, there is always space for an extra opinion I think, and if we don’t have that mentality, that feeling in our heart, “I can seek another opinion”, and you think “No, it’s my opinion that’s the final decision,” then really is wrong, I think, if we make our opinion the last opinion, our decision the last decision, then ninety percent of the time we will be wrong.’ (Participant 4; L380-384).

‘Even if a person, with a mental health issue, was a non-Muslim, walks in here and I feel, and I sense that, this person needs a bit of a, attention and support, I would really appreciate it if I could contact mental health services for this, I mean, this would be a great help, as a wider, community support, I believe.’ (Participant 4; L576-579).

Here, the Imam observed how ‘there is always space for people with more experience’ in dealing with the problems presented to them, placing emphasis on the valued roles of professionals and their input. The Imam further stated that they would ‘appreciate’ if they ‘could contact mental health services’ as this ‘would be a great help, as a wider, community support’ indicating a sense of confidence in what might be available, without knowing exactly what this might entail. Participant five shared a personal account of what is actually made available:
‘Recently, I was sent an email by somebody, who, clearly said he was depressed, he said “I am depressed, and they want me to go on medicine, is it halaal for me to do so?” I said of course, if you are, if you’ve got a physical ailment, you will take medicine, so likewise, you’ve got a mental problem which you yourself are confessing, and acknowledging, then of course, take that.’ (Participant 5; L26-29).

‘She was put into a special [secondary mental health service] hospital, and after a few months, after all these interviews [psychiatric assessments], consultations were done and everything, she reacted positively to the [antipsychotic] medication she was given, and, she was fine, that reinforced for me the fact that she didn’t have a Jinn problem, or a magic problem, she actually had a mental problem.’ (Participant 5; L94-97).

The Imam revealed the details about the consultation they provided to a Muslim individual on the matter of antidepressant medication, and reassured them that it is ‘halaal’ or permissible for them in Islam. Similar to participant two, the Imam ascribed medication for physical health issues akin to a mental health issue, which extended to the example of the Muslim individual who responded ‘positively to the medication she was given’ which ‘reinforced’ to them ‘the fact that she didn’t have a Jinn problem, or a magic problem, she actually had a mental health problem’. The notion of receiving psychotropic treatment for mental health difficulties was a shared understanding for the Imams and they seemed compliant to this approach. Participant six also confirmed this:

‘And they are professionals [mental health services], and they are looking, and taking care of these patients [secondary mental health inpatient settings], so if a patient is showing certain signs that he is, you know this issue medicalisation [symptoms of psychosis], so that is also, I found that also, is, needs to be addressed.’ (Participant 6; L37-40).
‘Working together, I think it is important, because it can happen also, it is nothing related to, you know, this Jinn and all that, they [those suffering from psychosis] just need, professional, medical help, medical care.’ (Participant 6; L355-356).

Participant six made reference to ‘this issue of medicalisation’ by which, they were referring to inpatients who received psychototropic intervention from secondary care mental health services. The Imam highlighted the fact that the professionals ‘are looking, and taking care of these patients’ who are ‘showing certain signs’ which ‘needs to be addressed’, by which they did not object to professionals essentially ‘doing their job’. Affirmed by participant five, participant six also denied the concept of Jinn being responsible for mental health difficulties, asserting that ‘medical help, medical care’ is the most suitable treatment. The insights provided by the Imams raises curiosity about the perceived role of professionals who are expected to either assess, provide treatment and/or refer onto other suitably qualified professionals.

Once the referral is made, and treatment is provided in either psychological or pharmacological form, professionals have a duty to educate themselves with the beliefs and supernatural explanations such as Jinn, black magic and the evil eye that is prevalent in the Muslim community, to enable Muslim clients to express their views freely without fear of being ridiculed or judged, although the underlying psychiatric disorders might be treated using conventional methods. While the Imams themselves dispelled the idea of Jinn being accountable for mental health problems, namely, psychosis, this is where the theme of the mending of the broken bridge took shape; the Imams themselves did not deny the existence or relevance of professionals, and displayed a strong compliance in favour of the Muslim community to seek and gain support from conventional services.
Although understanding is considered valuable, a health professional from a Muslim background may not be the first choice for some Muslim clients who fear their confidentiality will not be safeguarded from their community (Cinnirella & Loewenthal, 1999). With this in mind, Muslims who present to mental health services have a preference for therapists with basic knowledge and understanding of Islamic principles (Weatherhead & Daiches, 2010) or their cultural background (Kelly, 1996) due to a desire for treatment to comprise both Qur’anic guidance in the form of specific readings/prayers and Western medicine (Abu-Ras & Abu-Bader, 2008; Kelly, 1996). Muslim individuals may question the efficacy of the non-Muslim therapist who is unable to comprehend cultural and religious parameters, and subsequently make suggestions that may be in conflict with Islamic values and belief systems (Ali et al., 2004; Inayat, 2007). Such experiences could have a detrimental impact on the Muslim individual’s attitude toward seeking and receiving mental health treatment.

Adopting a culturally sensitive stance to mental health interventions with the Muslim community is fundamental. The Multi-Phase Model of Psychotherapy, Social Justice and Human Rights model (MPM) (Bemak & Chung, 2008; Bemak, Chung & Pedersen, 2003; Chung & Bemak, 2012) developed for the unique needs of the Muslim migrant community, is an excellent example of an approach that provides valuable resources to mental health professionals supporting this group. Following the MPM guidelines, the mental health professional is able to diversify their skills-set to meet the needs of the Muslim migrant individual; this may involve collaboration with significant others such as family members and friends, local religious and community leaders and community establishments such as education faculties and policy makers. Such an approach would be desirable in liaison with the Imams for the generic wider Muslim population.
This theme established how Imams themselves appeared to recommend that their Muslim congregants seek advice from professionals such as GPs, however further clarification would be useful to examine explanatory models of illness causation and how this is received and treated by professionals. Further investigation is required for professionals to be prepared to work in conjunction with Imams when necessary, as the Imams themselves are better positioned to provide consultation on matters of spirituality and religious belief systems for lucidity on the clinical presentations of Muslim clients. The concept of mending the broken bridge, clearly shown by the Imams themselves in their shared beliefs that professionals are indeed better placed to provide appropriate support merits further attention; this will create opportunities to identify and correct pitfalls pertaining to models of good practice by professionals themselves.

3.2 Organising theme two: ambivalent relationship with other professionals; frustration and positivity

When commenting on their experiences of working either directly or indirectly with professionals, or expressing their views about the resources provided by professionals, there appeared to be a divide of either feeling dissatisfied or disappointed or optimistic and encouraged by what was on offer. Participant one recognised the efforts made by the NHS, and also implicated the short coming in provisions:

‘Our NHS is trying to help and support, but the NHS fund is sometimes poor in meeting our needs, it is important to increase it, this is one department, one side. Second side is also important for us, second side is important to deal with mental health, only one [secondary mental health psychiatric] hospital is not enough.’ (Participant 1; L244-246).
‘It is very sad for the Muslim community, there was a big [secondary mental health psychiatric] hospital called XXX hospital in XXX, unfortunately it is two or three years closed, because they say there are funding problems this and that, but we have been very upset.’ (Participant 1; L249-251).

‘So it is very very sad for us, for our Muslim community here, that’s why we can’t control, as I said earlier on, the mosques, and other centres, only one [secondary mental health psychiatric] hospital, can’t control all the mental issues here, because of that lacking.’ (Participant 1; L253-255).

The deficiency of funding available within the NHS struck a chord with the Imam, who testified that it ‘important to deal with mental health, only one [secondary mental health psychiatric] hospital is not enough’ suggesting that the services provided by secondary mental health services are valued and recognised. Furthermore, the Imam noted how ‘it is very sad for the Muslim community’ in view of the ‘funding problems’ causing them to become ‘very upset’ placing additional pressure on mosques who struggle to ‘control all of the mental issues’ as a result of the shortcoming of services provided. While this Imam depicted a sincere sadness about the funding complications leading to a particular secondary mental health hospital being shut down, they also implied that the resources available at the mosque were stretched in response to meeting the demands of the Muslim community. This sense of dissatisfaction was also found with participant two:

‘So this is, thing, we are really, this is our duty, according to our knowledge, we should try to understand the system, and guide our people [Muslim community], to get the best of the facilities, and, yes, NHS are doing good, but still, everywhere there is need to improve.’ (Participant 2; L291-293).
The desire for improvement of NHS services is something which the Imam would appear to capitalise if this were made available, as they showed a willingness to ‘try to understand the system’ in order to ‘get the best of facilities’ for the Muslim community, yet ‘everywhere there is a need to improve’. This exemplified that the Imam also viewed themselves as a facilitator of services, rather than providing treatment or support for those suffering from mental health difficulties, with the possibility of feeling out of their depth. This was not helped by the absence of professionals that are not making themselves accessible to the Muslim community, leading to the Imam taking on challenges which may extend beyond their remit. Participant three further expanded on this:

‘And if there is something we can’t handle, then, you know, we have to be realistic, and we have to, you know, own up to our responsibility, and then, for the benefit of the community and the person suffering, it is only right that they should be referred to relevant authorities, and be given the support that they need which we can’t offer.’ (Participant 3; L262-266).

‘I mean there are, you know, continually, increasing number of Islamic centres popping up, and communities are spreading, developing, so I think perhaps, if the mental health services took initiative as well, because many of the communities are not really aware, of this sort of support, which is actually available.’ (Participant 3; L280-283).

‘And if there are, were, sort of institutions who were eager to support or help, or offer help, then you know, we run various different pilot schemes here from the masjid, for example, helping people to stop smoking, especially in Ramadan.’ (Participant 3; L296-298).
Being ‘realistic’ and the need to ‘own up’ to ‘responsibility’ in view of ‘the benefit of the community and the person suffering’ took precedence for this Imam, who felt ‘it is only right’ that the individual ‘should be referred to relevant authorities, and be given the support they need’ which they ‘can’t offer’. Similar to participant one, here the Imam has indicated that they might not be fully equipped to address the difficulties relating to mental health which are presented to them, and they go on to explain how ‘perhaps if the mental health services took initiative as well’ this might serve as beneficial ‘because many of the communities are not really aware of this sort of support, which is actually available’.

The Imam offered further clarification by stating if there were ‘institutions who were eager to support, or help, or offer help’ this would complement the ‘various different pilot schemes’ that are run by the mosque, ‘for example helping people stop smoking, especially in Ramadan’. While the Imam did not openly assert their discontent with specific professionals by keeping it open to ‘services’, they conveyed a sense of disconnection from professionals, as well as an invitation for professionals to be more present in the mosque to increase awareness and availability to the Muslim community. The Imam professed a need for professionals to seek out the mosques and take the time to understand how they can integrate and assimilate, in order to maximise on the schemes that the mosque itself has already established.

The idea of building a stronger foundation and the merging of roles between Imams and professionals became apparent, and an indirect plea from the Imams to receive ‘back-up’ from professionals. Continuing with this thread of professionals lacking a presence, participant four considered forging relationships with professionals as a constructive step towards widening resources for the community:
'We need to link up with every organisation that we can, and that we see helpful, towards our community. We work with, our Islamic centre here has been built as a community centre, it's for the whole [including the wider non-Muslim] community.' (Participant 4; L398-400).

'I find it a very, very important point, a very, very, important issue, to deal with organisations that have expertise in certain types of field, and I was just mentioning that example, of people coming here from refugee centres, you understand, they could be from every walk of life.' (Participant 4; L456-459).

The ‘need to link up with every organisation’ is seen as beneficial ‘for the whole [including the wider non-Muslim] community, and this Imam deemed it to be ‘a very, very important point, a very, very, important issue to deal with organisations that have expertise in certain types of fields’ as the mosque is accessed by those ‘from refugee centres’, and ‘they could be from every walk of life’. This implied hopefulness in the idea of building relationships with professionals, as the Imams portrayed feelings of limitations in meeting all of the demands placed on them by the Muslim community. Participant five openly proclaimed the following:

‘I have got a video on YouTube about it, that, you know, first port of call should be your doctor, and then the specialist.’ (Participant 5; L176-177).

‘So it’s a difficult thing to determine, what is what, but generally I would say zhikr first, if more extreme, then go to the doctors.’ (Participant 5; L181-182).
‘I would think that, they probably need to come up with a consultation post, or something like that, so have a number of Islamic scholars as consultants on certain issues.’ (Participant 5; L327-328).

The Imam has ‘a video on YouTube’ advocating that the ‘first port of call should be your doctor, and then the specialist’, although they would encourage ‘zhikr first’ which is type of Islamic focused prayer performed in a meditative fashion, by recitation of the Qur’an. If the difficulty were ‘more extreme’ they were accepting to ‘the specialist’ being turned to. Moreover, the Imam professed the ‘need to come up with a consultation post’ in which Islamic scholars can act ‘as consultations on certain issues’ and the desire to work more closely with professionals. Participant six builds on this proposal as follows:

‘I think there is a need for Imams to also study counselling, to get professional help from the NHS, because most of the people [Muslim community] will not go, access the services of the NHS, they come to the Imam, and Imams are different types, not every Imam will deal with this situation.’ (Participant 6; L376-379).

‘NHS could offer this service, Imam can attend this course, given this extra training, on how to deal with people who have mental health, so when they are looking at it, they shouldn’t, they don’t even have to look at the religious texts, just understanding the principles around it, the different types of it, I think this will be very beneficial.’ (Participant 6; L396-399).

Participant six highlighted the concept of ‘Imams to also study counselling, to get professional help from the NHS, because most of the people [Muslim community] will not go, access the services of the NHS’ as they initially present to the Imam, and ‘Imams are different types, not every Imam will deal with this situation.’ The participant further described
that the ‘NHS could offer this service’ and Imams can receive specific training to ‘deal with people who have mental health’ and not necessarily ‘look at the religious texts’ in order to ‘understand the principles around it, the different types of it’ which they asserted ‘will be very beneficial’. Theoretically this could be a logical step towards supporting Imams with identifying, assessing and supporting those who seek their counsel from a psychological and therapeutic framework, however participant six alluded to the reality of different Imams having different personality types, who may not be agreeable to such initiatives.

Further challenging the impression of Islamic ministers following an authoritarian system with inflexible ideologies, as discussed in the personal reflexivity section of the methodology chapter, it was surprising that the participants expressed a shared understanding of the role of professionals in the context of mental health difficulties, and at large offered hints of wishing for movement towards a merged system with health services. This may have prevailed as a process of the Imams themselves experiencing high levels of demand from the Muslim community, struggling to cope with the strain, and uncertainty about the provision of services that are available. However, some Imams identified the lack of awareness by professionals about the setting of mosques where Muslim clients gathered, and thus, missing opportunities to make themselves accessible. This is a rhetorical occurrence supported by The Sainsbury Centre Report (2002), which found that the providers of mental health services were not acquainted with faith and cultural sensitivity within community mental health services. The participants themselves offered a general awareness of health providers such as GPs and local secondary mental health settings, although any relationships with these providers seemed invisible, and the Imams depended on a system that was simply ‘there’ and held hope for the best outcome.
The frustrations and reliance on professionals from mainstream services was mirrored by the Imams’ distress signals related to a lack of direct support from the macro structure of community services, and the pressures on the infrastructure within the mosques. The Imams spoke about deficiency of critical support which they were not receiving, and the need for more collaboration with professionals was highlighted. While the Imams clearly showed a willingness to mend the broken bridge between themselves and professionals, the beginning of bridging the actual gap between mainstream support services and the Muslim community can only begin with a ‘visible’ dialogue for sustainable change to even occur; perhaps this will instil confidence in the Imams that there are equitable support services who they can work with, and rely on, to relieve them of some of the pressures they are experiencing.

The Open Society Institute Report (2005) which explored the way Muslims lived in the UK, called for the government to acknowledge and identify Muslims as a distinctive social group which may have implications for legal and political decision making, in order to safeguard them from discrimination in both the public and private sector. The Imams themselves could play a critical role in the distribution of service delivery to Muslims living in the UK, not only in terms of faith led services, but also operating more actively with the public sector who fail to recognise faith leaders as a distinctive figure when tailoring their services. The gap between faith sensitive services such as mosques and statutory community services has remained un-bridged. Imams appear to be caught ‘between’ systems and do not have clear pathways from where they can seek support.

For the Imams it was important that they had a reference point to services, namely GPs, and that this was recognised in the support they offered. Many felt it was necessary for professionals to know and understand ‘what to do’ as the Imams did not view themselves as experts in the field. This is not surprising given that they lead a service which is faith-based
and predominantly driven by religious doctrine, while remaining adaptable and sensitive to those who displayed mental health difficulties and making their best attempts to understand where the individual should go to receive more attention. For some Imams, a natural solution would be to merge with professionals and develop a clearer framework for signposting, while for others the recommendation of incorporating a coherent Islamic framework involving Imams or Islamic scholars to assist with matters that are unique to Islamic principles and intertwined with faith. This is not to imply that the Imams themselves were not capable of managing the mental health difficulties of the Muslim community, rather, they felt professionals would be able to provide a more rounded support service in terms of responding to the sheer demand.

4. Main theme two: alleviating distress

This theme uncovered the Imams’ experiences of attending to the psychological and emotional needs of the Muslim community, and the various methods they have adopted in attempting to soothe the distress presented to them. In the first organising theme ‘perceptiveness of causes related to poorer mental health’ the Imams drew attention to factors which have instigated psychological and emotional turbulence among Muslim individuals who have sought their counsel, including difficult life circumstances, specific obstacles or barriers and relationship difficulties. The second organising theme ‘reactivity to the needs of the Muslim community’ encompasses the various ways in which the Imams have engaged with Muslim individuals in response to their psychological and emotional turbulence.
4.1 Organising theme one: perceptiveness of causes related to poorer mental health

The Imams were sensitive to the various help seeking behaviours of Muslim individuals, and attempted to identify, understand and deconstruct the various issues which may have contributed to their poorer mental health. Participant one observed a number of different aspects in this regard;

‘And also we are responding in our Khutbah, in our Friday sermon, to tell them [Muslim congregation] not to do so, don’t be abused by their parents, by their colleagues, by their friends, students, or at school, and they have room to share their problems.’ (Participant 1; L65-68).

‘If problems are recognised then accordingly we advise them. For example someone facing problems, mentally and emotionally for his or her marriage, we are giving them support. Number one support is advise them, number two counselling them, number three asking them to be together with their good friends and good relatives. Number four we are giving them advice to go outside of the mosque, go for holidays, take your wife with you or your mum with you and go sometimes outside, or go to Umrah, so they are connected with Allah Subhanahu Wa Ta’ala so they can find some peace and tranquillity and mental support.’ (Participant 1; L80-86).

Time and attention was dedicated to sending a message of self-care to the Muslim community delivered by the Imam himself during the Friday Khutbah; this disclosure merits further attention. The Khutbah is delivered by an appointed Imam in the form of Islamic oratory, to deliver doctrinal narration from the Qur’an and Sunnah. The origins of the Khutbah date back to the practice of Prophet Mohammed (PBUH) who delivered Islamic
guidance based on the revelations of the Qur'an to Muslim congregants on matters pertaining to Islam, spiritual practice, worship, wider Islamic conduct and values.

The Khutbah itself is highly regarded as an environment where one can learn more about Islamic ruling and attain knowledge and understanding to strengthen religious and spiritual fitness. While it is not customary to dedicate topics to the Khutbah which are not explicitly related to Islamic doctrine, the Imam sensed a need to communicate the concept of looking after oneself and encouraging others not to be ‘abused by their parents, by their colleagues, by their friends, or at school.’ In a Khutbah setting, it is likely that this type of lecturing will instil hope and encouragement in others to face up to situations in which they feel victimised, since the delivery from the Imam carries a significant amount of weight and virtue for the attendees. Furthermore, given assurance that ‘they have room to share their problems’ creates a gateway for Muslim congregants to seek guidance on areas of their lives aside spirituality.

Facing marital problems is another area which the Imam recognised as creating difficulty both ‘mentally and emotionally’ and addressing this by ‘giving them support’ in the form of advice and counselling, and ‘asking them to be together with their good friends and relatives’ while also encouraging them ‘to go outside of the mosque, go for holidays’ which was particularly striking. The advice and counselling provided by the Imam encompassed the idea of self-care as discussed above, and taking practical steps towards attending to ones needs by targeting social isolation and taking a vacation. Including the religious element of Umrah and being ‘connected with Allah Subhanahu Wa Ta’ala’ to ‘find some peace and tranquillity and mental support’ synchronised the counselling and advice in the context of being mindful of one’s emotional needs.
In the role of an Islamic minister, accessing spiritual knowledge is an automatic reference point when explaining the distresses of humanity and losing touch with the purpose of creation, ‘and be not like those who forgot God and He caused them to be oblivious of their own selves or souls’ (Qur’an, 49:19). As such, poorer mental health can be attributed to weakened spiritual fitness which minimises God-consciousness and self-awareness with spiritual elevation and closeness to God. The Imam distinguished the different dimensions of the individual’s life which may require nurture in various ways, which was also found with participant two;

‘My job as an Imam, one of, part of our job activity is, because, even, you know, in psychology and psychiatry, when we are going to have treatment of different problems, so, there are different alternative techniques.’ (Participant 2; L19-21).

‘So different psychiatric problem, or psychological problem, these are also, most of them are related with our life, with our surroundings, so sometimes, some people are having other diseases and then they are getting depressed, sometimes they are having family problems, family issues, they are having psychiatric problems.’ (Participant 2; L34-37).

‘We all are human beings, we need to be loved, we need to be respected, we need someone should be there, to listen our problems, and if someone can give us solution, so, then everyone is happy.’ (Participant 2; L83-85).

Making a comparison ‘in psychology and psychiatry’ where there is capacity for ‘treatment of different problems’ and the availability of ‘different alternative techniques’ is likened to the ‘job activity’ of the Imam in this instance. That is to say, here, the Imam conceded how different presentations require alternative ways of being managed, and thus illustrating their
breadth of causation for mental health difficulties. This is strengthened by the distinction made between *psychology* and *psychiatry* by not assuming they are the same or mutually exclusive, rather, isolating each as an approach with their own identity.

It is highly probable that the observation made by the Imam derived from their experience as a trained physician; accordingly this enabled them to discern key differences between approaches to mental health amalgamated into their ‘job as an Imam.’ This type of validation pointed towards a diverse perceptiveness of mental health difficulties and indeed how they have been shaped, given that ‘different psychiatric problems, or psychological problems, these are also, most of them are related with our life’. Significance was given to ‘having other diseases’ which were deemed in part responsible for ‘getting depressed’ as well as ‘having family problems, family issues’ contributing to ‘having psychiatric problems.’ The Imam made associations with factors of vulnerability related to psychology, psychiatry, medical diseases and interpersonal struggles in family environments since ‘we are all human beings’ with a ‘need to be loved’ and ‘to be respected,’ and we ‘need someone’ who is able to ‘listen to our problems, and if someone can give us solution, then everyone is happy.’ In their description the Imam ascertained that these vulnerable life factors are ultimately accountable for poorer mental health as opposed to superstitious explanations of Jinn possession or a product of magic.

Jinn are not featured as the cause of symptoms, psychological or psychiatric problems, rather, medical diseases and life factors are considered instrumental to poorer mental health; this postulation made by the Imam laid closely to their open and non-judgemental manner with recognition that symptoms and depressive presentations were not attributed to possession by Jinn. As such, the Imam who held the role of both a medical and spiritual
practitioner placed weight on the need to be listened to since ‘we are all human beings.’

Participant three also remarked on indicators which compromised emotional wellbeing;

‘If a young man, or a young woman is going through an anxious period, or through depression, many of the times parents, you know, they will take the initiative, and they will approach us and to see if we can help in any way.’ (Participant 3; L64-67).

‘Many a times people they need to be, you know, because, as you know times are difficult many young people are out of jobs, they are just being, just being around with their family, not doing anything, with their backs against the wall, that can have its own problems and demands.’ (Participant 3; L126-129).

‘Obviously, we have to be careful how, because, you know, sometimes we have to be sensitive to each case, you know, we don’t want to be, seen to be interfering too much, or, especially violence cases, there have been cases of schizophrenia, and so, you know, we have to be careful in how far we can, involve ourselves.’ (Participant 3; L149-152).

Attention was given to the experiences of young people ‘who go through an anxious period, or through depression’ and ‘many of the times parents’ who are concerned ‘will take the initiative’ and approach the Imam to see whether they ‘can help in any way.’ Drawing on the idea of vulnerable life factors as noted by participant two, participant three also identified how ‘times are difficult for many young people who are out of jobs’ resulting in ‘just being around with their family, not doing anything, with their backs against the wall’ which ‘can have its own problems and demands.’ Taking into consideration how unemployment can lead to ‘problems and demands’ added a further dimension to the concept of vulnerable life
factors presented to the Imam, further implicating the Imam’s flexibility to hold this in mind when trying to help the young person(s) with anxiety or depression.

However, the Imam also voiced apprehension about the extent of their involvement, the need ‘to be careful’ and not viewed as being ‘seen to be interfering too much’ with instances of ‘violent cases’ and ‘cases of schizophrenia’ which has created caution ‘in how far’ they are prepared to ‘involve’ themselves. The dilemma posed to participant three was split between what was observed as a problem in producing anxiety and depression in young people, and balancing this between safeguarding their own self from subsequent threat. Making reference to the ‘violent cases’ and ‘cases of schizophrenia’ evidenced the Imam’s involvement in past situations where some form of threat may have arisen as a by-product of deteriorated mental state, and subsequently created a threat detection system in dealing with specific attributes of poorer mental health. Again, no linkage is made to Jinn possession or magic as determinants of poorer mental health, rather, this continued matter of vulnerable life factors. That is not to say that all Imams hold this notion, although the experiences thus far are rooted in well-known causes for distress that are not unique to the Muslim community and transferable to the wider society.

Participant four drew on areas of the lives of others which had a detrimental impact on their psychological wellbeing;

‘The issues that people come up with here, whether it be, divorce issues, children’s issues, you always have that feeling that there is something mentally, also in the background.’

(Participant 4; L27-29).
‘You get people, emotional, who become emotional, people sometimes sit there and stare, in blank, not knowing what’s next, what’s coming next, you give them a piece of advice and it’s like shock, “oh, I didn’t know that”, so in cases like that, you feel, I sense, that there is something playing on the person’s mind, and which then turns into a mental issue.’

(Participant 4; L33-36).

‘Issues in life affect us, they affect us emotionally, they affect us mentally, and, on the long run, people don’t think about it in the initial stages, but people start to realise in the long run, when they get a bit older, children are around, families around, so then, things start to come up.’ (Participant 4; L43-46).

‘As you see the world has completely changed, if we read, when we read mainly history books, and the past, people were sort of more, mentally fit, mainly, of course, the factor is that the food that we eat, affect our mental health, and the environment we live in, affects our mental health.’ (Participant 4; L53-56).

Among those featured are ‘divorce issues, children’s issues’ and those ‘who become emotional’ who ‘sit there and stare, in blank, not knowing what’s next’ where the Imam sensed ‘that there is something playing on the person’s mind, which then turns into a mental issue.’ The Imam expressed how ‘issues in life affect us, they affect us emotionally, they affect us mentally’ and ‘people start to realise in the long run, when they get a bit older.’ Furthermore, participant four commented on how ‘the world has completely changed’ since ‘when we read mainly history books, and the past, people were sort of more, mentally fit’ which the Imam attributed to ‘the food that we eat, affect our mental health, and the environment we live in, affects our mental health.’ It is widely accepted that a healthy and balanced diet will have a positive effect on both our physiological and psychological
wellbeing, although it is interesting to notice this repeated pattern of vulnerable life factors that are associated with causing poorer mental health, with focus on the family environment such as ‘divorce’ and ‘children’s issues.’

Similar to participant two it is notable to reveal that participant four also holds a dual role as a spiritual practitioner and an Islamic teacher to children up to the age of 16. In their role as a spiritual practitioner the Imam has engaged with adults who have presented a range of different challenges they have been faced with, whilst in their role as an Islamic teacher they have also come across those unique to children. Nevertheless, their identification of matters of concern aligned very closely to those discussed by their counterparts, also professed by participant five;

‘I think any society, any community is going to have mental problems, because, that’s just such a, it’s just such a human issue isn’t it, it’s just the way, different people, deal with these issues is one thing, and how people who have these problems, what they reference them to.’ (Participant 5; L16-19).

‘One of the big things, is that, mostly when it is something unexplainable, not biological, a problem, then people [members of the Muslim community] will generally try to associate that with either magic, Jinn behaviour, or something from the unseen, and that’s, basically, what I have been trying to dispel.’ (Participant 5; L21-24).

‘Once she [individual diagnosed with psychosis by secondary mental health professionals] had, the Qur’anic verses, and everything around her room, that would have been enough to get rid of any Jinn, but, it didn’t work for her, right, so, which means that, she misdiagnosed herself, and she should have gone to her doctors.’ (Participant 4; L97-99).
'We, as Muslims, I think we need to create awareness, by bringing these examples, these case studies, like look this is what happened, and this case they thought it was magic, or, some external influence, but yet, it was just a simple, chemical imbalance, or some deficiency of some sort.' (Participant 5; L124-127).

By normalising that ‘any society, any community is going to have mental problems’ given that it is ‘such a human issue’ brought to light ‘when it is something unexplainable, not biological’ this may lead individuals ‘to associate that with either magic, Jinn behaviour, or something from the unseen’, which this particular Imam has been ‘trying to dispel.’ The Imam further expanded on their encounter with a Muslim female diagnosed with psychosis who had ‘Qur’anic verses’ displayed ‘around her room, that would have been enough to get rid of any Jinn, but, it didn’t work for her’ following which the Imam concluded that ‘she misdiagnosed herself, and she should have gone to her doctors’. The Imam stipulated ‘a need to create awareness’ by looking at ‘examples’ and ‘case studies’ of situations leading to deterioration of mental health related to ‘magic, or, some external influence’ whilst ‘it was just a simple, chemical imbalance, or some deficiency of some sort.’

Participant five displayed a fervent view about the notion of misdiagnosis related to Jinn, magic and the influence of the unseen, and their desire to dispel these in place of biological explanations for illness causation. The Imam’s exposure to case studies seemed to have influenced their belief in this regard, and acceptance of the biopsychosocial model in explaining mental states such as psychosis rather than attributing them to Jinn possession or the influence of magic. Again, this experience may not be shared by all Imams, although the data gleaned thus far has derailed traditional belief systems that are not promoted by the Imams who have taken part in this study. Rather, causes of poorer mental health have been continuously affiliated with vulnerable life factors, also substantiated by participant six;
‘I would say, personally being attacked, given the way the media is portraying the Muslim image media [coverage of terrorism associated with Muslims], so they are being pressured, that they feel, they are being put, really down, because of, the way they have been looked at.’ (Participant 6; L31-33).

‘Naturally, every Muslim, they are, living in this world, what’s happening in other parts of the world, it’s only natural for the people to feel affected, so, when they are seeing in the media [coverage of terrorism associated with Muslims], then, lots of them, they maybe, driven to do certain things, which is obviously, they need support, they need help.’ (Participant 6; L31-33).

‘Many of the, you know, natural, woman may feel, or, man also may feel, that they that have come under black magic, but it’s nothing to do with that, so it’s like, trying to understand, you know investigate, What is the real issue?’ (Participant 6; L69-71).

‘Sometimes it has been found, that even, between husband and wife, a woman can behave in such a way, they can, maybe, drive the husband to, you know, become, maybe, physical abuse, mental abuse, so I say also we have to do reflection of our own self.’ (Participant 6; L196-199).

An aspect not covered thus far is the role of the media, which participant six highlighted in ‘the way the media is portraying the Muslim image [coverage of terrorism associated with Muslims]’ causing Muslim individuals to feel ‘really down, because of the way they have been looked at’ and ‘driven to do certain things’ for which ‘they need support, they need help.’ This sensitive area pertaining to Islamaphobia brought to the Imam’s awareness can also be categorised under the umbrella of vulnerable life factors in terms of wider societal problems and victimisation. Participant six also raised the point of those who felt they ‘have
come under black magic, but it’s nothing to do with it’ rather it was more a question of ‘what is the real issue’ as ‘sometimes it has been found, than even, between husband and wife’ the presence of ‘physical abuse, mental abuse’ can be better understood by a ‘reflection of our own self.’ An endeavour to understand ‘what is the real issue’ lead participant six to take an investigative approach to deconstructing attributes related to poorer mental health, which revealed variables such as physical and psychological abuse in marriages, rather than the interference of Jinn disrupting the relationship. Taking an explorative stance with self-reflection, put forward by the Imam, is far removed from superstitious explanations for psychological distress.

As we are reaching the end of this organising theme, a clear unison can be observed among all six participants in both their perceptiveness and experiences of alleviating distress in others; these have largely been found to corroborate with vulnerable life factors that can extend to the global community when understanding human distress. It is useful to keep in mind that the participants identified with the existence of Allah Subhanahu Wa Ta’ala, and with that remained a permanent connection to Islam as a way of life legitimising spiritual and psychological explanations for society as a whole. A natural integration of the psychological and spiritual self was conveyed to reach a state of better self-care to harmonise mental health and emotional stability. Bringing about this consciousness in the Imams’ efforts to alleviate distress in others can be traced back to the spiritual concept of remembrance of God in Islam, fundamental to the Qur’anic explanation for wellness; ‘those who believe and whose hearts have rest in the remembrance of Allah. Verily in the remembrance of Allah do hearts find rest’ (Qur’an, 13:28).

The heart of Islamic epistemology is rooted in the integration of the psychological and spiritual self. Similar to the qualitative approach used in this research to acquire and
contribute new information in the field of social sciences, substantiated by a rigorous and empirical approach, the quest for truth and implementing empirical methods are also coherent with Qur’anic provisions. Observing Islam augments an internal trust in one’s engagement within a dual physical and spiritual reality; this is not dissimilar to the essence of IPA when understanding phenomena. Comparatively, the most striking difference of the Islamic approach is embedded in the conviction of both the spiritual and physical realities emanating from Tawid (monotheism).

When considering the Islamic study of phenomena in contrast to IPA, experiences are not subject to the physical and material environments and one’s interaction with them. Human limits are established prior to investigating inquiry from an Islamic standpoint inherent to the revelation of the Qur’an as a source of Divine knowledge beyond human capacity, from which the concepts of Ruh (soul/spirit); Qalb (spiritual heart); Nafs (self/ego) and Aql (intellect) form the human psyche. Muslim scholars have deciphered human perception governed by these concepts (Ansari, 1992) and the study of both human behaviour and mental health have also been interpreted using these Qur’anic frameworks, (Rizvi, 1989) to provide empirical findings on the human ability to reason when studying interpersonal and social relations.

In the extensive Islamic writings on the subject of the psyche, the Qalb (spiritual heart) is considered the most important. The Qalb is believed to contain the deepest spiritual wisdom of an individual (Inayat, 2005) from which intuition and understanding emanate; through the Qalb the individual becomes inspired to fulfil their Tawid and submission to Allah Subhanahu Wa Ta’ala. The Ruh refers to a connection with The Divine (Inayat, 2005) and the account in the Qur’an for the creation of Adam (PBUH) (32:9) and Mary’s conception of Jesus (PBUH)
(66:12) creates a link between Allah Subhanahu Wa Ta’ala and humans (Homerin, 2006) thereby providing the source for an individual’s spiritual development.

The Ruh further activates the Aql; responsible for rational decision making and Nafs; for governing behaviour which pre-date the psychological concept of ego (Inayat, 2005). The Nafs are sub-divided into three segments; i) Nafs Ammarah; this represents all of the essential qualities of a person including physical appetite and regulating deviant behaviour; ii) Nafs Lawwamma; one’s consciousness and sense of morality between what is right and wrong, and regulating this accordingly; iii) Nafs Mutma’ina; the inner state of pleasure and tranquillity for an individual. From an Islamic perspective, these distinct attributes are innate and make up the whole person, thus, forming their relationship with Allah Subhanahu Wa Ta’ala, and the personal conflict they may experience in the interest of society.

The classification of psychological and psychiatric disorders originated from Western medicine and an ethnocentric knowledge base (Crawford, 1994); diagnoses are clustered by the observation of a wide range of clinical symptoms persistent over a period of time agreed upon as determinants of psychological ill health. This negates cultural sensitivity, and any detailed understanding of the philosophical and religious beliefs of the Muslim individual and how these influence their beliefs about health, illness and treatment. This could help explain why a large proportion of the Muslim community prefer to seek counsel and advice from the Imam, who represents a spiritual sphere set aside from the Western medical tradition aligned to a biological model of explanation for human distress with the absence of religious, social and environmental factors.
The philosophical underpinning of Cartesian dualism, the secular notion of the mind and body as separate entities prominent in Western cultures divides the experience of the person into isolated components such as feelings of anxiety, auditory hallucinations, depression, and so forth. This depletes the significance of other meaningful life events and ideologies which mould human experience, including religion and belief in Allah Subhanahu Wa Ta’ala. Essentially this detaches the role of religion when understanding human suffering and wider scope for human distress, marking the distinctive differences between Western and Islamic psychology. As outlined by Frager (1999) mainstream psychology developed in the West holds the Universe as a tangible entity devoid of purposeful meaning, while the core of Islamic psychology proclaims that the Universe came into existence by the Will of Allah Subhanahu Wa Ta’ala, and for this reason life has a purpose. This creates a partition between assertions for overcoming ‘unhelpful habits’ and tendencies and how these are addressed.

Western therapists give precedence to the concept of self and how an individual’s identity can be shaped or distorted in the loss of identity, and thus becomes a pathological state of being. The self can emerge as multiple compositions such as the source of transpersonal knowledge (Jung, 1933), or the adherent of motivation towards psychological development based on a hierarchy for self-actualisation (Maslow, 1954). Some discriminated between the personal and collective self (Ellemers, Spears & Doosie, 2002) whereby the personal self is characterised as an assiduous awareness of who one is, whilst the collective self materialised from one’s social identity. Both concepts are important from an Islamic perspective, although separating oneself with an individualist identity casts a wall between Allah Subhanahu Wa Ta’ala, prohibiting closeness to a spiritual reality. (Frager, 1999).
4.2 Organising theme two: reactivity to the needs of the Muslim community

The Imams were very open when discussing their experiences of directly or indirectly responding to the mental health needs of those who sought it, and described a number of ways this was achieved. Participant one spoke about the involvement of the mosque;

‘They [Muslim youth] are attached with the mosque, and they are always coming to the mosque, the Imam, talking their problems and sharing everything with the mosque, their worry, their health, their education and everything.’ (Participant 1; L48-50).

‘If problems are recognised then accordingly we advise them. For example someone facing problems, mentally and emotionally for his or her marriage, we are giving them support.’ (Participant 1; L80-81).

‘Many youth people Mashaa Allah they have taken our services and after that they are coming with a very smiley face.’ (Participant 1; L123-124).

‘Some months ago we had given a Khutba, a Friday sermon about health issues and especially highlighted mental health, especially, and people Mashaa Allah, around the corner from that evening many phone calls came, and many people physically came to take the opportunity to make an appointment to see Imam to get the help.’ (Participant 1; L134-137).

Attendance to the mosque signified to this Imam that the Muslim youth ‘are attached with the mosque, and they are always coming to the mosque’ since they are ‘sharing everything with the mosque, their worry, their health, their education’ indicating a sense of trust in confiding to the Imam. This was legitimised by the fact that ‘many youth people’ have taken up the
services of the mosque ‘and after they are coming with a smiley face’ displaying satisfaction. This was also extended to those ‘facing problems, mentally and emotionally for his or her marriage’ whereby the Imam was active in ‘giving them support’ to address the necessary issues that had arisen. In response to the problems brought to their attention, this instigated the Imam to hold a ‘Khutbah, a Friday sermon about health issues and especially highlighted mental health’ which encouraged the attendees of the congregation ‘that evening’ to make ‘many phone calls’ to the Imam, and ‘many people physically’ went to see the Imam ‘to take the opportunity to make an appointment’ and ‘to get the help’.

While the type of ‘help’ offered was not clarified at this point, the Imam’s efforts with reaching out to the Muslim community via the Khutbah resulted in a mass influx of those wishing to arrange appointments with them, to presumably, explore their circumstances further. This was only made possible by the Imam’s openness to discuss the taboo subject of mental health difficulties with the community by recognising this to be a problem area in the wider context of health issues. This created a doorway for the Muslim individual to approach the Imam with reassurance that they were not going to be judged for experiencing mental health difficulties, as the Imam was the person who encouraged examination of such kind in the first instance. Indeed, it seemed this was one of the methods the Imam employed when reacting to the topic of psychological distress, and taking into consideration the factors which contributed to its prevalence. Participant two took a pro-active approach in partnership with local mental health services;

‘Recently in XXX, in partnership with the NHS, this is a chaplaincy, voluntary chaplaincy training, for mental health diseases, this is 10 week course, some of the volunteers [from the mosque], they are enrolled, and they are getting training.’ (Participant 2; L122-124).
‘So in olden times, or maybe in some parts of the world also, there is the creature, that is Jinn, so you know people are having mental problem, and, they are thinking they having Jinn, so, we are not promoting this idea here, because, like Angels, Jinn exist, but as Angels are not harmful for any of us, likewise, Jinn are not.’ (Participant 2; L274-278).

‘Mainly with elder people, so these people, work for the country, work for the nation, when they were healthy, they done, whatever they could do best, of their skills, and time they have, given to the country and the nation, so when they are elders, so we need to support them, we need to take care of them.’ (Participant 2; L323-326).

Participant two outlined in their local town they had been working ‘in partnership with the NHS’ which they described as a ‘voluntary chaplaincy training for mental health diseases’ run as a ‘10 week course’ which members of the mosque ‘are enrolled, and they are getting training’ in liaison with the NHS to include those part of the Muslim community to be integrated with services. Without access to the aims and objectives of this particular NHS organisation it is difficult to comprehend why such as initiative evolved primarily, although it appeared promising with the involvement of this Imam, also a physician, to attend to the ‘mental health diseases’ suggesting a medical approach to mental healthcare. The conceptualisation of mental health difficulties as a ‘disease’ put forward by the Imam fits within the context of the Islamic viewpoint of psychological unrest and it’s connection as a ‘disease’ of the ‘spiritual heart’; this will be discussed in more detail later in this chapter.

The Imam clarified how ‘in olden times, or maybe in some parts of the world also, there is a creature, that is Jinn’ and ‘people are having mental problem, and, they are thinking they having Jinn’ whilst the Imam is ‘not promoting this idea’ given that ‘like Angels, Jinn exist, but as Angels are not harmful for any of us, likewise, Jinn are not’.
Declaring that Jinn are not responsible for causing psychological ill health, in a sense, might have strengthened the drive for the voluntary chaplaincy training with the NHS in order to disseminate this knowledge and understanding. The Imam held concern towards others, whether it was those with ‘mental health diseases’ or the elderly who ‘work for the county, work for the nation, when they were healthy’ therefore ‘when they are elders’ there is a ‘need to support them’ and to ‘take care of them’ in their efforts to source the provisions available, and maximise them. Here, their experience can be explained as a divide between their spiritual profession as an Imam looking out for the needs of the community, and also as a physician reacting to human distress and ways of remedying this. Participant three also shared their encounters with the Muslim community;

‘You’re probably aware people have different reasons why the people feel anxious, or, depression or anxiety, so, some are physical symptoms that are actually related with work, or family stress, etcetera, so they do approach us.’ (Participant 3; L17-20).

‘Many a times, as Muslims, I’m sure you’re aware, we believe in other beings, we believe in the dark spirits around which can have, an effect on the person’s personality, and as such people are, obviously mainstream health service, and people don’t appreciate that, obviously mainstream society doesn’t believe, or doesn’t accept those sort of issues.’ (Participant 3; L25-28).

‘And there was, there was one case where there was a young man, he was, he needed support and attention, and he was, he was referred to medical authorities, I think he was, for a while, he was put into an institution, and I think he gained, he recovered quite reasonably, and he is now back in the community, so he has been visiting us, regularly.’ (Participant 3; L249-252).
When narrating their interactions with others, the Imam established that ‘people have different reasons’ as to why they identify with ‘depression or anxiety’ and ‘some are physical symptoms that are actually related with work, or family stress’ presenting environmental factors which cause one to become distressed. However, the Imam also made reference to the belief in ‘other things’ such as ‘dark spirits around which can have, an effect on the person’s personality’ which ‘mainstream health services’ and mainstream society’ does not ‘accept those sort of issues’. In contrast to participant two who advocated that Jinns are not responsible for mental health problems, participant three believed otherwise, and further commented on such beliefs are not accepted among the ‘mainstream health services’ and ‘mainstream society’ posing as a conflict in belief systems.

Although, when describing the ‘young man’ who ‘needed support and attention’; ‘referred to medical authorities’; and ‘put into an institution’ whereby he ‘recovered quite reasonably’ and was ‘back in the community’ and attending the mosque ‘regularly’ there did not accompany any implication of ‘evil spirits’ as responsible. Moreover, the Imam did not object to ‘medical authorities’ attending to the young man experiencing the mental health crisis, nor did they question the actions of the ‘mainstream health services’ despite a lack of belief of ‘dark spirits’ which contribute to a change in a ‘person’s personality’. In this example, the Imam indirectly demonstrated compliance to the intervention of ‘medical authorities’ as a means of providing support to the Muslim community.

Participant four communicated a combination of listening to others and using Islamic ruling when reacting to the disclosures presented to them;
‘I have had several cases like that, cases, like people asking for support, in that sense, they are feeling down, they are feeling low, asking for, a lot of times, to be honest, I get people who come in here, and they just want to really talk to somebody, do you understand?’ (Participant 4; L108-110).

‘A lot of people come here, they want an Islamic answer, do you understand, in a lot of issues, where sometimes it’s very difficult, to relate an Islamic ruling, to an issue that’s actually happening in a person’s life now, so this is where we have to actually use Qiyas; Qiyas is actually to, relate, the person’s issue in front of you, to something may be happened in the past, in the time of the Prophet, in the time of our Sahaba Radyallah.’ (Participant 4; L283-288).

‘A lot of cases, where it could be, coming back to this child issue, and school issues.’ (Participant 4; L283-288).

This Imam noticed that ‘people asking for support’ when ‘feeling down, they are feeling low, asking for, a lot of times’ a space to ‘really talk to somebody’ in order to confide their issues in an environment where they felt they were able to do so. The Imam made himself available during times when others simply wished to ‘talk to somebody’ which resounds with a psychotherapeutic model of ‘truly listening’ when Muslim individuals felt the need to be heard.

The Imam projected a humanistic way of relating to those who required a space to voice their concerns, and with this, enabled the indirect growth of a therapeutic setting without any formal recognition of its development. In essence, the Imam harnessed the skills of a
therapist in their ability to relate to others, and offering ‘safeness’ in their ‘spiritual practice’.
The Imam further noted how ‘a lot of people’ searched for ‘an Islamic answer’ although ‘in a
lot of issues’ it can prove ‘very difficult, to relate to an Islamic ruling, to an issue that’s
actually happening in a person’s life now’. In order to integrate the desire of others into an
Islamic framework, the Imam drew upon the use of ‘Qiyas’ which involved relating ‘the
person’s issue in front of you, something may be happened in the past, in the time of the
Prophet’ (PBUH) and ‘Sahaba Radiyallah’ as a way of helping others to understand their
experiences with religious and spiritual insight.

The Imam reflected on the difficulty of actually trying to relate somebody’s personal
circumstances to the time of the ‘Prophet’ (PBUH) and the ‘Sahaba Radiyallah’, and ‘a lot of
cases’ were correlated to ‘child’ and ‘school issues’. Nonetheless their humanistic approach,
to listen to the person in front of them motivated their efforts to apply Islamic ruling to the
best of their capacity, even when this might not have necessarily fitted into a neat Qiyas that
the individual could compare to.

Returning to the concept of Jinn as described by participant three, participant five also drew
upon this notion of the unseen;

‘So Muslims believe that Jinn can possess, now Jinns can be good or bad, and, there is this
belief that in the Muslim community, so if you have somebody who is making strange sounds,
or, voices, or, and they are having experiences.’ (Participant 5; L49-52).
‘She was put into a special hospital [secondary mental health service], and after a few months, after all these interviews, consultations were done and everything, she reacted positively to the medication she was given, and, she was fine, that reinforced for me the fact that she, didn’t have, a Jinn problem.’ (Participant 5; L94-96).

Given that ‘Muslims believe that Jinn can possess’ participant five clarified that ‘Jinns can be good or bad, and, there is a belief in the Muslim community’ if ‘somebody who is making strange sounds, or voices, or, and they are having experiences' this could instil the belief in others about the existence of Jinn, and the extent to their involvement with creating psychological distress. With this said, participant five described a situation whereby a Muslim female was admitted to ‘a special hospital [secondary mental health service] and after a few months’ following a series of ‘interviews, consultations’ the outcome was that ‘she reacted positively to the medication she was given, and, she was fine' which ‘reinforced’ to the Imam ‘the fact that she didn’t have a Jinn problem’ and returned to a state of healthy mental health. If the individual discussed was possessed by a ‘bad’ Jinn the admittance to a mental health unit, mental health consultations and pharmacological treatment may not have relieved this person of the Jinn possession; this is what the Imam insinuated here.

Furthermore, the Imam professed the individual reacting ‘positively’ to the medication given ‘reinforced' the absence of a ‘Jinn problem' or the interference of the unseen. This also supported the views of participant two who displayed a strong rejection to the theory of Jinn possession, and likewise, participant five appeared to be share this line of thinking also. The denunciation of the power of Jinns may give rise to a critical stance by this Imam when members of the Muslim community report Jinn as responsible for psychological distress. This in turn may also shape the way in which this Imam responds to the mental health problems presented to them, by considering alternatives treatment approaches outside the
parameters of the mosque; this may initiate more active collaboration with local mainstream services already seen with participant two. Differentiating illness causation not otherwise explained by Jinn factors appeared to be an important step for this Imam towards recognising the various ways a Muslim individual can be affected, as well as evidence that mainstream approaches are able to adequately and successfully respond to mental health difficulties. When reacting to the needs of the Muslim community, this participant has experienced that Jinn might not be held accountable for mental health problems. Participant six also followed this reasoning;

‘Whenever they want to see an Imam, it’s always something saying, “I need Rukiya,” they feel that they are possessed, mainly related to Jinn issues.’ (Participant 6; L16-17).

‘This is what we are saying, is that, there are people generally, they may come to you, I say, if you bring fear of Allah in your life, Allah will open up an avenue for you.’ (Participant 6; L98-99).

‘Somebody comes, now you just can, obviously he doesn’t want to have anything to do with religion, he just wants somebody to speak to, so you may give, listen to him.’ (Participant 6; L114-115).

In view of the topic of Jinn the Imam shared how individuals came to them for the purpose of ‘Rukiya’ given that they believed to be ‘possessed, mainly related to Jinn issues’ while the Imam himself professed ‘fear of Allah’ Subhanahu Wa Ta’ala alternatively since ‘Allah will open up an avenue for you’ in their attempts to deter others from pursuing Rukiya. Rather than practicing Rukiya the Imam advocated seeking refuge from God to overcome personal
difficulties, since experiencing ‘possession’ or what felt like psychological distress can also indicate a trial or punishment from God which is to be repaired by turning to God during times of distress. This can also be understood as regaining a connection with God given that psychological distress can be perceived to represent some form of moral transgression and distancing oneself from God; within this frame the Imam’s guidance on reacting to the subject matter of Rukiya seemed plausible.

As outlined by participant two, and confirmed by participant five, Jinn possession is not the automatic default Imams turn to for understanding and analysing mental health difficulties; this trend has become apparent through the various accounts given thus far. Aside religious and spiritual modes of reacting to the needs of the Muslim individual, the Imam also commented how sometimes ‘somebody comes’ and ‘he doesn’t want to have anything to do with religion, he just wants somebody to speak to’ in which case the participant would ‘listen to him’ similar to that of participant four. The Imam comprehended that the Muslim individual may not wish for religious or spiritual guidance such as Qiyas or a type of Zhikr, rather they needed to be ‘heard’ and as observed with participant four, this participant also valued the art of ‘listening’ which did not accompany Islamic ruling as a prerequisite. This agility to gauge what the Muslim individual needed which the Imam ‘delivered’ accordingly, represented a sincere approach with reacting and adapting to the person in front of them.

A number of deterrents minimise the rate of Muslims accessing appropriate mental health support within mainstream systems, and a great proportion trust that Imaan protects oneself against ill health as well as helping to manage mental health problems when they do occur. As highlighted in this organising theme, Imams are consulted for a wide range of difficulties including mental health problems, and it is also well-documented that Islam holds a dominant position with shaping the understanding of the Muslim individual in terms of
experience and expression in mental distress (Badri, 2000; Ansari, 2002). This conviction is also supported by the tendency to conceptualise illness as occurring according to the Will of Allah Subhanahu Wa Ta’ala, returning us to Islamic epistemology and the fusion of the psychological and spiritual self.

As reviewed earlier, within Islamic psychology the human psyche is delineated by the Ruh (soul), Qalb (heart), Nafs (self/ego) and Aql (intellect); it is widely accepted that these reside in the region of the physical heart, also considered as the location of emotional pain. Accordingly, somatic symptoms play a significant role in the Muslim cultural system given that both psychological and spiritual developments are considered to take place in the Qalb (Sheikh & Gatrad, 2000). From this standpoint the correlation is made between ‘psyche’ and ‘soma’ and the various ways in which physical and psychological problems interact. The emphasis on treating ‘psychological’ and ‘psychiatric’ diseases, and attending to one’s physical health as advocated by the Imams reverberates this tradition of the psyche and the soma with alleviating distress.

Moreover, psychological unrest is attributed to manifestations of an incongruent Qalb thereby linked to an unstable Ruh which has become distant from its Creator, Allah Subhanahu Wa Ta’ala. With this conceptualisation a healthy state of psychological wellbeing is aligned with a ‘guided’ heart that is stable and within the sanctions of Islamic teachings, while symptoms of chronic ill feelings imply a ‘misguided’ heart and the disapproval of Allah Subhanahu Wa Ta’ala. This somatic state is often referred to as an aching heart, trembling of the heart or a pressure in the heart since the Qalb is the locus of thought, feeling, awareness and memory where the Ruh, Nafs and Alq reside. While the mind/head are responsible for animation, one’s ability to ‘think’ and to be ‘aware’ is found in the heart, ‘that is because they believed, and then they disbelieved; so their hearts were sealed over, and
they do not understand’ (Quran, 63:3). This is further substantiated by the Qur’an; ‘and We have certainly created for Hell many of the jinn and mankind. They have hearts with which they do not understand, they have eyes with which they do not see, and they have ears with which they do not hear. Those are like livestock; rather, they are more astray. It is they who are the heedless’ (7:179). This supports the perception that ‘illness’ occurs as illness of the heart within our body and ‘thinking’ is closely associated with feelings within this expression, since ‘in their hearts is a disease’ (Quran, 2:10).

Given that psychological distress in the practising Muslim community is generally articulated as moral transgression or the ordained Will of Higher Power, religious interventions are commonly employed for healing purposes. Sawm (fasting), Taubah (repentance) and Zhikr (recitation of the Quran) are widely resorted to for the treatment and healing process; correspondingly the belief in the treatment is plausibly allied with the belief about illness. The structure of this belief is reinforced by the motivation of regaining a meaningful connection/relationship with Allah Subhanahu Wa Ta’ala, whilst simultaneously enabling one to gain a cognitive insight of their situation. This is thought to moderate one from committing sin and thus relief from psychological unrest, resulting in better health. This understanding is also relayed in the Qur’an since ‘surely in the remembrance of Allah do hearts find rest’ (13:28).

Illness is one method of connection with Allah Subhanahu Wa Ta’ala, therefore ‘...an event, a mechanism of the body, that is serving to cleanse, purify, and balance us on the physical, emotional, mental, and spiritual planes’ (Rasool, 2000, p. 1479). This distinct mode of thinking is repeatedly found in various studies on the perspectives of Muslim community members encompassing both physical and mental illnesses (DeShaw, 2006; Ypinazar & Margolis, 2006; Shah et al., 2008; Padella et al., 2012). Conversely, psychological ill health
may also be regarded as a trial or punishment from Allah Subhanahu Wa Ta'ala (Rasool, 2000; Abu-Ras & Abu-Bader, 2008;) further substantiated by the belief of Kader (destiny) which holds a strong presence in Muslim culture (Shah et al., 2008).

Kader can also be perceived as positive acceptance from Allah Subhanahu Wa Ta'ala to optimise healing (Hasnain, Shaikh & Shanawani, 2008; Nabolsi & Carson, 2011), and opportunity to repair disconnection from Allah Subhanahu Wa Ta'ala or a diminished Imaan through regular prayer and a sense of self-responsibility (Cinnirella & Loewenthal, 1999; Padella et al., 2012; Youssef & Deane, 2006). Imams are often seen as facilitating the healing process by permission of Divine Will (Abu-Ras & Abu-Bader, 2008; Padela & Heisler, 2010; Padella et al., 2012) and thus are seminal with shaping attitudes and responses to illness in the Muslim community (Padella et al., 2012).

There is a strong presence of stigma that is associated to mental health and treatment of psychological conditions evident in multiple non-Western cultures. The stigma not only associates itself to the individual who is unwell, it also implicates the family whom that individual belongs to (Aloud & Rathur, 2009; Hsu & Alden, 2008). The belief that psychological distress are attributed to a lack of Imaan or a misguided heart in the Muslim community, discourage Muslim families and individuals from seeking help for their psychological problems for fear and anticipation that it may cause shame upon their family, or portrayed as being weak. Many non-Western cultures also hold that confessing a mental health problem is a form of ‘loss of face’ and shameful (Aloud & Rathur, 2009; Cauce et al., 2002; Sarfraz & Castle, 2002; Vogel, Wade & Hacker, 2007).
For the Muslim individual the social stigma is particularly profound, given that Islam is perceived as a pure source for healing and internal strength in the context of mental health (Ali, Milstein & Marzuk 2005; Ghaffari & Ciftci, 2010), and mental health problems are often expressed as physical symptoms of the body which are less stigmatised (Al-Krenawi, 2005; El-Islam, 2008). Substantial evidence suggests that explanatory models of illness vary considerably across cultures, which subsequently impacts the type of help that is sought for a particular illness (Lynch & Medin, 2006). Moreover, research signifies that beliefs about the cause of mental health problems will affect how mental health services are viewed and the prospect of seeking help (Hill & Bale, 1980); this may explain why Imams are approached since it is more socially acceptable to seek help within the community in order to protect the family from an unfavourable public opinion (Carolan et al., 2002; Ali, Milstein & Marzuk, 2005; Al-Krenawi & Graham, 2000).

5. Main theme three: role identity

The final theme encapsulated the various roles the Imams appeared to have taken on in their interactions with Muslim individuals who sought guidance when experiencing psychological distress. The first organising theme ‘becoming the learned helper’ depicted how the role of the Imams were multifaceted in the range of areas they provided consultation; this extended beyond the sphere of religion and spirituality. The second organising theme ‘embracing the role’ imparted personal accounts of how participants experienced their roles as Imams and the various pressures which accompanied this.

5.1 Organising theme one: becoming the learned helper

The Imams showed an openness and awareness of the various difficulties that can have an impact on an individual’s wellbeing, and have attempted to address these areas even when
it is not necessarily in the remit of their roles. Participant one commented on various aspects in this domain;

“We are here to support them always, with physical support and emotional support, giving them advice, suggestions, giving them some, what do you call it, if someone loneliness facing, then we are giving them companionship with our educated people they are going to support them.’ (Participant 1; L61-64).

‘Few months ago, in XXX, we highlighted a Khutba on parenting. When we discussed this matter in our Khutba and many people came to us to do some parenting courses and Mashaa Allah accordingly we started one with at least twenty-two people, and now this parenting course, which will be finishing Inshaa Allah XXX with thirteen sessions, males and females together, husband and wife, and they are taking it very seriously, they are learning and amongst those, twenty, few people were vulnerable and about to finish their relationship but Mashaa Allah they are now very very happy and came together, bounded together and Mashaa Allah they are living together very nicely with family. And also another course we designed, Inshaa Allah after Ramadan in XXX we are going to start, only for husband and wife, for couples.’ (Participant 1; L145-153).

‘We have in this mosque a deaf society, deaf organisation here it’s called al-ishara, ishara means sign in Arabic, so sign language people means deaf people, are accommodated here at least eighty people here for weekly Jummah, they are coming here to learn the Khutbah, and they are here even also, we have appointed two body language people, one is male and one is female, and all together about eighty people come every Friday to learn the Khutbah, it is a big mental issue.’ (Participant 1; L145-153).
Social isolation contributes to poorer mental health (Heikkinen & Kauppinen, 2004) and cognitive decline (Barnes et al., 2004; Wilson et al., 2007); this was recognised by participant one who advocated that providing ‘physical support and emotional support’ in the form of ‘giving advice, suggestions’ for ‘someone loneliness facing’ by ‘giving them companionship’ with ‘educated people’ who are ‘going to support them’ in the mosque setting. The Imam’s efforts to address social isolation emerged out of their experience of witnessing individuals whose mental wellbeing have declined as a consequence of seclusion. While it is not the responsibility of the Imam to address this area, they took it upon themselves by using the resources accessible to tackle this problem and involving other mosque members in the process.

In addition, the Imam also ‘highlighted a Khutbah on parenting’ where ‘many people came’ to undergo the ‘parenting courses’ in which ‘males and females together, husband and wife’ took the course ‘very seriously’ that included those who were ‘vulnerable and about to finish their relationship’ who following the course, were ‘very very happy and came together, bounded together’ and ‘living together very nicely with family.’ The Imam went on to describe how the success of the parenting course lead onto the anticipated start of a further course ‘only for husband and wife, for couples’ who may be going through relationship difficulties. Aside paying attention to systemic problems within families, the Imam also set up a ‘deaf society’ at the mosque ‘called al-ishara’ which ‘means sign in Arabic’ to accommodate the needs of people with auditory impairment. The dedication was such that the Imam accommodated ‘at least eighty people’ at the mosque ‘for weekly Jummah’ in order for them to ‘learn the Khutbah’ with the aid of two body language people [sign language interpreters] of each gender to ensure that both male and female congregation members received equal services.
Participant two also shared the numbers of ways their role as an Imam included religious and wider consultation not related to the spiritual self;

‘The other thing, that is like, hypnotherapy, counselling, likewise, in Qur’an it has been said, the words of Qur’an, verses of Qur’an, have treatment, Shifa, so there are different verses, and different chapters of Qur’an, so if we read in a particular way, so that can cure psychological problems, psychiatric problems.’ (Participant 2; L43-46).

‘So we have to work with the knowledge, with research, and something that is good, available for us in the form of NHS, in form of doctors, our medicine, spiritual treatment also. When someone is having problem, or seeking for the support, and we are support’. (Participant 2; L56-59).

‘You know, as Imam, as with the rest of religion, so we have direct contact with community members, so children, ladies, gents, young people, old people, and people trust on us, and our job is to guide them, the right way. So, first of all, that is anything they are going to share with us, that is confidential, so this is our professional requirement, that we have to have to keep confidential, the things that people, the information of people.’ (Participant 2; L79-83).

‘People, they contact us, having their problem, and it is not only mental problems [common mental health difficulties], many problems, people are coming and sharing, and we, wherever we can support them, and we can help them, so some people they are not having job, so if we can, guide them, and support them, if we have information there is jobs [from the local job centre], so we are helping them, to get the job.’ (Participant 2; L85-89).
Here, the Imam drew upon a number of different variables. Firstly they discussed how ‘like hypnotherapy, counselling, likewise in Qur’an it has been said, the words of Qur’an, verses of Qur’an, have treatment, Shifa’ and it is believed that the ‘different chapters of Qur’an’ when ‘read in a particular way’ has the ability to ‘cure psychological problems, psychiatric problems’. Drawing on the literature reviewed earlier in this chapter, it is not surprising that the Imam has used the Qur’an as a reference point to overcome mental health difficulties, and this is entirely plausible given their profession as a minister of Islam.

Nonetheless the Imam also attributed the need to ‘work with the knowledge, with research, and something that is good’ and the resources provided ‘in the form of NHS, in form of doctors, our medicine’ whilst taking into consideration ‘spiritual treatment also’. Following this, the Imam pointed out ‘as with the rest of religion’ they themselves ‘have direct contact with community members’ ranging from ‘children’ to ‘old people’ that ‘trust’ the Imam, and everything shared with them ‘is confidential’ which the participant viewed as their ‘professional requirement’ that they ‘have to keep confidential’ to preserve ‘the information of people’. This code of ethic observed by the Imam is very similar to that of the NHS or an institution which upholds anonymity and confidentiality, which further demonstrated their stance as a learned helper who followed regulations in the interest of protecting vulnerable individuals who shared sensitive information about their lives.

Building trust resulted in community members contacting the Imam ‘not only for mental problems’ [common mental health difficulties]’ since they have also been involved with supporting those who ‘are not having jobs’ by using information when a job vacancy has become available by ‘helping them’ in the process ‘to get the job’. The Imam’s expertise have extended beyond religious counsel given that suicide (Lewis & Sloggett, 1998; Blakely et al., 2003) and mental health difficulties (Paul & Moser, 2009) have been associated with
unemployment, in addition to negative changes in mental health state following job loss (Hudson, 2005). Similarly, participant three expressed how their position varied in the role of the learned helper;

‘We do offer counselling and we offer support, and wherever a need, we will help them, the community member, be it male or female, we assess, or get a, personal family problem, and we try and liaise with the family.’ (Participant 3; L20-22).

‘If a young man, or a young woman is going through an anxious period, or through depression, many of the times parents, you know, they will take the initiative, and they will approach us and to see if we can help in any way.’ (Participant 3; L64-67).

‘They [NHS smoking cessation service] come into the mosque on Fridays, they have their stand, and you know, they take names, and details, and offer confidential advice, like, the issue of smoking, is, there is a bit of stigma attached to smoking, especially around women, and, in Muslim families, as you’re aware, if there is a young girl who smokes, it’s a very big taboo, and so, they’re coming, and you know, they’ve offered, confidential services, and helped them overcome their problem.’ (Participant 3; L305-309).

‘If someone has a difficult patch then obviously, we try to make them aware, you know, of hardships and suffering, sometimes a test can come and we resort to Allah, and realise mostly for them, Allah blesses and Allah guides, solves our problems.’ (Participant 3; L123-126).
The Imam referred to how they 'offer counselling' and they 'offer support' when there is an identified need, and they are prepared to help 'the community member' whether 'male or female' who may be experiencing 'personal family' difficulties where they may 'liaise with the family' to resolve family conflicts. Even when 'a young man, or a young woman is going through an anxious period, or through depression, many of the times, parents' have also taken 'the initiative' to consult the Imam for their involvement; this echoed participant one with attending to systemic problems in the Muslim community. The Imam also revealed their involvement with an NHS smoking cessation service ‘who come into the mosque on Fridays‘ and ‘they have their stands’ to ‘offer confidential advice’ in relation to ‘the issue of smoking’ to which ‘there is a big stigma attached’ particularly for females. The Imam explained how ‘in Muslim families’ the concept of ‘a young girl who smokes’ is regarded as ‘a very big taboo’ therefore having the NHS smoking cessation service present at the mosque ‘has helped them overcome their problem’ supported by the Imam, since without their permission the service would not be available at the mosque.

The Imam also professed ‘if somebody has a difficult patch’ they ‘try to make them aware’ that ‘hardships and suffering’ can be ‘a test’ and to ‘resort to Allah’ since ‘Allah blesses and Allah guides, solves our problems’ which was also described by participant two. This served as a reminder of the spiritual role of the Imam as well as the alternative resources they have provided. Participant four gave a more detailed account of the religious and spiritual element of becoming the learned helper;

‘I have people come here, who are actually elder, each, who are facing a lot of issues, and then when you advise them, ok try to make connection with the Quran, try to read a little bit on a daily basis, they come back, and they feel, that some changes happened to me.’

(Participant 4; L60-62).
'It’s just a matter of, they have got an issue in their mind, they might be a hundred percent sure that I am going to see the Imam, he is not going to be able to do anything for me, but at least there’s somebody who is going to listen to me, and there’s somebody who I can talk to, and this is very important.’ (Participant 4; L110-113).

‘Listening to them, gives the feeling of at least, somebody has heard me, you know, it’s going to somebody’s ears, and when a child, not just a child even adults, when they have that feeling of, there is somebody who I can talk to freely, and it’s confidential.’ (Participant 4; L127-129).

‘To actually fall into mistakes, and given us the opportunity to repent, and this is the point where, we need to listen to people, when you listen to people, they will be more interested in learning how to repent.’ (Participant 4; L132-135).

‘We actually, take the Qur’an, as our manual, so we refer to the Qur’an, what am I going to do now, is it right, according to Qur’an, it is wrong according to Qur’an, where does it stand, is it something that is completely forbidden, is it something that is completely allowed, so we have the two extremes, or is it something in between, that maybe, disputed over, you understand, if there is a dispute, let me research, engage and seek in knowledge.’ (Participant 4; L424-439).

Participant four explicitly outlined how, when interacting with individuals ‘who are facing a lot of issues’ they ‘try to make connection with the Qur’an’ and encourage ‘to read a little bit on a daily basis’ with the outcome being individuals have reported ‘changes’ to their wellbeing. The Imam further stated if somebody has ‘got an issue in their mind’ and being available to speak to the individual ‘is very important’ given that ‘listening to them’ gives the individual the sense that ‘somebody has heard me’ which is ‘confidential’ also highlighted by participant
two. In connection to this, the Imam articulated when individuals ‘fall into mistakes’ it created an ‘opportunity to repent’ whereby they saw a ‘need to listen to people’ as ‘they will be more interested in learning how to repent.’

This idea of repentance was relayed back to the Qur’an as a ‘manual’ to understand ‘is it right’ according to Qur’an, or ‘is it wrong according to Qur’an’ and ‘is it something that is completely forbidden’ or ‘is it something that is completely allowed’. However, if something is ‘disputed over’ the Imam would ‘research, engage and seek knowledge.’ In this sense, the Imam’s religious knowledge is relied upon by the Muslim individual with understanding what is right and wrong according to the Qur’an, and helping them reach conclusions based on religious interpretations. A similar thread was also found with participant five;

‘I told her [Muslim female who sought religious consultation] to do specific type of meditation, and after about three weeks, I get an email from her, saying that, “I have been doing that meditation and now I am sleeping better than I ever slept even before my problems started, like I am completely fine”, so, a lot of things can be dealt with just by Zhikr, remembrance, so you have to gauge, I would have to gauge, what level is this problem at.’ (Participant 5; L150-153).

‘I try to be more versatile, but then I know my boundaries of how much I can help, so then, the other thing, from a spiritual perspective is that, if I go and give a lecture somewhere to two hundred people, maybe only twenty people will take it seriously, so the return I get is twenty people, right, maybe, because, everybody comes to a speech, but they don’t all come to implement, they come for entertainment, sometimes they come to meet friends, or whatever, when you write a book, again, it’s maybe five, ten percent that may take up something, but, when somebody comes to you with a problem, a Fatwa, or an issue like this, then that
generally has a ninety nine to a hundred percent return, in terms of spiritually, because you are helping them directly.’ (Participant 5; L277-284).

In line with becoming the learned helper, participant five drew upon a ‘specific type of meditation’ which they recommended to a Muslim female who sought religious consultation due to sleep difficulties; the individual reported a significant improvement to their sleep which signified to the Imam that ‘a lot things can be dealt with just by Zhikr, remembrance’ although they would ‘have to gauge’ firstly ‘what level is the problem at’ to make a recommendation. The Imam further stipulated that they ‘try to be more versatile’ whilst being mindful of their ‘boundaries of how much’ they ‘can help’ showing evidence of the internal gauging system they referred to.

When considering ‘a spiritual perspective’ the Imam reflected on when they ‘give a lecture somewhere to two hundred people, maybe only twenty people will take it seriously’ therefore the ‘return’ they will ‘get is twenty people’ whereby when ‘somebody comes to’ them directly ‘with a problem, a Fatwa, or an issue like this, then that generally has a ninety nine to a hundred percent return, in terms of spirituality’ since the individual is being helped ‘directly.’ Here, for the participant being the learned helper had a two-fold effect in that not only did they equip the individual with ‘spiritual tools’ with the hope of aiding the problem they wished to address, the Imam maintained it also boosted their ‘spiritual return’ which in Islam relates to pleasing Allah Subhanahu Wa Ta’ala and earning reward in the afterlife. This testament was also shared by participant six;

‘Qur’an is a book of healing, Shifa, so the Qur’an, we have to encourage people can use it as a means of curing their sickness, illness.’ (Participant 6; L64-65).
‘Sometimes obviously when somebody comes to you with a problem, now, as a person of faith we have to give them guidelines, that, if you have a problem, and if you are looking for help, are we performing our prayers?’ (Participant 6; L90-92).

‘So many issues, if you start by making a full recording, I think you could write a book, but we never record it, because, of not getting time, because you don’t have to do any of it, I just do it, because I feel people need it, obviously.’ (Participant 6; L306-308).

‘Even if it out of my work time, anything, you can’t, I just, this is, you know, you just have to, do it, because I look at it that way, I don’t say this is part of my duty.’ (Participant 6; L312-313).

As described by participant two also, participant six related back to the Qur’an as ‘a book of healing, Shifa’ ‘to encourage people’ to ‘use it as a means of curing their sickness, illness’ in their role as the learned helper, to pass on their knowledge ‘as a person of faith’ so that they can provide ‘guidelines’. They recalled with the ‘many issues’ if they were to make ‘a full recording’ they estimated they ‘could write a book’ on the accounts provided by others, however the Imam chose to ‘never record it’ due to ‘not getting time’. Nonetheless the Imam asserted that ‘people need it’, direction and guidelines which is also provided outside of their ‘work time’ as they feel they ‘just have to’ in their ‘duty’ to others. This sense of providing guidelines based on the Qur’an, drawing on religious guidelines and monitoring the effects of it is synonymous to an individual seeking support from any other professional who provides a personal service, and the Imam is relied upon as a reliable and trustworthy source, although there appears to be some indication that the role can be demanding if the Imam is working outside of their working hours to follow-up cases or respond to new ones.
In reaching the end of this organising theme, some clear patterns have emerged concerning the various ways the Imams undergo their roles as the learned helper which is not exclusive to religious and spiritual consultation and guidance, although religion interpretation has featured throughout. The Imams have focused on the role of spirituality as an important aspect in the life of the Muslim individual, whilst also taking into consideration ‘real life’ issues such as systemic problems which occur within households, including parenting, marital problems and difficulty with unemployment. A study conducted by Koeng, McCullough and Larson (2001) discovered that religious activity markedly contributed to social support which in turn enhanced recovery from mental illness and improved mental wellbeing. From an Islamic viewpoint, active engagement and connectedness with the community paired with religious participation is believed to preserve balance of the human body.

The Imams showed evidence of being actively involved with the Muslim community to ensure that their mental wellbeing was being addressed beyond the religious and spiritual domain. For example, running a parenting course and workshops for couples can work towards reducing stigma related to systemic problems, encourage a positive message about the realities of these types of difficulties and transparency in dealing with them. With regular communication and a better understanding of common problems faced by society as a whole, the Imams have given ‘permission’ to the Muslim community by engaging them with topics that are associated with psychological distress and stigma.

The Imams have been actively addressing issues traditionally associated with psychological therapy within the Muslim community without formal comprehensive psychotherapeutic training. With this said, the Imams operated in a professional manner with individuals that sought their consultation, by adhering to ethical codes such as confidentiality to preserve
trust and confidence. In their role of the learned helper, the Imams also linked in with external organisations who had certain specialisms to maximise opportunities for the Muslim community to be supported both inside and outside of the mosque. Such examples of working alongside an NHS smoking cessation initiative and collaborating with the local job centre assisted the Imams to fulfil their ‘duties’ to ensure appropriate sources of help were made accessible. The participants held a dutiful outlook towards the Muslim community, akin to a parental role to nurture and care for others, particularly for those who were considered ‘vulnerable’ including individuals who were isolated, suffered from disability such as auditory impairment, the unemployed and those identified as ‘at risk’ of falling into personal anguish. This care and consideration towards others extended beyond the requirements of their roles as an Imam.

5.2 Organising theme two: embracing the role

The participants provided insight into the demands placed upon them by their roles and the pressures they have been subjected to. In addition reflection and thought was also given to their own job satisfaction which encouraged them to perform their roles as Imams. Participant one shared a number of different aspects in this regard;

‘We are here three Imams, we are four Imams sorry, so, we are four Imams Mashaa Allah rota basis we do our work, we don’t face any problems but sometimes of course, as many people coming and sometimes feel stressed and a big burden, because the volume of cause and the problems we are receiving from the society, we have to deal with it but the volume is too high, that’s why sometimes it is true we are facing over-burden, or we can say it is, not too much, but sometimes some pressure. But we are trying to limit our damage and trying to give them [Muslim community] more comfort and more support, so we are distributing our tasks among our four, and we are trying to help them.’ (Participant 1; L176-182).
‘We have a fantastic team spirit within our Imam team, and as I said we are four Imams and two Muezzins, so all together six in our team. So as a large centre, we are trying to help the whole community in terms of their ethical [ethnic origin], in terms of their religious and spiritual guidance as well as community services.’ (Participant 1; L189-192).

‘We have mosque council, council of mosques in XXX, about fifty-four mosques together, we have a body of support.’ (Participant 1; L279-280).

Participant one explained how their team consisted of four Imams in total and duties were distributed on a rota system. The Imam disclosed that ‘sometimes of course’ they ‘feel stressed and a big burden’ due to ‘the volume of cause and the problems’ presented to them ‘from the society’ given that ‘the volume is too high.’ Moreover, the Imam confessed that ‘sometimes it is true’ that they ‘are facing over-burden’ however they have been ‘trying to limit’ the ‘damage’ by ‘trying to give’ the Muslim community ‘more comfort and more support’ by a distribution of tasks between the four Imams responsible for the pastoral service.

The Imam struggled to accept what seemed immense pressure despite revealing the strain of attending to high volumes of demand; this was justified by having ‘a fantastic team spirit’ with the ‘Imam team’ including the ‘Muezzins’ and together they have been ‘trying to help the whole community in terms of their ethical [ethnic origin], in terms of their religious and spiritual guidance as well as community services’. The Imam further stipulated that the presence of the ‘mosque council’ which consisted of ‘fifty-four mosques together’ provided ‘a body of support’ which they could lean on if required. This depicted the relentless and unconditional motivation of the participant to assume the vast pressures of undergoing their role whilst simultaneously embracing it. Participant two also articulated the pressures they have faced with attention to their own wellbeing and what kept them going;
‘You know, we are human being, so we are having different kind of pressure, and many, you are dealing with community, so, it’s not an easy job, so, you can’t keep happy to everyone.’ (Participant 2; L231-232).

‘We are human beings, so people are having things, we have to be with them, we should keep happy relations with them [Muslim community], and, if, we will, behave, that we are depressed, we are under pressure, so, when, Imam is like leader, so when leader is looking depressed, or, he is agitated, or he is under pressure, so then, how could he guide, the other people?’ (Participant 2; L240-244).

‘When we are energetic, and when we are committed with our skills, with our profession, so, we are happy when we are helping the people, so yes, you will work for yourself at the same time, when we are working for others, that is giving us more, motivation, more energy, and more, even love.’ (Participant 2; L369-372).

The Imam expressed the realness of being a ‘human being’ subjected to ‘having a different type of pressure’ when ‘dealing with the community’ given that their role is ‘not an easy job’ and is it not possible to please everybody. The participant also described how they ‘should keep happy relations’ with the Muslim community, and not to ‘behave’ that they ‘are depressed’ or ‘under pressure’ since the Imam ‘is like a leader’ and ‘when leader is looking depressed, or he is agitated, or he is under pressure,’ this would question their ability to guide others appropriately. The response provided by participant two was analogous to participant one in their sincerity with sharing the reality of the pressure of the role, whilst also justifying the rationale for coping with pressure by being ‘energetic’ and ‘committed’ with their ‘skills’ and ‘profession’ and being ‘happy’ in ‘helping the people’ which stimulated ‘motivation, more energy, and more, even love.’ While not openly acknowledged, there appeared to be a
sense of putting on a mask at times in order to maintain the status of the ‘leader’ which may have contributed to the weight of pressure experienced. Participant three also referred to the demands of the role:

‘Alhamdulillah, throughout the country, wherever Muslim communities have evolved and developed, you know they’ve established masjids and mosques and Islamic centres, it gives people a base to, you know resort to and to refer to, and, you know, somewhere where they can, you know, where they can reach out, and, they can gain support from us as well’.
(Participant 3; L146-149).

‘Asian community, predominantly, have family set up, where you know, there’s parents and uncles and aunties, and families are bound as well, so such case, you know, such families are quite sound and, it’s solid foundations. In many, Somali communities, people, Somali community is quite new to this country, and recent, so, in many cases young people don’t have that, that extended support, which perhaps meant, such cases have been difficult.’
(Participant 3; L164-169).

‘Part of the responsibility and the duty, and the job, is community service, so you have to be strong you know, to be able to rise to the challenges, and obviously I am not the only one, we have other Imams with us as well, and so, we consult each other.’ (Participant 3; L195-196).

The participant noted how ‘wherever Muslim communities have evolved and developed’ this has resulted in the establishment of ‘masjids and mosques and Islamic centres’ which ‘gives people a base’ to ‘reach out’ and ‘gain support’ from Imams. In particular, the Imam noted the ‘Asian community, predominantly, have a family set up’ whereby there are ‘parents and uncles and aunties, and families are bound well’ therefore ‘such families are quite sound’
with ‘solid foundations.’ Contrastingly, the ‘Somali community is quite new to this country’ and ‘in many cases young people’ do not have the wider network of ‘extended support’ and ‘such cases have been difficult’ for the Imam to attend to. With the growth of the Muslim community, the participant described their role as ‘duty’ towards ‘community service’ whereby they ‘have to be strong’ to ensure they are ‘able to rise to the challenges’ with the support of ‘other Imams’ with whom they ‘consult.’ This further demonstrated that the participant may not always feel completely equipped to meet the various demands and pressures they are faced with, nonetheless they are prepared to absorb all facets of their role with the back-up of their network of Imam colleagues. Participant four appeared to share this similar system of support in their role;

‘Alhamdulillah, because we have a big network of Imams in the UK, and as you may know I am actually a graduate from here, from as Islamic University in UK, so, we have a whole connection of people who are learned.’ (Participant 4; L263-265).

‘I have people in the background who I can rely upon, I can contact them if I am in a situation, and, I always tell the people of our community here, people who come to see me, if they don’t mind somewhere in between, if I get stuck somewhere with a question, or with an issue, they don’t mind if I pick up the phone, and call somebody, who I regard, is an expert in this sort of field.’ (Participant 4; L270-274).

‘I always like to seek a second, third opinion, before I give a judgment to a person, or before I give an answer to a person. There are many cases where I send people home, and tell them “sorry, I can’t help you,” I mean, which is, there is no harm in, I would rather help somebody by saying I can’t help you, then maybe putting them in a worse situation than they were already in.’ (Participant 4; L276-280).
It was noteworthy that participant four drew upon ‘a big network of Imams in the UK’ and ‘people in the background’ whom they could ‘rely upon’ and ‘contact’ and they felt comfortable to seek consent from community members, if they ever became ‘stuck somewhere with a question, or with an issue’ to ‘pick up the phone’ to consult with ‘an expert’ in the ‘field.’ The Imam stated that they ‘always like to seek a second, third opinion’ before they ‘give a judgement to a person, or before’ they ‘give an answer to a person’, and indeed ‘send people home’ if they felt unable to assist, as they would ‘rather help somebody by saying I can’t help you’ than ‘putting them in a worse situation than they were already in.’

This approach to the role is reminiscent to a multi-disciplinary team system, whereby the Imam liaises with others who they deem as experts in the field to reach the best outcome. However, the Imam’s sincerity to ‘send people home’ echoes the complexity of dealing with the demands placed upon them by the Muslim community, and they themselves may not always have the answers even after seeking consultation with colleagues, by acknowledging their own limitations and how far they are able to stretch themselves. Participant five voiced a resembling account;

‘I have tried to put a wall up there [when unable to provide religious/and or spiritual guidance], in between, because, you could make a lot of money, where you could become very popular, by doing this, there are charlatans out there that are charging huge amounts of money, with, you know, magical cures, that will sort your issue out, and, I know some family members, who have had certain issues, and, they have tried, at least ten different, practitioners, I would say, and they all make a promise, three months, you’re sorted, two weeks, you’re sorted, but then, it doesn’t, it doesn’t happen.’ (Participant 5; L215-220).
‘I’m just too busy, I am a workaholic, so I work, huge amounts, and I’ve got, not just one type of work I do to, [not to] let things impact me, maybe it’s a good thing in that sense, you know, I can just take the next call and, you know, take the next call, so, to tell you the truth I did not prepare for this interview at all, I didn’t even think about what I was going to say to you.’ (Participant 5; L235-239).

‘When I think that I can’t do it myself, see, from the spiritual perspective, the way we look at this, is, you’re not doing this for money, because you can make a huge amount of money here for just setting up shop.’ (Participant 5; L273-275).

Participant five ‘tried to put up a wall’ at times when they have felt unable to provide religious and/or spiritual guidance, since they could ‘make a lot of money’ or ‘become very popular’ since ‘there are charlatans out there that are charging huge amounts of money’ for ‘magical cures’ which ‘sort’ the ‘issue out’ however ‘they all make a promise’ and ‘it doesn’t happen.’ The Imam displayed objection against this sort of practice as it falsifies religious and spiritual ‘cures’ and works against their own ethical framework. The participant described themselves as ‘a workaholic’ who works ‘huge amounts’ with ‘not just on type of work’ therefore limiting the impact of their role, which they considered ‘a good thing’ as they ‘can just take the next call’. Although the participant asserted when they ‘think’ they ‘can’t do it’ themselves, they take a ‘spiritual perspective’ and recall that they are ‘not doing this for money’ and will do as much as they can within their ethical framework of embracing the role, since ‘you can make a huge amount of money’ by simply ‘setting up shop’.
And finally, participant six provided their insights about their role;

‘They need somebody that is very strong, somebody that, you cannot be a weak person yourself, and not everyone can deal with it, so there are, many many, out there who are bogus.’ (Participant 6; L161-163).

‘Now because I, obviously this is local, and maybe I was in XXX, so then I, at the moment I am using him [Imam colleague] for this part, I think there needs more people [Imams] to be trained in this field [mental health], because there is a large number, and most, because, people don’t contact, unless I, you know give referral.’ (Participant 6; L293-295).

‘Imams, obviously, studies only focused on classical texts, you are studying about grammar, you are studying about jurisprudence, you are studying about, all these things, obviously, this is, you studying about, but, most of this is not applied in life practically, because when you come to the real world, the Imam now has not studied psychology, not studied the, mental health, what is bipolar, what is OCD, you know, compulsive, all these issues, this is important.’ (Participant 6; L390-394).

‘It is like you know, sometimes you have, feel happy if somebody, you have solved somebody’s problems, and this can become, Sadaqah, because Prophet Sallallahu Alayhi Wasallam said even if you help somebody, or you remove a harmful object from the road you get the reward, you get Sadaqah, so this, I think conflict resolution, whatever, whatever we can use, I just feel maybe it is, Allah Subhanahu Wa Ta’ala has given us opportunity to help somebody, and if that can be, somebody’s Duaa’s prayers, and there has been cases, somebody comes here first, and says you know that time you did that, and you helped, made Duaa for me, so that sort of.’ (Participant 6; L319-329).
Being ‘somebody that is very strong’ who ‘cannot be a weak person’ is attributed by this participant in fulfilling their role, given that there are ‘many out there who are bogus’. Professed by participant two also, being ‘strong’ appeared to form an integral part of embracing the role, which is not helped by those who are not genuine in the field as described by participant five. The Imam also referred to drawing on the support of colleagues for covering different areas which are not accessible to them, however contended that ‘more people’ [Imams] need ‘to be trained in this field’ of mental health due to the ‘large number’ since ‘most people don’t contact’ unless the Imam himself was to make a referral recommendation. They linked this to Imam ‘studies only focused on classical texts’ including ‘jurisprudence’ however ‘most of this is not applied in life practically’ because ‘when you come to the real world, the Imam has now not studied psychology’ nor ‘mental health’ to understand ‘what is bipolar, what is OCD’ since ‘this is very important’.

In addition, the Imam also attributed their role to ‘Sadaqah’ because ‘even if you help somebody, or you have removed a harmful object from the road you get the reward, you get Sadaqah’ and similarly ‘conflict resolution’ can provide an ‘opportunity to help somebody’ in the form of ‘Duaa’s’ which may result in the individual being helped and returning to the Imam stating ‘that time you did that, and you helped, made Duaa for me’. This illustrated the different dimensions of the participant’s role embedded by their authenticity and passion to help those who come to them for guidance, whilst also acknowledging the constraints which may limit the appropriateness of support provided in some instances. Nonetheless, it is clear that the participant embraced all that the role encompassed, and a willingness to understand ways their role as an Imam can be enhanced in the context of mental health.
Upon reaching the end of this final organising theme, it is clear that the diversity of the role is an unequivocal characteristic which the Imams have embraced in their interactions with the Muslim community. Wenger (1998) postulated that identity is a powerful resource which is strengthened by a shared process of ‘being’ and ‘becoming’ through giving, taking and sharing with others; this is deemed as ‘identities of participation’. For the Imams, this participation has prevailed when discussing the various issues among and between colleagues and experts in the same field that were either contentious or ambiguous, brought forward by the Muslim community.

Through a process of a shared identity the participants were somehow more equipped to attend to the multiple demands of the Muslim community accessing their pastoral services, at times causing dilemmas, by receiving an empathic and supportive response from their colleagues and ‘sharing the load’. For the Imams, this appeared to give a lifeline when they may have struggled to make decisions entirely on their own. Moreover, this served as a safety net to reassure themselves of the actions taken according to religious and spiritual guidelines which they were already well versed in, and often used as a default. With this said, in line with empirical studies there is considerable evidence that positive religious coping contributes significantly in dealing with personal anguish for Muslims undergoing major life stressors (Abu Raiya et al., 2008; Aflakseir & Coleman, 2009; Ai, Peterson & Huang, 2003; Khan & Watson, 2006).

Research conducted by Ai et al. (2003) collected information relating to religiousness, war-related trauma, religious-spiritual coping, optimism and hope from Muslim participants who fled Kosovo and Bosnia and sought refuge in the United States. The outcome of the study found that higher religiousness was paired with positive religious coping which manifested into higher optimism. Supporting research by Aflakseir and Coleman (2009) investigated the
connection of religious coping to the mental health of Iranian war veterans who served in the Iran-Iraq war. With the use of a religious coping scale adapted from Pargament et al.'s (2000) scale designed specifically for use with the Persian population, the results indicated a positive correlation with religious coping and mental health status, and a negative association to PTSD symptoms.

Furthermore, Khan and Watson (2006) examined responses gleaned from Pakistani Muslim University students, who were asked to recall a major personal difficulty and the use of any religious methods of coping to relieve common mental health symptoms such as anxiety or depression. An eight item Pakistani Religious Coping Practices Scale was produced from the subsequent responses; this formed the components of ‘Gave Sadaqah in the name of Allah’ and ‘Read special Duaas for the solution of the problem’ which were associated to greater levels of religious motivation and interest, and reduced levels of depression. As advocated by the Imams, Islam can be a source of support, peace, tranquillity, strength and comfort; although they acknowledged that it can also present personal conflict and internal religious struggle for some Muslims. Pargament (2007) has proposed three dimensions of religious struggle; divine (tension in the individual’s relationship with the Divine), intrapsychic (ambiguity about religious beliefs such as the afterlife) and interpersonal (religiously-related conflicts with others) which can lead to negative religious coping.

In the case of the Imams, they often faced a balance between drawing upon religious methods of coping where appropriate, and using their own judgement call to establish whether a more generic and empathic approach was required with the absence of religious ruling. This is where part of the conflict occurred with the Imams given that there were instances when they themselves became uncertain as to how to best deal with a Fatwa or problem presented to them, if further consultation was required among their collegial
networks or if they simply were unable to address particular issues. The Imams were under pressure in most part to be a jack-of-all-trades and take an investigative stance to truly gauge and tease apart what is going on for the individual in front of them, while simultaneously considering what their next move might be.

Aside the pressures of meeting the demands of the Muslim community, the Imams positioned themselves as remaining ‘strong’ at all times; given their role as the religious leader in the Muslim community who are accessed as a common reference point usually during a crisis period, their ‘strength’ acted as their armour to uphold any type of distress. This had become more paramount with the threat of ‘charlatans’ and ‘bogus’ Imams who have used unorthodox methods to sell ‘religious products’ as a cure to mental health problems to vulnerable Muslims, and discredited the honest and sincere attempts of Imams who practice within ethical frameworks. This in part may provide some explanation to help understand why the mental health of some Muslim clients have become so severe, and admitted to secondary mental health services without any record of being treated or seen at the primary mental health care level. For the time being, Imams of all kinds remain the gatekeepers to managing the mental health needs of the Muslim community.

On reaching the end of the synthesis of analysis and discussion chapter, the strategy adopted to analyse and present the results of the IPA thematic analysis followed a theoretical mapping process; this involved three steps intended as a combined approach for the presentation of the results which assimilated into relevant discussion points. The first step focused on an initial descriptive mapping of the accounts provided which illuminated common themes around this group of participants, and therefore each organising theme was presented by illustrating extracts from the original orthographic transcriptions. This was followed by the second step of an interpretative mapping of the analysis with interpretative
claims of phenomena identified by the researcher encapsulated within the synthesis of the analysis and discussion towards the end of each main theme, as the final step, supported by the relevant literature that localised the overall experiential accounts of the participants. This strategy was followed when reviewing each of the three main themes from the beginning to the end.
CHAPTER FOUR:

FURTHER DISCUSSION AND CONCLUSION

1. Introduction to further discussion

This study aimed to explore the Imam’s experience of managing the mental health needs of the Muslim community. The research interviews revealed rich data from which three main themes emerged and have been discussed in detail with the corresponding organising themes with reference to the extant literature. This chapter explores the relationships between the key findings concerning limitations of the research; implications to the discipline of Counselling Psychology; further researcher reflexivity and recommendations for further research.

2. Limitations of the research

To my knowledge, this study is the first to have explored the Imam’s experiences of managing the mental health needs of the Muslim community in the UK at the time of completion of the thesis; however the study has several limitations. While appropriate within the field of qualitative research (Smith et al., 2009; Yardley, 2000) the sample size was relatively small, and conducted on a cluster of participants who may not be representative of the general population of Imams in the UK. Qualitative research within the field of Counselling Psychology may naturally raise issues pertaining to validity and reliability as a result of the various epistemological stances and reflexive approaches the researcher may assume during the collection of data and its interpretation. It was essential to establish and define the constituents of valid data and how this may impact the compilation and interpretation of qualitative findings.
Qualitative methods of research promote diversity within the scientific community and are advocated by Counselling Psychologists to broaden our understanding of complex human experiences in greater depth (Biggerstaff, 2012; Morrow & Smith, 2000; Goldman, 1976; Hill & Gronsky, 1984). The British Psychological Society (BPS) reserves a members section for Qualitative Methods in Psychology (QMiP) with over one thousand members and contributing to one of the largest sections in the BPS (Biggerstaff, 2012). However, the likelihood of not attaining objectivity is widely accepted within qualitative research although the matter of subjectivity is addressed with various epistemological and ontological stances.

The qualitative researcher has an ethical responsibility to remain conscious of their own subjectivity and recognising how this interacts in their research conduct when examining the quality and consistency of data analysis (Morrow, 2007). This equips the researcher to assess the validity of their research in addition to participant follow ups to confirm data collected reflects contextual significance to diminish researcher bias (Biggerstaff, 2012). The issue of subjectivity and researcher reflexivity have cast doubt on the validity and trustworthiness of qualitative data; in response to this discrepancy Shenton (2004) recommends qualitative researchers follow the structured protocol of Guba’s constructs:

i) Credibility (in preference to internal validity)
ii) Transferability (in preference to external validity/generalisability)
iii) Dependability (in preference to reliability)
iv) Confirmability (in preference to objectivity) (p.64)
Guba's constructs presents a clear framework for the researcher while also delineating the rigor of qualitative research and censorship of researcher subjectivity in the data (Shenton, 2004). Lincoln and Guba (1985) draw attention to the importance of credibility within qualitative research as essential for cementing trustworthiness in the data, further facilitated by harnessing good relationships with participants and establishing trust which strengthens internal validity and credibility (Erlandson et al., 1993). While attention was given to observe these guidelines, it must also be noted here that Imams with a good command of the English language were selected to participate in the research; this excluded a large pool of potential participants who may have provided different accounts of their experiences and shaped the results in a different light. The primary decision to select participants with a good command of the English language was to maintain authenticity between the researcher and participant, since translation would interfere with the hermeneutic process and potentially skew the data by introducing a third person. Moreover, there would be no guarantee that the interpreter would fully capture and correctly translate the account given by non-English speaking participants.

Despite taking care to develop a research interview schedule to aid the participants with responding openly (Arskey & Knight, 1999), the research schedule prompts could have been improved as the participants did not remain focused on the topic of discussion throughout; therefore parts of the data were not subjected to analysis. Additionally, prior to conducting the research interviews the administration member(s)/gatekeeper who granted access to the Imam had initially followed a screening system, to ensure I was not an undercover journalist intending to write an exposé depicting the mosque or Islam is an unfavourable manner. I was subjected to ‘passing’ a list of test questions such as the name of the institution I was affiliated with, the name of my supervisor and proof of my status as an academic researcher. These suspicions were swiftly lifted after the participant information sheet [appendix E] was provided, which explained the details of the research further. It also seemed to help when I
explained that I am a Muslim individual too, as it softened the scrutiny of being vetted as a security threat to the mosque.

Upon ‘passing’ the ‘screening’ stage by the administration member(s)/gatekeeper the Imams were of course informed of my request for participation in the research interview, a number of which agreed and have formed the data of the present study. Throughout the research interview process, I considered whether the Imams fully accepted my presence at face value as a bona fide researcher, and if there was any doubt in their minds about my intentions which influenced their choice of disclosure. Of course it would be difficult to truly know this without returning to the participants and posing this question to them, which is not possible in the face of researcher etiquette and ethical boundaries. More attention is given to this matter in the ‘further researcher reflexivity’ section of this chapter.

It is also necessary to acknowledge my position as a Muslim female ‘insider-researcher’ investigating a research topic concerning Islamic ministers and mental health. While sincere attempts were made to segregate my academic position and Islamic identity with the use of a reflective research diary, it is without doubt that the latter may have served an element of bias in the research even with every intention to minimise this. Perhaps it would have been too idealistic to anticipate that somehow, my involvement with the research could be isolated from my own world-view which is intrinsically loyal to and inspired by Islamic philosophy. While I have multiple identities, I am a Muslim woman fundamentally and my writing in this research has been shaped by this. Nonetheless, I have attempted to maintain objective neutrality in so far as realistically manageable. Please see the ‘further researcher reflexivity’ section of this chapter for more reflections on this area.
3. Implications to the discipline of Counselling Psychology practice

As mentioned in the eclectic literature review, it has been suggested that mental health professionals should consider seeking the views of formal religious leaders that may shed light on the help-seeking behaviours of Muslims, and provide lucidity for the significance of religious methods of coping (Mullick et al., 2013). Furthermore, research has identified a need to work towards reducing the stigma of accessing mental health services by implementing communication pathways with local mosques (Amri & Bemak, 2013); this will draw upon the preference for Muslims to seek psychological therapy from mental health professionals with an understanding of Islam (Weatherhead & Daiches, 2010). It is anticipated that the present research will contribute to the discipline of Counselling Psychology to provide community Counselling Psychologists, and other health providers within community mental healthcare settings a unique insight to the various experiences of the Imam with managing the mental health needs of the Muslim community. The data collected from the study signify two key areas which are particularly relevant for the attention of Counselling Psychology;

i) The fragmented relationship between Imams and community mental health services

ii) Pressure on Imams with meeting the high demands of addressing the mental health concerns of the Muslim community

The outcome of the research data found the majority of the Imams expressed a lack of presence of community mental healthcare services and often encouraged Muslim help-seekers to consult their GP for matters not related to religion or spirituality. This was largely due to the participants not having first-hand knowledge or direct access to services to which
individuals can be referred onto. Overall, the Imams acknowledged the intervention and usefulness of formal mental health services; in fact they demonstrated an acceptance that such services would be able to offer the correct intervention to help the Muslim individual. The contention lies within the ‘gap’ the Muslim individual might fall into if they choose not to consult their GP, disguise their symptoms as physical health problems or feel too ashamed or embarrassed to raise the matter again with the Imam. This can be potentially overcome by active collaboration between community Counselling Psychologists, health providers and local Imams to agree upon a suitable referral pathway which is seamless and enables the Muslim individual to be ‘handed over’ directly to receive the mental health support they may require.

When considering the unique needs of the Muslim community as outlined throughout different sections in this research, for such an initiative to be fruitful it may also be necessary for Counselling Psychologists and health providers to understand what might be culturally appropriate for engaging the Muslim individual. This could involve a basic understanding of Islamic beliefs, approach to mental health and how this may inform the treatment approach; openness to mediating and embracing the therapeutic involvement of the Imam; potential integration of specific Islamic tools to build trust in the therapeutic process; the family system and how this may interact with the Muslim client’s psychological therapy; stigma associated with seeking help for mental health issues with attention to confidentiality. This depiction of the multi-modal considerations of the Muslim client can be viewed in ‘figure 1’ on the next page.
The present study indicated that Imams have a critical position with responding to the psychological wellbeing of the Muslim community. Nonetheless the Imams themselves acknowledged their own pressures of keeping on top of the additional demands placed upon them, exacerbated by the absence of formal mental health training and stretched resources. In line with the recommendation above community Counselling Psychologists and health providers may wish to consider working towards an integrated and collaborative referral pathway, and co-working with Imams to encourage a shift in attitudes by the Muslim community to reduce stigma and discrimination with help-seeking for mental health problems. This will demand active collaboration between community Counselling Psychologists and health practitioners to gain reasonable and accurate understanding of one another’s roles in the first instance.
Furthermore, this may challenge the misconceptions and fears related to accessing mainstream community mental health services, given that the involvement of the Imam represents ‘safeness’ and ‘permission’ to receive psychological intervention. This is of particular importance taking into account the social stigma which may deter the Muslim client, given that Islam and the Qur’an are considered to provide Shifa, healing and internal strength in the context of mental health (Ali, Milstein & Marzuk, 2005; Ghaffari & Ciftci, 2010). There remains segregation between faith identity and western models of psychotherapy which predominantly do not incorporate the role of religion within clinical practice; this dearth may create suspicion and mistrust for Muslim clients who are increasingly faced by ‘Islamophobic prejudice’ and fear not being understood by a non-Muslim therapist.

Community Counselling Psychologists and health providers have a duty to sufficiently prepare themselves to work competently and sensitively with Muslim clients whose Islamic identity may shape their beliefs and world view, to harness a safe space and include issues pertaining to Islam as they would with any other client group requiring specific needs. Given that community Counselling Psychologists and health providers have a duty to work in this way with every client group requiring mental health attention, further education pertaining to the religious and cultural needs of the Islamic population may be required in order for a psychological approach to compliment the Muslim faith system. This can be strengthened in liaison with Imams and the religious-spiritual validation they are able to offer. The need for community Counselling Psychologists and health providers to understand and educate themselves about basic Islamic tenets, practices and beliefs becomes paramount when successfully engaging the Muslim community, as this will empower the Muslim client to explore concerns related to religion and spirituality for normalisation to reduce stigma and shame.
On the contrary Islam might not feature in the therapeutic domain although it is worthwhile to hold in mind for the mental health practitioner, given that Islam is entrenched in the life of the Muslim client at different layers of psychological and physical wellbeing (DeShaw, 2006; Ypinazar & Margolis, 2006; Shah et al., 2008; Padella et al., 2012). Community Counselling Psychologists and health providers may wish to take an inquisitive stance and openly explore how religion features, if at all, in the lives of their Muslim clients at the assessment stage of psychological therapy. In line with this it is advisable they take care to avoid generalised views about Islamic practice and not depend on unreliable sources disseminated by the media. Islam is a multilateral faith system practiced by different sects of Muslims in diverse ways; therefore some may follow specific rudiments of Islamic ruling that are not observed by others. This will encourage a therapeutic alliance with the Muslim client which may involve Islamic positive coping methods such as Zhikr, and considering difficult life events as a test from Allah Subhanahu Wa Ta’ala with the consultation and facilitation by the Imam.

To address the wide-spread issue of stigma concerning mental health difficulties and mistrust of the Muslim community towards western psychotherapy at large, Community Counselling Psychologists and health providers may wish to consider the findings of this research revealing the acceptance and willingness of Imams for co-working in reaching out to the Islamic public. This may involve a stronger presence for Community Counselling Psychologists and health providers within Islamic settings such as the mosque, to provide information and education about psychopathology and the various approaches to psychotherapy, which also echoes the Department of Health’s (2014) desire to work ‘with BME community leaders to encourage more people to use psychological therapies’ (p.13). Additionally, this may require attention to gender differences (Ali, Liu & Humedian, 2004) and sensitivity to both orthodox and flexible religious outlooks of Muslim clients towards psychotherapy (Dover, Miner & Dowson, 2007).
Accountability is not reserved for mental health providers and Imams in the management of the mental health needs of the Islamic population; Muslim individuals also have a shared responsibility to research and contact already established services that provide appropriate support. Aside seeking input from Imams, culturally sensitive Islamic counselling services are also available for those who seek it; these are largely independent providers in the private and third sectors offering specialist psychotherapy interventions. For example, a number of Islamic counselling services advertised through various websites (http://www.islamiccounselling.co.uk/; http://www.sakoon.co.uk/; http://www.barefootinstitute.com/; http://myf.org.uk/) provide culturally sensitive mental health support to the Muslim community either using an Islamic counselling framework, or the option of traditional psychotherapy with flexibility to discuss Islamic concepts with Muslim practitioners. Niche Islamic counselling services are dedicated to providing a choice to Muslims in Britain to enter psychotherapy tailored to the unique dilemmas they may face related to religion, culture, spirituality, and/or matters that may conflict with Islamic ideology which they do not wish to discuss with Imams, GPs or mainstream psychological services.

The development of the first accredited training programme in the UK for Islamic counselling (http://www.islamiccounselling.info/) is dedicated to providing guidance and promoting good practice for counsellors. Moreover, third sector initiatives such as the Muslim Youth Foundation (http://myf.org.uk/) run a number of projects for Muslim youths and the wider Islamic population to raise awareness of conflicting religious and contemporary social pressures, and provide a voluntary counselling service that aligns with a ‘value based’ rather than a ‘law based’ approach to Islam, to promote self-development and growth for those who experience psychological distress. Therefore emphasis on the effectiveness of mental health promotion within the Islamic community can also be better achieved by Imams in this regard, who are not alone in addressing the psychological distresses of the Muslim community. Moreover, Muslim communities have a responsibility to cultivate social norms that are
inclusive with an open-reflective approach to advice and guidance from mainstream non-Islamic services. Community infra-structures may need to revise their cultural notions and become more flexible to permit the facilitation of public dialogue pertaining to mental health and wider complex issues including sexual abuse, domestic violence, relationship difficulties, drug, alcohol and other behavioural addictions; this will serve to break down the barriers, shame and stigma associated with contemporary issues faced by Muslim clients in Britain.

It is interesting to note the Imams that partook in this study did not reference existing Islamic counselling services; it may be plausible they were unaware of the availability of mental health support within the parameters of the Muslim community. Therefore, similar to the Muslim community, there remains scope for Imams themselves to also establish communication networks with local culturally sensitive Islamic counselling services as additional signposting, and provide a vital link in supporting Muslim help-seekers presenting with mental health difficulties with a variety of options to choose from. More effective signposting by Imams, to culturally sensitive Islamic counselling services, may also ease the pressures of meeting the high demands of addressing the mental health concerns of the Muslim community. Of course, this may require the Imams also take appropriate steps to identifying established resources made available to their local community in the first instance; purely signposting the Muslim help-seeker to their GP, and/or waiting for statutory mental health services to approach them has not proved sufficient to date.

There is a call for action for all parties; joint partnerships between community Counselling Psychologists, health providers, Imams and public sectors of the community can develop a holistic approach to engender meaningful change. The present research is the first voice towards unveiling the organic nature of this phenomena until this point in time of writing this thesis, presenting the first suggestions and explorations in the UK.
4. Further researcher reflexivity

When providing the envelope entailing the £20.00 donation and information on support services [appendix G] the responses varied across participants. Participant one, two, three and six did not display any objection to accepting the donation, and appeared satisfied to receive this on the understanding that it was a contribution to the mosque for participation in the research. Although participant four declined to accept the donation at first, stating they did not wish to be remunerated for the interview as they earned a wage in their profession as an Imam. I sensitively informed the participant that it was a donation to the mosque for their involvement with the research process, and I was offering this as part of the agreement made as the researcher; upon this explanation the Imam appeared more at ease and decided to accept the contribution. They also requested that I complete a gift aid certificate to authenticate the donation which felt like a pleasant touch to the exchange. Participant five gave a similar reaction to participant four initially; however, once again upon reiterating the purpose of the contribution as a donation towards the mosque for their participation in the research process, this was accepted without further hesitation.

On my part, it was important that I maintained professionalism at all times in my interactions with participants as an academic researcher representing the University and the discipline of Counselling Psychology. I had prepared myself for the worse and very nearly changed the research topic for fear of not successfully recruiting willing participants; I had convinced myself that the Imams would not be welcoming to a female researcher given the strict boundaries relating to conduct with women as stipulated in Islamic jurisdiction. With the support of my research supervisor I mustered up the courage to attain ethical clearance [appendix D] and pursued the research; it was the best decision I had made.
I am very grateful for having the opportunity to interview the Imams, all of whom greeted me with respect, politeness and an openness to share their experiences in support of the research. However I would also like to take a step back and examine my role as a Muslim female ‘insider-researcher’ from a social constructionist stance. Acute mindfulness to my gender role as a Muslim woman and my position as an insider-researcher in a patriarchal establishment was of particular importance, to ensure I remained within reasonable boundaries of the mosque etiquette. This was facilitated by the knowledge I already possessed relating to this area, and the Imams themselves took extra care and caution to ensure that I felt comfortable at all times with arranging the practical set-up of the research interview itself. With this said, during the interviewing process with Imams I naturally found myself becoming assimilated into the setting of the research. This may have contributed to a lack of neutrality accentuated in my role as an insider-researcher, and how I had become immersed into the research environment as a congregation member in discourse with the Imam, the religious leader of the Muslim community.

The power differential that existed between myself as an insider-researcher and the Imams may have constructed a social environment where I remained unconsciously ‘compliant’ with the responses provided; this lack of neutrality played out in the research interviews with my apprehension to ‘interrupt’ the Imams when they incorporated unrelated topics into the research interview, since I should ‘know better’ than to interject when the Imams were speaking. My role as an insider-researcher also created a research environment where I was very conscious of my physical presence as a Muslim female by ensuring that I was perceptually ‘appropriate’ in my dress code, and refrained from asking the ‘wrong question’ as I did not wish to come across as ‘challenging’ or disregarding the accounts provided by the Imams. I found that I was automatically self-monitoring my conduct, speech and use of Islamic terminology to ensure I maintained the respect and trust of the Imams, since being
an insider-researcher also required that I observed the correct mannerisms as a Muslim individual to avoid causing offence which I deemed paramount.

I held a number of reservations when embarking on this organic research phenomena, as described with detail in the personal reflexivity section of the methodology chapter. To summarise, these were mainly related to preoccupation with Islamic regulations and rejection on the grounds of being a female entering a religious institution dominated by men; my speculation of Imams belonging to a dominant patriarchal culture whereby; psychological approaches may not be considered useful for alleviating distress in the Muslim community. These apprehensions were unfounded since the Imams agreed to participate in the research and my being female was not flagged as an issue, and they were refreshingly open to, and indeed drew upon what would be considered non-doctrinal strategies and approaches in their experiences of managing the mental health needs of the Muslim community.

When taking into consideration the negative media coverage of the Muslim community in Britain, the potential mental health needs of this population and the role of statutory mental health services, the research inquiry proposed to the Imams may have served as a motivation to partake and share their views with the knowledge that their anonymous data would be published. This may have shaped what the Imams chose to share in their research interviews as a potential opportunity to convey Islamic concepts in a virtuous light, and the impact this would have on the data gleaned when reporting the results of the research. As such, the Imams may have also chosen to reveal experiences that they considered desirable to preserve their positions as leaders of the Muslim community, either unconsciously or knowingly to minimise the potential of detrimental reporting on their experience of phenomena. A social constructionist stance deems it necessary to hold such possibilities in mind.
The Imams opened my eyes to Islamic psychology that I had not previously understood, such as the concepts of Ruh, Qalb, Nafs and Aql which form the human psyche. Wider reading inspired me to broaden my own understanding of these and how very similar Freud’s (1937) theory of personality and the three levels Id, Ego and Super-ego is reminiscent of the Qur’anic Nafs which corresponds to the psychological ego (Inayat, 2005) and assumes three forms (Netton, 1993) of Nafs Ammarah [inclination towards undesirable behaviour], Nafs Lawammah [censorship of conscience and sense of morality] and Nafs Mutma’inna [tranquillity and inner peace]. The research has shaped my own understanding of the cross-over between western and Islamic psychology which can be compatible when viewed with a critical lens, and applicable to treatment models of psychological therapy for the Muslim population. I am in a unique position as both a reflexive practitioner to understand the complexities of the clinical application of psychological therapy and how these can be enhanced in my role as a scientist practitioner; it is hoped that the present study has offered some useful insights in this regard, and my humble contribution to the discipline of Counselling Psychology will be valuable.

5. Recommendations for further research

There are a number of key areas that merit further research arising from the present findings. It would be useful to replicate the study and extend the sample to include non-English speaking participants with the aid of an interpreter; it would be valuable to observe whether responses remain unanimous or shift accordingly, with attention to developing a more focused research schedule. Such information can be used to compare against the findings of the present study and shed light on new findings to understand the experiences of the Imam furthermore, given that no prior research exists in this specific area and the need to strengthen validity.
A further recommendation would be for the replication of the study using a different qualitative methodological approach; Grounded Theory (GT) could be a suitable option given the emphasis on ‘the discovery of theory from data systematically obtained from social research’ (Glaser & Strauss, 1967, p.2). This will focus upon the integral social relationships of the Imams with community mental health services and other public sector health and community services, to uncover social processes and explore the role of contextual factors (Crooks, 2001). Given that the heart of the present IPA study has examined subjective experience, a natural progression onto GT seems viable to ‘get through and beyond conjecture and preconception to exactly the underlying processes of what is going on so that professionals and laymen alike could intervene with confidence to help resolve the participants’ main concern’ (Glaser, 1978, p.5).

The raison d’être for further research following the principles GT would be to strive for theoretical sensitivity, as the researcher will begin with some predetermined hypotheses derived from knowledge gained in the present study, and approach the data with openness to inform and direct analysis (Dey, 1999). This will subject the existing data to examination and comparison against emerging categories for integration into theory (Glaser, 1992). I believe this could be extremely enriching for mainstream service providers by using faith leaders as a key indicator to establish meaningful frameworks to appropriately respond to the mental health needs of the Muslim community. This may serve to create models of practice with the direct involvement of Imams as an effective intermediary entry point for improving the uptake of psychological therapy for the Islamic population. The GT approach could constitute a theory synthesis attempt that may enable a further step towards creating measurable scales or surveys in order to quantify the issues discussed in this study. This may further explicate the experiences of Imams and possibly constitute some findings in the realist world for the consideration of policy makers, who may be more likely to pay attention
to findings presented quantitatively in order to assess how this might impact on the provision of services provided.

6. Conclusion

This research endeavoured to explore the Imam’s experience of managing the mental health needs of the Muslim community; this is a novel area that has not been previously researched in the UK, at the time of completion of this thesis. This study was considered both topical and imperative given the contemporary issues faced by the Islamic population including stigma of accessing mental health services (Inayat, 2007) exacerbated by political demonisation (Tahir, 2005; Sheridan, 2006; Gottschalk & Greenberg, 2007; Ameli et al., 2007). In light of the paucity of research in this domain, recommendations were made for mental health professionals to consider the views of formal religious leaders to; understand the help-seeking behaviours of the Muslim community and clarity for the implication of religious methods of coping (Mullick et al., 2013) and; reduce stigma of accessing mental health services by establishing communication pathways with local mosques (Amri and Bemak, 2013).

A qualitative methodological approach seemed fitting to encapsulate the experiences of participants by the process of Interpretative Phenomenological Analysis (Smith et al., 2009). A compilation of transcripts from six semi-structured interviews with Imams were subjected to a Thematic Analysis (Landridge, 2004) deemed compatible with the phenomenological nature of IPA providing a ‘voice’ to participants (Larkin et al., 2006). This was achieved by ‘coding’ the individual accounts of participants from which three main themes materialised entitled Mending the broken bridge; Alleviating distress; Role identity.
The outcome of the data collected from this study found that the type of, and in most instances lack of collaboration between formal community based mental health services and mosques lead to Imams purely signposting Muslim clients to either their GP or to seek support from allied health professionals, with the rationale that the appropriate provision will be provided with limited follow-up. While the Imams expressed openness to refer onto formal services they were uncertain how to proceed with this, and anticipated that professionals would provide the appropriate care. With this said, the organic phenomena of this study found the Imams experienced their role as dutiful towards the Muslim individual whom they perceived as vulnerable, by attempting to relieve psychological distress using a range of spiritual and non-spiritual approaches, influenced by a relational landscape when connecting to others on a humanistic level. This was strengthened by their flexibility to position themselves according to the range of consultation demanded by the Muslim community extending beyond the sphere of religion and spirituality, by drawing on their binary skills of an Islamic minister and a learned-resourceful individual in the heart of the community.

This study has made a unique contribution to the dearth of literature in this area, providing exclusive insight to the experiences of formal Islamic ministers with addressing the mental health concerns of the Muslim community. Implications for the discipline of Counselling Psychology were recommended; for community Counselling Psychologists and health providers to establish a collaborative referral pathway and co-working with Imams to ‘catch’ Muslim individuals who fall through the gap with help-seeking for mental health problems. This will necessitate a transparent dialogue between all parties for understanding of one another’s roles, in line with the multi-modal considerations of the Muslim client framework.

Accountability is not reserved for mental health providers and Imams in the management of the mental health needs of the Islamic population; Muslim individuals also have a shared
responsibility to research and contact already established services that provide appropriate support. Aside seeking input from Imams, culturally sensitive Islamic counselling services are also available for those who seek it; these are largely independent providers in the private and third sectors offering specialist psychotherapy interventions with Muslim practitioners. These specialist niche services are dedicated to providing a choice to Muslims in Britain to enter psychotherapy tailored to the unique dilemmas they may face related to religion, culture, spirituality, and/or matters that may conflict with Islamic ideology which they do not wish to discuss with Imams, GPs or mainstream psychological services.

It is noteworthy the Imams that partook in this study did not reference already established Islamic counselling services; it may be plausible they were unaware of the availability of mental health support within the parameters of the Muslim community. Therefore, similar to the Muslim community, there remains scope for Imams themselves to also establish communication networks with local culturally sensitive Islamic counselling services as additional signposting, and provide a vital link in supporting Muslim help-seekers presenting with mental health difficulties with a variety of options to choose from. More effective signposting by Imams, to culturally sensitive Islamic counselling services, may also ease the pressures of meeting the high demands of addressing the mental health concerns of the Muslim community. Of course, this may require the Imams also take appropriate steps to identifying established resources made available to their local community in the first instance; purely signposting the Muslim help-seeker to their GP, and/or waiting for statutory mental health services to approach them has not proved sufficient to date. There is a call for action for all parties; joint partnerships between community Counselling Psychologists, health providers, Imams and public sectors of the community can develop a holistic approach to engender meaningful change.
Further qualitative research could be undertaken with a diverse sample group of non-English speaking participants with the aid of an interpreter; this may investigate whether, if at all, the experiences of Imams vary from a wide range of backgrounds. A further recommendation would be for the replication of the study using Grounded Theory (GT) (Glaser & Strauss, 1967) to explore the social relationships of Imams with community mental health services and other public sector health and community services; this may uncover social paradigms and contextual factors (Crooks, 2001) to promote a didactic dialogue for meaningful change. This may instigate models of practice with the direct involvement of Imams as conciliatory agents for the Muslim community. Furthermore, the GT approach could constitute a theory synthesis attempt that may enable a further step towards creating measurable scales or surveys in order to quantify the issues discussed in this study for the consideration of policy makers, who may be more likely to pay attention to findings presented quantitatively when assessing the provision of services provided.

The present research explored the experiences of the Imam in managing the mental health needs of the Muslim community; this is the first voice towards unveiling the organic nature of this phenomena at the time of completion of this thesis, presenting the first suggestions and explorations in the UK. Given that the Department of Health's (2014) aim to work ‘with BME community leaders to encourage more people to use psychological therapies’ (p.13) the research positions itself at a time when such inquiry appears relevant and topical in contemporary social science research.
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Appendix A: Script for telephone recruitment

Hello, my name is Ohi Choudhury and I am a trainee Counselling Psychologist from the department of Psychology at City University London.

At the moment it appears that many Muslims are underrepresented in mental health services, and research has recommended that mental health professionals should consider becoming more involved with Imams and religious leaders who are at the heart of the Muslim community. As part of my doctoral research thesis, I am specifically looking to understand the experiences of Imams in managing the mental health needs of the Muslim community.

Would you like me to continue and explain the purpose of my study?

Request person’s permission to ask questions to see if he/she provides permission to set up a meeting/speak to the Imam or qualifies for the research study.

If person says “No,” thank the person for his/her time and politely end call.
If person says “yes,” and offers an appointment to speak to the Imam, or meets the screening eligibility, follow the described;

The research will involve one face to face interview with yourself that will last up to a maximum of 1 hr. The interview questions are designed to be informal to understand your experience of providing support to Muslims experiencing mental health difficulties. The interview will be recorded with an audio recorder. You will be asked to sign a written consent form to confirm that you have agreed to take part in the study and to be audio recorded. I would like to assure you that all information recorded will be stored securely by myself and your confidentiality will be protected. We will have 15 minutes together after the interview has finished ensuring you have an opportunity to ask me any final questions.

The research will take place at the community mosque where you lead your congregation, if this is a suitable arrangement for you. A donation of £20 will be provided to your mosque, or a charity of your choice to express my gratitude for your time.

The study may not benefit you directly, although your involvement will be invaluable as it is anticipated this will help public sector mental health services to understand how to reach out to Muslims that may be experiencing mental health problems that require support. It is also hoped that your involvement will work towards reducing the stigma of accessing mental health services for Muslims and help mental health professionals reach out to the Muslim community.

Do you think you would like to take part in the research?
Appendix B: Script for email recruitment

Hello, my name is Ohi Choudhury and I am a trainee Counselling Psychologist from the department of Psychology at City University London.

At the moment it appears that many Muslims are underrepresented in mental health services, and research has recommended that mental health professionals should consider becoming more involved with Imams and religious leaders who are at the heart of the Muslim community. As part of my doctoral research thesis, I am specifically looking to understand the experiences of Imams in managing the mental health needs of the Muslim community.

The research will involve one face to face interview with yourself that will last up to a maximum of 1 hr. The interview questions are designed to be informal to understand your experience of providing support to Muslims experiencing mental health difficulties. The interview will be recorded with an audio recorder. You will be asked to sign a written consent form to confirm that you have agreed to take part in the study and to be audio recorded. I would like to assure you that all information recorded will be stored securely by myself and your confidentiality will be protected. We will have 15 minutes together after the interview has finished ensuring you have an opportunity to ask me any final questions.

The research will take place at the community mosque where you lead your congregation, if this is a suitable arrangement for you. A donation of £20 will be provided to your mosque, or a charity of your choice to express my gratitude for your time.

The study may not benefit you directly, although your involvement will be invaluable as it is anticipated this will help public sector mental health services understand how to reach out to Muslims that may be experiencing mental health problems that require support. It is also hoped that your involvement will work towards reducing the stigma of accessing mental health services for Muslims and help mental health professionals reach out to the Muslim community.

If you would like to participate in this research please contact me on;

XXXXXXXXXXXXX

A further participant information sheet will be provided. After receiving this I will establish further communication with yourself to confirm the details of the interview.
Appendix C: Interview schedule

1) What sort of problems do Muslim brothers or sisters talk to you about?

2) Do Muslim brothers or sisters talk about any emotional problems? For example do they ever talk about the state of their mind, feeling low, depressed or very nervous or anxious?

3) Do Muslim brothers or sisters ask your advice or opinion about how to manage the state of their mind when they are feeling low, depressed or very nervous or anxious? What advice do you give?

4) What is your experience of dealing with the emotional distress/difficulties of Muslim brothers and sisters?

5) Do you ever struggle to cope with the distressing and emotional information Muslim brothers and sisters share with you? If so, how do you cope?

6) Have there ever been times when you have been concerned or worried about the mental state of a Muslim brother or sister? If so, how did you manage this?

7) If there is a time, in the future, when you might be concerned or worried about the mental state of a Muslim brother or sister, how might you deal with this?

8) What is your opinion about mental health services that provide support for people suffering from mental health problems, such as anxiety and depression?

9) Do you know any local counselling or mental health services?

10) Would you recommend local counselling or mental health services to Muslim brothers or sisters?

11) Do you think mental health services could build better relationships with local mosques and Imams, if so, how?

12) How can mental health services help Muslims that are suffering from emotional problems, with your support or the support of local mosques?
Appendix D: University ethical approval form

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

- Ethical approval granted

Refer to the Department’s Research and Ethics Committee

Refer to the School’s Research and Ethics Committee

Signature ........................................... Date 16/05/14

Section D: To be completed by the 2nd Departmental staff member (Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)

I agree with the decision of the research supervisor as indicated above

Signature ........................................... Date 16/05/14
Appendix E: Participant information sheet

Title of study

The Imam’s experience of managing the mental health needs of the Muslim Community.

I would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

At the moment it appears that many Muslims are underrepresented in mental health services, and research has recommended that mental health professionals should consider becoming more involved with Imams and religious leaders who are at the heart of the Muslim community. As part of my doctoral research thesis, I am specifically looking to understand the experiences’ of Imams in managing the mental health needs of the Muslim community.

Why have I been invited?

You have been invited to take part in this study as you have been identified as an Imam who leads the congregation in your mosque. In total 6 Imams will be invited to participate in the research.

Do I have to take part?

Participation in the project is voluntary, and you can choose not to participate in part or all of the project. You can withdraw at any stage of the project without being penalised or disadvantaged in any way. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

The research will involve one face to face interview with yourself that will last up to a maximum of 1 hr. The interview questions are designed to be informal to understand your experience of providing support to Muslims experiencing mental health difficulties. The interview will be recorded with an audio recorder. You will be asked to sign a written consent form to confirm that you have agreed to take part in the study and to be audio recorded. I would like to assure you that all information recorded will be stored securely by myself and your confidentiality will be protected.
We will have 15 minutes together after the interview has finished ensuring you have an opportunity to ask me any final questions. The research will take place at the community mosque where you lead your congregation, if this is a suitable arrangement for you.

Expenses and Payments

A donation of £20 will be provided to your mosque, or a charity of your choice to express my gratitude for your time.

What do I have to do?

You will be required to spend up to 1 hour speaking to me about your experiences and answering some of my research questions.

What are the possible disadvantages and risks of taking part?

It is not anticipated that any harm will come to you as a result of this proposed research, however you will be provided with a list of independent support agencies in addition to the contact details of myself and my research supervisor should you require any assistance or support.

What are the possible benefits of taking part?

The study may not benefit you directly, although your involvement will be invaluable as it is anticipated this will help public sector mental health services understand how to reach out to Muslims that may be experiencing mental health problems that require support. It is also hoped that your involvement will work towards reducing the stigma of accessing mental health services for Muslims and help mental health professionals reach out to the Muslim community.

What will happen when the research study stops?

In the event of this happening all of the data provided by yourself including the signed consent and audio recordings with be discarded in a confidential manner. All electronic files will be deleted and all paper documentation will be shredded.

Will my taking part in the study be kept confidential?

Absolutely. I will be the only individual who will have access to the information provided by yourself before anonymising data. All of the data gathered will be stored in a secure format and only accessible by the myself; signed material will be stored in a safe at my home and audio recordings will be password protected on my laptop. Your name and other identifying information will be changed to protect your identity. After your information has been anonymised the data set will be included in the body of the results of the research paper.
What will happen to results of the research study?

The research will be printed and made available at the City University library where it will remain for 10 years, as per the University policy. It may be possible that the research will be submitted for future publication with a Psychology related journal. You will receive a copy of the final research paper.

What will happen if I don’t want to carry on with the study?

You may withdraw from the study without an explanation or penalty at any time.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: The Imam’s experience of managing the mental health needs of the Muslim community.

You could also write to the Secretary at:

Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone’s negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been approved by City University London Research Ethics Committee.
Further information and contact details

Research Supervisor:

Dr Pavlos Filippopoulos
Counselling Psychology
City University London
Northampton Square
London
EC1V 0HB
United Kingdom
School of Arts and Social Sciences

E: pavlos@city.ac.uk
T: +44 (0)20 7040 4557

Thank you for taking the time to read this information sheet.
## Appendix F: Participant consent form

Title of Study: The Imam’s experience of managing the mental health needs of the Muslim Community.

Please initial box

<p>| | |</p>
<table>
<thead>
<tr>
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</table>
| 1. | I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.  
   I understand this will involve:  
   - being interviewed by the researcher  
   - allowing the interview to be videotaped/audiotaped  
   - making myself available for a further interview should that be required |
| 2. | I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I understand that I will be given a transcript of data concerning me for my approval before it is included in the write-up of the research. |
| 3. | I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way. |
| 4. | I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998. |
| 5. | I agree to take part in the above study. |
When completed, 1 copy for participant; 1 copy for researcher file.
Appendix G: Participant support sheet

**Samaritans: 24/7 confidential listening service**

T: 08457 90 90 90  
Website: www.samaritans.org

**Turn 2 me: online support forum**

Website: www.turn2me.org

**Sakoon: Muslim counselling service**

T: 07943 561 561 or 07960 735611  
Website: www.sakoon.org.uk

**Islamic counselling service**

Website: www.islamiccounselling.info

**Sakina Muslim counselling service**

T: 0870 005 3084 / 0791 991 1920

**Researcher details:**

Name: Ohi Choudhury  
E: XXXXXXXXXXXX  
T: XXXXXXXXXXXX

**Research supervisor details:**

Dr Pavlos Filippopoulos  
E: Pavlos@city.ac.uk  
T: 020 7040 4564
Appendix H: Generated codes of thematic analysis

Level one coding: preliminary labels

EIHS- Expectation of intervention from healthcare services  
IHP- Involvement with healthcare professionals  
IOA- Involvement with other agencies  
NUHS- Needs unmet by healthcare services  
STAS- Signposting to appropriate services  
DWLHS- Desire to work in liaison with healthcare services  
FIMH- Factors impacting mental health  
AMHI- Awareness of mental health issues  
CWSP- Consideration of wider societal problems  
RTPD- Responding to psychological distress  
RTPDJMR- Responding to psychological distress Jinn or magic related  
PSIO- Promoting social interaction with others  
PNRCS- Promoting non-religious coping strategies  
PRCS- Promoting religious coping strategies  
SMC- Supporting members of the community  
WCWCSF- Working in collaboration with colleague(s) in the same field  
PRD- Pressure of responding to demand

Level two coding: generation of organising themes

OT1- dependence on other professionals for facilitating meaningful change  
OT2- ambivalent relationship with other professionals, frustration and disappointment  
OT3- perceptiveness of causes related to poorer mental health  
OT4- reactivity to the needs of the Muslim community  
OT5- becoming the learned helper  
OT6- embracing the role

Level three coding: generation of main themes

MT1- Mending the ‘broken’ bridge  
MT2- Alleviating distress  
MT3- Role identity

Key:

OT- organising theme, followed by number  
MT- main theme, followed by number
Appendix I: Thematic pattern generation chart

<table>
<thead>
<tr>
<th>CODES/LABELS</th>
<th>ORGANISING THEMES</th>
<th>MAIN THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>EIHS [Expectation of intervention from healthcare services]</td>
<td>1. Dependence on other professionals for facilitating meaningful change</td>
<td>1. Mending the ‘broken’ bridge</td>
</tr>
<tr>
<td>IHP [Involvement with healthcare professionals]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IOA [Involvement with other agencies]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUHS [Needs unmet by healthcare services]</td>
<td>2. Ambivalent relationship with other professionals; frustration and positivity</td>
<td></td>
</tr>
<tr>
<td>STAS [Signposting to appropriate services]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DWLHS [Desire to work in liaison with healthcare services]</td>
<td></td>
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<tr>
<td>FIMH [Factors impacting mental health]</td>
<td>1. Perceptiveness of causes related to poorer mental health</td>
<td>2. Alleviating distress</td>
</tr>
<tr>
<td>AMHI [Awareness of mental health issues]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CWSP [Consideration of wider societal problems]</td>
<td></td>
<td></td>
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<tr>
<td>RTPD [Responding to psychological distress]</td>
<td>2. Reactivity to the needs of the Muslim community</td>
<td></td>
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<tr>
<td>RTPDJMR [Responding to psychological distress Jinn or magic related]</td>
<td></td>
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<tr>
<td>PSIO [Promoting social interaction with others]</td>
<td>1. Becoming the learned helper</td>
<td>3. Role identity</td>
</tr>
<tr>
<td>PNRCS [Promoting non-religious coping strategies]</td>
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<tr>
<td>PRCS [Promoting religious coping strategies]</td>
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<td>SMC [Supporting members of the community]</td>
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<tr>
<td>WCWCSF [Working in collaboration with colleague(s) in the same field]</td>
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<tr>
<td>PRD [Pressure of responding to demand]</td>
<td>2. Embracing the role</td>
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</table>
### Appendix J: Table of thematic descriptive, interpretative & pattern coding

<table>
<thead>
<tr>
<th>First order descriptive coding</th>
<th>Second order interpretative coding/ organising themes</th>
<th>Third order pattern coding/ main themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>EIHS; Participant 1: L14-15; L57-59; L245-250; L261-262; L287-288; L303-305</td>
<td>OT1-MT1; Dependence on other professionals for facilitating meaningful change. Examples of extracts; Participant 1: “If you read all NHS schemes, it is their duty to help and support”. “They are living in British society and if they have any cultural problems or any emotional problems, they can go to Imam first, their first choice. Second to their GP to share, and then get some care from GP.” “XXX mental issue department, they are also coming forward to help and support us with their many methods, and their equipment, including their many posters and flyers and so on and so forth.”</td>
<td>MT1; Mending the ‘broken’ bridge. Examples of extracts; Participant 1: “We should say, culturally they are sometimes feeling very low and sometimes negativity also there, but, they are living in British society and if they have any cultural problems or any emotional problems, they can go to Imam first, their first choice, second to their GP to share, and then get some care from GP. So GP and can share and care their problems and give them ideas first, then advice, one of the top advice of the GP is to go to your Imam and see, because emotional support is not a medicine matter, to give some medicine and it will be cured within a week.”</td>
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<tr>
<td>Participant 2: L24-27; L29; L56-57; L273-274; L289-291</td>
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<td>Participant 3: L239-242; L281-283; L28-289; L290; L295-296</td>
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<td>Participant 4: L17-19; L379; L398-399; L551-553; L574-557</td>
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<tr>
<td>Participant 5: L25-26; L176-177; L182-183; L197-199; L313</td>
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<tr>
<td>Participant 6: L37-41; L37-41; L349-351; L355-356; L376-383; L396-399; L471-473</td>
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<tr>
<td>IHP; Participant 1:</td>
<td>Participant 2:</td>
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<tr>
<td>L15-16; L20-23; L25-228; L256-259</td>
<td>“So when people are coming to me also, if, I think people are having, physical problem, as in any disease, so I motivate them and request them to go visit their GP, and if problem is more severe, so they should ask GP to referral towards the consultant.”</td>
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<tr>
<td>Participant 2:</td>
<td>“We know what kind of sources are available, what kind of jobs, doctors, expertise, they are available around us, so, we try our best according to our knowledge, according to our employers, we try to guide them, and if we go through proper channel, and get treatment, and get the problem sorted out.”</td>
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<tr>
<td>L23-27; L100-103; L122-124; L135-136; L310-312</td>
<td>“With the other respect of treatment is, you know, one thing is the psychological effects, so when a patient is going and visiting a doctor, so, he or she is thinking now, they are in front of doctor and doctor will give them advice and medicine, and then they will be ok.”</td>
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<tr>
<td>Participant 3:</td>
<td>“It is very sad for the Muslim community, there was a big hospital called XXX hospital in London, in XXX, unfortunately it is two or three years closed, because they say there are funding problems this and that, but we have been very upset, very emotionally upset because the rate of health issues of mental health is growing up, and hospitals should be bigger than that hospital, they closed that now. So it is very very sad for us, for our Muslim community here, that’s why we can’t control, as I said earlier on, the mosques, and other centres, only one hospital, can’t control all the mental issues here, because of that lacking.”</td>
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<tr>
<td>L50-53; L73; L197-198; L225-226; L248-251; L298-300; L304-308; L312-314</td>
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<tr>
<td>Participant 4:</td>
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<td>L370-373; L456-458; L508-510</td>
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<tr>
<td>Participant 5:</td>
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<tr>
<td>L27-29; L94-97; L264-266</td>
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<td></td>
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<tr>
<td>Participant 6:</td>
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<tr>
<td>L346-347; L507-511</td>
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</table>
Participant 3:

“I am aware of quite a few general practitioners in our community, and people, people do go, we have no problem our, with our community members going to the GP, and even being passed forward to consultants for specialist treatment.”

“Because, some cases became violent, and so, you know, we’ve had to, involve the police, and so on and so forth.”

“When, when people who might be suffering, or have been, made aware of, you know, the importance of gaining help, of getting help, then obviously, then we assume that, GPs will take appropriate measures, and then, you know, forward their respective patients to, respective agencies, where they can get additional help.”

“In the community, for example, I personally, because we haven’t, we haven’t been involved in the mental health, institutions, at most, we have, like I said, referring the matter to the GP, and for them to get involved, and take responsibility”.

“When that hospital was existing, then we were working with them and I had done a course with them people for six days, I was there for a full six days and I learned some training from them, then we grouped, from multi-cultural society, Black, African, ethnic, Somali ethnic, Bangladeshi ethnic, Pakistani and so on and so forth, many people we have done courses with them. And they Alhamdulillah, taken, I should say, some benefit from us, but unfortunately, hospital is now closed. I don’t know what to do, there is no opportunity after that, I didn’t see any opportunity. I don’t want to blame the NHS, but they maybe should fund.”
| AMHI; Participant 1: L59-61; L65-68; L124-126; L200-203; L224-225; L315-320 |
| Participant 2: L14-17; L19-21; L27-29; L33-37; L83-85; L200-203; L288-230; L242-243; L271-272; L320-323; L374-378; L392-394; L402; L405 |
| Participant 3: L18-19; L65; L94-95; L151; L181-183; L229; L339-340; L383-384 |
| Participant 4: L24-29; L33-36; L39-41; L43-49; L627-630 |
| Participant 5: L16-19; L99-100; L186-190 |
| Participant 6: L22-24; L256-257; L274; L511-514 |

**Participant 4:**

“If I see there is an urgent case, where maybe, somebody is in danger, somebody could be hurt, or, something could happen that's not very pleasant in the community, then obviously, I would seek advice from, teachers, from my colleagues, elders, but not leaving out, the organisations that we have in the community.”

“So, there is always space, to contact people who are above, there is always space for people with more experience, there is always space for an extra opinion I think.”

“Even if a person, with a mental health issue, was a non-Muslim, walks in here and I feel, and I sense that, this person needs a bit of a, attention and support, I would really appreciate it if I could contact mental health services for this, I mean, this would be a great help, as a wider, community support, I believe.”

**Participant 2:**

“So here, with us, when people are, I am also doctor, medical doctor as well, as well as an Imam, so when people are coming to me also, if, I think people are having, physical problem, as in any disease, so I motivate them and request them to go visit their GP, and if problem is more severe, so they should ask GP to referral towards the consultant, so that they should have check-up, different tests, and if there is any problem so they have to get the medicine, and follow the instruction of their consultant. With the other respect of treatment is, you know, one thing is the psychological effects, so when a patient is going and visiting a doctor, so, he or she is thinking now, they are in front of doctor and doctor will give them advice and medicine, and then they will be ok.”

“So we have to work with the knowledge, with research, and something that is good, available for us in the form of NHS, in form of doctors, our medicine, spiritual treatment also. When someone is having problem, or seeking for the support, and we are support.”
<table>
<thead>
<tr>
<th>PSIO</th>
<th>Participant 1: L62-64; L82-83; L91-93-95; L218-219</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participant 2: L96-99; L86-90; L93-96; L200-203; L218-222</td>
</tr>
<tr>
<td></td>
<td>Participant 3: L92-94; L134-136; L143-145; L342-344</td>
</tr>
<tr>
<td></td>
<td>Participant 4: none identified</td>
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<tr>
<td></td>
<td>Participant 5: none identified</td>
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<tr>
<td></td>
<td>Participant 6: none identified</td>
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</tbody>
</table>

**Participant 5:**

“Recently, I was sent an email by somebody, who, clearly said he was depressed, he said "I am depressed, and they want me to go on medicine, is it halaal for me to do so?" I said of course."

“She was put into a special hospital, and after a few months, after all these interviews, consultations were done and everything, she reacted positively to the medication she was given, and, she was fine, that reinforced for me the fact that she, didn’t have, a Jinn problem, or a magic problem, she actually had, a, mental problem.”

“There is, first of all a local team of mental health, that is local team, and they are network, having network with different hospitals, having consultant, having all kinds, of, different machines to do the test, and, finally people are getting their diagnosis, so this is, thing, we are really, this is our duty, according to our knowledge, we should try to understand the system, and guide our people, to get the best of the facilities, and, yes, NHS are doing good, but still, everywhere there is need, to improve.”
<table>
<thead>
<tr>
<th>Participant 1:</th>
<th>Participant 6:</th>
</tr>
</thead>
<tbody>
<tr>
<td>L64-65; L105-108; L219-223; L317-320</td>
<td>“And they are professionals, and they are looking, and taking care of these patients, so if a patient is showing certain signs that he is, you know this issue medicalisation, so that is also, I found that also, is, needs to be addressed.”</td>
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<td>Participant 2:</td>
<td>“It has worked, NHS have been giving this provision for Muslim patients, so favourably I would say, even if patient is in hospital, and he is getting, the professional care, while he is given professional counselling, I think it is more supplementing, helping.”</td>
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<tr>
<td>L79-81; L132-135; L323-328</td>
<td>“Working together, I think it is important, because it can happen also, it is nothing related to, you know, this Jinn and all that, they just need, professional, medical help, medical care.”</td>
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<td>Participant 3:</td>
<td>Participant 3:</td>
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<tr>
<td>L21-22; L61-62, L65-67; L160-163; L304-308</td>
<td>“Alhamdulillah, we, and I am of aware quite a few general practitioners in our community, and people, people do go, we have no problem our, with our community members going to the GP, and even being passed forward to consultants for specialist treatment. Many a times there are other reasons which are beyond us, so, it’s basically, getting, all the support that we can, and, and getting all the support for the patients or the sufferers to get over whatever problem there may be, may be suffering.”</td>
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<td>Participant 4:</td>
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<td>L20-23; L71-73; L458-461</td>
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<td>Participant 5:</td>
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<td>L249-251</td>
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<td>Participant 6:</td>
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<td>L19-21; L22-23; L25-27; L129-133; L195-199; L206-209; L210-211; L241-242; L268-269; L281-282; L306-308; L312-313; L320-323; L335-336; L416-418</td>
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<tr>
<td>PNRCS; Participant 1:</td>
<td>L83-84; L145-147; L152-153; L62-64</td>
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<td>Participant 2:</td>
<td>L21-22; L40-43; L53-55; L85-90; L96-96; L100-103; L122-124; L134-136; L229-230; L267-269; L273-277; L289-291; L317; L321-323; L327; L349-351; L392-394; L405-407; L412;</td>
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<tr>
<td>Participant 3:</td>
<td>L21; L23-25; L51-53; L126-129; L184-185; L226-228; L248-251; L304-308; L240-344</td>
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<tr>
<td>Participant 4:</td>
<td>L110-113; L121-125; L127-129; L141-148</td>
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<tr>
<td>Participant 5:</td>
<td>L21-24; L26-29; L100-101; L111; L121-214; L148-149; L176-177</td>
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**OT2-MT1; Ambivalent relationship with other professionals; frustration and positivity. Examples of extracts;**

**Participant 1:**

"Our NHS is trying to help and support, but the NHS fund is sometimes poor in meeting our needs, it is important to increase it, this is one department, one side. Second side is also important for us, second side is important to deal with mental health, only one hospital is not enough."

"It is very sad for the Muslim community, there was a big hospital called XXX hospital in XXX, unfortunately it is two or three years closed, because they say there are funding problems this and that, but we have been very upset."

"So it is very very said for us, for our Muslim community here, that’s why we can’t control, as I said earlier on, the mosques, and other centres, only one hospital, can’t control all the mental issues here, because of that lacking."

"Number two, of course, as I said, the fund of mental health, if they say we don’t have any fund or we don’t have any time, this and that, they can say, but still we need, not only Muslim, in XXX, not just the Muslim population, no, even the English population, other societies."

"We offer support in our, in our capacity, and if there is something we can’t handle, then, you know, we have to be realistic, and we have to, you know, own up to our responsibility, and then, for the benefit of the community and the person suffering, it is only right that they should be referred to relevant authorities, and be given the support that they need which we can’t offer, and if there is something we can do, then you know, we will be happy and honoured to offer our services and our support, but if there’s something beyond us, there are many people are, they might have serious, physical issues, you know, problems, health issues, then you know obviously, if something is physical, then spiritual treatment sometimes isn’t effective, so, you know, it would be wrong for us, you know if, it could betray the trust and it wouldn’t be right for us to linger on, and, and not, and not get the person who is suffering the support that they deserve, and they need."
Participant 6:
L71-73; L114-119; L349-351; L360-364; L366-367; L469-471

Participant 2:
“So sometimes, just sitting people are sitting with us, and our counselling, can help them, in the improvement of their mental state, and at the same time if they are having any physical problem or any mental problem, so, we are guiding them, what are the proper channels, how they can be treated, and how they can go.”

“If the community member is having any mental illness, so, they will be able to suggest them, or to advise them, or to help them, so initially, if they can do counselling, they will do, otherwise, they know how the system is working, and then, they can advise them to go, to the doctor, or the mental health team.”

“So this is, thing, we are really, this is our duty, according to our knowledge, we should try to understand the system, and guide our people, to get the best of the facilities, and, yes, NHS are doing good, but still, everywhere there is need, to improve.”

“I mean there are, you know, continually, increasing number of Islamic centres, popping up, and communities are, spreading, developing, so I think perhaps, if the mental health services took initiative as well, because many of the communities are not really aware, of this sort of support, which is actually available. In the community, for example, I personally, because we haven’t, we haven’t been involved in the mental health, institutions, at most, we have, like I said, referring the matter to the GP, and for them to get involved, and take responsibility. Obviously, because, if a patient is suffering and needs attention, then, then the GP is the first point of contact, and support, who can refer the matter, to, to relevant authorities, we can’t make those referrals.”
Participant 3:

“And if there is something we can’t handle, then, you know, we have to be realistic, and we have to, you know, own up to our responsibility, and then, for the benefit of the community and the person suffering, it is only right that they should be referred to relevant authorities, and be given the support that they need which we can’t offer.”

“So, you know, it would be wrong for us, you know if, it could betray the trust and it wouldn’t be right for us to linger on, and, and not, and not get the person who is suffering the support that they deserve, and they need.”

“I mean there are, you know, continually, increasing number of Islamic centres, popping up, and communities are, spreading, developing, so I think perhaps, if the mental health services took initiative as well, because many of the communities are not really aware, of this sort of support, which is actually available.”

“And if there are, were, sort of, institutions who were, eager to support, or help, or offer help, then, you know, we, we run various different pilot schemes here from the masjid, for example, helping people to stop smoking, especially in Ramadan.”

“We run various different pilot schemes here from the masjid, for example, helping people to stop smoking, especially in Ramadan, when people are fasting, and they don’t smoke, in the past couple of years, in fact, every Ramadan, for the last three years in fact, we have been in collaboration with XXX council to run schemes whereby, surgeries have been able to offer help. they come into the mosque, on Fridays, they have, they have their stand, and you know, they take names, and details, and offer confidential advice, like, the issue of smoking, is, there is a bit of stigma attached to smoking, especially around women, and, in Muslim families, as you’re aware, if there is a young girl who smokes, it’s a very big taboo, and so, they’re coming, and you know, they’ve offered, confidential services, and helped them overcome their problem. We’ve had reasonable success, we were, obviously, we won’t say that every community member who smokes will stop smoking, there’s been some success along those lines, if there was, you know, on Fridays for example, we’ve got a very large attendance, a thousand plus people on Fridays. So if there was somebody, on the local health, mental health services, who would come round, and have a stand, you know we could encourage people, if they know people in their...
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<th>Participant 1:</th>
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<tr>
<td>L160-167; L190-194; L215-217</td>
<td>“We need to link up with every organisation that we can, and that we see helpful, towards our community. We work with, our Islamic centre here, has been built, as a community centre, it’s for the whole community.”</td>
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<td>Participant 2:</td>
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<td>L35-39; L339-344; L394-396</td>
<td>“I find it a very, very important point, a very, very, important issue, to deal with organisations, that have expertise in certain types of field, and I was just, mentioning that example, of people coming here from refugee centres, you understand, they could be from every walk of life.”</td>
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<td>Participant 3:</td>
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<td>L25-28; L94-95; L123-126; L134-136; L148-151; L181-183; L228-231; L304-308; 312-314</td>
<td>“We are in a mosque, and we usually deal with Muslims, even if a person, with a mental health issue, was a non-Muslim, walks in here and I feel, and I sense that, this person needs a bit of a, attention and support, I would really appreciate it if I could contact mental health services for this.”</td>
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<td>Participant 4:</td>
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<td>L36-38; L314-317; L400-402</td>
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<td>Participant 5:</td>
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<td>L141-142; L16-19; L21-24; L49-53; L121-214; L249-251</td>
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<td>Participant 6:</td>
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<td>L16-18; L19-21; L27-30; L33-36; L49-51; L66-71</td>
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<td>“I have got a video on YouTube about it, that, you know, first port of call should be, your doctor, and then the specialist.”</td>
<td>“If I see there is an urgent case, where maybe, somebody is in danger, somebody could be hurt, or, something could happen that's not very pleasant in the community, then obviously, I would seek advice from, teachers, from my colleagues, elders, but not leaving out, the organisations that we have in the community.”</td>
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<td>“So it’s a difficult thing to determine, what is what, but generally I would say zhikr first, if more extreme, then go to the doctors.”</td>
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<td>“I would think that, they probably need to come up with a consultation post, or, something like that, so have a number of, Islamic scholars, as consultants on certain issues.”</td>
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**Participant 1:**
- L177-180; L243-244; L254-256; L261-262; L282-285

**Participant 2:**
- L231-232; L240-244

**Participant 3:**
- L104-150; L109-110; L148-151; L194-195; L262-266; L267-271; L289-291; L295-296

**Participant 4:**
- L278-283; L349-351; L402-403

**Participant 5:**
- L161-163; L167-170; L224-227; L235-237; L256-257; L551-553

**Participant 6:**
- L63-64; L106-107; L282-284; L286-288; L329-331; L390-393; L419-421; L312-313
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<th>Participant 1:</th>
<th>Participant 1: L176-177; L180-182; 189-190</th>
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<td>Participant 2: none identified</td>
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<td>Participant 3:</td>
<td>Participant 3: L195-196</td>
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<td>Participant 4:</td>
<td>Participant 4: L263-265; L270-274; L276-278; L366-370</td>
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<td>Participant 5:</td>
<td>Participant 5: L54; L266-269</td>
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<td>Participant 6:</td>
<td>Participant 6: L60-63; L17-178; L186-187; L293-294</td>
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**Participant 6:**

"If somebody is in the hospital, and you know, this new government strategy, that's looking at everybody, you know to prevent issues, so I found it very, worrying because, now somebody is being looked at, even if he's a patient, but because he is a Muslim, they may look at him differently."

"Working together, I think it is important, because it can happen also, it is nothing related to, you know, this Jinn and all that, they just need, professional, medical help, medical care."

"I think there is a need for Imams, to also study counselling, to get professional help from the NHS, because most of the people will not go, access the services of the NHS, they come to the Imam, and, Imams are different types, not every Imam will deal with this situation."

"NHS could offer this service, Imam can attend this course, given this extra training, on how to deal with people who have mental health, so when they are looking at it, they shouldn't, they don't even have to look at the religious texts, just understanding, the principles around it, the different types of it, I think this will be very beneficial."

"In society, for example, my daily cases are, daily cases, my daily attachment is to children, I have children, I am involved with children every day, so safeguarding the children, for example here, talking on the practical field, is the teachers that I employ here, in our Madrasa, in our school, I want every teacher that comes here, to be DBS checked, I want every teacher that comes here, to have a basic, child protection knowledge, and knowing the effects, of children's emotions, knowing the effects when children are being abused, in any sort, in any sense, whether they are being neglected, whether they are being physically abused, mentally abused, these are all issues that we as leaders, because I call teachers leaders, teachers are leaders, they are role models, they come into our classrooms, they need to have basic background knowledge, of what kind of affects, can such and such thing, divorce for example, happening in the house, what kind of affect can it have on the child, how will it change the child, maybe the child's behaviour will change in my class, maybe the child will become completely closed and not talk to anybody, maybe it won't want to say a word in the class, so these are like signs for us to see, alert signs, I call them like, question marks, exclamation marks, ok, ding-dong, there is something going on"
OT1-MT2; Perceptiveness of causes related to poorer mental health. Examples of extracts;

Participant 1:

“Emotional support is not a medicine matter, to give some medicine and it will be cured within a week. Emotional is something very important when and it will be resolved with peace of mind and peace of mental, isn’t it.”

“And also we are responding in our Khutbah, in our Friday sermon, to tell them not to do so, don’t be abused by their parents, by their colleagues, by their friends, students, or at school, and they have to have room to share their problems.”

“If problems are recognised then accordingly we advise them. For example someone facing problems, mentally and emotionally for his or her marriage, we are giving them support.”

“If someone is coming for education for example, he is not feeling mentally very well, and also abused by his teacher or by his friends or peer group, then of course we have some other suggestions.”

“Our main issue is not Islam, as Muslims they can learn Islam of course obviously, but in our society, the British society we are living in, we have to consider this society’s problems.”

“That’s why our being, as Imam we have to support them how to integrate with the society, how to deal with the society, with love and harmony, otherwise it will be very difficult for them to find their way out, find their exit.”
Participant 2:

“My job as an Imam, one of, part of our job activity is, because, even, you know, in psychology and psychiatry, when we are going to have treatment of different problems, so, there are different alternative techniques.”

“With the other respect of treatment is, you know, one thing is the psychological effects, so when a patient is going and visiting a doctor, so, he or she is thinking now, they are in front of doctor and doctor will give them advice and medicine, and then they will be ok.”

“So different psychiatric problem, or psychological problem, these are also, most of them are related with our life, with our surroundings, so sometimes, some people are having other diseases and then they are getting depressed, sometimes they are having family problems, family issues, they are having psychiatric problems.”

“We all are human beings, we need to be loved, we need to be respected, we need someone should be there, to listen our problems, and if someone can give us solution, so, then everyone is happy.”

“I believe, the more organisations we can get hold of, get in touch with, like for example now, we have sent all of our teachers, for, child, safe learning, organisation, child safe learning certificate, so, it’s like one of those words, so, Alhamdulillah, we have referral members over there, where we need to contact, we can contact, the police services, and we can contact social services, so these contact details are very important for us. To be able to, help children, that come here, and even children, that maybe, don’t come here, children that we hear about, and, we have children talking about issues, if something comes to my ear that so and so child, is being abused at school, or somewhere else, and it’s my duty, as a human being, to sort of, create a safe environment for that type of issue, for the type of child, that’s going through such an issue, even if I don’t know that child, humanly, I believe, wherever I could be of service, wherever I could be of help, even if its anonymously, I could contact social services that so, and so, and so.”
Participant 3:

“If a young man, or a young woman is going through an anxious period, or through depression, many of the times parents, you know, they will take the initiative, and they will approach us and to see if we can help in any way.”

“Many a times people they need to be, you know, because, as you know times are difficult many young people who are out of jobs, they are just being, just being around with their family, not doing anything, with their backs against the wall, that can have its own problems and demands.”

“Obviously, we have to be careful how, because, you know, sometimes we have to be sensitive to each case, you know, we don’t want to be, seen to be interfering too much, or, especially violence cases, there have been cases of schizophrenia, and so, you know, we have to be careful in how far we can, involve ourselves.”

Participant 5:

“I would think that, they probably need to come up with a consultation post, or, something like that, so have a number of, Islamic scholars, as consultants on certain issues, and may be even have to bring them in for special clinics or something like that, to deal with certain issues, to maybe convince people, that look, it is a medical issue that you have, and not, not just a magical issue, so I can only see this working where, they, you know, we can help them out, hospitals, etcetera, or the NHS, we can help them out, however, if nothing works, I am just wondering, I don’t think the, the medical professional, can probably, be happy to say, Ok, this is an issue of magic.”
Participant 4:

“The issues that people come up with here, whether it be, divorce issues, children’s issues, you always have that feeling that there is something mentally, also in the background.”

“You get people, emotional, who become emotional, people sometimes sit there and stare, in blank, not knowing what’s next, what’s coming next, you give them a piece of advice and it’s like shock, “oh, I didn’t know that”, so in cases like that, you feel, I sense, that there is something playing on the person’s mind, and which then turns into a mental issue.”

“Issues in life affect us, they affect us emotionally, they affect us mentally, and, on the long run, people don’t think about it in the initial stages, but people start to realise in the long run, when they get a bit older, children are around, families around, so then, things start to come up.”

“As you see the world has completely changed, if we read, when we read mainly history books, and the past, people were sort of more, mentally fit, mainly, of course, the factor is that the food that we eat, affect our mental health, and the environment we live in, affects our mental health.”

“Recently, I was sent an email by somebody, who, clearly said he was depressed, he said “I am depressed, and they want me to go on medicine, is it halaal for me to do so?” I said of course, if you are, if you’ve got a physical ailment, you will take medicine, so likewise, you’ve got a mental problem which you yourself are confessing, and acknowledging, then of course, take that, he thought it was haraam for some sort, I think, because it goes into the unexplainable of something, that we are not so used to all the time, they think, it can, may contravene some issues of the Deen, and religion, or something like that.”

“An experience that I had, you know, local community, in XXX, so we were, approached by the local, I forget which organisation it was, actually the police, yes, because I worked as a chaplain with one of the police, the borough police, so, we were called into a case.”
Participant 5:

“I think any society, any community is going to have mental problems, because, that’s just such a, it’s just such a human issue isn’t it, it’s just the way, different people, deal with these issues is one thing, and how people who have these problems, what they reference them to.”

“One of the big things, is that, mostly when it is something unexplainable, not biological, a problem, then people will generally try to associate that with either magic, Jinn behaviour, or something from the unseen, and that’s, basically, what I have been trying to dispel.”

“Once she had, the Quranic verses, and everything around her room, that would have been enough to get rid of any Jinn, but, it didn’t work for her, right, so, which means that, she misdiagnosed herself, and she should have gone to her doctors.”

“We, as Muslims, I think we need to create awareness, by bringing these examples, these case studies, like look this is what happened, and this case they thought it was magic, or, some external influence, but yet, it was just a simple, chemical, imbalance, or some deficiency of some sort.”

“I have got a video on YouTube about it, that, you know, first port of call should be, your doctor, and then the specialist, then, if they cannot get, from all the checks, you know, and you’ve been seen by specialists, and, there have been cases where it is totally unexplainable, thirteen year old girl, finding these weird headaches, they just can’t work out how it came about, and then you’ve got the Rukiya people telling them, she’s got a spell, so then, that seems to make sense, in that case, and then sometimes, they do things for you, and, it works for a while, so that just reinforces, so it’s a difficult thing to determine, what is what, but generally I would say Zhikr first, if more extreme, then go to the doctors.”

“I say, very politely, that, I think you have an OCD problem, I think you should get special attention from the doctors for that, I won’t be able to help you anymore in this regard.”
**Participant 6:**

"You normally get, women, they feel that, their husband is, not treating them well, or they have been abused, so this is another serious concern with many marriages."

"I would say, personally being attacked, given the way the media is portraying the Muslim image, so they are being pressured, that they feel, they are being put, really down, because of, the way they have been looked at."

"Naturally, every Muslim, they are, living in this world, what's happening in other parts of the world, it’s only natural for the people to feel affected, so, when they are seeing in the media, then, lots of them, they maybe, driven to do certain things, which is obviously, they need support, they need help."

"Many of the, you know, natural, woman may feel, or, man also may feel, that that they have come under black magic, but it’s nothing to do with that, so it’s like, trying to understand, you know investigate, “What is the real issue?”"

"Sometimes it has been found, that even, between husband and wife, a woman can behave in such a way, they can, maybe, drive the husband to, you know, become, maybe, physical abuse, mental abuse, so I say also we have to do reflection of our own self."

"I think, one useful way would be to actually have a compilation of, cases where, there was definitely a medical problem, but could have taken to be a magical problem, to show, I think, one thing, yes, that's right, one of the things I, did think about, was to actually, show, specific, cases, where, it’s a medical problem, the symptoms of that medical problem, what happens when a person, has that, particular problem, but it could very easily be taken, to be, a magical problem, so for example, frothing at the mouth, making noises, what else, I'm not sure, there are cases like that which are definitely medical issues."

“Maybe, for the health services to do seminars in Masjids, in mosques, where they outline these things, and show, these are the problems, these are the issues, and, encouraging Imams to speak about them, and also the elders of the community, to educate them, so that when people have these issues, they can easily say, look, check this out, refer them.”
### Participant 1:

“[Muslim youth] are attached with the mosque, and they are always coming to the mosque, the Imam, talking their problems and sharing everything with the mosque, their worry, their health, their education and everything.”

“If problems are recognised then accordingly we advise them. For example someone facing problems, mentally and emotionally for his or her marriage, we are giving them support.”

“Many youth people Mashaa Allah they have taken our services and after that they are coming with a very smiley face.”

“Some months ago we had given a Khutba, a Friday sermon about health issues and especially highlighted mental health, especially, and people [Muslim congregation members] Mashaa Allah, around the corner from that evening many phone calls came, and many people physically came to take the opportunity to make an appointment to see Imam to get the help.”

### Participant 6:

“I see that need, and sometimes even if they, if it is not a Muslim, even if it is somebody, you can get somebody who is a counsellor, and he knows how to, and he understands people, you should, I think that is fine he does not have to be a Muslim, so if they have there, somebody to talk to, somebody they can, you know, get off whatever is on their chest, this is a, it is not a problem whether they are seeing even a non-Muslim, giving them that professional help, that is fine, only time is when they need, more extra, maybe spirituality, otherwise it is very great help, there can be many many Muslims, even husband and wife, they just need some counsellor, they don’t even need an Imam, so that can happen, Imam can make more problems, you know it depends, so they just need somebody just to give them counselling.”
Participant 2:

“Recently in XXX, in partnership with the NHS, this is a chaplaincy, voluntary chaplaincy training, for mental health diseases, this is 10 week course, some of the volunteers [from the mosque], they are enrolled, and they are getting training."

“So in olden times, or maybe in some parts of the world also, there is the creature, that is Jinn, so you know people are having mental problem, and, they are thinking they having Jinn, so, we are not promoting this idea here, because, like Angels, Jinn exist, but as Angels are not harmful for any of us, likewise, Jinn are not.”

“Mainly with elder people, so these people, work for the country, work for the nation, when they were healthy, they done, whatever they could do best, of their skills, and time they have, given to the country and the nation, so when they are elders, so we need to support them, we need to take care of them.”

“There is a need for Imams, to also study counselling, to get professional help from the NHS, because most of the people will not go, access the services of the NHS, they come to the Imam, and, Imams are different types, not every Imam will deal with this situation, it can be all same situation, but one Imam, you know, people are different personality types, this Imam may have a lot of anger in him, you know you can have that, so a lot of, so therefore, you also need training, and because most of the people, contacting Imam, they will look at him, and they will ask him, you know, we have this problem, Imam may need this, extra help, support, training also, if Imams are given extra, special training, I think it will remove a lot of burden from the NHS.”
Participant 3:

“You’re probably aware people have different reasons why the people feel anxious, or, depression or anxiety, so, some are physical symptoms that are actually related with work, or family stress, etcetera, so they do approach us.”

“Many a times, as Muslims, I’m sure you’re aware, we believe in other beings, we believe in the dark spirits [Jinns] around which can have, an effect on the person’s personality, and as such people are, obviously mainstream health service, and people don’t appreciate that, obviously mainstream society doesn’t believe, or doesn’t accept those sort of issues.”

“And there was, there was one case where there was a young man, he was, he needed support and attention, and he was, he was referred to medical authorities, I think he was, for a while, he was put into an institution, and I think he gained, he recovered quite reasonably, and he is now back in the community, so he has been visiting us, regularly.”

“Personally I think, obviously, at XXX hospital, I mean I, as the chaplain there, I do get referrals, if there is a patient who wants to see an Imam, and I think this is so important, if they didn’t have somebody to give them that support, somebody they feel comfortable with, so really, it has worked, NHS have been giving this provision for Muslim patients, so favourably I would say, even if patient is in hospital, and he is getting, the professional care, while he is given professional counselling, I think it is more supplementing, helping, Working together, I think it is important, because it can happen also, it is nothing related to, you know, this Jinn and all that, they just need, professional, medical help, medical care.”
Participant 4:

“I have had several cases like that, cases, like people asking for, support, in that sense, they are feeling down, they are feeling low, asking for, a lot of times, to be honest, I get people who come in here, and they just want to, really, talk to somebody, do you understand?”

“A lot of people come here, they want an Islamic answer, do you understand, in a lot of issues, where sometimes it’s very difficult, to relate an Islamic ruling, to an issue that’s actually happening in a person’s life now, so this is where we have to actually use Qiyas; Qiyas is actually to, relate, the person’s issue in front of you, to something may be happened in the past, in the time of the Prophet, in the time of our Sahaba Radiyallah.”

“A lot of cases, where it could be, coming back to this child issue, and school issues.”

“Imams, obviously, studies only focused on classical texts, you are studying about grammar, you are studying about jurisprudence, you are studying about, all these things, obviously, this is, you studying about, but, most of this is not applied in life practically, because when you come to the real world, the Imam now has not studied Psychology, not studied the, mental health, what is bipolar, what is OCD, you know, compulsive, all these issues, this is important, because normally Imam is addressing it, he may just say, OK, this is the ruling, and this is, he may be able to do that, but there is something else that is needed, you know, that I think, NHS could offer this service, Imam can attend this course, given this extra training, on how to deal with people who have mental health, so when they are looking at it, they shouldn’t, they don’t even have to look at the religious texts, just understanding, the principles around it, the different types of it, I think this will be very beneficial.”
| Participant 5:                                                                 | MT2: Alleviating distress. Examples of extracts; |
|                                                                              | Participant 1:                                    |
| “So Muslims believe that Jinn can possess, now Jinns can be good or bad, and, there is this belief that in the Muslim community, so if you have somebody who is making strange sounds, or, voices, or, and they are having experiences.” | “As Imam, we are doing here for a long time Mashaa Allah, I am here about 19 years. I am here and we are dealing with especially, youth. And our young people Mashaa Allah, they are very, very enthusiastic, to get in touch with Imam always. Especially their health situation we are looking at that as well. You will be more than happy to know that our mosque is XXX playing a role Mashaa Allah in the society, and especially in the way of Muslims. And they are attached with the mosque, and they always coming to the mosque, the Imam, talking their problems and sharing everything with the mosque, their worry, their health, their education and everything. So, in terms of their, their emotional many issues they are sharing with us and we are trying to help them.” |
| “She was put into a special hospital [secondary mental health service], and after a few months, after all these interviews, consultations were done and everything, she reacted positively to the medication she was given, and, she was fine, that reinforced for me the fact that she didn’t have a Jinn problem.” |
Participant 6:

“Whenever they want to see an Imam, it’s always something saying, “I need Rukiya”, they feel that they are possessed, mainly related to Jinn issues.”

“This is what we are saying, is that, there are people generally, they may come to you, I say, if you bring fear of Allah in your life, Allah will open up an avenue for you.”

“Somebody comes, now you just can, obviously he doesn’t want to have anything to do with religion, he just wants somebody to speak to, so you may give, listen to him.”

“Sometimes it has been found, that even, between husband and wife, a woman can behave in such a way, they can, maybe, drive the husband to, you know, become, maybe, physical abuse, mental abuse.”

“If someone is coming for education for example, he is not feeling mentally very well, and also abused by his teacher or by his friends or peer group, then of course we have some other suggestions. So to go outside, play with them, make them your friend, and be polite and gentle with your peer group, and then take them to, also outside of the work to go, enjoy, together.”
OT1-MT3; Becoming the learned helper. Examples of extracts;

Participant 1:

“We are here to support them always, with physical support and emotional support, giving them advice, suggestions, giving them some, what do you call it, if someone loneliness facing, then we are giving them companionship with our educated people they are going to support them.”

“Few months ago, maybe in February, we highlighted a Khutba on parenting. When we discussed this matter in our Khutba and many people came to us to do some parenting courses.”

“And also another course we designed, Inshaa Allah after Ramadan in XXX we are going to start, only for husband and wife, for couples.”

“We have in this mosque a deaf society, deaf organization here it’s called al-ishara, ishara means sign in Arabic, so sign language people means deaf people, are accommodated here at least eighty people here for weekly Jummah, they are coming here to learn the Khutbah, and they are here even also, we have appointed two body language people [sign language interpreters], one is male and one is female, and all together about eighty people come every Friday to learn the Khutbah, it is a big mental issue.”

“When they come for example, for a session, counselling session, advice session, and when they do, after that we get many types of good feedback we found is from the mosque, that they are supported better and are now continuing their life with peace and tranquillity. Many youth people Mashaa Allah they have taken our services and after that they are coming with a very smiley face. When they come and enter with moody face and going home with advice and suggestions, and when they are coming back after a few days, Mashaa Allah with a smiley face. And even sometimes people come with some gifts, and say “Imam gift for you because we are very happy and spending time with our family, we have very happy and have a gift to say thank you”. It is a very good opportunity for us, for our Muslim vulnerable and mental people, or any type of emotional people here to get the support and help from the XXX mosque.”
Participant 2:

“The other thing, that is like hypnotherapy, counselling, likewise, in Qur’an it has been said, the words of Qur’an, verses of Qur’an, have treatment, Shifa, so there are different verses, and different chapters of Qur’an, so if we read in a particular way, so that can cure psychological problems, psychiatric problems.”

“So we have to work with the knowledge, with research, and something that is good, available for us in the form of NHS, in form of doctors, our medicine, spiritual treatment also. When someone is having problem, or seeking for the support, and we are support”.

“You know, as Imam, as with the rest of religion, so we have direct contact with community members, so children, ladies, gents, young people, old people, and people trust on us, and our job is to guide them, the right way. So, first of all, that is anything they are going to share with us, that is confidential, so this is our professional requirement, that we have to have to keep confidential, the things that people, the information of people.”

“People, they contact us, having their problem, and it is not only mental problems [common mental health difficulties], many problems, people are coming and sharing, and we, wherever we can support them, and we can help them, so some people they are not having jobs, so if we can, guide them, and support them, if we have information there is job [from the local job centre], so we are helping them, to, get the job.”

Participant 2:

“So in olden times, or maybe in some parts of the world also, there is the creature, that is Jinn, so you know people are having mental problem, and, they are thinking they having Jinn, so, we are not promoting this idea here, because, like Angels, Jinn exist, but as Angels are not harmful for any of us, likewise, Jinn are not, and in different mental diseases, people can predict the future, or people can voice in different voices, people can see different shapes, different things, so, and, people can change their voice, so there are different states of mental diseases, and when people are less educated, so, maybe, their cultural things, customs, and, their society was promoting these things, which nowadays, Alhamdulillah, things are well developed.”
Participant 3:

“We do offer counselling and we offer support, and wherever a need, we will help them, the community member, be it male or female, we assess, or get a personal family problem, and we try and liaise with the family.”

“If a young man, or a young woman is going through an anxious period, or through depression, many of the times parents, you know, they will take the initiative, and they will approach us and to see if we can help in any way.”

“They [NHS smoking cessation service] come into the mosque, on Fridays, they have their stand, and you know, they take names, and details, and offer confidential advice, like, the issue of smoking.”

“If someone has a difficult patch then obviously, we try to make them aware, you know, of hardships and suffering, sometimes a test can come and we resort to Allah, and realise mostly for them, Allah blesses and Allah guides, solves our problems.”

“So, this is big population, and, as citizen of this country, so they need, medical facilities, to be provided, and, already NHS is working on this front, they have, they are contacting Muslim communities, and, Imams, and, but one thing as I told you, according to faith of Muslims, so they have thought and trust on God, so NHS need to develop, maybe, a team of people, who should work with, medical consultants, and the spiritual people, or maybe Imams, they should get training, or some other people, as chaplaincy work, so they should work in hospital, outside of hospital, so when the doctor giving the medicine, at the same time, there are different, alternate, techniques or treatments, so, which could help more, to the patients, or, mental patient, and that is, one of them is counselling, so, when someone is Muslim and doing counsel to their beliefs, through Quranic verses or through Hadith, so maybe that will work more, in a better way, for, our Muslim patients.”
<table>
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<td>“I have people come here, who are actually elder, each, who are facing a lot of issues, and then when you advise them, ok try to make connection with the Quran, try to read a little bit on a daily basis, they come back, and they feel, that some changes happened to me.”</td>
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<td>“It’s just a matter of, they have got an issue in their mind, they might be a hundred percent sure that I am going to see the Imam, he is not going to be able to do anything for me, but at least there’s somebody who is going to listen to me, and there’s somebody who I can talk to, and this is very important.”</td>
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<td>“Listening to them, gives the feeling of at least, somebody has heard me, you know, it’s going to somebody’s ears, and when a child, not just a child even adults, when they have that feeling of, there is somebody who I can talk to freely, and it’s confidential.”</td>
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<td>“To actually fall into mistakes, and given us the opportunity to repent, and this is the point where, we need to listen to people, when you listen to people, they will be more interested in learning how to repent.”</td>
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<td>“we actually, take the Qur’an, as our manual, so we refer to the Qur’an, what am I going to do now, is it right, according to Qur’an, it is wrong according to Qur’an, where does it stand, is it something that is completely forbidden, is it something that is completely allowed, so we have the two extremes, or is it something in between, that maybe, disputed over, you understand, if there is a dispute, let me research, engage and seek in knowledge.”</td>
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<td>“As you know, mental health, it is a very sensitive issue, and, it’s for everybody’s, it’s in anybody’s interest and everybody’s, benefit, to raise awareness, because obviously, when a person is going through a mental issue, not only is that particular individual affected, people around them are really are affected as well, who have to live with the actual person, so perhaps there, one thing is offering that person effective support, then there is the people around them, who can help them, perhaps, give them some advice, spend time with them.”</td>
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<td>“Mental problems, depression, anxiety, and you’re probably aware people have different reasons why the people feel anxious, or, depression or anxiety, so, some are physical symptoms that are actually related with work, or family stress, etcetera, so they do approach us, and we try, obviously, sometimes people are just looking for sympathy, and so, we do offer counselling and we offer support, and wherever a need, we will help them, the community member, be it male or female, we assess, or get a, personal family problem, and we try and liaise with the family.”</td>
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Participant 5:

“I told her [Muslim female who sought religious consultation] to do, specific type of, meditation, and after about three weeks, I get an email from her, saying that, "I have been doing that meditation, and now I am sleeping better than I ever slept even before my problems started, like I am completely fine", so, a lot of things can be dealt with just by Zhikr, remembrance, so you have to gauge, I would have to gauge, what level is this problem at.”

“I try to be more versatile, but then I know my boundaries of how much I can help, so then, the other thing, from a spiritual perspective is that, if I go and give a lecture somewhere, to two hundred people, maybe only twenty people will take it seriously, so the return I get is twenty people.”

“Many a times, as Muslims, I’m sure you’re aware, we believe in other beings, we believe in the dark spirits around which can have, an effect on the person’s personality, and as such people are, obviously mainstream health service, and people don’t appreciate that, obviously mainstream society doesn’t believe, or doesn’t accept those sort of issues, but we as Muslims, we believe very firmly that there are other factors as well which can influence people’s health, and their attitude and so on. Alhamdulillah we offer, we do offer support around, along those lines as well, and in many cases we found, quite a success, in such cases, helping people who are coming out of their shells, and patches, and going through difficult patches, and helping them, that sort of spiritual therapy helped them to get back on their feet and give some form of normality.”
Participant 6:

“Qur’an is a book of healing, Shifa, so the Qur’an, we have to encourage people can use it as a means of curing their sickness, illness.”

“Sometimes obviously when somebody comes to you with a problem, now, as a person of faith we have to give them guidelines, that, if you have a problem, and if you are looking for help, are we performing our prayers?”

“So many issues, if you start by making a full recording, I think you could write a book, but we never record it, because, of not getting time, because you don’t have to do any of it, I just do it, because I feel people need it, obviously.”

“Even if it out of my work time, anything, you can’t, I just, this is, you know, you just have to, do it, because I look at it that way, I don’t say this is part of my duty.”

Participant 4:

“As you see the world has completely changed, if we read, when we read mainly history books, and the past, people were sort of more, mentally fit, mainly, of course, the factor is that the food that we eat, affect our mental health, and the environment we live in, affects our mental health. From as Islamic perspective, I would also say, that people being distant from the Quran, the word of Allah, the word of God, and this also has an effect on our mental health, very big affect, and very severe affect, on mental health, is when, we are actually distant from the Quran, and we don’t really feel, attached to it anymore, you understand? So, which, on the contrary obviously starts to play on our mind, and I have people come here, who are actually elder, each, who are facing a lot of issues, and then when you advise them, ok try to make connection with the Quran, try to read a little bit on a daily basis, they come back, and they feel, that some changes happened to me.”
OT2-MT3; Embracing the role. Examples of extracts;

**Participant 1:**

“We are here three Imams, we are four Imams sorry, so, we are four Imams Mashaa Allah rota basis we do our work, we don’t face any problems but sometimes of course, as many people coming and sometimes feel stressed and a big burden.”

“We have a fantastic team spirit within our Imam team, and as I said we are four Imams and two Muezzins, so all together six in our team. So as a large centre, we are trying to help the whole community in terms of their ethical [ethnic origin], in terms of their religious and spiritual guidance as well as community services.”

“We have mosque council, council of mosques in XXX, about fifty-four mosques together, we have a body of support.”

“I have had several cases like that, cases, like people asking for, support, in that sense, they are feeling down, they are feeling low, asking for, a lot of times, to be honest, I get people who come in here, and they just want to, really, talk to somebody, do you understand? It’s just a matter of, they have got an issue in their mind, they might be a hundred percent sure that I am going to see the Imam, he is not going to be able to do anything for me, but at least there’s somebody who is going to listen to me, and there’s somebody who I can talk to, and this is very important, this is one of our teachings of the Prophet Sallallahu Aleyhi Wasallam.”
Participant 2:

“You know, we are human being, so we are having different kind of pressure, and many, you are dealing with community, so, it’s not an easy job, so, you can’t keep happy to everyone.”

“We are human beings, so people are having things, we have to be with them, we should keep happy relations with them [Muslim community], and, if, we will, behave, that we are depressed, we are under pressure, so, when, Imam is like leader, so when leader is looking depressed, or, he is agitated, or he is under pressure, so then, how could he guide, the other people?”

“When we are energetic, and when we are committed with our skills, with our profession, so, we are happy when we are helping the people, so yes, you will work for yourself at the same time, when we are working for others, that is giving us more, motivation, more energy, and more, even love.”

“A lot of cases of homeless people, and is, medical issues, which they might not be able to afford, which might be complicated, and they just, get fed up and give up on life, and this is their way of saying, “Ok, I don’t want anymore, I’ve given up on life, so I’m just going to, let myself deteriorate, over time”. And I feel these things need to be tackled, whether it’s, even if it’s, if I could refer a person, not necessarily being Muslim, obviously, because we are in a mosque, and we usually deal with Muslims, even if a person, with a mental health issue, was a non-Muslim, walks in here and I feel, and I sense that, this person needs a bit of a, attention and support, I would really appreciate it if I could contact mental health services for this, I mean, this would be a great help, as a wider, community support, I believe. The mosque here, is here as a mosque, we do our prayers, we do whatever we need to do, but it’s still a community centre, apart from the worship that we do which is an obligation to us, that’s part of our, of the centre here, but with a broader view, the centre is here for all types of services, the more the better, I believe.”
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<td>“Alhamdulillah, throughout the country, wherever Muslim communities have evolved and developed, you know they’ve established masjids and mosques and Islamic centres, it gives people a base to, you know resort to and to refer to, and, you know, somewhere where they can, you know, where they can reach out, and, they can gain support from us as well.”</td>
<td>“I think that’s probably, going to be the biggest distinction between how, many people from the Asian subcontinent and even people from Morocco, North Africa, would look at something, and people in a Western paradigm, may look at it, or reference it, differently, so I think, one of the big things, is that, mostly when it is something unexplainable, not biological, a problem, then people will generally try to associate that with either magic, Jinn behaviour, or something from the unseen, and that’s, basically, what I have been trying to dispel, that look, there is an issue, of, psychological problems, chemical imbalances in the brain.”</td>
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<td>“Part of the responsibility and the duty, and the job, is community service, so you have to be strong you know, to be able to rise to the challenges, and obviously I am not the only one, we have other Imams with us as well, and so, we consult each other.”</td>
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<td>“Asian community, predominantly, have family set up, where you know, there’s parents and uncles and aunties, and families are bound as well, so such case, you know, such families are quite sound and, it’s solid foundations. In many, Somali communities, people, Somali community is quite new to this country, and recent, so, in many cases young people don’t have that, that extended support, which perhaps meant, such cases have been difficult.”</td>
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Participant 4:

“Alhamdulillah, because we have a big network of Imams in the UK, and as you may know I am actually a graduate from here, from Islamic University in UK, so, we have a whole connection of people who are learned.”

“I have people in the background who I can rely upon, I can contact them if I am in a situation, and, I always tell the people of our community here, people who come to see me, if they don’t mind somewhere in between, if I get stuck somewhere with a question, or with an issue, they don’t mind if I pick up the phone, and call somebody, who I regard, is an expert in this sort of field.”

“I always like to seek a second, third opinion, before I give a judgment to a person, or before I give an answer to a person. There are many cases where I send people home, and tell them “sorry, I can’t help you,” I mean, which is, there is no harm in, I would rather help somebody by saying I can’t help you, then maybe putting them in a worse situation than they were already in.”

“A lot of people, I just tell them to do a certain type of Zhikr, and remembrance, a literary I would give them, of meditation, that normally, sorts a lot of things out, this woman who came, who, had just been divorced, she was in, she’s in, what you call it, works in insurance, she is doing quite well, career orientated woman, she had just been divorced, and that had really broken her, and she was feeling extremely depressed, she couldn’t sleep at night, I haven’t had any, professional, you know, counselling, training, but, I just feel like sometimes that people need to be spoken to, sternly, as opposed to, just kind of going along with what they say, anyway, then I told her to do, specific type of, meditation, and after about three weeks, I get an email from her, saying that, “I have been doing that meditation, and now I am sleeping better than I ever slept even before my problems started, like I am completely fine”, so, a lot of things can be dealt with just by Zhikr, remembrance, so you have to gauge, I would have to gauge, what level is this problem at.”
Participant 5:

“I have tried to put a wall up there [when unable to provide religious/and or spiritual guidance], in between, because, you could make a lot of money, where you could become very popular, by doing this, there are charlatans out there that are charging huge amounts of money, with, you know, magical cures, that will sort your issue out."

“I'm just too busy, I am a workaholic, so I work, huge amounts, and I've got, not just one type of work I do to, [not to] let things impact me, maybe it's a good thing in that sense, you know, I can just take the next call and, you know, take the next call, so, to tell you the truth I did not prepare for this interview at all, I didn’t even think about what I was going to say to you."

“When I think that I can't do it myself, see, from the spiritual perspective, the way we look at this, is, you're not doing this for money, because you can make a huge amount of money here for just setting up shop.”

“If it’s even more extreme, you've been to the doctors and it still doesn’t work, then, Rukiya, but then there is nothing wrong I would say with doing, say Surah Al-Bakarah, for example, it's just a standard Rukiya and very powerful, for anybody, even while you are going to the doctor, because, you know, it's like you are using two forms of medication.”
Participant 6:

“They need somebody that is very strong, somebody that, you cannot be a weak person yourself, and not everyone can deal with it, so there are many many, out there, who are bogus.”

“Now because I, obviously this is local, and maybe I was in XXX, so then I, at the moment I am using him for this part [Imam colleague], I think there needs more people [Imams] to be trained in this field [mental health], because there is a large number, and most, because, people don’t contact, unless I, you know, you know give referral.”

“Imams, obviously, studies only focused on classical texts, you are studying about grammar, you are studying about jurisprudence, you are studying about, all these things, obviously, this is, you studying about, but, most of this is not applied in life practically, because when you come to the real world, the Imam now has not studied Psychology, not studied the, mental health, what is bipolar, what is OCD, you know, compulsive, all these issues, this is important.”

“It is like you know, sometimes you have, feel happy if somebody, you have solved somebody’s problems, and this can become, Sadaqah, because Prophet Sallallahu Alayhi Wasallam said even if you help somebody, or you remove a harmful object from the road you get the reward, you get Sadaqah, so this, I think conflict resolution, whatever, whatever we can use, I just feel maybe it is, Allah Subhanahu Wa Ta’ala has given us opportunity to help somebody, and if that can be, somebody’s Duaa’s prayers, and there has been cases, somebody comes here first, and says you know that time you did that, and you helped, made Duaa for me.”

Participant 6:

“A lot of, especially our sisters, most of their problems, whenever they want to see an Imam, it’s always something saying, “I need Rukiya”, they feel that they are possessed, mainly related to Jinn issues, are predominant of the requests that I receive, whenever I am giving a call, “Imam, can you do Rukiya for me, can you see if I have a Jinn”, so I feel, that is the main problem. And obviously others, you normally get, women, they feel that, their husband is, not treating them well, or they have been abused, so this is another serious concern with many marriages, woman said “I am not happy in this marriage”, marriages are breaking down, these are very common I found, most of the questions that I get, either is, relating to, the conflict and dispute, between husband and wife, so these women they go into depression, there is nobody to talk to, and obviously they ask, they need Imam help and support, and the other is, obviously the Jinn issue, that is very, very common.”
“Naturally, every Muslim, they are, living in this world, what’s happening in other parts of the world, it’s only natural for the people to feel affected, so, when they are seeing in the media, then, lots of them, they maybe, driven to do certain things, which is obviously, they need support, they need help. But then, we are, looking at them, at these people, you know they may, you know like every Muslim is already, you know they say it, guilty until proven innocent, I think this is what is worrying, and it’s leading to more people, having this, mental stress and illness, these are patients who are already ill, and there have been two cases I have seen myself, where they were, actually sent, and this is recent, that they need to be put on this, you know, kind of programme, or prevent strategy, and I said they don’t need all these things, there is an Imam, we have some use and, that person has a problem, and I found this myself, I spoke to him, and I calmed the whole situation down, but where did he get that feeling, is what he listens to the radio, what he sees in the paper, media.”
“Somebody comes, now you just can, obviously he doesn’t want to have anything to do with religion, he just wants somebody to speak to, so you may give, listen to him, listen to him, and obviously, it can be challenging, because now, he doesn’t want, spiritual advice, he just wants somebody to, more like counselling, give him that support, say “Don’t worry”, so now we don’t have to say anything from Quran, you know, life is full of tests, challenges, and these types of challenges will come, and you have to be firm, to it’s just giving him, comfort.”
“What we do, if I get a call saying, even before I came in, a lady with the same problem, saying, they don’t know what is the problem, the husband, is, you know, doesn’t want to have anything to do with her, and everything, she was asking, can this be the effect of the black magic, the Jinn, obviously from the Quran we understand, it is an effect, but it also means, that it can also be, that sometimes, many of the, you know, natural, woman may feel, or, man also may feel, that they that have come under black magic, but it’s nothing to do with that, so it’s like, trying to understand, you know investigate, “What is the real issue?” And most of the time, they just say, “No, I think I have a Jinn, I have black magic”, then some, there are cases, nothing related, nothing connected to it, these are some of the points.”
“People generally, they may come to you, I say, if you bring fear of Allah in your life, Allah will open up an avenue for you, so we have to use the Quran as a book, because the Quran says, it is a book which is a physical healing, as well as spiritual healing, so people have different types of illness, and even if they have, even mental illness, then the Quran also says, if you do the Zhikr of Allah, (Imam recites the Quran in Arabic), the heart will get contentment, for some reason difficulty, and then he is using the names of Allah, or he is, just, you know, just reading Quran for example, this helps him, this is a healing for him, and that person, may have, a challenge in his life, may have illness, but he has no contact with Allah, then how do you address it? Obviously, now we are looking at, you cannot impose anything on any person, you may just advise him, and give him some advice.”
“I mean there have been cases where I said, Ok, now, this is the issue, that what is, what is causing here, there is something behind it, what has lead you to this manner, sometimes it has been found, that even, between husband and wife, a woman can behave in such a way, they can, maybe, drive the husband to, you know, become, maybe, physical abuse, mental abuse, so I say also we have to do reflection of our own self, because we always maybe, finding out, other people who are causing us, but the problem could be our own self, and, I say, now we have to see, you know, yourself as a person, your personality type, how are you, are you always, you know, you get these cases, especially, when there is, difficulty, dispute between husband and wife.”
MT3: Role identity. Examples of extracts;

Participant 1:

“Number one support is advise them, number two counselling them, number three asking them to be together with their good friends and good relatives. Number four we are giving them advice to go outside of the mosque, go for holidays, take your wife with you or your mum with you and go sometimes outside, or go to Umrah, so they are connected with Allah Subhanahu Wa Ta'ala so they can find some peace and tranquillity and mental support. So these are our advice.”

“If any girl comes, then we are also asking her to go to the girls department, in our mosque we have Mashaa Allah women only, separate youth girls department, they are dealing, they can help you. So we are sending them there.”
“We highlighted a Khutba on parenting. When we discussed this matter in our Khutba and many people came to us to do some parenting courses and Mashaa Allah accordingly we started one with at least twenty-two people, and now this parenting course, which will be finishing Inshaa Allah on XXX with thirteen sessions, males and females together, husband and wife, and they are taking it very seriously, they are learning and amongst those, twenty, few people were vulnerable and about to finish their relationship but Mashaa Allah they are now very very happy and came together, bounded together and Mashaa Allah they are living together very nicely with family. And also another course we designed, Inshaa Allah after Ramadan in XXX we are going to start, only for husband and wife, for couples.”
Participant 2:

“We are also looking into people to get more skills, more knowledge, we are organising their different courses, and giving them latest knowledge, different skills, so that, the things when they are changing, so they should have the latest skills, to carry on their jobs and their professions. And at the same time, so sometimes, just sitting people are sitting with us, and our counselling, can help them, in the improvement of their mental state, and at the same time if they are having any physical problem or any mental problem, so, we are guiding them, what are the proper channels, how they can be treated, and how they can go.”

“You know, as Imam, as with rest of religion, so we have direct contact with community members, so children, ladies, gents, young people, old people, and people trust on us, and our job is to guide them, the right way. So, first of all, that is anything they are going to share with us, that is confidential, so this is our professional requirement, that we have to have to keep confidential, the things that people, the information of people.”
"We are human beings, so people are having things, we have to be with them, we should keep, happy relation with them, and, if, we will, behave, that we are depressed, we are under pressure, so, when, Imam is like leader, so when leader is looking depressed, or, he is agitated, or he is under pressure, so then, how could he guide, the other people? So, as a leader, anyone who is leader, of any community, any nation, so, we need to be active, we need to be fresh, we need to be energetic, we need to be motivated, so that he should motivate others."
Participant 3:

“There have been cases where we have offered our support and help as well, and, Alhamdulillah with some cases we’ve had success, in some cases there were other complications, other reasons, so, other help has also needed to be resorted to.”

“Many a times people they need to be, you know, because, as you know times are difficult many young people are out of jobs, they are just being, just being around with their family, not doing anything, with their backs against the wall, that can have its own problems and its own demands, so just encouraging people you know, to be actively involved in something.”
“Part of an Islamic society where people help one another, support one another, that’s one of the main philosophies and reasons behind, congregation prayer, and Muslims meeting regularly, and Alhamdulillah, throughout the country, wherever Muslim communities have evolved and developed, you know they’ve established masjids and mosques and Islamic centres, it gives people a base to, you know resort to and to refer to, and, you know, somewhere where they can, you know, where they can reach out, and, they can gain support as well. Obviously, we have to be careful how, because, you know, sometimes we have to be sensitive to each case, you know, we don’t want to be, seen to be interfering too much, or, especially violence cases, there have been cases of schizophrenia, and so, you know, we have to be careful in how far we can, involve ourselves.”

“Part of the responsibility and the duty, and the job, community service, so you have to be strong you know, to be able to rise to the challenges, and obviously I am not the only one, we have other Imams with us as well, and so, we consult each other, and, other community, community members.”
Participant 4:

“People come up with other issues over here, mainly, community issues, marriages, divorces, births, maybe problems with parents and youngsters in the family, parents and children, children, parents, and so I have all these issues, mainly, because we deal with the community as a whole.”
“Listening to them, gives the feeling of least, somebody has heard me, you know, it's going to somebody's ears, and when a child, not just a child even adults, when they have that feeling of, there is somebody who I can talk to freely, and it's confidential. A lot of us make mistakes, just to give you an example, a lot of us make mistakes, in Islam, in the context of, mistakes are considered as, for example, sins, yes, which we fall into, it's a natural thing, Allah Subhanahu Wa Ta'ala made sins, Allah Subhanahu Wa Ta'ala has sent us to commit sins, to actually fall into mistakes, and given us the opportunity to repent, and this is the point where, we need to listen to people, when you listen to people, they will be more interested of learning how to repent and come back, and seek forgiveness for their mistake, but if a person does not really know and nobody is listening to him and nobody has actually advised them, about it, unfortunately the day and age we live in today, it's a very difficult age especially for secondary school children.”
"I have people in the background who I can rely upon, I can contact them if I am in a situation, and, I always tell the people of our community here, people who come to see me, if they don’t mind somewhere in between, if I get stuck somewhere with a question, or with an issue, they don’t mind if I pick up the phone, and call somebody, who I regard, is an expert in this sort of field, or maybe has more experience in this type of field, or, in that type of issue or question, so, they don’t really mind if I contact people who are elder than me, people who have got more experience than me, so I just get a second opinion, I always like to seek a second, third opinion, before I give a judgment to a person, or before I give an answer to a person. There are many cases where I send people home, and tell them "sorry, I can’t help you," I mean, which is, there is no harm in, I would rather help somebody by saying I can’t help you, than maybe putting them in a worse situation than they were already in, I might make a wrong judgment, I might not have heard the full story, I might have missed, part of, what’s happening in the person’s life, and it’s very vital, that you make sure you get every little bit of information, relating to a certain topic, to be able to actually, help the person, mentally, physically, Islamically."
"We actually, take the Quran, as our manual, so we refer to the Quran, what am I going to do now, is it right, according to Quran, it is wrong according to Quran, where does it stand, is it something that is completely forbidden, is it something that is completely allowed, so we have the two extremes, or is it something in between, that maybe, disputed over, you understand, if there is a dispute, let me research, engage and seek in knowledge, and a person that is learned, Allah Subhanahu Wa Ta'ala says, (Imam recites from the Quran in Arabic), “Can you say, that a person who is learned, and a person who has knowledge about a certain issue, is he, the same as the person who is completely ignorant about it”, you understand, you cannot compare these two. So, when a person actually learns, and seeks, advice, and seeks, knowledge, about a certain issue, then he will think twice, “Ok, now I think this is not right for me, ok now I am sure, this is ok to do”, so if you understand what I am trying to do?"
Participant 5:

“She was put into a special hospital, and after a few months, after all these interviews, consultations were done and everything, she reacted positively to the medication she was given, and, she was fine, that reinforced for me the fact that she didn’t have, a Jinn problem, or a magic problem, she actually had a mental problem, because, she, once she had, the Quranic verses, and everything around her room, that would have been enough to get rid of any Jinn, but, it didn’t work for her, right, so, which means that, she misdiagnosed herself, and she should have gone to her doctors, she should have gone to see a specialist, so that just reinforced for me, so I gave a Khutbah about this on Friday, that your first port of call should be the doctors.”
“Another organisation that was working on a similar case, I actually asked them to, send me, their case studies because the woman I spoke to, who was on this, she said I have a number of these cases, I was actually hoping that she, would send me the cases where, it was Muslims being diagnosed with a mental problem, that they assume was Jinn, because I think, we, as Muslims, I think we need to create awareness, by bringing these examples, these case studies, like look this is what happened, and this case they thought it was magic, or, some external influence, but yet, it was just a simple, chemical, imbalance, or some deficiency of some sort, or something like that, and, I have seen this in the Asian subcontinent, I have seen this in Moroccans, and then you also see many Africans that are non Muslim, so it’s not just a Muslim thing.”
"It would depend, if they were doing crazy things, or they were hearing sounds and things like that, I would tell them to do Zhikr as well, I would tell them to read Surah Al-Bakarah, as well, but, I would actually, tell them to go to, the hospital first, however, if you check my website I actually have a note on there that, we do not deal with magic issues, and Rukiya issues, because I don't have the time to, deal with even general questions, because I'm too busy, and these ones, fortunately, I can't really help, I don't think I can help too much, these are the people that would be in my local community, that I would try to help, or people just kind of, I could help, but I try to avoid these issues because I am not a specialist in this subject, so I will try to, you know, so I have actually put that note on there."
“There is another level which I really hate dealing with, OCD, that is, I can now probably even judge when somebody comes in with OCD, the question will be something like this, my, something like, “My wife changed the baby, and then, she may not have washed her hand properly, so then the basin must have been dirty, must have been, and then I went there, and I’m not sure if I did this, and then it may have gone on the carpet”, and they have this long, really well thought out trail, and if you answer that question you are in trouble.”

“I’m just too busy, I am a workaholic, so I work, huge amounts, and I’ve got, not just one type of work I do, I do at least five or six different types of work, so there are times when I don’t really have the time, to, let things impact me, maybe it’s a good thing in that sense, you know, I can just take the next call and, you know, take the next call, so, to tell you the truth I did not prepare for this interview at all, I didn’t even think about what I was going to say to you.”
“It depends on the situation, how you gauge it, and a lot of the time it will be from some other symptom, so what I would tell them to do is to get more personal attention, from somebody who is more local, why are you calling, you know, calling somebody in XXX, why don’t you speak to somebody locally and I will try to get them to somebody in XXX, in, where it is that they are calling from.”

“I try to be more versatile, but then I know my boundaries of how much I can help, so then, the other thing, from a spiritual perspective is that, if I go and give a lecture somewhere, to two hundred people, maybe only twenty people will take it seriously, so the return I get is twenty people, right, maybe, because, everybody comes to a speech, but they don’t all come to implement, they come for entertainment, sometimes they come to meet friends, or whatever, when you write a book, again, it’s maybe five, ten percent that may take up something, but, when somebody comes to you with a problem, a Fatwa, or an issue like this, then, that generally has a ninety nine to a hundred percent return, in terms of spiritually, because you are helping them directly.”
Participant 6:

“I gave him reassurance, I said, obviously Islam is very, teaching you, and even in this type of difficulty, you know, the example of the Prophet, example of the companions, they went through different types of challenges, so if there is people who have hate, who have animosity against you, then, it doesn’t mean you will behave unjust, that you must irritate somebody, you must put down somebody, Quran always makes it clear, always try and be fair, and justice, but you can use so many beautiful, with Quran, to calm somebody down. I mean, I think, and obviously for those who have the Jinn issue, I, normally, I wouldn’t want to deal with it personally, and say that “you have a Jinn” or something, I would rather refer it, to somebody, who is already, dealing in it, because, not, any, every Imam, can deal with this issue of Jinn, but you may have knowledge about it, doesn’t mean, you can help somebody, giving effect treatment. Although, Quran is a book of healing, Shifa, so the Quran, we have to encourage, people can use it as a means of curing their sickness, illness.”
"Taking people's money, it's just a business; sometimes you find certain ads, adverts, this person is he offers this service, and people, I think, especially, when the person is feeling nothing is happening, anybody who says 'I can help you,' then many take advantage. So because I know this one brother XXX, then normally I would ask him, for example, if there is somebody living in a different area, so I know an Imam there, who does this, I know this one. Sheikh, his name is, one is XXX, people who are not greedy and they are genuine."
“I think always there are, number one reference is, because, as well as, I have made myself accessible, so anybody can contact me it’s not a problem, it is just finding the time sometimes, I may have, somebody, like one time, this was only this weekend, where I had so many messages, to visit the person, and actually, virtually, every, ten minutes, calling me so many times, and then, I am on the way to the programme, you wouldn’t believe it in fact it was the same day, yeah, it was the same day, and so, then I had to call XXX, and I told him, now, always she wants me to go to her home and her help her, and the same thing she wanted Rukiya, so there are times we cannot manage it is impossible to, recognise every, and able to give, I would say, quality time to every person, that is virtually impossible.”
"I think there needs more people to be trained in this field, because there is a large number, and most, because, people don't contact, unless I, you know give referral, otherwise they will be sceptical, who is this, what is this, so I think they are more confident if they find that I say don’t worry, even now when I entered the hospital today, there was a sister she, came to hospital, she was leaving and then she seen me, and then, same issue, so just now, I said, for this issue, I may need to come to your home, but let's first see what is the problem, brother XXX, is able to see if it is the affect of Jinn, I mean to recite Quran is fine, I don't mind, but that is what most of the time is happening I found, so can you imagine if I had to deal with every problem."
“So many issues, if you start by making a full recording, I think you could write a book, but we never record it, because of not getting time, because you don’t have to do any of it, I just do it, because I feel people need it, obviously, part of the, but even if it out of my work time, anything, you can’t, I just, this is, you know, you just have to, do it, because I look at it that way, I don’t say this is part of my duty.”

“It is like you know, sometimes you have, feel happy if somebody, you have solved somebody’s problems, and this can become, Sadaqah, because Prophet Sallallahu Alayhi Wasallam said even if you help somebody, or you remove a harmful object from the road you get the reward, you get Sadaqah, so this, I think conflict resolution, whatever, whatever we can use, I just feel maybe it is, Allah Subhanahu Wa Ta'ala has given us opportunity to help somebody, and if that can be, somebody’s Duaa’s prayers, and there has been cases, somebody comes here first, and says you know that time you did that, and you helped, made Duaa for me, so that sort of.”
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Appendix K: Participant one example of annotated transcript for data analysis

R: 02:25-02:26
To learn that from you, so thank you.

P: 02:27-02:28
No problem. Second question please.

R: 02:29-02:36
So I am wondering what sort of problems do Muslim brothers or sisters talk to you about, in terms of any emotional problems, do they ever talk about anxiety or depression?

P: 02:37-02:38
Emotional problems?

R: 02:39
Yes that’s right.

P: 02:40-03:55
As Imam, we are doing here for a long time Mashaa Allah, I am here about 19 years. I am here and we are dealing with especially, youth. And our young people Mashaa Allah, they are very, very enthusiastic, to get in touch with Imam always. Especially their health situation we are looking at that as well (RTPD). You will be more than happy to know that our mosque is XXX playing a role Mashaa Allah in the society, and especially in the way of Muslims. And they are attached with the mosque, and they always coming to the mosque, the Imam, talking their problems and sharing everything with the mosque, their worry, their health, their education and everything. So, in terms of their, their emotional many issues they are sharing with us and we are trying to help them (RTPD).

R: 03:44
Alhamdulillah.

P: 03:45-05:59
We should say, culturally they are sometimes feeling very low and sometimes negativity also there, but, they are living in British society and if they have any cultural problems or any emotional problems, they can go to Imam first, their first choice (FIMH), second to their GP to share, and then get some care from GP. So GP and can share and care their problems and give them ideas first, then advice, one of the top advice of the GP is to go to your Imam and see (EIHS), because emotional support is not a medicine matter, to give some medicine and it will be cured within a week. Emotional is something very important when and it will be resolved with peace of mind and peace of mental, isn’t it (AMHI).
And it that case we are here to support them always, with physical support and emotional support, giving them advice, suggestions, giving them some, what do you call it, if someone loneliness facing, then we are giving them companionship with our educated people they are going to support them(PNRCS; PSIO). Also we have opened in our mosque youth club for them, and also we have some, if anyone is drug addicted we have Nafas to support their issue (SMC; FIMH). And also we are responding in our Khutbah, in our Friday sermon, to tell them not to do so, don’t be abused by their parents, by their colleagues, by their friends, students, or at school, and they have to have room to share their problems (AMHI; FIMH). So we are here to help them in every type of help, we are trying to give them support and help Inshaa Allah (RTPD).

R: 06:00-06:45

Mashaa Allah that sounds fantastic, so, quite a lot of things you mentioned there. So one of the things you mentioned are cultural issues and the Muslim community coming to the Imam to discuss any issues that they have in terms of integration, and also it sounds like from what you are saying they feel quite comfortable in going to see their GP and it sounds like you are quite comfortable in liaising with them as well about that. You made a very interesting point that it’s not just medication it has to come from the inside. I am really interested to learn, when a Muslim person comes to you and they say to you, “Imam Saab I am feeling depressed or anxious” what sort of advice do you give them? I understand you have communities, you have a youth centre you have advisory what sort of advice do you give them?

P: 06:46-07:29

If problems are recognised then accordingly we advise them. For example someone facing problems, mentally and emotionally for his or her marriage, we are giving them support (RTPD; FIMH). Number one support is advise them, number two counselling them, number three asking them to be together with their good friends and good relatives. Number four we are giving them advice to go outside of the mosque, go for holidays, take your wife with you or your mum with you and go sometimes outside, or go to Umrah, so they are connected with Allah Subhanahu Wa Ta’ala so they can find some peace and tranquillity and mental support. So these are our advice (RTPD; PSIO; PNRCS; PRCS).

R: 07:30-07:32

Ok, that sounds, sounds fantastic.

P: 07:33-08:22

If someone is coming for education for example, he is not feeling mentally very well, and also abused by his teacher or by his friends or peer group, then of course we have some other suggestions. So to go outside, play with them, make them your friend, and be polite and gentle with your peer group, and then take them to, also outside of the work to go, enjoy, together. If any girl comes, then we are also asking her to go to the girls department, in our mosque we have Mashaa Allah women only, separate youth girls department, they are dealing, they can help you. So we are sending them there (RTPD; PSIO; FIMH).
Appendix L: Participant six example of annotated transcript for data analysis

R: 25:23-25:29
Yes, it must be a lot of pressure on your shoulders as well, dealing with all these different issues with all of these different individuals.

P: 25:30-25:42
So many issues, if you start by making a full recording, I think you could write a book, but we never record it, because, of not getting time, because you don’t have to do any of it, I just do it, because I feel people need it, obviously (SMC).

R: 25:44-24:45
So you see it as part of your role?

P: 25:46-25:57
Part of the, but even if it out of my work time, anything, you can’t, I just, this is, you know, you just have to, do it, because I look at it that way, I don’t say this is part of my duty (PRD).

R: 25:58-25:59
It is like a desire a desire to help people?

P: 26:00-26:40
It is like you know, sometimes you have, feel happy if somebody, you have solved somebody’s problems, and this can become, Sadaqah, because Prophet Sallallahu Alayhi Wasallam said even if you help somebody, or you remove a harmful object from the road you get the reward (SMC), you get Sadaqah, so this, I think conflict resolution, whatever, whatever we can use, I just feel maybe it is, Allah Subhanahu Wa Ta’ala has given us opportunity to help somebody, and if that can be, somebody’s Duaa’s prayers, and there has been cases, somebody comes here first, and says you know that time you did that, and you helped, made Duaa for me, so that sort of (SMC).

R: 26:41-26:54
So for you, you feel happy to help other people, because for you, like you say, it gives you a sense of, peace, that you know that you are helping somebody else, and that sort of good blessing that you described.

P: 26:55-27:08
And this is for people I don’t even know, I have my own family, and they are calling me, and so, I get all that sometimes, they are in XXX, they are calling me, and this is the problem, but it is just a matter of giving time (PRD).
R: 27:09- 27:12

Yes, so for you, you are quite busy giving time to people.


Giving time, and modern time obviously, the phone has become, maybe very accessible for people
to contact me whenever they want (SMC).

R: 27:21- 27:59

And I am wondering, with the volume of people that come to see you with these different types of
problems, on one hand we have Rukiya, one time, on one hand we have this, sort of normal issues
around marital issues for example, people who might come with issues around, you know
depression or low mood, sometimes things that are said in the media about the Muslim community
that might cause upset, I am wondering what your opinion is about NHS mental health services, and
you know, what your thoughts would be, about, actually, Muslims accessing these sorts of services,
what is your opinion about that, so formal, psychological help?

P: 28:00- 28:50

Yes, I mean, at the end of it, personally I think, obviously, at XXX hospital, I mean I, as the chaplain
there, I do get referrals, if there is a patient who wants to see an Imam, and I think this is so
important (IHP), if they didn't have somebody to give them that support, somebody they feel
comfortable with, so really, it has worked, NHS have been giving this provision for Muslim patients,
so favourably I would say, even if patient is in hospital, and he is getting, the professional care, while
he is given professional counselling, I think it is more supplementing, helping (EIHS).

R: 28:51- 28:52

So working together?

P:28:53- 29:04

Working together, I think it is important, because it can happen also, it is nothing related to, you
know, this Jinn and all that, they just need, professional, medical help, medical care (DWLHS).

R: 29:05- 29:07

It sounds like you acknowledge that, you see that need.
I see that need, and sometimes even if they, if it is not a Muslim, even if it is somebody, you can get somebody who is a counsellor, and he knows how to, and he understands people, you should, I think that is fine he does not have to be a Muslim, so if they have there, somebody to talk to, somebody they can, you know, get off whatever is on their chest, this is a, it is not a problem whether they are seeing even a non-Muslim, giving them that professional help (PNRCS), that is fine, only time is when they need, more extra, maybe spirituality, otherwise it is very great help, there can be many many Muslim, even husband and wife, they just need some counsellor, they don’t even need an Imam, so that can happen, Imam can make more problems, you know it depends, so they just need somebody just to give them counselling (PNRCS).
Appendix M: Author guidelines for submission of journal article to psychology and psychotherapy: theory, research and practice. Wiley online library

Psychology and Psychotherapy: Theory, Research and Practice

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Edited By: Andrew Gumley and Matthias Schwannauer

Impact Factor: 1.441

ISI Journal Citation Reports © Ranking: 2014: 52/76 (Psychology); 73/119 (Psychology Clinical); 75/133 (Psychiatry (Social Science)); 93/140 (Psychiatry)

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Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

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Appendix N: Table of survey results extracted from study conducted by Ali, Milstein and Marzuk (2005)

Table 3

<table>
<thead>
<tr>
<th>Reason</th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
<th>Never N</th>
<th>%</th>
<th>Sometimes N</th>
<th>%</th>
<th>Often N</th>
<th>%</th>
<th>Very often N</th>
<th>%</th>
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<tbody>
<tr>
<td>Religious or spiritual guidance</td>
<td>57</td>
<td>3.12</td>
<td>.87</td>
<td>1</td>
<td>2</td>
<td>15</td>
<td>26</td>
<td>17</td>
<td>30</td>
<td>24</td>
<td>42</td>
</tr>
<tr>
<td>Relationship or marital concerns</td>
<td>55</td>
<td>2.82</td>
<td>.9</td>
<td>3</td>
<td>5</td>
<td>19</td>
<td>35</td>
<td>18</td>
<td>33</td>
<td>15</td>
<td>27</td>
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<tr>
<td>Parent-child concerns</td>
<td>56</td>
<td>2.90</td>
<td>.85</td>
<td>3</td>
<td>5</td>
<td>27</td>
<td>48</td>
<td>16</td>
<td>20</td>
<td>10</td>
<td>18</td>
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<tr>
<td>Death or dying</td>
<td>56</td>
<td>2.45</td>
<td>.95</td>
<td>8</td>
<td>14</td>
<td>25</td>
<td>45</td>
<td>13</td>
<td>23</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Financial or employment difficulties</td>
<td>54</td>
<td>2.41</td>
<td>.92</td>
<td>8</td>
<td>15</td>
<td>24</td>
<td>44</td>
<td>14</td>
<td>28</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Doubts or weakness in faith</td>
<td>56</td>
<td>2.38</td>
<td>.82</td>
<td>6</td>
<td>11</td>
<td>29</td>
<td>52</td>
<td>15</td>
<td>27</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Depression or sadness</td>
<td>55</td>
<td>2.24</td>
<td>.79</td>
<td>7</td>
<td>13</td>
<td>33</td>
<td>60</td>
<td>10</td>
<td>18</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Fear of being discriminated against</td>
<td>57</td>
<td>2.12</td>
<td>.87</td>
<td>12</td>
<td>21</td>
<td>32</td>
<td>56</td>
<td>7</td>
<td>12</td>
<td>6</td>
<td>11</td>
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<tr>
<td>Having been discriminated against</td>
<td>56</td>
<td>2.11</td>
<td>.8</td>
<td>11</td>
<td>20</td>
<td>32</td>
<td>57</td>
<td>9</td>
<td>16</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Physical or medical symptoms</td>
<td>55</td>
<td>1.93</td>
<td>.96</td>
<td>18</td>
<td>33</td>
<td>27</td>
<td>49</td>
<td>6</td>
<td>11</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Anxiety or nervousness</td>
<td>56</td>
<td>1.86</td>
<td>.72</td>
<td>17</td>
<td>30</td>
<td>32</td>
<td>57</td>
<td>5</td>
<td>9</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Sexual concerns</td>
<td>56</td>
<td>1.73</td>
<td>.88</td>
<td>28</td>
<td>50</td>
<td>18</td>
<td>32</td>
<td>7</td>
<td>13</td>
<td>3</td>
<td>5</td>
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<tr>
<td>Odd thoughts or actions</td>
<td>55</td>
<td>1.69</td>
<td>.99</td>
<td>23</td>
<td>42</td>
<td>27</td>
<td>49</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Problems with drugs or alcohol</td>
<td>56</td>
<td>1.5</td>
<td>.71</td>
<td>33</td>
<td>59</td>
<td>20</td>
<td>36</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>56</td>
<td>1.21</td>
<td>.62</td>
<td>48</td>
<td>86</td>
<td>6</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

* Some of the percentages total more than 100 percent because of rounding.

1 As measured by a Likert scale: 1, never; 2, sometimes; 3, often; and 4, very often.

1 The table of the survey results were extracted from the study conducted by Ali, Milstein and Marzuk (2005, p204), demonstrating the full range of reported reasons for which congregants sought counselling from Imams in the United States.
PART C: CLIENT STUDY

Cognitive behavioural therapy integration approach

for an adult survivor of childhood sexual abuse

1. Introduction, rationale and theoretical framework

This client study will discuss a Cognitive Behavioural Therapy (CBT) integration approach for an adult survivor of childhood sexual abuse (CSA). The client attended therapy with the view of working on their depression and low self-esteem which begun during their childhood and became pronounced in the last one year. The client identified becoming socially withdrawn, reclusive and stopped engaging with hobbies they had previously enjoyed. The client described being ‘trapped’ in a cycle of going to work, putting on a ‘mask’ in front of colleagues and returning home only to watch TV, listening to ‘sad’ songs/music or sitting in their bedroom with the curtains drawn and the lights turned off for long periods of time.

The client also reported suffering from recurrent nightmares about their experience of CSA which had become prominent in the last eight to nine months. The client had not previously undergone psychological therapy. The client expressed a strong interest in learning ways to change their thoughts and behaviours as well as practical strategies to build their confidence. The client also wished to address their difficulty with accessing/exploring emotions and feeling like a ‘normal’ person.

1 This client study is an assessed piece of clinical work completed in the final year of the professional Doctorate in Counselling Psychology (DPsych). Upon receiving positive feedback from the marker the decision was made to include this assessed client study, as it also synchronised with the main theme of the portfolio which sought to understand the broader social context of help-seeking behaviours. Please see the ‘preface’ section of this portfolio for more details.
The decision to present this case was to demonstrate the use of a CBT integration approach which appeared suitable based on the premise that maladaptive cognitions are responsible for emotional distress and behavioural problems (Beck, 1967). The overall aim of therapy was to encourage the client to challenge the validity of their maladaptive cognitions, modify maladaptive behavioural patterns and working collaboratively to empower the client in becoming an active agent capable of meaningful change (Marshall & Turnbull, 1996). CBT is a pragmatic model of therapy which aims to support clients with developing problem solving skills that can be accessed when presented with similar difficulties in the future.

Over the course of time CBT has become an overarching term to describe Beck’s cognitive therapy (Beck et al., 1979) which sought to investigate models of human emotion and behaviour. For the purpose of simplicity when discussing CBT throughout the intention is to refer to the original conceptualisation of cognitive therapy. The cognitive model was founded as a response to investigating the presentation and effective treatment of depression. The cognitive model postulates that negative early life experiences activate the growth of core beliefs which develop into dysfunctional assumptions that influence how an individual with depression may behave. The core beliefs can be triggered when the individual is exposed to a ’critical incident’ deemed to cause significant distress. This ensues onto negative automatic thoughts (NATs) characterised by the negative cognitive triad of the self, the world and the future. The NATs themselves are regarded responsible for changes in behavioural, affective, cognitive and somatic symptoms in depression. Cognitive therapy seeks to challenge the negative cognitive triad by isolating NATs and re-evaluating the core beliefs and assumptions (Beck et al., 1979).
Cognitive therapy is primarily concerned with incorporating therapeutic techniques such as guided discovery of schema beliefs and dysfunctional thought recording, followed by establishing a sound therapeutic alliance in the client-therapist relationship as this is thought to strengthen the effectiveness of techniques. Attention is given to agenda setting at the beginning of each session and collaborative problem-solving that takes place between the therapist and the client as the main agent of change. This is held crucial for the successful practice of homework assignments advocated in CBT. This type of collaborative engaging is practiced with the client in order to work towards solving the client’s difficulties in which they become an active participant in accomplishing homework assignments.

Currently there is no agreed universal definition for CSA although it has been described by Lev-Weisel (2008) as ‘a sexual act between an adult and a child, in which the child is utilised for the sexual satisfaction of the perpetrator’ (p.3). Statistics have indicated the prevalence of CSA as one out of three or four children (Briere & Elliot, 2003) and the majority of CSA survivors only receive therapeutic treatment after the age of 18 due to sexual abuse not being reported during childhood (Alaggia, 2005). Survivors of CSA have been found to develop complex needs in adulthood including trauma, anxiety, depression, substance misuse, sexual dysfunction, affect regulation difficulties, personality and dissociative disorders (Ross & O'Carroll, 2004) in addition to an increased risk of committing suicide (Sachs-Ericsson, 2009). Upon reaching adulthood CSA survivors come to the realisation that their old coping strategies which may have enabled them to survive the trauma of sexual abuse as children become ineffective; this heightens when confronted by the spheres of adult life such as forming emotional bonds with others, intimate companionship and starting a family, which reactivate maladaptive thinking patterns and initiate access to psychological therapy (Cole, 1992).
Understanding what is required to form a successful therapeutic relationship is a common theme that can be observed across all psychotherapeutic models in different variations; this is especially pertinent when working with survivors of CSA given the vulnerable history of this population who often arrive at their first session demoralised by the stigma of help-seeking in the first instance, accompanied by high levels of shame and self-criticism present in the disclosure of abuse to the therapist and apprehension of the therapist’s reaction (Ross & O’Carroll, 2004). In view of this it was felt that integrating the relational aspects of Person-Centred Therapy (PCT) developed by Rogers (1969) would be beneficial to assist in the healing process during therapy and the client’s desire to ‘access’ emotions with depth.

PCT focuses on the therapist immersing themselves into the world of their client facilitated by the therapeutic relationship through six ‘necessary and sufficient conditions’ for therapeutic personality development to occur within the client. This lends itself to awareness of conscious human experiences on the part of the client and not making assumptions about the content of their experiences however becoming more attuned to the process of their experiences. Humanistic psychotherapy aims to return the client to a state of self-actualisation and the role of the therapist is to act as a companion on the client’s journey of self-discovery through congruence, unconditional positive regard (UPR) and empathy. CBT stipulates that defective ‘schemas’ which refer to an index of maladaptive beliefs and rules clients follow regarding themselves, others and the world are responsible for emotional distress and behavioural problems (Beck, 1976). An integration of the concepts stipulated by both PCT and CBT have been chosen and applied in order to enhance the therapy experience for the client which involved practical skills training and attention to affect regulation through exploration of the self.
The overall aim of therapy was to encourage the client to challenge the validity of their maladaptive cognitions, modify maladaptive behavioural patterns and working collaboratively to empower the client in becoming an active agent capable of meaningful change through guided discovery. However the emphasis on empathy found in PCT represents a deep understanding of someone else's world, thus requiring emotional investment by the therapist to harness a therapeutic relationship which is both egalitarian and empowering. Working empathically with a client also serves to broaden the therapist's ability to respond sensitively and convey understanding, thus, encouraging the client to disclose cognitions and feelings which are otherwise not articulated.

While Beck et al. (1979) make reference to therapeutic skills necessary for successful cognitive therapy including warmth, accurate empathy, genuineness, and the building of trust in addition to more recent literature on CBT outlining the role of the therapeutic relationship with detail (Gilbert & Leahy, 2007), the specifics of empathy within the context of CBT remain largely unexplored. The properties of empathy that are found in CBT have derived from other psychotherapeutic models (Burns & Auerbach, 1996; Hoffart et al., 2002), therefore the integration of PCT accommodates the therapist with ‘sensing the feelings and personal meanings which the client is experiencing in each moment, when he can perceive these from ‘inside’, as they seem to the client, and when he can successfully communicate something of that understanding to his client’ (Rogers, 1967, p.62). However, the cognitive perspective of the therapist becoming ‘empathically attuned’ to the nonverbal communication of the client by communicating their acknowledgement of the client’s emotional frame of reference (Bohart et al., 2002) and an awareness of tone of voice with providing warmth, understanding and acceptance (Greenberg, 2004; Gilbert & Leahy, 2007) lends to the therapist being ‘emotionally engaged’ with the client’s narrative rather than ‘emotionally passive’ or ‘distant’.
Empathy is a crucial therapeutic skill when engaging with clients as it encourages the therapist to remain ‘real’, genuine and transparent to reflect trust and safeness in the therapy domain. In the case of working with adult survivors of CSA that have come forward for support, aside the validation and normalisation of the client’s feelings, Sanderson (1995) stipulates the therapist is to refrain from collecting facts relating to the experience and focus on what the client believed to have happened. This allies closely with the concept of UPR as found in PCT and a natural integration developed in the work undertaken with the client while addressing the emotional, cognitive and behavioural aspects of the impact of CSA in the presentation of depression, and developing adaptive behaviours and coping strategies for the future.

2. Profile of client and biographical details

For the purpose of confidentiality the client’s name has been changed to ‘Solomon’ and they will be referred to this pseudo name throughout. Solomon is a thirty-nine year old Afro-Caribbean male who is currently living in a rented house share accommodation. He presented as smartly dressed and always arrived at the exact time of session. Solomon self-referred to the third sector trauma service that I was on placement with, which provides long term integrative psychological therapy to adult survivors of CSA. Upon completion of the initial assessment with myself Solomon articulated his intention for seeking therapy was related to his underlying depression, issues with self-esteem and confidence that he believed to have stemmed from his history of CSA. Screening measures for anxiety and depression were not used as this was not a requirement stipulated by the third sector service.
Solomon is from the North of England and the youngest sibling in a family of two elder brothers and one half sister. Solomon’s parents separated when he was two or three years of age and was raised by his mother, whom he described as ‘emotionally unavailable’. Solomon was psychologically bullied by his two brothers up until early adolescence and was often made to feel ‘inferior’. Solomon did not have any contact with his father since childhood however learned of his passing two years ago through a family member. Solomon left his family home at the age of twenty to pursue his degree at a London University, and has continued to live in London upon establishing his career in the business sector. Presently, Solomon has an estranged relationship with his brothers and infrequent telephone contact with his mother and half sister.

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2 All identifiable details of the client, including their name and biographical details have been heavily fictionalised to protect and preserve their confidentiality and right to anonymity. Please see ‘figure 1’ at the end of this section of the document for consent pertaining to publication of this client study, as per the guidelines provided by City University London at the time of obtaining consent from the client.
3. Presenting problem

Solomon attended therapy in order to improve his state of depression, self-esteem and confidence which has been a difficulty since childhood, however described this becoming progressively worse over the last one year. The turning point for Solomon occurred approximately eight to nine months ago following acute stress at work causing a ‘break down’ and the onset of nightmares relating to Solomon’s history of CSA; this lead him to becoming reclusive, paranoid, avoidant and uncomfortable in social situations. This was made worse by Solomon’s difficulty with concentrating on what others were saying and lacking a desire to converse, accompanied by an overwhelming sense of hopelessness about the future, feeling ‘useless’ and ‘worthless’ which was further compounded by sleep disturbance as a result of the nightmares. Solomon also experienced thoughts of being ‘abnormal’ and ‘the future is hollow’. The first session began by Solomon explaining his decision to seek therapy was guided by feeling ‘out of control’ and overwhelmed by depression, accompanied by a pronounced sense of hopelessness about the future following his ‘breakdown’ at work some months earlier. Solomon did not provide any details about his history of CSA other than confirming his status as an adult survivor which continued to affect him and disclosure of the vivid nightmares relating to this. Solomon’s identified goals for therapy were as follows;

1) “I want to be normal again, like my old self and feel comfortable around people”
2) “I would like to see a future for myself and capable of achieving things”
3) “I want to believe in myself and become more self-assured”
4) “I want to find and learn who I am as a person”

While not explicitly outlined Solomon was aware that therapy will involve exploring the traumatic memories of CSA when he felt ready, and the impact of his journey into adulthood given the context of the service. This was discussed and agreed at session one.
4. CBT formulation

![CBT Diagram]

**EARLY EXPERIENCES**
Victim of CSA/ lacking nurture from mother/ bullying from brothers/separation of parents

**CORE BELIEFS/SCHEMAS**
I am unlovable/ I am worthless/ people take advantage of me/ the world is a cruel place

**UNDERLYING ASSUMPTIONS/CONDITIONAL BELIEF**
I have to hide how I feel / if I get close to people they will know the real me/ it is better not be assertive because I will make the wrong decisions

**TRIGGERS/PRECIPITANTS/CRITICAL INCIDENTS**
Breakdown at work/ onset of nightmares/ breakdown of previous long term relationship

**NEGATIVE AUTOMATIC THOUGHTS**
“I am abnormal”
“I have nothing good in my life”
“The future is hollow”
“I can’t face people”
“I am losing my mind”

**BEHAVIOURS**
Socially withdrawn
Making excuses
Lacking self-care
Stopped recreational hobbies
Avoid answering text messages
Drinking excessive alcohol
Listening to ‘sad’ songs/music
Sitting in darkness

**EMOTIONS**
Depressed
Anxious
Hopeless
Angry
Shame
Paranoid
Inferior
Out of control

**SOMATIC**
Sleep difficulties
Lethargy/tiredness
Nightmares
Concentration difficulties
Knot in stomach
5. Contract and therapy plan

Solomon and I agreed to meet weekly with the understanding that sessions will continue for a period of up to one year in view of the long term therapy contract offered by the service. Solomon and I also agreed a review at session eight and every six to eight weeks thereafter for the opportunity to discuss further needs and the direction of therapy. Discussion was had with Solomon explaining the terms and conditions of the maximum one year policy, his right to request a change of therapist and his right to terminate therapy at any given stage. The session fee was agreed at thirty pounds per hour which was remunerated by Solomon’s employer as part of the agreement made with the Occupational Health department.

The early phase of therapy focuses on developing trust and a sound therapeutic relationship with Solomon to normalise and provide psychoeducation on the symptoms and management of depression, stress management, identifying coping strategies and providing active listening in order to create a safe environment for Solomon to express and explore his emotional difficulties. This stage of therapy is arguably the most crucial given the vulnerability of CSA survivors, stigma associated with sexual violence and help-seeking; the therapeutic techniques of UPR, congruence and empathy were deemed crucial components during this phase as they are attributed to building a firm therapeutic relationship (Rogers, 1969).

The middle phase of therapy will shift towards exploration of CSA, when Solomon feels ready to disclose, and applying a trauma based cognitive approach (Bloom, 2000) when addressing the traumatic memories of CSA alongside cognitive restructuring (McDonagh et al., 2005).
While Solomon has not previously discussed his experience of CSA with anybody other than myself in the context of his referral to the service, observing the therapeutic skills of PCT as described by Rogers (1969) will harness transparency, sincerity and warmth when communicating with Solomon and accompanying him on his challenging journey.

The middle phase of therapy will also involve;

i) Acknowledging the abuse and its impact

ii) Exploring and experiencing the distressing emotions associated with the trauma memories which have been repressed

iii) Exploring the range of emotions associated with the perpetrator and the role of non-protective family members/significant others

iv) Emphasis will be placed on cognitive restructuring to challenge existing core beliefs and the formulation of new, helpful coping strategies in order to support Solomon with feeling more in control to deal with the impact the abuse had on his life

The final phase will involve Solomon engaging with the healing process in preparation for the termination of therapy. This will involve empowering Solomon to make his own decisions and choices by an improved sense of self, view of the world and new coping strategies incorporated into his behavioural repertoire. This may manifest when building trusting relationships with others, awareness of his needs and being assertive in situations/circumstances. Literature in the field of CSA stipulates that once an adult survivor has resolved the trauma of the sexual abuse and the affect which accompanies it, their presenting symptoms also dissipate naturally over the course of time (Sanderson 1995); this will be the end goal of therapy.
6. Development of therapy

6.1: Session one

Solomon described his reasons for accessing therapy as related to work related difficulties which had triggered a ‘breakdown’ and the onset of depression, followed by experiencing vivid nightmares relating to his experience of CSA. Solomon spoke in a very matter-of-fact way akin to surmising a business report, with minimal facial expression and a lack of emotion when describing his family structure and the events of his childhood. Solomon described his mother as ‘emotionally unavailable’ for most of his childhood and could not recall physical nor verbal affection, the absence of his father from a very young age and being psychologically bullied by his two elder brothers.

Solomon seemed to have a relationship with his half-sister although this was superficial. When listening to Solomon’s story it became clear why he was robotic given the limited nurture from his primary caregiver at the early stages of development and the reinforced victimisation by his brothers; perhaps connecting with these experiences emotionally would have felt overwhelming for Solomon at this point, or perhaps he was unaware of the lack of emotion in his account. I had become drawn towards Solomon and felt a strong sense of warmth towards him as the goals for therapy were outlined. Upon leaving Solomon shook my hand and offered his thanks, which felt much like ‘sealing’ a business contract.

6.2: Session two

Having returned to therapy Solomon disclosed that he had found our initial session challenging as it felt difficult sharing the private aspects of his life, although maintained that it felt ‘good’ to have someone listen to him intently without worrying about being judged or
coming across as ‘mad’. Following this Solomon volunteered brief details about his experience of CSA when I learned that the sexual abuse took place repeatedly under the age of twelve, and the perpetrator was his paternal cousin. This was all the information provided and Solomon changed the topic, indicating that he felt uncomfortable and did not wish to elaborate at this stage; I respected Solomon’s choice and did not probe further.

Following the disclosure Solomon’s facial expression had shifted from being ‘blank’ to becoming sombre as he lowered his gaze, revealed thoughts about suicidal ideation and diminished hope for the future. Given that the sense of hopelessness is a better predictor of suicidal behaviour than severity of depression (McMillan et al., 2007) I felt it was important to acknowledge that risk was a sensitive topic for Solomon by responding compassionately and normalising how he was feeling. After carrying out a risk assessment I was satisfied that Solomon was at low risk of following through a suicidal act, however we agreed to monitor this weekly and Solomon was made aware of the out of hours support agencies he can contact if required. Empathy is a useful tool in CBT for helping the client to feel understood and is also valuable in the development of the therapeutic alliance (Grant et al., 2008; Westbrook et al., 2007). I felt this was achieved here with Solomon’s disclosure of suicidal ideation and my trying to understand the problem without being alarmed, to demonstrate I had acknowledged his feelings and what he was going through.

6.3: Sessions three to six

The third session began with reviewing risk given Solomon’s previous indication of suicidal ideation and his thoughts in this regard remained largely unchanged; however he did not report any plans or intentions to end his life. Solomon revealed his limited social interaction with friends, becoming increasingly withdrawn, isolative and lacking engagement with things he previously enjoyed such as exercise and cooking meals. Solomon described how he had
felt ‘empty’, ‘sad’, had thoughts that he was a ‘failure’, ‘worthless’ and that ‘everything was pointless’ in his life, which was the reason given for spending a lot of time alone in his bedroom and avoiding his housemates. When we explored the baseline for activities, Solomon explained how during the week he would usually go to work in the morning, come home in the evening, spend time alone watching TV in his bedroom or listen to ‘sad’ songs/music.

This presented as an appropriate time to explain the rationale for ‘behavioural activation’ (BA) in CBT to address motivation in depression and revisiting the goals for therapy, part of which formed Solomon’s desire to be active again. BA has been found to be an effective treatment for depression in CBT as it targets the role of behavioural avoidance; emphasis is placed therefore on activity scheduling to support the client with addressing their avoidance behaviours and identifying the role of cognitive rumination which further serves avoidance and reinforces the state of depression (Lewinsohn et al., 1976; Hopko et al., 2003a).

The aim of BA was to encourage Solomon with refocusing his goals and finding meaning behind these once again in order to increase motivation and reinstate value in achieving activities. More specifically, the intention of BA was for Solomon to build small goals to re-establish daily routines which he had stopped since becoming depressed, increase pleasurable activities either independently or involving others and address important necessary issues to help him re-gain a sense of control using activity planners, diaries, implementing behavioural activation exercises and reviewing progress (Ekers et al., 2008).
In view of the principles of BA, the fourth, fifth and sixth sessions involved reviewing the homework assignments using activity scheduling and gradually Solomon became re-engaged with social interaction, going to the gym and preparing meals for himself three to four times weekly. As Solomon noticed an improvement in mood he naturally continued to integrate other activities into his life as a result of increased motivation and thoughts about suicidal ideation became less frequent. The therapeutic alliance and personal influence of the practitioner has been found to be more effective than the technique of the actual intervention itself (Lambert & Ogles, 2004); therefore integrating the PCT component of UPR contributed greatly towards cultivating the development of a healthy therapeutic relationship with Solomon and encouraging safeness for Solomon to review the homework tasks, reflect on his learning and overcome road blocks in his application of BA.

### 6.4: Session seven

I wished to build on the therapeutic alliance with Solomon and develop rapport (Safran & Muran, 2000) by empowering him to take control of his own recovery and encourage a sense of ownership with addressing NATs; given that significant progress was made with behavioural modification this seemed a natural progression which evolved into the use of ‘socratic questioning’ (Padesky, 1993). This revealed important details of Solomon’s early life experiences and identified the formation of core beliefs which developed from the bullying subjected by his two elder brothers and lack of emotional connectedness with his mother. These appeared to influence and reinforce Solomon’s core beliefs ‘I am unlovable’, ‘I am worthless’, ‘people take advantage of me’ and ‘the world is a cruel place’. These beliefs may have been perpetuated by the ending Solomon’s long term relationship during his mid twenties, after which he has not entered a romantic relationship.
During supervision the idea of Solomon taking the lead was explored given that CBT is a pragmatic therapy that seeks to help the client overcome difficulties by identifying and changing dysfunctional thinking, behaviour, and emotional responses (Beck, 1976). As this was Solomon’s first experience of therapy, I initially did not feel confident in seeing him due to the complexity of his difficulties and believed an experienced integrative practitioner would be suited to provide the skills for meaningful change. When reviewed with my supervisor they offered support and encouragement to take into consideration the wide-range of skills I was using in my therapeutic encounters with Solomon including UPR, and my feelings of anxiety naturally improved. As described by Mearns and Thorne (2007) ‘unconditional positive regard is the label given to the fundamental attitude of the person-centred counsellor towards her client’ (p.95) in addition to therapy offering an invitation to sensitively enter the world of the client, and explore their innermost intimate feelings while they are made to feel safe to allow such a deep relationship to take root. The supervisor’s role in normalising uncertainty for their supervisee is an important component in the training experience (Nezu et al., 2001) which provided the boost needed in my work with Solomon.

6.5: Sessions eight to nine

It was important to continue developing the therapeutic relationship with Solomon to ensure that he felt able to disclose sensitive information pertaining to CSA at a later stage in therapy. Therapists are better able to develop new clinical knowledge, skills and form more constructive attitudes as a result of supervision, and this may occur because of a direct transmission of ideas, information or techniques recommended by the supervisor (Westbrook et al., 2007). Supervision contributed greatly to my own confidence when attending to the therapeutic alliance whilst also involving Solomon in the process as stipulated by the CBT model, since he was the expert by his own experience, and my role as the therapist in facilitating growth and increasing understanding for meaningful change. This
was strengthened by empathy in the therapeutic relationship, as research in the field of CBT for treating depression has found that client recovery was significantly higher when treated by therapists who were perceived as empathic and warm, in comparison to therapists who emphasised technical interventions (Burns et al., 1992).

Sessions eight and nine were dedicated to the use of thought records (Greenberger & Padesky, 1995) to monitor NATs and from that explore alternative thinking styles. While Solomon found the process of looking for evidence for and against NATs insightful, as an approach he struggled to ‘believe’ the alternative thoughts. This presented as a dilemma since Solomon was not experiencing the meaningful shift I had hoped for and my own hypothesis of being inadequate resurfaced. In hindsight it may have been more useful to explore the source of the NATs, how this might have impacted other areas of Solomon’s life and whether this served the function of his negative sense of self (Kinsella & Garland, 2008). At this stage I could have challenged my own fear of asking questions related to Solomon’s history of CSA than preoccupied with the anxiety of re-traumatisation given that ‘a client is most at risk for becoming overwhelmed, possibly retraumatized, as a result of treatment when the therapy process accelerates faster than he (sic) can contain’ (Rothschild, 2000, p.78), therefore judging if Solomon was ready was my secondary dilemma here.

My fear of re-traumatisation and making links to CSA was given attention in supervision where I learned that my own anxiety of ‘intruding’ into Solomon’s past compromised an opportunity to demonstrate my authentic self as a therapist and neglect of transparency. Furthermore I was concerned that I would not be able to contain Solomon when he becomes upset. The client’s perception of their therapist’s characteristics (Wright & Davis, 1994) demonstrating warmth and building trust have been found to impact the successful outcome of therapy (Kazantzis et al., 2010), and my own preoccupation may have afforded the
opportunity to incorporate this strategy and for Solomon to build deeper psychological insight.

There were instances when Solomon broke off eye contact, despondency on his facial expression deepened and he looked towards the floor intermittently. In the PCT tradition Rennie (1998) stipulates that the therapist is better able to fuel the client’s experiences and facilitate deeper exploration by utilising the ‘felt-sense’ and drawing upon process identification by commenting on the client’s process issues. This is achieved by informing the client of their subtle behaviours and cues which they may not be aware of with feedback such as ‘you looked away as you mentioned’. The omission to make use of this with Solomon resulted in not exploring the meaning behind breaking eye contact and looking towards the floor, what that meant for him, what lead him to do that and any realisations he may have made. Process identification highlights thoughts and behaviours which may otherwise remain subconscious, and subsequently the client develops greater self-awareness. This also provides the client a way of ‘unlocking’ their problems by encouraging reflexivity which could have been promoted, if Solomon’s process issues were appropriately commented upon by making a statement such as ‘I noticed that you looked down towards the floor as you said that’ in order to enhance our therapeutic relationship.

**6.6: Sessions ten to eleven**

Conscious of the state of the therapeutic relationship and Solomon’s struggle with accepting his alternative thoughts these two sessions focused on collaboration and active participation, otherwise known as the ‘collaborative empiricism’ in CBT (Beck et al., 1979) which is integrated with a firm therapeutic alliance (Greenberger & Padesky, 1995). This enables the client to flourish and take an active role in their therapy rather than a passive recipient of therapy, and thereby sharing responsibility for treatment (Kinsella & Garland, 2008).
During supervision the idea of taking a ‘step back’ and becoming an 'observer' was considered with depth in my psychological and physical responses when unpicking Solomon’s difficulties; I attempted to adopt the role of the observer by re-visiting the formulation and giving Solomon autonomy with reviewing progress, and allowing for more silences in session to sit with my own feelings of uncertainty. This also mirrored the concept of ‘agency’ in PCT (Rogers, 1951) whereby clients arrive at therapy with incongruence, vulnerability and distress however the effective use of agency can act as a powerful component to draw the client’s attention to their own self. Solomon had identified that his experience of vivid nightmares had ceased completely during the last one month, and he had only recognised this upon reviewing the formulation. This marked the beginning of Solomon becoming a reflexive agent in his own locus of evaluation (Rogers, 1961) when exploring the significance this held for him in the context of his behavioural changes, improved energy levels and sleep. In view of this, Solomon made the decision to continue focusing on behavioural activation and building on his exercise regime.

6.7: Session twelve

The atmosphere felt very different unlike anything experienced before; while I was not entirely sure why it felt different I could sense a pronounced shift as Solomon entered the room. When sharing his goal of increasing exercise Solomon reflected on how he was feeling ‘much stronger’ both physically and emotionally, that perspiration during exercise felt like shedding ‘bad stuff’ from his body and also connected this to feeling more ‘in control’ psychologically; this had confirmed that the shift I felt was tuned in with Solomon before the session had begun. Given that we had worked towards building rapport and trust in the therapeutic relationship, for the first time in therapy I offered a connection to the CSA and not hindered by my own nervousness about opening a ‘Pandora’s box’.
The decision here was influenced by the idea of relational depth in PCT, where the therapist’s ultimate responsibility is to demonstrate genuine, caring attributes which create a setting for the client to feel at ease and ‘safe’ in the therapeutic process (Mearns & Thorne, 2007). The intention was to create a platform for Solomon to explore his own negative self-appraisals and acceptance of feelings that he was unable to achieve with the use of thought records, as relational depth equips the therapist with understanding the ‘whole’ client and the parts of them that are deemed less accessible. Relational depth appears to offer an intimate connection with the client that extends beyond the therapeutic relationship; it is an invisible thread which ties the client and the therapist together in experiencing a simultaneous ‘connectedness’ and shared experience; this was what I felt on this particular session with the anticipation that Solomon would recognise this also.

I experienced relationship depth with Solomon in a therapeutic way amid feelings of discomfort, by offering my observation to Solomon, in a sensitive manner, that exercising and feeling good about shedding ‘bad stuff’ from his body seems to reflect him taking control and ‘shedding’ the ‘bad stuff’ from the sexual abuse that took place during his childhood, and as an adult, he was in charge of what happened to his body and feeling more resilient might be related to this. Solomon met my gaze with deep contemplation for approximately five to six seconds, and then lowered his head looking down at the floor and a silence followed which lasted about one to two minutes. During this time I could feel the palpitations in my chest due to the uncertainty of Solomon’s response and the process he might have been going through, although I remained in silence drawing on the PCT concept that ‘it is no surprise that many therapists experience their deepest moments of relational depth with clients in silence’ (Mearns & Cooper, 2005, p.119).
My most meaningful therapeutic interaction occurred with Solomon at this point despite the anxiety building up in the room. As I waited patiently Solomon eventually met my gaze again with an intense sadness and tears in his eyes, sharing that he felt like a ‘broken’ person because of the sexual abuse that took place during childhood, and for the first time in his life, he felt like he was starting to live and taking control of his physical and psychological self. Solomon then went on to disclose his experience of isolation as a child, feelings of resentment and anger towards his mother, who was firstly ‘emotionally unavailable’ and secondly, failed to protect him from the repeated sexual abuse. Upon exploration of his sense of abandonment by his mother, it became clear that moving towards exploration of the relationship dynamics in his early life and the role of ‘non-protective others’ will require attention.

7. Conclusion of therapy and review

The therapeutic work will be continuing with Solomon for another nine months with the view of moving into the middle phase of treatment. The overall structure of the treatment will remain CBT focused in preparation for the trauma that may arise when exploring CSA, and as such, a cognitive based schema treatment for trauma will follow. This may entail a need to be vigilant and directive in responding to the range of emotional stimulation experienced by Solomon when processing traumatic material in the session, using the cognitive behavioural strategy of reliving. The rationale here is grounded in the understanding that ‘fear appraisal involves the activation of a pre-existing (trauma-induced) cognitive schema that leads the person to attend to evidence that is consistent with the schema and to ignore evidence that is inconsistent’ (Resick, 1992, p. 748). This approach is synonymous to systematic desensitisation which is traditionally found in the treatment of anxiety disorders whereby clients are gradually exposed to feared stimuli and learn to tolerate distress using helpful coping strategies (Beck & Emery, 1985) through socratic questioning and cognitive
restructuring to evaluate their thoughts, see others and the world as a less threatening place (Bloom, 2000). By working on the old core beliefs it is hoped that Solomon’s degree of conviction will lessen, and he will be able to arrive at new core beliefs such as ‘I am worthy of love’ and ‘I am able to make decisions about my life’.

In the view of psychotherapeutic practice, working with such complexity presented by those with a history of CSA is not a fluid process given the many variables that affect this client group; therefore encompassing PCT to harness trust in the therapeutic relationship by demonstrating genuineness and gaining the connectedness of relational depth the therapist supports the client to become aware of their own feelings, thoughts and processes which enables them to trust their own judgements and recognise their own value and worth.

In learning from this client study I have found in order to support Solomon with reaching his ultimate goal of wanting to ‘find and learn’ who he is as a person, I also have a responsibility to listen to what is going on within myself and share these insights in the therapeutic journey. Rogers (1961) notes ‘the more the therapist is able to listen acceptingly to what is going on within himself, and the more he is able to be the complexity of his feelings, without fear, the higher the degree of his congruence’ (p.61).

From a reflexive position as a Counselling Psychologist in the final year of training, I have completed a full circle and reminded about the humanistic skills of the therapist which are not defined by pragmatic theory; I was particularly struck by this approach to therapy in the first year of training when introduced to PCT and the delicate process of allowing myself to be human and vulnerable whilst understanding my own limitations, boundaries and practicing within ethical principles. In working with Solomon, I am learning to be brave with
addressing my internal processes and confronting them, and only by doing this am I able to honour the therapeutic relationship, and indeed, immerse myself fully in the challenges to come.

Figure 1: Consent form confirming permission obtained from the client for publication

3 In view of epistemology as a practitioner, I began in the realist position since the CBT orientation fits in this stance. However integration of the PCT relational component assimilated inter-subjectivity which brought me closer to my research epistemology as a constructive realist, reconnecting my overall position as a pragmatist.
REFERENCES FOR THE CLIENT STUDY


The Imam's Experience of Managing
the Mental Health Needs of the Muslim Community

Ohi Choudhury¹

¹ Counselling Psychologist, City University, London

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*Requests for reprints should be addressed to Ohi Choudhury, City University London, Northampton Square, London, EC1V 0HB (e-mail: ohinor.choudhury.1@city.ac.uk).
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