Portfolio Volume 1: Major Research Project

"Muslim Faith Leaders' Experiences of Providing Mental Health Support in the Community"

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Submitted to the University of Hertfordshire in partial fulfilment of the requirements of the degree of Doctor of Clinical Psychology

June 2021

Acknowledgements

In the name of Allah, the most Beneficent, the most Merciful, without whom none of this is possible. I would first like to give a huge and heartfelt ‘thank you’ to my participants; I am privileged having heard your stories, and I thank you for sharing them with such openness and generosity. To my consultant team: Ayan, Imam Qamruzzaman, Sara, Lizette, Angela and Jacqui; thank you for your invaluable support, encouragement, warmth, and direction throughout the process. Angela, my sincerest appreciation for you and your guidance, your zeal and activist spirit is so admirable; thank you for being such an inspiring teacher, mentor, sister, and friend. Afrah and Noreen, you are both such a blessing, going through this journey together, our regular check-ins and offloading made writing under COVID-19 restrictions bearable, and this would have been impossible to complete without you both.

I would like to express my deepest gratitude to my family for their endless support, particularly, for both Amma’s; thank you for the grandchild-care, your constant reminders of our purpose and for the values you instil in me about using my voice for good. I am forever thankful for both my sisters, my pillars of strength, whose support never wavered even when I was far from optimistic!

I am indebted to my husband Jabir for his love, patience, and constant encouragement. I could not have managed this without you and the way you imparted your Arabic linguistic skills and Islamic philosophy. This research project reflects your values as much as mine and I hope you are equally as proud of it. To my beautifully spirited son Ibrahim, my pride and joy; you kept me smiling throughout. Finally, this is for you Abba, I wish you could have seen how much you inspire my work and life. Insha’Allah, we reunite again in Jannah.

SCAN ME

This Nasheed (Islamic Song) was written and sung by Dr Asim Yusuf (Pen-name Talib Al-Habib), a Consultant Psychiatrist with a special interest in Islamic Spirituality and mental health. It is a description of the beautiful inward characteristics of Prophet (PBUH), our very first Muslim Faith Leader and describes how to be a manifestation of mercy and compassion for those in need, characteristics I witnessed in every Muslim Faith Leader I interviewed and which I hope to myself possess. I pray that listening to this gives you strength and hope when facing the challenges of your admirable acts of service.

It is narrated that the messenger of Allah (PBUH) said that:

Allah will say on the Day of Judgment, 'Son of Adam, I was sick, but you did not visit Me.'
'My Lord, how could I visit You when You are the Lord of the Worlds?'
'Did you not know that one of My servants was sick and you didn't visit him? If you had visited him, you would have found Me there.'
Then Allah will say, 'Son of Adam, I needed food, but you did not feed Me.'
'My Lord, how could I feed You when You are the Lord of the Worlds?'
'Did you not know that one of My servants was hungry, but you did not feed him? If you had fed him, you would have found its reward with Me.'
'Son of Adam, I was thirsty, but you did not give Me something to drink.'
'My Lord, how could I give a drink when You are the Lord of the Worlds?'
'Did you not know that one of My servants was thirsty, but you did not give him a drink? If you had given him a drink, you would have found its reward with Me.' (Al-Bukhari)

I hope this research and what may come after, is accepted as an act of Ibadah (worship) and service to the community and ultimately in the hope of finding Allah.

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Abstract

Muslim Faith Leaders play an important role in Muslim communities. Despite being a primary support resource, research examining their experiences providing mental health support is limited. Amidst rising levels of Islamophobia and significant unrest regarding the inequalities that racialised minority communities face accessing healthcare, this qualitative study explores Muslim Faith Leaders experiences and impact providing mental health support, their conceptualising of mental health difficulties, and their experiences collaborating with mainstream MHS. Thirteen Muslim Faith Leaders working in a variety of settings participated in semi-structured interviews. Four main themes were constructed from Thematic Analysis: *An Approach Grounded in the Islamic Worldview; A Complex Negotiation; Barriers, Stigma and Resistance to Accessing Support* and *Working Under the Shadow of Islamophobia.* These themes reflect the complexities Muslim Faith Leaders report in their roles, defining experiences at a personal and professional level, and potential consequences of bridging the gap between statutory and community services. The findings are discussed with reference to previous theory and research, highlighting the implications for therapeutic practice, community, and policy, including the role the clinical psychology profession has in advocating for better access to and acceptability of services, and better collaboration with Muslim Faith leaders for Muslim communities.

Language and Terminology

Notes on Style

The researcher writes in the first-person to describe reflexivity and the research process during sections that are naturally less formal, such as the introduction, and parts of the method section. The remainder of this thesis is written in the third-person.

Key Terms

Allah: This is the standard Arabic word for God used by Arabic-speaking Christians, Jews, and Muslims. The association of the word with Islam comes from the special status of Arabic as the language of Islam's holy scripture, the Quran. As Muslims consider the Quran in its original language as the literal word of God, Muslims believe that God described himself using the Arabic language as Allah. This Arabic word thus holds special significance for Muslims, regardless of their native tongue, because it was spoken by God himself.

Religion: *"...A particular system of faith and worship."* (Oxford English Dictionary, 2009). This refers to the action or conduct indicating belief in, obedience to, and submission to a higher power (God), and the performance of religious rites or observances.

Quran: The central Islamic religious text, which Muslims believe is a revelation from Allah.

Hadith / Sunnah: The teachings and practises of the Prophet Muhammad (peace be upon him; PBUH).

Faith: "... A conviction of the truth of certain doctrines of religion." (Collins Modern English Dictionary, 2014). This refers to an individual's confidence in their religious belief. Therefore, people can practise certain aspects of the same religion, but with varying amounts of belief or faith in their individual practise.

***Muslim Faith Leader*:** A title conceptualising those who hold particular skills and knowledge, having gone through some form of Islamic Sciences training. The term *Muslim Faith Leader* is preferred over "Imam", as the former is inclusive of scholars (Alims and Aalimah's – male and female graduates of the Islamic Sciences Alimiyyah Programs), chaplains, teachers and instructors, youth workers, and circle leaders including women, whereas the latter focuses on those who lead worship and other distinctively religious activities.

Help-seeking: An individual's attempts to seek help in the context of experiencing a mental health problem. This includes attempts to access and use a range of formal (e.g., professional mental health services, community/religiously based resources) and informal (e.g., friends, family) sources of help.

Mental health professional: Individuals trained to deal with mental health problems, including psychologists, psychiatrists, social workers, and family physicians (Mackenzie, Knox, Gekoksi, & Macaulay, 2004).

Mental health difficulties / Mental health problems: These are used interchangeably to refer to emotional problems that disturb one's daily routine and activities (e.g., learning, communicating, working, relationships), and includes distressing reactions to life events and circumstances (e.g. stress, bereavement, trauma). Moreover, these terms are preferred over *"mental illness",* which may align to a more medical model of understanding distress.

Mainstream mental health services / Mental health services/ Mental health care: These are used interchangeably to refer to formal mental health services, including psychotherapy, which are statutory (i.e., NHS) or privately run, usually staffed with mental health professionals including psychologists, psychiatrists, social workers, family therapists, counsellors, and psychotherapists, and those that utilise dominant Western approaches to therapy.

Muslim people / Muslims: These are used interchangeably throughout this study to refer to any individuals born Muslim or any person who has gone through the formal process of conversion to Islam.

Racially minoritised: This term is used in place of the acronym BAME (Black, Asian, and Minority Ethnic) considering the recent debates to replace the term due to its lack of precision, emphasis on skin colour, and that few racially minoritised people identify with this acronym (Commission on Race and Ethnic Disparities, 2021; Milner & Jumbe, 2020). Yasmin Gunaratnum's (2003) term *minoritised*, provides a social constructionist approach to understanding minoritisation as a social process shaped by power (Milner & Jumbe, 2020), whereby people are actively minoritised by others rather than naturally existing as a minority, as the terms racial minorities or ethnic minorities imply.

Sunni Islam: The largest branch of Islam followed by 85–90% of all Muslims. This thesis focuses on Sunni religious leadership, as accommodating the dynamics within Shia religious authority and other sects is beyond the scope of this research.

Clergy: This references Pastors, Rabbis, Imams and other religious leader who hold official positions of religious responsibility in their religious institutions.

Islamophobia: Describes 'anti-Muslim racism' as defined by the Runnymede Trust (Elahi & Khan, 2017). Any distinction, exclusion, or restriction towards, or preference against, Muslims (or those perceived as Muslims) that has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life (Elahi & Khan, 2017, p1).

Islamic Psychology: All aspects of Islamic teaching from the Holy Quran, Hadith and Sunnah that directly mention or relate to aspects of the human psyche, with particular emphasis on maintaining a healthy mental state or causes and treatments of an unhealthy mental state.

Abbreviations

MFL: Muslim Faith Leader

MHP: Mental Health Professional

FBO: Faith Based Organisation

CP: Clinical Psychologist

TA: Thematic Analysis

MHS: Mental Health Services

PBUH: Peace Be Upon Him

NHS: National Health Service

UK: United Kingdom

US: United States

Chapter 1: Introduction

1.1 Overview

This research explores MFLs' experiences of providing mental health support in the community, attending to how MFLs understand and work with those experiencing mental health difficulties and their experiences of collaborating with mainstream services. This qualitative study utilises thematic analysis (TA; Braun & Clarke, 2006). This chapter begins by outlining the researcher's relationship and epistemological position concerning the research topic. This is followed by an overview of the topic area, summarising relevant theoretical and research literature, before a systematic review of the literature concerning MFLs experiences of providing support. The chapter concludes with the rationale for the current study with respect to its relevance to clinical practice and research, and a statement of the research aims and questions.

1.2 Personal and Epistemological Position

1.2.1 My Relationship to this Research

"Every secret of a writer's soul, every experience of his life, every quality of his mind, is written largely in his works." **(Virginia Woolf, 1930)**

My relationship to this research area will undoubtedly provide an essential context through which I interpret and understand the experiences of my MFL participants. It is important for me to acknowledge this and to be aware of what my position might mean for the different stages of the research reflexivity process. As Maykut and Morehouse (1994) comment:

> *"The qualitative researcher's perspective is perhaps a paradoxical one: it is to be acutely tuned-in to the experiences and meaning systems of others, to indwell, and at the same time to be aware of how one's own biases and preconceptions may be influencing what one is trying to understand".* (p.123)

An honest exploration of my personal values and interests to understand their effect on my research can work towards balancing the "tension between involvement and detachment" (Berger 2015, p221). I occupy what Dwyer and Buckle (2009) refer to as 'the space in between'. I am both an insider and outsider to the characteristics of my participants. Being from a racially minoritised Muslim background provides me with an insider experience, allowing me to connect with the many challenges Muslims face in the UK, such as being subjected to increasing levels of Islamophobia and racism. At the same time, I also occupy an outsider position, having had no Islamic Sciences training and not occupying an

MFL position. This means I have limited awareness of the day-to-day challenges of the MFL role.

The Mosque, and having access to MFLs, plays an integral role for my family, so much so that my father seized an opportunity to live in a council house three doors from our local Mosque in Tower Hamlets. This was a rare privilege for a Muslim migrant family, which provided a much-needed sense of belonging for my father, being minoritised in a country during a time of increased racism. After my father's passing in 1995, I continued to hear about the value of MFLs to the community. They provided Islamic knowledge and guidance, even supporting my parents' ideas around naming their children. They also facilitated our supplementary education and gave invaluable spiritual and community support to my widowed mother.

I grew up with a deep appreciation for MFLs. This became more apparent during my early twenties, following several personal and family challenges and losing many loved ones. I sought support from MFLs to advise and guide me with my mental health in the hope to connect more to Allah and Prophet Muhammed's (PBUH) teachings. This support profoundly impacted me and demystified my beliefs about how I thought MFLs primarily took a jurisprudence approach, as the support they provided felt very nuanced and 'counselling orientated', reflective of my context and individual challenges.

My subsequent marriage to an MFL strengthened my interest in the work MFLs do. I remember being surprised, soon after being married, at how my husband would take calls at all hours and support people, many distressed, without thinking much of it. It was part of his role as an MFL. While I enjoyed support, training and importantly supervision while working

in MHS, my husband was also supporting communities considered ‘hard to reach’ by services without these support structures. The community he was supporting had built up a long-standing relationship with him and knew he was available to provide religious or spiritual guidance without waiting nor having to invest any money.

An experience I had working as an Assistant Psychologist affirmed my interest to conduct this research. I was supported to integrate my two areas of interest, psychology and Islam, to make psychology relevant for the predominantly Muslim community in Tower Hamlets. As part of this approach, we ran a workshop with Imams in the East London Mosque, co-delivered with the East London Foundation Trust’s Department of Religious, Spiritual and Cultural Care. This was my first experience hearing from Imams, some in tears and struggling when speaking about the overwhelming nature and vulnerabilities that come with an MFL position. I became increasingly curious about how they negotiate their own struggles with their communities’ expectations, and wondered how MFLs were often acting as a hidden workforce providing increasing access to and support for the Muslim communities but without commensurate support or recognition for their work.

1.2.2 Epistemology

Epistemology refers to the theory of knowledge; what is possible to know and whether the knowledge is reliable or valid (Willig, 2013). An epistemological position describes the researcher’s assumptions about the knowledge they discover and its relationship to reality. My general aim with this research is to hear about MFLs experiences providing support to the community. To explore this, I adopt a critical realist epistemological stance. This perspective lies between realism and relativism. A realist approach assumes the world

has knowable truths to explore and proposes that data derived from research directly reflects reality. Conversely, a relativist approach suggests that truth is constructed and that, therefore, there can be numerous interpretations of the same data (Harper, 2011).

Taking a critical realist stance "combines the realist ambition to gain a better understanding of what is 'really' going on in the world with the acknowledgement that the data the researcher gathers may not provide direct access to reality" (Willig, 2012, p.13). Harper (2011, p.88) describes critical realists as "ontological realists", in as much as they assume data can inform us about reality, but not offer a direct reflection of reality (Harper,2011). Harper also describes critical realist researchers as having an awareness of the importance of studying qualitative data in detail and considering it important to go beyond text into a broader historical, cultural, and social context.

This approach is appropriate for this research project as it supports my aims to locate the experiences of MFLs among broader contextual factors that may influence how MFLs provide support. Critical realism acknowledges that reality can be viewed from numerous perspectives, which distort reality in unique ways, thus reality appears different depending on the perspective from which it is viewed. This position was helpful for me to reflect my conscious perspective as being from a Muslim racially minoritised background, and having accessed support from MFLs in the past will undoubtedly distort the realities participants share.

1.2.3 Reflexivity

Researchers often gravitate towards issues they feel passionately about (Burnham, Palma, & Whitehouse, 2008), and it is essential I reflect on how, as a researcher and an individual, I am implicated in the research and the findings (Willig, 2013). Green and

Thorogood (2018) suggest it is impossible within qualitative research to achieve objectivity because both the research and the researcher are part of a world in which values and subjectivities are inevitable. This necessitates transparency from a researcher to make known the values, assumptions, prejudices, and personal relationship to the topic (King, 1996). I used the following methods to monitor my biases and to make reflexivity an active and ongoing process throughout the research:

- A reflective research journal (see Appendix K for an extract) to record thoughts, questions, curiosities, and supervisory discussions that influenced understanding and direction of project. I reflect on some of these notes in the discussion to allow opportunities for learning.
- Peer bracketing interviews (Tufford & Newman, 2012; see Appendix B for an extract) with another trainee (from a faith and racially minoritised background) with a similar epistemological approach to methodology and data analysis before data collection and again during the analysis stage.
- A group of 6 people (detailed in Chapter 2) to consult on recruitment, data collection and analysis. This consultative group also provided expertise on allocating and grouping themes and reviewed draft chapters.
- 'Coder reliability checks' with another trainee; sharing extracts of transcripts with each other, coding these separately and comparing codes with a reflexive discussion noting points of similarity and difference.

1.3 Overview of the Theoretical and Empirical Context of this Research

This section summarises the relevant literature and situates this within a wider context before a more focused systematic review of the literature concerning MFLs experiences of

providing mental health support. It begins by reviewing the consideration for researching religion, mental health and psychology. followed by a brief overview of the literature on Muslim mental health and help-seeking in Muslim and other religious communities. It then provides an overview of Islam and Islamic psychology with consideration to the current UK context in which Muslims live. An outline of the role of faith-based organisations and MFLs concludes this section.

1.3.1 Religion, Spirituality and Mental Health

Historically, psychologists viewed religion and spirituality as irrelevant to health management (Koenig, 1997); pathological, outdated, and guilt-inducing (Ellis, 1983; Freud, 1927). More recently, religious and spiritual practices are increasingly recognised as critical resources with positive impacts on how individuals manage their physical health and mental well-being (Fabricatore, Handal, & Fenzel, 2000; Koenig, 2012; Koenig et al., 2012). For example, research shows higher involvement in religious and spiritual beliefs and practices associate positively with indicators of psychological well-being such as life satisfaction, happiness, positive affect, and morale (Koenig, McCullough, & Larson, 2001). The past decade has seen greater interest within academic discourse by psychologists and psychiatrists, recognising the importance of religious and spiritual practices (Dein, Lewis, & Loewenthal, 2011). This includes a need for practitioners to pay greater attention to religion and spirituality in their discussions with clients in therapy (Cooper, 2012; Peden, 2012).

The imperative to consider religion and spirituality in mental health extends beyond academia into professional discourse. The Mental Health Foundation (2006) recommends addressing religion and spirituality within mental health settings. Other regulatory and

professional bodies provide similar support in national guidance across various settings where CPs practice (Commission for Healthcare Audit and Inspection, 2007; Department of Health, 2009; Royal College of Psychiatrists, 2013).

There is considerable evidence documenting disparities between White British and racially minoritised communities in terms of access to, experience with, and outcomes in MHS (Bhui et al., 2003; Commission on Race and Ethnic Disparities, 2021; Department of Health, 2005; 2007a, 2007b; Fernando, 2005; Laing, 2021). Despite research about culture and diversity, racism, and cultural adaptations to therapeutic practice (e.g., Fernando, 2017; Rathod et al., 2015; Younis 2021), certain racially minoritised communities are still not accessing services, are under-represented in voluntarily accessed services (such as out-patient talking therapies), and over-represented in non-voluntary services such as in-patient care under section (Weatherhead & Daiches, 2010). Structural inequalities underlying the discrepancies in mental health, such as poverty and racism, are overlooked as additional risk factors (Bignell et al., 2019; Younis, 2021)

1.3.2 Religiosity Gap, Mental Health Professionals and Clinical Psychology

Many authors highlight the influence of therapists' values on therapeutic processes, including spiritual and religious beliefs (Cooper, 2012; Post & Wade, 2009; Souza, 2002). Research suggests a 'religiosity gap' (Bergin & Jensen, 1990 p.7) regarding spirituality and religion where service users are likely to be more religious than MHPs (Baetz et al., 2004; Curlin et al., 2005; Neeleman & Persaud, 1995). This disparity could create barriers to help-seeking or successful treatment owing to the therapist or MHPs lack of knowledge, empathy and appropriate skills in dealing with religious issues, or avoiding religious and spiritual

topics in psychotherapy and counselling altogether (Bergin & Jensen, 1990; Bilgrave & Deluty, 2002; Crosby & Bossley, 2012; Delaney et al., 2007). Some psychologists report finding it particularly difficult to reflect on and utilise religion as a resource within their practice (Begum, 2012; Harbridge 2015; Joseph, 2014).

Clinical psychology professionals report a lack of training and guidance on addressing spiritual and/or religious material in clinical practice (Berger, 2007; Baker & Wang, 2004; Harbidge, 2015; Malins, 2011; Mills, 2010; Mulla, 2012; Myers & Baker, 1998). Although the British Psychological Society (2006; 2008; 2009) and Health and Care Professionals Council (2008) provide guidance focusing on 'diversity' as an umbrella term, exploration of its elements' unique considerations and differences is lacking. Begum (2012) also highlights a lack of specific guidance for UK CPs, adding to the perception that this particular aspect of diversity is not prioritised, reifying to the profession the notion that these issues are unimportant. This may lead to a lack of engagement with the roles of spirituality and religion within clinical practice and further alienates an already vulnerable group.

On a broader level, for the clinical psychology profession to support access to and crucially acceptance of talking therapies for Muslim and other minoritised communities, it is important to go beyond the practical and technical adjustments in treatment to more theoretical and philosophical modifications (Rathod, 2015; Tseng, 2008). Theoretical modifications include considering differences between how communities understand concepts of self, patterns of relationships, and coping styles, whereas a philosophical reorientation includes how different communities relate to goals in therapy, their views of acceptance versus overcoming, and spirituality (Tseng, 2008).

Research shows that religious identity (Nazroo, 1997) and religious coping techniques (Loewenthal et al., 2001) are more focal and commonly adopted in Muslim communities than in other religious groups, underpinning a greater need to attend to the unique spiritual needs of this community. For Muslim communities, adapted mental health interventions are more effective than secular methods in reducing experiences of mental health problems (Hook et al., 2010; Koenig et al., 2001; Mir et al., 2015) and improving quality of life (Lee et al., 2010). Potential mechanisms for the positive impact of faith adapted therapy include providing a sense of meaning and well-being (Gerwood, 2005), fostering social support (Scott, 2003), and through the act of surrendering control to a higher power (Cole, 2000).

1.3.3 Help-Seeking in Religious and Racially Minoritised Communities

Census data indicates over 67% of people in the UK identify as following a religion (ONS, 2011). Despite recognition that following a religion and/or having religious and spiritual beliefs are likely to impact seeking and receiving help for mental health difficulties, this area is neglected in clinical training, practice and research (Cinnirella & Loewenthal, 1999; Copsey, 1997; Friedli, 2000a, 2000b; Hill & Pargament, 2003; Mayers et al., 2007). Psychiatric contributions demonstrate that religious-based beliefs about mental health problems and other misfortune may influence help-seeking and compliance with interventions (Chadda et al., 2001; Cinnirella & Loewenthal, 1999; Cole et al., 1995; Leavey, Loewenthal, & King, 2007). Furthermore, religiously minded people's help-seeking attitudes indicate relatively negative views of secular MHS (Mitchell & Baker, 2000), with research showing these people may neglect to seek help altogether (Bjorck & Trice, 2006).

Mental health support approaches vary between different religious communities (Rathod, 2015), with influence from factors including cultural background, socioeconomic background, and previous associations (Cauce et al, 2002). Despite this, patterns emerge within religious communities regarding their preferences and behaviours when seeking help from FBO and Faith Leaders. For example, Lowenthal (2006) found Orthodox Jews prefer accessing support from FBOs and faith leaders over MHS due to their fear of stigmatisation, having their beliefs pathologised, and/or being perceived as godless by their community.

Similarly, Keating and Fretz (1990) conclude that highly religious Christians are less likely to obtain counselling because they anticipate it will be incompatible with their beliefs. Other research within Black-majority churches identifies them as important sources of help and support to the extent that members prefer these to more formal structures such as the NHS (Edge, 2013; Mantovani, Pizzolati & Edge, 2017). There are numerous potential explanations for this preference to access support from FBO and Faith Leaders over other MHS. These are often more accessible in terms of location within the community and language used, and more acceptable with regard to a religious communities' conceptualisation and understanding of mental health difficulties, which might integrate with supernatural or spiritual afflictions (Barker et al.,1990; Cinnirella & Loewenthal, 1999; Friedli, 2000; Leavey & King, 2007; Cole et al., 1995; Macmin & Foskett, 2004; McCabe & Priebe, 2004).

1.3.4 Islam and Help-Seeking in the Muslim Communities

Census data indicates Muslims are the largest religious minority group in the UK (ONS, 2011) at 2.7 million people (5% of the population), with higher concentrations in areas

such as Tower Hamlets (38%) and Newham (24%). This community is growing rapidly, with 1.2 million more people identifying as Muslim between 2001 and 2011 (ONS, 2013). As the largest and growing minority religion, Muslims represent the youngest (48% aged under 25), and most ethnically diverse (68% from a South Asian background, 10% reporting as Black African/Caribbean or British, and 11% identifying as 'Other Ethnic Group') of the main religious groups in the UK (ONS, 2013).

The word "Islam" means submission, obedience, and peace in the Arabic language. It is through submission and obedience to Allah that Muslims attain peace. Accordingly, Islam is considered a 'way of life', as it goes beyond a prescribed set of beliefs or practices (Alvi, 2014). The cornerstone of Islam is succinctly explained using the well-known report called 'Hadith Jibreel'[1] (Table 1), which refers to a man coming to prophet Muhammed (PBUH) and enquiring about the religion. It summarises the religion of Islam under the concepts of *Islam* (outward actions), *Iman* (inward beliefs), and *Ihsan* (equates to spirituality and means to achieve excellence in worshipping Allah; Ali, 2018).

"One day, we were sitting in the company of Allah's Apostle (peace be upon him) when there appeared before us a man dressed in pure white clothes, his hair extraordinarily black. There were no signs of travel on him. None amongst us recognised him.
At last, he sat with the Apostle (peace be upon him). He knelt before him, placed his palms on his thighs and said: Muhammad, inform me about al-Islam.

[1] In Sunni Islam, the Hadith of Gabriel (ḥadīth Jibreel) is the single most important hadith (report on the words and actions of the Islamic prophet Muhammad), of the last prophet of Islam. Its narrative contains the best summary of the core of Islam.

The Messenger of Allah (peace be upon him) said: Al-Islam implies that you testify that there is no god but Allah and that Muhammad is the messenger of Allah (Shahada), and you establish prayer (Salah), pay charity (Zakat), observe the fast of Ramadan (Sawm), and perform pilgrimage to the House (Hajj) if you are solvent enough (to bear the expense of) the journey.

He (the inquirer) said: You have told the truth.

He (Umar ibn al-Khattab) said: It amazed us that he would put the question and then he would himself verify the truth. He (the inquirer) said: Inform me about Iman (faith).

He (the Holy Prophet) replied: That you affirm your faith in Allah, in His angels, in His Books, in His Apostles, in the Day of Judgment, and you affirm your faith in the Divine Decree about good and evil.

He (the inquirer) said: You have told the truth. He (the inquirer) again said: Inform me about al-Ihsan (performance of good deeds).

He (the Holy Prophet) said: That you worship Allah as if you are seeing Him, for though you don't see Him, He, verily, sees you...Then he (the inquirer) went on his way, but I stayed with him (the Holy Prophet) for a long while. He then said to me: Umar, do you know who this inquirer was? I replied: Allah and His Apostle knows best. He (the Holy Prophet) remarked: He was Jibreel (the angel). He came to you in order to instruct you in matters of religion". (Sahih Muslim 1: 0001)

Table 1. 'Hadith Jibreel' summarising the core tenets of Sunni Islam.

Western and Islamic notions of mental health are fundamentally different. In Western societies, understanding mental health difficulties centres upon individual aspects such as the brain, cognition, and affect, which are the targets for any psychological or psychiatric recovery (Fernando, 2010; Martin, 2001). Muslim beliefs are heterogeneous, according to sect or culture amongst other factors, and though there may be an overlap between culture and religion, these aspects are not synonymous. The Islamic understanding of mental health

takes a more holistic view of both the self and community (Carter & Rashidi, 2003). Islamic psychology considers that mind, body, soul, and self are a single entity, and therefore should be understood in terms of imbalance of the person in a spiritual sense due to the state of their nafs (drives). As Sara Betteridge (2012) states, that the aim is to constantly travel on a journey towards a healthy heart and satisfied soul. The state of the heart is determined by the state of the nafs (drives) and so the relationship between these entities would determine a person's emotional and psychological well-being (see Figure 1).

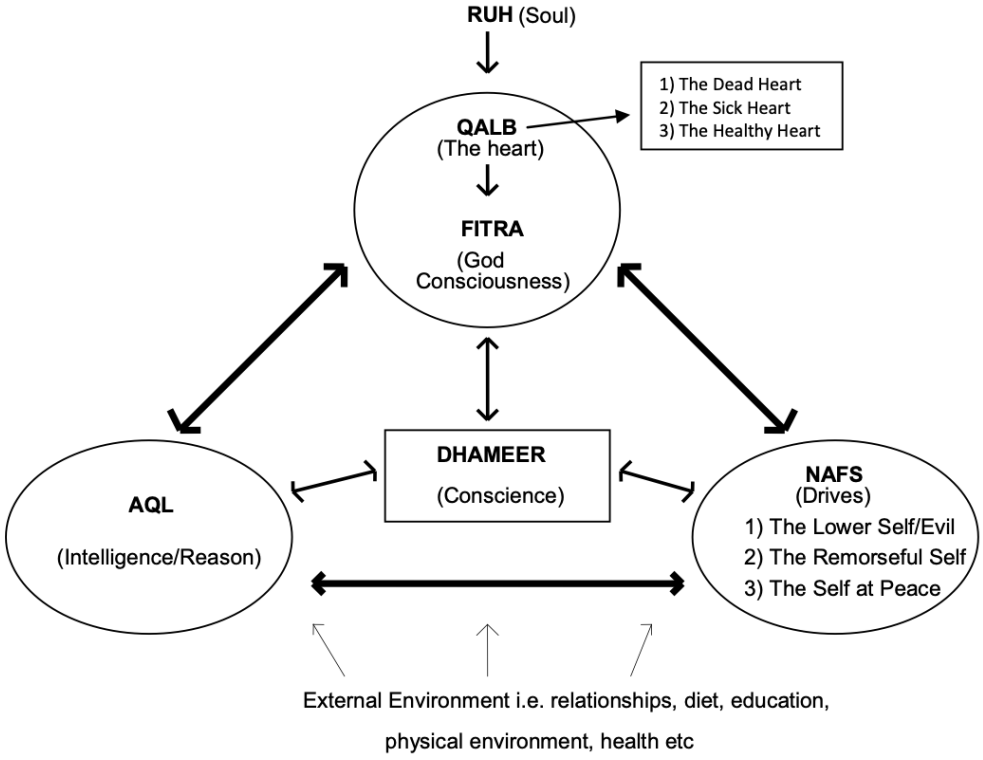


Figure 1: The Islamic concept of the self (Anam; 2011 as cited in Betteridge, 2012)

Furthermore, central aspects of the Islamic creed (as described above) help explain how Muslims often make sense of mental health difficulties. For example, Muslims view the belief in Qadr (fate or divine decree) as a test or punishment from Allah, which influences

perceptions of difficulties. It also often determines the type of help people seek and preferences of religious and traditional healing as the primary source of treatment (Borras et al., 2007). Similarly, Muslims believe that in trying to achieve Ihsan (spiritual excellence) they must continually strive against their own nafs (drives) that commands towards desires that may undermine a good mental state. Furthermore, there is a shared understanding among Muslim communities that mental health difficulties can have dualistic causes, such as socioeconomic background and life experiences, but also as a result of being tested by Allah or being inflicted by the unseen (another core aspect of the Islamic creed); black magic, Jinn influence, or evil eye (Ally & Laher, 2008; Haque, 2004; Weatherhead & Daiches, 2010).

Despite being a significant section of the UK population (ONS, 2011), Muslim beliefs about health and illness remain relatively unexplored (Khalifa et al., 2011). Given the ethnic diversity of Muslims in Britain, reports indicate these communities are less likely to access services, more likely to be subject to compulsory powers, more likely to experience poorer socioeconomic conditions and report poorer health and disability than the general UK population (Cabinet Office, 2017; Sheikh, 2007). The contentious Commission on Race and Ethnic Disparities report (2021) acknowledges that exposure to numerous and interconnected factors associated with the onset, progression, and relapse of mental health problems is more likely for racially minoritised communities.

The Mental Health Foundation report on spirituality 'Keeping the Faith' (2006), includes service users from the Muslim community. This report concludes a need for greater consideration of spiritual and religious needs as part of care and treatment. This reinforced

an earlier report commissioned by The Sainsbury Centre for Mental Health2 calling for greater partnership between MHS and the voluntary sector to consider religious beliefs (Copsey, 1997). This report found Muslim people preferred accessing support from community organisations as they felt comfortable speaking openly about their religious beliefs, which staff in statutory services perceived as taboo.

Research also reports stigma within religious communities and a belief that services are irrelevant (Sheikh & Gatrad, 2009; Weatherhead & Daiches, 2010). In one study, shame predicted unwillingness to seek professional mental healthcare among migrant British Muslims of South Asian origin (Pilkington et al., 2012). Rather than being viewed as a psychological and physical illness, some Muslims attribute mental health difficulties to metaphysical forces (i.e., Jinn influence) brought about by the sufferer's sinful life and own weakness (Ally & Laher, 2008; Haque, 2004; Weatherhead & Daiches, 2010). Furthermore, Khalifa et al. (2012) surveyed Muslims living in Leicester, in which 80% believed in Jinn, 60% believed that this was the cause of mental health difficulties, and that MFLs were the leading authorities in treatment for mental health problems; a view shown in other research within Muslim communities (Barn & Sidhu, 2005; Dein, Alexander, & Napier, 2008; Islam, Rabiee, & Singh, 2015). The factors discussed here help explain why Muslims are more likely to seek help from FBOs and MFLs due to the ease and comfort of accessing community-based services, levels of stigma and likelihood for religious explanations.

2 Now called The Centre for Mental Health

1.3.5 An Additional Barrier: A Community Under suspicion

A spate of terrorist attacks in the 21st century has created a perceived link between the religion of Islam and violence, religious fundamentalism, gender inequality, and the global 'war on terror' (Zempi, 2020). The subsequent fear of terrorism has led to negative media portrayal, intolerance, and increasing violence towards British Muslims over decades (Ahmed & Matthes, 2017; Bayrakli & Hafez, 2017). The British Government fails to clearly define Islamophobia, and Baroness Warsi characterises Islamophobia as a ‘bigotry blind-spot’ due to the way it is subject to ideological and intellectual justifications (Elahi & Khan, 2017).

Consequently, British Muslims report a deepening sense of alienation from British society and a diminishing sense of belonging, intensifying a perceived contradiction between being a faithful Muslim and a loyal British citizen (Ameli, 2004). This dissonance poses a threat to Muslims’ mental health (Ali, Liu, & Humedian, 2004; Ali, Milstein, & Marzuk, 2005; Sheridan, 2006), with reports of the Muslim community becoming more vulnerable to stress (Kunst, Sam, & Ulleberg, 2013), and at higher risk of psychological morbidity (Dadabhoy, 2018; Fazil & Cochrane, 2003). A recent focus on Muslims by policymakers, framed as the 'fight against terrorism' or 'civilisation threat' (Elahi & Khan, 2017) exacerbates this. For example, the Government's Prevent strategy (Home Office, 2015) places a statutory duty upon any statutory services and professionals, including the NHS, to identify and report individuals they suspect are vulnerable to radicalisation.

Many academics criticise this strategy for how it positions Muslims under suspicion of 'thought crimes' (e.g. Summerfield, 2016) and operating within ‘pre-criminal space’

(Goldberg, Jadhav, & Younis, 2017). Documented examples include The Open Society Justice Initiative report on Eroding Trust (2016) which highlights several examples of racial and religious profiling of Muslims through Prevent in the NHS and elsewhere. Younis and Jadhav's (2021) report findings of how NHS staff understand and practice counter-radicalisation training and highlight that the UK government's introduction of the Prevent statutory duty into health care is not evidence-based and reinforces racism by characterising Muslims as more readily associated with radicalisation.

These findings suggest Prevent encourages an association between Muslims and radicalisation and aligns with structures of whiteness and Islamophobia. This contradicts evidence indicating an association between extremist views and mental health, rather than religiosity (Bhui et al, 2020), and calls to question plans for vulnerability support hubs, which may blur the boundaries of security and care as NHS MHP are embedded within counter-terrorism police operations (Aked, Younis, & Heath-Kelly, 2021).

There are similarities in the characterisation of Irish and Muslim communities as both risky and suspect in counter-terrorism campaigns (Hickman et al., 2011). However, this is more intense for the Muslim community due to public perceptions of Muslims as a threat to British (and Western) values and culture, and more complex as Muslim communities are also burdened with racism. Unlike other faith communities, Islam and Islamic faith traditions are not equally articulated, with Islam being identified as the source of a potential ideological threat, a challenge that other faith leaders and religions do not have to contend with (Hickman et al, 2011). Younis (2021) argues that policies such as Prevent do not and could not exist in isolation and thus align with wider societal and political issues concerning racism, including Brexit's impact on racism and the criminalisation of people of colour, particularly

Black men. These issues help explain why such policies feature in healthcare and challenge the recent Commission on Race and Ethnic Disparities Report (2021) conclusion that structural racism does not exist in the UK.

Furthermore, the government views MFLs in the UK as central figures in tackling extremism, subjecting MFL to a 'good Imam' vs 'bad Imam' dichotomy. The 'good Imam' engages with civil society in the fight against extremism, and the 'bad Imam' inhibits integration (Birt, 2006; Birt & Lewis, 2013). Gafoor (2019) argues there is more nuance in religious leadership that requires appreciation and highlights a potential risk of reducing religious leadership into such a simplistic dichotomy as Lewis and Hamid (2018, p54) describe as the 'contextualised Imam' (an embodiment of civic virtues) and 'decontextualised Imam' (the one who may be deterred from serving).

Recently, Byrne, Mustafa, and Miah (2017) highlight potential new 'circles of fear' developing regarding Muslim communities accessing MHS. This concept proposes that fear of mainstream services leads to mistrust and avoidance until times of crisis where admission is more likely through aversive pathways and coercive treatment (Keating, Robertson, McCulloch, & Frances, 2002). Factors driving the underutilisation of MHS by Muslims include mistrust of service providers, fear of treatment, and fear of racism and discrimination (Inayat, 2005).

Kimberlé Crenshaw (1989) introduces the concept of intersectionality in her Black feminist critique of anti-discrimination, feminist theory, and anti-racist policies. This concept provides a better understanding of how the intersections of racism and sexism contribute to additional layers of structural oppression and discrimination of Black women. Crenshaw

makes an important contribution to this research by highlighting the diversity of experiences in Muslim people. This is due to the intersection of faith with ethnicity and gender and other characteristics, such that the experience of Islamophobia is different for Muslim men and women and different for Muslims from racially minoritised backgrounds. Given that Muslim communities are diverse and not a monolith, people may share beliefs inherent to Islam but have different approaches to understanding Islam as a way of life and the intersection of this with mental heatlh.

1.3.6 The Role of Muslim Faith Leaders and Faith-Based Organisations

Muslims regularly turn to MFLs during emotional and psychologically difficult times (Al-Krenawi et al., 2004; Cinnirella & Loewenthal, 1999; Dein, 2013; McCabe & Priebe, 2004). Cardiff University's Centre for the Study of Islam in the UK is working to identify the precise number of MFLs in the UK, and current estimates suggest approximately 3,000 MFL working in 1,200-1,500 Mosques (Gilliat-Ray 2010). Naqshabandi (2017) identifies 1,850 Mosques, which suggests Gilliat-Ray underestimates the number of UK MFLs. As MFLs encompass many different roles, including being Mosque-based, chaplains, scholars, academics, teachers, and youth workers (Mukadam et al., 2010), these figures do not accurately reflect the different roles MFL are employed in.

The largest producers of Sunni MFL in the UK are within traditional seminaries known as Darul Ulooms, where graduates complete between 6-9 years studying Islamic Sciences. Many MFLs complete their training abroad before taking up employment in the UK. MFLs play a significant role with a great deal of trust and respect, as this role encompasses being cultural brokers and religious translators for the communities, and within

hospitals, prisons, armed forces, and universities (Birt, 2006; Rassool, 2019). Despite holding such highly regarded and essential positions within Muslim communities, there is an increasingly widespread perception in Muslim communities that Imams are not equipped by their own training to help young British Muslims cope with issues such as unemployment, racism, and Islamophobia (Runnymede Trust, 1997). More recently, a report for the Muslim Council of Britain states that the development of Imams in Britain is insufficient, and the existing training is inadequate or otherwise lacking (Rahman, Ahmed, & Khan, 2006). Geaves (2008) notes these institutions have neither the resources nor the personnel to train graduates to the standard envisaged by government or wider society.

There is a dearth of literature regarding the context in which MFLs are employed. Mosque and community-based positions tend to have lower salaries than chaplaincy roles, and those trained abroad with English as a second language tend to be paid significantly lower still. This recognition that MFLs are amongst the lower paid across Abrahamic clergy and currently paid below the average UK salary means many graduates continue into non-MFL positions in other sectors (Muslim view, 2016). Chaplaincy roles within prison and NHS services are usually on part-time contracts, requiring MFLs to take on multiple employment positions to receive an adequate salary (Dudhwala, 2008; Hafiz, 2014). There is usually no security tied to MFLs employment, and training opportunities are rare. Despite recommendations from multiple reviewing bodies, improvement in employment and training are yet to emerge.

This section above describes the context within which Muslims and MFLs live and work, along with the vital role MFLs play within their communities and statutory services. With a growing Muslim population and their experiences of racism and Islamophobia,

research exploring MFLs experiences of providing support in the current context is crucially important. As MFLs are often the preferred source of support for their communities, an understanding of their approach is critical so the clinical psychology profession can better serve the needs of their Muslim service users. The systematic literature review in the next section explores this further.

Systematic Literature Review

1.4 Overview

This section presents a systematic review of literature relevant to the present study's research questions and aims. So far, this thesis demonstrates the broad societal context informing how MFLs experience their role and support their congregation or community members. This discussion highlights several factors representing the complexities that MFLs face, such as risks from increased scrutiny deriving from government policy, racism and Islamophobia, and low salary and limited opportunities for training and development. Despite acknowledging that MFLs play a significant role in supporting their community's wellbeing, an understanding of how MFLs experience providing support and how they navigate these challenges, given the lack of support and training is absent within academic literature.

Considering increasing levels of discrimination towards and targeting of Muslim identity and belief, Islamophobia, and the risk of 'new circles of fear' (Byrne, Mustafa, & Miah, 2017; Open Society Justice Initiative, 2016) alienating Muslim communities from MHS, it is especially pertinent for the clinical psychology profession to hear and learn from MFLs experiences to increase collaboration and mutual learning to support and reduce inequalities for the Muslim communities. Systematic literature reviews are rigorous, comprehensive, and high-quality reviews that aim to draw robust conclusions from the cumulative evidence-base for a particular topic, whilst highlighting gaps, providing

implications for practice, and directions for future research (Siddaway, Wood, & Hedges, 2019). This review seeks to answer the following research question:

What does the existing literature say about MFLs experiences of providing support for mental health difficulties?

Initial searches revealed most literature regarding FLs experiences providing MH support concentrates on other Abrahamic Faiths[3], primarily Christianity within the US. The researcher consequently made two decisions to widen the inclusion criteria and generate more results. Firstly, to include research from other Western, Muslim-minority countries within which the intra-societal dynamics MFLs face providing MH support are significantly different from Muslim-majority countries. Other systematic reviews in similar areas employ this strategy (e.g., Mustafa et al., 2017). Secondly, to include both qualitative and quantitative peer-reviewed publications.

1.5 Search Strategy Method

The researcher applied a standardised systematic literature review methodology per Siddaway and colleagues (2019). Searches were conducted in December 2020 using the following databases: Scopus, PubMed, Psych info, Psych Articles, Cinahl Plus, and Google Scholar. These databases were chosen as they incorporated literature from various disciplines including medicine, nursing, social work, and applied social sciences. Searches focused on

[3] *The Abrahamic Faiths comprise the three main monotheistic religions, Christianity, Judaism, and Islam.*

research published since 2000 to cover larger time span to generate more results. The following three concepts and associated search terms were used to conduct the search:

Concept 1: Terms Relating to Participant Group		**Concept 2: Terms relating to support**		**Concept 3: Terms relating to experiences of emotional distress**
"Muslim*" OR "Islam*" OR "Faith Lead*" OR "Muslim Faith Leader*" OR "Muslim Spiritual Lead*" OR "Imam*" OR "Muslim Religious Lead*" OR "Islamic clergy" OR "Clergy"	AND	"Support*" OR "help*" OR "therap*" OR "talk*" OR "talking therap*" OR "advis*" OR "caring*"	AND	"Emotional Distress" OR "Difficult*" OR "Mental health*" OR "Mental Illness*" OR "Psychological Distress*" OR "unhappiness*" OR "distress*" OR "sadness*"

Table 2: Search Terms

The researcher checked search terms against a thesaurus and added new terms emerging from the literature. The search terms were truncated where appropriate to yield all relevant papers (e.g., help* = helping, helped). Search terms were combined using the Boolean operators 'AND'/ 'OR' within the search terms (Table 2). Per Siddaway and colleagues' (2019) methodology, the researcher segmented the topic into individual concepts to create search terms, and considered alternative terminologies, erring on the side of sensitivity to ensure no relevant articles were missed. The researcher checked the Cochrane database for existing systematic reviews, which found a systematic review protocol currently in-progress, however this focuses on the experiences of MFLs supporting physical health. To further strengthen the search, search terms were left broad and employed across other electronic sources such as *The Journal of Muslim Mental Health*, *The Journal of Pastoral*

Care and Counselling, and *The Journal of Islamic Studies*. The researcher extracted additional citations from articles and reference lists. After removing duplicates and non-peer-reviewed literature, the researcher screened the title, abstract, and full text of the remaining peer-reviewed empirical literature using inclusion and exclusion criteria (Table 3). Next, the researcher searched for publications citing the screened articles. Search alerts across Scopus and Google highlighted emerging literature.

	Inclusion Criteria
1	The study must primarily include data from MFLs
2	The study must contain reference to experience related to mental health support
3	The study must be written or translated in English
4	The study must be peer reviewed
5	The study must be empirically based (e.g., not a review of previous literature)
6	The study must be published in the last 20 years (2000)
7	The study is relevant to mental health and wellbeing
8	Studies undertaken in Western countries

Table 3: Literature Search Inclusion Criteria

1.6 Results of Systematic Literature Review

Figure 2 presents a flow chart of search results, screening process, and (Prisma, 2009). The initial search identified 4,661 papers, of which 164 duplicates were removed. Screening titles and abstracts against inclusion criteria removed a further 4,497 papers. Applying these criteria to the full-text of remaining papers removed 24 papers.

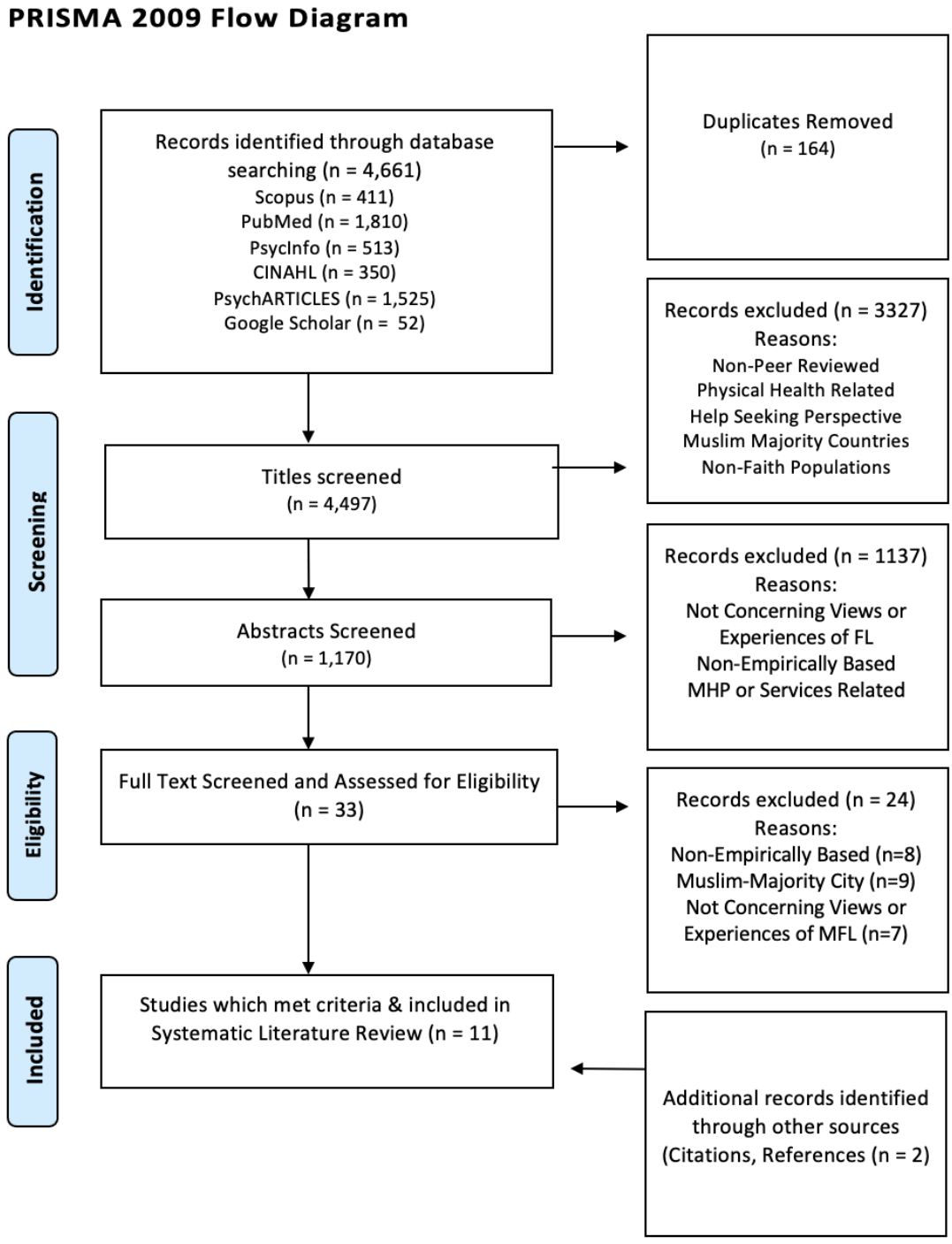
Two studies (Leavey, 2008; Leavey, Loewenthal, & King, 2007) used the same dataset, which was not primarily from MFLS, violating Inclusion Criteria 1. However, given

the scarcity of literature, and the ability to easily extract distinguishing findings specific to MFLs from Jewish and Christian Faith Leaders in the sample, this paper was included. The researcher considered, but ultimately excluded two other studies; Tobah, (2018) focuses on MFLs construction of mental health and depression and subsequently compared to those found in lay consumer health materials, rather than how they provide mental health support (Inclusion Criteria 2). Jones, Harris, and Esfahani (2019) compares views of Shia and Sunni Muslims in Australia and Iran on how they respond to Mosque-goers with scrupulosity (Inclusion Criteria 1/2).

This systematic literature review features eleven studies in total. This sample features four studies using quantitative (Abu-Ras et al., 2008; Ali, Milstein & Marzuk., 2005; Ali & Milstein, 2012; Meran & Mason, 2019), and seven studies using qualitative methods (Abu-Ras et al., 2008; Ally & Laher, 2007; Leavey et al., 2007; Meran & Mason, 2019; Padela et al., 2010; Rashid et al., 2012; Shah & Culbertson, 2011;). Table 4 presents a summary of each paper's findings, strengths, and limitations.

1.7 Results of Systematic Literature Review Search

Figure 2: Prisma Flow Diagram showing results of Literature Search



1.8 Summary of Findings

Table 4: Summary and Evaluation of Studies in the Systematic Literature Review

#	Author/Authors & Year	Title	Sample Details	Study Design	Summary of Key Findings	Strengths and Limitations
1	Abu-Ras, Gheith, & Cournos (2008)	The Imam's Role in Mental Health Promotion: A Study at 22 Mosques in New York City's Muslim Community	Forty-two Mosques responded to an invitation letter (30% response rate). 22 Imams and 102 worshippers participated.	Quantitative Cross-sectional survey conducted in face-to-face interview form with trained assessor. Separate questionnaires for Imams and worshippers. Univariate and bivariate analyses to establish sample descriptive statistics.	The mental health needs of the Muslim community in New York City have increased considerably since 9/11. Imams are often asked to address issues beyond the provisions of their religious and spiritual training. Most Imams had not received any formal training in Western psychotherapy interventions but play a central role in promoting congregants' mental wellbeing through unstructured psychotherapy interventions.	Strength: Quantifies the mental health issues of the Muslim community pre- and post-9/11, Explores the religious healing techniques employed by community Imams. Highlights major barriers to the utilisation of Western MHS. Limitations: Face-to-face method may influence response, small, non-random sample, mostly educated worshippers, and all fluent in English might not represent problems of poorer, less educated and non-English-speaking Muslim immigrants. Data collected exclusively in New York City, and may not be representative of other Muslim populations in the US.

2	Ali & Milstein (2012)	Mental Illness Recognition and Referral Practices Among Imams in the United States	Sixty-two participants from a diverse group of Imams responded to a survey sent to 730 US Mosques (8% return rate).	Quantitative cross-sectional self-report questionnaire included 79-items, a vignette, multiple Likert-type scales, and open-ended questions. This article uses same data set as Ali et al. (2005) but focused on vignette findings.	Imams are an important source of referrals and influence on the attitudes toward mental health and help-seeking.; Imams are able to recognize serious mental health problems. Imams appear more willing to collaborate with MHP if they have had previous consultation experiences.	Strength: Study one of first to describe and quantify the multiple mental health counselling roles of Muslim clergy across the United States. Large sample size and recruitment efforts. Reasons for low return rate considered (8%) Limitations: Barrier to imams whose primary language is not English, and who are over-burdened with obligations. One vignette adapted from previous studies and not tested before in the Muslim community. Research only conducted with Male Imams
3	Ali, Milstein & Marzuk (2005)	The Imam's Role in Meeting the Counselling Needs of Muslim Communities in the United States	Sixty-two participants from a diverse group of Imams responded to a	Quantitative cross-sectional self-report questionnaire included 79-items, a vignette, multiple Likert-type scales,	Communities ask Imams to address counselling issues that extend beyond religious and spiritual concerns, and include family problems, social needs, and psychiatric symptoms. 95%	Strength and limitations: (see Study #2)

			survey sent to 730 US Mosques (8% return rate).	and open-ended questions	of Imams spent a significant amount of time each week counselling congregants with psychiatric difficulties. However, Imams were less likely than clergy from other faith groups to have formal counselling training.	
4	Ally & Laher (2007)	South African Muslim Faith Healers Perceptions of Mental Illness: Understanding, Aetiology and Treatment	Non-probability convenience sample of six Muslim Faith-Healers born in South Africa with Indian backgrounds.	Qualitative semi-structured interview schedule, comprising 12 open- and 9 closed-ended questions. Thematic content analysis.	Faith Healers' perceptions fell into three categories: understanding of mental and spiritual illness; causes of mental and spiritual illness; and the treatment/methods of healing prescribed. Faith healers view difficulties as having dualistic causes but distinguish spiritual illnesses that present with physical and psychological symptoms. Perceived causes of mental health difficulties included environmental or	Strength: Interview schedule constructed in consultation with community members and academics familiar with the fields of religion and psychology. Limitations: Does not detail recruitment or data analysis process. Non-representative due to small and homogenous sample size. Does not offer limitations, areas for future research, or clinical implications.

					biological causes (stress, trauma, or chemical imbalances in the brain), although spiritual problems could present as mental ill-health. Treatments based within religious doctrine if illness is spiritual, and with psychologist or doctor if symptoms appear psychological or medical.	
5	Leavey, Loewenthal & King (2007)	Challenges to sanctuary: The clergy as a resource for mental health care in the community	Thirty-two UK-based male participants aged 37-68 from a range of religious and racially minoritised background including Christian	Qualitative study using semi-structured face-to-face Interviews. Grounded Theory Analysis	Clergy from all FBOs play an important but often confused role in the care of people with mental health problems. The central organisations and training bodies that prepare clergy for ministry do not recognise the scale and impact of this role. UK MHSs neglect a valuable resource and fail to engage with the beliefs and	Strength: High validity, diverse sample, explored challenges of religious Clergy across the major Abrahamic Faiths. Multiple reviewers ensured consensual and complementary understanding of themes. Limitations: Does not offer clinical implications or recognise study limitations, participants recruited from one geographical location, does not explore socio-political climate, which may influence role of clergy.

			ministers (n = 19), rabbis (n = 6), and Imams (n = 7)		values of religious and spiritually oriented patients	
6	Leavey (2008)	U.K. Clergy and People in Mental Distress: Community and Patterns of Pastoral Care	This article used same data set as Study #4 (Leavey et al., 2007)	This article used same data set as Study #4 (Leavey et al., 2007) but examines how religious leaders undertake pastoral care, and their views about their roles.	Faith leaders use four broad pastoral care approaches: Communitarian; counselling; pedagogic; and healing. Clear distinctions between faith groups regarding the motivation and conceptualisation of mental health pastoral care. Developing collaborative links between MHS and faith groups is likely to be fraught with complexity and uncertainty.	(As per Study #4)
7	Meran & Mason (2019)	Muslim Faith Leaders: De Facto Mental Health Providers and Key Allies in Dismantling	Forty-one UK-based male (n = 37) and female (n = 4) MFLs including	Quantitative survey study. Participants allocated to either depression or schizophrenia vignette conditions.	MFLs expressed comparatively less stigma toward individuals with mental health difficulties than found previously in the broader Muslim community. MFL participants frequently	Strength: Consideration of Islamophobia and current political climate. Clearly identify implications and further areas of research. Highlights importance of building trust with Muslim community. Limitations: Small sample size. Vignettes cannot truly mimic or evoke real-

		Barriers Preventing British Muslims from Accessing Mental Health Care	Imams, shaykhs, and graduates of religious leadership courses.	Non-parametric statistics were used. Spearman's Rho for correlations within the data. Differences between the depression and schizophrenia vignette conditions were analysed using a Mann-Whitney U test.	direct individuals with psychological difficulties to seek help from mainstream healthcare providers and actively encourage UK Muslim communities to overcome their aversion to MHS. Participants most frequently ascribe mental health difficulties to environmental, followed by biological, and then religious factors. However, they often embrace all three concurrently.	life responses, possibly compromising ecological validity. Social desirability bias might influence participants to report more positive attitudes toward those with mental health difficulties or be less inclined to admit to beliefs in spiritual causes and remedies.
8	Padela et al. (2010)	The Role of Imams in American Muslim Health: Perspectives of Muslim Community Leaders in Southeast Michigan	Twelve community leaders recruited through purposive sampling. 7 male and 5 female which	Qualitative semi-structured interviews (1–1.5hrs). Open-ended questions probed US Muslim health beliefs, health seeking behaviour, and health challenges.	Imams serve the US Muslim community in several health-related roles and play a significant role in Muslim medical-decision making. Four key roles identified: encouraging healthy behaviours through scripture-based messages in sermons;	Strengths: Addresses disparities in accessing healthcare. Captures different Muslim community leader experiences. Community based participatory design partnering with four key organisations utilising local expertise and knowledge. Interview probing questions iteratively adapted following initial interviews. Participants chosen by steering group offering invaluable insight. Limitations: Non-

			included 2 Imams. Most were Arab Americans, Sunni Muslims, and held advanced degrees. Participants represented a variety of countries of origin and play various roles in the US Muslim community.		performing religious rituals around life events and illnesses; advocating for Muslim patients and delivering cultural sensitivity training in hospitals, and; assisting in healthcare decisions for congregants. Participants identify several areas of cultural conflict and challenges for Imams, including not having enough medical knowledge, and challenges with transgressing ethical line between coercing Muslims to seek healthcare using religiously laden messages and general health promotion activities at the Mosque.	representative sample, subsection of US Muslim community within one geographic location.
9	Rashid, Copello, & Birchwood (2012)	Muslim faith healers' views on substance misuse and psychosis	Eight Faith healers from different areas of the UK	Qualitative semi-structured face-to face interviews (45-90mins) using 2	The religious leadership simultaneously held medical and religious beliefs about the causes of mental health	Strength: Thoughtful design, utilising researcher's language skills and conducting interviews in participants choice of language. Transcripts

			(72% response rate). Participants were from varied racially minoritised backgrounds and self-identified as Sunni Muslims	vignettes on psychosis and substance misuse. Grounded Theory Analysis.	difficulties, deploying both within the same narrative and finding no conflict between these. Faith healers' views fell into four categories: the cause and understanding of the disorder; guidance; critical comments towards healers and members of the community; and religion and science. Religious conceptualisations played a key role in understanding disorders and guidance given.	reviewed by native speakers. Vignettes and interview schedule piloted with multiple people. Limitations: Only 1 female participant, unspecified recruitment challenges.
10	Shah & Culbertson (2011)	Mental Health Awareness among Imams Serving New Zealand's Muslim Population	10 Imams recruited from local Mosques in Auckland. Imams were immigrants from various backgrounds	Qualitative semi-structured interviews conducted face-to-face. Thematic data analysis.	Imams can play a significant role in supporting their community members with accessing help for mental health issues, and there is a strong need to train Imams in basic mental health knowledge, and health professionals in cultural awareness.	Strength: Handwritten interview notes were checked with participants for accuracy. Outlines systemic and cultural differences of NZ Muslims. Explores future directions and implications Limitations: Small sample, no female participants. Analysis methodology unclear. Ethical considerations not described.

1 1	Watts, Murray & Pilkington (2013)	Understanding and supporting psychological wellbeing: an exploration of the experiences of Islamic scholars	Six UK-based male Imams recruited through purposive snowball sampling.	Qualitative methodology explores participants' experiences using. Interpretative phenomenological analysis.	Imams saw counselling and pastoral care as a core part of their role & acted in a manner analogous to central diagnostic practitioners: directing those with medical ailments to doctors, and those with jinn difficulties to a spiritual expert. Imams reflect that while they made referrals to medical services, a reciprocal relationship does not exist. Four themes emerged. First two themes explore the construction of psychological wellbeing in an Islamic support context. The third explores the process of treatment and its apparent medical parallels. The fourth addresses the nature of the duty of the Imam to provide support.	Strength: Clear reflexive considerations made of researcher positioning. Offers valuable contribution to the experiences of MFL providing support. Themes include notes as part of analysis audited by research team. Limitations: Sample represents male Imams and misses other faith leader perspectives; Outsider positioning of researcher not explored in detail. Socio-political climate not explored.

1.9 Assessing Study Quality

The researcher used two quality appraisal frameworks to review the quality of each study. As this systematic review includes qualitative studies informed by different epistemologies and variant methods, using a quality appraisal criteria that accounts for these complexities with paradigmatic practice when assessing quality (Tracy & Hinrichs, 2007).Tracy's (2010) "Big-Tent" Criteria for Qualitative Quality is a benchmark for demonstrating credibility and rigor amongst other criteria and, importantly, provides a simple approach to conceptualising across qualitative studies using different methodological paradigms (Tracy & Hinrichs, 2017), and was therefore applied. Table 4 presents the qualitative critical appraisal. Appendix A provides definitions of each aspect of these criteria to aid readers' understanding of this particular evaluation approach.

The quantitative studies included in this review are all cross sectional, therefore the researcher assessed the quality of these studies using the Appraisal Tool for Cross-sectional Studies (AXIS; Downes et al.,2016). Downes and colleagues developed AXIS through a rigorous process incorporating comprehensive review, testing, and consultation via a Delphi panel[4], to address the absence of critical appraisal tools specific to cross-sectional studies. AXIS enables researchers to report on the risk of bias when assessing quality. Table 5 presents the quantitative critical appraisal.

Throughout the review process, I reflected on my position as a Muslim researcher, and how this position may influence the subjective process of appraising articles written in contribution to the understanding of Muslim mental health. Appreciating the importance of

[4] *The Delphi Panel methodology is a scientific method for achieving expert consensus, which represents a structured process of collecting knowledge. This is done by defining a problem, developing questions for experts to resolve, selecting a panel of experts including academics and clinicians, employing open-ended questionnaires, performing controlled assessment and feedback, including qualitative and quantitative analysis (Hohmann et al., 2018).*

collaboration between MHS and MFLs, I was aware of the bias that might influence how I represent the quality of this literature. It has been claimed that credibility is determined when co-researchers or readers are confronted with the experience, they can recognize it. Lincoln and Guba (1985) suggest several techniques to increase the credibility of qualitative research, including prolonged engagement, persistent observation, researcher triangulation, and peer debriefing. In contrast, the methods to establish trustworthiness in quantitative research includes internal and external validity, reliability, and objectivity. By reading these studies multiple times during the systematic review, a greater critical awareness of each study's quality was achieved, two articles were shared (one quantitative, one qualitative) with peers to elicit feedback, enable reflexivity, and enhance the credibility of this review.

1.9.1 Aims

All studies included in this review are well written, with authors providing clear aims and rationale. Research aims varied between the papers, and included exploration of the conceptualisations, experiences, and challenges MFLs face providing mental health support to their communities in their role. Four studies focus on how MFLs recognise and conceptualise mental health difficulties (Ali & Milstein, 2012; Ally & Laher, 2007; Meran & Mason, 2019; Rashid et al., 2012); one study focuses on how MFLs role adapted to accommodate additional requests for support after 9-11 (Abu-Ras et al., 2008); whilst the other studies focus on the role MFLs play and explores the nature of the support they give (Ali et al., 2005; Ali & Milstein, 2012; Leavey, 2008; Leavey et al., 2007; Shah & Culbertson, 2011; Watts et al., 2014).

1.9.2 Country

This literature sample includes five studies conducted in the UK (Leavey, 2008; Leavey et al., 2007; Meran & Mason, 2019; Rashid et al., 2012; Watts et al., 2014); and four studies conducted in the US (Abu-Ras et al., 2008; Ali et al., 2005; Padela et al., 2010). The remaining studies were carried out in South Africa (Ally & Laher, 2007), and New Zealand (Shah & Culbertson, 2011). The original scope for this systematic review was to focus on studies and literature produced in the UK, as MFLs training and role in societies differ considerably between countries. By focusing on UK research, this review would be more relevant to the context and sample of this research project. The search found only five UK studies, which is insufficient for an in-depth review.

1.9.3 Sample

Sample sizes range from six to sixty-two participants, and researchers vary in the detail they provide. For the five studies with twelve or fewer participants, three give sufficient sample details (Padela et al., 2010; Rashid et al., 2012; Watts et al., 2014). It is unclear whether the small samples in Ally and Laher (n = 6; 2007); Shah and Culbertson (n = 10; 2011) result from decisions regarding the rationale and methodology, or challenges in recruitment.

Five studies focus on the experiences of MFLs in Mosque and non-Mosque based roles (Abu-Ras et al., 2008; Ally & Laher, 2007; Meran & Mason, 2019; Padela et al., 2010; Rashid et al., 2012), and from nine females (Meran & Mason, 2019; Padela et al., 2010). Most MFLs participating in studies in this review are Imams, who are by definition and societal understanding, males and typically Mosque-based (Mukadam et al., 2010). This might explain the limited representation of females. One study also includes congregation

worshippers in the sample (Abu-Ras et al., 2008). The remaining six studies focus on Imams' perspectives (Ali et al., 2005; Ali & Milstein, 2012; Leavey et al., 2007; Leavey, 2008; Shah & Culbertson, 2011; Watts et al., 2014).

1.9.4 Data Collection

Most studies present their data collection method clearly. All qualitative studies use semi-structured interviews conducted face-to-face (Abu-Ras et al., 2008; Ali et al., 2005; Ally & Laher, 2007; Leavey et al., 2007; Meran & Mason, 2019; Padela et al., 2010; Rashid et al., 2012). One qualitative study also collects data using the researchers and participants shared mother tongue and then later translated(Rashid et al., 2012). The four quantitative studies use cross-sectional self-report questionnaires (Abu-Ras et al., 2008; Ali et al., 2005; Ali & Milstein, 2012; Meran & Mason, 2019), three of which also use vignettes and Likert-type scales to explore MFLs understanding, aetiology, and treatment of mental health difficulties (Ali et al., 2005; Ali & Milstein, 2012; Meran & Mason, 2019). Abu-Ras et al., (2008) collected survey data from participants in face-to-face interview with a trained assessor.

Several qualitative studies (Ally & Laher, 2007; Padela et al., 2010; Watts et al., 2014) use multiple approaches regarding research design, and consultation with academics and community members, resulting in higher levels of transferability. These approaches include pilot interviews, co-constructing interview schedules, and using literature to inform study design. Some qualitative studies provide insufficient methodological detail (Ali & Milstein, 2012; Leavey et al., 2007; Shah & Culbertson, 2011), making it difficult to assess dependability. All quantitative studies clearly define their methodology, however, only Ali et al. (2005), detail the steps taken to maximise response rates.

1.9.5 Findings and Analysis

All studies use quotes (qualitative studies) and discussions (quantitative studies) to animate the data. Studies use various methods to analyse data, including Grounded Theory, IPA, and TA. Quantitative studies vary in using parametric and non-parametric analysis methods. Some studies provide insufficient detail regarding the process of analysis (Ali et al., 2005; Ally & Laher, 2007; Leavey, 2008; Shah & Culbertson, 2011), and some provide no evidence for credibility checks (Ali et al., 2005; Ali & Milstein, 2012; Ally & Laher, 2007; Rashid et al., 2012; Shah & Culbertson, 2011). Factors supporting credibility checks include multiple researchers, joint analysis, or review by a research team (Leavey et al., 2007; Watts et al., 2014; Padela et al., 2010). Only one study clarifies the researcher's position in relation to the topic by sharing personal reflexivity (Watts et al., 2014), which compromises the credibility of other studies.

1.10 Critical Appraisal.

1.10.1 Qualitative Studies Critical Appraisal

Table 5: Qualitative Studies Critical Appraisal

Qualitative Studies Assessed Using "Big-Tent" Criteria for Qualitative Quality (Tracy, 2010)							
Author/ Authors & Year	**Rashid, Copello & Birchwood (2012)**	**Leavey, Loewenthal, & King (2007)**	**Ally & Laher (2007)**	**Watts, Murray, & Pilkington (2013)**	**Padela et al., (2010)**	**Shah & Culbertson (2011)**	**Leavey (2008)**
Worthy Topic	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rich Rigor	Yes	Some (Participant demographics missing)	Yes	Yes	Yes	Some (Data analysis detail limited)	Some (Data analysis detail limited)
Sincerity	Some (Transparency about method; no mention of reflexivity)	Some (Transparency on method and analysis; no transparency on study challenges; no evidence of reflexivity)	Some (Transparency on methods; no evidence of reflexivity)	Yes	Yes	No	Some (Transparency about method and analysis; no transparency on study challenges; no evidence of reflexivity)
Credibility	Some (Thick descriptions of tacit knowledge; no description of triangulation or reflection)	Yes	Some (Thick descriptions; no description of triangulation or member reflections)	Yes	Yes	Some (Limited thick descriptions of findings)	Yes
Resonance	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Significant Contribution	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ethical	Yes	Yes	Yes	Yes	Yes	No	Yes
Meaningful Coherence	Yes	Some (Limited information on data collection and analysis)	Yes	Yes	Yes	Some (Limited information on methods and analysis)	

1.10.2 Quantitative Studies Critical Appraisal

Table 6: Quantitative Studies Critical Appraisal

Quantitative Studies Assessed Using Appraisal Tool for Cross-Sectional Studies (AXIS, 2016)				
Author/ Authors & Year	Ali, Milstein, & Marzuk (2005)	Abu-Ras, Gheith & Cournos (2008)	Meran & Mason (2019)	Ali & Milstein (2012)
Introduction				
1. Were the aims/objectives of the study clear?	Yes	Yes	Yes	Yes
Methods				
2. Was the study design appropriate for the stated aim(s)?	Yes	Yes	Yes	Yes
3. Was the sample size justified?	NS	NS	NS	NS
4. Was the target/reference population clearly defined? (Is it clear who the research was about?)	Yes	Yes	Yes	Yes

5. Was the sample frame taken from an appropriate population base so that it closely represented the Yes target/reference population under investigation?	Yes	Yes	Yes	Yes
6. Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?	Yes	Yes	Yes	Yes
7. Were measures undertaken to address and categorize non-responders?	Yes	No	No	No
8. Were the risk factor and outcome variables measured appropriate to the aims of the study?	ND	ND	ND	ND
9. Were the risk factor and outcome variables measured correctly using instruments/ measurements that had been trialled, piloted or published previously?	No	No	No	No
10. Is it clear what was used to determined statistical significance and/or precision estimates? (e.g., p values, CIs)	No	No	No	No
11. Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	Yes	Yes	Yes	Yes
Results				
12. Were the basic data adequately described?	Yes	Yes	Yes	Yes
13. Does the response rate raise concerns about non- response bias?	No	No	No	No
14. If appropriate, was information about non- responders described?	Yes	No	No	No
15. Were the results internally consistent?	Yes	Yes	Yes	Yes
16. Were the results for the analyses described in the methods, presented?	Yes	Yes	Yes	Yes
Discussion				
17. Were the authors' discussions and conclusions justified by the results?	Yes	Yes	Yes	Yes

18. Were the limitations of the study discussed?	Yes	Yes	Yes	Yes
Others				
19. Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?	NDis	NDis	NDis	NDis
20. Was ethical approval or consent of participants attained?	Yes	Yes	Yes	Yes

Abbreviations: ND – not described; NDis – not disclosed; NS – not stated

1.11 Synthesis Strategy

The researcher used a TA approach to synthesise findings following Braun and Clarke's (2006) guidelines. TA was chosen above other methodologies as it facilitates clear identification of prominent themes, with an organised and structured approach to dealing with the literature under these themes (Thomas & Harden, 2008). TA also offers a means of integrating qualitative and quantitative papers for synthesis (Dixon-Woods et al., 2005). Following familiarisation, the researcher made notes on prominent or recurring themes; extracting, aggregating, interpreting, and synthesising constructed patterns specific to the experiences of MFLs. Three main themes were developed through first carefully reading each study, grouping key concepts and findings and considering the critique of each study's quality, methodology and conceptual issues as detailed in Table 5 and 6. Synthesising papers includes extracting quotes from participants (first-order data), and interpreting data (second-order constructs).

1.12 Synthesis of Findings

1.12.1 A Guide for the Community

Overall, the studies within this systematic literature review explore the roles MFLs play in their communities as "crucial allies" (Meran & Mason, 2019, p.38), "key people" (Shah & Culbertson, 2011, p.89), and "the first port of call" (Leavey, 2008, p95), amongst other descriptions for the support they provide (Leavey, 2008). Eight studies detail what a MFL's role entails, ranging from providing religious and spiritual guidance, dealing with the sick, relationship difficulties, and providing mental health counselling (Abu-Ras et al., 2005; Ali et al., 2005; Ali & Milstein, 2012; Leavey, 2008; Leavey et al., 2007; Meran & Mason, 2019; Padela et

al., 2010; Shah & Culbertson, 2011). MFLs also report supporting people beyond the typical boundaries of a faith leader with difficulties arising from contextual factors such as poverty, immigration, racism, and Islamophobia (Abu-Ras et al., 2005; Ali et al., 2005; Leavey, 2008; Shah & Culbertson, 2011).

A common theme across all studies is that MFLs feel responsible for guiding or acting as a conduit, passing on Allah's knowledge for the betterment of their communities:

> *(Being an) Imam entails .... first and foremost, guiding the community ... and also visiting a sick person ... if somebody dies ... either you get involved in the washing of the body or directing (sic) people how to do that and ... praying for the deceased person.* (Padela et al., 2010 p.366)

For some MFLs, passing on Allah's knowledge also means advocating for a more caring and nurturing society as a duty to all Muslims to take community responsibility. These references often allude to the interdependence that MFLs promote, encouraging peer support, sharing supplications and techniques with others experiencing similar difficulties:

> *This blessing is coming through the chain, and I've been gifted a few prayers, a few formulas by some people, and I have tried those, and it works, so I teach others, and it's worked for them. So, when they come back and tell me that it's worked for them, I say well, teach others. Pass it on to other people, so that's how we help each other.* (Watts et al., 2014, p.374)

> *100% whether they understand it or not, it's incumbent, and it's not just the community it's people at large, it's a universal thing, we're not communities, we're a global society (...) the whole creation is family of God if you like, and we have to look at it as a whole rather than just pieces of jigsaw.* (Watts et al., 2014, p.374)

MFLs spoke about a range of skills they need to fulfil their roles, considering both psychological and spiritual approaches, and techniques including developing rapport, listening and being supportive, and identifying relevant prophetic stories and correct verses from the Quran for treatment:

> *So, I listen to them, first thing is a listening ear, where people don't have time to listen to somebody, people feel neglected, people be ignored. Nobody wants to listen to other people's problem, to other people's feelings, other people's viewpoint.* (Watts et al., 2014, p.372)

Three studies describe how the MFL role changed significantly after 9/11[5], which they attribute to a rise in people's experiences of racism, discrimination, and Islamophobia (Abu-Ras et al., 2005; Ali et al., 2005; Leavey et al., 2008). MFLs report that 9/11 had a negative effect on their life. Before 9/11, 97% of participants felt moderately to extremely safe, which decreased significantly to 18% post-9/11, with 80% experiencing some type of discrimination (Abu-Ras et al., 2005). MFLs are also increasingly asked to counsel for actual discrimination (Ali et al., 2005), dealing with the impact of harassment from hostile statutory law enforcing agents (Abu-

[5] *9/11 refers to four coordinated attacks by the Wahhabi terrorist group Al-Qaeda against the US on September 11, 2001*

Ras et al., 2005), and educating community members on their rights when facing immigration situations. MFLs in Ali and Milstein (2012) share concerns that in the current environment:

> *"psychological problems* [of Muslims] *will magnify even further"* and suggested several reasons, including *"cases of discrimination in the workplace . . . and harassment"* in the community; and government responses focused on *"monitoring sermons"* and freezing bank accounts during *"investigations"* making people *"afraid of FBI* (Federal Bureau of Investigations) *or CIA* (Central Intelligence Agency)*." That is, "revealing problems may have a negative impact on the status of the person"* and *"no one pays zakat* (obligatory charity) *to the Masjid* (Mosque) *anymore because of 9/11."* (Ali & Milstein, 2012, p.9)

1.12.2 An Aversion to Services

Racially minoritised and Muslim communities are often averse to engaging with mainstream MHS, often declining or ending support prematurely (Bhui & Morgan, 2007; Bowl, 2007; Cifti et al., 2013; Weatherhead & Daiches, 2010). Several reasons align with themes emerging from this systematic review. These factors are complicating for MFLs, who have to challenge fear and negative beliefs towards MHS. These include stigma and incompatibility of services due to their lack of understanding of Islam and belief in Jinn (Abu-Ras et al., 2005; Ali et al., 2005; Ali & Milstein, 2012; Leavey, 2008; Leavey et al., 2005; Meran & Mason 2019; Shah & Culbertson, 2011; Watts et al., 2014). The other factor MFLs highlight centres on their critical view regarding the dominance of medication, which people are reluctant to take for fear of long-term health consequences.

Findings in one study indicates MFLs raise the issue of stigma significantly more than other Abrahamic clergy (Leavey, 2008). This is particularly evident in the way MFLs speak about how questions about an individual's sanity have wider societal implications, even undermining marital chances:

> *Those who have mental problems – their children are more likely to be mentally ill and I think the same thing is believed by Bangladeshi's – if you are mad then it's very likely that other people in your family are . . . You will not allow your children to marry someone who may become mad in time.* (Leavey, 2008, p.96)

While MFLs' roles appear to hold dualistic perceptions towards the cause of mental health difficulties, they acknowledge that profoundly stigmatising community attitudes tend to determine a more religious understanding on mental health difficulties and help-seeking rather than psychological or psychiatric (Leavey, 2008). Consequently, MFL across several studies utilise religious explanations that all trials are from Allah to normalise and encourage help seeking (Leavey, 2007; Meran & Mason, 2019; Rashid et al., 2012; Watts et al., 2014):

> *Sometimes it's a trial from God (...) life is a trial anyway, every step and (...) and our whole life is a test and trial from God (...) you have to seek help to be successful in this trial* (Watts et al., 2014, p.370)

Nine studies explore MFLs perception, recognition, and diagnosis of mental health difficulties. Participants in these studies often suggest a dichotomous relationship between religious and Western approaches in the way that mainstream services can exclude spiritual explanations as causes of distress. Though MFLs agree that disentangling medical, psychological, and spiritual causes is difficult, they report a lack of consideration given to religious viewpoints, with mental health difficulties framed as coming from Allah or shaitan (Satan; Padela et al., 2010; Watts et al., 2014), or as a result of spiritual imbalance (Ally & Laher, 2007):

> *If it is a jinn case then science wouldn't believe it, they'll completely deny it, I have a relative who has a rare genetic disorder, no matter how much they treat it, it will still pass on generation by generation, some people say that others have done it to them, but you have to have belief in Allah, the scientific people believe that it's nothing to do with a higher being, but if the illness is not getting treated then you have to come to terms with that fact that it's up to Allah.* (Rashid et al., 2012, p. 664)

> *(...) medical people. I respect their profession (...) but if they have no knowledge (...) about the other side, the spiritual or pastoral care side, then it's a problem for them, they won't work you know, if it's "this is mumbo-jumbo".* (Watts et al., 2014, p. 372)

This leads to challenges integrating and supports a perception within Muslim communities that services will not respect or accommodate their beliefs and explanations. This lack of accessibility and compatibility means a dichotomous approach to receiving support:

> *If you go to the classical time, early centuries of Islam, the Muslim doctors used to be religious scholars as well, so you will find that most of the Muslim scholars, they are good doctors actually, so this alienation of the two fields is something un-Islamic.* (Rashid et al., 2012, p. 664)

MFLs also criticise the methods Western practitioners use, believing that medication provides short-term benefits but long-term consequences:

> *They prescribe you with medicine that has side effects and slowly, slowly the child becomes so used to the medicine that the medicine no longer has an effect on his body, so then they start doubling the dose, after this continuous pattern they will become addicted to the drug, so with psychologists that prescribe sleeping pills I'm personally against it, because first thing is with that child, it will hit them and secondly his willpower will become diminished to make any decisions.* (Rashid et al., 2012, p. 665)

1.12.3 The Need for Mutual Trust and Support

Another prominent theme across all studies is MFLs utilising multiple perspectives to explore a person's need, drawing on scientific, social, and spiritual traditions (Abu-Ras et al., 2005; Leavey et al., 2008; Leavey, 2007; Meran &Mason, 2019; Shah & Culbertson, 2011; Watts et al., 2014). MFLs acknowledge the importance and need for a collaborative approach to understand and treat mental health difficulties given the challenge of disentangling spiritual and medical phenomena (Leavey et al., 2007). To achieve this and provide holistic treatment (Watts

et al., 2013) while addressing spiritual imbalance (Leavey et al., 2007), MFLs argue for mutual trust and support between mainstream MHS and MFLs:

> *If someone seeks medical advice, we say that the treatment you're receiving should also be alongside spirituality, then both methods will come together, so just because one is working, it doesn't mean to say you drop the other method, both can be done at the same time.* (Rashid et al., 2012, p. 664)

MFLs overwhelmingly report actively encouraging their communities to overcome their aversion to services, and a number of studies discuss how MFLs encourage a holistic approach to addressing both spiritual and psychological needs. A key area needing further exploration arises from the finding that MHPs do not reciprocate MFLs' efforts to accommodate alternative aetiologies and multiple perspectives (Abu-Ras et al., 2005, Ally & Laher, 2007; Meran & Mason, 2019; Watts et al., 2014). Meran and Mason report that for MFLs, a belief in spiritual causes does not translate to a rejection of medical interventions. They question whether MHPs can, in turn, make room for religion and spirituality. Considering the strong aversion clients feel towards discussing religious beliefs for fear of being branded delusional or facing cultural insensitivity (Dein, 2013; De Souza, 2007), the literature in this review advocates for more collaboration between MHS and FBOs (Durà-Vilà et al., 2011). Several MFLs refer to this by speaking about seeking the appropriate support from the appropriate source, alluding to a desire for MHS to utilise their religious and spiritual expertise:

> *"...if I had to get a client coming in and you know they show err symptoms of err...let's take a flu for example right, I'll say to them you know what go to the doctor. The doctor is umm more knowledgeable with medical side...with the medical side so you rather go there where if I have a person coming in and you can see they emotional and they aren't affected in any spiritual way then I'll say you know what you rather go to a psychologist because you'll need someone who's going to help you get to your problems and explain to you why you are feeling that way..."* (Ally & Laher, 2007, p. 54)

One MFL with duties as a hospital chaplain describes needing a pragmatic and inclusive approach when uncertainties arise, advising the use of both medical intervention and prayer:

> *I persuade them to take medicine, and, in the meantime, I ask them to read some verses from the Quran so if the problem is from there (spiritual) the verses from the Quran will help them and if the problem is from there (biological or psychiatric) then the medicine is needed. We believe that prayer always has the power of healing.* (Leavey et al., 2007, p. 553)

One MFL, however, acknowledges the difficulty NHS and MHPs experience trying to improve treatment by incorporating religiosity:

> *How can they strike the right balance as far as their practice and as far as their education is concerned? And then they have the English population who more or less*

> *think the same as they do and then they've got the Asian population and with the Asian population it's not only the Muslims, it is the Hindus that also believe in supernatural things, the Sikhs, somewhat different, the Sikhs believe in supernatural things, there is the African people who believe in supernatural things and black magic, so as far as the National Health Service is concerned it is very difficult for them to find a way which is going to be appropriate for everybody, but I think at times what the GPs or the mental health practitioners should do is also refer people to their spiritual leaders.* (Rashid et al., 2012 p. 665)

Furthermore, MFLs report holding similar concerns to MHPs in fearing exploitation of clients by charlatan faith healers claiming to possess spiritual powers. They report this as a growing concern, synonymous to criminal activity, and hold critical views against some faith healers as well as members of the community:

> *If someone claims or boasts that he or she has got supernatural powers, here is where the problem lies because Quran says even the prophets that their knowledge of the unseen is limited to what God has given to them, they are not superhumans, even the prophets they are human beings like us*

> *If a patient goes to him, he has no other gain but financial, so I would recommend to the people not to go to them because they will heal for the first time, maybe heal him the second time and at the third time he'll deliberately ruin it so that his business keeps running* (Rashid et al., 2012, p. 663*)*

Members of the community are criticised for attributing every catastrophe to a supernatural phenomenon, which was a ‘‘very common’’ thing to do:

> *Anything that we do not want to be accountable for our own actions, we want to be lazy and being lazy is really easy, to put the blame on external factors, ‘I do not cause it to myself, no it’s just somebody else and it is supernatural’ this is a typical Muslim, a typical response from a person whose a transgressor ‘I didn’t do it, the others did it and it’s black magic’ and the guy who’s sitting in the hospital is perfectly ok ‘Listen Shaikh, they’ve done black magic on me’ (says mockingly) I said ‘You know?’ he said ‘Yeah’ I said ‘You are perfectly ok’ he says ‘You know?’ I say ‘Don’t ask again.’*
> (Rashid et al., 2012, p. 663)

To address these challenges, MFLs across the studies encourage mutual support through training and referral. Rashid et al. (2012) note one MFL who argues that making referrals to MFL would bridge this gap, and to do this MHPs need training to bridge the religiosity gap (Padela et al., 2008; Rashid et al., 2012). This view is shared by one MFLs with additional training:

> *I mean I feel quite comfortable nowadays working say with a Muslim client for instance where I am thinking in terms of psychological processes and I’m interpreting unconscious processes and so on and yet at the same time you know I’m bringing in say ideas from the Quran or from traditions itself and the Hadiths and it doesn’t seem like an either/or thing you know.* (Leavey et al., 2007, p. 556)

One MFL notes the lack of support and need to work together:

> *Alongside a need to work together, a lack of support towards their process, noting that "I don't think enough support (...) because, support means, either morally or financially. That's support ... morally they have no idea ... financially? [laughs]* (Watts et al., 2013, p. 374).

Furthermore, greater contact with MHS and training was correlated with lower levels of stigma amongst MFL, higher likelihood of referral, and better development of working relationships (Abu-Ras et al., 2005; Ali & Milstein, 2012, Meran & Mason, 2019; Padela, 2008; Rashid et al., 2012).

> *I can ask you if you allow me, is there any advice from your side on how to handle this kind of things? If you have any advice or criteria for me, in how to handle this kind of people.*

> *He told us, "Maybe a sheikh (Imam) comes from the Masjid (Mosque) (to educate healthcare workers about) when you come across these Muslims, this is the kind of beliefs ... that you might encounter". The goal of such activity is to provide staff with a cultural knowledge base and tools that can help healthcare professionals understand and facilitate care that is attuned to Muslim beliefs.... "many of the staff ... have no idea what Muslims believe ... once they know that they are more sensitive,*

> *and they know how to approach them (Muslims) ... and how to respect them and not offend them".* (Padela et al., 2010, p. 366)

1.13 Conclusions of Systematic Literature Review

This systematic literature review aims to understand what the literature says about MFLs' experiences providing mental health support. The findings synthesised here offer a much-needed contribution to the understanding of MFLs' roles and experiences, highlighting the critical role MFLs play in providing support beyond religious and spiritual concerns and often as a 'first port of call' for the Muslim communities. MFLs recognise a need for input from MHPs and do a great deal of work challenging the Muslim communities' aversion to MHS. To minimise disparities between MHS and FBOs, MFLs argue for mutual respect and support to collaborate, provide mutual training, and increase referrals. Expert-led services may alienate people using MFLs for support, which is concerning given greater levels of discrimination and Islamophobia after 9/11. Evidence shows MFLs are crucial allies in attempts to increase trust and collaboration, but lack vital resources and knowledge meaning they often work in isolation without adequate support.

1.14 Gaps in Literature

This systematic review highlights several gaps in the literature. Most papers explore the nature of support MFLs provide, the roles they play in their communities, and their perceptions and understanding of mental health. Though these findings are crucial, there is limited understanding on how MFLs experience their roles amidst limited support and training, and whether this impacts their own emotional wellbeing. The literature also identifies a need for greater awareness of the wider systemic and structural challenges. Though several papers touch

on wider contextual challenges, only quantitative research explores the impact of Islamophobia after 9/11, and socio-political changes and climate. It is vital to gain a qualitative insight into how MFLs relate to these challenges and, specifically, to the culture and context of the UK.

Few studies pinpoint the reasons why MFLs perceive collaborating with MHS as difficult, and the discomfort MFLs can experience when called for support. As MFLs have influence at individual- and community-levels in addressing the Muslim people's aversion to MHS, it is imperative to explore this further. This can facilitate collaboration among MFLs and MHPs for mutual benefit, with the overall aim of improving services for the Muslim communities.

1.15 Rationale and Aims for Current Research Project

This research project aims to elicit MFLs experiences providing mental health support in the community. The primary aim is to gather direct evidence from MFLs to contribute to the limited body of literature on their experiences providing support for mental health difficulties, and how they understand and conceptualise distress in relation to their role. The secondary aim is to explore MFLs experiences in collaborating with mainstream MHS. Finally, this research aims to help consider how socio-political factors influence a MFLs role, and how to promote ways to strengthen partnership initiatives between mainstream MHS and FBOs.

The following research questions explore these aims:

1) ***How do MFLs experience providing mental health support?***

2) ***How do MFLs experience collaborating with mental health services?***

Chapter 2: Methodology

2.1 Overview

This chapter details the methodology used to address the research questions identified above to investigate MFLs' experiences of providing mental health support in the community. A detailed justification for selecting thematic analysis is given along with information regarding the characteristics and recruitment of participants, and the research consultation process. Further information is provided about the data collection and analysis procedures, ethical considerations, and the quality appraisal for this project.

2.2 Rationale for a qualitative approach

As described earlier, the body of research concerning how MFLs support mental health difficulties is limited. Attempts to develop this literature often fail to represent the experiences of MFLs. Using a methodology that enables direct interaction with MFLs and aligns to project objectives was a priority, whilst acknowledging my influence as researcher in interpreting their accounts. Historically, positivist approaches dominate mental health research, often privileging objective truth as superior knowledge to subjective or interpretive knowledge (Gill, 2012; Rogers & Pilgrim, 2014; Slade, 2012). With this positioning, the researcher is likely to take an objective stance with a quantitative methodology (Burr, 2015), perpetuating societal divides between the

'expert' professional with access to this form of knowledge, and the subordinate 'participant' (Delvaux & Schoenaers, 2012). Qualitative methods enable researchers to explore in detail human experiences by discovering knowledge through the participant's subjective experience (Crowe, 1998). As a MHP trying to speak to MFLs, I was conscious participants might view me as an 'expert', and the power that may be at play within this dynamic. In trying to negotiate these considerations, it felt important not to situate the research within a positivist approach in order to avoid being viewed as an 'expert'. A qualitative approach also aligned better with my critical realist epistemological approach (Fletcher, 2017), which, as explained in Chapter 1, suggests the lens we use to view and hear their accounts shapes our interpretation of the reality each participant describes. Occupying both insider and outsider positions (see Chapter 1) in relation to participants means my interpretations will undoubtably have an impact, and this approach encourages me to think reflexively throughout the research process.

2.3 Why Thematic Analysis?

Thematic Analysis (TA; Braun & Clarke, 2006; Joffe, 2012) was selected as a good fit after considering my epistemological, axiological, and ontological position in relation to the research aims. Thematic analysis is "a method for recognising and organising patterns in content and meaning in qualitative data" (Braun & Clarke, 2006, p.84), and is fundamental for much, if not most, qualitative research (Joffe, 2012). Braun and Clarke (2006, p.15) state that thematic analysis "involves the searching across a data set to find repeated patterns of meaning". This is appropriate for this research as it allows exploration of MFLs' views to capture key themes and perspectives to better understand their perspective as a starting point.

That TA provides theoretical flexibility is another feature relevant to this research. As TA is independent of any pre-existing theoretical framework (Braun & Clarke, 2006), it offers researchers flexibility in their epistemological approach. In doing so, TA is a 'contextualist' method between realism and constructionism, and in line with theories such as critical realism; this project's epistemological position (Willig, 2012). The critical realist epistemological position acknowledges the study of 'persons-in-context' (Larkin, Watts & Cliffton, 2006, p.109). TA also accommodates inductive (bottom-up) and deductive (top-down) approaches to developing and understanding themes. As it is not possible to adopt a position purely from an inductive or deductive approach (Braun & Clarke, 2013), I chose to analyse from a primarily inductive position where the themes link strongly to the data and, unlike a deductive approach, independent of any pre-existing theoretical preconceptions or coding template. This choice aligns to my aim to contribute to an under-researched area. Similarly, I chose to code data on a semantic (surface) level to reduce the influence of my researcher role on how I interpret the data. The attempt to theorise the significance of the data and their broader meanings and implications will come from the latter stages of analysis after patterns from across data sets are identified (Patton, 1990).

2.4 Alternative Considerations

I also considered Interpretive Phenomenological Analysis (IPA; Smith & Osborn, 2004) and Grounded Theory (GT; Charmaz, 2006) as alternative qualitative approaches. IPA uses a smaller sample size, making it unsuitable; the aim for this research was to look at themes shared among participants rather than provide an in-depth exploration of each MFL's individual lived

experience. GT explores how processes occur within multiple contexts to develop an overarching theory (Charmaz, 2006). It also focuses on sociological processes, whereas the current study focuses predominantly on exploring individual experiences and understanding of meaning. Therefore, TA was deemed most appropriate.

2.5 Design

2.5.1 Participatory Research Design

As MFLs play an important role and act as a resource in supporting community wellbeing, it was important this research drew on their expertise and knowledge. I was aware that MFLs are also best placed to identify the challenges they face along with possible solutions. For these reasons I adopted a participatory research design. Participatory research aims to empower people through the process of constructing and using their own knowledge (Cornwall & Jewkes, 1995), and moves away from the idea of the 'outside expert' coming into a community to examine, theorise, and propose solutions. Participatory research proposes a collaborative approach to designing and conducting research and aligns with thematic analysis as both approaches understand knowledge as a co-construction (Liebenberg, Jamal, & Ikeda, 2020)

A consultative group was established to achieve this collaborative aim and provide consultation and guidance throughout the research process. This group comprised two MFLs, Imam Qamruzzaman Miah who is part of the East London Foundation Trusts' (ELFT) Department of Spiritual, Religious and Cultural Care, and Dr Sara Betteridge, a psychologist with extensive experience in Muslim chaplaincy. Another consultant and expert in the

consultative group was Ayan Hussein, a senior peer support worker. The consultants signed a consultant's agreement highlighting what they may expect from being involved as well as my responsibilities towards them throughout the research process (Appendix C). The three consultants joined my supervisor team, Dr Lizette Nolte and Dr Angela Byrne, later joined by Dr Jacqui Scott, for online meetings at different stages. Some examples of how this consultative group was utilised are shown below.

The consultants reviewed my research proposal, suggesting changes to the interview schedule, the participant information sheet, and research questions. Following approval from the University's research team I discussed the feedback I received with the consultants, which included thinking through aspects such as the demographics form and the inclusion / exclusion criteria. My initial plan was to recruit participants with Islamic sciences training in the UK but following consultation included MFLs with international training. I also consulted the group:

- after receiving ethics approval to discuss participant recruitment. Consultants gave feedback on the flyer, specifically supporting with wording and imagery and took part in discussions about potential participants and recruitment avenues, including snowball sampling from consultants' networks.
- After my pilot interview to evaluate the interview and think through the interviewee's feedback. This led to specific changes to the wording of some questions. For example: *How would you describe your understanding of mental health in relation to your Islamic and religious beliefs?* was changed to…*There are many different ways of thinking about mental health. What does mental health mean to you? How does this relate to your religious beliefs?*

- Mid-way through the interviewing process to discuss initial thoughts and broad findings from the interviews. This meeting guided how to progress with analysis and a collaborative decision was made to pause interviewing to commence preliminary analysis. We agreed this was a good way to support thinking in relation to initial potential themes that could guide the remaining interviews. This approach to starting analysis whilst data collection is still ongoing is not a standard one for TA given that it is generally recommended that researchers familiarise themselves with the whole body of data before starting the coding process (Braun and Clarke, 2006). However, given the pragmatism and flexibility of TA, and the central role that themes play in the analysis and reporting of qualitative data, a recently suggested approach, "Iterative Thematic Inquiry" (Morgan & Nica, 2020), calls for a process where cycles of coding may occur throughout the process of data collection.
- To share evolving thematic maps and agree how to organise themes. We subsequently met to finalise themes and agree important points of interest to explore in discussion.

Consultants shared reflections of being involved throughout the research process in Appendix R.

2.5.2 Involving Other Muslim Faith Leaders Through Consultation

Several MFLs interested in participating contacted me during the recruitment process. However, they did not meet the inclusion criteria due to their substantive mental health and counselling training. Two of these MFLs were invited to support other aspects of the research process due to their unique positioning and expertise holding a mental health role as well as a MFL position. These MFLs shared a flyer to facilitate recruitment and identified possible avenues for disseminating project findings.

2.6 Participants

2.6.1 Participation Criteria

This project used clear inclusion criteria (See Table 7) developed collaboratively with the consultative group prior to recruitment. Due to the scope of the project, participants needed to communicate verbally in English. This may have excluded many already marginalised MFLs whose experience, and expertise is valuable to this field. We explored the potential to include these MFLs as consultants, however all the MFLs who responded to the recruitment could communicate verbally in English. It was also agreed that in order to get a good breadth of experience, participants needed to occupy a MFL position and have supported a congregation member with their mental health difficulties. Additionally, it was jointly agreed that participants should not have formal mental health or counselling training but were qualified in Islamic Sciences as a MFL so that the experiences shared reflected that of the majority of MFLs experiences in the UK.

Table 7: Participant Inclusion Criteria

Inclusion Criteria
• Over the age of 18 and English Speaking • UK resident • Occupies an MFL position • Has worked as an MFL for a year or longer • Have supported a community or congregation member with their mental health difficulties

- No formal mental health or counselling training
- Have completed a higher level of Islamic Sciences Studies to fulfil roles of MFL

2.6.2 Recruitment

Through collaboration with research consultant to identify appropriate channels, recruitment took place primarily via social media, word-of-mouth, email, and sharing a flyer through faith-based WhatsApp groups. I adopted different sampling strategies at different stages of the research. I recruited the initial sample in stage 1 using purposive sampling to identify and select individuals who met the inclusion criteria and could provide proficient and well-informed accounts of their experience (Etikan, Musa, & Alkassim, 2016).

For stage two, the consultant team and I shared the research flyer through existing faith-based networks on WhatsApp, social media, and email. Four participants receiving the flyer through their WhatsApp contacts responded. For stage three, a snowball sampling approach was adopted, whereby participants recruiting potential participants from among their acquaintances based on their applicability to the inclusion criteria (Sedgewick, 2013). I also contacted known acquaintances with connections to MFLs and requested they share the research flyer with them, inviting those interested to make contact to enquire about participating. These different approaches were effective in recruiting the desired number of participants who met the inclusion criteria.

2.6.3 Participants

In total, 13 MFLs participated in this research. The sample include male (n=10) and female (n=3) participants, aged between 27-51. All participants identified as British Muslim and were in MFL positions. Table 8 provides demographic information for each participant. Decisions concerning what information to collect from participants on the demographics form (See Appendix G) was made jointly with the consultant's team. Given the small community of MFLs and that prominent, well recognised MFLs were identified and had shown interest in taking part, it was felt important to the consultative group that only the information necessary and which does not compromise the anonymity of the participants is requested. The consultative group reviewed a draft demographics form and then co-produced final demographics form with the researcher (See Appendix G).

Table 8: Participant demographic information

Pseudonym	Ethnicity	Gender / Sex	Age	FL Position	Time in MFL role (years)
Aisha	Bangladeshi	Female	27	Teacher	3
Muhammed	Pakistani	Male	39	Imam	15
Yunus	Gujerati	Male	51	Imam & Chaplain	30
Idris	Pakistani	Male	37	Prison Imam & Chaplain	11
Daniyal	Bangladeshi	Male	42	Imam & Islamic Studies Teacher	18
Ibrahim	Bangladeshi	Male	28	Imam	5
Fatima	Pakistani	Female	41	NHS Chaplain	4
Yacoub	Bangladeshi	Male	44	Imam & Islamic Studies Teacher	22

Adam	Arab	Male	33	Imam	15
Nusayba	Bangladeshi	Female	48	Manager in Mosque	27
Noah	Mixed White and Egyptian Arab	Male	33	Imam	10
Ihsaan	Djibouti	Male	35	Imam	5
Zayd	Mixed Somali and Yemen	Male	29	Imam	4

2.6.4 Interview Modality

Data collection used an individual semi-structured interview methodology as this was considered the most appropriate method to capture the MFLs experiences, while being the most commonly used format for interviewing (DiCicco & Crabtree, 2006). A semi-structured format offers flexibility in how the interview schedule is designed, refined, and conducted. The flexibility of this approach also provides a degree of freedom for interviewees to explain their thoughts and highlight areas of particular interest and for the interviewer to probe and explore certain responses in greater depth, and in particular to elicit and resolve apparent contradictions (Horton, Macve, & Struyven, 2004).

Due to COVID-19 restrictions and social distancing guidelines, ethical approval was granted to conduct interviews remotely instead of face-to-face. Virtual interviewing can be more convenient and empowering for participants, as they can participate from the comfort of their own homes and may feel a greater sense of control over their responses. Virtual interviews also removed geographic barriers to participation, enabling geographically dispersed people to

participate without requiring time and money to travel (Braun & Clarke, 2013). Despite these advantages, some richness in the data may be missing due to the inability to interview face-to-face.

There were however some disadvantages of interviewing virtually to consider prior to data collection. First, some visual cues are used differently in virtual versus face-to-face conversations. For example, head nodding is less frequent in virtual interviews, with fewer interruptions, and speakers tend to take longer turns between speaker transitions, which result in a less natural (i.e., more formal) interactions (Sedgwick & Spiers, 2009). Second, COVID-19 restrictions meant families were working and studying from home, which increased the likelihood of interruptions compared to face-to-face interviews. Participants often needed to refocus following interruptions, which might have impacted the richness of the data, and required more time to complete the interviews.

Participants could choose how they wished to be interviewed, and all chose to be interviewed online via Zoom. Following a description of what the virtual interview would involve, participants provided written and oral permission before the interviews.

2.7 Ethical Considerations

The University of Hertfordshire's Health, Science, Engineering & Technology Ethics Committee (Appendix D) protocol number LMS/PGT/UH/04178, approved this research following review with the project supervisory team. The initial ethics application was modified following guidance to concentrate data collection solely on virtual interviewing methods to abide

by COVID-19 social distancing guidelines. This research features several considerations to establish ethical rigour. These were communicated through a participant information sheet in line with the British Psychological Society's Ethical Guidelines (BPS, 2014) (Appendix D).

Each participant was given opportunities to ask clarification questions prior to taking part in the research and gave signed consent to confirm they were informed of the research aims and what participation would involve (Appendix H). Participants were informed about the confidentiality policy and the limits to this, wherein appropriate services would be informed should a participant disclose any potential harm to themselves or others. The participants were informed how interview data would be handled to maintain anonymity, including data storage, saving files separate to demographic and consent forms, using password-protected files, and assigning pseudonyms to de-identify participants.

Participants were told they could withdraw from the research until the data analysis stage, for which a date was given on the information sheet. As this research project asked participants about their experiences supporting mental health difficulties, it was important to consider how participation may evoke psychological distress in the MFLs. Participants were told that, should this happen during the interviews, I would respond in a compassionate way, drawing on my skills and experience as a clinical psychology trainee, and providing opportunities to pause or terminate the interview if necessary. Participants were also told they could have space to discuss and reflect during the interview debrief and provided with further details of where they could access support, should they require it.

2.8 Data Collection

2.8.1 Screening

Screening calls determined whether individuals met the inclusion criteria and gave them a chance to ask questions. Those that met the criteria and agreed to participate were sent the participant information sheet (Appendix E) and a link to a demographics form (Appendix G).

2.8.2 Resources

The semi-structured interviews were conducted over Zoom using a laptop. A printed interview schedule was used, and interviews were recorded on a Dictaphone and Zoom. The researcher kept a reflective journal to record thoughts and ideas after each interview. A reputable transcription service was used to transcribe some interviews. NVivo 12 software (QSR International, 2018) was used to analyse the data.

2.8.3 Interview Schedule

The researcher developed the interview schedule (Appendix I) by brainstorming a list of questions from the areas of interest and referring to related research (Smith, 1995). To start, the researcher asked basic questions and provided contextual information about the research to build trust and rapport, which was a key component of the schedule (Reinharz,1993). The main interview schedule covered three parts. The first part included questions about MFLs' conceptualisation of mental health. The second part included questions about MFLs' experiences of providing support. The final part included questions regarding MFLs' experiences of engaging

with mainstream services. The consultant and supervisory team reviewed this schedule to ensure it aligned to the research aims and questions. The schedule was reviewed again and updated after the pilot interview.

2.8.4 Pilot Interview

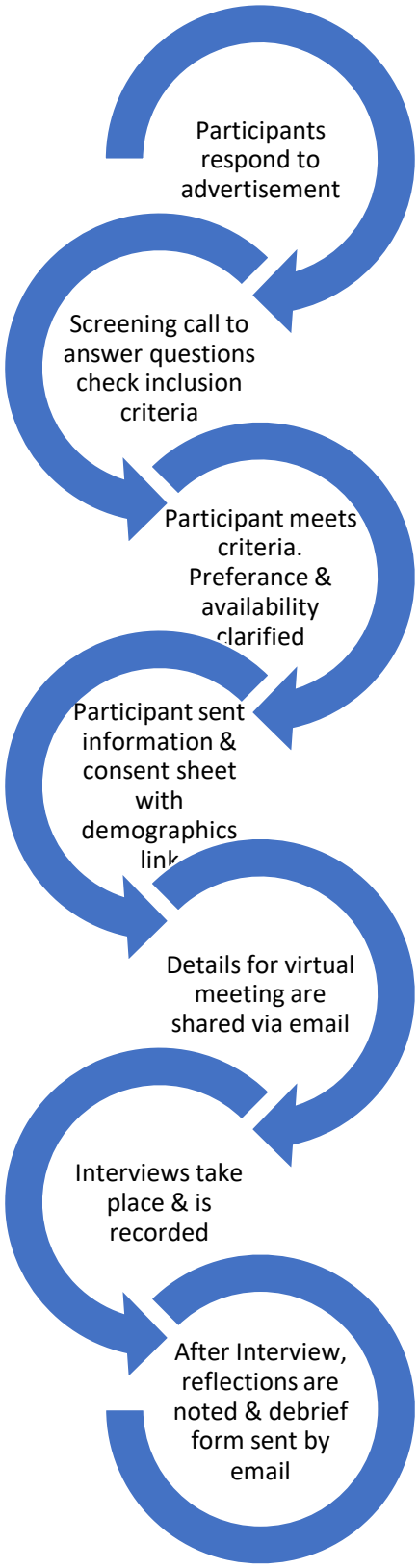
The researcher conducted a pilot interview to test pre-interview procedures and the interview, as well as to receive feedback on the questions and experience of being interviewed. A MFL from the researcher's wider network took part in this pilot and the interview was treated as a real interview. The researcher and interviewee spent time reflecting on the interview and providing feedback. This pilot interview also provided an opportunity for the researcher to experience any preconceptions and biases included in the question wording or the style of interviewing. The researcher discussed suggestions emerging from the pilot interview in a consultant meeting, resulting in changes to question wording and ordering of the different parts of the interview. In the absence of substantial changes to the schedule, and given the richness of the data, this interview was included as data after re-checking consent with the interviewee.

2.9 Interview Procedure

First, participants were sent an information sheet with the consent form (Appendix H). All interviews were held over Zoom due to the COVID-19 pandemic and attention was given to ensure that interviews took place in a quiet confidential space. At the beginning of the interview, the researcher outlined the practicalities of conducting the interview virtually and what should be done in case of interruption or disconnection. The researcher discussed the context of the research and her personal connections to the topic and prompted participants throughout the

interview to elaborate on their responses. Before the end of each interview, the researcher checked no sections were outstanding and encouraged the participants to talk on areas they felt relevant. At the immediate conclusion of each interview the researcher recorded her reflections, paying particular attention to her own feelings and what stood out from that interview (Appendix K). The researcher sent participants a debrief form (Appendix J) with details on additional services and data processing. Figure 3 presents a summary of this procedure.

Figure 3: Flow chart of interview procedure



2.10 Data Recording and Transcription

The researcher used an encrypted dictaphone to audio record all interviews for transcription, which was done by the researcher and a professional transcriber (see 3.8.2). were audio recorded using an encrypted dictaphone. Audio recordings were either transcribed by the researcher or through the use of a professional transcriber, who signed a non-disclosure confidentiality agreement (Appendix L). The researcher verified the accuracy of the transcriptions by me cross-referencing against audio recordings.

2.11 Data analysis

The researcher used TA to analyse data in NVivo 12 software using an inductive method to align the coding to the data source itself rather than being informed by previous theoretical or thematic guides. The process of analysis fits with Braun and Clarke's (2006) six phases to TA though some flexibility was given to start coding before the completion of interviews to allow for consultative group guidance, an aspect to thematic analysis that is more aligned to Morgan & Nica's 'iterative thematic inquiry' (2020). An example of this coding and theme development process is shown in appendices N and O.

The phases of analysis were:

Phase 1: Data familiarisation

The researcher listened to audio recordings and read transcripts multiple times in a familiarisation process. While reading transcripts, the researcher made annotations and kept memos to record particular points of interest in each interview. The transcripts, annotations, and memos were then transferred to NVivo 12 for further familiarisation.

Phase 2: Generating initial codes

The coding process involved going through all 13 transcripts using NVivo and coding line-by-line. An example coded transcript is in Appendix M. The initial codes were shared with the consultant and supervisory team for feedback and to facilitate reflection on how the researcher's own biases might manifest in her choice of codes. Investigator triangulation (Foster, 2012) was employed to validate the codes and identify how another researcher might code the same transcript extracts. The initial codes and style of coding were then discussed in a consultant meeting, which was particularly beneficial for discussing specific transcript extracts the researcher found challenging to code and sharing views on the credibility of the coding (Tracy, 2010).

Phase 3: Searching for themes

The next phase involved investigating the data from a broader thematic level (Braun & Clarke, 2006). The researcher used mind maps (Appendix N) to rigorously sort and experiment with different ways of grouping the codes to highlight potential relationships among these. This was an experimental and iterative process during which different themes were discarded, merged, or sorted into subordinate or superordinate themes. Inductive coding and theming mitigated the potential influence of pre-existing ideas or expectations within the literature. An initial thematic map of the themes and subthemes is presented in Appendix O.

Phase 4: Reviewing Themes

Over time, consistent themes and narratives were constructed from the data. The researcher reviewed potential themes against collated extracts (per Braun & Clarke, 2006) to create a

coherent and meaningful pattern and ensure themes were distinct. Following this, individual themes were validated against the entire data set. Following discussion with the consultant and supervisory team and agreement, the researcher finalised the overarching themes.

Phase 5: Defining and naming themes

The researcher and consultant team defined and refined themes to ensure the essence of each theme reflected the data (Braun & Clarke, 2006). This involved organising extracts for each theme into a 'coherent and internally consistent account' (Braun & Clarke, 2006). The final thematic map following this process is included in Chapter 4 and Appendix P.

Phase 6: Reporting

To construct a clear narrative of the themes and sub-themes, the researcher took time to discuss and reflect on my own position and understanding in relation to the chosen themes with the consultant and supervisory team. Braun and Clarke (2006) highlight the danger of simply paraphrasing a collection of extracts with no coherent analytic narrative, so the consideration of themes within the overall narrative played an important role in ensuring the report presented a concise, logical and rich story, which captures the majority of the data collected.

2.12 Quality, Validity and Self-Reflexivity

2.12.1 Assessing the quality of the current research project

The researcher assessed the quality of this project using the Eight "Big-Tent" criteria for Excellent Qualitative research (Tracy, 2010, see also Appendix A). Although the criteria used in

the systematic literature review allows for the consolidation of quantitative and qualitative methods, the current project is exclusively qualitative, so a focused set of criteria is more appropriate. Chapter 5 provides full details of the review of this research against these quality markers.

2.12.2 Self-Reflexivity

My own experiences will likely have influenced my own approach towards the research topic. This can be seen as a strength of the current study, in that it ensured I was able to build rapport and trust with participants, enabling them to speak openly about highly sensitive topics including Islamophobia. However, it was important to remain mindful of where it might impair the research and be transparent about research decisions and processes. As addressed in section 1.2.3, I recorded my reflections throughout the project in a research diary (Appendix K). In being transparent and by adopting various reflexive practices, I have tried to bracket and remain constantly reflexive to my own unconscious biases that may impact analysis and interpretation. The consultant and supervisory team also played a large role in how I maintained reflexivity throughout the research process, for example, noticing when I would try to communicate core Islamic ideas, within psychological frameworks, such as the belief of Jinn influence, to my mixed Muslim and Non-Muslim consultant team. This led to rich discussions, considering my own position to the topic and risks, given the UK context which views Islamic identity and beliefs as an ideological threat.

Chapter 3: Analysis

3.1 Overview

This chapter presents the analysis from thirteen interviews. Four main themes were constructed through TA relating to MFLs experiences providing mental health support: *an approach grounded in the Islamic worldview; a complex negotiation; barriers, stigma and resistance to accessing support,* and; *working under the shadow of Islamophobia*. Each theme comprises several subthemes, discussed in detail in this chapter with quotations from transcripts. The selection of quotes offering insight into these themes and subthemes is done with careful consideration, and in some instance is necessary to omit extracts in the interview data for brevity[6]. These themes reflect those experiences most commonly shared among MFLs, rather than a comprehensive account of every experience shared in interviews.

[6] An ellipsis within parentheses, i.e. (..), denotes where words or sentences are omitted.

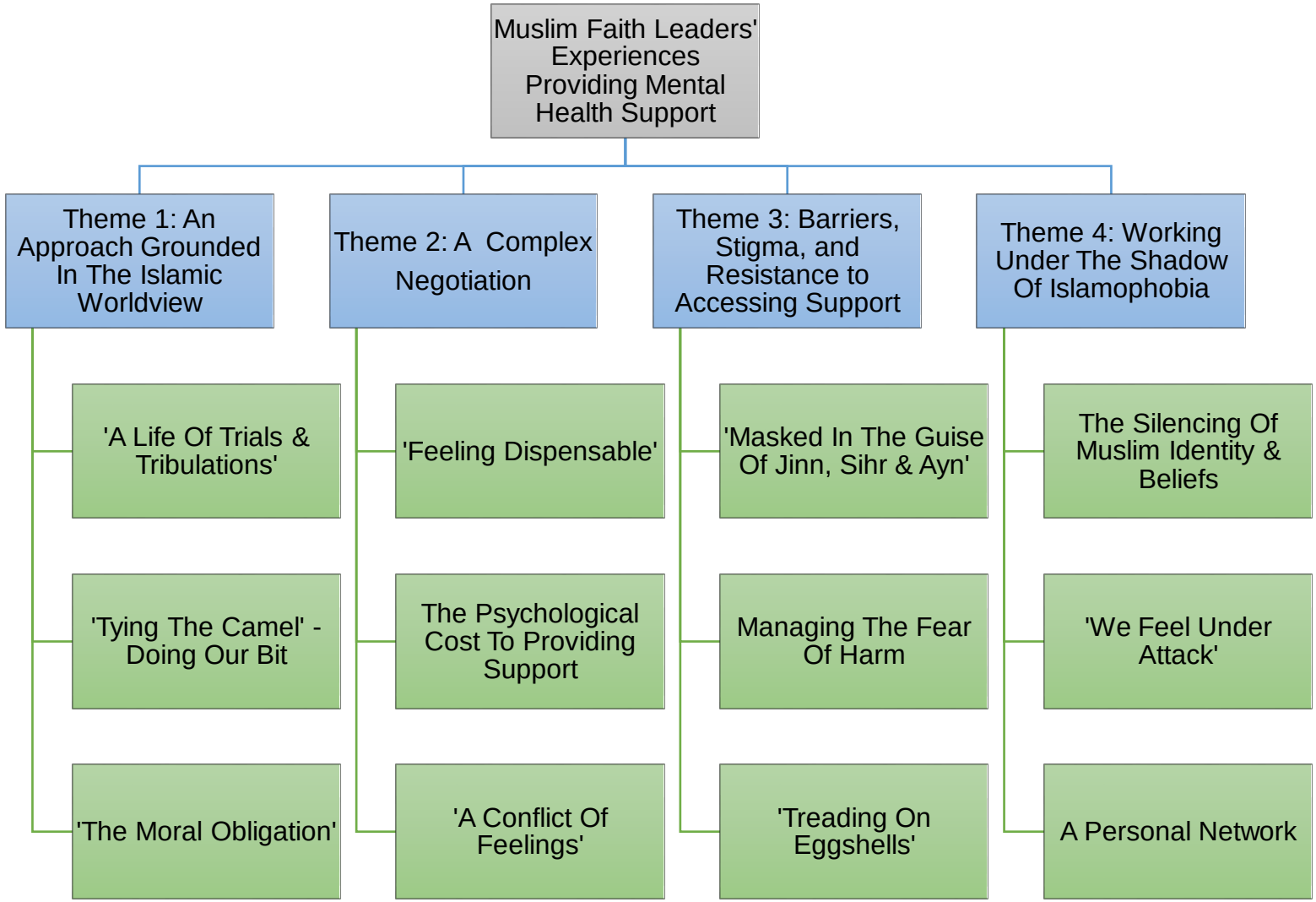


Figure 4: Themes and subthemes for participants' experiences providing mental health support.

3.2 Theme 1: An Approach Grounded in The Islamic Worldview

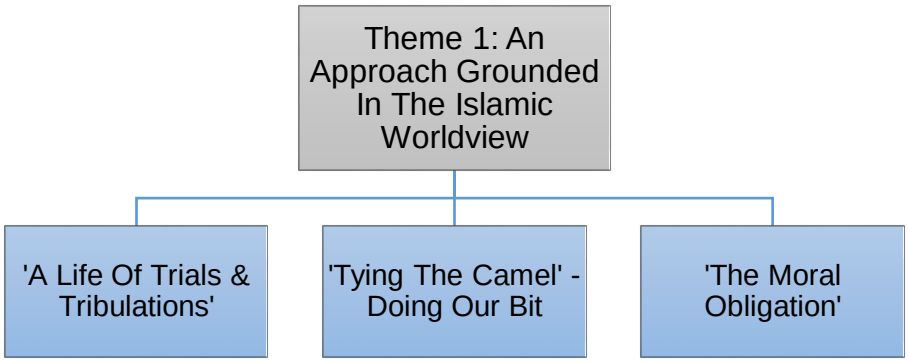


Figure 5: Theme 1: An Approach Grounded In The Islamic Worldview

This theme captures how participants conceptualise and understand mental health difficulties and their resolution, and how they understand their roles, which they describe as rooted in their Islamic worldview. Participants interpret this Islamic worldview from multiple perspectives, which their unique historical and cultural contexts influence. At its essence, the core aspect of the Muslim Worldview is submitting to Allah through what He has revealed in the Quran, and through His teachings given to the messenger; the prophet Muhammed (PBUH). Given that Islam is considered ‘a way of life’ it guides its followers in all aspects including how Muslims relate to their own mental wellbeing. Islamically, mental health is viewed as a holistic concept bringing together the mind, body, and soul. A potential clash of worldviews with western, secular approaches is highlighted by participants in that life, from the Muslim Worldview, is regarded as one of trials and tribulations and not for the pursuit of happiness and with wellbeing being viewed as a collective responsibility rather than individual. Participants make numerous references to the central role of fate in relation to tests and trials an individual faces, but also to each person’s obligation to seek help utilising a both/and approach to fate and personal agency, rather than either/or. Further, in this Muslim worldview, MFLs and their caring roles are perceived as obligations primarily understood as connecting people to those aspects of the faith that support wellbeing.

3.2.1 'A Life of Trials & Tribulations'

The title of this subtheme directly reflects phrasing participants use to articulate the Islamic worldview which conceptualises life as temporary and a test. All participants spoke about how Allah tests followers to prepare them for the eternal hereafter for several reasons, including as a way to return to worshipping Allah, to purify, to protect from a greater misfortune, to strengthen faith, and as a way that Allah shows His love to elevate believers' status. Participants articulate this through references to scriptures[7].

All participants refer to this Islamic perspective of life being a test:

> *Ibrahim*[8]*: "The Quran constantly repeats to have patience and this world is a very temporary life (...), the Quran actually says that Allah has designed the world as a place of suffering. So, if you are hoping to have that Utopian society, it's not going to happen because that's not the way the world is designed from the Islamic perspective.*

Participants describe having this perspective as enabling a source of comfort for those seeking support from them, as well as how they themselves understood their own challenges:

> *Ihsaan: "We view this world as being something temporary and it's kind of the lowest place in existence. It's an abode of tribulation and (...) was never meant to be a utopia for anybody. Having that kind of knowledge really saved me from*

[7] *An example of a reference used by participants to explain trials and tribulations – 'To each of you We have ordained a code of law and a way of life. If Allah had willed, He would have made you one community, but His Will is to test you with what He has given you. So compete with one another in doing good. To Allah you will all return'.(Quran 5:48)*

[8] *All names reflect pseudonyms given to participant due to anonymity and as described in Chapter 2.*

having a crisis. I could have had a mental health crisis myself because of all of these issues. But kind of putting things into perspective, having that kind of knowledge (…) really helped, it's a place of heartbreak"

Many participants also referred to a potential clash of worldviews when receiving support from Western secular orientated services and how a lack of understanding regarding the Muslims 'purpose of life' may prove incongruent to fundamental beliefs that Muslims hold, as described by Noah;

Noah: "The problem is, (…) you were trying to help them to live a life where, you know, they feel happy and content etc, but you know, from the Muslim perspective, you cannot acquire happiness in this life. This life hasn't been created for happiness. This life is a test. I truly believe one of the problems in the West is that we are teaching people to seek happiness in this life rather than teaching them to live for a higher purpose, you know?"

Noah goes on to emphasise this contrast in worldviews. He describes how viewing life as a series of trials and tribulations indicates a spiritually well-connected person, whereas a secular Western view would characterise this as symptomatic of being psychologically unwell:

Noah: When you read some of the biographies of the early scholars and spiritual masters of Islam, you find that (…) if we were to clinically assess them today, they would perhaps be diagnosed with clinical depression. Some of them would cry the nights, wouldn't touch food for long periods and feared

> *for what's coming in the akhirah[9] and for us we'd say that's a good thing (…) But today we'll be told, no, this person suffering from depression, suffering from (…) mental health. It is a modern Western approach to understanding ailments of the spiritual side, you know, the soul in the heart. But the Western approach today is an approach which doesn't recognise spirituality as it isn't proved with evidence.*

Thus, this view of living for a higher purpose often manifests in participants providing support. In their view, reminding and reconnecting people to their understanding of fate and the temporary nature of the world is crucial for people to making sense of and normalise difficulties. Participants describe the level of awareness towards these matters as often a barrier for people contextualising their difficulties in relation to others and to their faith:

> *Adam: From a mental health perspective, people always feel they are not in control of their lives, and the reality is no one is in control of their lives. They think that it's only them and that there must be something wrong with them. And when they see people who are successful, those people have somehow harnessed the world and everything around them to their own ends, which isn't the case. And when they feel powerless, they feel that they are weak. Then they think that they are deficient because an illusion is sold to them that you control your own fate. No one controls their own fate.*

[9] *Aakirah meaning Hereafter*

Participants frequently raise this perspective as helpful in how participants challenge self-blame and negative self-perceptions, as mental health is seen as one of life's trials, as Aisha highlights:

> *Aisha: If you are going through something, it's not necessarily a reflection on you as a person, but rather, it could be, for example, that test and it could be because...Because often when we think of tests and trials we just think, maybe family issues and all of that, but also mental health itself.*

3.2.2 'Tying the Camel' – Doing our bit

The Islamic saying 'Tying the camel' comes directly from prophetic teachings[10] and is used here as a metaphor to describe how participants' emphasise supporting people to utilise their own personal agency to access available support. Several participants describe having to challenge ideas of fate in people they support to not only encourage trusting Allah, but also because striving for your own wellbeing and recovery aligns with Islamic guidance. This is an important consideration that participants offer as a potential resolution to the clash between Islamic and secular Western by acknowledging personal responsibility:

> *Ihsaan: Because the whole point is preserving this person's well-being. You'll find, for example, if you read many of the prophetic traditions, many supplications like, oh, God Almighty, I ask you for well-being, Al-Aafia (Wellbeing), well-being in this world and wellbeing in the afterlife. Wellbeing*

[10] *Tying the camel is a reference to a saying of the prophet - One day Prophet Muhammad (PBUH) noticed a Bedouin (a nomadic Arab of the desert) leaving his camel without tying it. He asked the Bedouin, "Why don't you tie down your camel?" The Bedouin answered, "I placed my trust in Allah." At that, the Prophet (PBUH) said, "Tie your camel and place your trust in Allah" (Hadith Book – Tirmidhi, Hadith No; 2517)*

here is inclusive of, you know, mental health and all the other types of health. So, it's very it's taken very, very seriously. And it's something that that's really, really important.

Several participants also refer to the need for individuals to prioritise mental wellbeing, which if neglected, can undermine spiritual connections and religious practices. This quote represents a good example of participants' accounts of the reciprocal connection between spirituality and mental health:

Ibrahim: We are instructed by God to use our mind, anything that we do it has to come from a sound mind. And I think the well-being of your mental health would definitely affect your level of religiosity as well.

Some participants also call for balanced appreciation of spiritual and physical illnesses to align with the Islamic holistic view of the connection between mind and body:

Idris: We need to feed the soul as much as we are feeding the body. We need to feed the mind as much as we are feeding the stomach. We need to make sure that we worry about our spirituality as much as we are worried about our physicality (...) it's the same thing.

When talking about a person's relationship with bettering their own mental health, the concepts of strength and resilience imply a more collectivist understanding that incorporates patience and interdependence:

Muhammed: It is a person being able to deal with the challenges that Allah (SWT[11]) or what life sends us and to be able to still pull through that, to be able to still be strong enough to pull through those hardships or challenges that we have as a person (…) because of this Islamic heritage that we have that helps us deal with challenges from Allah. we came and to him we return, it was written by Allah, and so it is going to happen. Those help us pull through to an extent.

Aisha: So, I find it always goes down that route, where you're basically giving them that comfort and support but also telling them go and seek help. And that's actually you taking the means that Allah has provided to you.

Other participants perceive wellbeing to be a communal obligation, emphasising the collective social responsibility to preserve mental health. Participants refer to these as fundamental aspects of the Shariah[12]:

Ihsaan: Islamically we have the concept of wellbeing known as Al-Aafia, which is general wellbeing, it's something that plays a huge role in the Islamic tradition and also the Islamic injunctions. If you read the objectives of the Shariah one of the main ideas is about people's wellbeing Al-Aql, which means their sanity. So Islamically the concept of wellbeing, especially when it comes to a person's health, their mental health included, and preserving their mental

[11] *When writing the name of God (Allah), Muslims often follow it with the abbreviation "SWT," which stands for the Arabic words "Subhanahu wa ta'ala." Muslims use these or similar words to glorify God when mentioning his name.*

[12] *Shariah is derived from both the Quran & Hadith (Prophetic teachings). Shariah literally means "the clear, well-trodden path to water". Shariah acts as a code for living that all Muslims should adhere to, including prayers, fasting and donations to the poor.*

well-being is something which is considered to be a maqsad (objective), one of the reasons as to why the Shariah even exists.

As Islam is not a monolith, with many strands and different schools of thought, participants note variations in how much importance different cultures ascribe to exploring spiritual and mental wellbeing. They describe some communities (characterised by the Sufi movement[13]) as regarding attention to mental wellbeing as a fundamental part of worship, whilst other communities (Sunni communities within the South Asia region) place more emphasis on physical actions for religious obligations. Participants regard this as an important consideration as it often informs the level of concern different communities place on how to achieve wellbeing, striving for tranquillity, and purification of the self.

Yacoub: So, if you look at the whole Sufi genre, under the banner of Ihsaan (Spiritual excellence) or Akhlaq (Virtues or mannerism), you will find that a lot of it is about understanding anger, understanding sadness, understanding grief, understanding jealousy, understanding these kinds of things, you know, and then learning how to overcome them, right. So, if a person from a spiritual point of view is spiritually self-aware, then they are concerned about the level of their anger, they're concerned about the level of their anxiety, they're concerned about their mental equilibrium because they associate that with their ability to fulfil their religious obligations. To them, lowering your anger is a religious obligation, right because Allah criticizes it. To them raising the

[13] *Sufism, is mysticism in Islam, characterized by particular values, ritual practices, doctrines, and institutions. One definition relates Sufism to the inward dimension of Islam. Sufism is popular in such African countries as Egypt, Tunisia, Algeria, Morocco, and Senegal, where it is seen as a mystical expression of Islam.*

level of your generosity or the level of your compassion is an obligation. It's an obligation because Allah commands it.

3.2.3 'The Moral Obligation'

This subtheme describes participants' sharing of the dual nature of their roles, as both a responsibility and privilege, which they often associate with a sense of obligation towards Allah. Many participants speak of supporting people as fulfilling their own duties towards their community:

Ibrahim: I do feel a sense of responsibility, I suppose it's like a privilege as well where they are actually coming to an Imam and I'm able to be in that position. So, I suppose it's both, for me, it's a privilege as well as a sense of responsibility.

Several participants refer to this responsibility as part of building strong connections with their communities:

Daniyal: I should have a strong bond with my communities, that's how I look at it. So, I believe that, you know, I'm responsible for my community. This is how I look at myself. I'm responsible, you know, for their wellbeing.

Fatima describes her understanding differently to other participants, seeing it as 'Allah's work' and part of her fate. In her view this requires pure intentions, possibly with different implications to the way she provides support.

> *Fatima: Those people that come to me for help, it is because Allah has put me, there is nothing to do with me, so Allah knows that through me this person will get help and all I have to do is make sure I've got the right intention. I have to be in the right mind. I have to purify myself to be able to be doing Allah's work.*

Most participants consider their role as both a duty and a privilege, despite feeling obligated to support people:

> *Yacoub: So, for me, I see it as a duty and therefore, you know, being able to do duties is always a privilege. And people who come to you for help are giving you the opportunity to do your job.*

Several participants identify reward from Allah as a motivation for their work:

> *Nusaybah: We know from Allah that if you're helping somebody, that there is a reward for that and being with the oppressed. Obviously, there's such a greater level of reward. And I think that's the motivation that we have as Muslims to be conscious of that.*

Others speak of an intrinsic motivation driven by the happiness they experience in the support they provide.

> *Daniyal: So, I believe the reason why I'm happy is because I'm trying to help other people and that's what I believe in. I believe that as long as I help*

> *people, I don't really know... Money; it doesn't always bring happiness. What's bringing happiness to me is because I always try to help people. This is what I believe in and, alhamdulillah[14], it's working for me but that's also motivating me as well.*

Some participants also regard their obligations as worship and consider the monetary payment as an additional benefit to an already fulfilling job.

> *Adam: An Imam is a very fortunate person. In respect of him being paid to perform his obligations, it's an obligation to rewards you for and then you're paid also and rewarded monetarily to fulfil. So, it's an incredibly fulfilling job. Incredibly, I can't even express how fulfilling is. There are difficulties, no doubt about that.*

Yacoub shares his views of people trained as MFL who take on other roles for financial security, and the sense of duty to serve the community he feels comes with the role:

> *Yacoub: So, there are big questions around what is the purpose of an Imam, right? And I have very strong views about that, right. And I believe that people who study and train in seminaries are different from people who study at a university or other higher education institution and that they are duty-bound to serve. Yeah? And a lot of people end up not serving because of financial*

[14] Arabic phrase meaning "praise be to God", sometimes translated as "thank God".

issues, because of just the nature of modern living and so on. But for me, they are duty-bound.

Participants also reflect on the use of Quranic and Prophetic text in the support they give to people. Participants consider referencing Islamic text as the very reason people request support from an MFL as it connects them to their faith during difficult times:

Zayd: So, it does have an overwhelming impact upon us being Imams. We hold the knowledge to what Allah says in the Quran and what the prophet Muhammad says. Obviously as Muslims, we believe that Islam is not just a creed, or a system of belief, it is a complete way of life. So, the prophet Muhammad taught us everything that we know or need to know to basically navigate in this world. So, we use the verses that talk about mental health, the prophetic sayings that talk about mental health.

Overall, participants consider their MFL roles as a moral obligation, a privilege, and a responsibility. Some discuss the rewarding nature of the role as an act of worship, whilst others highlight the moral obligation and duty towards Allah and their communities, and Islamic teachings as the basis for the support they provide.

3.3 Theme 2: A Complex Negotiation

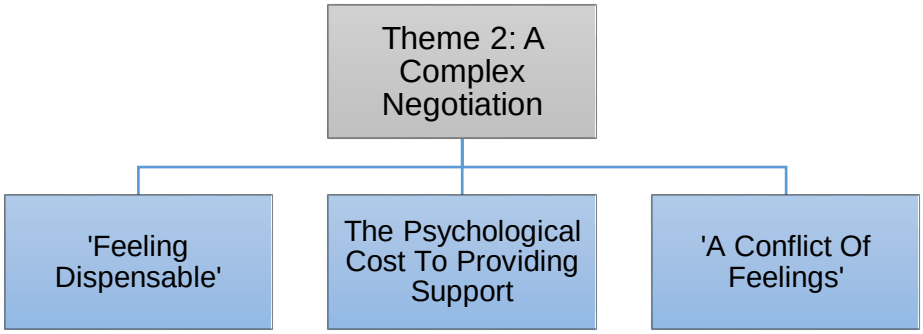


Figure 6: Theme 2: A Complex Negotiation

This theme reflects many participant accounts of the overwhelming nature of their roles as MFLs, and how they negotiate the complexities, finding balance between fulfilling their roles and managing the impact the role has on them. Each subtheme represents different MFL accounts of both the financial and psychological impact, and the internal reluctance many MFLs report experiencing when asked to support people with mental health difficulties.

3.3.1 ‘Feeling Dispensable’

All participants mention the financial cost of being an MFL, which leads to feeling unsupported or undervalued. Many accounts reflect needing to resist inequality but also being conscious of financial implications given the precarious nature of their employment. Many participants report a fear that they may lose their job, and recognise the power and inequality they face from employers and from a lack of recognition from the government and Muslim communities:

> *Noah: A friend of mine, he was being paid £1,200 a month after tax and he was working six days a week (...), didn't have a holiday for about two and a half years. And they just fired him, you know, a few months ago due to the whole Covid situation (...), but the way that they treated him was, you know, was horrific (...) it's a culture of our community. Then when lockdown began, no furlough, no pay. Just said, you know, we will see you later because we're not going to pay you because we're closing and we're not getting any money (...) We're paying cash in hand, you know, so it's just dispensable, basically.*

MFLs working in chaplaincy positions within the NHS share this feeling of injustice and inequality:

> *Fatima: So, when there is a need, they will call me out. Again, there's no payment for being on call, you only get the call out because you're employed on a zero-hour contract. So, because that's a different contract, you can't really challenge it. So, when you come in you get paid, if you don't come in you don't get paid. So, like I said, right from the beginning of this interview, I have to work with four organisations and I'm still not full time. Yeah and that's tiring, that's me working four times as hard as everybody else because you're not working for one organisation.*

The perception of 'being servants of God' is present in several accounts to explain why many MFLs resist speaking out against financial abuse. The account below represents complex negotiations participants report when considering the risk of being replaced by MFLs from overseas, who may be unaware of working regulations and vulnerable to exploitation:

> *Yunus: There are also many financial challenges for Imams (...) but we were trained thinking we are now servants of God, we don't need anything. Its financial abuse, how they control people have controlled a lot of the Imams, a lot of the Imams who came in from the subcontinent, on work permits, for the next five years, they just have to do whatever they're told, and the lucky ones will probably get the nice management committee to manage them, but the others they would have to go through a lot of trauma and you know, challenge themselves, but they will probably resist the temptation to speak out simply because if they tow the line, what if they lose their job or if the family would get sick. (...) many management committees are expecting them to get paid £100, £50 a week, it's very challenging for Imams and then expecting them to be ready, to do whatever they want 24/7, it's unrealistic.*

MFLs describe the financial challenges as resulting from a lack of recognition from the government in the preventative input MFLs make to mental health within communities:

> *Muhammed: But let's be frank, the vast majority of the Mosques are very, very small organisations, charities, that can barely make ends meet. Is it going to happen for them? (when speaking about equal pay) No. Should the government step in? Yes, because we're saving you from picking up a mess five years down the road. Prevention is better than cure, isn't it? You're going to be ending up paying a lot more if you don't deal with it. And we work as volunteers. We're not going to get paid as doctors and mental health professionals do.*

MFLs see financial support and recognition for their as crucial for developing the full potential of Islamic approaches to wellbeing, but that the current lack of these factors acts as a barrier:

> *Yacoub: So, how do we pay for it? (…) and if we can't pay for them ourselves, how do we make sure that the government pays for them? You know, developing an Islamic counseling model that is acknowledged by the state, that the state is willing to pay for. Because at the end of the day, it saves the NHS millions of pounds when a faith leader is able to deal with a person's mental health problems (…) we are citizens of this country and it's important that the government recognizes that and gives us fit for purpose solutions (…) So, for example, the Muslim charity sector, involves Imams. The Imams: they're kind of semi-voluntary people who are kind of third sector employees as well, right. And the government verbally acknowledges that they are an asset and a resource but doesn't provide any kind of support, right, infrastructural support.*

Given these challenges and the lack of support more generally, many participants need to make tough decisions to prevent the closing down of vital services within the community, despite the personal impact:

> *Daniyal: But unfortunately, because they are a private institute, they were struggling financially, and so now they can't pay me, and I can't even demand anything from them as well because they're on the brink of closing down. So*

> *that one sacrifice made me a strong person. It was either walk away or either stay there, try to help them. And I did stay there and tried to help them much as I can but it has affected me psychologically, massively. You know, that I've said to you many, many months where I didn't know what to do. You know, my wallet was empty, my bank was empty, you know, and I live in England, so it's very difficult. And I've got family to look after as well. I've got bills to pay. So, I went into debt, okay, knowing that Insha'Allah, time will come when I could pay all those people back, which I have, by the way.*

As these accounts indicate, being an Imam in a society that does not hold the same Muslim values is challenging. Due to a lack of financial and structural support, participants try to provide support in line with an Islamic worldview while living in a society that requires an amount of wealth to get by, which leaves them open to exploitation. These challenges allude to the reasons why participants describe feeling dispensable, whilst also evidencing the real strength MFLs demonstrate in holding onto their values; these challenges may be their test and so they may make sacrifices because they believe it is the right thing to do for their communities, employers, society, and themselves.

3.3.2 The Psychological Cost of Providing Support

Alongside financial challenges, all participants refer to the psychological cost and vicarious impact they experience in their roles without adequate support. Participants provide many reasons for the psychological impact, consequences of which include triggering own trauma and experiencing vicarious trauma:

Daniyal: I think many times it really affected me (...). For example, marriage problems have affected me. A lot of people are coming and (...) speaking to me about how abused they are and the fact that they are not being treated properly. This has affected me massively, you know.....there are times where I came home and I was all in tears, to be honest with you. Because I just said to my wife, I'm sorry, but I just had a horrible, horrible session with a sister.

Yunus: (...) So, when I hear somebody else's triggers my own lived experience, and you feel that you know, you don't help somebody at a critical juncture, and it's going to happen, then it might be a burden on my moral conscience, it's a difficult one, it's not easy.

Participants overwhelmingly report the vicarious impact that addressing issues of gender and power has on them, particularly with women experiencing domestic abuse. Participants acknowledge this as a primary area of support they provide, and that those seeking help generally are women:

Daniyal: She's been domestically abused and physically abused, mentally abused, and stuff like that. And the saddest thing is that she was divorced when she was pregnant as well. So, imagine how I felt. So yeah, you know, because I'm a human being. But at that time, I tried to show a face but she knew that her story is so strong and powerful where it has affected me as well. So, I wouldn't say that it didn't affect me, I think it has affected me but I still believe that I have to listen to her. I still believe that I have to be strong and let her

finish and find some words to give her some comfort. Otherwise, imagine I go out of the room crying, she goes crying, we haven't solved any problems here.

Some participants describe concern for the long-term personal impact of addressing abuse and supporting victims:

Noah: You know, a few weeks ago I was watching the news in the morning and an advert came on NSPCC about child abuse. And I don't know why I felt so sensitive. I just it hit me so hard. And, you know, I like I thought I think I'm a lot more sensitive to these things, just, you know, knowing that this is a reality is taking place and definitely it's the case. One of the challenges of being an Imam is remaining positive. You know, it's very, very difficult.

Ibrahim: So firstly, I'm worried about myself and that the whole point of mental health wellbeing awareness is for myself, is that I'm worried about myself. I'm worried about things that have not been addressed, not talked about, and things like that.

Participants also express the need to deal with the consequences of exposure to various forms of violence, including but not limited to domestic and gender-based abuse. Ibrahim, a prison chaplain, describes his traumatic experience:

Ibrahim: I've had huge personal experiences of trauma from the prison service. And I feel I haven't addressed it properly, I don't know what you call them, but regularly have, not flashbacks, but I have a panic moment when I

> *hear feet rustling (…) it really makes me anxious, really scared….and like I freeze. It's a trauma that needs to be addressed. So that rustling noise usually happens before a fight happens in Jummah (Friday prayers) in prison. There's no noise and it's a quick rustle and then you turn around and it's about three against four, and it's quite violent (…), So I'm just worried that, if a noise can really affect me that much, then there might be certain other things, which will affect me later on in life.*

While most MFLs feel that "*giving concern to your own mental health" (Aisha),* is important and necessary and prioritise this, some indicate they "*don't know how to manage it" (Ibrahim)…,* and a few reject this as a priority to avoid being "*another person asking for help" (Yunus).* Many participants also refer to the emotional aspect of the traumatic impact, and a lack of coping resources. Some accounts refer to a need for training, either in Islamic counselling training or a Western diagnostic approach, which they believe would protect them from this impact:

> *Ibrahim: we're human beings and Imams without sort of that professional training, maybe once you get that training, then maybe there are ways of fighting that (…)And so this sister that I was telling you about; I remember I couldn't when she told me that her husband beats her, that night I couldn't sleep, I was literally just hurt, she opened up to me confidentially and you know, what do I do? So, it's like; it's kind of hard, it does affect you emotionally, it definitely it does.*

3.3.3 'A Conflict of Feelings'

This subtheme captures the internal conflict participants experience because of the challenges of being an MFL, and their hesitations with dealing with mental health difficulties. Due to the moral obligation participant perceive, they report a struggle negotiating their commitment to the role with feeling unqualified or untrained in either Islamic or secular Western counselling approaches, and an awareness that role constraints limit the input they provide. Participants note the way these contrasting worldviews inform their roles as an added complexity. Although MFLs and MHP both work to alleviate distress in the people they support, they differ in the concern they may hold about a person's connection and responsibilities to Allah, and the extent to which they encourage people to fulfil their role as Muslims and abide by Islamic teachings. Participants express mutual trust and training between MFLs and MHPs as critical to address this challenge.

Muhammed describes the stress MFLs experience from having inadequate training to support mental health difficulties, and the reluctance some MFLs feel towards providing this support:

> *Muhammed: Awkward. I don't want to do it, don't feel qualified, stresses me out because I don't know if I am saying the right thing. And I try to avoid it as much as possible. I just try and get them to the doctor, the medical professionals (...) That's what I try and do, as minimum as possible because I don't want to cause damage.*

Many participants relate their reluctance to their training, and report managing this by limiting support to generic guidance, which gives them a sense of safety:

> *Yacoub: But, you know, but I'll be the first to admit that, by definition, it's very instructive because I'm not a counsellor. I'm not a therapist. A lot of it is instructing people on what I think on some of the generic things that they should do. And I suppose the more mental health gets attention and we realise that there is a need to be trained, I suppose the more people like myself will feel the need to be generic because there's a kind of safety in that. I don't know that everybody will do that but I certainly feel the need to be as generic as I can and advise people to do things that they probably already know that they need to do. My job is just to redirect, re-emphasize, re-focus, that kind of thing.*

Participants also share an overwhelming sense that the current MFL training and government support fails to meet their training needs. This addresses a fundamental concern that MFL training focuses on Islamic jurisprudence rather than mental health support, which compromises their ability to be leaders in the community by neglecting a core feature of their role.

> *Yunus: As an Imam (...) we are repeatedly told we are the chosen ones who are going to be the inheritors of the leaders of the world and encouraging this type of passion that we are the saviours of the world. And yet when distressed we find, you cannot be distressed (...) I don't think Imams are trained, when Imams, as part of their job description, say we are also counselling people. They (Imams) might be giving fatwas (Islamic rulings) but I don't think that a lot of them understand what's really going on, all the dynamics that are involved.*

The formal and informal expectations and portrayal of what an MFL should do from Islamic institutes and their communities seems to cause a sense of guilt in many accounts, which describe the level of sacrifice required to meet these expectations as unachievable:

> *Noah: To some extent I feel guilty. You know, the fact that there was there is just so much that needs to be done and I don't feel that I'm doing enough, which I'm definitely not. A conflict of feelings you know, like the reality is, if you're going to deal with everything that needs to be dealt with within a community, you're not going to have a family life. You're not going to have time for much else. And so, yeah, it's very difficult*.

Despite this reluctance and conflict, participants report a desire to support people due to the complex nature of cases they hear and acknowledging that members of the community need to feel safe before disclosing.

> *Aisha: the scariest ones are when it's (...) sexual abuse, especially when it's from a family member or something like that. Those are the ones I'm really scared to...I just want to actually just say go to my teacher. But then I also realise that there's a reason why this sister felt safe enough to come to me and open up about that. I think it's because I don't know enough. And so, I have that fear that I don't want to make things worse because of my lack of knowledge.*

Participants are hesitant to decline requests for support, describing many consequences from doing so. One participant also describes wanting to isolate themselves from the community to

limit people's expectations of them. The complexity MFLs face is shown in the interaction between a desire to escape the responsibility, and an understanding that this difficult role is their life test and fits with their beliefs:

> *Zayd: There are times were I just feel like not going to the Masjid (Mosque) at all or going somewhere else where I wouldn't see people I know, or I would see people who know I'm an Imam. So, there's times where it's nice to be unknown, basically, so that you could kind of run away from those possibilities, which is not good. But, um. So, yes, this is a test from Allah that we just have to you know, we've taken the responsibility of going out there and studying the religion and coming back and trying to make a positive impact on society. And it's not something that we should give up, something that we just need to ask Allah for steadfastness and continuing.*

> *Ibrahim: But that's because they want that advice from me or that sort of uplifting from me. That's why I have to, you know, sort of, I can't say no, it's just a, I suppose, a moral responsibility that you have upon another human being.*

> *Yunus: Because I have seen people you know, who have committed suicide because they did not get the spiritual health they wanted at the time. And that kind of actually also rings on my conscience (...) and you feel that you know, you don't help somebody at a critical juncture, and it's going to happen, then it might be a burden on my moral conscience, it's a difficult one, it's not easy.*

Participants express additional conflicts when speaking about their worldview and the conflicting nature of an MFL role, which the aim for the pleasure of and reward from Allah, in addition to supporting their community in comparison to an MHP role, which aims solely to reduce distress:

> *Noah: There are so many issues that adds to the pressure, as a therapist, when someone comes to you, you know, your sole interest is to help them, to become happy. But as an Imam, your interest is that person's akhirah (hereafter). Happiness is a consequence of living a good life within the framework of Islam. But as a therapist, if a person shows that they're happy with certain things, your role is to try to aid them in, you know, arriving at that place, for example. So that's another challenge, you know, dealing with that.*

Some participant's descriptions indicate the need for an Islamic counselling approach that gives support compatible with Islamic guidance and teachings:

> *Ihsaan: As an Imam. I recognise that what people are taught in therapy isn't exactly what is being taught by an Imam. An Imam is supposed to take command of, especially in a situation where they see that this person could get themselves into a huge amount of trouble. There are issues, obviously, where you leave it to them.....Sometimes you do let them make their own decisions or you don't really infringe too much, but there are other times which I think this kind of goes against maybe what people are taught in counselling. And so, where the Imam feels like, OK, if this person does this, they're getting themselves into trouble. I feel like I should intervene in a way and not*

encourage them to go down that route. So I think that's something where there's an incompatibility.

Other participants call for greater collaboration between MHS and MFL to address both spiritual and mental health, offering an additional way to manage the challenges.

Daniyal: So, once we'll work together, I think people will have confidence, they will come forward, they will know that I've got both here. The medics are here, the faith leaders are here as well. So, I could get my deen (faith) and dunya (worldly concerns). Secondly, the Imams will feel comfortable talking to them, knowing that he's got the backing. Sometime the Imams are afraid they might give wrong advice. They could make a mistake, okay. And now this time they could work together. If there are certain question he can't answer, he's got someone accessible that he could talk to. So, it's going to bring nothing but good, in my opinion.

However, participants are apprehensive towards hopes for collaboration, considering the risk of a lack of recognition and respect, as Idris describes;

Idris: I think it's extremely important to have faith leaders and everybody else working together. But at the same time when we work together with psychologists, we need to make sure that we respect each other's opinions. And my psychologists, they are pretty cool. They understand where my boundaries and things I won't compromise on. So if we're going to work together, we need to ensure that we are respectful.

3.4 Theme 3: Barriers, Stigma and Resistance to Accessing Support

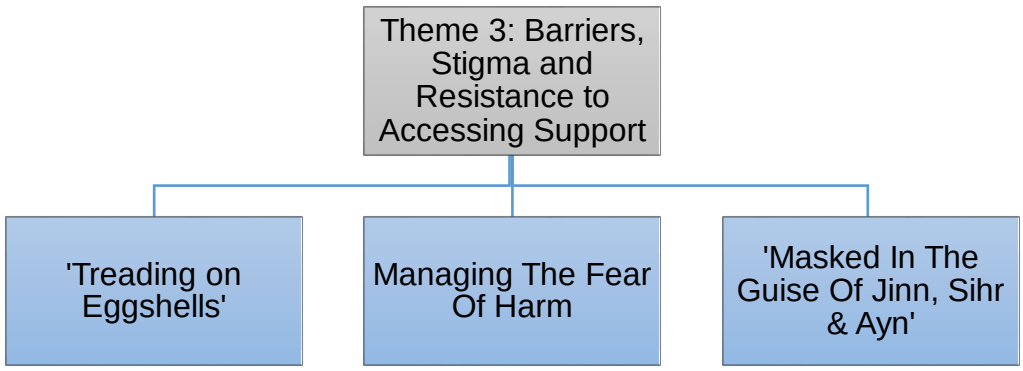


Figure 7: Theme 3: Barriers, Stigma and Resistance to Accessing Support

This theme explores many participants' reports of needing to encourage their communities to 'tie the camel' (see 3.2.2) to address their own mental health needs. MFLs describe mental health as often overlooked and unaddressed due to many barriers including stigma, people assuming a metaphysical cause to their difficulties rather than a psychological one, and community fear towards secular Western secular therapist and charlatan Ruqyah[15] healers. Participants describe the need to normalise and encourage help-seeking in their one-to-one support and regular sermons as an arduous task. This is met with resistance from community members due to the cultural and relational repercussions they associate with having a mental health diagnosis.

[15] *Ruqyah is when a person recites parts of the Quran or makes supplication using words transmitted from Hadith (teachings of the Prophet saw). Ruqyah is considered Quranic therapy for issues pertaining to the heart, mind, and soul, and used to treat metaphysical afflictions such as Sihr (Black Magic) Jinn (Possession) and Ayn (Evil Eye). Concerns exist for some people claiming to provide authentic Ruqyah, when actually charging extortionate amounts for innovated practices.*

3.4.1 'Treading on Eggshells'

In this subtheme, participants discuss their views and experiences managing the difficulties arising from the stigma of mental health difficulties, as Adam describes;

> *Adam: The problem is when people speak about mental health (...) you feel like you're treading on eggshells. Are we speaking about mental health disorders, or are we speaking about mental health itself and the state of the person's mental health and how healthy are they mentally?*

Many accounts describe a need for extreme sensitivity for fear of offending people by suggesting their difficulties may having psychological roots. The following account gives light to these experiences, with examples of the delicate approach they take:

> *Ihsaan: I forgot to mention the stigma that's attached. They feel like, if I go and seek help for this, it means that I have a mental health illness. And what would people think if they were to find out? Would my family think all my all my friends think so? That's preventing many people seeking help but going to the Imam is fine because everybody goes to the Imam, So, there's a disparity between the two. The stigma does exist very strong. I did even suggest that once and the person was offended for suggesting that he might have a problem or an issue. So (...) then I had to explain it in a different way which made the person understand, I would not say that you have issues or anything like that, just like, you know, services can be quite helpful, and I would make it so it's something very normal.*

For many, having a mental health difficulty has negative consequences, which participants understand as being the main reason for people's aversion and resistance;

> *Daniyal: There's a lot of people; Muslims are actually hiding their mental health difficulties. They don't want to talk about it. It's embarrassing for them because like I said to you, they believe it's a cultural baggage, oh so and so's going to say in that family, there's an individual, they got mental illness. It's going to stop them from progressing in marriage and stuff like that, you know. And I think, you know, how do you call it? many of the Imams, they don't want to take this on their board, like they've got no time.*

Consistent with other accounts, participants share concerns of needing to convince the people they support to take a dualistic approach, as some were restricting their avenues of support and only requesting input from secular Western MHSs as a last resort. The sensitive approach participants adopt is needed to manage the lack of formal process for people to access support, and because people can easily refuse advice and seek a more acceptable answer, in their opinion, elsewhere;

> *Aisha: I've had some students who have been going through certain things for years, and then they've gone to different people and they've tried different faith leaders. So, it's easier to convince them in a way, because it's like, look, you've tried everything, then what's the harm in trying this? And often they're at the end of their tether as well as in, they just feel tired now, but there's always a few that are a bit more stubborn and often those more stubborn ones actually, I*

> *would say that majority of them when I've mentioned going to a professional, they will basically just...they've come to you because they feel like you've got some sort of authority. But as soon as you say something they don't like then it's like, I'll go to another faith leader, that's it. So, it really depends on the person, some people are more forthcoming. Some people, they don't want to hear it, and probably take them another few years or something, or a few months or whatever it may be, hopefully until they realize that they can have that help.*

Participants make sense of this stigma of and resistance to accepting mental health difficulties in different ways, though many refer to the culture and influence of culturally familiar language in how people understand mental health difficulties, as Yacoub describes:

> *Yacoub: I don't think I have a theory on why that stigma is there other than to simply say that I don't think culturally we have any nuance in our understanding of mental health. So, something wrong with your mind is just, you know, in Bengali, it's just paglami, basically, you've gone mad and that lack of nuance regarding mental health creates the stigma. Nobody wants it to be known, to be known as a mad person. And so, all of the more subtle mental health issues are either brushed under the carpet or treated as you know, through jinn or some other kind of faith-based solution or intervention. Only the extreme cases of, you know, with people completely losing it and going into some kind of serious psychosis, only those types of problems are acknowledged as mental health problems.*

3.4.2 Managing the Fear of Harm

This subtheme captures participants' experience of an internal inertia when considering their own apprehensions and anxieties in referring to mainstream services and Ruqyah healers. Participants describe serious concerns that charlatan Ruqyah healers exploit people, and that secular Western MHPs undermine people's religious values and beliefs, making the task of encouraging their communities to seek professional help much harder. Participants fear rogue Raqi[16] practitioners can have long-lasting physical consequences, making people more unwell over time:

> *Nusaybah: And there's lots of rogue Raqis out there that could do more damage because that was one of my biggest fears that people are going online, getting all sorts of things and really making themselves sick.*

Many accounts refer to the contextual challenge of not having a statutory body governing and overseeing the Ruqyah healing practice, which participants report would likely reduce the risks these pose to people:

> *Yunus: I had a lady from the community who spent almost £3,000 on one spiritual Imam (…) he charges £4-500 for one consultation, and this is where I feel that the community are really being exploited. I think, ideally, if a statutory body could train up Imams who are willing to learn and are open to persuasion, then a statutory body should fund these type of Imams to do the*

[16] *The term 'Raqi' is used for an Islamic 'Spiritual **healer**'*

work that they expected to do, because a lot of the work, being done is when people call outside our normal working hours and some people don't have a problem charging X amount of fee but a conscious Imam would not ask for any money.

Due to these challenges many participants report a need to build trust with specific Ruqyah services, utilising a safer word-of-mouth approach before feeling comfortable to refer.

Yacoub: And Ruqyah is a really difficult thing to advise on, it's really difficult to refer people to a particular Ruqyah service provider because there's no regulated system. So, there isn't a kind of, a professional Ruqyah standard or anything like that. Everybody's doing their own thing. So, you only, effectively, if you've taken the risk to take somebody's help in the past and they turned out to be good, then you refer people to them saying, you know, like, my family's been through this, you know, I've been to that person before with something like that, which is quite arbitrary and subjective.

Participants also raise concerns towards mainstream services and secular Western therapists. These include concerns that the advice and support they give is not religiously informed, and may not align with the religious beliefs of the person seeking support:

Aisha: They feel like if they talk to their therapists, and they mention certain things they've gone through, then they have this fear that therapists will tell them, oh, you know, but you don't need to understand that along with your religion. And they have that fear that there'll be kind of encouraged or pushed

away from the religion and there's no background there, Islamic background so they have that fear.

Participants speaking from their own experience collaborating with non-Muslim MHPs regarding mainstream Muslim beliefs share these concerns. Yunus highlights the potential for people to receive advice that completely opposes their Muslim worldview:

Yunus: So in the end, after some weeks I spoke to another psychiatrist who was a non-Muslim and I asked her for some advice as to how I could maybe help a colleague who was a psychiatrist (and that person) actually said, "tell him not to believe in hell" and I responded by saying that I don't think that's going to work for a Muslim.

Participants also recognise that the fear and apprehension towards a secular approach that dismisses belief in supernatural forces may result in different explanations for the distress experienced. The sense-making of Muslims seeking help may not be fully acknowledged or supported, as NHS chaplain Fatima explains:

Fatima: And all you're putting it down to is hallucinations. So, in the end, because I don't really particularly get on, get along well with that consultant, I just took a sidestep, I thought you know what, you know best, I'll let you deal with it.

Idris, a prison chaplain, also describes needing to advocate for an alternative explanation, which is met with some resistance:

Idris: ...and second thing is that they're not open to Jinn influence and they're not open to black magic. Because they're not open to that discussion It's a bit harder. There is no religious side to them when they're speaking to someone, but there wouldn't be because the whole degree, not degree, the whole studies is based around atheism. It's got nothing to do religion.

3.4.3 'Masked in The Guise of Jinn, Sihr, Ayn'

Several participants discuss an additional factor affecting how likely people were to accept that they may be experiencing mental health difficulties, and that people often came requesting support to manage Jinn, Sihr, or Ayn[17]. Participants believe that a metaphysical explanation of their distress was a way to avoid the perceived repercussions of having a mental health diagnosis. Participants acknowledge that belief in Jinn, Sihr, and Ayn forms an article of faith within the Islamic creed. However, they felt a dichotomous approach was taken by community members who did not see seeking help from Ruqyah healers as well as MHPs as mutually exclusive, even at times assuming that seeking help from mainstream services as negating their trust in their fate and Islamic teachings as Aisha explains:

Aisha: We know in Islamic tradition there is such thing as sihr and ayn. But at the same time, because of that, there's people that they just go down that route. So, there was a student, it was very obvious that she was suffering from extreme anxiety. I told her, okay, it sounds like you're doing what you should be doing as a Muslim, you're seeking that help. Then I had to explain to her,

[17] *Sihr (Black Magic) Jinn influence (spirit) and Ayn (Evil Eye) describe afflictions of a metaphysical nature.*

> *it's time to go to a doctor and that doesn't contradict you relying and trusting in Allah and I find that I have to convince a lot of people even today. That's quite predominant where people feel like trusting in Allah and then going to a doctor, like a mental health professional is they're not...they can't be together.*

Many participants report their own struggles in trying to make sense of the aetiology between mental health difficulties and vulnerabilities to a metaphysical cause, noting that each can precede the other. However, participants typically report that many of the requests for support they receive are more likely a result of mental health difficulties than metaphysical causes.

> *Noah: I think many mental health issues within this community are masked in the guise of Ruqyah and magic and evil eye. There was a time in my life I felt quite sceptical about the word Jinn influence etc. and I would say I've seen cases where I would argue the person definitely has an issue related to Jinn influence, but you know, the vast majority, I would say are mental health issues related.*

Participants report this as a regular occurrence for most MFLs, and source of struggle in the way they have to resist people's aversion and hesitation and encourage acceptance of the possibility of a mental health difficulties:

> *Ihsaan: But they've been convinced that that's the case, one that actually maybe not the case. The vast majority of people coming to me that I've seen who want to Ruqyah, for example, as in reading Quran on them, they really*

were hesitant to even assume that what they're going through was a genuine mental health problem.

In summary, participants report having to commit a large part of their roles to managing people's reluctance and hesitation to access mainstream services due to the stigma and fear of harm from Ruqyah and psychological practitioners. Participants report people are more likely to manage these fears and anxieties through beliefs towards metaphysical causes such as Jinn, Sihr, and Ayn. Such beliefs provide a level of comfort because these demonstrate an Islamic approach to dealing with their distress, which people see as more culturally acceptable.

3.5 Theme 4: Working Under the Shadow of Islamophobia

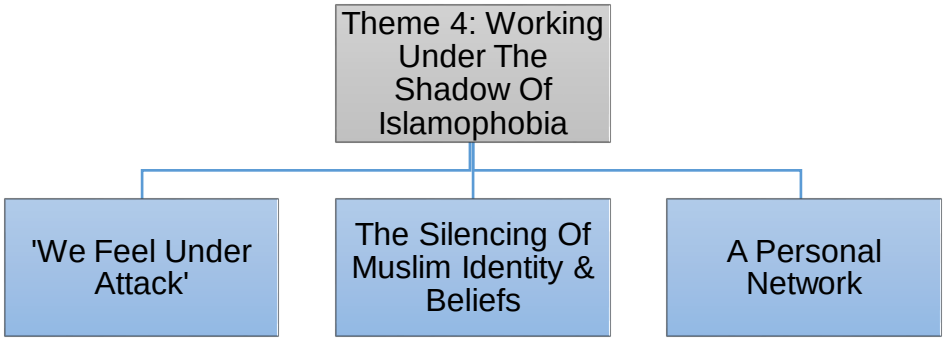


Figure 8: Theme 4: Working Under the Shadow of Islamophobia

This theme relates to powerful accounts of prevailing racism and Islamophobia, which add a further distressing obstruction in how participants conduct their roles. Participants describe having to navigate their own experiences along with supporting their communities regarding the impact of racism and Islamophobia. Participants reveal the extent of the struggle they experience abiding by 'acceptable speech', often informed through a secular Western anti-religious lens, resulting in participants self-censoring for fear of being maligned radical or extreme. Participants articulate this self-censorship affecting fundamental aspects of their Muslim identity. Subjects such as the belief in a heaven or hell, the belief in

Jinn, and considerations that come with a halal (lawful) and haram (unlawful) lifestyle are particularly contentious for participants, who report either avoiding talking about these altogether or making their message palatable to avoid any repercussions. Consequently, participants report feeling more comfortable seeking the input of Muslim MHP to whom they can refer and consult, rather than mainstream services. Participants regard this as extremely challenging given the under-representation of Muslim MHP.

3.5.1 'We Feel Under Attack'

This subtheme captures participant experiences as victims of racism and Islamophobia, and how they are trying to manage. Participants share accounts from various settings and described an overall sense of helplessness in trying to support mental wellbeing whilst witnessing an increasing level of distress with the people they support due to overwhelming reports of anti-Muslim sentiment, as Ihsaan describes:

> *Ihsaan: I would say that being somebody who's working in a Masjid, the way that Masjids are received in the communities in which they are based, you do get a sense of anti-Muslim sentiments and the fact that people are not comfortable. And look, I mean, I do understand, I don't really blame people for feeling that way because I do understand that the media has such a very, very strong impact and kind of like manipulating people's opinions about other people.*

Several participants describe witnessing Islamophobia directly, giving different explanations to make sense of why this occurs. Many accounts describe statutory services like the education system, prison service, and NHS as institutionally racist. Participants attribute

increasing levels of Islamophobia and racism to many factors including the influence of media, and the representation of those working alongside the Muslim clients, as Idris alludes:

> *Idris: Islamophobia is huge. So, it's on an everyday basis. Just being an Imam in the prison service, it (Islamophobia) is huge. The challenges that are faced, it's really hard because it's hard to explain, but the prison service is extremely institutionally racist (…). Officers are usually from the military, not exposed to Muslims, only exposed to Muslims on the news. It's very hard to explain in a few words, but every single thing is a challenge because this is a rise in use of force on Muslim prisoners. There's always a negative vibe around. We have to try harder to make relationships.*

Participants recognise that not every Muslim person's experience of Islamophobia is the same, giving light to the varied experiences that women and children in particular, or those vulnerable with mental health difficulties may face when coming in contact with statutory services:

> *Muhammed: Islamophobia and Prevent and all of that has a massive impact on parents, their children, and schooling, education, the attacking and fear that it has created. It is actually on the community as a whole where we feel that we're under attack.*

Nusaybah further illustrates the intersecting vulnerabilities Black Muslim women in particular face by sharing the consequences and the struggle she experiences in supporting and building confidence with the women she works with:

> *Nusaybah: So, you can see what is happening to some people's psyche and their mental health, you know the issues around Black Lives Matter for younger people, so actually, I've given my life, 27 years of women's empowerment, trying to get women out of the house, into employment, into jobs and to have a different experience. And it's almost like these kinds of issues are sending people back into their homes. And there's a lot of fear, people don't want to go…. But this, what's happening to people is having a real impact on people's lives.*

These direct and indirect experiences also inform the level of safety Nusaybah feels and the consequences women in the community face as a result of anti-Muslim hate crimes:

> *Nusaybah: And especially, when you've seen reprisal attacks after, you know, extremist attacks and things like that. And this whole thing on racism, niqab and hijab, you know, especially with Muslim women, is quite stressful. And girls have experienced so much, some are tolerant and more resilient than others with that. But there are others that we know that they've left university and left the workplace because they've had a bad experience in travelling (referring to Islamophobic attacks on public transport).*

In contrast, though some participants report being less affected in their work, they also strongly relay concerns for the people they support, as Idris describes:

Idris Yes. It's doesn't affect my day-to-day work. It doesn't affect the way I deliver my work, the Islamophobia. It affects my prisoners. Islamophobia they don't, they can't direct it at me. They can't direct at me. What they cannot direct at me, they can direct at my prisoners and be racist towards them, restrain them extra, use of force, call them names, make it difficult for those guys to attend my Jummah, make it difficult for them.

3.5.2 'The Silencing of Muslim Identity and Beliefs'

This subtheme conveys participant accounts of the impact Islamophobia has, particularly the level of self-censorship needed for participants to feel safe in their communities. Participants describe this day-to-day self-policing and avoiding of controversial, but fundamental, aspects of Muslim identity they feel society and legal policies such as Prevent might see as radical:

Zayd: So yeah, there is pressure because we live in a country that supposedly promotes freedom of speech. It feels like we Muslim communities or Imams are exempt from that. We don't have the freedom of preaching what we want to.

Participants working in an NHS setting describe actively avoiding making Islamic materials available to clients as part of the silencing of Muslim beliefs and identity, as Fatima illustrates.

Fatima: So, in generic chaplaincy, when I'm producing the booklets we have the order of service in there, and prayers and stuff, I tend to avoid Muslim prayers. I do that because of the perceived fear of 'Oh my god, we're reading

Muslim verses. 'Oh my God, that's the Quran?' So, just to avoid all of that, I'll probably just, you know, let it go through without even referring to is as though it is that.

Mosque-based MFL participants also report self-censorship in the sermons they deliver. They acknowledge that, despite knowing the importance of the teachings and feeling confident, for many participants the risks of speaking about controversial topics are just too great:

Adam: Obviously, some subjects I, I will actively avoid speaking about just because there are minefields and not because not because I'm not confident to speak about them. I could be very comfortable speaking about them. And it has nothing to do with it has nothing to do with my public profile. But it's because the rules of the game know the rules of engagement, the rules of the debate are against you, you know, and the odds are stacked against you from the start, meaning that there is no equal platform.

Several participants speak of the internal conflict and negotiation they go through, being aware of the moral obligations they have as MFL versus the risk of harm an Islamophobic societal lens presents them:

Yacoub: So, there's issues of self-censorship that I think now affects everyone across the board. Those who are self-censoring, it's causing this problem of guilty conscience and feeling as though, should I be saying these things anyway? It's my duty. So what if it causes problems, so what if I have to suffer? And those who are saying it are suffering, right. They're being attacked

and vilified and so on. So it's a difficult time in that sense. Like how do you talk about jinn openly?

Because of varying accounts of how Islamophobia affects Muslim identity, participants unanimously convey the disparity in experience of Muslims in comparison to other faith groups and faith leaders:

Ihsaan: I mean, there's certain things that anybody else would be able to speak about, but I wouldn't be able to speak about because the scrutiny is that much higher. So, for example, if I talk about any topic which is controversial, it's much more susceptible for it to be caught up in the media or people to kind of say things about Muslims. So, I'm very, very conscious of that. So, I avoid anything controversial

Many participants describe the Prevent agenda as responsible for participants' self-censorship, with wide-ranging consequences for themselves and their family and children.

Muhammed: So, I say that all the time, the Muslim community has no confidence to speak up now. They will be walked and trodden upon, they've taken extremism under the table now. Because now, no one's willing to talk, because they're fearful that our child will get referred to Prevent.

Participants describe this impact as affecting their mental wellbeing so much so that despite wanting to resist against extremism and fundamentalism, several participants regard Prevent as not only failing but also damaging the trust and safety that Muslims feel as British citizens:

> *Yunus: Also, an additional layer of challenge, we're living in a society which is very complex now, and I'm also critical of the Prevent program. I think the evidence is suggesting that a lot of people have suffered from mental health because of being referred to Prevent. Whilst at the same time I also believe that we as citizens of this country, have a duty different levels to help prevent these types of incidents happening where innocent people both Muslims and non-Muslims lose their lives. But again, a lot of them don't happen in the Mosques. It's very difficult they're happening outside of the Mosque arena, they're getting groomed and indoctrinated, many people are not coming to the Masjids, and they are not sharing their concerns or their point of views to the Imam.*

Finally, participants explain that the damage caused by Prevent is creating a lot of mistrust from Muslim communities towards statutory institutions, which acts as a barrier to collaborative working and providing fit-for-purpose solutions for Muslim people.

> *Noah: The government needs to understand, mental health institutions need to understand. In my training I've actually said to the teacher, there was a Prevent sign, I found that offensive because Prevent has targeted the Muslim community and caused many problems and they've been challenged so many times. So if the mental health sector want to work with faith leaders, they need to understand how they're working and what they're working towards. There's already a level of suspicion within ethnic minority communities and the Muslim community when it comes to government organisations. So, if we're*

going to work with organisations which have a track record of causing problems within the Muslim community, then of course, faith leaders are not going to be able to work with those sectors to a desirable level.

3.5.3 A Personal Network

Finally, this subtheme summarises recurrent accounts in all interviews where participants speak about the value of a personal network in seeking consultation and having referral options for the people they support. A strong sense of mistrust in the services, the experiences of racism and Islamophobia, and the other challenges relating to the clash of worldviews between MFLs and MHP means that participants are unlikely to feel safe and comfortable referring to MHS. Participants acknowledge this as a challenge given the scarcity of Muslim MHP:

Zayd: So, it has been definitely a big challenge for us Imams, because we don't really have anyone to refer to when it comes to advising people giving the necessary to support to the community (...) So we refer to certain Imams that we trust, and they have a lot of experience.

Several participants rely on highly valued individuals in their personal network for support:

Adam: If I didn't have two friends who are both counsellors. I wouldn't know who to refer them to. So, I only know two Muslim counsellors, literally. That's it (...). So, lack of expertise, also the inability not knowing who to refer people to is also a huge challenge.

Other participants relay the importance building their own networks and connections with professionals from a Muslim background to support their communities, emphasising the different level of trust they feel:

> *Daniyal: I think if you are a faith leader, then you have to ask help from the communities as well. So as an Imam myself, within my area, there are certain people, for example, a Muslim doctor, (…) a Muslim advisor, someone who does counselling. I try to work close with all of them because I know I can't do everything alone. They can even reach people as well, who could borrow people money and stuff like that, interest-free, to help with debt et cetera because there are some people, they're going to get kicked out tomorrow morning and stuff like that.*

3.6 Conclusion of Analysis

Overall, participants conceptualised mental health difficulties as stemming from dualistic causes, taking account life and contextual circumstances, but rooted in an Islamic worldview with participants describing life is view as temporal and a test. Participants highlighted a clash in worldviews with western secular approaches as a result of this and made numerous references to the central role of fate in relation to tests and trials an individual faces, but also to each person's obligation to seek help utilising a both/and approach to fate and personal agency, rather than either/or.

Insight was given to the complexities that come with an MFL role with accounts of MFLs reporting feeling overwhelmed due to the psychological cost of providing MH support whilst feeling inadequately trained and also due to the inequalities faced due to the financial

strain of having precarious employment. Due to the moral and religious obligation participant perceive, they report a struggle negotiating their commitment to the role with the challenges they face.

This is made more difficult considering that mental health is often overlooked and unaddressed by the communities' participants serve due to many barriers including stigma, people assuming a metaphysical cause to their difficulties rather than a psychological one, and community fear towards secular Western secular therapist and charlatan Ruqyah healers. Of great concern were the powerful accounts of prevailing racism and Islamophobia, which add a further distressing obstruction in how participants conduct their roles. Participants describe having to navigate their own experiences with their communities regarding racism and Islamophobia and reveal the extent of this struggle, abiding by 'acceptable speech', often informed through a secular Western anti-religious lens, resulting in participants self-censoring for fear of being maligned radical or extreme. Participants articulate this self-censorship affecting fundamental aspects of their Muslim identity.

Chapter 4: Discussion

4.1 Chapter Overview

This chapter discusses the findings from this research project, beginning with a summary of the results in relation to the research questions and the relevant theoretical and empirical literature. Next is a consideration of the clinical implications of this study. Subsequently, the quality of the study is considered by highlighting strengths and limitations. Recommendations for further research are presented, and finally concluding remarks and personal reflections.

4.2 Summary of Findings

This research set out to investigate MFLs' experiences of providing support for mental health difficulties and collaborating with mental health services and to share their understanding and conceptualising of mental health, given the limited body of research. The following section discusses the main findings of this research, relevant literature, and psychological theories concerning the research questions, which were:

1) How do MFLs experience providing mental health support?

2) How do MFLs experience collaborating with mental health services?

Considering all four themes together, the findings highlight the vital role that MFLs play supporting people and their communities. Participants speak of their role as a moral

obligation informed by the Islamic Worldview and overshadowed by several challenges including: the complexity of providing support in the face of inequalities, needing to manage barriers and their communities' aversion to accessing support and the fundamental concerns surrounding risks of being a MFL within the context of increasing hostility towards Muslims. These challenges also impede how MFLs approached and viewed collaborating with mainstream services.

4.3 Relevance of Findings to the Literature

Theme 1: An Approach Grounded in the Islamic Worldview

The first theme connects to both research questions, and emphasises a potential clash in worldviews between MFLs and Muslim communities with mainstream secular MHPs and services. This clash also connects with other research as discussed in the introduction and systematic review of a dichotomous relationship between approaches (Abu Ras, Gheith & Cournos, 2008; Ali & Milstein, 2012; Ally & Laher, 2008; Leavey, 2008; Meran & Mason, 2019; Rashid, Copello & Birchwood, 2010; Shah & Culberton, 2011; Watts, Murray & Pilkington, 2014) further alluding to a relationship of mutual suspicion (Bhugra,1997), and religious beliefs and practices often representing as negative or irrelevant (Ellis, 1988; Freud, 1927; Watters, 1992; Koenig, 1997).

The notion of trials and tribulations, does not appear in the systematic literature review except in passing (Padela et al., 2010; Rashid, Copello & Birchwood, 2010; Watts, Murray & Pilkington, 2014) making this an area not previously explored. However, the Islamic faith shares this view, that life is about suffering, with other spiritual orientations. For example, Buddhism views suffering (*dhukka*) as fundamental to human experience, which arises and from a person's attachments to the world; suffering includes physical pain,

psychological distress, and other forms of social suffering such as racism, sexism, or poverty (Hallisey, 1998). This view also appears in other theistic religions like Christianity (Byock, 1996; Schumm & Stoltzfus, 2007) and Judaism (Aiken, 1997).

A novel finding, stemming from the belief that life is a series of trials and tribulation is that participants report that supporting people to negotiate the internal conflict arising from 'trusting in Allah' (given that life is one of trials and tribulations) with utilising their own personal agency (Leavey, 2008; Padela et al., 2010) is not recognised as part of their role. This derives from a misunderstanding within their communities that, by accessing services and support, people are contradicting Islamic teachings around fate. 'Tying the Camel' was offered as a potential resolution to the clash in worldviews, as participants report that following Islamic guidance also means that one strives for his or her own wellbeing and recovery. However, given the clash of worldviews, participants face a dilemma exists when considering that seeking help from mainstream services may potentially mean that people's religious beliefs and identity are side-lined, as Leavey (2008) finds. This is explored further in Theme 3.

Consistent with the findings from the systematic literature review, participants regard their roles as a responsibility and privilege being a moral obligation from God (Abu-Ras et al, 2005; Ali & Milstein, 2012; Ali et al, 2005; Leavey et al, 2007; Meran & Mason, 2019; Padela et al, 2010; Leavey, 2008; Shah & Culbertson, 2011). The responsibility of providing support also highlights a wide range of areas participants respond to, including providing religious and spiritual guidance to dealing with complex concerns relating to supporting the impacts of discrimination, and dealing with issues pertaining to gender and power in relation to sexual and domestic abuse. These tie into the next theme.

Theme 2: A Complex Negotiation

The second theme captures the inequalities and impact of being an MFL, posing several difficulties, both on a personal and professional level. This theme reflects powerful accounts of the impact on participants navigating through the moral obligation of being an MFL. Participants report contextual challenges that varied according to their context of employment, whether in community, NHS, or prison services, which is also absent in earlier research. Concerns around employment, salary, and training and development are shared by all participants, which confirms concerns regarding the low salaries and unstable positions to which MFLs are recruited (Dudhwala, 2008; Hafiz, 2014; Muslim View, 2016), that training for MFLs is inadequate (Runnymede Trust, 1997) or has serious shortcomings (Rahman, Ahmed & Khan, 2006), and that institutions lack the resources or personnel to address these concerns (Geaves, 2008).

The literature on clergy vulnerability typically neglects the experience of MFLs. This secondary traumatisation experience is best articulated by the concept *vicarious trauma* (Sinclair & Hamill 2007) and is similar to other concepts including *compassion fatigue* (Figley, 1995), and *burnout* (Maslach et al., 2001). Researchers frequently use vicarious trauma refer to the secondary stress experience within mental health and counselling fields (Sinclair & Hamill, 2007), and define this as workers' reaction to the emotional demands placed upon them while they repeatedly support others with traumatic experiences (Jenkins & Baird, 2002).

Vicarious trauma has been described as involving profound changes in core aspects to the self (Pearlman & Saakvitne, 1995) such as identity, worldview, psychological needs and memory. These align to findings from this research and wider literature whereby participants reported poor work-related psychological health (Charlton et al. 2009; Francis & Turton 2004; Francis & Rutledge 2004), compassion fatigue (Flanelly et al, 2005; Roberts et al,

2003; Taylor et al, 2006) and also high levels of trauma (Holaday et al, 2001). In addition, literature on vicarious trauma within clergy have explained these as emerging from diverse sources, correlating to reports from participants, which includes, being 'on call' seven days a week, unrealistic expectations, isolation, feelings of failure and dealing with the pain and trauma of others (Burton & Burton 2009). The vicarious trauma literature makes an important contribution by arguing that having a framework of understanding trauma and mental health (Flannelly et al., 2005), and having peer and supervisory support (Hendron, Irving & Taylor, 2014), both help to reduce the impact of supporting those with traumatic experiences. This highlights the value of reports from MFLs about the importance of mental health training and supervision.

Due to these factors, participants describe a conflict; they are reluctant to provide support for mental health difficulties, but are aware the MFL roles comes with a moral obligation they feel committed to, which supports earlier research (Leavey, Loewenthal & King, 2007). Additionally, this supports McAllister's (1993) finding that religious professionals are often uncomfortable dealing with negative emotions, and Grosch and Olsen's (2000) report that the idealising clergy as 'father figures' can result in the clergy striving to fulfil what may be unrealistic expectations. These manifest as excessive workloads, not asking for help when needed, and being at the beck and call of their parishioners with little thought for their own well-being.

Theme 3: 'Barriers, Stigma & Resistance to Accessing Support'

Theme three, *'barriers, stigma & resistance to accessing support'* identified the crucial role that MFLs play in managing their community's aversion, whether this is with consciousness or not, which increased the barriers and stigma they held towards mental health difficulties and seeking help. Participants described feeling challenged in the way

their communities may prioritise religious and cultural explanations for their distress over an understanding based on poor mental health (Leavey, 2007, 2008; Meran & Mason, 2019; Rashid et al., 2012; Watts et al., 2014) and expressed apprehension in trusting both Ruqyah (spiritual healers) and MHPs. This aversion has been noted to impact on the way that Muslim communities engage with services as well as the likelihood of declining or ending support prematurely (Cifti et al., 2013; Bhui & Morgan, 2007; Bowl, 2007; Weatherhead & Daiches, 2010). A way to understand this further from literature on African American communities, is that this aversion acts as a self-protective strategy, due to experiences of racism and oppression resulting in a 'cultural mistrust' (Ridley, 1984; Whaley, 2001) or 'healthy cultural paranoia' of services (Grier & Cobbs 1968 as cited in Whaley, 2001).

Another original contribution of this research included the way MFLs have to negotiate a fear of harm to their communities as possible outcomes from interactions with both mental health professionals as well as Ruqyah healers. Previous research indicated that MFLs' agreed that though medical, psychological and spiritual causes are hard to disentangle, they reported a lack of consideration given to religious viewpoints, by mental health professionals who may exclude spiritual explanations and causes of distress (Inspirited Minds Report 2021; Khalifa et al., 2011; Padela et al., 2010; Watts et al., 2014). Unlike the findings of the systematic literature review, MFLs also reported a fear of exploitation from Ruqyah healers who may charge excessively without providing an authentic Ruqyah service, which they reported is difficult to trust due to an absence of a governing body.

Theme 4: Working Under the Shadow of Islamophobia

Finally, this theme reveals risks that MFLs face as a result of the current societal climate of increasing levels of hostility and discrimination against Islam and Muslims. Participants describe feeling silenced and fearful of expressing their Muslim identity and

beliefs such that they report needing to self-censor and be very self-vigilant for fear of attracting attention from Prevent or labelling as extremist. For example, participants report subjects such as beliefs in a hereafter, hell, and in Jinn are likely to cause controversy. This creates ethical dilemmas in how they negotiate their role as religious leaders and preach Islam in a manner palatable to a secular Western gaze.

These findings support those in the wider literature regarding how the MFL role changed significantly after 9/11 (Abu-Ras et al., 2008; Ali et al., 2005; Leavey et al., 2008), and the association of Islam with violence, religious fundamentalism and gender inequality (Zempi, 2020). Reports confirmed that there are increasing levels of Islamophobia (Elahi & Khan, 2017), alienation from British society and a diminishing sense of belonging, which intensifies a sense of contradiction between being a faithful Muslim and a loyal British citizen (Ameli, 2004).).

At the time of writing this thesis, national discussion surrounding the systemic denial of institutional racism is occurring, which highlights the socio-political context within which MFLs live and work. In the wake of Black Lives Matter protests and COVID-19 which exposed stark health inequalities, the race disparity report (Commission on Race and Ethnic Disparities, 2021) acknowledges that disparities in access to healthcare exist, but failed to address the nature of institutional racism. The findings of the present research argue otherwise, with participants disclosing layers of systematic discrimination, which they experience as racist and Islamophobic, due to their race and religious orientation amongst other identity categories. Numerous authors have supported these finding relating to the experiences of minoritised communities engaging with mental health services (Aked, Younis & Heath-Kelly, 2021; Bhui et al., 2003; Department of Health, 2005; 2007a, 2007b; Fernando, 2005; Keating & Robertson, 2004; Keating, Robertson, McCulloch, & Frances,

2002). The literature also notes how structural inequalities underlying the discrepancies in mental health, such as racism, are often overlooked as additional risk factors (Bignell et al., 2019; Younis, 2021).

An important framework for making sense of these findings is the 'New Circles of Fear' formulation (Byrne, Mustafa & Miah, 2017). Which emerged from concerns regarding African and Caribbean communities. This formulation refers to the process of 'othering', seeing people as a threat and so the consequences from services and MHPs often result in a negative relationship between communities and services (Keating, Robertson, McCulloch, & Frances, 2002). From this perspective, the current focus on radicalisation and terrorism is also resulting in Muslim communities being 'othered' and viewed as threats to British society. MFLs in this study highlighted how this is exacerbated by policies such as Prevent, which brings the role of securitising within mental health care settings and so risk further alienating Muslim communities from services. This can help further explain barriers to collaboration between MFLs and services, given the additional concerns about the level of trust and safety Muslim communities experience and points towards the structural and institutional change needed from services.

A recent report by Medact (Aked, Younis & Heath-Kelly, 2021) also highlights significant concerns related to 'NHS vulnerability support hubs' that embed NHS mental health staff within counter-terrorism police operations. The rationale behind these hubs stem from a view that vulnerability relating to mental health is associated with extremist views. However, participant accounts in this research describe needing to self-censor, as Muslim beliefs, and practices and increased religiosity are among factors that risk being perceived as factors relating to extremism and radicalisation (Open Society Justice Initiative, 2016; Younis & Jadhav, 2020). The Medact report (2021) argues that these policies

disproportionately target Muslims and that, to create a safer and fairer society, mental health concerns should be treated within already existing NHS safeguarding procedures and in caring rather than securitised environment.

4.4 Clinical Implications

This section draws on an ecological perspective will be drawn upon which offers a useful framework to examine MFLs relationships within their communities and the wider society[18](Bronfenbrenner, 1979; Kelly, 2006). Considering this and given the strong accounts of inequality, multiple levels of consideration may contribute to better support for individual and community wellbeing. The different levels for the implications comprise: macro (policy); exo (community); meso (profession); and micro (therapeutic). Macro-level implications are prioritised, as this research fundamentally highlights concerns towards the socio-political context for Muslim communities and because implementing recommendation on all other levels may prove unsuccessful or potentially pose greater risks to Muslims. This discussion proposes four key areas to increase access to and acceptability of services, increase mutual trust, and strengthen relations between MFLs and MHPs, which address:

1. The socio-political context in which MFLs and Muslim communities live and operate from.
2. The impact and inequalities faced by MFLs in their roles and the lack of support and training they receive;
3. Muslim communities' resistance to services, and related barriers and stigma, and;

[18] *Ecological systems theory was developed by Urie Bronfenbrenner. The theory identifies five environmental systems with which an individual interacts. These include the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem*

4. The incompatibility and potential clash between secular Western services and the Islamic Worldview.

Macro-Level Implications for Policy Makers

MFLs shared their experiences of feeling silenced in relation to their Muslim identity and beliefs as a result of living under the gaze of ongoing suspicion of Muslims in British society which they experience as racist and Islamophobic. This finding is in sharp contrast to the dismissal of institutional racism by the Commission on Race and Ethnic Disparities (2021), particularly in the wake of Black Lives Matter protests and COVID-19 (Aked, Younis & Heath-Kelly, 2021). Healthcare governing bodies are considering their own positions[19] relating to racial equality, diversity and inclusion. Given the new 'circles of fear' developing between Muslim communities and MHS (Byrne, Mustafa & Miah, 2017), policy makers within health bodies and the government can use these findings of this research to address policies that may hinder the level of trust and safety the Muslim communities experience from services. As these findings show, the Prevent agenda and related policies, risk othering and alienating Muslim communities from services for several reasons, including criticism for the way mainstream Muslim beliefs and practices risk being perceived as indicators of extremism and radicalisation (Younis & Jadhav, 2021; Open Society Justice Initiative, 2016).

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[19] The Royal College of Psychiatrists created a Race Equality Taskforce to tackle systemic racism and promote racial equality (RCP, 2020) and the British Psychological Society committed to promoting racial equality, diversity and inclusion within the institution (BPS, 2020)

Furthermore, the Medact report (2021) calls for mental health bodies and organisations to condemn and work to end the disproportionate targeting of Muslim through policies such as Prevent and the newly established NHS vulnerability support hubs. Medact argue treating mental health concerns should occur within already existing NHS safeguarding procedures to create a safe and fairer society, and thus in a caring environment rather than separated out and securitised disproportionately.

Furthermore, this research highlights many concerns regarding the psychological impact of supporting people with mental health concerns, with participant reports indicating possible vicarious trauma. It is important for policymakers to consider this research as reflecting the current state of MFLs and their training; the most recent report on this topic is over a decade old (Mukadam, 2010), and found no policy supporting FLs providing mental health support or the impact of this, despite acknowledging that FLs play a crucial role within communities. Given also, the current emphasis on staff support in NHS services, it will be important to consider how, or if, FLs are being considered as part of the workforce to benefit from this new awareness, developments and investment, given that employment benefits and rights vary across roles in the NHS.

Exo-Level Implications for Communities

Crucially, the MFLs in this research overwhelmingly report disappointment towards their training institutes, given they do not equip MFLs to manage people experiencing mental health difficulties. All participants argue strongly for better training and education prior to graduation, and ongoing training and supervision in therapeutic approaches when working in the community. Several implications for community services, educators and Muslim organisations, arise from these findings, in line with the Communities and Local Government

report on MFL training and development of MFLs (Mukadam et al., 2010). Some of these recommendations appear in Table 9, reflecting this project's findings and priorities.

Table 9: Implications for Community

By Whom	Implications for Community (adapted from Mukadam et al., 2010)
Community Organisations including Mosques	• Developing current UK MFL training to include concepts of applied theology and mental health. • Accrediting MFL training to increase post-graduate opportunities for further education. • Introducing ideas of 'trainee MFLs' to support these with further career progression that reflects the nature of support MFLs provide to their communities and also rewards per progressive salary bands. • Customising job descriptions to reflect the nature of 'unrecognised work' to ensure that MFLs are paid for the mental health support they provide and can protect time within working hours to carry out these duties. • Supporting MFLs to access funding for continued high quality CPD programmes. • Addressing the need for clinical supervision and support for MFL supporting people with MH difficulties. • Developing and Implementing policy related to support MFLs and reduce any psychological impact or vicarious trauma. This can include providing access to existing resources, employee benefits and employee rights – see macro level point above

	• Increasing working relations with local MHS for better partnership working and clearer referral pathways.

Meso-Level Implications for the Clinical Psychology Profession

Although there are many overlapping guidelines informing the way that clinical psychologists work with diversity (BPS, 2006; 2008; 2009; HPC, 2008; UKCP, 2019, RCPsych, 2013) and with community organisations (Thompson, Tribe & Zlotowitz, 2018), these guidelines tend to lack unique considerations, are often clustered under diversity, with none specific found for working with religious and faith communities. This is despite concerns that MHPs may lack the confidence, skills and training to deal with religious issues (Begum, 2012; Bergin & Jensen, 1990; Bilgrave & Deluty, 2002; Crosby & Bossley, 2012; Delaney et al., 2007; Harbridge 2015; Joseph, 2014). This research highlights the importance of why the profession should address and support specific training and guidance in this area. Considering that interdependence, spirituality, and experiences of discrimination are the overarching constructs that differentiate minoritised from majority populations (Hall,2001), there is an argument that the clinical psychology profession is is neglecting many communities by not providing specific guidance regarding religion and spirituality.

Furthermore, there is an urgent need to address the inequality the present study highlights regarding employment structures and opportunities (including employment benefits, salary, etc.) between minority faith chaplains and Christian chaplains (Dudhwala, 2008; Hafiz, 2014). To fully develop mutual trust, collaboration and knowledge exchange, whilst facilitating acceptability and credibility of services for faith communities, minoritised faith leaders need to have a more substantial and sustainable presence in NHS and prison service contexts. The clinical psychology profession has the opportunity to advocate for such representation and to insist on fair and sustainable MFL positions for their chaplaincy colleagues. Given the emphasis on collaborating with community services, it is also important for the profession is aware of the hostility that the profession represents and the potential for exploitation (from seeking collaboration) if MFLs lack adequate support through remuneration and employment benefits.

Moreover, as part of the NHS transformation plans that the new NHS Long Term Plan (NHS, 2019) investment enables, more attention is focussing on the way that the NHS works in partnership with the third sector and local communities to support people with mental health problems. The clinical psychology profession can advocate for services such as extending the BME Access service beyond Tower Hamlets and Hackney to provide choice and better service to marginalised communities.

Micro-Level Implications for therapeutic practice

The need for MFLs and MHP training and consultation appears, in all participant accounts. For MHPs, there exists a real need for therapists to do their own work due to the

potential mistrust or fear of mainstream secular services and the 'religiosity gap' (Bergin & Jensen, 1990). This may include addressing attitudes to religion and exploring its relevance for recovery, in supervision or reflective practice etc. The acronym of social 'GGRRAAACCEEESSS'[20], including religion and spirituality, aims to facilitate MHPs' reflection on identity and experience, and alertness to their own preconceptions that may impact on therapy and highlight areas of difference that risk being overlooked. Though some argue these 'graces' are equally important, MHPs may privilege some more than others, depending on their own positioning and comfort zone (Betteridge, 2012; Nolte, 2017). Examples of good practice already taking place have been highlighted throughout this section.

To give religion and spirituality similar or equal coverage in the therapy context, MHPs should pay attention to their own training and development needs (Nolte, 2017). Ways to facilitate this include supervision, training, and actively engaging and exploring discussions regarding religion and spirituality in therapeutic conversations with clients (Coyle & Lochner, 2011). Pargament (2007) also outlines the importance of proactively assessing religious beliefs and someone's 'spiritual story', particularly when relevant to the presenting problem, or as a useful resource to resolve difficulties.

However, Crossley and Salter (2005) caution against making assumptions about a client's religious practice, and that enquiry into spiritual practice may not always be justified. Griffith and Griffith (2002) suggest exploring this with clients using questions including 'what has sustained you?', 'from what sources do you draw strength?', and 'where do you find peace?'. It is important to consider the dynamics that may be present in circumstances

[20] Gender, Geography, Race, Religion, Age, Ability, Appearance, Class, Culture, Ethnicity, Education, Employment, Sexuality, Sexual orientation, and Spirituality (Butler, 2015); based on Burnham's (2012) initial nine areas.

where MHPs and clients appear to have similar or different racial or religious identities. Exploring how clients position themselves in relation a MHP's identity, and the meaning they attach to any contrast or resemblance is of utmost importance (Richards, 2003).

In relation to MFL training, all accounts referred to a desire for further training in to the assessing mental health difficulties, identifying suitable interventions and providing treatment. One way of MHPs supporting this is by collaborating with MFLs and FBOs, to share their respective expertise. MFLs can provide training to mainstream MHPs on the Islamic worldview and the faith-based support they provide and MHPs can provide training on assessing and providing therapeutic interventions. This supports several recommendations from New Ways of Working (BPS, 2007) and Clinical Psychology Leadership Development Framework (BPS, 2010) which advocate for more leadership and consultancy-based work in clinical psychology. Table 10 provides an example from work with MFLs in Tower Hamlets that motivated the present research.

Table 10: Implications for Therapeutic Practice – Sharing expertise

By Whom	Approach Used
East London Foundation Trust's (ELFT) Department of Spiritual Religious and Culture Care and the Tower Hamlets Psychology Department's BME Access Service (now	Two mental health workshops were delivered at the East London Mosque during 2015 with the first workshop including 30 Imams from the Association of Islamic Teachers representing the East London Boroughs and beyond. The second workshop including 40 male and female Muslim faith and community leaders. The workshops were considered a great success and aimed to increase trust and understanding and to think about ways of working together (Trust Talk, Working together article, 2015).

called The Community Engagement Service)	

Following the BPS guidelines on working with community organisations (Thompson, Tribe & Zlotowitz, 2016), it has also been noted that in order to communicate sensitively to different communities' beliefs around health, psychologists will need to move beyond entrenched positions of power and to do this it may help to learn 'a new language'. Communities, as well as experts by experience, frequently have much to teach psychologists as they may not be restricted in the way they view, understand or construct wellbeing, psychology or psychological help (Tribe, Weerasinghe, & Parameswaran, 2014). In light of this, co-produced approaches are encouraged, whereby MFLs can play a crucial role teaching and sharing expertise regarding the 'language' most accessible to Muslim communities. An example of how this has been done with Black Christian Pastors, shown below (Table 11).

Table 11: Implications for therapeutic practice – Training Faith Leaders

By Whom	Approach Used
Wandsworth Community Empowerment Network (WCEN), working in partnership with Wandsworth NHS clinical commissioning group and South West London and St George's Mental Health NHS Trust.	The Community Networks for Family Care Programme was run in 2011 and provided accredited training for 12 Black church pastors in systemic therapy as part of their ministerial and pastoral practice. This programme was successfully evaluated with positive accounts from the pastors regarding the anchoring of family therapy concepts to a faith-based narrative and the co-produced approach which meant that the pastors felt comfortable to reframe and translate concepts in a more accessible way for their parishioners (Burgess & Ali, 2016). The importance of these FLs being able to act as 'bridges'

	between therapeutic and non-therapeutic spaces was clear and also led to completing another round of systemic therapy training for MFLs in 2014 with participants reporting increased confidence and quality of their work supporting people as a result of receiving training (Khan, In Press).

Clinical psychologists can also share expertise in approaches FBOs, MFLs and NHS services can utilise, acting as a bridge by sharing information, learning about FBO approaches, and advocating for suitable interventions within NHS settings. Psychologists can facilitate this by building trust, attending FBO meetings, and providing clinical supervision to MFLs supporting congregation members. However, it is important that any partnership of this kind exists in a context of mutual respect and learning.

The choice of interventions MHPs offer to Muslim clients also requires attention, as these can contradict fundamental Muslim beliefs. Findings indicate an aversion towards MHSs for multiple reasons including experiences of Islamophobia, stigma, and a fear that MHS and MHPs may lack cultural and religious understanding. Betteridge (2012) interviewed Muslim Psychologists about their experience working with religion in therapy, and proposes MHPs can choose from three different approaches. These comprise: adapting western models to fit with religious beliefs; using faith-based interventions; and making use of pre-existing religious coping strategies. Appendix Q provides an example of this in practise. Some psychological models and approaches, such as systemic and community approaches, may lend themselves to exploring conversations around religion and spirituality with Muslim communities. Literature emphasising the importance of family and community for Muslim communities for recovery supports this (Al-Abdul-Jabbar & Al-Issa, 2000; Al-Krenawi et al., 1994; Ansari, 2002; Aziz, 1999; Ali et al., 2004; Sembhi and Dein, 1998;

Yilmaz & Weiss, 2008). Regardless of the approach, the critical factor is that MHS and MHPs offer choices appropriate for client's preferences, which aligns to government and NHS Long Term Plans[21] (Appendix Q outlines example interventions).

[21] *The NHS Long Term Plan (2019), Department of Health (2014), and NHS Five Year Forward View (2014) all emphasise the need for an equal response to mental and physical health increasing the direct control patients have over the care provided to them, and making good on the NHS promise to give patients choice over where and how they receive care.*

4.5 Critical Evaluation of Study Quality - Strengths and Limitations

The researcher considered and reviewed the quality of this study throughout this project with the supervisory and consultant team, using the 'Big-Tent' Criteria for Qualitative Quality (Tracy, 2010) as framework. Table 12 summarises how the study addresses each criterium.

Criteria for quality	Description of criteria	Strengths	Limitations
Worthy topic	The topic chosen for research is relevant, timely, significant, interesting	• Research highly relevant to NHS Long Term Plan and relevant to current context of increased awareness and focus on racial equality, diversity, and inclusion for minoritised populations. • Local and national debates on race, Islamophobia, and institutional racism means research and findings are timely and highly relevant. • Research is also significant given lack of research exploring MFL perspectives, which the systematic literature review highlights.	
Rich Rigor	Sufficient richness and abundance of data sources, samples. Rigorous data analysis procedure which is sufficiently complex and in-depth to be able	• Although the analysis of participants experiences was informed by the lens through which the researcher views the world, this research attempts to convey the voices of people holding a prominent position within Muslim communities and gives a unique insight to the implications of how clinical psychology and allied professions can work alongside MFLs.	• Though the researcher made many attempts to have representation from diverse MFL backgrounds, it was difficulty to recruit more female and non-South-Asian background MFLs

	to describe phenomena being studied	• A good sample size (13), comparable to similar qualitative research drawing from minoritised populations and with participants from different roles and backgrounds supports research to achieve 'data sufficiency' (Nelson, 2017). • Rigorous recruitment procedures were used to ensure abundant data collection. • Complex and appropriate analysis (TA) used, with consistency checks (e.g., by consultants, supervisors and peer) and reported in a transparent manner within the study.	• COVID-19 pandemic restricted other avenues of recruitment, thus potentially limiting the diversity of the sample. Though it was initially planned to recruit from different Mosques and community organisation, most of the recruitment happened online through different networks and email, likely impacting recruiting MFLs who lack computer access.
Sincerity	Self-reflexivity about researcher's biases, goals. Honesty, transparency about research process including mistakes	• Insider researcher position allows for a greater degree of trust and outsider position of not being a MFL, but being married to a MFL, means researcher is able to approach project with a deeper understanding of the challenges faced. • Self-reflexivity through several different ways examining epistemological and researcher positioning. Examples include using a reflective diary throughout the research process, openness about	• Due to research budgets and DClinPsy time constraints only English speaking MFLs were recruited. Given that participants made reference to MFLs who are from abroad as being more likely to face exploitation, this research may

		personal experience and how these might affect data collections and analysis. • A reflexive bracketing interview was conducted with peer from another faith and minority background (Tufford & Newman, 2012). • Regular reflective conversations with consultant and supervisory team, which assists with sense-making and managing personal biases. • Transparency achieved through describing the research process honestly and reflectively.	have excluded the more marginalised MFLs in society
Credibility	Study demonstrates trustworthiness and plausibility of research findings	• Participant quotations from multiple transcripts included in results to thicken descriptions and provide rich narratives. • Triangulation of themes by analysing from different perspectives, including consultants supported trustworthiness.	• Research findings are from MFLs with a Sunni background – other sects within Islam are not represented
Resonance	Study's ability to influence or move reader by presenting text which is clear, evocative, and promotes empathy and identification. Study's ability to generate knowledge resonance	• Difficult to objectively comment on whether this research moves people or is evocative, but seeking consultant feedback consistently enhanced the chances of a clear and evocative study. Research has transferability as readers may find it resonates with their own personal experiences. • A large number of direct quotes are used to allow the reader to connect closely with the material.	• Recruiting MFLs did not specify for or distinguish between different role types (e.g., NHS chaplains, Community independent MFLs, Prison chaplains). Each of their experiences are unique, and future research should explore specific

	for different contexts, situations, audiences.	• Within the discussion the resonance of the findings are explored and linked to theory, research, and current socio-political contexts	experiences and distinctions between different professions
Significant contribution	Study makes important contribution to the field by improving/extending knowledge, theoretical understandings, or clinical practice	• This research project contributes to a very limited literature regarding MFLs' experiences, and provides insight into the challenges they faced when trying to collaborate with MHS. The discussion makes recommendation for how NHS services can work together with MFLs. • Increasing interest in community psychology and co-produced initiatives within clinical psychology means these findings can contribute to emphasising the role MFLs play in their communities, and the importance of good community partnerships with MHS.	
Ethical	Adherence to professional/research ethics guidelines, responding ethically to issues which arise in research process	• Ethical approval was granted from UH ethics board. • The research report reflects on and addresses power dynamics and ethical issues. • Ethical considerations are discussed and adhered to throughout research project. • A strong consultative group supporting the research means that different viewpoints regarding ethics are considered. This group includes a Muslim expert by experience working as a MHP, an Imam	

		working as an NHS chaplain, a Muslim psychologist who previously worked as a chaplain, a psychologist working in a BME access service with Muslim communities, and two academic research supervisors.	
Meaningful coherence	Whether study achieves its stated aims. Coherence between epistemological position of research and research design, data collection, and analysis	• Attention given to coherent use of critical realist epistemology, interviews, and TA methodology, which are compatible and align to the project goal. • Existing literature, findings of this study, and interpretations are interconnected (see discussion), and meaningful implications and recommendations discussed. • COVID-19 restrictions meant that all interviews were conducted online. Although this could be seen as a limitation, for this population it meant that gender etiquettes of interaction felt much more comfortable, and scheduling could fit around MFLs' busy schedules without needing to travel.	• Most participants had been trained in UK seminaries and so likely to have held particular experiences in relation to the teaching and support they were given to address mental health difficulties.

Table 12: Assessment of the Quality of the Current Research Study using Tracy's (2010) Eight "Big Tent" Criteria for Excellent Qualitative Research

4.6 Outcomes and Recommendations for Future research

This research has achieved several outcomes:

- Two participants were supported to access placements within an IAPT and secondary care psychotherapy service as part of their ongoing mental health training.
- A growing network of support with participants sharing information of available training they find with researcher, for the benefit of other MFLs.
- Emerging opportunities to share and disseminate research findings within Prison services, Mosque, and community organisations.
- MFLs who are also MHPs have agreed to meet with researcher to discuss findings and implications.

Considering the findings, strengths and limitations of this research, along with the wider implications, several avenues for future research in this area emerge[22]:

- This study highlights the relational contexts impacting MFLs' experiences, and research exploring others' experiences in these interactions would further illuminate this field, including e.g.:
    - Clinical psychologists' perspective on the role of MFLs and/or collaborative work with MFLs;
    - Community members' views of accessing support from MFLs;

[22] *It may be useful for other researchers to know that amongst the participants, in the current context of a securitising society and the targeting of British Muslims as a suspect community, there was a sense that it felt important to approach and speak openly about these topics, such that the researcher should pay attention to the need to build trust and be aware of the risks posed to MFLs and fear of talking about Islamophobia and controversial policies such as Prevent.*

    - Those excluded from this research – e.g., non-English speaking or other minority Muslim sects (e.g. Shia, Sufi).

- A number of findings also deserve more in-depth exploration through further research, e.g.:
    - Experiences of collaborations with clinical psychologist from MFL perspective.
    - The impact of Prevent, Islamophobia on MFLs' roles and for them personally.
    - How MFLs address gender, power, inequality
    - How MFLs manage being vicariously impacted
    - The differences in inequality between Abrahamic faith clergy
- This study also points to further research about specific contexts of MFLs:
    - Examining experiences of MFLs in relation to their professional contexts (e.g., Prison MFL Chaplains, NHS MFL chaplains, mosque-based and independent MFLs);
    - Examining the unique experience of MFLs trained in Islamic counselling or other secular Western mental health approaches;
    - Examining experiences of MFLs providing support in different contexts, e.g., MFLs with different backgrounds, e.g., being non-South-Asian or female

- Examining the implementation of findings from the current study via community-level intervention in a participatory action approach.

4.7 Concluding Comments

This research aims to explore MFLs' experiences of providing mental health support in the community and collaborating with mainstream mental health services. Thematic Analysis of interviews with thirteen MFLs illustrates the profound complexity for MFLs supporting mental health difficulties. To our knowledge, this is the first research to describe and elucidate MFLs experiences providing mental health support, and the personal and professional impact this has. Thus, this study makes an important contribution to a small but growing body of research exploring the role of MFLs, and improves understanding of the nature of MFLs' roles, how they conceptualise mental health, and barriers pertaining to the local and socio-political landscape within which they provide support.

Findings emphasise barriers to collaborating with mainstream MHS, and how worldviews, policy, and inequality impede attempts to collaborate. However, this research also demonstrates the strong connections between MFLs and their communities, and how MFLs try to resolve Muslim people's aversion to certain avenues for support by advocating for more holistic approaches. These findings complement the existing literature, which predominantly focuses on the nature and conceptualising of mental health support. Overall, these findings are important for psychologists, community FBOs, and policymakers, particularly regarding ongoing controversies relating to racial inequality, diversity, and inclusion with attention needed specifically given the increasing levels of Islamophobia.

4.8 Final Reflections

I have always been drawn to working and conducting research in ways that I can bring my whole self, attempting to contribute to an area that holds personal resonance, and which aligns to my values of service to communities. Despite coming to this research feeling relatively well-acquainted with the challenges our MFLs face, I have learnt so much and appreciated the opportunity to hear participants speak about their personal experiences. I was struck by the layers of difficulties, some with quite uncanny similarities to my own experiences, and others seemingly surreal, which increases my deep appreciation and admiration to hear participants speak so openly about negotiating the challenges with their obvious commitment to Allah and their communities.

I am proud to have written this thesis through a transparent lens with my epistemological position and openness towards the research area. No man is an island, and knowing the importance of this research, I am particularly proud of what I have been able to achieve with my consultant team. The constraints of a DClinPsy often means that trainees are unable to fully engage in participatory research design given that, to be fully collaborative, it takes time, reflexivity, and a commitment to step down from our own entrenched positions of power to allow for the expertise of others to shine through.

Though I would have liked participant involvement in all aspects including research area, approach, and forming sustainable outcomes, I believe my consultant team comprising MFLs as well as psychologists helped shape crucial aspects. Most importantly, the consultant team helped me make sense of my position, being Muslim and sharing similar experiences with how to communicate the narratives of my participants in a way that is best understood

and that connect to wider systems. I believe these factors will significantly influence our direction, whether we are aware of this or not.

Throughout the research, I found drawing on my own experiences of being a Muslim woman and having accessed support from MFLs integral to the process. This and being married to a MFL supported my awareness of their challenges, and to sometimes name these explicitly with participants which, in my view, helped build trust. There was, however, an overarching feeling that I still represented a position of power, being a mental health professional and working from within the structures that pose risks to MFLs. Naming this challenge in a transparent way with the MFLs strengthened relationships during interviews. I understand this power dynamic was also convoluted with the fear and mistrust that MFLs spoke about given the current focus of radicalisation and policing of Muslim communities.

Being a Bangladeshi-Muslim, I felt overwhelmed at various points, hearing about additional layers of racism and Islamophobia, given that these experiences resonate with my lived reality, needing to negotiate British and Muslim identity that we have been institutionalised to believe, cannot complement each other. Needing to hide fundamental aspects of Muslim identity resonates deeply with me, for fear of being deemed as not upholding 'British values'. At times during the research write-up, I consequently felt somewhat paralysed under this secular Western gaze; knowing my audience, I felt the need to convey the experiences of MFLs in ways a non-Muslim reader would consider acceptable and this often sometimes meant I struggled with naming the experiences the MFLs shared explicitly, for example when naming themes. The support of my consultant team meant this journey of owning my own position and the positions of my MFLs felt more possible and less risky.

Over the course of this project, I held in mind people who inspired this research, the giants upon who's shoulders I stand, those in my consultant team that I am very fortunate to have involved, but also those who inspired my thinking and development. People such as Malik Badri, Tarek Younis, Omar Suleiman, Yasir Qadhi, Hamza Yusuf, Rania Awaad, Nimisha Patel, Suman Fernando, Abdullah Mia, Vikki Reynolds, Qulsoom Inayat, amongst many more. They all provided an easier path for me in exploring and addressing challenges facing our marginalised and Muslim communities and I am left wondering about the possibilities we can continue creating in the future.

'A goodly word as a goodly tree, whose root is firmly fixed, and its branches extended to the sky. Giving its fruit at all times, by the leave of its Lord and God sets forth parables for humankind in order they may contemplate' (Quran, 14:24-25)

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Appendices

Appendix A: Tracy's (2010) Big Tent Criteria

Criteria for quality (end goal)	Various means, practices, and methods through which to achieve
Worthy topic	The topic of the research is • Relevant • Timely • Significant • Interesting
Rich rigor	The study uses sufficient, abundant, appropriate, and complex • Theoretical constructs • Data and time in the field • Sample(s) • Context(s) • Data collection and analysis processes
Sincerity	The study is characterized by • Self-reflexivity about subjective values, biases, and inclinations of the researcher(s) • Transparency about the methods and challenges
Credibility	The research is marked by • Thick description, concrete detail, explication of tacit (nontextual) knowledge, and showing rather than telling • Triangulation or crystallization • Multivocality • Member reflections
Resonance	The research influences, affects, or moves particular readers or a variety of audiences through • Aesthetic, evocative representation • Naturalistic generalizations • Transferable findings
Significant contribution	The research provides a significant contribution • Conceptually/theoretically • Practically • Morally • Methodologically • Heuristically
Ethical	The research considers • Procedural ethics (such as human subjects) • Situational and culturally specific ethics • Relational ethics • Exiting ethics (leaving the scene and sharing the research)
Meaningful coherence	The study • Achieves what it purports to be about • Uses methods and procedures that fit its stated goals • Meaningfully interconnects literature, research questions/foci, findings, and interpretations with each other

Appendix B: Bracketing Interview

Bracketing interview 23/04/20 (Tufford & Newman, 2012)

Muslim Faith Leaders' Experiences of Providing Mental Health Support in the Community

1.Identify some of the interests that, as a researcher, you might take for granted in undertaking this research. This might include issues such as gaining access or obtaining a degree. Write down your personal issues in undertaking this research, the taken-for-granted assumptions associated with your gender, race, socioeconomic status, and the political milieu of your research. Finally, consider where the power is held in relation to your research project and where you belong in the power hierarchy.

Assumptions: being a Muslim woman with a certain level of understanding of faith, mental health – tapping into research – assumptions about faith and spirituality

Conscious about working with faith leaders with a different understanding how people come to them for support

Socio-political context: Islamophobia is high as it ever been, Muslim leaders under pressure to answer on what they are doing to reduce radicalisation. A lot of burden being placed on them. Activist role in helping faith leaders – placed more under attack, and often unpaid. Thinking about how they are already reducing amount of ppl that the NHS might see, they are doing a lot work

Power: Going in as a TCP – assumption that I know how to provide MH support and therapy – and I'm going to explore experiences of people who have not had mental health training. In a position of power – address and acknowledge that I'm interested in learning rather than finding the right or wrong way. A lot of trust building required in the process – faith leaders more

reluctant to refer to mainstream services due to possible neglect of faith issues. Imbalance of power in the room

2. Clarify your personal value systems and acknowledge areas in which you know you are subjective. These are issues to which you need to keep referring back when analyzing your data. This is an important strategy in developing a critical perspective through continuous self-evaluation (Hanson, 1994).

Values: Thinking highly of faith leaders, respect that we show them. Personal experience of personal support from FL – level of respect culturally and personal experiences might get in the way of analysis. More prone to portray findings in a positive light – potential bias. Is the respect element getting in the way of being curious?

3.Describe possible areas of potential role conflict. Are there particular types of people and/or situations in which you feel anxious, annoyed, at ease? Is the publication of your findings likely to cause problems with a group of people? Consider how this possibly could influence whom you approach or how you approach them. Make a mental note to recognize when anxiety, annoyance, or enjoyment arise in you during data collection and analysis.

Role conflict: Might feel uneasy with male FL: i.e., interactions between male and female in the same space. Inviting a RA to the interview process.

Annoyance levels: when I've spoken to psychological therapists/ MH about the value of the research, I tend to get questions about my choice of research above keeping It general – being questioned about the values and risks of seeing FL input being above NHS support. I foresee that some issues may arise with publication: incorporating Islamic ideas might cause discomfort as given majority non-religious audience. Seeing religion as 'primitive' – suggest as resource

not the main approach. I have to be conscious about being defensive / tailoring researcher to their approach

4. Identify gatekeepers' interests and consider the extent to which they are disposed favourably toward the project (Hanson, 1994). This can help you prevent potential role conflicts. The less conflict and anxiety you experience with regard to your research, the easier it is to maintain neutrality. Once you have started fieldwork, try to become attuned to the way in which your feelings are signalling a need for reflexive thought.

Gatekeepers: supervisors more aligned favourably with the project – Angela and Sara are pro to me doing the research and being critical of mainstream CP services, I might adopt that approach – which might be problematic. Role conflict more in how I analyse the findings i.e., Being an advocate

5.Recognize feelings that could indicate a lack of neutrality. These include avoiding situations in which you might experience negative feelings, seeking out situations in which you will experience positive feelings (such as friendly and articulate respondents), feeling guilty about some of your feelings, blaming others for your feelings, and feeling disengaged or aloof (Paterson & Groening, 1996)

Neutrality: 'certain type of Muslim faith leader that I might seek for' i.e., being trained in the UK – my hope is that they have a certain level of understanding that is closer to the authenticity of the teachings. Trying to avoid hearing about extreme views about how they tackle mental health difficulties. Reluctant to views about the spiritual solutions – risk of avoiding their extracts

6.Is anything new or surprising in your data collection or analysis? If not, is this cause for concern, or is it an indication of saturation? On occasion, stand back and ask your- self if you are "going native." Consult colleagues before you assume that you have reached saturation in your data analysis. You might be bored, blocked, or desensitized.

Data may look different with COVD-19 – concerned about the richness of the data. Having a semi-structured interviewed and knowing what to follow through.

7.When blocks occur in the research process, reframe them. Instead of getting frustrated when things do not go as planned, ask yourself, "Are there any methodical problems that can be transformed into opportunities?" For example, is there another group of people who can shed light on this phenomenon? Would an additional form of data collection, such as document analysis or diaries, give a greater insight? Often, blocks that occur in research can turn out to be blessings in disguise.

Male faith leaders might be more comfortable to doing the interviews over Zoom – less of the awkward things to figure out. Use the first and second interviews as dummy interviews to learn about the questions that I am asking and if the interview script and process is working.

Appendix C: Consultants Agreement

This agreement is intended to support conversations between the lead researcher with the supervisory team and co researcher / consultants to ensure clarity from the outset for this project.

Title of research project: ***Muslim Faith Leaders' Experiences of Providing Mental Health Support in the Community***

Research Team

Main Researcher: Shirin Azimoth Mustafa

Supervisory Team:

Dr Lizette Nolte: Senior Lecturer, DClinPsy, University of Hertfordshire
Dr Angela Byrne: Psychologist, BME Access Service, ELFT
Dr Jacqui Scott: Research Fellow, DClinPsy, University of Hertfordshire

Co Researchers / Consultants:

Ayan Hussain: Expert by Experience / Peer Support Worker, ELFT
Imam Qamruzzaman Miah: Muslim Co-ordinator – Department of Spiritual, Religious and Cultural Care, ELFT
Dr Sara Betteridge: Psychologist, BME Access Service, ELFT

Agreement

As the main researcher on this project, I agree to and take responsibility for:

Taking a lead to organise any meetings with the co researchers / consultants
Sending draft designs for research to consultants for feedback with clear notice of deadlines.
Giving adequate notice for interview times should consultants be interested to sit in and observe
Offering feedback about how involvement from consultants has added value to the research
Provide final electronic copies of the research to all consultants
Providing feedback of research findings and take lead and offer opportunities to collaborate on writing presentations and publications.
Acknowledge consultants in thesis write up and subsequent publications

As a consultant to this project, I understand that:

	Involvement as a consultant is purely on a voluntary basis and I can notify main researcher should commitments change
	Consultants may dip in and out at different stages of research depending on their area of expertise

And agree to:

	Provide feedback and expertise to different aspects of research design, recruitment, data collection and write-up.
	Express interest should I wish to sit in on interviews or collaborate on writing presentations or publications
	offer guidance and expertise on any ethical concerns or considerations at the earliest convenience
	Maintain anonymity of participants and abide by the ethical principles as outlined in the information sheet given to participants.

Signatures

Signature of main researcher: _____

Date: _____

Signature of Consultant: _____

Date: _____

Appendix D: Ethical Approval

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Shirin Azimoth Mustafa
CC	Lizette Nolte
FROM	Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair
DATE	05/06/2020

Protocol number:	**LMS/PGT/UH/04178**
Title of study:	Faith in Recovery: Muslim Faith Leaders' Experiences of Supporting Mental Health in the Community (Working Title)

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

no additional workers named

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 05/06/2020

To: 30/09/2021

Appendix E: Participant Information Sheet

Title of study:

Muslim Faith Leaders' Experiences of Providing Mental Health Support in the Community

Why have I been given/am I reading this information?

Before you decide whether you would like to take part in this research it is important that you understand what it is being conducted and what will be asked of you, should you decide to take part.

Please take your time to read the information below carefully. It aims to answer any questions that you may have about the research. However, if you have any further questions or if you are unclear about any information in these pages, please feel free to contact Shirin (the main researcher) – contact details are given at the end of this document.

What is this research about?

You are being invited to take part in a study conducted by Shirin Mustafa, a Trainee Clinical Psychologist at the University of Hertfordshire. This thesis is supervised by Dr Lizette Nolte (Clinical Lecturer, University of Hertfordshire) and Dr Angela Byrne (Clinical Psychologist, East London NHS Foundation Trust). The research aims to find out about the experiences that Muslim faith leaders have when supporting a community member with their mental health difficulties, how a Muslim faith leaders Islamic training influences this approach to support and whether this support impacts on their own emotional wellbeing.

Why am I interested in this research?

I have both personal and professional interest in this research. I have really valued the support and guidance given to me when accessing support from Muslim faith leaders and being from a Bangladeshi Muslim background and having worked in areas with high percentage of racially minoritised communities, I have also come to understand that faith and religion are considered very important in how mental health difficulties are understood and managed. People within minority communities will often ask Muslim faith leaders for support prior to or in addition of any mental health service. This, along with being married to an imam, I have become aware of the overwhelming and varied nature of the Muslim faith leader role which interests me. I have also worked professionally in a service that collaborated with faith and community-based organisations to deliver psychological therapies in ways that are most accepted by minoritised communities and I am aware that, despite the value, this approach is not available widely in mainstream MHS so I hope to explore experiences that Muslim faith leaders have when engaging with services in a hope to share learning and support opportunities for increased collaboration.

Can I take part in this study?

To take part in this study, you need to be:

- An adult (18 years and above)
- Have completed a higher level of Islamic Sciences Studies to fulfil role of Muslim faith leaders
- Occupy and worked within community in a Muslim faith leader role for longer than a year
- Have supported a community or congregation member with their mental health difficulties
- Have had no formal mental health or counselling training

What does taking part involve?

It is completely up to you whether or not you decide to take part in this study. You are free to withdraw at any time before the data is analysed on the 29th January 2021, without giving a reason. Any data provided will not be used in the results if you do withdraw before the analysis takes place. If you would like to support this research further, I would be grateful if you would forward the information sheet to your contacts that might meet the eligibility criteria.

If you do agree to take part, you will be asked to give your consent to complete an interview as well as some information about yourself (e.g., age, ethnicity, background of Islamic training). There will be a short 10-15-minute phone call to discuss eligibility. If eligible, and you are still interested we will agree to a time for an online interview that will be no longer than 90 minutes.

What are the benefits of taking part?

There is a lack of research looking at how Muslim faith leaders are making a valuable contribution to providing support for people from minority communities experiencing mental health difficulties. This study aims to contribute to limited research and fill the gap by exploring the conceptualising and experiences of Muslim faith leaders providing support and the impact this may have on their own wellbeing. Therefore, by taking part, you will be helping to build up a body of research on Muslim minority mental health and the importance of support and collaboration with faith and community-based organisations.

What are the possible disadvantages of taking part?

During the interview you may be asked some sensitive questions about the support you provide and how this may impact on your wellbeing. If participation in this research has caused you any distress, discomfort or upsetting feeling, you may wish to contact immediate sources of support such as your family, friends, GP or a therapist. The researcher will also provide information on organisations that you can contact that may be useful.

What will happen to my data?

All information you provide in this research is completely anonymous and confidential and will be used only for research purposes. The only limit to confidentiality would be in the case that any information is given which indicates that you or someone else is at risk of harm. In this case I would need to inform the appropriate agency but would aim to inform you first. The interview will be recorded and transcribed, without any identifying information attached so responses cannot be attributed to any person. There may be some short-anonymised quotes used in publications. Your data will be stored in accordance with the Data Protection Act 1998, and only research team will have access to the data. The data will be stored on a password-protected computer.

What will happen to the results of this study?

The data collected during the study will be used as a part of a Doctoral Clinical Psychology project at the University of Hertfordshire. Research findings will be submitted as part of doctoral thesis. In addition, I will write up an article for publication in a journal, again no participant will be identifiable. The research may be presented at conferences and written up for mainstream media. Ethical approval for this study has been obtained from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority and the UH ethics protocol number is LMS/PGT/UH/04178

What if I am concerned about some aspect of the study?

If you have any concerns about any aspect of this study, you should speak to Shirin, who will do her best to respond to any questions. If you would prefer to speak to any of the supervisors, that can also be arranged.

This study has been reviewed by The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar; University of Hertfordshire, College Lane, Hatfield, Hertfordshire, AL10 9AB.

What should I do now?

If you are interested in taking part, please complete the form below to indicate you have read the information and are happy to proceed.

If you are not interested in participating any further, you do not need to do anything. Thank you for your time in reading this information and considering the study.

Contact Details

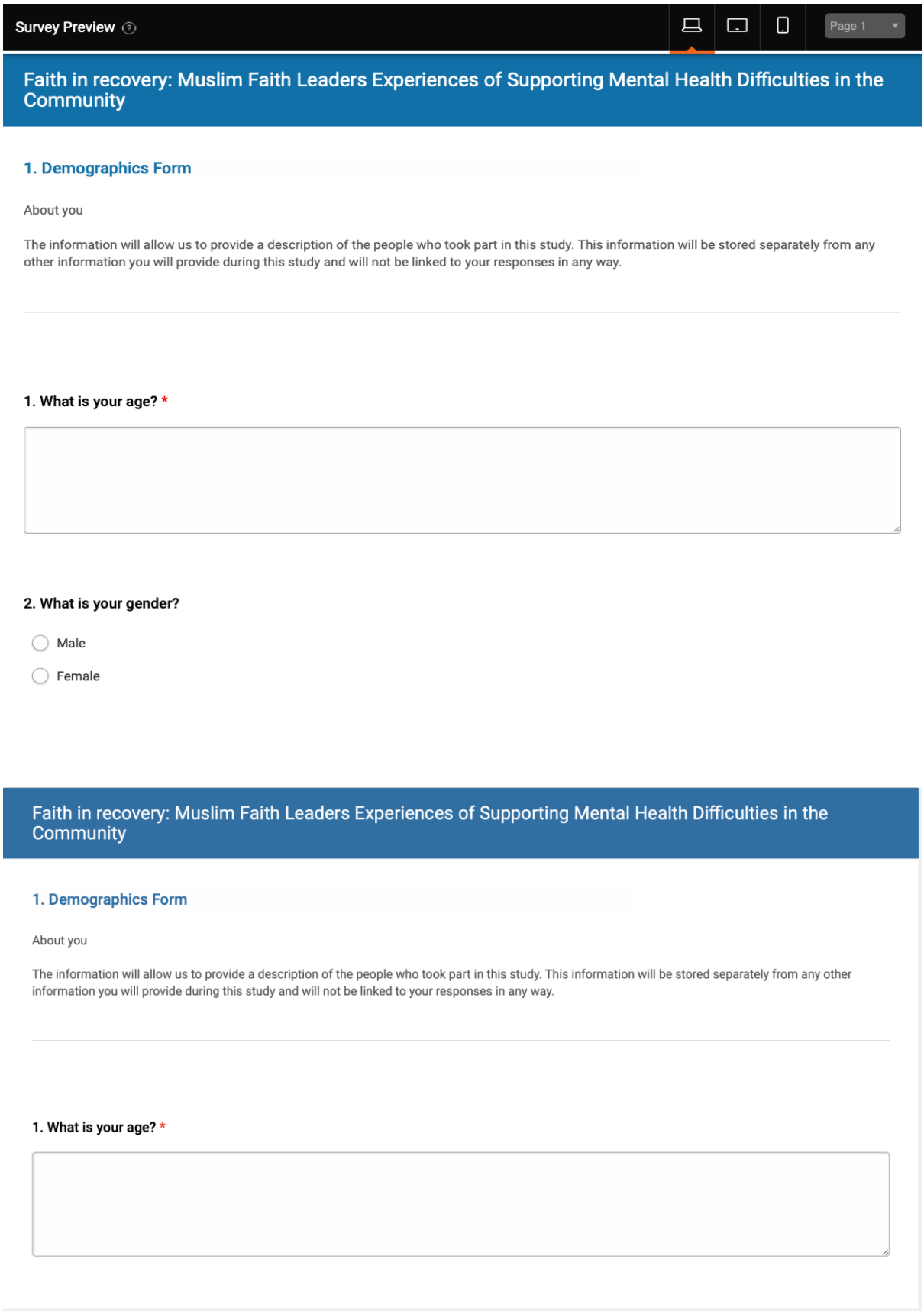
Main Researcher:
Shirin Azimoth Mustafa
Trainee Clinical Psychologist
Tel: 07983406659
Email: sm17aep@herts.ac.uk

Research Supervisor:
Dr Lizette Nolte
Clinical Lecturer in Clinical Psychology
Tel: 01707 286322
Email: l.nolte@herts.ac.uk

Research Supervisor:
Dr Angela Byrne
Clinical Psychologist
Email: angela.byrne7@nhs.net

Appendix F: Research Advertisement

Appendix G: Participant Demographic Form



2. What is your gender?

- ○ Male
- ○ Female

3. Ethnicity:

- ○ 1. White
- ○ English / Welsh / Scottish / Northern Irish / British
- ○ Irish
- ○ Any other White background, please describe below
- ○ 2. Mixed / Multiple ethnic groups
- ○ White and Black Caribbean
- ○ White and Black African
- ○ White and Asian
- ○ Any other Mixed / Multiple ethnic background, please describe below
- ○ 3. Another ethnic group

- ○ Arab
- ○ Any other ethnic group, please describe below
- ○ 4. Asian / Asian British
- ○ Indian
- ○ Pakistani
- ○ Bangladeshi
- ○ Chinese
- ○ Any other Asian background, please describe below
- ○ 5. Black / African / Caribbean / Black British
- ○ African
- ○ Caribbean
- ○ Any other Black / African / Caribbean background, please describe below
- ○ Other (please specify):

4. Education:
What is the highest degree or level of school you have completed? If currently enrolled, highest degree received.

- ○ University Higher Degree (e.g. MSc, PhD)
- ○ Diploma in higher education
- ○ Islamic Sciences Degree
- ○ A Level
- ○ AS Level
- ○ GCSE/O Level
- ○ Other school (inc. school leaving exam certificate/matriculation)
- ○ First degree level qualification including foundation degrees, graduate membership of a professional Institute, PGCE
- ○ Standard/Ordinary (O) Grade / Lower (Scotland)
- ○ Teaching qualification (excluding PGCE)
- ○ Other (please specify):

5. Employment Status:

- ☐ Employed for wages
- ☐ A homemaker
- ☐ Self-employed
- ☐ Retired
- ☐ A student
- ☐ Unable to work
- ☐ Out of work and looking for work
- ☐ Out of work but not currently looking for work
- ☐ Other (please specify):

6. What educational establishment did you complete your Islamic sciences program with?

7. What year did you graduate?

8. What is your position as a Muslim faith leader?

- [ ] Imam
- [ ] Alim / Alimah
- [ ] Community organisation worker
- [ ] Madrasah / tutor / teacher
- [ ] Chaplain
- [ ] Mosque Worker
- [ ] Other (please specify):

9. How long have you been working with the community?

10. Roughly how often, in a month, do you get asked to support with an individual's mental health?

- ( ) About Once
- ( ) Regularly, a few times a week
- ( ) 1-2 times a month
- ( ) more than a few times a month

Comments:

11. Have you ever sought support for your own mental health? If yes, Where have you sought support?

Finish Survey

Appendix H: Consent Form

Muslim Faith Leaders' Experiences of Providing Mental Health Support in the Community

Consent Form

I agree with the following statements (please tick if you agree):

- ☐ I confirm that I am above the age of 18.
- ☐ I confirm that I have read and understood the information sheet provided.
- ☐ I understand what my participation in the project involves. I have had any questions answered to my satisfaction.
- ☐ I understand I can withdraw at any time before the 29th January 2021 without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn.
- ☐ I understand that any information obtained will be kept confidential, unless the researcher is concerned for my safety or the safety of somebody else. When such concerns are raised these will be discussed with me.
- ☐ I agree that research data gathered for the study may be published and if this occurs precautions will be taken to protect my anonymity.
- ☐ Contact information has been provided should I wish to seek further information from the investigator at any time for purposes of clarification.

Audio recording of interviews is required. Please tick below to give consent to audio recording.

- ☐ I understand that my interview will be recorded using audio recording equipment and that this recording will be destroyed once the research study is completed.

Participant Name:
Participant Signature:
Date:

Researcher Name: Shirin Azimoth Mustafa
Researcher Signature:
Date:

If you would like feedback about the results of the study once completed, please provide contact details below

E-mail address: _____

Appendix I: Interview Schedule

Title of Study:

Muslim Faith Leaders' Experiences of Providing Mental Health Support in the Community

Introductory (warming the context) questions

1. What was it about this research project that interested you?

   prompts:

   a. Do you have any hopes for this research?

   b. Is there anything really important you want to make sure we talk about today? *(write this down to refer back to at the end)*

Questions about experiences of providing support

2. Can you tell me about what type of mental health difficulties people usually ask for support on?

   prompts

   a. Can you tell me about an experience of working with someone experiencing sadness / worry / mental health difficulties?

   b. would you normally work in this way?

   c. are there other things have you done/tried in these sorts of situations?

3. How do you make decisions about what type of support to provide?

Questions about Faith Leaders' Conceptualising of mental health

4. There are many different ways of thinking about mental health. What does mental health mean to you?

5. how does this fit with/relate to your Religious beliefs?

   prompts

a. What knowledge do you take from the Quran and Sunnah to help you talk about mental health?

b. How did your Islamic training help you in the way you support people experiencing mental health difficulties?

Challenges, opportunities and impact for Muslim faith Leaders

6. What is it like for you to be asked to support someone's mental health?

   prompts

   a. Have your own experiences changed your own view of the role of a Muslim Faith Leader?
   b. What has led to changes in opinion?

7. Do you find supporting people emotionally impacts on your own wellbeing?

   prompts

   a. How do you manage this?
   b. How do you manage impact on family, eetc
   c. Can you give me an example of how providing support impacts you personally?

8. What do you feel are some the challenges for providing mental health support as a faith leader?

   prompts

   a. Are you provided support for these challenges through your organisation? Or elsewhere?
   b. How do you feel the current societal context for e.g. Racism and Islamophobia influence the challenges that you have spoken about?
   c. Have you had to change your approach to providing support?
   d. Can you tell me a little bit about the job opportunities, funding or training available for Muslim faith leaders?

9. Based on your experiences, what would your hopes be for future faith leaders and faith organisations providing mental health support to communities?

Questions about the experiences of engaging with mainstream services.

10. From experience, I know that it can be difficult for people working within the community to know where to signpost or refer people for mental health support. Are you aware of where you can refer someone for psychological help?

prompts

a. Have you made any referrals to mental health services or done any joint work with any mental health professional? Signposting or referring?
   If yes, how do you feel about the process? How was your experience?
   If no, where would you usually refer people to get further support?
b. What prevented you from making a referral to a mental health service?
c. What would help you feel more confident in making direct referrals?
d. Do you feel MHS and Islamic approach to support are compatible??

11. What do you believe the challenges or opportunities of faith leaders and mental health services collaborating?

12. What would be your hopes for how Muslim faith leaders and Muslim faith organisations collaborating with mainstream mental health services?

Ending questions

13. What has it been like for you to answer these questions and be part of this research today?

prompt

a. Did we talk about what you expected to/wanted to?
b. Thinking back to what you said at the beginning of the interview. Is there anything else you would like to tell me about your experience of providing mental health support?
c. Anything else you think is important for me or mental health professionals to understand?

General Prompts:

- How did you experience that?
- What sense did you make of that?
- How do you make sense of that?
- What did that mean for you?
- How did you come to understand that?
- And what did you think about that?
- What do you make of that?
- What do you think happened there?
- Can you tell me more?
- Can you give me an example of that?

Appendix J: Debrief Information for Participants

Debrief Form

We really appreciate you taking the time to help us. The aim of the study is to explore Muslim faith leaders' experiences of providing support to people experiencing mental health difficulties and your generous contribution will help make an important contribution to understanding Muslim mental health.

What will happen next?

Your interview will be compared with others to see if there are any similar themes or patterns. We hope that this information will help us to understand more about the nature of support that Muslim faith leaders provide and the opportunities and challenges that they may face when engaging with mental health services. The results will be written up and disseminated and the information from the study will also support discussions to increase collaborations between mainstream services and faith organisation to help support the Muslim community.

Things to remember

- You have the right to withdraw from the study at any time before the analysis starts before the 29th January 2021.
- The information we have gathered will be kept anonymous and confidential within the limits already explained to you.
- You are entitled to have a summary of the research findings. This will be made available upon your request when the study is complete.

Sources of further support

The process of talking may have left you feeling a range of emotions and feelings. You might find it helpful to make use of a number of sources of support:

- Speaking with someone you know who you trust, such as your own family and friends.
- Your **GP** - Please consider contacting your GP if you are feeling low or anxious.
- **Psychological therapies** - If you think that you may benefit from engaging in a talking therapy (such as cognitive behavioural therapy), then you may wish to consider self-referring to your local psychological therapies service or asking your GP to refer you. To find your nearest service, you can search IAPT NHS on Nhs Choices
- **NHS Direct** - NHS Direct delivers telephone and internet information and advice about health, illness and health services, day and night, direct to the public. Call 111or go to www.nhsdirect.nhs.uk
- **Samaritans** - This is a 24 hour a day, free and confidential helpline for anyone experiencing any emotional distress. Freephone: 08457 909090; Website: www.samaritans.org
- **MIND** - is a leading mental health charity in England and Wales. The Mind Info Line offers confidential help on a range of mental health issues. Call 0300 123 3393 or go to www.mind.org.uk
- **Sakoon Islamic Counselling** - Organisation run by Professional Counsellors, who offer different types of therapy. Call 07943 561 561 or email; info@sakoon.co.uk; Website https://www.sakoon.co.uk
- **Zamzam counselling** – Accredited Muslim Counsellor and CBT therapist. Contact 07799485059 or email info@zamzamcounselling.co.uk.
- **Muslim Community Helpline** – The Muslim Community Helpline is a confidential, non-judgemental listening and emotional support service for Muslims. Call: 020 8904 8193 or 020 8908 6715 – Monday to Friday 10am to 1pm
- **The Maryam Women's Counselling Service** – Part of the Maryam Centre, East London Mosque. womenscounselling@londonmuslimcentre.org.uk or call 020 7650 3022

Appendix K: Reflective Journal Extract

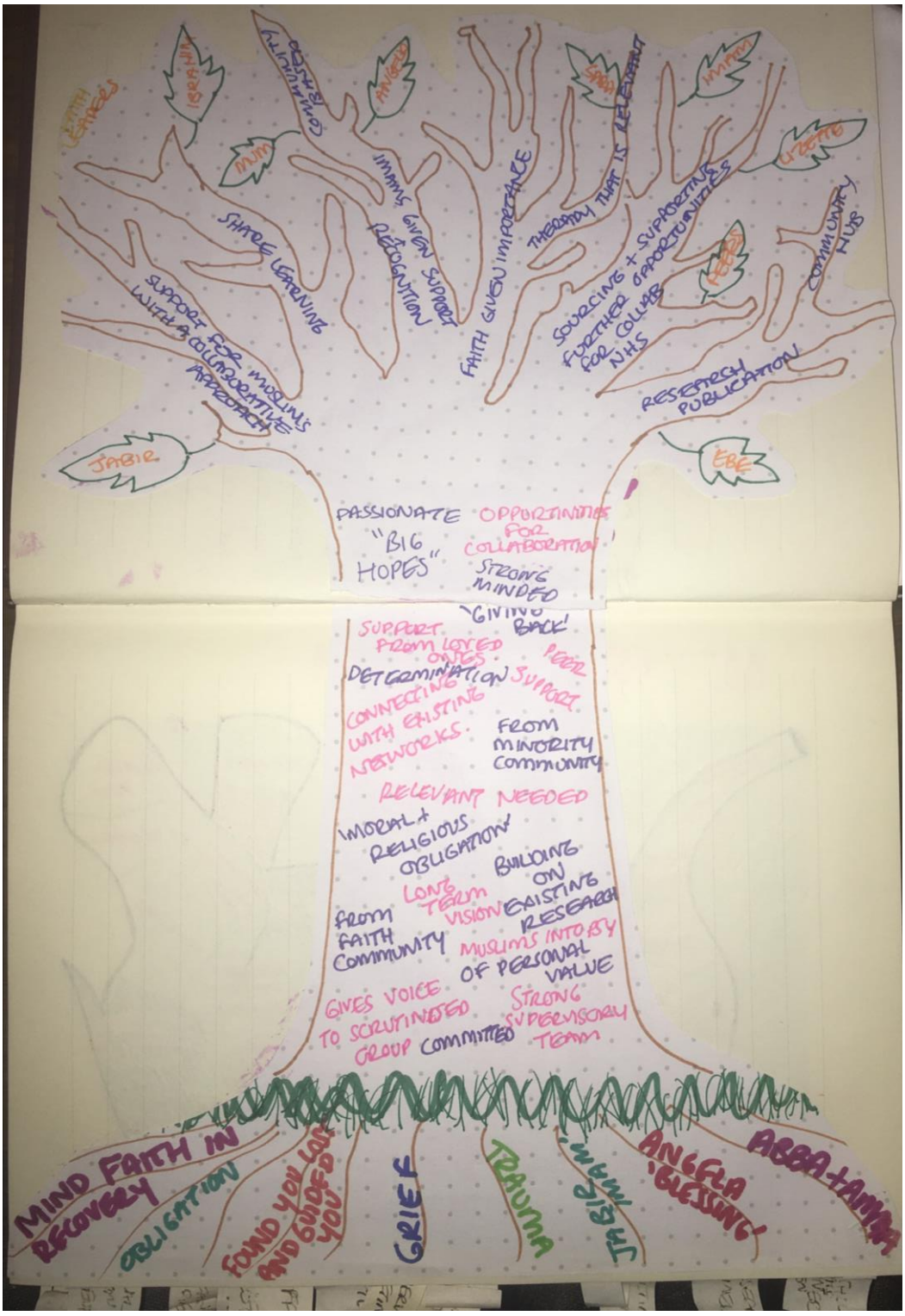
Journal entry after completing interview 2:

I may have taken for granted just how complex the cases being seen by MFL are. I feel overwhelmed at the moment and very struck by the level of trauma Idris described and is regularly exposed to. Witnessing violence, self-harm and suicide will undoubtably have an impact and it is no surprise why Idris was so forthcoming to take part in this research. I wonder whether the prison or NHS services are aware? It didn't come across that Idris is being supported through adequate training or supervision. Idris explained his fear for the long-term impact very eloquently and with a sense of urgency. I feel this sense of urgency too but also share in his frustrations that MFLs are let down long before even commencing their roles, from their training institutes.

Idris gave an interesting perspective that, given his Islamic training was in a boarding context, away from family and his support network, he learnt to build resilience against the challenges he faces at work. I haven't given much thought to the importance of faith leaders being trained in a boarding context, but interestingly given that these MFLs often are isolated whilst training, needing to look after themselves, it is no wonder Idris spoke about being able to connect with his prisoners more and recognising the importance of the small comforts that we may take for granted.

It sounded like, being within the context of a prison service means that he has much easier access to psychologists and joint collaborative working with other professionals. Idris spoke about this in a positive light, considering psychologists input valuable and how they, in turn, also value the input he makes. I wish I had gone further into detail with this and explored specific examples. It sounded like, as an MFL, Idris had provided his expertise regarding how to engage the people they work with but I couldn't get a sense whether he was also provided psychological expertise to make sense of the difficulties it described. I question whether MFL are being seen as completely part of the team, and so should have access to the employment benefits and training or whether they are just called into provide input relating to religious matters. This feels like a crucial aspect to this interview, whether the work and level of input relating to mental health difficulties is being recognised.

Tree of Life (Ncube, 2006) Journal Entry Completed During Research Proposal Stage Mapping Significant People, Research Roots and Dreams for the Future.



Appendix L: Non-Disclosure Confidentiality Agreement

University of Hertfordshire

Doctorate in Clinical Psychology

University of Hertfordshire

Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

Shirin Mustafa

And

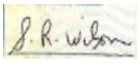
Sonia Wilson

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient agrees to stop transcription immediately if they recognise any parties mentioned on the audio recording, and to return the recording to the discloser.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Name: Sonia Wilson **Signed:** 

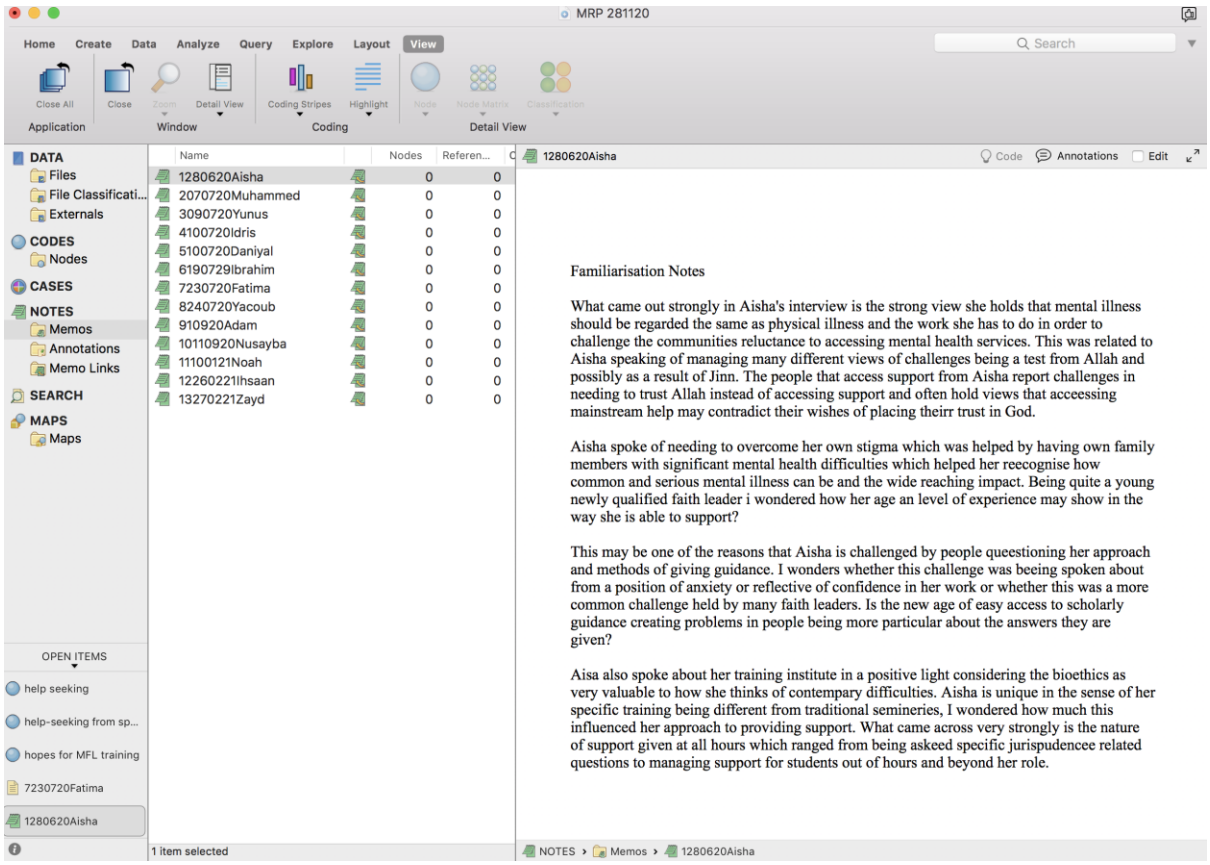
Date: August 8, 2020

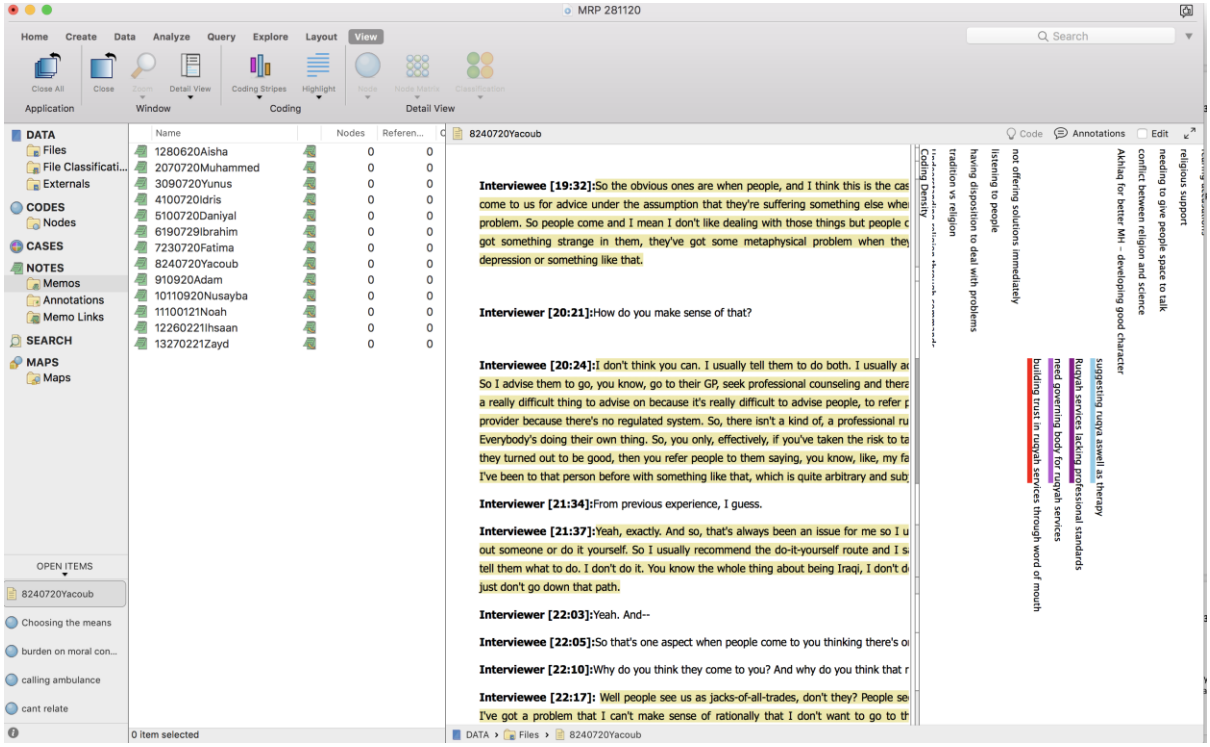
INVESTOR IN PEOPLE

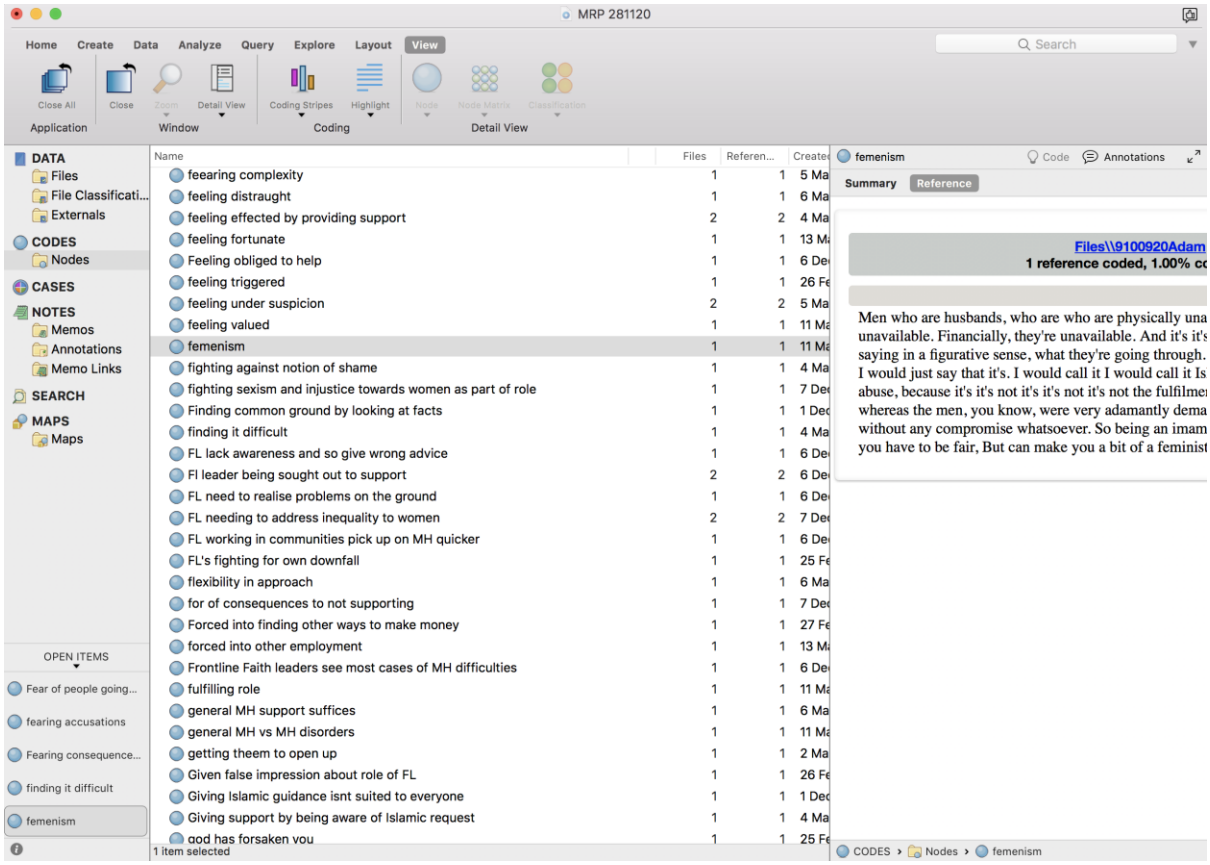
Student No: 15064361

Appendix M: Example of Coded Interview Transcript

Appendix N: Analysis Process



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feeling triggered 1 1 26 Fe
feeling under suspicion 2 2 5 Ma
feeling valued 1 1 11 Ma
femenism 1 1 11 Ma
fighting against notion of shame 1 1 4 Ma
fighting sexism and injustice towards women as part of role 1 1 7 De
Finding common ground by looking at facts 1 1 1 Dec
finding it difficult 1 1 4 Ma
FL lack awareness and so give wrong advice 1 1 6 De
Fl leader being sought out to support 2 2 6 De
FL need to realise problems on the ground 1 1 6 De
FL needing to address inequality to women 2 2 7 De
FL working in communities pick up on MH quicker 1 1 6 De
FL's fighting for own downfall 1 1 25 Fe
flexibility in approach 1 1 6 Ma
for of consequences to not supporting 1 1 7 De
Forced into finding other ways to make money 1 1 27 Fe
forced into other employment 1 1 13 Ma
Frontline Faith leaders see most cases of MH difficulties 1 1 6 De
fulfilling role 1 1 11 Ma
general MH support suffices 1 1 6 Ma
general MH vs MH disorders 1 1 11 Ma
getting theem to open up 1 1 2 Ma
Given false impression about role of FL 1 1 26 Fe
Giving Islamic guidance isnt suited to everyone 1 1 1 Dec
Giving support by being aware of Islamic request 1 1 4 Ma
god has forsaken you 1 1 25 Fe
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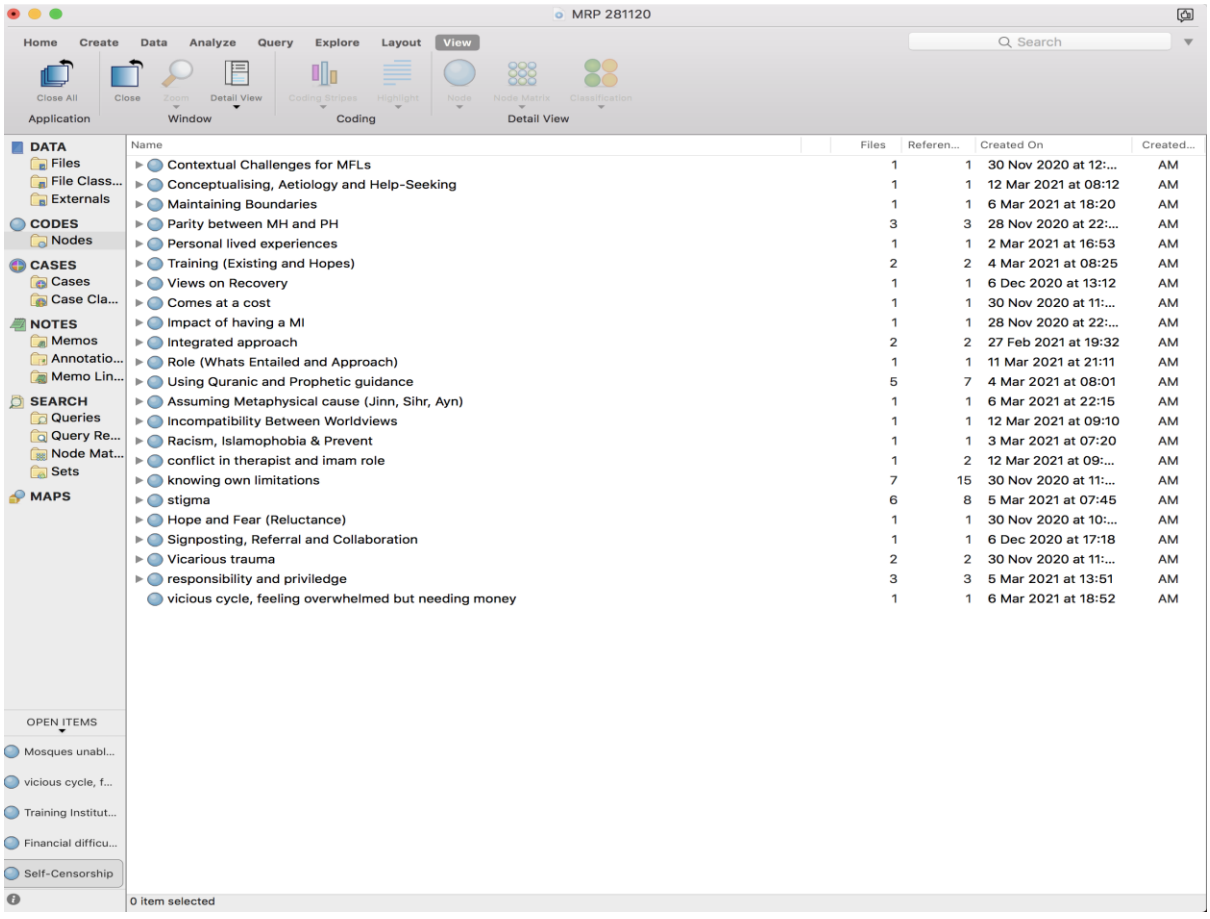
Men who are husbands, who are who are physically una
unavailable. Financially, they're unavailable. And it's it's
saying in a figurative sense, what they're going through.
I would just say that it's. I would call it I would call it Is
abuse, because it's it's not it's it's not it's not the fulfilme
whereas the men, you know, were very adamantly dema
without any compromise whatsoever. So being an imam
you have to be fair, But can make you a bit of a feminist
CODES › Nodes › femenism
OPEN ITEMS
Fear of people going...
fearing accusations
Fearing consequence...
finding it difficult
femenism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Contextual Challenges for MFLs 1 1 30 Nov 2020 at 12:... AM
Conceptualising, Aetiology and Help-Seeking 1 1 12 Mar 2021 at 08:12 AM
Maintaining Boundaries 1 1 6 Mar 2021 at 18:20 AM
Parity between MH and PH 3 3 28 Nov 2020 at 22:... AM
Personal lived experiences 1 1 2 Mar 2021 at 16:53 AM
Training (Existing and Hopes) 2 2 4 Mar 2021 at 08:25 AM
Views on Recovery 1 1 6 Dec 2020 at 13:12 AM
Comes at a cost 1 1 30 Nov 2020 at 11:... AM
Impact of having a MI 1 1 28 Nov 2020 at 22:... AM
Integrated approach 2 2 27 Feb 2021 at 19:32 AM
Role (Whats Entailed and Approach) 1 1 11 Mar 2021 at 21:11 AM
Using Quranic and Prophetic guidance 5 7 4 Mar 2021 at 08:01 AM
Assuming Metaphysical cause (Jinn, Sihr, Ayn) 1 1 6 Mar 2021 at 22:15 AM
Incompatibility Between Worldviews 1 1 12 Mar 2021 at 09:10 AM
Racism, Islamophobia & Prevent 1 1 3 Mar 2021 at 07:20 AM
conflict in therapist and imam role 1 2 12 Mar 2021 at 09:... AM
knowing own limitations 7 15 30 Nov 2020 at 11:... AM
stigma 6 8 5 Mar 2021 at 07:45 AM
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Signposting, Referral and Collaboration 1 1 6 Dec 2020 at 17:18 AM
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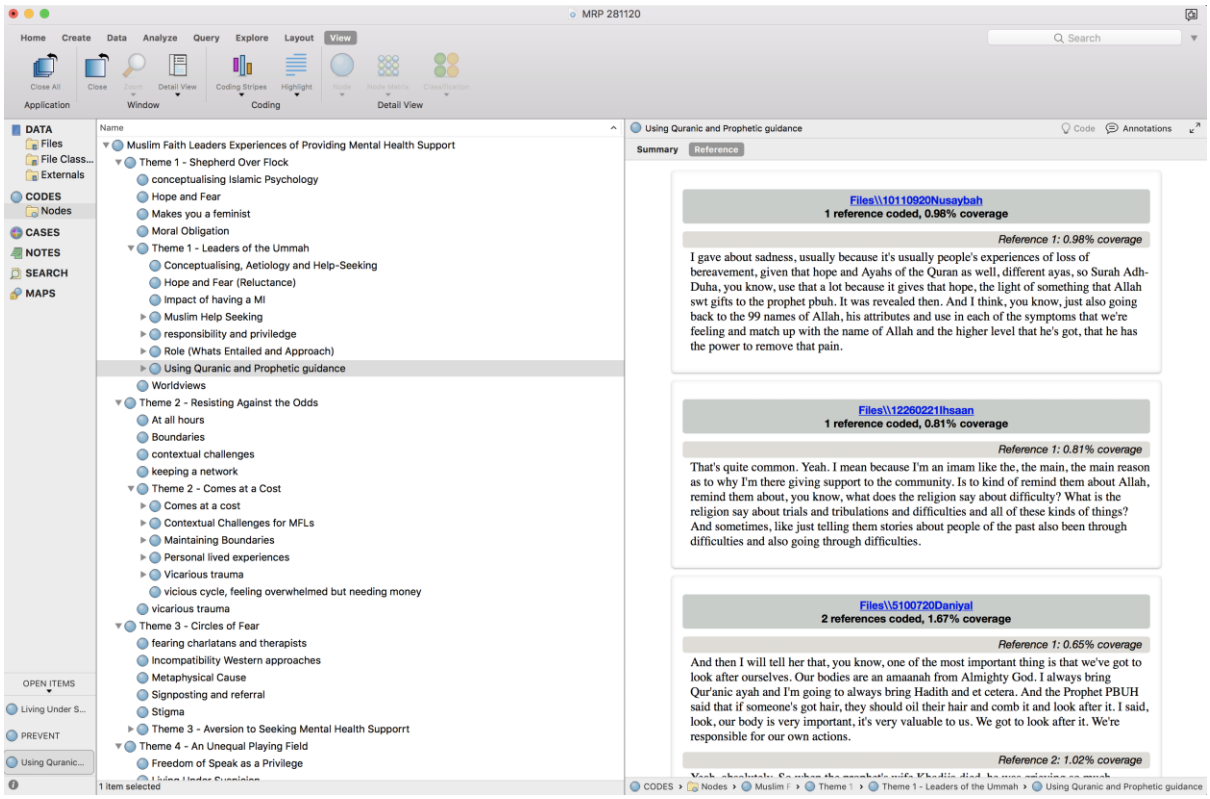
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Muslim Faith Leaders Experiences of Providing Mental Health Support
Theme 1 - Shepherd Over Flock
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Moral Obligation
Theme 1 - Leaders of the Ummah
Conceptualising, Aetiology and Help-Seeking
Hope and Fear (Reluctance)
Impact of having a MI
Muslim Help Seeking
responsibility and priviledge
Role (Whats Entailed and Approach)
Using Quranic and Prophetic guidance
Worldviews
Theme 2 - Resisting Against the Odds
At all hours
Boundaries
contextual challenges
keeping a network
Theme 2 - Comes at a Cost
Comes at a cost
Contextual Challenges for MFLs
Maintaining Boundaries
Personal lived experiences
Vicarious trauma
vicious cycle, feeling overwhelmed but needing money
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Theme 3 - Circles of Fear
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Incompatibility Western approaches
Metaphysical Cause
Signposting and referral
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I gave about sadness, usually because it's usually people's experiences of loss of bereavement, given that hope and Ayahs of the Quran as well, different ayas, so Surah Adh-Duha, you know, use that a lot because it gives that hope, the light of something that Allah swt gifts to the prophet pbuh. It was revealed then. And I think, you know, just also going back to the 99 names of Allah, his attributes and use in each of the symptoms that we're feeling and match up with the name of Allah and the higher level that he's got, that he has the power to remove that pain.
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That's quite common. Yeah. I mean because I'm an imam like the, the main, the main reason as to why I'm there giving support to the community. Is to kind of remind them about Allah, remind them about, you know, what does the religion say about difficulty? What is the religion say about trials and tribulations and difficulties and all of these kinds of things? And sometimes, like just telling them stories about people of the past also been through difficulties and also going through difficulties.
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And then I will tell her that, you know, one of the most important thing is that we've got to look after ourselves. Our bodies are an amaanah from Almighty God. I always bring Qur'anic ayah and I'm going to always bring Hadith and et cetera. And the Prophet PBUH said that if someone's got hair, they should oil their hair and comb it and look after it. I said, look, our body is very important, it's very valuable to us. We got to look after it. We're responsible for our own actions.
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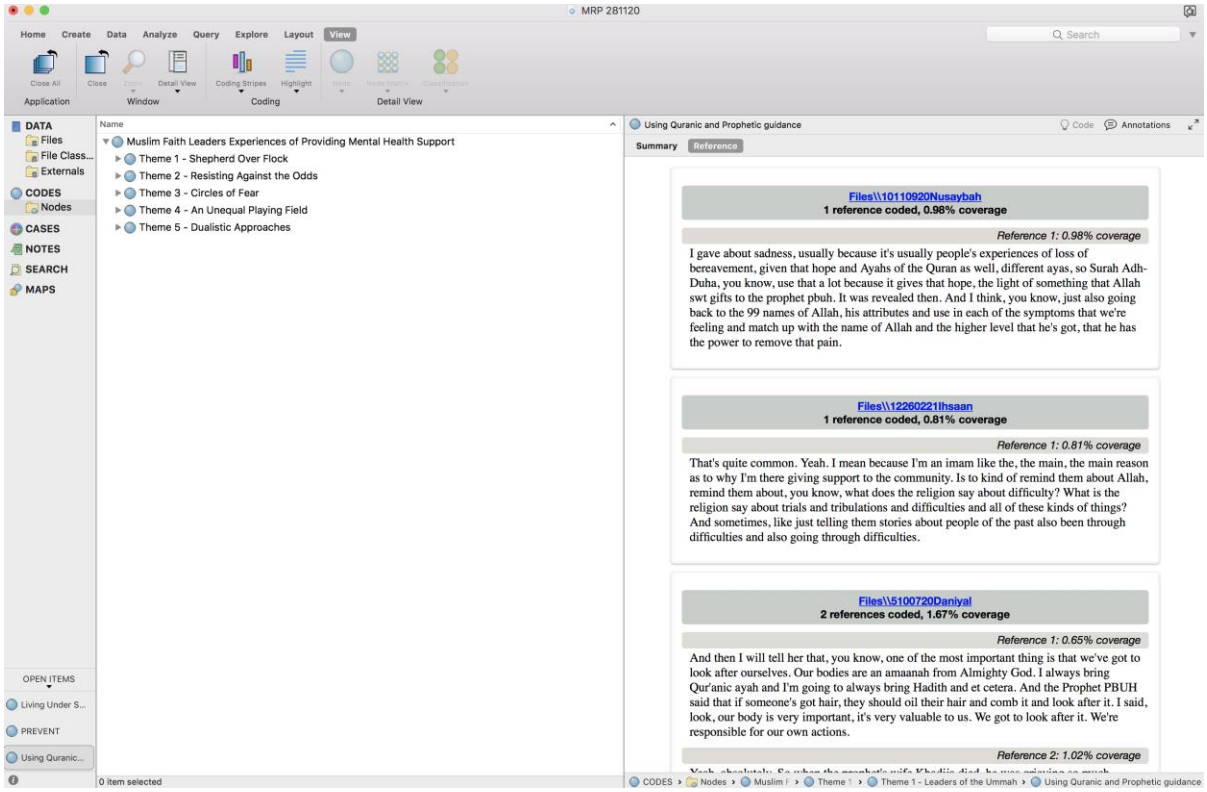
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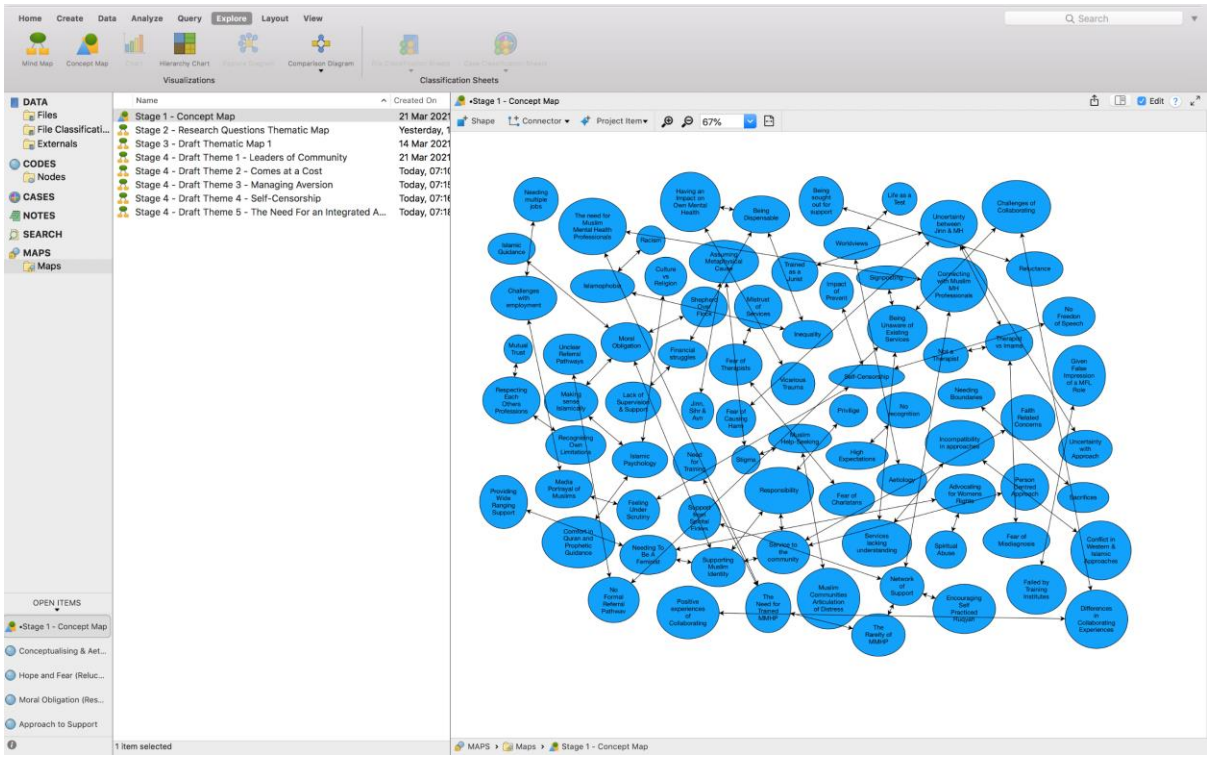
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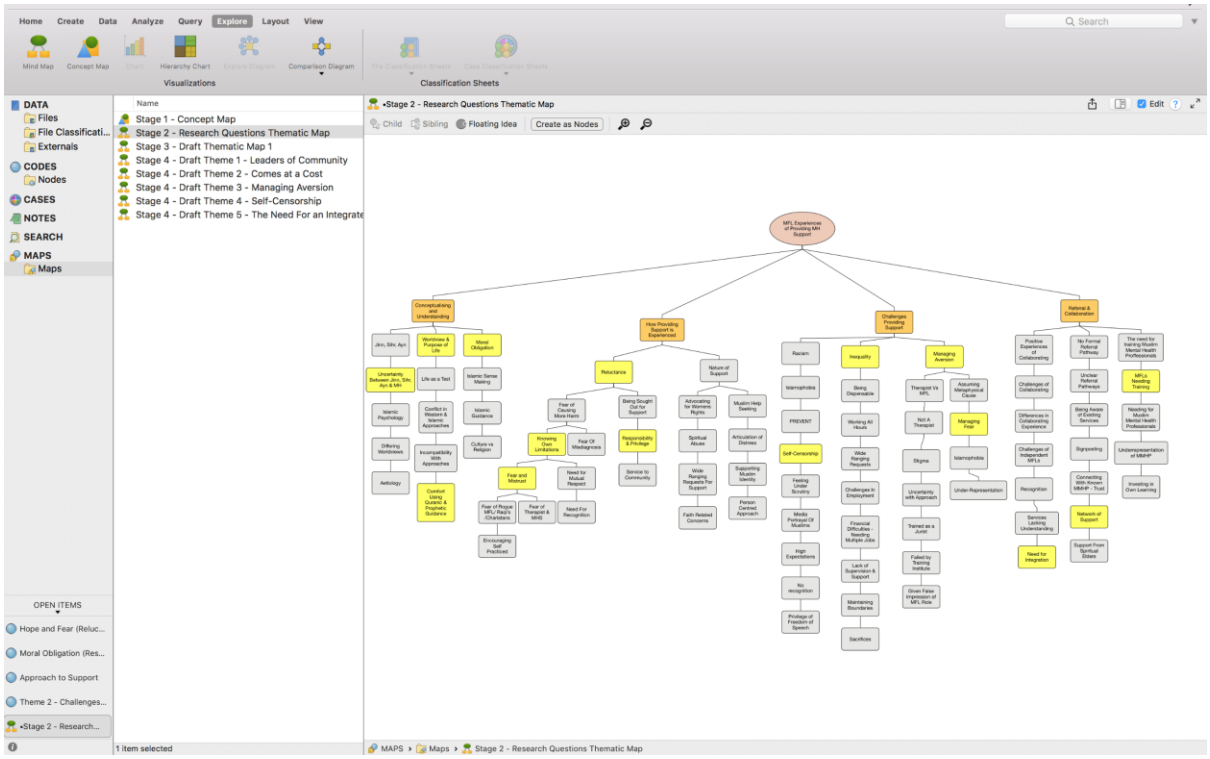
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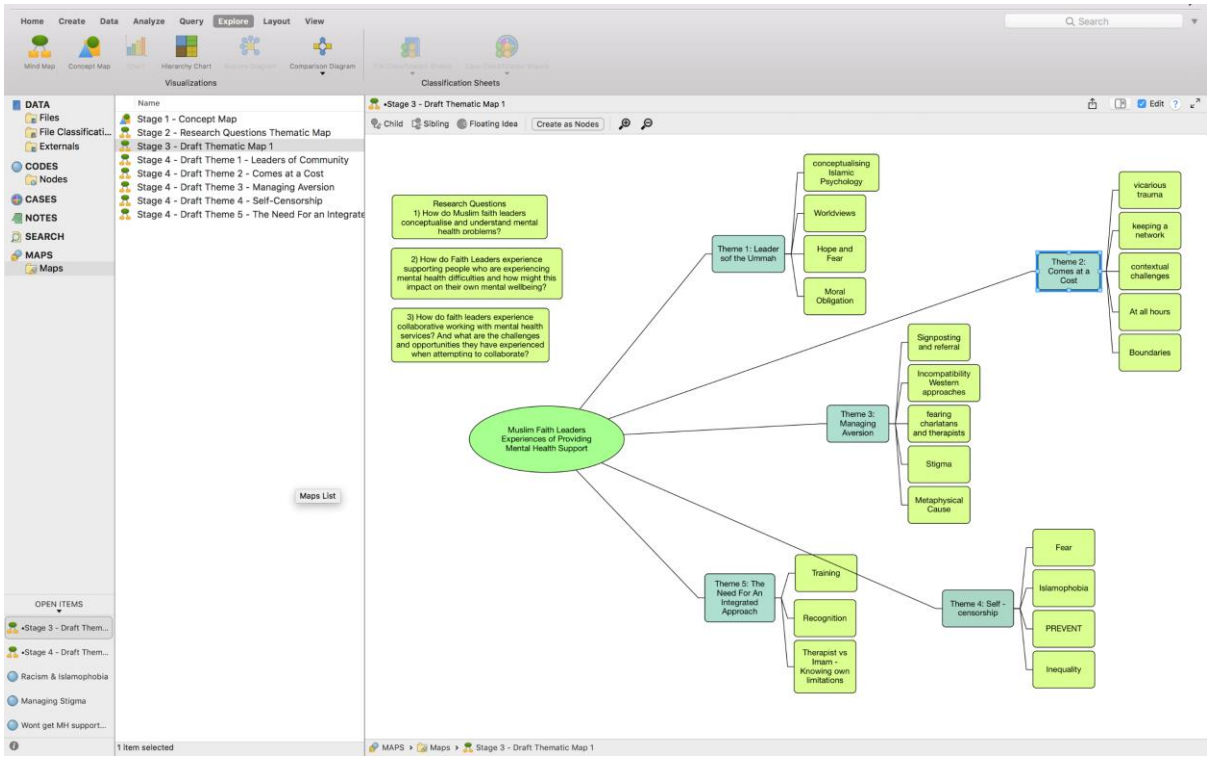
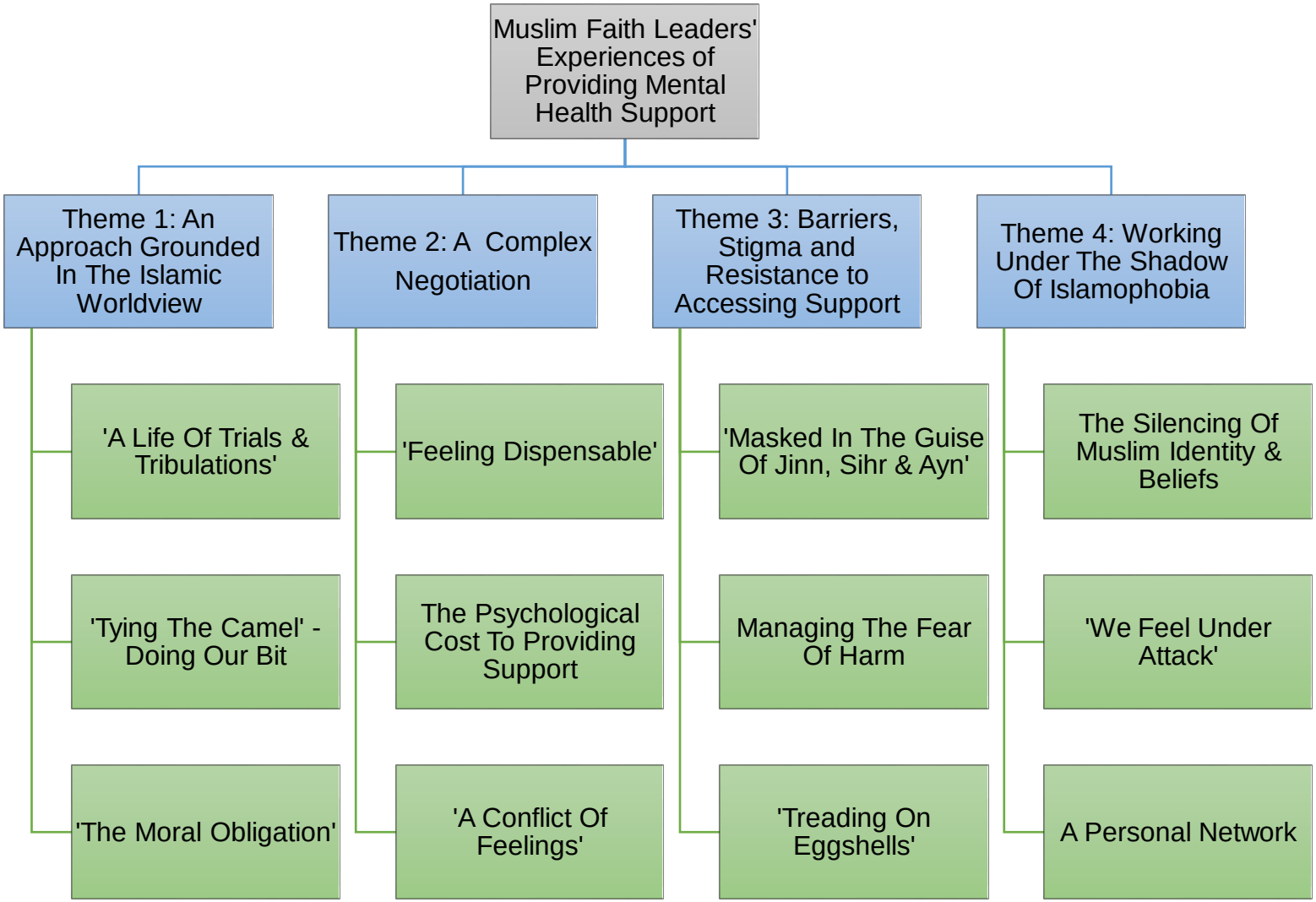
Appendix O: Preliminary Thematic Maps




Muslim Faith Leaders' Experiences of Providing Mental Health Support
Theme 1: Utopia vs A Life of Trials & Tribulations: An Approach Grounded In The Muslim Worldview
A Life of Utopia vs A Life of Trials & Tribulations
Tying the Camel - Striving for Aafiyah (Wellbeing) and Al-Qalbul Mutma'in (The Tranquil Heart)
The Moral Obligation: The Responsibility & Privilege That Comes With Providing Support
In The Remembrance of Allah Do Hearts Find Tranquility - The Use of Islamic Scriptures to Provide Support
Theme 2: The Challenges and Cost of Being A Muslim Faith Leader
'Feeling Dispensable': The Monetary Cost to being a Muslim Faith Leader
Experiencing Vicarious Trauma: The Psychological Cost to Providing support
'A Conflict Of Feelings': Reluctance Vs Guilt In Providing Support
Theme 3: Navigating The Masked Aversion To Services
'Treading On Eggshells': The Stigma Attached To Mental Health Difficulties
'Masked In The Guise Of Jinn, Sihr & Ayn': The Comfort Of Assuming A Metaphysical Cause
Managing The Fear Of Harm: Acting As An Intermediary Between Talking Therapy & Spiritual Healing
Theme 4: 'The Increasing Problem of Self-Censorship': The Impact of Racism, Islamophobia & The Prevent Agenda
'Fearful Of Being Maligned An Extremist': The Silencing of Muslim Identity & Beliefs
'We Feel That We Are Under Attack': The Everyday Challenge of Racism & Islamophobia
'Mistrust In The System' Prevent & The Privilege That Is Freedom Of Speech
Theme 5: Building Bridges Between Mental Health Services and Faith Communities
The Value of A Personal Network
Hopes for Dialogue and Mutual Training
Recognising Own Limitations: 'Trained As A Jurist Not A Therapist'
Signposting Rather Than Referral: The Importance of Clear Referral Pathways


Muslim Faith Leaders' Experiences of Providing Mental Health Support
Theme 1: An Approach Grounded In The Muslim Worldview
'A Life of Trials & Tribulations'
'Tying the Camel'
'The Moral Obligation'
'In The Remembrance of Allah Do Hearts Find Tranquility'
Theme 2: Challenges of Being A Muslim Faith Leader
'Feeling Dispensable'
The Psychological Cost to Providing support
'A Conflict Of Feelings'
Theme 3: Navigating The Masked Aversion To Services
'Treading On Eggshells'
'Masked In The Guise Of Jinn, Sihr & Ayn'
Managing The Fear Of Harm
Theme 4: Working Under The Shadow of Islamophobia
The Silencing of Muslim Identity & Beliefs
'We Feel Under Attack'
Prevent & The Privilege That Is Freedom Of Speech
Theme 5: Building Bridges For Holistic Care
A Personal Network
Mutual Trust & Training
'Trained As A Jurist Not A Therapist'



Appendix P: Final Thematic Map

Appendix Q: Therapeutic Implications

Category	Name	Description
Adapted Approaches	Systemic Family Therapy (SFT)	SFT is and interactional and collaborative approach which seeks to reduce distress and conflict within family dynamics by addressing and improving the systems of interactions between individuals (Johnstone & Dallos, 2014). Techniques within SFT that may be particularly useful for Muslim clients and MHPs include the cultural genogram which can facilitate and promote cultural awareness and sensitivity (Hardy & Laszloffy, 1995). Weatherhead and Daiches (2015) note that many theorists have specifically considered the appropriateness of family therapy for Muslim families (Messent 1992; Rubin and Nassar 1993; Daneshpour 1998) and called for adaptation to SFT to include an Islamic approach to understanding a concept of self, family dynamics and the role of extended family. Examples of SFT offered in a religiously sensitive way include a solution focused model of family therapy used with families in Turkey (Valiante, 2003) and an integrative SFT approach with an emphasis on the 'behavioural and concrete' used in families organised with a gender hierarchy.
	Narrative Therapy (NT)	In common with SFT and community psychology, NT does not see problems as lying within the person and so is highly attuned to a social justice focus in therapy (Kahn & Monk, 2017). By interweaving narrative theory with Foucault's analysis of modern power (Besley, 2002), MHPs can work with Muslim clients to deconstruct the problem, challenging oppressive dominant discourses (such as Muslims' beliefs being radical or extreme) which helps situate the problem in context (Harper & Spellman, 2014) and emphasising the politics of experience (White, 1995). Collective Narrative practices can also be adapted, such as the Tree of Life methodology (Ncube, 2006). An example of this can be seen from the Faith in Recovery work where the methodology was adapted to include Islamic ideas of wellbeing (Mustafa & Byrne, 2016).
	Open Dialogue (OP)	Influenced by family therapy, OD is a Finnish model of mental health service delivery and growing in popularity in the UK (Razzaque & Wood, 2015; Tribe et al, 2019). The approach is recommended by the Muslim psychologist and OD practitioner consultant involved in this research. Principles of OD include immediate response: social network inclusion; continuity and flexibility; responsibility, tolerating uncertainty and dialogue (Seikkula & Arnkil, 2006). Network meetings between the person, their network and mental health professionals aim to develop trust and shared understandings. The key elements of OD can complement Muslim communities' preferences in help-seeking as it mobilises the psychosocial resources in a clients' network and so can include MFLs in a collaborative approach to support.
	Adapted CBT Approaches	CBT is widely recognised intervention approach which combines a variety of cognitive, behavioural, problem solving and emotion focused techniques to change or modify maladaptive thinking which are responsible for the development and maintenance of emotional distress (Rassool, 2016). The philosophical and theoretical basis of different elements of CBT that align and conflict with Muslim beliefs have been examined by a number of authors (e.g., Beshai et al, 2012; Hodge & Nadir, 2008), with a number of considerations arising regarding the nature of reality, science vs empiricism, source of individual misfortune, locus of control and individual vs collective rights. Considerations regarding culturally adapting CBT with attention to experiences of trauma, coercive

		treatment and racism highlighted by Rathod et al (2009) and Naeem et al (2010; 2019) have helpfully given recommendations on how to adapt the many facets of therapy such as language and techniques.. Islamically-adapted CBT interventions have been offered, such as an Islamic perspective to cognitive restructuring (Hamdan, 2008); irrational beliefs and systematic desensitisation (Badri, 1967; 2013); depression and behavioural activation (Meer et al, 2012; Mir et al, 2015; 2019); and, chronic physical illness (Sabki et al, 2018; Pearce et al, 2015).
Faith-based and Islamic Counselling	Islamic Counselling	Islamic counselling is the incorporation of Islamic values, teachings and spirituality into the therapeutic processes, mechanisms and approaches (Sudan, 2017). Islamic Counselling incorporates aspects of mainstream counselling techniques with teachings from the Quran and Sunnah (Rassool, 2016) Most Islamic Counselling services are private, requiring fees, although some low cost or free alternatives may be available through local mosques such The Maryam Women's Counselling Service at East London Mosque or services listed here https://mcb.org.uk/resources/mental-health/. Given the accounts of barriers fear and stigma along with the clash of worldview reported by participants, Islamic counselling may be better suited for many Muslims. Several models of Islamic counselling now exist based on different ideologies and approaches. These include the Islamic Counselling practice Model (Rassool, 2016; Barise, 2005) Muslim Personal Law (Abdulla, 2007) Islamic counselling based on Sufism (Badri, 1979; Jafari, 1993) or Islamic counselling model by Dharamsi & Maynard (2010). Another proposed model includes Keshavarzi & Haque (2013), although this model is based within an Islamic collectivist context.
Pre-Existing Religious Coping Techniques	Ruqyah Traditional Healing	Given that the Quran is considered to offer perfect solace to a believer - both spiritually and physically, Ruqyah refers to the healing method based on the Quran and hadith (Prophetic sayings) through the recitation of the Quran, seeking of refuge, remembrance and supplication that is used as a means of treating sickness, evil eye, black magic and possession, amongst other problems. This is done by reading verses of the Quran, the names and attributes of Allah, or by using the prayers in Arabic or in a language the meaning of which is understood. The use of Ruqyah as a method of treatment is popular among the Islamic alternative healing practitioners, has an increasing evidence base for its effectiveness (Adynata & Idris, 2016; Afifuddin & Nooraini, 2016; York, 2011), and is also supported by wider literature on the positive influence of religious practice on health and wellbeing (Jones, 2004; Koenig 2001).
	Hijama – Wet Cupping therapy	The word 'Hijama' (Cupping) means 'drawing out' in Arabic. Cupping therapy has roots among many ancient healing systems including Chinese, Unani, traditional Korean, Tibetan, African, European, Arabic and Prophetic medicine, with variations in the types of cups used, methods of cupping, and application sites (Mehta & Dhapte, 2015). According to Islamic tradition, hijama is usually explicit to 'blood cupping' (El-Wakil, 2011). Hijama was recommended by the prophet Muhammad, who mentioned cupping in approximately 28 holy instructions or hadith (Saqlain, Ali, & Parveen, 2017). Hijama is recommended for a broad range of conditions; blood diseases such as haemophilia and hypertension, rheumatic conditions ranging from arthritis, sciatica, back pain, migraine, anxiety and general physical and mental well-being.
	Religious Practices –	The basic rites of Islam that were revealed to the Prophet are the "pillars" of Islam which provide Muslims with multiple practices as coping mechanisms against everyday stresses and hardships, to relieve anxiety and other negative mental states (Hitchcock, 2005; Abdel-Khalek, 2011). These are considered to be the entire ritual structure of the Islamic religion because they are the five essential and obligatory practices that all Muslims follow. These pillars also "have

	Five Pillars of Islam	certain disciplinary effects in curbing the excess desires of the believers, in teaching them to do things together for the welfare of the group and for the purification of their souls". The five rituals consist of: 1.) Shahada, the profession of faith, 2.) Salah, prayer, 3.) Zakah, almsgiving, 4.) Siyam, fasting, and 5.) Hajj, the pilgrimage.
	Prophetic Food	Many of the recommended foods by the Prophet have also been scientifically acknowledged for having nourishing or health benefitting properties (Moulvi, 2017; Salim, 2014 Ally & Laher, 2008). Examples of these food along with the prophetic narration are: Honey – "Make use of the two cures: Honey and the Quran" *(Ibn Majah, 1952)* Olive Oil – "Season (your food) with olive oil and anoint yourselves with it, for it comes from a blessed tree". (Ibn Majah, 1952) Dates - "If somebody takes some `Ajwa dates every morning, he will not be affected by poison or magic on that day till night". (Bukhari, 1966) Black seed oil – "You should eat this black seed, for in it there is healing from every disease, except death". (Ibn Majah, 1952) Wholegrain barley - 'Wholegrain barley gives rest to the heart and makes it active and relieves some of his sorrow and grief.'" (Bukhari, 1966)

Appendix R: Consultant Reflections

Sara Betteridge

"Overall, this process has been really good. At every stage it's made me think about my thesis and what it would have been like if I done something similar. I felt very much alone during my thesis, particularly when doing data analysis and discussion. What I found doing it this way with you, is that, right from the beginning the discussions that we were having as a group, the reflective nature of our discussions, I'm sure that many of those, very early, initial discussions are reflected in the research. Thoughts and ideas have been shared so freely that when it came to writing or thinking about interpreting, we had lots to think about. This whole process has felt very open, very fluid, people bounce ideas off each other. There has been a number of discussions that we have had where Angela said something, or Lizette said something, and ideas have sort of come through flowing through my mind and vice versa. So, the power of what I would call kind of a very open dialogue setting of these regular meetings, that we had were so conducive to ideas and thoughts being bounced around that I'm sure make up the crux of a lot of what has been written about alongside the data.

The group has been a very powerful space to explore ideas and hopefully make you feel like you're not on your own, to give you some other perspectives. It's crazy isn't it, like we all should be doing research like this. This has been a brilliant experience from my perspective. One of the main reasons that I like working in this way is because I often take on too much responsibility and working with a number of other people really helps to share that responsibility and what that does for me is allow my creative side to come out and allow my ideas to flourish. I get blocked if I feel like I'm holding too much responsibility and if I was your sole supervisor outside of the university, I probably would have got quite blocked along the way of how to help you. I suppose the flipside to that and maybe something to think about

is that when you do have so many people, making the expectations clear. I guess sometimes I felt like should I be responding to things and wondering, is there an expectation that she needs me to do XYZ, so maybe some discussions around what the expectations.

I would say for me, I suppose there were two highlights, one was going through the interview questions, I've done three pieces of research, and the research questions initially always come from an academic place, and I really appreciated having the pilot interview, to reflect on the interview questions, I found that brilliant, I love that process, from the initial questions and changing them to make sure that you're not leading them, your biases are not coming out. So, I really loved that meeting.

The other highlight was going through the analysis and the mind mapping. It just took me straight back to the nightmares of mine, and my goodness if I'd had a team like ours to help me. I mean I think, even now, my research would look very different, so I think that was invaluable to have seven people looking at that data. I don't think you can get more value than that, there's a huge difference between one person and seven people looking at data and ideas were coming out, being bounced off each other and what was being felt by the data was just incredible. I have not experienced data in that way before so that was that was really lovely and obviously part of the benefits of having a research team. Often for trainees doing their doctorates, they're on their own. So that was lovely, and you know again, you came up with initially is exactly what happens to people because you are so overwhelmed by the amount of data that it is difficult to make sense of it. When we were thinking about the names of the themes and those discussions, really bringing the data alive. It was like we helped you to get everything that was in your head out onto paper in a way that other people can make sense of it. I would be really interested in writing up the research and publishing".

Ayan Hussein

"It has been an honour to contribute, learn in the process and witness the findings of Shirin's research. As a Senior Peer-worker, part of my role is sharing my lived experiences of mental and emotional health distress. I believe there is a great need for this type of research as MFL's, Raqi (spiritual healers) are usually the first contact Muslims make when seeking emotional, mentally, or spiritual support. There are many points to this research I find intriguing and many that I am not surprised about. As a Muslim, Black (Somali), raised in London, who has experienced spiritual abuse at the hands of a man who claimed to be a Raqi (spiritual healer), this research means a lot to me. I am currently training as a trainee BACP Integrative therapist. One of my placements is with MindWorksUK, which work with Muslim clients. No doubt, this research has covered the importance of working with such clients holistically. The idea of recognising and validating clients' experiences, if they were to bring up their faith beliefs in therapy, having the ability to listen to their narrative rather than ignoring it.

My journey to what I call spiritual awakening started when I suffered from postpartum depression after the birth of my daughters. Before understanding what Mental Health looked like, I suffered in silence for a year when my first daughter was born. This was due to the lack of understanding of Mental Health and fear of being judged by the community.

Eventually, my family decided to turn to a faith healer to do Ruqya treatment, a form of exoticism in Islamic practice by a Raqi (spiritual healer). Ruqya in Islam is the recitation of the Quran, remembrance and supplications, and all used to treat sickness. My first experience of Ruqya was not a true representation of Islam. Unfortunately, the Raqi abused his power. Spiritual leaders/healers are in a position of trust. During this time, I felt

extremely vulnerable, and my family turned to this person for support. It was clear he was exerting control over my family for personal aims and financial gains. This raqi willfully electrocuted my hands while he recited the Quranic verses under the pretence of destroying the bad entity inside me. Things took a turn for the worse, and my mental health deteriorated, and I was taken to the hospital.

What I found interesting in the research is the learning of Raqi's and MFLs being completely different roles. I thought they did the same job. The findings show that most of the MFLs spoke about people in the community being exploited. This was definitely my first experience.

A decade later, my knowledge and understanding of mental health and life, in general, is completely different. I have been on a self-discovery journey, searching and exploring for different approaches that could aid me in becoming a more emotionally healthy individual. During this journey, I fell in and out, experiencing depression, anxiety and symptoms that could not have been medically explained. I went through the inner conflict of trying to understand the cause of my suffering and how I could be 'cured'? My family was adamant that the cause of my suffering was due to the evil eye, and I understood that it was mental health issues.

As part of my recovery journey, I found an answer. I was fortunate to participate in a 12-week course in 2019 run by Dr Sara Betteridge from the BME Access service in East London Foundation Trust, held in the Maryam centre East London Mosque. The main course content was understanding the Qalb (Heart), the Aql (Ability to reason) & the Nafs (Soul), how they function, how to nurture them & how to protect them. Understanding Mental health, the impact it has on the heart, mind, and soul. Psychological approaches to dealing with mental health complement Islamic approaches. As a person who suffers from anxiety, I have not

come across any Islamic institute or organisation that brings these two approaches together, providing a holistic approach for Muslim clients. This course helped me increase my self-confidence, mental, emotional and spiritual wellbeing, knowing my purpose and motivation. It was a profound introductory course that increased a deeper level to my relationship with Allah (God) and my relationship with myself. Throughout the 12 weeks, I felt connected and confident that my life was not just empty rituals. Even though I had a brief understanding at the time, what struck me on the course was the concept of CBT, understanding thoughts and emotions and thus our behaviours. How we view ourselves dictates how we see and interpret the world. I recognised that negative self-perception might also dictate a negative cognition perception of Allah. I gained many insights from the course, and one of them is knowing that Islam as a faith is very much a heart-centred one. As a Muslim, I found the holistic approach of western psychology and the Islamic perspective of the 'self' a life-changing course".

Imam Qamruzzaman Miah

"Being given the opportunity as a consultant in this research, was a privilege. It was an opportunity to learn and understand the experiences of imams and female scholars go through when helping people. when reading about their experiences, I was imagining myself there experiencing the same struggles as they have experienced. There were personal struggles too. I thought I was alone in this.

The themes and sub-themes have been articulated clearly in the research. They definitely link in with each other. I believe that this research will give readers much understanding and insight about the experiences of imams and female scholars supporting people in the Muslim community with their spiritual and mental health wellbeing".

Lizette Nolte

"I feel so grateful to have had the chance to work alongside Shirin and the consultant panel during this research. As a white woman who grew up in a Christian family and community, I have always been aware of the meaning and connection that faith and religion offer. It was a privilege to learn more about Islam and the role Muslim faith leaders play to support those struggling in their communities. Much of this resonated. Coming to understand more about an Islamic understanding of distress and the meaning of suffering in people's lives, I have become acutely aware of the tensions and contradictions between that world view and the approaches of a neoliberal, secular, western psychology. It has helped me understand why often the services we offer are seen as untrustworthy, invalid or not useful, and helped me learn about how we can do better. As an Afrikaner who grew up in South Africa under apartheid, I have always been aware of the devastating impact of racism on people's lives. However, hearing first-hand accounts of this and how Islamophobia impacts day to day, and learning specifically about the very real consequences of the Prevent agenda, I have become ever more determined to make visible the harm caused by these societal problems that have become imbedded in our policies and practices. I felt naïve to not have been aware of the employment contexts and salaries of faith leaders I have worked alongside in e.g., NHS Trusts in the past, and was really shocked and outraged about the blatant inequalities which should be challenged by all of us. As a researcher, working alongside the panel that Shirin has brought together has been a joyful and important learning experience. Shirin has confirmed for me the huge value of collaboration and bringing multiple perspectives to our research, and she created a space where I could be part of one way to implement this. This has shown again the value of relationships and connection and how it enhances what we can do and learn".

Jacqui Scott

"This is a brief reflection, as I joined this research team part-way through the research process, at a time when Shirin and the team she had created around her to inform the project were making sense of the themes. As a white woman, and someone who is not Muslim, I recognised the strength of the inclusive approach taken with this research but found myself wondering what I would helpfully contribute. I was also completely struck by the richness of the information in the participants' accounts and depth of meaning that the team was able to bring to discussions. I think this was in part due to Shirin's openness and ability to value all perspectives, the range of perspectives included, as well as the real value of her own perspective and knowledge. I'm hopeful that my 'outsider' curiosity was helpful to make the important insights explicit for those newer to understanding Muslim worldviews, without taking away from the authenticity of this powerful research. I have previously been drawn to the beauty of Islamic perspectives but struggled to make sense of what to do with this in hegemonic contexts (of which I therefore play a part). I also reflected on my own experience of previous trainings and the lack of value placed on culture, religious beliefs and practices. Seeing this research now taking place has highlighted the ways in which services are blind, and beyond that, the way that blindness creates the systemic injustices that play out and impact minoritised groups, as so eloquently described in Shirin's writing. With the insights that research conducted in this way can bring to psychological understandings, this also brought home to me areas that, as a clinician, I know need to be addressed by all of us in our work. I hope that this research goes far, and is read and utilised widely, in order to inform and create change".

Angela Byrne

"I had actually made the decision to stop supervising D Clin Psych theses a few years ago because of so many bad experiences of research being done in ways that felt unethical and exploitative of small community groups and that left me picking up the pieces. I agreed to get involved with this research because of knowing Shirin and her commitment to the work. From the first time we met, many years ago, before Shirin embarked on her journey towards clinical psychology training, she spoke of her dream of being able to combine psychology and faith for the benefit of Muslim communities. I had no doubt that she would identify a meaningful research topic and carry it through with great commitment, but I had not anticipated the richness and creativity of the process she would create with the consultant team. I am very glad I did agree to be involved as it has been a great experience and learning about how to conduct research in ethical and responsive ways.

Being part of a consultant team with different positions in relation to the topic has been very thought-provoking and not without challenges. At times the academic context felt very dominant and with little space to accommodate the perspectives from the lived experience and MFL consultants. Similarly, the secular gaze of academic psychology meant that discussions often focused on explaining religious concepts to the assumed secular audience. As an atheist and a clinical psychologist who is often talking about matters of faith, identity and inclusion to other professionals, this was a familiar position, but I often wondered what it was like for my religious co-consultants. It was important that we were able to discuss these dynamics and that different ways of seeking input were considered, including these reflective pieces.

Being part of a group with multiple perspectives was a constant learning experience and I loved the energy of co-creation present in our meetings. Another highlight of the research process for me was the fact that it has already brought about some of the recommended change. When it emerged that two of the participants were doing their Masters in CBT, Shirin informed us about their search for placements and I was pleased to be able to facilitate them gaining such placements in our services. For me, this is further confirmation of Shirin's commitment to this area of work, not just as an academic exercise but as a process for social change.

I'd like to give a final reflection on the wider context of the research. For much of the past decade, I have been working primarily with Muslim communities and this has brought me close to the daily reality of working in the shadow of Islamophobia and racism. I have witnessed how Muslim colleagues and communities can be placed under suspicion, constrained and threatened in numerous ways, including within the profession of psychology. Even as a non-Muslim, I have experienced some of this by association - aspects of my work that would usually be seen as benign suddenly being viewed with suspicion, the need to be constantly vigilant and careful with what I say lest it be misinterpreted. Therefore, I know that it takes courage to openly value Islam and to name Islamophobia. It shouldn't, but it does. Therefore, I feel that this is also a brave piece of research. I hope that the consultant team has provided a sense of solidarity and shared responsibility and that this model for conducting research will become more widespread".