Clarifying the place of religious concepts and practices in formulating and delivering personalised mental health care for depression in the UK Muslim population

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Dedication

This humble work is dedicated to my parents, who have been great exemplars of the therapeutic power of faith. My father, Murtaza Lakha, opened the door to scholarship through his inspiring and steadfast example throughout his life. My mother, Fatma Lakha, sustained the journey of learning through her ever-present encouragement and dedicated prayers, particularly after my father passed away.

وَٱخۡفِضۡ لَهُمَا جَنَاحَ ٱلذُّلِّ مِنَ ٱلرَّحۡمَةِ
وَقُل رَّبِّ ٱرۡحَمۡهُمَا كَمَا رَبَّيَانِي صَغِيرًا ﴿٢٤﴾

“And out of kindness, lower to them the wing of humility, and say:

‘My Lord, have mercy on them, just as they cared for me when I was young’”

(Qurʾān, Sūrat al-Isrāʾ 17:24).

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CHAPTER ONE: INTRODUCTION

Thesis Abstract

Research question: How might religious concepts and practices contribute to personalised mental health care for depression in the UK Muslim population?

This study begins by exploring the population data and literature context, before embarking upon three exercises. First, a conceptual objective requiring comparative analysis between Islamic theology with psychotherapeutic interventions approved by the National Institute for Health and Care Excellence (NICE) Guideline for depression in adults (NG 222). Deductive Content Analysis (DCA) method is utilised to identify ten contact points between Islamic and psychotherapeutic concepts, across two categories: goal setting, awareness of thoughts, recognising emotions, mindfulness practices, bodily awareness (forming the self-knowledge group); together with optimism and hope, motivation and agency, gratitude, relationships, and behaviour patterns (classified in the resilience group). These ten concepts are applied to five well-established Islamic practices of Qurʾānic recitation, daily prayer, fasting, mindfulness, and psalms.

Second, the empirical objective is to understand the views and experiences of service users and therapists on the viability of the above comparative framework in practice, together with broader insights into their treatment for depression in the Muslim community. Data collection was undertaken through 30 semi-structured interviews across both cohorts and analysed using Framework Analysis methods.

Third, the practice objective seeks symbiosis between the findings of the first two sections, to gain insights into the acceptability and viability of faith-based adaptations to NICE approved psychotherapies, while also considering whether such adaptations are practicable in a health care delivery context, focussing on obtaining practical coherence with person-centred mental care, while countering stigma and maximising the efficacy of existing resources. This process identified opportunities to empower therapists with training materials and seeking regulatory clarification on how to raise the subject of religion in therapy. In addition, a framework for Faith-Informed Therapy (FIT) was identified that can provide a vehicle for delivering a practitioner's chosen intervention from the NICE Guideline in a way that harnesses the religious commitments and perspectives of Muslims.

1.1 Background

Personalised mental health care has been a long-standing goal for the UK National Health Service (NHS), but has often proved elusive. NHS guidance is that a personalised approach to mental health treatment should take into account a person's culture and identity (NHS England, 2014),[1] of which faith is an integral aspect. A global population study by The Pew Research Center (2012) suggests that 84% of people worldwide are religiously affiliated. Nevertheless, the literature appears to have a gap in this area, as highlighted in the *Lancet Psychiatry*:

> *"No other social phenomenon is so widespread, yet all but ignored by academic psychiatry" (Rosmarin et al., 2021).*

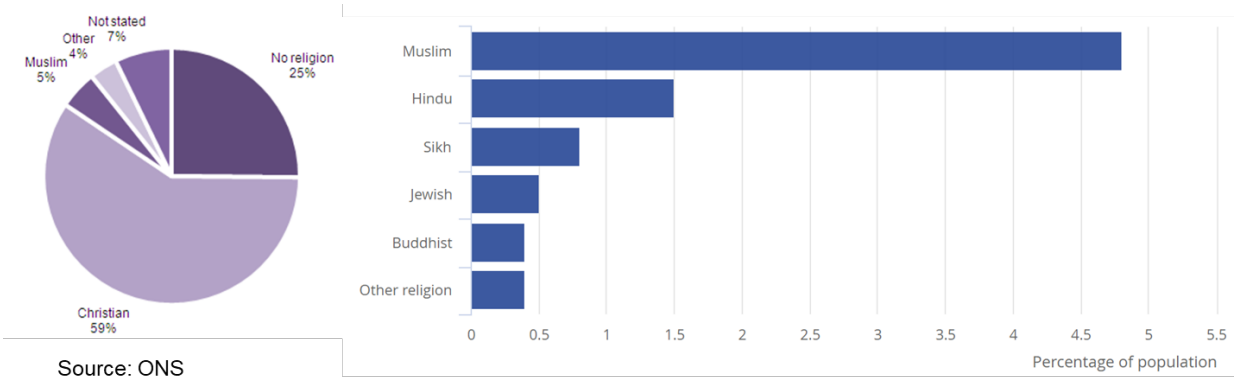
The impetus herein to investigate connections between religion and mental health, particularly depression in the UK Muslim community, is corroborated by early studies on Christian populations, showing that interventions that draw on faith can be effective in treating and preventing depression (Lipsker & Oordt, 1990). This has added to voices calling for more culturally nuanced research on non-Christian faith communities (Collicutt, 2011).

[1] This study follows the American Psychological Association (2020) official guide to APA style (7th edition), together with the Library of Congress method for Arabic to English transliteration (https://www.loc.gov/catdir/cpso/romanization/arabic.pdf) [accessed 30 September 2025].

1.1.1 UK Muslim Population

Data from the 2011 UK census showed that over two thirds of people in England and Wales are religiously affiliated, with Muslims being the largest minority, with approximately 3m people (c.5% of the UK) (Office of National Statistics, 2011):

Figure 1.1.A: Religious affiliation in England and Wales



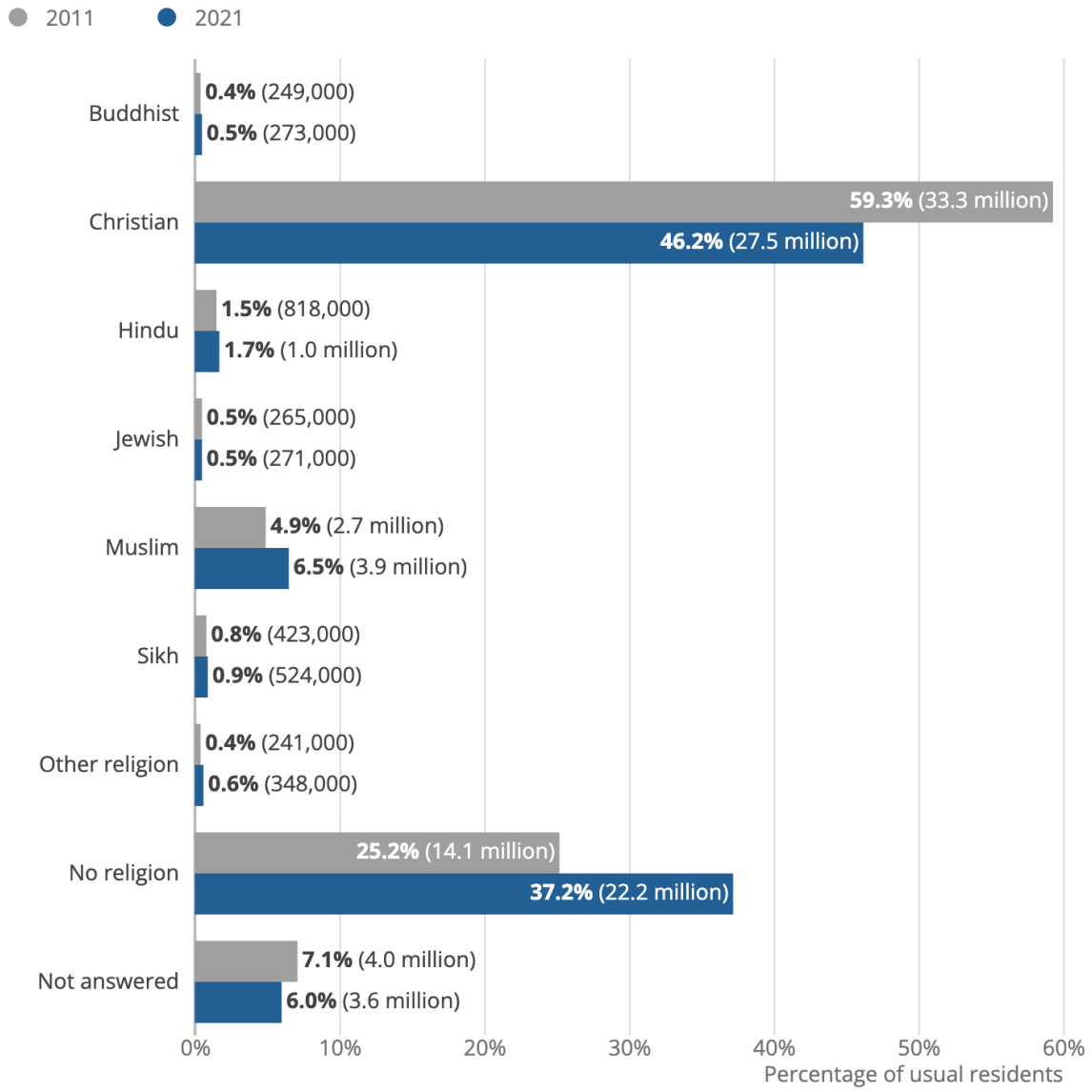
Source: ONS

The most recent Census in 2021 showed that the Muslim population grew during the followed decade to nearly 4m people, equivalent to 6.5% of the national population (see Figure 1.1.B below). Such growth means that the issue under consideration in this project is increasing in importance over time and needs to be addressed urgently, as the number of Muslims suffering poor mental health is likely to be growing.

The age distribution aspect of the demographic data is important, as it shows that the British Muslim community is considerably younger than the overall UK population, with an average of 27 years, compared with the median age of 40 years for the population as a whole (Office of National Statistics, 2021). This means that the literature on the importance of early interventions for mental health

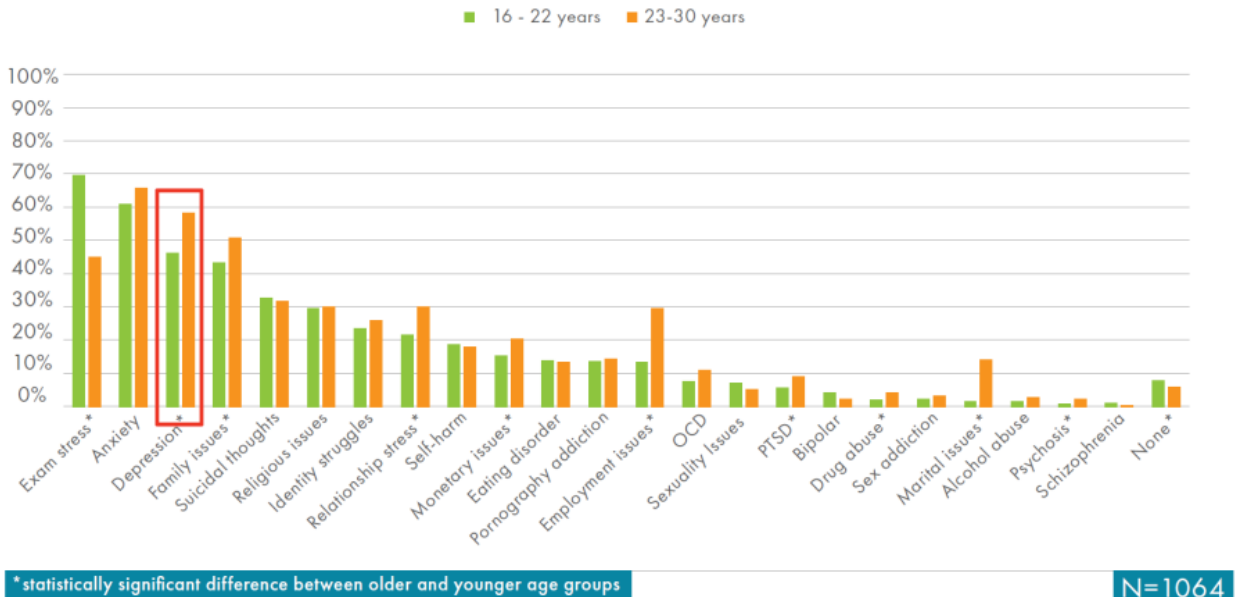
needs to be considered as well. For instance, a study by the Muslim Youth Helpline (2019) of over a thousand Muslim adolescents found that many were vulnerable to an array of mental health challenges, 52%of whom had suffered from depression (see Figure 1.1.C below).

Figure 1.1.B: Religious composition, 2011 and 2021, England and Wales



Source: ONS

Figure 1.1.C: Mental health conditions young Muslims have suffered from



Source: Muslim Youth Helpline

There is growing evidence of a significant mental health disease burden in the UK Muslim population (Smith et al., 2025), however, mental health services for Muslim communities in England and Wales are disjointed and require better collaboration (Abrar & Hargreaves, 2023).

1.1.2 Literature Review

For the purposes of this study, a narrative review is undertaken, as this method is more appropriate than a scoping review or systematic review for this research area, because there still aren't, as yet, a sufficient number of peer reviewed journal articles in this field. As it currently stands, there are a few journal articles, supplemented by reports from charitable groups and a several exploratory books. Hence, a narrative method represents are more appropriate approach to the literature from the perspective of addressing the research question at hand. This is

particularly the case since narrative reviews provide '*scholarly summary along with interpretation and critique*', thereby potentially contributing a deeper understanding of the field through broad perspectives, rather than the relatively narrow field of view that a systematic review would offer (Greenhalgh et al., 2018).

Within the category of narrative reviews, this exercise adopts a hermeneutic review method, to create an interpretive understanding (Boell & Cecez-Kecmanovic, 2014). For instance, Dixon-Woods et al. (2006) conducted such an interpretive review of the literature on access to healthcare by vulnerable groups in the UK, showing how such a review approach can focus on the essential tasks of induction and interpretation for advancing theoretical understanding.

In the context of this research question, Cucchi (2022) has helpfully provided a narrative review on integrating Cognitive Behavioural Therapy (CBT) and Islamic principles in psychology and psychotherapy, from a global perspective. It finds that the substantial ontological and epistemological differences between CBT and Islamic theology, compounded by the legacy of psychotherapy's negative early stance towards religious beliefs, have had profound negative ramifications. In particular, this review finds that that as a result, Muslims tend to be more ambivalent towards approaching mental health services than other religious groups. Instead, studies such as Bhui et al. (2008), examining how people from different ethnicities use religious and spiritual coping, found that faith communities, particularly Bangladeshi Muslims, use religious coping, which can promote recovery and longer term resilience.

As regards the scale of the disease burden, there is increasing evidence that depression is a large and growing problem, particularly in the UK Muslim community, with data from the Pew Research Center that Muslims are vulnerable to above average rates of depression (Keshavarzi & Haque, 2013). This is compounded by the above findings that Muslims are less likely to seek counselling services, due to concerns that their Islamic values will not be respected or considered in the therapeutic encounter (Dwairy, 2006). This double-deficiency creates a profound disease burden that requires urgent attention, necessitating careful analysis of religious ethical concepts and practices, in the context of their application in the design and delivery of mental health care for Muslims (Haque, 2001). However, a global review of studies on depression among Muslims found that the literature offers few robust explanations for the prevalence of depression in this group and how treatment needs to be adapted to improve effectiveness (Walpole et al., 2013).

On a positive note, the limited literature we do have clearly suggests that treatments which are sensitive to religious ethical values and faith-based concepts are important to Muslims, as they are more likely to use religious coping techniques than other faith communities (Loewenthal et al., 2001). There is reason to be optimistic about the value of this approach, since a review of US clinical trials examining the effect of religion on health found that psychotherapy based on Islamic ethics improved recovery times of anxiety and depression for Muslims (Townsend et al., 2002).

This approach has been piloted in the UK by the charity Mind, combining Cognitive-Behavioural Therapy (CBT) and Islamic ethical teachings in an information pamphlet to make psychotherapy more accessible for Muslims (Hewing & Clarke, 2014). Other attempts to do this include modified CBT (Beshai et al., 2013). Pearce et al. (2015) offer one of the most rigorous efforts to create religiously adapted CBT (RCBT) for major depression in patients with chronic medical illness, having created bespoke RCBT manuals for five major world religions, including Christianity, Hinduism, Buddhism, Judaism, and Islam.[2] These manuals work thematically, for instance drawing on teachings regarding gratitude (or other virtues) from scripture, to enable an individual to break a negative ruminative cycle and reframe their thinking. The results suggested that for religious patients, customising therapeutic interventions according to faith traditions is at least as effective in reducing depression than secular treatments. Whilst it appears that Muslims with depression may value faith-adapted psychotherapeutic interventions, service providers need more support to deliver them (Mir et al, 2015). Kuyken et al. (2009) offer a '*Collaborative Case Conceptualization*' framework which could help to bridge this gap, as it promotes a more personalised approach to CBT, facilitating greater self-awareness and building resilience. Faith informed adaptations may also be important for mindfulness-based interventions, as they have religious origins (Feldman & Kuyken, 2019), the inclusion of which could support accessibility, through making them more normalised for faith communities. From a preventative perspective,

[2] For the purposes of this study, the terms 'patient' and 'client' will be used interchangeably to refer to service users of psychotherapeutic interventions for mental health care. This is to capture the breadth of professions represented among the study participants, ranging from therapists who may typically use the term 'client', to psychiatrists and family physicians (GPs) who have referred to service users as 'patients'.

there is also evidence of a link between religious commitment and resilience to major depression (Koenig, 2012), particularly among high risk groups (Kasen et al., 2012).

The literature on Islamic psychology and psychotherapy include influential works that can be characterised as setting the 'top-down' and 'bottom-up' parameters of the current debate. At the top-down end is a philosophical approach to conceptualising Islamic psychology and psychotherapy (Rothman, 2021), including empirically considering how therapists may apply them clinically (Rothman & Coyle, 2020). There is clustering of studies at this end of the spectrum, with other related approaches, such as Traditional Islamically Integrated Psychotherapy (TIIP), presented more fully by Keshavarzi et al. (2020), drawing up "traditional" Sunnī theology, Islamic philosophical approaches to epistemology and ontology, together with mystical Ṣūfī literature. The challenge of this 'top-down' approach is that connections to psychology operate at an esoteric level, with concepts such as 'spirit' (*rūḥ*), 'intellect' or 'cognition' (*ʿaql*), 'heart' (*qalb*) and 'self' (*nafs*), which may be somewhat remote for pragmatic connection with psychotherapeutic interventions in clinical settings, particularly when delivered by non-Muslims. All these challenges create a practice deficit for top-down approaches, compounded by some also having an empirical deficit, by being solely reliant upon conceptual theorising.

At the other end of the spectrum is an influential 'bottom-up' body of work related to Behavioural Activation (BA) interventions that are adapted for Muslims, notably Ghazala Mir et al. (2015), albeit with limited success and various challenges,

including practitioners dropping out of the study, some due to lack of confidence in the adapted intervention. One of the challenges of this approach is the research design that focusses on BA, thereby limiting the extent of engagement with the rich traditions of Islamic metacognitive concepts and practices, many of which are well established across the UK Muslim community. Despite these limitations, Mir et al have made important contributions to the literature through a pragmatic attempt at Islamically adapting an entire intervention that is offered on the NHS (Mir et al., 2019; Mir & Hussain, 2016; G. Mir et al., 2015; Mir et al., 2024).

One of the findings of this narrative review is that there appears to be a gap in the literature, specifically in the middle of the top-down to bottom-up spectrum. There is a need for a framework that connects practical Islamic concepts and practices with the broad spectrum of psychotherapeutic techniques offered across a range of interventions for depression, spanning cognitive, behavioural, relationship, and mindfulness approaches. This would serve to mitigate the Islamic practice and psychotherapeutic application deficits of many current approaches.

It should be noted that for the purposes of this thesis, the terms '*religious concepts and practices*' are defined broadly, so as to capture pertinent theologically grounded ethics, behaviours and values emanating from a set of faith-based commitments. This does not require belief by clinicians in order to engage with it, nor does it imply any exclusivist claims to distinguish it from nonreligious ethics or moral philosophy (Reeder, 1998). Rather, this heuristic seeks to enable the exploration of the personal social contexts and overarching value commitments in which specific religious frameworks seek to shape behaviours and decision-

making, enabling mental health service providers to translate and tailor personalised mental health services to faith communities. In the specific case of Islam, the primary religious concepts and practices will be drawn from scripture (the Qurʾān), psalms (*duʿāʾ*) and interpersonal ethics (*akhlāq*).

The term '*faith-based community*' is used herein to refer to a population that is defined by shared religious ethics, identity, beliefs, commitments, values, concepts and practices, despite comprising of individuals from diverse cultures. For instance, the term '*UK Muslim community*' captures individuals from a large range of cultures, with important nuances, but who nonetheless share a common core understanding of Islam and self-identify as 'Muslim', notwithstanding their many differences. There arises a need to distinguish religion from culture, as different cultural lenses can colour religious interpretation, resulting in cultural values being dressed in religious garb, which can cause conflict between religion and culture. Both religious and cultural beliefs and values could influence moral judgements and self-perception, thereby potentially affecting the efficacy of some psychiatric interventions. Therefore, it is important that these two variables are differentiated carefully in any analysis, in order to see the impact of each individually on the psychotherapeutic encounter.

In summary, the rationale that lies behind this research project is that more detailed consideration of religious concepts and practices, in ways that pay close attention to the personal experiences of Muslims with depression and their service providers, could improve patient experience and service provision. It is expected that attending to different components of religious life may contribute to

personalised mental health, offering Muslims choices about their care in ways that are sensitive to, and congruent with, their lived practices and ethical frameworks, whilst demystifying therapy and reducing stigma. Just as importantly, there is a need to carefully address faith-based psychotherapeutic concepts and practices in ways that are congruent with NHS interventions for depression, and that can be accommodated within existing therapist-client relationships and service models, thereby empowering both patients and clinicians in the quest for better personalised mental health services.

1.2 Research Design

The literature above has guided the research question of this study and informed its aims and objectives, as set out below.

Research question: How might religious concepts and practices contribute to personalised mental health care for depression in the UK Muslim population?

1.2.1 Aims & Objectives

1. Conceptual Objective: Undertake a comparative analysis between Islamic concepts and practices with psychotherapeutic interventions in the National Institute for Health and Care Excellence (NICE) Guideline for depression in adults.

2. Empirical Objective: Investigate the perspectives and experiences of Muslims receiving mental health care for depression and their service providers; as well as explore their views and experiences as they relate to the potential contact points identified in Objective 1, and what further amendments to them may be required.

3. Practice Objective: Analyse the viability of such faith-based connections to NICE approved psychotherapies, first from the perspective of Muslims' views about appropriate treatment, respect for their values, developing acceptability, trustworthiness, and agency; while also considering the second aspect of whether such adaptations are practicable in a health care delivery context, focussing on obtaining practical coherence with person-centred treatment for depression.

1.2.2 Methodology

The research question above requires a qualitative epistemic framework to facilitate a detailed understanding of participants' values, experiences, and attitudes; balanced by a reflexive and transparent exposition of the researcher's role in data collection and analysis (Singh, 2017). This qualitative research design draws inspiration from a practical Symbiotic Empirical Ethics (SEE) methodology (Frith, 2012), as developed within the field of bioethics. This approach connects, in an iterative and integrated fashion, the comparative conceptual aspect of this project, with empirical interview data. Such an approach offers a myriad of ways of understanding how the concepts and values considered in this research question may "*take shape through embodied processes and practices of lived experiences in local contexts*" (Singh, 2017); and how understandings of these concepts and values ought to be refined by the insights gained from taking this stance. Hence, the methodology is a didactic process to create symbiosis between conceptual development and phases of empirical studies, which is relevant for this research design.

Frith's (2012) symbiotic methodology arises from an epistemic perspective that, "*sees practice as informing theory just as theory informs practice – the two are symbiotically related*." Such an approach is appropriate for this research question, as it regards the origins of theory as rooted in experience, hence achieving symbiosis becomes important and Frith (2012) outlines a five-step process for achieving it. First, describe the practical circumstances or case; second, identify specific relevant theories and principles; third, use those theories as a priori lenses to examine the empirical data; fourth, enable insights from the data to prompt

refinements or extensions of the theory; and fifth, draw normative conclusions or recommendations. This approach aims to produce ethical insights that are both contextually grounded and normatively robust. Whilst the research question is not strictly about ethical aspects of personalised mental health, nor seeking normative outcomes, this methodology is nonetheless appropriate, as it enables the two hemispheres of the project to interact symbiotically.

SEE as a methodology has been influential in the medical ethics research arena, for instance having been adopted for approaching ethical questions in practice (Redhead et al., 2024). There has nevertheless been challenge, as some have noted that methodologies such as SEE risk being vague in execution. For instance, there are concerns about transparency, such as how exactly one moves from thematic analysis of interviews to “ought” statements? If the process isn’t clearly defined, there’s a risk of cherry-picking data to fit a preconceived stance or allowing biases to seep into the research design under the guise of theory refinement (Mihailov et al., 2022). However, the same study also finds that when executed correctly, SEE doesn’t derive normative views mechanistically from the data, but rather used empirical data to test and inform normative positions. In the context of this study, empirical data can reveal whether a given principle (such as personalisation of psychotherapeutic interventions) is feasible or how people interpret it, thereby providing a platform to rigorously test conceptual positions and theories (Mihailov et al., 2022).

One of the alternative potential methodologies considered for this research design was Reflective Equilibrium (RE), which like SEE, seeks coherence between

particular judgments and general principles. To a certain extent, the development of SEE was partly inspired by a wide reflective equilibrium style of reasoning. Ives and Draper (2009) describe an "*encounters with experience*" model of RE where the researcher enters the field, gathers data, and iteratively adjusts theory and data interpretations to seek balance. Whilst this is similar to the iterative approach in SEE, the key difference is that SEE lays out a concrete five-step procedure that can be consistently implemented. As such, whereas RE can be relatively unstructured, SEE operationalises the process in a framework that promotes consistency. In addition, whereas RE strives for internal coherence, SEE also emphasises external validity, thereby ensuring outputs from such methodologies have what Dunn et al. (2012) would regard as critical practical relevance and acceptability, which is very valuable for this research question.

Given the methodological strengths of SEE, this project is advanced by lessons from how Frith (2012) connects conceptual understanding with empirical insight, all within a symbiotic relationship, that sees both as mutually reinforcing. Hence, SEE is an overarching approach and set of commitments that are taken seriously and learned from, however, this study is not formally applying SEE as a methodology, as it is not strictly a 'empirical ethics' project.

Notwithstanding the above clarification, the five-step process of SEE has been applied within this research design, in pursuit of symbiosis between the conceptual and empirical. The first step of describing the practical circumstances of the research context began with the discussion in Section 1.1 above, setting out the parameters of the UK Muslim population and the experience thus far in the

literature of personalised psychotherapeutic interventions for depression. This process continues below with reflexive reflection, situating the researcher in this research project. Second, the process of identifying specific concepts is undertaken in Chapters 2 and 3 below, employing Deductive Content Analysis. Third, the ten contact points between Islam and psychotherapy identified above are used as a priori lenses to analyse the semi-structured interview data of practitioners across a range of disciplines and service users from the UK Muslim community. The fourth and fifth steps of using empirical insights to refine conceptual analysis and ascertaining appropriate recommendations or implications have been undertaken in Chapter 7, which contains a discussion of the results and analysis, how they relate to each other and any symbiosis.

Reflexivity

Qualitative inquiry is grounded in interpretivist and constructivist paradigms that reject the idea of the researcher as a neutral observer. Instead, the researcher's subjectivity, in the form of their values, experiences, perspectives and knowledge, is viewed as inexorably intertwined with the research process (Mortari, 2015). 'Reflexivity' refers to a researcher's critical self-awareness about this influence, involving a continuous process of self-critique and examination of one's own biases, assumptions, and positions of influence, together with how these shape knowledge production (Day, 2012). Furthermore, reflexivity should not necessarily be a solitary exercise, but rather a collaborative process across a research team (Olmos-Vega et al., 2023).

With the above points in mind, the researcher in this project has been conscious of being the sole researcher. However, at all times there were two supervisors to provide reflective challenge and test assumptions. In addition, the researcher has also had positions of responsibility in the UK Muslims community through ministry work. Hence, the conceptual work discussed herein, particularly from Chapter 3, has been shared with and debated with Muslim communities across the UK, online and on global Muslim TV channels. Indeed, this project has been supported and advanced by a significant portfolio of public engagement activities that has both advanced the recruitment strategy, and assisted in holding up a mirror for the researcher's reflexive personal evaluation. Whilst the researcher's role in the Muslim community as a Shaykh assisted in building trust in the project, thereby encouraging participants to come forward, particularly males who may have been resultant to participate in reach on such a sensitive topic. However, there was also the risk of unintended consequences of participants giving answers that they may not have given to another researcher. As a result, the interview protocols were designed with the supervisors to mitigate such risks by being both clear and consistent across all participants (see Appendix 4.3). The process of data analysis was discussed with the supervisory team at regular intervals, thereby also mitigating the risk of bias. In addition, careful analysis was undertaken to ensure contraindicating and divergent findings were not overlooked (see Section 7.1.2).

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CHAPTER TWO: COMPARATIVE RESEARCH METHODS

The process of building a bridge between Islamic faith-based concepts and practises and psychotherapeutic interventions for depression offered in the NHS, as per the National Institute for Health and Care Excellence (NICE) Guideline for depression in adults (NG 222), requires a clear method for symbiosis between both sets of texts. For this purpose, Deductive Content Analysis has been selected, as it provides a transparent approach to identifying and using a priori sources, in this case the NICE Guideline, to read other sources, which are theological texts in this study. As regards sources for Islam, since this project is about Muslims in contemporary Britain, appropriate contemporary sources have been selected to reflect well-established practice and familiar concepts in the wider UK Muslim community, particularly those that connect with psychotherapeutic techniques from interventions recommended in the NICE Guideline. The outcome of the analysis is a coding matrix that identifies ten psychotherapeutic techniques from the interventions recommended in the NICE Guideline that are congruent with Islamic concepts and practices. This framework is then applied to developing an analysis matrix that provides a heat map illustrating the strength of connections between those ten techniques and each of the relevant interventions for depression from the NICE Guideline.

2.1 Methods for comparing psychotherapy and Islam

This section is devoted to explicating methods adopted for a comparative analysis between NICE approved psychotherapeutic interventions for depression in Clinical Guideline 222 (NICE, 2022), with Islamic concepts and practices that are widely known and practiced in the UK Muslim community. The first part of the following discussion begins with introducing the primary method employed herein, the deductive form of Content Analysis, which is an established qualitative research method (Section 2.2). Thereafter, methods for promoting trustworthiness of Content Analysis are considered (Section 2.3), together with alternative methods and why these were not selected (Section 2.4). The second part of the discussion (Section 2.5) applies the Deductive Content Analysis method introduced in 2.2 to the process of deriving relevant psychotherapeutic techniques from the NICE Guideline (2022) that relate directly to the research question. The resulting ten concepts provide a lens through which psychotherapeutic dimensions of common Islamic concepts and practices can be identified and encapsulated within two broad categories of self-knowledge and resilience. The research question provides the perspective through which the NICE Guideline can be observed, which in turn serves as the a priori text for identifying relevant psychotherapeutic aspects of Islam (spanning scripture and worship), as summarised in the diagram below.

Figure 2.1.A: Deductive Content Analysis method for comparative analysis

In summary, using a Deductive Content Analysis method, ten psychotherapeutic techniques are identified from NICE approved interventions that are relevant to the research question. These techniques provide the coding framework for examining contemporary Islamic sources, with the aim of identifying psychotherapeutic correlates. The findings from each step are presented as tables of heat maps that constitute the analysis matrix for each component of the research design, culminating in an aggregate analysis matrix (in Section 2.5), a heat map that illustrates the contact points and extent of psychotherapeutic similitude between the NICE guideline for interventions for depression among adults (2010) and Islamic concepts and practices that are commonly known in the UK Muslim community.

2.1.1 Deductive Content Analysis

Deductive Content Analysis is a well-established methodology that has been used across health-related research, ranging from nursing (Kyngäs & Kaakinen, 2020) to counselling (McKibben et al., 2020). This is a method that is also well suited to undertaking comparative analysis, often utilised to address research questions that seek to compare specific concepts across different contexts (Kyngäs & Kaakinen, 2020). Hence, this method is ideal for addressing the comparative

analysis aim of this project. As discussed in Chapter 1, undertaking a careful and rigorous comparison of psychotherapeutic concepts from Islam and the NICE Guideline for depression is important for considering person-centred mental health care for Muslims in the UK experiencing depression, particularly in relation to adapting existing interventions, so as to make them more accessible and easier to adhere to for this population, that has long suffered from health inequality.

From the broad range of qualitative empirical methods, Content Analysis is particularly pertinent to this research question, as it can be been applied to any form of text or audio-visual data, including theological content, such as sermons (McKibben et al., 2020). A second useful feature of Content Analysis is that it can provide a clear exposition of multi-faceted topics, employing matrix summaries to distil complex results. This is in keeping with other qualitative methods, particularly Framework Analysis, that has been designed chiefly for interview data (Spencer & Ritchie, 2012), which is why it has been employed in this study, as the method for empirical analysis of interviews with service users and providers. Elo and Kyngäs (2008) point out that Content Analysis has considerable methodological flexibility, accommodating a range of data types, with inductive and deductive approaches.

Deductive Content Analysis is a version of Content Analysis that has the added feature of foregrounding earlier knowledge, to guide initial coding frameworks. This method is ideal for addressing the research question, given the pre-existing structure of clinical guidelines and the need to be attentive to the conceptual framework provided by Clinical Guideline 222 (NICE, 2022). Hence, this deductive approach provides valuable methodological structure that can serve to frame and

address the research question, since "*any written material can serve as the input for deductive content analysis*" (Kyngäs & Kaakinen, 2020).

McKibben et al (2020), who follow Krippendorff (2018), provide a clear analytical structure for conducting Deductive Content Analysis, consisting of four steps which they refer to as '*unitizing*', '*sampling*', '*recording*', and '*reducing*' (see Figure 2.1.B). This framework provides a clear method for structuring the content analysis of this comparative study, enabling the analysis of texts in a comparative fashion across different sources (from NICE and Islam).

Deductive Content Analysis facilitates insights to emerge from the data and to be organised into a priori deductive categories, unless the data suggests that entirely new categories are necessary. Such a balance between being guided by earlier knowledge, whilst remaining open minded about new findings, mitigates the risk of narrow deductive approaches that foreclose such possibilities of unexpected findings from the evidence, as warned by Neuendorf (2011). The components of the Deductive Content Analysis method applied herein are explicated below, in keeping with the process set out by McKibben et al. (2020).

Figure 2.1.B: Deductive Content Analysis methodological process

Step 1: Unitizing data for analysis

The aim of this first step is to identify the data sources that need to be analysed, in order to properly address the research question. A salient feature of Content Analysis, both deductive and inductive, is that it can handle a broad range of data 'units', including text, audio, video, and photographic sources. The appropriate unit of data to be analysed for this study is textual content, rather than audio, video or images, given that the NICE guideline and relevant Islamic sources are textual.

Step 2: Sampling units

Having established what form of data units are relevant for a research question, the next challenge is one of sampling, to determine which units are to be analysed (Krippendorff, 2018). Sampling strategies are varied, including purposive, randomised, quota, stratified, and multistage (Neuendorf, 2011). Purposive sampling is commonly used in qualitative studies (McKibben et al., 2020), which have the advantage of being pragmatic and focussed on the research question, but require a transparent rationale. The purposive sampling strategy used herein is discussed in each specific iteration of the research process below (Sections 2.2 and 2.3). The character of the textual units in the sample herein is sections of text, typically paragraphs, that capture the contextual meaning of the point being made. Details and nuances are identified through appropriate focus on sentences, or in some cases specific critical words, where they are instrumental in shaping the direction of the paragraph overall. Hence, both literal interpretation and wider contextual readings capture the complexity of connotations, thereby weaving a rich tapestry of meaning that is relevant and specific to the research question.

Step 3: Recording categories

This process harnesses previous knowledge (i.e. a priori texts) to establish an initial coding framework, by clarifying categories for interpreting the sample units (Krippendorff, 2018). As McKibben et al (2020) note, "*Researchers organize their a priori categories into a codebook that clearly identifies each category and its levels*". Hence, the conceptual framework is mapped out, clarifying the thematic content the researcher expects to find in the sample (textual) units. As such, the a priori theory or body of literature guides the approach to data coding. Therefore, the clarity of category definitions is important for the internal validity and reliability of the resulting coding framework (Neuendorf, 2017). This process can be summarised in a coding sheet or matrix that can be referred to while the researcher is reducing units into categories, i.e. doing the actual coding (McKibben et al., 2020). Details of how this step is implemented herein are set out in Sections 2.2 and 2.3.

Once *a priori* categories have been established, they can be operationalised by creating categorical variables that can be binary, scored '0' if the category is absent from a given sample unit, or '1' if it is present (Wester & McKibben, 2016). Alternatively, a multi-level process can be utilised for operationalisation, enabling greater nuance in the coding framework and subsequent analysis matrix. For instance, Avent et al. (2015) followed the latter approach for studying peer feedback in counselling supervision, with multiple levels for each category. This is the preferred approach for this study, as set out further in the applied Sections 2.2 and 2.3 below.

Step 4: Reducing units into categories

Reducing is the deductive coding process of inferring categories from the data, based on the codebook from the preceding step, whilst retaining flexibility to include new or unexpected findings (Krippendorff, 2018). The coding process should ideally be conducted by a team of coders, regularly tracking interrater reliability, with recourse to a consensus process for reconciling inconsistencies between coders (McKibben et al., 2020). However, one of the limitations of this study is that with a single researcher, it was not feasible to have multiple coders for each text. In an attempt to limit the risks from this weakness, three mitigations have been established. First, reflexivity is built into the research design at the outset (in Chapter 1), making the coder's perspective explicit (both to himself and readers), thereby providing transparency and vigilance regarding potential bias. Second, all source texts and analysis are available to two independent supervisors, who can conduct random audit checks on any coding. Third, upon completion of the coding process, a cross check was undertaken by the researcher against the extant literature to establish credibility in light of previous knowledge (see the discussion in Chapter 7).

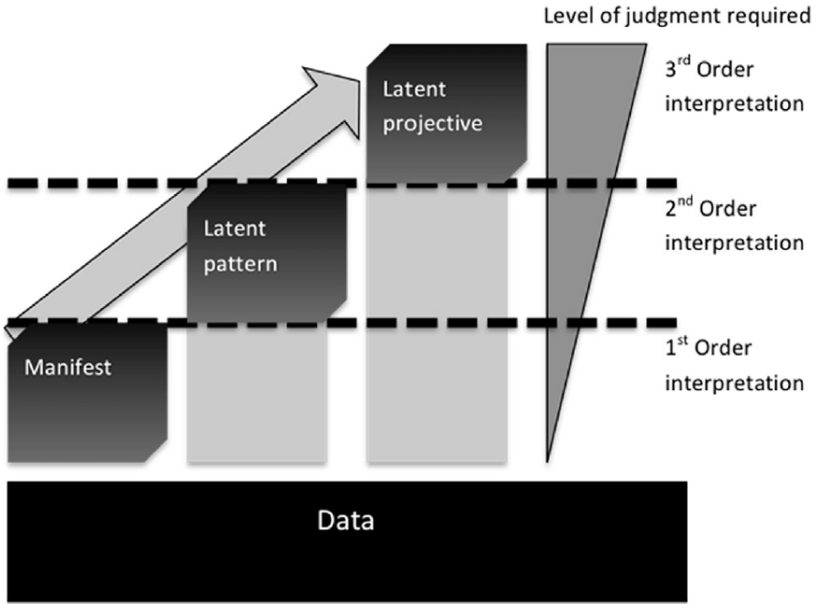
Turning to the critical methodological issue of *how* text is to be interpreted in order to be coded, in a guide of how to employ Content Analysis in a qualitative study, Bengtsson (2016) points out, *"The researcher must choose whether the analysis should be of a broad surface structure (a manifest analysis) or of a deep structure (a latent analysis)."* In this study, the depth and complexity of the research question requires that the method of applying a coding framework will be to primarily seek 'latent' (implicit) meanings, as opposed to simpler 'manifest'

(explicit) meanings (Gray & Densten, 1998), so as to explore the purposive deeper structure, rather than the literal surface appearance of a given aspect of NICE guidance or Islamic teachings. Seeking 'latent' meanings is important for research questions relating to psychology of religion, particularly when focussed on mental health, since these contexts are generally oriented towards deeper experiential and perceptual questions, such as how an individual may interpret and apply a particular concept in daily life, thereby requiring reflection upon direct connotations, indirect associations and deeper understandings. In their discussion of Content Analysis methods, Gray and Densten (1998) highlight the importance of looking beyond simplistic statistical frequencies of certain observable or 'manifest' phrases or comments, but rather to look deeper at the 'latent' structural meaning conveyed by a text.

Notwithstanding the above emphasis on latent interpretation, Cash and Snider (2014) point out that it is helpful to maintain a balance between explicit manifest and implicit latent insights, so as not to overlook the direct value of literal statements, particularly when differentiating phenomena and descriptions of experiences. Ultimately, Kleinheksel et al. (2020) find that one of the strengths of Content Analysis is the possibility of synthesizing both latent and manifest findings, so as to bring to fruition the potential of a rich and nuanced understanding that this qualitative data analysis method offers. In an attempt to link these modes of interpretation, Cash and Snider (2014) offer a framework with three levels of judgement required from the coder. First order '*manifest*' interpretation consists of a literal reading of the manifest text, with minimal judgement required. Second order '*latent pattern*' interpretation requires

judgements regarding patterns in the first order or raw data, ascribing meaning based on extant theory. Third order '*latent projective*' interpretation requires greater judgement from the researcher to identify deeper processes underpinning the second order patterns. This approach is applicable to this study and is illustrated below.

Figure 2.1.C: Framework linking manifest and latent interpretation for coding



Source: Cash and Snider (2014, p. 451)

The next aspect of 'Step 4: Reducing units into categories' is the process of summarising the resulting comparative analysis in the form of a table, with texts as rows and thematic categories as columns, known as an '*analysis matrix*' in the Content Analysis literature (Kyngäs & Kaakinen, 2020). Such results tables are typically populated with numbers or text denoting category levels (Miake-Lye et al., 2020). However, analysis matrices have also been presented as heat maps in a range of health research studies. For instance, in their Content Analysis of

pregnancy support groups, Wexler et al. (2020) presented two separate heat maps (with different colours) into one overarching table, combining such visual reporting with concise textual comments. Such heat maps operationalise their categories with many levels using a number of colour gradients. In a recent study of evidence for physical distancing to control COVID-19, Jones et al. (2020) presented their analysis matrix in a simpler format, as a heat map illustrating low, medium and high levels of each category, denoted by red, amber and green. Content Analysis has often been utilised for literature reviews. In a broad survey of organizational readiness for change, Miake-Lye et al. (2020) presented their analysis matrix in a single colour heat map of five shades of blue, facilitating five-level operationalisation of each category. Thus, heat maps are an established form of presenting analysis matrices in a clear format.

Given the research question, together with the aim of this comparative analysis, a feasible and appropriate degree of granularity is four categorical levels, denoting strong, moderate, weak, or no relationship between a coding concept (‘recording category’) and the textual data (‘sampling unit’). This builds on the clarity of the three-level approach of Jones et al. (2020), by adding the possibility of a null result, which provides analytical equipoise for this study. Borderline cases are determined with recourse to the judgement of second order ‘latent projective’ interpretation discussed above, in keeping with Cash and Snider (2014).

2.1.2 Trustworthiness of Content Analysis

There is considerable literature on the trustworthiness of qualitative research in general. As regards the specific context of trustworthiness of Content Analysis, Kyngäs et al. (2020) follow the framework of Lincoln and Guba (1985), which sets trustworthiness as the primary criterion for appraising the rigour of qualitative research. As outlined in the steps below, this study has sought to implement their key recommendations across the five dimensions of credibility, dependability, confirmability, authenticity, and transferability.

Credibility

This dimension of trustworthiness is contingent upon two aspects. First, the research design being robust enough to ensure that the findings are believable. Second, clear measures are adopted to generate confidence in the reporting methods. In striving for these objectives, the method herein aims for clarity and transparency. Deductive Content Analysis has the advantage of being explicit about the source of the coding categories (in this case the NICE Guideline NG222), as well as being clear about findings, through the summary table (analysis matrix) presentation. An important consideration is openness about both the strengths and the limitations of the study. The discussion and conclusion chapters (7 and 8) of this study are relevant for this objective. The confidence of the researcher is also regarded as critical by Kyngäs et al. (2020), which is why Chapter 1 also has a section on reflexivity, so as to establish transparency at the outset regarding the familiarity, commitments and experiences of the researcher, together with consideration of potential risk of bias, so that the resulting

transparency enables the reader and researcher to ‘walk together’ through the entire analytic process.

Dependability

The central factor in determining dependability is the consistency of the “…*research starting point, data collection, and analysis*” (Kyngäs et al., 2020). One of the attractions of Deductive Content Analysis is that it provides an internally consistent method for addressing the research question, by harnessing existing knowledge and applying it to a new context. This project harnesses the psychotherapeutic categories of the NICE guideline and applies them to the context of Islamic texts, for the objective of identifying congruent concepts, values and practices. Dependability is promoted by the internal consistency of the methods employed and transparency about how they are implemented. It is for this reason that the categorisation process above has been made explicit, with a matrix summary of findings, so as to facilitate evaluation of the research design and implementation.

As noted above, an important limitation of this study is that the peer examination approach to generating dependability was not an option, as this study has only a single researcher, thereby precluding the possibility of rigorous inter coder reliability (ICR) assessments and quantitative ICR coefficients to demonstrate dependability numerically. However, dialogue between colleagues is also regarded by Kyngäs et al. (2020) as relevant for generating credibility, which this study benefits from through team supervision and wider discussion with other

researchers, both informally and through structured formats, including lectures, seminars, and conference presentations.

Confirmability

The extent to which the data supports the findings of a study determines confirmability. The Deductive Content Analysis method offers a powerful tool for building this aspect of trustworthiness through the reporting framework. The matrix reporting approach, summarising categories and data sources, explicitly shows which specific data sources identified each category (Miake-Lye et al., 2020). In this regard, it should be easier for researchers to spot their own biases in the findings. For instance, if there are large gaps in the results matrix, or if credibility has been sacrificed to populate certain cells in the matrix, in an unreasonable or inappropriate fashion. The transparency of the matrix approach of reporting results is invaluable, as it effectively holds up a mirror for researchers to check for their own biases in findings that may not be supported by the data. In such instances, peer review can also very helpful, which this study benefits from.

Authenticity

Referencing of underlying sources in identifying categories builds the authenticity of trustworthy research. Such citations of texts should support each category, which is why Step 3 in the applications below provides narratives for each intervention described in the NICE guideline and how each relates to the identification of the ten psychotherapeutic categories, explicitly linking the ‘results’ in the Categorical Matrix (Figure 2.2.A) to the ‘data’ in the NICE guideline.

Transferability

Trustworthiness in the context of transferability denotes the potential applicability of research findings to different contexts. In this sense, the current study has sought to be focussed on the specific research question. As such, the extent of transferability would be constrained to consideration of interventions for depression among other faith communities, beyond the Muslim community. This limited degree of transferability could nevertheless be very beneficial to members of other faith groups, who collectively form approximately two thirds of the UK population, according to census data (Office of National Statistics, 2011).

The cumulative effect of the above measures to promote these five different dimensions of trustworthiness should provide robustness to this study, hopefully fulfilling the quest for rigour, for which Lincoln and Guba (1985) set trustworthiness as the primary criterion.

2.1.3 Alternative considerations

Prior to explicating the precise application of Deductive Content Analysis to this study, it is important to outline alternative methodological strategies, and to reflect upon why these were not ultimately chosen.

Hermeneutics

Hermeneutics is a natural starting point when seeking a method for interpreting texts, particularly in a theological context (Schleiermacher, 1998). More specifically, when the research question contains psychological dimensions, or consideration of latent meanings, Schleiermacher's approach to hermeneutics becomes a reasonable methodological candidate, given his pioneering explicit inclusion of psychology in the theory of textual interpretation (Schleiermacher, 1998). Unsurprisingly, with the recent rise of wider interest in psychology and mental health, there is resurging interest in the hermeneutics of this leading German Romanticist philosopher. As a biblical scholar, exegesis was a primary interest for Schleiermacher. However, as a liberal theologian, he was keen to interpret Christian teaching by taking into consideration modern knowledge, science and ethics (McGrath, 2013). As such, he sought to include psychology as a component of exegesis to access latent meanings, particularly when manifest or literal interpretation of scripture conflicted with prevailing knowledge. His route into psychology was through the philosophy of language, building on Herder's doctrine that thinking is contingent upon and constrained by language, such that ideas were constrained to linguistic parameters. However, Schleiermacher also posited that images play an essential role in meaning as well (Forster, 2005). Whilst

Schleiermacher's approach to hermeneutics is broad and interesting, a key challenge for researchers is operationalising this method in a way that is sufficiently structured to meet credibility and dependability criteria for trustworthiness of modern medical research.

Phenomenology

Given the importance of considering structures of experience and consciousness when reflecting upon personalised interventions for depression, it is reasonable to also consider phenomenology, particularly comparative phenomenology, as this study compares Islamic and psychotherapeutic concepts and practices, as applied to the lived experiences of Muslims in the UK. Furthermore, there is precedent in the literature for using this approach to compare Hindu scripture with positive psychology (Pattni, 2016). In addition, Interpretative Phenomenological Analysis (IPA) is also used for health psychology studies, providing insights into lived experiences (Smith & Osborn, 2015). However, Deductive Content Analysis provides a clearer method for operationalising the analysis required for this research question, particularly if consistency is a required benchmark to adhere to, since the framework is codified far more explicitly and transparently than a typical phenomenological approach, which for this research question, appears more as a style of thinking than a method that can be implemented in a robust fashion with adequate procedural transparency and rigour. Given a different research question, perhaps one that was not as clinically oriented, the flexibility that phenomenology offers might have been more attractive. However, the importance of harnessing existing knowledge in the NICE guideline, via a deductive process, makes the

chosen method more trustworthy and robust than a phenomenological approach may have offered.

Abductive Analysis

Within the realms of qualitive methods, there is value in Abductive Analysis as a method for linking ideas that are not explicitly related, particularly using the approach of Tavory and Timmermans (2014). However, this method is far more complex, as it connects ideas indirectly, thereby comparing unfavourably to Deductive Content Analysis on the criteria of simplicity, transparency, consistency (dependability) and credibility of clear results (due to its complexity). Furthermore, by drawing abductive connections between psychotherapy and Islam, the method risks seriously underestimating the strength of correlations between psychotherapy and Islam, whereas Deductive Content Analysis provides an approach to explicitly show the congruence between them in a way that can be operationalised, given the clarity of the deductive reasoning method for such comparative analysis, whereas abductive reasoning does not provide such a clear chain of reasoning with explicit foundations built upon previous knowledge. In the context of the current research question and the central role of the NICE guideline in mental health services, the deductive clarity offered by the DCA method is of critical importance to this study.

2.2 Identifying Islamic concepts in the NICE Guidelines

In order to derive relevant psychotherapeutic techniques from the interventions for depression approved in the National Institute for Health and Care Excellence (NICE) guideline for depression in adults (NG 222), a Deductive Content Analysis was undertaken, so as to provide the basis for subsequent comparison to Islamic concepts and practices. The four-step method outlined above has been implemented and set out below.

Step 1: Unitizing data for analysis

The unit for analysis is the text of the NICE Guideline for depression in adults - Clinical Guideline 222 (NICE, 2022), which is an online textual publication, rather than audio, video or images (such as photography and artwork that could be relevant for some religious traditions).

Step 2: Sampling units

The NICE guideline offers evidence-based recommendations to health and social care professionals in England, but also applies to Wales. Whilst the term ‘guideline’ may suggest practitioners are free not to follow them, the judiciary have established in several landmark cases that have shaped common law in this field that the NICE guidelines are the yardstick for clinicians and cannot be ignored. For instance, in *R (Elizabeth Rose) -v- Thanet Clinical Commissioning Group* (2014), it was held that the CCG did not have the discretion not to follow NICE guidance

because they disagreed with it. The importance of abiding by the NICE guidelines was reiterated in the landmark case of *Montgomery -v- Lanarkshire* (2015). Hence, service providers across the range of clinical disciplines are expected to pay heed to the NICE guidelines, as a key benchmark of health care provision.

The *NICE Guideline on the Treatment and Management of Depression in Adults* Clinical Guideline 222 (NICE, 2022), which replaced Clinical Guideline 90 (National Collaborating Centre for Mental Health, 2010), includes evidence-based guidance on psychotherapeutic interventions. This body of knowledge is regarded as clinically important in the UK National Health Service (NHS), thereby making it particularly well suited to this study, given the research question focusses on UK based Muslims experiencing depression.

Step 3: Recording categories

The process of identifying, defining, and operationalising categories from the NICE guideline can be structured as a response to two sequential questions, starting broadly and then focussing more narrowly. Such a ‘general-to-specific’ order is regarded as a key feature of the deductive method of organisation, in contrast to the ‘specific-to-general’ order, which is a characteristic of the inductive method (Rizvi, 2005, pp. 27–28).

Part A: Which part(s) of the NICE guideline NG222 are relevant for addressing the research question?

When the NICE guideline is examined through the lens of the specific research question that this study seeks to address, the psychotherapeutic interventions in the recommendations come into sharp focus. Since pharmacological interventions such as SSRI antidepressants are beyond the scope of this study, those recommendations in the NICE Guideline are not relevant for this study, as they are unrelated to religious concepts and practices. Hence, the focus of this study is aspects of the text that relate to first-line psychological treatments for less severe and more severe depression, whereby faith-based considerations may be incorporated into case conceptualisation by a service provider seeking to deliver personalised mental health care.

The most relevant parts of the NICE Guideline NG222 for the research question at hand are the treatment options set out in Tables 1 and 2, which draw a distinction between ‘less severe depression’ and ‘more severe depression’. These interventions are presented “*in order of the committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors*” (NICE, 2022, pp. 31–61).

Part B: Which relevant psychotherapeutic techniques are contained in interventions for depression from parts of the NICE guideline NG222 identified in Part A?

The process of addressing this specific query required analysing the NICE guideline using a latent interpretative method, within the parameters of relevance for the wider research question. As discussed above, latent interpretation is supported by the literature. Furthermore, in the specific context of this exercise, a latent approach is a common feature of studies where prior theory can support the analysis (Cash & Snider, 2014), such as in relation to the personalised mental health component of the research question. This is particularly the case for studies with a range of definitions regarding key concepts (Chakrabarti, 2006), as is the case with the Islamic dimension of the research question, as well as studies of a highly contextual and cognitive nature (Hayes, 1989), such as psychotherapeutic interventions for depression within the NICE guideline.

As regards the prior training and contextual expertise of the coder in such studies, Amabile (1982) highlight the role of expert opinion for a latent projective approach, just as Sarkar and Chakrabarti (2011) use the intuition of experts as one form of validation of their evaluation method. This relates to the reflexivity discussion in Chapter 1, that sets out the relevance of the researcher's theological background and training. In addition, there is also critical reflection built into the process through supervisory support, to create parameters on potential biases in intuition and opinion.

The focus of the analysis was to ascertain the Islamically relevant psychotherapeutic techniques in each intervention, viewed through the specific lens of this research question. Based on this Deductive Content Analysis method, ten techniques were identified across the range of psychotherapeutic interventions in NICE guideline NG222, with group-based or individual versions of interventions such as Cognitive Behavioural Therapy (CBT) or Behavioural Activation (BA) considered together. The most relevant parts of the NICE guideline for this step in the DCA method are the key features of each psychotherapeutic intervention, with descriptions of how each treatment is delivered, together with wider considerations (NICE, 2022, pp. 31–61).

The outcome of the process, based on a latent projective approach, was the following ten psychotherapeutic techniques (or ‘recoding categories’ in DCA terminology). These ten are classified into two groups of five in ‘self-knowledge’ and ‘resilience’ categories, based on thematic congruence between the techniques, as summarised in the coding matrix below (Figure 2.2.A).

Specific details of which psychotherapeutic techniques feature in each intervention, and to what extent, are set out in the discussion under Step 4 below, as summarised in the *Analysis matrix of interventions* (Figure 2.2.B).

Figure 2.2.A: Categorical coding matrix from NICE Guideline NG222

SELF-KNOWLEDGE GROUP	RESILIENCE GROUP
Goal setting	Optimism and hope
Awareness of thoughts	Motivation and agency
Recognising emotions	Gratitude
Mindfulness practices	Relationships
Bodily awareness	Behaviour patterns

It should be noted that the two over-arching categories of ‘self-knowledge’ and ‘resilience’, with five therapeutic techniques allocated to each, have considerable overlaps and connections between them. Hence, the groups should be considered as two sides of the same coin of mental health techniques, rather than a Venn diagram construct of entirely distinct areas sharing some overlaps. Given the cross-relationships between the groups, their constituent techniques could justifiably be moved from one to the other. Ultimately, it does not make much difference beyond presentational convenience, as the subsequent analysis is undertaken with regard to individual techniques, rather than at group level aggregations.

It should be noted that the ten techniques above have commonly understood definitions in psychotherapy, albeit with some technical and potentially contested connotations. In the interests of transparency and clarity, natural interpretations, based on standard dictionary definitions of each term, are used in this analysis.

Two factors are relevant in this regard. First, the NICE Guideline does not dwell on semantic differences of definitions, but instead relies upon common interpretations. We can therefore conclude that such differences are not critical to making analytic progress within the NICE framework. Second, the research question at hand does not require digressing into contested definitions of these concepts, particularly since they would be clarified between a clinician and patient, as part of a good therapeutic alliance. Hence, this study seeks to emulate the approach utilised in the NICE guideline and uses common definitions, thereby mitigating the risk of unnecessary confusion that could detract from the aim of clarity and simplicity.

Step 4: Reducing units into categories

In order to derive a deeper exposition of the specific question in Part B above and address it clearly with an analysis matrix, relevant sections of the NICE Guideline (as identified above) were coded deductively and latently, on the basis of the coding categories identified in Step 3 above (summarised in the coding matrix in Figure 2.2.A). Based on this deductive approach, the strength of connection between each intervention and the ten psychotherapeutic techniques from Step 3 above were identified and scored. The results are summarised in the heat map below, *Analysis matrix of interventions* (Figure 2.2.B). Interventions are presented in the order in which they appear in the NICE Guideline, focussing on individual therapies (not group treatments), since this research project is about personalised mental health. Scores were deliberately kept qualitative, with colours rather than numbers, to resist the temptation of false quantification, thereby remaining explicit

that this is a qualitative assessment of links between each category and intervention. The approach of using colours in this way to create heat maps was discussed in Section 2.1 above and has been adopted in a number of studies, including Wexler et al. (2020), Jones et al. (2020) and Miake-Lye et al. (2020).

The qualitative score ascribed to each link between a category and intervention is either '*strongly related*', '*moderately related*', '*weakly related*', or '*unrelated*', as per the commentary below for each intervention. The level '*strongly related*' is ascribed to a technique that is clearly mentioned (manifest) or implied (latent) in the NICE guideline. An implied presence would occur where the points mentioned in the text require the technique in question as an integral part of the intervention. A technique would be scored as '*moderately related*' if the considerations above were only met through third order '*latent projective*' interpretation (see Figure 2.1.C). The classification of '*weakly related*' would apply to a technique that was not explicitly mentioned in the NICE Guideline text and a latent reading produces a reasonable, though weak link. Techniques that are largely irrelevant for a given intervention are classified as '*unrelated*', in the quest for trustworthiness. The key factor for boundary conditions is the context of the research question, such that where potential congruence exists, a technique may be upgraded accordingly. Notwithstanding the above, it is not reasonable to get overly concerned about any individual score, since nothing critical hinges on whether techniques are categorised as 'strongly' or 'moderately' related, as it is the general pattern of analytical congruence, particularly points of contact, that each analysis matrix reveals through the heat map method.

Figure 2.2.B: Analysis matrix of interventions from NICE Guideline NG222

	SELF-KNOWLEDGE					RESILIENCE				
	Goal setting	Awareness of thoughts	Recognising emotions	Mindfulness practices	Bodily awareness	Optimism and hope	Motivation and agency	Gratitude	Relationships	Behaviour patterns
Guided Self-Help										
Cognitive Behavioural Therapy										
Behavioural Activation										
Mindfulness and Meditation										
Problem Solving										
Interpersonal Psychotherapy										
Counselling										
Short Term Psychodynamic Psychotherapy										

Strongly related	
Moderately related	
Weakly related	
Unrelated	

Key for qualitative scoring

The ten psychotherapeutic techniques in the coding matrix above (Figure 2.2.A) had reasonably strong connections to at least one intervention from the NICE Guideline, as illustrated in the above Analysis matrix of interventions (Figure 2.2.B). Other than these ten techniques, no other relevant techniques emerged from the DCA exercise. To be clear, the order of the techniques is not implied by the NICE guideline, but is simply for presentational convenience herein, based on thematic congruence of the techniques. There are no hierarchical implications, nor assumptions about clinical efficacy within the order in which they appear. With the above qualifications in mind, a summary of the connections between each intervention from the NICE Guideline and the ten psychotherapeutic techniques is set out below.

Guided Self-Help (GSH): according to the narrative in the NICE Guideline, this intervention could include materials from CBT and BA. Hence the considerations discussed below for both those interventions would apply. However, GSH is broader and more flexible, with clear goals oriented towards resolving current issues. Hence, relationships and to a lesser extent, gratitude practices, could be relevant. Overall, GSH has the broadest congruence to the ten psychotherapeutic techniques identified in the coding matrix (Figure 2.2.A).

Cognitive Behavioural Therapy (CBT): this intervention is from the original model developed by Aaron T. Beck (1979). Primary ideas include meta cognition and learning self-evaluation techniques to manage thoughts, emotions, and behaviours. Group Cognitive Behavioural Therapy added skills related to relationships and relaxation. Whilst there is no direct mention of goal setting, it

would be an implied (latent) feature of this intervention, since it is presented as a structured programme, during which goal setting would be a natural start, particularly given the clear educational thrust, which is likely to entail some degree of hope when embarking upon the process. Whilst there is no explicit link to mindfulness practices, the concomitant meta-cognition training is directly congruent with it. The practice of gratitude appears unrelated.

Behavioural Activation: this learning-based model encourages a focus on positive task-focused activity. The importance of the therapeutic alliance introduces links to goal setting and optimism. Focussing on positive behaviour patterns is likely to impact upon relationships, optimism and a sense of agency. No connections were found with mindfulness practices or gratitude practices, although they may form part of the positive behaviours advocated by this intervention.

Mindfulness-Based Cognitive Therapy (MBCT): this was presented in the previous NICE Guideline CG 90 (National Collaborating Centre for Mental Health, 2010) as part of the CBT family, with specific focus on mindfulness practices, bodily awareness and behaviour patterns, which are reasonably likely to have an impact on relationships. In addition, there is a sense of agency and goal setting, together with self-compassion, thereby also creating a connection with gratitude.

Problem Solving: this model emphasises learning to manage the link between depression and social problem solving, together with challenges such as rumination. Given the focussed nature of the intervention on implementing coping behaviours, particularly in a social setting, a sense of agency is clear, together

with awareness of thoughts and emotions. Goal setting is explicit, while optimism is somewhat related to the structure of the therapeutic alliance. However, there are no discernible links to meditation, bodily awareness or gratitude practice.

Interpersonal Therapy: there is an obvious focus on positively managing external relationships, rather than internal meta-cognition. Gratitude is likely to be important in maintaining relationships. No links to meditation or bodily awareness were identified.

Counselling: the profound personalisation of this intervention and generalised description in the NICE guideline suggest clear goal setting in the context of broad self-awareness, which would be required to formulate the objective of counselling. The citation of the British Association for Counselling and Psychotherapy (BACP) brings in factors that would promote "*a greater sense of well-being*", which in the context of the research question, could reasonably include all the categories, albeit with varying degrees of application.

Short Term Psychodynamic Psychotherapy (STPP): the exploratory and non-directive nature of this therapy suggests lesser relevance of goal setting compared to other interventions, with great emphasis on awareness of thoughts (both conscious and unconscious), emotions, behaviours, and particularly relationships. The role of meditation, personal agency, or gratitude are unclear.

2.3 Deriving psychotherapeutic concepts from Islam

The next methodological step in the overall research design (illustrated in Figure 2.1.A) builds on the 'general-to-specific' method adopted for Step 3 of the DCA process in Section 2.2, with Part A and B questions being used to derive psychotherapeutic concepts from the NICE guideline. This subsequent stage takes a further step and builds upon those insights by using the coding framework in Figure 2.2.A to ascertain which Islamic concepts and practices are relevant for this study, and to derive psychotherapeutic contact points from them. This requires posing the next sequential question.

Part C: Which key Islamic concepts and practices that are widely known in the UK Muslim community potentially contain some or all of the psychotherapeutic techniques identified in Part B?

The range of Islamic sources set out in Step 2 below ('sampling units') explicate the core practices of Islam, clarifying the lived reality of this faith community. The concepts discussed are not abstract theology, but practical and enacted Islamic values. As such, the response to the question in Part C above consists of commonly known and widely practiced aspects of Islam. First, scripture has a prominent role, particularly the first chapter of the Qurʾān, which consists of seven verses that are recited ten times a day in five obligatory prayers. Second, daily prayers that are spread across five points of the day, from early morning to evening. Third, fasting, particularly the obligatory fasts during the month of *Ramaḍān*. Fourth, mindfulness practices that are implemented daily across a

range of Islamic communities. Fifth, the rich collection of Islamic psalms is a resource for the Muslim community that is used regularly, typically daily or at least once a week in many Islamic communities. The first three of these aspects of Islamic lived experience are obligatory and stipulated in Islamic law, while the fourth and fifth are optional, though sufficiently well-known and practiced to be relevant herein. Whilst there are many other Islamic concepts and practices that could potentially also be relevant, these five cover a sufficient proportion of the terrain to make them sufficient for this study, and their importance make them necessary. Collectively, therefore, they are both necessary and sufficient for addressing the research question.

In order to provide sufficient granularity to the analysis to be useful in a practical context, this analysis is undertaken sequentially in the following chapter, focussing first on Islamic Scripture (first chapter of the Qurʾān) in Section 3.1, followed by the five daily prayers in 3.2, fasting in 3.3, mindfulness in 3.4, and psalms in 3.5, culminating in an overall summary of contact points in 3.6. Each of the sections follow the Deductive Content Analysis method, each with their own analysis matrices. Section 3.6 contains an aggregate analysis matrix that synthesises the overall comparative analysis, presenting a summary of contact points between psychotherapeutic and Islamic concepts.

Step 1: Unitizing data for analysis

The ‘unit’ for analysis is textual data, specifically the relevant religious texts outlined below, rather than audio, video or images.

Step 2: Sampling units

For this study, the 'sampling unit' consists of paragraphs and stanzas of text that may shed light on potential similarities between Islamic concepts and practices on the one hand and techniques from psychotherapeutic interventions for depression in the NICE Guideline on the other. For the purposes of this comparative analysis, a pragmatic approach was adopted for purposive sampling, with the following two selection criteria: first, Islamic texts in English that facilitate finding practical contact points or congruence with psychotherapeutic interventions for depression; and second, texts that are broadly historically contemporary to the NICE guidelines, rather than classical theological treatises that may contain material that could be less accessible or relevant to service providers and clinicians who provide interventions for depression to Muslims in twenty-first century Britain. This second criterion may itself be a 'contact point', by being historically contemporary with the NICE guideline. An important consideration is that nothing significant for the research question is lost by focussing on modern texts in English, rather than classical texts in Arabic. This is because the selected modern texts contain all the Arabic liturgy and scripture required for practising Muslims in modern day Britain. Whilst there are a great number of texts that could arguably fulfil both the above criteria, the texts selected below capture the day-to-day faith practices of contemporary Muslims across denominations in clear and accessible formats.

The primary text of Islam is Qurʾānic scripture, the analysis of which includes exegetical texts such as *Al-Mīzān* (Ṭabāṭabāʾī, 1983) and more recently, *The*

Study Qurʾān (Nasr et al., 2015), selected due to their broad ecumenical approach and analytical clarity. The Muslim community is generally well versed with the first chapter of the Qurʾān, known as *Sūrat al-Fātiḥah*, which consists of seven short verses and is required to be recited in each of the five daily prayers (*ṣalāh*). Therefore, it is recited at least ten times each day. Hence, this is a pragmatic starting point in the quest to find comparative material. The above two selected exegeses fulfil the purposive strategy of addressing the research question.

After examining scripture, the discussion moves to required practises mandated by scripture in Islamic law (*fiqh*), particularly the five obligatory daily prayers (*ṣalāh*) mentioned above, together with fasting (*ṣawm*), which is required during the Islamic month of *Ramaḍān*, but also recommended at other times of the year. In order to explore potential connections with psychotherapeutic principles in the NICE Guideline, a simple and clear modern text of these concepts and practices was selected: *The Core of Islam* (Milani, 2011), written by one of the foremost contemporary Islamic scholars in the UK, takes an ecumenical approach and is therefore representative of the main denominations and jurisprudential traditions within Islam. Following a discussion of daily prayers, the next section reflects upon fasting, drawing upon the insights of *Sulūk al-ʿĀrifīn (Path of the Mystics)* by Javad Tabrizi (2005), that provides considerable psychological insights into fasting, together with *Mafātīḥ al-Jinān (Keys of the Heavens)* by Abbas Qummi (2003), which is a pragmatic prayer manual. Thereafter, considerations of mindfulness meditation in Islam are enriched by *Kernal of the Kernal*, a manual of esoteric spiritual practices by Ṭabāṭabāʾī (2003), and a paper on *Muraqaba as a Mindfulness-Based Therapy in Islamic Psychotherapy*, by Isgandarova (2019).

The fifth dimension of comparative analysis is the rich literature of psalms (*duʿāʾ*) in the Islamic tradition. William Chittick's translation of *al-Ṣaḥīfah al-Sajjādiyya* (Zayn al-ʿĀbidīn, 1988) makes accessible in modern English perhaps the oldest extant collection of Islamic psalms, which contain substantial cognitive and behavioural psychological content, used mainly in the Shīʿa Muslim community, but also known in the Ṣūfī and Sunnī communities.

Step 3: Recording categories

The Deductive Content Analysis conducted in Section 2.2 above provides the a priori categories for this step, as summarised in the coding matrix in Figure 2.2.A.

Step 4: Reducing units into categories

The texts set out in Step 2 above are coded deductively using a latent method, so as to derive the main psychotherapeutic aspects of the first chapter of the Qurʾān, daily prayer, fasting, mindfulness practices and key psalms. Each will be summarised in a separate analysis matrix heat map in subsequent sections.

Latent interpretation is a particularly important method for this step in the Deductive Content Analysis, since deriving psychotherapeutic dimensions of Islamic concepts and practices requires delving into "*a deep structure*" (Bengtsson, 2016), necessitating multidisciplinary considerations, spanning theological and psychological factors. For instance, as part of the five daily prayers, there are components involving recitation while standing, bowing and

prostrating. Crucially, there is also rising from prostration, when one is on the ground, to return to a standing position. The process of getting back to one's feet is repeated twelve times each day, over the course of the five daily prayers (distributed through the day from early morning to evening). Whilst a manifest coding approach would simply note the rising movement and invocations recited during it, a latent interpretation would reveal the deeper psychotherapeutic aspects of building resilience that this symbolic movement of rising to one's feet offers, particularly when considered in light of the empowering invocations recited at the time. The centrality of this prayer practice for so many Muslims in the contemporary UK context is a function of its importance in Islamic law. As such, many employers, particularly in the public sector, have accommodated Muslim employees' wish to pray during the working day by making provision in the workplace for prayer rooms or other private spaces.

The final part of the Deductive Content Analysis method is the overall analysis matrix, presented in Section 3.6 as an aggregate analysis matrix that summarises the comparative analysis and addresses the research question by illustrating in a heat map the potential points of contact between psychotherapeutic concepts from the NICE Guideline and Islam.

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CHAPTER THREE: COMPARATIVE CONCEPTUAL ANALYSIS

Deductive Content Analysis is used as a method to undertake a comparative analysis between Islamic concepts and practices, with psychotherapeutic techniques from the NICE guideline for depression (NG222), within two broad categories of self-knowledge and resilience. These techniques were applied as ten components of a coding framework to identify correlates from five key Islamic concepts and practices: scripture, daily prayers, fasting, mindfulness and psalms. The results are structured in analysis matrices, aggregated in an overall matrix that reveals a variety of contact points between concepts and practices from Islam and the NICE Guideline. These symbiotic connections differ from previous studies by considering Islamic practices as potential *vehicles* for psychotherapeutic interventions, rather than *alternatives* to them, thereby empowering service providers to deliver personalised psychotherapeutic interventions to Muslims.

The comparative analysis undertaken herein informs the interview study in subsequent chapters, which address the empirical objective of the project to investigate the perspectives and experiences of Muslims receiving mental health care for depression and their service providers, as well as explore their views and experiences as they relate to the potential contact points identified from the comparative analysis, together with identifying what further amendments to them may be required, in order to further the delivery of personalised mental healthcare.

3.1 Psychotherapy within Islamic Scripture (Qurʾān)

The Muslim community is generally well versed with the first chapter of the Qurʾān, known as Sūrat al-Fātiḥah, which contains seven short verses and is required to be recited twice in each of the five daily prayers (ṣalāh), distributed from early morning, to the afternoon and evening. It is therefore recited at least ten times each day by devout Muslims. This chapter is also recited as a spiritual gift for the sick and those who have died. It is commonly taught to young children and memorised, particularly to facilitate performance of daily prayers. Given its centrality to Islamic daily practice, it is a natural starting point in the quest for comparative material.

Two exegetical texts will provide the a priori source for the Deductive Content Analysis process: Al-Mīzān (Ṭabāṭabāʾī, 1983); and The Study Qurʾān (Nasr et al., 2015). Al-Mīzān is a famous work by ʿAllāmah al-Sayyid Muḥammad Ḥusayn al-Ṭabāṭabāʾī, published in twenty volumes of Arabic, providing a detailed analysis of each verse of the entire Qurʾān, using internal cross-referencing from across the Qurʾān and also focussing on grammar and syntax, thereby capturing linguistic nuance, which is often where psychological dimensions of a verse can be found. As such, it is regarded as a classic in the Qurʾānic exegesis (tafsīr) and interpretation (taʾwīl) literature, featuring in prominent compilations. One such modern compilation is The Study Qurʾān, which provides breadth of perspective, by distilling insights from a range of prominent exegetical works. The combination of these two sources provides this study with the requisite depth and breadth to explore connections with psychotherapy.

3.1.1 Introduction to the first chapter of the Qurʾān (Sūrat al-Fātiḥah)

Scripture is of central importance in Islam and the Qurʾān is regarded as the primary source of Islamic spiritual teachings (Mayer, 2011). The Qurʾān consists of 114 chapters (singular *sūrah*), each of which has a unique name. The first chapter is called *Sūrat al-Fātiḥah* (The Opening Chapter), consisting of seven verses. Despite its brevity, the content spans theology, spirituality and psychology.[3] This first chapter is also widely known as *Sūrat al-Ḥamd* (Chapter of Praise). Given it's prominence in the Islamic consciousness, it has been the subject of Islamic art and often the page containing *Sūrat al-Fātiḥah* in printed copies of the Qurʾān is ornately decorated and sometimes illuminated in gold leaf, as illustrated in Figure 2.2.A (MS Digby Or. 2, 1541).

In keeping with the parameters of the research question at hand, this analysis will focus on relevant aspects of each verse, as identified through the '*Reducing Units Into Categories*' stage of the Deductive Content Analysis process (Step 4). Hence, as set out in Section 2.1 above, pertinent aspects of the interpretation and exegesis from *Al-Mīzān* (Ṭabāṭabāʾī, 1983) and *The Study Qurʾān* (Nasr et al., 2015) will be coded deductively using a latent method, so as to derive the main psychotherapeutic aspects of the first chapter of the Qurʾān, using Figure 2.2.A above as the coding framework.

[3] Qurʾānic referencing convention is in the format of chapter (*sūra*): verse (*āyah*). As such, the opening chapter is referenced as 1:1-7.

Figure 3.1.A: Illuminated specimen of Sūrat al-Fātiḥah in a Qurʾān manuscript

Source: Oxford, Bodleian Library MS Digby Or. 2 (1541 CE); fol. 4v

The communal context in which this chapter is used varies widely. *The Study Quran* (Nasr et al., 2015) sets out a range of contexts within which *Sūrat al-Fātiḥah* is utilised in the Muslim community, serving as an opening for many functions in everyday Islamic life. It is often recited at the beginning of religious services, at the start of a meal, as a grace to bless the food and thanksgiving. It is also recited at funerals and more generally for the benefit of the soul of someone (or a group of people) who has (or have) passed away. It can also be used as a blessing for the sick, hence one of its titles is "The Cure" (*al-Shifāʾ*). From a daily practice perspective, it is recited in each cycle (*rakʿah*) of all the canonical prayers, therefore recited at least ten times a day, across the five obligatory daily prayers (*ṣalāh*). As a result, Nasr et al. (2015) points out that it is also known as *Sūrat al-Ṣalāh* (The Chapter of the Prayer).

As regards the status of *Sūrat al-Fātiḥah* in the Muslim consciousness, Nasr et al. (2015) point out that the numerous commentaries of it, some consisting of "*hundreds of pages*", is indicative of its exalted status. One of the titles given for this chapter is *Umm al-kitāb* (Mother of the Book), as it is regarded as a precis of the Qurʾānic text and its most important chapter. *The Study Quran* goes on to explicate this idea with reference to a teaching of ʿAlī ibn Abī Ṭālib (*as*) (d. 661),[4] the Prophet Muḥammad's (*saw*) cousin and son-in-law, who became the first *Imām* (apostle) of Shīʿa Islam (632–61) and the fourth Caliph of Sunnī Islam (656–61), "*The whole of the Quran is contained in the Fātiḥah, the whole of the Fātiḥah*

[4] The suffix (*saw*) is a common honorific used in Islam after the name of Prophet Muḥammad, denoting the abbreviation of *ṣallā-Llāhu ʿalayhī wa ʾālihī wa sallam* (blessings and peace of Allāh be upon him and his progeny), or simply *ṣallā-Llāhu ʿalayhī wa sallam* (blessings and peace of Allāh be upon him). Similarly, the suffix (*as*) after the name of an apostle (*imām* in Shīʿa Islam) abbreviates *ʿalayhi-salām* (peace be upon him).

in the bismillāh [the first verse]*, the whole of the bismillāh in the bāʾ* [the opening letter ب]*, and the whole of the bāʾ in the diacritical point under the bāʾ*." This diacritical point (a dot) represents the primordial beginning of creation.

When examining the above through the lens of the coding framework in Figure 2.2.A, the elements that come into focus are goal setting, optimism and hope, motivation and agency, gratitude, and relationships, as they are all directly related to the contextual use of *Sūrat al-Fātiḥah*. Indirectly related psychotherapeutic concepts include awareness of thoughts, recognising emotions, as well as behaviour patterns, through the use of this chapter in daily prayers.

As illustrated in Figure 3.1.A, *Sūrat al-Fātiḥah* is a short chapter that consists of just seven short verses (each called an '*āyah*'), which take about half a minute to recite all together, as is apparent in the transliteration below. Despite the relative brevity of this opening chapter of the Qurʾān, there is a deep richness to the content, particularly from a psychotherapeutic perspective, as explored in the following Deductive Content Analysis.

3.1.2 Psychotherapeutic aspects of each verse of Sūrat al-Fātiḥah

This analysis is divided into three parts, to examine how each verse may relate to psychotherapeutic concepts. First, the original Arabic of each Qurʾānic verse is presented, so as to root the discussion in scripture, regarded as sacred by

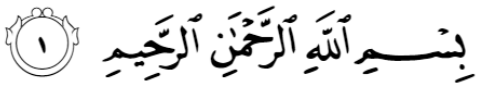
Muslims and would therefore carry important salience.[5] Second, each verse will be transliterated to make the Qurʾānic text accessible to non-Arabic readers.[6] Third, the Arabic is translated into current UK English. Since translation is an act of interpretation, where there are multiple candidate translations, the one that is accessible to the widest audience has been selected, in order to make it usable by mental health service providers and patients who may not have any prior theological training. Fourth, the exegetical literature in the two selected sources is considered in the context of the research question, including consideration of grammar and syntax, where linguistic analysis may be relevant. Fifth, a latent interpretation of psychological connotations and implications is explored, as per the methods discussion above.

[5] The Arabic text of the Qurʾān is widely available in published texts and online, including https://quran.com/, which has been used herein due to image clarity.

[6] The method of transliteration employed herein is Library of Congress (LoC), due to its wide adoption in research literature (https://www.loc.gov/catdir/cpso/romanization/arabic.pdf) [accessed 30 September 2025]. However, it should be noted that this can differ from the way Arabic text is actually pronounced. For instance, the LoC approach to transliterating the definite article as "*al-*", regardless of whether the initial consonant of the word to which it is attached is a 'sun' or 'moon' letter (Rule 17c), generates disparity between the academic transliteration convention and correct Arabic pronunciation. For instance, unlike the transliteration presented for Verse 1:1, the pronunciation would be "*bismi-llāhi r-raḥmāni r-raḥīm*". This is a common issue in transliterating Arabic into English. For instance, Nasr (2015) sets out the following in the transliteration preface of *The Study Quran*,

> *"When spoken or recited, the l in the definite article al- takes on the sound that follows it in the case of certain consonants, traditionally called 'sun letters': t, th, d, dh, r, z, s, sh, ṣ, ḍ, ṭ, ẓ, l, n. For example, al-nūr is pronounced an-noor, not al-noor."*

Verse 1:1



“Bismi-Llāhi al-Raḥmāni al-Raḥīm.”

“In the Name of Allāh, the Most Compassionate, the Most Merciful.”

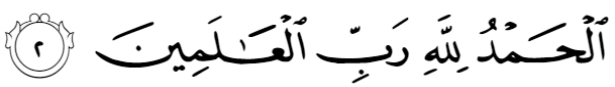
All but one of the 114 chapters of the Qurʾān begin with this verse, known as the “*bismillāh*”. As a result, this verse has a very important place in the Islamic consciousness, particularly when commencing any action, whether a large project or a short journey. One of the reasons for the prominence of this verse in goal setting for Muslims is the widely accepted teaching (*ḥadīth*) of the Prophet Muḥammad (saw), “*Every important affair not begun with the name of Allāh shall remain incomplete…*” (Ṭabāṭabāʾī, 1983). The implication being that actions performed with the intention of being for the sake of Allāh and undertaken in His name shall be abiding, perhaps even beyond the efforts of the individual, thereby giving that action a share of eternity, to the extent that it is related to Allāh (due to His attribute as the Eternal).

Both sources suggest that from a grammatical perspective, the preposition “*bi* ” (in or with), in the phrase “*In the name of Allāh*", is related to an implied verb, “I begin” or “I seek help”. This has direct links to goal setting in psychotherapy, together with optimism and motivation, as it puts the reciter in an active (rather than passive) mode of engagement, as a cause in our own life, assisted and supported by God. This could bolster a sense of agency and confidence to move forward in life, which can itself be a therapeutic aim.

Ṭabāṭabāʾī (1983) focuses on the term "*al-Ism*" (the [Divine] Name), as an introduction to the 'personhood' of Allāh, through this primary Divine Name. However, many other Divine Names convey His attributes, at least a hundred of which are often displayed in Islamic art. Two attributes are introduced in this verse as superlatives, by way of the theologically important Divine Names, *al-Raḥmān* (the Most Compassionate) and *al-Raḥīm* (the Most Merciful), which are used in mindfulness meditation (*dhikr*), particularly in the *Ṣūfī* tradition of Islam (see 3.4).

Given the relational aspects of this verse (with Divinity), it has potential psychotherapeutic contact points with countering loneliness, by making one feel supported in a relationship with the Divine, together with engendering a sense of confident purposeful action (and positive reinforcement of it), thereby facilitating behavioural activation (Lewinsohn, 1975). Such ideas are indirectly related to awareness of thoughts and emotions, as one examines one's intention and associated feelings, together with the potential for a sense of gratitude for the support and opportunity, provided the intention is appropriately framed.

Verse 1:2



*"al-Ḥamduli*Llāhi *rabbi al-ʿālamīn."*

"All praise be to Allah, Lord of the worlds."

For Nasr et al. (2015), praise translates *al-ḥamd*, related to extolling the Praiseworthy (*Maḥmūd*) and giving thanks to Him for all the bounties, abilities and opportunities He has bestowed in this world, as well as for the future reward that will be given in the next world. From a grammatical perspective, praise (*al-ḥamd*) is rendered in the definite rather than the indefinite, indicating that *all* forms of praise and *all* gratitude belong to God. Reflecting on future oriented thanks for blessings in the hereafter, in the context of His compassion and mercy, particularly since linguistically the superlative is invoked, could serve to mitigate soteriological anxiety and rumination, together with assisting reframing current triggers for anxiety or depression in order to reduce negative automatic thinking patterns associated with those triggers.

Nasr et al. (2015) note firstly that this universal approach to gratitude is associated with the following teaching of the of the Prophet Muḥammad (saw): "*When you say, 'Praise be to God, Lord of the worlds,' you will have thanked God and He will increase your bounty.*" Secondly, whereas gratitude (*shukr*) is given for what one has already received, praise is given for the qualities the One who is praised possesses prior to having bestowed anything and is thus more universal.

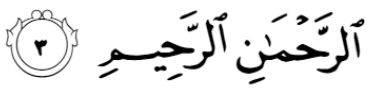
Similar to the *bismillāh* (in the name of God), the term '*al-ḤamduliLlāh*' (praise be to God) is frequently used by Muslims in a range of different contexts in ordinary life.[7] However, whereas the *bismillāh* is employed to consecrate a deed at its beginning, 'praise be to God' is employed to thank God for an act or event upon its

[7] The terms 'God' and 'Allāh' are used interchangeably herein. However, there is theological debate around differences between the terms that is not relevant to the research question at hand.

completion. It should be noted that traditional Islamic behavioural etiquette (*adab*) teaches that whenever one is asked how one is feeling, the correct response should be Praise be to God, no matter one's condition. This is common practice in the Muslim community and could be harnessed therapeutically to reframe one's perspective, prompting identification of and reflection upon something in one's life for which to praise God. An additional point of reframing is potentially available from the concept of *Lord of the worlds*, as placing a source of anxiety or challenge in the widest context of *al-ʿālamīn* (the entirety of creation) can be a therapeutic form of zooming out and revaluating the true scale of a particular problem.

From a relationship perspective, Lord renders *rabb*, which has connotations of a loving caretaker, with links to "cultivation" (*tarbiyah*), since God is the Caretaker (*murabbī*) of all things, including of human hearts and souls. This recognition of the relational aspect of the verse could serve to both cultivate confidence and agency, as well as mitigate low esteem, as scripture regards each of us a worthy of being worthy of benefiting from Divine love, invoking *rabb*.

Verse 1:3



"Al-Raḥmāni ʾal-Raḥīm"

"The Most Compassionate, the Most Merciful."

Nasr et al. (2015) point out that his verse repeats two Divine Names from the bismillāh, the Compassionate (al-Raḥmān) and the Merciful (al-Raḥīm), with al-

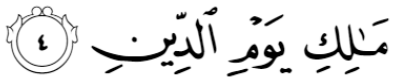
Raḥmān (the title of Sūrah 55) being a Divine Name implying the Loving-Mercy by which God brings forth existence, which therefore cannot be ascribed to anyone other than Allāh. Etymologically, both Names are intensifications of the word raḥmah, meaning “Mercy” or “Loving-Mercy.” This could help to mitigate soteriological anxiety, as well as obsessive or compulsive behaviours around excessive concern about correctly abiding by religious rules and prayer practices. This short but richly complex verse also has implications for managing emotions of low self-worth, as it can help to build self-compassion and self-esteem through the recognition that if this scripture suggests that God views each of us as worthy of His love and compassion, perhaps we could follow suit.

Nasr et al. (2015) present the relationship between these two attributive Names as different forms of light: “al-Raḥmān is like the light of the sun that illuminates the whole sky, and al-Raḥīm is like the particular ray of sunlight that touches a creature.” Ṭabāṭabāʾī (1983) contextualises this differently, citing Jaʿfar al-Ṣādiq (as), the sixth Imām of the Shīʿa tradition, to whom has been attributed the statement that, “al-Raḥmān (the Beneficent) is a special name with a general attribute; and al-Raḥīm (the Merciful) is a general name with a special attribute.”

From the perspective of Islamic metaphysics and cosmology, Nasr et al. (2015) provide an account of primordial creation as the Divine breath of the Compassionate” (Nafas al-Raḥmān) upon the immutable essences (al-aʿyān al-thābitah), which are the archetypes of all things in Divine Knowledge. Therefore, “…the very existence of the world is in essence nothing but the breath of Divine Compassion.” This preeminent role of compassion in scripture could be a contact

point with concepts of compassion in mindfulness based psychotherapeutic interventions. One possible application may be to addressing the maintenance cycles of low self-esteem and rumination, particularly as manifested in depression. The possibility of cultivating feelings of being blessed, and both loved and lovable, could be supportive in a therapeutic context.

Verse 1:4



“Māliki yawmi al-dīn.”

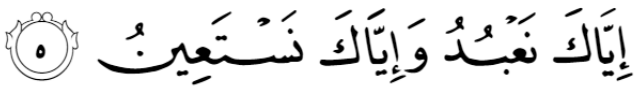
“Master of the Day of Judgment.”

This verse balances the hope and optimism of the first three verses with a grounded sense of responsibility. It balances the preceding declaration of innumerable gifts and benevolence bestowed upon humanity, with a recognition of ultimate accountability that can serve as a vaccine to inoculate the heart against undue exuberance or arrogance, encouraging an optimistic and cheerful disposition, grounded in humility. Hence, Nasr et al. (2015) cite advice attributed to the Prophet Muḥammad (saw), “Bring yourself to account before you are brought to account. And weigh your deeds before your deeds are weighed.”

Contact points with psychotherapeutic concepts include self-reflection leading to awareness of behaviour patterns and accountability for relationships, which theologically are a source of important responsibilities for which one would have to give account. Such reflection is indirectly related to improved awareness of

thoughts and emotions, together with physical actions, that may assist or hinder one's deeds when held to account. There is both motivation and optimism available in this verse, for success is achievable through Grace, which will be ultimately rewarded.

Verse 1:5



"Iyyāka naʿbudu wa iyyāka nastaʿīn."

"You [alone] do we worship and You [alone] do we ask for help."

Accordind to Nasr et al. (2015), this verse characterises humanity's servitude before God, as reflected by various linguistic tools. First, the construction of the sentence in which the direct object is placed before the verb (Ṭabāṭabāʾī, 1983). The syntax of the verse is structured to be predicated upon the unity or oneness of God (tawḥīd), a critical pillar of the Islamic creed, i.e. "You [alone] do we worship" (Iyyāka naʿbudu), rather than "We worship you" (naʿbudū iyyāka). Placing the concept of 'iyyaka' front and centre circumscribes the entire verse upon the unity of God. This sentence structure itself creates contact points with concepts such as awareness of thoughts but exercising the muscle of metacognition, requiring an evaluation of thinking patterns, while explicitly clarifying goal setting. In addition, the process of asking for help with confidence in the second half of the verse can serve to build optimism and motivation. This is alluded to in the Islamic mystical literature by Khomeini (2015) and has connections to cognitive therapy. For instance, when considering Aaron T Beck's (1979) seminal insight into the

importance of identifying and addressing negative automatic thoughts, recitation of this verse can provide a mirror to identify the extent to which maladaptive thoughts cloud one's experience of feeling blessed and Divinely supported.

The second grammatical point noted by both sources is that in verse 5 of this chapter, there is a clear shift to directly addressing God in the second person, a marked change from the third-person praise and glorification of God in vv. 1–4. To address Allāh as the Exalted Provider and Helper in the first-person plural rather than the singular also implies humility before the Divine (Ṭabāṭabāʾī, 1983), both because one is not focused solely upon oneself and because one acknowledges that ultimately only God has the right to say "I". Furthermore, the plural pronoun ("we") elevates participation in a collective above potentially egocentric individuality, facilitating humility and mitigating undue self-importance.

Ṭabāṭabāʾī (1983) offers a further psychological interpretation of the first-person plural, such that the worshipper should be present before Allāh, not only with one's body but also with one's heart and soul. Ṭabāṭabāʾī is therefore requiring of the supplicant a reasonable level of metacognition, necessitating awareness of different faculties within, all of which need to be summoned together to address God and seek help. Nasr et al. (2015) cite Ṭabāṭabāʾī (1983) in explicating the mindset of how this ought to be done, quoting Jaʿfar al-Ṣādiq (as), who is reported to have said,

> *"Worship is of three kinds: some people worship God out of fear, and that is the worship of slaves; other people worship God seeking reward, and that is*

the worship of hirelings; and some people worship God out of love, and that is the worship of those who are free, and that is the most excellent worship."

Freedom therefore becomes critical, although it requires the presence of many of the psychotherapeutic concepts considered herein.

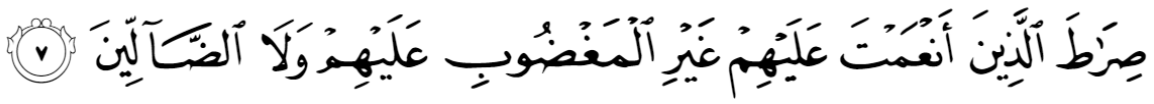
Verse 1:6

"Ihdinā al-ṣirāṭa al-mustaqīm."

"Guide us upon the straight path."

Nasr et al. (2015) present a distinctly resilience oriented interpretation of this verse, suggesting that "guide us" can be understood as a prayer for perseverance and steadfastness in following "the straight path". This invocation is to be supported with application of intellect to reach the truth upon a balanced 'middle way' that avoids extremes of worldliness or asceticism, thereby integrating the outward law (the exoteric) with inward spirituality (the esoteric). Hence, the Islamic community (ummah) is referred to as a middle community in the Qurʾān (2:143), avoiding extremism of any kind, but rather embracing balace. In order to achieve this, the recommended mindset is to understand the journey as "walking with God to God", since the Qurʾān asserts that Allāh guides the believers "… to Himself upon a straight path" (4:175), particularly as Prophet Hūd asserted, "… Truly my Lord is upon a straight path" (11:56). There are contact points here with a number of self-knowledge and resilience oriented psychotherapeutic concepts.

Verse 1:7


صِرَٰطَ ٱلَّذِينَ أَنعَمتَ عَلَيهِم غَيرِ ٱلمَغضُوبِ عَلَيهِم وَلَا ٱلضَّآلِّينَ ٧

“Ṣirāṭaʾlladhīna ʾanʿamta ʿalayhim, ghayriʾl-maghḍūbi ʿalayhim, walā al-ḍāllīn.”

“The path of those whom You have blessed, not of those who incur [Your] wrath, nor of those who are astray.”

Nasr et al. (2015) suggest that “*Those whom You have blessed*”, refers to actions already performed by God in the past, thereby conveying finality and certitude that God’s blessing has already occurred. “*Those who incur [Your] wrath*” implies that despite having already acted in a manner that may warrant Divine Punishment, God’s Wrath has not yet been sent to them, as the potential for repentance and forgiveness remains, since “…*God guides to Himself whosoever turns [to Him] in repentance*” (13:27). This creates a strong sense of accountability for one’s behaviour, while enabling strategically setting goals that abide by one’s values, facilitating a sense of agency and hope. A particularly important aspect of this is retention of hope after mistakes have been committed, such that one’s future is not condemned due to one’s past. The importance of hope in this context has been discussed by Khomeini (2015), such that hope for redemption can be harnessed to address rumination and can assist to (re-)establish balance.

3.1.3 Analysis matrix of psychotherapy and Sūrat al-Fātiḥah

The numerous contact points identified in this discussion are summarised below in the analysis matrix of psychotherapy and *Sūrat al-Fātiḥah* (Figure 2.2.B), with the same boundary conditions established in Section 2.3 above. The “Overall” score is derived by considering the greatest extent of relatedness for each coding category, across all seven verses of *Sūrat al-Fātiḥah*. To reiterate, the overall score is not provided by averaging the preceding individual component scores, as may be reasonable in a quantitative study. Rather, in keeping with the qualitative research design herein, each overall score represents a qualitative assessment of the strength of the most promising contact point(s). Hence, the strongest score from the individual components feeds into the overall row, which ultimately features in the aggregate summary analysis matrix (Figure 3.6.B). This distinctly qualitative approach provides an assessment of the overall potential for congruence between this particular dimension of Islam and NICE approved psychotherapeutic interventions for depression.

In summary, the matrix shows that *Sūrat al-Fātiḥah* provides strong connections to goal setting, metacognition and mindfulness concepts, together with potential for cultivating resilience through building optimism and a greater sense of personal agency, supplemented with a self-evaluation of behaviour patterns, supported by an attitude of gratitude. Relationships are indirectly related and there is less focus on physical connectedness to the body.

Figure 3.1.B: Analysis matrix of psychotherapy and *Sūrat al-Fātiḥah* (1:1-7)

	SELF-KNOWLEDGE					RESILIENCE				
	Goal setting	Awareness of thoughts	Recognising emotions	Mindfulness practices	Bodily awareness	Optimism and hope	Motivation and agency	Gratitude	Relationships	Behaviour patterns
Context & usage										
Verse 1:1										
Verse 1:2										
Verse 1:3										
Verse 1:4										
Verse 1:5										
Verse 1:6										
Verse 1:7										
OVERALL										

Strongly related	
Moderately related	
Weakly related	
Unrelated	

Key for qualitative scoring

3.2 Psychotherapy within daily prayers (*ṣalāh*)

Adhering to the Deductive Content Analysis method, the a priori source text for this section of the comparative analysis is Milani (2011), as discussed above. This rigorous yet accessible text is particularly appropriate, as it not only takes an ecumenical approach, but does so in a way that presupposes no prior knowledge of Islam, thereby making it congruent with the methodological approach adopted herein.

Building on a scriptural foundation, Milani (2011) introduces the role of daily prayers (*ṣalāh*, صَلاة) in Islamic worship practices using Qurʾānic verses, such as 20:14, which commands believers to establish prayer to remember God. However, very strong emphasis is placed on the internal psychological state of the worshipper, rather than simply the external ritual movements and recitations. Within the Deductive Content Analysis methodological framework, the context of daily prayer spans both self-knowledge and resilience in the coding framework. There is particular focus on metacognition and relationship with the Divine, rooted in an attitude of gratitude.

Milani (2011) sets out the five daily prayers that are obligatory upon adults, subject to certain exceptions. Each ṣalāh consists of two to four units (*rakaʿāt*), which comprise of standing (*qiyām*), bowing (*rukūʿ*), prostrating (*sujūd*), and sitting (*julūs* or *taslīm*). Figure 3.2.A below broadly illustrates these positions, though unlike in these diagrams, the back should be straight in each position. The five daily prayers are spread throughout the day, each with their prescribed timings, from

the early morning to late evening: *Fajr* has two units and is recited at dawn (before sunrise); the afternoon prayers *Ẓuhr* and *ʿAṣr* consist of four units each and are observed noon and late afternoon; whereas the evening prayers of *Maghrib* and *ʿIshāʾ* are three and four units respectively, performed at dusk (shortly after sunset) and later in the evening. Hence, there are a total of seventeen units (*rakaʿāt*) across the five daily prayers. Whilst the time taken for each prayer varies between individuals and their choices of which Qurʾānic chapters to recite, the typical time taken is approximately five to ten minutes per *ṣalāh*. This is potentially relevant from a clinical perspective, since ṣalāh is therefore a short enough activity to be feasible to incorporate into daily life (for Muslim patients/clients who wish to), as a practise that may have potential contact points with psychotherapeutic interventions.

In a global study, the Pew Research Center (2016) found widespread observance of daily prayer, across both men and women, such that in the vast majority of countries where Muslim populations were surveyed (34 out of 40), similar shares of Muslim men and women reported praying every day (71% and 72% respectively). This data illustrates the practical importance of this religious practice, thereby making it potentially relevant from a psychotherapeutic and population mental health perspective.

3.2.1 Introduction to daily prayers (ṣalāh)

Turning more specifically to the mechanics and methods of *ṣalāh*, it is appropriate to build on the principles of the primacy of Qurʾānic scripture, as set out in Section 3.1. There are many verses that relate to the daily prayer, some of which have important connections to elements of the coding framework, particularly those relating to metacognition. For instance, *Sūrat al-Māʿūn* (The Small Kindnesses) 107:4-5, "*So woe to those who pray [4]; yet are unmindful of their prayer [5]*." In addition to the Qurʾānic warning, as cited by Milani (2011), there are also promising messages of hope to those who are mindful during their *ṣalāh*. A noteworthy case is *Sūrat al-Muʾminūn* (The Believers) 23:1-2, "*Successful indeed are the believers [1]: those who during their prayer are humbly intent [2]*." Turning to the resilience dimension of the analysis matrix concepts, the Qurʾān draws an explicit connection between patience as resilience and *ṣalāh* practice, "*O you who have believed, seek comfort through patience and prayer; indeed, Allah is with the patient*" (*Sūrat al-Baqarah 2:153).* The term for patience (*ṣabr*) used in this verse is noteworthy, as it conveys connotations of resilient steadfastness, in an active (rather than passive) form of patience, rooted in hope and a palpable sense of agency.

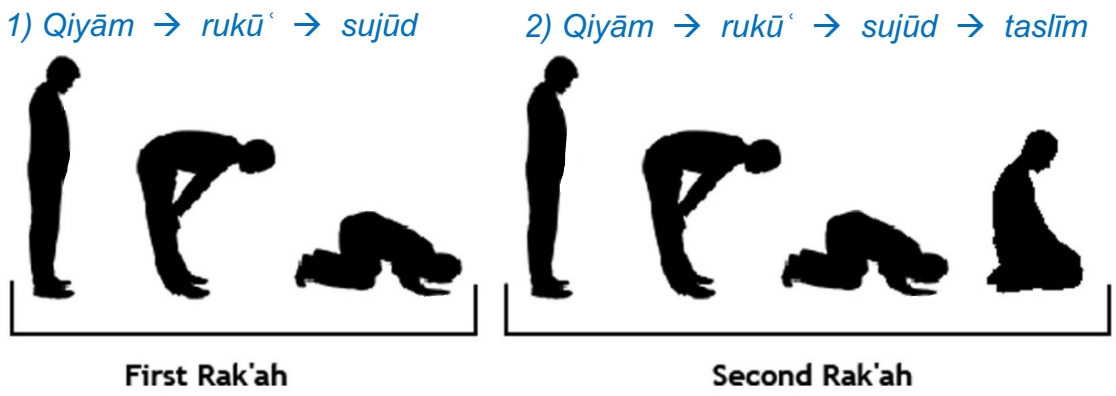
From behavioural and relationship perspectives, obligatory prayers can be performed either in solitude (*furādā*) or collectively (*jamāʿah*). When performed in congregation, as shown in Figure 3.2.B, worshippers line up in rows behind a leader (*imām*). Certain prayers are performed only in congregation, such as Friday prayers (*Ṣalāt al-Jumuʿah*), that includes two sermons (singular *khuṭbah*),

delivered by the *imām*. Milani (2011) echoes the widely established teachings that congregational prayers are vastly preferable and far more highly rewarded than individual prayers, such are the benefits of social interactions and congregational dynamics from praying together with others.

Viewing these aspects of Milani (2011) through the lens of the coding framework brings into sharp focus the centrality of metacognition in *ṣalāh*, principally awareness of thoughts, but also recognising emotions, thereby potentially serving as a tool to break the maintenance cycle of rumination, particularly negative automatic thoughts. In addition, several concepts that are related to resilience are also highlighted, including hope, gratitude, and relationships. Both of these dimensions of self-knowledge and resilience are explicated in detail in Section 3.2.2 below and summarised in the subsequent analysis matrix in Figure 3.2.C.

From a pragmatic perspective, the discipline required to establish daily prayer behaviour patterns is clear from the timings of the five daily prayers, distributed as opportunities for experiencing mindful presence throughout the day (Qurʾān 23:1-2). The existence of this disciplined practice throughout the day and across the week could serve as a contact point with psychotherapeutic interventions that require adherence to achieve therapeutic efficacy.

Figure 3.2.A: Physical positions within daily prayers (*ṣalāh*)



Source: https://quranalbums.wordpress.com/2015/08/16/salat-prayer/ [8]

Figure 3.2.B: Illustration of congregational prayer (*ṣalāt al-jamāʿah*)

Source: https://mecca.net/data1/images/islamic-photos/2017-4/7-14-d.jpg [9]

[8] Website accessed on 29 August 2021

[9] Website accessed on 29 August 2021

3.2.2 Psychotherapeutic aspects of daily prayers (ṣalāh)

The structure of daily prayers (*ṣalāh*) consists of a series of inter-connected components, each of which serve related but different functions, both theologically and psychologically, as the discussion below explicates. The eight-part structure below has been classified with regard to the content in Milani (2011), viewed through the lens of the research question at hand.

Step 1: Ablution (*wuḍūʾ*)

Appropriate preparation is an obligatory aspect of daily prayers, particularly clean clothes and ablution. *Wuḍūʾ* (partial ablution) involves using a minimal amount of water to cleanse the face, arms, feet and also wipe the head. This form of ablution is the most common and differs from *ghusl* (full ablution) where the whole body is washed in a structured shower (head, right side, then left side) or full immersion in a body of water. *Wuḍūʾ* contrasts with *tayammum* (dry ablution), which substitutes water for sand, soil, clay or stone (among other things), principally due to water scarcity or other harmful effects on the person. In addition to setting out these physical aspects of ablution, Milani (2011) stresses that the early Arabic texts suggest that the meaning of *wuḍūʾ "… encompasses mental as well as physical cleansing."* When this is considered through a latent reading, the notion of mental cleansing is congruent with texts of the mystical dimension of *ṣalāh*, such as Khomeini (2015). Such transcendent texts describe the mindset of an individual who is truly in the present moment during ablution, for whom *wuḍūʾ* is a mindfulness practice, as an experience of the ego fading away in the face of the

congregational whole, just as a single drop of water used for the *wuḍūʾ* merges unrecognisably into the rest of the water, there is an unveiling of the true oneness of Allāh (*tawḥīd*), the central tenet of the Islamic creed. Whilst such mystical experiences may be rare, what is readily accessible to practitioners during ablution is the metacognition that *wuḍūʾ* facilitates, grounded in the mindful cleansing of the body.

Step 2: Direction (*qiblah*)

Milani (2011) points out that Muslims pray in the direction of the *Kaʿbah* (lit. 'cube'), referred to by Muslims as 'House of God' (*Bayt Allāh*), situated in *al-Masjid al-Ḥarām* (the Sacred Mosque) in Mecca, which has been the global epicentre of Muslim worship and the site of Muslim pilgrimage (to be performed at least once by each person who has the means), regarded by Muslims as having been built by Abraham as a monument to *tawḥīd* (cf. Qurʾān 22:26).

Examining this from a latent psychological perspective highlights a few implicit aspects of this practice that has potentially important psychotherapeutic associations. First, *qiblah* should perhaps be regarded as much more of an inner orientation and not just an act of facing a particular direction on a compass, as discussed in Islamic mystical literature such as Amuli (1989). As such, turning towards *qiblah* becomes a simultaneous orientation towards mindful presence of connection with God, whilst turning away from the ruminations of the world (*dunya*) and its worries (i.e. the opposite side of the coin). Second, it should be noted that in that state of mindful presence, there is freedom from both the past

and future, as the *qiblah* stage of prayer is about connection with God in the present moment, as preparation for the encounter with Divinity that is about to begin with the commencement of *ṣalāh*. Third, with regard to cultivating resilience, particularly for mitigating feelings of loneliness, even when the prayer is offered in solitude rather than congregation, orientation towards the *Kaʿbah* creates a point of contact with all Muslims globally, not just across space, but also with Muslims of previous generations, across time, including saints (*awliyāʾ*) and prophets (*anbiyāʾ*) across the ages.

Among the preparations for *ṣalāh*, Milani (2011) also discussed the calls to prayer (*adhān* and *iqāmah*). Two points are relevant here for the question at hand. First, the calls to prayer explicitly invoke the Islamic creed in relation to the prophethood of Muḥammad (saw), one of those with whom one would be connecting when orientating oneself towards *qiblah*, thereby reiterating that relationship. Second, the *iqāmah* call to prayer contains a thought provoking verse, "*The prayer has (already) been established [started]" (qad qāmati al-ṣalāh)*. However, from a procedural perspective, according to Islamic law (*sharīʿah* or it's human understanding *fiqh*) the *ṣalāh* could not have started yet and begins later, suggesting that this must be an assertion about the psychological state of the worshipper, such that the appropriate degree of mindfulness is expected to have been established to feel a connection with God, so that when the prayer legally commences, the psychological connection would already have been established. Looking at this through the coding framework, this mental state would not only be a form of mindfulness practice, with the associated awareness of thoughts and feelings, but could also generate hope and gratitude, as part of focussing upon

Divinity. Concentrating on the present moment and relinquishing the shackles of rumination creates important contact points with psychotherapeutic interventions in the NICE guideline.

Step 3: Intention (*niyyah*)

The primary *a priori* source for this stage of the Deductive Content Analysis, Milani (2011), follows the wider Islamic literature in demarcating the formulation of intention in prayer (*niyyah*) as the first essential and obligatory component of the *ṣalāh*. Whilst the exact words, or indeed language, of formulating one's intention is flexible, the clarity of mind required to be conscious and present to what one is doing and why is essential. Milani (2011) points out that the recommended intention to "*draw close*" to God requires constancy of concentration throughout the prayer, such that *niyyah* encompasses the entire prayer, rather than simply being one stage of it.

As regards the coding of this, not only is *niyyah* directly related to invoking motivation for goal setting, but the psychological aspects of it are intimately connected to awareness of thoughts and emotions, as formulating intention at a deeper level requires a metacognitive awareness of one's current state, thereby also relating to aspects of mindfulness practice. In addition, intention in prayer is inherently an exercise in optimism and hope, as without it the practice would be rendered meaningless according to treatises on the esoteric dimensions of *ṣalāh*, such as Khomeini (2015) and Amuli (1989). With regard to the metacognitive point above regarding awareness of thoughts, particularly negative ones, and

recognising unhelpful emptions, there are important parallels to psychotherapeutic techniques offered by Beck et al. (2005) in relation to substituting automatic negative thoughts with more accurate thoughts that have a more helpful emotional effect. That process, supported within a therapeutic partnership, requires considerable self-reflection, which bears important points of contact with *niyyah*.

Step 4: Standing (*qiyām*)

Much of the prayer is spent in a state of standing (*qiyām*), in recitation of the Qurʾān (*qirāʾah*), beginning with *Sūrat al-Fātiḥah* and typically followed another short *surah*, as per one's choice and self-expression. This process commences with the consecratory legal commencement (*takbīrat al-iḥrām*), consisting of raising both hands and reciting "*Allāhu Akbar*", literally meaning *God is the Greatest*, but the grammatical use of the superlative of great relates to a deeper meaning of God being greater than all aspirations, worries, hopes and fears, such that when the prayer is consecrated with the assertion "*Allāhu Akbar*", the worshipper lays down all those forms of distraction and solely concentrates on connecting with Allāh, as He is deemed *'Akbar'* to all else. Therefore, for Milani (2011), the *takbīrat al-iḥrām* is a test of sincerity and an opportunity for self-evaluation of the extent of the worshipper's reliance upon Allāh (*tawakkul*). Hence, it could be viewed as priming for this form of metacognition, facilitating deeper awareness of thoughts and emotions. From a mindfulness perspective, it is reasonable to understand it as a form of relinquishing resistance to reality as it is, rather than clinging to an image or expectation of reality as one would wish it to

be. In this sense it is an invitation to enter the sacred space of the present moment, as a psychological cue to mindfulness.

Step 5: Bowing (*rukūʿ*)

Milani (2011) discusses both the physical and mental dimensions of bowing, setting out how the bowing is combined with recitation of a short doxology, during which a mindset of unconditional submission to God is invoked. Viewing this through the lens of latent interpretation unveils important implicit spiritual psychology. First, it is important in *rukūʿ* to cultivate the ability to accept reality as it is, rather than how we would wish it to be; thereby relinquishing resistance to what is happening in the lives of worshippers, together with rumination about it. Second, a related attribute appears to be the ability to see oneself as a flexible being, bowing and yielding to what arises, in harmony with the flow of life's vicissitudes. This also has important ramifications for how the individual views self and identity, ideally in a less fixated or rigid way. Indeed, the term '*Islām*' means to surrender or submit (to God's will). Third, the short one line doxology of praise used at this stage of *ṣalāh* (from the Qurʾān verse 56:74) is a form of *dhikr* (remembrance), which is associated with Islamic mindfulness practice (discussed further in Section 2.5 below), regarding which Milani cites the Qurʾānic verse 13:28 that declares, "…*truly in the remembrance ['dhikr'] of Allāh hearts find tranquillity.*" Fourth, the completion of the *rukūʿ* movement consists of rising from the state of bowing back to standing upright, with a statement of confidence and hope, declaring, "*Indeed Allāh hears one who praises Him."* This has connotations of universality, such that regardless of how worshippers may view themselves,

with whatever level of self-esteem they may have, the prayer is structured to remind each individual that theologically they are heard, which can be helpful for building a sense of self-worth. This is assertion is made all the more powerful when combined with the physical movement of rising from bowing to standing, contributing to a renewed sense of self.

Step 6: Prostrating (*sujūd*)

The image of a Muslim in prostration on the ground during prayer (*sujūd*) is a commonly recognised symbol of Islam. The image in Figure 2.3.B of congregational prayer at the *Kaʿbah* in Mecca shows the stage of prostration. Milani (2011) points out that this physical movement is accompanied by the Qurʾānic (87:1) doxology, “Glory be to my Lord, the Most High.” However, there is flexibility for other recitations, providing an opportunity for self-expression and personal inspiration. There are two prostrations in each unit (*rakaʿah*) with a brief moment of sitting in between. From a psychological perspective, what is recited during the pause has potential therapeutic congruence: “*I seek forgiveness from my [loving] Lord and turn [back] to Him*.” The word used for Lord, *Rabb*, with connotations of a loving and nurturing creator, as discussed in Section 3.1. This offers worshippers the opportunity to let go of all actual or perceived mistakes, turning refreshed and anew to the path that inspires them. It is worth noting that this invitation for renewal is presented seventeen times a day, in each unit across the five daily prayers. This creates clear contact points with psychotherapeutic interventions utilising optimism or motivation to cultivate hope or personal agency.

Step 7: Rising (nuhūḍ)

A critical but often underestimated step in *ṣalāh* is the process by which one goes from the end of each unit, when one is seated on the ground after prostration, back to one's feet into a standing position (*qiyām*) for the next unit (*rakaʿah*). Taking a latent approach to reading Milani (2011) highlights the psychological dimension of this process, which explicitly models resilience, rising from the ground back to one's feet, akin to responding to adversity that may knock us to the ground, from which we have the potential to recover. Since there are seventeen units across the five daily prayers, this process is undertaken no less than a dozen times a day, serving as a powerful metaphor of personal resilience in the face of the challenges of each day. The recitation that often accompanies this movement is instructional, declaring, "*By the strength of God, and by His power, I stand* [i.e. once again]…" It should be noted that the Arabic word for power here is '*quwwah*', which is often translated as 'faculty', implying that by the faculty bestowed upon me by God, I stand. In addition to the motivation, agency and optimism aspects of resilience related coding categories, this also relates to self-knowledge related codes and goal setting.

Step 8: Completion (taslīm)

Tashahhud is recited at the end of every two units, with *taslīm* added at the end of the *ṣalāh*. As the penultimate component of the prayer, *tashahhud* consists of a reassertion of the Islam creed of the unity of God and prophethood of Muhammad (saw), to whom blessings are sent at the conclusion of prayer in the *taslīm*,

together with others. The relevance of this stage is to bring together the various strands of the prayer discussed above, with an abiding sense of gratitude for the teachings of the prayer, relationship with those around you, particularly during congregational prayer, rooted in a renewed sense of purpose and direction.

3.2.3 Analysis matrix of psychotherapy and daily prayers (ṣalāh)

The various contact points identified in this discussion are summarised below in the analysis matrix of psychotherapy and *ṣalāh* (Figure 3.2.C), abiding by the same boundary conditions as the preceding analysis matrices.

The overall scores are based upon the relative relationships between each of the eight steps of *ṣalāh* with the ten psychotherapeutic categories. The resulting analysis matrix suggests that even though the daily prayers are a legal obligation in Islamic law, each component of *ṣalāh* has potentially relevant psychological dimensions. From a practical perspective, the points of contact identified through this Deductive Content Analysis method are within reach of lay worshippers, as they do not necessarily require any further time to be spent on the prayer. Rather, they entail a mental shift of perspective, so as to change the experience and psychological value of the same physical movements and recitations undertaken anyway, in fulfilment of Islamic legal obligations. Both the self-knowledge and resilience categories are well represented across the eight components of *ṣalāh*. What is striking from the overall row is the number of elements of *ṣalāh* that are directly to psychotherapeutic categories (8 of 10), with mindfulness and behaviour patterns being indirectly related to several components of daily prayers. The

aggregate effect is to create a rich opportunity for building bridges between NICE approved clinical interventions for depression and Islamic prayer practices that are well established in the Muslim community.

Figure 3.2.C: Analysis matrix of psychotherapy and daily prayers (*ṣalāh*)

	SELF-KNOWLEDGE					RESILIENCE				
	Goal setting	Awareness of thoughts	Recognising emotions	Mindfulness practices	Bodily awareness	Optimism and hope	Motivation and agency	Gratitude	Relationships	Behaviour patterns
Context & usage										
1. Ablution										
2. Direction										
3. Intention										
4. Standing										
5. Bowing										
6. Prostrating										
7. Rising										
8. Completion										
OVERALL										

Strongly related	
Moderately related	
Weakly related	
Unrelated	

Key for qualitative scoring

3.3 Psychotherapy within Islamic fasting (*ṣawm*)

Often when people think about Islam, the initial impression they form is one of a legalistic theology, a religion that is based on rules and not necessarily about psychology. Yet, when we look at the early period of Islam and consider the earliest teachings, we find that Islam has considerable practical psychology, with ethical parameters that enable us to fulfil our potential as human beings (Tabrizi, 2005). This is reflected in a well-established *ḥadīth* (teaching) in which the Prophet Muḥammad (saw) is narrated to have said, "*The primary purpose for which I have been sent is the perfection of human character* (*innama buithtu liutammima makārim al-akhlāq*)." Whilst *'akhlāq'* is soften translated as 'ethics', when we consider its practical and applied dimensions, it is rich in psychology and has various contact points with psychotherapeutic techniques.

The overall Islamic framework is designed to bind together the different dimensions considered above. The *sharīʿah* (Divine Islamic law), or rather it's human interpretation (*fiqh*), based upon jurisprudential principles (*uṣūl al-fiqh*), creates the parameters for practices that give life to Islamic spirituality. However, balance is important, since when Muslims become fixated with the legalistic side of the *sharīʿah*, risks arise of missing the potential for a spiritual experience, since constant worry about the box-ticking exercise of fulfilling legal obligations and avoiding that which is forbidden. It is important to note that this discussion is not in any way about denigrating Islamic law, but rather to celebrate the law for what it enables and facilitates, that which potentially empowers and facilitates growth. It

can be the catalyst that results in the flourishing and opening of the heart to the Grace of Divinity in the present moment.

In this sense, when it comes to the practice and psychology of fasting (*ṣawm*), one finds that the fasting month of *Ramaḍān* is particularly sacred and sanctified, even though fasting is recommended to be practiced throughout the year. All the laws relating to the month of *Ramaḍān*, including rules that turn optional practices of other months into obligations for that month, while determining actions permissible in other months as prohibited in that month, effectively narrow behavioural parameters, thereby making the operationalisation of spiritual practice more safeguarded and protected. This accentuates the potential for psycho-spiritual growth and development from the practice of fasting.

3.3.1 Introduction to Islamic fasting (ṣawm)

Two sources are used for this component of the Deductive Content Analysis process. First, *Sulūk al-ʿĀrifīn (Path of the Mystics)* by Javad Tabrizi (2005) is famous text relating to many spiritual dimensions of fasting in Islam, spanning the physical, social, and mental. Second, *Mafātīḥ al-Jinān (Keys of the Heavens)* by Abbas Qummi (2003) is a well-known prayer text in Shīʿa Islam that contains material applicable across the Muslim community.

When introducing the various dimensions of fasting, Qummi (2003) cites Imām Jaʿfar al-Ṣādiq (as), to whom is attributed the teaching that when one observes a fast, one's ears, eyes, hair, skin and all the parts of the body should

also observe abstinence from what is forbidden and even from that which is discouraged, such that, "*One's day of fasting should not be the same as the day when one is not fasting.*" He added that,

> *"… fasting should not be confined to abstaining from eating and drinking, but the tongue must be protected from falsehood, the eyes from seeing anything forbidden; one must not indulge in disputes, jealousy, backbiting, contentions, false oaths or even true ones, abuses, obscenity, oppression, senseless behaviour, small heartedness, inattentiveness to the remembrance of Allāh and prayers, and utterances which should not be spoken, but one should be patient and truthful and keep away from evil and evil talk, falsehood, false accusation, contentions, evil suspicions, backbiting and tale telling."*

This sets a context to the breadth of the fasting experience, making clear that it is not simply about abstaining from food, drink and other physical restrictions.

In that regard, Qummi (2003) quotes ʿAlī ibn Abī Ṭālib (as) (d. 661) as having said,

> *"There are so many people who fast but whose share is only hunger and thirst; and there are so many worshippers whose only share from the worship is exhaustion."*

This suggests that fasting and prayer cannot be just about the external legalistic aspect of fulfilling literal obligations. Rather, as Tabrizi (2005) advocates, the aim

of fasting is about emptying negativities, so as to free oneself from the distractions that may create barriers to self-understanding and self-realisation.

3.3.2 Psychotherapeutic aspects of Islamic fasting (ṣawm)

When we look at the structure of a fast from the perspective of Islamic law, we see that throughout the framework of the fast, the laws facilitate a process of introspection and self-knowledge, while cultivating self-discipline. The following discussion is demarcated into three categories, spanning fasting of the body, heart, mind, and spirit.

Fasting of the body

Tabrizi (2005) discusses the legal parameters of Islamic fasting (*ṣawm*): no eating or drinking between dawn and dusk, together with abstinence from other forms of physical stimulation, including sexual activity or smoking. This are circumscribed by strict eligibility criteria, such as those who are sick, too weak, or travelling are prohibited from fasting.

The fast commences at the time of *imsāk*, which is typically a few minutes before the time of the morning (*fajr*) prayer at dawn (approximately an hour or more before sunrise), which is when the fast officially begins (Tabrizi, 2005). It is interesting that the term *imsāk* is not about starting or commencing, but rather it is about withholding and abstaining. The lexicographical root of '*masaka*' means to withhold or retain (in this context withhold responses to urges that may arise). In this sense, *imsāk* serves as a metaphor for an applied form of mindfulness practice for the body (to withhold physical urges such as hunger or thirst), mindfulness practice for the mind (to withhold following mental urges in the form of

thoughts), and mindfulness practice for the ‘heart’ (to withhold following emotional urges in the form of feelings). Each of these aspects are explicated below.

The physical opening of the fast at dusk (shortly after sunset) is accompanied by recitation of one of several short psalms, consisting of a few verses that spiritually ground the individual in the present moment, providing an opportunity to collect their thoughts and emotions in the sacred space of celebrating the opening of the fast (*ifṭār*) (Qummi, 2003). What is important to note, with regard to psychotherapeutic contact points of this practice, is the mindset created by the psalms recited when opening the fast, preceded with the first verse of the Qurʾān (1:1 as discussed in Section 3.1 above), all of which is set out by Qummi (2003). Hence, the overall experience is about the combination of the practice of fasting and the concepts in the psalms, working in tandem.

Whilst the emotional and mental aspects of fasting are discussed in further detail below, what is pertinent for the fasting of the body is the mindfulness engendered by the physical process of holding, tasting and eating the first morsal of food. In this regard, it is helpful to recall the exercise of mindfully eating a raisin from Mindfulness Based Cognitive Therapy (Segal et al., 2013). Hence, even though the fasting of the body appears to be about *not* eating, the mindfulness teachings for *ifṭār* offer an opportunity for mindful eating and awareness of the body, as the first bite is taken to open the fast (usually of a fresh date). Connected to the body centred mindfulness aspect of *ifṭār* is the profound sense of gratitude for that food, as amplified by recitation of psalms, so as to engender a sense of deep appreciation for food that is all too often taken for granted (mindful eating). This

gratitude provides another, albeit indirect, connection to the concepts in the NICE guideline.

Having considered the commencement and conclusion of the fasting of the body, it is also important to reflect upon the experience during the day of fasting. Direct experience of “tasting” the physical sensations of hunger and thirst is regarded as important for empathetic social connections, discussed further below, particularly with regard to creating connection with others, softening the emotional heart, and cultivating humility, since a powerful person can be humbled by a simple glass of water during fast. As a result, “tasting” hunger and thirst becomes really important as a process for cultivating humility. And yet, in a pragmatic therapeutic sense, it is also profoundly connected with mindful awareness of the body, bringing oneself out of the experience of “living in the head” (Williams et al., 2007). Crucially, it is critical to feel those uncomfortable sensations and *be* with them, accepting and not resisting them. As such, it is a form of mindfulness practice of the body.

Fasting of the heart

The concept of ‘heart’ is used in Islamic texts to refer to emotional and social aspects of an individual, related to the concept of *qalb* (spiritual heart) and *nafs* (psychological self) (Tabrizi, 2005). The practices considered above from a physical perspective also have important emotional and social dimensions.

From an individual perspective, the emotional dimension can be powerfully impacted by the physical aspect of fasting. Whilst an individual may have to

counter, through awareness and restraint, emotions of frustration, weariness or anger due to hunger or thirst, there is also the potential to use those same physical sensations to elicit more (spiritually or socially positive emotions. For instance, through reflective contemplation (*tafakkur*), highly recommended practice during fasting and generally (Tabrizi, 2005), a person may be humbled by reflecting upon their vulnerability and the fragility of life, contemplating how all their strengths and faculties can be undermined by a glass of water (or lack thereof). From a wider communal perspective, tasting thirst and hunger and reflecting upon that visceral experience can open the heart to create connection with others, particularly the poor and malnourished. Hence, a key social practice during the month of fasting (*Ramaḍān*) is giving charity. Whilst these emotional experiences may offer contact points with concepts related to affect and relationship-building in psychotherapy, there is also a potential divergence herein. This is because in Islam, particularly for mystics, an important aspect of spiritual development is the feeling of weakness to break the arrogance of ego (*nafs*) and open the heart to a deep trust in Allāh (*tawakkul*), as the ultimate source of all strength (Tabrizi, 2005). This is captured by an important doxology for spiritual wayfarers known as the *Ḥawqala*, "*There is no strength nor power, except by God*" (*lā ḥawla wa-lā quwwata illā bi-llāh*) (Qummi, 2003). At first glance this appears to contradict the undermine the psychotherapeutic notion of self-agency. However, upon closer examination, when looking at indirect effect, rather than direct form, there may well be meaningful congruence, particularly for people suffering from depression, who may be feeling that their personal strength is depleted or even exhausted. Furthermore, this may be significant among those experiencing "learned helplessness" and passivity, particularly if they experienced trauma (Seligman,

1972). The fasting of the heart in relation to the *Ḥawqala* becomes important for rebuilding self-agency from an indirect approach, as the point of that doxology is not to leave a person feeling bereft, but rather to replace individual or ego orientated confidence and agency with a spiritually rooted, and perhaps more humble, form of motivation. When viewed in this way, the fasting process of accepting and embracing vulnerability and weakness, through 'tasting' the hunger or thirst, can be harnessed as a coping mechanism to access a different source of agency, one that is places God as the initiating force, thereby relieving the individual of the obligation, yet leaving them free to direct any energy that may arise from that reframing into whichever direction may motivate them, thereby also fuelling goal setting of a different kind.

Turning to another dimension of the fasting of the heart, the discussion above regarding the physical opening of the fast (*ifṭār)* has important relationship correlates, since it is often a communal behaviour, shared with family or the wider community (if at a mosque). The psalms to be recited during *ifṭār*, such as one reported by Qummi (2003), encourage re-evaluation of (i) how we relate to God, (ii) ourselves, and (iii) others, as triangular relationship model.

Closely connected to how we relate to others is the concept of fasting of the speech, reflecting upon how we interact with others. The concept of *imsāk* can be applied to the fasting of the tongue (Tabrizi, 2005), seeking to withhold negative comments, backbiting, false accusations, or idle gossip.

Fasting of the mind

The mental dimension of the fast can be described as an exercise in mindfulness, since one is aiming to practice *imsāk* (withholding) of mental indulgences, including being present and not carried away by random trains of thought (Tabrizi, 2005). Just as the physical fast creates space in the body by emptying the stomach, similarly, the mental fast can serve to create mental space by quietening the inner dialogue that fills the mental arena.

An element of the fasting of the mind relates to exercises in focussed contemplation and reflection (*tafakkur*). Through the process of self-evaluation, practitioners may learn about their relationship to themselves, together with their general thinking and behaviour patterns, particularly our addictions, whether it's addictions to certain foods or drinks, whether it's addictions to smoking, addictions to sexuality, or other vices, such as addictions to backbiting. The mental aspect of fasting also has connections to the psychotherapeutic concept of reframing, such that so that problems, anxieties and triggers for depression could be put in a wider context, particularly at end of the fast.

There is a strong emphasis in Islam relating to forgiveness *(istigfār)*, particular during the fasting month of *Ramaḍān* (Qummi, 2003). This relates both to forgiving others and seeking forgiveness for our own trespasses against others, seeking renewal of that relationship and rejuvenation of both parties, particular among family relations (*ṣilat al-raḥm*).

3.3.3 Analysis matrix of psychotherapy and Islamic fasting (ṣawm)

The points of contact discussed above are summarised below in the analysis matrix of psychotherapy and Islamic fasting *(ṣawm)* (Figure 3.3.A).

Amalgamating the discussion above and individual cells of the matrix into an overall vector, it becomes clear that fasting has noteworthy points of contact with the NICE guideline, particularly with regard to mindfulness practices, bodily awareness, and behaviour patterns. And yet, as discussed above in relation to direct versus indirect effects, there is potential congruence in relation to resilience categories such as agency, gratitude and relationships, together with metacognition.

By disaggregating the practice of *ṣawm* into its constituent elements of fasting of the body, heart, and mind, certain psychotherapeutic attributes of Islamic fasting have come into clearer focus. For instance, the psychology of how to open the fast during the evening meal and mindful eating techniques from MBCT have clear connections, particularly when considered in light of the prayers recommended to be recited at the time that foster that mindset. Furthermore, social aspects of the experience of *ṣawm* have important psychotherapeutic aspects of cultivating empathy and re(building) relationships. Fasting of the mind fosters metacognition, which the contemplation advocated during *ṣawm* can fuel the development of an attitude of gratitude.

Figure 3.3.A: Analysis matrix of psychotherapy and Islamic fasting (*ṣawm*)

	SELF-KNOWLEDGE					RESILIENCE				
	Goal setting	Awareness of thoughts	Recognising emotions	Mindfulness practices	Bodily awareness	Optimism and hope	Motivation and agency	Gratitude	Relationships	Behaviour patterns
Context & usage										
Fasting of body										
Fasting of heart										
Fasting of mind										
OVERALL										

Strongly related	
Moderately related	
Weakly related	
Unrelated	

Key for qualitative scoring

3.4 Psychotherapy within Islamic mindfulness practices (*dhikr*)

It is important to clarify at the outset that the focus of this comparative analysis is on Islamic mindfulness *meditation* practices, as the preceding sections on scripture, prayer, and fasting have each contained mindfulness practices, with notable connections to mindfulness from the NICE Guideline for depression. Whilst the term *dhikr* is often used to refer to Islamic meditation, there are many forms of *dhikr* practice, not all of which are meditative. In addition, there are other forms of meditation in Islam that are classified differently, as discussed below.

Despite the current secular presentation of mindfulness interventions, historians of science, such as Harrington and Dunne (2015), point out that mindfulness techniques have deep roots in global religious traditions, including notable Buddhist origins (Feldman & Kuyken, 2019). For instance, early therapies such as Mindfulness-Based Stress Reduction, developed by Kabat-Zinn (1990), drew upon Buddhist traditions for self-reformation and emerged as simultaneously medical and spiritual. Mindfulness meditation practices have offered individuals across the ages an opportunity to bear witness to their mind and body in the present moment, by dispassionately observing their thoughts and emotions (Williams et al., 2007). A number of mindfulness programmes have demonstrated varied psychological and neurobiological effects, ranging from reduction in relapse of depression, to lower blood pressure and substance abuse (Chiesa & Serretti, 2010). Therefore, in the context of the research question at hand that requires identifying contact points between Islamic concepts and practices, with psychotherapeutic interventions from the NICE Guideline for depression in adults, it is important to

explore how Islamic mindfulness meditation techniques relate to those offered in the NHS under the auspices of the recommendations of the NICE committee.

Of the various mindfulness-based interventions, the NICE guideline recommends Mindfulness-Based Cognitive Therapy (MBCT), a psychotherapeutic programme originally developed for depression, that combines cognitive therapy with meditation (Segal et al., 2013). MBCT features in the NICE guideline for relapse prevention, as it benefits from numerous empirical studies and adoption in clinical settings, with effects such as cognitive-affective neural plasticity (Allen et al., 2012), evidence of efficacy in pain relief (Zeidan et al., 2015), and emotional resilience to anxiety (Evans et al., 2008).

A fundamental challenge inherent in mindfulness interventions is the establishment of a regular practice routine. This issue is highlighted in a seminal study by Crane et al. (2014), who identified a significant association between frequency of formal MBCT meditation practice at home and relapse of major depression, suggesting that those who practiced at least three days a week reduced the risk of relapse by fifty per cent, compared to those who reported fewer days of formal home practice. This creates the possibility that if existing structures in daily life can be harnessed for easier delivery and better concordance of mindfulness interventions, the outcomes may be positive for diverse social groups. One of the accessible sources of such structures is religious prayers, which often require consistent practice and contain many mindfulness techniques.

A limited number of studies have compared MBCT and prayer from the Christian tradition using *Centering Prayer* as an *alternative* to MBCT (Knabb, 2012), rather than prayer as a *vehicle* for MBCT. This is an important distinction, as such studies risk comparing different phenomena, since Christian? prayers can be performed in many different ways and mental states. Whilst there are variations of *Centering Prayer*, the form used in empirical studies such as Knabb (2012) and Johnson et al. (2009) appear to consist of four steps: first sitting relaxed for a few minutes with eyes closed; second, choosing a sacred word; third, 'centering' or focussing on that word; and fourth, remaining in silence at the closure of the prayer period, typically lasting a total of twenty minutes (Finney & Malony, 1985).

The contact points discussed below differ from the above studies by considering Islamic practices as potential *vehicles* for MBCT practices, rather than *alternatives* to them. This is made possible due to the idea espoused by scholars across generations, such as Ṭabāṭabāʾī (2003), that "…*the straight path is one which combines the exoteric and the esoteric*." This creates an opening for incorporating meditative techniques into common practice. Note that the allusion to "*the straight path*" refers to the prayer, *"Guide us upon the straight path,"* from the opening chapter of the Qurʾān, *Sūrat al-Fātiḥah* 1:6 (see Section 3.1).

3.4.1 Introduction to Islamic mindfulness practices

The analysis of mindfulness meditation practices in Islam is a very large topic that is well beyond the scope of this study. The Ṣūfī literature alone is vast and spans

epochs, cultures, languages, jurisprudential commitments, and theological orientations. There is also a great diversity in Islamic mindfulness meditation techniques, ranging from traditional seated meditation to whirling dervishes performing a moving meditation (*samāʿ*), as illustrated in Figure 3.4.A below. One common feature across all practitioners is that as Muslims, they recognise the primacy of Qurʾānic scripture, which emphasises the importance of remembrance of Allāh and invocation of Divine attributes, known as *dhikr*, which is a common practice across all the major denominations, thereby making it relevant for the research question herein. For instance, the Qurʾān asserts, "… *Surely in the remembrance of Allah do hearts find comfort*" (*Sūrat al-Raʿd* 13:28). The term for "*remembrance*" in this verse is "*dhikr*". Two other common concepts across the spectrum of Islamic meditative traditions are *tafakkur* (contemplation or reflection) and *nafs*, which can broadly be described as psychological self or ego, compared to the spiritual heart (*qalb*). There are layers of translational nuance that are beyond the scope of this study, however, the definitions above are applicable for the purposes herein. For instance, when it comes to metacognitive self-reflection, the Qurʾān (*Sūrat al-Rūm* 30:8) asks the rhetorical question, "*Do they not reflect upon themselves*?" The term for "reflect" is the same verb as "*tafakkur*", whilst the term of "themselves" is the same linguistic root as "*nafs*". These core concepts are used widely across Islamic mindfulness meditation practices. How they take shape in daily life and what they consist of is explored below.

Figure 3.4.A: Illustration of a Ṣūfī meditative spiritual concert *(samāʿ)*

Source: Oxford, Bodleian Library MS. Ouseley Add. 24 (1552); fol. 119a

3.4.2 Psychotherapeutic aspects of Islamic mindfulness practices

When the literature on Islamic mindfulness is viewed through the lens of the research question, the focus turns to contemporary sources in English that can be accessible to members of the UK Muslim community experiencing depression and mental health service providers. In particular, sources that speak to psychotherapeutic dimensions of mindfulness related Islamic practices, that are both theologically sound from the perspective of the wider Islamic literature, whilst also promoting accessibility and adherence to psychotherapeutic interventions from the NICE Guideline. In this regard, two relevant textual sources that emerge from this process are "*Kernal of the Kernal"*, a manual of spiritual progress for general readers by Ṭabāṭabāʾī (2003), and a recent article on "*Muraqaba as a Mindfulness-Based Therapy in Islamic Psychotherapy"*, by Isgandarova (2019). The Deductive Content Analysis (DCA) method can help to address the research question, by enabling us to focus on content from these sources that offer potential contact points with the NICE guideline.

The DCA process suggests three categories of Islamic mindfulness practices are important to consider, as they constitute the core mindfulness techniques utilised across a range of Islamic communities: remembrance (*dhikr*); invocation (*tasbīḥ*); and observation (*murāqabah*), each of which is explored below. These also have direct correlation with mindfulness related interventions for depression from the NICE Guideline, in particular *Mindfulness-Based Cognitive Therapy (MBCT).*

Remembrance practice (*dhikr*)

The literature from the Islamic tradition shows a number of prayers in the form of a doxology (*dhikr*), with repeated recitation of Arabic words of Divine exaltation, used for focussing attention on the breath or the particular prayer, with the aim of generating awareness of thoughts and clarity of mind, together with recognising and managing emotions, thereby cultivating mindfulness (Helminski, 1992). *Dhikr* (remembrance) is a core part of Islamic meditation practices, particularly in the Ṣūfī traditions. There are a range of Islamic meditative practices that consist of prayers in the form of a doxology, consisting of recitation of Arabic words of Divine exaltation (Helminski, 1992). However, there is considerable diversity in across dhikr practices and Ṭabāṭabāʾī (2003) draws a distinction between external and internal remembrance. The external is regarded as purely verbal or exoteric, with little attention to its meaning, and therefore offering modest benefit for progress on the esoteric meditative path. On the other hand, the internal (meditative) form of *dhikr* is often silent invocation whereby attention is focused on the meaning, thereby accelerating the progress of the practitioner.

Ṭabāṭabāʾī (2003) notes that when embarking upon such *dhikr* meditation, the spiritual traveller may struggle to keep control of the mind and avoid the seduction of perpetual streams of thoughts. Hence, he advises, "*In a situation like this, the wayfarer must remain firm like a majestic mountain*." Therefore, harnessing the *dhikr* remembrance, typically by focussing on a Divine Name, such as "*Yā-Allāh*" (O Lord), with the hope of regaining his focus. Ṭabāṭabāʾī (2003, p. 115) asserts, "*He must meditate upon a particular Divine Name ceaselessly and focus upon it*

outwardly and inwardly (with his heart and his eye) until those memories [ruminations] are forced out of the abode of his heart." This approach is corroborated by the Qurʾān in *Sūrat al-Aʿrāf* (7:201), "*Indeed, when Satan whispers to those [who are] mindful of Allah, they remember their Lord, [through which] they then start to see matters clearly*." Satan is regarded as the source of negative thoughts, distractions, and rumination. On the other hand, meditative remembrance practice (*dhikr*) is offered as a way to (re)gain control (and ultimately mastery) of thoughts. Isgandarova (2019) clarifies that dhikr can be performed individually or in a group. Figure 3.4.A shows and example of the spiritual concert (*samāʿ*), performed by Ṣūfī whirling dervishes reciting *dhikr* to create a deep meditative state.

From a psychotherapeutic perspective, the noticing or sub-vocalisation of "in/out" when tracking the breath during an MBCT Mindfulness of the Breath exercise, uses "*the breath as an anchor to gently reconnect with the here and now each time you notice that your mind has wandered…*" (Segal et al., 2013, p. 172). Similarly, in dhikr practice, the phrase "*Ya-Allāh*" (O Lord) or "*Allāh-Hu*", considered one of the most sacred chants in the Ṣūfī tradition (Isgandarova, 2019), could be utilised for a similar purpose of anchoring attention, with the added advantage of spiritual salience for Muslims. In addition to points of contact on meditative practice, there are also associated connections to awareness of thoughts and emotions, through the self-awareness such practices can generate. From a resilience perspective, gratitude is a key connotation of most *dhikr* phrases. If the dhikr is performed in congregation, either seated or moving, such

as with the *samāʿ*, then relationship related psychotherapeutic dimensions can also be invoked.

Invocation practice (*tasbīḥ*)

A closely related practice to *dhikr* in Islamic mindfulness meditation is *tasbīḥ* (invocation), the literal meaning of which is glorification, as its linguistic root is to glorify. This practice involves recitation of a set doxology of glorification, often repeated a prescribed number of times. Hence, in order to keep count, rosaries are often used. The link to dhikr is that the doxologies often contain names of Allāh used in dhikr, but differ in their length, as common *tasbīḥ* phrases can be a sentence long, drawing upon Qurʾānic verses or *ḥadīth* teachings. From the perspective of identifying Islamic practices that could be used as vehicles for psychotherapeutic interventions, the *Tasbīḥ of Fāṭimah* (as), daughter of the Prophet Muḥammad (saw), is well-known in the Muslim community and often recited after the daily prayers (*ṣalāh*). The format is set out by Qummi (2003) as 34 repetitions of "*Allāhu akbar*" ("God is Greater [than everything]"), known as "*Takbīr*"; 33 recitations of "*al-ḥamdu lillāh*" ("All praise is due to God"), called "*Taḥmīd*"; and finally 33 invocations of "*subḥānallah*" ("Glorified is God"), this specific dhikr is also known as "*Tasbīh*" due to having the same etymological root. The total of 100 recitations makes the *Tasbīḥ of Fāṭimah (as)* a close ended invocation that is often completed with a rosary of 100 beads.

As regards specific contact points with psychotherapy, the three components of the *Tasbīḥ of Fāṭima (as)* provide structural and temporal congruence with the

Three-minute breathing space (3MBS) MBCT technique, given its three parts and duration (Williams et al., 2007). Segal et al. (2013, p. 384) clarify the purpose of the exercise, such that, "*The skill being taught in the 3MBS is the intentional and flexible engagement of two types of attention: one that is open and wide-angle, and another that is focused or narrow-angle*." The above *Tasbīḥ* can be practised with different mental states, including as set out in this MBCT practice, in which case the contact point could be made relatively strong. Other relevant psychotherapeutic aspects of *Tasbīḥ* forms of Islamic meditation include metacognition, particularly if doxologies that promote self-reflection are selected.

Observation practice (*murāqabah*)

According to Ṭabāṭabāʾī (2003), one of the most important requirements in the esoteric path is *murāqabah,* constant attention or observation, often involving dhikr recitation, including in conjunction with physical postures and/or breathing. This is corroborated by Isgandarova (2019), who suggests this form of practice is widely used as an Islamic contemplative exercise, particularly for training the *nafs* (ego or self) in Ṣūfī psychology. It should be noted that the term *nafs* is technical and the subject of considerable analysis, with at least three dimensions mentioned in the Qurʾān. For instance, *Sūrat al-Shams* (91:9), which sets the platform for sublimation, declares, "*One who purifies it [the nafs] has succeeded*." It is interesting to note that the term for sublimation or spiritual purification of the self (*nafs*) that is used in Ṣūfī literature (*tazkiya*) is closely related to the key operative term of this verse, "*zakkāhā*" (to purify it [i.e. the self]). Similar terms can also be found in *Sūrat al-Aʿlá* (87:14), which uses the term "*tazakká*" and *Sūrat al-Jumʿa*

(62:2), which contains the related concept "*yuzakkīhim*". Hence, it appears that not only is meditation important in Islam, but it has a clear purpose of purifying the *nafs* of its negative impulses, distractedness, and ruminative tendencies. According to Isgandarova (2019), in Ṣūfī *murāqabah* practices, the *sālik* (one who follows the spiritual path) carefully observes his/her *nafs* (self) and acquires knowledge about it by being mindful of his/her inner feelings and outer surroundings. For instance, Isgandarova (2019) reports that in the Naqshbandīyah form of *murāqabah* practice, the *sālik* imagines white light entering through the stomach when he/she inhales through the nose and recites a *dhikr*.

As regards connections to MBCT psychotherapy, first, Isgandarova (2019) points out the psycho-spiritual progress in the Ṣūfī tradition requires a teacher (*Shaykh*), in keeping with other spiritual traditions, just as psychotherapeutic mindfulness training necessitates a person in authority to teach each meditative practice. Second, there is a congruence between the more open observational practice of *murāqabah* meditation and MBCT Sitting Meditation, "*the aim [of which] is not to prevent [the] mind wandering but to become more intimate with its patterns*" (Segal et al., 2013, p. 187). The open explorative aspect of this form of meditation acquits the individual with the vicissitudes of the mind in strikingly similar ways, with both approaches teaching the importance of attention to thoughts and feelings that arise (conscious noticing), without getting attached to any given thought pattern, nor seduced into following any train of emotions. Hence, there are points of contact across metacognitive coding categories, as well as agency and motivation, without which such practice would not be sustainable.

3.4.3 Analysis matrix of psychotherapy and Islamic mindfulness practices

The various contact points identified in this discussion are summarised below in the analysis matrix of psychotherapy and Islamic mindfulness practices (Figure 3.4.B). Boundary conditions are once again the same as before.

The decision to structure the analysis above into three dimensions has been fruitful, with *dhikr*-based remembrance practice as the common base of most Islamic mindfulness meditation, leading to contemplative doxologies in the form of *tasbīḥ*, and open form observational meditation (*murāqabah*). Each of the three have been shown to have connections with various MBCT practices: first, *dhikr* having demonstrable compatibility with Mindfulness of the Breath; second, *Tasbīḥ of Fāṭima (as)* having structural parallels to the *Three-minute breathing space*; and third, observational *murāqabah* meditation being relatively congruent with MBCT Sitting Meditation. However, beyond direct meditation and associated metacognitive awareness of thoughts and emotions, other coding categories were far less prominent, with the notable exceptions of motivation and gratitude categories of resilience related psychotherapeutic techniques.

Figure 3.4.B: Analysis matrix of psychotherapy and Islamic mindfulness

	SELF-KNOWLEDGE					RESILIENCE				
	Goal setting	Awareness of thoughts	Recognising emotions	Mindfulness practices	Bodily awareness	Optimism and hope	Motivation and agency	Gratitude	Relationships	Behaviour patterns
Context & usage										
Remembrance										
Invocation										
Observation										
OVERALL										

Strongly related	
Moderately related	
Weakly related	
Unrelated	

Key for qualitative scoring

3.5 Psychotherapy within Islamic psalms (*duʿāʾ*)

Psalms (duʿāʾ) in Islam draw a distinction between asking or supplicating for something as a wish list, versus supplication as a form of seeking support to deal with a specific issue. Separating the events of life from our experience of those events appears to be an approach demonstrated by the Qurʾānic story of Prophet Zacharia (as), who prayed for a son for years but did not get his wish until quite late in life, yet declared that his prayers over the interim years had not been in vain, nor unanswered: "*My Lord, my bones have weakened and my hair is ashen grey, but never, my Lord, have my prayers [duʿāʾ] been in vain [unanswered]*" (Sūrat Maryam 19:4). This context to psalms and supplication in Islam is important from a psychotherapeutic perspective, since it enables an individual to focus on process rather than being fixated upon or ruminating over a given outcome. The description of the experiences of Prophet Zacharia (as) in the chapter on Mary in the Qurʾān points to this approach, as he is narrated to have been quite anxious about the future of his community after him (verse 19:5) and not having an heir concerned him. According to this parable, one of his coping mechanisms was to "*supplicate to His Lord privately*" (19:3). This outpouring of emotion in his personal psalms appears to have had a beneficial impact upon him, given the assertion he makes in verse 19:4 above that his prayers were not in vain, even though the specific outcome he was praying for (an heir) was not transpiring. This practice of using psalms for private supplication also appears to have value in engendering greater awareness of emotions, as Prophet Zacharia was able to clearly articulate his feelings of anxiety in verse 19:5. This creates a potentially useful contextual contact point with NICE approved psychotherapeutic concepts and practices.

3.5.1 Introduction to Islamic psalms (duʿāʾ)

The key text for the Deductive Content Analysis of this subject will be William Chittick's *The Psalms of Islam*, a translation of *al-Ṣaḥīfah al-Sajjādiyya* (Zayn al-ʿĀbidīn, 1988). The text is well known in the Shīʿa community, within which it is attributed to ʿAlī b. Ḥusayn b. ʿAlī b. Abī Ṭālib (d. 92/710), the great- grandson of the Prophet Muḥammad (saw), who was given the title Zayn al-ʿĀbidīn (adornment of the worshippers). Chittick regards this text as, "*the oldest prayer manual in Islamic sources and one of the most seminal works of Islamic spirituality of the early period*." Whilst manuscripts of the text provide an *isnād* (chain of narration), it is beyond the scope of this study of verify it, as the focus of this study is the psychotherapeutic components of the text. The arrangement of the text allows us to draw a certain distinction between the fifty-four psalms which make the main body of the text, together with additional supplications in fourteen addenda (including prayers for each day of the week) and the fifteen *munajāt* (whispered or intimate prayers usually recited privately in seclusion). Chittick's translation from classical Arabic into contemporary English (Zayn al-ʿĀbidīn, 1988), including an extensive preface situating the text for a modern reader, is a pioneering contribution that makes it relevant for the research question at hand, as it makes the psalms in *al-Ṣaḥīfah al-Sajjādiyya* accessible to UK Muslims and any mental health service providers who may wish to engage with this genre of Islamic literature that is rich in psychotherapeutic concepts.

A consistent theme that appears across the psalms of *al-Ṣaḥīfah al-Sajjādiyya* is the key Islamic concept of *akhlāq* (psychological character development and

ethics). In fact, the psalm that is sometimes considered the heart of the corpus of *al-Ṣaḥīfah al-Sajjādiyya* is *Duʿāʾ Makārim al-Akhlāq* (*Psalm for the Perfection of Character*). This title draws upon both branches of Islamic primary sources, the Qurʾān and *ḥadīth* (teaching of the Prophet Muḥammad [saw]). The Qurʾān, addresses Prophet Muḥammad (saw) as one with great moral character, with *Sūrat al-Qalam* (68:4) using the word *khuluqin* (the indefinite singular of the related plural *akhlāq*). In addition, *ḥadīth 273* of al-Bukhārī's (d. 870) collection of ethics teachings (*al-Adab al-Mufrad*) narrates that Prophet Muḥammad (saw) said, "*[The primary purpose for which] I was sent [was] to perfect good character*" *(Innama buʿithtu liʾutammima makārim al-akhlāq)* [إنما بعثت لأتمم مكارم الأخلاق] (Bukhārī, 2001). This situates the subject of *akhlāq* as being at the heart of the Islam.

The title of this twentieth psalm (*Makārim al-Akhlāq)* is shared by several prominent books by that title. Walzer (2012) notes that under this title several collections of ethics related teachings *(ahadīth)* of the Prophet Muḥammad (saw) were compiled from the 9th century onwards, including eminent scholars, such as Ibn Abi 'l-Dunyā, al-Kharāʾiṭī, al-Ṭabarsī. Furthermore, the famous al-Ghazāli (d. 1111) in his *al-Munkidh* defines *akhlāq* as a branch of [Islamic] philosophy that consists of, "*defining the characteristics and moral constitutions of the soul and the method of moderating and controlling them*" (Walzer, 2012). This sheds light on why psychological concepts from *akhlāq* that relate to self-analysis and metacognition, generating awareness of thoughts, emotions and behaviours, could potentially serve as bridges to various NICE approved psychotherapeutic

interventions, such as Cognitive Behavioural Therapy (CBT), which shares some similar objectives.

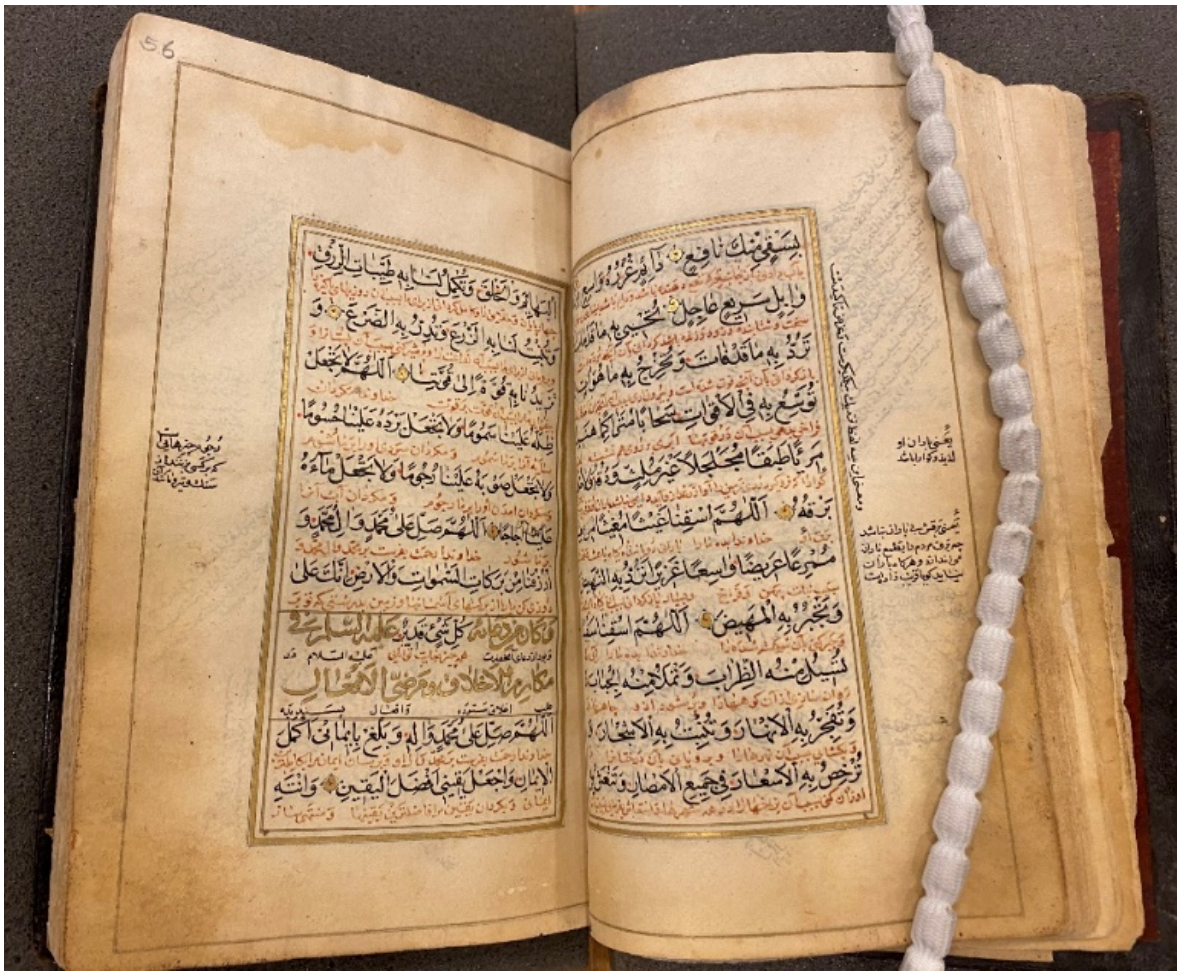
In the classification of branches of Islamic philosophy, one of the most influential works that established *akhlāq* as a part of practical philosophy and ethics is *Tahdhīb al-akhlāq* by Abū ʿAlī Ahmad b. Muhammad b. Yaʿqūb Miskawayh (d. 1030), translated into English from Arabic by Constantine Zurayk (1968). A discussion of *akhlāq* in Islamic philosophy and theology would be incomplete without consideration of the contributions of the Andalusian philosopher and jurist Alī ibn Ahmad Ibn Hazm (d. 456 / 1064), especially in his *al-Akhlaq Wa'l-Siyar*, a treatise on ethics, theology and psychology. Ibn Hazm's Andalusian upbringing was somewhat different to his Persian contemporary Miskawayh. Also noteworthy is Ibn Hazm's literalist jurisprudential orientation, codifying the *Zāhirī* (literalist) doctrine and applying its method to all the Qurʾānic sciences. The approach to *akhlāq* adopted by Ibn Hazm (as translated by Muhammad Abu Laylah) shows its intrinsic inter-weaving of philosophy (particularly ethics and ontological orientations of being), theology (especially with regard to eschatology) and psychology (notably in relation to depression and anxiety). For instance, paragraph five is pertinent (Ibn Ḥazm, 1990), "*I have tried to find one goal which everyone would agree to be excellent and worthy of being striven after. I have found only one: to be free from anxiety.*" This psychological insight is philosophically and theologically generalised in the conclusion of paragraph eight (Ibn Ḥazm, 1990), "*You should therefore understand that there is only one objective to strive for, it is to dispel anxiety; and only one path leads to this, and this is the service of the most high God*." Thus, all of Ibn Ḥazm's psychology and

moral science concentrates on action, but an action purged of any ego-based motive and entirely determined by the thought of God.

In the paradigm of al-Sayyid ʻAlī Khān al-Madanī al-Shīrāzī (d. 1707), who wrote a comprehensive commentary of *al-Ṣaḥīfah al-Sajjādiyya*, called *Riyāḍ al-Sālikīn (al-Shīrāzī, 1994),* the concept of *akhlāq* relates to the collection of character traits that can be cultivated and developed, thereby making the process of striving towards *makārim al-akhlāq* a journey of personal development. This well-respected and widely referenced commentary extends to seven volumes and the discussion of *Duʿāʾ Makārim al-akhlāq* runs to approximately ninety pages of Arabic, even though the psalm itself is only about six pages long.

Whilst *al-Ṣaḥīfah al-Sajjādiyya* does not present itself as a medical text, it does however deal with several mental health related topics, particularly in relation to anxiety and depression. For instance, Psalm 7 relates to dealing with and managing worry, Psalm 15 is specifically for sickness, Psalm 23 pertains to overall well-being, Psalm 50 addresses the emotion of fear, and Psalm 64 seeks the removal of worries.

Figure 3.5.A: Illustration of an Islamic psalm (*Duʿāʾ Makārim al-Akhlāq*)



Source: Oxford, Bodleian Library MS. Arab. e. 229, fol.56 (18th C.),
al-Ṣaḥīfah al-Sajjādiyya

3.5.2 Psychotherapeutic aspects of Islamic psalms (duʿāʾ)

The research question at hand requires identifying specific contact points between Islamic concepts and practices, with particular psychotherapeutic interventions, resulting in pragmatic approaches to delivering personalised mental health interventions for depression to the UK Muslim community. Therefore, when considering the rich genre of Islamic psalms, it is necessary to focus on individual psalms, with the aim of identifying precise contact points with psychotherapy.

Given the interest in *al-Ṣaḥīfah al-Sajjādiyya* over the centuries, it has attracted a number of scholars across the generations, who have written commentaries on either the entire text or certain of its psalms, notably al-Shīrāzī (1994). Among the psalms that have generated the most commentary and reflection is *Duʿāʾ Makārim al-Akhlāq* (Psalm 20), a psalm seeking character perfection and what Chittick *calls "Noble moral traits"* (Zayn al-ʿĀbidīn, 1988). This psalm is also known among the laity, perhaps because of its liturgical use and hence familiarity, particularly within the Shīʿa tradition. Given its focus on *akhlāq*, with its rich psychology, it provides a good case study to explore an example of an Islamic psalm, from the perspective of the research question at hand of identifying potential touch points with psychotherapy. The first verse will be considered in more detail than the subsequent ones, since the aim of the exercise is illustrating the feasibility of making connections between Islam and psychotherapy, rather than engaging in a detailed psychological exegesis of this psalm.

Psalm 20:1-5

The opening verse begins with *salawaat*, a prayer for blessings of God upon Muḥammad (saw) and his family ("*Allahumma ṣalli ʿala Muḥammadin wa ālihi*"). This is a customary practice for the psalms of *al-Ṣaḥīfah al-Sajjādiyya* and is widely used in Islamic psalms, as good etiquette for any form of supplication. The second part of the first verse, "*Wa balligh bi ʾīmānī ʾakmala al-ʾīmān*," can be translated as, "*[O God] cause my faith to reach the most perfect faith*." It should be noted that *īmān* (faith), has been deemed as the opposite of fear (al-Shīrāzī, 1994). The next (third) section of the first verse says, "*Make my certainty the most excellent certainty*," (*Wʾajʿal yaqīnī ʾafḍala al-yaqīn*). Shīrāzī begins with analysing the Arabic grammar and lexicography, pointing out that the operative word (certainty [of belief in God]) is not a standard verbal noun (*maṣdar*), but rather a derivative of it, a remote form known as "*ism maṣdar"*. In the analysis that follows, it becomes clear that engaging with grammatical nuance is important for uncovering deeper dimensions of *akhlāq*, since this verb form relates to the consequences of an action upon the one performing it. Hence, the implication of staying firm upon faith (*ʾīmān)* is that the believer becomes imbibed with certainty, corresponding to the chronology of the verses, moving from *ʾīmān* to *yaqīn* (certainty). Moving to part four of the first verse, the psalm continues with the critical supplication, "*Take my intention to the best of intentions*," (*Wʾantahi bi niyyatī ʾila ʾaḥsani al-niyyāt*).

From a psychotherapeutic perspective, this verse facilitates metacognition through consideration of the quality of intention and introspection on different motivations.

The fifth and final part of first verse brings the preceding inner dimensions into contact with the outer world through action and behaviour. The invocation is, "*[Take] my works to the best of works*," (*Wa bi ʿamalīʾila aḥsani al-aʿmāl).* For Shīrāzī, the concept of *"aḥsani al-aʿmāl"* (best of works or deeds) is entirely a function of the quality of the intention (*niyyah*) (al-Shīrāzī, 1994). This hypothesis is supported by a number of *ahadīth* and Qurʾānic verses. Of particular interest to Shīrāzī is *Sūrat al-Mulk* (67:2), which says, "*[He] who created death and life to test you and reveal which of you does best – He is the Mighty, the Forgiving*." This Qurʾānic verse situates the last verse of the first stanza into a wider soteriological context, giving a broad perspective to the importance of *akhlāq*. From a psychotherapeutic perspective, the movement in the psalm from self-reflection to action, i.e. from metacognition to behavioural activation, illustrates the range of applications for these concepts across diverse NICE approved interventions, particularly Cognitive Behavioural Therapy and Behavioural Activation.

Many of the sentiments above are reflected in the second verse, particularly in relation to intention. Verse three adds a thought-provoking inter-personal dimension with the invocation, "*Let good flow out from my hands upon the people and efface it not by my making them feel obliged*!" The (re)construction of relationships and social engagement rooted in a well-grounded sense of self continues in verse four: "… *raise me not a single degree before the people without lowering me its like in myself*…"

Psalm 20:6-10

Verse seven is particularly focussed on healing a range of relationships, and engenders reflection upon the state of a variety of family and wider communal relationships, together with behaviour patterns, particularly those that have served as maintenance factors for damaged relationships.

Psalm 20:11-15

Verse eleven addresses anxiety about physical weakness, while verses twelve and thirteen serve as mirrors for negative behaviour patterns and associated negative emotions.

Psalm 20:16-20 and 21-25

The primary thrust of both of these stanzas is building optimism and hope, with supplications that could be employed to counter a sense of loneliness through building a relationship with God.

Psalm 20:26-30

The final stanza returns to metacognition and awareness of emotions, in the context of seeking God's help to do so. In addition to having contact points with self-knowledge related psychotherapeutic categories, the psalm also seeks to develop resilience, not just through cultivating optimism and hope (for Divine

assistance), but also a profound and active sense of gratitude (*shukr*), which takes on the role of a psychological vaccine, inoculating the heart against arrogance. The psalmist presents humility and gratitude as mutually reinforcing. Used with appropriate self-refection, such psalms can enable and empower a reader to reframe specific challenging situations, in light of wider assistance and support that may be available, whilst providing psychological fuel for perseverance.

The excerpts discussed above provide a synopsis of Step 4 of the DCA method discussed in Section 2.1 above ('*Reducing units into categories*'), such that the 'units' of verses have been examined through the a priori coding framework of the ten psychotherapeutic categories presented in Figure 2.2.A above.

3.5.3 Analysis matrix of psychotherapy and Islamic psalms (duʿāʾ)

The myriad of contact points identified between this key Islamic psalm and a range of psychotherapeutic techniques from the NICE guideline are summarised below in the analysis matrix of psychotherapy and Islamic psalms *(duʿāʾ)* (Figure 3.5.B).

Duʿāʾ Makārim al-Akhlāq, Psalm 20 from *al-Ṣaḥīfah al-Sajjādiyya*, is demonstrably rich in metacognitive content, holding up various mirrors for readers to see their thinking patterns and emotions, particularly destructive or generally unhelpful ones. Discussion regarding intention adds clear goal setting congruence. As with psalms and supplications more generally, recitation can cultivate a strong sense of optimism and hope.

Figure 3.5.B: Analysis matrix of psychotherapy and Islamic psalms (*duʿāʾ*)

	SELF-KNOWLEDGE					RESILIENCE				
	Goal setting	Awareness of thoughts	Recognising emotions	Mindfulness practices	Bodily awareness	Optimism and hope	Motivation and agency	Gratitude	Relationships	Behaviour patterns
Context & usage										
Psalm 20:1-5										
Psalm 20:6-10										
Psalm 20:11-15										
Psalm 20:16-20										
Psalm 20:21-25										
Psalm 20:26-30										
OVERALL										

Strongly related	
Moderately related	
Weakly related	
Unrelated	

Key for qualitative scoring

3.6 Summary of contact points between psychotherapy and Islam

The numerous contact points identified in this chapter are summarised below in the aggregate analysis matrix that provides a summary of contact points between psychotherapy and Islam (Figure 3.6.B). This matrix has been constructed by taking the “overall” row from each of the preceding five analysis matrices, spanning a range of Islamic concepts and practices.

The summary analysis matrix (Figure 3.6.B) shows that each psychotherapeutic coding category from the NICE guideline has at least one Islamic correlate, and typically two to four, thereby providing choice for those who wish to communicate one in terms of the other, as summarised in Figure 3.6.A below.

From the analysis herein, it appears that there are strong metacognitive dimensions to several Islamic concepts and practices. There is also good representation of behavioural psychotherapy, together with analysis of relationships, which are given great importance, particularly familial ties. In addition, there are also a variety of mindfulness practices that offer congruence with MBCT approaches. It appears that Sūrat al-Fātiḥah (Qurʾān 1:1-7) and daily prayers have general applicability, whereas fasting, mindfulness practices and psalms have more specific psychotherapeutic contact points. Hence, it is beneficial to look across the entire spectrum of psychotherapeutic interventions recommended in the NICE Guideline for depression in adults (NG 222).

Figure 3.6.A: Islamic correlates of psychotherapeutic categories

Psychotherapeutic category	Key Islamic concepts or practices
Goal setting	Qurʾān (1:1-7), daily prayers, psalms
Awareness of thoughts	Qurʾān (1:1-7), daily prayers, mindfulness, psalms
Recognising emotions	Daily prayers, mindfulness, and psalms
Mindfulness practices	Qurʾān (1:1-7), fasting, and Islamic mindfulness
Bodily awareness	Daily prayers, fasting
Optimism and hope	Qurʾān (1:1-7), daily prayers
Motivation and agency	Qurʾān (1:1-7), daily prayers
Gratitude	Qurʾān (1:1-7), daily prayers
Relationships	Daily prayers, psalms
Behaviour patterns	Qurʾān (1:1-7), fasting

The value of the comparative analysis in this chapter is in identifying bridges between psychotherapeutic interventions from the NICE guideline for depression among adults and a range of Islamic concepts and practices. In so doing, the conceptual objective of the study (set out in Chapter 1) has been addressed, namely to explicate the theological foundations of potential Islamic correlates of psychotherapeutic techniques utilised in NHS interventions for depression, as set out in the NICE Guideline (NG 222).

The Deductive Content Analysis method employed for this comparative work has facilitated the identification of a number of explicit and implicit contact points, that upon closer examination at a micro level, by testing each sub-component of key dimensions of Islamic practice, have yielded important translatable insights with potential for clinical application.

Therefore, the next step is to explore the practical potential of this analysis and how viable it may be to bring it to fruition within health care services by considering these comparative conceptual insights, and their potential for practical application, by exploring the views and experiences of service users and service providers (clinicians across a range of services). This would address the empirical objective of this study (from Chapter 1), to investigate the perspectives and experiences of Muslims receiving mental health care for depression and their service providers, as well as explore their views and experiences as they relate to the potential contact points identified from the conceptual objective, together with exploring what further amendments to them may be required in order to further the delivery of personalised mental healthcare. This is the focus of the next chapter.

Figure 3.6.B: Summary analysis matrix of psychotherapy and Islam

	SELF-KNOWLEDGE					RESILIENCE				
	Goal setting	Awareness of thoughts	Recognising emotions	Mindfulness practices	Bodily awareness	Optimism and hope	Motivation and agency	Gratitude	Relationships	Behaviour patterns
Qurʾān (1:1-7)										
Daily prayers										
Fasting										
Mindfulness										
Psalms										

Strongly related	
Moderately related	
Weakly related	
Unrelated	

Key for qualitative scoring

3.7 References for Chapter Three

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CHAPTER FOUR: INTERVIEW RESEARCH METHODS

The previous conceptual part of this study consisted of deriving psychotherapeutic concepts and techniques from the interventions recommended by the NICE Guidelines for depression that are congruent with Islamic concepts. The framework that was derived consisted of ten elements, with five relating to self-knowledge (metacognition) and five to building resilience. These ten factors were compared with five central aspects of Islam that are well-known and established practices in the Muslim community: scripture, in particular the first chapter of the Qurʾān; daily prayers (*ṣalāh*); fasting (*ṣawm*); mindfulness practices (*dhikr*); and psalms (*duʿāʾ)*. This yielded a summary of Islamic correlates of the ten psychotherapeutic categories identified from the NICE Guidelines. This addressed the first aim of this study, as discussed in Chapter 1, fulfilling the conceptual objective of exploring contact points between Islamic concepts and psychotherapeutic techniques from interventions for depression in the NICE Guideline for depression in adults (NG 222) (NICE, 2022).

In order to address the overall research question of, "*Clarifying the place of religion in formulating and delivering personalised mental health care for depression in the UK Muslim population"*, the conceptual aim is supported by an empirical aim of this study. As such, the above conceptual analysis served as an a priori input into the empirical investigation of the perspectives and experiences of Muslims receiving mental health care for depression and their service providers; as well as exploring their views of the potential adaptations identified above. This

empirical study uses interview methods to examine the perspectives of Muslims who have experienced depression, together with therapists who have provided psychotherapeutic interventions for depression to the Muslim community. The data collected from both sides of the therapeutic partnership spans the role and potential value of faith-adapted treatments, as well as wider considerations of stigma and institutional factors supporting personalised mental healthcare.

As discussed in Chapter 1, the research design of this study is inspired by the iterative symbiosis of conceptual and empirical analysis, such that there is interaction between conceptual mapping (from the comparative analysis in the previous chapter) and empirical insights from interviews with service users and therapists (discussed in the following chapters).

The appropriate empirical approach for collecting the complex experiential data required to address the research question herein was qualitative methods, so as to develop a rich and nuanced understanding of values, experiences and perspectives of both service users and providers (Fox, 2008). Within the broad spectrum of qualitative analysis, the specific technique employed for this study was the semi-structured interview method, as it facilitates exploring a range of topics, whilst retaining flexibility to probe deeper into particularly rich data, and subsequently opens a range of analytic strategies (Singh, 2017).

With regard to the specific research question herein, such an approach has been advocated in the literature for religion and mental health:

> *“Qualitative methods are ideal for examining the role that religion plays in maintaining, enhancing, or worsening mental health... Qualitative methods play a pivotal role in understanding the relationship between religion and mental health, and provide information that quantitative research cannot.”* (Koenig, 2018, p. 21)

Given the purpose of the study from the research question and the interview data collected, it was important to select a method for analysing the qualitative data that could facilitate a priori input and a deductive approach (as discussed below). Framework Analysis provides a powerful yet flexible analytical approach for this purpose (Ritchie & Spencer, 1994), that is thematic in nature. In this regard, it is similar to Thematic Analysis, which is particularly useful for psychology related studies, as it provides theoretical freedom in offering a complex account of data that is detailed and sophisticated (Braun & Clarke, 2006), without being limited by epistemic commitments of similar methods, such as constructionist grounded theory from Charmaz (2006).

The following sections delve deeper into the interview methods employed and subsequent Framework Analysis of the data collected.

4.1 Interview methods

This empirical project has two objectives that help to clarify the place of religion in formulating and delivering personalised mental health care for depression in the UK Muslim population. First, to further develop conceptual insights for personalised psychotherapeutic interventions for Muslims, by analysing data from service users and service providers. Second, to explore the views of both groups relating to faith-adapted interventions for Muslims that are aligned with NICE approved mental health treatments. These two aspects could identify new insights into how personal understandings of religion can influence mental health experiences, as well as how formulation and delivery of personalised psychotherapeutic interventions for depression can be improved.

The literature provides guidance on the value of interview based qualitative methods for obtaining the subtle and nuanced insights required for high quality psychotherapeutic research (Kvale & Brinkmann, 2015; McLeod, 2011). Within the range of interview methods, semi-structured interviews are well supported, for the balance they provide between consistency of interview content and flexibility to capture individual insights. For instance, a recent paper on psychotherapists' experiences in delivering treatment for major depression in a Muslim context found this method effective for identifying complex and multidimensional factors, with themes related to both patients and therapists (Senan & Alsulaiman, 2025).

However, it should be noted that that there are influential critiques of qualitative interviews in psychology. For instance, Potter and Hepburn (2005) point out that

traditional qualitative interviews are often treated too simplistically, exacerbated by factors such as the artificiality of the interview setting and the tendency to omit the interviewer's influence in analysis. The focus of their critique was principally on open-ended or conversational qualitative interviews, some of the limitations of which are mitigated by semi-structured interview methods. In a response by Smith et al. (2005), the interview method, particularly in semi-structured format, is defended as a valuable tool for accessing participants' lived experiences and meanings, provided there is due attention to reflexivity.

As noted on the discussion on reflexivity in Section 1.2.2, clear interview protocols further support consistency of approach and mitigating risks of bias, since there is only one researcher conducting interviews in this study, albeit with the support of a supervisory team.

The empirical method employed was semi-structured interviews of approximately 60-90 minutes (n=30, 15 Muslim service users diagnosed with depression and 15 mental health service providers from a variety of clinical disciplines), recruited predominantly in Oxford, London and Birmingham, harnessing community-based networks, cultivated by the researcher over the preceding decade. The location of interviews was generally by telephone or online video calls. Interviews were recorded on a secure audio device and supporting questionnaires stored (for at least 3 years) on secure University servers allocated to the Department of Psychiatry, Oxford.

It is important to clarify the terminology used in this discussion. The term ‘service user’ is used synonymously with ‘patient’ or ‘client’, so as to capture conventions from different healthcare disciplines. For instance, whereas psychiatrists and GPs in the study typically used the term ‘patient’ during interviews, clinical psychologists and psychotherapist generally used the term ‘client’. In this study, all three terms (participant, patient, and client) are used interchangeably to denote service users, specifically adult Muslims in the UK who have experienced depression. Where appropriate, some service providers are also referred to as ‘clinicians’ in the data and therefore also the following analysis.

A recognised benchmark for best practice in collecting and analysing interview-based empirical data is the Consolidated Criteria For Reporting Qualitative Research (COREQ), developed by Tong et al. (2007). This framework for interview based empirical research is designed to improve the credibility of qualitative studies, particularly by promoting transparency and trustworthiness of interview findings and interpretations. There are thirty-two criteria, spanning three categories of researcher reflexivity; study design, including sampling methods; and analysis of findings. Whilst the COREQ framework has been influential in the literature, it should be noted that it has also attracted considerable criticism, not least with regard to the development of the checklist (Buus & Perron, 2020). In the particular context of methods in psychology, Braun and Clarke (2024) warn of the simplistic (mis)application of COREQ and incongruent reporting, among other factors. Nevertheless, for this study COREQ is used as an approach to focus on best practice and avoid bias. Such a values based use of COREQ is also in keeping with how critics like Braun and Clarke (2024) would advocate its use.

These elements are reflected in the discussion below, which begins with the prerequisite of ethical approval, followed by an exposition of the interview protocols and purposive sampling. The discussion includes how interview guides were initially developed, tested with a pilot interview, and further refined through insights gleaned during early interviews. This iterative approach is consistent with the overall research design and keeps the conceptual and empirical hemispheres of this project constantly connected.

4.1.1 Research ethics

University of Oxford regulations require studies that collect human data to receive prior ethical approval. This study was evaluated by the Central University Research Ethics Committee (CUREC) and approved under reference R53467/RE001, dated 26 September 2017 (see Appendix 4.1). In keeping with best practice, insights gleaned from the first set of interviews led to the refinement of protocols for subsequent data gathering, which necessitated amended interview protocols to be submitted for ethical assessment (approved under R53467/RE002 on 14 October 2020). The following provides a synopsis of the main elements of the study that were appraised by the Research Ethics Committee.

The inclusion criteria for service users were UK Muslims who have suffered from depression (either diagnosed by a health care professional or who have self-diagnosed). Service providers were selected from UK practitioners who have provided therapy for depression to Muslims, such as psychologists, psychiatrists, General Practitioners (GPs) / physicians, counsellors, and other mental health practitioners (regardless of whether they were from the Muslim community or not).

Exclusion criteria related to individuals who may not be in a position to participate in a discussion of this nature due to psychological or physical impairment(s), English language difficulties, or where the researcher believes it would not be in the best interests of the individual to participate, such as due to safeguarding considerations. The judgement was typically made on the basis of responses to emails or telephone conversions, rather than a formal assessment. Exclusion

criteria for practitioners were restricted to cases where clinicians had not provided psychotherapeutic interventions for depression to UK Muslim patients. The faith or cultural backgrounds of practitioners were not included in inclusion or exclusion criteria, since Muslims are treated by a range of service providers in the UK health system, particularly publicly provided care in the National Health Service (NHS).

The recruitment method was purposive sampling, utilising community channels cultivated by the researcher over the preceding ten years. This included mosques and community groups in Oxford, London, Birmingham and elsewhere. No recruitment was to be undertaken through the NHS. Once an individual responded to a participant information sheet, distributed at Muslim community centres and mosques, a more detailed email was sent enclosing a consent form, questionnaire, and participant information sheet (enclosed in Appendix 4.2-4.4). After the interview, a debrief email was sent, containing information on sources of mental health assistance, in case participants required further support as a result of the discussions in the interview.

As regards the number of participants (n=30), fifteen interviews were conducted with service users from diverse cultural backgrounds and age groups, together with fifteen interviews with service providers, representing a range of mental health-related disciplines. The following section will shed further light on participants, sampling methods, and data saturation.

From a research ethics perspective, obtaining informed consent was crucial. Hence, the recommended consent form and participant information templates

were utilised, following CUREC Approved Procedure 04 (see Appendix 4.2 and 4.3). These materials were sent to participants in advance and consent was obtained prior to each interview. Any potential risks regarding capacity to give informed consent were evaluated during initial email interactions, as well as in the early stage of any interview, as part of the process of reviewing the consent form together and checking the participant's understanding of what they were consenting to. Precautions to protect the welfare of participants were important in this study, due to having potentially vulnerable individuals with depression.

With specific regard to safeguarding, efforts were made with the research design and interview protocols to be sensitive to participants with depression and to minimise the risk of distress. As per standard safeguarding protocols, if any risk of serious harm to other people had been identified, confidentiality could have been waived. In addition, if an adverse event was to occur, the researcher had access to an experienced member of staff (in person or by telephone) who could have been contacted in the event that a participant became distressed or appeared to be at risk of serious harm. Thankfully no such circumstance came to pass and there were no adverse events that needed to be recorded.

The final item of ethical review related to data management and confidentiality. As per standard procedure in qualitative research, all interview data has been anonymised to ensure that individuals cannot be identified herein or in published materials. The data has been stored on the University of Oxford servers, thereby benefitting from all their security infrastructure and backup protocols. For further information, see the Data Management Plan in Appendix 4.6.

4.1.2 Interview protocols and sampling

The preceding chapter established substantive contact points between Islamic concepts and practices with psychotherapeutic interventions for depression from the NICE Guideline for depression. This comparative analysis serves as a framework for interview questions to explore the views of service users and providers. The interview protocols were structured into three sections, drawing upon different elements of the preceding conceptual analysis. This began by asking participants about potential points of contact between ten Islamic and ten psychotherapeutic concepts (see Appendix 4.5 for full details), providing the context for how faith-adapted psychotherapy could work. The conversation then extended to potential applications of such contact points into personalised therapies for depression for the Muslim population and the need for person-centred care more widely. The third section of the interview protocols concerned questions regarding meeting the needs of individual service users and providers from social, clinical, and institutional perspectives. There was also time at the beginning and end for participants to share other insights and experiences related to the topic, thereby creating vital space for unexpected insights and capturing relevant data that did not fit into the above categories. This is how the protocol design harnessed the benefits of semi-structured interview methods.

An important example of the benefits of such flexibility is in relation to how Islamic history came to unexpectedly feature in the data. The preceding conceptual chapter, that served as an a priori source for the interview protocol, was rooted in

Islamic practices and concepts that are generally well understood in the UK Muslim community today. This contemporary approach therefore continued in the interview protocol. It was also deemed prudent to avoid factors related to Islamic history in the interview topic guide, so as to avoid potential sources of tension that can arise from differing perspectives on historical figures and events. Nevertheless, given the salience of history in how Muslims understand themselves and their faith, service users spoke about how they use historical events to help them contextualise and cope with their own depression. For instance, the experience of how historical figures in scripture managed adversity. This added richness to the data was made possible by the flexibility of the semi-structured qualitative interview method.

In keeping with best practice for testing risks and appropriateness of interview questions, a pilot interview was undertaken with an Arab Muslim female in her forties, who had been diagnosed with depression. This person was recruited through community contacts at one of the mosques in Oxford. The interview did not appear to cause any distress, or any adverse reactions. Rather than the discussion of religious adaptations to therapy causing sensitivity or discomfort, the participant was very engaged and active in the discussion, providing a number of interesting insights into how such adaptations could be implemented and the benefit she may have gained if such personalised mental health treatment had been offered to her. Hence, even though the subject matter of the interviews was potentially sensitive, this approach to discussing religion and its therapeutic correlates did not appear to incur significant risk of causing distress to this participant.

Having established a viable interview protocol and tested it with a pilot interview, the next step was to determine a robust strategy for sampling and recruitment of interview participants, both service users and providers. The qualitative research literature provides guidance in how to do this for psychological studies, such as the four-dimensional approach of Robinson (2014), which integrates theoretical and practical considerations, and has been adopted herein. First, a sample universe was established with inclusion and exclusion criteria, as outlined in the preceding section.

Second, a target sample size was determined, with regard to both theoretical and practical factors, taking into account saturation (as discussed below), together with time and resource constraints. Previous qualitative studies in the field of depression among Muslims suggests that the target sample size of 30 for this study is reasonable, albeit consisting of both service users and providers. For instance, a UK study of faith-adapted behavioural activation therapy for treatment of depression among Muslims had 29 participants, consisting of 19 patients and 13 mental health practitioners (Mir et al., 2015). From a wider cultural perspective, a recent worldwide qualitative systematic review of anxiety and depression among South Asians with long-term conditions identified 21 qualitative studies, including some with 30 participants (Awan et al., 2022).

The third factor in qualitative sampling was devising a sampling strategy, using a combination of methods from Robinson (2014). This study adopted a ‘purposive’ approach, rather than ‘random’ or ‘convenience’ sampling, so as to ensure that

different professional disciplines of service providers and cultural diversity of service users were represented in the study. This ensured heterogeneity of participants across both data sets. The fourth dimension of qualitative sampling in this framework was the actual process of recruiting participants, which Robinson (2014) calls 'sourcing sample'. There were several decisions that were required for this step: (i) not financially remunerating participants, as there was no funding to do so; (ii) adopting email-based recruitment, so as to maximise the network effects of community referral processes; and (iii) to use limited advertising by providing participant information sheets at some local Islamic centres (with prior permission).

The recruitment aspect of the study necessitates reflexivity. The researcher serves as a *Shaykh* (Muslim priest) in the UK, which facilitated recruitment by building trust in the study, particularly for accessing harder to reach groups, such as Muslim men with depression and women with postnatal depression. However, there was also a risk of potential bias from working within specific communities. As a result, networks of others in the Muslim community were also used, who could reach individuals in different cultural groups (unconnected to the researcher).

An important consideration in qualitative sampling is data 'saturation', i.e. the question of how many interviews are deemed sufficient for addressing research questions. In this regard, guidance from Baker and Edwards (2012), who collated insights from a range of practitioners, suggested that the theoretical approach of collecting data until no new themes emerge, as derived from the seminal account of grounded theory from Glaser and Strauss (1967), is not necessarily feasible or

pragmatic. Based on the studies they considered, Baker and Edwards (2012) suggest that provided participants were drawn from a representative sample, 15 interviews have provided reasonable saturation for well-defined research questions. A similar conclusion was reached by Guest et al. (2006) in their evocatively titled review study, "*How Many Interviews Are Enough?*" This study reported that thematic saturation was achieved within the first 12 interviews and meta-themes could be identified much earlier, by the first 6 interviews. For the purpose of addressing the research question, this empirical research project also sought thematic saturation, which was broadly found after a similar number of interviews as Guest et al. (2006), for both cohorts of service users and therapists. Hence, the wider literature as well as the specific experience of thematic saturation in this study supports the sample sizes in this project, consisting of 15 participants for each category (therapists and clients/patients), resulting in a total of 30 participants across both cohorts of service users and providers. Within each category, the recruitment objective was to maximise heterogeneity across demographic factors for service users and professions for service providers, to discover insights and differences (if any) that could inform future studies. Both groups included males and females, with service users spanning adolescents to older adults, from Arab, Pakistani, and other cultures. Service providers, from Muslim and non-Muslim backgrounds, consisted of clinical psychologists, psychiatrists, counsellors/therapists, physicians (GPs), as well as a palliative care consultant, providing a broad spectrum of professionals treating and managing depression in the UK Muslim community. Such a heterogeneous sample was the best way to answer this research question, as it relates to the broad cultural range of Muslims in the UK and various clinical settings in which they are treated.

4.2 Analytical methods

Further to the discussion above, setting out the methodological choice of qualitative data collection, in the form of semi-structured interviews, the next step is to clarify which method of qualitative data analysis is appropriate for this study. In keeping with the decision-making approach set out above, the choice of analytical method is driven by the research question and overall aims and objectives of the study. The purpose of qualitative empirical analysis, regardless of which particular method is adopted, is well-established in the literature:

> *"Qualitative data analysis is the classification and interpretation of linguistic (or visual) material to make statements about implicit and explicit dimensions and structures of meaning-making in the material and what is represented in it." (Flick, 2013, p. 5)*

Within these broad purposes, the range of specific analytical methods is vast, ranging from inductive to deductive, with various blended iterations of each, such as Constructivist Grounded Theory (Charmaz, 2006) and Thematic Analysis (Braun & Clarke, 2006). For the specific purposes of this study, a method of analysis was required that connected the conceptual and empirical dimensions herein, providing a flexible balance between being led by the data in an inductive sense, whilst working in the context of *a priori* materials in a deductive way. Furthermore, given the policy related aims and objectives of this study, it was also necessary to have a method of analysing interview data that led to clear outcomes that could inform future policy and lead to positive translational impact. After extensive deliberation, the method of Framework Analysis was selected, as

pioneered by Ritchie and Spencer (1994). The section below examines various dimensions of operationalising this method of qualitative data analysis in the context of this study and research question. In so doing, the following discussion explores, with reference to various studies in mental health and related fields, how the outputs of the empirical framework analysis at the end of this chapter provide the kind of clear insights that can be brought together with the conceptual mapping developed in the preceding chapter. From a comparative perspective, there is also reflection on how Framework Analysis is a better methodological choice for this study than alternative methods such as Thematic Analysis.

4.2.1 Framework Analysis

Over the last three decades, researchers have applied and developed the framework approach to qualitative data analysis, across a range of subjects, due to its methodological strengths:

> *"Framework Analysis is flexible, systematic, and rigorous, offering clarity, transparency, an audit trail, an option for theme-based and case-based analysis and for readily retrievable data." (Ward et al., 2013)*

A particular area of interest has been in the field of applied policy research. As some have noted,

> *"Framework analysis is a qualitative method that is aptly suited for applied policy research. It can be said to be quite similar to grounded theory; however, framework analysis differs in that it is better adapted to research*

that has specific questions, a limited time frame, a pre-designed sample and a priori issues... Framework analysis provides an excellent tool to assess policies and procedures from the very people that they affect."
(Srivastava & Thomson, 2009)

The literature suggests that studies with similar research questions have also used this data analysis method. For instance, when examining interview data on how people from different ethnicities use religious and spiritual coping with mental distress, Bhui et al. (2008) employed the Framework approach to qualitative data analysis, "*to ensure consistent and transparent analysis that ensures validity and reliability in interpreting findings*." Their analysis resulted in themes that were grouped in overarching thematic categories, thereby providing clarity regarding clustering of themes, such as components of religious coping.

In the context of this study, the outputs of Framework Analysis transparently facilitate connections with the preceding conceptual mapping, and how these can be brought together in a way that is relevant to policy and practice. As such, it facilitates the objective of analysing the viability of faith-based adaptations, with regard to respect for patient values, developing acceptability, trustworthiness and agency, together with practicability in a health care delivery context, focussing on obtaining practical coherence with person-centred mental care.

In their seminal paper setting out Framework Analysis as a method in its own right, Ritchie and Spencer (1994) speak of "*actionable outcomes*", of which the data herein suggests several, as discussed in the sections below. This research

question, together with the aims and objectives set out above, appear to fit all four categories of studies that Jane Ritchie and Liz Spencer regard as relevant for this method: ‘contextual’ (depression in the UK Muslim population); ‘diagnostic’ (identifying potential faith-adapted adaptations to interventions for depression); ‘evaluative’ (listening to feedback from service users and providers); and ‘strategic’ (clarifying next steps and required resources). These four categories explicate the point made by Srivastava and Thomson (2009) above, specifically how Framework Analysis is well suited to studies such as this, with *a priori* contexts and research questions, yielding assessments of policies and procedures of faith-informed interventions for depression, “*from the very people that they affect*”, both service users and providers.

Framework Analysis has many useful features for this study, particularly with regard to systematically summarising large datasets in succinct matrices, enabling both “*theme-based and case-based analysis*”, as noted by (Ward et al., 2013). while enabling comparisons between ‘cases’ (interviews) –The ability to predicate coding of interview transcripts on *a priori* material is a powerful deductive approach that enables analysts to explore new analytical insights, relative to existing knowledge. Notwithstanding the deductive drivers of Framework Analysis, it also facilitates the incorporation of inductively derived insights, principally from case-based analysis. This is why it was important for the interview protocol to include both open-ended questions and specific opportunities at the beginning and end of each interview for participants to share other insights, experiences and perspectives. Whilst the deductive approach was important for incorporating the preceding conceptual mapping of contact points between Islam and

psychotherapy into the topic guide, the inductive dimension was also important because it led to insights about factors outside the topic guide, such as the role of Islamic history and the particularities of experiences related to specific forms of depression, such as post-partum depression.

The literature shows that Framework Analysis has been successfully applied to psychological studies of depression (Parkinson et al., 2016). The approach can be summarised in the structure below from Gale et al. (2013), that outlines seven procedural steps for operationalising Framework Analysis in multi-disciplinary health research, clarifying and separating some of the five broad categories in the original paper by Ritchie and Spencer (1994).

The process began with transcription as the first stage, whereby audio recordings were transcribed verbatim, though without the need to include pauses, since the content was the primary consideration. The second stage of familiarisation with the interview, using both audio recordings and transcripts, served as a foundation for the third stage of coding the data, an act of interpretation by the researcher in seeking to paraphrase or label a key concept raised by the participant. In keeping with the spirit of balance in Framework Analysis, codes were informed by the preceding conceptual analysis (as *a priori* input), but were also open to new insights, seeking equilibrium between indictive and deductive drivers. Whilst many proponents of Framework Analysis emphasise the value of multiple coders for independence and ensuring insights in the data are not overlooked, there was only a sole researcher in this project. To mitigate the potential detrimental risks of this resource limitation, there were two experienced supervisors with whom codes

and data were regularly discussed. The process of coding early interviews led to the fourth step in the analytical procedure, whereby an analytical framework was developed, such that codes were grouped into thematic categories. This framework was then used for indexing subsequent transcripts in the fifth stage. Computer Assisted Qualitative Data Analysis Software (CAQDAS) is widely recommended, including by Gale et al. (2013), and in this project NVIVO was the chosen software. The subsequent sixth stage of aggregating and 'charting' data into a framework matrix is relatively unique to this method of qualitative data analysis, whereby themes form the columns and cases (interviews) are in rows. The task of summarising a vast dataset into a succinct matrix requires interpretative judgement from the analyst, including selection of pertinent quotations. The final seventh stage was interpreting the data, including through analytical memos over time, to clarify concepts, identify connections, create case based typologies and thematic categories, with the aim of identifying associations and developing explanations, theories and strategies (Gale et al., 2013).

Notwithstanding the considerable strengths of Framework Analysis, the limitations of this method should also be noted. Practitioners who have used this approach, such as Ward et al. (2013), point out that this is a time intensive exercise, in keeping with other rigorous qualitative analytical methods. In addition, the attribute of flexibility that was cited as a strength of Framework Analysis in the discussion above can also be weakness, if it results in drawing premature conclusions. In order to mitigate these risks, the COREQ safeguards discussed above were utilised to ensure transparency of the underlying data for each analytical theme, through appropriate direct quotes, together with clear signposting of the role of *a*

priori materials, as has been done in the preceding chapter, clearly setting out how contact points between Islam and psychotherapy were derived. Thereafter, transparency of the interview protocols, together with the framework matrices showing what each participant said about each theme, showed typological congruence between cases, such as between the perspectives of certain types of service providers, for instance GPs or psychiatrists. The detail of how thematic categories are supported by underlying data mitigates the risk of jumping to premature conclusions, which is why the following chapters focus specifically on each data set, for service users and providers, subsequently bringing them together in a way that Framework Analysis facilitates clearly and transparently.

4.2.2 Analytical choices

One of the features of empirical analysis, particularly in qualitative research, is the impact of decisions regarding analytical methods and how data is presented. Hence, it is important to clarify the key decisions made in this study. The guiding principle of analytical choices was alignment with the aims and objectives for addressing the research question, as discussed at the outset of the project.

First, the relative choice of Framework Analysis needs to be put into context, in comparison to other viable methods, principally Thematic Analysis, as conceptualised for psychological studies by Braun and Clarke (2006), who present Thematic Analysis as a method for identifying and evaluating themes, as patterns in the data to be presented using data extracts and charts. There are striking

procedural similarities between Thematic Analysis and Framework Analysis, resulting in many comparable features in identifying and presenting data analysis. In specific, the above version of Thematic Analysis consists of the following steps: (i) familiarization; (ii) generating initial codes; (iii) searching for themes; (iv) reviewing themes; (v) defining and naming themes; and (vi) producing the report. These features make it a flexible method that can be applied to a range of research purposes, particularly since it is compatible with deductive, inductive and blended constructionist epistemic paradigms. However, this flexibility has attractive criticism from those who regard it as symptomatic of the "*anything goes*" critique of qualitative research (Antaki et al., 2003).

The choice made in this study, between Framework Analysis and Thematic Analysis, was also made by previous qualitative research studies relating to mental health. One such example was a study exploring young people's experiences of depression by Parkinson et al. (2016). When evaluating the relative choice with Thematic Analysis, their view was:

> *"Framework analysis was considered to be a better choice than thematic analysis, because it emphasizes how both a priori issues and emergent data driven themes should guide the development of the analytic framework." (Parkinson et al., 2016, p. 112)*

Second, applying the literature above to the choice of how to present the findings in a succinct way in the following two sections, thematic data from each dataset is segmented by service users and providers. Themes from each data set are explored and explicated with direct quotes from service users and providers, as

Spencer and Ritchie (2012) suggest that extracts of raw data build credibility of qualitative research methods in mental health and psychotherapy.

Third, when reconciling the vastness of the data from thirty relatively long and detailed interviews, with the requirement of succinctness in reporting (with respect to word limits), a choice had to be made on how to balance *breadth* (in terms of number of voices) versus *depth* (of understanding the mindsets and contextual experiences of participants). In keeping with the psychological studies cited above, select exemplar cases (presented in rows in the framework matrix) were chosen to illustrate the diversity of participants and the breadth of their views across all thematic categories (i.e. framework matrix columns). This method differs from the alternative approach of having a much wider range of voices, selected eclectically and without them being represented in all themes, risking insufficient depth of understanding each participant's context and wider perspectives. In this regard, Framework Analysis is relatively unique in its approach of presenting participants as 'cases' (i.e. rows) in a framework matrix, with thematic columns grouped by categories, resulting in a table that has cells summarising each participant's view (if any) on the specific theme in each column (Spencer & Ritchie, 2012).

Fourth, an aggregate approach to Framework Analysis was chosen for the final section to bring the two data cohorts together, in order to highlight or clarify similarities and differences between service users and providers. This is facilitated by examining relevant extracts of each framework matrix, in keeping with the approach demonstrated by Hackett and Strickland (2019) in their worked example

for using Framework Analysis to analyse qualitative data. This method of ‘data summaries’ in the form of a matrix was also advocated by the worked example of Framework Analysis by Ward et al. (2013), pointing out that such an approach can provide a succinct precis of the data, rather than risking the error of providing too much information. This approach of showing aggregate framework matrices can be traced to the early foundations of Framework Analysis, such as in the seminal papers discussed above. However, due to the flexibility that Framework Analysis provides for data presentation, aggregation is not always used. Given the aims and objectives of this study, the insights and clarity provided by aggregate presentation was helpful, particularly for synthesizing insights from both service user and provider datasets, which are considered in detail in the next chapters.

4.3 Appendices to Chapter Four

Appendix 4.1: CUREC Ethics Approval

MEDICAL SCIENCES INTER-DIVISIONAL RESEARCH ETHICS COMMITTEE

Research Services, University of Oxford, Wellington Square, Oxford, OX1 2JD
Tel: +44(0)1865 616577 Fax: +44(0)1865 280467
ethics@medsci.ox.ac.uk

CONFIDENTIAL

Ref: R53467/RE001

Gulamabbas Lakha
Department of Psychiatry
University of Oxford
Warneford Hospital
Oxford

26th September 2017

Dear Gulamabbas

Research Ethics Approval - CUREC 1

Study title: Clarifying the place of religious ethics in formulating and delivering personalised mental health care for depression in the UK Muslim Population (Short Title: Religious ethics and personalised mental health care for UK Muslims with depression)

The above application has been considered on behalf of the Medical Sciences Inter-divisional Research Ethics Committee (IDREC) in accordance with the procedures laid down by the University for Ethical Approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted for a period of **2 years**, commencing on **26th September 2017**. The reference number for this study is **R53467/RE001**.

This is **subject to:**

a) **your following the BPS guidelines for online research**
b) **your agreeing to follow Approved Procedure 04**
c) **it is your responsibility to comply with the requirements for administering any tests or questionnaires and, if in doubt, to contact the publisher of those tests or questionnaires.**
d) **if new research staff are engaged, the PI is responsible for ensuring they are suitably qualified by training and/or experience.**

I would like to remind you that your study may be selected for review by the MS IDREC during an annual audit.

Amendments

Should there be any subsequent changes to the study, which raise ethical issues not covered in the original application, you should submit details to the IDREC for consideration and approval. If there are significant alterations then the Committee will require a succinct letter explaining these. If your study received University Sponsorship through CTRG, then the amendment will first need to be submitted to CTRG for approval of continued Sponsorship.

Please do not hesitate to contact me if you have any queries.

Yours Sincerely

H. Barby-Porritt

Dr. Helen Barnby-Porritt
Research Ethics Manager, Medical Sciences

Appendix 4.2: Participant Information Sheet

Department of Psychiatry
University of Oxford
Warneford Hospital
Oxford, OX3 7JX

Researcher: Gulamabbas Lakha
Direct Line: 01865 613180
E-Mail: gulamabbas.lakha@psych.ox.ac.uk

PARTICIPANT INFORMATION SHEET

Religious ethics and personalised mental health care for UK Muslims with depression

Ethics Approval Reference: R53467/RE002

1. ***Background and aims of the study***

This study seeks to answer the question of how Islamic concepts and practices could be used in psychological treatments for depression in the UK Muslim community. This is important because depression exists in the UK Muslim population, however, despite having considerable psychological content, the spiritual traditions that shape the identity of this community are not being adequately utilised to improve therapies for Muslims with depression. This study will investigate how the current situation can be improved, by identifying ways to combine religious teachings and scientific treatments. This research is part of a doctoral degree (DPhil in Psychiatry) undertaken by Gulamabbas Lakha ("the researcher").

2. ***Why have I been invited to take part?***

You have been invited because you have identified yourself as either a Muslim adult in the UK who has suffered from depression, or as a mental health professional who has provided psychotherapy for depression to Muslims in the UK.

Exclusion criteria would relate to individuals who may not be in a position to participate in a discussion of this nature due to psychological or physical impairment(s), English language difficulties, or where the researcher believes it would not be in the best interest of the individual to participate, such as due to safeguarding considerations.

3. ***Do I have to take part?***

No. You can ask questions about the study before deciding whether or not to participate. If you do agree to participate, you may withdraw yourself and your data from the study at any time up to 2 weeks after interview, without giving a reason and without penalty, by advising the researcher of this decision.

4. ***What will happen in the study?***

If you are happy to take part in the study, you will be asked to complete a brief questionnaire and participate in an interview discussion with Gulamabbas Lakha, to discuss the value of various potential Islamic adaptations to established therapies for depression.

The interview should take approximately 90 minutes, but could take longer if you need more time. There are not expected to be any follow-up meetings, however, it may be necessary to have a subsequent conversation (by telephone or email) to clarify certain questions.

The interview can take place at a time and place convenient to you, including at your home if you prefer, or online via Microsoft Teams, Zoom, Skype, or by telephone. The conversation will be audio-recorded, however, your comments will be anonymised so that your confidentiality will be protected.

5. Are there any potential risks in taking part?

It is not expected that there would be any material risks in taking part. However, discussing depression may be distressing to some people and the researcher will try to reduce this risk by focussing the conversation on ways to improve therapies.

6. Are there any benefits in taking part?

Whilst there may be no direct benefit to you from taking part in this research, and there will be no payment for taking part in this study, your contribution could be important to this research, which could in the future help other people suffering from depression.

What happens to the data provided?

The information you provide during the study is the **research data**. Any research data from which you can be identified (questionnaires and audio recordings) is known as **personal data**.

This includes more sensitive categories of personal data such as your racial or ethnic origin, religious background and data concerning your experience of mental health challenges and treatments you were offered.

Personal / sensitive data and other research data (including consent forms) will be stored in an encrypted and password protected format in Oxford for at least 3 years after publication or public release of the work.

The DPhil researcher and two supervisors, including a transcriber, will have access to the research data. Responsible members of the University of Oxford may be given access to data for monitoring and/or audit of the research.

We would like your permission to use direct quotes anonymously in any research outputs.

We would like your permission to use anonymised data in future studies, and to share data with other researchers (e.g. in online databases). All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

7. Will the research be published?

The research may be published, primarily in academic or professional journals, however, all data and direct quotes will be anonymised.

The University of Oxford is committed to the dissemination of its research for the benefit of society and the economy and, in support of this commitment, has established an online archive of research materials. This archive includes digital copies of student theses successfully submitted as part of a University of Oxford postgraduate degree programme. Holding the archive online gives easy access for researchers to the full text of freely available theses, thereby increasing the likely impact and use of that research.

If you agree to participate in this study, the research will be written up as a thesis. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published open access. However, if used, your data will be anonymised.

8. Who has reviewed this study?

This study has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee (reference number: R53467/RE002).

9. *Who do I contact if I have a concern about the study or I wish to complain?*

If you have a concern about any aspect of this study, please speak to the researcher, who will do his best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how he intends to deal with it. If you remain unhappy or wish to make a formal complaint, please contact the relevant chair of the Research Ethics Committee at the University of Oxford who will seek to resolve the matter in a reasonably expeditious manner:

Chair, Medical Sciences Inter-Divisional Research Ethics Committee; Email: ethics@medsci.ox.ac.uk; Address: Research Services, University of Oxford, Wellington Square, Oxford OX1 2JD

10. Data Protection

The University of Oxford is the data controller with respect to your personal data, and as such will determine how your personal data is used in the study.
The University will process your personal data for the purpose of the research outlined above. Research is a task that is performed in the public interest.
Further information about your rights with respect to your personal data is available from http://www.admin.ox.ac.uk/councilsec/compliance/gdpr/individualrights/.

11. Further Information and Contact Details

If you would like to discuss this study with someone beforehand (or if you have questions afterwards), please contact the researcher (Gulamabbas Lakha), whose contact details are available above.

Thank you very much for your time and interest in this research.

Appendix 4.3: Online Participant Consent Form

Muslims with depression

Consent Form

Thank you for considering this study, which has been approved by the University of Oxford Central University Research Ethics Committee (approval reference XXX).

I confirm that I have read and understand the information sheet Version 4 dated September 2017 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

- Yes
- No

I understand that my participation is voluntary and that I am free to withdraw at any time up to 2 weeks after interview, without giving any reason, and without penalty.

- Yes
- No

I understand that research data collected during the study may be looked at by designated individuals from the University of Oxford where it is relevant to my taking part in this study. I give permission for these individuals to have access to this data.

- Yes
- No

I understand who will have access to personal data provided, how the data will be stored and what will happen to the data at the end of the project.

- Yes
- No

I understand that all information will be kept strictly confidential except in rare circumstances in which it is judged that I am, or someone else is, at immediate risk of serious harm, or where information is requested by a court of law.

- Yes
- No

I understand that this project has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee.

- Yes
- No

I understand how to raise a concern or make a complaint.

- Yes
- No

I agree to take part in the above study.

- Yes
- No

I agree for my personal data to be kept in a secure database for the purpose of contacting me about follow-up questions or future studies. *Optional*

- Yes
- No

Appendix 4.4: Participant Questionnaires

Department of Psychiatry
University of Oxford
Warneford Hospital
Oxford, OX3 7JX

Principal Investigator: Professor Ilina Singh
University Direct Line: 01865 912223
University E-Mail: ilina.singh@psych.ox.ac.uk

Researcher: Gulamabbas Lakha
Direct Line: 01865 613180
E-Mail: gulamabbas.lakha@psych.ox.ac.uk

SERVICE USER QUESTIONNAIRE

Religious ethics and personalised mental health care for UK Muslims with depression

Study Summary: Clarifying the place of Islamic ethics in formulating and delivering personalised mental health care for depression in the UK Muslim population

Ethics Approval Reference:

Name: _____ Date: _____

1. Please state your age: _____
2. How would you describe your religious identity? _____
3. How would you describe your cultural identity? _____
4. Where in the UK do you live (town/city)? _____
5. What is your highest educational qualification? _____
6. What is your occupation? _____
7. Have you been diagnosed with depression, or any other mental health conditions? If so, by whom?
   _____
8. What treatments for depression were you offered and how did you find them?
   _____
   _____
9. If you chose not to access mental health services, please can you outline why not?
   _____
   _____
10. What could have been done better, either in your treatment or to encourage you to seek treatment?
    _____
    _____

Thank you for completing this questionnaire. Your responses will be anonymised and kept confidential. Please kindly return this form to Gulamabbas Lakha, preferably electronically, or by post.

Department of Psychiatry
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SERVICE PROVIDER QUESTIONNAIRE

Religious ethics and personalised mental health care for UK Muslims with depression

Study Summary: Clarifying the place of Islamic ethics in formulating and delivering personalised mental health care for depression in the UK Muslim population

Ethics Approval Reference:

Name: _____ Date: _____

1. What is your occupation? _____
2. Where do you practice (town/city)? _____
3. What mental health services do you provide? _____
4. Is the faith of your patients typically included in case conceptualisation or treatment? If so, how?
   _____
5. What treatments for depression do you typically focus on?
   _____
6. Please outline your experience of providing psychological therapies for depression to Muslim patients.
   _____
7. Please state any specific experience you may have had with adolescent Muslims with depression.
   _____
8. Please state any specific experience you may have had with or older Muslims with depression.
   _____
9. What do you think can be done to improve services for depression to the UK Muslim population, both in terms of treatment and encouraging potential users to seek treatment?
10. Could IAPT (Improving Access to Psychological Therapies) and online services help? If so, how?
    _____

Thank you for completing this questionnaire. Your responses will be anonymised and kept confidential. Please kindly return this form to Gulamabbas Lakha, preferably electronically, or by post.

Appendix 4.5: Interview Protocols

INTERVIEW PROTOCOL – TOPIC GUIDE FOR SERVICE USERS (Version 6 – September 2020)

	SECTION 1: PARTICIPANT LED CONNECTIONS
1	Please consider the following two lists of 10 psychotherapeutic and Islamic concepts for 5 mins and tell me whether you see any connections and why? [*Provide a printed randomised list*] Psychotherapeutic list: goal setting; mindfulness meditation; optimism and hope; motivation; awareness of emotions; gratitude; building good relationships; awareness of thoughts; behaviour patterns; identifying tension or relaxation in the body. Islamic list: *nafs* (inner self); *niyyat* (intention); *ʾakhlāq* (interpersonal ethics); *dhikr* or *tasbīḥ* (invocation); *ṣalāt* (daily prayer); *duʿāʾ* (supplication); *shukr* (thankfulness); *istigfār* (seeking forgiveness); *tawakkul* (trust in God); *tafakkur* (reflection).
	SECTION 2: VALIDITY OF POTENTIAL ADAPTATIONS TO 5 COMMON THERAPIES FOR DEPRESSION
2.1	For therapies that encourage **awareness of thoughts and emotions**, would it make any difference if they were described using Islamic concepts from the Qurʾān or *ḥadīth* (teachings of the Prophet Muhammad) that encourage self-analysis? If so, **which** Islamic concepts and **why**? Is there a therapeutic role for examples from **Islamic history**?
2.2	How do you understand **mindfulness** therapy? [*Provide vignette if participant is unclear*] If mindfulness therapies, such as breathing meditation, were based on Islamic concepts, would it make any difference to your **understanding** and likelihood of **practicing** regularly and why? If so, which Islamic concepts would make the most difference to you, how and why?
2.3	For therapies based on **gratitude practices**, would it make any difference if they used Islamic concepts? If so, which ones and why? What difference would such adaptation make to your **understanding** of the therapy and your frequency of **practice**?
2.4	For therapies that build **optimism and hope**, would it make any difference if they used Islamic concepts? If so, which ones and why? What difference would such adaptation make to your **understanding** of the therapy and your frequency of **practice**?
2.5	For therapies that encourage **building good relationships**, would it make any difference if they used Islamic concepts? If so, which ones and why? What difference would such adaptation make to your **understanding** of the therapy and your frequency of **practice**?
	SECTION 3: MEETING THE NEEDS OF INDIVIDUAL SERVICE USERS
3.1	If such Islamic adaptations were offered to you, would it affect your **choice** to have therapy? Would religious adaptations make any difference to the likelihood of you **practicing** a therapy regularly, such as watching your thoughts and emotions or establishing a new habit?
3.2	What could support the **delivery** of Faith Informed Therapy (FIT) in your life? - Role of **culture** (good/bad): stigma, community, friends, social attitudes, behaviours (on/offline). - Adapt for young people: role of **parents** and their views regarding faith and psychotherapy - Adapt for older adults: role and views of **carers** (both professional and relatives)
3.3	Are there **other** religious practices that could help you with depression? If so, which ones and why?
3.4	Does it matter if faith informed therapies are offered **early**, when someone is first diagnosed with depression, or offered later, after standard treatments were tried? What difference could it have made to **you** if you had been offered a faith based therapy early?
3.5	Would it matter to you whether you were offered a psychological therapy that uses Islamic teachings by a mental health **professional** who is Muslim or non-Muslim? If so, why?
3.6	Would it matter to you whether the **therapist** was male or female? If so, why?
3.7	Would it matter if the faith informed therapy was offered in a clinic, or a mosque, or online? Why?
3.8	Could anything have been done better, either in your treatment or to encourage you to seek treatment? Is there **anything else** you would like to say on this subject?

	SECTION 1: PRACTITIONER HISTORY AND THERAPEUTIC EXPERIENCE
1.1	Is the faith of your patients typically included in case conceptualisation or treatment? If so, how?
1.2	Please outline your experience of providing psychological therapies for depression to Muslims.
1.3	What do you think can be done to **improve** services for depression to the UK Muslim population, both in terms of treatment and **encouraging** potential users to seek treatment? Could IAPT help?
	SECTION 2: VALIDITY OF POTENTIAL ADAPTATIONS TO 5 COMMON THERAPIES FOR DEPRESSION
2.1	Please consider the following two lists of 10 psychotherapeutic and Islamic concepts for 5 mins and tell me whether you see any connections and why? [*Provide a printed randomised list*] Psychotherapeutic list: goal setting; mindfulness meditation; optimism and hope; motivation; awareness of emotions; gratitude; building good relationships; awareness of thoughts; behaviour patterns; identifying tension or relaxation in the body. Islamic list: *nafs* (inner self); *niyyat* (intention); *ʾakhlāq* (interpersonal ethics); *dhikr* or *tasbīḥ* (invocation); *ṣalāt* (daily prayer); *duʿāʾ* (supplication); *shukr* (thankfulness); *istigfār* (seeking forgiveness); *tawakkul* (trust in God); *tafakkur* (reflection). [*Clarify any concepts as required*]
2.2	For therapies that encourage **awareness of thoughts and emotions**, could it make any difference if they were described using Islamic concepts from the Qurʾān or *ḥadīth* (teachings of the Prophet Muhammad) that encourage self-analysis? If so, **which** Islamic concepts and **why**? Is there a therapeutic role for examples from **Islamic history**?
2.3	If **mindfulness** therapies, such as breathing meditation, were based on Islamic concepts, could it make any difference to patients' **understanding** and likelihood of **practicing** regularly and why? If so, which Islamic concepts could make the most difference to your patients, how and why?
2.4	For therapies based on **gratitude practices**, could it make any difference if they used Islamic concepts? If so, which ones and why? What difference could such adaptation make to your patients' **understanding** of the therapy and frequency of **practice**?
2.5	For therapies that build **optimism and hope**, would it make any difference if they used Islamic concepts? If so, which ones and why? What difference would such adaptation make to your patients' **understanding** of the therapy and frequency of **practice**?
2.6	For therapies that encourage **building good relationships**, could it make any difference if they used Islamic concepts? If so, which ones and why? What difference could such adaptation make to your patients' **understanding** of the therapy and frequency of **practice**?
2.7	If such Islamic adaptations were offered, would it affect the **choice** to have therapy? Would religious adaptations make any difference to the likelihood of one **practicing** a therapy regularly, such as watching thoughts and emotions or establishing a new habit?
	SECTION 3: MEETING THE NEEDS OF INDIVIDUAL SERVICE USERS & PROVIDERS
3.1	Which **personal or social factors** could support the **delivery** of Faith Informed Therapy (FIT)? - Role of **culture** (good/bad): stigma, community, friends, social attitudes, behaviours (on/offline). - Adapt for young people: role of **parents** and their views regarding faith and psychotherapy - Adapt for older adults: role of **carers** (both professional and relatives) and their views
3.2	Does it matter if faith adapted therapies are offered **early**, when someone is first diagnosed with depression? What difference could early faith adapted intervention have made to your patients?
3.3	How could you deliver such faith adapted interventions and what **obstacles** do you envisage?
3.4	What **support and/or training** would you require to enable you to deliver faith adapted therapies? Could **local faith communities**, including Muslim chaplains, assist you? If so, how?
3.5	Is there **anything else** you would like to say on this subject? Are there **other mental health** services (therapeutic or care giving) that could be faith adapted? For instance, IAPT and online services?

Appendix 4.6: Data Management Plan

Data Management Plan for Post-Graduate Research Projects

Researcher: Gulamabbas Lakha
Project Title: Clarifying the place of religion in formulating and delivering personalised mental health care for depression to the UK Muslim population
Project Duration: 2 years
Project Context: This project has two objectives: first, to investigate the principles underpinning personalised mental health for the UK Muslim population; and second, to explore adapted interventions for depression among Muslims that are aligned with existing mental health treatments, informed by interviews with service users and providers.
1. What data will be produced? Qualitative research methods will be employed for this study, based on semi-structured interviews of approximately 60-90 minutes (n=30, 15 service users diagnosed with depression and 15 service providers), to be recruited predominantly from Oxford, London and Birmingham, using community-based networks, cultivated by the researcher over the last 10 years. The interview protocols and supporting questionnaires will be reviewed and improved if necessary. The location of interviews is expected to be in participant homes (following Best Practice Guidance 10), by telephone or online. No remuneration is expected to be provided to participants. Interviews will be recorded on a secure audio device and supporting questionnaires will be stored (for at least 3 years) on secure University servers allocated to the Department of Psychiatry (in keeping with CUREC Best Practice Guidance 09). Data will be analysed using qualitative analysis methods and results will be collated for a DPhil thesis. Interview transcripts will be stored in MS Word format. Interview recordings will be on separate audio files of approximately 25MB-50MB each.
2. How will the data be documented and described? Interview recordings will be transcribed into MS Word files, which will be anonymised with alias names for participants. The file names will be interview numbers with alias names. As part of standard qualitative research methods, quotes from interview transcripts will be included in the DPhil thesis (and any subsequent publications) using only alias names, so as to protect confidentiality.

3. How will the data be stored and backed up during the lifetime of the project?

The researcher will ensure the audio data files from the recording device and transcripts from the computer used for data analysis will be backed up regularly on a password protected and encrypted external hard drive (kept with the researcher), as well as on the University of Oxford cloud storage system. There will also be a spreadsheet kept with the researcher to map participants and their aliases, stored on a password protected and encrypted device. Only the researcher and supervisor would have access to the data.

4. Legal and ethical issues

University of Oxford regulations require studies that collect human data to receive prior ethical approval. This study was evaluated by the Central University Research Ethics Committee (CUREC) and approved under reference R53467/RE001. In keeping with best practice, insights gleaning from the first set of interviews led to the refinement of protocols for subsequent data gathering, which necessitated amended interview protocols to be submitted for ethical assessment (approved under R53467/RE002). This type of study was classified under the "CUREC-1" procedure, which reviewed the study design, participant protections and data security, among other considerations.

5. What are the plans for long-term archiving and data sharing after submission of the thesis?

The data will remain with the researcher and stored on his secure University of Oxford cloud backup folder. There are no anticipated future users of any of the digital data. Selected anonymised data extracts will be included in research papers published, but there are no plans to publish the full datasets (even in anonymised form).

Signed: Gulamabbas Lakha	**Version:** 1
Date Created: October 2017	**Date Amended:** October 2020

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CHAPTER FIVE: ANALYSIS OF SERVICE USER DATA

This analysis of interview data from service users has been structured into three categories, spanning a triumvirate of insights into how personal understandings of religion can influence mental health experiences. The first concerns how service users make sense of the relationship between psychotherapeutic techniques and faith-based practices. The data suggested this consisted of personal dimensions of what it means to be a 'good Muslim', expanding to broader theological and psychological reassessments of religious ideas and practices as psychotherapeutic. The second analytical category relates to stigma, both the reality of living in the shadow of stigma, together with various ways of overcoming and managing stigma. This requires delving deeper into the distinctions between stigma due to misunderstanding religion, versus the broader cultural dimension of stigma, that appears to be driven by societal preconceptions about depression, its causes, and how men and women should deal with it respectively. There is also stigma relating to particular forms and causes of depression, notably postpartum depression. The third strand of the analysis sheds light on the challenge of finding common ground in the therapeutic encounter and utilising resources that are available, such as skilled therapists from across the cultural spectrum. The analysis extends to consider missing components of support, from both the NHS and Islamic institutions, with special regard to gaps in services that can be mitigated at relatively low cost and time.

As noted in the preceding chapter, whilst Islamic history was not initially included in the interview protocol, several participants raised history as an important component of their faith that helped in their journey of recovery from depression and as a coping tool when they were experiencing depressive episodes. As such, history is a cross-cutting theme in the data that illuminates a different way to understand faith and psychotherapy. In addition to being a resource to counter personal stigma, from a wider communal context, it appears history can also be utilised by Islamic centres to mitigate social stigma of depression. The data shows that history is a multi-faceted resource that serves three relevant functions. First, in assisting to triangulate faith, psychotherapy and depression. Second, as a tool to destigmatise the experience of depression. Third, history is a resource for Islamic institutions to better support community members with depression. Hence, history is a cross-sectional theme that will be explicated across the three thematic categories of connecting psychotherapy and religion, coping with stigma, and resources for the therapeutic encounter.

From a research methods perspective, the above approach to organising the analysis is based on the thematic categories in the framework matrix (i.e. the columns), explicated by cases of individual participants (i.e. the rows of the framework matrix), quotes from whom serve to illuminate specific thematic insights. Framework Analysis thus facilities interactive analysis of thematic categories, including nuanced sub-themes, whilst keeping the testimony of participants in clear sight. Framework matrices that summarise both dimensions of themes and cases are presented at the end of each section below.

5.1 Making sense of the relationship between psychotherapy and faith

The data captured various ways in which service users connected religious concepts and psychotherapeutic techniques. In the first part of interviews with service users, participants were presented with two lists of ten concepts from Islam and psychotherapy respectively, then asked if they saw any connections between them and if so, why? The items on each list were based on the preceding conceptual analysis, which orientated the empirical inquiry. However, that mapping was not shared with participants and they were free to draw their own connections, if any (see interview protocols in Appendix 4.5 in Chapter 4).

5.1.1 Being a 'good Muslim'

The data suggests that service users distinguish between three distinct relationships. First, one's *spiritual relationship* with Islam, i.e. what faithfulness means to them as Muslims. Second, the *psychological relationship* between faith and depression. Third, the *social relationship* between religion and secularism, in the specific contexts of their experiences of living in Britain today, as a secular country in the twenty-first century.

The thematic category of *being a 'good Muslim'* relates to faithfulness to one's religion and what that means in different contexts. The complexity of this question came through in many interviews, as participants re-evaluated their personal

understandings. Hence, their process of creating meaning was unfolding over the course of the interview, uncovering the multitude of factors discussed below.

Within the milieu of all the issues participants were grappling with, there is an interplay between religion and secularism, particularly with regard to how the two come together for Muslims with depression living in the secular context of the UK. This important theme was a common thread underlying many interview conversations, revealing how individuals reconcile this dichotomy in their lived experience of depression:

> *"The mindset is kind of like influenced by religious and non-religious [factors]. So, I guess I'd have two different answers... a religious and a non-religious answer..." (Musa).*

The interaction between secular and religious factors manifests in various contexts. One such example is how secular mindfulness techniques relate to Islamic concepts of *tafakkur* (reflection) and *nafs* (spiritual self). Looking deeper at Musa's case (introduced above), reveals how this balance can arise:

> *"The spirit, the nafs part ... pretty much defines who you are. So, in order to connect to that, you need to be mindful of the environment and the time you're in." (Musa)*

Interviewees such as Yusuf lamented that one of the prevalent ideas in the community regarding being a 'good Muslim' is that by simply having stronger faith in God, one can dispel mental ill health, which they regarded as stigmatising to those suffering from depression. Participants countered that maladaptive narrative

by analysing their unique personal journeys, as people of faith experiencing depression. In particular, the data showed how they utilised self-reflection on cultivating hope and optimism to deepen their connection between being a person of faith and managing depression. Hence, specific mechanisms of action of both religion and psychotherapy were considered together, as correlated and potentially mutually reinforcing:

> *"OK, I can have more faith [to deal with depression]. But actually, what steps can I take to have more faith and to ensure that I can go from point A to B [in the journey to recovery]... I think it would be to break down and compartmentalise different aspects of faith, but also mental wellbeing. And what I mean by that is ... for example, optimism and hope: you could bind that and overlap it with faith as an overall concept. You know, if you have strong faith, you have optimism, you have hope... But we know that there's a list of other parts to the overall pie, there's other parts of the picture. So actually how is that faith-based therapy touching, hitting all those different touch points? An individual can be like, 'I've got absolute undying, unwavering faith in my religion, in God. However, I also appreciate and I'm aware that perhaps there's not enough reflection and inner reflection going on and that's another area.' So I think it's understanding that there's not a 'one size fits all' approach and that it needs to be broken down."* (Yusuf)

The first line of the quote above provides insight into what it supposedly means to be a 'good Muslim', whereby Yusuf sets the context of people being told to "*have more faith*", as he puts it. However, he seems to regard that as simplistic and counters it by delving deeper into how different elements of faith, particularly hope

and self-reflection, can enrich and also reconcile the connection between simultaneously being a person of faith and someone experiencing depression. Furthermore, Yusuf's point about there not being a "*one size fits all*" provides a cue to investigate the importance of person-centred approaches to connecting religious and psychotherapeutic concepts, such that specific aspects of each dimension are "*broken down*", as discussed in the following section.

5.1.2 Reassessing religion as psychotherapeutic

To further examine participants' perspectives on potential intersections between Islamic and psychotherapeutic concepts, the interview protocol presented ten points from each and asked interviewees to discuss any connections they observed. The following analysis is divided into two broad thematic groups, to highlight the breadth of insights from service users. The first explores the process of enhancing self-awareness, while the second examines various approaches to building resilience.

5.1.2.i Enhancing self-awareness

Service users regarded cultivating self-awareness and deepening understanding of one's thought processes (i.e. metacognition) as a feature of both psychotherapy and Islam. In specific, they recognised the value of *akhlāq* as potentially beneficial to them therapeutically. This is the Islamic concept of personal development through self-understanding, discussed in detail in Chapter 3 above, in the context of psalms as mirrors for generating insights into ones' thinking, emotions, and interactions with others. The data suggested various forms of overlap, such as connecting cognition and behaviour:

> *"And there's a focus [in therapy] on your mindset and what you think and how you feel and your behaviour ... you can link that to akhlāq." (Musa)*

Awareness of thoughts was also connected with intention (*niyyah*) by various interviewees. Participants explained how harnessing intention for active goal setting can inject a sense of agency to reframe ruminative thoughts. For instance, when asked to identify possible connections between a list of Islamic concepts and psychotherapeutic techniques relating to awareness of thoughts, Musa commented,

> *"[Intention/niyyah is] I guess kind of having a projector in your mind of what you want to do or where you want those things... And why you want to do them, almost like what's the mindset behind doing that, what's motivating those ideas and thoughts?" (Musa)*

In addition to specific goal-setting aspects of intention (*niyyah*), participants also identified a broader aspect of thinking patterns: when asked about what links, if any, may exist between supplicatory psalms (*duʿāʾ*) and psychotherapy, a service user who had benefitted from counselling for depression responded,

> *"Well, awareness of emotions ... optimism and hope." (Adam)*

This practice of reciting psalms (*duʿāʾ*) was cited in the data as broadly supportive of metacognitive reframing, i.e. changing one's thinking about a specific challenge, for instance by zooming out and putting it in a wider context, through better understanding of one's own thinking processes, thereby also altering the experience of that difficulty:

> *"... If you are thinking negatively, or you are not in a good mood in terms of your, of your negative emotions or your body situation, you can always make duʿāʾ [supplicatory psalms] and speak to Allah." (Asma)*

Hence, it appears that the process of conversing with God through psalms can enable individuals like Asma to gain perspective of their negative thinking patterns by 'talking' through what they are thinking and feeling about specific aspects of their lives that are challenging. In a similar metacognitive vein, some found that focussing awareness on their attachments gave them a sense of freedom from associated fears, resulting in greater mental space:

> *"So because ... of the attachment in everything that we've got to let go of ... we are weak in our thoughts ...we are fearful ...There's a lot of fear in us when we are attached to things. But, if you detach ... you become more, what's the word? Free! You're liberated. Yes. And that way, ... there's nothing that that you have to fear about." (Adam)*

When probed further about which ideas from Islam could help him, he responded by citing techniques that promote metacognition:

> *"I would say tawakkul... Yeah, tawakkul and tafakkur, trust in God and reflection." (Adam)*

Adam went on to expand on his understanding about the value of trusting God (*tawakkul*), as a technique for achieving detachment:

> *"I believe that whatever problems that we have in this world, ok, we have to trust in God... If we are falling into depression... We've got to let go and trust in God and to reflect, reflect that we, we are here as it is on a journey... We need to ... let go and just live a bit more lightly." (Adam)*

Conversely, one possible theological complication was highlighted by some participants who drew attention to the potential misalignment between a person's agency in setting goals, versus the force of perceived Divine decree:

> *"You are placing trust in Him and thinking that what He's doing is... good, even though you may not see it exactly in those lines and letting Him being the goal setter in your life." (Musa)*

It therefore appears there are at least two different ways of understanding trust in God and its effects. The first relates to creating greater inner space and freedom, by reconciling internal conflict and resistance to reality as it is, rather than holding on to attachments to certain preconceptions (i.e. Adam's mindfulness approach); whereas the second method relinquishes some agency by letting go of clearly defined life goals and having more openness to whatever life may bring (i.e. Musa's theological approach). This suggests there are differences in the way individuals operationalise the Islamic concept of trust in God (*tawakkul*). It appears that a key factor in determining which perspective one adopts is the extent of reflection, '*tafakkur*' as Adam phrased it in his more active mindfulness method, compared to Musa's relatively passive theological perspective of accepting life events as Divine decree.

Within the category of mindfulness, participants had differing perceptions of how it applied to themselves, from deeply meditative to distinctly non-meditative forms of mindfulness.

> *"I started reading books on CBT - it helped a lot. But the breakthrough came about maybe a year or two ago when I discovered ... mindfulness... And to*

be honest to you, that may not only make me overcome depression, or more or less overcome depression, but also made me a lot stronger. So I think mindfulness is the future for depression." (Adam)

Adam went on to connect secular mindfulness to the obligatory daily prayers in Islam (*ṣalāh*):

"So it [ṣalāh] would be mindfulness meditation... I would say the five daily prayers [ṣalāh]... would be like living in the moment... I would say too the five daily prayers would be part of the mindfulness." (Adam)

Interestingly, there need not be a dichotomy between religious and secular approaches. Instead, a combined approach was advocated by some participants:

"The ṣalāh five times a day that we are on, on our prayer mat, I do use mindfulness and living in the moment [in the prayer]... But on my daily life, I use [secular] mindfulness because ... [when] we are out and about until we break at ṣalāh time, we don't have any other... So I think maybe it's best to use mindfulness in religious practice when you are in ṣalāh, with the rest of the day in the secular [mindfulness] practice." (Adam)

The data suggested that faith-based presentations of mindfulness techniques may positively impact accessibility and adherence of such interventions:

"It would make a difference to the likelihood of me practicing it... Because, you know, like it's religious, so I wouldn't turn it down... and I would do it. I would do it as much as it's recommended." (Musa)

With regard to the meditative aspect of secular mindfulness, some interviewees associated it with Islamic meditation (*dhikr)*:

> *"... Mindfulness meditation is similar to dhikr or tasbīḥ [invocation] ... I used to do this every time when I suffered depression, a lot." (Adam)*

Similarly, Khadija says,

> *"Dhikr and tasbīḥ [invocation], I just, I find that very meditative. And ... after prayers [ṣalāh] I wish lots of tasbīḥs, I have always found that very peaceful."*

In summary, the data shows that service users identified a variety of contact points between Islamic and psychotherapeutic concepts, particularly with regard to how religious practices that enhance self-awareness can be therapeutic for them.

5.1.2.ii Building resilience

The second thematic category of reassessing religion as psychotherapeutic is building resilience, which provides a different mechanism of action to enhancing self-awareness, as per the conceptual analysis in Chapter 3. The empirical insights relating to building resilience encompass a variety of approaches, including physical activity, managing relationships, gratitude practice, and extends to reflection upon events from Islamic History. Such breadth of data-driven findings was due to the flexibility of semi-structured interview methods, combined with the multi-level perspectives of Framework Analysis.

Whilst physical exercise was not formally in the topic guide, the open-ended components of semi-structured interviews provided space for participants to share connections between Islam and well-being that drew upon their individual experiences and perspectives. This was especially the case for service users who regarded physical activity as relatively overlooked in their view of Islam:

> *"[Exercise] is an Islamic practice because I have read ḥadīth [teaching of Prophet Muḥammad (p)] where the Prophet would say you should teach your sons and children archery and horse riding and he was contextualizing that because those were the sports of the time, but also what people did for leisure and for fitness at the time. So, in today's age, that that context could spread to many things that fit description and context of our time ... It covers a wide range of things - a lot more than what more religious people tend to think." (Musa)*

Turning to social dimensions of resilience, a potential link between ethics (*akhlāq*) and building good relationships also appears in the data from many participants, such that the interpersonal ethics of *akhlāq* could encourage (re)building supportive relationships:

> *"I guess I would want to add akhlāq [ethics] ... to the building good relationships in the secular part."* (Musa).

A key relationship for people of faith is their relationship with God, particularly when considering trust in God (*tawakkul*), which has important implications for building resilience:

> *"Yeah, tawakkul is definitely optimism and hope, trust in God." (Adam)*

Moving from social to cognitive methods for building resilience, the concept of gratitude was widely cited as having efficacy and appeared in a myriad contexts, with connections to many psychotherapeutic interventions. The practice of thankfulness (*shukr*) is well established in the Islamic literature and culture. It is therefore unsurprising that many participants drew that connection:

"Gratitude ... is clearly to do with shukr [thankfulness]." (Adam)

Gratitude was understood in a multi-dimensional way, with some highlighting connotations of optimism and hope:

"I'd say that being thankful ... relates to that [optimism and hope]" (Musa)

Service users provided nuanced and rich explanations of how they thought gratitude practice could impact upon the psychotherapeutic journey, i.e. its mechanism of action. Firstly, gratitude (or the absence thereof) was regarded as shedding light on depressive thought processes, particularly ruminations on what a person may lack, both in absolute and relative terms; and thereby viewing oneself as less successful compared to others. Secondly, gratitude facilitates reframing by focussing on what one does have, or has accomplished. For instance, consider the following reflection:

"... Stress sometimes can cause depression, and it does cause depression ... You got to detach... you've got to be grateful for what you have and you've got to try and ... appreciate what you have... For instance, your family, your friends, your prayers, your religion and so on... We look at other people, what they have ... The ego drives us to be depressed because we are so

engrossed into things like, you know, looking at the Joneses of this world, look what they have and what I want. And it causes more, more harm than good. Just look at what you have and don't look at the other side." (Adam)

As regards methods for operationalising gratitude practice, some service users utilise their Islamic mindfulness-based prayers of *dhikr* and *tasbīḥ*. For instance, the above participant used a common Islamic thankfulness meditation that consisted of repeatedly reciting "*al-ḥamdu l-illāh"* (praise be to God):

"I would relate to al-ḥamdu l-illāh [repetitions of 'praise be to God'] better than the secular [gratitude] practice ... There's nothing more than to be grateful to God for what you have in life... So I would say [reciting] al-ḥamdu l-illāh will be more important to me than anything else." (Adam)

It should be noted that not all participants had a positive view regarding gratitude practice as building resilience. One had the opposite view, since in her experience, gratitude practice was distinctly unhelpful. As such, the data had a variant finding, suggesting a contraindication for one who found gratitude exercises debilitating, rather than empowering. This negative experience was due to being overwhelmed by the idea that she can never thank God sufficiently for what she has been given:

"When I start practicing gratitude, there is so much that I start feeling overwhelmed, that it has the opposite effect in me and I just say to Allah that you know what, thank you for everything! I cannot, I cannot just list two things or three things. It's so deep and it's so much and I think that depth comes from our faith because we are told ... that you can never thank Allah

[enough], because [if you thank Him] you will need to [also] thank Him for giving you the tawfīq [spiritual insight] for thanking Him. It's a never-ending cycle! You will never break that cycle! That overwhelms me. So I try not to get into the gratitude thing." (Khadija)

The case of Khadija's reaction to gratitude practice is an interesting illustration of the insightful power of qualitative research methods, which are able to examine such contrasting, contradictory, or unaligned perspectives, which so often exist in diverse populations, including the dataset of this study. Framework Analysis provides a transparent synopsis of the wider theme in the framework matrix (in columns), whilst creating the space to highlight supportive or divergent individual cases (in rows), thereby providing vital context to understanding how an overall theme is experienced within a diverse community. This process and insights from it are explored further in the discussion chapter below.

In a similar vein of contraindication, another participant's views were also shaped by previous negative experiences of religious practices. When asked about Islamic gratitude exercises (*shukr*) and supplicatory psalms (*duʿāʾ*), Musa responded:

"I've tried that technique in the past... But I didn't really get what I needed to get from that in a way. I did it a lot and I was kind of like, I don't want to say tired of it, but you know, it didn't really help my situation." (Musa)

It is noteworthy that whilst Musa had a negative view about gratitude practice and reciting psalms, it was for the opposite reason to Khadija. Whereas she got overwhelmed by the strength of feelings that arose, Musa was left underwhelmed

by the lack of any resonance. Hence, it appears that there are various ways in which individuals can have non-aligned experiences, including potential dissonance between Islamic and psychotherapeutic concepts.

Turning to building resilience through increasing motivation, when presented with lists of Islamic and psychotherapeutic concepts and asked if they saw any connections between them relating to intention and goal setting, some interviewees didn't seem to find any:

> *"Those kind of ideas [i.e. motivation] that I feel are kind of lacking in the Islamic one [list of concepts]... and [also] the one before that [optimism and hope]." (Musa)*

However, earlier in the interview that same participant had identified a connection between the Islamic concept of gratitude (*shukr*) with psychotherapeutic ideas of optimism and hope. For this young Arab man, the process of reassessing Islamic concepts as being potentially aligned with psychotherapeutic techniques was iterative and not always consistent, sometimes changing his assessment of a concept upon further reflection, suggesting he may have been re-evaluating preconceptions. This is an important finding, suggesting that re-examining faith as psychotherapeutic can be challenging, iterative and a non-linear process that at times can be inconsistent.

A third aberrant finding arose in the discussion about whether or not interventions that utilise hope and optimism could benefit from being presented in faith terms, i.e. with Islamic correlates. It appears that for some Muslims there is a problem of

not knowing enough about Islamic teachings on this matter. Consider for instance the following interesting self-observation:

> *"I haven't found any Islamic traditions for that - I don't know any, so if someone was to present that to me, it would make a difference to my understanding and implementation of it." (Musa)*

This is an important finding, as it points to a potential epistemic threshold that might be operating in this line of practice, since a Muslim might simply not have sufficient knowledge of their faith, its commitments and practices to get much value from a faith-based approach to psychotherapy. This aspect of the data and the potential ramifications of it are considered in the discussion chapter below.

The above three contraindications identified in the data (maladaptive experiences, inconsistent appraisals of religion and/or psychotherapy, and unmet epistemic thresholds) may have different contexts, but individually and collectively they highlight the complexity of considering religious and therapeutic techniques together. The findings show the importance of service users' own understandings of their faith traditions, which can be limited in some ways. They also shed light on the very personal (and complex) relationship between demonstrating and practicing one's faith.

The final theme in the category of building resilience relates to data on how reflecting upon and re-examining events from Islamic history can serve as a resource for mental health. For interventions that promote building awareness of behaviours, some participants thought there may be value in presenting

psychotherapeutic techniques using case studies from Islamic history. The potential mechanism of action for one young man suffering from depression is set out below:

> *“I would have proof that it can work... because like in the [Islamic] story, it tells you the end of it - like what happened in the story and the effect it [the behavioural technique] can have on personalities. In the secular one it's more of a suggestion... I wouldn't know what the end result is.” (Musa)*

Whilst various participants mentioned the positive impact that reflecting upon historical events had for them, through learning from the experiences of historical figures, the analysis in this section will focus on a particular case study, as it was the clearest case for connecting Islamic historical sources to support psychotherapeutic interventions.

When Asma was recounting her experience of depression following a miscarriage, she offered insights into what helped her at the time, as well as what she has learned subsequently. Whilst the specific context of this data was postnatal depression, the findings could also have applicability to other forms of depression.

A recurring theme in the data was the potential benefit of positive role models from Islamic history. For instance, in relation to bereavement due to miscarriage and coping with the associated depression:

> *“... You would think that that great lady, Bibi Fatima Zahra [daughter and sole surviving child of the Prophet Muḥammad (p)] had a miscarriage and still she carried on... For me, the lesson ... from her life, is not that she carried on with*

day-to-day life, everyone can do that... What she did was she defended the wilayat [spiritual leadership] in that situation. That is the, that is the point for me that gives me strength... She did not sit down like a weak lady or fragile... So relating with these personalities in terms of hardship, yes, definitely you get a lot of strength from that." (Asma)

Examining this testimony suggests Asma harnessed that historical event to rebuild a sense of agency and thereby fortify her resilience. Reflecting upon challenging experiences of historical figures appears to have facilitated the reframing of her own miscarriage and associated postnatal depression, together with the concomitant stigma surrounding it. Whilst stigmatisation of depression is explored in the next section, at this juncture it is important to note the connection in the data between building resilience and challenging stigma.

The "*strength*" Asma says she got from reflecting upon the history of Lady Fatima appears to have two mechanisms of action: first, building resilience; and second, empowering her to counter the stigma she faced. The strength to challenge stigma appears in the statement below, advocating raising awareness of bereaved parents who have experienced miscarriage and providing special events for them at mosques to help them to cope with the associated depression:

"But for me the Islamic source [of] Karbala[10] and the recitation of the museeba [lament] should be channelized and should be put into our situation where we get the strength. It's not just the recitation of majlis [sermon] and traditional and conventional sort of things. It should be very specific to our situation [of bereavement through miscarriage]." (Asma)

Asma is suggesting re-training clergy to present alternative dimensions of Islamic history, focussing on psychological applications of historical events, i.e. as Asma phrased it, "...*should be channelized and should be put into our situation*".

Several participants referred to the events of Karbala as having been therapeutically helpful and supportive during their experiences of depression. For instance, Asma explained how she sought support from the history of Karbala to help her sister, whose husband died when a terrorist detonated a suicide bomb at a Shia Muslim religious service [*majlis*] in Pakistan. Asma explained that she called her sister and comforted her by narrating that,

"... When Zainab [p] was leaving Karbala as a captive, she came to her brother's body and she said ... [Oh Allah accept this sacrifice from us]... those exact words I told my sister and she said that that gave me [her] a lot of strength." (Asma)

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[10] A point of clarification is required to contextualise the specific historical event mentioned in the data above. The history of the events at Karbala (in Iraq) in 680 CE hold a pivotal position in Shia Islam, though it is also marked in some Sunnī Muslim communities as well. In summary, Imām al-Ḥusayn b. ʿAlī (p), the grandson of Prophet Muḥammad (p), took a stand against the injustices of the tyrant at the time (Yazīd b. Muʿāwiya), whose army killed Imām al-Ḥusayn (p) and his companions in Karbala, together with his family, including young children. The ladies of the family, led by his sister, Lady Zaynab (p), were taken captive and imprisoned in Damascus (the capital of Yazīd's government). The commemoration of this historical event, the anniversary of which (ʿĀshūrāʾ) is on the tenth of the first Islamic month (Muḥarram), is a key part of the Shia Muslim calendar and shapes the religious identity of that community.

In summary, the broad thematic category of psychotherapy and faith consists of two themes to faithfulness to Islam (being a '*good Muslim*') and reassessing religion as psychotherapeutic (through enhancing self-awareness and building resilience). The data examined in this section is summarised in the framework matrix extract below, in keeping with the Framework Analysis method, set out in the preceding chapter. Colour coding is used to make matrix navigation easier, such that black text denotes views that are broadly aligned with the theme, blue text highlights a materially different perspective or unique insight, whereas red text calls attention to a contrarian view that contraindicates the theme. For instance, Asma's view of reassessing religion as psychotherapeutic is in red because her experience contraindicates the initial stance of the interview topic guide to avoid history, due to risks of encountering theologically contentious ideas, particularly those that demarcate differences between denominations of Islam. Conversely, Asma found reflecting upon certain events from Islamic history as deeply therapeutic. From a wider perspective, findings that are congruent across service user and provider datasets have been shaded in the same colour across the respective framework matrices (discussed further in Chapter 7 below).

Figure 5.1.A: Service user framework matrix extract - psychotherapy & faith

USERS 1.1: PSYCHOTHERAPY & FAITH		
	1.1.1 Faithfulness	1.1.2 Reassessing Religion
Adam	Depression was not viewed as symptomatic of weak faith personally, but aware of wider perception in the community that it is.	Found the reassessment very rewarding and drew a number of connections between Islamic concepts or practices and psychotherapy, e.g. links between daily prayers and mindfulness.
Musa	Tension between free will and trust in God, with regard to his 'destiny' to have depression versus his free will based efforts to change that.	Whilst initially not expecting any value in links between religion and psychotherapy, upon reflection he found many sources of added value.
Asma	Community aspects of faith can be supportive, but needs to be better structured.	Reflecting upon examples from Islamic history, which talk about experiencing grief, including of miscarriage, can be helpful.
Khadija	Faith and religiosity were deemed independent.	Contrarian view of gratitude practice as overwhelming, rather than building resilience.
Yusuf	Took a very practical approach to mental health, so didn't connect it to faithfulness.	Found daily prayer as meditative and mindful, creating a space for reflection.

Key:

Black text = views that are broadly aligned with the theme

Blue text = a materially different perspective or unique insight

Red text = a contrarian view that contraindicates the theme

5.2 Living in the shadow of stigma and overcoming it

Stigma relating to mental health was a salient feature of the experiences of Muslim service users in this study. The analysis below categorises experiences of stigma into two forms, either stemming from religion or culture, so as not to conflate these distinct factors, even though there are correlations and interactions between them, particularly through self-stigmatisation.

5.2.1 Stigma related to religion

Some individuals experiencing depression have had to deal with the compounding effects of self-stigmatisation, due to how they understand both faith and depression. The data suggests that this typically occurs when experiences of anxiety or depression are viewed as symptoms of spiritual weakness, i.e. as barometers of faithlessness and lack of trust in God. The danger of such self-stigmatisation is that people experiencing depression say that it adds a toxic layer of guilt, spiritual anxiety and self-doubt to the existing emotional challenges they were already experiencing due to the depression. Whilst this phenomenon may be categorised as 'self-stigmatisation', it is important to note that it arises from deep societal stigma about depression that is then adopted by those suffering from mental health challenges.

To that extent, participants regarded bringing religion into psychotherapy as having the potential to mitigate some those stigmas, by reframing some of the

underlying assumptions and raising awareness of the practical reality of mental health challenges:

> *"There is overlap between the two [religion and psychotherapy]. Helping people to see the overlap can encourage them to become more open minded towards ... seeking practical help. I guess, first and foremost, even acknowledging that there is a problem to be solved. I think in a community, especially culturally speaking, rather than religiously speaking, in a community that perhaps still needs to progress and be more open-minded to the topic of mental health, I think this will really help ... It can help them to bring mental health to the forefront of discussion, which right now [it] isn't."* (Yusuf)

As discussed in Section 5.1.2.ii above, one of the unexpected findings in the data was the way Muslims experiencing depression use Islamic history to learn about how eminent historical figures managed similar experiences, by harnessing their faith to cope with the life challenges they faced, rather than viewing experiences of low mood as casting doubt on the strength of their faith. When considering this dimension of the interview with Asma, it is important to note that she got comfort from a sixteenth century text ('*Heart Comforter*') on spiritual rewards for the bereaved. It appears such historical sources helped to counter the stigmatisation she experienced by reframing religious concepts through alternative presentations of primary theological sources:

> *"So basically the book is a compilation of Islamic traditions, sayings of our aimma [saints] and Prophet Muḥammad (p). And the traditions and the*

aḥadīth are beautiful, they're marvellous, no doubt about it. And some things you don't know and you just read and say Subhanallah [Hallelujah]!" (Asma)

In addition to the theological insights from that historical text that enabled Asma to reframe her experience of depression, she also took inspiration from the personal story of the author:

"But for me reading the introduction and and the reason why that book had been compiled was the point that attracted me to that book. And it was the life history of al-Shahīd al-Thanī because he was a very learned ʿālim [Islamic scholar] and he went through the same situation [of losing infants] ... his life history and his this particular thing that matched my situation ... had more effect on me." (Asma)

Therefore, a key finding from the empirical analysis is that individuals like Asma get comfort from finding parallel life experiences to eminent historical figures, as it helps them to counter stigmas related to depression. The data suggests that knowing they have some similarities with individuals whose faith is regarded as strong, and not compromised by their psychological challenges, empowers those suffering from depression to overcome the debilitating effects of both external (social) and internal (self-imposed) stigma.

Asma's testimony also shows how it may be possible to mitigate some religious stigma by reframing early Islamic history as therapeutic. This newly reframed perspective provided comfort to her by normalising the depression she was experiencing (due to bereavement from miscarriage) and destigmatised it:

“I was surprised! I was surprised after my miscarriage [when] ... I realized that my Prophet [Muḥammad (p)] is standing with his arms wide open to comfort me because he has been through the same situation with his four sons and I never thought about it... I always read about Prophet that his four sons died and Bibi Khadija [his wife] was very sad. She was in sorrow. The traditions and the history writes about the situation very clearly, but I never realized that situation.” (Asma)

A different influential aspect of religious self-stigma arose from how service users described dissonance between notions of their free-will and trust in God. Concepts related to theological determinism mattered to some participants, such as whether the depression they were experiencing was predestined, and if so, whether it could (or should) be mitigated by exercising free-will based efforts to change that experience of depression, including through seeking psychotherapy:

“I believe trust [in God] in a way kind of diminishes the notion of free-will, that you can do anything that you want to do, because everything that you're going to do, to a degree in God's Law, has already been decided and you are where you are for a reason and you're going where you're going for a reason. So whatever effort that you try to put into changing the direction of that, the will that you've got, kind of ... gets in the way of that.” (Musa)

Such cases of stigmas from religious perceptions highlight the need to shed light on this phenomenon. This data illustrates the complex challenges related to stigmas from intertwining theological convictions and mental health challenges, including how they can lead some individuals from faith communities to exacerbate their own suffering through self-stigmatisation.

5.2.2 Stigma rooted in culture

The data suggests that understanding depression in faith communities requires culture and religion to be differentiated and not conflated. The experience of individuals from the same religion can differ due to varied cultural backgrounds, since societal stigmas about depression vary across cultures. Similarly, people from the same culture may have different experiences due to having varied religions or denominations. Hence, religion and culture should perhaps be viewed as a matrix, with each forming a different axis, rather than a simplistic vector or list, as often seen in tick-box surveys. One area where this is demonstrated is the data relating to stigma from differing gender expectations, in the specific context of individuals who are Muslim by religion and from a Pakistani cultural background:

> *"The stigma around mental health is is rooted in the expectation of, let's say, around gender roles... Number one, I think it stems from a hierarchy of power within our culture and community where, you know, men are expected to behave and speak and act in one way. Women are expected to behave and act in another way. We are taught to adopt a very hypermasculine gender role and to be the man of the house, to be the man of the community. You know, you don't ask for help, you provide the help."* (Yusuf)

The above quote highlights the stigma that this young person experienced due to being a man with depression from a Pakistani Muslim background, i.e. from that particular intersection (or cell) in the culture/religion matrix.

However, a simple two-dimensional analytical model of culture and religion may be inadequate when we consider intertemporal data across generations. As such, perhaps a third axis of time (i.e. across generations) is also required to build an image with sufficiently high resolution to enable therapists to really view the reality of their client's lived experiences. Such three-dimensional analysis would capture how a particular culture/religion combination (e.g. Pakistani Muslim) can vary profoundly across generations. If we look deeper into the experience of this individual, to understand the sources of cultural stigma that Yusuf faced from being a Pakistani Muslim man with depression, the role of changing views over time comes into focus:

> *"I just, I think the concern is... perhaps a generational disconnect as well. And within the UK and a lot of our parents have immigrated from other countries... My parents immigrated from Pakistan. I was born and raised in London. So straight away there's a cultural difference and there's a disconnect both generationally and culturally... I think then it also then leads on to the stigma around mental health."* (Yusuf)

When such powerful multi-faceted influences coalesce onto an adolescent experiencing mental health challenges for the first time, the experience can be overwhelming. Stigmatisation of depression can exacerbate the psychological challenge and lead to a further deterioration in mental health. Consider for instance the testimony below:

> *"I remember when I was first diagnosed with anxiety when I was 17, the first thing my dad said to me when I came back and I told him what the doctor said is, 'They don't know anything. This isn't how I raised you to be as a*

man.' That was the first response I got. And that's not obviously the response I wanted to hear. Straight away it made me feel like hold on, maybe I am inadequate and insufficient as a man that he is trying to raise me to be... And he says that because of the way that he was raised within his community. So I think that's where it stems from." (Yusuf)

When asked about presenting psychotherapeutic concepts in religious terms, Yusuf thought it could have potential destigmatising value and mitigate some of the challenges discussed above:

"I think it comes back to number one, the acknowledgment of its existence, and secondly, the willingness to have those difficult conversations. I think people are more open to having those conversations when you're speaking their language... I mean rooting the conversation in something that is relatable and more receptive to their understanding." (Yusuf)

This participant went on to clarify that framing psychotherapeutic concepts in religious terms can create a safe space within a therapeutic encounter to resolve faith and mental health related stigmas, particularly in Pakistani culture:

"So for people in my community, that perhaps have come from a background of, you know, mental health doesn't exist and these ... aren't a big issue, but we're willing to have conversations around faith and religion and God, then we can tailor it to a style that makes sense to them and they can consume and process... I think they'll become more open minded to having those conversations." (Yusuf)

The analysis of cultural stigmatisation of depression also requires distinguishing between cultural stigmas related to different causes of depression. The data suggests that close family who may be well intentioned and supportive can nevertheless perpetuate stigmatisation of depression. For instance, how depression resulting from miscarriage is stigmatised provides a lens to observe the dynamics of this unwitting, yet powerfully negative, form of cultural stigmatisation. This was highlighted by Asma when she recalled her experiences of reaching out to her sister for support following her miscarriage,

> *"My sister told me when you will have a next child he'll be alive, you'll be happy and you will forget this all. But now I tell my sister, 'no that's not the case'. You cannot forget your that child and your experience." (Asma)*

Depression due to miscarriage also appears to suffer from implicit stigma in the form of societal neglect and lack of support from Islamic institutions. As a result, those who have experienced it sometimes only have other sufferers for support:

> *"We just talk to each other. But nobody tells us. No ʿālim [Islamic scholar] would stand up and tell us that how we could apply or how we could channelize the museeba [lament] of Ahlulbayt [the Prophet Muḥammad (p) and his family] into our specific situation. This is, this is why I'm so angry that we need to go to church to remember our son, but we cannot go to our Islamic centre ... They can give us a strength. I thought over and over again, why would I not hold this [service] in my own house or hire the hall and organize this? But who would do that for me? I don't know how to do this." (Asma)*

In this moving and at times tearful account of her own experience, and those of others, Asma sheds light on a clear gap in service provision by Islamic centres. Furthermore, it reveals that there is demand for religious services from Muslims suffering this form of depression, which is why some of them go to Christian church services held to remember children who died in miscarriage.

The data above shows the possibility of overcoming stigma and empowering those with depression from faith communities. Another participant also spoke about the importance of taking a stand about depression in general. In order to understand the context of that point, it is important to set the cultural context and stigmatising experiences she encountered from her community:

> *"I think Pakistanis, Indians, anyone from the Subcontinent really, we really tend to brush things under the carpet. Even now, even though we've advanced quite a lot, people don't want their families to know they're depressed or, you know, I mean people from my own generation who are qualified professionals in the UK, studying and living in the UK, knowing that I have depression and that I am taking anti-depressants have kicked me when I'm down because I wasn't functional on most of my days. So there is that lack of understanding."* (Khadija)

Fortunately, from the darkness of the above experiences emerged a new, more enlightened, perspective that empowered Khadija to speak openly about her experiences, as an advocate for change and overcoming stigma:

> *"But once I started getting better, I realized that we need to have these conversations. So out of three people, let's say two of them were like that*

[i.e. stigmatising], but one of them, for example, [I] had an effect on one of them and instead of saying to me, 'You're not doing this, you're not doing that,' knowing that I had depression and having no understanding of it, having no inclination to understand it like the others, she actually began asking me, 'I can see that you're not able to', for example, 'do these tasks.' 'How can I help?' So me talking about that helped them understand - it got through to someone. (Khadija)

Whilst the above example was in relation to a younger person, the impact of speaking openly can have profound influence over older generations as well:

"A few weeks ago, my father-in-law asked me about my mental health, which was like, I was blown away! I've actually discussed this in therapy because I was like, I've always been open with my parents-in-law, that I've had struggles with mental health and I have been depressed... I didn't expect any acknowledgement or or anything from them or any change in them at all because they are too old. But some change happened. And he actually gave me a very sweet disclaimer that, 'I don't know the right words, I don't know how to ask this, but how are you doing in terms of, you know, your psychological health and, you know, are you seeing a counsellor? How does it work? Do you have to take a pill for it?' And [I] explained how counselling works and I was on antidepressants once upon a time and I'm not anymore. So so that was, it was really encouraging for me ... these conversations need to take place. And it's not easy... It's important to stand up for yourself and for others, even if you feel like it's so difficult, because in the wider community, these things really make a difference." (Khadija)

The data discussed above on the themes of religious and cultural stigma are summarised in the framework matrix extract below. The shaded cells show congruence with service provider data and will be discussed in Chapter 7 below. The overall message from service users encouraged analytical distinction between religious and cultural stigmas, including testimony on how they can be mitigated.

Figure 5.2.A: Service user framework matrix extract - stigma

USERS 1.2: STIGMA		
	1.2.1 Misunderstanding Religion	1.2.2 Cultural Stigmas
Adam	Did not view depression as a reflection of limited religiosity.	Had positive family support, such as advice from his father regarding various prayer practices to help with depression.
Musa	Views on predestination can be self-stigmatising. An idea of being destined to have depression can undermine free-will based efforts to recover.	No stigma relating to depression was mentioned.
Asma	Islamic leaders can overlook the specific experience of an individual - instead providing generalised advice.	Didn't get the support she wanted for depression following miscarriage, which was deeply stigmatised in her Pakistani culture.
Khadija	Did not view depression as a reflection of limited religiosity.	Powerful experience of challenging cultural stigma by clearly discussing her experiences, thereby influencing both young and older people.
Yusuf	Conflation of South Asian, particularly Pakistani, culture with religion is a problem that needs to be overcome with education.	Faith-based approaches to psychotherapy can mitigate cultural stigmas around mental health challenges.

5.3 Creating strong therapeutic partnerships

Service users spoke at length about various elements of their experiences in therapy that supported their journey to recovery, as well as explaining a myriad of limitations that held back their progress, or in some cases caused further distress. The analysis below explores how service users harness resources that are currently available, particularly the services of excellent therapists who have helped Muslims with depression, even though they may not have had formal training in Islam or the cultural challenges faced by the Muslim community. The analysis then moves to themes relating to missing components identified by service users, both in relation to the therapeutic encounter and wider institutional considerations.

5.3.1 Utilising existing resources

A number of participants spoke positively about the resources that were offered to them. In the context of counselling and prescribed medication, Adam described his experiences in the following way:

> *"... Once I'd spoken to the lady about my depression, then she suggested about how to overcome depression through therapy as well as medication. So it was like a side by side, psychotherapy as well as medication." (Adam)*

For those who had only followed the path of psychotherapy, there is clear evidence of the positive outcomes achieved through existing resources, when Muslims have availed themselves of those resources. In the context of Cognitive

Behavioural Therapy, Yusuf, a Pakistani man in his mid-twenties, described the requirements for a successful outcome, based on what he experienced from a female English therapist (i.e. not being culturally or religiously matched):

> *"The individual that I did see at that time did a great job of, I guess not just listening or giving me the answers. I think what separates the good from the great is somebody who is able to encourage me to ask the right questions and find the answers for myself. And I think providing that level of education and self-sufficiency, I think, is what made it very effective, because it wasn't the case that if I come out of therapy, you know, that's it - I'm left in the world to just handle things. It was [that] I've been given the tools to now self-regulate, become aware of patterns of behaviour, become aware of how to remedy things proactively, because I've been given the tools and the educational experience of how to solve problems. So, I think that was really what I found most useful."* (Yusuf)

It is important to note that a positive outcome such as this, delivered by a therapist from a different cultural and religious background (i.e. non-matched), is predicated upon their cultural competence:

> *"The actual individual who I spoke to seemed to be very culturally sensitive and very experienced and aware of my experiences ... I think having that open, constructive conversation felt a lot more comfortable. I got more confident and trusting of the person that I was talking to." (Yusuf)*

Probing further into the question of matching the faith of the therapist and client, when asked whether it would matter whether a psychological therapy that uses

Islamic teachings was offered by a mental health professional who is Muslim or non-Muslim, there appears to be nuance, with professional competence being the overriding concern:

> *"... Maybe I would prefer a Muslim ... because if I want to ask them questions, they may be able to answer me. But it won't make any difference ... As long as they are helpful and they know what they're saying [and] they're doing." (Adam)*

Notwithstanding the above, there were divergent views on this matter across participants. The primary concern across interviewees was that the subject of faith should be approached carefully and in a respectful way. With regard to service delivery of faith-informed approaches to psychotherapy, participants were asked if it would make a difference whether therapists presenting psychotherapeutic concepts in Islamic terms were themselves Muslim or non-Muslim. Consider the nuanced response below:

> *"I would say on the non-Muslim giving it [i.e. faith-based psychotherapy] to you, that would be a yes and a no...The negative outlook would be them giving it to you, but you knowing that they probably don't believe it or they may not be as optimistic about it, etc. And the positive outlook would be that even though they don't believe it generally, they see benefits in it which have been proved and they are giving it to you knowing confidently that it does work, you understand?" (Musa)*

This emphasises the importance of therapists approaching the subject of faith respectfully and conveying confidence in any faith-adapted intervention they are providing, regardless of whether they are from the Muslim community or not.

Whilst entirely expected, it should nevertheless be noted that there is strong evidence in the data of Muslim service users benefitting from service providers of other faiths. For instance, when Asma was describing the counselling she received from a Jewish NHS clinician for the depression she experienced following a miscarriage, she was keen to highlight her positive experience,

> *"I liked that lady ... I told her if it was my own family or my family elders, if I, if I told my present situation to them, they would have given me the same piece of advice that she was giving me. She was very good... I liked her advice at that time. That was very positive and very helpful."* (Asma)

Others have gone further still. Khadija, a Muslim Pakistani woman, had a male non-Muslim Polish therapist (i.e. non-matched), with whom she had a very powerful therapeutic alliance:

> *"I found, as a consumer of therapy, with a person who is as different from me as possible, in terms of race, culture, gender, everything... I found Allah through him, which is really weird."* (Khadija)

The data suggests here that it is possible for there to be a strong psychotherapeutic partnership when the patient and clinician are not matched by culture or religion. Khadija was therefore making a subtle but important point that existing resources in the NHS (where she was treated), can be harnessed for faith

communities, including UK Muslims, provided the critical components underpinning strong therapeutic alliances, particularly respect and trust, are well established. Khadija's early experiences reiterate this point, when she experienced the opposite kind of treatment from her first therapist:

> *"But I must say here that I have had my very, very first experience with a mental health professional, was an Islamic, was a faith-based one and it was such a bad experience that have I run away from religious people like you would not believe!"* (Khadija)

When probed further about the context and key drivers of the negative experience, Khadija explained,

> *"This was a lady who ... [was an] ālimah [female Islamic scholar] very, very, very well respected and famous in our community and very close to us as a family. That's why I thought I could approach her... And she has twenty years of experience, of counselling families... So when I... first started feeling so bad ... my husband and I decided like that she's a trustworthy person, she's a counsellor and she's obviously an ālimah [female Islamic scholar] and she would be able to help and, you know, you can talk to her."* (Khadija)

It is noteworthy that the communal reputation of the therapist, as a person who was dual trained, in theology and psychotherapy, was initially attractive to Khadija, serving as a catalyst to engage with therapy and making the notion of therapy accessible. However, her experience of that therapeutic encounter was negative:

> *"And the amount of judgment that I received from her was ... And the thing is, at that time, I believed it, I internalised it like how oppressed people*

internalise oppression. You know, she was like, 'If you've committed a ghunā [sin] don't tell me'. And I was like, 'I haven't committed a ghunā [sin]'. So, for context, I was sexually assaulted repeatedly growing up. And I am telling her about that and she's like, 'no no wait, wait, wait. If you've done any ghunā [sin], don't tell me'. I have literally told you I was a child and I was sexually assaulted. How, how is that my fault? But by her saying that, then I was like, I don't know, was I party to that in some way? You know, it was so damaging to me... I feel like she made that an excuse because she couldn't hold that space. So that was, that it was like really, really bad." (Khadija)

This appears to be an example of a therapist whose own faith has created barriers to her ability to listen and give non-judgemental care to someone who needs it. The point seems that faith-based therapies can be deeply harmful as well as helpful, both to the patient and to the practitioner. Khadija warns,

"But now at the moment where I am, I'm just extremely suspicious of faith-based counselling and I want to learn more about it. And I do believe that there is more research and more training that needs to go into it... On the surface, it would always help, but in the longer term, unless the person is very well trained in both the things, they shouldn't do that because then they'll probably [be] in over their heads and they'll be misguiding people, either from the therapeutic side or Islamic side." (Khadija)

This participant's negative experience of faith-based counselling is a noteworthy contraindication in the data. Notwithstanding the clear reservations about faith and therapy that Khadija held, it is interesting that when she later moved to a non-

Muslim, Polish male therapist, who was skilled in holding a space that made her feel safe to bring in whatever was important to her, she herself adapted the interventions he provided (compassion focussed mindfulness), to align with her religious concepts in her own language (Urdu):

> *“He didn't bring in the religious ideas... I've always brought in the religious ideas. In fact, I feel extremely uncomfortable talking about religion with him, even though I know that he's not going to be judgmental or anything like that. But it's just, it's my issues with my religion that I just do not want to speak about that. But [when] I have brought it up, he's been perfectly normal about it. He's not been like, oh that's amazing, or you shouldn't do that. He's been perfectly neutral, like it's completely up to you. ‘This is the central idea [of psychotherapy] - use it how you will.’”* (Khadija)

This data illustrates an interesting method by which a service user took a personal approach to bringing religion into therapy. This was made possible by the therapist holding a safe space in which the service user felt comfortable discussing her faith. It is noteworthy that the therapist did not have to be knowledgeable in Islam to empower Khadija to apply concepts from her faith in a way that she felt was useful and appropriate for her. This is an example of utilising existing resources for personalised care. The critical clarification Khadija makes is that any discussion of religion must be initiated by the client, not the therapist (i.e. patient-led therapy):

> *“As soon as a therapist begins talking about religion, I would expect them to be very well versed in it. So, if you've spent six years studying counselling, I expect you to have studied six years, at least, studying Islam as well before you could talk to me about that. But if you're just a secular therapist, you will*

hold space for whatever I bring, you know. And in that way the counsellor doesn't have the responsibility of ensuring whether my beliefs are correct or not, because they're my beliefs." (Khadija)

Building on this insight, when Khadija was asked to reflect upon whether it would be helpful for therapists to proactively raise religious concepts, or whether they should just leave it to the client/patient to bring in religion if they want to, her response was fascinating, particularly in light of her strong prior objections to therapists introducing religion:

"I think yes, there's no harm in [therapists] asking [about religion]. If they were comfortable with it and if they asked the client or they made it very clear to them that if you wanted to bring in a religion, even though it's different to mine, or even though it's same, either way, my religion and my thinking of it wouldn't affect what we do here. That might be very empowering for the client, because I went through a lot of a period of when I was very, very concerned. Can I bring this up? This is about religion. Should I say this to him? And when I did, I realised all of these actually he's ok with it!" (Khadija)

This data sheds light on how faith can successfully be included in therapy. It appears a critical aspect of Khadija's positive experience with her Polish male therapist was that she felt he would not judge her and would be comfortable discussing her religious beliefs, in whatever ways she understood them. Hence, the data indicates that giving clients an option to introduce religion, if they wish, can be empowering, provided it is done appropriately, without assumptions being made by the therapist. This data also shows how existing resources, both

respectful therapists and patients' values, can be harnessed to personalise psychotherapeutic interventions for depression.

When participants were asked about the potential benefits of implementing such a person-centred approach early in the treatment journey, it appears early intervention could have positive impact:

> *"It [i.e. early personalised intervention] would have definitely reduced my, for example, recovery time, because I think for people who are, who are followers of any faith... I've read these articles where they say that ... having that faith has shown more recovery rates in people because they have that hope, that optimism built into them because of that faith. So, you know, it's useful from a psychological perspective as well."* (Khadija)

In a move towards matching clients and therapists, despite what she said about benefits she obtained from a non-Muslim therapist, Khadija thought that if she had an appropriate therapist who was Muslim, her recovery would have accelerated:

> *"So because I am a practicing Muslim, if I had got a good Islamic counsellor, I would have reached the place I am [now] much sooner... I would get a lot of value in that. Again, with the disclaimer that if the therapist isn't properly trained in Islam, they're very clear that I'm using, I am following the therapeutic model and I'm using surface level Islamic teachings because you are Muslim and I'm Muslim and we can both agree on these points - we can both relate like this... I'm using these ḥadīth and Qurʾānic things from, for example, whichever modality I'm operating from."* (Khadija)

It also appears that participants would not mind the gender of the therapist. This means that the full breadth of psychotherapists across the NHS system are relevant to this research question. Furthermore, the NHS setting can also be an important factor. When asked about the venue and physical location where therapy is provided, there was general support across participants for therapy in a clinical setting, rather than a mosque, so as to make it separate from their usual setting and ensure confidentiality.

In summary, the overall thrust of the data suggests that there are a number of existing resources, in the form of respectful therapists, patients' own values, and secular NHS settings, to facilitate effective personalised mental health interventions for depression that enable Muslim service users to harness their faith-based concepts and practices.

5.3.2 Missing components

This section of the analysis will explore the gaps in service provision and missing elements for good mental healthcare identified by service users. The data in the preceding section has made clear that if person-centred care is to achieve its potential, the life perspectives of Muslim service users need to be incorporated into their treatment journey. Furthermore, the preceding data showed how failure to understand the life context of the client can result in a fundamental breakdown of the therapeutic alliance.

From a wider perspective on the gaps within psychotherapeutic interventions for depression among the UK Muslim population, the case of Yusuf, a young Pakistani man, exemplifies experiences that were similarly articulated by multiple service users:

> *"I have had ... experiences of people that are ... unable to tailor their service and support based on your background, which I think is a problem within the industry... And I felt that my experience was horrible. So after a couple of sessions, I gave up in that circumstance."* (Yusuf)

The challenges created by what participants perceived as a lack of sufficient cultural competence among therapists is not simply about losing hope or trust in the therapeutic partnership, but also breakdowns in the practical usefulness of therapists' suggestions:

> *"[The therapist was] unable to relate and I think maybe not open to empathizing, understanding in that sense. And I think the inability to relate*

does add sort of difficulty, because then the responses you get back are just not practical and they're not culturally sensitive." (Yusuf)

Several participants found that when therapists lack a clear understanding of the context within which their clients are living, their proposed solutions may be ineffective, culturally inappropriate, or alienate the client. For instance,

"...The solutions that were provided didn't take into account how the family system works in South Asian culture... So, coming back with an answer, 'Why didn't you just say this to your Dad' doesn't really work! ... Having to try to explain that to someone who hasn't lived through it, or is completely unaware of it, or have never come across it, is very difficult." (Yusuf)

Turning to adolescent care, there are notable gaps, particularly in relation to early intervention. For instance, a young Yemeni man who had been diagnosed with depression was prescribed SSRIs for four to five years, without being offered psychotherapy. Unfortunately, he only subsequently realised the potential benefit of therapy and asked for it after experiencing little benefit from the medication and also suffering side effects.

"I kept the problems to myself... I felt like I didn't want to talk about it. So it was only later on ... that I went to seek help for it. I wanted that kind of help [psychotherapy] you know, but I didn't get it unfortunately." (Musa)

There appears to be an unmet need for more personalised interventions, with this service user calling for,

“More empathy, care and need to understand the patient ... [you] are just not anther patient, but more like a person that you would want to empathise and understand you.” (Musa)

Another potential gap in service provision may be the sequencing of interventions. When participants were asked about potential differences if a religiously adapted therapy is offered before or after secular therapies, some service users suggested an alternative approach:

“Maybe it should go side by side, rather than early or later, a bit of each... At the time when I was offered [therapy] ... my dad kind of helped me with the religious aspect rather than the secular aspect... I would say maybe so it could work side by side.” (Adam)

When asked what could have been done better in treatment or to encourage seeking treatment, Asma commented in her survey form prior to the interview on the distinct lack of faith-based support,

“It would have been much better if [I] could have received counselling or any form of support from any religious person/ center.” (Asma, Survey)

Furthermore, this theme was explicitly raised by her during the interview, lamenting,

“...At that time, I never got any help from any Islamic channel, which I am very annoyed about and I'm very angry.” (Asma)

Building on what was discussed in the previous section, Asma shared what she had seen from others who had been through similar experiences and identified a missing component of potential care from religious institutions,

> *"I saw couples going through the same situation... but nobody could get any help from anyone - from any mowlana [priest], from any ālim [male Islamic scholar], from any ālimah [female Islamic scholar], from the Islamic centre. So they had to go to NHS, to GPs, to churches to commemorate, to remember the babies [who died in miscarriage] and we still go to the church. And when [my husband] and I talked about it, that our Islamic centre should provide this this kind of service... to counsel the couples who go through these kinds of situations." (Asma)*

This data suggests that some service users appear to have an expectation that faith groups should be actively engaging in addressing mental health challenges in their communities and not to leave everything to the NHS or private therapists.

Finally, notwithstanding the discussion above regarding clients and therapists not necessarily needing to be matched, with regard to using the resources currently available, one gap in service provision that also arose in the data was the potential benefit of having groups of therapists from the same cultural and religious background being more widely known in the community:

> *"I think having someone that understands you can relate to you and/or that looks like you can really help the person in need to, number one, to feel more comfortable and confident in that safe space environment... I know there are certain conversations I would feel more or less comfortable having*

depending on who I talk to. And I think that just comes down to shared experiences." (Yusuf)

The analysis in this section of themes related to the therapeutic encounter is summarised in the table below, separating the two themes of resources that are currently available, as well as missing components. The following chapter builds on this analysis by considering perspectives from the other side of the therapeutic partnership, listening to service providers from different professional disciplines.

Figure 5.3.A: Service user framework matrix extract – therapeutic encounter

USERS 1.3: THERAPEUTIC ENCOUNTER		
	1.3.1 Resources	1.3.2 Missing Components
Adam	Happy to have therapists who are Muslim or non-Muslim, male or female, or in a mosque or clinic. Hence, current resources are sufficient.	If he had a Muslim therapist, it would have enabled him to ask questions regarding Islamic comparisons to the therapy.
Musa	The standard secular interventions do have considerable trust vested in them, as they are deemed to be based on rigorous research.	Not offered any talking therapies, only SSRI medication for depression and anxiety that was ineffective and caused side effects.
Asma	Very positive experience of a non-Muslim counsellor, showing that matching by culture/religion is not essential.	Strong rebuke of (historic) lack of mental health support from Islamic centres, particularly structured support for miscarriages and the resulting post-natal depression.
Khadija	Pointed out positive experiences of having a therapist who was a Polish non-Muslim man, i.e. not matched, who held a space where she felt able to bring in religion.	Respect and professionalism were missing from an earlier therapeutic encounter with a counsellor who was also a female Pakistani Muslim woman.
Yusuf	Culturally competent therapists can add tremendous value in providing tools for managing depression, provided they are sensitive.	Some therapists who do not understand South Asian culture have been difficult to work with, as some of their suggestions are unworkable, such as in relation to family relationships.

CHAPTER SIX: ANALYSIS OF SERVICE PROVIDER DATA

The data from service providers consists of interviews with physicians in general practice (GPs), psychologists, psychiatrists, psychotherapists and practitioners from related fields. Insights from their interviews highlighted commitment to and challenges of providing personalised psychotherapy for faith communities. Service providers were clear about their motivations to take faith seriously in the clinical setting, but also shared concerns about a number of challenges to enacting this approach, including principled worries, such as respectful patient-centred engagement and countering stigma, together with practical difficulties, specifically institutional funding and policy limitations. This is balanced by provisional ideas on how these challenges might be addressed, particularly through new training and information materials, as well as making better use of social and community resources.

6.1 Personalising psychotherapy for faith communities

Therapists in this study across disciplines were clear in their motivation to provide personalised psychotherapy and that faith was often a key factor in doing so, as it is often a defining aspect of their clients' life-perspectives, influencing their core beliefs about themselves and the world around them, as well as their daily habits and practices. In that regard, clinicians saw value in connecting to patients' faiths, as a mechanism for improving accessibility to the therapeutic techniques they wanted to offer, but also as instrumental in providing a framework for integrating those techniques into daily practice, thereby positively influencing adherence.

It is important to note that the data from service providers on this topic reiterates many points made by service users in the preceding chapter, such that the active establishment of respect as the bedrock and guiding principle of the therapeutic partnership goes a long way to ensuring its success. Conversely, when respect breaks down, so too does the therapeutic potential of the psychological intervention. Furthermore, in the case of a patient feeling stigmatised, it may prevent any therapy at all, thereby making it all the more important for service providers to make their clients feel respected.

6.1.1 Discussing faith respectfully

Data from service providers showed a clear desire among clinicians to establish collaborative and respectful therapeutic partnerships with service users. As one clinical psychologist explained,

“In terms of providing therapy and therapeutic concepts within a therapeutic framework ... it's not me “doing” an intervention to the client, to the patient ... this is a collaborative approach. And one of the things which I make very clear to them [is], this is my personal understanding of therapy... As we're going along this process, this is a collaborative journey.” (Dr Fatima)

The above point about collaboration was developed by others, including non-Muslim clinicians, further exploring the impact of engaging with a patient’s faith, as integral to person-centred care and the therapeutic partnership:

“I think that [faith-adapted interventions] would be extremely valuable ... ultimately it is about person centred care, isn't it? Personalising the treatment to what the patient knows and practices ... would help in improving the therapeutic relationship with the patient. And we know that that is the single most thing ... that has the evidence of success of therapy, any type of therapy. And I suppose if the therapist is aware of all these things that are part of a Muslim patient's daily practices, it would just improve that relationship.” (Dr Shilpa)

Data from a number of practitioners in this study suggests that their motivation for exploring and understanding the faith of their patients stems from their view that faith and religion can be important positive (and negative) factors in a patient’s experience and understanding of mental health challenges:

“I guess for people who do identify as being either quite religious or spiritual ... I often like to think about how, if at all, their faith is important to how they are making sense of those difficulties. And I think that having worked with

people, that can go both ways. Faith can be something that gives lots of people meaning and purpose and it can be a very good resource. But there's also times where I have been kind of aware of cases where people might feel that their difficulties might be linked into being punished as well. And I think that's also important and how people can make sense of that difficulty and and the control that they might have in being able to move forward."
(Dr Faiza)

The above view of Dr Faiza, regarding a sense of being punished, echoes what Musa was saying (in Section 5.2.1 above) about having a sense of being destined to experience depression. Both, service user and provider, reflected on the two sides of the coin of theological determinism and its risk of undermining agency in psychotherapy, since agency is contingent upon confidence in one's free will.

Several psychiatrists, physicians and psychotherapists stated in their interviews that religion and religious language can be important in the therapeutic encounter, particularly for making psychotherapy accessible to members of faith communities:

"I have no doubt that the language in which you talk about something, I mean, can impact upon the efficacy of your therapy... I have a lot of experience with Christian CBT and Christian people and if you could describe, you know, emotions and thoughts in terms of Biblical parables and teaching from the Bible, it makes it so much more simple for them to understand. So I would imagine that Islamic concepts would actually increase efficacy of psychotherapy. It's a really good, good area to investigate." (Dr Cohen)

Hence, it appears that one of the driving factors that motivates clinicians to bring faith into their clinical encounters is that they believe doing so can improve the efficacy of their interventions for individuals from faith communities, even if they themselves may not be from that particular background:

> *"And if you can phrase it from the Islamic psychological point of view, I think that would be extremely beneficial, I think it would help them both understand and to encourage practice." (Dr Cohen)*

According to service providers in this dataset, language matters: phrasing psychotherapeutic concepts in faith-adapted terms is not just deemed to be helpful for initial accessibility, but longer-term adherence to therapy as well:

> *"I personally think if you can frame therapy in a religious or cultural language that they understand, not only does it obviously help them to understand it, but it would encourage them to do it more." (Dr Cohen)*

Other service providers echoed the sentiment above, regarding whether framing psychotherapy using Islamic concepts and practice could help with accessibility and understanding psychotherapeutic concepts, as well as adherence to them:

> *"I do think so. And I have found that in practice, actually... for both [accessibility and adherence] ... I was working with [a client] within an Islamic conceptualization ... And then we would give homework in CBT ... And what I found was that her adherence to what we had set as homework increased because she was seeing it from this Islamic concept - sort of basic framework." (Dr Fatima)*

The data in this study suggested that not only is personalisation by faith potentially therapeutically useful, but also that it has to be done respectfully. The two criteria that emerged for conveying respect to the patient/client were: first, to create a safe space wherein the participant can introduce and lead a conversation on religion, rather than for the practitioner to follow their own assumptions about their client's religion or faith; and second, to be responsive to those prompts (if provided), as explained by a GP:

> *"... Generally speaking, in terms of faith, not just Islam, it's not always apparent that the person may be of a particular faith, unless they have a job or their name suggests that they're Muslim. So, I wouldn't normally ask that question up front. If it was volunteered by the patient, or it's apparent that they are Muslim, using Islam as the example, then I may say, OK, have you ever considered how the religion or how religion impacts your view to mood and depression? So even ... if they're Muslim, I wouldn't necessarily assume that they would use religion as a means to try and reach solace. So, I would ask them, do you use religion to try and help you? Do you pray? Do you make duʿāʾ [invocation]? Do you make supplication? And if they are not really forthcoming in that, then I don't pursue that. And I just go down the normal route of talking therapy, antidepressants and that sort of thing."*
>
> *(Dr Ali)*

Furthermore, the data suggests that even after the subject of faith is raised, there is still a long way to go before religion can be properly integrated into the therapy provided. For instance, when probed about if and how the faith of patients is

typically included in case conceptualisation, the response below suggests a stepped approach to incorporating faith into a treatment plan:

> *"If I am aware that the patient is (a) of a particular faith, and (b) considers this an element of their life, then I may address this as part of the consultation - both in terms of manifestation and treatment of their problem."*
> (Dr Ali)

When probed further about his approach to case conceptualisation, this physician clarified how he would try to personalise the interaction:

> *"If I do get the impression that the person in front of me has some religious inclination, then I would try to address that in the consultation and saying, 'do you find that you're engaging in prayer? And engaging in supplication helps you try and overcome some of these symptoms?' And sometimes in suggesting some therapeutic interventions, I may say that this might help you if you just try and engage in these activities."* (Dr Ali)

Another clinician provided a rather more forthright approach to the subject of faith. The psychiatrist below would lead with direct questions on faith:

> *"I think there's one question we would usually ask, which is, 'do you have a faith?' 'What is your faith?' 'Is your faith important in any way?' I think if they say, 'no, I don't have a faith', I normally stop there. So, I mean, if they say, 'no I'm a staunch atheist', I don't address it." (Dr Cohen).*

Another psychiatrist in the study also had a similarly direct approach to asking about faith because she sees it as an important feature of treatment:

"Any new patient that I see, we would always ask a question about if they are religious, if they have any spiritual belief systems that they follow. And and then we ask about ... their social life, ask how much they engage in ... religious organizations, for example, going to church, or ... how much they draw from their religious or spiritual community, because that is quite an important aspect in thinking about the support systems. Eventually we try to incorporate [that] into the [patient] management plan." (Dr Shilpa)

Apart from the above psychiatrists, clinical psychologists in the study also thought faith was an important topic to proactively discuss early in the therapeutic encounter. For instance, when asked if the faith of participants is typically included in case conceptualisation, the response was clear:

"Yes, asking clients if they follow a certain faith, how their faith is part of their life, the relationship between their faith and current presentation - e.g. is their faith a resource during difficult times? Does their difficulties make it hard for them to pray or do things they would like to." (Dr Faiza)

From a methodological perspective, some psychiatrists regard understanding a patient's faith as part of case conceptualisation:

"It's about knowing the patient and understanding how a particular treatment modality fits in with their belief system. And it's about kind of understanding the patient first of all and seeing whether some of the techniques or strategies ... can be modulated according to their [religious] practices." (Dr Shilpa)

This becomes particularly important at the more severe end of the depression spectrum, where tapping into faith-based concepts could make a meaningful impact on patient safety and well-being:

> *"Let's say if a patient is suicidal. We might, we might kind of bring in the faith in there. What is the concept of suicide in their faith, for example? And if let's say, if that's considered a sin, how can we actually use that ... as a protective factor...? So, in that respect, yes, some faith-based beliefs are used. And sometimes, you know, if they are into certain techniques like meditative practices, that ties in with their faith system." (Dr Shilpa)*

Probing further on the role of religion revealed potential mechanisms of action in the processes by which religion can impact mental health:

> *"So I guess it's something that somebody is feeling quite connected to... It could be a direct connection, I guess with their God, or it could be a direct connection to their community... [But] they feel quite isolated and withdrawn. So maybe that connection is very important in that moment." (Dr Faiza)*

In the specific context of working with members of the Muslim population, Dr Cohen, a non-Muslim psychiatrist, felt comfortable approaching the subject directly and said he has worked with 100-200 Muslim patients over the last decade:

> *"I would typically ask, if I'm working with Muslim patients, about you know, their practices of Islam and about whether they find it helpful to their mental health in any way, or how they associate it with their mental health in any way... So if they say they do have a faith, I'll ask them what faith they have.*

But more interesting is how does that faith impact upon their life?"

(Dr Cohen)

This last question is particularly pertinent to the research question herein. The motivation of clinicians to investigate how faith impacts upon the lives of Muslims with depression appears to arise from clinical experience that religion can influence the experience of mental health and potential recovery from challenges such as depression. For instance:

"...Trusting God and optimism and hope is very related, because in the people I've worked with, [patients with] medical problems who are Muslim, they often ... believe that God will cure them. It says in the Qurʾān doesn't it that Allah never gives you more than you can deal with.[11] So, I think that that would actually facilitate a process of hope and optimism." (Dr Cohen)

The data considered in this section suggests that clinicians are currently bringing faith-based concepts and practices into the clinical encounter, albeit not necessarily with a comprehensive or consistent framework for doing so. Notwithstanding the desire of many clinicians in this study to provide respectful and personalised psychotherapy that incorporates the spiritual convictions of service users, there are a number of important challenges that both sides (service users and providers) have to overcome in order to build meaningful therapeutic partnerships, as discussed in the following section.

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[11] "*Allāh does not burden any person with more than [s/he] can bear...*" (Qurʾān 2:286).

6.1.2 Managing challenges

Clinicians in this study cited several hurdles they face in providing faith-adapted psychotherapy. The first is a concern about inadvertently being disrespectful, by raising the topic of religion in a way that participants may find condescending. There was anxiety among some clinicians, particularly Muslim GPs, regarding unintentionally showing disrespect by citing religious tenets:

> *"I'm afraid of trying to patronize people and talk down to them by saying you should display good akhlāq [interpersonal ethics] because the Prophet [Muḥammad (p)] always displayed good akhlāq and said, 'I am only here to teach mankind how to behave well.' So I wouldn't want to go down the road of, 'Oh, well, I'm just lecturing you. I'm just patronising you. And you should do this as a Muslim.'" (Dr Ali)*

This family physician goes on to explain that one strategy for mitigating that risk could be to ascertain the way an individual perceives religion, at the outset of the therapeutic encounter, in keeping with what other clinicians said about discussing faith respectfully (in the preceding section):

> *"I really think it depends on the individual and their willingness to engage with that line of [religiously adapted] intervention ... If I get the impression that even if they have a faith and even if they are Muslim, they are not really engaged with that, I wouldn't want to try and force it upon them because I thought that would be helpful." (Dr Ali)*

This approach of being patient-led yielded an interesting distinction between religious doctrines and spirituality more broadly:

> *"If that [i.e. psychotherapeutic concepts] can be couched in the terms of spirituality, because I do think lots of people can relate more to that, rather than ... if they're told it's ... dogma and it's, you know, a belief they have to adhere to." (Dr Ali)*

In addition to a risk of potentially forcing a discussion about religion upon an unwitting participant, a second challenge clinicians mentioned for treating Muslims with depression was of inadvertently stigmatising their patients by prematurely diagnosing them with depression, without preparing the necessary groundwork, difficult as that may be within the time constraints of therapy sessions. Hence, in order to navigate cultural stigmas, the style of engaging in questions about mental health may be shaped by concerns about stigmatising patients.

For instance, one barrier to Muslim patients coming forward from South Asian cultures is the stigma and disrespect some face from their own (extended) families when sharing symptoms of depression:

> *"So you are seen as being lazy, forgetful, and then not encouraged to seek help." (Dr Ahmed)*

Therefore, clinicians believed it is important to be sensitive about the potential of such preconceived misconceptions, prior to stating the diagnosis of depression. Furthermore, this risk may be exacerbated when family members attend

consultations to serve as translators, which can inhibit the patient from opening up and speaking freely:

“... Relatives will be sitting with them and it can be challenging when the therapist is relying on the relatives to translate, so we can't even say 'can you excuse us?'. It is easier ... where we can arrange a translator.” (Dr Ahmed)

According to the data, one of the manifestations of this challenge of cultural stigma appears to be patients with psychological problems presenting only physical symptoms, as they are more culturally acceptable to seek medical assistance for than mental health problems, such as depression. However, for clinicians to reframe potentially psychosomatic symptoms is a delicate process, that if executed without due care, could be viewed by the patient as disrespectful and/or stigmatising. For instance, the psychiatrist below sheds light on the process of carefully and gently navigating such encounters:

“It's about accepting and validating that, ‘yes you do have a headache, you do have a body ache - it's not all in your mind.’ Just like that, because people are experiencing those physical symptoms. It's not like, you know, they're just making it up. So it's about kind of validating. Rather than just saying, ‘no it's not headache, it's depression or anxiety’... validate that and then, you know, link it to how ... it's just another manifestation of depressive symptoms and how mind and body are linked to each other.” (Dr Shilpa)

Probing further into the data, it appears that managing the challenge of stigma also requires a broader approach, according to the clinical psychologist below:

“I think it's also thinking about the wider level interventions and tackling stigma of mental health and how mental health isn't necessarily maybe openly spoken about in families, in families as well as larger communities. And I think that might have an impact on being able to access services.” (Dr Faiza)

An important finding in the interviews is that some clinicians also drew distinctions between cultural and religious factors, echoing the culture/religion matrix in the previous chapter, as well as similar differentiation made by service users in the preceding section above:

“...How people from different cultures and religious groups might describe their presentation is different. So, I guess more Westernized ways of talking about mental health might be using more language about thoughts... And people might not describe how they're feeling in that language and that might be missed.” (Dr Faiza)

Turning to theological challenges, the data suggests that service providers also have to manage challenges arising from patients’ culture-based understandings of religion, since lack of sufficient knowledge of their own faith tradition can be an initial hurdle in therapy:

“So often they haven't really thought about that [religion and mental health]. Maybe as they practice their religion as a ritual, or they feel that unfortunately their religion doesn't really accommodate them and in fact is rather disparaging. I don't mean religion per say, I mean ... the access they have to the mosque, to other people in that environment... are kind of dismissive of

them, or if not dismissive, very ill informed about what depression is. So that's often the response that I get when inquiring about that." (Dr Ali)

Further along the spectrum of such approaches, some psychiatrists explicitly advocate for theologically accurate understandings of religion, without inhibitions about coming across as proselytising. Their approach is to identify and mitigate psychologically maladaptive misunderstandings of religion, for therapeutic benefit, even if they themselves do not come from the same faith tradition:

"It's not for me as a doctor to quote the Qurʾān or to tell them about the Qurʾān, but I actually say to them, as I would to a Christian patient or Jewish patient, you know, for your homework, could you find me a passage in the Qurʾān or Ḥadīth [teachings of the Prophet Muḥammad (p)], which confirms your views, that you know, this is [for instance] Jinn [poltergeists], you know, [or] this is a punishment and they often can't do that. So, in fact it's like a test of rationality, you know. They can't find it. So, it's not that I quote the passage that says it does. It's more they can't find any evidence, which I use as a form of cognitive therapy." (Dr Cohen)

The data from practitioners discussed above sheds light on their motivations for including faith in therapy, as their experience suggests that religion can be important in framing the experience of mental health and recovery. However, the data also highlighted various challenges service providers face for implementing personalised psychotherapeutic interventions for depression in the UK Muslim population. The framework matrix extract below illustrates the diversity of

approaches practitioners are currently adopting. The next section explores how clinicians could be supported in overcoming some of the challenges identified.

Figure 6.1.A: Service provider framework matrix extract – respect

PROVIDERS 2.1: THERAPEUTIC PARTNERSHIP		
	2.1.1 Respectfulness	2.1.2 Disrespect
Dr Ali	As this GP has become more experienced, he is confident in raising religion in a way that is respectful, by being led by the patient.	There is a danger of patronizing people when invoking religious doctrines. Hence, clinicians need to ascertain the way the individual perceives religion at the outset.
Dr Fatima	It's not me “doing” an intervention to the client, to the patient ... this is a collaborative approach. So this is a journey of the development of the self.	No concerns raised.
Dr Cohen	Confident about asking about faith and how it impacts mental health.	Concerned about the impact of stigma, particularly in Pakistani and Bangladeshi communities.
Dr Ahmed	Patient led, this clinician does not raise the question of religion unless the patient does.	Stigma is an important factor that affects certain cultures, such as South Asians, that hinders patients from seeking help.
Dr Shilpa	Any new patient would always be asked if they are religious, how much they engage with their religious or spiritual community, as support.	Concerned about stigma in the Muslim community.

6.2 Supporting clinicians

The sections above illustrated the motivation service providers had for offering faith-informed and personalised mental health services to religious communities, including Muslims in the UK. However, the data also showed that in order for them to be able to do so effectively and consistently, certain key support structures need to be put in place. A number of clinicians voiced concerns about not having adequate training in how to handle conversations about faith during a consultation. Their concerns ranged from not having sufficient information about theological concepts and connections with psychotherapy, to fears of being viewed as proselytising if they mentioned religion and possibly being deemed to have breached professional guidelines.

6.2.1 Training and educational resources

Service providers identified various challenges they face in providing personalised psychotherapeutic interventions to faith communities, not least their relative unfamiliarity with psychotherapy in general, compared to other interventions. This appears to be a particular concern among GPs in this study, as they may have had limited training in this area. Hence, some clinicians in primary care may feel more comfortable offering the medication pathway, rather than psychotherapeutic interventions, particularly in relation to religion. This can be especially true of less experienced family physicians, who may feel more confident prescribing antidepressants, rather than engaging in a deeper conversation with their patients:

“OK, so my practice has changed as I've become more experienced. So initially, especially having just qualified as a GP, I would probably go for the medication route fairly early on because I would think, oh, someone is depressed, they need medication. Let's try and solve that problem through the chemical route.” (Dr Ali)

However, it appears from this interview that as clinicians become more exposed to patients with depression and develop greater understanding of their needs, the treatment they offer becomes reorientated towards psychotherapy. This echoes the testimony discussed in the preceding chapter by the adolescent male service user (Musa), who was initially just offered medication and only much later given the option of psychotherapy, after it was found that the SSRIs prescribed had not been effective. It is important to reflect upon the parallels between the journey that Musa experienced as a service user, with the professional development journey of the physician below:

“Having seen lots of people with depression over that time ... I realise that often they don't fill the repeat prescription and they often don't come back and see me or another GP. So, I wondered why this was and I spoke to my trainer when I was a registrar, and he said they wanted to talk to you to offload their burden. That was what they needed. They needed that face-to-face. There is the model called ‘the doctor as the drug’.” (Dr Ali)

The challenges clinicians face in incorporating faith-based considerations into their current case conceptualisation models also included the issue of training, particularly if they are to have the confidence to ask about faith as part of a

consistent protocol. When asked if faith should be part of a standard case conceptualisation model for practitioners, the above clinician explained:

> *"Yes, I do, because I think there is a move towards and a realisation of the fact that faith, or more broadly spirituality, can be very beneficial. If we look at palliative care, end of life care, then there has been lots of at least anecdotal evidence that praying and engaging in spiritual practice provides certainly mental relief and sometimes even physical relief to patients. And they will often have priests in hospices and so on, to whom patients can turn. So, I think, as well as the classic questions that we ask about sleep, appetite, mood, interest, libido, maybe ... even if it's just a tick box, faith should be added on to that. And then if the patient isn't willing to engage, then we just leave it."* (Dr Ali)

However, other GPs were concerned about the method of bringing faith into therapy, beyond a tick box item on a list of standard questions. The complexity of blending theological and mental health discussions was daunting for some physicians, even those from a Muslim background, as they struggled with incorporating faith-based concepts and practices into secular consultations:

> *"I would find it very difficult to bring this into a consultation with a Muslim patient ... The problem is if you, if you're not sure what you're doing, it can be harmful ... So, if you don't have any mental illness, you can have the discussion, you know, thanking [God] for all of the blessings and [seeking] forgiveness [for shortcomings]. When you are not well and you've got this mental issue, it's quite easy to ... look at it in the opposite way. And if you are not very skilled at presenting... it can be taken in the wrong way." (Dr Ahmed)*

The challenge of inadequate training was also raised by clinical psychologists in the study. For instance, when asked about how she could deliver faith-adapted interventions and what obstacles she envisages, Dr Fatima commented,

> *"I would find it difficult because I'm not Islamically trained... Over the years I have adapted my therapy, my interventions, to enable people of faith... I had a conceptual block because I was Western trained and that's all I knew. So so this has come from experience. It has grown out of interest, but only now I'm at a kind of, I would say, position or level of confidence to be able to employ these sorts of concepts... It's taken about two and a half years to develop that confidence, to integrate. Yeah, and I still don't do it well. There is no model, so I'm sure I don't do it. I don't do it right. You know, I do what I do the best I can." (Dr Fatima)*

The lack of a model for incorporating faith into therapy appears to be a core gap in the training of therapists. When asked what could be done to improve services for depression to the UK Muslim population, both in terms of treatment and encouraging potential users to seek treatment, another clinical psychologist responded as follows:

> *"In relation to services, improved training in how religion can be discussed during the assessment process and letting clients know that it is okay to bring their faith into the therapy room." (Dr Faiza)*

It's important to note that this practitioner was also of the view that such training needs to be quite wide in its scope and reach across clinical disciplines:

“I think training needs to be happening across very different levels, so across all professional groups in terms of nurses, therapists, whether it's psychiatry training as well and also occupational therapists, social workers, everybody. These kinds of professionals working across the mental health profession.” (Dr Faiza)

There is potentially need for redesigning core training for new practitioners to incorporate faith-based understandings early, as part of their core professional toolkit:

“I think even when people are training and entering it, I think these wider contexts like spirituality and religion are important to be included in training and how people might be able to have those conversations with people, how they might want to be able to bring that in if it's an important thing for that person.” (Dr Faiza)

This need for training is apparently not just restricted to new clinicians, but also relates to those with experience:

“But I do think training from the very beginning, so it's incorporated as part of your role. And also I guess it's also bringing that into services that already exist for people who have been in the profession for a while. I do think that's quite important.” (Dr Faiza)

Participants also described the importance of being equipped with the correct educational resources:

"If not done properly, it can appear that I am a better Muslim than you are ... So, if not done properly it can be taken wrong. But having some sort of leaflet or any such thing would work better and can be used by any [practitioner] ... The leaflet will help, [because] then you are not imposing your [own personal] views on them." (Dr Ahmed)

In effect, the above GPs are making two points. First, officially approved information leaflets that highlight contact points between religion and psychotherapy could give clinicians the confidence to systematically include faith in a therapeutic consultation, i.e. not just a potentially simplistic tick box exercise, but practical resources to share with patients to facilitate therapeutically meaningful discussions. Second, such resources would also go some way towards alleviating concern among some service providers that talking about religion could be misconstrued as proselytising, rather than providing personalised mental health care.

At the other end of the confidence spectrum, there are clinicians who are happy to engage with Muslim patients using Islamic concepts and scripture, even if they may not be from the Muslim community or trained in Islam. For instance, in the context of challenging unhelpful assumptions, including maladaptive views of Islamic scripture, psychiatrists like Dr Cohen would be comfortable to do so, particularly if they are supported with basic training:

"So, if I'm using therapy with a Muslim patient, you know, and I knew enough about the Qurʾān, how to get involved, you know, and to use it. I would perhaps include some homework to reading the Qurʾān about what it

accurately says about a different scenario. In other words, you know that it doesn't say in the Qurʾān that all misfortune is caused by Jinn [poltergeists] or jadu by magic." (Dr Cohen)

Other psychiatrists also intimated that in order to operationalise faith-adapted interventions, training and information resources may be required to guide clinicians about points of contact between Islamic and psychotherapeutic concepts:

"I think it would just be easier for a therapist overall [from having informative leaflets]. I would see that the success of the therapy would be higher if these concepts are incorporated in the usual therapy that we offer." (Dr Shilpa)

The data suggests that training at a granular level, highlighting specific contact points between particular Islamic and psychotherapeutic notions would be required to enable clinicians to deliver the type of personalised care they aspire to. Consider the following perspective,

"So, if I'm offering formal psychotherapy, you know, or a psychologist is offering a form of therapy, again, I think for them it is even more important that they have, they know, the ins and outs of the [Islamic] therapeutic techniques ... to know more about that and be trained almost in incorporating those. So, it would require a specific training around that." (Dr Shilpa)

When this question of what form of training or information materials would be helpful, it became apparent that the role of leaflets would not simply be as

information to be distributed, but rather as tools to facilitate conversations between therapists and clients:

> *"...What I find personally quite helpful is going through those leaflets myself with the patient, rather than just giving them the leaflet, or saying you can download it from this particular site, because that just develops a dialogue and that, that that is more helpful than just, just giving out the leaflet." (Dr Shilpa).*

Furthermore, clinicians have clear ideas about the attributes of good educational materials:

> *"It needs to be simple, it needs to be concise, and it needs to be user friendly, really. And sometimes it's helpful if it is kind of, you know, drawn from within the community, as to using their views incorporated into into that leaflet." (Dr Shilpa)*

Notwithstanding the above positive sentiment, there is a warning about the risk of being too quick to draft and release any such materials without adequate review:

> *"... It would be helpful if it is tested out, rather than just [saying] we have created a leaflet and it goes [out]. You know if there is a bit of an iterative process that has gone into into it prior to it being launched." (Dr Shilpa)*

Turning to the question of how training could potentially be provided, one suggestion was the service provided by the UK NHS called Improving Access to Psychological Services (IAPT), now called NHS Talking Therapies:

"IAPT could arrange training for practitioners for incorporating faith-based information into assessment and conceptualisation." (Dr Fatima)

It therefore appears from the data above, representing voices from a range of clinical disciplines, that the required training should be viewed as multidimensional, incorporating both education for clinicians, as well as materials that enable clinicians to educate their patients, working in a collaborative fashion.

6.2.2 Institutional and policy infrastructure

As seen in the preceding section above, there are concerns among some service providers, particularly GPs from the Muslim community, regarding the risk of appearing to proselytise when discussing religion and thereby breaching professional guidelines. When asked whether the faith of their patients is brought into the equation when providing therapy for mental health challenges, particularly depression, some were clearly of the view that it is not appropriate to discuss faith:

"...Especially with depression or any mental health [condition], [I am] careful not to bring in any faith issues, because sometimes you know, I think they sort of separate the professional. The way I treat a patient at my surgery ... or [give] guidance or signposting that I would give to somebody within the community is slightly different - for obviously then that I am contractually bound to provide guidance [and] treatment management for registered patients according to what the guidelines are." (Dr Ahmed)

One of the concerns here is related to the lack of knowledge regarding the patient's faith commitments:

> *"Not knowing, you know, that they might have a faith or ... whether they would be practising that faith or not, you can't question them. So, one has to be very careful in the sense that whatever management plan or treatment that you give them, you have to be careful in what you say ... I'm careful about bringing the faith into into discussion at [patient] management level because it can be perceived wrongly." (Dr Ahmed)*

Clinicians appear to be approaching this question from a risk management perspective, with a view to mitigating the risks of inadvertently doing any harm, for instance by triggering guilt relating to breach of religious tenets:

> *"[If] they are feeling low, and [having] thoughts of self-harming and then I go and give them ideas that your faith or any faith doesn't allow self-harming, so you're putting them into further guilt. So, I'm careful, especially when it comes to mental health and depression." (Dr Ahmed)*

The combination of the above concerns leads some physicians, including those who are themselves Muslims, to conclude,

> *"I don't take any faith issue into consideration at the [patient] management level." (Dr Ahmed)*

On the other hand, some clinical psychologists proposed policy solutions to alleviate the concerns of colleagues regarding the risk of being deemed to have breached policy and appearing to proselytise:

"I guess one of the things that might help is to have it regulated." (Dr Fatima)

In summary, the interviews with practitioners have highlighted a problem and proposed a potential solution: effective regulation, combined with broadening policy guidelines, may give confidence to clinicians who are worried about accusations of proselytising when discussing faith. The range of views discussed above regarding training and resources are summarised in the framework matrix extract below, including divergent findings and concerns about proselyting.

Figure 6.2.A: Service provider framework matrix extract – training

PROVIDERS 2.2: TRAINING		
	2.2.1 Empowerment	2.2.2 Personalisation vs Proselytising
Dr Ali	If religion were to be part of the standard case conceptualisation model taught to clinicians, then there would be a framework that a practitioner could use to engage a client on religion.	Should be client led to ensure the appropriate approach to personalisation, regardless of the practitioner's familiarity with a patient's religion or culture.
Dr Fatima	NHS: IAPT could arrange training for practitioners for incorporating faith based information into assessment and conceptualisation.	There is strong demand for personalised / faith-adapted psychotherapy, with regular referrals from within the Muslim community
Dr Cohen	Believes in the importance of working with the faith-based beliefs of patients/clients.	Challenges patients' misunderstandings of religion, by setting homework for them to find the basis of unhelpful assumptions in scripture.
Dr Ahmed	From a cultural accessibility perspective, IAPT has been helpful with provision of multi-lingual therapists (relevant for some Muslim communities).	Serious concern about the risk of appearing to proselytise when discussing religion and thereby breaching professional guidelines.
Dr Shilpa	It is important that therapists know Islamic therapeutic techniques and be trained in incorporating them into interventions.	It's about knowing the patient and understanding how a particular treatment modality fits with their belief system. Providing personalised therapy makes therapists drawn to engaging with faith.

6.3 Structurally improving accessibility and adherence

Service providers are quite keen to speak about their vision for structural improvements in accessibility to mental health services for faith communities, which they expect requires addressing obstacles and harnessing existing resources. Among the common themes that arose across service providers was the need to adequately direct members of faith communities, particularly Muslims, to mental health services. This was due to stigma about depression and misconceptions regarding the compatibility of psychotherapy with Islam.

6.3.1 Addressing obstacles

Service users appear to believe that if there are to be structural and long term improvements in tackling the dual deficits they see in their practices of below average access to psychotherapy and weaker adherence to interventions in the Muslim community, then that process has to begin with acknowledging and addressing factors that create obstacles and keep them in place. Hence, a repeated theme in the data is the key challenge for psychotherapeutic interventions, particularly in comparison to pharmacological treatments for depression, of relative unfamiliarity in the wider population. As one psychiatrist in the study stated,

> *"I think the problem with a lot of culturally based psychotherapy or non-cultural, you know, ordinary Western psychotherapy is it's totally alien to people." (Dr Cohen)*

This may be particularly exacerbated in faith communities, as one clinical psychologist who provides voluntary services to the UK Muslim population noted:

> *"... People of faith aren't always benefiting from Western models of psychotherapy and they're looking to faith. And just from my own experience, the number of [Muslim] community referrals I get on a weekly basis is very large, and not only from here, from abroad, from Canada, from America... So on one day last week, I got five just on one date from the community and that included people from Canada and here. And then I get from from other countries as well... But it's difficult just because I work full time in the NHS and I don't work privately. So it's just difficult with [a] voluntary body to maintain that level of interest and referral because we are getting a lot of [demand for] the service." (Dr Fatima)*

When therapists were asked what they think can be done to improve services for depression in the UK Muslim population, both in terms of treatment and encouraging potential users to seek treatment, two key themes were consistent, as reflected in data discussed above:

> *"First and foremost, raise awareness [and] second, remove stigma."*
> (Dr Ali)

This sentiment was echoed by psychiatrists who meet Muslim patients later in their journey, thereby facing the extra challenge of late referral, i.e. when the depression has become severe, rather than at the early intervention stages, which is another obstacle to providing effective treatment that needs to be addressed:

"Proportionately, we don't get as many referrals for someone from a Muslim community for depression. Perhaps, you know, it may be due to stigma of mental illness, lack of awareness. And usually if you do, they are usually at the severe end of the spectrum." (Dr Shilpa)

With regard to making therapy less stigmatised and more accessible, using faith-based concepts and practices was viewed as potentially helpful:

"If some of that [Islamic] terminology were used, then I think it may help Muslim patients become more aware of those concepts and also maybe enable [them] to look at examples from Islam where they are implemented." (Dr Ali)

Going further, the mechanism of action by which accessibility could be upgraded appears to be about connecting with a participant's life experiences for reframing psychotherapy as potentially congruent with their Islamic beliefs and practices:

"I think providing people with other ways to consider something that is from their own experience, even if that's just the experience of having heard about it before, allows them to consider something from another angle. So hopefully the more angles you allow someone to consider something from, the greater the likelihood that they may respond positively. (Dr Ali)

Turning to adherence with psychotherapeutic techniques, such religious adaptations may make a difference to addressing the obstacle of adherence to talking therapies. Consider for instance the challenge of service users practicing therapy regularly. When asked about the potential value of framing techniques

such as observing thoughts and establishing a new habit of metacognition in faith-based ways, one GP said,

> *"I think it would at least give them the opportunity to try to adhere to them more. Whether they were successful or not would depend on the individual. But at least if they were afforded these comparisons of another experience that was familiar to them, that would hopefully allow them to try to adhere to them more frequently than just the secular approach." (Dr Ali)*

This is also the case when introducing mindfulness-based interventions:

> *"...if this parallel were drawn with dhikr [Islamic meditation] and being mindful, then I think again, it's another opportunity for them to think about it in a way that's familiar to them and hopefully adhere." (Dr Ali)*

Clinicians also raised the need to address the obstacle of cultural barriers inhibiting female patients from accessing therapy:

> *"I think in this country, where the majority of Muslims are South Asian, there is still a very patriarchal hierarchy. And evidence has shown that particularly Muslim women are suffering from depression. They are not really encouraged to talk about it. And there may be other factors at play that they may not be educated, they may not go out to work. They may only have contact with their family. So, their access to other people, to information, is very limited." (Dr Ali)*

Another previous theme that arose in the data relating to obstacles that need to be addressed concerned the ways in which Muslim patients' (mis)understandings of

Islam can act to hinder the accessibility and acceptability of psychotherapy, as illustrated in the following case where a non-Muslim psychiatrist describes his encounter with a Muslim patient:

> *"A lady who was quite depressed, very low in mood, came to see us. She was Muslim and her husband had been involved in domestic violence with her. And she actually came up and told me that she didn't think that divorce was possible, which is misguided. I think it's obviously possible in Islam. But she felt a great sense of duty to her husband. But in fact, she didn't really want to have any psychological intervention because she believed God, Allah, would actually change the husband's behaviour. So, she was almost praying for a miracle. And I don't think she understood it was permissible to have any sort of medical psychological help. So, it's sort of issues like that where people I think, from my point of view, I believe they have a slightly incorrect understanding of what Islam teaches, who I help and try to educate about psychotherapy." (Dr Cohen)*

Turning to institutional factors that cause obstacles, The challenge of limited psychotherapeutic resources arose consistently in the data, together with the associated problem of long waiting lists to see therapists:

> *"The only problem ... with the NHS is we are constrained in the ability and access to talking therapies." (Dr Ali)*

That overall pressure on mental health services is further compounded in the context of personalised interventions for faith communities. Practitioners from the

Muslim community said that often faith-adapted interventions are not available in the NHS and Muslim psychologists are offering such services on a pro bono basis:

“That's not available in [the NHS]. We're volunteers. That's community work.” (Dr Fatima)

This is one illustration of funding arising in the data as an obstacle. However, it is interesting how funding pressures are sometimes resulting in innovations that harness faith-based connections to achieve tight targets. For instance, how the concept of *niyyah* (intention) may be linked to goal setting in a quick and simple way to achieve objectives in the first session of therapy:

“The CBT model ... says goal setting has to be completed by the end of Session One... The reason that it's so strict is because of funding - it's as simple as that! We don't have enough sessions... And so, [for] goal setting, that's why I'm making that connection between niyyah [intention] and goal setting in session One. That will get you kick started... to the extent that it is... from pre-contemplation to contemplation and it's kind of the first stage.” (Dr Fatima)

Other challenges in the context of IAPT services were also raised:

“...Whether or not there is space to talk about or consider things like faith and religion and spirituality and how that can be brought into the room - because IAPT is so CBT based and how CBT is administered and delivered can vary according to clinicians. You could do it in a very manualised way, or you could do CBT which also holds across larger, more systemic contextual factors, which would also include culture, spirituality and faith. And you could

think about that and bring that into the room... There's lots of wider contextual factors that I think often get missed in those services." (Dr Faiza)

Such institutional obstacles that should be addressed also extend to team dynamics in psychological services, with regard to how service providers collaborate with other colleagues:

"And also thinking about [faith related factors] as a team, when you might be having discussions or formulations as a team, that you're thinking about these things at a different level as well. Unfortunately, in services now, there's often very little space to reflect and to think about things in such a wider context." (Dr Faiza)

In summary, service providers have pointed out numerous obstacles that they think need to be addressed to structurally improve accessibility and adherence. These range from cultural to institutional, policy and regulatory factors. Cultural obstacles include unwillingness to seek psychotherapy, leading to greater resulting severity of cases (due to later referral), as well as the need to reframe psychotherapy as congruent with Islam. Addressing cultural obstacles include identifying misconceptions about what Islam actually teaches, such as permissibility of divorce in abusive marriages, or even that psychotherapy is allowed. Cultural challenges also extend to female specific barriers. Second, institutional factors such as time and funding restrictions also contribute to the overall challenges that clinicians need to cope with. Third, policy factors relate to overly narrow protocols about how interventions are to be delivered, such as CBT in NHS services, and the need to broaden them to include wider spiritual

considerations that are important to patients. A crucial policy obstacle identified is the lack of protocols or regulations that make it clear that discussing a patient's religion is not proselytising, but sound person-centred care, thereby giving clinicians the confidence to fully engage with all that is important to their patients, without fear of regulatory reprimands.

6.3.2 Harnessing existing resources

The challenges set out in the data discussed above should be set in juxtapose with positive data from service providers who highlighted readily available resources that could be harnessed to address some of those obstacles. Institutional resources include some NHS centres and mosques or community centres who collaborate to promote mental health awareness. Human resources also consist of a growing number of Muslim clinicians, particularly psychologists and psychotherapists, who provide voluntary services to the community.

The role of religious community centres and faith leaders to combat stigma is a key theme that arose in the testimony of clinicians, particularly those who were themselves from the Muslim community and had participated in mosque-based health promotions and medical screenings:

> *"I think we have moved some way in highlighting certain organic diseases like diabetes, obesity, so people are aware of these. And these are commonly dealt with in health screening sessions that may occur in mosques and Islamic centres up and down the UK. I think we have been very*

neglectful of highlighting and raising awareness of mental health issues as a problem. And I think that, unfortunately, my own personal attitude has changed towards this as well. I used to think that as Muslims we shouldn't get depressed because we have a religion to which we can adhere, which should give us solace, which should give us a means of contemplation. But having been through some life experiences myself and having seen lots of patients go through different life experiences, I realised that whilst the religion may do that, we still get depressed as Muslims, we still experience vicissitudes of life and they do affect us adversely ... I think we need to inculcate that in the mosque / Islamic centre ethos that, that mental health problems are not something that don't exist and not something that should be considered taboo, but should be highlighted and talked about openly."
(Dr Ali)

Engaging faith leaders is important, but it depends on their wider understanding of the environment and the generation they are from:

"*First of all, we have to educate the [Muslim] chaplain and the priest."*
(Dr Ahmed)

In that regard, some clinicians have worked to bridge the gap between the clinic and community, such as Dr Cohen, as non-Muslim psychiatrist, who has worked with the Pakistani Muslim community in Northern England and London:

"... What I've done is quite a bit of work with the mosques and the mental health services to try to unite mosques with mental health services. So, I've been along for meetings with the East London Mosque ... and the imams to

get them to meet up with mental health providers. In the past I worked with an organisation called Social Action for Health, which was a charity, but it looks at mental health in the Muslim community, particularly in India and Bangladesh, Pakistan, and try to bring joint meetings." (Dr Cohen)

The level of engagement with faith leaders that some psychiatrists provide includes asking patients to invite their imams [priests] to therapy sessions, so as to help the patient correct any relevant religious misunderstanding they may have:

"I sometimes would actually try and see people with an imam, who's obviously got an infinitely better knowledge of the Qurʾān than I have. So, you know, if we're doing therapy of a supportive nature, I mean, I might ask the client if they mind if the imam comes along so we can share views." (Dr Cohen)

In the specific context of where people feel the challenges in their lives are due to them being religiously punished, there appears to be a role for faith leaders in the clinical encounter:

"I think it's interesting to think about where the person's getting those thoughts and ideas about punishment. So where the idea of punishment has come from ... if that can be deconstructed or if that can be perceived in different ways... If the person is consenting to it, I would also want to think about whether or not we could be in contact with somebody in their community as well who might also be able to share that knowledge about religion and help the person to kind of make sense of things – [that] may be an alternative way that could be more helpful for them." (Dr Faiza)

Faith leaders are also being used as resources for Muslim clinical psychologists and psychotherapists to improve the services they provide to Muslim mental health patients:

> *"We started off having this as an Islamic kind of guidance / supervision group so that we could be Islamic guided in our practice." (Dr Fatima)*

On an optimistic note, there is a view that a lot can be achieved in terms of mitigating the effects of stigma and lack of awareness, by working with third-sector faith organisations and religious leaders to change perceptions regarding mental illness and available treatment resources:

> *"I think a lot can be done, really. There needs to be more awareness within the community, perhaps having faith leaders in community having awareness. And then the message going via them ... becomes more receptive to the community if it is coming through them, rather than coming from doctors and healthcare clinicians." (Dr Shilpa)*

The role of outreach can be even wider than normally considered, even extending to faith healers, who would typically not be included in such collaborations:

> *"Perhaps the faith leaders can work with mental health services... If you are working with faith leaders and even faith healers, because people will go to them for their problems and it is, you know, for them to know where to ... refer to, or even consult to in case they are concerned about a particular individual." (Dr Shilpa)*

A special category of resources that arose in the data are mental health practitioners who provide voluntary services to the Muslim community in their personal time, many of whom are also employed as NHS clinicians:

> *We have a group of Muslim psychologists and psychotherapists and in my experience, the people ... who come to that group, are people who have had negative experiences of NHS or other standard therapies, because they felt that it hasn't been helpful or effective for them. And they come looking for a Muslim counsellor or therapist because they want to understand their distress from the Islamic perspective. (Dr Fatima)*

A distinctive finding in the data concerned how institutional administrative factors in NHS services created opportunities for collaboration between clinicians and faith community organisations. This arose in the context of challenges posed by NHS funding restrictions that created outreach opportunities, due to funding being linked to policy targets:

> *We have to have a certain number of referrals in order to maintain the funding. So we have tried different things to try to increase access, because IAPT is about Increasing Access to Psychological Therapy for everybody. So one of the service commitments is to do outreach work. So a lot of us have gone to various community centres, faith centres, faith groups, mosques and temples and other faith institutions. (Dr Fatima)*

In this way, faith leaders and religious centres are viewed as pivotal in signposting the availability of mental health services and the validity of seeking them out. In addition, through direct engagement, religious communities and faith leaders are

seen as important allies in supporting and facilitating mental healthcare, thereby potentially improving accessibility to treatment and adherence to the interventions provided. The breadth of data analysed in this section is summarised in the framework matrix extract below, highlighting the main thematic insights discussed above, together with alternative perspectives, including divergent views.

Figure 6.3.A: Service provider framework matrix extract – signposting

PROVIDERS 2.3: SIGNPOSTING		
	2.3.1 Accessibility	2.3.2 Faith Leaders
Dr Ali	Muslim women are suffering from depression, but not really encouraged to talk about it. There may be other factors at play: they may not be educated; or they may not go out to work.	Need to inculcate in the mosque ethos that mental health problems exist, and they're not something that should be considered taboo, but should be highlighted and talked about openly.
Dr Fatima	IAPT: one of the service commitments is to do outreach work. So a lot of clinicians have gone to faith centres, faith groups, mosques and temples.	Faith leaders support Muslim psychologists providing voluntary psychotherapy by offering Islamic guidance / supervision for practice.
Dr Cohen	Has worked to facilitate connection between faith communities and health services, including providing education on mental health.	Proactively engages with Imams, including inviting them to a therapy session if a patient would like to discuss relevant aspects of religion.
Dr Ahmed	If the patient shows an interest in faith and going private, then they could be signposted to private therapists who are Muslim. For NHS patients, IAPT has been helpful.	"We have to educate the [Muslim] chaplain and the priest."
Dr Shilpa	Proportionately don't get many referrals from the Muslim community for depression, perhaps due to stigma or lack of awareness. When referred, they are usually at the severe end of the spectrum.	There needs to be more awareness within the community - the message going via faith leaders becomes receptive to the community, rather than coming from doctors and healthcare clinicians.

CHAPTER SEVEN: DISCUSSION

This chapter draws upon the interview data analysis to explore the viability of faith-based adaptations, with regard to respect for patient values, developing acceptability, trustworthiness and agency; together with practicability in a health care delivery context, focussing on obtaining practical coherence with person-centred mental care.

This discussion is structured into three parts. The first seeks to explore the combined analytical insights of the previous chapters, by synthesizing insights from both interview datasets, to identify common ground and clarify divergent findings in the data, then integrating conceptual and interview analysis. This also explores methodological congruence between Deductive Content Analysis (employed for the comparative analysis in Chapter 3) and Framework Analysis (used for interview analysis in Chapters 5 and 6).

The second part of this discussion identifies opportunities and challenges for personalised care from the interview data, commencing with policy implications and clarifying General Medical Council regulatory parameters. This is important because it is clear from a range of service providers that faith is discussed in the therapeutic encounter, but is being done in an ad hoc way, differently by each practitioner, rather than in a cohesive and consistent fashion, across disciplines. The discussion then examines implications for clinical practice and empowerment through training; together with engagement between therapists and faith communities, in both clinical and community settings, extending to reflections on

intra-practitioner and intra-community forms of engagement. These are considered in the contexts of providing personalised mental health interventions for Muslims, signposting services, as well as countering stigma and enabling faith communities to better support individuals experiencing depression.

The third section of this chapter seeks to draw together the various strands of this study into the beginnings of a Faith-Informed Therapy framework, with reflections on how it may contribute to clinical practice and where it is situated in the broader literature.

7.1 Aggregating analytical insights

Further to the discussion in Section 4.2 above on analytical methods and the approach to Framework Analysis adopted in this research design, the two interview datasets can be brought together to ascertain the collective insights of both service users and providers. In specific, points of congruence or dissonance between them can be examined.

The approach adopted herein utilises extracts of the respective framework matrices, in keeping with Ward et al. (2013), as well as Hackett and Strickland (2019). As set out in Chapter 4, the extracts presented from each framework matrix focus on the main interviewees quoted in the preceding qualitative data analysis. Whilst the detailed discussions in Chapters 5 and 6 provide specificity on the views of service users and providers on key themes from their interviews, the extracts of framework matrices at the end of each sub-section presented a synopsis of what specific participants (in rows) said regarding each theme (in columns), with the contents of each cell summarising the salient points made by each interviewee on specific themes. As such, both framework matrices (for service users and providers) provide synopses of the respective datasets.

Aggregating analytical insights across both sides of the therapeutic partnership is essential for understanding the overall context of the research question at hand. In order to ease comparison between extracts from the respective framework matrices below, similar points made by both cohorts are shaded in the same colour. Such inter-cohort comparison yields interesting insights that are explored

in the following discussion. In addition, notable intra-group agreements, between participants in the same dataset discussing a given theme, are highlighted in blue text. In contrast, important contraindicators and divergent findings are presented in red. Thus, the discussion below tracks the major points of contact between the two datasets, together with differing perspectives between clients and practitioners.

Once insights across the interview datasets have been aggregated, the discussion will expand to include findings from the earlier conceptual analysis (from Chapter 3), that provided a priori input to the interview protocols from theological and psychotherapeutic sources (notably the NICE Guideline on Depression). Viewed together, the combined findings from conceptual and interview analysis, based on Deductive Content Analysis and Framework Analysis respectively, provide an overall approach to addressing the research question, offering insights into the challenge of providing personalised psychotherapeutic interventions for depression to Muslims in the United Kingdom.

7.1.1 Synthesizing insights from both interview datasets

The Framework Analysis method provides a visual synopsis of the data that reveals connections between the two datasets across four dimensions. First, presenting how faith-based adaptations of psychotherapeutic interventions for depression can promote accessibility and encourage adherence to a given therapy for the Muslim community; second, how stigmas related to mental health arise and can be managed; third, the role of psychotherapists from the same or

other cultural background; and fourth, the role of leaders in faith communities and Imams (Muslim priests). These four dimensions are examined below, across three major thematic clusters, with reference to extracts from each framework matrix.

The first relates to psychotherapy and faith for service users, together with how providers viewed integrating faith into their interventions, within the overall context of building collaborative therapeutic partnerships. Extracts of the respective Framework Matrices in Figures 7.1.A and 7.1.B below shaded in purple show participants Adam, Musa and Yusuf were able to identify links between Islamic concepts and practices with psychotherapeutic techniques, that echoed what clinicians such as Drs Fatima, Cohen, and Shilpa were saying about how they found it important to connect their treatments to the values and habits already established in the lives of their patients, in order to connect with them and demonstrate how the techniques they wanted to share about managing depression are consistent with the Islamic value system. Furthermore, the insights of Drs Cohen and Shilpa (in blue text) are matched, with regard to how they bring faith into therapy early in the treatments they offer to Muslims.

Figure 7.1.A: Service user framework matrix extract - psychotherapy & faith

USERS 1.1: PSYCHOTHERAPY & FAITH		
	1.1.1 Faithfulness	1.1.2 Reassessing Religion
Adam	Depression was not viewed as symptomatic of weak faith personally, but aware of wider perception in the community that it is.	Found the reassessment very rewarding and drew a number of connections between Islamic concepts or practices and psychotherapy, e.g. links between daily prayers and mindfulness.
Musa	Tension between free will and trust in God, with regard to his 'destiny' to have depression versus his free will based efforts to change that.	Whilst initially not expecting any value in links between religion and psychotherapy, upon reflection he found many sources of added value.
Asma	Community aspects of faith can be supportive, but needs to be better structured.	Reflecting upon examples from Islamic history, which talk about experiencing grief, including of miscarriage, can be helpful.
Khadija	Faith and religiosity were deemed independent.	Contrarian view of gratitude practice as overwhelming, rather than building resilience.
Yusuf	Took a very practical approach to mental health, so didn't connect it to faithfulness.	Found daily prayer as meditative and mindful, creating a space for reflection.

Figure 7.1.B: Service provider framework matrix extract – respect

PROVIDERS 2.1: THERAPEUTIC PARTNERSHIP		
	2.1.1 Respectfulness	2.1.2 Disrespect
Dr Ali	As this GP has become more experienced, he is confident in raising religion in a way that is respectful, by being led by the patient.	There is a danger of patronizing people when invoking religious doctrines. Hence, clinicians need to ascertain the way the individual perceives religion at the outset.
Dr Fatima	It's not me “doing” an intervention to the client, to the patient ... this is a collaborative approach. So this is a journey of the development of the self.	No concerns raised.
Dr Cohen	Confident about asking about faith and how it impacts mental health.	Concerned about the impact of stigma, particularly in Pakistani and Bangladeshi communities.
Dr Ahmed	Patient led, this clinician does not raise the question of religion unless the patient does.	Stigma is an important factor that affects certain cultures, such as South Asians, that hinders patients from seeking help.
Dr Shilpa	Any new patient would always be asked if they are religious, how much they engage with their religious or spiritual community, as support.	Concerned about stigma in the Muslim community.

Key:

Black text = views that are broadly aligned with the theme

Blue text = a materially different perspective or unique insight

Red text = a contrarian view that contraindicates the theme

Shaded cells = congruent findings across service user and provider datasets

The second dimension of synthesizing insights from the two groups of interviewees relates to how they discussed stigma, for which there are two points of contact between the datasets. As highlighted in beige shading in Figure 7.1.B (above) and Figure 7.1.C (below), clinicians' concerns regarding the inhibiting effect of stigmas about mental health, particularly among Pakistanis, were reflected in what Muslims who experienced depression (such as Asma and Yusuf) were saying about the detrimental effects of stigma in South Asian populations that conflated religion with culture. Both sides of the therapeutic alliance were thus concerned that cultural stigmas were a barrier to Muslims with depression seeking professional medical assistance.

On a positive note, the comments shaded blue in Figures 7.1.C and 7.1.D (below) suggest that according to patients such as Yusuf, GPs who think like Dr Ali, and psychiatrists such as Dr Shilpa, including faith as a standard feature of therapy can mitigate stigma and promote accessibility for Muslims to mental health treatments.

Furthermore, the comments in blue text from Khadija and Yusuf in Figure 7.1.A above are noteworthy different views. Both service users viewed depression and

faith as independent, i.e. having depression does not mean a person has weak faith, providing examples of powerful de-stigmatising perspectives.

More specifically, a key mechanism of action by which faith-adapted interventions can help to destigmatise depression and facilitate discussion on mental health appears to be around simultaneity, such that one can be a faithful adherent of a religion whilst experiencing depression, i.e. talking about them together and highlighting their congruence.

From a broader perspective, it appears from both datasets that discussing faith in psychotherapy can serve both educational and destigmatising functions. In effect, it's not just about making psychotherapy more accessible, but rather normalising and validating the entire concept of having depression as a person of faith. See for instance the extract from Yusuf in Figure 7.1.C below (shaded in blue).

Figure 7.1.C: Service user framework matrix extract - stigma

USERS 1.2: STIGMA		
	1.2.1 Misunderstanding Religion	1.2.2 Cultural Stigmas
Adam	Did not view depression as a reflection of limited religiosity.	Had positive family support, such as advice from his father regarding various prayer practices to help with depression.
Musa	Views on predestination can be self-stigmatising. An idea of being destined to have depression can undermine free-will based efforts to recover.	No stigma relating to depression was mentioned.
Asma	Islamic leaders can overlook the specific experience of an individual - instead providing generalised advice.	Didn't get the support she wanted for depression following miscarriage, which was deeply stigmatised in her Pakistani culture.
Khadija	Did not view depression as a reflection of limited religiosity.	Powerful experience of challenging cultural stigma by clearly discussing her experiences, thereby influencing both young and older people.
Yusuf	Conflation of South Asian, particularly Pakistani, culture with religion is a problem that needs to be overcome with education.	Faith-based approaches to psychotherapy can mitigate cultural stigmas around mental health challenges.

Figure 7.1.D: Service provider framework matrix extract – training

PROVIDERS 2.2: TRAINING		
	2.2.1 Empowerment	2.2.2 Personalisation vs Proselytising
Dr Ali	If religion were to be part of the standard case conceptualisation model taught to clinicians, then there would be a framework that a practitioner could use to engage a client on religion.	Should be client led to ensure the appropriate approach to personalisation, regardless of the practitioner's familiarity with a patient's religion or culture.
Dr Fatima	NHS: IAPT could arrange training for practitioners for incorporating faith based information into assessment and conceptualisation.	There is strong demand for personalised / faith-adapted psychotherapy, with regular referrals from within the Muslim community
Dr Cohen	Believes in the importance of working with the faith-based beliefs of patients/clients.	Challenges patients' misunderstandings of religion, by setting homework for them to find the basis of unhelpful assumptions in scripture.
Dr Ahmed	From a cultural accessibility perspective, IAPT has been helpful with provision of multi-lingual therapists (relevant for some Muslim communities).	Serious concern about the risk of appearing to proselytise when discussing religion and thereby breaching professional guidelines.
Dr Shilpa	It is important that therapists know Islamic therapeutic techniques and be trained in incorporating them into interventions.	It's about knowing the patient and understanding how a particular treatment modality fits with their belief system. Providing personalised therapy makes therapists drawn to engaging with faith.

The third point of contact across the datasets relates to faith-based matching of therapists to clients. This discussion, which is indicated by green shading in Figures 7.1.D (above), 7.1.E, and 7.1.F (below), examined both the perceived importance and unimportance of this practice. Psychiatrists such as Drs Shilpa and Cohen were passionate advocates for connecting with the faith of their Muslim patients using Islamic concepts and practices, even though they themselves were not Muslim. They were also keen to work with mosques and Muslim faith leaders. This reflects the experiences of Asma and Khadija, who had very positive experiences with non-Muslim therapists who were able to bring faith into therapy in a respectful and appropriate way, being led by their patients. This is an important finding across the datasets, as it counters the idea expressed by some service users that matching of a patient and clinician by culture and religion is essential for effective personalised psychotherapy.

This illustrates the complexity of the issue, together powerful methods therapists can use to empower Muslim clients to discuss their faith: simply by holding a non-judgemental space. It appears a critical aspect of the kind of positive therapeutic encounter that Khadija experienced was that she felt her therapist would not judge her and would be comfortable discussing her religious beliefs in the way she understood them (see Figure 7.1.E below). Hence, the data indicates that giving clients an option to introduce religion, if they wish, can be empowering, provided it is done appropriately, without therapists making premature assumptions.

The fourth point of congruence between the two datasets relates to the role of faith community leaders, particularly Muslim priests. Figures 7.1.E and 7.1.F below

contain cells shaded pink that discuss the importance of mental health practitioners reaching out to work with Imams and the critical role they have in promoting awareness of mental health challenges, as legitimate experiences of faithful Muslims, together with signposting relevant healthcare services. This extends to providing support in the form of specific religious services.

This gap in service provision (from Islamic centres) also speaks to inadequate partnerships between NHS mental health services and faith-based community centres, a concern voiced by practitioners such as Drs Ali, Cohen, Ahmed and Shilpa (see Figure 7.1.F below).

Figure 7.1.E: Service user framework matrix extract – therapeutic encounter

USERS 1.3: THERAPEUTIC ENCOUNTER		
	1.3.1 Resources	1.3.2 Missing Components
Adam	Happy to have therapists who are Muslim or non-Muslim, male or female, or in a mosque or clinic. Hence, current resources are sufficient.	If he had a Muslim therapist, it would have enabled him to ask questions regarding Islamic comparisons to the therapy.
Musa	The standard secular interventions do have considerable trust vested in them, as they are deemed to be based on rigorous research.	Not offered any talking therapies, only SSRI medication for depression and anxiety that was ineffective and caused side effects.
Asma	Very positive experience of a non-Muslim counsellor, showing that matching by culture/religion is not essential.	Strong rebuke of (historic) lack of mental health support from Islamic centres, particularly structured support for miscarriages and the resulting post-natal depression.
Khadija	Pointed out positive experiences of having a therapist who was a Polish non-Muslim man, i.e. not matched, who held a space where she felt able to bring in religion.	Respect and professionalism were missing from an earlier therapeutic encounter with a counsellor who was also a female Pakistani Muslim woman.
Yusuf	Culturally competent therapists can add tremendous value in providing tools for managing depression, provided they are sensitive.	Some therapists who do not understand South Asian culture have been difficult to work with, as some of their suggestions are unworkable, such as in relation to family relationships.

Figure 7.1.F: Service provider framework matrix extract - signposting

PROVIDERS 2.3: SIGNPOSTING		
	2.3.1 Accessibility	2.3.2 Faith Leaders
Dr Ali	Muslim women are suffering from depression, but not really encouraged to talk about it. There may be other factors at play: they may not be educated; or they may not go out to work.	Need to inculcate in the mosque ethos that mental health problems exist, and they're not something that should be considered taboo, but should be highlighted and talked about openly.
Dr Fatima	IAPT: one of the service commitments is to do outreach work. So a lot of clinicians have gone to faith centres, faith groups, mosques and temples.	Faith leaders support Muslim psychologists providing voluntary psychotherapy by offering Islamic guidance / supervision for practice.
Dr Cohen	Has worked to facilitate connection between faith communities and health services, including providing education on mental health.	Proactively engages with Imams, including inviting them to a therapy session if a patient would like to discuss relevant aspects of religion.
Dr Ahmed	If the patient shows an interest in faith and going private, then they could be signposted to private therapists who are Muslim. For NHS patients, IAPT has been helpful.	"We have to educate the [Muslim] chaplain and the priest."
Dr Shilpa	Proportionately don't get many referrals from the Muslim community for depression, perhaps due to stigma or lack of awareness. When referred, they are usually at the severe end of the spectrum.	There needs to be more awareness within the community - the message going via faith leaders becomes receptive to the community, rather than coming from doctors and healthcare clinicians.

7.1.2 Clarifying divergent findings in the data

Both datasets contain salient solitary insights that diverge from other interviewees, either by offering insights into a matter that is not discussed by others, or by providing a contraindication. Framework Analysis facilitates the identification of these datapoints through the matrix presentation method used above. From this analysis, there are five key divergent findings, as discussed below.

First, with regard to reassessing religion as psychotherapeutic, Figure 7.1.A contains a point from Asma about using Islamic history to reframe one's experience of depression, in light of how prominent historical figures coped with similar adversity (as discussed in Section 5.1.2.ii on building resilience). This was a divergent finding in the sense of an unexpected insight, rather than contrarian finding. Nevertheless, it counters the initial idea in the interview protocol to avoid discussion of history due to potential risk of controversy.

Second, whereas most service users regarded Islamic gratitude practices (*shukr*) as broadly therapeutic, by prompting reframing and focus on positive aspects of life, one participant (Khadija) had a contraindication, such that she found it overwhelming and detracted from building resilience. The mechanism of this maladaptation was through the emotional pathway of guilt, that was activated when considering aspects of her life she should or could be grateful for (see Figure 7.1.A above). This possibility was not considered by the service providers in this study, who viewed gratitude practice as a positive technique.

Third, Figure 7.1.D suggests that service providers' views on including faith in the clinical encounter was broadly positive, expect in the case of Dr Ahmed, who strongly regarded it as a dangerous practice that potentially constituted proselytising. However, it should be noted that the data from service users does not suggest any of them regarded it as such.

Fourth, data in Figures 7.1.E and 7.1.F regarding people going to private Muslim counsellors, sometimes because they had negative experiences in the NHS, supports the concept of matching therapists and clients, contrary to some of the data from clients who said matching was not necessarily important, as they had great experiences from non-Muslim therapists (as discussed above). However, the contraindication from Khadija in Figure 7.1.E is important, with regard to her negative experience of a therapist who was from her own Pakistani community, i.e. a practitioner who was matched by both culture and religion, but who Khadija thought was disrespectful, thereby reiterating the consistent message in both datasets of how respect is the bedrock of sound personalised mental health treatment, beyond any simple notions of matching.

Fifth, it is noteworthy that Dr Shilpa found that she gets disproportionately fewer Muslim patients in her psychiatric clinic (Figure 7.1.F). This potentially divergent finding highlights an issue that she attributes to Muslims not getting treatment early, due to stigma or lack of awareness. Hence, by the time Muslim patients arrive at her clinic, they are already at the more severe end of the spectrum.

Sixth, there was a divergent finding from a psychiatrist who reported the maladaptive effects of some of his Muslim patients' assumptions about Islam, as he found a problem relating to some of them being adversely affected by not knowing enough about Islamic teachings. Even though he personally did not come from the Muslim community, Dr Cohen was confident that some of the views his Muslim patients held about Islam were theologically incorrect and unhelpful to their mental health. He therefore sought to actively challenge those views by setting homework for his patients to find evidence of those maladaptive views in the Qurʾān, which they could not, thereby enabling him to get them to re-evaluate their faith in a way that helped their recovery (see Figure 7.1.D). He has also sought to bring patients' priests (Imams) into the clinic so that they could all together discuss unhelpful assumptions about religion that a patient was making, such that the Imam could then provide theological information, enabling the patient to reassess their views (see Figure 7.1.F).

This provides an insight into a potential limitation of faith-adapted psychotherapeutic approaches, as it may suggest an epistemic threshold that might be operating in this line of practice: a Muslim might simply not have adequate knowledge of their faith and its commitments and practices to get any value from a faith-based approach. This raises a question about whether faith-adapted interventions require a prior judgment to be made about a Muslim patient's knowledge of Islamic concepts and practices, rather than just a personal assessment of their commitment to the faith. Hence, education of service users may be required prior to effective faith-based psychotherapy.

The collective insights from interview data considered here provide a foundation for further reflection in the context of the previous conceptual analysis in Chapter 3. Hence, the following section discusses broader perspectives encompassing findings from the both the conceptual and interview dimensions of this study.

7.1.3 Contextualising conceptual and interview analysis

The research design of this study has benefitted from having conceptual and interview dimensions, each of which have provided unique insights. The task of contextualising the two sets of analysis can be undertaken by following the same approach as above, when service user and provider datasets were synthesised by looked at them together, to identify points of congruence and difference. In this sense, the interview analysis turns the comparative analysis into something more nuanced, sensitising it to the lived reality of Muslims with depression and grounding it in the practical reality of current service provision.

The Deductive Content Analysis (DCA) method employed in Chapter 3 for the conceptual analysis is congruent with the Framework Analysis (FA) method used for interview analysis, particularly since both facilitate comparative thematic analysis and present findings in succinct matrices. Hence, two pertinent charts from Chapter 3, where the conceptual analysis was developed and presented, have been reproduced below for ease of navigation. The categorical coding matrix in Figure 7.1.G below provides a synopsis of the comparative analysis between the NICE guidelines for depression and Islamic theological sources, as discussed in detail in Chapter 3. When this is compared with the above extracts of the Framework Matrices, each on the ten elements of the coding matrix, consisting of self-knowledge and building resilience, can be identified in the data from service users and providers, as detailed in Chapters 5 and 6 above. For instance, it's important to note the connection between building resilience and challenging

stigma in the interview data (from both practitioners and patients), with the psychotherapeutic techniques in the resilience group of the coding matrix.

Figure 7.1.G: Categorical coding matrix from NICE guidelines (from Ch 3)

SELF-KNOWLEDGE GROUP	RESILIENCE GROUP
Goal setting	Optimism and hope
Awareness of thoughts	Motivation and agency
Recognising emotions	Gratitude
Mindfulness practices	Relationships
Bodily awareness	Behaviour patterns

In addition, insights from the Summary matrix of psychotherapy and Islam (see Figure 7.1.H below) can serve to provide concrete contact points between psychotherapeutic techniques and Islamic concepts or practices that practitioners requested in the interview data analysed in Chapter 6.

Moving forward in the integration between interview and conceptual insights, there was clear data from service users about how some people experiencing depression utilise examples from Islamic history, as inspiration from how respected historical figures coped with adversity. This empirical finding prompted further conceptual research, yielding interesting additional points of contact between psychotherapeutic techniques (such as reframing), with specific historical events from Qurʾānic scripture.

In particular, the interview data from service providers in Chapter 6 suggested that some patients needed support with re-evaluating certain religious concepts. For instance, one may think of supplication (*duʿāʾ*) as relating simply to seeking Divine help to change a particular circumstance, which may or may not improve. Hence, the efficacy of such prayers can be determined purely in terms of whether or not a specific problem was alleviated, i.e. a somewhat 'transactional' perspective. However, an alternative way of looking at such prayers (*duʿāʾ*) is the method advocated by the Qurʾānic narratives of prophets such as Abraham and Zachariah, who used prayer as a mechanism to manage their *experience* of difficult life circumstances and serious adversity, even if the problems remained and were not immediately alleviated. This 'experience' based approach, in contrast with a 'transactional' attitude, has much in common with 'reframing' techniques from psychotherapy, which seek to understand the factual and perceived circumstances of one's life from a broader perspective, with the aim of generating greater resilience. As such, the challenging life circumstances may still be present, but the impact they have on one's experience of life may be moderated, thereby generating greater empowerment and resilience in the face of that adversity. When asked about the potential efficacy of drawing the above distinction between transactional versus experience-based approaches to supplicatory prayer, one participant responded as follows,

> *"It's more realistic, understandable... It just seems like a more interesting concept – it's something that I perhaps haven't tried. It's a very big distinction between the two." (Musa)*

This is an example of the symbiosis between conceptual and interview analysis to better understand the research question herein, yielding insights into providing personalised psychotherapeutic interventions for Muslims with depression.

Figure 7.1.H: Summary matrix of psychotherapy and Islam (from Chapter 3)

	SELF-KNOWLEDGE					RESILIENCE				
	Goal setting	Awareness of thoughts	Recognising emotions	Mindfulness practices	Bodily awareness	Optimism and hope	Motivation and agency	Gratitude	Relationships	Behaviour patterns
Qurʾān (1:1-7)										
Daily prayers										
Fasting										
Mindfulness										
Psalms										

Strongly related	
Moderately related	
Weakly related	
Unrelated	

Key for qualitative scoring

7.2 Opportunities and challenges for personalised care

The combined insights from the conceptual analysis in Chapter 3 with the interviews in Chapters 5 and 6 have shown that there are important opportunities to address the challenges that have been raised by service users and providers. The section below will examine three specific opportunities that appear to be within reach and feasible to implement. This discussion is structured into three parts, consisting of implications for policy, practice and engagement.

First, for many UK Muslim patients the first entry to the health care system is via their GP, yet the data in this study suggests that some family physicians require clarification of the regulatory boundary between offering personalised care to faith communities, versus the risk of being deemed to be proselytising. Second, once a patient has embarked upon psychotherapy, their individual therapist may face a theological knowledge gap (discussed in Section 6.2 above). This is a reflection of theological epistemic challenges faced by service users when reassessing religion as psychotherapeutic. Third, better engagement between mental health service providers and faith community organisations could assist religious leaders to sign-post psychotherapeutic services, as well as mitigate the stigma related to depression (and potentially other mental health challenges).

7.2.1 Policy implications: clarifying regulatory parameters

One of the interesting findings of the data from service providers was the broad diversity of approaches to raising the subject of a patient's faith in the therapeutic encounter. The clinicians' methods varied dramatically, from psychiatrists such as Dr Shilpa who regularly discussed religion early in therapy, to family physicians such as Dr Ahmed's reticence to discussing religion at all, due to concerns about regulatory breaches of proselytising. This profound difference in understanding between clinicians who are both regulated by the UK General Medical Council (GMC) highlights an important need for regulatory clarification and advice on best practice. This could be addressed through engagement with the regulator, perhaps through a qualitative study consisting of interviews with senior policy makers at the GMC, asking where they see the boundary between delivering personalised mental health for faith communities, versus proselytising. If this results in clear guidance from the GMC suggesting that if appropriate it is acceptable to raise the subject of religion in a clinical setting, it could address the concerns of GPs such as Dr Ahmed who avoid it, whilst also providing assurance to psychiatrists such as Dr Shilpa when being proactive in discussing religion with members of faith communities.

The literature shows that the GMC has been open to employing qualitative research methods for seeking policy clarification. For instance, they employed such an approach when exploring patient and public views to inform the Good medical practice review (General Medical Council, 2023). Hence, a focussed qualitative study of the form used in this research could add value. For instance,

such a study could have a semi-structured interview design, explicated with Framework Analysis, in keeping with its origins in policymaking (Ritchie & Spencer, 1994). In addition, the interview topic guide could be seeded with the analysis in Chapter 6, which could provide clarity in situating the research question within the challenges of contemporary clinical practice and the diversity of current approaches.

7.2.2 Practice implications: empowerment through training

The data analysis in Chapter 6, particularly in Section 6.2.1, highlighted themes discussed by several practitioners related to the need for better training to equip them to serve patients/clients from the UK Muslim community. The challenges they described could be addressed by two separate but related training programmes, that could serve to inform and empower service providers across a range of disciplines.

7.2.2.1 The value of accessible literature on faith and therapy

The first is about offering training in the form of courses or clear and accessible literature demonstrating connections between religion and psychotherapy. For instance, when the interview topic guide in the study above presented ten concepts from Islam and psychotherapy each, requesting practitioners to explore any connections they saw between them, the feedback was very interesting (see Section 6.1). One noteworthy example of a simple guide that attempted to show

connections between psychotherapy and Islam was developed by Hewing and Clarke (2014) the mental health charity MIND. This took examples from Islamic sources and showed links to psychotherapeutic concepts. A development of this approach would be to utilise the above conceptual mapping consisting of two lists of ten Islamic and ten psychotherapeutic concepts in the interview Topic Guides (see Appendix 4.5), which were developed through the conceptual analysis in Chapter 3 that compared Islamic theological sources with psychotherapeutic techniques from the interventions recommended by the NICE Guideline for Depression (National Collaborating Centre for Mental Health, 2010). The psychotherapeutic list consisted of the following common techniques: goal setting; mindfulness meditation; optimism and hope; motivation; awareness of emotions; gratitude; building good relationships; awareness of thoughts; behaviour patterns; identifying tension or relaxation in the body. The Islamic concepts and practices were: *nafs* (inner self); *niyyat* (intention); *akhlāq* (interpersonal ethics); *dhikr* or *tasbīḥ* (invocation); *ṣalāt* (daily prayer); *duʿāʾ* (supplication); *shukr* (thankfulness); *istigfār* (seeking forgiveness); *tawakkul* (trust in God); *tafakkur* (reflection). Various service providers, such as Dr Shilpa (see Section 6.2.1) suggested that leaflets showing connections between Islam and psychotherapy using the above elements could be beneficial for practitioners' own learning, as well as providing materials that could be explored together with patients/clients, as part of personalised mental health care. Such independently produced leaflets that pointed out contact points between therapies like CBT and Islamic concepts and practices, would enable clinicians to talk about religion without suggesting it was their own view or theological knowledge, thereby enabling the clinician to retain independence.

7.2.2.2 The need for clear clinical protocols relating to faith and therapy

The second implication for practice that arises from the interview data is the potential value of new protocols to provide guidance on best practice for delivering personalised mental health interventions to faith communities. Several clinicians reported that the lack of a model or protocol for incorporating faith into therapy appears to be a core gap in the training of therapists (see Section 6.2). For instance, when asked if faith should be part of a standard case conceptualisation model for practitioners, the one clinical psychologist explained:

> *It's taken about two and a half years to develop that confidence, to integrate. Yeah, and I still don't do it well. There is no model, so I'm sure ... I don't do it right... I do the best I can." (Dr Fatima)*

It may be important to provide practitioners such structure and training, since they believe that if religion were to be part of a standard case conceptualisation model taught to clinicians, then there would be a framework for engaging with a client on the subject of religion. In the absence of that, they may either do what feels right to them, or simply avoid the whole subject of faith, due to the sentiment expressed above of not having been trained to do so.

On a positive note, one of the beneficial resource utilisation implications of such protocols would be to make it easier for a wider range of practitioners to provide personalised mental health services to Muslims, even if they have no prior theological or cultural connection to Muslim communities, thereby mitigating the need for cultural and/or religious matching of service users and providers.

7.2.3 Engagement implications: working with faith communities

Reflections upon the above Framework Analysis of interviews with practitioners and Muslims experiencing depression highlights four clear implications for how engagement between and within the two groups can address several challenges that came to light in the data. The first two are forms of inter-group engagement, whereas the third and fourth relate to intra-group engagement, each embracing a specific opportunity to address a particular challenge arising in the interview data. The four implications set out below also differ according to setting, with the first and third being in a clinical setting, while the second and fourth would be implemented in Muslim community centres or mosques.

First, several clinicians called for bringing faith leaders (Imams) into the clinic to engage with practitioners and patients (where appropriate). The challenge such interactions could mitigate is the lack of understanding and context some service providers may have regarding Islamic concepts and practices, particularly with regard to how they may be congruent with psychotherapeutic interventions (see Section 6.3.2 above). In addition, such interactions could also help Imams to destigmatise depression (see Section 5.2.1), by giving them a better understanding of how psychotherapy works and thereby empower them to signpost services more effectively. From a patient perspective, some psychiatrists suggested there could be value in inviting a patient's Imam to a therapy session to support the individual in reassessing religion as psychotherapeutic and also to challenge unhelpful assumptions or misconceptions about Islam (see Section 6.3.2). This could also be a way to manage faith-based concerns patients may

have about engaging in therapy. From a resource perspective, if a patient's particular Imam is not able to come to a clinical session, many NHS hospitals have Muslim chaplains, who may be able to serve this function. It is important to note that bringing any faith leader into a therapy session could only be done with prior permission from and in full consultation with the patient in advance.

The second form of engagement was mentioned by various clinical psychologists and psychiatrists who have actively participated in outreach projects, visiting local mosques and Muslim community centres. Framing such encounters in a community setting can be a power destigmatising factor, normalising mental health challenges and signposting services to those individuals who may otherwise be reticent to engage with the health service (see Section 6.3 above).

Third, turning to intra-community engagement, some service users lamented the lack of services their own mosques and Muslim organisations had failed to provide that could have supported their recovery from depression. One specific example of this is in the particular context of supporting recently bereaved parents, including those experiencing depression after a miscarriage. The testimony of Asma in Section 5.1.2.ii and later in Section 5.3.2, shows that absence of support from mosques can be an indirect, but nonetheless significant, form of institutional stigmatisation. Furthermore, it also shows that correcting this service gap does not need to be resource intensive, since Asma is simply asking for a dedicated religious service, which would be straight forward to organise for most Islamic centres and relatively low cost.

The fourth dimension of engagement is intra-practitioner, relating to structured conversations in multi-disciplinary clinical teams, to address faith-based factors in therapy. For instance, Dr Faiza pointed out how time pressures often mean such reflection is squeezed out, whereas in her opinion as a clinical psychologist, it is important to make time to have such discussions as a team (see Section 6.3.1).

All the four aspects of engagement, whether in clinical or community settings, including intra-community and intra-practitioner conversations, have four important attributes for personalised mental health services. First, they are relatively cost-effective ways of building bridges and breaking down barriers. Second, they can promote signposting, particularly in communities where there is resistance to psychotherapy. Third, they can serve to mitigate stigma, particularly when psychotherapy is advocated by faith leaders. Fourth, it can promote more efficient resource utilisation in clinical settings by pooling skills and insights across teams of practitioners working together.

7.3 Towards Faith-Informed Therapy (FIT)

The preceding chapters of comparative and interview analysis have provided many thematic threads that can be drawn together and organised in a way that provides structure and consistency to the endeavour of personalised mental health interventions for depression among faith communities. As one potential way forward that emerges from this study, this discussion presents the beginnings of a novel Faith-Informed Therapy (FIT) framework, with reflections on how it may contribute to clinical practice and where it is situated in the broader literature.

It's important to situate FIT as a framework in the context of practice: it's not aimed at being operationalised as an intervention in its own right, but rather as an approach to communicating the techniques of a practitioner's chosen therapy, making delivery of it more accessible and adherence to it easier, by building on a service user's existing foundations of faith-based concepts and practices.

To begin with definitions, there is a distinction between 'faith-informed therapy' and 'faith-adapted therapy'. For the purposes of this discussion, 'faith-informed' is deemed to refer to an application of an underpinning framework, *across interventions*, rather than a specific faith-adapted distinct intervention (of which there are several examples in the literature, considered in Sections 1.1.2 and 7.3.2. Therefore, this *'faith-informed'* approach that arises from the analysis within this study is about lubricating the machinery of a practitioner's chosen intervention, with information about concepts and practices from the service user's faith tradition that are relevant to the psychotherapeutic intervention they are given,

thereby seeking to improve the accessibility of and adherence to that intervention, particularly if it is among those that are within the NICE guideline for depression, since that is the context from which this framework has been developed. To be clear, this framework does not seek to be a separate intervention in itself. Rather, it is a facilitator of a wide variety of interventions. The structural components of this framework are illustrated in Figure 7.3.A and set out below.

1. Balance between theology and population mental health

This first dimension has received considerable attention since medieval times. Classical scholars have wrestled with notions of self and soul for centuries. Islamic scripture and theological doctrines have been analysed in the context of contemporary mental health services and psychotherapeutic frameworks. There have been notable attempts to develop frameworks to combine psychotherapy with religious concepts, or spirituality more broadly. One of the leading current models, Spiritually Integrated Psychotherapy, offered by Pargament (2011), has been adapted into various forms of Islamically Integrated Psychotherapy in a recent edited volume (Al-Karam, 2018). One limitation of these approaches is that they suffer from a conceptual specificity gap, whereby despite seeking to unite faith and professional practice, there are few tangible correlates proposed between specific psychotherapeutic techniques and faith-based concepts and practices. The Deductive Content Analysis method employed in this study has resulted in the identification, specification and revision of a set of ten specific points of contact that can be employed by service users and providers alike, with analysis of connections between specific techniques from psychotherapy and Islam (see Chapters 2 and 3).

2. Therapeutic balance between clients and therapists

Clarity about the disease burden of depression in the UK Muslim population is lacking. A recent survey of global Muslim mental health research found that only 11% of 2,652 articles focussed on issues relating to stigma, religiosity, spiritualty or identity, with the most typical themes focussing on war, trauma, violence and PTSD (Altalib et al., 2019). Yet, stigma is one of the most pertinent concerns for UK Muslims from the empirical data collected in this study thus far. The second limitation of the current religious psychology literature is the serious matter of an empirical gap, whereby the concepts provided are not generally underpinned by richly nuanced qualitative data, nor even simple quantitative tests. Hence, the theoretical concepts have not been co-developed or refined in light of the experience of patients and clinicians, but have been curated in a more abstract theoretical setting, which may be vulnerable to biases.

Therefore, listening to the voices of a target population is critical to developing personalised mental health services for them. Qualitative methods are particularly well suited to capturing the nuances of stigma and need to demystify psychotherapy. It is essential to also include clinicians in the process of developing any viable framework for person-centred treatment, thereby maximising the chances of it being practicable in a health care delivery context. This provides the opportunity to broaden the scope of professions included, not just the traditional list of counsellors, clinical psychologists and psychiatrists, but also extending to other health care professionals who provide support for depression, notably palliative care specialists and GPs. A key aspect of such engagement is to understand the training needs of practitioners and what they

need to feel empowered to have discussions about religious matters with their patients, particularly if they do not know much about that religion.

3. Faith-Informed Therapy (FIT) Framework

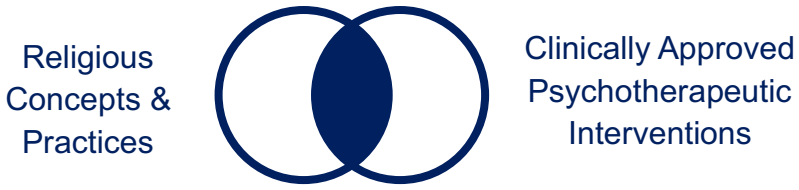
In order to reconcile all four of the above dimensions, a conceptual balance needs to be struck between theology and population mental health, whilst simultaneously also striking a therapeutic balance between service users and providers.

The area at the centre of the diagram above, where all four dimensions are adequately and appropriately included, constitutes the centre ground of this arena, where a provisional clinical framework for how personalised mental health care for UK Muslims might be implemented in practice. A possible shorthand description of this point of convergence is 'Faith-Informed Therapy' (FIT), as one potential clinical model of what appropriate and fully inclusive faith-based therapy for this group should consist of. The FIT framework also addresses four limitations in the current literature: (1) conceptual specificity gap; (2) empirical gap; (3) internal gap of appropriate adaptations to NICE approved interventions for depression; and (4) external gap in relation to barriers to engagement with services and encounters with therapy (discussed below).

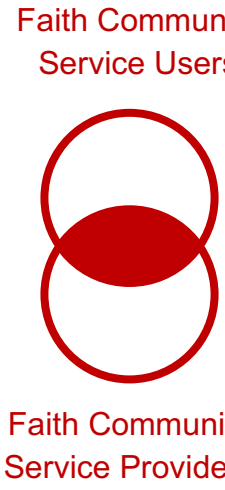
Given the realities of therapeutic encounters and established models of service delivery, a flexible approach such as this, given its adaptability to different interventions and individual patient requirements, could fulfil a well-established goal of mental health treatment: personalised, respectful, destigmatising care.

Figure 7.3.A: Generalised Faith-Informed Therapy (FIT) Framework

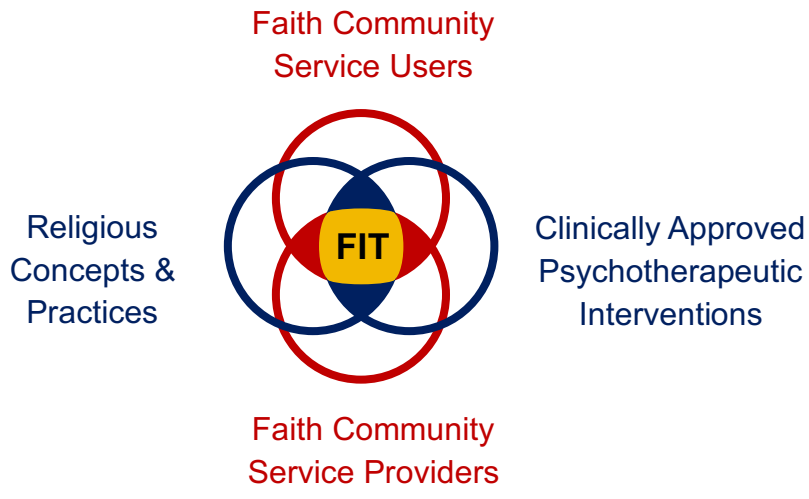
1. Balance Between Theology & Population Mental Health



2. Therapeutic Balance Between Clients & Therapists



3. Faith-Informed Therapy (FIT) Framework



7.3.1 Faith-Informed Therapy and psychotherapeutic practice

From a psychotherapeutic perspective, the components of the FIT framework are each empirically based. The first dimension employs Deductive Content Analysis methods to balance population mental health best practice, in this case from the NICE Guideline on depression, with theological concepts and practices from Islam (from Chapter 3). The second dimension utilises Framework Analysis to balance requirements from service users and providers (from Chapters 5 and 6). The third component synthesizes the previous two elements (see Section 7.1 above).

The above formulation of the FIT framework raises further nomenclature related questions. First, the distinction between 'faith', 'religion' and 'spirituality'. With regard to this approach, 'faith' was chosen as it balances the theological and psychological factors required for personalised mental health. This is because 'religion' carries connotations of legalistic rigidity (i.e. Islamic Sharīʿa), which may not always serve the reflexive and flexible requirements of self-analysis and personally discovered psychotherapeutic meaning from theological practices. On the other hand, 'spirituality' can often be associated with an inner life that may not be related to a formal religion or community, thereby not necessarily benefitting from the scaffolding provided by theological practices and faith community organisations. Therefore, the specific choice of the term '*faith*' is not merely semantics, but a specific analytical choice that avoids the potential conflation risks of the words 'religion' or 'spirituality', while capturing deeply held beliefs and world view that may form key components of a Muslim's identity.

A key aspect of the FIT framework in the context of psychotherapeutic practice is that it is relatively easy to integrate, since the information it is based upon is essentially about contact points between concepts and practices from a service user's faith tradition and the therapist's chosen intervention. In that regard, the sentiments of psychiatrists who expressed clear ideas about the attributes of good informative materials are worth reiterating:

> *"It needs to be simple, it needs to be concise, and it needs to be user friendly, really. And sometimes it's helpful if it is kind of, you know, drawn from within the community, as to using their views incorporated into into that leaflet." (Dr Shilpa)*

Whilst the FIT framework herein responds to this request, more research is required into its incorporation into psychotherapeutic practice.

7.3.2 Faith-Informed Therapy in the context of the literature

The specific approach that the FIT framework seeks to take benefits from the prior literature that founded this field of research. In particular, two important contributors stand out as having been influential to the development of the FIT framework. First, Koenig (2012), who combines religion and spirituality with the abbreviation '*R/S*' to aggregate empirical insights on health outcomes from being a person who has faith in a religion or spiritual tradition. This study and the wider body of work from which it emanates influenced the clear focus of the FIT framework on practical mental health outcomes. Second, '*Spiritually Integrated Psychotherapy*' from Pargament (2011), who showed the mental health benefits of combining the spirituality found in religious traditions with psychotherapeutic intervention. Hence, even though this Faith-Informed Therapy approach differs in terminology and nomenclature from the above works, they have been influential to its development and objectives.

The specific term 'Faith-Informed Therapy' does not appear to be used much in the literature. However, one example of its explicit use is by Foreman (2017), though his description of the term is much more philosophical and 'top-down' in approach. This is very different to the granular approach of the FIT framework herein, which has been explicitly derived from theological and clinical sources.

With regard to the literature on Islam and psychotherapy, the approaches in the literature can be broadly categorised as top-down (i.e. theological) or bottom-up

(i.e. psychotherapeutic). An influential example of the top-down approach is Rothman (2021), who uses Islamic philosophical approaches to explaining psychological aspects of self and mind. Whilst they are theologically rooted, the drawback of such top-down approaches is that they can abstract away from the practical aspects of psychotherapeutic techniques. Hence, the risk is to weaken the process of building accessibility and adherence, that are essential to effective personalised mental health interventions for faith communities. On the other hand, bottom-up approaches that are very focussed on a specific interventions, such as Mir et al. (2015) that concentrated on Behavioural Activation, have the advantage of being connected to a specific NICE approved psychotherapeutic intervention, but may lack the breadth to really build wider accessibility and adherence. Hence, the Faith-Informed Therapy framework herein can add to the literature in this field, by providing a different system that balances top-down and bottom-up methods.

A notable attempt to balance faith and psychotherapy was the aforementioned Islamically adapted Behavioural Activation study by Mir et al. (2015). One of the limitations of that approach was that the framework therein was not designed to capture the richness of the metacognitive aspects of Islamic psychology. Yet, the data we have found in Chapter 5 suggests that Muslims value the self-reflective and metacognitive dimensions of daily prayers and psalms. Not taking account of the views and values of the target population can be a serious impediment to developing viable personalised mental health frameworks.

One of the contributions of the approach taken in this study is close theological reflection across the five dimensions of Islam considered in Chapter 3, spanning

scripture, daily prayer, fasting, mindfulness practices and psalms. By virtue of being theologically rooted, the related psychotherapeutic connections can serve as bridges that are strong enough to bear the weight of personal understandings of religion and how they influence mental health experiences and treatment.

The findings of this study can potentially contribute to the gap in the literature identified in Section 1.1.2, by balancing the current main top-down philosophical and bottom-up behavioural approaches. By virtue of this project being in the middle of that spectrum, it simultaneously accommodate cognitive, behavioural, relational, and mindfulness approaches, from a perspective that is theologically well grounded and attentive to empirical practical experience, both from service user and provider perspectives. Unlike the top-down approaches, the connections between Islam and psychotherapeutic interventions in this study are made at the level of practices, establishing direct contact that is tangible and implementable, thereby facilitating accessibility and adherence. The theological commitments and philosophical basis of prescribed practices are therefore left in the realms of Islamic literature.

It therefore becomes clear that the *level* at which connections between Islam and psychotherapy is made matters, since if it is too high (i.e. overly philosophical or mystical), it has an applicability deficit, whereas if the connection is made too low (i.e. purely behavioural), then there can be accessibility deficits (such as from missing cognitive/conceptual links from established prayer practices). Hence, a balanced approach can provide an equilibrium between theology, psychotherapy, mental health services, and lived experiences.

7.4 References for Chapter Seven

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CHAPTER EIGHT: CONCLUSION

This project has consisted of three distinct phases, beginning with comparative conceptual analysis, which informed the subsequent empirical interview data gathering and analysis, culminating in a symbiosis of the comparative and empirical findings in the third phase. The process of reviewing this project as a whole is undertaken in two parts. First, an evaluation of the research process; and second, an exploration of future research directions in which the findings from this thesis can be taken further in future studies.

8.1 Evaluation of research design

This study has sought to address the research question through the three objectives set as part of the research aims and design. First, a conceptual objective requiring comparative analysis between Islamic theology with psychotherapeutic interventions approved by the NICE Guideline for depression in adults (NG 222). Deductive Content Analysis (DCA) methods facilitated the identification of ten contact points between Islamic and psychotherapeutic concepts, across two categories: goal setting, awareness of thoughts, recognising emotions, mindfulness practices, bodily awareness (forming the self-knowledge group); together with optimism and hope, motivation and agency, gratitude, relationships, and behaviour patterns (classified in the resilience group). These ten concepts were applied to five well-established Islamic practices of Qurʾānic recitation, daily prayer, fasting, mindfulness, and psalms.

Second, the empirical objective is to understand the views and experiences of service users and therapists on the viability of the above comparative framework in practice, together with broader insights into their treatment for depression in the Muslim community. Data collection was undertaken through 30 semi-structured interviews across both cohorts and analysed using Framework Analysis methods. The data analysis identified a number of divergent findings, including the potential presence of an epistemic threshold for faith-based interventions to work, such that service users require a certain base level of Islamic knowledge to avail themselves of faith-informed interventions. In addition, the importance of respect shone brighter than any concerns regarding culturally matching therapists with their clients, suggesting that provided there is a strong foundation of respect, the therapeutic alliance can be strong and fruitful, regardless of the cultural differences between service users and their therapists.

Third, the practice objective seeks symbiosis between the findings of the first two sections, to gain insights into the acceptability and viability of faith-based adaptations to NICE approved psychotherapies, while also considering whether such adaptations are practicable in a health care delivery context, focussing on obtaining practical coherence with person-centred mental care, while countering stigma and maximising the efficacy of existing resources. This process identified opportunities to empower therapists with training materials and regulatory clarification on how to raise the subject of religion in therapy.

From an evaluation of methods perspective, both Deductive Content Analysis and Framework Analysis are complementary methods that have relatively consistent

protocols, thereby facilitating identification of symbiotic contact points. In addition, the iterative aspects of the methodology and research design enabled interview findings (such as the importance of Islamic history for some service users) to influence and update the conceptual analysis. The process by which the above steps were undertaken, documented and collaboratively discussed with the supervisory team mitigated the limitation of having a single researcher and associated risks of bias. A continual process of reflexivity facilitated self-critique and metacognition for the researcher to remain vigilant of the risks of bias and discussed it with supervisors. Hence, Section 7.1.2 is noteworthy in its clear identification of contraindicating and divergent findings.

In addition, a framework for Faith-Informed Therapy (FIT) was identified that can provide a vehicle for delivering a practitioner's chosen intervention from the NICE Guideline, in a way that harnesses the religious commitments and perspectives of Muslims. It was also discussed how the FIT approach developed herein has the potential to make a contribution to the literature through the close reading of theological texts with the NICE Guideline, with the five-dimensional contact points illustrated in the comparative analysis.

8.2 Future research directions

The *NICE Guideline on the Treatment and Management of Depression in Adults* Clinical Guideline 222 (NICE, 2022) proposes recommendations for research that could relate to the findings from this study, specifically with regard to relapse prevention (Recommendation 2), further-line psychological or psychosocial treatments (Recommendation 3), particularly in relation to chronic depression (Recommendation 4), and with regard to promoting access to groups who are "*under-served and underrepresented in current services*" (Recommendation 5). On a different note, Recommendation 6 in the NICE Guideline suggests research on peer support, which the findings herein for post-natal depression suggests may be a fruitful area of study as "*an effective and cost-effective treatment*".[12]

The Nice Guideline presents Guided Self-Help as being delivered with "*printed or digital materials*". However, there is naturally a warning of "*Less capacity for individual adaptations than individual psychological treatments*." However, if the findings from the comparative analysis in Chapter 3, as modified by the interview study, can be presented in faith-informed materials, that could facilitate a more personalised version of Guided Self-Help. This could be a productive future study, given the importance that the NICE committee places on Guided self-help as an intervention for depression. In summary, the collective findings from this thesis have the potential for generating a number of productive future research studies.

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[12] NICE. (2022). NICE Guideline - Depression in adults: treatment and management (NG222). National Institute for Health and Care Excellence. Retrieved from www.nice.org.uk/guidance/ng222