Portfolio Volume 1: Major Research Project

Therapeutically Trained Muslim Faith Leaders' Experiences of Islamically Informed Therapeutic Support in the Muslim Community

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Key Terms

Critical psychology: An epistemological position emphasising the need to challenge mainstream psychological research and its understanding of human behaviour and thought. Critical psychology recognizes the dynamic nature of these, and the influence of social, linguistic, and self-representation factors. It underscores the importance of addressing social issues within psychology and advocates for re-evaluating established psychological models of the mind and self. These models often limit change, and critical psychology calls for a genuinely critical approach in both research and practice.

Cultural competence: Skills, knowledge, attitudes and practises that allow healthcare professionals to facilitate interventions to service users from multiple cultural backgrounds.

Cultural humility: A process of self-reflection to examine and challenge one's own cultural beliefs, judgments, biases and power imbalances when interacting with another person's culture (Tervalon & Murray-García, 1998). This includes showing respect, openness and understanding of the worldview of a person from a different culture.

Culture: Encompasses the dynamic and nuanced worldviews and lifestyles of a community which share values, traditions, beliefs, customs, expectations, norms and rules of conduct (Betancourt & López, 1993).

Depoliticization: The change process whereby something is no longer connected to politics. In the context of the psychology field, it is the act of understanding mental health outside of its sociopolitical context. In particular, the act of depoliticising has a unique impact on Muslim mental health because their lived experiences are not considered within the current and historical sociopolitical context, in relation to the racialisation of Muslims within the counter terrorism agenda in the UK.

Faith: Incorporates the concepts of religion or spirituality and is often a term used to describe both in psychological interventions (Anderson et al., 2015; Dein, 2020).

Global majority: Refers to a group of various ethnic and cultural people in the world considered minorities and who do not consider themselves to be White. This term replaces the controversial acronym BAME (Black, Asian, Minority Ethnic), which lacks clear definition, places emphasis on skin colour, and limits the nuance of one's identity, including the process of being minoritised by others as socially shaped by power within a global and local contexts (Milner & Jumbe, 2020).

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Help-seeking: An individual's effort to obtain support in relation to a mental health problem from various officially recognised (e.g., mental health services, community faith-based resources) and informal (e.g., friends, family) support systems.

Islamic Psychology: Despite the absence of consensus and adequate coherence in the philosophical, conceptual and theological base, this term refers to the knowledge, study and understanding of the mental processes, behaviour and soul (i.e., causes and treatments of healthy and unhealthy states) derived from the Holy Qur'an, Prophetic teachings, rationality and empirical psychology principles (Hamid, 1977; Kaplick & Skinner, 2017; Khan, 1996; Rassool, 2023b; Vahab, 1996). It emphasises centring the spiritual heart of the person and preserving a healthy mental state.

Islamophobia: Also referred to as anti-Muslim hatred which reflects UK hate crime legislation and embeds the anti-racism paradigms. The term refers to the increased fear, suspicion, violence towards, and racialisation of perceived Muslims as a threat of terrorism in public imagery and British values. This is perpetuated through anti-Muslim activities and behaviour informed by government strategies (Younis, 2022). The term is "rooted in racism and a type of racism that targets expressions of Muslimness or perceived Muslimness" with the effect of nullifying, impairing the recognition, excluding or restricting the human rights and essential freedom of Muslims' economic, public, political, cultural, and social life (All Party Parliamentary Group on British Muslims, 2017, pg. 11; Elahi & Khan, 2017).

Mainstream mental health services/ Mental health services: Denotes statutory mental health and/or psychotherapy services (i.e., NHS), or privately or mental health/therapy services run by a third sector organisation. These comprise professionals such as counsellors, family therapists, psychotherapists, psychologists, psychiatrists, social workers and others who use mainstream Western therapeutic approaches.

Mental health difficulties/ Mental health problem: Refers to psychological and emotional issues that impact an individual's day-to-day functioning (work, relationships, routine, communicating, learning), and distressing responses to life events (trauma, stress, bereavement).

Mental health professional: A person with a professional mental health training background, including family physicians, social workers, psychiatrists, psychologists (Mackenzie et al., 2004).

Muslim Faith Leader: Islamic scholars who are graduates of the Islamic Sciences Alimiyyah programme (males: Alims; and females: Aalimahs), teachers, chaplains, youth workers and circle leaders who complete a form of Islamic Sciences training and hold specialist skills and

knowledge. This is favoured over the term "imam", which describes only those who lead worship or perform other specific religious duties.

Muslims/ Muslim community: Used interchangeably to refer to individuals who are either born Muslim or who have formally engaged with the conversion process to Islam.

Religion: An organised system of beliefs, practices, rituals and traditions to enable an individual to get closer to the divine and sacred (Moreira-Almeida & Koenig, 2006).

Secular therapy: Psychological therapy, practices, attitudes and models, that use evidence-based interventions to tackle mental health issues without religious or spiritual basis.

Spirituality: A sense of individual connection and the search for existential meaning, belongingness and acceptance (Moreira-Almeida & Koenig, 2006).

Therapeutically trained: Professional training in any psychological therapy or counselling recognised by a professional body (i.e., British Association for Behavioural & Cognitive Psychotherapies, British Association for Counselling and Psychotherapy, British Psychological Society, university or alternative).

Abbreviations

AA: African American

CBT: Cognitive Behavioural Therapy

FAPI: Faith-Adapted Psychological Interventions

FBCO: Faith-Based Community Organisations

FBTS: Faith-Based Therapy Services

MFL: Muslim Faith Leaders

MHP: Mental Health Professionals

MHS: Mental Health Service

NHS: National Health Service

SAW: Sallallahu Alayhi Wasallam (Peace be Upon Him)

TTMFL: Therapeutically Trained Muslim Faith Leaders

UK: United Kingdom

USA: United States

Abstract

Therapeutically Trained Muslim Faith Leaders (TTMFL) utilise a unique set of skills, knowledge and experience to provide a holistic approach to the Muslim community when managing mental health difficulties. Despite literature showing that they are trusted sources of mental health support, research exploring this enhanced role is minimal. With growing levels of Islamophobia and the racial and religious inequalities among minority ethnic communities accessing healthcare, it is important to consider TTMFL experiences of delivering Islamically informed therapeutic support in the Muslim community, focusing on factors that support or hinder implementation in the community and National Health Services. In this qualitative study, ten TTMFL trained in different secular modalities and working in various settings participated in semi-structured interviews. Five themes revealed from the thematic analysis reflected their experiences of delivering faith-adapted therapeutic support for Muslims: Different Worldviews; Grassroots Faith-Based Therapy Service; Enabling Therapy Aligned with Muslim Client's Faith Needs; Challenges in Embedding Faith-Adapted Support in Communities and Collaboration as a Lever for Implementation. The findings reflect the complexities in the duality of their role, conceptualising and implementing relevant Islamic adaptations at a systemic and individual level to reduce the gap between statutory and community services and to work effectively to meet the spiritual needs of the Muslim clients. The themes are examined in relation to research and theory, emphasising implications for policymakers, the community, the clinical psychology profession and therapeutic practice through advocacy, support and guidance for accessing faith and culturally tailored psychological services.

Chapter 1: Introduction

1.1 Overview

From the 2021 Census, self-identified British Muslims comprise 6.5% (3.9 million) of the population in England and Wales, an increase of 4.9% since the 2011 census (Office for National Statistics; ONS), 2022). Despite the lack of data on the Muslim population's ethnic composition, the minority ethnic population rose from 14% to 18% of the overall population. In London, 25.3% of residents reported a religion other than Christianity, with the Tower Hamlets borough comprising the largest Muslim population in the country (39.9%). The Muslim Council of Britain's initial analysis (Muslim Council of Britain, 2024) indicates 39% of Muslims live in deprived areas in England and Wales, such as Tower Hamlets and Newham (London), Blackburn with Darwen (Lancashire), Sparkbrook and Washwood Heath (Birmingham), Manningham (Bradford) and Leicester. This suggests a greater need to support them.

1.2 Mental Health Inequalities in Muslim Communities.

Muslims comprise a religious minority in the UK, and a significant proportion are from the global majority. Mental health inequalities exist in this group, including comparatively poor access to mental health services, health outcomes and recovery rates (Hussain, 2022; Lowther-Payne et al., 2023; Moller et al., 2019; Weatherhead & Daiches, 2010). This is catalysed by Islamophobia and the PREVENT strategy, designed to counter terrorism and radicalization, perpetuating fear, mistrust and alienating Muslims on micro and macro levels (Aked et al., 2021; Byrne et al., 2017; Dadabhoy, 2018; Harbidge, 2015). The counterterrorism policies like PREVENT unnecessarily and disproportionately criminalises Muslims in mental health and securitisation processes and is counterintuitive given that there are pre-existing valid and upheld safeguarding procedures which are designed to protect vulnerable individuals regardless of their background from abuse, exploitation and harm and provide appropriate care to manage their well-being (Aked et al., 2021; Heath-Kelly, 2019). Against a backdrop of multiple disadvantages, it is important to consider effective ways to support members of the Muslim community in the UK with positive mental health prevention, intervention, and management.

1.3 Personal and Epistemological Position

1.3.1 Epistemology

Epistemology examines the theory of knowledge among the scope, processes and possibilities used through which it is acquired, created and disseminated (Scotland, 2012). An epistemological position signifies the assumptions held by a researcher regarding their knowledge development and the link to reality. My aim is to explore the experiences of Therapeutically Trained Muslim Faith Leaders (TTMFL) facilitating Islamically informed therapeutic support in the Muslim community. To achieve this, I use a critical realist epistemological stance integrating aspects of relativism and realism, which enables enhanced considerations of current global affairs whilst recognising the information gathered may not grant entry to direct reality (Willig, 2012, p.13). A realist method suggests there are truths in the world and that research data mirrors this reality. However, a relativist method acknowledges researchers can interpret data in various ways, creating multiple truths (Harper, 2011). Combined, critical realism suggests reality derives from and is shaped by multiple perspectives; thus, apparent reality depends on perspective. I apply a critical realist approach to explore the data in detail, recognising its significance within broader historical, social, and cultural factors (Harper, 2011).

The critical realist approach is relevant for this study as I examine TTMFL experiences within historical and contemporary contexts that may impact how they offer support. It is beneficial

for me to reflect upon this stance; as being a Muslim from a racially marginalised background will undoubtedly contribute to my understanding of the realities participants disclose.

Observing the challenges the Muslim population face in accessing mental health services propelled me to investigate issues around secular therapy in Muslim communities from the perspective of TTMFL, with the intention of increasing faith and cultural understanding within mental health services and among professionals. Therefore, my relationship with this research involves ongoing reflection of my own and different perspectives, alongside discussion with the research team to aid awareness of positioning and how I approach the project and analysis.

1.3.2 Self-reflexivity

It is common for researchers to investigate topics they feel passionate about (Burnham et al., 2008). Accordingly, it is vital that I reflect on my role as researcher and the impact this has on the research and outcomes (Willig, 2013). Pure objectivity is unfeasible within qualitative research, as the study and the researcher embody values and subjectivities within their world (Green & Thorogood, 2018). Thus, there is an overriding need for researchers to highlight prejudices, assumptions, values, and individual relation to the respective subject (King, 1996). I use the following processes to ensure I actively reflect and check my biases throughout the research:

- A reflective research diary (see extracts Appendix A) to document my reflections, positions, assumptions, curiosities, queries and supervisory consultations influencing the focus and understanding of the project and develop learning opportunities.
- A team of five people with expertise in the research topic (detailed in Chapter 3) convened to consult on methodology: research aims and materials, recruitment, data collection and analysis such as grouping themes. They also reviewed draft chapters.
- Coder reliability checks: sharing transcript excerpts with consultants, coding these independently, comparing the codes, and engaging in a reflexive discussion about similarities and differences.

Constantly being challenged through the above methods helped to reduce biased interpretation and influences from my subjective personal experiences, allowing for a balanced understanding of the data.

My experiences will have inevitably influenced how I conducted this research. However, these experiences enabled me to build a rapport with the participants in the way that they may have

felt more comfortable speaking about sensitive topics, such as Islamophobia and LGBTQIA+. On the other hand, a weakness I held in mind was that my experiences impacted how I analysed the data and my research choices. Reflections were recorded throughout the project in the researcher's research diary (Appendix A)

To ensure the researcher adopted reflexive practices, bracketing was a tool that maintained the reflexivity of any unconscious biases that influenced the data analysis and reporting. Triangulation was also a key tool within the project, whereby the research consultants and the supervisory team encouraged consistent reflexivity throughout the research process. For example, when I assumed that all religious Muslims would find it more comfortable accessing a visibly Muslim therapist. This influenced further discussions around my position on the subject and the risks of homogenising the Muslim mental health experience.

1.4 Overview of the Theoretical and Empirical Context of this Research

This section synopsises the pertinent literature. It begins by outlining research into Muslim communities' approach to help-seeking, followed by literature on religion in the therapy room. It then provides a rich understanding between culture and religion. Next, I cover research on faith-adapted therapy and the spectrum of adaptations. This section concludes by conceptualising secular therapy and alignment with Islamic beliefs and values.

1.4.1 Muslim Communities' Approach to Help-Seeking

The Muslim population is heterogeneous, with identities that encapsulate ethnic identity, cultural heritage, and religious and Islamic practices (Abbas, 2004). Muslims report that their religious affiliation to Islam positively influences their sense of identity, well-being and community, providing meaning and importance in their lives and buffering against numerous stressors such as discrimination, racialisation, Islamophobia, and acculturative stress (Adam, 2016; Dadabhoy, 2018; Harbidge, 2015; Kathawalla & Syed, 2021). Furthermore, Tarabi (2016) found second-generation Muslim Pakistani men in the UK disengaged from therapy if it excluded Islam, emphasising the important role of religion in Muslims' lives.

An individual's socioeconomic background and culture can influence help-seeking behaviours in different religious communities, particularly for mental health difficulties, which are sometimes reported as a spiritual illness (Nsereko et al., 2011). Moreover, societal cultural beliefs play a role in cultivating societal responses to individuals with mental health conditions, stereotyping communities, and service provision (Link et al., 1999). Proportionally, Muslim groups are underrepresented in MHS, suggesting services are inaccessible (Cabinet Office, 2017; Muslim Youth Helpline, 2019; Saleem & Martin, 2018). Several reasons can account for barriers to help-seeking, including mistrust and avoidance of MHS and treatment, fear of racism and discrimination (Inayat, 2005), the perceived irrelevance of MHS (Sheikh & Gatrad,

2009; Weatherhead & Daiches, 2010), shame around seeking qualified mental healthcare among British South Asian Muslims (Pilkington et al., 2012), attribution of psychological and physical illnesses to metaphysical forces (i.e., jinn), the sufferer's sins and weaknesses (e.g., Ally & Laher, 2008), and the traditional psychiatric care model alienating alternative worldviews and beliefs (Mantovani et al., 2017). Medicalising moral issues and pathologizing religious experiences can also lead to disengagement and ineffective therapy (Darley, 2021). Furthermore, some religious Muslims view psychiatry and psychology with distrust and caution, whilst some faith leaders view these as anti-religious and fear therapists may challenge religious beliefs, suggesting inter-relational barriers to psychological care for this community (Breakey, 2001).

Research shows that faith groups and religious individuals commonly prefer to seek psychological help from informal mediums, such as faith-based community organisations (FBCO) and Faith Leaders (Hays, 2015; Matanovic, 2020). For the Muslim community in particular, this would include seeking help from Muslim community organisations and Muslim Faith Leaders (MFL), rather than accessing formal secular structures, such as counselling and the NHS (Al-Krenawi et al., 2004; Dein, 2013). MFL possess high levels of religious knowledge, credentials and education, including religious rulings, history, philosophy, and figures. For some Muslims, MFL are prominent authorities for providing emotional and psychological support within the community (Cinnirella & Loewenthal, 1999; McCabe & Priebe, 2004), including treating mental health problems (e.g., Islam et al., 2015). The appeal of MFL in this role may stem from reduced language barriers and less stigma when offering consultations to families (Alsam, 1979), collectively recognising and appreciating beliefs, culturally understanding symptoms, and preserving cultural identity. Although some clients acknowledge that therapists need not share similar religious beliefs, only that they are non-judgemental, open and genuine (Post & Wade, 2009), there remains a concern that secular therapy views strong religious beliefs negatively (Mayers et al., 2007). This represents a significant barrier to access.

Unsurprisingly, the utilisation of FBCO and MFL and their conceptualisation of psychological problems through a spiritual lens, can have significant impacts on recognising problems (i.e., religious communities reporting the issues), encouraging help-seeking behaviours, access rates of MHS, treatment compliance and outcomes (Lafuze et al., 2002; McCabe & Priebe, 2004). Religion plays a key role for Muslims in helping them manage situations of significant distress and pain, providing hope, and protecting against self-harm and suicide (Heilman & Witztum, 2000). This suggests that FBCO and MFL are trusted and crucial mental health gatekeepers. They are a preferred source of support within Muslim communities and a more appropriate, non-stigmatising, and religiously accessible community-based service open to

religious explanations. As such, Mental Health Practitioners (MHP) can develop a deeper understanding and cultural sensitivity (Bhui et al., 1995) of religious worldviews from MFL. Furthermore, MHS can learn from and collaborate with MFL to co-create interventions and deliver solutions that improve access to support within specific communities.

1.4.2 Religion in the Therapy Room

(Jung, 1913) argued for religion as a resource to support psychological well-being. Despite this, western traditions typically separate religion and spirituality from healthcare (Koenig, 1997), seeing these as taboo (Kung, 1986), incompatible with reality, irrational, guilt-inducing, lacking a scientific foundation, and as a form of dependency (Arthur, 2018; Ellis, 1988; Freud, 1927; Thomson, 1996). Perhaps unsurprisingly, psychologists and psychiatrists are generally less religious than their patients (Curlin et al., 2005). This might undermine their knowledge and appreciation of religious issues, their ability to manage these with skill and empathy, causing them to see these as less critical or avoiding them altogether in psychotherapy, counselling, and clinical psychology (Delaney et al., 2007). In addition, the religiosity of MHP can impact their confidence in dealing with religion in the therapy room (Betteridge, 2012). Within the European cultural context, the legitimacy of talking about religion is culturally influenced, where religious teachings are commonly restricted to private and personal beliefs exempt from public and scientific discourse (Asad, 1993; Mir & Sheikh, 2010). This could explain why clinical psychologists possessing religious/spiritual beliefs feel silenced in their practice and raise it in supervision(Arthur, 2018). Spiritual and religious beliefs also influence therapeutic processes based on the therapists' values (Cooper, 2012; Post & Wade, 2009; Souza, 2002), especially within the MHS context where being 'politically correct' is prioritised (Harrison, 2013). This may explain why MHPs, including psychologists, find it challenging to use religion as a means of therapy (Begum, 2012; Harbidge, 2015; Joseph, 2014), highlighting another barrier in supporting communities with religious beliefs.

Nevertheless, spirituality and religion are essential indices for mental and physical health. This includes promoting spiritual, cognitive, psychological, and social resources to reinforce positive mental health, well-being, hope, meaning, purpose, solace, self-esteem, and personal control (Koenig, 1997; Smith et al., 2003). Psychotherapy has been well-documented as a cultural by-product and not a universal healing practice. Literature from the global South emphasises the need for Western therapies to adhere to religious practices, values, and philosophies for religious populations (Lalchandani, 2020). This can include utilising traditional healers, indigenous and spiritual healing practices with an adapted Western psychotherapeutic and counselling framework (Bedi, 2018). However, language barriers prevent research from the global South, including those with large Muslim populations, from

entering Western discourse and practice around psychological interventions (Haque et al., 2016).

Despite increasing curiosity towards mental health and religion in academic journals, mental health policies and professional guidelines over the last 30 years (Dein et al., 2011; Guthrie & Stickley, 2008), research is still minimal (Hill & Pargament, 2008) . Furthermore, psychologists have an ethical and moral duty to acknowledge that the world is governed by power dynamics, which affect how an individual may interact in a secular therapeutic setting, possibly limiting how much they comfortably disclose (Harrison, 2013). More specifically, clinical psychology regulatory bodies lack the exploration of religious and spiritual resources (Baker & Wang, 2004; Mulla, 2011), suggesting these do not prioritise this aspect of diversity (Begum, 2012). This highlights the challenges in providing recommendations for clinical psychology training courses, including religion and spirituality in practice (Plante, 2008).

1.4.3. Culture vs Religion

The literature points to the issues of equating 'religion', 'faith' and 'spirituality' with race, ethnicity, and culture, although some regarded these differently (e.g., Duarte-Velez et al., 2010). This can devalue the religious paradigm and limit the contextual nuances surrounding a person's life (Adebolajo, 2022; Badri, 2018). Badri (2018) argues that the literature places a significant emphasis on cultural, social, and physical differences but neglects the important belief systems within a culture. Despite social science literature suggesting that the term 'spiritual' resonates with all people who have a religion and do not (Dein, 2020), this thesis will use faith to incorporate religious and spiritual adaptation processes in psychological interventions (Anderson et al., 2015).

1.4.4. The Most Suitable Terminology – Adaptation Vs Informed.

Cultural adaptations are defined as evidence-based interventions that modify and incorporate components including the "client's language, culture and context in a way that is congruent with their cultural patterns, meanings, and values" (Bernal et al., 2009, p. 362). Other researchers allude to cultural adaptation as a process that adheres to and maintains core principles while integrating cultural factors and processes of engagement to ensure acceptability and effectiveness (Barrera et al., 2013; Chu & Leino, 2017). Faith, too, can be an important cultural adaptation (Weisman et al., 2006), yet research including these elements is limited. Research favours the term "culturally informed" because of the primary inclusion of culture within the intervention (Santisteban & Mena, 2009). However, the term "adaptation" is widely used, and therefore "faith-adaptation" is used in this thesis for consistency.

1.4.5 Faith-Adapted Therapy: Spectrum of Adaptations

Faith-adapted psychological interventions are more efficacious in diminishing psychological difficulties for religious clients than non-spiritual approaches (Captari et al., 2018; Koenig et al., 2012) and increasing quality of life (Lee et al., 2010). However, investigations comparing these to non-spiritual interventions remain nascent. Nurturing social support (Scott, 2003), offering meaning and purpose to life (Gerwood, 2005), and the deed of submitting control to a greater authority (Cole, 1999) may facilitate faith-adapted therapy and healing.

Cultural and faith adaptations are primarily implemented for cognitive behavioural therapy (CBT; Anik et al., 2021; Pearce & Koenig, 2013), although systemic approaches such as systemic family therapy, solution-focused and narrative approaches (Burgess & Ali, 2015; Khan, 2021; Span, 2009) include a spectrum of adaptations. For example, using religious scriptures to provide alternative stories of hope to clients with problem-saturated stories in therapy.

Costa and Moreira-Almeida (2022) reports that faith-adaptation studies focus more on Christian clients. Although diverse religions feature overlapping concepts and practices that can be implemented in therapy to treat different faith-orientated clients (Rosmarin, 2018), it still limits their relevance for other faith groups and warrants exploring Muslim experiences of pastoral adaptations.

Naeem and colleagues (2023) explored various culturally adapted frameworks developed, implemented, and evaluated over the last three decades. Research using these frameworks focused on implementing intricacies and different elements of the respective religion, spirituality and culture to interventions, whilst being congruent with the therapeutic model (Duarte-Velez et al., 2010; Rathod et al., 2019). However, Naeem et al. (2023) found that these frameworks did not consider theoretical and philosophical adaptations to the therapy, to avoid deviating from the fundamental model of a specific treatment. Although most meta-analyses exhibit moderate to large effect sizes, they had methodological problems, including not accounting for theoretical groundwork and cultural concerns. Therefore, caution is required when interpreting these findings.

The present research uses Tseng and colleagues' (1999; 2005) framework of cultural adaptations for psychotherapies to identify different types of faith adaptations. This was chosen as it influenced the cultural adaptation procedure and preserved the core concepts in psychotherapeutic interventions (Bhui et al., 2015; Naeem et al., 2023; Rathod et al., 2013). Therefore, this framework serves as a relevant and valuable guide for integrating Islamic principles into faith adapted therapy for Muslim clients. Tseng et al.'s (1999; 2005) framework focuses on four levels of adaptations: technical, practical, theoretical and philosophical. First,

technical adjustments involve processes and skills in therapy, including the mode and manner of intervention are the most basic level of adaption (Rathod et al., 2019). This incorporates the role of the environment, medicine, religion, family structures, goals, the choice of treatment, and the therapeutic relationship. Second, practical adjustments explore societal factors that influence performance in therapy and the development of trust towards healthcare systems. These comprise reputation of health systems, funding provisions, immigration policies, economic circumstances, discrimination, racism, and stigma connected to mental illness. Third, theoretical adjustments involve adapting concepts that align with an individual's cultural strengths. For example, personality changes, individuality and collectiveness, parent-child relationships, defence mechanisms, self and ego boundaries, mind and body, and coping strategies. Fourth, philosophical alignment centres on the client's outlook on life (e.g. the meaning of life, acceptance, maturity, and normality), which impacts the targets agreed upon in therapy and the client's stance towards growth. This may include the level of acculturation, beliefs around illness, and cultural views towards psychotherapy.

The most common adaptations found across research using these frameworks and models are theoretical and technical adjustments, such as community involvement, content, concepts, context, goals, language, metaphors, methods, persons, and therapeutic relationship (Anik et al., 2021; Rathod et al., 2019). Betteridge (2012) argues that a therapist who shares their faith with the client, is not always necessary to build a therapeutic alliance to improve outcomes, as a therapist with sound knowledge and confidence in religion and CBT can effectively challenge religious cognitions. Although contradictory evidence shows that the therapist's identity and faith are significant in predicting therapeutic outcomes and credibility (Hussain, 2023), more research is needed to include theoretical and philosophical modifications within psychological interventions (Rathod et al., 2015; Tseng & Streltzer, 2008). This raises questions about whether secular modalities can adequately integrate faith adaptations or whether a completely different model, including religious, philosophical and theoretical underpinnings is more suitable for the respective populations.

1.5 Conceptualization of secular therapy: alignment with Islamic beliefs and values.

1.5.1 Islamic Psychology and Worldview

According to Islamic psychology, an excellent mental state embraces achieving Ihsan (spiritual excellence) and continually resisting one's Nafs ("drives" that influence one's desires) that may challenge a good mental state (Badri, 2018; Keshavarzi & Haque, 2013; Rothman, 2021). These values, beliefs and dependence upon God can form a crucial element of faith. They influence the manner of help-seeking and choice of traditional and faith healing as the prime foundation of an intervention (Borras et al., 2007), instead of using doctors and medication (Griffith, 1998). Although Islamic psychology offers an opportunity to engage

closely with and address a Muslim clients identity, the conceptualisation of the term is still debated (Al-Karam, 2018) and poses challenges to framework such as the theoretical inconsistency, integration with Western psychology, evidence-based validity, ethical concerns, cross-cultural and religious relevance and applicability (e.g., Rassool, 2023a). This therefore warrants further research and developments to establish credibility of the framework.

Islamic beliefs and values influence Muslim perceptions of difficulties. These include concepts around Qadr (predestination), calamity as a test or punishment from Allah, belief in divine healing from disease and the nurturance of the soul, supporting each other as an 'Ummah' (community) and possessing different explanatory models (i.e., supernatural causes of mental health problems through sorcery; Mustafa, 2021). This may be contentious for Western MHP.

Similar beliefs are found in other ethnoreligious communities, such as Christianity and Judaism (Garraway, 2018; Leavey, 2010), which indicates shared similar processes, practices, values, and attitudes around the suspicions of 'secular influences' which therapists can hold in mind when working with faith in therapy (Baker & Wang, 2004; Kada, 2019, p. 6). Therefore, faith leaders may be more appropriate to address mental health problems through spiritual practices.

Interestingly, the type of psychotherapeutic orientation may link with the religious/spiritual worldview counselling and clinical psychologists recommend. For example, those with Christian beliefs might recommend cognitive behavioural approaches, whereas those with Eastern/mystical beliefs might recommend existential and humanistic-focused psychologists (Bilgrave & Deluty, 2002). This suggests that a client's and therapist's worldviews and values can influence the psychological framework they seek out.

1.5.2 CBT and Faith

Psychological therapies, such as CBT, place a theoretical emphasis on MHP being a scientist-practitioner, taking on a neutral and value-free stance where a person's freedom to choose how they create meaning is exercised. In contrast, religious conceptualisations often frame problems deriving from sinful behaviour and thought (Darley, 2021; Leavey et al., 2012). Although MHPs may view this as related to guilt, morality and the conscience, which limits the resolution (Leavey et al., 2012), the secular therapeutic stance can be problematic and misaligned with Muslim beliefs and values. Firstly, CBT is grounded in Western individualistic values that emphasise an individual being in control of one's destiny and identifying hardship as related to one's internal locus of control (Beshai et al., 2013). However, research on Islam-adapted CBT highlights theoretical conflicts between Islam and CBT. For example, where CBT theory attributes distress to faulty thinking, an Islamic view includes external factors such as biopsychosocial and spiritual difficulties being a test from Allah and showing His love and

patience to his creation (Al-Krenawi & Graham, 2000; Tarabi, 2016; Utz, 2012). This holds true for other religions like Christianity, where the locus of control is attributed to the spiritual influence and inner essence of Christ (Darley, 2021). Garraway's (2018) holistic CBT model suggests that the influence works primarily from the outside in (i.e. external locus). This indicates that MHP need awareness and confidence to include a person's religious perspectives in therapy (Carter & Rashidi, 2004), and consider the suitability of models used in religious populations, focusing on the cosmological locus of control.

Furthermore, the emphasis on individualism in CBT warrants considering the likelihood of expectation and norm conflicts between individualistic and collectivistic values early on in therapy, which might undermine the therapeutic relationship and outcomes (Nezu, 2010; Tarabi, 2016). This is in line with Islamic teachings, whereby Muslims are part of an "Ummah" (worldwide community) (Daneshpour, 2003) and their individual needs are in service to the broader community (Al-Krenawi & Graham, 2000; Al-Mateen, 2004). Yet, contradictory evidence shows that Muslims brought up in Western societies adopt Western individualism and are less motivated to follow their Eastern collectivistic culture (Ali & Aboul-Fotouh, 2011), which may suggest a need for a tailored and balanced approach when working with Muslim communities and distinguishing between values and beliefs that are cultural and those that are religious (Walpole et al., 2013). Mir et al. (2015, 2019) investigated this approach, finding that therapists delivering culturally and faith-adapted CBT to Muslims is feasible and acceptable.

Recent studies directly include a fifth spiritual component incorporating faith into the CBT framework, such that it involves reasoning, emotions, environment and religion/spirituality (Garraway, 2018; Hodge, 2011; Pearce et al., 2015). However, most western-based psychotherapies, including humanistic approaches, are fundamentally secular, ignore the importance of the soul and lack ideology around 'good' and 'evil', which are crucial in Islam (Khalid, 2006; Penny, 2006). By encapsulating a broader perspective of human nature and the self, Islamic theology can complement western-based psychotherapy that features theological restrictions between religion and psychology (Arshad, 2007).

1.5.3 Psychodynamic Therapy and Religion

Despite traditional psychodynamic therapy not welcoming religion (e.g., Koenig, 2010), Freud (1986) acknowledged the concept of an afterlife as a 'pleasure principle' to support mental purposes. This is consistent with the Muslim worldview, where Muslims intentions and actions can work towards greater reward in the afterlife. Later dynamic theories about the influence of external factors, such as early life events, on adulthood complement this Islamic view. Interpreting this as anything other than the person's truth or reality may jeopardise congruence

in therapy and the therapeutic relationship (Betteridge, 2012). It is important that interpretations of psychotherapeutic techniques that can facilitate therapeutic progress, such as identifying defences and resistance to change, do not contest Islamic beliefs as this might undermine their efficacy.

While some therapies complement and are congruent with religious philosophies, such as Jung's view of the self (Corbett, 2013; Stein, 1984), other elements of traditional psychodynamic therapy do not theoretically align with Abrahamic traditions. For example, the concept of repression or denial (Freud, 1937), which may misinterpret a Christian exercising self-surrender of their desires, emotions, behaviours and cognitions to meet what is lawful and unlawful in Christianity, where in fact, self-awareness and acceptance proscribes the ability to be in denial as it may hinder their journey to sanctification and Christ-actualization. Furthermore, Freud believed that sexual drives begin in nature and are biological (Freud, 1986) and that evil does not exist, instead, man is selfish and aggressive by nature (Badri, 1996, p. 172). In contrast, the Islamic view incorporates basic instinctual 'drives' as neither sexual nor solely driven by biological forces, but influenced by the mind ('aql), and that a man is born in the state of God consciousness with a natural inclination towards good (Penny, 2006). Such contrasts raise questions about what model is most suited to help assess, formulate, and deliver treatment plans that address emotional and cognitive nuances among religious populations. Lastly, research deduced that psychological interventions that use psychedelics, hypnosis or meditation are incompatible with Islam, as these alter the state of consciousness. The consciousness of the mind (cognitions) is essential for prayer (Badri, 1979). Similarly, transcendental psychology (i.e., yoga and Buddhist mindfulness practices) does not necessarily fit within the Christian philosophy (Bretherton et al., 2016, p.19) because of fear of being externally influenced and lead away from spiritual truths by worldly wisdom or secular ideas conflicting with divine wisdom and their spiritual beliefs and integrity (Cragun & Friedlander, 2012, p. 386). Therefore, these practices would be unsuitable for Christian clients, particularly evangelical Christians. It is, therefore, essential to be mindful of the divergent philosophical underpinnings and approaches to align with different religions.

1.5.4 Integrative Therapies Integrating Islamic Principles and Beliefs

Models and approaches have been theoretically developed for Muslim communities utilising Western psychotherapies, such as client-centred and cognitive models integrating Islamic principles and beliefs linking to the emotion, body, soul, and spirit (Carter & Rashidi, 2004; 2003; Keshavarzi & Haque, 2013). Inayat (2001) also outlined critical differences between integrative and Islamic counselling, whereby the former contextualises the client within a social framework, whilst the latter includes this as well as developing a proximate relationship with a Divine source for both the client and therapist. Betteridge's (2012) study found that Muslim

therapists' experiences of working with religion in therapy adopted a consolidative approach centred on the wishes of the client. This suggests that secular therapies can work alongside Islamic beliefs and values, wherein the understanding and awareness of one's faith, sharing a similar cognitive level and interests with the therapist, may be sufficient to develop genuineness, empathy and person-centeredness of the client, to build a good therapeutic relationship (Post & Wade, 2009; Zane et al., 2005). However, there is limited empirical evidence to show the effectiveness of such practical adaptations.

Despite the theoretical and philosophical misalignment of some secular therapies with Islamic beliefs and values, there are helpful practical methods and techniques (i.e., eye contact, prayer, family involvement and counsellor/client match; working with the same gender; using Islamic journaling towards their journey to God) therapists can integrate for religious clients, independent from the therapy's original philosophies (Ali et al., 2004; Betteridge, 2012; Carter & Rashidi, 2004). Similar therapy adaptations exist for Christianity (e.g., Duarte-Velez et al., 2010), Hinduism (e.g., Lalchandani, 2020), Judaism (e.g., Golker & Cioffi, 2021), Taoism (e.g., Ding et al., 2020) and Sikhism (e.g., Currie & Bedi, 2018). Qualitative research on UK Muslim therapists' experiences integrating religion into secular therapy found this complementary and compatible with Muslim clients (Alli, 2019; Betteridge, 2012). Similarly, Christian faith leaders and clinical psychologists found that mainstream psychological explanations are consistent with their conceptualisations of mental health, which is associated with natural, social, biological, economic, and spiritual causes (Joseph, 2014). This shows it is possible to develop meaning-making by sharing and holding religious and scientific knowledge and worldviews (Przybylinski & Andersen, 2015). However, Mustafa's (2021) research on MFL supporting the Muslim community suggests that the secular and Islamic worldviews may not always be complementary. Particularly, within the sociocultural political context which challenges its integration into different areas of life, advocates alternative values (e.g., secularism, individualism, materialism) and encourages conflicts within and outside Muslim communities potentially hindering the practice and preservation of the Islamic worldview in the Western world. Therefore, an approach built on the Islamic worldview is needed.

This chapter summarises the significance of MHP integrating faith-adaptations in psychological therapy to ensure it is more meaningful, acceptable and effective in meeting the needs of clients of faith. Next, I provide a systematic literature review to expand the understanding of clinicians' experiences of delivering faith-adapted psychological interventions (FAPI) and identify faith adaptations when working with clients of faith.

CHAPTER 2: Systematic Literature Review

2.1 Overview

This chapter reports on a novel systematic literature review that informs the current study's research questions and aims. The systematic review investigates clinicians' experiences of delivering FAPI. The previous chapter detailed that religion and spirituality sit uncomfortably in the broad organisational and therapeutic context. Religion and spirituality within psychological therapy have been acknowledged as important cultural adaptations, and faith-adapted interventions can be effective in reducing psychological distress. Therefore, further insight is needed to recognise the tools and adaptations required to support faith communities and how secular barriers and enablers are navigated. This is especially important for religious communities, such as Muslim communities, who face significant levels of discrimination and where systemic societal issues can act as a barrier to access mental health services (Inayat, 2005).

Religious communities seek help from informal mediums, such as FBCO and faith leaders, for their psychological difficulties, over formal structures, such as counselling and the NHS (Mustafa, 2021; Joseph, 2014). The utilisation of FBCO and faith leaders, with their conceptualisation of psychological problems from a spiritual lens, can have significant implications on the recognition of problems, improvement in help-seeking behaviours, treatment compliance and utilisation rates of mental health services for religious communities (Lafuze et al., 2002; McCabe & Priebe, 2004). As such, MHP can gain a deeper understanding and cultural sensitivity (Bhui et al., 1995) of religious worldviews from FBCO and faith leaders

and develop appropriate and meaningful faith-adaptations for the respective religious and spiritual population. This questions the extent to which psychological therapies are meeting the needs of faith-based communities; hence, this review focused on faith and aimed to initially summarise clinicians' experiences of delivering FAPI in the context of the UK and then consider data from outside the UK.

Systematic reviews thoroughly and comprehensively identify, evaluate, and summarise existing evidence on a specific topic to draw evidence-based conclusions, and suggest clinical implications and areas for further research (Willig, 2013). The current review endeavoured to achieve the following research question:

What are clinicians' experiences of delivering FAPI in current qualitative literature?

The following objectives were explored:

- To summarise the evidence of clinicians' experience delivering FAPI.
- To establish the extent to which qualitative research in this area has included service users from different faith backgrounds.
- To understand the nature of the faith-adaptations, for example, technical, practical, theoretical, and philosophical (Tseng, 1999; Rathod et al., 2019).

Previous literature reviews on faith-adapted therapy primarily investigated quantitative data (Anderson et al., 2015; Costa & Moreira-Almeida, 2022; Lim et al., 2014). Researchers have investigated perspectives of clinician's experiences with religion and spirituality in therapy (e.g., Bier, 2022; Burgess & Ali, 2015), however, no systematic literature review has yet explored qualitative evidence of clinicians' experiences of delivering faith-adapted therapies. Investigating clinicians' knowledge, experiences, and tools that they use will provide richer details and help to gain a comprehensive overview of faith adaptations used in therapy. It may also help with identifying adaptations relevant to the global Muslim population of more than 1.9 billion.

2.2 Search Strategy Method

A standardised methodology was applied to undertake the systematic literature review (Siddaway et al., 2019). On July 30th, 2023, five electronic bibliographic databases were systematically searched for published studies, as they included literature from varying fields such as applied sciences, nursing, social work, psychology, and medicine: Scopus, MEDLINE, PubMed, CINAHL, and PsycINFO. Additional citations from relevant articles and reference lists were also searched to reduce publication bias. Grey literature (lateral search techniques)

was identified to increase inclusivity via Open Grey, EBSCO Open dissertations, Grey Lit, and Google Scholar (e.g. the first 100 papers). Given that the research topic is a niche area, there were no limits to search dates to produce more results. The following Table 1 presents three concepts and their related search terms:

Table 1

Search Terms

Concept 1: Population *Clinician's*		**Concept 2: Exposure/ Terms relevant to *faith-adaptations.***		**Concept 3: Outcomes/ Terms relevant to *experiences of delivering faith-adapted psychological interventions.***
Clinician OR therapist OR psychologist OR psychotherapist OR counsellor OR psychoanalyst OR psychiatrist OR healer OR nurse OR shrink OR physician OR analyst OR adviser OR doctor.	AND	"faith-adapted" OR "faith-adapted therapy" OR "faith-adapted psychological interventions" OR "faith-adapted mental health support" OR "faith-adapted psychological support" OR "faith-based" OR "faith-based therapy" OR "faith-based psychological interventions " OR "faith-based mental health support " OR "faith-based psychological support " OR "faith sensitive" OR "faith sensitive therapy" OR "faith sensitive psychological interventions" OR "faith sensitive mental health support" OR "faith sensitive psychological support" OR "religio* adapted" OR "religio* adapted therapy" OR "religio* adapted psychological interventions" OR "religio* adapted mental health support" OR "religio* adapted	AND	Perspective OR attitude OR experience OR explor* OR angle OR view* OR outlook OR reflections OR evaluation OR barriers OR benefits OR enablers

		psychological support" OR "religiously-adapted" OR "religiously-adapted therapy" OR "religiously-adapted psychological interventions" OR "religiously-adapted mental health support" OR "religiously-adapted psychological support" OR "spiritually adapted" OR "spiritually adapted therapy" OR "spiritually adapted psychological interventions" OR "spiritually adapted mental health support" OR "spiritually adapted psychological support".	

The PEO (population, exposure, outcome) search strategy is commonly used for qualitative studies and was used for this research because it encompassed a simpler focus in understanding the relationship between the exposure and the outcome on the specific population compared to the SPIDER search strategy which includes more complexity such as design and research elements (Martinez et al., 2023). In addition, PICOS is traditionally used to search for quantitative research in systemic reviews and therefore not applicable for this research (Martinez et al., 2023). Therefore, the PEO strategy was developed and combined with selected search terms. Terms have been checked alongside a thesaurus, and alternative terms from this were included. This was in line with Siddaway et al.'s (2019) method, which increased sensitivity to ensure that all relevant papers were noticed. The search strategy was implemented initially in PubMed and modified for use in the respective databases, using both free text and MeSH terms, relevant vocabulary, truncation where appropriate (e.g., explor* = exploring, explored), Boolean operators ('OR' and 'AND'), and adjunct terms (Table 1). The search terminologies were comprehensive and applied in electronic sources such as The Journal of Islamic Studies, The Journal of Muslim Mental Health, Care and Counselling, and The Journal of Pastoral Psychology to increase the search scope. The Cochrane database was searched for existing systematic reviews and showed that no reviews had been undertaken or were in progress. Due to the limited literature in this research area, the search strategy was not confined to a specific time frame in order to maximize the number of papers available for review.

Covidence was used to undertake the review by three researchers (FM, A and SS) as recommended (Higgins et al., 2019). After removing duplicates, the two reviewers (FM and A) independently applied the study selection process to confirm eligibility by screening all titles

and abstracts. Full texts were retrieved for those that seemed suitable and screened against criteria (Table 2). Eligible studies were retained for full-text data extraction and included in the review. To manage resources efficiently, full data extraction was completed by the primary author, whilst the second (A) and third reviewers (SS) checked 70% of a random sample of the extracted data. This is in line with practice guidelines for reviews including reviewing 10-20% of the sample (Nussbaumer-Streit et al., 2023). Any disagreements between the reviewers over the eligibility of the studies were resolved and, in instances of disagreement, were resolved by a third review (SS).

Table 2

Literature Search Inclusion and Exclusion Criteria

	Inclusion criteria	Exclusion criteria
1	Clinicians who have appropriate clinical training (e.g., psychologist, therapist, psychotherapist, counsellor).	Anyone who is not a clinician with appropriate clinical training.
2	Participants who are 18 years and above.	Participants who are 18 years and below.
3	Written in English.	Written in non-English.
4	Include qualitative experiences of delivering a psychological therapy that has a religious or spiritual adaptation.	Quantitative assessments of therapy delivery.
5	Be about religious or spiritual adaptations within psychological therapy.	Not about religious or spiritual adaptations within psychological therapy.
6	Have no geographical limit.	Quantitative in methodology and data analysis.
7	Be empirically based and is qualitative in methodology and data analysis.	

2.3 Results of Systematic Literature Review

A Prisma flow diagram of the search results and screening process is presented in Figure 1 (Liberati et al., 2009). The searches identified 1197 papers from which 470 duplicates were removed. After screening titles and abstracts using the inclusion and exclusion criteria, 683 papers were removed.

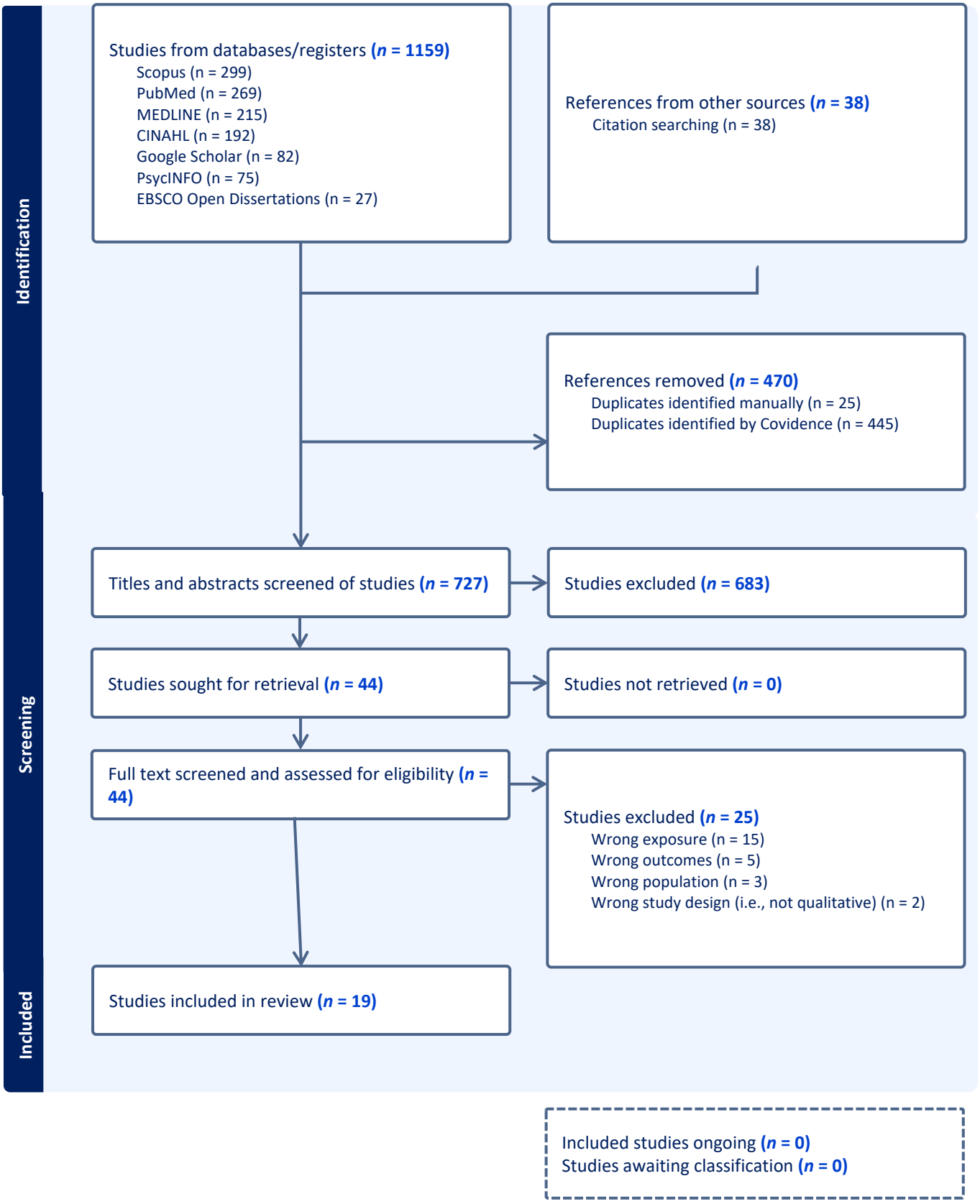
In the final full-text stage, a further 25 papers were excluded. Some papers did not explicitly mention that their research investigated faith-adapted psychological therapy, which would have challenged inclusion criteria 5; however, given the scarcity of the literature and that the faith adaptation was implied within the respective findings, these papers were included (Gill, 2018; Suara, 2022) . A further twenty papers were excluded, of which five did not undertake qualitative experiences of the clinician (inclusion criteria 4/5); and fifteen did not capture the clinician's experiences delivering FAPI, violating criteria four.

The systematic literature review, therefore, includes 19 studies in total, all of which are qualitative in methodology. Table 3 outlines a summary of the findings of each paper and strengths, and limitations.

2.4 Results of Systematic Literature Review Search

Figure 1

PRISMA 2009 Flow Diagram Presenting Results from Literature Search



2.5 Summary of Findings

Table 3

Summary and Evaluation of Studies in the Systematic Literature Review

#	Author/ Authors & Year	Title	Sample details (ethnicity and faith of participants and clients served, therapeutic intervention, *if stated)*; Role of participants.	Methodology	Summary of Key Findings	Strengths and Limitations
1	Bell-Tolliver and Wilkerson (2011)	The Use of Spirituality and Kinship as Contributors to Successful Therapy Outcomes with African American Families	*n* = 30 (9 males, 21 females); Range (20–70) African American 24 = Protestant 3 = Pentecostal; 2 = Christian; 1= Christian scientist Providing family therapy to a population with belief in God. No specific client religion was identified.	Snowball sampling Semi-structured interviews Interpretative, phenomenological Analysis	Three themes emerged: • Kinship as a strength in therapy • Religion or spirituality as a strength in therapy • The influence of kinship bonds and spirituality on therapy These themes brought success in outcomes like family functioning.	Strengths: The paper focuses on the cultural nuances of African American families, which is often overlooked in mainstream approaches and helps to understand the community's strengths and incorporate faith into therapy; and provides practical and clinical guidelines for therapists. The sample size included participants from different areas, increasing the validity. The reliability of the findings was

			Therapists licensed from the field of marriage and family therapy, social work, psychology, and counselling. USA			strengthened through participants double-checking transcripts. Limitations: The findings may not be generalisable to other cultural and ethnic groups; the positive focus on faith might highlight a biased view whereby the author overlooks the challenging aspects; the understanding of the relationship between faith and kinship is in its infancy and needs further exploration.
2	Crossley and Salter (2005)	A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy	*n* = 8 (4 male, 4 females) Participants reported having various spiritual beliefs and values, including being aligned with religious structures, atheist views and tenets separate from transcendent concepts.	Voluntary and theoretical sampling Semi-structured Interviews Grounded theory methodology	Two core categories were developed: • Spirituality as an elusive concept (the multiplicity of the meaning around spirituality and not engaging with it) • Finding harmony with spiritual beliefs	Strengths: Employing a grounded theory approach allowed for rich data collection, prolonged engagement with the subjective experiences of clinical psychologists. The development of a framework grounded on the experiences of the practitioners also discussed practical clinical implications in addressing spiritual

			Clinical psychologists practising ranged from 3 months to 24 years (*M:* 11.75 years). Participants theoretical positionings included: 2= Eclectic; 2= cognitive-behavioural; 2 = personal construct; 1 = systemic 1 = community psychology UK		(understanding and respecting beliefs)	issues in training and practice. The use of consistent peer discussion of the findings, as well as the transparency of the researchers position to it, enhances the trustworthiness of the study. Although, the study was conducted more than 10 years ago which can be argued as being irrelevant to the current times, the body of literature is limited but growing suggesting that the study's findings are important in understanding how clinicians work with spirituality. Limitations: There was a small sample size comprising of NHS psychologists and the lack of demographic details such as ethnicity and religion of participants limits the generalisability to psychologists in other settings, therapists of other professions and

						of diverse backgrounds. The lack of contextual information of the settings in which these psychologists practice may have limited the applicability of the findings. Furthermore, the study lacks specific guidance in how the models can be practically applied in therapy and therefore clear examples and practice steps would increase clinical utility. While qualitative methodology enabled for a rich theoretical discussion, the data lacks empirical data to support the theories.
3	Evans and Devlin (2016)	Client-led Spiritual Interventions: Faith-integrated Professionalism in the Context of a Christian Faith-	*n* = 10 (9 females) Practicing Christians; Delivered to Christians mostly and Muslims (but different adaptation	Voluntary sampling Interviews An adapted phenomenologic	Three themes emerged: • Using flexibility, discernment, and a client-led approach. • Trust in God and spiritual receptiveness.	Strengths: Explores a niche area exploring Christian practitioners integrating faith in their practice; has clinical relevance and implications in relation to ethical

		based Organisation	depending on competence). Senior professional counsellors with over 15 years of experience working with clients who actively sought to explore faith and spirituality in therapy. Australia	al hermeneutical approach (Englander, 2012; Moustakas, 1994).	• Managing tensions between professional, personal, and organisational values.	considerations in delivering faith interventions. Limitations: While there were valuable insights from the findings, the small sample size with a heavy reliance on experienced practitioners, limits the generalisability; the study could benefit from providing specific examples and guidelines around the implementation of faith in everyday practice. The lack of diversity in perspectives limits the application of findings to counsellors from other faiths. Given the religious focus was on Christianity, participants responses may have been biased and the study could have mentioned how these were addressed.
4	Gill (2018)	Acknowledging the unseen:	*n* = 8	Voluntary sampling	Three key components were presented in the model.	Strengths: The findings are highly relevant as it provides a culturally

		Muslim practitioners' understandings and processes of alleviating emotional distress with British Muslims	Muslim participants and delivered to Muslim clients. Clinical psychologists, Muslim youth group lead, community faith healer, Imam, CBT therapist, counsellor, and outreach worker. UK	Semi-structured Interviews Grounded theory	• Practitioners' understanding of Islam and wellbeing (Islamic resources used, like Qur'an, Hadith, Islamic values and practice, belief and reliance in God as the ultimate controller of wellbeing; the spiritual heart in formulation) • Engaging with various British Muslims (through non-judgmental collaborative stance, acceptance that God is the utmost judge, including religious concepts and Qur'anic verses and practice if requested by client, practitioner keeps private Islamic views detached from work).	sensitive perspective and holistic therapeutic practices of supporting the British Muslim community, contributing to a broader understanding of psychological theory with religious philosophy that is often overloaded in psychological literature and secular models. The sample included practitioners (professional and non-professional), across various socioeconomic boroughs within Britain, therefore showing a representative population and a broader scope of therapeutic interventions beyond mainstream MHS. The qualitative method enabled an in-depth investigation of the practitioners' experiences and beliefs, capturing the nuances and complexities of the cultural context. Practical implications have been

					• Therapeutic processes used to alleviate emotional distress (practitioners insight of the self at the core of any intervention, use of Islam and free will to empower clients to find their personal agency, use of Prophetic stories, Islamic metaphors and stories from Qur'an and Hadith, acknowledging ultimate healing comes from God, limitations of removing emotional distress through cognisance of self, encourage openness to God, prayer and supplication, submission to God, therapeutic restrictions to gain an awareness of God's	suggested which make the findings clinically relevant and applicable. Limitations: While the constructivist grounded theory methodology allowed to show the process enacted by Muslim practitioners to address Muslims' emotional distress, the clinical effectiveness of the model is limited by the lack of empirical data. Additionally, despite efforts to minimize researcher bias through supervision, the findings are influenced by the researcher's interpretation of the data and epistemological position, affecting the objectivity of the model. The small sample consistent of all but one practitioner who were recognized as South Asian limits the generalizability and representativeness of the findings

					wisdom, achieving a balance)	to other Muslim populations and cultural groups. No participants from the third sector were recruited, therefore study did not fully capture therapeutic practices outside of mainstream services. The findings may not also be applicable to non-Muslim of non-religious practitioners too.
5	Hood (2022)	A Critical Investigation into the Use of Spiritual and Religious Interventions (SRIs) by Professional Counsellors	*n* = 15 (mixed gender) Christian Delivered to Christians mostly, also Muslims, Buddhists and Hindus (over 60% of the participants were Australian) Professional registered counsellors	Invited survey respondents to attend one of 4 focus group discussions on questions from preliminary findings from a mixed methods approach. Semi-structured Focus groups	Four interventions surfaced from the findings: forgiveness, prayer, meditation/mindfulness, and scripture reading. Two theories were developed: • Factors influencing the use of spiritual and religious interventions (SRIs) (three factors extrinsic to the counsellor - client characteristics, the context of the counselling conversation and code of	Strengths: the research is highly relevant, timely and offered practical guidelines and advice on the use of SRIs ethically and effectively, especially in the context of counsellors facing conflicting guidelines around the use of SRIs. Research provides a robust framework of implementing SRIs. The use of a mixed methods approach allowed for richer and broader exploration of the topic, capturing multiple perspectives of different faiths which strengthened

			Australia	using grounded theory methodology.	ethics; and three intrinsic - counsellors own spirituality, capability, and professional self-identity. • A classification of SRIs (including four categories and levels of integration: personal, universal, typical and special)	the applicability and validity of the findings. Limitations: The ambiguous definitions related to SRIs hindered the consistency and clarity of the research, even though there were attempts to create a working definition; the sample consisted of Protestant Christians, which may limit the generalizability to other religious and spiritual traditions; the complexity of the project from using mixed methods and grounded theory approach might make it difficult for practitioners to adopt the complex theories into their everyday practice.
6	Jacobs (2010)	Exploring Religion and Spirituality in Clinical Practice	*n* = 40, (16 males, 24 women)	8 focus groups. Thematic analysis	The following themes emerged: • Participants' definitions of spirituality and religion (fluidity of definitions and	Strengths: The findings are relevant and valid to the existing and current literature and present times which enables the fluid use of the definitions of spirituality and

			30 = White; 4 = African Americans; 2 = Hispanics; 2 = Asian; 1 = biracial; 1 = unknown Religious affiliation: 19 = private spiritual or religious practice was strongly related to their religious affiliation; 12 = religious affiliation and spiritual practices overlapped into other religious practices; 9 = connected with particular spiritual practices but no religious affiliation. Participants worked with 10 = Christian; 3 = Jewish; 2 = Buddhist; 2 = Neopagan They did not exclusively serve one religious group.		the importance of theoretical orientation) • Intake and assessment • Mindfulness and reflective practices • Paying attention (about spirituality and religion in therapeutic practice) The findings signified the need for theoretically established practitioners integrating spiritual and religious beliefs and practices into personal and professional domains to support clients to make meaning of their life situations.	religion in clinical practice. The sample included ethnically diverse therapists which enhanced the cultural responsiveness and applicability of the findings. Practical strategies on integrating religion and spirituality into clinical interventions have been provided highlighting relevant clinical implications and emphasising cultural sensitivity and holistic centred care. The author included case studies and real-world examples to support the application of theoretical ideas. The coding process engaged two researchers which enhanced the reliability of the findings. Limitations: The findings do not delve deeply into specific religious or spiritual traditions; therefore, the application may be superficial. The

			Doctoral-level psychologists, social workers, master's-level clinicians, family therapists and pastoral counsellors, who have been qualified for 5 years. Majority trained in psychodynamic theoretical orientation. USA			study was also limited by the small size of focus groups, which did not meet the expected number. The theoretical orientation of the participants limited the range of views explored, thus limiting the applicability of findings for clinicians who use different theoretical orientations. Given that participants self-selected, this may have also skewed the findings towards a more positive perspective in spiritual interventions.
7	Johnson (1989)	Psychotherapy and spirituality: Techniques, interventions and inner attitudes	*n* = 12 (5 male, 7 female) White, middle-class, well-educated, from varied educational and religious backgrounds. 1= Jewish; 1= mystic/ shaman; 1 = Unitarian	Structured interviews Analysed according to Fowler's Manual (Moseley et al., 1986)	Spirituality can be integrated into psychotherapy through a variety of techniques, interventions, rituals, and inner attitudes (TIRIA). 65 techniques were categorised as psychic, humanistic, transpersonal, bodywork, unique.	Strengths: The use of personal in-depth interviews allowed for a rich understanding of spirituality in psychotherapeutic interventions. The analysis process involved multiple coders, enhancing the reliability of the findings. Although, the study was conducted more than

			Universalist Minister; 1= spiritual healer; 2 = holistic methods of spirituality Siddha Yoga; 1 = Sikh Dam 1 = a course in miracles; 11 = Buddhist practices; 1 = spiritual; 1 = religion comes from within Psychotherapists, psychologists, family therapists, Jungian analyst, and hypnotherapist; licenced between 7-38 years. USA		Eight interventions and 21 rituals emerged. However, the therapist's inner spiritual self and attitudes became key for the transpersonal psychotherapist and it was seen as more important than any TIRIA.	10 years ago, it can be argued that it is irrelevant to the current times. However, the body of literature is limited but growing suggesting that the study's findings are important in understanding how clinicians work specifically with spirituality and religion. Therefore, this can inform clinical and practical implications for therapists. Furthermore, most culturally and faith adapted research also focuses on CBT (Anik et al., 2021), however, this study focuses on faith adaptions within psychotherapy which adds to the limited literature. Limitations: Given the limited time in phone and face to face interviews, therapist perspectives may have not been explored in detail. The sample size was small and not representative of ethnic

						diverse groups; therefore the findings may not be generalisable to non-white populations.
8	Johnson, Hayes and Wade (2007)	Psychotherapy with troubled spirits: A qualitative investigation	*n* = 12 Range: 38-62 years old (*M:* 49.58, *SD*:/ 7.08). 10 = White 1 = Latino 1 = unidentified race or ethnicity Buddhist (*n* = 2); Unitarian (*n* = 2); Episcopalian (*n* = 1) Presbyterian (*n* = 2) Disciples of Christ (*n* = 1) Evangelical Christian (*n* = 2) Non-affiliated (*n* = 1) Mennonite with New Age, Pagan, and other added sensibilities (*n* = 1)	Purposive sampling Interviews Consensual qualitative research (CQR) method	Analyses presented four categories related to psychotherapy including spiritual issues: • Therapist approach (secular and spiritual approaches) • Identification of spiritual issues (conceptualisation of spiritual problem, types of spiritual problems, diagnosis) • Therapeutic process (therapist interventions: spiritually themed, secular, responses in therapy, trajectory of therapy) • Therapeutic outcomes.	Strengths: Despite the study being older than 10 years, the study still provides in-depth qualitative data contributing to an underexplored research area. The findings are also consistent with literature and current clinical practice that advocates for clinicians using a spiritual problem assessment and pluralistic approach to clients' faith, respecting diverse beliefs. The study also provides current clinical and practical implications for supervisors, educators and therapists to address spiritual problems. The researchers used bracketing to manage their influence on the data analysis.

			Eight psychologists, one qualified professional counsellor, two clinical social workers, and one qualified marriage and family therapist. USA			Limitations: With a small sample consisting of 12 psychologist volunteers, the findings may not be generalizable to or representative of other therapists. The bias towards more White heterosexual therapists who are from Christian traditions, limits the varied perspectives on spiritual issues and may not reflect approaches of therapists from other ethnic backgrounds. The findings also primarily focused on cases that were successful, therefore providing an unbalanced view of therapeutic processes. Information of the race or ethnicity of the therapists' clients was limited, therefore, it is unclear whether the findings are limited to a particular racial or ethnic group of clients.

9	McCoy et al. (2004)	Conceptual bases of Christian, faith-based substance abuse rehabilitation programs: qualitative analysis of staff interviews.	*n* = 11 Evangelical Christians. Delivered Faith-Based Substance Abuse Rehabilitation Programs to Christians, Catholic or Protestant, but results suggest that it can include men and women of different faiths. Two program site administrators, two staff counsellors and seven clinical directors. USA	Convenience sample Semi-structured Interviews Grounded Theory	Four principal themes reflected how spirituality is incorporated into the substance abuse intervention: • Program elements of faith-based recovery programs • Centring of spirituality to the rehabilitation process • Ideas of addiction • Notions of rehabilitation (the turning point, salvation, a stable relationship with God, the inclusion of others, as disciples of God, constant awareness of relapse). Core components were secular; however, the activities were rooted powerfully in the Christian belief system.	Strengths: The research recognised and differentiated specific components of the Christian, faith-based programmes from secular models, which provides a comprehensive insight into the role of faith in interventions for substance abuse; staff members of the faith-based programme were interviewed, which is a unique population shedding light on the practical elements and challenges of running faith-based approaches; and the qualitative methodology allowed for an exploration of rich and nuanced views. Although the study was conducted over a decade ago, it remains relevant today. The body of literature on this topic is limited but expanding, indicating that the study's findings are crucial for understanding how clinicians integrate spirituality and religion into

						their work. Therefore, it still holds valuable insights for informing clinical and practical implications for therapists. Additionally, while much culturally and faith-adapted research centers on CBT (Anik et al., 2021), this study uniquely focuses on faith adaptations within a faith-based rehabilitation program, contributing to the relatively scarce literature in this area. Limitations: The sample is not representative, nor generalisable to programmes for non-evangelical Christians, other faith-based programmes nor non-Christian spiritual approaches and contexts. The interviews from staff may have been biased and portraying the programmes in a positive light; understanding the impact of these

						faith-based programmes are limited to the staff's perspectives rather than clients; the findings might be outdated given that it was conducted in 2005 and therefore the study may not be applicable in the current context where there has been changes in societal attitudes, substance abuse and shifts in religious practices.
10	McVittie and Tiliopoulos (2007)	When 2–3% really matters: The (un)importance of religiosity in psychotherapy	*n* = 6 (3 male and 3 female). 1= Church of Scotland 1= an atheist 4 = Identified as being agnostic or atheist. One psychiatrist and five clinical psychologists. Years of practice experience (Range= 5-18; *M* = 7)	Purposive sample Semi-structured Interviews Comprehensive analysis of data was undertaken aligned with the Wetherell	The following three themes were developed: • Religious beliefs as limiting relevance to specific groups • Interpreting the role of clients' religious beliefs in therapy • Applicability of religious beliefs in psychotherapeutic training	Strengths: Although the study was conducted over a decade ago, the findings are relevant within the context of discursive social psychology, thus enhancing the relevance and credibility of findings. Furthermore, the paper also offers relevant and timely clinical implications in the current NHS context such as further training around therapists' attitudes towards religiosity and fostering inclusive conversations including

			UK	(1998) approach.		religious beliefs in therapeutic settings (Arundell et al., 2021; Jafari, 2016; NHS Golden Jubilee, 2023). The methodology allowed for interview data to be analysed in a way that it provided a deeper understanding of the research area. Limitations: The small sample size limits the generalizability of the findings and cannot be extended to all religious beliefs. Furthermore, the religious backgrounds of the participants may have influenced their responses and therefore limiting access to a range of perspectives. The scope of the analysis limits a comprehensive understanding of other factors that may influence the integration of religiosity in therapy.

11	Miller and Chavier (2013)	Clinicians' Experiences of Integrating Prayer in the Therapeutic Process	*n* = 17 (6 male, 11 female) 1 = Brazilian; 1 = Puerto Rican; 1 =Honduran; 1 = Mexican; 7 = White; 1 = Japanese; 1 =. Indian; 1 = African American; 1 = Iranian American; 1 = Afghani American; 1 = White/Latino 1 = Other: Buddhist; 1 = Buddhist/Shinto; 1 = Buddhist/Catholic; 3 = Catholic;1 = Catholic/Protestant; 3 = Protestant; 1 =Hindu; 2 = Muslim; 2 =Jewish; 2 = Latter-Day Saints. Qualified marriage and family therapists or interns/associates.	Maximum variation sampling Semi-structured Interviews Interpretative Phenomenological Analysis	Seven themes that were revealed across faiths: • Definition of prayer • Prayer as connection with God/transcendent and client • Ethical boundaries • Use of prayer depends upon context of therapeutic practice • Direct versus indirect prayer interventions • Prayer as used for self-of-therapist care • Use of prayer changes as therapist grows and develops over time	Strengths: The authors applied several methods to manage their biases in their data analysis process, such as investigator triangulation, data triangulation reflexivity, member checking. This transparency heightened the credibility of the data analysis and findings. Participants were from diverse faiths highlighting the broader application and generalizability of using prayer in therapy. Limitations: Only 8 out of 17 participants provided feedback, thus, affecting credibility of member checks and verification from the participants perspectives. The first author had existing relationships with participants which may have introduced potential bias in the data interpretation. Despite the diversity

			USA			of sample being a strength, the interpretations may have limited depth and nuanced insights of other faiths compared to homogeneous samples. Furthermore, the understanding of prayer may have varied among participants which may have affected the study's coherence of participants definition of using prayer in therapy. Lastly, the second author's absence from some interviews may have impacted consistency and depth of data interpretation. This may question the reliability of findings.
12	Mir et al. (2015)	Adapted behavioural activation for the treatment of depression in Muslims	*n* = 3 References to mixed religion of participants, however delivered BA-CBT to Muslim clients	Face to face interviews did not follow a structured protocol but used a topic guide in which	Two key areas emerged: • Social context: professionals identified the merit of family involvement in raising awareness of depression and ameliorating support and communication.	Strengths: The study contributes to the existing literature and acknowledges the importance of cultural sensitivity and considerations when adapting therapy to meet the cultural and religious needs of patients;

			Therapists with one year of psychological training. Bradford, UK	themes were identified to discuss. Qualitative Framework Analysis Purposive sampling	Some therapists refrained from family involvement, given to insufficient training. • Therapy and Religion	interviews included a range of therapists across the organisational level which provided a richer insight into the application of the adaptations. Research suggests clinical implications such as improving access. Limitations: The small sample size limits the generalisability of the findings; there were insufficient direct quotes from therapists limiting the range of perspectives and experiences captured; the authors were involved in the development and implementation of the therapy which could have influenced and biased the interpretation of the results.

13	Ringel and Park (2008)	Intimate partner violence (IPV) in the evangelical community: Faith-based interventions and implications for practice	*n* =11 clinicians (6 male, 5 female) and 8 pastors mixed, (6 male, 2 female) Range: 23 - 67 years old Clinicians: All Caucasian. 5 = non-Evangelical Christian denominations; 3 = Evangelical Southern Baptists; 2 = conservative Evangelical denominations; 1 = Evangelical non-denominational church Evangelical Baptist church Pastors: 5 = liberal denomination 2 = conservative denominations 3 = African American; 1 = Caucasian	Snowball sampling technique Interviews Constant comparison methodology of grounded theory	Two main themes emerged: • Religious and social values as support and barriers to seeking help (submission, forgiveness, shame, and fear of social ostracism) • Remaining within tradition but adopting several clinical interventions.	Strengths: Although the study was conducted over a decade ago, it remains relevant today. Therefore, it still holds valuable insights for informing clinical and practical implications for therapists to incorporate religious values and traditions into therapy particularly for those from an Evangelical background. The study contributes to the existing literature signifying the value of religious beliefs in IPV interventions within Evangelical communities. Additionally, while much culturally and faith-adapted research centres on CBT (Anik et al., 2021), this study uniquely focuses on faith adaptations within IPV interventions, contributing to the relatively scarce literature in this area. Furthermore, the participants from diverse clinical backgrounds and denominations

			Both groups practiced extensively with Evangelical clients through Christian counselling centers, pastoral counselling agencies, pastoral counselling agencies and private practice. Clinicians and pastors experienced in providing counselling to parishioners. Clinical experience ranged from 3 to 31 years. USA			enables the recognition of diverse needs and the application of findings to be recognized across subgroups. Limitations: Given the study's small convenient sample and skew towards liberal pastors, the findings are limited by its bias and may not reflect the viewpoints of the wider and diverse Evangelical community. The findings also limits the generalizability to other religious or non-religious communities.
14	Robinson (2016)	African American pastors' experiences and perceptions of suicide prevention and	*n* = 10 (9 males, 1 female) Range (30-77 years old) African American, female, Christian.	Voluntary sampling Semi-structured Interviews	8 principle themes and 4 sub-themes emerged: • Pastoral limitations (spiritual counsellor) • Listening skills • Hope	Strengths: The study provides nuanced insight into African American pastors' experiences with suicide prevention and postvention services. The use of qualitative methodology included semi-

		postvention services	Providing suicide prevention and postvention services to Christian clients. Pastors, experience varied significantly, from 4 years to 49 years. USA	Thematic analysis	• The after-life • Mental illness • Love • Pastoral experiences • Collaboration (confidentiality, resource availability, and in-house human services professionals)	structured interviews which allowed for rich and detailed narratives of experiences to be obtained. There is also credibility of the findings given that the bracketing method was adopted before data collection to reduce biases, preconceptions, and prejudgments. The study offered practical implications which suggests developing culturally competent and integrated care. Limitations: The small sample size of 10 pastors limits the generalisability of the findings. Given that majority of participants are from the Baptism denomination and male, the study did not allow for comprehensive representation of African American pastor populations from other denominations and female. Furthermore, 2 out of 10 interviews

						were conducted in person limiting obtaining further insight from the pastors' mannerisms, and consequently affecting the quality of the data collected.
15	Stansbury et al. (2018)	Community engagement with African American clergy: faith-based model for culturally competent practice.	*n* = 18 (*M* = 51), all male. Range (36-68 years old) African American Baptist Church, implies serving clients who were of the Baptist church. Clergy USA	Purposive sample Interviews Constant comparative methods (Glaser, 1992)	The primary emergent theme: Shepherding the flock was used to organise a pastoral care model to support elder congregants which includes five central elements: • Pastoral awareness • Pastoral screening • Pastoral counselling (active listening and spiritual interventions – prayer and biblical scriptures, altering behaviour patterns) • Internal ministries • Follow-up with elder congregants and/or family members)	Strengths: The credibility and reliability of the interpretation of data were enhanced through member checking of transcript validation as well as multiple coders. The findings have cultural relevance, acknowledges the holistic role of religion in mental health care and contributes meaningfully to the niche body of literature exploring experiences of Clergy's. The study also provides implications around empowering communities and Clergy's to take active roles in community-driven health initiatives and developing partnerships with faith-based

						organisations to access hard-to-reach populations. Limitations: The sample is homogenous of African American Baptist Church Christians limiting the generalizability of findings to other denominations and ethnic populations. The lack of quantitative data limits a comprehensive understanding of the Clergy's role in mental health care. The study on Clergy's did not provide direct treatment and sufficient attention to examining the patterns of care offered in the faith-based settings. Therefore, limits a comprehensive understanding of the care their provided.
16	Suara (2022)	Practitioner's Incorporation of Religious	*n* = 6 (1 male) 1 = White 2 = Asian American	Structured Interviews	Several themes and sub-themes were developed relating to	Strengths: The study contributes to the body of literature incorporating religious beliefs and practices for

		Content Within Cognitive Behavioral Therapy (CBT) for Muslims with Depressive Symptoms	3 = Middle Eastern All Muslim with one identifying as a revert or convert Delivered CBT to Muslim Clients Independently licensed mental health providers where they incorporated Islamic material into their therapy approach for the treatment of depressive Symptoms. 3= licensed professional counsellors; 1= licensed marriage and family therapist; 1 = clinical psychologist; 1 = psychiatrist.	Grounded theory methodology	integration of religious content within CBT: • Characteristics of Muslim clients (presenting problems, client therapeutic engagement and stigma, client religiosity) • Overall treatment approaches (modification of CBT techniques, behavioural and cognitive approaches) • Treatment recommendations (recommendations for non-Muslim and Muslim therapists) • Importance of understanding common Islamic practices (prayer, fasting, charity, reading the	Muslim clients; the grounded theory methodology enabled to explore themes deeply and provide rich descriptions and examples; the study offers practical implications and strategies for clinical practice working with Muslim clients. Limitations: The small sample size limits generalizability of the findings; there is a selection bias towards Muslim therapists which prevented a comprehensive understanding of FAPI between Muslim and non-Muslim therapists and allowing to explore variations in therapeutic practices across different cultural and religious backgrounds; the interviews conducted by the researcher who is a Muslim therapist may

			USA		Qur'an, dhikr, hadith, tawbah) Engaging common Islamic beliefs (one must fully trust and rely on Allah (god), life is only temporary, focusing on the hereafter or afterlife, perceiving difficulties as a test from Allah (God), remembering sins are forgiven, with hardship, there is ease, focusing on Allah's (God's) blessings, remembering that Allah (God) is compassionate and merciful).	have introduced bias and potentially influencing participant responses and interpretation of data; the snowball sampling method may have limited the diversity of perspectives and participants.
17	Tipton et al. (2021)	Beyond Integration: A Phenomenology of Faith-Informed Clinical Practice	*n* = 10 (5 male, 5 female), Range = 34-60 years old, *M* = 46 years) 9 = White, 1 = Latina Christians	Purposeful criterion sampling Semi-structured Interviews	Six overarching themes emerged to comprehend faith-informed practice from the clinician's viewpoint: • Faith-informed practice appears from an eternal perspective. • Specific hopes of the faith-informed clinician. • The inner world of clinician's	Strengths: The study provides a rich narrative of faith informed clinicians which is strengthened by the clinical and practical implications suggested for counsellors and training programmes; the researcher acknowledged and made attempts to reduce their biases.

			Clinicians qualified for independent practice, trained in evangelical institutions, and provided therapy for at least 5 years. USA	Transcendental phenomenological approach and a reflective structural analysis used (Moustakas, 1994).	• Reciprocal influences between professional development and faith. • Experiences of clinical problems distinct to clients of faith. • Educational precursors to faith-informed practice.	Limitations: the sample lacked diversity of perspectives and an under-representation of global majority groups which suggests that the findings may not be generalizable, limiting its broader application. Although the study provided theoretical insights and reflections of faith informed practice, there was a lack of clinical examples to illustrate practical relevance.
18	Vandenberghe and Prado (2012)	Spirituality and Religion in Psychotherapy: Views of Brazilian Psychotherapists	*n* = 27 females Latina 12 = Roman Catholics 6 = Evangelical Christians 2 = Logosophists 7= Kardecist Spiritists Clinical psychologists (either behaviour or CBT therapists), with independent practice	Intentional sampling Unstructured Interviews Grounded theory analysis.	Two categories with six respective sub-categories and multiple codes emerged: (1) Cultural competence tightrope walking • Seeking to respect client religion • Tackling client religious issues • Therapist religion influences professional behaviour	Strengths: the study uses a qualitative approach which allowed for a rich insight into how Brazilian Psychotherapists use spirituality and religion in therapy and thus contributing to the literature and offering a unique understanding from a cultural perspective; examines its findings to various elements such as therapeutic techniques, ethical considerations

			experience ranging from 1 to 34 years (*M* = 9.26; *SD* = 7.68) Central Brazil		(2) Religion and spirituality are cultural resources • Therapist appreciation of daily life strengths (spirituality as providing a broader sense of meaning, healthy activities, teachings and social support) • Therapist use of client resources as therapeutic aids (clients' religion and spirituality as therapy aids) • Therapist spirituality is a professional asset in enhancing their interventions and managing the emotional tensions of engaging in therapy	and cultural competence; the authors provide clinical and research implications and guidance to therapists navigating religious and spiritual concepts in therapy sessions such as cultural sensitivity. Limitations: While theoretical concepts are discussed, the lack of concrete examples may challenge the application of these principles in everyday therapeutic practices; the findings may not be generalisable to psychologists of other faiths or cultures outside of those studied in the research.
19	Williams (2017)	Exploring religion and spirituality in psychological therapy	*n* = 5 (3 males, 2 females), 40+ years old Christian, White	Semi-structured interviews	Three superordinate themes emerged: • Unchartered territory • Complex meanings of religion/ spirituality	Strengths: The phenomenological approach allowed for an in-depth exploration and detailed analysis of the psychologists lived experiences of addressing faith issues in

			Diverse religious beliefs of clients Clinical Psychologists, UK	Interpretative Phenomenological Analysis	• Bringing religion/ spirituality into the room.	therapy and enhances the applicability of the findings into clinical practice. Limitations: Due to the homogeneity of the sample, generalisability of the study does not represent broader populations of psychologists in non-NHS therapy settings; the lack of negative experiences and participants self-selection may have suggested biased findings and a balanced perspective.

2.6 Assessing Study Quality

The Critical Appraisal Skills Programme's (CASP, 2018) Qualitative Research Checklist was used to assess the quality of articles. CASP is used widely to appraise the quality, integrity and value of qualitative papers (Dixon-Woods et al., 2007). The checklist has ten questions that evaluate the standard of studies regarding the appropriateness of the researcher's position, research design, ethics, recruitment, data collection, rigour of the analysis, and coherence of findings. Appendix B provides further details about each question asked within the CASP Qualitative Checklist to support the readers' understanding of this specific appraisal process. One reviewer reviewed all the papers, while the second reviewed a random selection of 50% of the records. Any differences were resolved by consensus within the research team.

The rated quality of thirteen papers were good, whilst six were moderate (see Appendix C for full results). All but two papers answered the first three questions of the CASP Qualitative Research Checklist as required by CASP (2018), demonstrating that they were deemed of good quality to contribute to the review. All papers within this review were pertinent to the questions, thus were considered necessary for inclusion (Dixon-Woods et al., 2007). Quality issues, strengths and weaknesses were captured and summarised in Table 3 and Appendix C.

All papers provided clear statements of their research, which was appropriate for qualitative methodology. Most papers reported using appropriate research designs; however, this needed to be clarified for Mir et al. (2015) and Suara (2022). Most papers reported precise details about participant recruitment (except Evans & Devlin, 2016; Johnson et al., 2007), eleven papers provided sufficient details, and six papers reported a questionable amount of information for data collection. Whereas in six papers, the reporting of data collection was questionable. Thirteen papers provided sufficient details, and three papers provided acceptable data on the analysis process. A satisfactory amount of participant quotations were presented to evidence that the findings and themes were grounded in the data. All but two papers (Evans & Devlin, 2016; Ringel & Park, 2008) specified the credibility of findings through member checking, peer review discussions and triangulation.

An issue that arose from evaluating the papers was the lack of information specifying the researcher's position during the data collection, specifically about the formation of the research question and the analysis process. However, a few researchers explored and evidenced their data collection and analysis biases. In addition, many studies omitted information about the author's epistemological stance. The only studies that clearly stated their position were Gill (2018), Hood (2022) and Williams (2017). Information related to saturation of data across

papers was mixed due to different methodologies; however, for papers where the methodology was more relevant (i.e., grounded theory), all but one paper met saturation (Suara, 2022), indicating that enough data was obtained to corroborate the study findings.

Additionally, attention to ethical issues across papers was mixed. In many instances, there was insufficient evidence concerning the explanation of the research given to the participants, and only ten papers mentioned ethical approval (Evans & Devlin, 2016; Gill, 2018; Hood, 2022; Jacobs, 2010; McCoy et al., 2004; Mir et al., 2015; Stansbury et al., 2018; Suara, 2022; Vandenberghe & Prado, 2012; Williams, 2017). Some papers had a larger sample size using phenomenological approaches, which may have impacted obtaining rich and detailed experiences of participants (Smith et al., 2009). This was specifically relevant to Bell-Tolliver and Wilkerson (2011) and Miller and Chavier (2013), where the sample size fluctuated between 17 to 30. Therefore, from the quality of the papers included, caution should be taken in interpreting the review findings.

While reviewing, I contemplated on my role as a Muslim researcher and how that may impact the quality appraisal of the papers written, so I have applied several techniques to reduce bias and increase the integrity of this qualitative literature, including researcher triangulation, persistent observation, prolonged engagement, and peer debriefing. As such, half of the qualitative papers included in the systematic review were shared with a peer to gain a heightened critical awareness of individual study's quality and increased credibility through feedback and reflexivity.

2.6.1 Aims

All papers in this review had well-defined aims and research objectives; however, these differed between papers. All papers alluded to examining or exploring therapists' experiences and attitudes in addressing or working with spirituality and religion in therapy (Crossley & Salter, 2005; Evans & Devlin, 2016; Hood, 2022; Jacobs, 2010; Johnson, 1989; Mir et al., 2015; McVittie & Tiliopoulos, 2007; Suara, 2022; Tipton, 2021; Vandenberghe & Prado, 2012; Williams, 2017). Johnson et al. (2007) focused particularly on philosophical frameworks, assessment and diagnosis, and therapeutic practices, whilst Miller and Chavier (2013) focused on using tools such as prayer in the therapeutic process. Bell-Tolliver & Wilkerson (2011) explored religion as a strength for African Americans (AA). Gill (2018) explored the nature of therapeutic processes by Muslim practitioners. Meanwhile, Ringel and Park (2008) explored clinicians working with Evangelical clients using faith-based interventions. Robinson (2016) focused on AA pastors and their experiences in providing suicide prevention and post intervention services to members of their congregation. Similarly, Stansbury et al. (2018) focused on Clergy's experience in mental health intervention. McCoy et al. (2004) focused on

staff experiences of implementing a faith-based addiction intervention. Two papers made explicit mention of exploring therapies that were faith-modified (i.e., religiously modified CBT, Suara, 2022) or faith-informed (Tipton, 2021).

2.6.2 Country

The preliminary scope for this systematic review was to investigate literature from the UK, since the conceptualisation of Muslim distress and therapeutic adaptations differs between societies and countries, making UK research more appropriate for this research project. Only five of the sample studies were UK based (Crossley & Salter, 2005; Gill, 2018; McVittie & Tiliopoulos, 2007; Mir et al., 2015; Williams, 2017), which was insufficient for a comprehensive review. The rest included two from Australia (Evans & Devlin, 2016; Hood, 2022), one from Brazil (Vandenberghe & Prado, 2012) and twelve from the USA.

2.6.3 Sample

Sample sizes varied between three to forty participants and the details provided by the researchers varied. Of the thirteen papers with twelve or less participants, elevan provided adequate sample details (Crossley & Salter, 2005; Evans & Devlin, 2016; Gill, 2018; Johnson, 1989; McCoy et al., 2004; McVittie & Tiliopoulos, 2007; Ringel & Park, 2008; Robinson, 2016; Suara, 2022; Williams, 2017). The small sample size for Mir et al. (n = 3; 2015) adequately explained attrition as the factor. Mir et al. (2015) initially recruited ten participants; however, seven dropped out for various reasons that were explicitly mentioned, and this left 3 participants.

Four studies focused on the experiences of therapists (Bell-Tolliver & Wilkerson, 2011; Johnson, 1989; Miller & Chavier, 2013; Mir et al., 2015), four on clinical psychologists (Crossley & Salter, 2005; McVittie & Tiliopoulos, 2007; Vandenberghe & Prado, 2012; Williams, 2017), three on professional counsellors (Evans & Devlin, 2016; Hood, 2022; Tipton, 2021), three on pastors or Clergy's (Ringel & Park, 2008; Robinson, 2016; Stansbury et al., 2018), and four studies had a mixed sample of different mental health professionals (Gill, 2018; Jacobs, 2010; Johnson et al., 2007; Suara, 2022). McCoy et al. (2004) was the only paper that focused on staff who facilitated counselling within a faith-based programme.

Whilst all papers mentioned the participant's faith affiliation and the respective religions used to adapt the psychological intervention, five papers mentioned working with a mix of faith populations (Bell-Tolliver & Wilkerson, 2011; Evans & Devlin, 2016; Hood, 2022; Jacobs, 2010; Williams, 2017), three papers solely worked with Muslims (Gill, 2018; Mir et al., 2015; Suara, 2022) and four papers reported working with Christians (McCoy et al., 2004; Ringel & Park, 2008; Robinson, 2016; Stansbury et al., 2018). All papers reported that participants

included therapeutically trained clinicians such as psychologists, clergy/ pastors, counsellors, social workers, a psychiatrist, psychotherapists, and family therapists.

2.6.4 Data Collection

Many of the papers provided clear information on their data collection method. Two papers conducted face-to-face focus groups (Hood, 2022; Jacobs, 2010). The remaining 17 papers conducted interviews: semi-structured (Bell-Tolliver & Wilkerson, 2011; Crossley & Salter, 2005; McCoy et al., 2004; McVittie & Tiliopoulos, 2007; Miller & Chavier, 2013; Mir et al., 2015; Robinson, 2016; Tipton, 2021; Williams, 2017); structured (Johnson, 1989; Suara, 2022); and unstructured (Vandenberghe & Prado, 2012). Four studies did not mention the structure of their interviews (Evans & Devlin, 2016; Johnson et al., 2007; Ringel & Park, 2008; Stansbury et al., 2018). While Suara (2022) reported that they conducted their interviews online, six papers failed to mention the location of interview (Crossley & Salter, 2005; Evans & Devlin, 2016; McVittie & Tiliopoulos, 2007; Ringel & Park, 2008; Stansbury et al., 2018; Vandenberghe & Prado, 2012).

2.6.5 Findings and Analysis

All studies used quotes to elaborate their findings. Various methods were used across studies to analyse data, including Thematic Analysis (TA), Interpretative Phenomenological Analysis (IPA), Grounded Theory, Fowler's manual (Moseley et al., 1986), the Wetherell approach (1998), consensual qualitative research and constant comparative methods. Most papers provided sufficient evidence concerning the rigours of the analysis process, six papers did not (Evans & Devlin, 2016; McCoy et al., 2004; McVittie & Tiliopoulos, 2007; Mir et al., 2015; Ringel & Park, 2008; Tipton et al., 2021). Most papers reported credibility checks, including triangulation, respondent validation and having more than one analyst, except in two studies (Evans & Devlin, 2016; Ringel & Park, 2008). Only six papers considered the researcher's position during analysis and data selection (Crossley & Salter, 2005; Gill, 2018; Johnson et al., 2007; Miller & Chavier, 2013; Tipton, 2021; Williams, 2017), which jeopardises the reliability of the other studies.

2.7 Synthesis Strategy

The researcher synthesised all the data using NVivo software (version 14) to amalgamate included research findings. The final thematic synthesis involved the research team to validate an accurate data representation.

Thematic synthesis was chosen as it allows for the synthesis of data from several papers and enables the identification of noticeable themes, in a structured and organised way (Braun & Clarke, 2006; Thomas & Harden, 2008). Three main themes were developed by carefully following the three stages of thematic synthesis: (1) line-by-line coding for familiarisation with

the data and noting recurring themes, (2) establishing descriptive themes whereby results were extracted, aggregated and summarised from the primary studies, and (3) establishing analytical themes whereby concepts were further interpreted and elaborated beyond the principal findings and specific to clinicians' experiences' of delivering FAPI (Braun & Clarke, 2006). In stages 2 and 3, the researchers checked the consistency of the themes to the original codes. The benefits of the analysis process in thematic synthesis are: transparency, proximity to the results of the principal studies, and effective analysis of multiple findings (Thomas & Harden, 2008). The studies were critiqued based on their methodological issues, as highlighted in Appendix C. Combining the papers, extracting quotations from participants (first-order constructs), and analysing the data (secondary-order constructs) are accompanied and structured as themes and sub-themes.

If sufficient data was found, the findings were thematically compared using Rathod et al. (2019) and Tseng's (1999) framework of cultural adaptations for psychotherapies, comparing the studies specific faith adaptation with other faith adaptations.

2.8 Synthesis of Findings

2.8.1 Factors Influencing the Therapeutic Relationship

Overall, the studies in the systematic literature review explored how the therapeutic relationship is influenced when clinicians work with faith populations by "showing and communicating respect for clients' spiritual beliefs and values" (Johnson et al., 2007, p. 457), collaboratively waiting "for the client to mention spiritual beliefs" (Crossley & Salter, 2005, p. 15) before addressing faith; maintaining "an openness to [what] the client is saying … about their own spirituality (Miller & Chavier, 2013, p. 82) amongst other factors.

2.8.1.1 Lead by The Client: The Therapist Follows the Client's Lead in Using Spirituality

A shared theme across studies was that clinicians felt that including faith-interventions in the therapeutic relationship was led by the client and addressed with caution. By trusting the client's autonomy and choice, one may prevent triggering any religious trauma, shame or personal moral failure or sin.

Following the clients' lead, respecting and honouring them, making sure that prayer does not trigger trauma is vital to avoid harm. Prayer is a powerful tool that can quickly become abusive if used with the wrong intention (Miller & Chavier, 2013, p.82)

2.8.1.2 Meaning-Making: Developing a Shared Understanding of the Problem

For some clinicians, the ability to increase a trusting therapeutic relationship was due to the therapist's confidence in their ability to understand and assist the work effectively with clients,

given their shared values and religious affinity. References highlight that outcomes may come easier from therapist-client matching in religious views:

[Therapists] are more motivated and have more positive expectancies concerning treatment of matched clients. Also, the enhanced connectedness derived from shared values and world-views makes it easier for the therapist to validate client experiences: "I was able to understand her [and] help her better because I shared her religion and faith." (Vandenberghe & Prado 2012 p.85).

2.8.1.3 Non-Specific Relational Factors

Several studies referenced numerous non-specific relational factors that supported the development of rapport when working with religious and spiritual people. These included a call to cultural humility, embracing diversity within faith populations and the ability to be non-judgemental with clients regardless of being faith-matched:

When you're a Muslim therapist working with Muslim clients… educate yourself, be patient, learn more about your client, and don't assume you know. Because I've had Muslim clients, where I was like oh wow, nothing, you wouldn't even know that they were Muslim. (Suara, 2022, p.61).

Four studies described clinicians' need for clients to be seen and heard when developing a trusting relationship (Bell-Tolliver & Wilkerson, 2011; Johnson et al., 2007; Robinson, 2016; Stansbury et al., 2018). This was particularly important in developing trust and problem-solving with their clients. For example, using listening to "list [the clients] options… [whereby the therapist] trust[ed the clients] are astute enough to make the choice" (Stansbury et al., 2018, p.1513) and to "listen for [sic] what the client is not saying [as] most of the time they would not tell you what's the problem, but [therapists] have been trained to hear and see what they are not saying." (Robinson, 2016, p. 67). Clinicians have also described using clients' faith as a tool of empowerment and encouragement to find meaning and purpose in the face of adversity, which "supports resilience by helping [the client] to understand misfortune and frustration in a broader context. When one is less entangled in one's issues, they look less ominous and can be dealt with in more serene ways. It is "easier [. . .] to confront problems from a transcendent perspective" (Vandenberghe & Prado, 2012, p.86).

Recognising priorities in therapy, such as forming a trusting relationship and addressing this in a sequential manner, was key to inviting discussion related to faith:

I recognized that my client needed to address his anger at his wife before he could attempt to focus on spiritual matters. And before that, he needed to trust me. Only after we established a trusting relationship was he able to discuss his issues with God. (Johnson et al., 2007, p.457)

In addition, respect was explored across papers, as a non-specific relationship factor that clinicians used to prevent ruptures in the therapeutic relationship, including being aware of emotional attachments to faith, feelings of shame and defensiveness, and avoiding insensitive remarks and needless disclosures.:

Our participants felt that professionals need to communicate respect toward religion as a dimension of client identity by avoiding three types of errors: provoking client sensitivities, criticizing client religion, and needlessly disclosing therapist religious issues. (Vandenberghe & Prado, 2012, p.82).

2.8.2 Balancing Models and Approaches to Therapy

2.8.2.1 Faith Interventions

Commonly, across studies, clinicians included a range of faith interventions within therapy to cater to clients' faith needs. The adaptations seemed more intuitive than structured and included addressing religious and spiritual aspects within secular psychological models of understanding by:

…drawing upon aspects of both processes may be required at different points in a client's life, or indeed therapy, acknowledging the holistic entity of the client in mind, body and soul. (Gill, 2018, p. 2-27)

Across all studies, clinicians referred to the importance of their spiritual wellbeing and used prayer within and outside the therapy room:

[prayer] is a powerful, connecting process that helps the therapist feel as if they are not alone. The following statement by a Protestant woman explained it: There's always the dual conversation going on, you know, between myself and the client and between me and God, [which] is just very much part of who I am and I, I believe that I gain a lot of my insight and direction from the Spirit in session. (Miller & Chavier, 2013, p.81)

Another quote by the same author emphasises that prayer may be applicable for clients who are spiritual, so it is important to provide a person-centred approach, respecting the clients spiritual needs:

A Protestant man stated, "if a client is receptive to it and … has ... somewhat of a spiritual sense of self … prayer would lend itself to … being an effective intervention. (Miller & Chavier, 2013, p.83)

Several studies highlight that highly spiritual clinicians have used other faith components within therapy to aid the therapeutic processes, such as using their spirituality to renew their sense of meaning and purpose through religious scripture and practices: "*[clinicians] saw*

themselves as connecting to the Eternal One through prayer and Scripture. They believed they were being used and empowered by God in the client's healing process, and described the experience of being alongside a client and witnessing God work". (Tipton et al., 2021, p. 5), beliefs: "*I did reveal my own [religious training] … and so I think that was helpful to [client] because it gave her a sense that I wasn't just some liberal psychotherapist who didn't have any idea about the [religious] text"* (Johnson et al., 2007, p. 456), encouraging a closeness to God: a*cknowledging limitations of exclusive focus on processes which encourage an insight to the self, or those encouraging a closeness or insight into God's wisdom, participants highlighted the benefits of establishing balance and synergy of these processes.* (Gill, 2018, p. 2-27), and helpful recovery concepts about moving forward with one's life and directing priorities towards spirituality and community: *Perhaps the most critical and powerful element in the process of recovery, according to our study respondents, is the concept of salvation. This concept was also referred to as 'a power of resurrection,' 'being a new creation,' the 'window to eternity,' or a 'miracle of recovery.' Salvation is viewed as providing a spiritual transformation* (McCoy et al., 2004, p.7).

2.8.2.2 Embracing a Pluralistic Spiritual Perspective

Seven studies detailed taking various approaches, ranging from finding a secular model fitting with religion and spirituality, to clinicians incorporating what they are familiar with and using a dynamic and flexible approach (Gill, 2018; McVittie & Tiliopoulos, 2007; Miller & Chavier, 2013; Ringel & Park, 2008; Robinson, 2016; Vandenberghe & Prado, 2012; Williams, 2017). One study highlighted the need to embrace a pluralistic spiritual perspective to find an equal weighting between the secular and spiritual perspectives and empower the client to explore their own beliefs and values:

I encourage them to find passages that teach on love, that show love between husband and wife. If they are stuck on a negative passage, just expand on it." She explained that there are two perspectives: that the Bible is central and encompasses truth, and that the Bible can be used as a frame of reference. She stated that she gave equal weight to psychology and Bible... She showed clients that there were a variety of options and helped them recognize that they had a voice (Ringel & Park, 2008, p.353).

2.8.2.3 Community and Support System-Based Interventions

Some studies explored engaging in community and support system-based interventions within faith-interventions (McCoy et al., 2004; Stansbury et al., 2018; Vandenberghe & Prado, 2012). One study identified that the context within which the therapy occurs sustains engagement of faith clients:

A treatment activity may be much more attractive for the religious client when it has a religious connotation. Religious communities provide opportunities for meeting people, obtaining support, and engaging in creative practices that may help in homework activities and behavioural experiments. (Vandenberghe & Prado, 2012, p. 86)

2.8.3 Barriers and Enablers When Working with Clients who Have a Faith Background

2.8.3.1 Systemic Barriers

Some studies reported that a range of systemic barriers interfered with how a clinician works with clients' faith backgrounds. This includes "a negative attitude towards expressing Christian faith freely in society" (Hood, 2022, p. 209), where clinicians "received no formal instruction on the use of, or benefits of using, faith-interventions in practice in their undergraduate degree programs" (Evans & Devlin, 2016, p. 364) and where religious beliefs within clinical practice are either "a matter of psychology or illness [other than with a] priest or faith leader than with a therapist" and "removed altogether from the therapeutic realm", (McVittie & Tiliopoulos, 2007, p. 13).

2.8.3.2 Therapist's Experience, Skill, and Confidence Level

Another common theme found across papers was that clinicians' experience, skill, and confidence either worked as an enabler or a barrier when working with clients of faith backgrounds. In one case, a clinician's strength of spirituality determined their ability to cope with interpersonal boundaries:

In particular, client issues that would otherwise be personally threatening for the therapist become less ominous: "Without strong spirituality, the therapist would not be able to deal with some situations in the treatment setting". Or more affirmatively: "Nothing that is theirs can scare me". (Vandenberghe & Prado, 2012, p. 87)

In another case, clinicians reported that therapists are responsible for educating themselves of their client's religious and cultural backgrounds, as this was important in serving their idiosyncratic needs and preventing harm:

Another recommendation a participant made was to acknowledge both cultural and religious factors that could influence a client's presenting problems: "So, I would say that if you're a non-Muslim therapist working with Muslims, please do your due diligence and educate yourself not only on the religious principles but on the nuances of cultural influences...(for example) I know that honor kills do still totally happen, and those are things we have ethical responsibilities to be aware of, as far as what we're recommending our clients do. (Suara, 2022, p. 60).

Despite clinicians being skilled in bringing in faith with their clients, one paper identified limitations of working with spiritual clients who ask about sensitive topics in relation to the

client's faith position, as it acted as an "impediment of the therapeutic process". However, the clinician resolves this by going back to the client-centred approach, discerning what may be helpful for the client's wellbeing:

When clients start interviewing me about my views on headship in marriage or about same-sex relationships to check that I have "a biblical position", that's uncomfortable. I limit those discussions. They lead to stuckness in the work. On the other hand, I can discern when a little bit of information will be useful. If a client says "God is judging me for this", I might say "no, God is weeping with you". (Evans & Devlin, 2016, p. 366)

2.8.4 Nature of Faith Adaptations

The themes overlap with the framework of cultural adaptations for psychotherapies (Tseng, 1999; Rathod et al., 2019). Papers cite several technical adaptations comprising five subthemes: client-led, non-specific relational factors, meaning-making, community and support system-based interventions, and faith interventions (Bell-Tolliver & Wilkerson, 2011; Johnson et al., 2007; McCoy et al., 2004; Miller & Chavier, 2013; Robinson, 2016; Stansbury et al., 2018; Vandenberghe & Prado, 2012; Suara, 2022). Client-led and non-specific relational factor adaptations both seek to develop the therapeutic relationship between client and therapist. The former incorporates the client's choice and religion into therapy by waiting for them to mention their faith beliefs, including questions about faith in assessment, or asking about beliefs sensitively when the client openly practices their faith. The latter by communicating non-judgementally, non-assumptively, empathetically and respectfully about a client's faith beliefs, values and practice while using these as a source of resilience and empowerment.

Meaning-making and community and support system-based interventions refer to adaptations to the therapeutic environment such as providing therapy within a spiritually meaningful location (e.g., place of worship; Stansbury, 2018). These adaptations also include matching a client with a therapist who shares the same faith (i.e., therapist-client faith matching), and involving community members and faith leaders to enhance connectedness and engagement in therapy through shared values, meanings and worldview. Finally, faith interventions naturally incorporate religion, which is a feature of technical adaptations. For example, incorporating religious texts and practices, prayer within and outside the therapy room, and concepts around God, faith beliefs and principles.

Practical adaptations link in with the following subthemes: systemic barriers, therapist understanding of clients, and therapist's experience, skill, and confidence (Evans & Devlin, 2016; Hood, 2022; McVittie & Tiliopoulos, 2007; Ringel & Park, 2008; Vandenberghe & Prado,

2012; Suara, 2022). Practical adaptations to reduce systemic barriers and enhance therapists' understanding, experience, skills, and confidence when working with clients of faith include educating and training MHP about faith-sensitive practices. The training also includes addressing and challenging any biases therapists may have about Muslim clients' identities, which could be shaped by societal, cultural, and religious narratives (Suara, 2022). Through these adaptations, it can influence a clients performance in therapy and improve helpseeking from and trust towards healthcare systems (Ringel & Park, 2008).

Theoretical and philosophical adaptations comprise a combination of subthemes: therapist's experience, skill, and confidence, embracing a pluralistic spiritual perspective, faith interventions and community and support system-based interventions (Evans & Devlin, 2016; Gill, 2018; Johnson et al., 2007; McCoy et al., 2004; McVittie & Tiliopoulos, 2007; Miller & Chavier, 2013; Ringel & Park, 2008; Robinson, 2016; Stansbury et al., 2018; Tipton et al., 2021; Vandenberghe & Prado, 2012; Williams, 2017; Suara, 2022). The following theoretical adaptations modify concepts that align with an individual's cultural strengths. For example, therapists using their faith to recognise and address the client's spiritual growth and worldview. Adaptations to embrace a pluralistic spiritual perspective involve considering and appreciating multiple spiritual paths and coping strategies in connecting to God, adopting an equal weighting to psychology and religious scriptures, and recognising the connection between the body, mind and spirit. Faith interventions include using hope as a concept of living and coping through difficulties, whereas community and support system-based adaptations incorporate the client's sense of individuality and collectiveness. Philosophical adaptations cited in the above subthemes illustrate therapy as aligning with the client's faith, centring their outlook, inviting meaning to their lives, and influencing their progress in therapy.

2.9 Conclusions of Systematic Literature Review

The systematic review is the first to investigate evidence of clinicians' experiences' of delivering FAPI, establishing the extent to which they have been inclusive of service users from different faith backgrounds and understanding the nature of the faith-adaptations according to faith. The findings highlight the role of religion and spirituality within secular psychological interventions for faith populations, emphasising the importance of faith adaptations. Whilst Islam is the context here for this empirical project, the outcome is of applied value to other faith groups. The faith-adaptations reported were also consistent with Tseng's (1999) framework. Moreover, some barriers might be faced when trying to include these adaptations. Clinicians shared non-specific relational therapeutic factors, allowing the client to take the lead in discussing faith and taking opportunities to make meaning as foundational to the therapeutic process and the therapeutic engagement of faith populations.

To further enhance this, clinicians noted the need to balance delivering FAPI in a balanced approach between secular modalities and spiritual/ religious frameworks. This can be either adapting a secular model by including religious and spiritual components or adopting a solely spiritually focused framework. In addition, embracing a pluralistic spiritual perspective and involving a client's community and support system within the therapy seemed paramount. However, when the clinicians asked and not assumed the clients' idiosyncratic religious, spiritual, and cultural needs (Suara, 2020, p. 40), it made for a better experience for the clients. What was notable from the evidence was that Muslim therapists working with Muslim clients advised clinicians to be mindful of the harms of holding assumptions about Muslims derived from the news and society. This suggests a need to be aware of Muslim distress being attributed at both a micro and macro level, especially given the increased levels of Islamophobia and discrimination over the last two decades (Aked et al., 2021; Byrne et al., 2017; Dadabhoy, 2018). However, the clinicians also acknowledged insufficient training to work with faith populations, including the skills and knowledge needed to include faith within their work, thus contributing to the gap between theory and practice (Jafari, 2016; Mollah et al., 2018; Nolte, 2017).

2.10 Gaps in Literature

Despite noteworthy findings on clinician's experiences of delivering FAPI, the tools used to make this possible, and the barriers that make it challenging to address these, there is a partial understanding of the specificities and the effectiveness of these adaptations since only a few studies explored minoritised religions such as Islam, instead most explored Christianity.

The papers included in the review did not differentiate between the specific faith-adaptations used in therapy. Although it was challenging to compare faith-adaptations, the present findings insinuate that various FAPI included all adaptations, with no mention of one adaptation being superior to the other. This suggests that further research is needed to explore idiosyncratic adaptations for respective religions and spirituality within therapy (Mustafa, 2021). This review highlights the significance of adaptations, but what is missing is a typology that can support clinicians and inform future training design (Arundell et al., 2021).

Most papers on religion, spirituality and therapy were set in the USA, and it was apparent that the therapist's faith matched with their clients. However, the level of religiosity of both was not explicit. Therefore, it would be essential to investigate whether the themes apply within therapy for people from minoritised religions (i.e. Islam), where Muslims vary in religious practice according to culture, traditions and level of integration and assimilation in the UK (Gill, 2018). In contrast, a higher level of assimilation and a longer stay in the dominant culture may significantly impact Muslims' connection to their religious practices and identity. This

disconnect often results from external pressures to conform to the majority's cultural norms, expectations, and social structures (Eid, 2014). Consequently, Muslims who have assimilated more may be less inclined to seek faith-adapted therapy, either to align with the dominant group's norms or to avoid association with an identity that is negatively perceived (Eid, 2014). On the other hand, Muslims who have managed to preserve their religious identity while integrating into Western culture are likely to remain attuned to their religious practices and may be more receptive to faith-based adaptations in therapy (Rassool, 2015). In addition, the religious context and public healthcare services provision differ between the UK and the USA. Therefore, the themes may not quickly transfer to the British society. This is true for cases where primary care mental health services are bound by offering a limited number of sessions to clients in a structured way, leaving little room for the clinician to develop a rich, nuanced and pluralistic understanding of the client's religious, spiritual practices and beliefs within the time-limited therapeutic sessions (Clark & Turpin, 2008).

The need to explore whether the current themes are found in specific faiths is paramount. An area that has yet not been explored in research is the experiences of MFL who are also therapeutically trained. The experiences of TTMFL is an important area of research, as they are often the first point of contact for mental health support within Muslim communities (Al-Krenawi et al., 2004; Dein, 2013; Mustafa, 2021). Their unique position provides valuable insights into effective therapeutic approaches, as well as the challenges faced by the Muslim community, such as the impact of Islamophobia and the influence of the PREVENT strategy on accessing therapy (Aked et al., 2021; Byrne et al., 2017). Additionally, TTMFL possess both secular therapeutic and Islamic training, enabling them to identify and articulate the cultural and faith-based adaptations needed for effective therapy. By focusing on TTMFL in this research project, we can address a significant gap in the literature, ultimately fostering collaboration between MFL and MHP in creating more culturally sensitive and humanized services for Muslim communities.

2.11 Rationale and Aims for Current Research Project

The research project aims to investigate TTMFL experiences of Islamically informed therapeutic support in the Muslim community.

The main objective was to collect first-hand evidence from TTMFL, to add to the narrow literature on their experiences and knowledge of delivering faith-informed psychological therapy in the Muslim community and how they conceptualise Islamically informed adaptations about their support.

The secondary aim was to identify similarities and differences in Islamic and secular psychological therapy adaptations within the UK, as reported by the TTMFL. Lastly, this

research explores the enablers to implementing the adaptations in the community and the socio-political barriers to implementing them into the NHS.

The subsequent research questions explore these aims:

1. What are the views of TTMFL on psychological interventions in the NHS?
    a. Their understanding of the range of psychological interventions in the NHS.
    b. Their experience in delivering psychological interventions in the NHS.
    c. Their perspective on how Muslim patients experience psychological interventions in the NHS.
2. How do participants integrate Islamic and secular interventions into their everyday practice, and what are their advantages?
    a. The model they apply in their practice.
    b. Secular interventions MFLs use in their practice.
3. What are the challenges of TTMFL incorporating Islamic / secular interventions with Muslim clients?
    a. Any conflicts between Islamic and secular knowledge in theory.
    b. Any conflicts in applying Islamic and secular knowledge together.
4. What barriers do participants perceive in implementing Islamic approaches at a service level?
    a. Suggestions for further development.
5. What adaptations are needed to implement Islamic approaches in the NHS, and how can the Islamic interventions be applied to support the Muslim community?
    a. What Islamic interventions would be beneficial to incorporate in patient care?

Chapter 3: Methodology

3.1 Overview

This chapter outlines the methodology used to explore the experiences of TTMFL in providing Islamically informed therapeutic support within the Muslim community. The rationale for selecting thematic analysis is provided, as well as information concerning the recruitment and sample chosen, the research consultation process, data collection, analysis process, ethical considerations, and the quality review for this research.

3.2 Rationale for a Qualitative Approach

Influenced by Mustafa's (2021) research, MFL reported providing general mental health support to the Muslim community despite continuous barriers to accessing MHS. This investigation hoped to expand upon the existing, limited body of research surrounding the views and experiences of MFL who are therapeutically trained and composed of a small cohort whose perspectives have rarely been researched. It was, therefore, necessary to scope for information using a more direct qualitative approach and methodology, consistent with the research objectives, to explore their personal accounts in depth.

Positivist approaches focus on finding the objective truth and are often seen as credible knowledge in mental health research compared to subjective knowledge (Rogers & Pilgrim, 2021; Slade, 2012). Undertaking a quantitative methodology takes the stance of objective truth being sought (Burr, 2015) by researchers who have access to this type of knowledge (Delvaux & Schoenaers, 2012). In contrast, qualitative approaches allow researchers to deeply understand subjective experiences, realities, and knowledge of humans (Crowe, 1998). I believed it necessary to carefully consider the power dynamics at play between my researcher/professional role working in the NHS and with TTMFL in order for them to openly

and comfortably share their experiences rather than viewing me as the 'expert.' Therefore, a positivist approach did not seem suitable here. A qualitative approach was more consistent with my pragmatic critical realist epistemological stance (Fletcher, 2017), whereby the researcher's lens is used to listen to the participants' experiences to evaluate the reality portrayed by each of them. As I embody both the insider and outsider position (see Chapter 1), my evaluations of the participants' experiences will unquestionably influence me, and the qualitative approach allows for continuous reflection.

3.3 Why Thematic Analysis?

Thematic Analysis (TA; Braun & Clarke, 2006; Joffe, 2012) was deemed a good fit for this current project because it aligns with the epistemological stance relative to the research aims and critical psychology perspectives (Clarke et al., 2014). Braun and Clarke (2006, p.84) describe thematic analysis as "a method for recognising and organising patterns in content and meaning in qualitative data" and is essential for most qualitative research (Joffe, 2012). Thus, TA is suitable for this research because it captures essential themes around TTMFL perspectives, which is crucial to contribute effectively to the niche research area and better understand the TTMFL perspectives (Clarke & Braun, 2017).

TA facilitates taking inductive and deductive approaches to develop themes. Still, as it is not feasible to take one position purely (Braun & Clarke, 2013), an inductive approach has been adopted initially where themes are linked piquantly to the original data, followed by a deductive approach using the research questions and Tseng et al.'s (1999; 2005) framework of cultural adaptations for psychotherapies. TA is most relevant for this research as it offers theoretical flexibility, is not bound to any theoretical framework, nor does it rely on existing assumptions. Therefore, it offers the researchers flexibility in their epistemological approach (Braun & Clarke, 2006).

Consistent with the project's pragmatic critical realist epistemological stance as situated within critical realism and positioned to recognise the 'persons in context' (Larkin et al., 2006. p. 109), TA is an approach contextualised between realism and constructionism (Willig, 2012). Similarly, Mustafa's (2021) data was initially superficially coded to minimise personal bias when interpreting the current data. After the themes from across the data sets were identified, the broader meanings and implications supported theorising the latter stages of data analysis (Patton, 1990).

3.4 Alternative Considerations

Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2004) and Grounded Theory (GT; Charmaz, 2006) were considered as potential alternative qualitative approaches. IPA focuses on in-depth exploration of each participant's experience using a small sample size. However, this current research aimed to develop common themes between the participants. GT investigates sociological processes within various contexts to form an all-encompassing theory (Charmaz, 2006). The current study, however, is a new research area. Therefore, the focus was to scope, interpret and understand particular themes within the data aligned to the specific research questions and Tseng et al. (1999; 2005) framework of cultural adaptations for psychotherapies. These themes can inform future research on developing a theory. As such, TA was most suitable.

3.5 Design

3.5.1 Co-Creation of The Research Process

Given TTMFL work with Muslim communities and being the sample target, their experience and expertise are necessary for the project. Additionally, voices from British Muslim practitioners and service users of NHS MHS are limited in literature. Therefore, including the above will allow for gathering more profound knowledge and solutions from different lenses, shedding light on the constraints of psychological therapeutic support available for the Muslim communities (Bansal et al., 2022). As a result, I used a qualitative research design with a robust use of consultants, which involves empowering, developing and using people's knowledge, allowing the 'insider expert' to be at the forefront of a project to inspect, theorise and suggest solutions (Cornwall & Jewkes, 1995). Qualitative research also appreciates the co-construction of knowledge, similar to that of TA (Liebenberg et al., 2020), emphasising collaboration in the research design and implementation.

To achieve this, consultants were recruited via social media advertising to form a consultation group to guide the research process. The group involved one MFL, Dr Shaykh Abu Ibrahim, who actively supports the Muslim community; Sara Khan, a CBT therapist in a community MHS and an expert by experience and a former service user. All consultants signed a consultant agreement form (e.g., similar to Mustafa, 2021), which highlighted what their involvement could entail and what I would expect from them through the research process (Appendix D). The consultants joined online meetings at different stages, some with my supervisory team, Professor Shivani Sharma and Dr Angela Byrne.

The consultants co-created the research aims, objectives, questions and title in preparation for the research proposal and ethics. Some research materials were also co-created, such as

the interview schedule and research advertisement, whilst others were reviewed, such as the participant information sheet, consent forms, debrief and demographics questions.

The initial plan, for me, was to recruit participants who were qualified in both Islamic sciences and secular therapeutic training of at least one year. However, consultants suggested leniency on the formal secular therapeutic training received by MFL, acknowledging that most may have acquired training on an ad-hoc basis and not for a full year. So, following consultation, the sample included MFL with therapeutic training of any duration to expand the pool of participants.

I also consulted the group:

- On the recruitment, such as supporting the formatting, wording and imagery of the flyers and the avenues for advertisement, such as social media and consultants' networks, establishing snowball sampling.
- On the pilot interview to assess the interview questions and approach. The consultant MFL took part as the interviewee, and other consultants observed and provided feedback. This led to changes to the wording; shortening and collapsing questions that sought similar answers. For example, *have you experienced any issues/ challenges arising when you incorporate Islamic knowledge into secular therapy?* was changed to … *When you integrate Islamic and/or secular approaches into psychological interventions, what challenges have you experienced arising with Muslim clients you work with?*
- To code two participants with one consultant and share the developing themes with all the consultants, to agree on how to make sense of them before finalizing themes and identifying areas of key interest for discussion. Reflections of consultants about their experience in the research process are shared in Appendix E.

3.5.2 Involving Muslim Faith Leaders, Muslims, and a Muslim Mental Health Organisation Through Consultation

Several MFL and Muslims expressed interest in consulting on this research project. However, they did not meet the inclusion criteria because of insufficient mental health training, experience, and availability. Nonetheless, due to their access to the TTMFL and Muslim community, they supported the recruitment process by sharing the research flyer. Inspirited Minds, a UK-based Muslim mental health charity, that provides training to MFL, also published the flyer across social media and in their newsletter to drive recruitment.

3.6 Participants

3.6.1 Participation Criteria

The current research used distinct inclusion criteria (Table 4), similar to Mustafa (2021), and was reviewed by both the consultant and supervisory groups. Given the project's limited resources, participants were required to speak in English; potentially excluding TTMFL who could have otherwise contributed their valuable expertise to this research area. There was a consensus in including participants who occupied MFL roles with a completed Islamic science qualification and secular therapeutic training, supporting Muslims with their mental health difficulties, and had sufficient experience in this. It was essential to include both Islamic science qualification and secular therapeutic training to ensure that participants were well-versed in understanding the two worldviews from a mental health perspective, with unique experiences compared to the qualifications of general MFL positions.

Table 4

Participant Inclusion Criteria

Inclusion Criteria
• An adult (18 years and above) • English speaking • UK resident • Completed a higher level of Islamic science studies to fulfil the role of Muslim faith leaders* • Have formal secular mental health or therapeutic/counselling training** • Occupy and worked within the community in a Muslim faith leader role for longer than a year • Have supported a Muslim community or congregation member with their emotional or mental health difficulties, lifestyle concerns and/or distressing circumstances.
*a Muslim community leader role (i.e., someone who has an influential known position within their community)
** i.e., BABCP, BACP, PG Cert or relevant counselling training

3.6.2 Recruitment

The recruitment pathway was discussed in collaboration with the research consultants to find appropriate avenues. This primarily included distributing the e-poster on social media to Muslim majority and Islamic-orientated WhatsApp groups, emailing Muslim and therapy-

related organisations and through word of mouth. The recruitment process mirrored Mustafa's research (2021). Diverse sampling methods were used at different stages of the research project. Initially, purposive sampling was adopted to help pinpoint participants who met the exact inclusion criteria and provide informed experiences (Etikan et al., 2016). Then, the research consultant team and the researcher shared the flyer (Appendix F) through faith-based networks on WhatsApp, email, and social media. Finally, the snowball sampling method was implemented, where participants recruited prospective participants in their network based on the inclusion criteria. Flyers were also distributed around to known connections of TTMFL and requested that those interested make contact about participating. These different strategies helped to recruit the required number of participants.

3.6.3 Participants

Altogether, ten TTMFL participated in this research. The sample comprised of male (*n* = 7) and female (*n* = 3) participants aged between 33 – 55. All participants were British Muslim and held both a MFL and a therapeutic role. Table 5 shows the demographic details for each participant. All the participant names outlined are pseudonyms.

Table 5

Demographic Details for Each Participant

Pseudonym	Ethnicity	Gender (male/ female)	Age	Therapeutic role and primary modality	Secondary models/approaches used
Muhammed	Somali	Male	39	CBT therapist; CBT	Psychodynamic, person-centred and SFT
Fariha	Pakistani	Female	40	Therapist; REBT	ACT, CBT-E, SFT, CFT, EMDR, Assertiveness Training, Mindfulness
Umama	Bangladeshi	Female	44	Counsellor; SFT	Informal counselling, signposting.
Ismaeel	Mixed White and	Male	38	CBT therapist; CBT.	Person-centred.

	Egyptian Arab				
Haroon	Bangladeshi	Male	41	Counsellor; SFT (Egan model) and Islamic.	Person-centred.
Juwariyah	Indian	Female	35	Clinical Psychologist; NET and Trauma-focused CBT.	Broadly humanistic psychology, CFT, DBT, CBT and systemic therapies.
Yusuf	Bangladeshi	Male	42	Counsellor/ chaplain; spiritual assessments.	CBT
Umar	Yemeni	Male	55	Integrative counsellor, person-centred therapy.	CBT, trauma-informed therapy, somatic therapy, bereavement, Islamic counselling, transactional analysis, and attachment theory.
Zakariya	South African Indian	Male	53	Family systemic therapist; systemic therapy.	SFT.
Yahya	Palestinian (Arab)	Male	33	Counsellor; person-centred.	N/A

Note. ACT, Acceptance and Commitment Therapy; CBT, Cognitive Behavioural Therapy; CBT-E, Cognitive Behaviour Therapy for Eating Disorder; CFT, Compassion-Focused Therapy; DBT, Dialectical Behavioural Therapy; EMDR, Eye Movement Desensitisation Reprocessing; NET, Narrative Exposure Therapy; REBT, Rational Emotive Behaviour Therapy; SFT, Solution-Focused Therapy.

Using Mustafa's (2021) demographics form as an initial template, the information obtained from participants during the eligibility screening call was collectively amended, agreed upon,

and finalised with the consultant team and the researcher (See Appendix G). It felt necessary to approach this mindfully to strike a balance between obtaining information required to assess eligibility and avoiding intrusive questioning to mitigate any offence received when questioning people's qualifications.

3.6.4 Interview Modality

An individual semi-structured interview approach was used for data collection as it is the most used format for interviewing (DiCicco-Bloom & Crabtree, 2006) and allowed for rich data collection about the TTMFL experiences. Semi-structured interviews allowed for flexibility to refine the interview schedule in the questioning and how it was delivered. The flexibility also enabled the interviewer to probe specific responses of the interviewee in more depth, to elicit a greater explanation of the interviewee's thoughts and areas of interest (Horton et al., 2004).

One participant chose to attend face-to-face in an office familiar to the participant, whilst nine preferred to join on Microsoft Teams, given that it was more convenient and geographically accessible, due to their busy schedules and not needing to spend money and time to travel (Braun & Clarke, 2013). At the start of the interview, the interview style and process was explained, and participants provided written and oral consent before the interviews were initiated. Virtual interviewing may have felt more comfortable for participants, with more control over their responses. However, the advantages of interviewing virtually may be undermined by loss of the richness of data, such as visual cues and head nodding gained from face-to-face interviews. These affect the fluency of the interaction and make it less natural, as virtual interviews have fewer interruptions, with longer turns in speaking before the speaker transition (Sedgwick & Spiers, 2009).

3.7 Ethical Considerations

This research was approved by The University of Hertfordshire's Health, Science, Engineering & Technology Ethics Committee (Appendix H) protocol number LMS/PGR/UH/05399, following review by the supervisory team. This research process featured ethical considerations through the participant information sheet consistent with the British Psychological Society's Ethical Guidelines (Oates et al., 2021).

Participants were given chances to ask questions before participating in the research and were given electronic participant information (Appendix I) and consent forms (Appendix J) on Qualtrics, indicating that they were informed of the research aims and the research involvement. Participants were also informed about the limitations of confidentiality, particularly around the disclosure to appropriate services if a participant discloses any possible harm to themselves or others. In addition, participants were encouraged to anonymise any

therapeutic work they shared in the interview to protect their client's confidentiality. The participants were informed about how the interview data would be managed to conserve anonymity, including storing and managing data on the secure University GDPR-compliant OneDrive, saving files using assigned pseudonyms, separate from the demographic forms, consent forms and audio/video recordings and using password-protection. The audio/video recordings were destroyed after the transcripts had been completed.

Participants were cognisant about the interview being video and audio recorded, and they were allowed to withdraw from the research until the data analysis stage, where a date was mentioned on the information sheet. The study asked participants about their experiences in providing Islamically informed psychological therapy to the Muslim communities. Discussing mental health and social situations can trigger personal difficulties and reminders of emotive memories; therefore, it was essential to be mindful of the psychological impact on the TTMFL. Participants were told that if they felt any discomfort during the interview, they could pause, whilst holding their discomfort with compassion as a clinical psychology trainee or terminate the interview if necessary. They were also allowed to reflect and discuss any concerns during the debrief. They were offered aftercare if needed (i.e., signposted to support services on the debrief form, Appendix K). The researcher was offered pre- and debriefs by the supervisor team if concerns arose.

3.8 Data Collection

3.8.1 Screening

All those who expressed interest through email or message on social media were given further information about the study, including the Qualtrics electronic participant information sheet and consent form. Those who provided consent and reported to have met the criteria were then invited to a short 10–15-minute phone screening to discuss eligibility, ask demographic questions, and allow participants to ask questions. The research consultants reviewed the demographic questions (Appendix G), where it was agreed to remove the question around the participant's dominant language spoken, as it was deemed irrelevant to the project. Those who met the participant criteria were then invited for an interview for 1.5 hours, either face-to-face or virtually.

3.8.2 Resources

The interviews were conducted virtually, over Microsoft Teams, using a laptop, and one face-to-face interview in a space convenient to the TTMFL. Microsoft Teams recording was used to audio/video record the interviews. A printed interview schedule was used by the researcher to note down reflections during and after each interview. The researcher transcribed the interview. NVivo 14 software (Lumivero, 2023) was used to analyse the data.

3.8.3 Interview Schedule

The semi-structured interview schedule included a list of open-ended questions developed and reviewed by the research consultants and supervisory team (Appendix L), to ensure sufficient clarification of the participants' responses could be obtained. This was done by brainstorming ideas of interest aligned with the research aims and questions related to relevant research (Smith, 1995). The initial questions aimed to build trust and rapport, which included a question about TTMFL interest in their roles (Reinharz, 1993). The focal part of the interview schedule focused on three areas: current practices of TTMFL, Islamic and/ or secular practices that they use, and the barriers and recommendations for applying their practices in MHS. After the pilot interview, the interview schedule was further reviewed and updated with the consultants and supervisory team and literature review.

3.8.4 Pilot Interview

The researcher conducted a pilot interview to assess the interview process, including an opportunity to become aware of any biases in the question-wording, interview style and approach and receive feedback on the questions. The MFL and the research consultants took part in this pilot, which was delivered as an authentic interview. The researcher, interviewee, the two remaining research consultants and one supervisor observed and shared their reflections and feedback about the interview, which resulted in changes to question-wording, summarising parts and reducing the number of questions to avoid repetition in the interview.

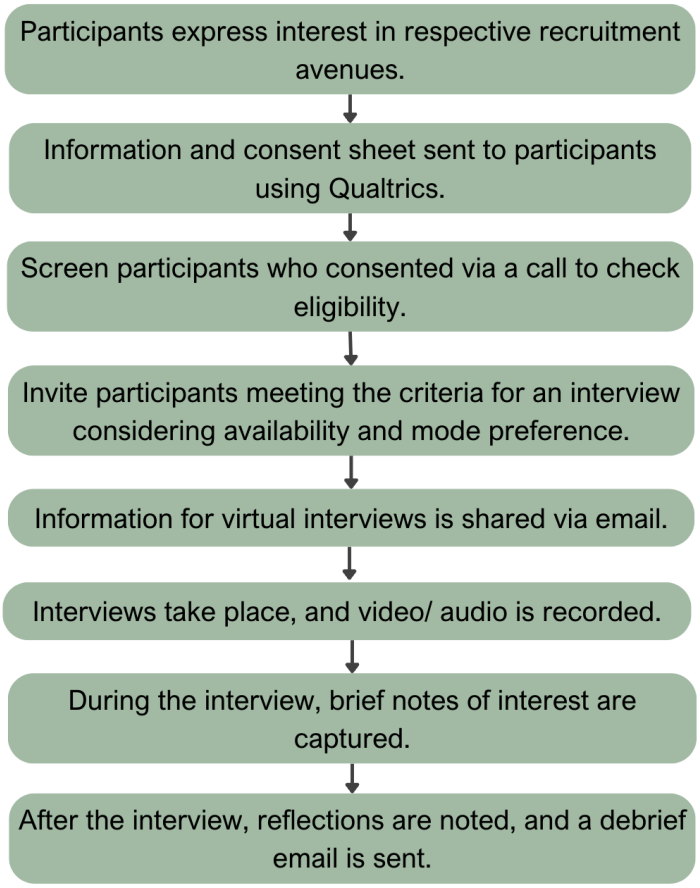
3.9 Interview Procedure

At the beginning of the interview, consent was re-confirmed after receiving reassurance from the participants that they had read and understood the participant information sheet. The practicalities of the interview, whether face-to-face or on Microsoft Teams~~,~~ were discussed, including what happens in instances of disconnection or interruption and ensuring a quiet and confidential space. The background of the research was mentioned, and participants were encouraged to expand on their answers throughout the interview. Some participants requested, and were provided with, questions before the interview to prepare their answers.

Before the end of each interview, the researcher checked that all sections were covered and reassured participants to speak on their areas of interest. After the interview, participants were given a chance to ask questions and were sent a debrief form (Appendix K) with details of support services. The ethics, data analysis and dissemination intentions was also shared with them. After each interview, the researcher recorded her contemplations, noting her feelings and significant areas of interest (Appendix A). Figure 2 shows a summary of the interview process.

Figure 2

Flowchart of the Interview Process



3.10 Data Recording and Transcription

The university's licence of Microsoft Teams recording, which is secure and GDPR-compliant, was used to audio and video record the interviews. These were transcribed by the researcher. The researcher noted down reflections during and after each interview.

3.11 Data Analysis

The six-stage process of Thematic Analysis (TA; Braun & Clarke, 2006, see Table 6) was used as the primary analysis to assess the qualitative data in NVivo 14 software. An inductive process was adopted to ensure the codes aligned with the original data. Data analysis took place after all interviews and transcripts were completed. Appendices P, Q and R provide the coding and theme development process. The initial coding process involved the researcher and one consultant (ST) coding and analysing the first two interviews independently, coming together to triangulate analysis findings and validate the codes before analysing the rest of the data (Foster, 2012).

Table 6

Six-stage Process of Thematic Analysis for the Current Research Project

The phases of analysis included:

Phase 1: Data familiarisation

The researcher engaged in this familiarisation phase by listening to the video/audio recording, reading the transcripts several times and making notes (See Appendix M). The transcripts were then transferred onto NVivo 14, whereby the researcher annotated points of particular interest for each interview, to enhance the familiarisation process.

Phase 2: Generating initial codes.

Initial code and concept generation involved reviewing all ten transcripts and inductively coding each sentence or chunk using NVivo 14, whilst holding in mind the research question (See Appendix M for an example). The researcher and one consultant (A) independently coded the first two transcripts before discussing similarities and differences in coding, after which the researcher coded all data independently (Foster, 2012). Before starting the coding process, the researcher and consultant (A) first noted their biases which were revisited when discussing their choice of codes (see Appendix A for reflections). After all initial codes were generated, they were shared with the consultant and supervisory team to facilitate the validation of codes (Foster, 2012). They supported the researcher's reflection on her biases in the chosen codes and discussed extracts the researcher found particularly challenging.

Phase 3: Searching for themes

The next stage included merging the codes with similar meanings into categories and exploring a wider thematic lens (Braun & Clarke, 2006). The researcher developed mind maps to thoroughly explore relationships between the codes and find various ways to organise them. This stage included an iterative process where themes were continuously refined, merged or discarded and classified into subordinate or superordinate themes. Appendix N shows a preliminary thematic map of themes and subthemes.

Phase 4: Reviewing themes

Coherent themes and narratives were developed over time. In addition, all the extracts were examined against the potential themes, to validate each individual theme, ensuring that the themes were distinct, coherent, and meaningful. The themes and subthemes were presented, reviewed, reflected upon and finalised following discussions with supervisors and consultants, to create the overarching themes.

Phase 5: Defining and naming themes.

This process included defining and refining the themes throughout, by the researcher and with the support of the supervisory and consultant team, to ensure that each theme reflected the data and that it was coherent and consistent (Braun & Clarke, 2006). The definitive thematic map is included in Appendix O and the Chapter 4.

Phase 6: Reporting

To tell a strong story of the themes and subthemes, the researcher reflected on her position concerning the final themes with the consultants and the supervisors. It was necessary to consider the themes within the narrative, rather than merely paraphrasing the collated extracts, to ensure coherent analysis and story development representative of the rich data collected.

3.12 Quality and Validity

3.12.1 Assessing the Quality of the Current Research Project

The researcher used the Critical Appraisal Skills Programme Qualitative Research Checklist (CASP, 2018, see Appendix B) to assess the quality of this project. Given that this research is solely qualitative, it seemed appropriate to use this criterion. Chapter 5 provides details of the quality assessment of this research against the quality checklist.

Chapter 4: Analysis

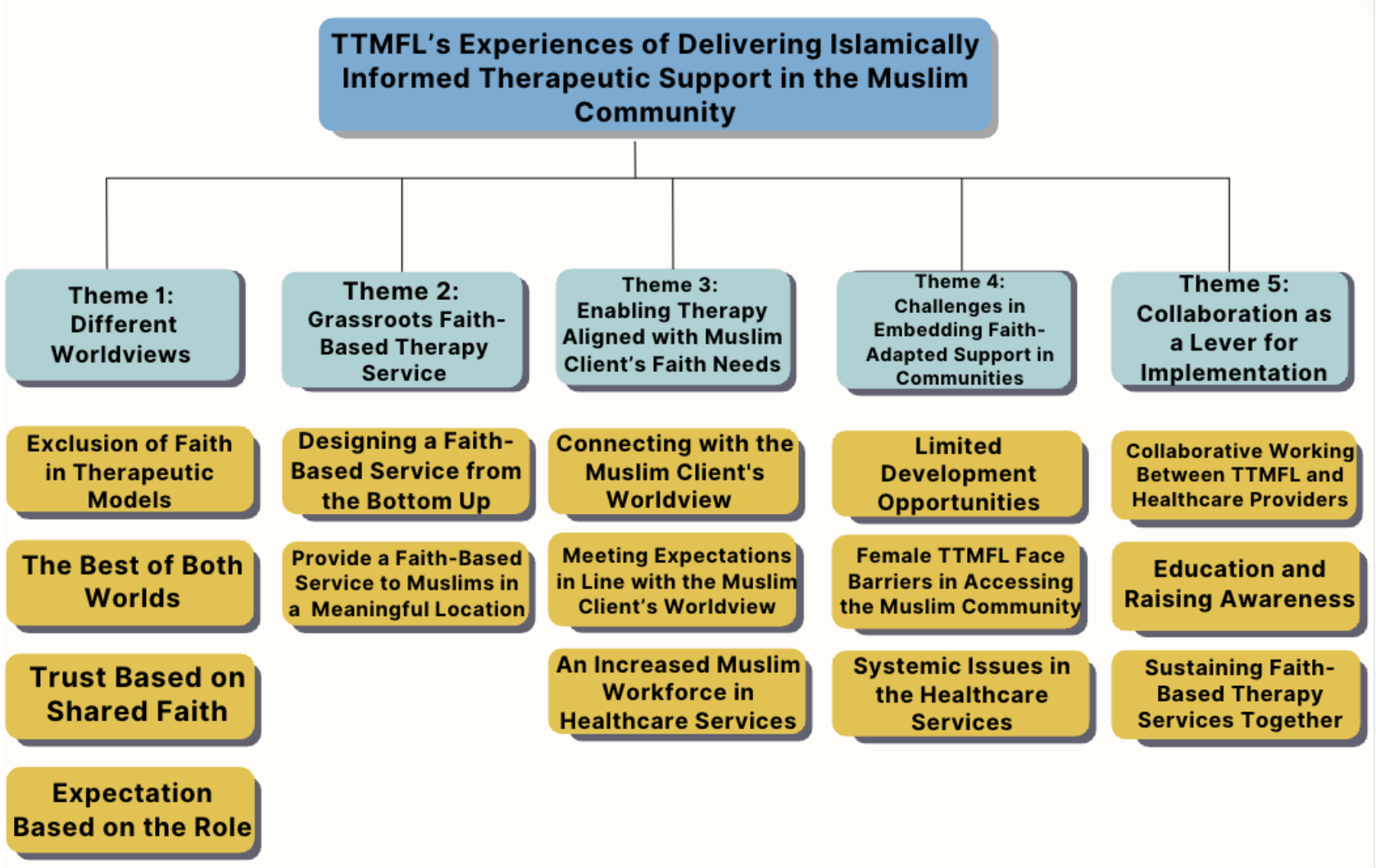
4.1 Overview

Chapter 4 shows the analysis from ten interviews. Using thematic analysis, 5 themes were identified, showing the experiences of TTMFL delivering Islamic-informed therapeutic support: Different Worldviews; Grassroots Faith-Based Therapy Service; Enabling Therapy Aligned with Muslim Client's Faith Needs; Challenges in Embedding Faith-Adapted Support in Communities and Collaboration as a Lever for Implementation.

Each theme has associated sub-themes, which this chapter discusses in detail, accompanied by the original quotes from the transcripts to enrich the themes and bring them to life. The carefully chosen quotes provide an understanding of the themes and sub-themes, reflecting experiences shared among the TTMFL instead of an in-depth analysis of each experience. It was sometimes important to shorten sentences for succinctness as indicated through an ellipsis within parentheses (i.e. (..)).

Figure 3

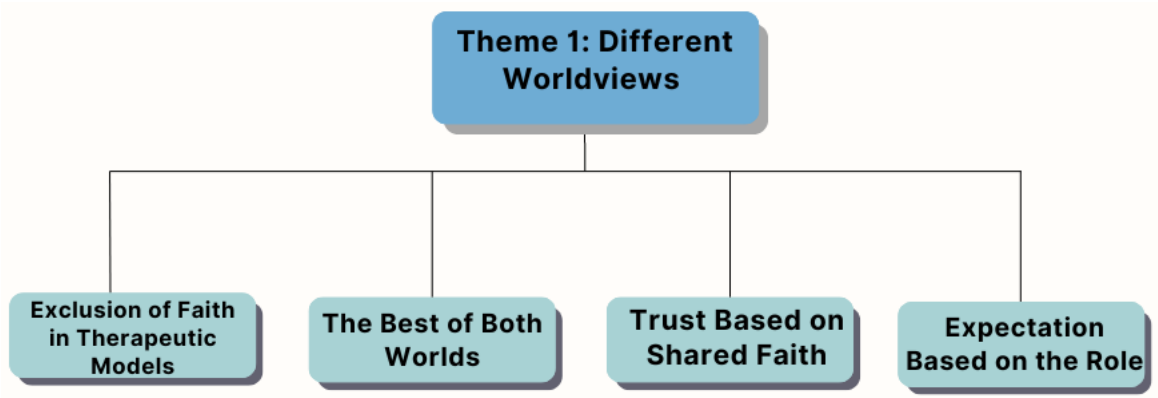
Themes and Subthemes for TTMFL' Experiences of Delivering Islamically Informed Therapeutic Support in the Muslim Community.



4.2 Theme 1: Different Worldviews

Figure 4

Theme 1: Different Worldviews



Participants highlighted that Western secular frameworks are epistemologically incompatible with the Quran and Sunnah. However, some participants commented that Western interventions can be adapted to be compatible. Furthermore, TTMFL emphasised the significance of the trusting relationship with their Muslim clients, which was influenced by the context in which the therapy took place and the secular approach used. Participants also expressed their challenges working therapeutically with clients, holding a dual role as an MFL and a therapist, whereby there is a shift from advising clients, to collaborating with and supporting them to identify their solutions.

4.2.1 Exclusion of Faith in Therapeutic Models

The name of this subtheme echoes all participants' conceptualisation of secular therapeutic models, as one that excludes Islam and faith from therapeutic work with Muslim clients. All participants spoke about how traditional therapeutic models are foundationally different from Islamic epistemology and ontology, because they are Eurocentric, individualistic and secular. They do not have a core focus of worshipping Allah, follow the teachings of the Prophet Muhammad (PBUH), nor have a collectivistic lens; questioning whether secular models can be integrated without this foundation.

One participant emphasised the Islamic model, including God, would work better when a therapist is working with Muslims, rather than secular models:

Umar: "lot of the modalities, they set in Eurocentric (..) they don't take other people's cultures *and all religiosity into account (..)The Islamic model is inclusive because God is the one who created us (..) psychologists and counsellors (..) they don't place any emphasis on faith. (..) clashes happen, because if (..) the client is resisting because the client is not being understood, then you're gonna have clashes between the two narratives".*

Furthermore, an Islamic counselling framework is more likely to invite trust from the Muslim client to the Muslim therapist because of the mutual understanding of faith that is included in the therapy, compared to a secular therapist:

Umar: "Islamic counselling provides commonalities between the client and the therapist, where in the mainstream there is that gap [that] is unfilled (..) because the client is coming from one perspective and the practitioners coming from a different perspective based on their secular training that doesn't have faith as an integral part of it".

The Islamic framework of psychological therapy was inferred as going beyond the thinking and feeling that we commonly see in secular psychology, such as a person's sense of self and accountability in relation to themselves, God, and others:

Juwariyah: "Islamic epistemology or ontology of purpose, pain, everything psyche related (..) isn't only in the mind. Whereas (..) secular psychology is all about what you're thinking and feeling within yourself (..) the Islamic framework starts with you, your accountability, what you do, and you as part of a wider system (..) you can navigate between individualistic and collective sense of self within the Islamic framework".

Another participant highlighted the differences between the Islamic and secular approaches. The Islamic approach includes concepts of the unseen and sin vs good deeds, whereas the secular approach holds back from these concepts, further making therapeutic approaches unsuitable for Muslims:

Ismaeel: "the spirituality side, the unseen, (..) the theology and the idea of sin (..) something being bad and something being good, (..) in the secular approach, you can't say that something is bad (..) there are many differences (..) they all contribute to the NHS currently not providing the suitable setting for Muslims."

4.2.2 The Best of Both Worlds

This subtheme emphasises how participants found that integrating both Islamic and secular knowledge supports providing holistic therapy to Muslim clients:

Umar: "you've got the best of both worlds, as long as you know what you need and (..) how to manage things (..) you have sound principles and (..) understanding. So knowledge is key".

Juwariyah: "I think having a good understanding of the models that are provided, especially within the NHS setting under the NICE guidelines. If you have a good foundation of that (..), its then adapting the use of those models by incorporating spirituality and faith"

4.2.3 Trust Based on Shared Faith

The theme of trust refers to all participants acknowledging that their Muslim clients developed trust with them more easily due to being Muslim and Islamically knowledgeable, with their actions closely aligned to Islamic values. Participants highlighted that the shared faith increased trust and facilitated positive outcomes with them, such as Muslims feeling better understood compared with non-Muslim therapists:

Fariha: "[with] the Muslim ones [clients], the fact that you are Muslim first and then (..) [an Islamic] scholar, really does help them (..) build their trust (..) the[re's] definitely been very (..) positive outcomes(..) there's more and more Muslims that are open to (..) getting help and having therapy".

Yahya: "if the [Muslim] client and the person [therapist] is Muslim, having that background for being part of the same religion (..) the same culture can help you [therapist] understand some issues better than someone who is outside that religion or (..) that culture (..) if the counsellor or the psychologist doesn't have that cultural knowledge background (..) [they] could lack in empathizing with (..) that person".

One participant conveyed that TTMFL accredited by secular bodies, such as BACP, would not necessarily engender trust:

Haroon: "an interest of BACP (..) you know the ideology, worldview, the secular world (..) I don't need to adopt (..) there's a lot of trust in the Muslim community because of that".

Despite MFL being trusted by the community, trust is nuanced, and it is not expected that all Muslims will automatically trust TTMFL, if it is not obvious that they are providing Islamically informed therapy:

Yahya: "I can imagine some Muslims being a bit sceptical if they go to the Imam and he's only applying secular psychological practice. Then they'll feel like, [what] was the point (..) I might as well go to the NHS".

Some TTMFL described that they often experience needing to rebuild trust with their Muslim clients and re-engage them meaningfully in Islamically informed therapy, especially when

Muslim clients had previously distrustful experiences with secular therapy that didn't acknowledge their faith, culture and background:

Umar: "I have seen people who went to therapy in good faith, but then the person [secular therapist] did not (..) understand their faith or their culture or their background and (..) then that become a turnoff for the person to access (..) therapeutic interventions that are based on their faith because they already have that negative experience from the person who was a (..) secularly trained individual who did not understand or did not focus on helping that person to bring their whole self, including their faith, into the therapeutic arena".

4.2.4 Expectation Based on the Role

Participants described that Muslim clients had different expectations of TTMFL dependent upon their role as imams who are expected to fix problems, or as therapists who work collaboratively towards healing:

Muhammad: " in my experience as an imam (..) [Muslim clients] want you to fix their problems (..) many of them do not want to have a collaborative discussion, many of them do not want to engage in a way in which you give them some responsibility about (..) what their problem is, what their challenges are and how to move forward and (..) As a therapist, I believe that many of the Muslim clients that I've (..) seen, they've had (..) somewhat of an understanding (..) of the expectations are in therapy (..) they understand the collaborative nature of therapy, (..) there's a huge amount of responsibility that is on them".

Furthermore, participants described Muslim clients opening up to TTMFL primarily as faith leaders and then as therapists. However, the latter took longer, despite including Islamic content within the therapy:

Ismaeel: "[Muslim clients] usually open up to me as a faith leader, not as a therapist. Although I have had individuals that have opened up to me as a therapist, it took a longer time to get there and even then, (..) as a therapist using (..)faith leader skills, I was quoting Quran every now and again, quoting Hadith etc. (..) there was maybe a relationship that was building based upon that".

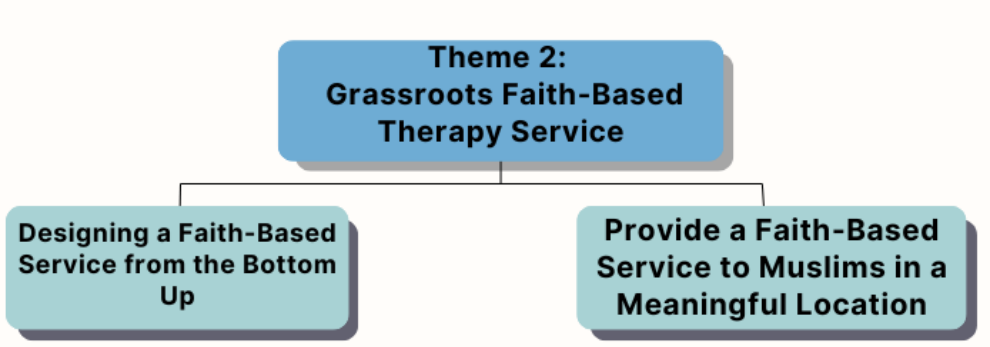
Participants referred to navigating their conflicting roles as both a faith leader and a therapist, balancing advice giving as a faith leader and allowing the Muslim client to reach their own conclusion:

Yahya: "I do sometimes feel like there is a conflict between the two roles, and in my experience I tried to adopt both roles. As a counsellor it's not always befitting to give advice. Rather, it is better to facilitate conversation and allow that person to come to [their] own conclusion, to firstly recognizing the problem and then solving the problem. Whereas sometimes [Muslim

clients] want just direct answers. (..) they wanna know what's halal and haram, what's permissible, what's not permissible, "am I doing something wrong? How do I change it? How do I fix it?" (..) sometimes it could be 2-3 sessions of listening and sometimes I might mention (..) "Now I'm gonna put my imam hat on" and (..) give like some practical advice [from] the Islamic point of view in the last maybe 5 to 10 minutes"

Figure 5

Theme 2: Grassroots Faith-Based Therapy Service



4.3 Theme 2: Grassroots Faith-Based Therapy Service

This theme describes several participants' expressions of the Muslim community needing a grassroots faith-based therapy service which serves them and their mental health needs; where therapy and mental health education are set within settings that Muslims feel most spiritually aligned and responsive to. These were seen as powerful routes that can address access issues.

4.3.1 Designing a Faith-Based Service from the Bottom Up

Participants emphasised the need for a faith-based service that is run by and serves the Muslim community separate from healthcare providers, that empowers mosques and faith-based grassroots organisations to become psychological therapy hubs for the Muslim community:

Ismaeel: "I think if they [NHS] really want to help Muslim communities, they need to empower Muslims (..) to offer [therapy] services to their own communities. And when I say empower (..) I mean give Muslims the reins to develop their own kind of mental health and helping facilities and allow them to direct, (..) dictate and instruct rather than kind of trying to adapt a system which has been designed based upon a philosophy and a framework which is not necessarily in line with the Islamic one".

Umar: "it's about designing the services from the bottom up, working with the communities, working with the people who are working in the ground (..) there's the saying, (..) 'nothing for us without us'. (..)You provide for people, you don't do things to people. (..) You don't design the house and then (..) try[sic] to put the windows and the doors and the different rooms after (..) you have a plan (..) [of] what the house is going to look like and where the window is going to be in, how you're going to fit them. (..) you don't come and say (..) "I'm gonna change this and change that after you already designed the service". That's very difficult thing to achieve, but if you designed the service from the outset with the inclusion of the people who you going to serve, then you're more likely to carry a service that is going towards inclusivity".

4.3.2 Provide a Faith-Based Service to Muslims in a Meaningful Location

Some participants described providing therapy to Muslims within settings that they trust and are meaningful, such as within a mosque or a graveyard, to feel spiritually connected:

Yahya: "if it's [therapy] in a masjid(..) there's no kind of other vested interests [like in the NHS]. And I can imagine that some Muslims will prefer to just go to the imam who they (..) might trust more".

Juwariyah: "if they want to (..) do something that incorporates their faith [in their therapy], to be able to do that in a safe space, (..) why can't we go to a mosque (..) why can't we go to a graveyard if we needed to".

Some participants also referred to raising awareness collectively, through khuthbah's (Islamic sermons) which target wider Muslim communities, to tackle mental health stigma:

Zakariya: So, awareness, education is important. It needs to be also delivered as a topic in the khuthbah and sermon. I think all this is important. And (..) many times, when somebody feels ill and sick (..) cultural[ly], they say "this could be black magic, this could be the arms of the jinn", and (..) it could be psychosis. It could be nothing related to that also".

Figure 6

Theme 3: Enabling Therapy Aligned with Muslim Client's Faith Needs

4.4 Theme 3: Enabling Therapy Aligned with Muslim Client's Faith Needs

This theme refers to faith-adaptations that would meet the needs of Muslim clients in the therapy room. All participants detailed connecting with the Muslim client's worldview through nurturing the therapeutic relationship, ensuring they felt heard and validated, and allowing the client to lead and initiate conversation about faith and Islamic worldviews early on in therapy. Participants also accentuated that non-Muslim therapists can further connect with the Muslim clients' worldview through a relationship with God, Quran, Sunnah, Ruqya (Islamic healing), trials and tribulations, the hereafter and forgiveness, whilst using meaningful language that would help the interpretation. Participants described meeting the expectations of Muslim clients' worldview by including actions in line with Islam, using clear instructions and approaching male and female Muslim clients differently. Participants also emphasised systemic adaptations are necessary, i.e. increasing the Muslim therapist workforce in healthcare services.

4.4.1 Connecting with the Muslim Client's Worldview

For a non-Muslim therapist to connect with Muslim clients, there is a lot that they need to consider. Participants' responses described nurturing the therapeutic relationship first as an intervention to support Muslim clients to feel understood in therapy and then use their faith as a vehicle for transformation:

Umar: " The work of the counsellor is almost like the work of a gardener(..) You have to clean the soil first, prepare it, (..) then you have to plant the seeds, (..) then you have to look after them, (..) you have to water them, [and] make sure they have lights (..) that's in Islamic counselling and that's kind of the process of Tazkiyah, or self-purification (..), a form of self-transformation (..) the analogy of the garden is (..) allow[ing] the person to heal, (..) by listening

to them, by enabling them to have a sense of perspective to overcome their difficulty, to understand, (..) to have a space for the pain to be aired and to be explored (..). We have this concept in Arabic, (..) Tahlia (..)a sense of emptying first before you can beautify and purify (..) you have to open up the dialogue and to facilitate for connection and communication (..) then you are able to build that therapeutic alliance and then through that you are able to work and (..) when you have the trust and the connection, you're able to use interventions after that. (..) The main thing is to develop the trust (..) the relationship (..) Muslim clients (..) they just want to be understood and want to be helped (..)when they go to mainstream services, they're not being understood by people who provide mainstream or secular therapies. And sometimes that's why (..) they come for (..) Islamic based counselling because they feel comfortable that someone who understand[s] their faith (..) is an integral part of them and their identity [and] also had to find solutions (..) using the[ir] faith as a vehicle for transformation (..) and overcoming that (..) difficulty in adversity".

Some participants highlighted the need to follow the client's lead in their understanding of Islam, to tap into the Muslim client's worldview and prevent therapists from projecting any assumptions on the client's levels of practice:

Juwariyah: "We need to always centre the client (..) we need to be mindful that we're not projecting our ideas of Islam onto them (..) rather what do they mean about Islam and how we can complement that (..) be mindful not to put people into boxes because Islam is diverse as a faith(..) similar in the way that we work in psychology (..) it's thinking about the person that is sitting in front of you and what they need".

Some participants orientated and set the tone in therapy by helpfully initiating conversations around faith and Islamic worldview:

Umama: "when you meet that client for the first time (..) it's important to ask them (..) just like you ask them their name, their age and even gender (..)"do you have a belief that you, (..) associate with, to help me understand your worldview" (..) whether they are somebody of faith or not, and whether they are practicing or not (..) what's important to them, what's not important to them (..)".

Participants highlighted that the therapy they provided centred around God and the Fitra, which is the primordial nature towards believing in a creator:

Fariha: "bringing God into the centre of everything (..) discussing the actual religion and actual God, I think it would really help and to discuss Allah SWT"

Umar: "Fitra is that primordial nature that God has created human beings upon, and then people change according to their upbringing to how they are parented, how they are nurtured,

how they are given significant care by the[ir] significant [care] givers (..)I think what sometimes happens, that people have moved away from their Fitra, its about (..) orient[ing] them toward the Fitra first and then being able to do the [therapy] work after that."

Some participants further highlight that using the Islamic framework of therapy, including the belief and moral system of God, with examples of the Prophet (sallallahu alaihi wasallam, SAW), is key in maintaining a connection with God, from which Muslims can benefit:

Haroon: " By following the example set by the Prophet (SAW), the whole (..) belief system, the whole moral system of Islam, (..) that obviously NHS can't adopt, but I think that's the only way Muslims can benefit".

Ismaeel: "I based [intervention methods] within an Islamic framework. So, the Islamic framework (..) would be the faith and(..) the Fiqh, so the rulings, how to worship, etc and the faith i.e. the six pillars of faith: so belief in Allah, belief in the messengers, belief in the books, belief in divine decree, belief in the day of judgment and belief in angels. So usually it's [intervention] around belief in Allah, belief in divine decree. Those two are the key kind of components that are often (..) used and then I'll use the [secular] intervention method".

Participants further denoted using Prophetic references and Islamic values to describe the framework of Islam and address the therapeutic challenges of Muslim clients:

Ismaeel: "The solution (..) to the mental health crisis (..) is to reattach ourselves to a framework of belief and spirituality. And I truly believe that's (..) what's missing in society today (..) But also from an Islamic perspective (..) we believe that (..) this life is not everything (..) we believe in the hereafter and there's a Hadith of the Prophet (SAW), he said "whoever wakes up in the morning, and he's safe in his environment, he has enough food for the day, he has health in his body or her body, the earth has been given to them at the palm of their hand". So sometimes it's about having that sense of reality".

Half of the participants said that interventions, such as CBT, are easily adapted to the Islamic model of therapy, such that including the Qur'an and Sunnah allows for comprehensive therapy to be provided, aligning with the Muslim client identity but also with the Muslim therapist:

Umar: "as a Muslim counsellor, (..) my benchmark is the Quran and sunnah (..) meaning that everything that is compatible with Quran and Sunnah I use. For example, (..) If I have a client who comes to me and they have negative thoughts (..) I can use CBT techniques because I can realign those kind of techniques with Quran and Sunnah (..) I remember in the Seerah [story] of the Prophet (SAW) (..) he worked (..) many years with his companions to change their thought process, to change their belief system about themselves, God, the world around

them. So, if you can change that, you can change your Aqeedah, your belief (..) then you are able to change how you feel about the world around you, and then you are able to change your behaviour and your relationships. So, for me, that's CBT technique".

A few participants referred to a need for therapists to incorporate Islamic concepts of the unseen (i.e., black magic, jinn) and Qur'anic healing (i.e. Ruqya) in formulations with Muslim clients:

Juwariyah: "I've had experiences where, [therapists] haven't considered (..) the concept of black magic or being impacted by a Jinn or they don't know things around Ruqya and (..) other healing methods and they (..) get dismissed when we're formulating for the (..) client in front of us".

Some participants included theological concepts, such as trials and tribulations, within the therapy to explain the concept of Qadr (a divine decree and predestination) and the purpose of a Muslim working towards the hereafter, to not only understand why suffering happens but also manage adversities in life:

Muhammad: "As an imam(..) what I would describe as theological article of faith, knowing that things always happen for reason. One way in which I could get [clients] to conceptualize what they were experiencing was by, adding that element into (..) the formulation. For example (..) relating to trigger, I would get somebody (..) to understand the concept of Qadr [predestination] (..) [I] may give them an understanding that (..) things don't happen for no reason, but (..) there is a divine element, (..) everything has been predestined".

Umar: "faith allows [clients] to (..) find a pathway of dealing with the situation and then being able to recognize that this life (..) full of trials and tribulations, but also there is a reward at the end of it, because we feel that as Muslims, our faith informs us. That this life is transitory, and the eternal life is the life of the hereafter, and that also gives people a sense of ease of dealing with difficulty in this life".

Another participant emphasised the importance of using the concept of Tawbah (repentance) to instil hope by focusing on the afterlife, rather than present life alone, for Muslim clients:

Zakariya: "the doors of tawbah, repentance, [are] always open (..) you give him [client] the conditions of Tawbah: you abstain from the sin; you have sadness as you have committed sin; and you will not return to the sin again. So obviously you give them the conditions [of Tawbah], but (..) now imagine, if you give somebody a hope, (..)you remember Allah and you ask for forgiveness. And who is there to forgive except Allah".

Participants often used Islamic terminology to establish the therapeutic relationship and support in the interpretation of relevant content:

Juwariyah: "saying Salaam is the most respectful thing (..) I don't always say, oh, goodbye, take care and look after yourself. I'm more like fee amanallah or like giving them a little dua [prayer] before they leave, and I think that really helps with building that therapeutic rapport."

Muhammad: "giving [clients] the understanding of (..) the mind that was given to us by Allah for example (..) the way that our bodies was designed in our creation (..) when Allah created us, (..) adding and injecting things that [clients] already know within our [Islamic] tradition and (..) using that as a premise for the therapy (..) In any formulation, you could use for example Qadr (..) the whole concept of the vicious flower, you know the idea of shar (..) good things and bad things like (..) khair-ul-shar, for example, God Almighty says, you know, "we test you with good and bad" (..) So how do you know these bad things are happening? It doesn't mean you're a bad person. It's just (..) means(..) this is a test, it's a trial or tribulation, so using (..) these terminologies, which are very familiar with the Muslim community and utilizing them (..) within the therapeutic setting (..) in the clinical work and (..) being able to get them to understand it from that paradigm".

4.4.2 Meeting Expectations in Line with the Muslim Client's Worldview

All participants reflected on the application of outer actions within the therapy arena by referencing Qur'an and Sunnah, such that Muslim clients are encouraged to engage in good deeds, like the remembrance of Allah (adhkaar) and performing their Salah (obligatory prayers), to support them in developing their Imaan (faith) and cleansing the heart/ soul:

Zakariya: "bringing a person closer to the Prophetic way (..) I think it is (..) very powerful tool for remedy (..) there are times we encourage people (..) like saying - Allah basically says (..) "Verily in the remembrance of Allah do hearts find peace" (..) when we use some of the guidance from the Prophet (SAW), certain adhkaar for protection (..)simple dua's for all occasions [e.g.] leaving the toilet, entering, leaving the home (..) this is also very powerful.. there could be somebody (..) he has this uneasiness because he has no in his life (...) how do[es] a person develop the quality of isteeqaam - steadfastness".

Ismaeel: "Allah (SWT) tells us in the Qur'an, for example, that you know "whoever follows Allah and his guidance will have a good life (Hayyatul Tayyibah) and those who disobey Allah will live a strenuous and difficult life" that's the framework from which I base my work and we do have discussions about (..) how good deeds can make you feel good, bad deeds can make you feel bad".

Some participants conveyed the importance of abstaining from sin to maintain a spiritually pure heart and steadfastness in the path to God:

Yahya: "the common answers to questions related to mental health are from a spiritual point of view (..) the consequences and impact of sins versus the impact of good deeds and how that helps, (..) the importance of cleansing your heart or your soul, and how having a soft, pure heart makes you happy in comparison to having a hard heart effects the Imaan".

Participants stressed that Muslim clients prefer being given instructions, as practical advice is commonly given and expected of MFL, and Muslims believe that Islam has clearer answers, in comparison to the NHS approach, which bases answers based on the client's perceptions:

Ismaeel: "one thing I have noticed with Muslims (..) is that Muslims like instruction, (..) and they like (..)[to] be told "OK, let's do this, let's do that". Whereas with the NHS approach (..) [if] someone comes to you and says "I feel depressed". "OK, why did you feel depressed?" "I don't know". "OK, let's investigate". It's [NHS therapy] always based upon (..) their perception of the world. But if you don't know and cannot define happiness, how can you help someone become happy? (..) Whereas with Islam, it's much clearer. "OK, you want to be happy? This is what happiness looks like. Let's work towards that".

Participants reported cultural gender differences in help-seeking behaviours. For example, Muslim females are more likely to open up easily with TTMFL, whereas Muslim males will access TTMFL but take longer to open up:

Ismaeel: "Females prefer to engage in therapy over the phone, most of the time (..) they're much more open and transparent about things, whereas men (..) sometimes it takes a bit of time to (..) get them to open up and express themselves".

However, participants reported that female Muslim clients face additional challenges of trusting the therapeutic process, consequently limiting themselves, due to guilt and fear related to exposing their marital conflicts.

Fariha: "there was this fear of "I'm sharing my personal details, my difficulties in my marriage" There was some sort sense of guilt going on there".

4.4.3 An Increased Muslim Workforce in Healthcare Services

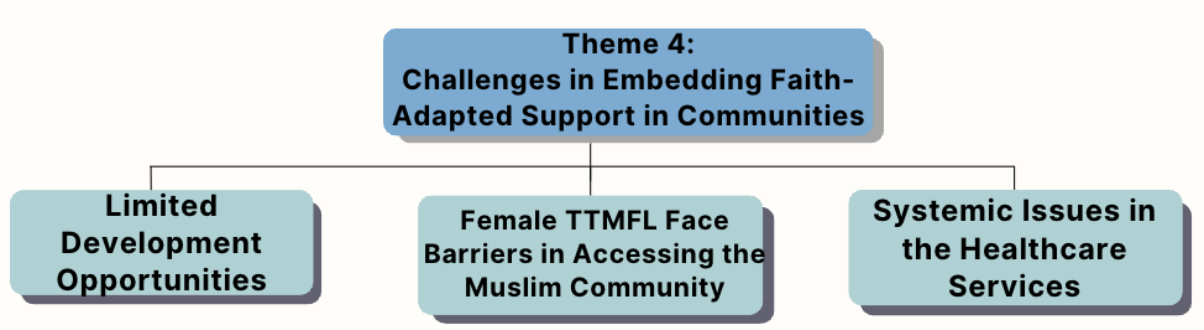
Participants described that there is a need for more Muslim professionals at different levels within healthcare services, to influence a change in structures and conversations, and provide therapy that is aligned with Muslim clients:

Juwariyah: "I think we need more Muslims on each level. So not only as therapist, but as service leads (..) executive positions and stakeholder positions. (..)that could make a huge

difference in the narratives and the conversations had about Islamic psychology within mental health settings (..) So essentially, if we train more clinical psychologists who also have an Islamic psychology framework (..) that's one of the solutions".

Figure 7

Theme 4: Challenges in Embedding Faith-Adapted Support in Communities



4.5 Theme 4: Challenges in Embedding Faith-Adapted Support in Communities

This theme denotes the participants' challenging experiences in serving the Muslim community. Such challenges included limited professional development opportunities, bodies, and support systems; restrictions faced by female TTMFL accessing the Muslim community through mosques; and systemic issues that impact Muslims' ability to engage with MHS.

4.5.1 Limited Development Opportunities

Participants described feeling quite limited in their professional development and suggested a need for a professional body to enhance their therapeutic knowledge and skills, by producing new theories and models for Muslims whilst managing vicarious trauma:

Muhammad: "in North America, they have a large Muslim psychological network. I haven't seen that here in the UK to be honest. Having that (..) over here (..) would really help because it would (..) enable every (..) qualified Muslim psychologist, (..) psychotherapists and psychiatrists (..) [to] work with each other and to liaise with each other and to create more modalities (..) that we would find acceptable within our tradition, our paradigm (..) having that is extremely important".

4.5.2 Female TTMFL Face Barriers in Accessing the Muslim Community

One female participant recognised intersectionality issues like gender diversity and power issues. She reported the challenges of female TTMFL collaborating with the local mosques which hindered her accessing the Muslim community:

Fariha: "I've tried to collaborate with the local mosques, but they don't seem to want to collaborate or (..)... don't wanna let anybody (female Muslims] into their mosque. And that's one thing that I found (..) it's a bit of a shame (..) mosques are not very open to, (..) provide counselling and they're OK for the Muslim males to provide some sort of therapy or counselling (..) [with] no training".

4.5.3 Systemic Issues in the Healthcare Services

Participants reported limited resources to support creating an integrated system within healthcare services to target Muslim clients' needs more effectively:

Muhammad: "Unfortunately I feel like we don't have enough (..) resources (..) that enable us to be able to create this integrated system within the NHS (..) That would allow many Muslims to feel comfortable. (..) I feel like that's what many Muslim clients are looking for".

Participants described that institutional and societal racism impacts Muslim staff members being able to progress:

Haroon: "But unfortunately, the NHS, the institution is racist historically, even now, and they don't treat NHS staff members equally, even Muslims (..) and the black minority generally (..) the jobs that they (..) get, there's inherent bias and racism right. (..) they [NHS] need to do more and for you as a Muslim (..) you need to be aware that you are working in a system that treats you as second class, ontologically epistemologically".

Another participant highlighted that racialised policies and procedures, such as PREVENT, are significant structural barriers for Muslim communities to access therapy, as they increase fear of being misunderstood and judged:

Ismaeel: "you know they're [Muslim community] afraid of PREVENT, so they're afraid that when they open up within the NHS just they're going to be referred".

Participants acknowledged that MHS need to do a lot of work to reassure insular communities of their helpful nature, highlighting further that they need to branch out and be proactive in accommodating Muslim clients:

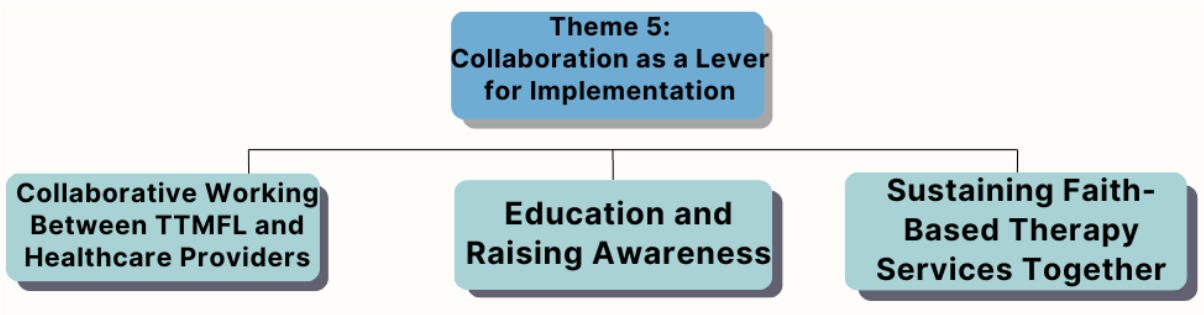
Ismaeel: "So in certain communities, (..) they don't integrate too much (..) into other communities, and so (..) there are perceptions that develop and so the NHS needs to do a lot, to (..) let people know that we're not here to spy on you, we're here to help you".

How TTMFL were viewed in the therapeutic field by MHP was also conveyed by one participant, in that this perception impacted the TTMFL ability to feel respected and valued as part of the team with legitimate credentials:

Zakariya: "It would be quite challenging for the Imam to get involved in any of the real professional setting (..) within family systemic therapy, because I think the way that things are, so toxic over the way people [NHS staff] are thinking [about] the imam, they will be probably scrutinize if he's [TTMFL] suitable to give therapy".

Figure 8

Theme 5: Collaboration as a Lever for Implementation



4.6 Theme 5: Collaboration as a Lever for Implementation

This theme centres around mutual collaboration between the TTMFL and healthcare providers, sharing learning of secular and Islamic therapy and working together to ensure the sustainability of a faith-based therapy service (FBTS).

4.6.1 Collaborative Working Between TTMFL and Healthcare Providers

Several participants highlighted the benefit of both Islamic and psychology-based scholarship in therapy to Muslim clients such as sharing Islamically focused formulations and interventions:

Ismaeel: "you need to [have] a collaboration between Islamic scholarship and (..)a psychology-based scholarship. So you need to have the two come together, and they need to both (..) sit down and develop something where you have those that are equipped with the knowledge of the tools and the interventions and you have those that are equipped with the knowledge of the philosophy, the theology and also the spiritual framework".

Muhammad: "Muslims who are qualified in psychotherapy, psychology (..) we need to get together and be able to create our own formulations for every single disorder that exists and (..) introduce that to the NHS and say "look through our experience as Muslim therapists, as Muslim psychologists, (..) we've noticed that these formulations worked for many people in the Islamic community. (..) We've got (..) a very strong understanding and reasoning to believe

that these formulations, (..) when it's complemented by the Islamic (..) beliefs, it works for Muslim clients".

Another participant referenced a time when he worked with a Muslim patient to prevent the deterioration of Muslim clients and healthcare staff's misunderstanding of the client's distress:

Zakariya: "what may not be a sign of extremism, it just [may] mean something that somebody wants to practice, his Deen [faith]. This can be difficult, especially in that [NHS] setting, because I think we can give better support to anyone who may have a misunderstanding [of Qur'anic verses], because sometimes these are the issues that caus[e] (..)an increase of mental health [issues]".

A few participants noted that collaboratively working with healthcare services can also involve training MFL, given that they can provide therapy in the community:

Ismaeel: "because the imam is the first point (..) contact within many Muslim communities when something goes wrong, (..) so if you equip the [Imam] and (..) you train the[m], then the[y] will be able to help and offer mental health services".

TTMFL also discussed being gatekeepers for healthcare services, such as developing a pathway to increase access to therapeutic services for the Muslim community, by bridging the gap of accessible therapy and religious advice between healthcare services and Muslim community organisations:

Yahya: "if the mosque doesn't have that [psychological therapy] facility, they don't [sic] have that resource(..) they [the mosque] can coordinate with the local GP (..) and their [mosque] reference has some weight that we [imams can] have some meetings and we feel like (..) we can deal with your services [NHS] for that [Muslim client]. Lastly, like a referral system between mosques and the local GP. And I think that can go both ways. Sometimes the local practice can also refer them [Muslim client] to the imam, to the local mosque if they want religious advice".

Zakariya: "[Imam] could have that capacity and ability to signpost a person because he may know better. Meaning an imam [TTMFL] can even know whether it is more suitable for the person to be signposted to (..) the NHS".

One participant highlighted a community psychology approach whereby psychologists branch out proactively and work collaboratively with Muslims in their communities and apply interventions drawing from an Islamic framework, which is distinct from secular models that they have trained in:

Juwariyah: "there needs to be, like a community psychology approach (..) psychologist need to first embed themselves within these communities (..) but not (..) come in with just their secular knowledge, (..) how can you draw on Islam and the coping mechanisms and (..) how can we use that to influence the way we work psychologically (..) whether that is like partnerships with Muslim organizations (..) [and] faith leaders".

4.6.2 Education and Raising Awareness

All participants emphasised educating healthcare services about the Muslims worldview. A few participants referred to raising awareness about the misunderstandings of extremism commonly associated to Muslims and how this may impact them accessing healthcare services due to the fear of being labelled, misunderstood and suppressed in expressing themselves freely in therapy:

Zakariya: "I mean the solution is again education, awareness, making people realize that (..), you know how they been portraying the image of the Muslim and how they've been tarnishing the image, especially in these movies (..) only until recent times like what's happening right now here in Gaza, in Palestine, we are finding, people are beginning to realize (..) how the Muslims have been demonized, how [they have] been portrayed when somebody is wearing a beard and a turban, "this is a jihadist and Islamist and all this". I think education is really important, that if somebody is practicing and he wants to practice his religion, this is not sign of extremism, this is in fact going to be better [spiritually for the person]".

Some participants referred to raising awareness about Islamic concepts and its history:

Muhammad: "more education would be important because we have a tradition in CBT anyway. (..) I've read Al-Balkhi (..) his book on CBT and (..) Imam Al-Ghazali's works. And I've also read many works of many of the pioneers in Islamic spirituality (..) what they've taught and (..) written about (..) how the mind works and spirituality, (..) and the human soul is very much exactly what we would find today (..) in which many experts in the NHS would describe a person who's going through any type of disorder. (..) I think that would really help (..) [to] make it mainstream and (..) normalized and enable Muslims to (..) realize that actually there is (..) a modality that does respect their faith (..), acknowledges them as a community and (..) valued members of society".

Zakariya: "Maybe a presentation should be given to the NHS (..) there is this issue that they [NHS] are not considering the evil eye and the jinn and (..) generally explaining (..) how it can be understood in the NHS".

A few participants underscored that healthcare services need to recognise the significance of using prophetic healing methods for physical and mental well-being of Muslim clients:

Zakariya: "I think NHS can develop and use this [prophetic healing methods] (..) you know somebody may need hijama [wet cupping] (..) like somebody may need support and (..) looking for (..) this concern about physical well-being as well as mental well-being (..) the prophetic medicine is also important to help and bring about support for the patient.(..) I think this may give your patient more confidence, especially if (..) he is following Islam, then he would always be also looking for this as a solution".

4.6.3 Sustaining Faith-Based Therapy Services Together

Some participants emphasised the need for funding for faith-based community projects to make therapy more accessible to the Muslim community and for faith-based grassroot organisations to be sustainable:

Yahya: "It would be good for them [NHS] to also fund some projects (..) run by the local Muslim community. (..) That might help with access as well; they [the Muslim community] might want to go to an organization instead of the mainstream NHS".

Some participants also referred to the importance of MHS and mosques linking together and referring potential Muslim clients to faith-based therapeutic grassroots organisations to provide better access to and choice of therapy in the Muslim community:

Yusuf: "Once the Muslims are trained [i.e., TTMFL], then they can use that training to build a rapport in-house [NHS], but also in the local areas, in the local mosque and community centres, working with the mosque to maybe even build something like a weekly, (..) monthly program. Muslim-based [organisations like] Inspirited Minds, (..) you've got Sukoon and other organisation for Muslim chaplains (..) to connect, these organisations within the [NHS] Trusts to provide some form of network and then once that network is built and (..) rapport has been OK, (..) I think that['s] (..) when there will be a gateway for organisations to come in and provide [tailored therapy to Muslims in the community]".

Participants also referred to healthcare services connecting, collaborating with and empowering grassroots organisations and mosques to ease the therapeutic process for Muslim clients and address their mental health needs earlier before they worsen:

Umar: "You know, there are lot of [grassroot] volunteer organizations, so empowering them. There are a lot of mosques and you know, for example [for] Muslims the first point of access is the mosque, the masjid (..) and [NHS] developing services, working with the faith sector, and especially the mosques (..) to help develop them, use them as a resource and collaborate with them and use them as part of the toolkit to help the client. So rather than kind of (..) people working in silos (..) and they don't connect with one another, and that kind of has a significant detrimental impact on the client because the clients then has to navigate so many services to

achieve one outcome, where if there is a connection and collaboration, then the journey of the client can be managed more seamlessly".

4.7 Conclusion of Analysis

In conclusion, participants' experiences of Islamically informed therapeutic support in the Muslim community involved a rich skill set and knowledge of integrating secular and Islamic knowledge; resulting in them providing Islamically informed therapy to the Muslim community and aligning foundationally with the Islamic worldview - one that is often excluded in secular therapeutic modalities. Despite TTMFL being perceived as being trusted by Muslim clients based on their shared faith, participants shared the complexities of the dual but separate roles, such that Muslim clients perceive them as either therapists or MFL, which consequently positions the participants to give Islamic advice or collaboratively identify solutions for their struggles.

Given the lack of faith in secular therapy services solving unaddressed mental health difficulties in Muslim communities, participants pointed out a need for a grassroots FBTS which is Muslim-run and led within a spiritually meaningful location for Muslims.

Participants made numerous references to the different ways faith-adapted therapy can meet the faith needs of Muslim clients in the therapy room. This includes inviting the Muslim clients' relationship with God and Islamic beliefs into therapy, such as being predestined to face trials and tribulations in understanding the main purpose of working *towards the hereafter* and holding onto hope through seeking forgiveness from Allah. The participants also noted using Islamic language and actions within the therapy. They described various ways non-Muslim therapists could connect with the Muslim clients' worldview and meet the expectations of this within the therapy. Participants painted therapeutic adaptations on a wider level, whereby they highlighted the need to engage with Muslims within their context and increase the Muslim workforce in health care services.

However, participants found that providing effective Islamically informed therapy posed challenges, such as limited development opportunities and female TTMFL being restricted in accessing the Muslim community, as well as systemic barriers in healthcare services, such as lack of resources, racism, Islamophobia, and discriminatory strategies targeting Muslims, which hinder participants ability to navigate secular healthcare services with ease and offer effective therapy to Muslim clients.

Therefore, participants described that healthcare services, faith-based organisations and TTMFL should collaboratively work together to improve access to therapy services for Muslim clients and indirectly improve professional development opportunities for TTMFL. Participants also made references to educating and raising awareness both in healthcare services and the

Muslim community to tackle professional biases towards Muslims and mental health stigma. Participants further articulated sustaining FBTS by injecting funding into these faith-based organisations and empowering them through collaborations and sharing meaningful resources.

Chapter 5: Discussion

5.1 Chapter Overview

This chapter reviews and summarises the study's results in reference to the research questions and relevant literature. It then discusses the clinical implications of this research and critically evaluates the study by presenting its strengths and weaknesses. Finally, future research recommendations, concluding comments and final reflections are presented.

5.2 Summary of Findings

Although research has been done with MFL before, this is the first research to investigate TTMFL experiences delivering Islamically informed therapeutic support in the Muslim community, how they conceptualise Islamically informed adaptations, similarities and differences in Islamic and secular psychological therapy adaptations, enablers, ease of implementing the Islamic adaptations in the community and the socio-political barriers in implementing these within the NHS.

This section presents the primary findings of this study, the related literature and theories pertaining to the research questions, which were:

1. What are the views of TTMFL on psychological interventions in the NHS?
2. How do participants integrate Islamic and secular interventions into their everyday practice, and what are their advantages?
3. What are the challenges of TTMFL incorporating Islamic / secular interventions with Muslim clients?
4. What barriers do participants perceive in implementing Islamic approaches at a service level?
5. What adaptations are needed to implement Islamic approaches in the NHS, and how can the Islamic interventions be applied to support the Muslim community?

TTMFL shared their experiences and knowledge of delivering Islamically informed therapeutic support in the Muslim community. The findings from all five themes show that TTMFL possess unique experiences and skills whilst facing challenges in providing Islamically informed therapy to this community. Despite Muslim clients trusting TTMFL based on their shared faith, there are challenges regarding their expectations of how TTMLs balance secular and Islamic worldviews and approaches. Participants spoke of their dual role of being grounded in an Islamic worldview but using therapeutic models that exclude faith. Participants highlight the limitations of MHS for the Muslim community. They point to a need for a Muslim-run, grassroots faith-based therapy service delivered within a meaningful location. Participants share different ways therapists can meet Muslim clients' faith needs in the therapy room by including the relationship with God, Quran, Sunnah, Ruqya (Islamic healing), Islamic beliefs around trials and tribulations, the hereafter and forgiveness, and using meaningful language that would help the interpretation. This also includes meeting expectations that align with the Muslim client's worldview, such as providing actions that are compatible with Islam, giving instructions, approaching gender differences in help-seeking, and increasing the Muslim workforce in health care services. However, TTMFL faced numerous challenges, including limited development opportunities, female TTMFL limited access to the Muslim community, and systemic issues in healthcare services. Therefore, there is a need for collaboration between TTMFL and healthcare providers to educate, raise awareness, and sustain FBTS.

5.3 Relevance of Findings to the Literature

Theme 1: Different Worldviews

The first theme relates to research questions 1 and 5. It emphasises TTMFL view of secular psychological therapeutic modalities excluding the role of faith, which is essential when working with Muslim clients in community and healthcare settings. This finding is consistent with the literature describing religion as unhelpful, incompatible, and unrelated to healthcare (Koenig, 1997), and removed from the therapeutic realm (Mir & Sheikh, 2010). Western psychotherapies ignore the importance of the soul and lack the ideology around 'good' and 'evil, which is the pinnacle of Islam (Khalid, 2006). The premise of secular modalities like CBT being Western and individualistic, attribute control of one's destiny and suffering to the individual (Beshai et al., 2013), rather than external factors, such as biopsychosocial and spiritual difficulties being a test and a trial from Allah (Utz's, 2012). This highlights a mismatch of lenses between therapists and Muslim clients, which could undermine engagement and satisfaction (Cragun & Friedlander, 2012) if, for instance, therapists conveyed contradictory religious views or avoided exploring issues related to the clients' faith.

Participants referred to incorporating their Islamic worldview and centring God in all their therapeutic work with their Muslim clients. From the Islamic psychology perspective and

traditions, mental health is holistically linked with the mind, body, and soul (Asadzandi, 2018). Most Muslims navigate mental health challenges by grounding themselves through their submission to Allah and following what is revealed in the Quran and the Prophetic teachings (Sunnah) by the Prophet Muhammad (SAW) (Verwey, 2018). This contrasts with the globalisation of mainstream secular and Euro-American psychology, which individualises, pathologizes and depoliticises distress rather than changing the actual socio-political cause that shapes the distress (poverty, racism, discrimination, humanitarian crises). This suggests that the discipline is a practice of "cultural imposition for the non-white majority of the world" (Hubis, 2015; Hussein, 1985, p.65). Therefore, this theme of different worldviews resonates within the wider Muslim context since these views are sometimes held as an act of resistance to white supremacy and a system that largely ignores their histories and injustices committed unto them. Accordingly, the secular Western therapy system does a disservice to Muslim clients; rather than acknowledging this complex history, their thoughts and behaviours are depoliticised and othered in therapeutic spaces simply because their worldview differs from the West (Younis, 2022). Thus, this theme mirrors a sociogenic approach to mental health that focuses on a person's dynamic relationship to the environment and consequent impact on the psyche, contrasting with Western psychology, which enforces a universal understanding of human psychology.

TTMFL acknowledge and balance the different worldviews between secular psychological models and Islamic psychology in therapy. The literature supports this approach (e.g., Betteridge, 2012), suggesting that both approaches together can holistically meet Muslim clients' needs, regardless of any underlying philosophical differences (Agilkaya-Sahin, 2019) and support genuineness, empathy and person-centeredness in the therapeutic relationship (Post & Wade, 2009). Balancing approaches is also successful in faith-adaptations across religions, such as Christianity (e.g., Pearce & Koenig, 2013), Hinduism (e.g., Lalchandani, 2020), Judaism (e.g., Golker & Cioffi, 2021), and Sikhism (e.g., Currie & Bedi, 2018) too. Yet, Mustafa's (2021) research on MFL supporting the Muslim community suggests that secular and Islamic worldviews may not always be complementary, especially within the sociocultural political context of Islamophobia. However, the current findings suggest that Muslims undergoing psychological therapy grounded in the Islamic worldview would feel some liberation.

Like Mustafa (2021), TTMFL notice that a shared faith and providing therapy grounded in Islamic knowledge helps develop trust. Client-therapist matching is a common technical adaptation in culturally adapted therapy (Rathod et al., 2019; Tseng, 1999). This finding makes sense in the context of shared faith, ethnicity, values, and worldviews influencing therapeutic processes as it supports mutual understanding and validating clients' experiences (Cooper,

2012; Hamilton, 2024). However, TTMFL referred to Muslim clients' expectations of their approach as based on their role as a teacher and/or therapist and how this duality might be confusing. The traditional therapist's style is one of education and Socratic dialogue; however, this does not align with Muslim culture. Muslims are more receptive to a directive and instructional approach (Naeem et al., 2016), where authority figures are seen as sources of guidance, support, and enlightenment (Laungani, 2004; Naeem et al., 2010). This highlights the idiosyncrasies of Muslim help-seeking and reinforces the differences between the secular and Islamic worldviews not just for TTMFL but also for Muslim clients.

Theme 2: Grassroots Faith-Based Therapy Service.

This theme connects to research questions 1 and 5 and the previous theme, given the different worldviews and depoliticisation of Muslim distress in therapy. Therefore, it makes sense that participants reported establishing a grassroots faith-based therapy service that is independently led and run by Muslims to serve the Muslim community separate from the NHS. TTMFL also report the importance of delivering therapy to Muslims within a meaningful setting, such as a mosque or a graveyard. Unlike secular therapy, which excludes avoids faith in the bereavement process (Dyer & Hagedorn, 2013), Muslims may find having therapy in the graveyard helpful as it could realign them to their spiritual purpose and beliefs that death is inevitable and of reuniting with loved ones in the hereafter. Islam is not just a faith in a definitive sense but also a way of life that informs practices and rituals in life events such as marriage, divorce, and burial. Thus, embedding therapy in the community can be extremely helpful. Similarly, the literature shows consistent findings to this current research in using community and support system-based involvement within FAPI. This type of involvement supports sustaining engagement of religious clients (Musbahi et al., 2022) and highlights the significance of embedding therapy in the community. This adaptation is particularly important given a shared sense of threat within Muslim communities about their religious thoughts and emotions being securitised from radicalisation and extremism in MHS (Younis, 2022), consequently damaging Muslims' trust towards MHS (O'Toole et al., 2016). Therefore, adapting therapy that galvanises the Muslim communities' resources, such as their collective affinity, may offer some reassurance, reduce fear and support psychological safety when exploring their distress (Byrne et al., 2017). This points to the need for an independent therapy service, and a psychological framework that fulfils the liberatory potential of therapeutic work and encourages Muslims to resist the conditions of securitisation and Islamophobia (Younis, 2022). Nonetheless, Muslim disengagement from MHS (Moller et al., 2019) and their desire to form and govern their own FBTS aligned with Islamic principles and philosophy is an example of resistance to the establishment causing their distress (Inspirited Minds, 2019; The Lantern Initiative CIC et al., 2021). This raises questions about the suitability and acceptance

of non-Muslims providing therapy, which further supports the need to underpin therapeutic support in Islamic philosophy and within the Muslim community; especially since community psychology is a movement to meet the needs and values of community populations (Thompson et al., 2018).

Theme 3: Enabling Therapy Aligned with Muslim Client's Faith Needs

This theme links in with research questions 2 and 5 and indicates other ways in which non-Muslim therapists can accommodate Muslim clients' faith needs in the therapy room. It is critical guidance given the religiosity gap and MHPs' lack of confidence in working with faith during therapy (Betteridge, 2012). In the context of the two previous themes, where the therapeutic conditions in MHS securitise and depoliticise Muslim thoughts and emotions (Younis, 2022), making faith-adaptations and adjustments is possible, although it only plasters over the social issues contributing to Muslim distress, rather than truly empowering Muslims to attain liberation.

This theme highlights several technical adaptations. Participants highlight connecting with the Muslim client's worldview by developing trust as key in any therapeutic relationship. Consistent with previous research (e.g. Bell-Tolliver & Wilkerson, 2011; Johnson et al., 2007; Robinson, 2016; Stansbury et al., 2018), therapists initiating conversations about faith early develops trust and helps clients feel heard and seen. This includes therapists who do not share the same faith but embody cultural humility by being non-judgemental (Suara, 2022) and demonstrating respect towards clients (Judd, 2019). In contrast, Crossley and Salter (2005) suggest that practitioners wait for clients to mention anything about faith before addressing it themselves in therapy. However, in the socio-political context of depoliticising Muslim distress in the therapy room in MHS, waiting for a Muslim client to bring up their faith may maintain the cycle of fear of state surveillance and avoidance, thus deterring their ability to seek appropriate help (Byrne et al., 2017).

TTMFL may also feel comfortable initiating conversations about faith because of having shared faith (Keshavarzi & Haque, 2013; Mustafa, 2021) and believing they would understand their client's Islamic beliefs better than non-Muslim therapists (Qasqas & Jerry, 2014). This suggests that TTMFL are better positioned to initiate conversations about faith and encourage Muslim clients to talk about this. However, having a therapist who shares the same faith background as the client may not always make facilitating conversations about faith easier. For instance, clients who have experienced spiritual abuse from an authority figure, such as an MFL or teacher, may have had their well-being and relationship with their faith impacted (Chowdhury et al., 2022). As a result, working with a therapist who shares their faith could subconsciously trigger associations with the trauma, making it difficult to build a trusting

relationship and suggestive of not all therapy for Muslims needing to be provided by TTMFL. However, Miller & Chavier, (2013) highlighted that in cases of spiritual trauma, if the client agrees to work with someone who shares their faith, it is crucial to follow the client's lead when using faith resources as a tool, in order to avoid causing further harm. Additionally, given that TTMFL comprise a small group of therapists with dual specialist areas, it raises practical questions around capacity levels among TTMFL and whether they can effectively fulfil the emotional needs of the growing Muslim community (Mustafa, 2021).

For non-Muslim therapists, following the client's lead is crucial (Evans & Devlin, 2016), especially where there is a heterogeneity of both practising and non-practising Muslims with varied mental health needs (Eltaiba & Harries, 2015; Suara, 2022). Client-led therapy further holds true for Muslim clients who prefer to meet a non-Muslim and want to keep their faith separate from therapy, especially when they have faced harm from faith practices (e.g., spiritual abuse from a MFL or teacher) and parental expectations (Miller & Chavier, 2013). According to this research, it is unclear if it is helpful for non-Muslim therapists to bring up faith or wait, but rather it might be important to adopt a flexible approach where the therapist gauges whether it could be helpful and recognise the client as an individual before being Muslim.

There were technical and philosophical adaptations identified in this theme which showed that connecting with the Muslim worldview includes inviting the client's relationship with God. This finding is consistent with the literature on FAPI whereby faith was used by therapists to help clients to connect with God and their spirituality. This included religious practices such as prayer (Miller & Chavier, 2013), use of scripture (Tipton et al., 2021), religious and spiritual beliefs (Johnson et al., 2007), using clients' faith as a tool of resilience and encouragement to confront problems (Vandenberghe & Prado, 2012) and encouraging closeness to God (McCoy et al., 2004). Additionally, using Islamic language in interventions and familiarising clients with the content of the therapy (e.g., Dawood et al., 2023; Keshavarzi & Khan, 2018) also supports a Muslim client to interpret their experiences and address their faith needs directly (Gill, 2018; Suara, 2022). This demonstrates the importance of using therapeutic tools relevant and meaningful to a Muslim client's faith, including the language Muslim clients are familiar with, to meet their faith and therapeutic needs.

Furthermore, the current findings show that Muslim clients prefer the therapeutic dialogue to be instructional and give Islamic advice. This is consistent with theme one, showing that Muslims have different worldviews and receive help differently, and research showing that Muslims prefer a directive and guided style in therapy (e.g., İme, 2019; Tarabi et al., 2020). Participants suggest CBT might be easier to adapt than other approaches as it permits

direction from the therapist. However, as mentioned earlier, the collaborative style is something that Muslims may not be familiar with.

Participants report meeting clients' expectations in line with the Muslim worldview, particularly gender differences in help-seeking behaviours. Whereas Muslim females prefer to engage and open up in therapy over the phone with a male TTMFL, Muslim males accessing TTMFL take longer to open up. In a rare example of discussion around such gender differences within the literature, Suara (2022) touched upon clinicians educating themselves on the religious and cultural differences in gender interactions to better serve the idiosyncratic needs of Muslims. As such, Muslim males across cultures struggle to talk about their mental health because of self-stigma and pressure to conform to masculine norms (Alam, 2023). However, in Islam, this is countered by the Prophet Muhammad, who wept due to the death of his son (Sahih al-Bukhari 1303). For TTMFL connecting a Muslim clients' worldview to meet their faith needs therapeutically, it is important to be aware that masculine norms found in cultures of South Asian and Arab origin may not align with Islamic Prophetic masculinity. Therefore, if resistance arises, it is worth holding in mind the mismatch between cultural expectations and faith and encourage male clients to clarify this where possible.

On the other hand, females preferring phone-based therapy with a male therapist may derive from cultural and Islamic norms and an inclination to maintain a physical boundary with the opposite gender (Arshad & Falconier, 2019; Khan, 2014). Muslim female clients may also prefer male therapists due to the cultural perception of Islamic scholars only being male, as well as the limited awareness of and resistance to Muslim female scholars (Liberatore, 2019; Majid, 1998), suggesting a need to carefully consider gender interactions with female Muslim clients and therapists.

In addition to adjustments within the therapy room, participants report a need for more Muslim professionals within the NHS who could improve how therapy is provided. The lack of service adaptations and the need for more Muslim professionals could be due to healthcare staff protecting their positions and favouring their professional knowledge and skills (Dodd et al., 2022; Scheppers et al., 2006). With service adaptations, it could reduce the religiosity gap amongst MHPs and improve skills and knowledge to address religious issues directly (e.g., Crosby & Bossley, 2012), therefore warranting more faith-based practitioners to influence the delivery of therapy to meet Muslim clients' faith needs. This aligns with the commitment to increasing diversity and representation, including spirituality, within the NHS and psychology profession (British Psychological Society, 2020; Health Professions Council, 2008; NHS Golden Jubilee, 2023; United Kingdom Council for Psychotherapy, 2019). A range of areas already consider faith needs such as in public administration (Collins & Kakabadse, 2006),

nursing (Kincheloe et al., 2018), sociology (Guest, 2016), oncology (Sharma et al., 2012) and palliative care (Voetmann et al., 2022), suggesting incorporating faith into practice is feasible.

Theme 4: Challenges in Embedding Faith-Adapted Support in Communities

This theme covers research questions 3 and 4. It highlights the difficulties TTMFL face in providing effective therapy to the Muslim community. These difficulties are overshadowed by limited development opportunities that inhibit participants from developing skills, knowledge, and self-care. Continued professional development can help TTMFL address tensions across professional, personal, and organisational ideals (Evans & Devlin, 2016). Moreover, TTMFL accessing Muslim therapist networks, such as the Muslim Counsellor and Psychotherapist Network (2023), would aid in providing effective therapy.

A novel finding is that female TTMFL feel obstructed in accessing Muslim clients, particularly in mosques, which is not present in the literature. The few female participants included in this study demonstrates the lack of female leadership and how Muslim women are still positioned within male-dominant cultural systems (Ewing, 2008), which prevent them from taking on leadership roles in mosque committees and contradicts perspectives of female leadership in Islam seen in some Western European countries (Nyhagen, 2019). Therefore, Muslim females, including TTMFL, are commonly excluded from accessing faith spaces in the UK (Citizens U. K., 2017), requiring further considerations from TTMFL and the Muslim community to meet female Muslim clients' therapeutic needs (Saleem & Martin, 2018).

A debatable finding is the suggestion that MHS needs to be more proactive in accommodating insular Muslim communities. The term 'insular' is understandable in the current sociopolitical context where Muslim communities often face hostility, racism, anti-Muslim hatred, social exclusion, alienation, prejudice, and discrimination—forces that are reinforced politically, socially, and by the media (Erdenir, 2010; Mohiuddin, 2017). These experiences contribute to marginalization, fear, mistrust, and avoidance of unsafe spaces (Byrne et al., 2017), making integration difficult. However, the notion that Muslims do not integrate is a common stereotype (Archick et al., 2011; Field, 2007) that may have been internalized, suggesting that their beliefs are not in line with Western values of justice, freedom, and democracy. Nevertheless, it has been argued that Muslims can integrate into society by adhering to civic values that are essential within secular and modern European nation-states and multiculturalism (Anjum et al., 2017; Triandafyllidou, 2022).

Participants also highlight negative attitudes from working in healthcare services. TTMFL perceived being viewed as 'faith leaders' in the therapeutic field rather than 'therapists' despite having legitimate credentials, impacting their ability to feel respected and valued as part of the team. Consistent with previous research, Hood (2022) highlighted the negative attitudes

towards expressing the Christian faith unreservedly in a secular society, which can reinforce these inaccurate narratives of therapy. This suggests that TTMFL outward displays of faith undermines others' perceptions of their skills, reinforcing the subconscious lens of suspicion they are seen through (Younis, 2022). Alternatively, the lack of understanding or unfamiliarity with how TTMFL work (Meran, 2019; Mustafa, 2021) can also explain this experience. This suggests that to effectively embed faith-adapted therapeutic support in the Muslim community, we must empower TTMFL by reducing the systemic barriers hindering their professional therapeutic progression, such as contextualising applications for therapeutic training programmes to recognise diverse identities (University of Essex, 2021), reflective practice on race and racial discrimination (Kusi, 2020), training on defensive dynamics (McInnis, 2021), and initiatives increasing the diverse workforce within the psychology profession (Aspiring Clinical Psychologists Access Scheme : NHS, 2024).

Theme 5: Collaboration as a Lever for Implementation

This theme focuses on research question 5 and highlights the need for collaborative work between TTMFL and healthcare providers. This involves improving multidisciplinary working, knowledge and skills, and referral pathways of psychological interventions between MHS and the Muslim communities to better meet their needs. This collaborative work could sustain FBTS in the Muslim community.

This theme is consistent with Abrar and Hargreaves' (2023) findings about collaboration among faith-sensitive mental health services and faith communities. These partnerships fill gaps in public mental health provisions using public resources while also educating clinical staff. As such, TTMFL describes the need to develop an effective referral process between the MHS and Muslim community organisations to increase access to therapeutic services. The benefits of collaborative approaches to increase the choice of therapy to meet the needs of Muslim clients are evidenced in the examples of the preliminary initiative in Tower Hamlets, where Muslim clients in the NHS were referred to faith-based approaches, including Islamic counselling run by the *Lateef Project*, commissioned by the NHS (GP Care Group CIC, 2022), and the Greater Manchester Mental Health Spiritual Care Strategy (2019) successfully integrating mental health services and faith groups. Although MFL are often mental health gatekeepers for the Muslim community and better-positioned to signpost Muslims to healthcare providers (Mustafa, 2021), current findings show that this referral process to MHS and faith-based therapeutic services in mosques or in the community is yet to be developed and established consistently.

While the participants highlighted the benefits of collaboration between TTMFL and healthcare providers, the importance of incorporating evidence-based approaches in these collaborations

was not explicitly mentioned, except for the mutual exchange of Islamic and secular knowledge. This omission raises the question of whether TTMFL were less familiar with or less exposed to evidence-based practices, which might explain their emphasis on the need for collaboration with mainstream health services (MHS). Moreover, although the study acknowledged that TTMFL were trained in evidence-based methods like CBT and counselling (National Institute for Health and Care Excellence, 2011), it did not capture or analyse their experiences within the NHS in detail, possibly due to their irregular employment patterns within the NHS, as highlighted in previous research (Mustafa, 2021). This could suggest that evidence-based practices and the evaluation of outcomes were not emphasized in their work as much as in MHS settings (Devlin & Appleby, 2010). Additionally, a previous systematic review indicates that evidence-based therapies, such as Islamically modified CBT, can reduce symptoms of depression and anxiety and improve functioning among religious Muslim individuals (Munawar et al., 2023). This highlights the potential benefits of incorporating evidence-based practices in collaborations and suggests that TTMFL, who have direct access to the Muslim community, could be trained to deliver these interventions effectively to meet the community's mental health needs. Furthermore, psychiatry in the Islamic world has historically been grounded in scientific approaches (Awaad et al., 2020), suggesting that evidence-based methods align with Islamic traditions and would be beneficial to the Muslim community. Therefore, integrating evidence-based approaches alongside both Islamic and secular knowledge in care pathways within mainstream mental health services should be considered.

Another way of working collaboratively includes education and raising awareness. This can help to reduce the religiosity gap of MHP in MHS (Crosby & Bossley, 2012), increase the understanding of the Islamic worldview and support collaboration with current grassroots Muslim FBCO, such as *Inspirited Minds* and the *Lantern Initiative*, who offer workshops around Muslim mental health. *Spirit in Mind* is another example of a successful collaborative partnership apart of South-West Yorkshire Trust NHS Foundation in which resources and expertise are shared between faith communities, faith-based mental health services, and clinical staff. It is paramount and timely to raise awareness of Islamic concepts, along with the negative psychological impact of the misrepresentation and conflation of the term 'extremism', commonly linked with the Muslim identity in MHS and societally (Aked et al., 2021; Byrne et al., 2017). Suara (2022) highlights cultural sensitivity and therapists' diligence in educating themselves on their biases related to religious and cultural principles and practices towards Muslim clients and practitioners. For example, if clinicians deconstruct 'extremism', it is important to establish what is considered extreme and what is not but could easily be misconstrued as extreme. Similarly, MHS can mutually educate MFL to increase the Muslim

community's understanding of mental health and reduce the stigma surrounding it, by improving their mental health literacy and collaborating with these in a contextually sensitive way when they deliver Khuthba's (Friday sermons) or events (Hodge et al., 2024; Tanhan & Francisco, 2019). Khuthbah's would disseminate knowledge widely, in a less stigmatising and confronting way, whilst powerfully validating mental health issues faced by the community (Burford-Rice et al., 2022).

The novelty of the findings related to sustaining FBTS aligns with community psychology principles and meeting the Muslim communities needs. Previous research mentions MHS collaborating with Muslim FBCO, charities, faith leaders, and community groups (Tanhan & Strack, 2020), but not being able to sustain a faith-based service, despite these existing naturally. However, It important to be mindful that FBCO are commonly run by volunteers with little to no clinical training, overshadowed by economic and systemic barriers (Emon & Hasan, 2021). This suggests FBCO require further critical support to combat racism and discrimination in society and address Muslim distress.

Overall, to improve mental health care services for Muslims, non-Muslim therapists and healthcare providers should receive training on the Islamic framework, enabling them to incorporate various technical, practical, theoretical, and philosophical adaptations. This could involve integrating Islamic concepts, resources, and practices into therapy to align with Muslim clients' worldviews and expectations. Additionally, the service delivery process should be adjusted to better meet the needs of the Muslim community. For example, therapists could work collaboratively with TTMFL through consultation, sharing knowledge and skills to enhance the effectiveness of therapy. Furthermore, this approach could extend beyond MHS through outreach work. Non-Muslim therapists could partner with FBCO and TTMFL to deliver therapy to Muslims who may prefer to access support within their community rather than through the MHS. This strategy would holistically address the mental health needs of the Muslim community by providing greater choice and access to therapy for those who use MHS and those who do not.

5.4 Clinical Implications

This section covers clinical implications emerging from this research. It addresses the dynamic relationships of inequality across multiple contextual levels and the importance of understanding individuals within their context rather than in isolation from their circumstances (Tanhan & Francisco, 2019). Implications for policymakers, the Muslim community, services and therapists are noted. It also describes four main areas to improve access and suitability of services for the Muslim community:

1. Navigating the differences between the secular psychology and Islamic worldview, alongside Muslim clients and TTMFL resistance to MHS.
2. Incorporating Muslim client's worldview and expectations within the therapy room.
3. Advocating and strengthening collaborative working between TTMFL, Muslim therapy services, and MHP.
4. Supporting the design and implementation of FBTS.

Policy Implications

Structurally, TTMFL are supporting the Muslim community with limited professional developmental opportunities and without Muslim professional bodies to support their tailored work. Yet, TTMFL perceive that MHP categorise them into supporting Muslims from a religious perspective rather than therapeutically. The Medact report (Aked et al., 2021) advocates for addressing concerns within existing NHS safeguarding procedures, as Muslims are disproportionately targeted in mental health and securitisation policies. It raises concerns about the psychological well-being and disempowerment of TTMFL supporting Muslim clients to access Islamically informed therapeutic support. The report emphasises that policymakers revise the MFLs' responsibilities and training, as recent reports and policies are outdated and do not include specific responsibilities related to providing specialist therapy (Mukadam et al., 2010). Furthermore, given the importance of staff support in the NHS, policymakers should consider TTMFL recruitment, provide professional developmental and training opportunities and access to bodies with genuine interest in faith-based approaches, such as those delivered by *Inspirited Minds* and *The Lantern Initiative* (Inspirited Minds, 2019). It is also important for policymakers to consider collaborative working and mutual learning within processes between MHP and TTMFL such as opportunities for reverse mentoring (Heliot, 2020).

Furthermore, TTMFL note the sustainability of grassroots FBTS for the Muslim community. These may have been suggested by participants given the longstanding effects of the PREVENT strategy and relevant policies securitising and policing conventional Muslim beliefs and practices in British society, as signs of risk, radicalisation and extremism.

Therefore, the effects of these maintain experiences of discrimination, othering and isolating Muslim communities from MHS (Younis, 2022; Younis & Jadhav, 2020) and risking new 'circles of fear' developing within the Muslim community (Byrne et al., 2017). This would suggest a need to find alternative provision that is community-led and long standing. Government and healthcare policymakers should draw on these research findings to reassess and revise strategies and guidelines that reduce the safety and trust of Muslim communities using MHS.

Social and Environmental Implications

TTMFL express a dire need for a sustainable faith-based therapy service for the Muslim community separate from the NHS. They identify funding and related training to support running and leading the service at a community level, which could be from Muslim organisational and community funding bodies and community resources. Existing resources and training opportunities are available to meet TTMFL professional and personal needs to serve the Muslim community (Inspirited Minds, 2019; Khan, 2021). This is also consistent with the training and development recommendations in the Communities and Local Government report on MFL (Mukadam et al., 2010).

Furthermore, as female TTMFL report barriers in accessing and collaborating with mosques to support female Muslim clients, it is essential mosques and Islamic centres advocate for and provide female spaces for female TTMFL to support them within the community. This is consistent with current initiatives to dismantle such barriers (Muslim Council of Britain, 2019). It is also important for mosques and Muslim organisations to collaborate with FBTS, like *Inspirited Mind* and *Muslim Youth Helpline* to teach the Muslim community about mental health and enhance referrals to them.

Service Development Implications

Despite guidelines advising clinical psychologists on working with diversity and community organisations, there remains a need for specific guidance for working with faith communities (e.g., Thompson et al., 2018). Without this, there is a risk of neglecting faith communities (Hall, 2001) and perpetuating professional concerns about the level of confidence, skills, and training of MHP in addressing religious issues (Harbidge, 2015; Joseph, 2014). Additionally, TTMFL request a Muslim therapist body to support them with their clinical work with Muslims, similar to *Muslim Counsellor and Psychotherapist Network*. The current findings further emphasise the necessity for the psychology profession to provide specific training and guidance on faith.

As TTMFL identify a need for FBTS separate from MHS, it is imperative healthcare providers advocate for increased therapeutic options for the Muslim community and provide guidelines for Muslims and other faith groups on how to create, design and fund their own FBTS. Empowering Muslim communities to govern their own FBTS outside of MHS can help to increase their trust in seeking help and accessing psychological support due to shared religious affinity, consequently supporting the healing of their psychological distress. This raises challenges such as limited financial, human and developmental resources required to run a self-serving organisation. *Inspirited Minds* is a Muslim grassroots faith-based therapy service established in 2014, however there remains no guidance on developing a similar

service. Such guidance can inform how to implement a faith-based community psychology approach when MHS work with Muslims, and address some of the resource barriers of running an independent faith-based therapy service. For example, acknowledging the Muslim clients' worldview, therapists from the Muslim community providing therapy in a meaningful location, approaching gender interactions differently, and working collaboratively with faith leaders to address Muslim clients' needs.

The NHS Long-Term Plan focuses on transformation plans about engaging in partnership and collaboration work with third-sector organisations to support the mental health needs of local communities (NHS, 2019). The psychology profession can advocate for fair and sustainable representation of psychological therapy and ensure that TTMFL benefit from opportunities to increase the Muslim workforce by including them in training and service developments, such as developing guidance in working with faith communities (Braam, 2021). The Recovery College in Tower Hamlets and Hackney, East London NHS Foundation Trust, demonstrate collaborative approaches involving MFL in delivering clinical training (e.g., working with Jinn and black magic) to equip non-Muslim clinicians to better support the local Muslim communities. The clinical psychology profession can take lead in advocating for these partnership initiatives in new locations and help reduce inequalities in employment between minoritised faith and Christian chaplains (Hafiz, 2015), meet the multicultural needs of stakeholders (Lazaridou & Fernando, 2022), and improve productivity, problem-solving and employee professional development of TTMFL (Schlosser, 2019).

Additionally, the psychology profession can advocate for developing longer-term initiatives by drawing a closer link between spirituality and mental health, which otherwise feeds into an attitude that only scientific empiricism psychology can treat mental health, thereby excluding TTMFL input. NHS-funded faith-based approaches (e.g. *Lateef Project* providing Islamic counselling in Tower Hamlets) and faith-adapted approaches such as *Faith in Recovery* (Mustafa & Byrne, 2016) are examples of providing enhanced options for therapy including FAPI in MHS to instigate an alternative welcoming attitude between faith and mental health.

Clinical Implications

Participants commonly discuss the need for collaborative work and knowledge sharing between TTMFL, FBCO, and MHP. Therefore, sharing expertise through consultation and co-producing training and resources with MHP and the Muslim community is important to bridge the 'religiosity gap', address perceived mistrust and fear of MHS (Bergin & Jensen, 1990), TTMFL professional and psychological needs (British Psychological Society, 2007, 2010), and facilitate engagement with and increased choice of therapy for Muslim communities (Thompson et al., 2018). Training can upskill MHP to apply several Islamic adaptations,

prompting them to continue reflecting on their skills, knowledge and biases that might impact therapy, through supervision or reflective practice by using social 'GGRRAAACCEEESSS' (Burnham, 2012) which includes religion and spirituality (Nolte, 2017).

TTMFL suggest initiating conversations about faith early in therapy. Therefore, with training, non-Muslim MHP can proactively assess religious beliefs when relevant to the client's difficulties (Pargament & Saunders, 2007). However, this may not always be welcomed (Casey et al., 2022) given that the current UK socio-political context securitises and suspiciously monitors Muslims' thoughts and emotions in therapy, motivating them to be hesitant to share their distress. Thus, it is advisable MHP appreciate the nuances of racial and religious identities and enact sensitive considerations (Richards, 2003) to empower Muslim clients to challenge structural oppression and achieve liberation (Younis, 2022). Achieving respectful and non-assumptive conversations about Muslim clients' religious practices in therapy is possible through sociocultural sensitivity (Mosher et al., 2017) and political reflexivity training (Younis, 2022). These implications all focus beyond the technical and theoretical adaptations and into practical considerations.

TTMFL stress the significance of centring Islam in Muslim clients' therapy; therefore interventions should align with their worldview. Concurrently, MHP should be mindful of the probable inconsistencies between a client's understanding and conflation of central Muslim beliefs with cultural beliefs (Betteridge, 2012). Underpinning psychological principles with an Islamic framework that highlights understanding of distress and healing (Ibrahim & Whitley, 2021), and community and family support, also aligns with the holistic needs of Muslim communities (Yilmaz & Weiss, 2008).

Overall, collaboration and co-production work between TTMFL, FBCO, and MHP related to therapy with an Islamic, community and socio-political lens are paramount to providing effective therapeutic support to Muslim communities. Government and NHS long-term plans and frameworks should reflect on faith-adapted interventions, initiatives, and approaches that meet Muslim clients' needs (e.g., Mustafa, 2021, provides example interventions)

5.5 Evaluation of Study Quality

The current study's strengths and limitations were assessed using the Critical Appraisal Skills Programme's Qualitative Research Checklist (CASP, 2018). Table 7 summarises how the study covers each criterion.

Table 7

Strengths and Limitations of the Current Research Study using Critical Appraisal Skills Programme's Qualitative Research Checklist

Screening Questions	Description of criteria	Strengths	Limitations
Clear statement of the aims of the research?	Goal of the research; why it is important; its relevance.	• Research outlines the importance of exploring the perspectives of TTMFL given the limited research in this area. • Findings are pertinent to NHS Long Term Plan and initiatives related to equality, diversity and inclusion for marginalised communities. • This study is fitting and appropriate in the current context of Islamophobia, racism and institutional racism.	
Is a qualitative methodology appropriate?	Seek to interpret actions and/or subjective experience of participants; Is qualitative the right	• Study investigates TTMFL subjective experiences of delivering Islamically informed therapeutic support in the Muslim community, for which a qualitative methodology addressed the research goal.	• As there was a small population that possessed unique perspectives, IPA would have allowed for a richer understanding of the TTMFL subjective experiences.

	methodology for addressing research goal.		
Research design appropriate to address the aims of the research?	Research design justified.	• Qualitative study with consultants from the Muslim community allowed to co-create and construct the project and gather meaningful data to identify TTMFL conceptualisation of delivering Islamically iinformed therapy and the challenges of and the needs of the Muslim community, consistent with the research aims. • Using the critical realist epistemology, TA methodology and interviews align with the research aims.	• Though attempts were made to have an ethnically representative consultant group, it was difficult to sufficiently recruit Muslims from non-South-Asian backgrounds. • Participants were not included in the co-creation of the research due to the research budget and time constraints of the DClinPsy.
Was the recruitment strategy appropriate to the aims of the research?	Explained how participants were selected; explained why participants selected were most appropriate for study; discussions around recruitment.	• As the participants are from a niche and hard to find population, purposive and snowball sampling was the most appropriate strategy to recruit TTMFL. • TTMFL were appropriate for investigating the experiences related to the research aims. • Recruitment invested in advertising online and communicated with mosques, therapy, and community organisations via email,	• Despite several attempts to contact several organisations linked to the Muslim communities, there may have been TTMFL who were missed due to lack of computer access and therapy networks around them to find out about the research, as highlighted in the themes about limited professional opportunities.

		increasing the reach. Recruitment from mosques, social media, faith-based, and community organisations attracted therapists with experience working with both non-Muslim and Muslim clients, both from the third sector and NHS. Their familiarity with differences provided richer opinions. • As the original inclusion criteria limited the recruitment for a sufficient sample, it was adjusted to include participants who obtained formal therapeutic training over any time frame. This allowed for greater access to this unique population.	• Diversity of sample may have potentially limited other sects within Islam; however, data were not collected to identify this, nor did it specify or distinguish between the different sects (i.e., Sufi, Shi'a, Ismaili) when recruiting TTMFL. Future research should explore experiences and differences between different sects. • There were intersectionality issues whereby 70% of the participants were male and aged between 33-55, whereas 30% were female and aged between 35-44 suggesting limited representation of gender and age diversity.
Was the data collected in a way that addressed the research issue?	Setting for data collection justified; clear how data was collected; method chosen justified; methods explicit; methods modified during the study; if so how	• Given the geographical limitations and busy schedules of TTMFL, data collection using virtual options enabled inclusion of wider ethnic and gender representation and meant that gender etiquettes of interaction were more relaxed.	• As most interviews were virtual, some nuances of face-to-face interviews may have been missed (e.g., body language that may have supported the facilitation and interpretation of answers) and this

	and why; the form of data is clear; saturation of data discussed.	• Semi-structured interview schedule were piloted and refined to meet the research aims and allowed opportunities for participants to expand their answers. • Data sufficiency is supported for this research project's sample size (10) which compares with other qualitative research exploring participants from marginalised populations of different roles and backgrounds (Nelson, 2017).	option may have narrowed the diversity of the sample.
Relationship between researcher/participants adequately considered?	Researcher critically examined own role for bias and influence; responded to events/implications of any changes to research design.	• Being an insider positioned researcher allows for an enhanced level of assurance. Also, positioned as an outsider from not being a TTMFL means that researcher is able to appreciate the complexities of the participants role and gives a more objective perspective. • Researcher used several ways to engage in self-reflexivity to explore researcher and epistemological positioning (e.g., used supervisors, consultants and a reflective journal consistently during the research process to explore personal biases and how	

		that might influence data collection and interpretation).	
Have ethical issues been taken into consideration?	Sufficient details of how research explained to participant; researcher discussed issues raised by study (e.g. consent); approval sought from ethics committee.	• UH ethics board provided ethical approval. • The researcher discussed and adhered to ethical considerations throughout the project and reflected on power dynamics. • A solid consultant group comprising of a Muslim working as a MHP, a MFL who is a counsellor and works in the community with previous experience working in a FBCO, a Muslim with lived experience, a psychologist who has worked with Muslim communities in a BME access service and one academic research supervisor means that ethical considerations were implemented from different perspectives. • Additionally, lived experience consultant did not want to be named and this was considered within the write-up to maintain confidentiality.	
Was the data analysis sufficiently rigorous?	In-depth description of the analysis process; if	• Description of the analysis (TA) was provided in depth and the process checked	

	thematic analysis, is it precise how categories/themes are derived from data; explained how the data presented was selected from the original sample; sufficient data presented to support findings; contradictory data taken into account; the researcher examined their own role (e.g. analysis/data presented).	and triangulated for consistency (i.e., by including supervisors and consultants) and discussed transparently, honestly and reflectively within the study. • There is a coherent explanation of how codes/themes were derived and presented from the original sample, highlighting several direct quotes across multiple transcripts for the reader to connect attentively to the rich narratives. • This research endeavoured to share the voices and unique perspectives of TTMFL and provides sufficient implications for clinical psychology and allied health professionals who can work collaboratively with TTMFL as well as empower the Muslim communities to develop and sustain their own FBTS. • The researcher provides evidence of written reflexivity, noted their position and biases before and after data analysis and engaged in consistent reflexive dialogue with supervisory and consultant team to address	

		personal biases and enhance understanding.	
Is there a clear statement of findings?	Findings explicit; discussion of evidence for and against researchers' arguments; researcher discussed credibility of own findings (e.g. triangulation); findings discussed in relation to original research question.	• Findings are connected explicitly to the research questions, theory, research and current socio-political contexts. • Findings are discussed in relation to the novel information found and that which resonates with previous literature. • The researcher engaged in triangulation of themes, with the support of consultants sharing different perspective during the data analysis process which supported credibility and trustworthiness of the themes developed.	
10. How valuable is the research?	Discussed contributions to existing knowledge/understanding; identify new areas where research is necessary; discussed whether/how findings transfer to other populations.	• This research contributes to a under-researched area and a small body of literature regarding TTMFL unique experiences in delivering Islamic informed therapeutic support, providing insight into the duality of their role and the systemic barriers when trying to provide effective support to Muslim communities.	

		• The discussion provides meaningful suggestions to healthcare providers to collaborate with and empower TTMFL, faith communities and FBCO/ FBTS.	
Level of Personal and Public Involvement (PPI), checking and challenging (additional quality check not originally included as part of CASP)	Discussed PPI and the impact of research findings.	• As community psychology and co-produced approaches have recently developed an increased interest in clinical psychology, the current research included a consultant group comprising of a Muslim working as a MHP, a MFL working in the community with previous experience working in a FBCO, a Muslim with lived experience to inform research activities. • Furthermore, the research findings can influence advocacy of TTMFL positions in MHS and in the community, and the significance of collaborative working between the two to cater to the faith needs of the Muslim clients, and support to develop and sustain independent Muslim FBTS to support Muslim communities.	

5.6 Outcomes and Recommendations for Future Research

This study has reached four outcomes:

- One consultant who is a Muslim client and received therapy from MHS was involved in the research and prospective publication.
- Shared a network of Muslim therapists with participants to continue staying connected with peers to support the Muslim community within this niche therapeutic area.
- Disseminated findings and supported co-developing an Imam and Community Leaders mental health training with one participant for an FBCO called Inspirited Minds.

Given the strengths and limitations of this study, in addition to the broader implications, there are numerous opportunities and need for further research:

- Several findings warrant further investigation prompting future research.
  e.g.:
    - Experiences of Muslims who have lived experiences of mental health issues and received Islamically informed therapy from TTMFL would help validate the recommendations of the study.
    - Experiences of non-Muslim Therapists delivering Islamically informed therapeutic support.
    - Experiences of FBTS supporting the Muslim community.
    - Experiences of TTMFL experiences in working collaboratively with FBCO, and MHP.
    - How Prevent, Islamophobia impacts the TTMFL role.
    - Female TTMFL experiences working within the Muslim community.
    - Experiences of collaboration between MHS, TTMFL and FBCO.
    - Solution-focused therapy has gained recent attraction because of its compatibility with the Islamic perspective. Therefore, exploring the different psychological models compatible with the Islamic framework may offer insight into a richer understanding of the mechanisms that apply better to the Muslim community.
- This research highlights the interpersonal dynamics influencing the TTMFL on different systemic levels, therefore researching the experiences and perceptions of others; would further contribute to this field:
    - MHP perception on the role of TTMFL in MHS and collaboratively working with them.
    - FBCO and FBTS outlook on working with TTMFL.

  - The research did not collect data on minority Muslim sects and excluded other groups; therefore, it would be important to explore these for future research—e.g., Shia, Sufi, Ismaili, and non-English-speaking.

- The findings also highlight further research in specific situations of TTMFL to explore:
  - The experiences of female TTMFL who support the Muslim community in diverse contexts, e.g., TTMFL of different ethnicities, such as non-South Asians.
  - TTMFL working in different contexts (e.g., mosques, charities, chaplaincy services, community settings that is not linked to the mosque, e.g., Ruqya services).
  - The differences in Islamic approaches depending on the modality used (i.e., single models or integrative).
  - What makes CBT easier and acceptable to Islamically adapt compared to other models.
  - Burden and burnout within the TTMFL community.
  - Ideas about faith-integrated services and grassroots faith-based mental health services using focus groups.
- Evaluating the application of the current research findings at a community-level intervention.

5.7 Concluding Comments

This research investigates TTMFL experiences of delivering Islamically informed therapeutic support in the Muslim community, and the implementation of this in the community and MHS within the socio-political context. Thematic analysis of interviews with ten TTMFL shows the nuance required to meet the faith needs of Muslim clients on a micro-, exo- and macro-level. This is the first research exploring TTMFL experiences delivering Islamically informed therapeutic support. Thus, this study contributes significantly to the nascent body of research exploring TTMFL and ameliorates understanding of the duality of their role, how they conceptualise Islamically informed therapy compared to secular psychological therapy, and the barriers to supporting Muslim clients effectively, including the socio-political structures TTMFL work in.

Findings highlight how the secular psychology worldview within the socio-political context, combined with discriminatory policies, acts as a barrier for TTMFL to provide effective therapy and therefore demonstrates a need for further collaboration with MHP and support and

guidance needed to sustain separate FBTS that is led and run by and for the Muslim community. This research also shows that TTMFL hold a natural affinity to the Muslim community, and that they can support MHP to understand the Islamic worldview and apply Islamic approaches so MHP can also support and advocate for Muslim communities. The findings contribute to the very narrow literature, which mainly focuses on MFL experiences of supporting the Muslim community's mental health, and conceptualisation of faith-adaptations across religions. Overall, the results are significant for psychologists, Muslim communities, FBCO, and policymakers, specifically relating to addressing the dynamics between racial and religious inequalities in healthcare with a specific need to address the Muslim client's needs in the context of growing levels of Islamophobia.

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6 Appendices

Appendix A: Reflective Research Journal Extract

18.10.2024 - Bracketing diary entry

Power: Doing this research will give me the opportunity to obtain a Doctorate in Clinical Psychology. Most of the participants I will potentially interview may not have had this opportunity and that may impact how the participants view my professional title, potentially as someone who has 'expert' knowledge in the therapeutic field. Previous research showed that MFLs have limited training, which makes me feel sad and I wonder whether my gender and education might influence how they perceive me and what they share with me in interviews. For example, whether they would question / perceive me as a woman who should not be engaging in further education/ front facing work with males. I acknowledge that this might be coming from a cultural lens.

Assumptions/ biases: My Muslim identity motivates me to find positive findings which can bias what I code and what I report. Given the current geopolitical context surrounding Muslims and Palestinians, I anticipate that discrimination and prejudice would come up in interviews. I'm mindful of the racial discrimination of the Muslim community and how this might feed into the understanding of NHS therapy not being accessible for Muslims because of the surveillance. I also think that I am looking for adaptations that are community-orientated and not within the NHS, as therapy there can be restrictive, individualising and pathologizing of mental health

difficulties. It makes me wonder that this will not cater to the Muslim needs and I'm very aware of this bias. I'm also thinking about philosophical orientations and factors which make the Islamic adaptation different to other religions. I'm inclined to find distinctiveness in adaptations for UK Muslims and of course this stems from how Muslims are attacked and targeted in Western society.

I feel quite overprotective of the Muslim community. I think I have a heightened awareness of Islamophobia, so I would try to find things that are distinctively Islamic that will apply solely to the Muslim community. I have a bias around therapeutically trained Muslim faith leaders being the only people with expert knowledge of Islam and have greater access to the Muslim community needs. Therefore I'll heavily rely on their views on adaptations and I may think that their views are what will suit and accommodate the Muslim communities mental health needs. I'll also be biased towards hearing about the Islamic traditional routes to supporting people in distress, for example wet cupping or Islamic incantations (Ruqya). Also I have prior knowledge of the need to take a holistic approach with the Muslim community which includes the physical, the spiritual, the social and the psychological and how these all might look within an intervention. This may also suggest my biased views towards Islamic therapy rather than secular therapy.

Personal value system: my identity as a Muslim and my belief that Islam/ Allah heals all types of distress as experienced in my own healing journey through life, this might influence me/ show my biases in searching for and showing positive findings about Islamic informed therapy working well for TTMFL. Also, my desire for health justice and equality for the global majority could be pushing me to look for positive findings - will my value for social justice work and my conviction in Islam impact what type of questions I ask and what information I attend to more during the interviews and analysis process?

Role conflict: anticipating that a lot of TTMFL may be male and wonder how my interactions will be like with a male (i.e., eye contact, physical distance). I have great respect for MFLs due to the wealth of Islamic knowledge they have. I am worried that some MFLs may not have significant therapeutic training given that this population group is small. I'm mindful that there may be points that might come from a cultural lens and may invalidate mental health experiences, due to a lack of understanding, which may contribute to me feeling defensive and feeling an urge to share an alternative perspective. I am also mindful that the current geopolitical context in Palestine may be the focus of many of the interviews and that might trigger a lot of distress for both the interviewee and myself, taking away from the focus of the research topic. For publication, I am apprehensive that non-Muslim audiences may challenge

this type of research, especially when talking about adaptations for one community group. I am wary that if I publish this research then I may face overt and covert Islamophobia, therefore I need to use my consultants and supervisory team to discuss what would be productive to consider in the reporting.

Gatekeepers: Three consultants (one of whom has a PhD) are from various professional and personal backgrounds and are strongly invested in this research, however, when we regularly meet to discuss data, they will share different critical perspectives; Angela is also in favour of this project and is critical of mainstream psychological therapy. She can ensure that I reflect on my biases and consider alternative perspectives/ questions in relation to both secular and Islamic psychological interventions in the NHS and the community.

Neutrality and how to manage this: I might be seeking for particular TTMFL with both training backgrounds and experiences as I assume that having both will give them an understanding about how secular therapy works. Therefore, if they do not have enough secular experiences, this might make me avoidant to engage with the conversation and feeling a bit confused about how I would navigate this conversation as it would be helpful for interview participants to have knowledge of both secular and Islamic therapy so that I could evaluate the utility of Islamic psychological approaches. also I hope that they will have relevant knowledge and understanding to help them to answer the question sufficiently or at least specific client examples around their clients experiences in accessing NHS therapy. That would relate to part of the research questions.

I may be reluctant to hear perspectives about the positives of secular approaches helping the Muslim community—therefore, it would be important for me to be mindful of this feeling and still encourage these views from participants.

Addressing blocks during research process: can undertake a pilot study with the consultant who partially meets the criteria of the study to familiarise myself with the questions and assess the structure and facilitation of the interview schedule prior to the actual interviews.

Diary entry after finishing interview 2:

The client often used Arabic terms which made me think that he was comfortable using this because he assumed that I was familiar with these terms (i.e. dhikr, Amanah, ruqya). This taught me that insider researcher helps to ease the conversation and is perhaps time efficient and takes away the cognitive load of explaining. Insider researcher is important to have a mutual understanding. Mirrors the client matching adaptation and requirement in therapy to

make it easier for clients and therapist to understand one another, however, assumptions can be wrong too of similar characteristics of individuals.

I also noticed that a lot of the key areas of interests I jotted down were very similar to Mustafa (2020). Although the participant did not reference the psychological secular models they used, it was interesting how the pt suggested that the secular models were useful and had links to Islamic traditions, but it did not include the spiritual side to it so needed to be included in.

He also explored the similarities and differences of secular therapy – clients with positive experiences of secular found that it helped them to understand their condition better and negative experiences was the opposite of this.

I noticed that I wanted the participant to tell me more about the secular models he uses. He did reference outcoming the progress of his Muslim clients which was similar to CBT and highlight the strengths and weaknesses. He did mention coaching which I don't think was apart of the psychological interventions that is formally known but there's some coaching involved. He also mentioned patient centred approach with is Rogerian – this is important. I wanted him to talk more about that – but it looked like the relationship and seeing the patient holistically was important. No conflicts were brought up which rejects my assumptions / previous literature that argues that secular therapies can conflict with religious patients. It seems like the relationship is important and I noticed that "Trust" between client and therapist (including client matching) and harnessing that the client has the answers were the main factors influencing the relationship.

I wanted him to include more adaptations that's we can include – maybe I can give prompts in the next interview about thinking about it individually, as a team and as a service, theoretically and practically, technically and philosophically.

<u>Diary entry after finishing interview 7:</u>

I may have assumed an "automatic trust" between the TTMFL and the Muslims they offer therapy to. Juwariayh mentioned that she built relationships from a nonjudgmental active listening stance when she worked with all types of Muslims, practising and nonpracticing. I remember talking about my preconceived ideas at the start of the project about what I would probably find in the data, particularly around this concept of Muslims trusting MFLs easier. But I remember my research supervisors mentioning that some Muslims don't want to access a Muslim therapist because of a fear of judgment. However, this interview made me wonder whether the therapeutic trust was built as a result of using Juwariayh's therapeutic skills or whether it was based on her being Muslim with an Islamic scholarship. I wish I had the opportunity and time to ask her how her clients related to her and what she felt had influenced

them to trust her. I got a sense that there was a natural understanding between her and her Muslim clients, as they would often seek Islamic advice from her therapeutic approach, and often she would engage in Islamic advice-giving if requested. This seemed like a natural expectation for her to do, whether it was within therapy or not. wondered about the dual role she adopted, but I am also curious about how her role was viewed by her Muslim clients. This dual role also paralleled with Yahya's interview, where he spoke about wearing different hats and finding a balance between being a non-judgemental therapist who actively listens and validates versus providing Islamic advice around managing mental health and social challenges. I do wonder how Juwariyah navigates between the two approaches. This seemed like an interesting area to explore further as this approach is very different from secular psychological interventions, where advice is not usually given, and the power of the therapeutic relationship is managed through collaboration. However, within the TTMFL-Muslim client dynamic, it seems like there is a position of an expert. I wonder if Muslim clients prefer a direction and whether this may be due to knowing that Allah (God) has the solutions/eases to all problems, as noted in the Qur'an.

She mentioned references to using Qur'an and Hadith in her therapeutic support, which makes me wonder about the limited role religion has in mainstream mental health services and how these tools help connect Muslim clients to their purpose and meet their spiritual needs. It also seems like a technical faith adaptation used in previous research. Could including different Islamic tools be used as an adaptation within therapy for Muslims by non-Muslim therapists? It makes me wonder what answer Juwariyah would have given me if I had asked her if a non-Muslim were to deliver therapy referencing the Qur'an and Hadith and whether it would seem credible and engaging to the Muslim client.

Appendix B: CASP Qualitative Research Checklist

CASP
Critical Appraisal Skills Programme

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a Qualitative research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

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4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

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6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

CASP
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Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix C: Qualitative Studies Critical Appraisal

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Screening Questions																			
1. Clear statement of the aims of the research?	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
o The goal of the research	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
o Why it important	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
o Its relevance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Is a qualitative methodology appropriate?	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
o Seek to interpret actions and/or subjective experience of participants	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
o Is qualitative the right methodology for addressing research goal	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Detailed Questions																			
3. Research design appropriate to address the aims of the research? o Research design justified	**Y** Y	**Y** Y	**N** N	**Y** Y	**Y** Y	**Y** Y	**Y** Y	**Y** Y	**N** N	**Y** Y	**Y** Y	**C** C	**Y** Y	**Y** Y	**Y** Y	**Y** Y	**C** C	**Y** Y	**Y** Y
4. Was the recruitment strategy appropriate to the aims of the research? o Explained how participants were selected o Explained why participants selected were most appropriate for study o Discussions around recruitment	**Y** Y Y N	**Y** Y Y N	**N** C N N	**Y** Y Y N	**Y** Y Y N	**Y** Y Y N	**Y** Y Y N	**Y** Y Y N	**Y** Y Y N	**Y** Y Y N	**Y** Y Y N	**Y** Y Y Y	**Y** Y Y Y	**Y** Y Y N	**Y** Y Y N	**Y** Y Y N	**Y** Y C Y	**Y** Y Y N	**Y** Y Y N

5. Was the data collected in a way that addressed the research issue?	**Y**	**Y**	**N**	**Y**	**Y**	**Y**	**Y**	**C**	**Y**	**C**	**C**	**Y**	**C**	**Y**	**Y**	**Y**	**N**	**C**	**C**
o Setting for data collection justified	Y	Y	N	Y	Y	Y	Y	N	C	N	N	Y	N	Y	Y	N	N	N	N
o Clear how data was collected	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
o Method chosen justified	Y	Y	N	Y	N	C	Y	Y	N	N	Y	Y	Y	Y	N	Y	N	Y	N
o Methods explicit	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
o Methods modified during the study; if so how and why	NA	NA	N	NA	Y	NA	NA	NA	C	NA	NA	NA	NA	NA	NA	C	NA	C	NA
o The form of data is clear	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
o Saturation of data discussed	N	Y	N	Y	Y	N	N	**N**	Y	**N**	**N**	N	**N**	Y	Y	N	N	Y	Y

6. Relationship between researcher/participants adequately considered? o Researcher critically examined own role for bias and influence; o Responded to events/implications of any changes to research design	**N** C N	**Y** Y N	**N** N N	**Y** Y NA	**Y** Y NA	**N** N N	**Y** Y C	**Y** Y N	**N** N N	**N** N N	**N** N N	**N** N N	**N** N N	**Y** Y NA	**N** N NA	**Y** Y N	**C** C N	**N** N C	**N** N N
7. Have ethical issues been taken into consideration? o Sufficient details of how research explained to participants	**N** N	**N** N	**Y** N	**Y** Y	**Y** Y	**C** C	**N** N	**C** N	**C** N	**N** N	**N** N	**C** N	**N** N	**Y** Y	**Y** Y	**Y** Y	**Y** Y	**N** N	**N** N

o Researcher discussed issues raised by study (e.g. consent) o Approval sought from ethics committee	N N	N N	Y Y	Y Y	N Y	N Y	N N	Y N	C Y	N C	N N	N Y	N N	Y N	Y Y	Y Y	N Y	N C	N Y
8. Was the data analysis sufficiently rigorous? o In-depth description of the analysis process o If thematic analysis, is it precise how categories/themes are derived from data? o Explained how the data presented was selected from the original sample o Sufficient data presented to support findings	**Y** Y Y N Y	**Y** Y Y C Y	**N** N N N Y	**Y** Y Y Y Y	**Y** Y C Y Y	**Y** N Y Y Y	**Y** Y NA Y Y	**Y** Y Y Y Y	**C** Y N C Y	**N** N N N Y	**Y** Y Y N Y	**N** N N N Y	**C** N Y N Y	**Y** Y Y C Y	**Y** Y Y N Y	**Y** Y Y Y Y	**C** Y N N Y	**Y** Y C Y Y	**Y** Y NA Y Y

o Contradictory data taken into account	Y	Y	C	Y	C	C	N	Y	C	Y	Y	C	Y	Y	Y	C	C	Y	Y
o The researcher examined their own role (e.g. analysis/data presented)	N	Y	N	Y	N	N	C	Y	N	N	Y	N	N	C	C	Y	C	Y	N
9. Is there a clear statement of findings?	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
o Findings explicit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
o Discussion of evidence for and against researchers arguments	Y	Y	C	Y	C	N	Y	Y	N	Y	N	Y	Y	Y	Y	C	C	Y	Y
o Researcher discussed credibility of own findings (e.g. triangulation)	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
o Findings discussed in relation to original research question	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

10. How valuable is the research?	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**C**	**Y**	**Y**	**Y**	**Y**	**Y**	**C**
o Discussed contributions to existing knowledge/understanding	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
o Identify new areas where research is necessary	Y	N	Y	Y	Y	Y	Y	Y	C	N	N	N	N	Y	Y	Y	Y	N
o Discussed whether/how findings transfer to other populations	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N

Key

Yes = Y

No = N

Can't tell = C

Appendix D: Consultants Agreement Form

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: ***How do we devise Islamic/ spiritually informed interventions in NHS settings for the Muslim community?***

Support in the Community

Research Team

Main Researcher: Farhana Maleque

Supervisory Team:

Dr Shivani Sharma: Associate Professor, University of Hertfordshire

Dr Angela Byrne: Clinical Psychologist

Co Researchers / Consultants:

Expert by Experience

Sara Khan: CBT Therapist

Sheikh Abu Ibrahim: Muslim Faith Leader

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.
Offering feedback about how involvement from consultants has added value to the research
Giving adequate notice for interview times should consultants be interested to sit in and observe
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 E: Consultants Reflections

Aaliyah

"I joined this project in October 2022 after seeing the call for consultants on LinkedIn. At the time I joined, I was a second year BSc Psychology student in a London university. I was very interested in both clinical and research psychology so having the opportunity to be involved in a DClinPsy research project was exiting. I of course joined as a lived-experience consultant, and I recall initially feeling nervous as I am usually very anxious about self-disclosure. I remember having a really good feeling about the trainee psychologist (sister Farhana) that she would not push me to share anything I was not comfortable sharing, and she has consistently been respectful and mindful of my boundaries. I also asked to not be identified within this research as the lived-experience consultant which has also been respected and which I really appreciate. I am really grateful that I was able to partake in this research in a way that I was comfortable with.

This research means a lot to me for several reasons. Firstly, we know that therapeutically trained MFLs are an emerging and underrepresented group in research. It felt gratifying knowing I would be involved in meaningful research. Increasingly, I have realised how important it is to research staff and not just the clinical population and I also wanted to get involved with this research for this reason. Faith-adapted therapy was something I was not familiar with (in fact, I did not even know it existed!) and it was interesting learning more about the adaptations (i.e., technical/philosophical adaptation etc). This research was also timely in terms of what is happening in the current sociopolitical landscape i.e., the genocide in Gaza. I found it enlightening/sobering learning that censorship and invisible 'red tape' have been a barrier in their work.

This project is special to me as it has also been beneficial for my professional development. I feel fortunate to have been involved in part 1 (systematic literature review) of this research, which taught me important skills such as abstract screening using a software called 'Covidence'. I have also really enjoyed working collaboratively with the wider consultant team and learning from their wisdom and insights. I have found a mentor/ally in Sister Farhana which I am also really grateful for. As an aspiring mental health professional who is Muslim, being involved in the project was a really interesting experience"

Shaykh Dr Islam Uddin (Abu Ibrahim)

"It was a pleasure to work alongside Farhana and the consultant panel during this research. When the topic was first mentioned and I was invited to join the panel, I found it to be an intriguing subject and I had no doubt it would be of great benefit to many once completed. I am pleased to say that I am glad I participated in the project and my initial thoughts proved to be right. I thoroughly enjoyed the discussions through the different stages of the research and the insights gained from the rich data collected.

As an imam and counsellor, I found the research findings interesting, and I would often bring reflections from my practices and compare them with other practitioners. I was careful to allow the other consultants to express their opinions during the meetings and valued their contributions. Farhana's receptiveness to feedback, even when it differed from her thoughts, particularly impressed me, allowing free-flowing discussions during our consultation sessions. I can see Farhana has put much effort into writing this thesis and I am honoured to be part of the journey to her achieving a doctorate"

Sara Tehzeeb Khan

"I first thought it would be interesting to collaborate with this project because I was increasingly becoming aware of how many of my Muslim clients were itching to bring up spirituality in their therapy sessions despite knowingly engaging with a secular CBT therapy style in a secular public health setting. I was genuinely curious about how therapy and spirituality could be linked and (as a proud NHS employee) if this is something that could be developed within the NHS. The consultation group definitely did not disappoint in regard to discussions around spirituality, Islam, Muslim attitudes, therapy and the NHS. The discussions held within the group were respectful and different opinions were acknowledged and validated. In particular, I learned a lot from Sheik Dr Abu Ibrahim who provided insight on how mental health might be bought up in consultations aimed at delivering information related to Islamic Jurisprudence, and how mental health issues may be addressed within an Islamic setting. After discussions with other group members I realised that I often relied a lot on my own anecdotal experience of Muslim clients to decide what might be relevant for them, however listening to other group members and unpicking data collected from therapeutically trained MFLs really bought to light the varying issues that may be important to address such as fears around being viewed as extreme and the need for more female therapists who are also scholars of Islam and can operate comfortably in mosques. Prior to my involvement with the consultation group, I believe I had a somewhat romantic view of how easily a culturally and religiously sensitive service could form alongside or with the NHS, however, the project has helped me to understand more about the barriers that need to be addressed first (for clients and therapists) in order to develop the foundations for this. While I have never personally felt inclined to conduct academic research, being part of the consultation group has made me appreciate the necessity for a structured investigation of the questions raised in this project and a critical analysis to highlight important implications for individuals who would like to see a closer relationship between MFLs and secular therapy services. Overall, I feel privileged to be part of a project that I hope is the trailblazer for future projects that seek to expand on this research topic inshallah (God willing)"

Appendix F: Research advertisement

University of Hertfordshire UH

TAKE PART IN MUSLIM MENTAL HEALTH RESEARCH

ABOUT THE RESEARCH

We are interested in learning more about **Muslim Faith leaders**' experiences of **mental health support in the community**. Sharing your expertise in this research will tremendously assist us to learn how best to support and work with Muslims in the community experiencing mental health difficulties.

We hope to hear from both male and female Muslim faith leaders inshaAllah.

WHO CAN TAKE PART?

- Completed a higher level of Islamic Sciences Studies to fulfil the role of a Muslim Faith Leader*
- Have formal secular mental health or therapeutic/ counselling training **
- An adult (18 years and above); English speaking; UK resident
- Occupy and worked within the community in a Muslim Faith/Community leader role for longer than a year
- Have supported a Muslim community or congregation member for their emotional or mental health difficulties, lifestyle concerns and/or distressing circumstances.

* OR a Muslim Community Leader (i.e., someone who has an influential known position within their community)
** i.e., BABCP, BACP, PG Cert.

WHAT WILL TAKING PART INVOLVE

60-90 minute interviews (online or in person)

GET IN TOUCH

If you would like to find out more, please contact Farhana Maleque (Trainee Clinical Psychologist & Prinicipal Investigator):
f.maleque@herts.ac.uk

This is an official notification by a student at the University of Hertfordshire in respect of a study involving human participants and part of the Doctorate in Clinical Psychology.
Title of study: Muslim Faith Leaders' experiences of Islamically-informed mental health support in the Muslim community.
Protocol number: LMS/PGR/UH/05399
Approving committee: The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority.
If you have any queries concerning this document, please contact me or my supervisor Dr Shivani Sharma, s.3.sharma@herts.ac.uk

Appendix G: Participant Demographics Schedule

Demographics schedule for the 10-15 minute screening eligibility call

Tick where prospective participant meets the inclusion criteria

Thank potential participant for showing interest.

Name (initials):

☐ (Over the age of 18)

☐ (English speaking)

Gender:

Location:

☐ (lives in the UK)

Age:

Questions for MFLs:

Islamic sciences qualification name:

Islamic sciences qualification institute:

Islamic sciences graduation year:

Muslim community leaders (only) influential position/ role in the community:

☐ Have completed a higher level of Islamic Sciences Studies to fulfil the role of a Muslim Faith Leader OR Muslim Community Leader (i.e., someone who is in an influential known position within their community).

Mental health/ therapeutic training qualification name:

Mental health/ therapeutic training qualification institute:

Mental health/ therapeutic training graduation year:

☐ Have formal secular mental health or therapeutic/ counselling training (i.e., BABCP, BACP, PG Cert)

How long participant occupied and worked within community as a Muslim Faith/Community leader:

☐ Occupy and worked within community in a Muslim Faith/Community leader role longer than a year

Has the participant supported a Muslim community or congregation:

☐ Have supported/ advised a Muslim community or congregation member for their emotional or mental health difficulties, lifestyle concerns, distressing events/circumstances, or wellbeing.

What models are you trained in?

What do you use predominantly in your practice?

Appendix H: Ethical Approval

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Farhana Maleque
CC	Dr Shivani Sharma
FROM	Dr Rebecca Knight, Health, Science, Engineering & Technology ECDA Vice Chair
DATE	11/07/2023

Protocol number: **LMS/PGR/UH/05399**

Title of study: Therapeutically trained Muslim Faith Leaders' experiences of Islamically-informed mental health support in the Muslim community.

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:

Angela Byrne (secondary/field supervisor)
Consultants: Dr Sheikh Abu Ibrahim, [redacted] Sara Khan

Conditions of approval specific to your study:

Ethics approval has been granted subject to the following conditions being seen and approved by the supervisor as addressed prior to recruitment and data collection:

1. Please consider a more secure procedure for receiving signed consent forms, e.g. a brief Qualtrics survey that hosts the information sheet and consent form.

2. Change the wording "research data...will be permanently deleted" on the EC6, to reflect your response to 15.2 on the EC1 "the research team will keep anonymous data indefinitely"

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: 11/07/2023

To: 30/09/2024

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Appendix I: Participant Information Form

Restart Survey | Place Bookmark | Tools

Participant information sheet

Therapeutically trained Muslim Faith Leaders' experiences of Islamically-informed mental health support in the Muslim community.

Why have I been given this information?

Before you decide whether you would like to take part in this research, it is important that you understand the study 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 study. However, if you have any further questions or if you are unsure about any information in these pages, please feel free to contact Farhana Maleque (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 Farhana Maleque (Trainee Clinical Psychologist at the University of Hertfordshire). This thesis is supervised by Dr Shivani Sharma (Associate Professor in Research – Health Inequalities, University of Hertfordshire) and Dr Angela Byrne (Clinical Psychologist).

The research aims to explore:

- the experiences of Muslim Faith Leaders facilitating Islamically-informed mental health support in the Muslim community
- any perceived barriers that may arise in implementing such adaptations in the NHS.

Why am I interested in this research?

As I identify as a British Bangladeshi Muslim who has experienced the power of Islam in giving me meaning and purpose in life, I have often wondered how significantly the knowledge of Islam held and distributed by our Muslim Faith Leaders plays a role in this. Professionally, I have also worked in services where I have observed the Muslim community's reliance on Muslim Faith Leaders (MFL) for support, directly and indirectly, through their sermons and work within the community. Given that Muslim Faith Leaders are the first point of contact for many Muslim communities and are, understandably, respected and trusted by them, it highlights that they have knowledge and skills that many NHS mental health professionals and services do not necessarily possess.

Therefore, I am curious to find out what Islamically-informed skills and knowledge therapeutically trained MFL specifically possess and use to continuously support Muslims struggling with mental health difficulties and whether these can be transferred, adapted, and utilised within mainstream services. I hope that through this research I will be able to find out how our community's MFL work therapeutically, to develop an Islamic informed psychological support framework that can support the Muslim community in accessing and engaging in mainstream services.

Can I take part in this study?

To take part in the study you need to be:

- An adult (18 years and above)
- English speaking
- UK resident
- Have completed a higher level of Islamic Sciences Studies to fulfil the role of a Muslim Faith Leader OR Muslim Community Leader (i.e., someone who is in an influential* known position within their community).
- Occupy and worked within community in a Muslim Faith/Community leader role* longer than a year
- Have supported/ advised a Muslim community or congregation member for their emotional or mental health difficulties, lifestyle concerns, distressing events/circumstances, or wellbeing**
- Have formal secular mental health or therapeutic/ counselling training (i.e., BABCP, BACP, PG Cert)

*Imam, teacher, chaplain, volunteer, leading a health and social care enterprise within the Muslim community, leading an organisation that is faith/Islam-based

** in a therapeutic interaction and in their everyday work

What does taking part involve?

It is completely up to you whether you decide to take part in this study as it is voluntary. If you do decide to take part, you may withdraw for any reason at any stage before the data is analyzed approximate around the 29th of January 2024. If you do withdraw, any data that you do provide will not be used in the results before the analysis takes place.

If you do agree to take part, you will be asked to give your consent to take part in the study and invited to a short 10-15-minute phone call to discuss eligibility where you will be asked to provide information about yourself (e.g., age, email address, dominant language spoken, gender, location, ethnicity, information around your Islamic and therapeutic training, your Muslim community leader role and supporting their community). If eligible, and you are still interested we will agree a time for a one-to-one online interview led by myself that will be no longer than 90 minutes.

You may ask any questions before deciding to take part by contacting the principal researcher, Farhana Maleque.

What are the benefits of taking part?

There is a lack of research looking at how MFLs provide support for Muslim communities experiencing mental health difficulties. This study aims to fill the knowledge gap in the field by exploring the unique experiences of MFLs who are trained both Islamically and therapeutically. The research aims to identify Islamic adaptations that can be used in psychological support within NHS contexts to support the Muslim community. Therefore, by taking part, you will be helping to build up a body of research on

Muslim mental health and support the development of interventions that is Islamically informed which can potentially support more Muslims accessing mainstream mental health services.

What are the possible disadvantages of taking part?

During the interview, you may be asked some sensitive questions about the support you provide to the Muslim community. If participation in this research causes you any distress or discomfort, you may wish to contact a source of support. The researcher will provide information about organisations that you can contact that may be useful.

How will my data be used?

The information you provide will be completely anonymous and confidential and will be used for the purposes of the research only. The limits of confidentiality would be if you disclose information that puts yourself or someone else at risk of harm, then I would need to inform the appropriate agency. However, I aim to inform you first before this step.

Your responses from the interview will be recorded and transcribed guaranteeing anonymity and confidentiality. This means that any information responses that identifies participants will be removed from the data.

There may be some quotes using pseudonyms in publications. Your data will be securely stored on a password-protected computer, managed, and accessed on a secure University OneDrive that only the research team will have access to. This will be in accordance with the Data Protection Act 1998 and GDPR 2018. The audio/ video recording of interviews will be destroyed after transcripts have been made.

Limited personal data will be collected for this study in the interview; however, this data will be stored separately in a different folder from the interviews on the OneDrive.

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 the doctoral thesis. The audio/video recording will be destroyed after transcripts have been made. I will endeavour to write up an article for publication in an academic journal with no identifiable participant information. 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/PGR/UH/05399

The research team will keep anonymous data indefinitely.

Who will have access to my data?

No third parties will have access to your data. Your data will not be shared outside of the research team conducting this study.

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

If you would like further information or would like to discuss any concerns or details personally, please get in touch by emailing Farhana at *f.maleque@herts.ac.uk* who will do her best to respond to any questions. Alternatively, if you prefer to speak to my supervisor, you can email Dr Shivani Sharma (s.3.sharma@herts.ac.uk).

We will acknowledge your concerns within 10 working days and provide you information about how it would be dealt with.

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 at the following address: 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 consent 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 very much for reading this information and considering taking part in this study.

Contact Details

Main Researcher:

Farhana Maleque

Trainee Clinical Psychologist

Tel: 07940715072

Email: f.maleque@herts.ac.uk

Research Supervisor:

Dr Shivani Sharma

Associate Professor in Research – Health Inequalities

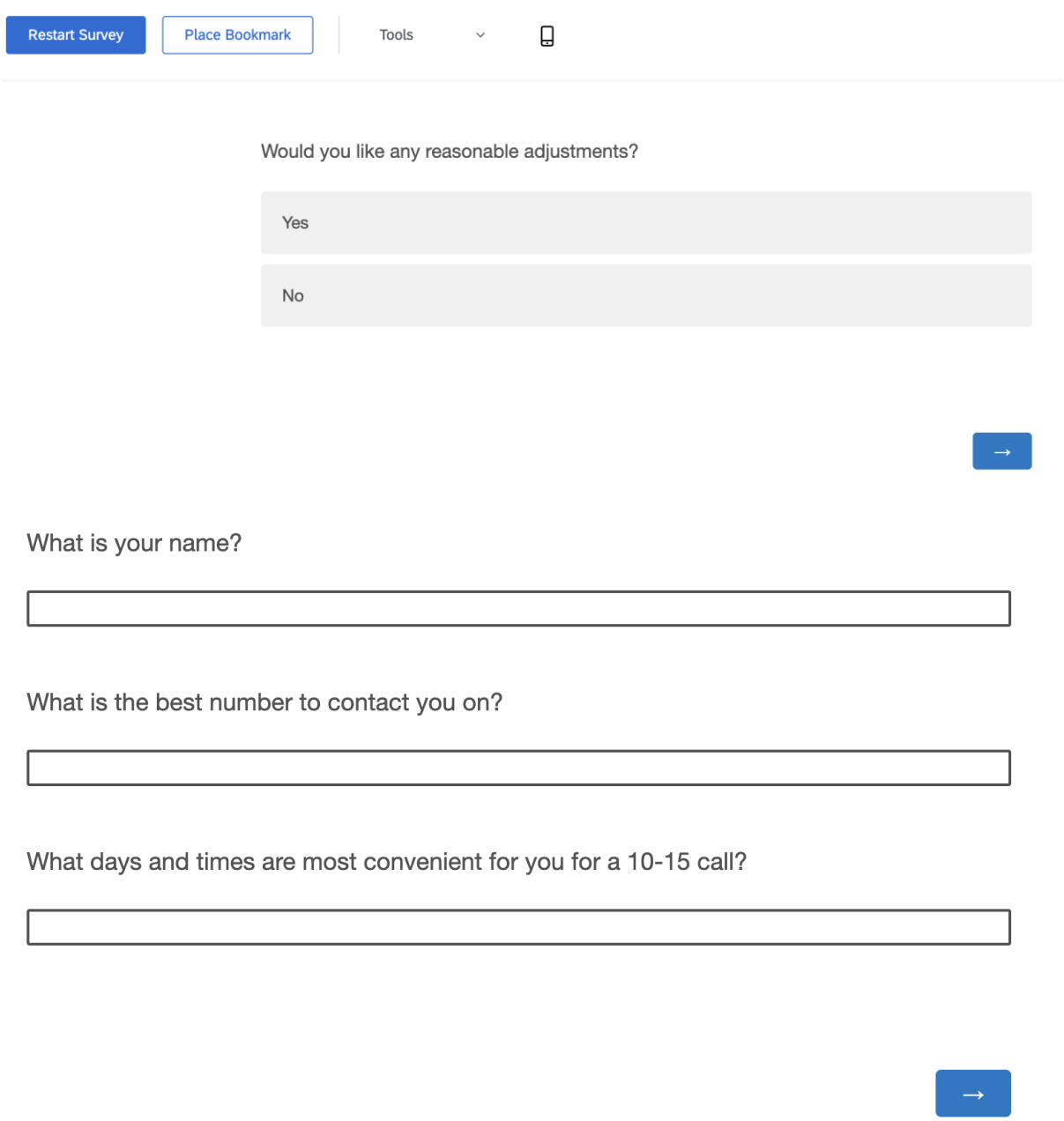
Email: s.3.sharma@herts.ac.uk

I have read the information above and agree to participate with the understanding that the data I submit will be processed accordingly.

Yes

No

→


Restart Survey
Place Bookmark
Tools
Would you like any reasonable adjustments?
Yes
No
→
What is your name?
What is the best number to contact you on?
What days and times are most convenient for you for a 10-15 call?
→

Appendix J: Consent Form

By consenting to take part, you agree to 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. Any questions that I have had have been answered.
- I understand that I can withdraw at any time before the 29th of January 2024 without giving reasons and 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 understand how the information I provide will be anonymised from any identifiable information and stored on a secure University OneDrive which will be deleted after transcripts have been created (please refer to the Participant Information sheet for more information).
- I agree that the research data gathered for the study may be published and if this occurs precautions will be taken to protect my anonymity.
- I understand that there is an opportunity to access support services if I feel that I need emotional or psychological support because of my participation.
- Contact information has been provided should I wish to seek further information from the investigator at any time for purposes of clarification.

Video/ audio recording of interviews is required. Please tick below to give consent to video/ audio recording.
I understand that my interview will be recorded using video/ audio recording equipment and that this recording will be destroyed once the research study is completed.

- [ ] I consent
- [ ] I do not consent

→

Appendix K: Debrief document

Thank you for taking the time to help us with this study. The aim of the study is to explore Muslim Faith Leaders experiences in delivering Islamically informed mental health support in the Muslim community and any perceived barriers that may arise in implementing such adaptations in the NHS and how we can improve services for the Muslim community in the UK.

The information you provided will be used for research purposes only. No data you provided can be linked to you and it can be withdrawn from the study at any time during the interview or up until the data analysis. If you would like to ask questions or communicate your concerns about the study, please email Farhana Maleque (principal researcher): f.maleque@herts.ac.uk or Dr Shivani Sharma (research supervisor): s.3.sharma@herts.ac.uk.

What will happen next?

All data collected will be analysed to identify similarities and differences in experiences/themes. The results will then be written up and disseminated (i.e., published as a journal and poster presentation) which can contribute to discussions focusing on developing Islamically informed mental health support and interventions within mainstream mental health services to address the mental health needs of the Muslim community.

Things to remember

- You have the right to withdraw from the study at any time before the analysis starts approximately before the 29th of January 2024.
- 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 several 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 talking therapy (such as cognitive behavioural therapy), then you may wish to consider self-referring to your local psychological therapies service via the website or ask your GP to refer you. To find your nearest service, you can search IAPT NHS or NHS Choices.
- **NHS Direct -** delivers telephone and internet information and advice about health, illness and health services, day and night, directly to the public. Call 111 or go to www.nhsdirect.nhs.uk
- **Samaritans** – this is a 24 hour a day, free and confidential helpline for anyone experiencing any emotional distress. Free phone: 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** - is an organisation run by professional counsellors, who offer different types of therapy. Call 07943 561 561 or e-mail; info@sakoon.co.uk; Website https://www.sakoon.co.uk
- **Inspirited Minds Counselling** - provides a range of therapies, including Islamic counselling by accredited counsellors and therapists. Email: info@inspiritedminds.org.uk or visit their website: www.inspiritedminds.org.uk/get-help
- **Zamzam counselling** - provides accredited Muslim counsellors and CBT therapists. Contact 07799485059 or e-mail info@zamzamcounselling.co.uk
- **Muslim community helpline** – The Muslim Community Helpline is a confidential, non-judgmental 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. Women's counselling@Londonmuslimcentre.org.uk or call 020 7650 3022.

Appendix L: Interview Schedule

Title of study: Therapeutically trained Muslim Faith Leaders' experiences of Islamically informed mental health interventions in the Muslim community.

Check that the consent and participant info sheet and that they are okay with video recording.

Clarify the aims:

The research aims to explore the experiences of Muslim faith leaders facilitating Islamic-informed psychological interventions to the Muslim community, their ideas on Islamic adaptations and/or models that would be necessary to implement in NHS and non-NHS settings, and their views on the barriers that might come in implementing these adaptations.

There will be discussions that may require you to share your therapeutic work. Understandably, you would be naturally accustomed to your everyday practice, therefore please can you anonymise, as far as you can, the work you've done to maintain the confidentiality of the clients you have worked with.

Some practicalities before we proceed:

Address any technical difficulties, connectivity, wait and if unresponsive leave and come back.

Ensure that you're in a private room

Check sound is okay.

Encourage a paper and pen to support answers - take your time to answer as we have 1.5 hours and we can use this opportunity for you to open up about your experiences.

Researcher will be jotting some notes down as a reminder of interesting points.

If you need water please feel free

It is important I follow the questions that I have at hand. This is because the research methods require me to be a neutral researcher who listens to participants without judgment so it does not bias the data. At times, I will follow up with prompt questions if needed.

Will be using the word secular – do you know what this means? - "not connected with religious or spiritual matters".

Any questions before we proceed?

Warm-up question

1. What has interested you in becoming a therapeutically trained Muslim Faith leader one who with an Islamic Science and therapeutic background?

Questions about experiences of working as a faith leader and a therapist.

2. Tell me about your experience working with Muslims as a faith leader and a therapist.

Prompts:

   a. What is your knowledge of psychological interventions in the NHS?
      i. *Note: are you aware of mainstream psychological models*
   b. Have you undertaken any training to support you in this understanding?
   c. Do you have experience in providing psychological interventions in the NHS? (directly or indirectly supporting the Muslim community)

3. What are your experiences in providing psychological interventions to Muslim patients? Are there any positive experiences? Negative experiences?
4. What are your experiences and knowledge of how Muslim patients experience psychological support in the Mental Health Services?

   Prompt:

   a. Are there any positive experiences? Negative experiences?

Questions about experiences in delivering Islamic and/ or secular psychological interventions.

5. How do you integrate Islamic and secular psychological interventions into your everyday practice?
6. What are the advantages of doing that?

Prompts:

   a. What models do you apply in your therapeutic practice?
   b. What have you noticed are the differences between the Islamic and secular models?
   c. What have you noticed are the similarities between the Islamic and secular models?

Questions about challenges in delivering Islamic and/ or secular psychological interventions.

7. When you integrate Islamic and/or secular approaches into psychological interventions, what challenges have you experienced arising with Muslim clients you work with? (Prompt: systemic, resourcing)

Prompts:

a. Do you think there are conflicts between Islamic and secular psychological knowledge and practice?
b. If so, what are these and can you give examples?
c. What are the challenges in applying Islamic psychological interventions with your Muslim clients?
d. What are the challenges in applying secular psychological interventions with your Muslim clients?

Questions about implementing Islamic psychological interventions in the NHS and the community.

8. What do you think are the adaptations needed to implement Islamic psychological interventions in the NHS? (prompts: processes, structures, practical).

Prompts:

a. How can these Islamic approaches be applied to psychological interventions in the NHS?

9. How can Islamic psychological interventions be applied to support the Muslim community?

Prompts:

a. What Islamic approaches have you used in your experiences that you feel would be beneficial to incorporate into psychological interventions?
b. What recommendation would you suggest to the NHS to implement to support the Muslim community?

Questions about the challenges and solution in implementing Islamic psychological interventions in the NHS and the community.

10. What barriers do you perceive to be when implementing Islamic psychological interventions at a service level within the NHS?
11. What do you think are the solutions to overcome these barriers?

Ending questions

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/want to do?

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 psychological interventions to Muslim clients?

c. Anything else you think is essential for me or mental health professionals to understand?

d. Is there anything else you want to share today about what we discussed? (write this down to refer to at the end)

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?

What will happen next?

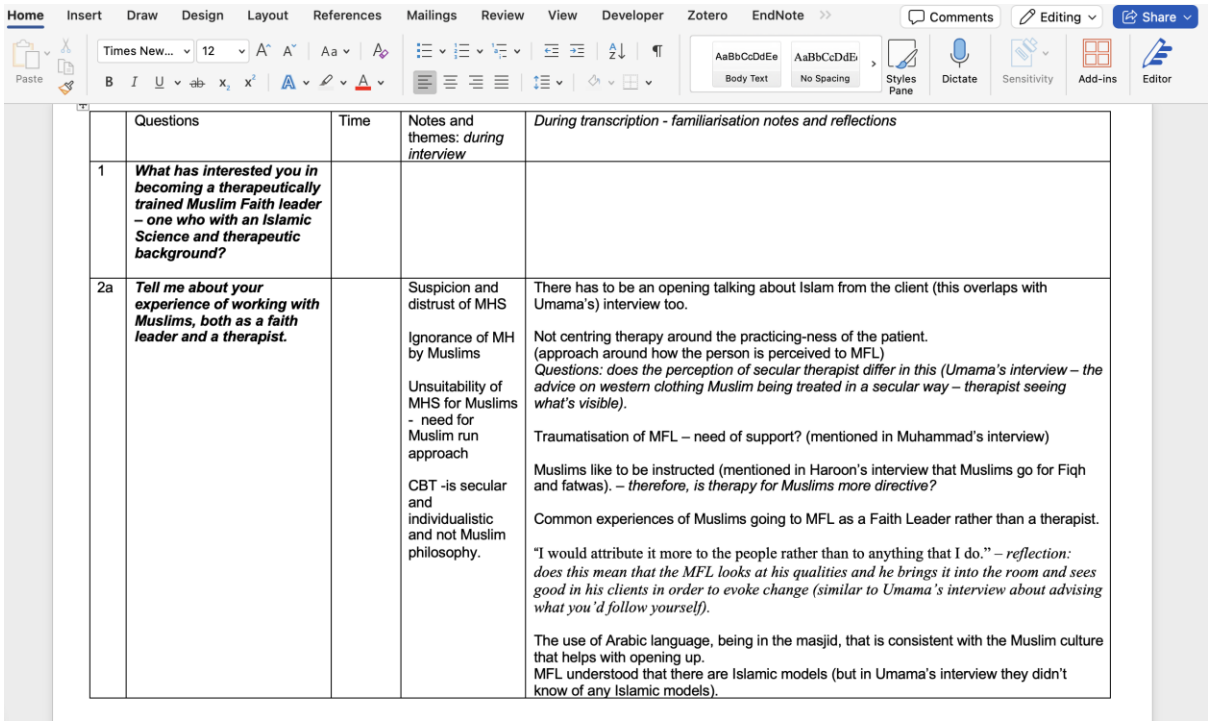
All data collected will be analysed to identify similarities and differences in experiences/themes. The results will then be written up and disseminated (i.e., published as a journal and poster presentation) which can contribute to discussions focusing on developing Islamically informed psychological interventions within mainstream mental health services to address the mental health needs of the Muslim community.

Will send you debrief information shortly.

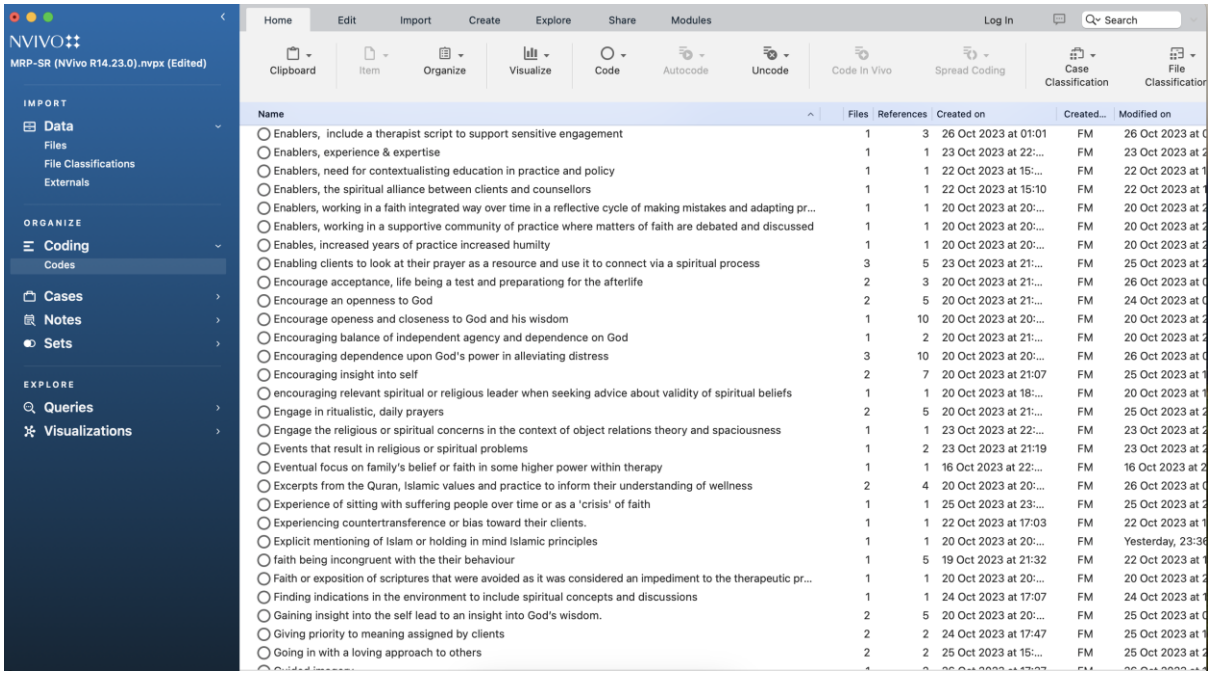
And you can withdraw at any time before end of January 2024.

If you'd like to get involved in checking the themes developed that come out before writing up, please let me know.

Appendix M: Analysis Process: Familiarisation, Initial Coding , Concept Maps



	Questions	Time	Notes and themes: *during interview*	*During transcription - familiarisation notes and reflections*
1	***What has interested you in becoming a therapeutically trained Muslim Faith leader – one who with an Islamic Science and therapeutic background?***			
2a	***Tell me about your experience of working with Muslims, both as a faith leader and a therapist.***		Suspicion and distrust of MHS Ignorance of MH by Muslims Unsuitability of MHS for Muslims - need for Muslim run approach CBT -is secular and individualistic and not Muslim philosophy.	There has to be an opening talking about Islam from the client (this overlaps with Umama's) interview too. Not centring therapy around the practicing-ness of the patient. (approach around how the person is perceived to MFL) *Questions: does the perception of secular therapist differ in this (Umama's interview – the advice on western clothing Muslim being treated in a secular way – therapist seeing what's visible).* Traumatisation of MFL – need of support? (mentioned in Muhammad's interview) Muslims like to be instructed (mentioned in Haroon's interview that Muslims go for Fiqh and fatwas). – *therefore, is therapy for Muslims more directive?* Common experiences of Muslims going to MFL as a Faith Leader rather than a therapist. "I would attribute it more to the people rather than to anything that I do." – *reflection: does this mean that the MFL looks at his qualities and he brings it into the room and sees good in his clients in order to evoke change (similar to Umama's interview about advising what you'd follow yourself).* The use of Arabic language, being in the masjid, that is consistent with the Muslim culture that helps with opening up. MFL understood that there are Islamic models (but in Umama's interview they didn't know of any Islamic models).



Name	Description
Bringing in whatever spiritual needs comes into and from the assessment *I would bring that into the therapy according to whatever we, the assessment comes up with and any other guidance as well that they might need*	
Challenging and empowering the client to find their answer by checking the Islamic knowledge and fiqh and the dissonance with their unislamic beliefs and ritual *So then with that I bought the answer. Is there some sort of actual law that says you've got to wash your hands 20 times? Yeah. Is there some sort of law that says you know it's got to be perfect. And what is perfect? Umm. And then does it, then I bought in the other part of it. Is it, does it make sense that you must, you know, wash your hands 20 times.*	
Differences in secular and practicing families - secular families dont need Islamic help and can receive secular psychological help whereas practicing families have a preference for faith -related support *think, from family to family. It be assessed Sometimes, there may be a family that's very secular. They don't need any Islamic help and support. They only want uh, and you know that helps psychologically that helps. So that's that's the preference of the family. But there are families that only want a support from the faith perspective.*	
Not validating or agreeing with what the client says *Without, without, without endorsing what the client saying, without validating, without agreeing with what the client is saying.*	
Providing care based on the clients context where the therapist provides *I don't think it's like one type of care, for one type of population. I think is being able to understand and then provide the care based on the context that the person provides, but I don't know if I've answered that question, so let me know.*	**More community approach**
Secular vs non secular approach as described by the MFL (non-disclosure of client faith vs when client discloses and requests faith to be considered) *So you know when you have your initial session, you would jot down as much as possible about the person their world view. You know whether they are somebody or faith or not, and whether they are practicing or not You know what's important to them? What's not important to them? What's actually, you know, a problem? What it is that they've actually brought to the table that they need your help. And as I said, so it's all for me, I feel like it's actually really all about, you know, pretty secular in that sense.* *You know, but the actually therapy, but where it becomes a non secular if you like is when the person represents themselves, as you know saying I'm a Muslim, I'm a Christian, I'm a Jew and then you need to take into consideration if they're saying and I want to know the values and according to you know, my religion, I want to be able to do the right thing. So of course then you will accommodate that.*	**Linked to being led by client??** Secular - ask about the person's worldview, someone of faith or not, practicing or not, what is and what isn't important to them, whats the problem Non-secular is when the person represents themselves as a faith/ religion

Feb 26, 2024 20

Community needs and principled approach

Islamic interventions in the community - psychologists need to first embed themselves within these communities, then meaning making with Muslims there and understand how best to support not necessarily using models that they were trained in

Juwariyah: *I think there needs to be. Like a community psychology approach to be able to incorporate or embed Islamic psychology, like I think we have. I again I'm repeating myself, but I feel like we have very separate conversations and I think that psychologist need to first embed themselves within these communities as well and. Yeah, I think it has to be both ways. I think it's not, uh, I don't think it's like I think we need to be a mutual understanding and connection between the, we say, the NHS and Community services and religious spaces and to be able to Apply, Like I think we have very separate conversations. That, I mean, and I think we need psychologist in spaces where Muslims are, but not to come in with just their secular knowledge, but to also understand the meaning making of Muslims within that community and how we are able to support using interventions that might not necessarily Be the ones we train in, but how can we draw on, How come you draw on Islam and the coping mechanisms and the things that Islam says uh to like, How can we use that to influence the way we work psychologically, if that makes sense?*

I think it's a give and take process, I think that some Muslims don't access the NHS because they don't particularly feel like they will be understood from where they're coming from or their identity. So, I think they need to be more of an incorporation, as in we're learning from you. Uh. Because if you're not going to go and get an Islamic psychology degree, you can still know what the community wants and means, we're having conversations with them and what works for them and what doesn't work for them and what spaces can we have in the community that are psychologically informed, where they're still using things uh from their faith in their cultures as well.

Islamic psychological interventions be applied to support the Muslim community - using the imams as gatekeeper before signposting to NHS based on suitability

Zakariya: *So, we need to use the interventions and see because there are times where, the one that is, you know. He should have that, we could say, credential or he could have that capacity and ability to sign post a person because he may know better. Meaning an imam can even know whether it is more suitable for the person to be signposted to you know the NHS and at times you know the healing.*

Recommendation for NHS - community approach and fund projects that is run by local Muslim community

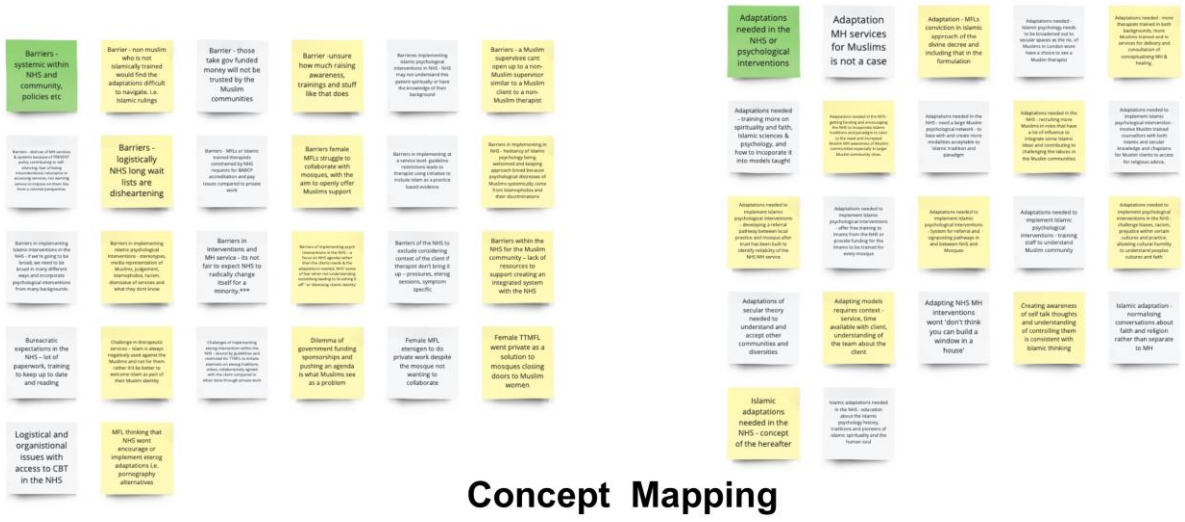
Yahya: *It would be good for them to also fund some projects that UM, that is run by the local Muslim community. That might give, that might help with access as well, they might want to go to an organization in instead of the mainstream NHS.*

Recommendation for the community - 'mosques need to become this hub of our community where everything is available'

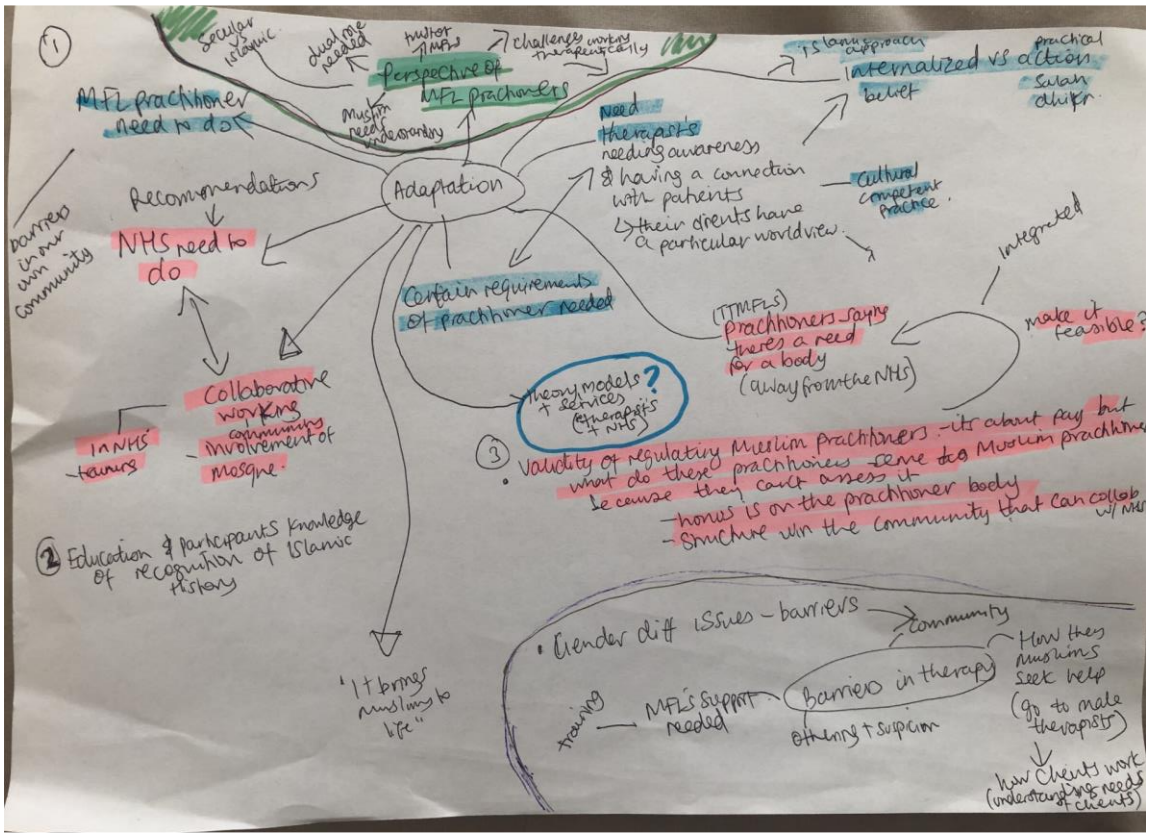
Fariha: *they need to provide a service for local Muslim communities where there's everything available, mental health help, you know, for kids to babies, to young women, young children, young men, everything. We need something. We need the mosques to become this hub of our community where everything is available there.*

Solution - Helping Muslim communities means empowering them to offer MH services to their own communities (i.e., giving them reins to develop, dictate and instruct their own MH facilities rather than adopting a system, framework unaligned with Islam

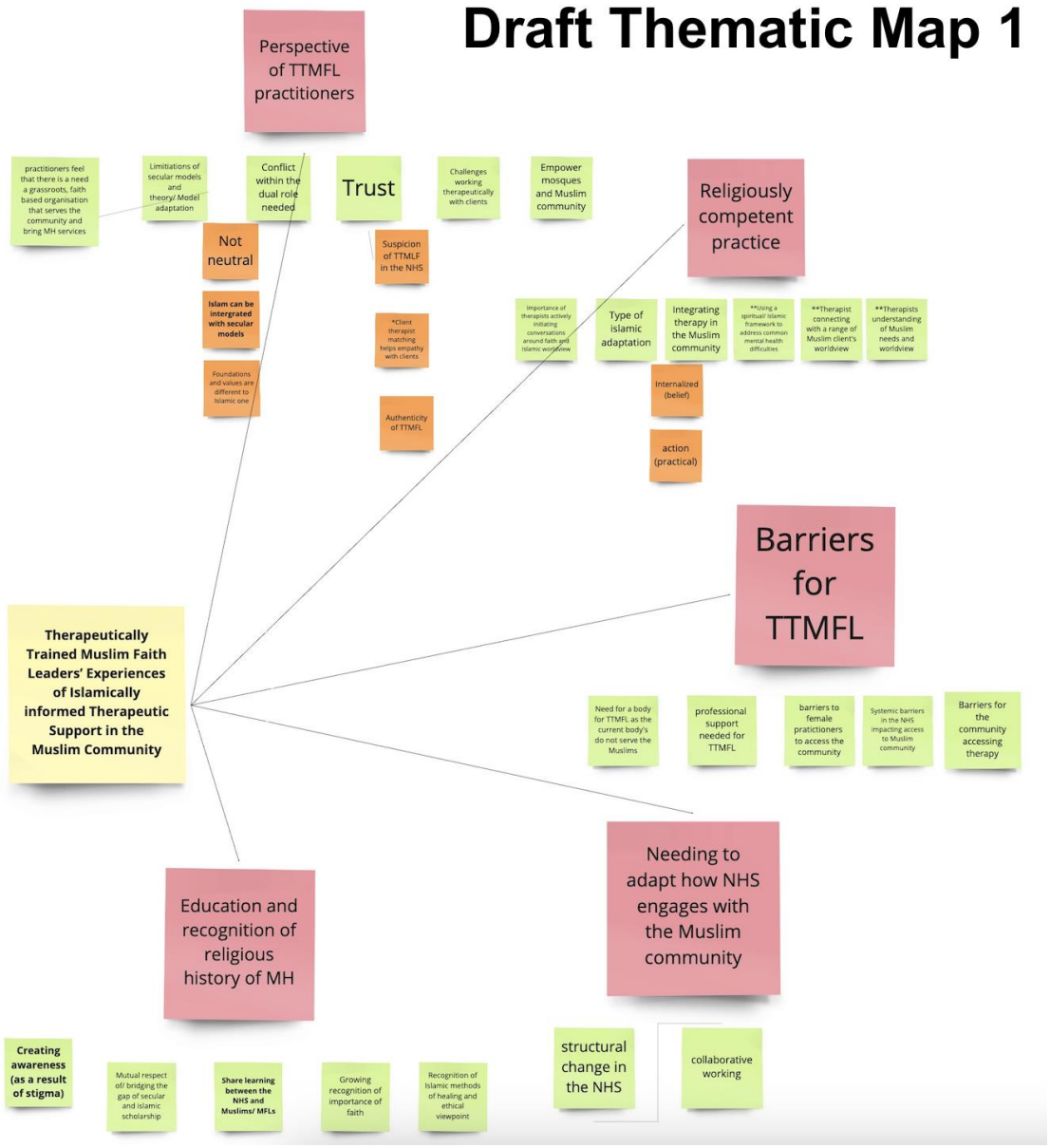
Ismaeel: *And then thirdly, I think if they really want to help Muslim communities, they need to empower Muslims and to offer services to their own communities. And when I say in empower, I don't mean empower as in, you know, patronize and I mean give Muslims the reins to develop their own kind of mental health and helping facilities and allow them to direct, you know, and dictate and instruct rather than kind of trying to adapt a system which has been designed based upon a philosophy and a framework which is not necessarily in line with the Islamic one.*

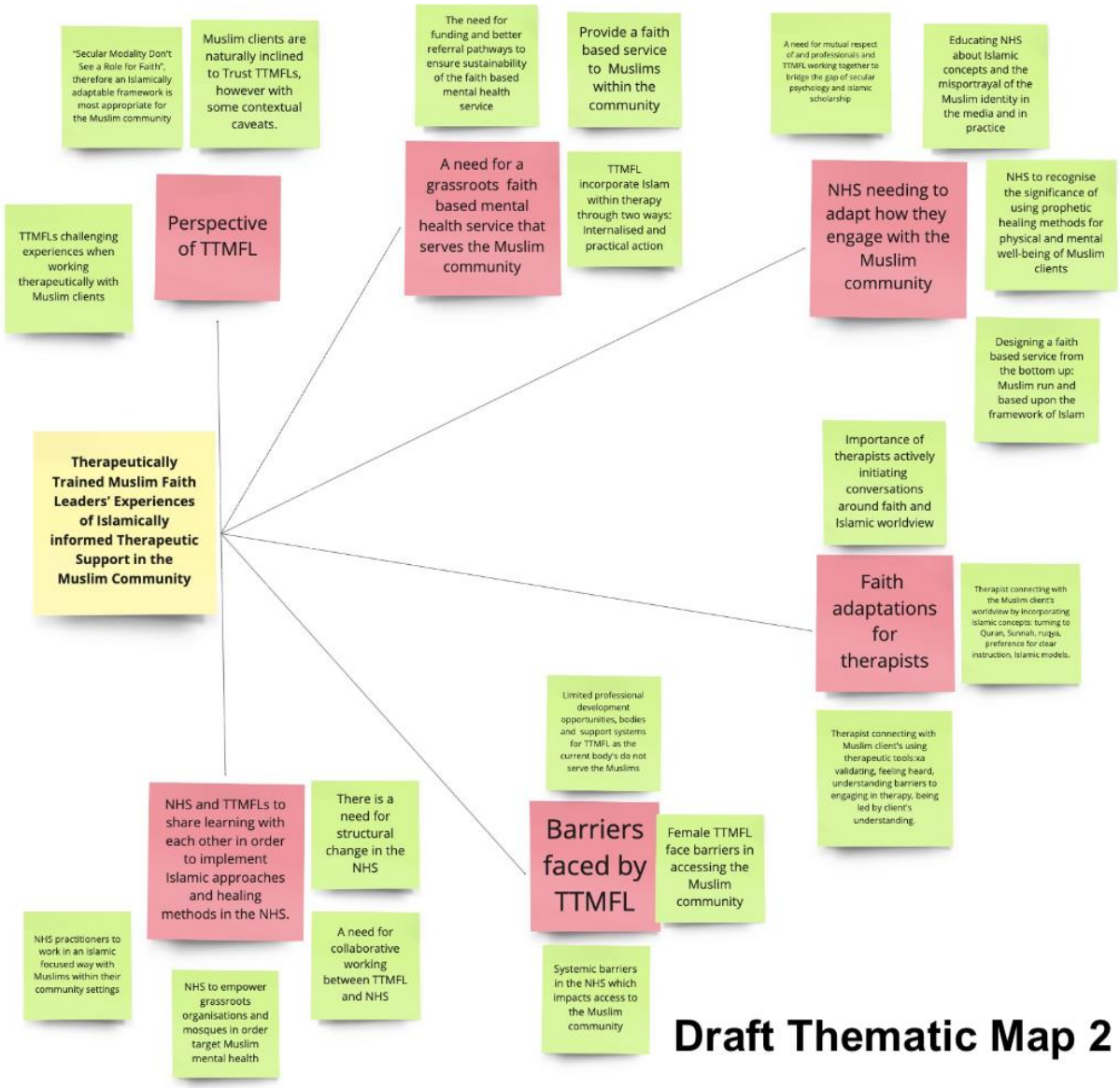


Research Question Thematic Map



Appendix N: Preliminary Thematic Map of Themes and Subthemes




"Secular Modality Don't See a Role for Faith", therefore an Islamically adaptable framework is most appropriate for the Muslim community
Muslim clients are naturally inclined to Trust TTMFLs, however with some contextual caveats.
TTMFLs challenging experiences when working therapeutically with Muslim clients
Perspective of TTMFL
The need for funding and better referral pathways to ensure sustainability of the faith based mental health service
Provide a faith based service to Muslims within the community
A need for a grassroots faith based mental health service that serves the Muslim community
TTMFL incorporate Islam within therapy through two ways: Internalised and practical action
A need for mutual respect of and professionals and TTMFL working together to bridge the gap of secular psychology and islamic scholarship
Educating NHS about Islamic concepts and the misportrayal of the Muslim identity in the media and in practice
NHS needing to adapt how they engage with the Muslim community
NHS to recognise the significance of using prophetic healing methods for physical and mental well-being of Muslim clients
Designing a faith based service from the bottom up: Muslim run and based upon the framework of Islam
Therapeutically Trained Muslim Faith Leaders' Experiences of Islamically informed Therapeutic Support in the Muslim Community
Importance of therapists actively initiating conversations around faith and Islamic worldview
Faith adaptations for therapists
Therapist connecting with the Muslim client's worldview by incorporating islamic concepts: turning to Quran, Sunnah, rugya, preference for clear instruction, Islamic models.
Therapist connecting with Muslim client's using therapeutic tools:xa validating, feeling heard, understanding barriers to engaging in therapy, being led by client's understanding.
Limited professional development opportunities, bodies and support systems for TTMFL as the current body's do not serve the Muslims
Barriers faced by TTMFL
Female TTMFL face barriers in accessing the Muslim community
Systemic barriers in the NHS which impacts access to the Muslim community
NHS and TTMFLs to share learning with each other in order to implement Islamic approaches and healing methods in the NHS.
There is a need for structural change in the NHS
A need for collaborative working between TTMFL and NHS
NHS practitioners to work in an islamic focused way with Muslims within their community settings
NHS to empower grassroots organisations and mosques in order target Muslim mental health
Draft Thematic Map 2

Appendix O: Definitive Thematic Map