

**The influence of religion on the understanding of and attitudes to mental health
and illness in Muslim patients in the UK**

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List of abbreviations

DOH: Department of Health

Pbuh: Peace be upon him

PCT: Primary Care Trust

Swt: Subhanahu Wa Ta'ala, ('Glorious and Exalted is He' in English). (This is uttered after the name of God). This abbreviation will be used when specifically mentioned in quotations from participants and scholars.

Saw: Sallallahu alaihi wasallam ('peace and blessing be upon him' in English). (This is uttered and written after the name of Prophet Muhammad).

ﷺ : 'Sallallahu alaihi wasallam' written in the Arabic language¹.

¹ The words 'Subhanahu Wa Ta'ala' have been uttered by all the scholars and participants in the interviews after the name of Allah. The abbreviation (swt) will be used in the quotations to reflect this otherwise God or Allah will be used in the main text. The words 'Sallallahu alaihi wasallam' have been uttered by the scholars and participants. This is also written in Islamic literature. ﷺ will be used in the quotations and thesis to represent this.

Abstract

Title: The influence of religion on the understanding of and attitudes to mental health and illness in Muslim patients in the UK

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Background

In the UK, primary care providers are involved in delivering community care and are the gatekeepers to specialist services. The second most frequent reason for consulting the General Practitioner relates to mental health difficulties. There may be variations in the pathways to care for Muslims with mental illness. The literature showed a paucity of high quality literature in the field of Islam and mental health.

Objectives

The thesis investigated the aspects belonging to the Islamic faith, which are most important to Muslims suffering from mental health difficulties and illness. The study focused on gaining a deeper understanding how Islamic beliefs and views influence the perceptions and attitude of Muslims towards mental health and illness and how this helped them cope or did not. Connected to this was the objective of identifying barriers and facilitators relevant to pathways to care, involving existing care systems and Muslim scholars who may be consulted.

Methodology

A qualitative approach was utilised to address the research questions. Semi-structured in-depth interviewing took place with Muslim patients and scholars. 16 patients from 12 different ethnic groups were interviewed. All the patients had experience suffering from mental illness. 17 traditional scholars from 10 different ethnic groups participated in the study, 13 male and 4 female scholars.

Results

The study highlighted a number of important insights in relation to the interface between Islam and mental health. Muslims hold a specific view in the outlook on life, pain and suffering. These views fall outside the realms of mental illness. Islam facilitates a sense of purpose and meaning of life. In the Islamic tradition, health, well-being, emotional and mental health are recognized and conceptualised in a distinct manner through expressions, meaning and strong spiritual dimension. However the majority of scholars were only familiar with a small number of emotional concepts in the Qur'an and Hadith. Religious beliefs influenced the perceptions of Muslims towards mental health and illness along with alternative explanations and notions such as punishment and weak faith explored. Understanding and dealing with emotions was less frequently highlighted by scholars in comparison to other coping strategies.

The pathway to care for Muslims was examined and highlighted specific factors that might act as facilitators or barriers to accessing mental health care. Muslims hold a different model of mental health. Even if distress is recognised as a mental health problem, there are barriers for Muslims accessing help. Muslims also utilised diverse coping strategies in a holistic manner, some of which were specific to their faith. Muslims accessed scholars in their role supporting people with mental

health issues but there were some negative experiences when attending the mosque and dealing with Imams. Scholars held a limited understanding of mental health and mental illness.

Discussion

It was imperative to understand the nuances that exist in Islamic concepts and its context relevant to the person. It was argued there needed to be an understanding of how these concepts connected to the understanding of the individual, their spiritual development and how the person chooses to practice their faith. Islam for Muslims was not necessarily understood to be about prevention of depression or other mental health difficulties. Rather, it was perceived as a means to understand their experiences and alleviate pain and suffering. Belonging to the Islamic faith could help with certain circumstances, which also depended on the context and the person's understanding and application of their faith. Furthermore, faith provided a mechanism for the individual to develop resilience and facilitate recovery.

There is a richness of specific concepts used in Islamic tradition which has not been previously described in medical literature. Muslims adopted a variety of coping strategies which centred on different levels including individual, community, relationship with God & Prophet Muhammad ﷺ and religious practices. The impact of emotional difficulties and distress and usefulness of strategies for the person needs to be considered. Social strategies shaped by a religious outlook were utilised. Conventional approaches and Islamic concepts are not mutually exclusive and may be seen as complementary. People may resort to spiritual practices to avoid dealing with emotional difficulties.

The strengths of the study included the methodological process, with the recruitment of diverse participants and qualified scholars. There was a deeper analysis of the concepts and findings highlighted the importance to contextualise these concepts in relation to the individual. The study was limited as it did not consider the socio-political background of scholars, no recruitment of participants took place from the third sector and all the interviews took place in English.

Conclusion

There are important facets of the Islamic faith in relation to mental health and well-being that are of value to Muslims. Central to this is the distinct ontological perspective Muslims hold. The understanding of emotional and mental health from an Islamic perspective does not necessarily rely on realms of illness or scientific outlook. The Islamic paradigm is conceptualised in a distinct manner and does not fit with the traditional western medical model. It is evident the prism through which Muslims understand their religious beliefs cannot be ignored as they influence perceptions towards mental illness, care and treatment. An awareness of these areas can improve an understanding of the pathway to care for a Muslim, accessibility to services and explanatory models. Muslim scholars play a crucial role in supporting individuals with mental health needs. Here lies an opportunity to develop community based interventions and address the challenges in relation to training needs.

Declaration

That no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Preface

My personal journey

This section examines the personal reasons and motivations why the researcher undertook the PhD, exploring some of his thoughts, experiences, and reflections leading to his decision to formally study the area of Islam and mental health.

Registration for a PhD took place in April 2009, and I enrolled at University having promised never to pursue further studies again when I passed my post-graduate psychiatry exams in 2004. So why did I start this journey?

2007 was a difficult year where I was admitted to hospital for the first time and receiving numerous investigations over a six month period. It was a time as a family we became closer but also an opportunity to return back to my faith, as a source of support and protection. To be honest, it was the first time I had thoughts deep down in my heart about dying. It led me to think about leaving a legacy where doing some good will also help others. My faith helped me make sense of my difficulties and facilitated me to move forward. Was it easy? Far from it, I experienced a lot of emotions during that period and at times, felt overwhelmed. Maybe I had to travel, on a personal journey to development myself, understand myself, my faith and maybe the research work was a means for me to do that.

The following year, one of my close friends became unwell mentally. He was at University with me and our friendship was further strengthened through our time

playing football together for a number of years. He had chosen not to approach his GP in the first instance and came to me for advice. Rather than receiving no help and concern he would become more isolated, I encouraged him to deal with the problem through family and friends and consulting a religious scholar. At the time, it was clear my friend and his family had a fear of approaching the GP for being misunderstood. When he opened up to me about some of his symptoms, I asked myself if he spoke with the GP, would the professionals even understand his experiences? Would they even think outside the box and consider involving a religious scholar and encourage religious therapy as part of the wider treatment? My friend recovered after a few months and I found myself thinking, how many people are in a similar situation and furthermore, fearful of approaching professional services? And even when they are engaged with services, how many of those people are receiving appropriate care which is responsive to their needs? This is not to ignore medical treatment but to consider a holistic approach for everyone. These were some of the questions travelling through my mind.

Being part of the Muslim community, I feel I have more insight into some of the challenges facing the Muslim community which are not necessarily discussed openly in the mosques and community centres. I have also seen some friends who have shared their difficulties and stories relating to how their faith has helped them through their experience and given them a sense of peace and contentment. I also knew some people did not find the experience of speaking with some imams and scholars helpful. Negative to the point, where they then found it difficult asking others for help as the individuals in 'religious authority' did not or could not help. Finding a scholar or imam

who understood the dimension of mental health and wellbeing and tying it with Islamic principles seemed next to impossible. I would like to be proven wrong but skills like empathy and good communication were also a rare commodity in my view amongst those in positions of religious authority in mosques and wider community.

Professionally, I worked in mental health for almost a decade before starting my PhD. I enjoyed my day to day job on one level, coming into work not knowing what to expect and hearing people tell their different stories. On another level, I felt quite frustrated about hearing about people being misunderstood, fearful of professionals, care being less culturally appropriate resulting in disengagement from services. I was becoming disheartened with hearing negative comments such as, 'I don't know' and 'religion has nothing to do with mental health' from professionals. It was clear to me this section of the community was getting a raw deal ('disadvantaged' as they say) from services. Every few months, I was asked informally to see people with mental health difficulties from within the community. These calls came from families themselves, scholars, even other Muslim professionals, not just my own home town Glasgow and Manchester where I was working, but other parts of the country too. I asked each time why they don't seek help and a similar story emerged. In my view this couldn't be right.

Speaking also with scholars, I really felt the need to bridge the gap between mental health and Islam. It was evident to me there were some imams and scholars who really didn't know much about mental health. This work wasn't just an opportunity but a

necessity for the Muslim community. I didn't really need it for my clinical career; I was already a consultant when I started the research.

Thus, over the last 10 years, reflecting through this, it was due to a combination of my personal experience with my own difficulties and returning back to my faith, experience with my friend, looking at issues ongoing in the community, knowledge gaps among scholars and imams and professionally, I wanted to be able to do more, I then decided to pursue the PhD.

I am a Sunni Muslim belonging to the Pakistani community, born and brought up in Glasgow, Scotland. I was aware of the potential bias I may be carrying, holding preconceived ideas whilst exploring this area of research. It was for this reason, I deliberately sought out supervisors who did not belong to the same faith group who would be seen as providing more of an objective and critical perspective to the work. The journey continues.

1 Chapter 1 – Overview

1.1 Introduction

The aim of the introduction is to provide the reader with a brief overview to the subject area of religion and mental health. A statement of thesis outlines a concise summary of the leading arguments of the thesis, focus of study and informs the reader of what to expect in this study. An argument is presented to support the necessity of the research to be undertaken in the Muslim community. The pathways in mental health care within a British context are described. The main research question and boundaries of research are defined. The author concludes the chapter with an overview of the thesis, a 'road map' of themes and discussion.

1.2 Background

There is a growing interest in the area of religion and mental health in the rapidly changing world of migration, social media and diverse cultures living in various societies. The involvement of spiritual and religious factors in the care of patients has been shown to be associated positively with better mental health outcomes such as a reduction in symptoms of depression and anxiety (Swinton, 2001). The *Handbook of Religion and Health* (Koenig et al., 2001), one of the most authoritative pieces of work in this area identified over 1200 studies involving religion and health. Many of the studies showed religion to have a beneficial influence on mental health (Koenig, 2001).

Several studies have found a positive relationship between aspects of religious practice, such as community involvement, church attendance and mental health (Koenig et al., 2001). People may resort to religious coping strategies in times of difficulty and distress. Members of the Christian

Church in the US dealt with life stressors by turning to God, praying and reading the Bible as well as seeking help from the clergy (Pargament, 1990).

Islam is the second largest religion worldwide, estimated at around 1.6 billion Muslims or 23% of the global population (The Global Religious Landscape, 2012). Most live in the Asia-Pacific region (62%) followed by North Africa and Middle East (20%). An estimated 3% of Muslims reside in Europe.

1.3 Statement of thesis

It is necessary to understand the interface between Islam with mental health and well-being as Muslims possess a distinctive outlook to pain and suffering. They hold specific beliefs integral to their faith which influences their perceptions towards mental illness. Mental illness is conceptualised in Islamic tradition which does not fit with the traditional western medical model. There are also factors related to belonging to the Muslim faith that facilitate or hinder their pathway to care. When faced with distress, Muslims may use coping strategies specific to their faith.

This thesis examines the interface between Islam with mental health and well-being. The study investigates the attitudes and perceptions towards mental health and illness among Muslim participants with mental illness and how this may be influenced by their religious beliefs. It highlights aspects of religion in relation to mental health and well-being which are most important to Muslims. The research includes the examination of the Muslim philosophy of life and their outlook to pain and suffering. How mental illness is understood in the Islamic tradition is also explored. There is discussion on the role of scholars in supporting people with mental health needs and their perceptions towards mental illness. Furthermore, the thesis examines the journey a Muslim undertakes when

accessing formal mental health care and their experience with services. Finally, the study also explores how Muslims cope or do not cope with their illness, probing into how Muslims come to a resolution when faced with distress.

1.4 Drivers for research in the Muslim community

There are wider drivers which highlight the importance of conducting research exploring mental health in the Muslim community. These are:

1.4.1 The changing landscape

1.4.2 Policies and legislation

1.4.3 Views of service users and voluntary sector

1.4.4 Existing literature

1.4.1 Changing landscape

In the UK, the latest census (Office for National Statistics, 2011) (National Records of Scotland, 2013) informs us that 33.2 million people in England and Wales and 1.7 million in Scotland describes themselves as Christians and 2.7 million and 77,000 people as Muslim in England/Wales and Scotland respectively with Muslims being the most ethnically diverse. There has been an increase of 2% (England/Wales) and 0.6% (Scotland) of Muslims compared to the 2001 census. The Muslim community is the fastest growing faith in England (Beckford et al, 2006).

Beckford et al (2006) discusses the changing discourse in Britain over the last fifty years and interest in religious communities:

“Over the last fifty years, the discourse in Britain about ‘racialised minorities’ has mutated from ‘colour’ in the 1950s and 1960s (Banton, 1955; Rose, 1969) to ‘race’ in the 1960s, 70s and 80s (Rex and Moore, 1967; Smith, 1989) to ‘ethnicity’ in the 90s (Modood et al 1997) and to ‘religion’ in the present time. This focus on religion has been driven both by major international events which have highlighted the political demands associated with religious movements and by an increasing recognition by academics, policy-makers and service providers of the importance of religion in defining identity, particularly among minority communities” (Beckford et al, 2006, p11).

Findings from the Public Studies Institute survey highlights that ninety-five percent of Muslims view their faith to be *‘fairly’* or *‘very’* important (Modood et al., 1997). It is therefore important to understand the diverse beliefs systems held by Muslims.

1.4.2 Policies and legislation

The Human Rights Act 1998 gave a degree of legal protection against discrimination on the grounds of religion and respect for religious beliefs. Two pieces of legislation however, have given further protection against inequality. In 2000, Article 9 of the European Convention on Human Rights was introduced:

“Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching practice and observance”.

The second part of The Equality Act 2006 which came into force in 2007 states that people of any faith should receive equal services:

“unlawful to discriminate in providing goods, facilities or services to the public on the grounds of sex, race, disability, gender, sexual orientation, and religion or belief”.

There is now a responsibility placed on NHS services to provide appropriate services for all people of any faith. The Department of Health document, *‘NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff’* (DOH, 2003) reports that NHS Trusts in England and Wales should provide accessible and suitable spaces for prayer, reflection and religious services. In Scotland, it is now a requirement for all NHS facilities to provide religious and spiritual provision (The Scottish Government, 2009). The experiences of patients are increasingly being used as a measure of the quality of healthcare (Jenkinson et al., 2002). As one of its standards, the Healthcare Commission requires acute inpatient services to report on how spiritual needs of clients are met (HealthCare Commission, 2007).

More recently, The Department of Health document (2010), published the document, *Essence of Care* which states that religion needs to be considered when *“diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services”* (p4).

1.4.3 Views of service users and voluntary sector

A report commissioned by one of the largest UK mental health charities, The Sainsbury Centre for Mental Health (now called The Centre for Mental Health) supports a greater partnership between mental health services and the voluntary sector and the need to consider religious beliefs (Copsey, 1997). Views were obtained from a number of faith communities included people belonging to the

Muslim faith. Four mosques were visited in London. Many people accessed community organisations as they felt comfortable speaking openly about their religious beliefs. They felt there were fewer barriers in the voluntary sector and discussion of spiritual beliefs was seen as a taboo subject by staff working in state-maintained facilities. Lessons can be drawn from the experience of users to help enhance the delivery of care by mainstream services and to break down barriers affecting access to care.

The Mental Health Foundation, another key charity in the UK, published a report on spirituality *'Keeping the faith'* (2007) involving faith communities including service users from the Muslim community. The report concludes there needs to be a greater consideration of one's spiritual and religious needs as part of their care and treatment.

In a study of fifty-five Muslim service users using focus groups and individual interviews, Cortis (2000) reported the service users wanted their religious taken into consideration during their care. They perceived nursing staff lacked cultural and religious awareness. They also talked about nurses holding stereotypical assumptions about Islam. The importance of hearing the voice of service users has been summarised by this Muslim participant:

“nurses are not particularly interested to find out about our way of life. I feel that it is [the] nurses’ duty to get to know some things about our customs or at least learn from us. This will be a great help to nurses as well, but they [nurses] do not want to know anything, and they do not ask us anything either” (p114).

1.4.4 Existing literature

There has been a growth of literature in the area of religion and mental health in recent decades (Sims & Cook, 2009). A review of the literature concluded most of this work encompassed the Christian faith (Cornah, 2006). There is however a scarcity of research involving Muslims and the Islamic faith. This area will be further discussed in the background section.

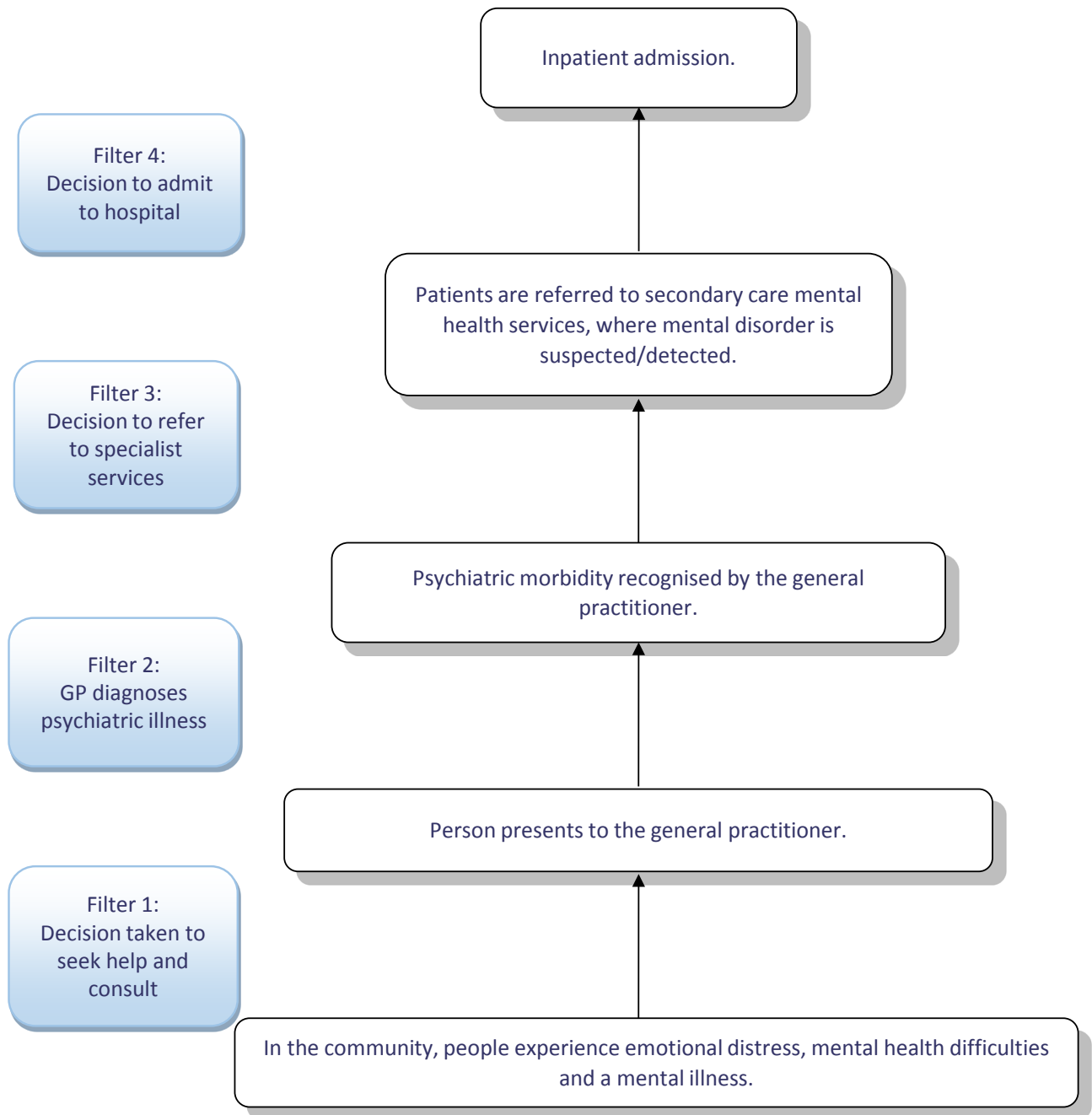
1.5 Context of British Mental Health Care

In the UK, primary care providers are the gatekeepers to specialist services (Gask et al., 2009). Consultations relating to mental health problems are the second most common reason for GP contact (McCormick et al., 1995). The pathway an individual with mental health problems may take to access psychiatric care can be understood using the framework developed by Goldberg & Huxley (1980). This model is a useful starting point to understand points where and who an individual may access when seeking help (see diagram 1 on page 28). This is influenced by the level of severity of the person's difficulties.

There are five levels and four filters described, starting from the community where an individual experiences an episode of mental disorder, moving to primary care where the individual seeks help from the primary care physician and then when the mental disorder is recognised by the physician, referred and treated by mental health services and lastly, individuals who are admitted to hospital for the treatment of their mental disorder. There are key professionals present to allow passage through the referral filtering process to reach the next level of service. This begins with the individual presenting themselves for a consultation with the general practitioner. The General Practitioner (GP) holds an important position at this stage as they provide a diagnosis and treatment

plan for the person with mental health difficulties. A GP also make a decision whether or not to refer to other specialists (Goldberg, Gask & Morriss, 2008). Finally, those individuals with greater severity of mental illness, may receive treatment by the psychiatrist in the community. These filters, whilst designed to facilitate the correct treatment for patients, may also act as barriers to equitable access to enhanced services.

Diagram 1: Pathway for a person presenting with mental health problems to accessing psychiatric care (adapted from Goldberg & Huxley, 1980).



There may be some variation in the pathways to care for those such as individuals with a psychotic illness who may be referred directly to mental health services from presentation in police custody or the accident and emergency department (Gater et al., 1991). In a study of inpatients in London, Lloyd & Moodley (1992) reported Black people (defined as Afro Caribbean) were more likely to be prescribed anti-psychotic medication compared with the White population. Davies et al., (1996) found Black and ethnic minorities suffering with mental illness were more likely to be detained under the Mental Health Act compared to White people.

Bhui & Bhugra (2002) also argued the original Goldberg & Huxley model could be made more inclusive for black and ethnic minority patients by including collaborative links with the voluntary sector and contact with traditional healers. There is now considerable evidence that people from black and ethnic minorities differ from White British in their access to services, utilisation and treatment received in Britain (Bhui & Bhugra, 2002; Bhui et al., 2003). This will be explored further in the discussions chapter.

A conflict between professional beliefs and cultural ones may hinder pathways to care (Campbell, Cornish, & McLean, 2004). Hackett et al., (2009) found working closer with the voluntary sector have shown to increase referrals to mainstream services in the Pakistani community. Rudell et al. (2008) reported patients with common mental disorders patients explored alternative avenues for help such as involvement of traditional healers and family support before engaging with services.

Considering there are factors that influence an individual's pathway to care, coupled with the wider drivers discussed earlier, I personally felt it important to examine mental health issues in the Muslim community. In particular, I felt it would be useful to determine during Muslims' contact with

services, if there was a mis-match between a Muslim's own religious beliefs and with views held by professionals. I also wanted to explore Muslim patients experience in accessing mental health care. Furthermore, I was keen to study whether or not there were alternative means of coping and use of informal supports such as use of religious scholars during their journey.

1.6 Main objectives of research

This thesis has the following broad objectives:

1. To improve the understanding on how religious beliefs and practices influences a Muslim's understanding of their mental health problems, and helped them cope or did not help them cope.
2. To identify the barriers and facilitators to pathways to care, involving existing care systems and specifically Muslim scholars who may be consulted.

There are specific research questions which will be explored further in detail in the objectives chapter.

1.7 Boundaries of research

The focus of the study is to gain a deeper understanding of the relationship between Islam and mental health in terms of beliefs, perceptions and attitudes towards mental health in the Muslim community. Capturing the experience of Muslim patients using services and how they use aspects of faith as a coping strategy is important. In reality, there may be an interaction between one's religious beliefs, cultural background, community, personal and family life. It is therefore difficult to completely separate the role of culture in an individual's life. Cultural practices will be discussed where salient findings have been found from the data however they will not be explored in detail as the focus of this study is primarily examining the interface between religion with mental health rather than the influence from cultural factors. Also, it will be difficult to derive conclusions based on culture as the number of participants from each ethnic group would be small.

Secondly, like other faith communities, Muslims come from a diverse group divided not just by ethnicity but also historical and socio-political divisions. For example, there may be some groups of people who follow the opinion of those who have traditionally learnt from similar academic institutions. Also, there may be some Muslims who take literal interpretations of religious scriptures whereas others may accept a more modern outlook to the writings. Examining the influence of these socio-political factors is clearly important however, it falls outside the scope of this study.

Lastly, whilst it is important to look at the perception of service providers in meeting the needs of Muslim mental health patients and to determine what response is needed from the UK healthcare system in order to ensure the needs of people of a Muslim faith who have mental health problems are acknowledged and addressed, this goes beyond the boundaries of the research.

1.8 Overview of thesis

The context and relevance of the work on Islam and mental health in this introductory chapter has been discussed, providing a rationale for this study.

The reader may not necessarily be familiar with the core tenets of the Islamic faith. The second chapter presents the basics of the Islamic faith and the key words used in this study.

The third chapter aims to provide background of the existing literature. I will provide an overview of the association between religion and health and in particular highlighting contrasting views. The review will consider themes and factors that have emerged from the literature that are pertinent to the area of study, in particular perceptions towards mental illness, use of religious strategies in how Muslims cope or do not cope and experience with services. The chapter concludes with the argument that this area of research is under developed and the objectives set out are the most appropriate area of research at this point.

The objectives are summarised in chapter four, with the aim of capturing views from two groups, Muslim individuals who have suffered from mental illness and Muslim scholars. The gaps in the literature will be mapped against the objectives.

Moving onto chapter five, this comprises the methodology section. This details the design of the study, why the choice was made to do the study in this manner, how the participants were selected and data analysis. A focal area of this chapter will be to highlight the real experience of recruiting participants for the study and the challenges relating to the ethics process.

The results of the study are considered under four chapters (chapters six-nine) which emerged from the themes borne from the data.

Chapter six will explore the Muslim philosophy of life, pain and suffering. The meaning attached to mental illness from a Muslim's view is discussed in this section. Perceptions towards mental illness from a participants' and scholars' perspective will be covered in chapter seven. Chapter eight will examine how Muslims cope or do not cope with mental illness. The concluding findings chapter will be a focus on the Muslim's pathway to care, examining the barriers and facilitators to care in chapter nine.

The objectives of the study will be linked to the summary of findings and literature in chapter ten-the discussion. Strengths and limitations of the study will be identified with implications of research findings discussed. The PhD thesis will close with concluding remarks.

The next chapter will detail an introduction to Islam, which will facilitate an understanding of the tenets of Islam and the Muslim community.

2 Chapter 2 – The religion of Islam

The previous chapter dealt with the necessity of this research, outline of mental health care in Britain, areas of focus and overview of thesis. This second chapter sets out information about the religion of Islam, which will help orientate the reader in future chapters.

This chapter has been divided into three sections. Firstly, the section provides an introduction to the religion of Islam, giving an overview of the core principles of the Muslim faith.

In the second section, there will be discussion on the members of Muslim community; highlighting that in fact they are a heterogeneous group of individuals who not only share common principles, but may differ in their practice of their faith.

Lastly, an explanation will be provided for the definitions used in the thesis which is intended to serve as a reference to the reader.

2.1 Introduction to Islam

The corners of the world have seen many religions born out of nations, tribes or after a founder; for example, Buddhism and Sikhism. However, Islam has neither emerged following the appearance of a Prophet, nor is it the faith of one country and region; it is seen by devotees as a universal religion for the past, present and future generations (Mawdudi, 2003). The word '*Islam*' comes from the Arabic language which means submission, obedience and peace. Accepting God's command is a way of submission and putting the commands into practice through daily life is obedience (Sarwar, 2008). Peace is acquired through this path of submission and obedience to God. This is why Islam

is considered a 'way of life' as it goes beyond a prescribed collection of beliefs or practices (Alvi, 2014). A Muslim is someone who accepts this way of life.

The cornerstone of Islam can be succinctly explained using the well-known report called 'Hadith Jibreel' which summarises the religion of Islam under the concepts of *Islam*, *Iman* and *Ihsan*. The story relates to a man coming to Prophet Muhammadﷺ,² the Messenger of God, enquiring about the Muslim religion. It is narrated by Umar ibn Khattab, one of the companions of the Messenger of God:

“One day we were sitting in the company of Allah's Apostle (peace be upon him) when there appeared before us a man dressed in pure white clothes, his hair extraordinarily black. There were no signs of travel on him. None amongst us recognized him.

At last he sat with the Apostle (peace be upon him) He knelt before him placed his palms on his thighs and said: Muhammad, inform me about al-Islam.

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

He (the inquirer) said: You have told the truth. He (Umar ibn al-Khattab) said: It amazed us that he would put the question and then he would himself verify the truth.

He (the inquirer) said: Inform me about Iman (faith).

²ﷺ means 'peace be upon him', abbreviated as 'pbuh'. This is uttered and written after the name of Prophet Muhammad.

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

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

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

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

(Sahih Muslim 1: 0001).

Islam refers to outward actions, *Iman* to inward beliefs and *Ihsan* equates to spirituality and means to achieve excellence in one's life (Ali, 2013). The meaning and aspects of these concepts are elaborated upon in the following table.

Table 1 Understanding the religion of Islam

Islam	Iman	Ihsan
<p>Outward actions The five pillars of Islam</p>	<p>Inward beliefs Six articles of true faith</p>	<p>Spirituality Perfection and awareness</p>
<p><u>Shahadah</u> Declaration of faith that there is no god except God and that Muhammad ﷺ is the messenger of God</p> <p><u>Salah</u> The 5 compulsory daily prayers</p> <p><u>Zakat</u> Almsgiving contribution</p> <p><u>Sawm</u> Fasting during the month of Ramadhan</p> <p><u>Hajj</u> Pilgrimage to Makkah once in a life time for those who are able to do so physically/financially</p>	<p><u>Belief in God</u> In Arabic, the name of God is Allah. To believe in the oneness and uniqueness of God.</p> <p><u>Belief in the Angels of God</u> Angels are created from divine light. Some of the well-known angels are Jibreel (Gabriel) and Mikal (Michael).</p> <p><u>Belief in the Books of God</u> Whilst the Qur'an is the holy book of Muslims, Muslims also believe in the revealed books of the Torah, Psalms, Scrolls of Abraham and the Gospel as scriptures sent to mankind as a guidance.</p> <p><u>The Messengers of God</u> Muslims believe in all the prophets of God. They believe that Adam (pbuh) is the first Prophet and Muhammadﷺ as the last Prophet. Numerous prophets were sent for guiding mankind in different eras and different nations.</p> <p><u>Belief in the Day of Judgement/life after death</u> Muslims believe in life after death. They believe everyone will be resurrected from the dead and their actions judged by God. People will be rewarded and entered into paradise or punished and sent to hell.</p> <p><u>Belief in qadar (predestination, divine destiny)</u> God is the creator of universe and has knowledge of everything before they happen. Nothing happens without His will and power.</p>	<p><u>Perfection of faith</u></p> <p><u>Constant awareness of God</u> Ihsan which equates to spirituality means excellence or perfection and this is achieved through building a special relationship with God, with themselves and God's creation. A person is constantly aware of God's presence and remains throughout his or her life on the path of attaining excellence in spirituality.</p>

God says in Qur'an:

"I have only created the Jinn and man to worship Me" (Qur'an 51:56).

This sets out that the purpose of Muslim life is to worship God. It is therefore a responsibility for a Muslim to understand the religious practices (Islam), the true realities of faith (Iman), and to strive to become closer and aware of God (Ihsan).

The theme of the uniqueness of God is repeatedly described in the Qur'an. The Qur'an which literally means '*recitation*' is the sacred book revealed by God to Prophet Muhammadﷺ over a period of 23 years. Prophet Muhammad ﷺ was born in the year 571 CE in the city of Makkah. He was known by local people as the '*Al-Amin*', the trustworthy, respected for his honesty and kindness. At the age of 40, he received his first revelation of the Qur'an through Angel Jibreel. The reports relating to the words, actions and approval of Prophet Muhammadﷺ are referred to as 'hadith'.

The Qur'an and the example of Prophet Muhammadﷺ (referred to as 'sunnah') are generally the two main sources of religious guidance for the Muslim community.

2.2 Who are the Muslim community?

These core tenets discussed in the first section of this chapter are a useful starting point to understanding the foundations of Islam as a way of life. Muslims, be it from Sunni or Shi'a background, culture, school of thought will concur on the fundamental principles, scriptural sources and Oneness of God and *"Yet this unity of principles also produce a multitude of interpretations and affiliations"* (Ramadan, 2017, p123). To begin to understand the Muslim community, there needs to be an appreciation of the spectrum of expressions of faith that exist within the Muslim community and factors that contribute towards the diverse beliefs held by the Muslim community. This will now be discussed in this section.

There are varying perspectives derived from the readings of scriptures and the text. It is simply not sufficient to understand any religion as an abstract set of principles but to observe how religion is practiced and to contextualise this with respect to local culture and customs. The beliefs held by individual Muslims does not necessarily reflect what Islam signifies to majority of Muslims (Bijlefeld, 1984):

"...there are persons and events that obscure rather than reflect what many of those who live in it see as the true character of their faith" (p220 *ibid*).

The majority of Muslims worldwide identify themselves as Sunni Muslims (around 90%) (Pew Research Center's Forum on Religion & Public Life, 2009). A commonly used term is 'Ahl al-Sunnah wa al-Jama'ah', which refers to the community of Muslims who follow mainstream Sunni Islam (Mohammed, 2017a). There are three main groupings within Sunni Islam who developed their own approach to the area of study relating to verifying what religious beliefs Muslims should

hold, reasons for this and refuting any misunderstanding surrounding these religious beliefs. These groups are the Ash'aris, Maturidis and Atharis. The area of practice and legal understanding can be understood under four schools of Sunni Law (Hanafi, Maliki, Shafi'i and Hanbali schools). There are others who only take their guidance from time of Prophet Muhammad ﷺ and his companions.

In Islamic history, sectarian divisions have emerged, stemming from disagreements in political succession, for example Shi'a Muslims. This related to the leadership that should have succeeded Prophet Muhammad ﷺ after his death. The Sunni and Shi'a split is considered the most significant ideological and historical division among the Muslim community (Sophie Gilliat-Ray, 2010).

There are also groupings with the Shi'a: the earliest division of the Shi'a community and closest to the Sunni Muslims are the Zaydis. There are two other main ones, Ismailis and the Ithna ashariyyah (also known as the Twelvers). The Twelvers are the largest group in the Shi'a world. Over a period of time, doctrinal differences also manifested between Sunni and Shi'a Muslims.

The practice of Islam might be changing between the generations of Muslims living in Britain and those living in the countries of their origins (Mandaville & Hussain, 2015). For example, those older generation Muslims who grew up living in Muslim majority countries might readily accept aspects of daily practice as part of their faith. Islam in these countries is seen very much as part of the social fabric. However, the younger Muslim generation who do not share the same experiences as their parents, may regard some of these practices as cultural and specific to their origin of their parents' country.

Furthermore, there are wider influences that need to be considered for Muslims living in Britain, where Muslims are a minority, are the impact of social and political marginalisation experienced by Muslim groups, which affects the extent they feel at home (Karlsen & Nazroo, 2015).

Another set of layers describing the Muslim community and equally applying to other communities, are the cultural aspects and ethnicity. Culture shapes human behaviours and beliefs. There are many different perspectives to understanding culture and its relationship to mental health. Culture has been defined by Helman (2007) as *“a set of guidelines (both explicit and implicit) that individuals inherit as members of a particular society, and that tell them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation- by the use of symbols, language, art and ritual”* (p2). ‘Culture’ is a dynamic concept which should not be used to stereotype individuals or groups and must be placed in context of place, time and local circumstances (Helman, 2007).

Helman (2007) further argues through the process of acculturation and its context, individuals might view themselves as possessing multiple cultural identities. Redfield et al. (1936) were the first to define acculturation as *“the phenomena which results when groups of individuals having different cultures come into continuous first hand contact with subsequent changes in the original cultural patterns of either or both groups”* (Ibid, p149). The work by Bhui et al (2007) reported cultural identity, displayed by clothing preferences, affects mental health. Bangladeshi pupils (aged between 11-14 years) preferring traditional clothing were less likely to develop mental health

difficulties later on when compared to Bangladeshi pupils who showed an equal preference for their own clothing and other cultures.

Culture is closely related to ethnicity in a number of ways and not simply understood as the relationship can be affected by historical and social factors. Ethnicity “*acknowledges the place of history, language and culture in the construction of subjectivity and identity, as well as the fact that all discourse is placed positioned, situated, and all knowledge is contextual*” (Hall, 1992, p257).

However, the ties that bring people from a specific ethnic group together may not be clear and not necessarily understood solely on social similarity (culture) or physical appearance (race) (Fernando, 2002) but both crucially may be involved. A feature of ethnicity is people having a sense of belonging. The feeling can also be fuelled from how society perceives people. The sense of belonging may change and arise from number of reasons, for example the feeling of belonging could be based on race in a society where people have experienced racism rather than the experience of group members as culturally related.

The Qur’an and Sunnah are the two primary sources of law for acquiring Islamic rulings. There are other sources of Islamic law, including secondary supporting ones such as ‘Urf, which corresponds to the local customs and practices of a given society (Mohammed, 2016e). ‘Urf (custom) is primarily applied in the areas of commercial and family law. It is important to consider:

“Customs can change from what is considered good to the reverse...varies in different regions”
(Al-Shatibi, quoted in Mohammed, 2016e, p141).

Sophie Gilliat-Ray (2010) highlights the challenge of using the words ‘the Muslim community’ as there underlies the assumption of ‘homogeneity’ with this group of people in her book “Muslims in Britain”. The author is a Professor in Religious and Theological Studies, and Director for the Centre for the Study of Islam in the UK at Cardiff University. The methodological approach reported was the study of anthropological and sociological publications which examined research with Muslims in specific locations in Britain. She argued is still meaningful to consider Muslims living in Britain as a:

“distinctive social group, on the basis of a generally shared set of core religious beliefs. These translate into religious practices that are often undertaken as part of ‘belonging’ (however loosely) to a distinctive faith ‘community’ ” (introduction section pxii *ibid*).

Muslims might choose to express or practice their faith in different ways. This is influenced by the choices made by the individual. It is therefore important to consider how this is shaped by circumstances and context. Themes such as belonging and identity also have to be considered when attempting to contextualise Islam in the West (Mandaville & Hussain, 2015). Defining the nature of the Muslim community and belonging is challenging and raises many questions:

“Defining this identity exactly is difficult because numerous other factors interfere in the analysis. Is there indeed a Muslim identity and, if so, is it of a religious or a cultural nature? Is the Muslim to be defined in the context of the notion of umma [Muslim community] or could he/she simply be a Muslim citizen of any European nation? To which group or body does he/she belong first, to the umma or the country he/she lives in a resident or citizen...the definition of Muslim identity can only be seen as open, dynamic, based on principles indeed, but in constant interaction with the environment” (Ramadan, 2002, p153/195).

The ideas and views Muslims living in Britain hold could be seen as being influenced by the religious movements from Muslim majority countries, leading to varying interpretations of religious scriptures. These groups differ in their affiliation to religious schools, which continue to shape the experiences of Muslims in Britain (Sophie Gilliat-Ray, 2010). There are people in any society or faith group who would differ in their understanding based on their interpretation of the texts they follow. Muslim community is not an exception. Ramadan (1999) explains groups in Muslim community who have certain tendencies towards a particular reading of Islamic texts and take a socio-political and doctrinal attitude based on those reading. Tariq Ramadan, a Professor of contemporary Islamic Studies at the Faculty of Theology, University of Oxford describes five main trends: Literalist, who read the religious sources literally without historical context; traditionalist, who follow one school of law; reformists, who believe Muslims must use science and independent reason in shaping their understanding; rationalists, who possess a secular approach and state reason is of primary importance over religious texts; and mystics, who consider not just the reading of the mind but the heart and hidden meanings.

It is common for cultural heritage to play in how people understand the religious texts.

Ramadan (2017) argues previous generation scholars were influenced by the environment and culture they lived in, through the prism of their place and time.

Concluding this introductory section relating to Islam, it is important to acknowledge that the Muslim community are a heterogeneous group of individuals. There are intersections overlapping with culture which might be difficult to disentangle. A number of factors need to be considered and placed in context to begin to understand who the Muslim community and acknowledging the nuances that are present. The relevant areas discussed here relate to an individual's cultural beliefs

and practices, country of origin, religious schools, socio-political connection, interpretations of religious teaching, identity and sense of belonging.

2.3 Definitions

A number of terms/concepts have been used in this thesis. It is particularly important to explore some of these terms as some of them do not have an English equivalent. It may also be that meanings are lost in translation or the concept may have several meanings and difficult to translate into English, depending on the context in which they are used. Some of the terms have been explained briefly throughout the thesis with the key ones explained more in detail below. This will enable the reader to use this section as a reference point when reading through the thesis.

Afiyah: is usually translated as well-being.

Allah³: *is the Arabic word for God. The belief in Allah forms part of the declaration of faith which is recited by all people of the Islamic faith. The words Subhanahu Wa Ta'ala (swt) are uttered after the name of Allah, which means 'Glorious and Exalted is He'. The uniqueness and oneness of God (referred to as Tawhid) is the core aspect of Islamic faith (Sarwar, 2008) and can be summarised in this salient verse of the Quran:*

“Say, He is Allah, the One. Allah is Eternal and Absolute. None is born of Him, nor is He born. And there is none like Him” (Holy Quran, 112: 1-4).

³ The word ‘Allah’ will be used interchangeably with the word ‘God’ in this study.

Companions: *The term is referred to those who actually saw the prophet Muhammad (pbuh) and believed in him as a last prophet of Islam.*

Deen: *(sometimes spelt Din): Arabic word meaning 'religion' or 'way of life' (Sarwar, 2008).*

Du'a: *"A supplication to Allah, or asking Allah for favour, blessing and mercy" (Sarwar, 2008, p222). It comes from a verb root signifying "to call out, to summon" (Ibn Manzur, cited in Qadhi, 2003, p21). Qadhi (2003) summaries the usage of Du'a in the Quran such as act of worship, seeking of aid, a request, a call, praising God, speech and a question to God. Du'a is considered one of the best ways to become closer to God and shows the individuals need of God's help.*

Hadith (plural Ahadith): generally, means a statement, advice or message. It refers to the *"words, actions or tacit approval, as well as matters relating to the blessed physical or moral characteristics of the Prophet of God (pbuh)"* (Mohammed, 2016a, p78). Collections of ahadith for example include Sahih Bukhari, Sahih Muslim, Sunan al-Tirmidhi.

Imam: *someone who leads prayers in congregation. In the mosque, the role of the imam is usually an appointed role.*

Kismet: *is the Urdu word for Qadar (see Qada/Qadar explanation).*

Muhammad ﷺ: is the final prophet of Islam, born in 571 AD in Makkah, Arabia.

Sometimes 'rasulullah' is used which means 'messenger of God'.

Pbuh: The Pbuh is an acronym of 'peace be upon him' and is uttered and written after the name of a Prophet of God. The Arabic for this is ﷺ and transliteration is 'Sallallahu alaihi wasalam'.

Qada/Qadar: relates to predestination and is an essential part of Islamic doctrine. Qadar means “*the actual manifestation of entities, in keeping with God's pre-eternal knowledge*” (Mohammed, 2017c, p118). Qadar also means destiny or power. Qada differs from Qadar which means a judgment or decision: “*qada is the all-encompassing and general decree from eternity, whereas qadar refers to the detailed manifestation of the decree*” (Fath al-Bari, quoted in Mohammed, 2017c, p118).

Qur'an: is the holy book of Muslims which was revealed to Prophet Muhammad ﷺ through Angel Jibreel (Gabriel) as guidance for humanity. It is the final book sent by God and is the main source of religious guidance for Muslims along with the Sunnah of the Prophet Muhammad ﷺ. It comes from the Arabic root which means 'a recitation' and is considered the direct speech of God (Mohammed, 2016b). The reading of the Quran is an act of worship.

Ramadhan: the ninth month of the Islamic lunar calendar. It is the month of fasting (obligatory) for Muslims. The calendar has twelve months.

Salah: The five obligatory prayers performed every day. *It is a “type of worship which consists of recitation, bowing and prostration”* (Mohammed, 2016c, p105).

Subhanahu Wa Ta'ala: are uttered or written after the name of Allah, which means 'Glorious and Exalted is He'. Sometimes written as 'swt' as an acronym.

Sunnah: literally means a pathway. It is the example of Prophet Muhammadﷺ, practically used and applied. It is a source of guidance for Muslims to lead their lives. One usage of the word sunnah is that it is near to being synonymous with 'hadith' however indicates a *“stronger sense of actual practice and authoritative action than the word hadith”* (Mohammed, 2016a, p78). Therefore the application of information (hadith) is the sunnah.

Surah: corresponds to a chapter of the book of guidance, the Qur'an.

The information highlighted in this chapter helps provide a foundation for understanding of the Islamic faith and heterogeneous nature of people who follow it. This will enable a greater understanding of who are the Muslim community and their core beliefs when considering the literature presented in the next chapter.

3 Chapter 3 – Background Section

3.1 Introduction

The previous chapter provided an overview of central facets of the Islamic faith, general concepts relating to health from an Islamic perspective and discussion on the heterogeneous nature of the Muslim community. This chapter now focuses towards the subject area of mental health and considers three aspects: association between religion and mental health, understanding the interface between Islam and mental health and rationale for this study. This will position the study in a broader context.

This chapter begins with an overview of writings relating to religion, not related to the Islamic faith as a useful starting point to introducing the literature in this field of study. This will help orientate the reader to the main concepts covering religion and mental health. The discussion will explore not just the positive relationship between religion and mental health but also some of the challenges and contrasting views between them.

The next three sections will be more specific and provide useful threads of discussion in the literature pertaining to the understanding of Islam, Muslims and mental health. This will bring out what is known in this area and highlight aspects where there is little exchange of ideas. The studies described in these sections will be summarised in table format in chapter 13.

The second section explores how Islamic beliefs and practices may influence the perceptions and attitudes of Muslims toward mental health and illness. This is important as religious beliefs a Muslim holds may impact on their perceptions towards mental health. This overlaps with the third section,

highlighting what religious coping strategies a Muslim may use when dealing with mental health difficulties. The fourth section examines the role of Muslim religious figures in supporting the mental health needs of Muslims, and to study their perceptions towards mental health and care.

The fifth section explores the experience Muslims may have with mental health care services. This helps to identify barriers and facilitators of pathways to care.

The last section of the chapter provides a rationale for this study and details specific objectives to be examined.

3.2 Religion and Health

3.2.1 Relationship between religion and health

The literature covering religion and mental health can be categorised broadly into the following areas:

- 1) Religious community support.
- 2) Individual coping strategies.
- 3) Positive emotions & psychological well-being.
- 4) Perceptions and attitudes towards mental illness.

Most studies highlight the positive effects that church, mosque or membership of other religious groups have on the psychological wellbeing of the participants. A recent review into the relationship between depression and support from religious groups was carried out by Dein (2006). His review, which covered primarily the Christian and Jewish faith (due to paucity of studies in other religions), found that people who were members of local religious groups tend to have a lower incidence of depression. He also found several studies which seemed to suggest that religious belief can help

speed recovery from illness. Dein reported that the mechanism of action was that being part of a religious organised movement provided social support which helps foster feelings of wellbeing.

Other large surveys and studies (Ellison et al., 2001; Swinton, 2001) have found that a belief in the afterlife and religious participation are associated with increased psychological well-being. Again, the mechanism may be that belonging to a religious community strengthens relationships and social networks, and protects individuals from social isolation.

Literature on how religious belief and practice affect the mental health of the individual also tends towards a positive view. For people suffering from mental illness (Tepper et al., 2001) and caring for those with mental illness (Rammohan et al., 2002), religious belief and practice, have been found to be a source of peace and strength. Notably, Tepper found a 'dose-response relationship' between religious practice and a decrease in distressing symptoms amongst those with severe and enduring mental illness.

Even for those without a diagnosis of mental illness, there can be found in the literature (Koenig, 2005) a positive correlation between psychological health and religious belief. Religious practice seems to encourage emotions such as 'gratefulness', 'forgiveness', 'hope' and the 'sense that life is meaningful'. Gratitude, in particular, appears to be a signifier of increased contentment and reduced levels of anxiety and depression (McCullough et al., 2002). Participants in McCullough's study who were inclined to be more 'grateful' also reported increased religious activity such as church attendance, increased praying and reading religious literature and a closer relationship with God. Ingersoll-Dayton et al. (2009) explored the link between forgiveness and psychological well-being in a study of 20 elderly participants who had been involved in conflict with others. The participants

attended weekly sessions over two months relating to aspects of forgiveness. Participants had the opportunity to re-examine past events and feelings and control the resentment they had been harbouring. These authors found that participants self-reported a lower level of depressive symptoms. Murphy et al. (2000) found greater hope was identified with a stronger religious belief in a study of 271 participants with depression. In a larger study of 1,126 participants of Christian faith, Krause (2002) reported participants who attended church and were involved in the congregation had a closer relationship with God and were more optimistic about life. Similarly, Krause (2003) in a further study found people with a greater sense of religious meaning and purpose of life reported a higher level of self-esteem, life satisfaction and optimism.

3.2.2 Contrasting views of the benefits of religion on health

There are however, contrasting views of the benefits of religion on health. Koenig (2001) conducted a review of the literature where 724 studies were identified in the area of mental health and religion and found 6% of studies reported negative mental health outcomes.

Sloan et al. (1999) argued there was a lack of consistent results. For example, church attendance or involvement was not associated with lower mortality (Idler & Kasl, 1997). However, there was no uniform definition of religion or spirituality, which makes it difficult to compare study designs. Although studies have reported an association between religion and health, Levin (1994) argued it was not clear that the relationship between religion and health was causal i.e. 'do religious practices lead to favourable health outcomes?'

Koenig (2005) suggested a number of examples where religion may not be helpful. People may feel frustrated their prayers are not being answered and hold the view that they are being punished by God, leading to feeling of anger, loss of meaning in life and isolation. Koenig et al. (1998) have argued this may lead to worsening mental health. People may find it difficult to deal with certain opinions held by their faith, leading to internal struggles for the person. Also, some people with mental illness may feel more vulnerable if they strive to perform excessive religious activities which may exclude them from certain social groups. There may be excessive guilt and stigmatisation present leading to a worsening mental state. Koenig et al. (2001) concluded that there may be delay or failure to seek medical help in some people due to over-reliance in religious activities.

Perceptions and attitudes towards mental illness which may not necessarily be viewed as positive have been studied in religious communities. In one focus group study of traditional healers in a parish church in Nigeria, Agara et al. (2008) examined healers about their knowledge of mental illness. Over 90% said mental illness was caused by witchcraft and punishment as a result of past sins. Stanford & McAlister (2008), in a study of 85 participants with mental illness, explored experiences with their local church. Over 40% of the participants reported the church dismissed their diagnosis. The church member and senior pastor held the most negative views. The participants also reported other negative attitudes present within the church members such as mental illness being regarded as personal sin, related to demonic possession and the view medication was not helpful and should be stopped.

In summary, studies examining the relationship between religion and mental health primarily show benefits. There are also studies, which describe challenges and negative experiences for participant's mental health and well-being. Most studies are quantitative in nature, conducted in the US and

include participants primarily from Christianity and Judaism with fewer studies looking at the Muslim community (Cornah 2006).

3.3 Religious beliefs

Beliefs about mental illness have been studied in the general population in Britain (Kuyken et al., 1992), but there is a paucity of knowledge about the impact of religious beliefs on causation and treatment of mental illness (Cinnirella & Loewenthal, 1999). It is important to examine religious beliefs and views of mental illness as this may influence the perception and attitude of patients towards mental health and its treatment. These views may play a role in patient decision making pertaining to treatment (Hill & Bale, 1980).

3.3.1 The influence of external causes (Jinn, sihr, nazr)

A number of studies describe perceptions prevalent in the Muslim community towards mental illness. From an Islamic perspective, God created angels, humans and Jinn. Muslims believe that Jinn are created from fire and live in their own space, not visible to people. There is also mention of external causes affecting Muslims including nazr (evil eye) and sihr (black magic). These beliefs are relevant in this study (this is discussed in detail later in chapter 7), in terms of these causes being part of Muslim belief, the extent they may influence an individual and symptoms a person might complain of.

Most of the studies conducted in the UK recruited participants from a South Asian background rather than reflecting a broader diversity. The methods section of this study (Chapter 5) will describe the diversity of Muslims who were interviewed for this study.

Fewer studies involving other ethnic groups have been undertaken, such as Turkish Muslims living in London (Leavey et al., 2007). This study included 9 participants who presented with psychosis. Participants believed their illness was related to the evil eye and magic.

Dein and his colleagues (2008) examined 40 Muslims from the Bangladeshi community living in East London. The majority of participants suffered from depression or schizophrenia. They found participants reported the influence of Jinn affected their misfortune, mood changes, chaotic behaviour, unfaithfulness in marriage and unexplained physical complaints. The setting of this study was in a deprived community that had experienced racism, high levels of unemployment, social problems, housing issues and poor health care provision. These are the risk factors which can marginalise any community in society and might have influenced the perceptions of the participants. The authors drew out remarks highlighting contrasting views relating to the extent Jinn that affected people, impacted by the influence and interplay of culture with religion:

“people often confused the two [religion and culture] and believed, wrongly, that many behaviours were Qur’anic in origin when this was not the case...too many members of the community held jinn to cause problems, whereas this is rarely the case” (p38).

There was little information on how the data analysis was carried out.

Where there was no obvious cause for symptoms of depression, spiritual reasons might also be considered (Hussain & Cochrane, 2002). This might not necessarily be recognised by doctors:

“Jinns can cause you to be sad or very withdrawn or make you physically ill...the doctors won't be able to find a cure” (p298). All the 6 women in this study suffered from depression.

Most of the studies in the literature describing the religious perceptions of mental illness were quantitative in nature (Khalifa et al., 2011; Al-Adawi et al., 2002; Bagasra & Mackinem, 2014; Mullick et al., 2012; Razali et al., 1996). The majority of these studies recruited participants from the general public with little information about their mental health history and whether they had contact with mental health services. This study will recruit individuals with current or history of mental illness. This is described on page 96.

3.3.2 Life as a test

The view that mental illness is related to a test ordained by God is a commonly held belief described in the literature. Participants from these studies did not suffer from mental illness. Furthermore, there is limited description of this concept; this is expanded upon later in this study (page p145).

In a study of first-generation older Muslim Pakistanis in England examining distress (Hussain, 2006), mental health difficulties were described as part of participants '*test*' by God in this world where success in the after-life was attained through being patient (*sabr*) to gain God's favour during difficult times. The main limitation in this study of 33 participants, is that it was not clear how many suffered from a mental disorder or had actually accessed mental health services. This paucity of data from participants who have accessed mental health services or suffered from mental illness is evident in other studies examining this similar theme (life as a test) (Weatherhead & Daiches, 2010) where only three participants reported contact with mental health services. This study recruited students from Lancaster University in the UK, described:

“Life is basically a test I am going through and I would like to pass this test, and in the process of passing this test is a lot of satisfaction” (p79). Life's test was seen as an aspect of life to be acceptable with, and viewed positively, as it was an opportunity to prepare for the after-life.

This finding is not consistent with one study, where Indian Muslims working as volunteer counsellors in a community organisation in Johannesburg reported mixed views from their clients (Laher & Khan, 2011). One counsellor described how some of her clients found it difficult to accept life as a test in a positive manner and sometimes reported anger about it:

“I know I’m being tested and this is very difficult, and I don’t why...they may be angry about it” (p73-74). No views were elicited directly from clients, this is in contrast to this study where individuals were recruited with mental illness.

In contrast to the literature relating to perceptions of mental illness, most of the studies were qualitative in nature; the similarity between the two concepts being with limited discussion of this concept and interpretation of results. Abu-Ras (2008), in his study of congregant members visiting mosques in New York reported 98% of the respondents describing mental illness as a *“test of one's faith”* (p166). Another drawback to the study was that the question posed in the questionnaire could be seen as leading (*“Do you believe that life stressors are a test of one’s faith?”*).

3.3.3 Predestination

The different elements to predestination are discussed later in the results chapter (page 153). The concept of health and illness was referred to as a predetermined fate as *“written from birth”* which *“You cannot run away”* (p778) in a qualitative study of elderly Muslims in United Arab Emirates (Ypinazar & Margolis, 2006). The participants in this particular study had not suffered a mental

illness or were neither diagnosed as suffering from a mental disorder. Comparatively, Hussain (2006) found contrasting views in his qualitative study of Muslims in England. According to Hussain, seeking medical intervention or treatment was perceived as an action which may result in the deterioration of a patient's symptoms as it was an attempt to change one's destiny, ultimately leading to punishment from God:

“they feared that God might punish them for taking action rather than accepting their kismet”
(p153).

3.3.4 Lack of faith

Muslims may also believe depression or schizophrenia to be related to lack of faith as highlighted by Cinnirella & Loewenthal (1999): *“lack of faith and failure to pray regularly”* (p515). It was not clear how many of the Muslim participants suffered from mental illness in this UK study.

Similarly abandoning the faith leading to punishment was a view held by some households in Kenya to be the cause of schizophrenia (Muga & Jenkins, 2008). Once again it was unclear how many suffered from mental illness.

3.3.5 Punishment from God

Examining distress in Pakistani Elderly Muslims in the UK, Hussain (2006) found punishment for disobedience and sinful actions was a perception held by Muslims as a cause of their mental distress: *“distress was caused by God, either as a curse to punish them for sins”* (p153).

Participants in this study expressed distress in their lives and were not necessarily suffering from mental illness. Other authors also describe this concept (Weatherhead & Daiches, 2010; Haj-Yahia, 1999). The majority of the participants in these studies did not suffer from mental illness.

3.3.6 Health and illness comes from God

Muslims believe health and illness comes from God and nothing occurs without His Permission, His Will. This view was expressed by Turkish Muslims living in London who suffered from first episode psychosis (Leavey et al., 2007). It was also the most commonly area discussed in another UK study, (Weatherhead & Daiches, 2010): *“No matter what calamity falls on me, the first thing I say to myself, because I believe in divine will”* (p81).

This concept was also the most frequently held perception towards mental illness among people attending a general outpatient setting (Zafar et al, 2008). It was further described in an UAE study, whereby the ultimate cure and outcome lies with God and Him only: *“sickness is from Allah and health is from Allah”* (Ypinazar & Margolis, 2006, p780).

3.3.7 Concept of Satan

Whittaker et al (2005) reported beliefs relating to Satan were evident in the Somalia Muslim community in a study conducted in England. It was not clear how many people suffered from mental illness. In an US study of congregant members attending Mosques, Abu-Ras (2008) found 84% of worshippers believed mental illness was related to devil possession. Similar numbers were highlighted in a sample of Arab participants of Christian and Muslim faith living in Australia (Youssef & Deane, 2006).

3.4 Use of religious strategies

A greater understanding of religious coping can help promote practices which may be able to support people with common mental health difficulties (Bhui et al., 2007). Encouraging coping strategies may also help towards recovery. Previous studies have shown ethnic minority communities display a greater tendency towards religious strategies during periods of mental distress (Loewenthal et al., 2001). This section looked at how Muslims used their faith to cope or did not cope with their mental illness. Most of the literature describes area of religious practices rather than wider religious strategies utilised by Muslims with focus on Muslims of South Asian heritage.

3.4.1 Faith as strength

The different strands relevant to belonging to the Muslim faith emerged from this study and are discussed on page p241. Turning to faith, for Muslims was seen as a mechanism of coping (Penny et al., 2009). This gave a meaning to their difficulties and hope for the future. A sense of empowerment through their faith was also experienced as summarised by the authors:

“Meaning was given to difficulties through the language of belief. Some participants found belief empowering, because it gave them a way of understanding the problem and the possibility of influencing it” (p978).

3.4.2 Religious practices

Religious practices such as prayer and Qur'an recital have been described in the literature. However, the authors provide little explanation about these practices. These are expanded upon on page p284. The Quran was seen as a central point of guidance, enabling individuals to understand and deal with

their difficulties (Whittaker et al., 2005; Johnsdotter et al., 2011). These two studies only included Muslims of Somali origin with the first study only examining views from 5 participants.

Bhui et al. (2007) in his examination of religious coping among six ethnic groups found Muslims and Black Caribbean Christians used religious coping more often than other groups. Most of the participants in this study were of South-Asian background. Respondents were interviewed using Clinical Interview Schedule-Revised (Lewis et al., 1992). This is an instrument which helps assess common mental disorders. Less than half of the Muslim participants measured above the score which indicates a common mental disorder. Practices such as prayer, using beads, reciting verses from the Quran and listening to tapes helped Muslim participants. One participant identified prayer as helping give perspective to their difficulties:

“clear the mind...what little problem there was” (p146).

The authors conclude *“Reciting religious verses and also using prayer beads were other ways of inducing these states of no worry”* (p146).

Muslim participants reported less distress, being able to clear one's mind and help solve problems when using religious practices.

Prayer and faith were found to be helpful in coping with depression for the Muslim group compared with Christians, Hindu, Jewish and no religion (Loewenthal et al., 2001). The authors reported Muslim participants were more likely to incorporate religious prayers as part of their daily activities as a coping mechanism. Similar results were found in Muslims coping with depression (Hussain and Cochrane, 2003) and community leaders (Al-Rawi et al., 2012). All the participants in the Loewenthal and Hussain and Cochrane papers were of South Asian background.

3.4.3 Role of God

One of the themes described in a small numbers of papers is the role of God (Hussain and Cochrane, 2003; Penny et al, 2009). There was little in depth discussion relating to the relationship of God with the individual. A number of dimensions to the relationship with God and the person are considered later on page 302. Trust and confidence in God's help was seen as comforting (Cinnirella & Loewenthal, 1999) as described by one of the participants who suffered from mental illness:

“when we have a problem we concentrate on it and talk to Allah (swt) about it and ask for help from Him. When someone has faith in Allah and talks to Him about a problem it lifts all sorrow and gloomy moods because the person is sure that Allah knows they have asked for help, and He will help them. It brings positiveness in life. If someone doesn't have all this they will be depressed for sure” (p515).

3.4.4 Mosque involvement

There was a positive link between congregational involvement and mosque attendance with giving and receiving emotional support (Nguyen et al., 2013). Muslims who visited the mosque were more involved with the congregation members who received and gave higher levels of emotional support. Women received and gave more support than men. There was no discussion on whether Muslims faced any difficulties in the mosque.

3.4.5 Family and community support

Community support was seen to be integral in Muslim life where people talked to others including friends and family about their problems (Johnsdotter et al., 2011):

“Psychological problems in general are handled among friends and family. It’s a matter of mutual social support that people talk about their problems with each other”. One participant said *“We are all psychologists to each other”* (p745).

Similar results were reported by Whittaker et al. (2005).

3.4.6 Use of religious figures

The literature shows Muslims access religious figures for their mental health difficulties. In the UK, Cinnirella & Loewenthal (1999) compared different ethnic groups (Pakistani Muslim, White Christian, Afro-Caribbean Christian, Orthodox Jewish and Indian Hindu) and found Muslim participants believed it would be more helpful to visit a religious figure than other groups. It is unclear how many suffered from mental illness. Similar findings have been found in other UK studies (Dein & Sembhi, 2001). Both studies recruited participants from a specific ethnic group (South Asian). Studies highlighted benefits of accessing religious figures with less discussion on challenges in utilising them.

A number of studies described how people accessed faith healers prior to seeking professional help. In a study of 134 Muslim psychiatric patients in Malaysia (Razali & Najib, 2000), most people saw a faith healer prior to seeing a psychiatrist. Most of the patients primarily suffered from a psychotic illness, bipolar illness or severe depression. Similarly, Al-Solaim & Loewenthal (2011) found in a study of fifteen women with a diagnosis of obsessive compulsive disorder in Saudi Arabia, all the women had consulted a faith healer prior to professional help. The healers were involved in reading specific verses from the Quran, giving the women Zamzam (holy water to drink) and giving oil to be poured over the body. Also, religious leaders were also seen as the first point of contact for advice

and counselling in the Arab community in Australia (Youssef & Deane, 2006) and people attending a psychiatric clinic in the United Arab Emirates (Salem et al, 2009).

Muslims living in Pakistan found it difficult to discuss their psychological issues outside the family with shame and guilt being a hindrance to accessing help from professionals, and in these circumstances they accessed religious healers (Farooqi, 2006). Scholars helped alleviate mental distress (Molsa et al., 2010). Furthermore, religious figures have been used for ruqya shariya, a type of treatment using incantations with roots in the Quran (Eneborg, 2013) and religious support such as help with their prayers (Javaheri, 2006; Qidwai & Azam, 2002; Vanaleesin et al., 2010).

Saeed et al (2000) found Muslim faith healers were used primarily by people who complained of *Saya* (meaning an evil spirit casting a shadow onto the individual), Jinn infliction and *Churail* possession (a demon who presents as a young woman with the aim of seducing men and thereafter possessing them). The role of the religious leader was integral in supporting members of the Arab community in Australia (Youssef & Deane, 2006). They were seen as someone who could help with solving difficult problems and symptoms and distress as a consequence of mental illness in a confidential manner.

3.4.7 Other traditional practices

Use of other traditional practices by Muslims was evident. Johnsdotter et al. (2011) in a study of Somalia Muslims in Sweden, found the consumption of blessed water (called *tahliil* or *ashar* water) where the Quran was read over the water and there was ritualistic blowing over water. Another method individuals used was writing Quranic verses with black ink on a piece of wood and rinsing this in water. Most of the 23 participants in this study would attempt other forms of traditional

practices and only consider attending psychiatric clinic as a last option. Use of amulets was also used for protection against witchcraft, evil eye or spirits (Molsa et al., 2010).

The use of specific herbs such as black seed was reported by Al-Rawi et al. (2012). Applied therapy was mentioned which included wet cupping (or Hijama). (Cupping is a traditional form of medicine found in cultures such as Chinese and Muslim. Suction is applied to the skin to increase blood flow and promote healing). Dietary advice was also considered important and use of olive oil and honey. There was mention of healing practices not always originating from Islamic tradition but with roots in cultural heritage. Examples given were use of herbs such as sunflower found among the Lebanese and sage tea used in Syria.

3.5 Religious figures: their role and perceptions

This section examines the role religious figures play in meeting the mental health needs of Muslims, their experience dealing with members of the Muslim community and perceptions towards mental illness. Religious figures can be understood as individuals who are accessed by the Muslim community for religious support, such as Imams (individual who leads prayers in the mosque), faith healers (an individual who heals sick people through religious methods such as prayer and belief) and traditional scholars (someone who has a formal qualification). Most of the studies included Imams or faith healers and did not recruit traditional scholars. The participants were primarily male. There were no studies examining views of scholars towards pain and suffering.

The various roles of Imams in healthcare was described by Padela et al. (2011): Imams promoted healthy patterns of behaviour through their sermons; undertaking religious activities such as burials,

visiting the sick and playing a role as a counsellor or providing alternative therapies; engaging in hospitals and delivering cultural training programmes and advising in decisions pertinent to someone's health. The drawback to the study was the authors gained the views of community leaders rather than Imams directly.

Reasons for consultation with an Imam can be religious or spiritual guidance, marital difficulties, parenting and death and dying however the role can go further in seeing people with depression, anxiety, “odd” thoughts and suicidal thoughts (Ali et al., 2005). The mosque was viewed as a place of psychological support. This study had a very low response rate (8%). Other reasons for consultation might be marital problems and beliefs such as misfortune (Leavey, 2008). Leavey also reported Imams involvement in youth issues, drug taking and family problems. The main limitation in the Leavey study was the small number of participants (7) and all participants were men.

Abu-Ras et al. (2008) examined the experience of 22 Imams in mental health promotion in the United States and found 95% of the Imams reported difficulty in distinguishing between symptoms and signs of mental illnesses. They also did not refer congregant members to mental health services. This was related to the finding that 91% of the Imams were not aware of local mental health services. The survey return rate was 15%.

Imams are less likely to have formal training in counselling or mental health (Ali et al, 2005; Ali & Milstein, 2012).

The perceptions of religious figures towards mental illness was also explored. Two studies were found. In understanding the causation of psychosis with use of vignettes, healers cited psychosocial reasons such as major life events or traumatic childhood (Rashid et al., 2012). They also mentioned possession by Jinn as a cause. The Jinn was perceived to affect individuals when there were low

levels of religiosity. Faith healers reported during their contact with the community, Muslims would use supernatural causes as a scapegoat to blame an external cause rather than look internally. There was also concern that fake healers who claimed to hold special healing powers were involved in making false claims to the community. In the same study when exploring the cause of substance misuse, the healers cited social issues commonly such as adverse upbringing, broken families and peer pressure. In contrast to the psycho-social factors that may play a part in psychosis, religious reasons were rarely mentioned. All participants except one came from South Asian background. There were 8 participants of whom one was female.

Maulana's (a title used for a religious scholar primarily from South Asian background) believed Jinn, black magic and evil eye as well as biological and social reasons could cause mental illness (Ally & Laher, 2008). Jinn were reported to lead to fear and hallucinations and the evil eye was thought to cause tiredness, sleep and appetite disturbance. The number of participants was small (6), of whom only 4 possessed a recognised formal qualification through an Islamic institution. All were Indian in background.

3.6 Contact with services

This section looks at the level of knowledge, accessibility and experience of Muslims towards mental health care and services. This is useful as can help identify factors which might act as barriers and facilitators of pathways to care. Cultural issues have been discussed in detail in the literature. Most of the UK studies recruited Muslims of South Asian background and in a number of studies discussed here, there is little information provided about a participant's mental health.

3.6.1 Lack of awareness of services

Lack of awareness of mental health services was apparent in studies of Muslims in the UK. Factors which further compounded this were limited command of the English language and restricted social network:

“I don’t speak the language, so I didn’t know where to go for help” (Hussain and Cochrane, 2003, p38).

“If I had any other friends from any other countries, I would ask them where they would go”
(Whittaker et al, 2005, p184).

Issues relating to lack of awareness of services was also reported in international studies, in Malaysia (Abdul Kadir & Bifulco, 2010) and in Australia (Youssef & Deane, 2006). This appeared to be related to lack of advertising and community participation:

“I don't think there is a good advertisement for that, especially in the Arabic language. I think a lot of effort needs to be put in there” (Youssef & Deane, 2006, p55).

Two of the papers did not provide details about whether the participants suffered from mental illness or not (Whittaker et al., 2005; Youssef & Deane, 2006).

3.6.2 Reluctance to access services

There was evidence of reluctance to engage with services and concealment of symptoms. Patients suffering with psychosis discouraged their family members from initiating contact with mental health services as reported in a study of Turkish citizens residing in London (Leavey et al., 2007). Comparatively, studies conducted by Zafar et al (2008) and Qidawi & Azam (2002) found that lack of engagement with mainstream mental health services for Muslims residing outside the UK. People

said they would seek religious or social help or do nothing. Similar results were found in the US (Khan, 2006). Except for the Leavey study, the majority of the participants included in these other studies did not have a mental illness.

3.6.3 Attitudes to seeking help

Muslims were less likely to seek professional help compared to people who had no religious affiliation (Sheikh & Furnham, 2000). The authors studied participants of British Asian, Western European and Pakistani background in England and Pakistan. Hamid & Furnham (2012), in another UK study examined attitude towards help for mental illness involving Arab Muslims and British Caucasians. The Arab Muslims held stronger supernatural beliefs towards mental illness compared with British Caucasians, and the former were found to hold less positive attitudes towards seeking help compared with British Caucasians. A higher level of education and older age indicated a more positive attitude in seeking help. Al-Krenawi et al. (2004) conducted a study of 262 female Arab Muslims living in United Arab Emirates, Jordan and Israel found that younger Muslims and single Muslim women held less positive attitudes towards seeking help from mental health services compared with older participants and married women. There were no significant differences between nationalities.

3.6.4 Barrier to accessing help: Izzat, shame, denial and language

These factors can have impact on accessing mental health services. The studies discussed here included participants with little or no history of mental illness.

The loss of izzat could lead to higher levels of distress and reluctance to access professional help. This may make them more vulnerable to developing common mental health disorders. Understanding the relationship of cultural factors such as izzat with Islam might be poorly understood. Reference is made here and will be discussed later in the findings section.

Izzat refers to the concept of honour. The relationship between izzat and Islam may be difficult to understand as it appears to be dependent on positive or negative perceptions of the individual and his wider family. The interpretation of izzat may differ from family to family. It is important to consider how Muslims understand the concept of honour through both the Islamic perspective and its influence from a cultural perspective.

There is no agreed definition on the term izzat within literature review as it appears to be described as a complex concept. The concept of izzat is therefore discussed in more depth in the findings section. It is described in one study as honour, a reflection of the family status in the community (Hussain, 2006): *“If wealth is lost, then nothing is lost; if health is lost, then something is lost; if izzat is lost, then everything is lost”* (p155). Another description is personal respect/honour and prestige, status from a community perspective (Chew-Graham et al., 2002). In this study, it was suggested that izzat could be misused to coerce females to remain silent. The burden of upholding the family honour was placed primarily on the women of the house. This led to high expectation of the women being wives, mothers, daughters and daughter in laws, creating an environment where the women experienced being controlled: *“You see, it was my fault they said, I had let the family down. They couldn’t see it was the family, they blamed me for spoiling izzat”* (p341).

There was awareness among women these negative views were not accepted in the Qur'an and related to cultural issues. It was also perceived this was being misused by the community to reinforce stereotypical roles of woman. This view was also fuelled by the media as perceived by the women.

Shame relating to mental illness has been primarily described in the Pakistani community with some studies including the Arab and South African population (Youssef & Deane, 2006; Laher & Khan, 2011; Hussain, 2006; Gilbert et al., 2004). Most of these studies mention the shame in speaking about mental health difficulties outside the family home. Individuals reported they were more likely to say they were suffering from being '*nervous*' rather than accepting a more serious mental illness as this was seen as less shameful. Most of the participants reported shame and stigma as the main barrier to utilising formal mental health services, as one participant described:

“They underutilize these services because of the feeling of embarrassment and social stigma attached to anything to do with mental health, as it would imply that they are outside the bounds of normality” (Youssef & Deane, 2006, p53).

This shame reflected on the parents to the extent they would not come forward to seek help for their children, preferring for them to be kept at home (Laher & Khan, 2011):

“our community, you know, they have this, uh, embarrassment and they can't come forth with their children who are mentally or physically ill...In our community they will keep them with the maid at home!” (p75).

High reported levels of izzat and shame were linked with a reduced intention to accept psychological help in British Muslims of South Asian background (Pilkington et al, 2011). The authors also found

acculturation and education levels were related positively to intention to access mental health services. Shame was also found to be a barrier to accessing mental health services in Arab Muslims in the US (Aloud & Rathur, 2009).

Relating to shame, is denial of suffering from mental illness. Denial can occur among the individual, family or community level. Muslim participants reported others from the same community denied the existence of mental illness (Cinnirella & Loewenthal, 1999):

“the older members of the community and men do not believe that depression exists. They say a woman is just making it up, she is just a housewife and has nothing better to do” (p519).

This made it difficult for individuals to interact with others and reduce the likelihood to seek help.

Families also denied the existence of mental illness for a number of reasons such as being particularly concerned about the marriage proposals being rejected if there was mental illness in the family (Youssef & Deane, 2006):

“He [the groom] must not be ignorant...It is his right to withdraw from the marriage if this illness has hereditary causes” (p54).

Counsellors, in their experience of treating Muslim patients in South Africa, reported patients would blame other reasons for their problems (Laher & Khan, 2011):

“there are very few (clients) that believe they have a mental illness...I don't know if it's the patients themselves or if it's their family members that are in denial” (p77).

Language was cited in one study as the main reason why someone would not seek help from the hospital (in 37% of cases) followed by social stigma (35% of cases). This was conducted with

Pakistani Muslims living in Sheffield (Tabassum et al., 2000). Language problems were also reported in other ethnic groups such as Arabs (Youssef & Deane, 2006).

3.6.5 **Barrier to accessing help: Community exclusion and isolation**

Over the last two decades, a number of studies have described public views that Muslims with mental illness are being excluded by the wider Muslim community leading to a sense of isolation for the affected individual. In most of these, participants have primarily been drawn from the general public rather than people suffering from mental illness.

Shoaib & Peel (2003) described two main themes of isolation and staying silent; powerful cultural factors which may lead to suffering in silence. This could escalate to the situation where '*going mad*' is seen as the only way of coping. Furthermore, concealment of problems occurred where Muslims perceived they were being judged by others (Whittaker et al., 2005). Tabassum and colleagues (2000) found even if social interaction took place in Pakistani Muslims living in England, this was only at a superficial level where more than three-quarters of the participants were not prepared to develop a close relationship with someone with mental illness. Furthermore, all 74 participants in this study refused to consider marrying someone with mental illness. Muslims may be '*doubly stigmatized*' where they are excluded from both the wider community (based on their ethnic group) and their own community (for being mentally ill) (Cinnirella & Loewenthal, 1999, p519). Negative attitudes prevalent in the community may exclude people with mental illness further such as perceptions they are violent, unable to maintain relationships and not trustworthy (Javed et al., 2006; Al-Adawi, 2002; Kadri et al., 2004).

Contrary to these findings, contact with people with mental illness was also seen as a means of doing meritorious work and becoming close to God (Vanaleesin et al., 2010).

3.6.6 Barrier to accessing help: experiencing discrimination and prejudice

The problem of discrimination and prejudice can be illustrated in a number of international studies. Labels such as '*dumb*', '*off her head*' and '*crazy*' are used in a stigmatising manner (Laher & Khan, 2011, p75). Lack of empathy displayed by community members towards people with mental illness can lead individuals to complain more of physical complaints rather than mental health difficulties. Furthermore, there was a preference to speak about problems such as jadoo (black magic) rather than mental illness as this was more acceptable in the local community. The authors highlight that the issues relating to stigma and negative treatment towards mentally unwell, although prevalent, are perceived by some of the Muslim community as related to cultural upbringing rather than Islamic values. This study only considered perceptions of volunteer counsellors rather than people with mental illness.

Discrimination and feelings of prejudice extend beyond the individual and affected families negatively. Kadri et al. (2004) conducted a study in Morocco which explored the impact of Schizophrenia on the family and reported most families had difficult lives and reported poor sleep pattern and relationship difficulties. The families also experienced mockery, maltreatment and mistrust. Around one-third of respondents also reported they felt neglected by their neighbours and that people were afraid of them. Similar stigmatising attitudes have been found in relatives of people with mental illness in Ethiopia (Shibre et al., 2001) and the Arab community in Australia (Youssef & Deane, 2006).

3.6.7 Preference to see professional from same race and faith

According to a study by Cinnirella & Loewenthal (1999), Muslims preferred to be assessed by a professional belonging to the same religion or ethnic group. It was reported that a Muslim professional would have better awareness of the social, cultural and religious issues to meet the needs of the patient:

“our circumstances are different. Our personality is different, our family background is different”
(p514)

For example, an expectation that the Muslim Practitioner would be able to make reference to the Quran and mental illness when treating a Muslim patient.

This was also reported in women presenting with psychological distress in the UK (Chew-Graham et al., 2002). Counsellors working in a community organisation reported the same experience with their clients (Laher & Khan, 2011). The authors reported that accessing services that were culturally aware of the religious needs was seen as important as *“it has an Islamic ethos or a Muslim perspective...having a Muslim ethos has encouraged more people to use the service”* (p74).

However, Youssef & Deane (2006) discussed even although Arab participants would approach a GP of a similar background, they voiced their concerns about confidentiality leading to a sense of fear and reluctance to discuss fully difficulties with the doctor from the same background:

“Confidentiality is nonexistent in the Arabic community...that creates fear in people wanting to seek any help” (p57).

Shoaib & Peel (2003) also reported people were reluctant to access services where they had concerns around confidentiality.

3.6.8 Experience with services

The literature highlights the experience and unmet needs of Muslims in relation to their religion. People may feel the services are not sensitive and responsive to their faith (Al-Krenawi, 1999). In this study of 60 Bedouin-Arab Muslim patients, the author concluded:

“Because of the huge cultural gap and widely different explanatory models, 50% of the patients terminated their treatment after two sessions” (p62).

In a study of Asians inpatients (Greenwood et al, 2000), people reported staff held assumptions about them, that all Asians were the same and they shared the same values and identity. It was also suggested that staff required education and training in cultural and religious awareness with no washing facilities or prayer place in hospital:

“there are no facilities to do ‘vuzu’ (ritual washing)” (p401).

Although patients accepted taking medication, they also used traditional methods which were not discussed with the professionals involved in their care. Communication was reported to be a barrier to help seeking where people found it difficult to express themselves. Patient and carers wanted more information about the treatment provided. Some of the patients reported a preference to focus on dealing with their symptoms rather than being given a diagnosis or detailed explanation for their difficulties. They preferred to use the words *'behavioural problems'* or *'depression'* (p397) rather than mental illness.

The authors of one study stated people might not access telephone help-lines due to the perception the advisor handling the call would not understand their religious or cultural background however there was no data provided in the paper to support this (Chew-Graham et al., 2002).

3.7 Study rationale

This section brings out the literature which details studies relating to areas of discussion relevant to Muslims, Islam and mental health and illness. The key concepts which have emerged have been summarised in diagram 2 (page 81), highlighting the focus and gaps in the literature. The literature detailed in this chapter considers four areas: perceptions of mental illness, religious coping strategies, views and perceptions of Muslim religious figures towards mental illness and contact with services.

The studies are disparate in their methodology and demographics. Focus groups, questionnaires and one to one interviews have been used to explore these complex issues. What is apparent is that most studies did not aim to examine the interface between Islam and mental illness directly; rather the studies were undertaken to explore cultural factors in diverse ethnic groups (primarily of South-Asian background in the UK and Arab community in the US) or others were epidemiological studies conducted in Muslim countries to identify characteristics of mental illness and their course.

There is a paucity of high quality literature in the area of Islam and mental health. Further studies are required to address Muslim perceptions of mental illnesses; their view of pain and suffering in relation to mental health; and how Muslims cope with their mental health difficulties. Future research should also explore barriers and facilitators of pathways to care. It is also important to examine in greater depth scholars' view of towards mental illness and how mental illness is understood in the Islamic tradition. It is difficult at times to segregate the impact of cultural issues in the diverse ethnic

backgrounds but future studies should examine religious factors as a primary focus. There is a need to recruit to such studies Muslims of diverse ethnic backgrounds and who have a history of mental illness.

As I have mentioned in Chapter 1, the focus at the start of the PhD was to examine the interface between Islam and mental health and illness. It was clear through exploring not just my own personal and professional experience but the literature; the study became more specific to examining this area of study from the perspective of the four areas highlighted earlier namely, religious beliefs, religious coping strategies, experience with services and views of scholars.

This chapter provides a background to religion and mental health, starting with a brief introduction to the association between religion and mental health and narrowing the review to Muslims and Islamic faith and concluding with rationale for this study. The objectives will be developed for the gaps identified in the next chapter.

4 Chapter 4 - Objectives

4.1 Objective Overview

In the last chapter, the background literature sets out the research towards aspects of religion in relation to mental health and well-being that are most important to people of the Islamic faith.

This chapter outlines the objectives of the thesis. Two main objectives will be presented with a number of specific research questions relating to the two groups to be interviewed- patients and scholars. The objectives have been mapped in light of the gaps in the literature. The gaps in the literature review will be presented in a table format along with the objectives. The topic guide used in the study is attached in the appendix 1 (page 517).

4.2 Objectives of study

The objectives of this project are:

1. To improve the understanding on how religious beliefs and practices influences a Muslim's understanding of their mental health problems, and helped them cope or did not help them cope.
2. To identify the barriers and facilitators to pathways to care, involving existing care systems and specifically Muslim scholars who may be consulted.

These objectives were developed following review of the literature, particularly considering the gaps where areas were underdeveloped or limitations existed. The following diagram (2) will outline the gaps in existing literature which will be mapped with the objectives.

Diagram 2:

Summary of literature and outline of objectives

Summary of literature	Obj
<p>Attitudes to and perceptions of mental illness (participants perspective)</p> <ul style="list-style-type: none"> • Widely researched area in the UK and internationally • Majority of participants were mentally healthy individuals/public perspective. • Most of UK studies recruited participants primarily South Asian background. • Evidence of little description/depth of analysis of Islamic concepts • Most papers did not investigate the relationship Islam/Mental illness directly. • Most papers were primarily quantitative and patients suffered from depression/schizophrenia. 	1
<p>Perceptions of mental illness (from scholars perspective)</p> <ul style="list-style-type: none"> • Small number of studies • Most of religious figures were faith healers or Imams and South Asian background. • No studies included female traditional scholars • Primarily quantitative in methodology 	1 2
<p>Outlook on life (in relation to pain and suffering)</p> <ul style="list-style-type: none"> • Salient concepts identified in literature (predestination, test). • Little discussion around meanings to concepts related to how pain and suffering understood. • Most studies did not set out to study interface with Islam as core objective • Majority of the people not suffer from mental illness • Literature exist which capture views of Imams but no papers were identified which exclusively recruited Muslim scholars. 	1 2
<p>Coping strategies</p> <ul style="list-style-type: none"> • Existing literature highlight that Muslim resort to consulting religious figures, described in a number of studies in UK and abroad. • Use of religious practices found to be helpful. • Data descriptive in nature. • Lack of analysis. • Little detailed description on the wider strategies used by Muslims. • Limited discussion relating to level of understanding, challenges and difficulties a Muslim with mental illness experienced in respect to aspects of their faith and impact of mental illness. 	1 2
<p>Conceptualisation of distress and mental health</p> <ul style="list-style-type: none"> • Little description how distress and emotional difficulties are expressed from an Islamic tradition. 	2
<p>Experience with services</p> <ul style="list-style-type: none"> • Key papers exist highlighting care pathways and access to services • Cultural issues were covered in detail in existing literature. • Studies highlight unmet needs and dissatisfaction with services • There were barriers to accessing professional help. • However, most of the UK studies recruited Muslims of South Asian background. • Little detailed description on the wider strategies used by Muslims. • There was little information provided about a participant’s mental health. 	2

Objective 1

To improve the understanding on how religious beliefs and practices influences a Muslim’s understanding of their mental health problems, and helped them cope or did not help them cope.

Objective 2

To identify the barriers and facilitators to pathways to care, involving existing care systems and specifically to explore role and perceptions of Muslim scholars who may be consulted.

4.3 Specific research questions

Table 2 With respect to patients

What are the beliefs, knowledge and understanding towards mental health among patients?

How does religion influence the understanding of mental health problems?

Do religious views play a role on patient decision making pertaining to treatment?

What aspects of religious coping are important to patients with mental health difficulties?

What are the key factors that may affect the understanding and attitudes towards mental health and treatment?

What is the level of awareness, accessibility and experience of Muslim patients in using mental health services? To explore the mental health needs of Muslim patients.

Table 3: With respect to scholars

What is the understanding and attitude of religious scholars regarding mental health?

What are the practical experiences of religious practitioners in providing support to mental health patients and agencies?

What do religious practitioners believe are the aetiologies of mental illness?

What do religious scholars think would be helpful in the delivery of treatment and care to patients with mental health difficulties?

The study objectives and related research questions have been outlined in this chapter. The subsequent chapter will present how the study objectives have been met.

5 Chapter 5 – Material and methods

The objectives of the study were presented in chapter 4. This chapter provides an overview of the methodological approach chosen for this thesis to meet the study objectives. It considers the argument for the choice of qualitative design for this study. Furthermore, the theoretical methodological approach is described, drawing on approaches from grounded theory with a constructivist stance. The approach to sampling is described followed by the planned process of recruitment and the actual experience in engaging scholars, professionals and patients. This section also discusses the ethical issues and process of approval.

The analysis of data is detailed, examining thematic analysis, its benefits and challenges. For the reader, it is also useful to understand the self-reflection process and this chapter includes a section on subjectivity and reflexivity, detailing potential researcher bias and how this is managed. Following this, the area of rigour and quality is explored.

5.1 Choice of qualitative approach

A qualitative approach was selected as the design of choice primarily due to the following reasons:

- 1) There was little information evident in existing literature relating to Islam and mental health and this method enables information to be gained at this exploratory stage (Pope & Mays, 1995).
- 2) It is important to consider the methods of data collection, which will enable a greater understanding of the phenomenon to be examined and achieve the aims of the study (Green

& Thorogood, 2009). This method allows a richer and in-depth description of an individual's experiences and beliefs. Through the process of data analysis, there is a better understanding of the nature of the issue which leads to theory development (Bryman, 2012). The area of study examines the interface between Islam and mental health and illness, involving complex questions and wide ranging views which can only be explored through in-depth interviewing. It is argued that qualitative research is able to capture the participant's perspective closer than quantitative work through detailed interviewing (Denzin & Lincoln, 2011). This inductive and interpretive approach, drawing on principles of grounded theory is more suited for this study.

- 3) This study is not a statistical trial and as such it is not concerned so much with external factors which lead to a particular kind of behaviour. Rather, this study is concerned with meaning and associated interaction. This approach allows the exploration of the experiences of individuals in their given context (Corbin & Strauss, 2008). This chimes with the ontological and epistemological position of qualitative methods which holds that reality is made up of shared meanings and not pre-existing objective facts (Denzin & Lincoln, 2011).
- 4) Muslim participants are a 'hard to reach community' to involve in research (Dowrick et al, 2009; Perry & El-Hassan, 2008). It was therefore felt this group would more likely engage in the manner of one to one interviewing rather than via a questionnaire approach.
- 5) Lee (1993) argues employing a qualitative approach is more appropriate in research areas that are considered sensitive, where the participant may view as being 'highly personal' or 'confidential'. This study could be perceived by participants in this way.

5.2 Theoretical and methodological approach

Qualitative research methods contain a variety of approaches, with many elements shared and overlapped by epistemology and procedures (Holloway and Todres, 2003). There are also distinctive components to the different approaches with different emphasis. Commonly, the source of qualitative data include observations, interviews and documents (Patton, 2002; McCracken, 1988). In most cases, the approaches are concerned with meaning and associated interaction (Donovan & Sanders, 2005).

Interviews can encompass range of techniques from structured survey interview to unstructured form of interview and conducted at individual level or in focus groups (McCracken, 1988). The methods of data analysis lie on a spectrum in terms of degrees of interpretation, from basic description (relating to content analysis) to grounded theory (Donovan & Sanders, 2005).

Defining qualitative research is viewed as contentious as there is no one way to cluster qualitative methods due to the diversity of data collection and analytical methods; it is therefore helpful making sense on how these methods are influenced by theoretical approaches (Gubrium and Holstein, 1997).

The researcher perceives the world with collection of ideas and framework (relating to theory, ontology) that encompasses a set of questions (epistemology), and which are consequently examined in specific ways (methodology, analysis) (Denzin & Lincoln, 2011). This may be referred to as a paradigm or interpretive framework (Guba, 1990). Denzin & Lincoln (2011) argue

“All research is interpretative: guided by a set of beliefs and feelings about the world and how it should be understood and studied” (p13).

In the landscape of social science inquiry, comes out the various paradigms competing for legitimacy and academic authority. There are continued polarizing discussions on the relationship between the researcher (the observer) and the researched (observed) (Taylor & Bogdan, 1998). Multiple perspectives have been outlined but have often been grouped in categories along a continuum including positivism, post-positivism, critical theory and constructivism. One end of the spectrum is the belief of the realism, held by the positivist, that reality can be known objectively through the lens of an unbiased researcher (Lincoln et al., 2011). Positivists hold the ontological belief that there is a single reality, a single truth that can be measured. The other end is the constructivist position, arguing that objective reality is non-existent and knowledge is subjective. Constructivism incorporate a relativist outlook, where multiple realities exist and reality are constructed intersubjectively through understanding and meaning developed socially (Guba and Lincoln, 1994). In essence, this means knowledge is constructed through lived experiences and interactions with others. The majority of qualitative researchers position themselves between these two views (Taylor & Bogdan, 1998).

This work draws on some principles and techniques of a grounded theory approach, and has resonance with the version of grounded theory adopted by Charmaz, and described as ‘grounded theory with a phenomenological cast’. The ontological and epistemological position taken here is one of a constructivist stance. This fits well with the objectives of this study, by facilitating an understanding through interpretation of subject perceptions (Denzin & Lincoln, 2011). In a grounded theory approach, there are multiple phases of analysis. Steps applied in the coding phase

(open, axial and focused), help describe and segment the data, observe for patterns, and finally refine selective themes. The practical work of identifying, describing and analysis of these patterns in the data is driven by the analytical process of thematic analysis (see page 112).

Grounded theory comprises of a collection of systematic, yet flexible guidelines for performing inductive qualitative inquiry, directed toward theory construction (Bryant & Charmaz, 2008). The analysis is non-linear, iterative process where the researcher goes back to the data and is developed over time (Ely et al., 1997, Willig and Rogers, 2008).

Since the grounded theory method was developed by the sociologists Glaser and Strauss in 1967, in their classic book - *The Discovery of Grounded Theory*, it has evolved and been re-examined, leading to different versions. Many researchers today do not necessary adhere to the original Glaser and Strauss approach, instead drawing on elements of grounded theory (Murphy et al., 1998). The originators themselves refined their own ideas separately, with Strauss co-authoring with Juliet M. Corbin (Strauss & Corbin, 1990), on placing data into preconceived categories which Glaser contended against, based on his opinion categories were emergent from within the data. This makes it difficult, if not impossible to agree on one definition of 'grounded theory' and the shift of emphasis should be towards the practical consideration of the guidelines for qualitative researchers (Dey, 1999).

Researchers such as Charmaz (2006), Clarke (2003) and Bryant (2002) have since adopted their own approaches and moved away from earlier versions (which were known for its positivistic assumptions) towards a constructivist position of grounded theory. This position places an

emphasis on the interpretative nature of reality, co-constructed between the researcher and the subject in the research process. Charmaz (2006) has suggested components of grounded theory such as coding and sampling can be adapted by researchers and used flexibly in studies.

Unlike belief in complete objectivity, which is the epistemological dimension positivists propagate, findings are seen as a result of the interaction between the inquirer and the inquired in constructivism, taking a subjective position (Guba, 1990). The assumption is people cannot separate themselves from what they know, where lived experiences shape individuals and this comes out during interaction with subjects. (Guba and Lincoln, 1994; Denzin & Lincoln, 2011).

In addition to the ontological and epistemological dimensions described above (which Guba (1990) argued as one component), the last area of understanding paradigms, is consideration of methodology. This process is described as hermeneutic and dialectic in the constructivist paradigm (Guba, 1990). This consists of eliciting and refining individual constructions, and comparing and contrasting these constructions through investigation.

The constructivist position can be argued to strengthen the basic grounded theory guidelines by addressing areas such as reflexivity, effect of existing literature and prior knowledge and research context (Bryant & Charmaz, 2008). The approach, as emphasized by Charmaz (2011) adopts a pragmatic foundation of grounded theory (Charmaz, 2011). Originally, grounded theory was presented as completely inductive however this position takes the view it is a combination, beginning with an inductive approach to inquiry and to a degree, deductive reasoning as the inquiry process proceeds (Charmaz, 2008).

The spectrum of interpretative approaches discussed links to the practical approach of thematic analysis. This draws the epistemological links between theory and method. Thematic analysis is one of the most commonly used analytic approaches for encoding qualitative data (Boyatzis, 1998). Boyatzis (1998) argue thematic analysis is a tool or process for understanding qualitative information, that is used with the majority of qualitative methods rather than being a specific methodology. This is in contrast to others such as Braun and Clarke (2006), who are of the view that thematic analysis should be viewed as a distinct method in itself:

“foundational method for qualitative analysis...It is the first qualitative method of analysis that researchers should learn, as it provides core skills that will be useful for conducting many other forms of qualitative analysis” (P76).

In considering the interface between Islam and mental health, it is argued that this area on one level, while unique in its personal and individual meaning, does share common concepts and themes between individuals. This makes conducting this research by a thematic approach the most appropriate form of investigation.

Thematic analysis offers a numbers of benefits. It allows a degree of flexibility, which is accessible to new researchers and lends itself to different schools of thought (Caulfield & Hill, 2014). This compatibility also facilitates communication between researchers who employ different qualitative methods (Boyatzis, 1998).

Thematic analysis is a method which goes beyond locating explicit words or phrases and/or counting frequency words, and concentrates on identifying, describing and analysing patterns in the data, referred to as ‘themes’ (Guest et al, 2012). It helps to capture meanings found in the data.

Doing thematic analysis requires time; consequently, researchers may opt to undertake superficial level of coding, which does not truly reflect the data (Caulfield & Hill, 2014). There is also the criticism of lack of concise guidelines in areas of qualitative research whereby 'anything goes' (Antaki et al, 2002). Another point to consider is:

“The challenge to the qualitative researcher is to use thematic analysis to draw the richness of the themes from the raw information without reducing the insights to a trivial level for the sake of consistency of judgement” (Boyatzis, 1998, p14).

The guidelines used in grounded theory which guided the process of research, data collection, analysis and generation of theory was as follows:

theoretical sampling, theoretical saturation, open coding moving to selective coding, drawing on data to develop conceptual categories, constant comparative analysis in an iterative manner, search for variation in categories and memo writing.

These strategies and thematic analysis will be described further in the remaining sections of this chapter.

5.3 Study design

A qualitative study utilising semi-structured in-depth interviewing with Muslim participants⁴ and religious scholars.

The NHS Research Ethics Committee (North West- Greater Manchester North) finally approved the study in 2010 (reference 10/H1013/30). The issues arising from the process of seeking ethical approval will be discussed in the relevant sections. A copy of the ethics approval letter and documents used in the recruitment process are attached in the appendices (number 10/H1011/51).

5.4 Study setting

This was primarily a community (including GP practices) and inpatient study where the participants were interviewed either during their hospital stay or when discharged back to the community.

Approval was sought from the following six Primary Care Trusts and three mental health trusts:

- Salford PCT
- Trafford PCT
- Bolton PCT
- Manchester PCT
- Bury PCT
- Stockport PCT
- Greater Manchester West Mental Health Foundation Trust
- Pennine Care Foundation NHS Trust
- Manchester Mental Health & Social Care Trust

⁴ The word 'participants' will be used interchangeably with the word 'patients' in this study. This is because there are parts of the thesis where it is more appropriate to use 'patients' to reflect the group of people described.

5.5 Sample

5.5.1 Theoretical approach to sampling

At the start of the study, purposive sampling was conducted for the selection of religious scholars. This is whereby a small number of religious scholars were deliberately identified based on their experience, who were likely to be in a position to provide information relevant to the objectives of the study (Patton, 2002). After the initial interviews, a theoretical sampling strategy was used (Strauss & Corbin, 1990). This approach is based on the relevance to produce knowledge necessary to understanding the area of work rather than representativeness and randomness (Popay et al., 1998). This is the process of *“data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges”* (Glaser & Strauss, 1967, p45).

This sampling process helps guides the selection of participants and themes of inquiry. The use of journal entries helped document personal reflections and facilitate the sampling strategy. For example, some of the scholars interviewed in the earlier stages of the interview process discussed the importance of religious strategies to cope with mental illness. Future scholars were considered who had experience of dealing with distress from an Islamic perspective. Also, scholars interviewed initially spoke about the negative experience of individuals who accessed the mosque. Later scholars were accessed who worked in the mosque to gain their views.

It has been argued that such sampling techniques can produce non representative samples but the views of this group were crucial in building a detailed understanding of the relationship between

Islam and aspects of mental health and illness. This is a group which is often difficult to access.

Blumer (1979) argued it is better to have:

“half dozen individuals with such knowledge constitute a far better 'representative sample' than a thousand individuals who may be involved in the action that is being formed but who are not knowledgeable about that formation” (p156).

In the initial stages, contact was made with specific groups in order to locate participants with a broad level of knowledge, in order to:

“maximize the possibilities of obtaining data and leads for more data on their question. They will also begin by talking to the most knowledgeable people to get a line on relevancies and leads to track down more data and where and how to locate oneself for a rich supply of data” (Glaser, 1978, p45).

After the initial data was collected and analysed, the process of theoretical sampling commenced, according to the emerging categories (Charmaz, 2011). Although the participants in this study came from diverse ethnic groups, ages and geographical areas, the selection of the participants was not based on set criteria at the beginning of the study, rather their sampling was based on testing out categories against new data (Coyne, 1997) and to increase the opportunity to developing concepts (Corbin & Strauss, 2008). This allowed variations to be uncovered and to observe for relationships or patterns between concepts. This process lends itself to producing in-depth meaningful data.

Sampling was completed when the point of saturation was reached; this was at the stage where themes were repetitive and no new insight was gained to add to the research question.

5.5.2 Planned recruitment of patients

The primary aim of the study was to gather views from participants of the Islamic faith who have suffered from a range of mental illnesses. In order to be more encompassing in capturing a wider range of view-points, it was imperative to interview participants of diverse ethnic backgrounds. All the participants were aged between 18 and 65 and had a pre-existing diagnosis of mental illness. The diagnosis was made by the recruiting professional. Patients with florid psychotic symptoms, suicidal risk, learning disability, dementia and substance abuse were excluded. The exclusion criteria was discussed with the recruiting professional who informed me with the diagnosis and current participant presentation. I took this decision to exclude patients with specific presentations and diagnosis as it was felt there would be wider factors to consider during the recruitment process which may be difficult to manage. This included whether the participant would be able to engage in the interview, concern about unpredictable behaviour and increased distress symptoms. I also planned to recruit participants who were under secondary care services (either in hospital or under the community mental health team) and primary care (where they have accessed the general practitioner for assessment and treatment of their mental illness). This would further allow participants being recruited with varying degrees of presentation. The professionals involved in the recruitment process were provided with information about the exclusion criteria. The professionals who recruited the participants would initially ensure the individual had the capacity to take part in the study. Capacity was reassessed by me during the completion of the consent form. The central principle of consent when recruiting participants for research purposes is that the participants understand the purpose of the research study and participation is voluntary. Furthermore, the participant should not be coerced or persuaded against their will into the research (Green & Thorogood, 2009).

At the outset, I planned to identify areas where it was known there were higher rates of Muslims residing and contact general practitioners and psychiatrists who worked in these areas. This would be done by an initial telephone call to the practice to speak with the general practitioner, introducing the study and follow up by study information being sent by email where interest was expressed. I also intended to contact psychiatrists and nurses directly by phone and email. In the first instance, I would contact professionals who were personally known to him to help in the recruitment. I would offer to visit the place of practice to discuss the research direct with the doctor. The recruitment process and experience will be discussed later on page 104.

5.5.3 Planned recruitment of religious scholars

The inclusion criteria for the religious figures were Muslim scholars with experience of dealing with individuals with mental health difficulties. I recruited scholars through local mosques and one of the NHS chaplaincy departments. A letter was sent to the mosques followed by contact with the mosque.

Once I identified interested scholars, I spoke with them directly and if they agreed, an invitation letter and information sheet was provided by me. On their agreement to take part, a meeting was arranged at a local mosque or place of their preference. A snowballing technique was used where scholars were asked if they knew other scholars who might be interested in taking part in the study (Morse, 2004).

5.5.4 **Sample collection procedure**

The study was granted approval from the University of Manchester Ethics committee. Following this, I and one of the supervisors, Professor Linda Gask attended the NHS ethics committee to present the study, however the proposal was rejected at the first ethics review meeting. A second revised application was made. The issues will be discussed in the relevant sections and also where relevant, explored in the subjectivity and reflexivity section.

This section highlights the experience of engaging the professional and scholars. A flowchart outlining the recruitment of patients and scholars will be included, as well as a table detailing basic demographics of the participants.

Diagram 3: Recruitment of participants

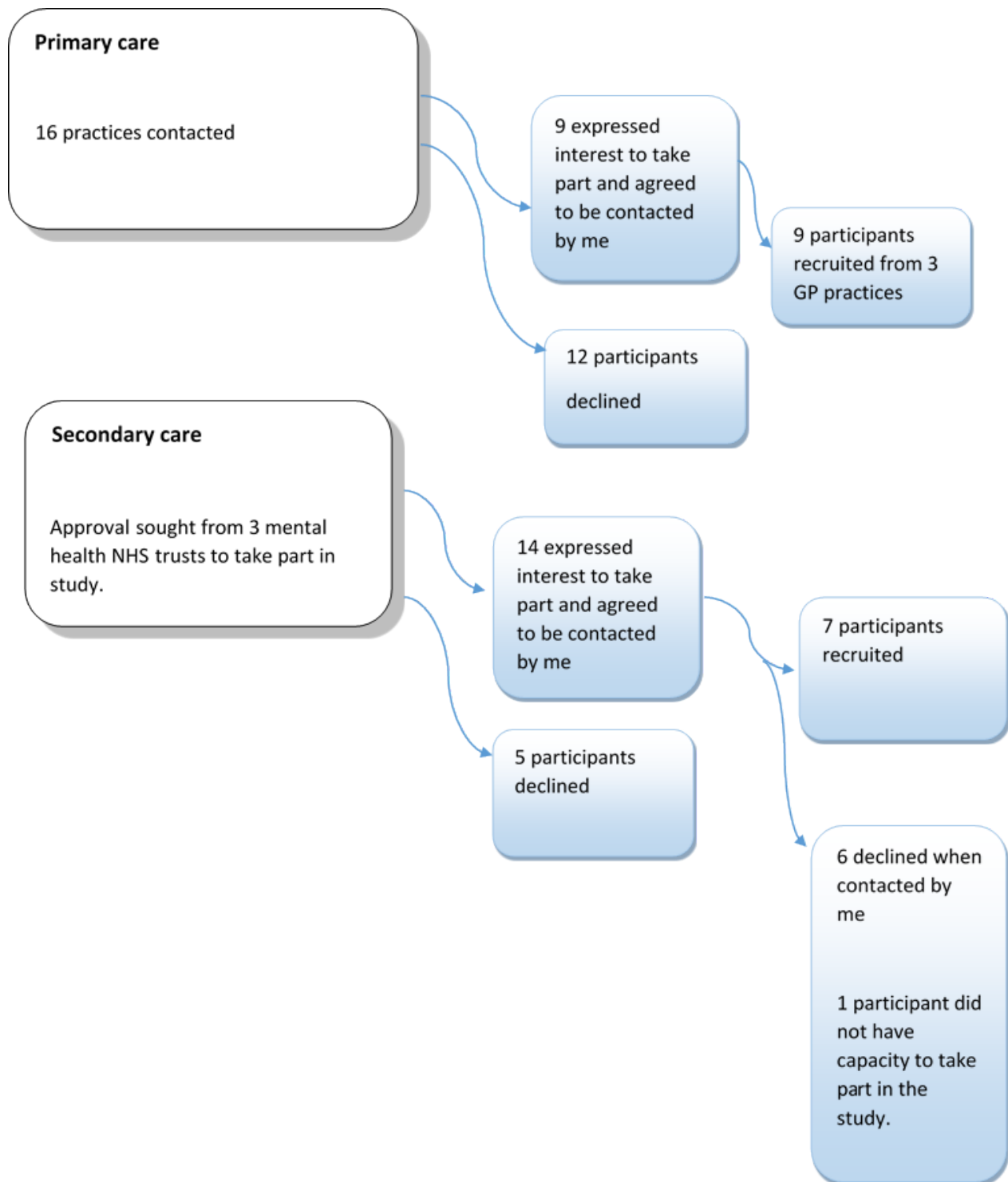


Diagram 4: Recruitment of scholars

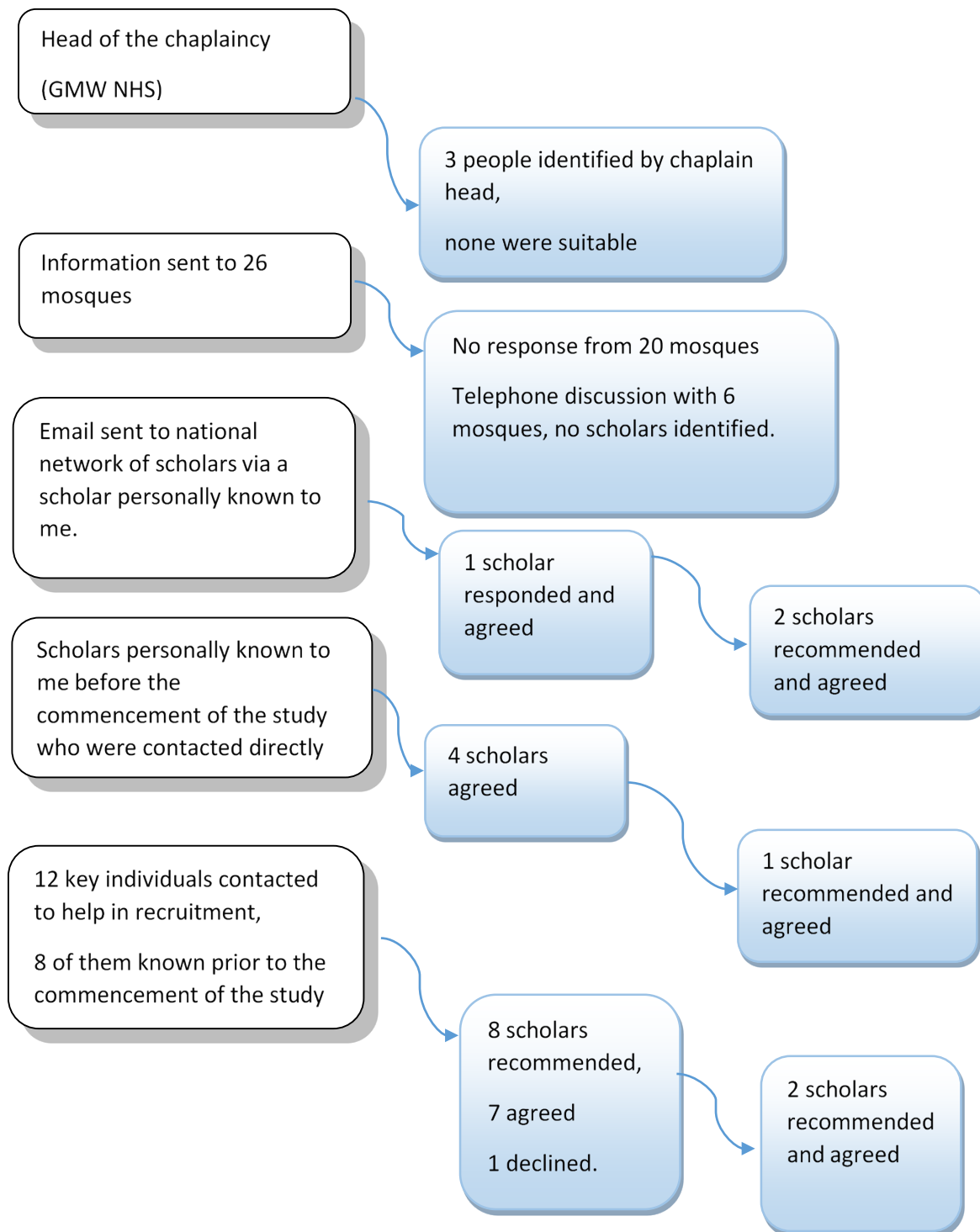


Table 4 Participant information

	Ethnicity of participant	Diagnosis	Gender	Source of recruitment
1	Pakistani	Schizophrenia	Female	Primary care
2	Tunisian	Psychotic depression	Female	Secondary care
3	Pakistani	Depression	Female	Primary care
4	Somalian	Schizophrenia	Male	Secondary care
5	Indian	Obsessive compulsive disorder	Female	Secondary care
6	Malaysian	Depression	Female	Primary care
7	White British	Schizophrenia	Male	Secondary care
8	Kenyan	Schizophrenia	Male	Secondary care
9	Bangladeshi	Anxiety	Male	Secondary care
10	Pakistani	Depression	Female	Primary care
11	Indian	Depression	Male	Secondary care
12	Iraqi	Mixed anxiety and depression	Male	Primary care
13	Palestinian	Stress Depression	Male	Primary care
14	Somalian	Depression	Female	Primary care
15	Yemeni	Schizophrenia	Female	Primary care
16	Syrian	Schizophrenia	Male	Primary care

Table 5 Scholar information

	Ethnicity	Gender	Primary location of work
1	Indian	Male	Blackburn
2	Pakistani	Male	Glasgow
3	Indian	Male	Manchester
4	Mixed	Male	Glasgow
5	Pakistani	Male	Glasgow
6	Iraqi	Male	Leeds
7	South African	Male	Bradford
8	Bangladeshi	Male	Oldham
9	Bangladeshi	Male	Oldham
10	Egyptian	Male	Manchester
11	Indian	Female	Blackburn
12	Palestinian	Male	Liverpool
13	Bangladeshi	Female	North Wales
14	Pakistani	Female	Bury
15	Black	Male	Oldham
16	Pakistani	Female	Manchester
17	White British	Male	Keighley

Experience of engaging professionals

Access approval was gained from 6 primary care organisations: Bolton PCT, Bury PCT, Manchester PCT, Oldham PCT, Trafford PCT and Stockport PCT.

The recruitment of participants was challenging and took eighteen months to complete. Firstly, trying to gain the support of GP practices was difficult. Responses were delayed where I contacted each practice on two or three occasions to try and receive a response. In most cases, there was no response at all. It was not clear if the GP was making the decision about taking part in the study or if it was the practice manager. Sixteen medical practices in the Greater Manchester area were contacted by me to identify suitable patients. Telephone contact was made in all cases followed up by information being sent by email or post. One practice asked if there was a financial incentive in recruiting per patient and another suggested sitting all day in the practice and approaching patients directly. Of the sixteen practices contacted, five practices agreed to take part in the study.

It was difficult to directly communicate with GPs because of their tight schedules and other managerial commitments even when I mentioned I was a doctor working in the NHS. During the initial planning phase, I was frequently directed to the practice manager or one of the medical secretaries; this caused delay in the data collection.

I made the offer to visit all the practices however only four arranged a formal visit to the practice to discuss the study directly. Despite most of the primary care staff being intrigued by the study, only a few agreed to take part in the study. Out of the five practices, only three were proactive and engaged in recruiting patients. Two of these practices were from Manchester PCT and 1 from Stockport PCT.

The other two practices ceased to show interest and failed to respond to calls or emails. I therefore met the GPs from these three practices to explain the importance of the work and deadlines remaining to interview the patients.

Permission from three mental health trusts was granted: Greater Manchester West NHS Foundation Trusts, Manchester Mental Health and Social Care NHS Trust and Pennine Care NHS Foundation Trust. I telephoned medical HR department to request study information be sent to psychiatrists working in the three mental health trusts however I was advised to contact individual psychiatrists direct. I contacted fifteen psychiatrists, six nurses, four social workers by telephone from these trusts. Eight of these psychiatrists, three nurses, one social worker were personally known me. Eleven psychiatrists, three nurses and two social workers agreed to take part. To aid and facilitate the recruitment process, I offered to organise an information session at their place of work however all the professionals felt this was not necessary.

Recruitment process of patients

The ethical committee recommended that there should be the provision of a self-addressed pre-stamped envelope indicating an expression of interest to take part in the study. Professor Gask however highlighted to the committee this procedure had been unsuccessful when recruiting participants from the ethnic minority community and proved ineffective in previous studies she had been involved in. This study supported this view as none of the participants responded to the self-addressed envelopes/reply slips. The committee also stated that potential patients should not be recruited directly by me. It was clarified for the second review that the first contact with patients would be made by the recruiting team and not by me. The recruiting team were the clinical team who

were involved with the patient. This was either the general practitioner, psychiatrist, nurse or social worker.

In primary care, the general practitioner made the first approach to potential patient participants and gained permission for their details to be passed on to me if interest had been shown to take part in the study. I sent out a written invitation letter and information sheet about the study plus a reply slip to potential patient participants. A healthcare professional (nurse or doctor) from the practice followed up the letter with a telephone call to the potential participants after seven days to gain consent for me to make contact with them if they were interested in taking part in the study.

No participants were recruited in the first four months. Nine participants were recruited from primary care. Twelve participants declined to participate. Initially fourteen participants from secondary care agreed to take part in the study however only seven participants were recruited, from one trust, Greater Manchester West Mental Health Foundation Trust. Five participants declined to take part when asked by clinical teams. A further six participants changed their mind to participate when I contacted them. I felt one participant did not have capacity to consent. All but one were born Muslims.

Experience of engaging patients for recruitment

During discussions with GPs and Psychiatrists, the issue raised by some participants approached was around confidentiality and concern that other people would find out they had mental illness. Underpinning confidentiality is the protection of an individual's privacy who is being researched (Kaiser, 2009).

Some found it unusual a study was being conducted on Islam and even more so by a psychiatrist. In order to improve recruitment, I did not mention my role as a psychiatrist when speaking with potential

participants. Furthermore, I changed my approach to engage participants. Rather than starting by emphasising what was important about the study from his perspective, I took the approach to highlight, it was an opportunity for the participant themselves to talk about their own experience relating to mental health and the role belonging to their faith played in this.

Recruitment process of religious scholars

The second group of people interviewed were religious figures. Religious figures can be described as those people who are approached for religious support by members of the Muslim community. These can include hakims (practitioners who have specialised in traditional medicine), raaqi (someone who performs ruqyah, recitation for protection and healing), members of mosque committee, pir (a title given by sections of the Muslim community for a spiritual leader, particularly from the Pakistani and Indian community), ustadhs (a title for a teacher, it is sometimes used by some to signify someone who is knowledgeable though may not have had formal Islamic education and not to the high degree of a scholar), imams (someone who leads prayers in the mosque) and traditional scholars (someone who has a formal qualification).

The ethics committee were concerned that only religious figures known to me would be included in the study. Reassurance was given that religious figures would also be contacted who were not known or were familiar to me. The head of the chaplaincy department, Greater Manchester West Mental Health Foundation Trust was asked for a list of scholars who had worked with individuals with mental illness. Three names were provided however none of them were scholars. Information about the study was sent out to twenty-six Mosques in the Greater Manchester area. Information about Mosques and Islamic centres were obtained from the Muslim Directory, a UK directory listing Mosques in the UK.

The scholars based in these mosques were asked to participate in the study by letter. A follow up phone call after 1-3 weeks was made to the mosque to speak with the scholar.

For the purpose of this study, traditional scholars were selected because:

- 1) Scholars are seen by the Muslim community as the most authoritative source of Islamic knowledge (there may be scholars whose first language is not English and whose primary education is not from the UK).
- 2) In their role within the mosque, they are seen as the Imam. An Imam is an individual who leads congregational prayers in the mosque.
- 3) They are more accessible by the community compared with other religious figures. This group would also have been the most approachable for me.
- 4) Scholars generally have a wide range of experience of issues within the community whereas other religious figures may have experience only in specific areas.

Experience of recruiting religious scholars

There were no responses from the mosques following the invitation letter being sent out. I was only able to speak directly to a person from within the mosque on six occasions. No participants came forward by this approach. Three names were provided by the head of chaplaincy however they fell outside the criteria of selection.

No scholars were recruited in the first month so I widened my search outside the Manchester area to Greater Manchester. Even at four months, there had only been queries on the nature of study but no participants were identified. It was clear this approach was not working.

At this stage, I changed the manner I was approaching scholars and also considered scholars from other geographical areas. I contacted a scholar personally knew and asked if information about the study could be shared with his contacts. Information was then sent to a national network of scholars with a personal recommendation from the scholar to support the study. One scholar came forward, based in Blackburn. I communicated with four scholars directly who were personally known to me too. All of them agreed to take part in the study. These were the only scholars familiar to me prior to the commencement of the study.

I approached key individuals who could play an influential part in influencing scholars on my behalf. I met these key individuals at the mosque, Islamic events or at their home. In total twelve key individuals were approached. Eight of the key individuals were already known to me prior to commencement of the study. These individuals were primarily congregant members, mosque committee members, Muslims who were involved in community work or those who kept in close company of scholars. This was either done through a face to face meeting or by telephone calls. Through this interaction, the key individual was asked if there was a scholar known to them who could be approached. Written information was given to the individual with emails/phone numbers exchanged. On most occasions, another time was organised where the key individual introduced me to the scholar during prayers in the mosque or where this was not possible, phoned the scholar on my behalf. A meeting was organised with interested scholars. At this initial meeting with the scholar, general information was given about the study and if the scholar was interested, a meeting date was set. Key individuals were involved in supporting the recruitment of most of the scholars. I met eight of the scholars once prior to formally interviewing them. Scholars were asked if they knew other potential participants who may be interested in the study. I then contacted these scholars. Seven scholars were recruited this way. In three of the interviews with female scholars, a relative or family

friend of the participant was present in the adjacent room. A telephone call to all the scholars prior to the interview took place to discuss the study.

Nine of the scholars asked about my background, community work involvement, mosques I visited and scholars I knew. I responded by giving names of scholars I was familiar with on a personal level who were not involved in the study. I had worked with these scholars in community work previously and had asked them prior to the study if their name could be mentioned for reference purposes. After each interview the scholars were asked by me if their name could be mentioned with other potential participants as a reference, taking into consideration no information about their views would be discussed with others. This was not part of the ethics approval application but was felt to be important as the majority of scholars approached, asked who else had been involved in the study. This was particularly important as it placed them at ease and trust was able to be formed prior to the interview taking place. All scholars agreed to this and signed a consent form to take part in the study. Most of the scholars came from the North-West of England with one residing in North-Wales and three from Glasgow. This process of recruiting and interviewing scholars took around twenty one months. Seventeen scholars in total took part in the study. Four of them were female.

5.6 Interviews

The interviews were carried out by me under the supervision of Professor Linda Gask and Dr Heather Burroughs. All interviews were audio taped with consent, and transcribed. The patient interviews lasted from 45 minutes to 120 minutes and the scholars were longer, up to 180 minutes. The interviews were semi-structured and utilised a topic guide (**See appendix 1**). The interviews took place in a location decided by the patients and scholars themselves. This occurred in varying locations. In preparation for the second ethics meeting, I took account of all the concerns raised by the ethics committee such as confidentiality, privacy and provision of translators. No translators were required. All the interviews were conducted in a private clinic room or at patient's home without any interruptions. Most of the patients preferred to be interviewed at home, followed by their GP practice. Five of the interviews with the scholars took place in their home, two interviews at their offices and the remaining conducted in the Mosque.

The interviews were conducted in one meeting to make it easier for the patients. The scholars were given the choice to complete their interview in a single meeting or the opportunity to return to the interview at a later date. Five of the scholars volunteered this option of completing the interview in further meetings.

At the start of the interview, I gave the patients and scholars the opportunity for any questions from the information sheet or about the study. Once the participants were placed at ease and satisfied to go ahead with the interview, they were given time to read the consent form. Once this was completed, I sought permission to commence the interview and started the recording for the interview.

Semi-structured interviewing allowed for flexibility and enabled the interviewee to enrich the interview with their own understanding and experiences (Mason, 2004). Open questions were used to generate free-flowing responses and focal questions for clarity and further exploration.

The topic guide contained questions and grouping of topics were used as a guide which enabled me to ask questions in different ways depending on the interview context and participant (Lindlof & Taylor, 2002). Some of the areas covered in the topic guide for the patients group encapsulated the beliefs, knowledge and understanding towards mental illness, the importance of religion and how faith influences the level of understanding of mental illness, the level of awareness, accessibility and experiences of Muslim patients using services. For the religious scholars, prompts covered the understanding and attitude towards mental illness, exploring their beliefs towards causation of mental illness and how Islam helps or hinders people with mental health problems.

The topic guide was developed on the basis of existing literature (discussed in the background chapter) and to explore areas relating to the aims and objectives of the study. The topic guide for the patients was discussed with my supervisors prior to commencement of the interviews. The topic guide for the scholars was also discussed with the supervisors and pre-tested with two religious scholars. As interviews progressed, additional topics were added as new topics were identified. This iterative process, which was responsive to emerging data, enabled further areas to be explored in subsequent interviews (Charmaz, 2006). Hand-written notes were written in the form of memo notes. These were primarily written at home. This helped reflect on the interview, review existing areas and consider new areas to approach.

The ethics committee accepted how distress would be managed by me and I explained what support would be available to participants after the interviews if required. I would contact the professional

who facilitated the recruitment to discuss any concerns such as risk or levels of distress. I also reinforced at the end of the interview the discussion was confidential. The interviews were concluded by asking the participants if there was anything else that the participants wanted to mention and by thanking them for their assistance.

5.7 Data analysis

Thematic analysis approach

The process of thematic analysis used in this study will now be outlined, using the guide by Braun and Clarke (2006). This framework was selected as it provides a structure to explain the steps taken in the analytical process. It therefore not only enhances the understanding of the theory behind this methodology but also helps the reader gain insight into how the process translates in practice. It is also regarded as a landmark publication in thematic analysis (Willig and Rogers, 2007).

Six phases are described in their paper, which will now be discussed.

Table 6: Thematic analysis process (adapted from Braun and Clarke, 2006)

Phase	Description
Phase 1: I was familiarizing myself with the data.	This involves transcribing the interviews, immersing themselves in the data by reading and re-reading and recording initial ideas.
Phase 2: Generating initial codes.	Codes are produced from the data, initially capturing large number of codes and then focusing to more selective codes.
Phase 3: Searching for themes	Codes are collated together into sub-categories and categories and gathered so possible themes are developed.
Phase 4: Reviewing the themes	The themes are reviewed and ‘thematic map’ of analysis developed, highlighting the main themes developed from the data set.
Phase 5: Defining and naming the themes	The themes are organised and reviewed, considering the overarching story the data is trying to tell. Names are ascribed to each theme.
Phase 6: Producing the report	This involves relating the analysis back to the research question. Also considering the literature and at the end, completion of the findings report.

The process of thematic analysis started with familiarising myself with the data. This was done by transcribing the verbal data (interviews) into written format. An audio transcription software was used, that allowed the audio to be played back. Any reference to specific people was removed, ensuring the transcripts were anonymous. Brief notes and ideas were also recorded at this stage. Transcription is a useful way of knowing the data (Riessman, 1993). This first phase is an active process of immersing into the data, whereby there is reading and re-reading of the data.

The second phase involved generating codes. This allowed the transcripts to be fragmented into sizeable pieces of information whereby emerging ideas could be identified. Two steps were useful in this process (Charmaz, 1995), the process of open coding and focussed coding. The transcriptions were initially open coded. This process generated large numbers of codes which minimised the risk of missing relevant categories. This process allowed the exploration of a number of theoretical directions and highlighted areas where data was limited or needed further exploration (Charmaz, 2006).

The second stage was focused coding where the codes are more selective and conceptual (Glaser, 1978). This process helped to explain larger divisions of data. This involved use of the most frequent or significant earlier codes to work through large volume of data. Codes were grouped together and patterns noted. Data was compared against other data which developed more focused codes. Sub-categories and categories were developed in the light of the emerging data (stemming from the focused coding). There was data coded which fell in one category or coded into numerous categories.

Codes are the “*most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon*” (Boyatzis, 1998, p63). Coding is the method or process of describing what the data is saying (Charmaz, 1995). Coding is a term used for categorising data; identifying and labelling patterns in the data and placing them into categories. This allows similarities and distinctions to be captured. This is the conceptualised process to consider “*how the substantive codes may relate to each other as hypotheses to be integrated into a theory*” (Glaser, 1978. p72), exploring possible relationships and patterns between categories and begin to tell an analytic story.

One of the decisions that need to take place in thematic analysis is around how to approach the data, which can be performed inductively or deductively (or both). The approach conducted here was both, inductive reasoning at the start of the inquiry process and deductively as the analysis progressed.

An inductive approach is able to capture an individual’s perspective closer and in a more meaningful way. Inductive coding works from a ‘bottom up’ direction, using the data as a beginning point to identify meanings, building it up to sub-categories and categories, and development of themes (Willig and Rogers, 2007; Frith and Gleeson, 2004). This approach is data-driven where the coding process is not conveniently suited to conform to predefined coding structures or accommodated to my own preconceptions (Braun and Clarke, 2006). One has to however bear in mind that I am not completely absent from my own epistemological and theoretical stance and bring with my own perspective to the analysis (Willig and Rogers, 2007). My own reflections towards possible bias and how this was managed throughout the analytical process are in discussed in table 9 (on page 125-130).

The deductive approach tackles the data ‘top-down’, where the researcher considers existing concepts and theories as a foundation for data interpretations (Braun and Clarke, 2006). The outcome of this analysis is likely to result in a detailed analysis in a specific part of the data rather than overall data (Braun and Clarke, 2006).

As there are no standardised categories, the challenge for any researcher is the process of coding which requires time and effort. There is the risk of coding in a purely rigid manner where the researcher codes what is stated in the text (Bauer, 2000). What is coded is linked to the specific questions and objectives of the study that need exploring (Joffe and Yardley, 2004).

Table 7 Example of coding

Category	Subcategory	Open codes
Negative experience in Community	Living with community	Feeling of being judged Difficult to make friends People talking about me
Experience with services	Asking for professional help	Mistrust with professionals Little information given by GP Misunderstanding Problems with communication
Causes of mental illness	Thinking about why problems happen	Life as a test Health like a gift Predestination

The data was managed using the software QSR Nvivo version 9.

Computer packages aided me in the initial stages of analysis when I attempted to understand the content of text. It allows researchers to undertake more interviews than if manual analyses was being conducted (Joffe and Yardley, 2004). The retrieval of information was straightforward by usage of the software. It further enabled the pattern of codes and connections between codes to be observed. I was able to go back and look at the context where the coded segments had come from. This would have been difficult if this analysis stage was manually conducted, using printed transcripts. Software packages are primarily useful at the beginning of this analysis process, managing information and going back to recapture information when trying to understand context of the codes. One has to bear in mind it does not conduct the crux of the analysis which is to decode the meaning of the data (Joffe and Yardley, 2004).

Phases three to six relates to the development of themes. Questions and possible hypotheses about the data, and themes emerging from earlier interviews were further explored in subsequent interviews. Interview schedules were subjected to ongoing review and modification as necessary. When saturation occurred (where there was no more new data emerging), categories and themes were developed which eventually developed into the hypotheses. The data collection and analysis were simultaneously conducted. The two informed each other which helped to make comparisons at various stages of analysis. This constant comparative approach in an iterative process helps the researcher interact in a closer manner with their data and elevate the abstract level of analysis (Charmaz, 2011). Almost half of the patient data set was analysed separately before analysis took place with the religious scholar data set. An example of some of the concepts which emerged in the data and were explored and analysed is given here:

Table 8: An example of data collected and analysed (at basic level) simultaneously

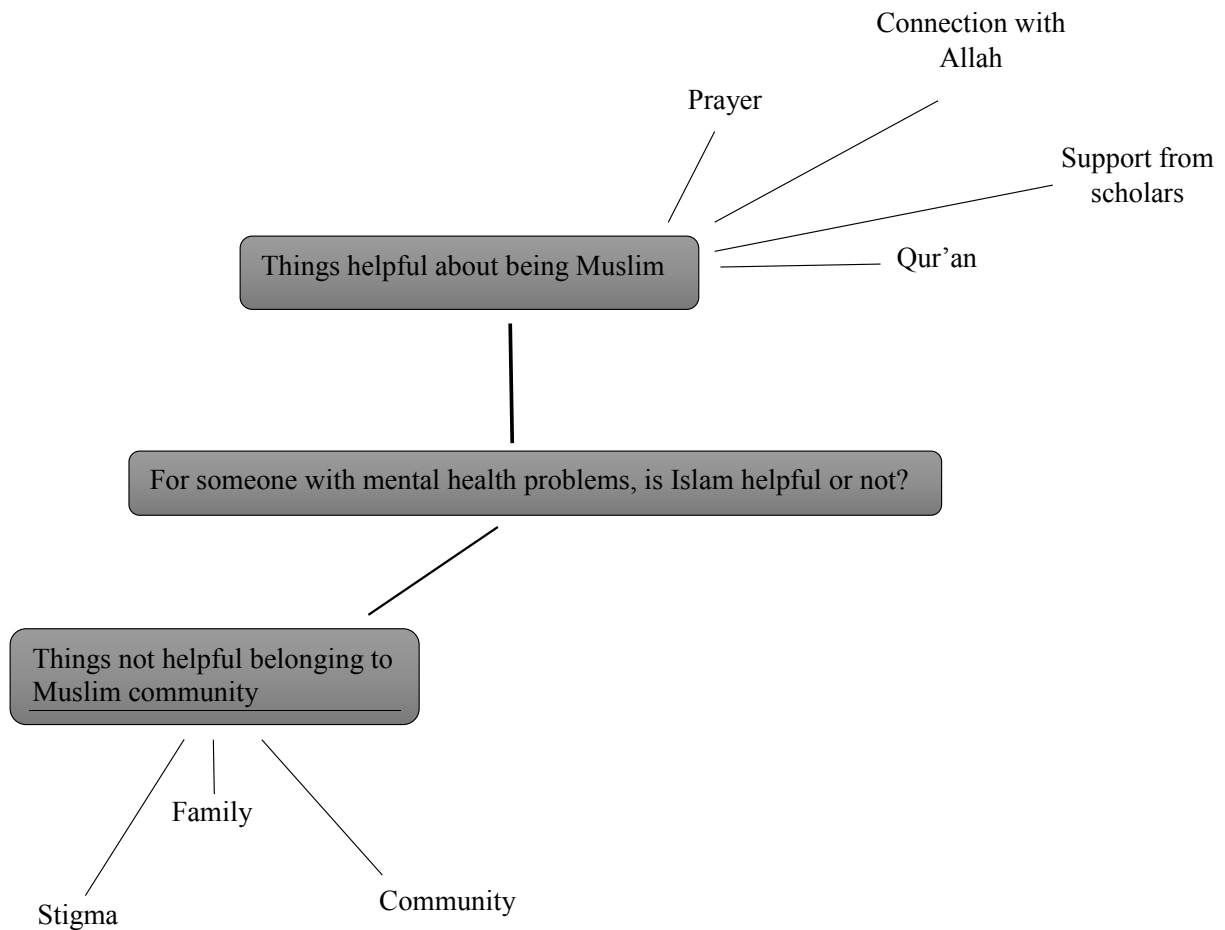
Patient data	Concepts discussed	Explored with other patients/analysis	Explored with scholars/analysis
Patients believed destiny could be changed by their prayers	Predestination	Not all patients held the same view; small number believed their destiny could not be changed	The concept was found to be more nuanced in its meaning when explored with scholars; they explained individuals have a choice in making decisions through their own actions and ability to change their destiny.
Patients saw their difficulties relating to the spiritual heart.	Concept of the heart	The heart was seen as a source of comfort and means of spiritual purification. There was also the view the heart could be affected with spiritual illnesses.	Scholars considered individuals may not always aware of this concept due to limited knowledge and less self-reflective.

In phase three, once the categories were developed, there was consideration as to how this related to the next stage of analysis, searching for potential themes. I looked to explore relationships between codes and between themes and considering the different levels of themes (sub-themes and themes). Arranging the codes into piles of paper and moving the piles together to see how they might fit with developing themes was also practically useful.

What constitutes a theme? This could be related to prevalence, however determining prevalence does not need to be performed in one way. The higher number of occurrences of data does not automatically equate to either a theme or a theme of more importance. A theme may be described by number of data items or minimally or not at all in other data items. The relevance of a theme also has to be linked to understanding the overall research question. Determining a theme therefore requires the judgement of the researcher and exercising a degree of flexibility.

Phase four included reviewing the themes and further refining them. Developing a thematic map was a useful way to gain ideas of overarching themes (figure 5). New themes emerged from the analysis. This helps consider relationships between categories and begin to organise thematic heading (Attride-Stirling, 2001).

Diagram 5: Example of thematic map



The next phase builds on the previous one, and defines and names the themes.

The themes were described in relation to their content and meanings and succinctly named, providing the reader with a feeling of the themed story.

The last stage, phase six involves linking the analysis to the research question and completing the report findings. This will be discussed in the results chapters.

5.8 Subjectivity and reflexivity

From an epistemological perspective (discussed under section ‘Theoretical and methodological approach’ on page 86), the interview is regarded as a co-construction between the researcher and subject and therefore factors relevant to this need to be considered during the interview process and analysis stage. Information is provided about my background in terms of my own faith and belonging to the same faith as the participants and scholars. My role as a doctor and psychiatrist, clinical and personal experience is also discussed. These will be explored in detail under ‘How potential bias was managed’ (see table 9, page125-130).

Qualitative researchers are faced with methodological issues not necessarily considered part of the research design. Subjectivity refers to the life experiences of the researcher and factors (such as social and cultural) that can contribute to assumptions and biases the researcher holds (St Louis & Barton, 2002). Researchers live in this world with events and experiences of their own life and bring with them their own personal backgrounds and pre-existing knowledge. They may want to undertake analysis with ‘tabula rasa’, free of biases (Dey, 1993) however theorists such as Layder (1988) and Charmaz (2006) argue it is not possible to entirely displace these views during their research. The subjectivity of the researcher might exist throughout the research process, from selection of the research topic, study design, and influence the data analysis through to the writing phase. This highlights one of the criticisms of qualitative research, the lack of objective reality which could cause researcher bias such as argued by Mays & Pope (1995): *“an assembly of anecdote and personal impressions, strongly subject to researcher bias”* and *“lacks reproducibility- the research is so personal to the researcher that there is no guarantee that a different researcher would not come to radically different conclusions”* (p109).

There needs to be an exploration of questions about subjectivity in relation to its intersections between the participants perspective, researchers position and viewpoint, and the unintended and intended research outcomes (St Louis & Barton, 2002). This study can be seen through the lens of interaction between me, participants and the research area (Altheide & Johnson, 2011). It is therefore important for me to adopt a reflective position, acknowledging and challenging my own assumptions, biases and preconceived ideas. This allows a greater level of openness in the interpretation and understanding of the lens through which I formulate my own interpretation. Furthermore, taking a reflective position can create a distance from the data and facilitate seeing meanings and patterns which otherwise might be overlooked or taken out of context.

I have many roles in my life (a Muslim, Psychiatrist, belonging to Muslim community, British). One way of understanding subjectivity is look at myself as an 'insider' or 'outsider' (Dwyer & Buckle, 2009). There arises the position of whether I am seen as an 'insider' to the area of study or member of the group being studied; sharing the experience, characteristic, role, membership with the participants or viewed as an 'outsider' to the shared commonalities by the participants.

Being a researcher with shared characteristics of the participants might allow the potential for complex and rich knowledge to be gained, access to hard to reach group and for improved rapport with participants (Le Gallais, 2008; Kanuha, 2000). However, where the researcher is viewed as an insider, the research may generate a feeling of sameness (Jenkins, 2000) and collective identity (Viskovic & Robson, 2001). There may also be an attempt to fit responses to situations in a certain way (Scahill, 2005) and lead the researcher to perceive what they anticipate (Hockey, 1993).

However, Dwyer & Buckle (2009) argue whilst there are strengths and weakness with the researcher being described as an insider or outsider, it is useful to also consider the notion that researchers could position themselves in both the inside and outside space rather than binary entities, where only one space is occupied. Le Gallais (2008) contests the binary entity (with insiders and outsiders characteristics described in each end) and states a more apt approach to understanding the subjectivity of researchers, is as a continuum. This is because researchers who are perceived to hold an insider position may in fact also have outsider characteristics and vice versa.

It is generally agreed researcher subjectivity affects their research (Reichertz, 2015). What needs to be highlighted is communicating the factors that might play a role in the researchers subjectivity and how this is addressed rather than trying to eliminate subjectivity in research (Finlay, 2008). The research needs to include a description on how my own life events and experiences shaped the area of research I was studying. Furthermore, how are assumptions that have emerged during the process of interacting with the data addressed? For example, holding preconceived ideas about the data or sharing the same views as the participants.

Reflexivity is one approach to evaluate how subjective elements impact on data collection and analysis (Finlay, 2002). Reflexivity, in research terms can be explained as a process of self-awareness analysis of the dynamics between the researcher and the one being researched (the subject). This entails a dynamic and continuous self-awareness process. This is in contrast to 'reflection', which can be considered as 'thinking about' something following a situation (Finlay & Gough, 2003). Reflexivity requires the researcher to critically look inwardly and self-reflect on the

many avenues in which their background, interests, behaviour, positioning, views and assumptions affect the research process. The use of reflexivity by the researcher can increase the trustworthiness and integrity of their work (Finlay, 2002). This process requires the researcher to critically reflect prior to starting the intended action (research work), reflect during the research and at end of the work (Schön, 1991). Some of the tools I used in this process of research to facilitate reflexivity were:

- a) Brief autobiography details. This is where I provide a description of my personal experience and beliefs that might influence the research (Denscombe, 2000). This has been described in table 9 (page 125-130).
- b) Research journal containing memo writings. This included brief points highlighting main conversation topics, my own personal reaction and response to the interview. This helped me reflect and revisit some of his views (Le Gallais, 2008, Shepherd, 2006). These were written within 24 hours of interview completion.
- c) Regular supervision. Supervision can be used to engage with and address my own subjectivity (Elliott et al, 2012). This was a space for the supervisors to engage me in discussions where factors of subjectivity were explored for their relevance and potential bias highlighted. Involvement with the supervisory team in analysis is a form of triangulation, going beyond my single voice.
- d) Consideration of my own stance in the insider/outsider continuum. This can aid the exploration of my position in the area of study (Hellowell, 2006) (See table 9).

This following section looks further at the process of reflexivity, acknowledging the impact of my own subjectivity, rendering this as transparent as possible by looking at areas bias could have played a part in the topic of research, the interviewing process and analysis of data.

Table 9: How potential bias was managed

Potential bias	Reflective process	How I managed this?
<p>Being a Muslim</p>	<p>As a Sunni British Muslim of Pakistani heritage, I was aware of belonging to the Muslim faith, I might share similar views to the participants and scholars. I could hold the stance of being an ‘insider’. Furthermore, I might have pre-conceived belief systems about the Muslim community prior to the commencement of study.</p> <p>Examples of some of the views that differed from my own and which I found difficult to acknowledge:</p> <ul style="list-style-type: none"> • View that some participants believed that Satan is able to completely control them. • View that influence of Jinn is very common. • View that mental illness is judged to be related to weakness in faith and as a punishment. • View that some participants developed doubt and blame toward God. <p>It can also be argued this was a choice of research as I am a Muslim and wanted to study Muslim views.</p> <p>Furthermore, being a Muslim, I thought about whether or not this would help me recruit the participants and allow greater access to scholars.</p> <p>I have also studied Islam informally and formally, as part of an Islamic studies course. This could give me additional insight into aspects of the Islamic faith and issues affecting the Muslim community. This pre-</p>	<p>Through the process of building on discussions I have had, being more reflective as the PhD progressed, I had to challenge my own preconceived views and this created a better understanding as the interviews continued.</p> <p>Through discussions in supervision, that I had to be mindful of not over-reading into something I agreed with and ignoring things that I disagreed with. Reflecting on this, I don't think in the initial discussions with the supervisors, I took on board my level of preconceived assumptions which could potentially have been a source of unidentified researcher bias.</p> <p>I have also spent time speaking with two scholars who I knew on a personal level and they gave me advice on my experience doing the research. This has helped greatly where they have explained how people are at different spiritual levels and come from different backgrounds and may not always agree with your view-points, particular where culture clashes with religion.</p> <p>I became more aware of my motivations and implicit biases as I progressed in my research work. This was discussed in supervision which I reflected upon, to ensure my own views did not affect the responses provided by participants.</p> <p>I have outlined how my pre-knowledge affected by data generation and analysis in the discussion section (on page 417).</p>

	knowledge could also affect data generation and analysis.	
Potential bias	Reflective process	How I managed this?
My clinical experience	<p>Reflecting on my own clinical practice, I have become more cynical of how services have changed in the last five years and level of care provided to patients suffering from mental illness, not just Muslims but all people. I was able to empathise more with the stories told by some of the participants.</p> <p>I have found it difficult not looking through the lens of the psychiatrist as this is what I have been looking at since starting Psychiatry in 2000.</p> <p>Examples of some of the views that differed from my own and which I found difficult to acknowledge:</p> <ul style="list-style-type: none"> • Where participants said medication was not helpful at all. • Where a participant said all mental illnesses were caused by nafs (ego/spirit). 	<p>Discussion in supervision and attending workshops on cultural psychiatry, I have been open to the idea there can be many terms of references, different lay explanations to one's belief systems which do not necessarily fit in the biological framework.</p> <p>I have been mindful not to agree/disagree with the experience of the participants. This happened in the initial interviews where I nodded my head in the first two interviews.</p> <p>I have also discussed issues with a GP and two psychiatrists, one who has undertook research in cultural psychiatry and another who has experience working with Muslims.</p>
Being part of the same community	<p>I could be seen as being part of the community, where there may be a fear in the hearts of the patients that I would go away and talk about their problems.</p> <p>I have experience working with individuals and organisations from the Muslim community and aware of some of the challenges facing Muslims with mental health difficulties.</p>	<p>I repeated the importance of confidentiality at the end of the interview to place the participants at ease.</p> <p>My experience working with the Muslim community helped guide me to focus on some of the areas which I wanted to explore, I considered the issues at the beginning of the research however was not led by my pre-existing knowledge during the data collection or analysis.</p>

Potential bias	Reflective process	How I managed this?
Direct experience with friends	<p>In 2011, I had a close friend who experienced mental health difficulties and where the family believed he was affected by Jinn. The family whom I have known for over twenty years approached me to ask for advice and support for their son. I agreed to support him on an informal basis but made it clear I would not be able to start any medication if this was required. There may have been an external influence affecting him as suggested by a scholar but I told the family, mental illness could not be ignored. I was conscious of how other members of the community would react if 'word got out' and concern from the family's view-point how their son would have been treated by others. I approached the situation with the view of keeping all options open, looking at physical causes, religious and mental health. He was seen by a Muslim GP privately, a scholar, and myself. The family made the decision not to approach the GP. He slowly made some recovery and after a period of six months, the family asked whether they should take their son to the GP. I responded by suggesting the family consider this option with a view of accessing psychological help. I was reluctant to give this advice at the start of his difficulties as</p> <p>I felt professionals would not necessarily understand his complaints and end up giving him a diagnosis which may not fit with his presentation. I was of the view the doctors would not be able to understand the context of his religious beliefs. I also believed they would not consider caring for him in the community, rather rush him into hospital. Also, my other concern was he would be given lots of medication. In my view, potentially if my friend accessed professional help at the beginning, this may have created a negative experience for him and the family, and consequently affect engagement and trust longer term between my friend and professionals/mental health services.</p>	<p>I acknowledged a similar story was being told by some of the participants where they felt they were not mentally unwell but affected by other causes.</p> <p>The experiences might promote insight through examining these personal experiences and responses.</p> <p>It was important for me not to start sympathising and probing participants in a certain way but to engage them in the discussion, to tell their story and for me to sit back. As the interviews progressed, I relied less on specific questions/topic guide and asked fewer questions.</p> <p>I have detailed my personal experience in the introduction section.</p>

	<p>He was able to make a full recovery after a year.</p> <p>I had a previous experience with another friend. In 2007 when he became mentally unwell and asked for my advice. He refused to access the GP in the first instance. I suggested he seek support from his family, social circle and visit a scholar. My friend made a recovery after a few months.</p>	
Potential bias	Reflective process	How I managed this?
Personal experience	There might have been the issue where I related the illness of participants to mine. I have been unwell physically in the past and could have shared my own experiences with participants.	I was mindful I did not share my own experiences in relation to illness with others.
My first language being English	<p>It may be I would prefer to conduct my interviews in English.</p> <p>English is my first language with good understanding of Urdu and Punjabi however I am not fluent speaking in these languages.</p>	<p>This was discussed in the ethics meeting whereby it was made clear translators would be provided where an individual requested this.</p> <p>Professionals who were helping recruit patients were also informed of this provision.</p>
My role as a Psychiatrist, Doctor and impact of this identity on scholars	<p>A number of scholars asked me about my background, community work I have been involved in, mosques I attend and scholars I personally were familiar with.</p> <p>This could have had an impact on the decision on part of the scholar to agree to take part in the study and also during the interview.</p> <p>I could be perceived by the scholars as being an expert in mental health and they might put forward responses which I expect.</p>	<p>I reflected on this and discussed in supervision. This was seen as the process of building trust with the scholar.</p> <p>It was important to highlight to scholars it was their interview, not mine. I wanted to capture their views irrespective of my own.</p>

Potential bias	Reflective process	How I managed this?
<p>My role as a Psychiatrist, Doctor and impact of this identity on patients</p>	<p>Participants were aware (from the recruiting team) I was a psychiatrist. I was mindful of this and made it clear to them, my role was a researcher and not as a psychiatrist.</p> <p>Being a psychiatrist/medical doctor, I was well aware of the impact this could have. How would I come across? The perception of authority, fear that may be projected towards others. I could be seen as an 'outsider' to the participants.</p> <p>In two of the interviews, the patients asked my view about the clinical management at the end of the interview. I directed them to their general practitioner.</p> <p>This made me think, were some participants more inclined to see me knowing I was a psychiatrist. My own reflections include longer waiting times to see a psychiatrist and could participants be agreeable to take part in the study, where they may see it as an opportunity to ask about themselves.</p> <p>The area of study related to mental health. There might be the idea of stigma being perceived by individuals, which could be influenced either by their own past or current experience suffering with mental illness or other research studies. This could affect their decision to take part in the study.</p>	<p>I examined the impact of my position as a Psychiatrist. I was aware discussing my perspective could impact on the participants and scholars.</p> <p>During the first contact, I dressed in a casual manner and never in formal clothing. I also introduced myself with my first name, 'Imran' rather than 'Dr Ali'.</p> <p>I did not mention my profession and when asked specifically about their clinical care and treatment, I diverted the response to their GP or own psychiatrist as someone more appropriate.</p> <p>I was aware participants may refuse to take part in the study. I provided a clear outline of the study to professionals helping with recruitment, that the study focus extended to looking at aspects of the Islamic faith which was important to the person rather than focusing on the area of mental illness.</p>

Potential bias	Reflective process	How I managed this?
<p>Impact on research topic on patients and scholars.</p>	<p>The area of study related to mental health. There might be the idea of stigma being perceived by individuals, which could be influenced either by their own past or current experience suffering with mental illness or other research studies. This could affect their decision to take part in the study.</p> <p>Also, the subject area could have influenced a scholars decision to take part in the study. If the scholar held the view this was not a useful area of exploration, they may not favour taking part in the study.</p>	<p>I was aware participants may refuse to take part in the study. I provided a clear outline of the study to professionals helping with recruitment, that the study focus extended to looking aspects of the Islamic faith which was important to the person rather than focusing on the area of mental illness.</p> <p>I made it clear through verbal and written information, of the importance of the study and contribution participants would make.</p>

5.9 Rigour and quality

The field of health carries with it a long established traditional biomedical approach to research, utilising primarily quantitative methods and where qualitative research is “*criticised for lacking scientific rigour*” (Mays & Pope, 1995, p311). The trustworthiness of research by qualitative methods is challenged by proponents of positivist tradition (Shenton, 2004). Validity in this tradition can be understood as encapsulating concepts such as objectivity, fact, reason, universal laws, mathematical data (Winter, 2000; Golafshani, 2003).

The examination of validity helps to answer whether the findings are trustworthy (Yardley, 2008).

There is however no consensus on assessing validity in qualitative research (Yardley, 2000).

Darawsheh (2014) highlights reflexivity has a place in promoting rigour and quality of qualitative research. This is to be considered particularly when undertaking research with ‘other’ ethnic groups (Adamson and Donovan, 2002). A useful approach to understanding validity and quality is use of guidelines. One however needs to bear in mind the issue of criteria being too rigid and impeding methodological development (Reicher, 2000). Generally, qualitative researchers are of the view that rigour and quality of their work be assessed on its own standing, rather than rated against checklists (Donovan & Sanders, 2005).

Yardley (2000, 2008) developed criteria for assessing validity. This was used in this study as its interpretation is open to degree of flexibility and can be related to wide range of qualitative methods. Yardley argued four aspects as characteristic of good qualitative. These will now be outlined.

Sensitivity to context

This was considered as follows:

- a) Reviewing the relevant theoretical literature and previous empirical work (Yardley, 2000; 2008) is important to begin to understand the context of a qualitative study. This also includes awareness of the socio-cultural setting. The previous chapter considers this information. This identified factors relevant to mental health and illness in Muslims and gaps in the literature.
- b) The perspectives of participants have been considered by use of quotations in the results chapters.
- c) Connecting the findings to relevant literature in the discussion chapter.

Commitment and rigour

Through “*in-depth engagement with topic*” (Yardley, 2000, p219) and data collection, data was analysed with degree of depth and breath, to draw out meaningful data.

Transparency and coherence

Coherence was achieved through clarity for the argument of conducting the study. It also describes the “*fit between the research question and the philosophical perspective adopted, and the method of investigation and analysis undertaken*” (Yardley, 2000, p222). The aim of this study was to examine the relationship between Islam and mental health and a thematic analysis of interviews with patients with mental illness and Muslim scholars could provide this description. Transparency is achieved through a clear process of research and methodology described in detail in this chapter. It also includes exploring my own assumptions and views. This is detailed in the reflexivity sub-section in this chapter.

Impact and importance

The validity of the research is also judged on its impact and importance (Yardley, 2000). The importance of this research area and necessity to conduct this study area has been described in earlier chapters. The study can also impact on practice by facilitating the understanding of perceptions and coping strategies in Muslims. This bridges the gap between research and practice (Swanson et al., 1997).

5.10 Conclusion

This research examining the interface between Islam and mental illness entails the exploration of difficult and complex questions with a wide spectrum of views. A qualitative approach was deemed the most appropriate method to address the research question, drawing on modified approaches from grounded theory. Two groups of participants were selected: Muslim patients with current or past history of mental illness, and Muslim scholars. Patients were recruited through General Practitioners in Manchester and mental health trusts. The process of engaging professionals to help with recruitment of patients was discussed. Also described was the experience of recruiting religious scholars. Ethical issues and process of approval have been highlighted. A theoretical sampling strategy was undertaken for the recruitment of scholars and data analysis using a thematic approach. Subjectivity was an important area highlighting potential areas of bias and reflexivity has been explored.

An overview of the methodological approach has been presented here. This includes the data collection and analysis process. The findings will now be presented in the results chapters.

6 Chapter 6 – Understanding of the religious dimension of health. The Muslim philosophy of life: pain and suffering

6.1 Structure of the findings chapters

The analysis of the data will be covered over four chapters, 6 – 9.

The findings from the first three chapters will explore the Muslim philosophy of life, as well as how pain and suffering are understood from an Islamic perspective. Further, how Islamic beliefs influence a person's understanding towards mental illness and in the third chapter, how a person's outlook on life and religious beliefs help them cope, or not, with their mental illness. These chapters address the first objective of this study, namely to:

“better understand how religious beliefs and practices influenced people's understanding of their mental health problems, and helped them cope or did not help them cope”.

Chapter 9 considers contact with services from a Muslim's perspective with a focus on barriers and facilitators that may be distinct to the Muslim community or play a significant role in their accessing formal mental health care. This addresses the second objective of this thesis:

“identify the barriers and facilitators of helpful pathways to care, involving existing care systems but specifically Islamic scholars and religious leaders who may be consulted”.

A thematic structure will be outlined in this introduction. Each of the chapters has been set out in the same format, to help orientate the reader in understanding the levels of analysis: use of quotations for specific reasons, making sense of the data through interpretation, drawing out the similarities and distinctions within each group/between the two groups, summarising what the findings add in comparison to previous literature and setting out the concepts and themes.

The chapters will begin with a brief introduction to the subject area and its significance. The core themes and sub-themes will be presented at the start of the results chapter 6-8. This will provide an overview of themes covered for each group to guide the reader and map out the comparisons and distinctions across the groups. In each chapter, the sections will contain quotations and contextual descriptions to bring a greater understanding of the themes grounded in the experiences of the participants. The data from scholars will be presented in the second section of each chapter.

Verbatim quotations have been selected to represent the findings for a number of reasons. Firstly, where they have a clear meaning and demonstrate a depth of description. They also provide a representation of arguments and counter-arguments. Also, where the selected quotations reinforce a rich illustration of the emerged themes. The use of ellipsis (...) in a sentence denotes omitted text. The addition of square brackets signifies explanatory text. Where quotations have been used previously due to its relevance, this will be highlighted in the footnote.

Secondly, how the concepts and themes emerged from the data will be made clear in the relevant sections. This will provide clarity on whether the headings have either emerged from: the responses to the interview schedule, non-verbal cues/expressions and physical reactions from the interviewees, drawn from existing literature, based on the researchers' understanding of prior Islamic knowledge, through reflexivity and the researchers' interpreting interviewees phrases, making sense/conceptualising of the developing concepts and themes through an inductive approach or a combination of these.

A finer look at the analysis will take place in each of the chapters, with similarities and differences drawn out between each group and the two groups. Where there is new information or additional dimension to the analysis, this will be brought out. The value of this comparison will be examined. The state of the art of knowledge on the topic will be outlined at end of the chapter, bringing out what is already known on the topic, gaps in the literature and what this study has added. Each chapter will then end with a summary of the main findings.

The mention of 'scholars' refers to the scholars involved in the study rather than scholars in Islam (unless otherwise stated).

Diagram 6: Thematic structure of findings

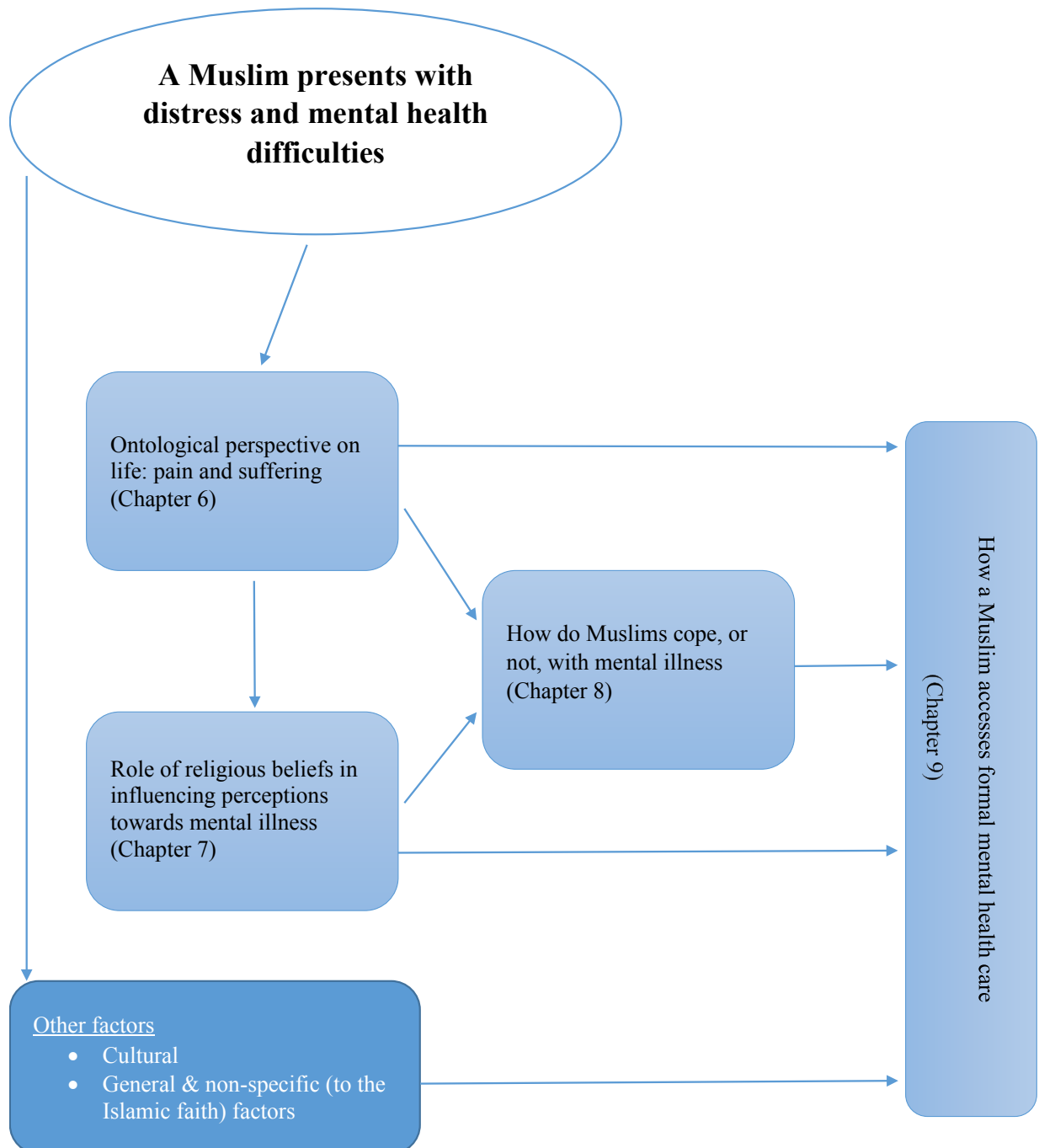


Diagram 7: Overview of findings

	Outlook on life	Perceptions towards mental illness	Coping strategies	Pathway for Muslims
<p>Context</p> <p>Examining two groups:</p> <p>A Muslim suffering from mental illness.</p> <p>A scholar who has experience dealing with people with mental health difficulties.</p> <p>What are their views relating understanding of pain and suffering, and causes of distress and mental health difficulties; and what is helpful or not in getting better?</p>	<p>Muslims present with a specific ontological perspective, unique to their faith.</p> <p>The emerged concepts provide a prism of understanding towards pain and suffering which fall outside the realm of mental illness.</p> <p>Outlook relates to facilitating a sense of purpose and meaning of life.</p> <p>Islam presents a perspective on why God allows suffering.</p> <p>It is a question open to interpretation on whether belonging to the Islamic faith can prevent mental illness.</p> <p>Islam provides a mechanism for the individual to develop resilience and facilitate recovery.</p> <p>In Islamic tradition, health, wellbeing, mental health/emotional health are conceptualised in a distinct manner.</p>	<p>Muslims hold perceptions towards causes of mental illness that are sensitive to their religious beliefs.</p> <p>This paradigm is integral to Muslim beliefs.</p> <p>There is the description of a spiritual force within humans, constituting of four spiritual elements. This determines a person's behavior and personality.</p> <p>Spiritual dimension of health formulated. This is in contrast to the Cartesian mind/body split.</p> <p>Muslims may attribute alternative causes such as punishment and weak faith. These notions have to be understood further.</p> <p>Other non-religious explanations may need to be considered.</p> <p>There may be psychological/social factors in addition to religious ones that play a role in the vulnerability to being affected by other realities (Jinn, sihr, nazr)/Satan.</p>	<p>Muslims use number of coping strategies specific to their faith in a holistic approach. This is at multiple levels.</p> <p>Social strategies shaped by a religious outlook used.</p> <p>Factors highlighted such as managing one's emotional health and receiving psychological support. Conventional approaches and Islamic concepts are not mutually exclusive and may be seen as complementary.</p> <p>Process of change identified steps a person goes through during their recovery journey.</p> <p>Relationship with God is a central axis a Muslim life revolves around.</p> <p>There are also challenges undertaking religious practices and negative experiences with Imams.</p> <p>There may be use of spiritual ideas/practices to avoid facing emotional difficulties.</p> <p>Emotional support was less frequently discussed by scholars in comparison to other coping strategies.</p>	<p>There are barriers and facilitators specific for Muslims accessing mental health care.</p> <p>A Muslim may not formulate their distress as a mental health problem. They may hold a different model of mental health.</p> <p>Even if distress is recognised as mental health related, there may still be barriers to accessing help.</p> <p>There are alternative pathways of support including support from imams and scholars.</p> <p>There are expressions of emotional distress & difficulties related to Islam.</p> <p>Pathways to care are linked with explanatory models.</p> <p>These areas need to be considered when engaging Muslims in distress and mental health difficulties.</p>

Finer grained analysis

- A number of nuances exist in understanding Islamic concepts.
- Extended discussions and narratives need to be considered.
- Emerged concepts relate to each other and themes are inter-connected which affect pathway for Muslims.
- Contextual factors need to be considered- coping strategies are not mutually exclusive, level of understanding and spiritual development may vary for a person, impact of mental illness on the person, cultural factors, usefulness for the person, semantic meaning of words and expressions need to be understood.
- There are key similarities and differences that exist within the two groups (participants and scholars) and between the two groups.
- The pathway simply outlines access to mental health care is affected by differing expressions of distress & explanatory models. It does not signify that formulating these emotional/spiritual difficulties as a medical condition as appropriate. Also, even if a person recognises their problems as mental health related, they may still not access professional help. This does not mean this it is unfavourable as they may choose an alternative form of help.

6.2 Introduction

To acquire an understanding of Muslims' perception of their mental health, it is necessary to examine the Muslim philosophy of life; pain and suffering. This chapter illustrates data that emerged which describes the Muslim philosophy of life as a core subject area. This topic is discussed at the beginning of the findings' section as other topics stem from this main key theme and appear to be connected. This section on Muslim philosophy of life will therefore help the reader to begin to navigate around the subsequent chapters relating to how religious beliefs influence Muslims' understanding towards their mental illness and how this helps them cope, or not, with their mental illness.

The author also considered it important to examine in this chapter how the concepts health, well-being, mental health and mental illness are conceptualised within the Islamic tradition, prior to gaining an understanding of their religious beliefs and how this might influence perceptions towards mental illness in the next chapter.

Why is it therefore critical to examine the Muslim philosophy of life and examine its correlation to mental health difficulties and illness?

It is a question of whether or not the definition of mental health relies upon a scientific outlook and the realms of illness or a question of what Muslims consider as normative. And just as others have reflected on links between other cultures, traditions and faiths, the author is interested in the specific context of the Islamic faith and mental illness. As outlined in chapter 3, the study of Islam and mental health raises many conceptual questions as well as empirical ones, particularly in the area of (1) meanings attached to mental illness (encompassing experiences, stories, beliefs) and (2) the

nature of facts (the truth and agreement around psychiatric diagnosis).

The first section of this chapter focuses solely on data derived from the participants interviewed in this study. The corresponding views of scholars will be presented in the second section of this chapter, bringing out similarities and differences with participants.

Diagram 8: Overview of themes and sub-themes (1)

Participants

Scholars

Area of study

Understanding the Muslim outlook of life and its relation to mental health difficulties, pain and suffering

How concepts health, well-being, mental health and mental illness are understood from Islamic perspective

My destiny

Purpose of mental illness

- Life as a test
- Spiritual growth
 - Remembrance of God
- Spiritual wisdom
 - Spiritual purification
 - Blessing from God
 - Protection
 - Sign of love

Balance

- Balance of two worlds

Predestination

- Freedom of choice
- Capacity to change one's destiny
- Practical effort

Purpose of mental illness

- Life as a test
- Spiritual growth
 - Remembrance of God
 - Spiritual transformational factors
 - Spiritual awakening
- Spiritual wisdom
 - Sign of righteousness
 - Blessing of God
 - Protection
 - Spiritual purification
 - Spiritual elevation
- Why God allows suffering

Balance

- Fitrah
- Balance of two worlds

Will of God

- Everything occurs with God's Will
- Good and ill health comes from God

Nature of man

- An Islamic perspective on the nature of the human

Understanding health, well-being, mental health and mental illness

- Islamic perspective on health and well-being
- Understanding of mental health and mental illness

The most frequently discussed areas related to predestination, life as a test and remembrance of God (under purpose of mental illness).

Similar to participants, scholars commonly discussed predestination, life as a test and remembrance of God.

Scholars discussed all the areas covered by participants however predestination and life as a test were explored in more depth.

Scholars also frequently brought up spiritual wisdom and spiritual growth.

6.3 Participants' views

This first section will present the following themes from the participants' data:

- My destiny
- Purpose of mental illness
- Balance of two worlds

6.3.1 My destiny

Illness as part of destiny is consistent with the Muslim philosophy of life. This will be further reflected upon in the discussion. The concept 'my destiny' came from direct quotations used by small number of participants. This phrase also captures the meaning being implied by participants, that God already knows what happens to them in this life and their mental health difficulties was part of this. The idea of predestination was taken from the interview schedule.

Predestination, is the fundamental belief held by participants was qadar⁵, God's knowledge of all things in pre-eternity. Everything is predestined, already known to God before life. This includes life experiences and events. This appears to provide participants a sense of understanding of their circumstances and mental health difficulties:

"everything is decided before your life...Like my son, the second one he cannot get a job and I said to him your rizq [sustenance] from Allah is written in your Kismet [urdu for qadar]" (P6, Female Malaysian).

The majority of participants discussed qadar being a central facet to their religious belief. When

⁵ Qadar is the concept of divine destiny in Islam. All things to come is already known to God. It is one of the articles of the Islamic belief. This is explored further in discussion chapter (page 38).

asked directly about belief in predestination, one participant went as far as saying he was not a Muslim if he did not believe in predestination:

"I am not Muslim otherwise" (P4, Male Somalia).

There were varying views how participants understood the concept of qadar. Slightly more participants believed their destiny could not be changed. This participant who continued to have symptoms of schizophrenia despite being on medication, did not feel he would get better; he was probed further and asked if his destiny could then be changed:

"I cannot change my kismet....still have problems...there isn't a cure for everything" (P8, Male Kenyan).

Participant 11 was of the view that any attempt to take action and change would be going against destiny. He was further asked about this and he expressed his opinion any action would be wrong:

"Whatever is written in naseeb [urdu for destiny] and qadr, this is kismet and this comes from Allah...no, that is not possible...no, not do anything, against kismet...wrong to do this, against kismet, comes from Allah" (P11, Male Indian).

This might lead to little effort being exerted for change and hinder an individual from seeking help. An example of a female participant suffering from chronic pain and depression is given. She felt the treatment offered to her was ineffective and accepted her situation as part of her destiny; this led to a sense of helplessness and feeling despondent:

"I am tired now and no help for my pain. How many times to go to GP? I still feel not happy. I have been to counsellor, doctor in hospital, GP, appointments but not feel better. I see Dr ... I just make dua and read Quran in the house and trust in my Allah. I have been on so many tablets that Dr...."

not feel like giving me more, he say. They have not worked. What can I do?" (P3, Female Pakistani).

A smaller number of participants however did not believe their destiny was necessarily fixed and could be altered:

"Again it is part of my Kismet...it is pre-destined that I was going to have the depression and the test is how I deal with it, you know, do I blame everything on Allah? and sit back and say woe is me and say this is it, every illness comes from Allah...but I have to help myself as well. I can't just sit here feeling sorry for myself I need to go and get the help that is out there. Because the solutions are out there for nearly every problem there is" (P10, Female Pakistani).

Another participant who believed in changing her destiny, shared her view that there was goodness in God's plan:

"it is ordained by Allah, nothing is ours, we plan something but the master planner plans it differently it is always for the better" (P6, Female Malaysian).

The analysis suggests a person's understanding of the concept of predestination affects whether they feel they can change their destiny and this could impact on the steps they take to seek help. Individuals who feel their destiny cannot change may feel less control over their situation and have a sense of helplessness.

Qadar is such a central belief, it may be understandable why Muslims might frequently relate back to this, particularly, in their times of pain and suffering.

6.3.2 Purpose of mental illness

Participants discussed a number of reasons that could explain why they were suffering from a mental health difficulties and mental illness from a religious perspective. This was in response to questions from the interview schedule, asked in an indirect manner, why they became ill and also directly, for example whether their experiences were a result being tested by God. What came out from the participant's data was there was another explanation presented by individual's why things occur, good and bad. Exploring this purpose seemed to navigate a person through their illness and create meaning through their faith. This led to conceptualising the idea of 'purpose of mental illness'.

This has been grouped under three headings: life as a place where they are tested, spiritual growth and spiritual wisdom. The majority of participants discussed their difficulties related to being tested in this life, followed by a time to remember God (part of spiritual growth) with a smaller number of participants discussing the other areas.

6.3.2.1 Life as a test

The notion of Divine trial is referred to as *ibtilā'*. This life as a place to be tested by God has been briefly described in previous literature and the idea incorporated in the interview schedule.

Understanding the concept of life being full of trials and tribulations is relevant as a person's own difficulties may be seen as a test as indicated from the data. The majority of participants tended to conceptualise their suffering as being part of a test rather than as mental health problems:

"This world like a journey, a traveller in this life where I am tested" (P11, Male Indian).

This appears to help some of the participants place their difficulties in perspective, with a positive mind-set:

"The test is this world is to help remember Allah and is like ticket to the future life, jannah [paradise], it is to help be successfully in the hereafter" (P2, Female Tunisian).

A Muslim view of eternity is indicated here, where the journey in this life is regarded as temporary with the after-life viewed as eternal. This is further discussed on page 156.

However, not all the participants shared this positive outlook with a small number not expecting to be tested through their suffering of mental illness:

"To be honest we don't expect things like this, to be tested in this way...don't have the strength to deal with them anymore" (P10, Female Pakistani).

Another aspect emerged related to the idea of prevention. A minority of participants shared their view that role of their faith was to prevent mental health problems from occurring:

"My faith has helped me with my problem and stopped problems...this has been as a test from Allah as I said in this world and if Allah tests me again with this illness, I will say alhamdolilahi [all praise is to God] and believe my problems will be prevented" (P2, Female Tunisian).

Some of the participants were also of the view the test was not just for themselves but for others:

"I think it is about how they react. Like I said this person made that comment to someone who was suffering with severe mental health and they were not sympathetic, caring or understanding so that is a test for them" (P10, Female Pakistani).

The concept of life involving trials for the person was an important outlook held by Muslims, which seems to be intertwined with other facets of the Muslim way of life such as remembrance of God: *"to see how much we turn to Allah, how much we remember Allah in our daily life and only at the end we know if we have passed the test or not, but that is what I do believe...this is the true purpose of life, worship Him"* (P10, Female Pakistani).

The concept of life where individuals are tested emerged as a salient theme in Muslim life. The understanding that life in essence is with trials and tribulations could help explain why individuals frame their experiences relating to this theme.

6.3.2.2 Spiritual growth

The purpose behind trials and tribulations in a person's life overlaps with the concept named here as 'spiritual growth'. The experience of mental health difficulties and illness could be interpreted relating to the development of an individual's level of spirituality. This is where an individual strives to grow themselves spiritually through their own actions and fostering qualities, which strengthens their connection with their faith. Naming this area 'spiritual growth' in essence captures the underlying meaning.

6.3.2.3 Remembrance of God

In relation to this concept of ‘spiritual growth’, remembrance of God⁶ was discussed the most.

This emerged direct from the data. Participants spoke about good and difficult times being a time to remember the creator, God.

This could be seen as a source of comfort and strength for participants:

“I remember Him when I am low and I have trust in Him. You know, like a comfort tablet. Better. We need Allah as we can do everything all the time but we still need His help, all the time” (P4, Male Somalia).

The quote *“If we remember Allah, Allah will remember us”* used by the following participant was used similarly by other participants. This participant was asked about the purpose of life and in response, mentioned the remembrance of God:

"This gets me strong [smiled]. If we remember Allah, Allah will remember us. You know he is happy" (P5, Female Indian).

This could be explained by the fact there is a similar reference found in hadith.

6.3.2.4 Spiritual wisdom

In contrast to spiritual growth, fewer participants discussed the area relating to wisdom as a purpose of mental illness. The conceptualisation of this term came through understanding the phrases discussed by participants whereby there seemed to be an indication pointing to an underlying

⁶ Remembrance of God includes specific ‘dhikr’ and generally mentioning God or anything related to Him. It has a special significance for Muslims, which purifies the heart and helps an individual attain success and salvation (Murad, 2008).

benefit or goodness for the person. Participants were subsequently asked directly about it. The two concepts 'spiritual wisdom' and 'spiritual growth' seem similar but the main distinction between the two concepts is that spiritual wisdom relates to areas which explains why God may allow suffering whereas spiritual growth is attained through a person's direct actions which is a process of self-development. Also, the dimensions to spiritual growth are tangible, whereas the aspects to spiritual wisdom are not visible, nor it is possible for the person to be definitive about the individual aspects of wisdom as specifically pointing to the underlying reason at that point of pain and suffering.

6.3.2.5 Spiritual purification

The experience of their mental illness could be seen as a journey where the wisdom entails a process of purifying the individual. A minority of participants believed their sins would be washed away and rewards given. This is described by this participant who felt she was not a good Muslim in her youth and never prayed until she was older; understanding her difficulties as washing away her sins appears to be a source of hope and peace for her:

"if somebody is very ill one that their sins are washed away and secondly whatever prayers they make Allah will listen to those prayers even more, and again, sometimes when I have been really low or upset I have thought about that, you know it is a way of being cleansed of any sins I have had or any dua I make whilst I am very upset...listen to that prayer so instead of making me feel Oh woe is me, it sort of give me a don't worry about it you will be okay, inshallah there will be something good out of it, either one of your prayers will be heard or your sins will be cleansed, so it stops me going lower into my despair. It really gives me that comfort and support...Yes, sins washed away with difficulties" (P10, Female Pakistani).

6.3.2.6 Difficulties as a blessing from God

There is a parallel here with the idea of suffering as purification. Mental health difficulties may be a blessing from God. Reflecting on one's problem and viewing their situation as a blessing whilst experiencing mental health difficulties was described here:

"blessing as well, you can learn a lot from this problem...so this is good there is the blessing of this"
(P4, Male Somalia).

6.3.2.7 Experience seen as a protection

The experience of suffering from difficulties could be seen as a protection from another worse situation. Three of the participants discussed this. This appears to help them place their own situation in perspective. This participant described her anxiety of not being married but was then able to think if she were married, this could have caused more difficulties in her life:

"that is one of the ways I do rationalise it that Allah is protecting me from something...my mum and gran get upset they worry that I am not getting married yet and what is going to happen to you, obviously this impacts on to me because I get upset seeing them upset ...if I was married now maybe this would have caused major problems in my marriage so maybe he is getting me to a point where I am maybe strong enough emotionally and then get married, or the right people have not come and they would make my situation worse and Allah is protecting me" (P10, Female Pakistani).

For this participant, who experienced symptoms of psychosis and felt isolated, distant from her friends and family and unable to speak about her problems said:

"faith will protect you from these bigger things, so it is like protection from any other bad things that you will never get from doing them" (P2, Female Tunisian).

6.3.2.8 Experience seen as a sign of love

A small number of participants shared their thoughts around their difficulties being a reflection of God's love showered over them:

"I do sort of I mean one of the things I used to hear when I was young was that Allah tests those he loves the most" (P10, Female Pakistani).

6.3.3 Balance of two worlds

In addition to the idea of predestination, purpose of mental illness, the concept of balance emerged from the data. This relates to weighing the idea of this life which is short and temporary versus the after-life, which is permanent and long-lasting, leading to the idea of 'balance' between the two places.

Balance of this life versus the after-life

A small of participants discussed their view that life in this world is a short, temporary abode and a gateway to the after-life. This appears to help participants place their difficulties in perspective and aid their understanding of why things happen in life:

"The test is this world is to help remember Allah and is like ticket to the future life, jannat [paradise], it is to help be successfully in the hereafter, inshallah [God Willing]" (P2, Female Tunisian).

Some of the participants appear to accept that pain and hardship would happen in this world with some saying true, longstanding peace of mind is only possible in the after-life and not this world. This participant who suffered from Schizophrenia and experienced long standing difficulties, described their experience of living in this life as being like a traveller on a journey passing through this world. Furthermore, she described the perspective of balancing the expectations of this world versus the after-life

"this world, you do good and will go through difficulties and the reward in the after-life. Dunya [this world] is not for sakoona [peace of mind] and sakoona for akhirah [after-life] which will be forever. This world like a journey, a traveller in this life where I am tested" (P11, Female Indian).

6.4 Scholars' views

This section now moves on to the data from the scholars interviewed in the study. Similarities and differences with data from participants will also be drawn out in this section.

The following themes will be discussed:

- Predestination
- Purpose of mental illness
- Balance
- Belief in the Will of God

All the themes discussed by the participants were covered in the interviews with scholars.

The scholars discussed the area of predestination similar to participants but brought out layers of discussion connected to understanding this concept in a more nuanced way.

The purpose of mental illness was discussed more in detail, with new areas described; this related to spiritual wisdom and growth. Fitrah (see page 166) (as part of balance) and belief in the Will of God were newly discussed by scholars.

6.4.1 **Predestination: freedom of choice, capacity to change one's destiny and effort required.**

The notion of 'predestination' was used directly from phrases used by scholars. Similar to participants, the majority of scholars discussed predestination as part of their belief system:

"what He has decreed...that is written from God" (Scholar 2).

Some of the scholars echoed their experience with the Muslim community, where they felt there were mixed views evident around the understanding of predestination:

“Misunderstanding of qadar is, they don’t make steps to their situation, they [Muslim community] don’t believe their destiny can be changed...it doesn’t mean you give up your means to changing your situation” (Scholar 15).

This is similar to the participants data, where there were contrasting views with slightly more participants of the opinion destiny could not be changed.

Pertinent to this concept are three areas of relevance which can be understood from the data from scholars, in understanding the principle of predestination: freedom of choice, capacity to change one's destiny and effort required in this.

Relating to the question of choice, God does not compel a human being to do something by force but allows them to make choices and act accordingly through their own actions. A person has the free-will to make decisions for themselves, whether that be, to take steps to change or seek help for their difficulties or decide not to ask for help:

“to choose, to remedy a situation also is the part of understanding qadar” (Scholar 2).

“There is no compulsion, Allah swt does not force you to do things, these are your own choices, you have choice to look at your situation, you decide to ask for it, support or not”

(Scholar 15).

Qadar also encapsulates the meaning that a person has the capacity to change their destiny. As this scholar highlights, a person does not really know what has been set out in their destiny:

“We can still work and change what we may think is our future” (Scholar 7).

The idea of having the power and choice to change events could be understood under the concept kasb:

“people being aware they have the volition and choice to change things, kasb, this goes against the fatalistic view” (Scholar 2).

Muslims may not feel that their destiny can change, developing a fatalistic stance as argued by scholar 2; this is presented as a cultural understanding of ‘qadar’:

“Just accept it and almost lie down in the face of it rather than be proactive and try and change the situation...it is more of a cultural trend”.

People may also justify their situation on qadar:

“when things go wrong in the past, and it is their own doing, and they are do learn and keep on doing it, they are quick to blame it on qadar, their understanding on qadar, quick blame, it’s qadar, cannot do anything about it” (Scholar 5).

The last area of discussion related to taking responsibility and exerting effort in changing one's destiny. This practical effort or response to alleviate an illness or situation is considered a part of qadar:

“You try your utmost best and you don't just accept things” (Scholar 5).

Scholar 15 was directly about the extent a person can understand qadar. He suggested only a limited understanding is possible and also indicated not to get too preoccupied about it:

“it’s difficult to fully understand qadar completely, also we do not do too much research, delve too much into it...are aspects that can change and aspects that cannot change” (Scholar 15).

It also appears part of destiny is fixed and another layer to it, is that it is conditional on actions.

An individual's destiny therefore may be changed, as it is influenced by the choices made in life and actions. The idea of predestination may be used to console the past but not necessarily used to justify the future.

The findings from the scholars data appear to illustrate not just the relevance of the concept of predestination but also layers of understanding surrounding this concept.

6.4.2 Purpose of mental illness

The Muslim philosophy of life further encompasses an understanding as to why a Muslim may experience hardship and difficulties in life. Scholars discussed why, in their opinion, mental health difficulties and illness may occur from a religious perspective. This could give an insight into why a Muslim undergoes pain and suffering and creating a greater understanding of purpose in life.

The scholars provided further description on the concepts compared to participants. There is also additional information not discussed by participants which relate to spiritual growth and wisdom.

6.4.2.1 The Divine trial

Similar to the participants, the majority of the scholars discussed this life being a place of trials and tribulations. This appears to be a central perspective in Muslim life that every person undergoes a test in this world:

“This dunya [world] is a test, life a test for us and everyone” (Scholar 3).

All the scholars discussed this particular concept, which was the most frequently discussed area by them. Scholars described nature of life as:

“People go through various suffering, pain, Allah swt has created man in toil and struggling”
(Scholar 12).

The idea of struggle as part of life was explored further through two Arabic terms, mu3anat and mujahadah:

“mu3anat, to struggle, you are suffering with something...to intend something, to really roll up your sleeves, concerned about it...could mean inflicted by hardship, many nuances...mujahadah, basically pushing yourself, exerting effort, not giving up” (Scholar 17).

The description of toil is provided by another scholar. The trial is not without purpose. The reason of the test is to place people in categories according to their good or bad deeds. And according to these categories/status, a person may have success in the afterlife or not:

“created out of turmoil...to imply the meaning of constant unfulfilled longing, and in that sense [...] man is created in the world to be tested...to create categories of people, to see who is the best of them in deeds, in action” (Scholar 2).

One may understand the purpose of the test for Muslims is to return to God, to ask Him for help and remember the purpose of his existence in this world in the first place, to worship God:

“to see how grateful they are, thankful, how much they remember Allah swt...Ask Allah for help...remember our purpose of why we were created, to worship Allah swt” (Scholar 12).

Another purpose of tests is to bring goodness to the individual as described here:

“If Allah (swt) wants good for a servant...they undergo difficulties” (Scholar 7).

An important facet emerged from the interviews with the scholars is that the test may be continuous (as opposed to specific times when the person is tested) and those God loves most are tested more so, as this scholar described:

“think about their circumstances, events in their lives to be part of test such as difficult marriage, financial problems but people can be continuously tested... people closest to the Prophets are given the most affliction” (Scholar 2).

An individual's mental illness might also be a test for others, similar to the view of the participants:

“It is also a test for others which one does not think about” (Scholar 2).

People may not necessarily understand the concept of life as a test or recognise their difficulties as being part of this:

“there are some who misunderstand, and I say they may not necessarily recognise this when it happens, that you are being tested in this way with the difficulties” (Scholar 15).

This could be due to their level of spiritual awareness or possessing a differing level of understanding or perspective towards their difficulties. The impact of a person's mental illness might also affect this.

The same scholar provided an additional view that some Muslims might readily accept the idea of life being a test as an escape or excuse to avoiding tackling their difficulties, rather than fully understanding the purpose of the test:

“Muslims use it, life as a test as an excuse...rather than find solutions, they say life is a test, it's like saying things like, ‘it is not important, it is trivial, just get on with it. Stop complaining’. It's probable how they perceive, instead of finding practically solutions, they see it as a cop out, not really understand what the test, being tested is all about” (Scholar 15).

The scholars appeared to draw a distinction between the normal understandings of a test in an exam in comparison to the Islamic perspective of a test. For a student sitting their exams, they are not aware of the exam questions and not permitted to ask the invigilator for assistance. The Islamic understanding is a person is encouraged to ask for help to the Examiner (being God) repeatedly. The person is himself aware of the proposed questions in the test and the purpose of the test is for them to pass it. The trials are suggested to be relative to the person. In addition, the test does not necessarily need to be through painful experience but also during prosperous times:

“they are familiar with the exam hall and the examiner, they have been through exams where examiner is to pass or fail them, if you do not think about another model, then they will not understand....It is their frame of reference...Allah swt in this other frame of reference is the Examiner and He is the reminding people so to pass them, the hardship is not to fail them... with wealth, family, good career, these are testing times... Allah will make it easy for you and not burden

the person...the tests are specific for the person, how much they can bear, burden and type of test, also, something that is important to person, they think about” (Scholar 5).

The idea that tests are specific and relevant was described further:

“Tests are relevant according to the person and their capacity and experiences, Allah sends them something that is suitable and apt, to take them forward” (Scholar 17).

This also ties with the idea of not being burdened by trials, described on page 282.

Life is a place where individuals are tested in the face of trials and tribulations. A number of different facets surround the understanding of the notion of Divine trial. What can be understood is that the Divine trial is a means through which a person’s spiritual life is enriched and that eventually his return is to God. This is further discussed in the next section entitled ‘spiritual growth’ and ‘spiritual wisdom’. Trials are seen as positive and not as a God’s punishment. This is further discussion on page 246.

6.4.2.2 Spiritual growth

The scholars considered that the experiences of one's illness might appear to be related to spiritual development and growth. Scholars were questioned from the interview schedule about spiritual benefits to pain, suffering and hardship in life. As areas emerged, subsequent scholars were probed about them. In contrast to the data from participants, new areas from the scholars data emerged, which related to spiritual awakening and transformational factors.

Similar to the participants, the scholars discussed remembrance of God the most:

“is submission...dhikr [remembrance] of Allah swt” (Scholar 5).

A small number of scholars discussed how an individual's spiritual journey might enable the development of factors such as humility, patience, gratefulness, sincerity for God and contentment with what has been given to the person.

“to make humble, grateful of what is given...it's about self-reflection...its [Islam] give you a mechanism how to live your life in this world, helps you how to deal with calamities in this life, these experiences are to make us sincere to Allah swt” (Scholar 5).

“the condition of a believer is strange, at times of good he gets rewarded because he is grateful, at times of misfortune he still gets rewarded because of his patience” (Scholar 8).

“being content with what Allah has given you” (Scholar 5).

This could be understood as refinement one's character.

A smaller number of the scholars said the reason why people experienced worldly difficulties was to bring them back to the path of Islam:

“usually an affliction is usually a wake up call, or a chance or an opportunity rather than a difficulty” (Scholar 2).

6.4.2.3 Spiritual wisdom

Scholars discussed this area more frequently compared to participants. One of the scholars defined this particular concept as 'wisdom':

“there is wisdom behind affliction...may be blessing...maybe saving someone from another calamity or another difficulty...people are brought into this world with a certain maturity of the soul, this is further matured through episodes of tests” (Scholar 2).

This ties with the previous concept of life being a test, where it is suggested that the experience of difficulty is a soul building process. However, not every person develops or improves through pain and hardship. A person would also need to understand why difficulties occur from this perspective of soul making.

Here it is suggested that it may be a blessing from God and protection from a greater difficulty. The same scholar was then asked where there is no difficulty in a person's life, then consequently could the person feel he is not being loved by God. He responded by suggesting that this occurs in people with a strong connection with spirituality:

“God loves people, He tests people in many ways but if converse happens, they may feel they are not being loved by God, they are not being tested, they are not loved, blessed. This can happen in people of higher spiritual states, they can fall in a type of spiritual depression because of that”

(Scholar 2).

It could be inferred that this does not apply to a person of a lower spiritual level due to their distance from their faith and possessing a less stronger connection with God.

This could lead to developing negative thoughts towards God as suggested by scholar 2 and scholar 17 here:

“An expectation on how one should be living one's spiritual practices is a problem, one of major issues is where someone is dysfunctional in certain area of life, they may think they are spiritually flawed, very common...in spiritual communities, ‘why can't I keep pushing myself’, ‘why do I keep failing, I must be spiritually flawed’, ‘something spiritually wrong with me, Allah must not love, Allah must not want good for me’ ” (Scholar 17).

Participants developed these negative thoughts as described on page 295.

A person's difficulties may be a reflection of God's love showered over them and a sign of righteousness:

“those who are close and loved to Allah who are tested the most, righteousness in the way”

(Scholar 3).

Scholars perceived suffering as a way of removing one's sins and achieving an elevation of rank in the after-life:

“when a person falls ill, so his sins get forgiven...his ranks are elevated” (Scholar 9).

Another reason might be to remind the person of his position as someone who is in need, turn to God in supplication and the position of God as the One who has power of all affairs:

“to show your need, as a servant...where you are asking for help, where you are the impoverished one and Allah (swt) is the enriched one, the self-sufficient” (Scholar 5).

This indicates the idea of submission and servitude to God. This appears to point to the importance of attachment with God. This may be empowering for some people but for others, this might not be recognised.

Suffering from a mental illness may be a way of purifying a person. Individuals might reflect on their experiences and turn to Islam for further guidance and support in an attempt to be stronger in the face of adversity:

“like a spiritual growth that happens through difficulty and adversity that they understand”

(Scholar 2).

“about illness...this is way of purifying the soul” (Scholar 9).

These aspects of spiritual wisdom can be seen as a way to explain why God allows suffering and the wisdom behind bad or difficult things. This corresponds to the area of ‘theodicy’.

This scholar described the importance of understanding the difficulties associated with evil and suffering and its connection with spiritual wisdom as:

“Often people can skew their understanding of Islam due to partial knowledge. On the issue of good and evil, the correct understanding is that, all actions are ultimately created by God, otherwise God Himself would be deficient, having some things outside of his control...Difficulties can befall a person as a means to test their patience and to elevate their spiritual status with God” (Scholar 5).

“one needs to think about the idea of evil, bad things. Evil, is deprived of good, because of the distance of it, this is part of an Islamic understanding” (Scholar 2).

A further perspective is provided here where it is suggested the purpose of difficulties can be for reasons specific or dependent to the individual:

“Calamities of all types can be either a reminder or a blessing - it depends on the person. For someone who is maintain their obligations and abstains from major sins, calamities are a means to draw closer to Allah as they teach us key traits such as reliance on God instead of people and gratitude for the blessings we have. As for someone who is distant from Allah, then calamities provide a powerful reminder to the person to return to God” (Scholar 16).

This scholar was asked about people’s reaction to difficulties and why their reactions may differ.

He suggested this reflected an internal state of the heart:

“The reaction of people could be an indication of their spiritual state in their heart...for example if the person becomes angry against God, doubts about God then that could be lack of faith, understanding and indicates negative state of the heart, they react negatively to it, has negative detriment on the person. If the person is patience then it is a purification for them” (Scholar 2).
A negative reaction to difficulties could then lead to a further deterioration in a person’s mental health.

Individuals though may not necessarily understand the spiritual wisdom behind mental health difficulties. This could occur where heedlessness and lack of certainty is involved:

“People do not understand generally, maybe they forget, they become heedless of the theme...lack of certainty...lack of spiritual development” (Scholar 15).

It would therefore seem important to gauge the person's level of spiritual development and provide advice accordingly including problem solving:

“if they are spiritually developed you would explain that to them [spiritual wisdom], otherwise you would get them to look at the wider picture...simple problem solve. If you were a doctor you don't explain how the medicine works you just say 'you just take that' and that will be it, unless they are able to understand...to do with their insight” (Scholar 2).

This suggests the person providing spiritual advice should be varying their approach when engaging with people and offering guidance based on the spiritual insight. It appears this is not a simple judgement, as the assessment of a person’s level of insight may be influenced by the assessors experience to make that judgement coupled with having the ability to tailor the counsel appropriately. Furthermore, this appears to suggest that people are at different levels of their

spiritual development and therefore could explain why participants discussed areas relating to spiritual wisdom and spiritual growth less.

It appears what is also important about spiritual wisdom is accepting that it may not be evident or understood what specifically the spiritual wisdom but knowing that it is present:

"there is wisdom behind affliction that we don't really realise or we can't realise or come to understand either. We know there is a wisdom, but we can't pinpoint the wisdom" (Scholar 2).

In light of these three concepts discussed under 'purpose of mental illness' (life as a test, opportunity for spiritual growth and spiritual wisdom), belonging to the Islamic faith was understood as not necessarily about preventing mental health difficulties. It was about using their faith as a mechanism to understand and deal with their difficulties. There could however be situations where Islam provided a support mechanism in preventing mental health difficulties and an example given was where depression and anxiety related to worldly affairs:

"Islam is not about stopping depression or spiritual unease, but it is about helping one to come to terms with why a human will be afflicted by such traits and how they come about. Spiritual ailments in a general sense are part and parcel of tribulations that effect people through their lives and as a such, faith looks at how one can learn from them...One thing that should be said though is that Islam does mitigate depression that arises out of worldly anxiety for wealth and livelihood, as we believe that God provides" (Scholar 2).

There were also contrasting views on the role of faith on prevention of mental illnesses among scholars. This scholar was asked directly about prevention; he took another stance and was clear in his view that aspects of Islam did stop mental illnesses from developing:

“I think all the aspects like reliance in Allah, standing steadfast, peace of mind, eman, ihsan are what stops you from getting depressed it stops you from developing mental illness, it basically keeps your mind working in the right way, in a positive way, because when you have reliance on Allah” (Scholar 5).

This is similar to the participants view about faith preventing mental health difficulties.

Despite holding views about destiny and trials of life, a person may still become overwhelmed and their illness impact them to the extent they are not able to regulate their emotions:

“about qadar, trials asked about...it is about how to regulate and process these things on a physiological level, that’s why I always bring it back to the body, this piece is so missing in Muslim community and everyone, you can have a theologically correct understanding of things, but if you do not know how to regulate your nervous system, how to process things in a healthy integrative way, it is really going to challenge you, and you are thinking ‘I am a failure’, ‘I do not practice what I preach’ ” (Scholar 17).

This is also congruous with the view of scholar 2, where the purpose of Islam is not necessarily to stop a mental illness from developing.

Another layer to consider when exploring the purpose of mental illness, is indicated by scholar 5.

He suggested that people have a limited understanding about why events occur in life:

“we don’t know everything, it is like the ant on the carpet, the ant is unable to see the next set of patterns, see what the creator of the carpet can see, as Rumi said. We have that limited knowledge, and don’t know the wider plan for everything” (Scholar 5).

6.4.3 Balance

A small number of scholars described this particular idea in the interviews as relating to ‘fitrah’ and slightly more, balance of this world with the after-life. The balance of ‘two worlds’ came from the participants data and scholars were subsequently questioned about it and generally about spiritual balance and life perspective. Fitrah emerged only from the scholars data though.

6.4.3.1 Concept of fitrah

The concept of fitrah⁷ was an area discussed by scholars only. This could be because people may not feel it necessary to articulate this but practice it through their religious practices and beliefs. Furthermore, some may view it as a theological topic discussed in academic circles.

Scholar 5 explains how fitrah could provide a balance for the person:

“natural balanced way a human being comes into this world...recognise Allah (swt)...inclined to wholesome, good things and stay away from other things...Allah (swt) created you for a certain purpose and if you follow that then your life will be balanced, positive wellbeing. All these laws that Allah swt gives you are there to give you equilibrium and this can be contentment and when this is messed up then that is when despair happens, sadness happens” (Scholar 5).

Fitrah seems here to make one inclined towards choosing the most suitable path, which favours consistency between one’s purpose in life and their actual actions; and this appears to bring contentment in life. The laws of God here represent guidelines allowing discovering one’s purpose

⁷ Fitrah refers to the belief that people are born into this world free of sins, with an innate disposition to believe in God (Alvi, 2015).

in life and how to fulfil it. Thus, performing good deeds and building a tighter relationship with God is seen as a key element for reaching *balance*, and ultimately achieving wellbeing in this life.

6.4.3.2 Balance of this life versus the after-life

The scholars discussed the outlook on life linked with the after-life:

“this life, this one here should be a shadow of the hereafter. So in reality you should work for the hereafter the everlasting life and we should do it here...If there is no balance between this world and the hereafter, this can lead to depression, where your heart will be broken” (Scholar 10).

This was similar to the views of participants.

Muslims could place their situation in this context, where they consider difficulties as short-lived and something better is waiting for them in the after-life. This could explain why Muslims might feel a sense of hope and meaning through their difficulties.

Related to this concept, was the suggestion to remember death:

“We will experience death, all of us, this is a thing that is certain. There is the hadith about remembering the destroyer of pleasure, which is referring to death. This is the bridge to the hereafter, this is, I am saying, will allow us to think about how short this world is” (Scholar 12).

The remembrance of ones' morality and others may allow a person to consider their temporal existence and prepare for the after-life. However, this depends on the person's outlook on life, their understanding of these Islamic concepts and consideration needs to be given on the severity of their mental illness. For some, this could be beneficial but for others, this could be negative and counter-productive.

6.4.4 Belief in the Will of God

The concept of the ‘Will of God’ was brought up in the discussion by some scholars at some point when they were trying to expand on the causes of ill health:

“it is the power of Allah...we as Muslims believe this, Will of Allah...we believe ultimately, ultimate that beyond all cause and reason it is always the hand of Allah swt so yes we will believe and take the advice and medication and everything prescribed by doctors, but our faith and reliance is above that in a higher power, higher being and that is Allah swt. Will of Allah swt over all things, nothing happens without His permission” (Scholar 1).

The Will (or Volition) of God is one of the core attributes⁸ of God. The ‘Will of God’ was expressed in the context of this discussion as being the source of every happening, action or occurrence, whether judged good or bad from a human being perspective. The main idea here is that nothing could come into being or simply happen without being ‘activated’, or its existence and occurrence being allowed, by God through His Will. In other words, nothing can exist outside the Will and Knowledge of God, independently from the Power of God, and from this standpoint, God is the source of good and bad, thereby denying the possibility of attributing any occurrence to another claimed god.

Thus, good health as illness, both occur through the Will of God. He is the one who causes illness and the He is the one who grants healing, in the sense that nothing can overcome His Will or exist by itself:

⁸ An attribute refers to ‘any quality used to describe a thing of essence. Since God exists essentially we can use any of a number of attributes to describe Him’ (Mohammed, 2017b, p34).

“health good and bad coming from Allah” (Scholar 8).

“People have good health, no problems, and then can say, others not good, always in pain, not feeling well. All of this, everything happen at Allah’s Will, none other but Allah swt” (Scholar 12).

Furthermore, what can be understood is that whatever action one takes as a cure seems to be fulfilling one’s obligation towards oneself, but not the actual source of healing, simply a means by which God may grant healing if He wishes. The ultimate decision and the actual healing are attributed to God. In other words, the doctor’s knowledge, prescription and provided treatments, in the case healing occurs, are seen as a means through which God’s Will manifests, but not the source or actual cause of cure in themselves. God may also decide otherwise, and an illness may acquire a chronic form despite involvement from doctors and receiving treatment.

The following quote illustrate these ideas:

“the doctor is like the helper, he gives the medicines and treatment but the shifa comes from Allah swt” (Scholar 12).

The Will of God is closely related to the idea of predestination, although a subtle distinction does exist between both concepts. Predestination relates to God’s foreknowledge of things before they occur, while the Will of God is what allows the manifestation of those events and the necessary condition for them to come into being. Furthermore, none can repulse or defer the Will of God by causing the happening of something or stopping it. If God wants an event to take place, it will come into existence, if God does not want it to be, then that event will not occur.

Depending on how this relationship between the Will of God and predestination is understood, a person may feel helpless and feel they have no control over their illness. They may feel they have no free will themselves. This may also impact on their willingness to invest efforts to facilitate their healing process and change their situation. This has already been discussed on page 153 and will be further explored on page p353.

Since everything is only possible through the Will of God, the role of God is considered paramount to Muslim life and this is essential in understanding the prism through which a Muslim understands and responds to their difficulties. This explains the reason as to why a Muslim might focus on strengthening his relationship with God and returning to Him in remembrance in periods of illness.

6.4.5 **Human nature**

The next chapter deals with the nature of the soul and spiritual elements which constitute an individual. Before one explores this area, it is useful to understand the nature of man from an Islamic perspective. These are now discussed.

One of the ways this has been understood is through the meaning of the word ‘insan’, described by scholar 2:

“number of possible meanings, insan can relate to humans being forgetful and negligent...another possible reason why humans have been referred to al-insan, is the man attains knowledge and understanding through perception” (Scholar 2).

This scholar was further asked about ‘insan’. He suggested it signified a man displaying affection to others and requires affection from other people:

“insaan [man] is [from] uns which means affection or opposite of loneliness. Humans have a need for affection and don't like isolation, hence the need for interaction, social relationships” (Scholar 5).

Scholar 17 raised further on the understanding of insaan (man), where man requires to be able perceive things through interaction and also the search to find meaning:

“Insaan is profound word, idea of attachment theory is huge, representing in the word insaan, uns, requires affection, to mean apparent, nuance to be apparency, humans need to be able to see things, articulate things, so they can have meaning...human is about finding meaning in things, and attachment, so they need to be able to articulate things so they can find meaning and understanding who they, their role, animals do not need meaning. Attachment, finding solace beyond themselves...see things perceive things and touch them, that's another nuance of the word insan, humans to touch things, opposite of... is jinn, jinn need to be hidden, humans need sort of clarity to touch things...”.

Man are not self-sufficient and in need of a Creator, as indicated here:

“to show your need, as a servant...where you are asking for help, where you are the impoverished one and Allah (swt) is the enriched one, the self-sufficient” (Scholar 5).

A human does not have complete capacity to understand all knowledge as suggested here:

“we don't know everything, it is like the ant on the carpet, the ant is unable to see the next set of patterns, see what the creator of the carpet can see, as Rumi said. We have that limited knowledge, and don't know the wider plan for everything” (Scholar 5).

There was also the suggestion man yearns for the presence of God:

“The Human has many elements- the soul being just one. The soul is celestial in nature cause it came from the realm/world of the souls. It longs to return from where it came, so it’s the spiritual dimension in us, in that zikr of any type soothes it, strengths it, nourishes it. It wants to be with God” (Scholar 5).

This appears to point to the soul not just being connected to this life, but before life and after death.

It was mentioned that humans have a greater clarity on abstracting things that are either right and wrong:

“We have greater clarity than other creation if we are able to integrate everything...man, another distinct quality to them, they are able to co-operate with each other, which is different to other mammals...greater clarity of what is right and what is wrong” (Scholar 17).

Greater co-operation with others was also suggested here.

It was indicated from an Islamic perspective, an aspect of the nature of man signified they are created with a sense of incomplete fulfilment. Parallels with spiritual growth (as described on page 260) was described here:

“Human being are created to feel some sort of lack of fulfilment, that is why always searching on, that is why they are always progressing, so practice makes progress, not practice makes perfect because we never attain perfection, that is with God, humans are designed to constantly be progressing and learn more, they are finite so they will always learn more...concept of God is that He is the absolute...we are constantly growing.

In our awareness of this absolute being and we are attaching ourselves to it and as our consciousness and perception and awareness is being expanded we are growing in God, everything we have attained, is an attachment to God, that is truth obviously and this is always expanding, so it is about connecting to something beyond ourselves, that is what humans inherently need, is to know there is someone there for them, obviously we talk about how we need someone stronger for us, and we have the concept of absolute, absolute power that we can take the burdens all life and hand to, that helps us so much mentally, and spiritually...our framework is limited and we are moving on with the world, passing of time, our awareness is expanding, expanding” (Scholar 17).

Other themes such as attachment with God and realisation of a greater meaning comes out here, with the person gaining an awareness of the spiritual truths over the passage of time.

The purpose of mental illness extended to discussions exploring the question of purpose of life and finding meaning. The worship of God was explained as the purpose of life for Muslims, not necessarily restricted to ritualistic practices but more apt, about achieving meaning and the path one takes to achieve that:

“To Worship Allah, understanding what is worship is important, worship, sounds limited, that is big problem with Muslims, they are only religious if they are doing worship, and that cause exacerbation of symptoms of anxiety, especially if they fall short in these things, worship needs to be broadened in its definition of what we mean by worship and means to closer to God, first and foremost, miss fajr [prayer], fact that you are concerned about it, is a blessing from Allah, so rather than becoming anxious, I missed fajr, and I am terrible, but alhamdulillah, I feel I have some concern and this is a gift and something I can work on long term, when I work on symptoms on anxiety, to wake up far fresher to pray, so if I worry it and down about it, it can make things worse,

so I pose it to them, is it not better to have a better state of health, rather than worrying, and then you may miss fajr, so it is not about doing worship ritually, the purpose of life for Muslims, is to find greater meaning in life, like everybody, children always ask about why they need meaning in life, gain meaning in life, and act upon it, worship is two-fold, its self-enquiry, it's about discovering about more about one self and role and purpose, gaining meaning, and then about the journey to implement those things in your life, which is worship...people concerned about practices...understanding oneself, and one's relationship and you may not do as much worship, then you consciousness and presence around your worship, and so I think, understanding his role with Allah, the people, and himself, and gain greater meaning how to apply that fall under confines of worship”.

Scholar 17 touches upon the relationship the person has with God, other people and themselves.

Being connected with others and thinking beyond oneself is described by scholar 2:

“if you have not found something that is your goal in life then you are always thinking what is the point. That is the thing about, I always feel that if you are in a Community, a larger Community, you find your way in life through dealing with other people, you find your place through tasting different experiences and thinking Oh perhaps this is where I should be. If you have never experienced that you will never know that so this idea voids not knowing why you are here, what your purpose in life is, you know what role can you play in your kind of mundane life that is wider than yourself. That is what people are looking for which is why religion is important, it gives you a kind of existence higher than your own existence. It is just whatever views you have on Earth”.

6.5 Similarities and differences between the two groups

Relating to predestination

The comparison between the two groups brought out the centrality of the notion of predestination. Both groups frequently discussed this fundamental belief. In analysing the participant's data, it was evident participants held differing views about whether or not destiny could be changed. The analysis was deepened through the data obtained from scholars which allowed for a more fine grained understanding on this principle of predestination. This related to three aspects defined around predestination: freedom of choice, capacity to change one's destiny, and practical effort.

Relating to purpose of mental illness

The analysis showed there are a number of reasons that could explain why Muslims may be suffering from mental health difficulties from a religious perspective. The findings have been categorised under three headings: life as a place where they are tested, spiritual growth and spiritual wisdom.

Both groups commonly discussed the idea that life in this world was a place of trials and tribulations. Through the analysis, an understanding was gained from the participant's data, on how this helped a person's perspective towards their pain and suffering. Within the participants group, what came out from the data was that a small number did not relate their difficulties as part of God's test. An additional insight was gained from the scholars' data on the purpose of being tested, to return to God and ask Him for help. The nature of the test was further detailed as not necessarily being based on single events or experiences but could be continuous and occurring in prosperous times.

The other area where similar data emerged from both groups was the remembrance of God (as part

of spiritual growth).

Another value in analysing both groups was that it emerged how individual concepts were intertwined with each other, such as being tested connected with remembrance of God.

Comparing the data from both groups, it was evident that in contrast to the participant's, scholars frequently discussed the areas of spiritual wisdom and spiritual growth. The additional data added from scholars included spiritual wisdom and secondly, concepts relating to spiritual purification, spiritual transformational factors and awakening (as part of spiritual growth).

There were differing views on whether Islam prevented mental illness, with some of the participants and smaller number of scholars taking this view.

Balance

There was similar data from both groups relating to the balance of this life versus the after-life. The findings highlighted new data from scholars relating to the concept of 'fitrah'.

Belief in the Will of God

This was closely related to predestination and emerged from the scholars data.

Nature of man

Scholars discussed the nature of the human, which ties with the spiritual elements discussed on p215.

6.6 Understanding health, well-being, mental health and illness

The chapter so far has examined the perspective from participants and scholars on the outlook to life in relation to pain, suffering and mental health difficulties. The emerged themes begin to build an understanding on purpose of mental health difficulties and to make sense of life events. An important area to explore in at this conjecture is to understand the concepts of health, well-being, mental health and mental illness from an Islamic perspective before perceptions towards causes of mental health difficulties and mental illness are examined (in the next chapter). Scholars were asked from the interview schedule about their understanding of these terms and concepts. Scholars were also probed directly about individual concepts by the researcher.

6.6.1 Islamic perspective on health and well-being

6.6.1.1 Afiyah (well-being)

The concepts health and well-being were explored with the scholars from the interview schedule. Concepts were referred to as 'Afiyah' meaning 'well-being' and 'Sihha', corresponding to 'health' which were used directly by scholars. Scholars commonly discussed these ideas:

“sihha and afiyah which is health and well-being and opposite is marad, sickness” (Scholar 7).

“Social is included in this idea of afiyah where we see people, interact...This is important part alongside psychological, physical and spiritual aspect” (Scholar 10).

It was suggested afiyah extended to psychological, physical and social aspects of a person.

The importance of 'afiyah' was emphasised by this scholar, who pointed out that Muslims are encouraged to pray to God for 'afiyah' on a daily basis, for example:

“a prophetic dua [supplication]...read every day...Allah gives you a state of wellbeing” (Scholar 5).

This also relates to the role of God, which was outlined in earlier in the chapter, on page 168.

Afiyah was further explained to be understood as a spiritual balance (of fear and hope) as suggested here:

“fear and hope are two extremes and to balance them is to have a general indicator of your spiritual wellbeing” (Scholar 2).

An imbalance of fear and hope is suggested to lead to difficulties (discussed on page 220).

This understanding of wellbeing from an Islamic perspective appears to provide insight as to why Muslims may relate wellbeing in their prayers and ask God for recovery.

6.6.1.2 Sihha (health)

Alongside the concept of well-being, scholars also discussed the position of health in Islam in a holistic way. Health was not merely viewed as the absence of illness. The core aspects of health appeared to include spirituality alongside physical wellbeing:

“mind, body, heart is all connected and not separate” (Scholar 10).

Health was also explained as a gift and sign of blessing from God:

“health as a gift of God” (Scholar 10).

“blessing from Allah (swt)” (Scholar 9).

Furthermore, health was understood as a loan from God, which necessitates responsibility to preserve it:

“360 bones in your body you have to give the right for all of them, the body is not your but Allahs swt, He has given like say a loan” (Scholar 7).

This level of accountability to preserve health was referred to as an amanah (or trust):

“The body is an amanah [trust] given to us in this world and like a gift where we will be accounted for to look after this” (Scholar 4).

The body could also be understood as important as it is the place where the ruh resides (see page 226).

This strong emphasis of the role of God in one's health, explains why Muslims return to remembering Him, be it in good health or ill health.

The terms 'well-being' and 'health' are well recognised in Islamic tradition, and what emerges from this data is the manner they are conceptualised is specific for Muslims, with elements of spirituality, the mind and body not being separate and close relationship with God. The concepts appear to be intertwined in both the Muslim outlook on life and in understanding the purpose why individuals experience both good and poor health. This view thus contrasts with the Cartesian mind/body split underlying the traditional medical model or existing secular frameworks.

6.6.2 Understanding of ‘mental health’ and ‘mental illness’ among scholars

Chapter 9 describes how participants with mental illness approached scholars for mental health support. A scholar’s understanding of the term and concept of mental health and mental illness is therefore crucial as this could be affect the view of the person they are supporting.

There was a general consensus between scholars interviewed that the actual terms 'mental health' and 'mental illness' were not used historically by Muslim physicians or in Islamic text:

“Not the actual words. These are western concepts that have developed over the years” (Scholar 7).

Even though the terms were not used, the area of mental health was recognised. The majority of scholars talked about 'ilm al-nafs', corresponding to the area of mental health in Muslim cultures of the past:

“the ilm al nafs which is the science of the self, now if you translate science of the self you would get roughly what we are talking about mental health...the work of al-Balkhi is probably the most important contribution by an early Muslim scholar. The title of his book was masaalih al-abdaan wal anfus. He uses the plural of nafs and so I think ilm al-nafs would be appropriate. And Allah knows best” (Scholar 4).

There were varying on the use of this. 'Ilm al-nafs' was seen as a modern term by this scholar:

“ilm al nafs, this is a modern usage” (Scholar 17).

A small number of scholars also made reference to the Arabic word of *“amrad al-qalb”* (Scholar 7) and *“al-Tibb al-Ruhani, tibb al-qalb”* (Scholar 12) referring to 'diseases of the heart' and 'medicine of the heart and spiritual health'.

Though recognised by scholars, the subject of mental health was described as a specialist area, not necessarily studied by all scholars:

“Probably, maybe they are non-specialists, may be they have not looked into it” (Scholar 5).

This study found that in relation to understanding the concepts, scholars were more familiar with the terms 'health' as opposed to 'mental health' and 'mental illness'. The data illustrated scholars having very limited understanding of the concepts of mental health and mental illness. Less than

one third of scholars indicated awareness with these concepts in their responses. This is evident from the description provided by the scholars:

“Mental health and mental illness is not very common” (Scholar 1).

“I would say both of them [mental health and illness] are the same” (Scholar 8).

This scholar explained his view that mental illness was primarily caused by nafs (this is explained in chapter 7, on page 195):

“Sometimes, drugs and alcohol sometimes, and lifestyle. The main cause of mental illness is the weakness of the Nafs. The nafs we are talking about is the selfish self, it’s on different levels religious” (Scholar 7).

This view was not described by any of the other scholars.

Another scholar described three reasons behind mental health problems- genetics, addiction problems and difficult life situations:

“Being mad sometimes mental health come to home, break the door, break some things, okay this time he is outside control, mental health nobody may understand, there are three causes, one people have genetic problems from the family, some people have the shock life and the third one from drugs” (Scholar 6).

He appears to point out mental health is related to being out of control, breaking things and made reference to being mad.

When he was probed further about the distinction between mental illness and mental health, he reported:

“No much different, my understanding...may be mental illness he brought it to him by drugs or taking some haram thing, do sin”.

What was also understood from his explanation was that mental illness was self-inflicted or associated with sin.

However in contrast to this, one scholar explained:

"Mental health is one aspect of health that might become incomplete or reduced from the level of health to an illness which might be something which is internal in the function of the body or the person, or it might be because of factors from outside which have caused it to become strained or ill. So therefore mental health is when somebody's in balance and contents in a good state and mental ill health is where some internal dysfunction is taking place or pressure from outside has caused a weakness within the mental state and these are to the 2 elements of mental ill health"

(Scholar 4).

This scholar reported the importance of balance and factors, either internal or external to the person affecting the mental health of an individual.

This scholar was asked if concepts related to mental health were present in the Qur'an and Hadith.

He reported that even although the terms were not used, the understanding of the concepts was understood in the Islamic tradition:

“The concept is well understood and people know it, it is just phrased differently, but the actual words, terminology I think, like we mentioned, especially from the Indo sub-continent is the tendency to, unfortunately, in a sense is always when something is wrong, when there is no medical or physical explanation...find it difficult to understand these terms” (Scholar 1).

He particularly emphasised there was a misunderstanding about mental health among people of South Asian background.

Another scholar pointed out the misunderstanding of mental health among the Muslim community: *"They don't understand, mental health is almost like [...] somebody can be almost perfectly normal, work have a family but they have a mental problem and that word 'mental problem' is a bit strong. So the stigma is still there. I would never use the word 'mental', 'mental problem', people from mosque, Imams, local people misunderstand and say this and that about others, say they are mad and not right in head, don't fit in"* (Scholar 7).

The idea of stigma is brought up with the usage of the word 'mental'.

Even although scholar 1 reported emotional concepts were understood from an Islamic tradition, this was not always evident. Scholars were asked from the topic guide of specific concepts relating to mental/emotional health or mental illness in the primary sources, this being the Qur'an and Hadith. A small number of scholars were not aware of any evidence to support the concepts: *"There is nothing explicit to my mind about it as far as I can recall"* (Scholar 3).

"There is nothing about this mental illness...in the Quran" (Scholar 6).

Another layer to the discussion, was the findings elicited to the emphasis on meanings rather than terminologies. This is described here:

"So the terminology is different but it is found in the very early generations of Islam like the word waswasa [whispers]...the concept is there it is just the terminology which is different, even the construct is not dissimilar to modern psychology it is just that it is framed in a different terminology" (Scholar 4).

“we don't make a big fuss about terminologies as long as the understanding is the same” (Scholar 7).

6.6.3 Specific description of emotional and mental health concepts in Islamic sources

As discussed in previous section, scholars were asked directly from the interview schedule about whether concepts existed in the Qur'an and Hadith. Only a small number of scholars were able to describe concepts relating to mental health/emotions with usage of specific language and meaning from the Islamic tradition. Data emerged when the researcher asked scholars about terms and concepts he was familiar with before the study. This is further described under the role of the researcher in data generation, on page 368.

Sadness or emotional distress might occur as part of an individual's life experience or related to stressors. One type of sadness described is where an individual loses hope over an opportunity or situation they feel have missed out of, referred to as 'asaa' (similar to Ya's):

“Ya's is basically [...] losing hope, to grieve. Similar root to 'asaa', sometimes translated as despair...'asaa' means to be caught up with something...remembering what one perceives to have missed at the Mercy and Grace of God leading the heart to become detached without any form of hope” (Scholar 2).

Tay'asū is suggested as another description of the word despair:

“Tay'asū, despair, in the Qur'an there is the story of Yusuf, one of the most profound stories in the Qur'an” (Scholar 17).

Scholar 2 further explained al-ya's or hopelessness in God is where a person could find themselves feeling preoccupied and ruminating over something they expected but did not materialise. They may feel devoid of God's Grace and Mercy, which may lead to hopelessness:

"A person may be in situation where they feel they have missed out of the Mercy of God, Grace of God and the person is hopeless, leading to the heart feeling detached...this is called al-ya's"

(Scholar 2).

Here, two examples given relate to huzn and a more severe form, bathth:

"bathth they talk about the most extreme form of huzn...so bathth is when becomes manifest almost physically so you see it, whereas huzn when you come depressed you almost don't see it you put on a brave face... bathth...translate as suffering" (Scholar 2).

The word 'grief' was suggestion to be a translation for the word huzn:

"Yusuf's father was in grief, and Allah knows best. We also call the year the Prophet's (pbuh) wife and uncle died the year of Huzn. Huzn is translated as grief" (Scholar 17).

Another term explored with the same scholar was jaza³⁹. A distinction being this was related to external causes:

"Jaza3 is similar to grief however it is external whilst grief can be held internally, basically anxiety, has means of losing one's patience, and becoming restless".

⁹ The number 3 used here denotes the Arabic letter 'ayn.

The explanation of the word bathth and other words here suggests the importance of understanding meanings and expressions and not just translating them:

“bathth means to spread, to scatter something. So it is almost what has happened is that your consciousness has been scattered, it is not central, it is not focused. It is depression and suffering and it is related to everything you have been lost, you lose control of all that, it's affects your thinking, your relationship with other people” (Scholar 2).

Bathth was also described as corresponding to anxiety.

“Bathth is where one's thoughts and self are all over the place, so this could be anxiety as well” (Scholar 17).

Forms of emotional distress have been described as 'ghamm' (depression) and 'hamm' (concern, sorrow):

“hamm is more of a concern...ghamm is anxiety... huzn is specifically a type of depression...would be sadness, can be said to be sorrow or despair “ (Scholar 2).

“Hamm, it is a lighter degree of stress or sorrow a person feels than huzn, huzn would mean a more deeper, a more heavier use of the same” (Scholar 1).

“all linguistic terms, grief, affliction, anxiety they are all found in hadith...worry” (Scholar 4).

It was suggested the word ghamm could indicate depression rather than anxiety. The scholar further indicated the importance of understanding words through specialist dictionaries. He also used other words for anxiety (idtirab, qalaq):

“When trying to get to the bottom of what words mean it is important to refer to Quranic dictionaries that get to the essence of the root of the word, Ghamm is about darkness enveloping

something so that light, ease, health or beauty does not get in. I wouldn't translate it as anxiety. It is a good word for depression...it may be difficult as well understanding terms in English from Arabic” (Scholar 17).

“Anxiety might be Idtirab or qalaq which literally means shaken up” (Scholar 17).

This also indicates that it is not simply a matter of translating words from Arabic to English but understanding the context of the words and how they are used in the Arabic language.

The distinction between ghamm and hamm was drawn out here when asked directly to these scholars:

“Each of the words used in the Quran and Sunnah have a slightly different meaning, for example, hamm refers to anxiety about something that has not yet occurred and ghamm anxiety about something that has already occurred” (Scholar 4).

“Hamm is more about something that concerns you about the future that you want to get on with and cannot rest until you do” (Scholar 17).

Emotions such as anger and obsessions are described:

“Anger, there a lots of way this is expressed in the Qur’an, ghadab, ghayd, wasawuss” (Scholar 17).

Another type of experience is the word 'ahsaba'. This is used in relation to 'affliction', related to the word 'muhsaba'; the word also signifying hardship or difficulty as explained here which any Muslim can experience as part of his life's test:

“Ahsaba which means to hit, to be afflicted with something, physical or mental. It is used as muhsaba difficulty, hardship...also means to hit the mark. Like your archery and muhsiba is the archery you hit the target” (Scholar 2).

This seems to suggest that difficulties in life are not by coincidence but ordained by God and specifically for the person.

Similar to this word, is the use of us'ri and hazan:

“The Qur'an states with hardship will be ease, us'ri meaning hardship and hazan, is a hardship or difficult matter. Hazan is different from huzn, some people confused them” (Scholar 17).

The idea of burden or weighty matter, wizr is used here:

“removed you from your burden, the verse from the Qur'an, weighty, wizr here for a weighty matter” (Scholar 17).

The idea of losing heart and feeling emptied are suggested here:

“in the heart of Moses' mother, it became empty, relates to occupied and consumed here, the use of farighan, needs to read the context when understanding words, one can consider this as feeling emptied” (Scholar 17).

“Wahn, weakness like a verb, to do with weakness like a web that is about to fray away due to its age, so weak that you are about to break and collapse...language can be used metaphorically and means resolve, and here 'losing heart' mentioned in Qur'an with the companions” (Scholar 17).

There were also words that led to emotional distress:

“Durr is harm...it brings about distress” (Scholar 17).

The word *karb* has been used in the Qur'an, explained as a tightness of the heart:

“use of the word karb...intense and tight and constrict. Like tightness of the heart, knot that is really tight that does not get undone, nuance of coming from above, that tightness could be external factors, tightness on the heart” (Scholar 17).

Another situation is where there is regret and remorse relating to a situation, referred to as *asaf*:

“There is asaf, which is more about regret and remorse and sadness over something that did not occur the way you wanted” (Scholar 17).

This scholar was asked directly how the emotion 'fear' is used where he described the use in a number of ways:

“Fear used in number of ways, khawf, linked sometimes to the fear of something that is coming which you are ignorant of or lack knowledge. There is lack of safety. There is an emptiness inside due to that supposed danger. Shocked and shaken all of a sudden by the occurrence of something, this is faza'. Another word wajaal, weakened by fear and paralysed or collapsed whereby you become weak. It can be linked to anxiety and irritation that is on the verge of collapse, faraag, is wishing to get away from something due to fear, safety, shaken and stripped of safety, ru'b, Opposite of desire, rahab linked to a constant fear and alert and one being physically affected by that fear like being gaunt but still holding oneself together, khashah, linked to fear with knowledge and awe and veneration, it is linked to attention and vigilance and feeling tension”.

Related to spirituality is the emotional state *tadaru'*. This is a level of humility whereby an individual may experience an emotional state and ask God for help, knowing it is only Him who can

help. This type of emotion is not seen as a mental illness but an emotional and spiritual state a Muslims in a subservience manner find themselves in:

“Tadaru' is the last throw of the dice...It is opening yourself up, emptying yourself out emotionally and spiritually, to speak your heart and every desire you want and everything you want rectifying...you can ask you do it dua, with tadaru', to do with humility...You are about to sink, you can't swim nobody can save you so you turn towards the power that can save you, that is a tadaru'” (Scholar 2).

One aspect linked to the spiritual health was expressed through the condition of the ‘chest’ or ‘sadr’. This expression of distress was described in one of the chapters of the Qur’an relating to Prophet Yaqub who lost his eyesight, waiting in anguish for his lost son, Yousuf. The constriction of the chest may lead to distress or mental health difficulties and expansion reflects positive mental well-being, called ‘dhaiq al-sadr’ and ‘inshirah al-sadr’ respectively in the Quran. Other words used were 'kabeth' and 'baset' meaning 'sadness' and 'happiness':

“kabeth means spiritual contraction of the chest and baset means elation, you know expansion...there is inshirah al-sadr (baset) and dhaiq al-sadr (kabeth), which is same but different terms. also hayatan dhanqah, this means a life which is very full of stress...there is also the distress, dhaiq nafsi” (Scholar 7).

“Sharh al-sadr is one that comes to mind” (Scholar 17).

A minority of scholars discussed how historically Muslim physicians used diagnosis:

“types of neurosis...OCD [obsessive compulsive disorder]” (Scholar 4).

“melancholy” (Scholar 2).

“there were physicians who described disorders of odd behaviour and paranoia” (Scholar 1).

There was also mention of loss of capacity and insanity in Islamic tradition relating to individuals suffering from severe mental illness. This has been used to give allowance for those people who otherwise are required to undertake certain religious practices such as praying and fasting:

“Islam recognises just like there are physical ailments and illnesses, similarly there will be mental, spiritual emotion. All these are valid concepts in Islam and people do suffer from it. That is why you will find with Islamic Jurisprudence...the condition of a person being mukallif [sane], the very first condition of anything...is that of being sane...aspects of confused states” (Scholar 1).

The terms 'majoon' and 'janoon' are used to refer to those people who do not have capacity or are mentally unwell (janoon is sometimes translated as insanity or madness):

“people are not mentally stable they use the word majoon, the word majoon is used for the person who is not mentally stable...here is no capacity” (Scholar 8).

“Janoon which is translated you can say insane” (Scholar 9).

There was discussion on how Islamic terms relating to emotional health were categorised in the past. Scholar 17 described there were individual terms used but no overarching category for emotional health. This was viewed as surprising considering the use of terms in the Qur'an and Hadith. Terms mentioned were shu'ur (described as feeling, to sense something, subtle intuition) and 'awatif (emotions) and wijdaan (to experience). It also appears from the discussion that it is not a simple process of translation to Arabic but looking at how terms classically were understood and the nuances behind them:

“In the Futuhat, Ibn Arabi uses the term al-la-sh'ur, deriving it from the Qur'anic word al ash'urun, suggesting realm of feeling that is below the consciousness,

There is shu'ur and 'awatif in plural, 'atifa. Shu'ur is about intuition, something that is subtle, not so obvious...we have specific feelings and emotions, and don't have term that categorising them. Ihsaas, is translation, about the senses, what is picked up, shu'ur is similar, sense of picking up something that is not obvious on the surface, feelings can fall into that I suppose, but not as a category. In modern Arabic, masha'ir is most common word, wijdaan is experience of something. Shu'ur is verbal noun to sense something, 'sensing' something better than 'feeling', masha'ir plural term of feeling, classically don't think it was used as masha'ir is used for rites for hajj. Like, wijdaan, to find something, to experience something, to be present, all these nuances...there is no word to encapsulate overarching term for emotional health. To classify them we don't have one, which is strange".

In relation to the conceptualisation of emotional and mental health in the Islamic tradition, concepts alluding to emotional and mental health difficulties are recognised in the Qur'an and Hadith. Some of the descriptions could also be framed as a spiritual dimension of health. Also, some of the expressions might not be recognised or amount to a mental illness that would fit in a traditional western medical model. This can be compared to a distinction between sadness and depression in western mental health. There is use of diagnosis in Muslim culture. There does not seem to be an overarching category for emotional health used in the Islamic tradition.

Scholars described less usage of specific terminology, rather there was more emphasis of underlying meanings to signify mental health difficulties. There was also a focus of describing people's problems from a spiritual perspective and towards developing practical strategies. This area has been discussed on page 158.

Only a small number of scholars described emotional concepts in the Qur'an and Hadith. It also transpired from the data that more scholars who participated in the study lacked understanding of the concepts of 'mental health' and 'mental illness'.

6.7 Summary

In relation to philosophy of life, Muslims appear to possess a specific ontological perspective, which is unique to their faith. This encompasses themes of predestination, purpose of mental illness, balance and Will of God. These areas form an understanding on Muslim views and attitudes towards suffering and difficulties, which is based through a religious lens. This will be developed further in the discussion chapter, linking to wider notions such as illness beliefs about causations and candidacy. The data identified the four main themes have a connecting thread, 'God', as a central focus and importance for Muslims. The relationship with God impacts on how Muslims cope with their mental illness and will be examined further in chapter 8.

A number of nuances were uncovered relating to these themes. Predestination contained facets relating to freedom of choice, capacity to change one's situation and exerting practical effort. There was a deeper meaning provided in relation to life as a test such as the purpose of the test. These were important aspects, which enabled the reader to obtain a richer understanding of the themes.

Another layer to the discussion was the variation in understanding of these ideas between participants and scholars. Furthermore, scholars and participants differed in the extent these themes and sub-themes were discussed. The main commonality were the areas frequently discussed by participants and scholars: 'predestination', 'life as a test' and 'remembrance of God'. The main distinction was that the two areas scholars commonly discussed (spiritual growth, spiritual wisdom), were less frequently found in the participants data (except for the component of remembrance of God as part of spiritual growth). The nature of man was explored from a scholarly perspective.

New areas also emerged from the findings, not previously described in medical literature where systematic research has been conducted (related to spiritual wisdom, spiritual growth and fitrah).

Furthermore, from a scholarly perspective, the religion of Islam was not simply understood as a way of preventing mental health difficulties. This is in contrast to minority view of participants who felt their faith would stop their difficulties. A time of pain and hardship was viewed as time to reflect on the purpose of their suffering, maturing of the soul and developing a closeness with God. There are a number of concepts such as 'life as a test', 'spiritual growth' and 'wisdom', which appeared to provide a mechanism for understanding why mental health difficulties and illness might occur in individuals. This presents an Islamic perspective on why God allows suffering. Islam could provide a framework of response to worldly difficulties through understanding this purpose of pain and suffering with *a sense of perseverance and adapting to difficulties*. However, a deeper exploration of the data showed the varying levels of understanding and awareness among the participants. This needs to be considered during the provision of religious support.

The data amongst scholars also indicated the view that a person needs to be of a certain level of spiritual development to recognise and understand the spiritual aspect of their life. This could explain why scholars focussed on concepts that were simpler to understand such as 'life as a test' and 'remembrance of God' in more depth in contrast to areas relating to spiritual growth and wisdom. Furthermore, Muslims familiarise themselves with these concepts from an early age and are used frequently in the Muslim community.

The findings also indicate that in the Islamic tradition, health, well-being and individual terms relating to emotional/mental health difficulties are conceptualised in a distinct manner. The Islamic

paradigm encompasses a spiritual dimension of health with close relationship with God and outlook to life.

This first results' chapter outlines key themes relevant to the Muslim outlook to life. An understanding on how health and well-being is understood from an Islamic perspective is also presented. This provides a foundation where further themes can be developed in the subject area of Islam and mental health. This section leads onto the next chapter, which will examine the perceptions towards mental health difficulties and illness.

7 Chapter 7 - The perceptions towards causes of mental health difficulties and mental illness: Impact of religious beliefs

7.1 Introduction

The first chapter provides an understanding where the reader can begin to make sense of meaning and purpose of aspects of life, why events and experiences occur in the way they do. The understanding of concepts around health and well-being were also provided. This chapter examines how religious beliefs influence knowledge and attitude towards the causes of mental illness and mental health difficulties amongst Muslims.

The understanding of religious beliefs and views may be of particular importance as these combined may influence attitudes and perceptions toward (1) mental illness and (2) care and treatment. The question then arises; why is it particularly important to study those individuals belonging to the Islamic faith?

Muslim men and women hold distinctive beliefs, which are fundamental to their faith. One may find it difficult to comprehend those beliefs by attempting to grasp knowledge and awareness of cultural beliefs alone. It is therefore important to go a step further by exploring these beliefs in more detail to gain a key insight into a number of perceptions, which Muslims may or may not attribute towards causes of mental health difficulties and illness.

Diagram 9: Overview of themes and sub-themes (2)

Participants

Scholars

Area of study

Perceptions towards causes of mental illness:
Impact of religious beliefs

Inside me: the heart and nafs

Other realities

- Jinn
- Sihr
- Nazr

Satan affects me

Being punished and weak faith

Spiritual elements of the individual: the heart and nafs

Understanding other realities

- Jinn
- Sihr
- Nazr

Satan affects me

Punishment, weak faith and mental illness

Spiritual and life imbalance

- Imbalance of life
- Imbalance of spiritual elements
- Imbalance of spiritual well-being

The majority of participants explored Satan the most followed by Jinn and Sihr as explanatory causes of mental health difficulties.

Scholars frequently discussed the internal causes (heart, nafs) and Satan as causes of distress and mental health difficulties.

7.2 Participants' views

Themes emerging from the data that relate to religious beliefs or beliefs participants perceive as being linked with religion can be broadly summarised as below:

- Inside me: the heart and nafs
- Other realities
- Satan affects me.
- Being punished and weak faith

The majority of participants discussed Satan the most followed by Jinn and sihr (here represented as part of the 'other realities').

7.2.1 Inside me: the heart and nafs

A small number of participants discussed the spiritual heart (qalb in Arabic) and nafs (referring to the ego or self)¹⁰. These concepts were not set out in the interview schedule but added later as the interviews progressed to address this theme. The mention of 'heart' and 'nafs' were used by the participants in response to direct questioning. The notion of 'inside me' came around through a verbal expression of a participant and emotionally strengthened when they made a non-verbal expression gesturing the nafs coming from within. Also, both terms are used together as they are interlinked with each other, where the state of the heart is determined by the nafs.

What was interesting was only one of the participants used the Arabic word for 'heart'. This is in contrast to nafs, which participants referred to (and not using 'ego' or 'self'). This could be as nafs

¹⁰ Islamic belief states the heart and nafs are two of the four spiritual elements which shape the behaviour and personality of an individual, the four as outlined by the Muslim scholar Al-Ghazali, are the heart (qalb), intelligence (aql), soul (ruh) and ego/self (nafs) (Ali, 2013).

is more familiar compared to the Arabic equivalent for 'heart'. Also, there are different semantic meanings to the word 'heart' in Arabic, of which qalb is one. This will be returned to in the discussion chapter, highlighting the role on the researcher on data generation, on page 322.

The idea of the 'heart' was presented in English to the participants. In the process of interviewing, where there was use of Arabic terms by participants, this would be added to the interview schedule and used in future participant interviews. Otherwise, the terms in English were used.

The heart is a spiritual faculty where there is the experience of comfort and a way of achieving piety and staying on the righteous path:

“When it [heart] is healthy, I feel a sense of piety, comfort and doing right things and these things, to be close to Allah, this helps with my depression. When our heart is healthy then we remember Allah more and Allah will remember us” (P2, Female Tunisian).

She seems to imply that through a greater spiritual state of heart, this led to her being close with her faith and stronger connection with God.

The heart was also regarded as locus of purifying oneself:

“The heart is the centre of human beings, not our brain (points to head), it is where we think and feel and decide what is right or wrong, a healthy heart, one that is free of disease is at peace, close to Allah. It is like a purification process, way and this is one of main ways we will work through our problems in this world here and will lead to success in hereafter life” (P6, Female Malaysian).

The same participant talked about ailments that could affect the heart, manifesting itself as a number of symptoms including jealousy and anger:

“They can cause mental health problem to each other...anger and grief and jealousy and whatever. The issue, disease of heart” (P6, Female Malaysian).

These appear to be strong feelings emanating from this participant, which interestingly she did not associate with her own mental health problems.

However, the majority of participants either had not heard of the ‘heart’ or could not explain it when asked directly about it:

“I have heard about this but cannot explain...not sure” (P5, Female Indian).

“I have not really looked into it that much to be honest” (P10, Female Pakistani).

The second spiritual element that emerged from the participant’s data was the nafs. The semantics of nafs and its usage will be discussed more in detail in the discussion chapter.

Difficulty controlling one’s nafs led to individuals feeling unsettled:

“Nafs is inside me...you have to fight against nafs...makes me unsettled if this [nafs] is not controlled” (P9, Male Bangladeshi).

Here the use of nafs could be comparable to the psychological understanding of ‘drive’.

Nafs appears to be influenced by ‘desires’. Nafs was suggested to affect any individual and it was implied nafs have to be harnessed by the person. Overcoming nafs seemed to help individuals feel content, spiritually strong and able to find an internal strength to tackle life stressors:

“Nafs, means desire, wants, everyone experiences this. You have to tame the nafs, control the nafs....nafs like different levels and control them, I feel like content and feel strong spiritually”
(P11, Male Indian).

“Nafs is like a struggle against oneself, if I am able to beat those feelings, then this will give me the strength to fight other things in life, as what I fight inside (points to chest) is the strongest jihad”
(P6, Female Malaysian).

This implies the idea of nafs as struggling against the self. This is referred to as Jihad al nafs.

Similar to the heart, the majority of participants had limited knowledge and awareness about nafs. Participants did not bring up the idea of nafs independently and were asked directly from the interview schedule if they had heard of nafs or able to explain it. Their responses were:

“I am not too sure” (P8, Male Kenyan).

“No, I don’t know” (P13, Male Palestinian).

“No, no understand” (P7, Male Caucasian).

7.2.2 Other realities

The concepts heart and nafs discussed in the previous section have been described as internal causes, coming from within the person. Participants also discussed beliefs that were extraneous to them, as a cause of mental illness. These areas discussed did not fit in domains such as physical, psychological, social or environmental causes. Participants believed these entities and effects to exist and be real, leading to the development of the term framed as ‘other realities’.

These realities include the existence of Jinn, sihr and the nazr. In contrast to nafs and the heart, participants discussed these reasons more commonly. This could be related to participants looking to attribute their difficulties externally rather than looking for internal reasons for their difficulties. The externalisation of aetiology will be explored in the discussion chapter.

In addition to humans and angels, it is part of the Islamic belief that God created Jinn. Some participants were of the view it was possible for Jinn to possess human beings but discussed this was an issue in other people rather than themselves personally:

“They [Jinn] could in others...not in my situation” (P9, Male Bangladeshi).

There was no further description on how this would affect others by this participant.

Only a minority of participants said Jinn affected them directly:

“Jinn do anger more inside and crying, I don’t know why I crying” (P4, Male Somalia).

This could be related to people making their own judgement or being informed by others they are not affected by Jinn. It might also be connected to the idea of heuristic fallacy, where participants describe that Jinn can affect people but not affect them.

Participants felt Jinn could completely control people:

“We know Jinn can have full control of people, feel no help as difficult to get rid of him...stop my arms from working” (P9, Male Bangladeshi).

This person perceived parts of his limbs were not functioning properly. This could lead to a feeling of helplessness.

Another participant described feeling anxious, a sense of fear and suffering from headaches. He appeared preoccupied when discussing this and repeated some of his words to reflect this:

“the Jinn is annoying me, upset. Want it to go away...annoying me, worry, it was worry. I am scared...I feel low, sore head” (P11, Male Indian).

It was suggested that there was a fear of being misunderstood when discussing beliefs around Jinn. This led to a lack of openness and created a barrier to accessing medical attention:

“I also believe they don't seek treatment from the doctor as the doctor will not understand, the doctor will not know where to start, 'what's he talking about?' [doctor may ask]” (P10, Female Pakistani).

The data also indicated that these participants who described a different perspective towards their mental illness delayed in consulting their doctor. One participant, who believed his symptoms of schizophrenia were related to Jinn, was asked if he had visited the GP straight away once he became unwell. He sought help from a religious practitioner and waited 6 months before consulting his GP, he responded by saying:

“no, I wait...maybe 6,7, months... because I met a brother from Tunisia who come from hospital and when he tell me his problem, I recognise that I get the same problem that is why I go to the hospital and say I want to see a doctor” (P4, Male Somalia).

It was only after meeting a person who complained of similar symptoms he went to the GP.

Another participant, who suffered from depression, waited a year before seeking medical assistance from his doctor:

“It was long time, cannot remember, maybe a year or two...this was a Jinn problem and Imam understand this, doctor not understand” (P11, Male Indian).

Similar to the perception of Jinn above, participants commonly related sihr¹¹ as a cause of mental illness. The common belief of these participants was that sihr affected the mental health of other individuals rather than affecting their own mental illness. This could be for similar explanations provided for why Jinn influenced others and not themselves (discussed on page 197). It was suggested one of the effects of sihr was marital separation:

“Black magic is not good, black magic can break marriages and make separation between husband, wife” (P4, Male Somalia).

Another participant who held the view sihr affected others, was asked directly how this could manifest. He described feelings of mistrust and occurrences, which could not explained such as things moving around the house:

“Sihr is bad, we don’t say white magic or black magic, all magic is bad. Someone feel see things move in house, and they turn behind and see nothing, what has happened. I am thinking and people not trust other people, this no trust and sihr make this happen” (P11, Male Indian).

Only a minority of participants suggested sihr as being a cause of deterioration of their own mental illness:

¹¹ According to Philips (1997), black magic (or Jadoo in Urdu, Sihr in Arabic) refers to an act of bewitchment or incantation upon someone.

“I always think that, Jadoo, Nazr. You know like when I was a young girl I was quite bubbly and happy and then everything just finished...yes I always say to my husband, I am sure somebody has done something to me and then my husband tells me no, no, no you should not think that” (P5, Female Indian).

This participant described how she changed from when she was younger. She was asked directly if this could be related to sihr or nazr (evil eye). Her narrative appears to be contested by her husband. This links with the idea of negotiating the understanding of distress through the participants lens with significant others.

This participant complained from pain across her knees, which impeded her praying regularly. She perceived her pain and lethargy was linked with sihr and disagreed with the diagnosis given by the GP:

“sometimes do not pray due to pain in knees...well I don't know, my pain cannot find reason, is this not real...Jadoo...this is all possible. (name of GP) say I have depression and should take these tablets. My pain, doctor not know, Jadoo can do this, the pain, the tiredness, this all” (P3, Female Pakistani).

The role of God seemed to be relevant here, where God is considered the ultimate decision-maker power in all affairs, deciding who is affected by sihr. It may be then people are likely to rely on religious cures and reliance in God rather than explore other avenues of help:

“Sihr cause depression... it will never affect people unless Allah wants you should even if you have sihr you should believe that Allah is the main doer” (P2, Female Tunisian).

This also links back to the idea discussed on page 168, where anything that occurs, is contingent on the Will of God.

Another religious belief that emerged in addition to Jinn and sihr was the belief in nazr (evil eye)¹².

This participant was told by her GP that she suffered from depression and obsessive compulsive disorder however was convinced sihr and nazr was the cause of her problems:

“she [doctor] told me that I had obsessive compulsive disorder and depression, that was the name of my illness...I always think that, jadoo, nazr...I am sure somebody has done something to me”

(P5, Female Indian).

This could also be a barrier to accessing help where required. This participant suggested it was easier to blame nazr for difficulties rather than attribute it to mental illness:

“when you are depressed you physically look worse, so they will say, oh someone has put a nazr on her” (P10, Female Pakistani).

What emerged was participants discussed Jinn and sihr more commonly in contrast to nazr. This may be related to the perception that Jinn and sihr has more negative impact on people as suggested by this participant:

“But nazr and hasad [envy] I don't find them as being too big a restriction on people dealing with the problem, but black magic and jinn, I think that really hinders people because as soon as a

¹² Nazr is referred to *“The origin of the evil is liking something, then the evil soul follows it, pursues it and seeks to do harm to it, seeking help to apply its poison by looking at the object”* (Ibn Al-Qayyim, cited in Ibraaheem Ameen, 2005, p253).

family have belief in black magic or jinn, they then don't seek medicinal treatment via the GP route they go straight to an Imam or someone who claims to be a pir [religious figure] or something and just speak to them about this person's problem and say can you deal with this situation and they go down a completely different tangent of trying to treat the person, which I have found when I have heard in a lot of cases ultimately has made the person a lot worse, because one you already have anxiety or depression or whatever and you are already feeling so bad about yourself and if your whole family effectively turns against you and listens to some person” (P10, Female Pakistani).

There seemed to be the suggestion that family might exacerbate the situation where mental health help is needed by seeking consultation from a religious figure and only considering other realities as a cause of mental illness.

The participant has also mentioned envy. This is regarded as an ailment of the heart, coming from within the person. This is in contrast to *nazr*, which is emanates from an external cause.

7.2.3 Satan affects me

‘Satan affects me’ has been used to capture the experience of participants describing the effects of Satan¹³ on their mental health difficulties. This came across in the interviews as affecting them at a deeper and personal level:

“if Satan is present it makes my mood feel like is my life not meaningful, what am I praying for, I am not leading a good life, I have this depression, I have this and that” (P2, Female Tunisian).

¹³ Satan is called Iblis in Arabic, one of the Jinn, is a creation of God however he refused to obey God's command when asked to prostrate to Adam. Satan rebelled and vowed to lead mankind astray (Al-Hanbali, 2003). The use of Satan in this thesis refers to Iblis or his followers.

Participants described Satan slightly more than Jinn and sihr magic. This could be because people might be more accepting of Satan as a root cause of their problems as this is considered to affect anyone, regardless whether they have mental health or spiritual difficulties or not. Satan also has a specific purpose, to mislead people. This is why Satan has been grouped as a distinct concept rather than grouped with the other causes discussed previously.

During the discussion of the level of Satan's influence upon an individual, more participants appeared to have a passive outlook whereby they believed Satan exerted power in influencing their behaviour as this participant responded to the question 'do you feel Satan can control you?':

"Yes, he [Satan] has power" (P9, Male Bangladeshi).

This was compared to a smaller number of participants who held the view Satan exercised limited control over an individual. Some participants were of the firm belief that God alone would be sufficient to help them and Satan did not have power to control them:

"if Satan is present it makes my mood feel like is my life not meaningful, what am I praying for, I am not leading a good life, I have this depression...no, we have full trust in Allah and he will remember us" (P2, Female Tunisian).

This participant discussed their perception that Satan caused low mood and purposeless in their life; they were then asked if Satan had power to the extent to have complete influence over them.

Another participant related Satan as being connected to a test from God:

"I know first of all it is a test from God...the main cause is Satan, I do believe this"

(P4, Male Somalia).

The same participant described his perception that Satan was able to place ideas in his mind. There was a reluctance to discuss these areas relating to Satan with the doctor due to possible misunderstanding:

“Satan puts you ideas on your heart and on your mind...well, doctors not understand” (P4, Male Somalia).

Data from participant 4 highlights a connection between perceptions towards difficulties and their outlook to life where life is considered a test (discussed in the previous chapter on page 156). Being aware of these beliefs towards life could facilitate a greater awareness of perceptions held by Muslims towards suffering and difficulties. Furthermore, understanding these perceived beliefs more deeply may help people (such as possessing knowledge of the limited power of these realities) and knowing that faith can act as a protection against the effects of other realities:

“Allah has told us that we can protect ourselves through what we do, what we recite, duas we read, how we purify ourselves, as I said the community tends to blame everything of these [Jinn, sihr, nazr, Satan] things and understanding our beliefs better we understand the limited power these things have in front of Allah and what we can do as a Muslim to protect ourselves and get better...It's like knowing your own weakness, your own enemies, the negatives” (P10, Female Pakistani).

This was in response to asking the participant why exploring the area relating to other realities (Jinn, sihr, nazr) and Satan may be important.

7.2.4 Being punished and weak faith

It is interesting to note the lay Muslim participant's perception of belief also relates to punishment from God and being a weak Muslim. These two ideas have been conceptualised from the participant responses and observing non-verbal expressions of guilt and distress. These beliefs might affect the manner in which they understand their difficulties and so exacerbate their level of distress.

Slightly more participants did not believe mental illness was caused by punishment from God. Some of the participants discussed the idea of punishment with slightly more people explaining a wider purpose to the punishment rather than in a distressing or harmful way. Punishment will be discussed from a scholarly perspective on page 243. Participants indicated punishment was a way of washing away sins or as a protection from other problems:

"maybe Allah wants to wash away some of my sins, bad actions, punishment...so we [ask] Allah to protect us" (P3, Female Pakistani).

*"This comes from Allah, he give punishment, he gives and takes. It up to Him. He can save you from bigger problems"*¹⁴ (P11, Male Indian).

The first chapter outlines other aspects of the purpose of mental illness (on page 145).

However, there were a small number of participants who interpreted the punishment negatively, with guilt. One talked about his distance from Islam and sinful actions in the past and not as a way of washing away their sins:

¹⁴ This has been used a second time due to its relevance.

*“definitely a punishment...the punishment was running away from the Religion. For my sins...I regret having started smoking and not being religious”*¹⁵ (P8, Male Kenyan).

There were also contrasting views among the participants relating to the area of weakness in faith as a cause of mental illness. The majority did not feel mental illness was related to weakness of faith. For the minority who believed it was related to being weak in faith, it was suggested to be related to being less spiritual, where they felt they were not practising as much as they should be:

“I was weak in my faith” (P8, Male Kenyan).

One person did not have the confidence to find a job and spoke about his perception of being treated differently from others because of his mental illness. Following this, he was directly asked about self-judgement. He responded by saying he judged himself and was neglectful of his daily prayers:

“people will notice the difference, they will see you different from others, So I did not feel I could get a job, I help out in the house...sometimes I did judge...it was difficult and felt down and worried... I am not strong Muslim, weak Muslim not praying, forgetting” (P9, Male Bangladeshi).

Where a person is not able to fulfil their religious duties such as praying, this may lead to the development of inwardly negative feelings such as self-blame and judging themselves (as being a weak Muslim spiritually).

A Muslim might be particularly more affected in situations where they perceive other individuals to be judgmental about them, treating them negatively and indifferently:

¹⁵ This has been used a second time due to its relevance.

“you have got depression because you are not a very good Muslim...I was very reluctant to talk to my friends about depression” (P10, Female Pakistani).

The views of punishment and weakness in faith held by participants could affect whether they understand their difficulties relating to mental illness. This is discussed further from a scholarly perspective on page 208.

7.3 Scholars' views

This section moves on to discuss data from the scholars and contrasting views and similarities discussed. The aim is to provide a picture on how difficulties are perceived by qualified religious scholars from an Islamic paradigm. These difficulties may be related to emotional/mental health difficulties, mental illness or the spiritual domain.

Themes emerging from the data can be broadly summarised as below:

- Spiritual elements of the individual.
- Spiritual and life imbalance.
- Understanding other realities
- Satan affects me.
- Punishment, weak faith and mental illness.

Scholars frequently discussed the spiritual elements and Satan.

Scholars were asked from the interview schedule about possible explanations for a person's emotional/mental health difficulties and mental illness. Scholars held a range of views relating to either religious reasons, other reasons (psychological/social/medical causes for example) or a number of these.

Very few scholars highlighted the importance of considering a range of reasons for causes of mental illness rather than singling it down to one factor. One scholar explained:

“you need to consider various situations, it can be this or that and not rule out religious causes, but also I would say, look at more than one thing, could be religious and mental health. People do not

and its obvious there are not that many people who have the view of thinking about spiritual and health, mental health together” (Scholar 5).

It could be expected that scholars favour a religious paradigm as an explanatory cause for mental illness due to their background.

7.3.1 Spiritual elements

In the previous section, the concept ‘inside me: the heart and nafs’ was developed from a small number of participants, corresponding to internal, spiritual aspects of the individual. This in contrast to how commonly these were described by scholars. All of the scholars who participated in the study discussed the concepts and difficulties arising from the heart ‘qalb’ and ego ‘nafs’. These were discussed in more detail, building an understanding of the nature of an individual from an Islamic perspective, pointing towards to the conceptualisation of these aspects as spiritual health. The other elements, ‘aql (intellect) and ruh (soul) were highlighted by some of the scholars and the interaction between all the elements. These were not framed as a mental illness. This gave rise to the idea of spiritual elements of the individual.

7.3.1.1 The heart

The data indicates the heart is described in a number of ways. The spiritual heart was seen as being related to positive mental health:

“In the body there is a morsel of flesh [heart] and if it is healthy then the whole of the body is healthy...the understanding of the heart is not a physical pumping organ, but the mental state”

(Scholar 4).

The word 'heart' was used rather than 'qalb' in the interviews, as it was already known by the researcher that the 'heart' signified several expressions. This will be explored in the discussion chapter. The researcher was aware of the different layers of the heart and asked directly about this: *“What needs to be appreciated, is there are different Arabic words for the heart, used in different situations, times, there is no exact synonym, and the heart can be used in general way or specific way. Sadr, sometimes translated as chest or breast, gives idea of something hidden, can say treasure chest. It is most external. This is where Shaytan whispers, secrets kept and ego commanding to evil. And now the next layer there is, qalb, this literally means flipping or turning over. Pointing to nature of heart changing constantly, such as emotions and decisions undergo change. This changing of the heart is a normal state of the heart. The qalb, this can either be a sound heart or sick one, where diseases of heart occur...al-Fuaad, this can be described as the inner chamber, and is indicating a sense of burning, kindling, in its derivative, indicating roasting of meat under the flame, good way of understanding. So referring to how much a burning heart is inflamed with emotions, like emotional cover. And the al-Lubb, representing the intellect, this means the most inner core of something, marrow, it is pure intellect, free from blemishes, free from the turmoil of emotions, able to see the truth, seeing the signs of God, the pure intellect...the emotional, psychological side cannot be ignored”* (Scholar 5).

The 'qalb' as a place of emotions was also described by another scholar:

“The heart is described as the seat of the emotions. Sicknesses of the heart are emotional, spiritual and mental illnesses...seat of emotions, thing that changes, it comes from root word inqilaab to mean to turn, keeping on changing, the emotional state and contained in the jism [body]” (Scholar 4).

The heart encapsulates not just spiritual aspects but also emotional and mental health related.

The description of the heart by scholar 5 being sound and also could be affected by spiritual ailments is described by other scholars. The heart was referred to as 'qalbun saleem' (translated as a 'sound heart'), signifying a settled emotional state:

“Qalbun saleem, it's what you are aiming towards... Peaceful, tranquil so it is more about tranquility, it is like weeding the garden, once you have weeded the garden you are able to focus on there, what is positive...idea of settled heart, free of illness, refers to the mind, the consciousness” (Scholar 2).

The same scholar was asked to explain the mind which he mentioned:

“The mind is a person's self-perception and how a person uses this. I think the closest word for this is 'tasawur', but not in the technical sense used in formal logic”.

This scholar's understanding of the mind drew parallels to scholar 2 and also contemporary views:

“Interesting as Dr Daniel Siegel has really definition of the mind, as a relationship between energy flow, information picked up from energy flow, mind just in the head, it is not even restricted to body, it's anything you pick up as an energy and then you draw information from that, that is the mind, realm of the mind”

“Mind is more broader than cognition...mind, energy and information, any sort of energy, and how you can extrapolate meaning from that, is the mind, is beyond what is in the head, and it is the soul that is able to do this, soul is beyond this” (Scholar 17).

This appears to suggest the person has an interaction with the mind.

Scholar 5 described the nature of the heart as being changeable. This is echoed by this scholar, who also ties the link of the heart being tested:

“by nature turbid and changing. It is part of the destiny of the heart to be so...a sound heart that can endure the turbid nature of being tested” (Scholar 2).

The idea of the heart being changeable is also connected to being flexibility:

“I see qalb, we shift and change and bring in statement by Imam al-Junayd, the heart goes through forty stages in a day, talk about flexibility and adapt to situations” (Scholar 17).

Going beyond the discussion of the fluctuating nature of the heart, the nature of the heart was explained as a place of constant assessment:

“Heart, qalb meaning of fluctuations, it does but Qur’anically, more about being able to assess something, whether it’s right or wrong, right corpse of direction, not necessarily settled state of heart, speaking about it from spiritually point of view, no-one is settled, nature is that it is constantly analysing, got clarity how to act. Rust concept and polishing it” (Scholar 17).

Ailments were described that affect the heart spiritually and which manifest in a number of ways such as anger, doubt and preoccupation:

“Spiritual heart diseases...deceit, doubt, showing off or you have anger within your heart or you have enmity towards someone, or you backbite, even thinking negative about someone” (Scholar 3).

Heedlessness (or ghaflah) was described as the main spiritual disease of the heart:

“Imam al-Junayd [Muslim scholar from the 9th Century] said that ghaflah is the main source, the source of all the diseases of the heart, overlooking something, neglecting the divine purpose behind creation, the heart is afflicted by heedlessness” (Scholar 2).

Envy and jealousy were highlighted as a spiritual disease:

“Issues of jealousy...categorised as disease of the heart in Islam...a spiritual problem” (Scholar 8).

“envy, this is malicious, a person, he wish a blessing is pulled from another person, envy is a great trap of Shaytan [Satan]” (Scholar 12).

Another aspect to diseases of the heart related to muhlikat (vices). This is described on page 301.

Scholar 2 was asked directly how these were grouped:

“Shubuhah and shahawat, shubuhah, not having appreciation of God’s blessing, failing to recognise this and the other [shahawat], the base desires, arrogance etc”.

He also suggested personality traits are linked with the qalb:

“Personality traits are inbuilt from before birth, and then are ordered by the person through tarbiyyah of parents or tazkiyah of the person themselves”.

This appears to correspond to the nurturing of personality traits.

The heart was described as playing a role in influencing one’s actions and interconnected with one’s spiritual state. It appears from this scholar’s description, the heart undergoes a spiritual struggle as negative thoughts attempt to enter the heart:

“the heart is the spiritual affair...one’s heart and one’s spiritual state, which will then influence the actions... the heart really the king of the human being, regulates, controls everything the person doing...the heart influences the ears, eyes, thinking about your notions... person’s notions, thoughts have an influence of the person’s heart so the heart, needs to be protected, insinuations and notions. Protected through worship of Allah, spiritual fortress for the heart, once you open the doors and there if there is no struggle to protect from these notions or automatic thoughts, then you are allowing those arrows, every single notion is like an arrow flying towards the heart. If there is no struggle against that, you are allowing all of those arrows to attack the spiritual heart” (Scholar 15).

The idea of ‘sakina’ is introduced here. The nature of heart is changeable (described earlier on page 210), going through turbulence and then reaching a state of sakina or spiritual tranquillity:

“spiritual tranquillity that comes after turbidity and doubt, so it presupposes trials and difficulties that cause doubt, but then is brought into a state of stillness. It assumes trials and difficulties that are a test, after which if a person adopts religious counsel they will attain stillness. Hence, marriage is referred to in Quran as means of gaining this sakinah” (Scholar 2).

A comparison to married life was given as marriage is considered to have highs and lows in the relationship.

Another description of the heart relates to God consciousness and developing patience in the face of adversity. This scholar was asked directly about the meaning of the heart being tested:

“The heart has been tested for tawqa [God consciousness]...there are varying opinions from the exegetes as to what it means. It most likely means that Allah has “trained” their hearts. Other meanings mentioned are that it is to indicate their patience during tribulations, or just meaning

patience altogether, or meaning Allah “knew” the righteousness in their hearts, or Allah “purified” their hearts” (Scholar 15).

In the previous section, on page 194, the data showed only a small number of participants were able to discuss the heart and nafs. This could be understood by this scholar’s explanation that there might be lack of knowledge and awareness of diseases of the heart in the Muslim community, which consequently could affect the choices people make:

“if someone has studied tazkiyah [self-development/purification of the heart], aspects of qalb [heart] etc, then they choose to ignore but most people do not know much about this area so they are not aware, people are not self-reflective and they need guidance, knowledge” (Scholar 5).

7.3.1.2 Nafs

There are three levels of nafs, which relate to levels of spirituality:

“the commanding Nafs, al-ammara, al-lawamma, blaming self, other one is al-mutma'innah, the soul that is at peace” (Scholar 3).

This scholar was asked to explain the different types of nafs:

“The commanding nafs, commanding towards evil. The al-lawamma nafs, blaming nafs, when person has refined his nafs but falls into sin, and immediately his nafs will rebuke him, chastise him and make him do tawbah [repentance], al-mutma'innah, state of nafs not concerned with disobedience, it is seeking pleasure of Allah swt” (Scholar 15).

Nafs has been suggested to be used in two ways, one usage encapsulates all the spiritual elements, used as the soul here or can be used as an individual entity, to mean the human needs:

“it [nafs] is not blameworthy, it’s the essence of the person...literature talks about bringing you down, we need to reframe this, the soul and nafs juxtaposed, descartian dichotomy, I believe they need to be integrated into a holistic way rather than two opposites. Nafs is all of them and something else when you are trying to break into categories, when compartmentalising into one facet, refer to base, human needs...and the whole person, nafs, used as soul. Compared to a riding beast, you have to take it away with you” (Scholar 17).

Nafs was indicated to have not just spiritual effects but others as well:

“Nafs not just spiritual, mental and physical as well” (Scholar 17).

Nafs was described as the 'ego' or 'lower self', the tendency to pursue desires, as a cause of difficulties. One scholar pointed out:

“combat that [nafs] by trying to keep your head above water...the ego is constantly pushing you down into the water and your soul [ruh] is constantly trying to keep you afloat and you are constantly in this kind of constant state of battle with your lower self, like wild horse and if you tame it then it becomes tame for the rest of its life and if you don't try and tame it then it remains wild” (Scholar 2).

Scholar 15 was asked directly if the nafs was inherently bad. He responded using the description of the taming of the horse mentioned by scholar 2 previously:

“Nature of nafs is inclined to evil, when its refined then it doesn't do that, like a horse, try to tame it by three things, starve it by not indulging in its passions, then over burden it, heavy load done by acts of worship and last thing, is appeal to the Owner of the beast for assistance, asking Allah for assistance to overpower the nafs, once its refined it is not bad then. Primordial state is that nafs is

inclined to evil. *It is difficult for it to be totally refined. Nafs is driven by you, your appetite, your desires, could be influenced by hawa [caprice], they are two separate things but generally can be interlinked*” (Scholar 15).

There seems to be the comparable use of nafs as the lowest level of the soul. The nafs come from within the person and involves a process of disciplining them. Nafs is used synonymously with the soul here.

This scholar suggested that the nafs have to be purified and tamed:

“the nafs are within us. You can't get rid of the nafs, you can't extract it from your body, so it is in you and you have to cover it and purify it which is quite important for people to understand as well” (Scholar 3).

The nafs was described as an aspect of self which requires rectification.

It seems the concept of nafs can be described relating to different stages of spirituality. It is an internal struggle for the individual concerned as he is constantly tempted by his internal desires; this may lead to wrongful actions and worldly difficulties rather than spiritual tranquillity and contentment. An awareness of these stages of nafs may provide a reflective framework for individuals to have a check and balance system, to aspire towards a higher spiritual stage and reflect on one's shortcomings linked to a lower spiritual stage. The classification of these stages of nafs could equip Muslims with a self-monitoring of their spiritual level. However, self-rectification may not be possible for everyone and they may require support and guidance from others.

A lack of awareness or knowledge of nafs might therefore explain one of the reasons of being less spiritual:

“People are not constantly aware of their nafs, the effects. They are spiritually distant from their Islam” (Scholar 12).

Here, scholars offer a perspective of judgement from the understanding of faith. This stance will be discussed further in the discussion chapter.

One scholar considered nafs was the primary reason as to why a person suffered from mental illness:

*“Sometimes, drugs and alcohol sometimes, and lifestyle. The main cause of mental illness is the weakness of the Nafs. The nafs we are talking about is the selfish self, it’s on different levels”*¹⁶
(Scholar 7).

This scholar appears to be corresponding to the unbalanced, lower level of nafs as a cause of mental health problems, which can be developed to higher stations of the soul.

The scholars’ opinion reflected their belief that the Muslim community required greater awareness and guidance in the area of spirituality specific to nafs and the qalb. Scholars considered that guidance was necessary due to lack of awareness in individuals. This could result in reduced capacity for self-reflection. Individuals were encouraged to assess their inward self in a better attempt to help them recognise their spiritual difficulties and take the relevant steps to strive in achieving the highest form of spirituality. It was suggested individuals need to consider these

¹⁶ This has been used a second time due to its relevance.

internal causes and not necessarily blame external reasons for their difficulties:

“the qalb requires internal effort, self-rectification, where no else is looking, it is not like praying, where others can remind you, this is a realisation the person comes and they need to look at the change...the nafs is same, the struggle with nafs, looking inside and not blaming outside causes [like Jinn, sihr]” (Scholar 5).

This is in contrast to the discourse of some of the participants, who externalised their difficulties either through illness or ‘other realities’ rather than inwardly rectification and spiritual development.

These elements are understood as distinct entities and also interchangeably to signify the same spiritual force within a person (table 13):

7.3.1.3 ‘Aql (intellect) and Ruh (soul) and the interaction between the four spiritual elements

The remaining spiritual elements, intellect (‘aql)¹⁷ and soul (ruh)¹⁸ were described here:

“the ruh is from celestial realm, that propensity to push you towards spirituality, the ruh is always attracted to the positive, when you strengthen the ruh, you see those people who are happy, always content, confident with life...’Aql is, actually is from higher perspective, seeing things from a true light, you can have someone who has 10 PhDs and he doesn't have intellect, it's like insight, its understanding, not simply intelligence, ‘aql will help you see things in true light like things can change when in difficulty” (Scholar 5).

17 ‘Aql refers to the ‘force of knowledge, and the capacity through which one know. It can sometimes be used to refer to a subtle force through which one perceives and understands, a meaning shared with the others words explained here as heart” (Mohammed, 2016, p57). It relates to reason, logic, beliefs.

18 The word ‘soul’ can be used interchangeable and has been used here to refer to as the ‘ruh’. It has also be referred to as ‘nafs’ in the data.

Scholars discussed these two areas of intellect ('aql) and soul (ruh) less frequently in relation to the nafs and qalb. In addition, none of the participants explored this area.

Scholars were asked to explain 'aql and the ruh:

“the 'aql is the faculty that sets out to restrict the destructive tendencies of the ego via pathways such as thinking and logic (common sense)” (Scholar 2).

“looking at this, 'aql, knowledge, the beliefs that influence thinking, the knowledge that influence thinking...very few people know about the ruh, not much can be known about it” (Scholar 15).

“while the ruh has a prior existence unrestricted by temporal restraints and so can be seen venturing into areas such as dreamlike states and visions” (Scholar 2).

“when someone has greater expansion, they can see things broader, new meaning, and this is to do with ruh” (Scholar 17).

The 'aql having a restrictive element is mentioned here again:

“point of 'aql is that it restrains someone, resilience, being able to have strength over impulses” (Scholar 17).

A distinction between the nafs and the ruh is described here:

“You will hear most people speaking the nafs as being lower and base but I don't see it that way I see it as I explained, nafs is to do with the earthly things and the ruh the heavenly and when integrated they all channel towards the higher” (Scholar 17).

The interaction between the spiritual elements was asked directly:

“The spiritual soul[ruh] is truly spiritual, but the soul [ruh] when it comes into contact with the body [jism] it becomes an ego...like the lower self...be a spiritual life force...that dragging down of the soul by the body is called the nafs” (Scholar 2).

This is explored further with same scholar. The body or jism is mentioned again through which the ruh makes contact with and where the ruh resides:

“The jism is a receptacle within which the ruh takes residence, thereby emerging as the ego due to the demands of the body and environment within which it operates... my understanding is that the ‘aql is the faculty that sets out to restrict the destructive tendencies of the ego (say nafs al-Ammarah), while the qalb is the place of divine guidance and reflection. Both can overcome nafs al-Ammarah, but from different vantage points”.

This interaction between the four spiritual elements in a number of ways is explained here:

“Nafs, ego sense of oneself, which is always limited, if we conceptualise something then it is going to be something short of real reality, ruh is true reality. Persona as jung. Not necessarily negative, but in Sufi terms they see it like that. Always limited. It’s one perception. Aql is tying something, holding it back, sense of strength and resilience to control oneself, heart assessing things for what they are, aql is ability to act upon it. Ruh, is ones true ability, which is beyond one’s ability to articulate, because it is ones true being, unconscious, linked with unconscious...towards ones good, visions...soul, one true nature, always fleeting, not fully articulated” (Scholar 17).

“Nafs is the drive to eat, lower thing, lower is not a negative thing, it’s an earthly thing, heart assesses it, is this the right thing to do, and the ‘aql is the one now that ‘I have decided it is a good

thing to do or bad thing to do’, the ‘aql is the one that restrains it, if it is not a good thing and is like a break, and release if good, gives it the ability to do it” (Scholar 17).

The four spiritual elements are further explored in the discussion chapter on page 417.

7.3.2 Spiritual and life imbalance

The theme of balance is outlined in the earlier chapter, on page 166. Several areas relating to the concept ‘spiritual and life imbalance’ emerged from the data that could potentially be linked to one’s difficulties. This came out from discussions in supervision where the data pointed to a sense where people might struggle with two or more things relating to life not sitting in equilibrium, out of balance. The use of ‘balance’ was also directly used by scholars. These can be summarised as relating to this world versus the after-life, imbalance of spiritual elements and imbalance of spiritual well-being. This section describes the imbalance of these areas.

7.3.2.1 Imbalance of life

The balance of this life and preparing for the after-life was described in the earlier chapter by scholars and participants, on page 167, explaining that the life in this world is connected to the after-life. This understanding of imbalance of life was primarily developed from scholars data. This might be because participants focused on other concepts such as predestination and life being a place of trials as areas of importance from their perspective.

The importance of thinking beyond this life was highlighted, not just living for the times in this world but having a level of concern or anxiety for the after-life; in other words, Muslims should live in this world bearing in mind how this may affect them prepare for the after-life. This concern or worry known as 'fikar' in Arabic was normal level of spiritual feeling and not a mental illness:

“low grade anxiety for everyone, this is normal for Muslims...we should be worrying about if our actions will suffice and what will happen in the after-life...This is balanced between hope in Allah Subhanahu Wa Ta'ala [Glorious and Exalted is He], in the after-world, hope we will be successful” (Scholar 7).

There was also discussion about people developing an excessive attachment to this world, losing the fikar of the after-life, and consequently leading to mental health difficulties:

“Attachment to this world can lead to depression” (Scholar 9).

Scholars viewed worldly attachment as a ‘spiritual problem’ rather than defining it as mental health issue. They also spoke about how living a materialistic lifestyle further strengthened the attachment to this world leading to spiritual imbalance:

“If a person is anxious it is usually related to their interaction with the world and the fact that they feel they are always going to not give them enough of itself and they are constantly trying to grab hold of whatever they can in the shortest period of time not realising that God has appointed plenty of time for everything, so that is obviously a spiritual imbalance” (Scholar 2).

This scholar suggested the idea of living in the moment as a way of balance and further mentioned it was a state that required development:

“People are thinking about the future, past, worried and there is saying, a Sufi is a child of the time. It’s about living in the moment. It is not easy and about the person developing themselves” (Scholar 16).

This is referred to as ‘hudur (presence):

‘Hudur, presence, be it the moment, the son of the moment, contemplative practice, trying to be present, understanding what Allah is calling you for at that moment, time’ (Scholar 17).

The theme of excessive attachment to this world correlated to a loss of purpose in life here:

“Little purpose in this life, too much dunya, to know that this is Allah testing us is half the solution. I have seen also, like confusion is because of depression” (Scholar 7).

The imbalance might slant, not just towards this world but also towards the after-life. This was relevant for people who are preoccupied about the future in an excessive manner, going beyond having an acceptable level of concern (fikar). Scholars talked about developing anxiety and depression particularly where people may be unprepared for the after-life:

“this idea of having depression based on the fact that you don’t know what your state is in the hereafter that is also a type of imbalance, because it is going from one extreme to another”

(Scholar 2).

A ‘balance of life’ would seem to give perspective on a person’s life however; attachment to this world or preoccupation about the future leads to a ‘spiritual imbalance’ which in turn could result in spiritual ailments. There is also interesting as appears to be connected with the idea of ‘living in the moment’ but not being trapped in it. This might be difficult for people to do and require a process of development.

Failed expectations in life could impact negatively on the person:

“one of major issues is idealism, perception on how things should be in ones ideas, this can happen with the person developing an over-romanticised view of Islam and how it should be, and thus reality not always conform with that, and that can cause rigidity, bleak outlook of life and that can have impact on one’s wellbeing, that can manifest in families, how wives should be, how husbands should be, husband not spiritual enough, not realistic enough” (Scholar 17).

This is similarly described on page 306. Hopelessness was also suggested to be related to depression (see page 306).

7.3.2.2 Imbalance of spiritual elements

In the earlier section named ‘Spiritual elements of the individual’ on page 208, the spiritual elements emerged from the data, which were described to constitute an individual.

A minority of scholars discussed the bringing together of all these elements in an equilibrium in people’s lives.

This imbalance was described here:

“[the] spiritual realm is the realm relating to spirit which is the ruh and also the heart which is in a sense the consciousness of the human being and the religions tell right from wrong, which is also related to the intellect as well...the heart... the Nafs...having understood what the realm of all these four things are then...you are better able to deal with imbalances which occur in a human being” (Scholar 2).

There appears to be the notion of consciousness being connected to the spiritual heart being put

forward here.

From this perspective, it appeared when the four spiritual elements were balanced; this could be a spiritual force for the individual. The state of the heart appears to be determined by propensity towards spirituality, giving victory to the ruh or driven by desires, towards the lower level of nafs.

7.3.2.3 Imbalance of spiritual well-being

There was a type of spiritual imbalance affecting individuals relating to Iman (faith). This is described on page 175 where the spiritual well-being is reflected by an equilibrium of fear and hope.

This imbalance might be related to fear, either thinking excessively of what the future held for them or having no concern at all. This correlated with having no hope in God's Mercy or excessive hope as explained by one scholar:

“if there is an excess of fear, then it leads to despair and despondency. If there is an excess of hope then this will lead to a person becoming over confident” (Scholar 1).

“this balance of hope and fear...there is no balance then one of the two will happen. If a person has complete fear all the time then he is going to give up hope, and he won't go to ask for help, because there is no point...and those people where there is no fear and they have completely let go of everything. When there is an imbalance between it, people either feel dejected and don't want no help whatsoever or when they just completely let go and are not concerned about their own wealth and of others” (Scholar 8).

This scholar described depression occurring when a person moves away from their faith:

“the only depression that you have is you are far away from Allah from Islam which is to some extent true, you do get depression” (Scholar 3).

This scholar could perhaps be suggesting depression is a distance from God and purely a spiritual concern. No other causes of depression were explored by the scholar.

7.3.3 Understanding other realities

A number of external, non-natural causes were discussed that may appear to suggest as a cause of mental health difficulties. These include the existence of Jinn, sihr and nazr as real, similar to the views of participants. However, what emerged from the data, was a deeper level of exploration of these entities and effects by examining the context of one’s difficulties and not excluding other reasons as possible explanations. Thus, this theme has been termed as ‘understanding other realities’ rather than ‘other realities’. The majority of scholars discussed sihr and nazr more frequently as a possible cause of mental health difficulties as opposed to Jinn. The effects of Jinn were considered rare.

Scholars were asked from the interview schedule about religious beliefs that might influence perceptions towards mental illness. As the interviews progressed, questions were developed and areas emerged relating to possible mechanisms of these effects, symptoms and how to distinguish between these realities and mental illness, treatment suggestions and whether there were situations where person might be more vulnerable.

7.3.3.1 Effects of Jinn

Jinn were described as an entity unseen to humans:

“cannot be seen by men, invisible, hidden to the people. Also the Jinn get married, they have children, eat, drink” (Scholar 12).

The impact of Jinn was considered not just restricted to spiritual effects and suggested to impact on one’s mood and behaviour:

“there are not just the spiritual effects, but consequently psychological, people are affected, mood, their behaviour changes, there are psychological effects people are affected by through this” (Scholar 17).

Scholar 12 described Jinn with possession of special powers such as:

“The Jinn, they can do power, change and, take different forms, they can change into human, animals like dogs, snakes. Also in writings, the Jinn can move things, heavy things” (Scholar 12).

The majority of scholars discussed their opinion that Jinn do affect humans however a small number were dismissive of this:

“...they [community] want to hear that it is Jinn or black magic but no, no...jinn cannot go inside” (Scholar 6).

Another scholar also highlighted there were scholars within the larger community who did not believe in the effects of Jinn:

“There are scholars [2 names mentioned] who do not believe in Jinn effects, that Jinn cannot affect people, they do not believe in it (Scholar 15).

Among the majority view, there were differing opinions among the scholars as to whether (1) Jinn enters into an individual physically (possession) and therein exerting control from within or (2) whether there was influence from Jinn externally. The majority of scholars agreed on the latter view.

Scholars were asked directly about how Jinn could possibly affect people:

“the possession, it does happen. The Jinn can enter in the bloodstream” (Scholar 7).

This is in contrast to what has been suggested here by scholar 16 (and others) where Jinn have an influence on the person externally rather than physically entering inside a person. Two views were suggested: either the Jinn could touch the person or there is a level of interaction/engagement between the Jinn and the affected person:

“mas, is the touching of something, to touch, Jinn can do this and is not good” (Scholar 16).

“[Jinn] affect you from outside” (Scholar 6).

“this concept where Jinn for example enters into somebody and takes control of him...I have really not been able to come across clear instances of possession...how does he possess a human being, does he come into him take control of his head. Enters him, or does he just have sort of like a puppet, he is not in him, but in some ways” (Scholar 1).

When scholar 2 described possession as an abstract, he was asked to elaborate on this:

“We believe in possession as an abstract...my understanding of this abstraction is that it takes place not in the person physically, but in his spiritual, psychological, cultural projections, which are where the jinn would engage with them. This essentially preserves the volition of the human actions and hence responsibility” (Scholar 2).

Scholar 1 and 2 appear to suggest Jinn affects individuals through interaction or engagement between the Jinn and individual.

Scholars discussed Jinn less than the participants and also felt the effects of Jinn were rare.

There were also contrasting views between scholars and participants about effects and power of Jinn. This scholar was of the view Jinn did not have the power to affect a person to the extent they are controlled completely by the person:

“Jinn can't control...the Jinn he can't control your mind and the Jinn he can't tell you to do something. But people not understand this and they then develop more problems” (Scholar 6).

This is in comparison to the minority view of participants who believe Jinn could completely control people.

Scholars highlighted how, in their experience, Muslims in the general community differed in their opinion about the idea of Jinn having the ability to exert either complete influence or restricted control over an individual. Some scholars were of the view that those individuals with less spiritual strength and knowledge would be the ones highly afflicted:

“there is struggle between your soul, yours nafs and the jinn, whoever is stronger, will overpower the other...a lot of people give up, they were weak...People are just not aware this...there is void there that people do not have the knowledge that needs to be filled” (Scholar 5).

There seems to be an interesting and powerful parallel here between less strength and knowledge being associated with development of mental distress. Again, there appears to be an evaluative judgement made here by scholars.

One of the scholars was asked why Jinn would influence people and he suggested one of the ways was revenge:

“The Jinn can affect people and there does not always needs to be magic there all the time. We are told about saying bismillah [in the name of God] when pouring hot water down the sink, or not urinating in certain places like holes as these are where Jinn stay, if you harm them, they can take revenge” (Scholar 5).

Scholar 17 was also asked if there were circumstances where a person might be more susceptible to the effects of Jinn. He appears to suggest a psychological component:

“there are, person likely to be affected, weak state of mind, fragile more prone, dark spiritual forces” (Scholar 17).

This scholar was asked directly about whether the lack of development of the ‘aql (intellect) could make someone more susceptible to the effects of Jinn. He responded:

“if someone is weak, weak disposition, someone not have real resolve, then they are vulnerable to all sorts of things...if someone’s weak, they have a rundown system, you can branch that out, broaden it out, they are vulnerable to other things, they can be vulnerable to jinn” (Scholar 17).

As suggested by scholar 15 on page 226, some of the scholars brought up the view amongst sections of the Muslim scholar community who dismiss the actual effects of Jinn (and sihr). This scholar put forward his view that this could be in reaction to the Muslim community overemphasising these effects of Jinn, sihr:

“The Jinn, it is the unknown, and only real thing we know is from our sources and that called [in arabic] in aqeedah [science of Islamic creed], that are relayed to us, that we cannot assert through

objective scientific study, so very careful to dismiss such things as Quran affirms it, interpretation is possible and only interpret where there is a real necessity...There are scholars who dismiss the idea of Jinn, sihr...I feel a lot of scholars dismissing these things is just a reaction towards the obsession the Muslim community have upon labelling everything magic, going from one extreme to another, I have a balanced middle path” (Scholar 17).

The same scholar raised the argument whereby some scholars of Islam have objected to the effects of Jinn due to their volition being taken away from the person and consequently hold no responsibility for their actions. He does not feel this argument has a basis:

“Jinn can possess you and touch you, not outside the realms of impossibility, and I know people do not like that as think that takes away peoples responsibility, of action, but there are many things that take people out of responsibility, like PTSD, I was reading about a man, killed his partner in a shower having heard an explosion when outside and felt he was back in engagement in battle, he was sent to court, he was sent down for it, man was in distressed, unaware of what he was doing, doesn't take away his responsibility, he was given treatment, sectioned, but to put him in prison showed a lack of understanding, as sometimes people are not responsible, it doesn't make they don't need treatment, I don't see that as a strong argument”.

Distinguishing between Jinn and mental illness was identified as difficult but there could be a reaction/change in person's behaviour in response to religious practices such as recitation of the Qur'an.

“there is a reactionary response, the person, there is a conscious awareness, interact with the Jinn, person drawing into it, the interaction, what the Jinn is doing” (Scholar 2).

However the reaction could be explained by the person having prior knowledge that the Jinn could react to the Qur'an for example:

“it is very hard to tell to tell difference between Jinn, mental illness, it could be a reaction to recitation of the Qur'an. Person could be reacting, sub-conscious reaction to Qur'an, as one identifies they are possessed, aware and one knows from their background, or could be from collective unconscious, from their community that jinn don't like Qur'an, they could be reacting to that, at end we are looking for, with improvement and if that helps then go for it, but it needs to be coupled with other measures, looking at psychological side as mentioned...the approach involves others ways of help, the person who is facilitating the help, has to be qualified, difficult to find such people, has to read certain verses and other religious practices” (Scholar 17).

A wider approach not just entailing religious practices was suggested. This is further discussed by scholar 2 on page 243.

There was discussion about how common the presence of the Jinn was in the Muslim community overall. The effects of Jinn was perceived to be rare. From the scholars' experience however, it appeared that the Muslim community tended to think about non-natural causes for mental illness, such as Jinn in the first instance before mental health causes:

“most of community will think first about supernatural causes rather than normal causes... God causes things to happen, and they happen, inflict mental illness, natural consequence of cause and effect. It is logical that we think of natural reasons first, does the mind not go towards natural causes? If you are hungry, you eat, same thing with illness, you are ill, you look at natural cause for it” (Scholar 2).

“99% of the time it is not [Jinn] (Scholar 8).

Scholar 2 was probed further about his response about thinking about natural reasons before considering other ones. He responded by emphasising that natural causes should be formulated in the first instance unless there is evidence pointing to alternative causes:

“One thinks logically about causation, as I have mentioned, there is a relationship between observed causes and its effects and also unseen or intangible causes and effects, to then think of other things like Jinn, there has to be proofs to indicate this” (Scholar 2).

Another scholar reiterated a similar view where he compared the experience of scholars today to those scholars from 800 years ago in medieval times. Even through time and different generations, scholars in the past have held the view that the influence of Jinn is rare. He submitted:

“we are talking of scholars who lived 800 years ago...one of them is Abu Zayd al-Balkhi and the other one is ibn Sina...the vast majority of people in his time were suffering from illnesses which were not related to the jinn...so thinking about the illnesses first rather than these external factors” (Scholar 4).

The views of the scholars appeared to suggest that Muslims overall held varying opinions as to how common the effects of Jinn actually were. Muslims might attribute their mental health difficulties to be due to possession, or control, by Jinn rather than accepting that a genuine mental health condition existed.

Scholars were asked directly by the researcher as to why individuals may attribute reasons such as Jinn for an explanation for their mental health difficulties. A number of reasons were described by scholars. Being under the control of Jinn was *less stigmatising* when compared with mental illness.

Mental health stigma might result in societal discrimination and isolation whereas suggesting that an individual was under the influence of Jinn was more acceptable in the Muslim community.

Scholar 12 stated:

“it may be those people may, not want to face real, hard situation, problems and easy to say Jinn... they are avoiding face the reality, real problems and not take responsibility” (Scholar 12).

A person considered suffering from the influence of Jinn is also subject to stigmatising attitudes themselves. However, due to the manner in which the person narrates it to themselves and others in the community, it could be acceptable.

The term ‘depression’ was less familiar in Muslim families as opposed to relaying stories of Jinn from one generation to another:

“our grandparents would not know about depression, they knew about Jinn, the stories in the families so people have grown up with hearing about these stories...for part of the community, it is more culturally accepted, the way they look at things” (Scholar 5).

It was also indicated that sections of the Muslim community perceive Jinn as being more culturally accepted.

Further, it might be a way for individuals to understand and accept their mental health problems as relating to Jinn where no other explanation was available:

“people don't actually find a solution to the basic things...from a doctor they can't find a solution, or other people they can't find a solution, they need closure” (Scholar 8).

This could indicate the importance of considering other explanations people hold when discussing religious beliefs.

As described on page 218, people may look at externalising their problems to reasons relating to Jinn and sihr rather than internal causes:

*“the nafs is same, the struggle with nafs, looking inside and not blaming outside causes [like Jinn, sihr]”*¹⁹ (Scholar 5).

The same scholar was further probed about this area and he pointed out that people lacked understanding about depression and anxiety. Furthermore, he highlighted people attributing Jinn for their problems could be a way of shifting blame and avoiding particular circumstances:

“There are people who have depression and other problems, that can be social reasons, marriage problems, so these situations and the idea of bringing up Jinn, talking about Jinn, is about not understanding what depression, anxiety, these problems is about... thinking about other reasons you have asked, I see people and I would say is a way of not accepting responsibility for things they are involved in and pushing that blame, avoiding facing those situations” (Scholar 5).

Scholar 5 mentioned that blame may be attributed to Jinn due to misfortune:

“People think about Jinn when there is misfortune, ‘Oh, this has happened and it is the Jinn’, same situation could be for sihr, where they blame these reasons for this or that misfortune happening to them, their families, this is common thing people think about” (Scholar 5).

¹⁹ Part of this quote has been used a second time due to its relevance.

In contrast to other viewpoints, this scholar appears to take a less judgemental approach when working with people who might be distancing themselves from responsibility. It was suggested that attributing other realities for one's difficulties could be viewed as a coping mechanism:

“the other issue with dismissiveness with these things, it is not very considerate because he may using that as a coping mechanism, I understand these things can be used in order to dissociate from any sort of individual responsibility towards it and that's a problem, so we suggest what we can do but overall, could it be magic, jinn, effect of jinn, nazr, I think it could be a way of saying nothing wrong with me and rather there is something out there, in some circumstances can be empowering so I meet people where they are at, without dismissing other things” (Scholar 17).

This could indicate that it may be more useful working with the person without necessarily dismissing the beliefs the persons holds.

A small number of scholars were dismissive of Jinn affecting people. The majority of scholars believed in the influence of Jinn rather than Jinn possession. Scholars considered that the effects of Jinn as rare and they were of the opinion that the Muslim community would regard the effects of Jinn as a plausible explanation for their mental health difficulties rather than exploring other causes. A number of explanations were put forward by scholars to understand why individuals may attribute their situation to Jinn.

7.3.3.2 Influence of sihr

The majority of scholars suggested that sihr could have a possible reason for mental health difficulties/psychological consequences:

“Black Magic...these cause mental health problem” (Scholar 6).

“Sihr cause depression, person change, angry, person not make good decisions for themselves”

(Scholar 12).

“Strange occurrences which no doctor can explain, things in the house are moved, affects person, muscle aches, seeing nightmares and person sees dogs, snakes” (Scholar 5).

“starts with sihr, there is the impact of sihr, having the psychological impact on the person”

(Scholar 17).

This scholar was asked how sihr occurs and presented his view that the person involved in sihr engaged with acts forbidden in Islam and in return, received help of evil Jinn:

“The sahir [person doing the sihr] is disobeying Allah swt, by doing haram [forbidden] acts, and then they get assistance from the evil Jinn, more kufr [disbelief] they do, more assistance they get from Jinn. Just like men, there are good and bad jinn, evil jinn are involved” (Scholar 5).

Similar to Jinn, there could be alternative reasons why people might consider sihr. One example could be where there is no other medical explanation for one’s problems:

“When there is no answer, person not better after see the doctor, take this or that medicine then need to look at other reason, looking at for example influence of black magic” (Scholar 12).

This would also suggest not excluding consultation with professionals such as doctors.

Supporting someone inflicted with sihr concentrated on the cure, rather than attempting to understand how or where the sihr came from. Also social and physical aspects were suggested:

“general mental health problems could be related to black magic, which again, it is not important where it came from, the important thing is how to cure it. Basically to remind them and get them to recite certain things based on what are the issues” (Scholar 2).

“verses, specific Qur’anic verses, reciting them is crucial in the getting better of the person...also socially doing social, support from others, sitting with them and I believe in benefits, sports, football [smiled]” (Scholar 15).

It might not be possible to work out where the sihr originated from and similar to Scholar 2, the recommendation was to focus on specific religious practices as a means of help:

“This can take years to find the black magic, where it can come from, here there, who did it, Satan can also mislead you, play tricks, play with what you think so the advice given is to recite specific Qur’anic ayahs [verses], inshallah the inflicted person will get better” (Scholar 12).

Physical contact was not seen as necessary to perform sihr on others. It is one of the ways of Satan misleading human through false worship and associating the power of God to Satan and others.

One of the scholars pointed out that external factors such as sihr and nazr might affect an individual due to moral decline within society:

“there has also been a decline of morality so more people are involved in doing these things” (Scholar 5).

When the same scholar discussed sihr, he was asked further why some people may suffer from sihr and others may not. He put forward explanations why some people may be more susceptible to the effects of sihr than others. He suggested that if a person is affected by sihr, the impact of this is lessened through protection of one’s faith. One of the ways this is done is through practices such as words of remembrance of God:

“There is shield of iman [faith] around the person, and this is strengthened by adhkar [words of remembrance of God] as a protection and that will make you less likely to suffer, break down from attack from sihr. They can attack you from all over but really if you have the attack from sihr, the effects are minimal when you are protected through reading the Quran. Another thing to remember is about being strong minded, a person is weakened to the attack from sihr if they have low self-esteem, extreme emotion, anger, the effects of sihr is stronger then” (Scholar 5).

A similar point about extreme emotions was made by this scholar who used the word ‘weaker states’ when she suggested a person may be more affected in these psychological states:

“There are certain points, when a person is more susceptible to certain things, and this happens in emotional unstable states, extreme happiness, extreme worry, anxiety and this is what you can call weaker states, some people call this weak energy” (Scholar 16).

Scholar 2 spoke about the preservation of volition when discussing Jinn (on page 227). This is similarly discussed in relation to sihr. He suggests the effects of sihr are limited and similar to scholar 16, a person might be more vulnerable in certain situations:

“The primary interest here is again the volition of the human actions and hence responsibility. Sihr cannot violate this principle, so whatever the basis of sihr is, it is not a compulsion on a person, more spiritual, psychological, cultural projections instilled this time by a human actor (the magician). So I am sceptical of the inherent potency of sihr if the person being influenced isn't open to being 'influenced' ”.

It seems a person is less vulnerable from the effects of sihr, if they strong minded, good self-esteem and able to regulate their emotions. This appears to highlight that protection from sihr includes not exclusively religious practices but also psychological aspects.

This scholar suggested that:

“Sihr and nazr is definitely more common than Jinn” (Scholar 15).

Scholars might not feel they had to make the point about how frequent sihr or nazr occurred, unlike their discussions on Jinn.

In comparison to Jinn, determining whether someone was inflicted by sihr or nazr was suggested to be based on history and presentation. The basis on which to pronounce whether a person was under the influence of Jinn was informed by their response to religious activity such as reciting the Qur’an to them rather than basing it on a collection of symptoms:

“So you could recite and they would respond in a certain way...[influence of Jinn] is that it usually episodes behaviour, out of character, it is not a constant, there is nothing that shows symptomatic on a day to day basis that shows the person is [affected]. Whereas black magic, evil eye, jealousy there is symptomatic signs there that show the person has been affected...anxiety and depression, feeling unsettled, that don't have a natural reason” (Scholar 2).

“based on history, presentation, if someone comes with sihr, guide them to people with experience, credibility, which is difficult to ascertain, and we resort to them with duas in morning and evening, certain verses related to helping sihr, alongside addressing mental illness to strengthen them.

Histories, family situation and as well as general health, emotional wellbeing, look at, I have no issues, sidr leaves, reading over things, if it helps then it helps” (Scholar 17).

It was also suggested here that other information is required and not just looking at religious aspects.

One way to identify the effects of sihr was suggested through examining a person's clothing:

"she gave her [a person] a t-shirt, came back and said he is affected by magic...heard of that about cloth" (Scholar 17).

7.3.3.3 Nazr

In addition, to Jinn and sihr, nazr (evil eye) existed:

"we know the influence of evil eye is true and cause trouble and difficulty" (Scholar 12).

"Nazr is a reality as the Prophet [Muhammad] (saw) said" (Scholar 17).

Symptoms of nazr might include:

"They become withdrawn, doesn't meet people, not leave the house, get worried over this thing, small things" (Scholar 12).

"anxiety, nazr can affect you in number of ways, being negative, pessimistic" (Scholar 17).

This occurred by a glance of:

"looking at a person with envy, greed and that evil, which is real, affecting person with harming person, the harm cause trouble, loss, difficulty, accidents" (Scholar 12).

Parallel was drawn with contemporary work, where nazr was considered to be related not just to jealousy but where certain individuals could be sensitive to other energies or affected by a person's wonder:

“In terms of nazr, al-ain, I have read some interested stuff by Rupert Sheldrake called science delusion and he has a chapter on the effects of the eye. He is a biologist from Cambridge and brings with examples, anecdotal examples, not tested in lab, about situations where people have felt the definite presence of the eye from another person, we spoke the eye is not necessarily jealous, and can be ‘wonder’, and there are some people have an energy presence, energy definitely in there and this idea or concept of energy is very important and from an Islamic perspective, we distinguish between energies from more eastern tradition, [name] who does Hijima, cupping, said based on body meridians, just as every society did so, to get the energies to flow and we have no problem with this, energies, chakras, the only distinction is that God is not energy, and we do not have an inherent power in the energy, rather and this is my distinction between Islamic tradition and eastern...So sometimes people can have certain types of energy, or be sensitive to energy, that I do not have any issue with it and this is where the eye falls into it” (Scholar 17).

The same scholar further described his experience where he suggested people are affected by being in other people's presence and where other energies are picked up:

“someone being in company of someone and being affected by them, I have seen numerous cases, susceptible to eye, have you heard of highly sensitive people syndrome, pick up other people energy, my sort of own opinion, people not brought up in safe environments, they are very aware of their own environment, aware of what's around them, grow up, they are much aware of their security, need of safety and other people's states...we know people we pick up other people's energy, no doubt about that, affect our states, transference in psychology...how we feel about other people's energy”.

When asked about treatment, it was suggested a combination of religious and psychological be considered:

“When talking about treatment, difficult, get other people who gave it, do wudhu [ablution] with water and use that water, bath it. By reading the Qur’anic verses, people are cautious about sharing they were not close to, as they may think they may get affected. Highly sensitive people, don’t ignore the psychology, is helpful to look at” (Scholar 17).

Possible approaches how to deal with individuals presenting with concerns relating to other realities is further explored in the discussion section on page 387.

7.3.4 Satan affects me

The same heading used by participants is entitled here, to emphasise the real effects of Satan described by scholars. The majority of scholars described the ‘whispers’²⁰ of Satan:

“Whispering of the Devil...what it shows is that a person's mental activity can be affected by the outside” (Scholar 2).

What seems to be understood here, is that one of the ways thoughts originate is from Satan.

Another source thinking comes from is internally, from one’s nafs. Nafs is previously described on page 209. Satan places temptations in people as proposed here:

²⁰ Whispers or waswasa in Arabic, refers to temptations, obsessive thoughts or doubts coming from Satan (Utz, 2011).

“Satan's target is the heart, he does not whisper in the ear, he whispers to your heart...he whispers to you, he gives you the ideas, he insinuates this to you because he knows your weaknesses, he preys on your weaknesses, suggests temptations, desires” (Scholar 3).

The effects of Satan was suggested to be affect anyone and more common than the involvement of Jinn:

“Satanic whispers is the most common one, it happens to everybody, that is undoubtedly the most cases but the possession, it does happen” (Scholar 7).

Isolation might make the person more vulnerable to the influence of Satan:

“There needs to be a sense of belonging for people. It has been mentioned in this way that a sheep that moves away from its flock it becomes easier for the wolf to prey on, it is the same way, a person who does not stick with the community, he goes away and separates himself from the community, Satan has an easier, can attack him easier, so being with the community and staying with the community. This isolation makes you more vulnerable to mental health” (Scholar 9).

Here it is stated that isolation leads to mental health issues. One of the issues to consider here is that the impact of mental health (and related factors such as stigma and cultural issues) could also lead to the person distancing themselves from people.

Scholars were of the view that Satan caused distraction and doubt among people. The power of Satan was explained by scholars: people might feel fully misled, or under the control of Satan, to enact the decisions they made whereas the responsibility lay in the hands of the individual through their own choices and actions. This is in contrast to the views of participants which have been

discussed on page 203. It was suggested the impact of Satan is greater for those who are of less spiritual strength, and less Islamic knowledge, and preyed on a person's weaknesses:

"Shaytan [Satan] works in lots of ways, affecting anyone, Shaytan makes you think you twice, thrice over situations, thinking you have done something wrong, bad...reality is Shaytan only whispers to you, people will say 'it was Shaytan' and try and blame him, but no, no he cannot control you" (Scholar 12).

"Shaytan sees a weakness in people and goes after them and places certain doubts in them" (Scholar 7).

"Shaytan go for weaker people... Shaytan can distract people who are less stronger, related to lack of knowledge that this is possible, Shaytan will say he only whispered and created doubt but it was the person who did it" (Scholar 5).

It was also suggested to avoid places of impurity:

"Traditional they talk about places Shaytan frequents that was impure, so we are called, and also psychological impact, and physical aspect of avoiding of impurity as its symbolic, in that by avoiding the material impurities, are symbolic of mental impurity, and spiritual impurity and its reminder to avoid mental and spiritual impurity as well to take away from our natural disposition" (Scholar 17).

Whispers of Satan, alongside diseases of the heart and nafs were described to be more common than other causes:

"wasawus and nafs problems is very common" (Scholar 7).

"This is what I see community complain of first, Jinn, nazr, hasad and sihr and it is usually some other issues, social, nafs, diseases of heart are all more common" (Scholar 9).

Here it is pointed out that other realities are put forward by Muslims rather than internal causes and social problems. There seems to be the view presented by some of the scholars how common certain causes are over others one, which they claim clash with the views of Muslims in the community.

The difference between whispers of Satan and OCD was drawn out here:

“it is not that clear, what is Shaytanic, need to ask, is this thought taking me away from my nature, that is whether this is carnal, is this thought taking me away from my nature, is it making me weaker, is shaytanic, as nature is that he takes you away from the my nature and making me weaker, he calls you away from nature, from fitrah...if a thought comes to you that is not productive, more harm by entertaining it, then its shaytanic” (Scholar 17).

Use of religious language was further suggested to be used sensitively according to the person’s presentation:

“Now the problem is if the person becomes obsessive and then says ‘oh my God that’s the devil’, that’s the problem, that’s why I try and stay away from religious nomenclature. Here if I feel, assess the person, if I feel this info not being yours but the devils, then support the person and say it is not inherent flaw in them, and use that language.

If they already having obsessive worries, fretting over things then I am cautious about bringing religious language in, back to, what do you notice about your body, and processing it physiologically rather than staying in mind, can’t win with thoughts that are difficult” (Scholar 17).

There appeared to be the suggestion that understanding where thoughts came from was useful, of particular relevance was the nafs and satanic ones. This could give a person reassurance that these

thoughts are external and that recovery was possible. The effects of Satan were also suggested to impact psychologically:

“four thoughts, come from God, I see that, understand as opening a reality, where you are thinking of buying something and then realisation to do something else, angels and the most important, notions are two relevant this topic, one carnal, relating to nafs that are natural appetites, hunger, sex, sleep. Part of the nature of self, not necessarily negative, but with the devilish or Shaytanic ones, they call us, to go to excess with those things, they call us to act outside even our nature, affects against our very nature, out of sync with nature, and second one that affects us, encourage carnal desires to beyond the limits...More we entertain the thoughts, more they become part of our nature, natural impulses become tainted, polluted by those Shaytanic ones, are external, that is useful to know as that can be helpful, they talk about that in mindfulness, therapy, ‘I have the thoughts but do not have to act upon it’, but more you sit with the thought, more it becomes the carnal kind...Shaytanic thoughts, part of psychological aspect to them, they hover over the heart but they cannot fully get complete grip on so shows we can fully recover from them, we can dispel them, we can go against them and ignore them, there is psychological effect of that” (Scholar 17).

Scholar 17 was asked further about thoughts from God and Angels with this response:

“notions, impulses come upon one’s mind, angelic ones, any suggestions to good. My understanding of divine ones, expansion of consciousness, looking at things differently, Allah gives you a greater perspective, with greater clarity, I consider this a divine notion, Angelic, good impulses, saying nice word, charity” (Scholar 17).

Another level to the discussion about thoughts, was the different degrees of thoughts an individual may experience. This scholar was asked directly about the different levels:

“al-hajis, sudden, fleeting, not notice sometimes, al-khatir, a thought given more attention, either pay attention or ignore...hadith al-nafs, inner dialogue, talking of the self. When thoughts come into action, its ‘azm...these can be good thoughts and bad thoughts, so when become determined with a thought, they become obsessive, obsessive thoughts. There seems grades, degrees on how thoughts come, and what eventually they lead to, and whether they are dismissed or actually carried out” (Scholar 17).

When there was discussion with the scholar, on the distinguishing factors between the effects of these realities/Satan and mental illness. He pointed to the importance of being open to a number of plausible causes:

“Is it a spiritual or psychological issue, the problem is this dichotomy, that it has to be one or the other. It is obvious that even if it is spiritual, it will show up psychologically way, and physical way and obviously when we are talking about the spiritual, we are talking about something that cannot be measured per se.

There can be devilish thoughts and can be enmeshed with one’s own thoughts so there is an influence [psychologically].

And most situations, difficult to separate the two. From Islamic perspective, we have certain tools and using other treatments is no problem alongside. We can take other approaches and tackle it psychological or physiological, through diet, exercise, physical etc and see if it has a knock-off effect on spiritual aspects...we can try those other things [spiritual] we can try them alongside others...but this attitude of dismissal, I am very apprehensive of that, we are talking about things we don’t know much about, people have spoken about it of the past, people experienced it, and we have texts that suggest that it is possible so what is the harm in including it rather than total

dismissal, so I think it's a reaction, it's a defensive position, towards criticism against religion, I am very cautious and don't like attitude" (Scholar 17).

7.3.5 Punishment, weak faith and mental illness

Scholars discussed their experience of working with the Muslim community and their own view of punishment and weak faith being related to mental illness. The notion of punishment from God and being a weak Muslim was borne out of the data from the participants, which differed from the scholars, thus another heading used to illustrate the views of scholars. This was explored with the scholars and these concepts was developed further.

As highlighted on page 159, *ibtilā'*, the notion of the Divine trial was explained as positive and with purpose. This was indicated here when this scholar was asked directly about it:

"Mental illness is not a punishment. Balā, ibtilā' has two qualities that we can talk about, makes clear the good in something and makes manifest what is good already in that thing" (Scholar 4).

From the scholars' perspective, some Muslims might perceive a situation as punishment. This viewpoint seemed to be dependent on a person's perception of why the difficulties occur:

"You find in the life stories of all the Prophets, they experience which to us is seen as a misfortune, to us it may seem that Abraham alaihis salam [peace and blessing be upon him] lost all his family, he was punished, but for him it was a test and a means of elevating his status" (Scholar 8).

This is in contrast to others who understood pain and suffering as a trial and spiritually, as a way of elevating one's spiritual level.

Some scholars explained the Muslim individual's perception of punishment as an expiation or atonement of sins based on an individual's previous wrongdoing. Here this scholar is interpreting the position of the community from his perspective:

"Many people think in their mind, first thing is punishment, they have depression, and they are being punished for their sins" (Scholar 12).

Whilst there was the idea of difficulties in this life being perceived with expiation of sins, it was asked directly whether this extended to 'punishment':

"The hadith is saying difficulties in life are a positive, cause expiation of sins in this world via illness, difficulties, pain etc is better than being held to account in the hereafter. So it's 'punishment' in the sense of expiation of sins. Seems they have done a literal translation, so yes it is a purification. Better to have pain for a few years, be patient and have less...for sins in hereafter. Cause the world is temporary, and so is pain etc. But hereafter is more longer lasting".
(Scholar 5).

The scholar referred to a reference where the term 'punishment' was used.

A small number of scholars used the word 'punishment' however more scholars took the stance using this term was not appropriate.

When asked directly about this, Scholar 8 commented on the punishment of God only as a possibility and that others could not say if a person was undergoing definite punishment. This might be one of several possible reasons, but the truth was only within the knowledge of God:
"it may be a punishment but only Allah swt can say this for definite, we are not in a position to make that judgment" (Scholar 8).

Scholar 8 who used the term ‘punishment’ was further asked about the meaning of this:

“We should be positive and talk about purification process rather than punishment, there may be less punishment in the after-life as a result of the difficulties here in this world but this is seen as purification and not punishment, we have to remember Allah swt loves us more, raising our ranks”
(Scholar 8).

Although this outlook has been argued, there has to be the acknowledgment that not every individual will share this mind-set and perceive their experience as positive, particularly if they are suffering from a mental illness of greater severity.

Scholar 16 responded to this use of ‘punishment’ when asked why other scholars would use it:

“There is the issue with using punishment word. God does not punish people, it is to bring people back to Him, a means of purification...there is a problem with using the word”.
(Scholar 16).

Another scholar shared a similar view:

“It is poor use of language, if for example a tsunami happens, a person who lacks knowledge of Islamic theology may take the perspective, it is God’s punishment, for people, for their sins but another person could look at the situation in another way and say it is God’s test, testing them, may be for sins, may be for others reasons, but it is not a punishment as retribution, things are done for educational reasons, restorative reasons, to bring person back to God but not as retribution”
(Scholar 2).

None of the scholars perceived difficulties in a negative way, for example as a sentence, but rather they framed it positively, as a process of spiritual growth and purification for the person.

It appears from the scholars data that there is an issue with use of the term ‘punishment’ rather than understanding the concept surrounding the discussion on punishment. The concept was understood to be related to purification, the spiritual development of the person and bringing the person back to God rather than punishment as a way of retribution.

The scholar indicates one of the possibilities of suffering is the connection with sin.

“Often people can skew their understanding of Islam due to partial knowledge. On the issue of good and evil, the correct understanding is that, all actions are ultimately created by God, otherwise God Himself would be deficient, having some things outside of his control. However, the human being has free will in choosing a good or evil action. Sometimes people can be overtly negative which may impact their mental health. They may believe that evil befalling them is due to their inner evil inclined self or due to something wrong they must be doing, and the evil, difficulty is a punishment for their behaviour. This understanding needs to [be] corrected. All humans are prone to error except Prophets, thus it is natural to sin from time to time. God leaves the doors of repentance open, so a person can redeem themselves immediately and without any delay. Further, evil, difficulty befalling a person is not necessarily due to their sinning, although it can be. Difficulties can befall a person as a means to test their patience and to elevate their spiritual status with God” (Scholar 5).

There could be a situation where a person internalises a sense of punishment to point they develop an emotional response at personal level. However, the scholar states all humans (except prophets) are prone to sin but suffering cannot be extended to punishment from God. A person may find it difficult to understand that God allows bad and suffering but what can be understood from scholar 5, there appears to be an element of goodness in difficulties and underlying spiritual wisdom.

Another aspect which needs to be considered is personal responsibility. A person has the free choice to make decisions, good or bad as the findings indicate in chapter 6, on page 154. There could be a situation where a person enacts a decision, which consequently has a negative impact on their mental health and overall life situation. The person could then relate to this to self-blame and spiral into a personal response to punishment. Another way to frame this example, is taking personal responsibility for one's actions, which might be more apt (as long as capacity is not impaired due to mental illness).

Scholars thought that there must be some degree of spiritual understanding of why someone has their life difficulties but this needed to be interlinked with the wider context encapsulating other concepts found within Islam. The idea of 'perceived punishment' appears to be understood as a matter subjective to the person. It is for this reason; Scholar 2 suggested avoiding the term 'punishment':

"A person is not fully cognisant of the reason for the test they are experiencing in life and so making any correlation would be a subjective...how you view the World and God's punishment for example. You can have a person, two person afflicted with the same affliction and the reasons would be different in the eyes of God, but you do not know which reasons it is why the person is having a difficult time. Is it because it is a wakeup call, is it because they are being purified, is it because they have sinned in this World and that will balance the books in this World and they won't be punished in the hereafter. All those various scenarios...because there is a problem in their understanding there in that they always relate difficulties to punishment, that they must have done something wrong, rather than saying that God is testing them to become better in ranks, more spiritually aware people. There is so many possibilities to it that you should not close the doors to

other possible interpretation because why you would just look at the, the prompt of the person that came to you, because that is obviously the kind of pessimistic, fatalistic understanding that they will have, that it is written that 'I will be punished for this and sins in past'. It's not healthy speaking about punishment. We should focus on how to deal with it and how to alleviate it which is to look at what they can do to change that situation" (Scholar 2).

Related to these findings, the idea of 'perceived punishment' and 'self-punishment' is explored in the discussion chapter (page 389).

The data suggested that creating an association between 'punishment' and mental illness is not appropriate or beneficial, with the intended concept of purification and spiritual development either not being recognised or misunderstood among Muslims. What emerged here was the scholars' emphasis on broader perspective of opportunity, positive outlook and spiritual wisdom underlying difficulties rather than looking narrowly at deserved punishment for one's sins and wrongdoings. This is in contrast to some of the participants who perceived they were being punished.

The other idea discussed was whether an individual suffering from mental illness has a weakness in their faith. This can be described whereby a person might look inwardly and describe they are distant from their faith. They might feel they were not strong spiritually and feel they ought to do more to become closer to their faith.

Scholars were asked directly about whether mental illness could be a sign of weakness in faith. Some of them suggested this could be the case, pointing to a fluctuating level of faith:

“If iman is lost, you will suffer from insecurity and instability because people are so dragged to worldly affairs then their iman will become weak, iman becomes weak and this weakness of iman will affect your heart, your soul, your brain. Then you will walk in this world upside down, you will walk with your head not with your feet” (Scholar 12).

“It is a sign that they are not as close to Allah as they would like to be. It is a sign that they need to come forward they need to make an effort. Yes with a view where faith increases and decreases one day you could wake up full of Iman, and the next day you could wake up feeling very much opposite” (Scholar 13).

It was also described as a distance from God:

“I would say it is a sign of your distance from Allah” (Scholar 14).

Scholar 2 previously highlighted on page 163, that a person’s reaction to difficulties may be indicative of their spiritual state and lack of faith:

“The reaction of people could be an indication of their spiritual state in their heart...for example if the person becomes angry against God, doubts about God then that could be lack of faith”.

It was also indicated that this should not extend to judging or assuming someone with mental illness has a weak faith:

“I would say no, no-one can say mental illness is a weakness of faith, no, I would say this is because Allah loves you, he tests the people he loves” (Scholar 4).

This was something for God to judge and not for others, and a matter between the individual and God:

“We cannot say it is weakness of the person faith, this is between Allah swt and that person. There is no-one here that can judge in this manner” (Scholar 2).

The words ‘weak faith’²¹ (or weakness of faith) have been used here as it was described by participants and some of the scholars in the study.

The changes that occur within an individual has been argued not to be related to ‘faith’ but another view; relating to actions and proximity to God and related to the spiritual conviction of the person.

The heart has been mentioned connected to this:

*“the heart is mentioned as a metaphor for actions since it is the place where an increase or decrease of actions is felt... in terms of conviction in the heart - the centre of spiritual conviction”*²²

(Scholar 2).

Accordingly, it seemed important to understand such issues as Muslims from the community might judge individuals to be weak Muslims and receiving punishment. Consequently, those individuals might feel ambivalent about discussing their problems. Furthermore, the presence of these views might contribute towards negative cognitions and exacerbate a person’s mental health problems.

Delay in treatment may also occur. This will be discussed on page 342.

21 This is used either in a general sense or more specifically, as ‘iman’. See page 389 for further discussion.

22 This quote has been used a second time due to its relevance to the area discussed, on page 297.

7.4 Similarities and differences between the two groups

Relating to Spiritual elements of the individual

The analysis indicated that participants in contrast to scholars, discussed this area less commonly. The concepts shared by the two groups related to the heart and to nafs. The value in examining both groups was in bringing out the significance of these Islamic concepts. A key finding noted was the limited knowledge and awareness evident among the participants.

The data from scholars added a more complete picture on the spiritual make-up of an individual from an Islamic perspective. Scholars described the heart and its nature of being changing, and spiritual diseases that affect it. The semantic meanings underlying the words such as ‘heart’ and ‘nafs’ emerged from the scholars data. Explanations were further provided by the scholars group for the limited knowledge and awareness among the Muslim community.

Relating to spiritual and life imbalance

Data emerged relating to the imbalance of this world versus the after-life which was similar for both groups. The analysis showed new areas from the scholars data: imbalance of spiritual elements and imbalance of spiritual well-being.

Relating to ‘other realities’

Participants and scholars similarly described the existence of external causes as part of the Muslim belief, namely Jinn, sihr and the nazr. However, there were considerable distinctions between the two groups.

What emerged from the analysis phase was the externalisation of problems by participants in contrast to focusing on internal issues. This is in contrast to the perspectives of scholars who

focused predominantly on internal factors. The views of scholars develops the thread of changing oneself through practical effort (discussed on page 327).

What was apparent from analysing the participants data was the idea of an heuristic fallacy, where participants believed in the effects of Jinn towards others, but not necessarily in their directly affecting them as individuals. This will be explored further in the discussion chapter. Also, there were varied views present such as the extent to which Jinn were able to control people among participants. The scholars did not hold the position that Jinn could overpower a person. The findings from the participants contributed towards the nuances behind the discussion around Jinn.

The data from scholars added additional layers to the analysis. Factors emerged from the scholars data that could explain why individuals understood their difficulties as relating to Jinn. For example, arriving at the conclusion of Jinn without considering natural reasons such as mental health difficulties as an explanation for their problems. Scholars differed from participants in considering how common Jinn affected people. Jinn was viewed as less stigmatising and more familiar among individuals and families according to scholars. The notion was raised that Jinn might be considered where no other cause was found. Difference existed as to whether Jinn possessed individuals physically from within or whether there was influence from externally. These are factors to consider which begin to understand why a person may commonly think about Jinn as a root of their problems. The scholars attempt to make sense of what happens to people when Jinn affect people.

The data in relation to sihr and nazr was similar for both groups. There was some additional insight though from scholars group around focus on religious help on a practical level rather than

investigating where the origins of sihr. Also, sihr and nazr were understood from a scholarly perspective related to collection of symptoms rather than Jinn which was in reaction to religious activity.

Another key finding covering Jinn, sihr and nazr (as well as effects of Satan), when analysing the scholars data was that only small number of scholars mentioned exploring more than one reason why a person undergoes difficulties. This involved considering both mental health and religious reasons as plausible causes and not necessarily dismissing one cause over another. Furthermore, very few scholars spoke about consideration of factors that might make someone more vulnerable to these effects and treatment involving psychological aspects of care.

Relating to Satan

The data showed participants did not agree among themselves whether Satan exercised full control on them or whether such control was limited. This is in contrast to the scholars, who were unanimous in their view that Satan could not overpower a person. This echoed the idea of having freedom of choice and free will as discussed in the earlier chapter, on page 204.

Otherwise, the participants data was similar to the scholars. Both groups discussed the effects of Satan more than the 'other realities'.

Relating to thoughts and degrees of thoughts

A small number of the scholars described where thoughts, notions could come from and also different degrees of thoughts a person may experience.

Relating to punishment and weak faith

There was no consensus among participants and between participants and scholars on understanding of punishment. Slightly more participants did not believe mental illness was related to punishment from God. Pain and suffering related to mental illness or life experiences was not framed as punishment but understood as washing away one's sins or protection from other difficulties. This view was not accepted by other participants who felt they were punished negatively due to sinful actions. Scholars were of the view the term 'punishment' was not appropriate.

A small number of participants felt their mental illness was related to being a weak Muslim. A person may be distant from God and struggling with aspects of their faith. Scholars were however of the view that mental illness could not be associated as a sign indicative of a weak Muslim. This was a matter between the person and God and not for others to judge in this matter.

7.5 Summary

The findings in this chapter indicate a connection with themes emerged in the first chapter, which explored the Muslim outlook on life and its relationship with pain and suffering. These have been mentioned/highlighted in the relevant sections in the chapter.

One way of understanding what makes us human from an Islamic perspective is the framework describing the four spiritual elements, which shape an individual's behaviour and personality: qalb (heart), nafs (ego/self), 'aql (intellect) and the ruh (soul). This connects with the idea of the spiritual dimension of health (described earlier chapter on page 209). Though nafs is not just restricted to spiritual elements but mental and physical aspects. There was a distinction between scholars and participants on how frequently and depth this theme was discussed, with minority of participants discussing this area. It is therefore important to be aware that there will be themes discussed where both groups vary in their level of awareness and understanding. This might be explained by level of awareness and knowledge affecting individuals and people blaming external factors. Scholars also discussed spiritual imbalance affecting people. Both spiritual elements and spiritual imbalance were framed as facets of spiritual health rather than a mental illness. This will be explored further in the discussion chapter. These are new areas not discussed in literature where appropriate research methodology has been used.

There was a deeper level of analysis evident from the findings. The findings indicate Muslims hold perceptions that are sensitive to their religious beliefs such as influence of Satan, nazr, sihr and Jinn, which play a role in beliefs about the aetiology of mental health difficulties. Individuals might point to external causes rather than internal ones. This could explain why participants frequently discussed the 'other realities' as causes of mental health difficulties. The scholars discussed the

issue of Jinn affecting the Muslim community less compared to participants. Scholars felt the influence of Jinn was rare and discussed more commonly the effects of sihr and nazr. Satan was described as the most frequent explanation of these religious beliefs. There were varying views between the two groups on whether Jinn influence people externally or could actually possess an individual physically.

Understood through a small number of scholars, another layer added to the data related to understanding these realities in their context, in terms of considering socio-cultural and psychological factors and alternative explanations. It was suggested a person might be more vulnerable to effects of these realities and Satan in certain situations such as isolation, low self-esteem and holding cultural beliefs. Furthermore, a number of possible explanations for one's difficulties may exist and require further exploring. The scholars pointed to reasons not related to Islamic beliefs such as Muslims blaming non-natural causes for mental illness such as Jinn. This could be because attributing difficulties to Jinn was less stigmatising for the person or where no other explanation was found. It was suggested treatment for these realities and Satan should not be restricted to religious help and extended to social and psychological approaches in treatment.

The area of punishment and weak Muslim was another theme where participants reported contrasting views compared with scholars. Scholars described mental illness should not be associated as a sign of weakness in faith. They were also of the view that pain and suffering be viewed as a spiritual wisdom rather than a form a punishment. The sub-theme of spiritual wisdom has been previously explored on page 148.

In the area of understanding religious beliefs Muslims hold, this section highlights a number of key salient themes but also a deeper exploration show variations between participants views and also between participants and scholars. Similar to what was highlighted in chapter 6, the discussions around concepts and themes cannot necessarily be reduced to a question, 'what beliefs do Muslims hold' which has a binary answer, but understanding the relevance of those beliefs for the person.

This chapter has dealt with important religious beliefs and how these influence perceptions towards mental health difficulties and illness. The next chapter deals with how Muslims cope or do not cope with mental illness.

8 Chapter 8 - How do Muslims cope, or not, with mental illness?

8.1 Introduction

The findings in the previous two chapters explored the Muslim outlook to life and perceptions toward mental health difficulties and illness, as described by study participants and scholars. The themes are relevant as they impact on how Muslims cope with their mental illness. The connection between the themes will be highlighted where relevant.

Muslims may use informal supports and involve religious scholars rather than get engaged with health services even if they were to accept their experience as being related to mental health. This will be explored further here.

This chapter explores in more in depth:

1. What coping strategies Muslims use?
2. Which are related to areas of their faith?
3. How do Muslims suffering with mental illness rationalise their thoughts?
4. How do they come to a resolution?
5. What mechanisms do they employ when faced with distress and difficulties?
6. Factors to consider during the process of change/recovery.

Diagram 10: Overview of themes and sub-themes (3)

Participants

Scholars

Area of study

Exploring how Muslims cope or do not cope with mental illness

My faith and me

- Belonging to the Muslim faith
- Sabr and other transformational concepts
- Inspirations and solace

Beyond me: connection with the community

- Contact with scholars and imams
- Community involvement and charity
- Social support

Relationships

- Connection with God
- Relationship with Prophet Muhammad ﷺ

Religious practices I do or cannot do

- Qur'an
- Prayer
- Supplication (dua)
- Mosque attendance
- Fasting
- Complementary therapies

Transformational concepts relating to faith

- Individuals factors

Connection with the community

- Being part of the community and social support
- Contact with scholars and imams

Relationships

- Connection with God
- Relationship with Prophet Muhammad ﷺ

Religious practices I do or cannot do

- Qur'an
- Prayer
- Supplication (dua)
- Mosque attendance

Exercise and diet

Emotional support

Process of change

Belonging to the Muslim faith emerged primarily from participants data.

The most frequently discussed areas related to sabr. Participants discussed complementary therapies.

Scholars discussed more facets to relationship with God and other transformational concepts. New areas relating to process of change emerged.

Emotional support was less frequently discussed compared to religious practices.

8.2 Participants' views

In the first section of this chapter, the analysis will explore the following themes that have emerged from the participants' data:

- My faith and me
- Beyond me: connection with the community
- Relationships
- Religious practices I do or cannot do

8.2.1 My faith and me

Participants were questioned about the role of faith and its meaning in their lives. They were asked to share their experiences, that helped give them strength but also elements that were difficult. A number of facets emerged from the data. Some of participants directly used 'my faith' when describing their Muslim faith. This is relevant as it seems to indicate the expression of faith and its connection by the participants. The data further reported that participants expressed their connection with their faith at an individual and personal level. This is why 'me' was conjured in this heading alongside 'my faith', adding another layer of significance for the participant. Three dimensions will now be explored.

8.2.1.1 Belonging to the Muslim faith

The experience of living with mental illness is difficult and challenging for any individual, regardless of their background. The conducted interviews suggested that, for participants being of the Muslim faith could either mitigate or exacerbate those challenges.

Some of the participants told how they resorted to their faith in times of difficulties, be this related to physical health or mental health:

“we will be patient and accept it and try our best to solve it whether it is mental problem or physical...you should first be patient and you have faith...this comes from our faith, our faith come from dua and from the Quran” (P2, Female Tunisian).

This participant drew on two facets of coping strategies connected with their faith: *sabr* (described on page 266) and the religious practice of *dua* and recitation of the Qur’an (discussed on page 285). The understanding of this person’s faith is connected to their outlook to life, that her difficulties are part of being tested. This is indicated in an earlier excerpt discussed on page 145.

Faith might be a source of strength during periods of distress and mechanism of understanding and controlling their emotions. This participant felt overwhelmed with her anxiety but turned to her prayers and understanding the purpose of life for strength (described on page 261); here the use of ‘my faith’ in her expression seemed to add a deeper meaning to her words:

“I think if I had not had the prayers and my belief and trust in God I think I still would have been letting those emotions and anxiety get heavier on me because I would feel like I had no control over anything, where I feel my faith...to rationalise some of the things...my belief, my Iman...fighting against it all. This helped give understanding to my problems, why I was going through all of this” (P10, Female Pakistani).

A risk of not being in control was suggested here. Her practice in continuous prayer and firm belief in God helped her control her emotions and overcome the difficulties she was experiencing at home.

The experiences shared by these two participants seemingly point to the theme of belonging to the Muslim faith being interconnected with the Muslim outlook to life (as discussed on page 161).

There were however opposing accounts where a small number of participants described moments in their life where they perceived they were not in control of their feelings and circumstances around them, which led to increased distress:

“I cannot change anything, these things, I cannot find a job, looked every week. Really worried about this, my family, children, too much worry...so not speak with other people” (P9, Male Bangladeshi).

There seems to be other fatalistic positions held by participants such as the control of Satan or the idea of destiny being fixed (discussed on page 154 and 248).

From one participant’s perspective, the control an individual had was limited; whereby individuals could only plan and act in their affairs to a degree. This was connected to the idea of God having ultimate control over all matters. This did not appear to cause conflict for the person and was found to be comforting:

*“we plan something but the master planner plans it differently it is always for the better”*²³ (P6, Female Malaysian).

For the minority of participants however, mixed feelings towards faith seemed to emerge. For example, one participant found coping with the death of her husband very difficult. The negative thoughts seemed to extend to blaming God and not just related to an emotional response to losing

²³ This has been used a second time due to its relevance.

her husband. She was later able to draw strength from her faith which appeared to have helped her with the thoughts of suicide:

“Allah has not been kind to me He has taken my husband away so why should I pray...everything you blame God’, Yes I have doubts, I have that experience, that is negative...I had bad thoughts and I cry why do I get these bad thoughts, it is not me...when your faith is strong it means a lot...I was so negative, I was going to end my life...I had faith” (P6, Female Malaysian).

It appeared that faith reinforced a sense of personal identity. Some participants described their primary identity as being Muslim first and foremost. For some, ethnicity could not be ignored and was also seen as an salient part of their background and culture. A strong religious identity appeared to be reported with greater confidence:

“when you are a Muslim right...You are clear who you are. Gives you like sense of pride, confidence to say ‘We are Muslim’ ” (P5, Female Indian).

When participants were asked if there was a loss of identity, a small number reported this. This was shared by this participant who experienced it at a time of social stressors:

“identity is so much to each and everyone, part of who you are. It’s like there was so much going on, dad passing away, pressure of my family and I didn’t really know...who I was anymore...this is my identity, who I am, what I stand for, what I do, my faith, my religion” (P10, Female Pakistani).

Identity is also relevant as refers to the extent illness impacts on a person’s sense of self. This will be discussed further in the discussion chapter.

There was a sense of greater confidence related to their faith, in participants who possessed a clear purpose of life from a Muslim perspective, that one strives to become close to their Creator and understands the temporary nature of this world as suggested here:

“who is your Creator, what are you doing here, when you are feeling down, you turn to something and you say right, I will kneel down and pray, it will give me satisfaction, purpose, in this I found the answer...before you get happiness you got to have pain” (P6, Female Malaysian).

Part of understanding their faith could also point to the expectation, to experience happiness; one will also need to go through the opposite emotion of pain and sadness.

Not everyone experienced a strong sense of purpose in life. Also, what was apparent was the same person can experience both strengths and difficulties. The participant described earlier also talked about a loss of purpose at a time where they felt they were not practicing their faith religiously as they ought to- describing feelings of being distant from their faith. She had grown up in Malaysia, felt isolated with only a small number of friends to turn to following the death of her husband, not knowing which direction she was heading:

“My life has been turned upside down” (P6, Female Malaysian).

She related her feelings of distance to not praying:

“thinking about not praying, makes me, I get upset and worried, guilt that I have not yet prayed, this is back of mind” (P6, Female Malaysian).

Another participant described her severity of depression and anxiety affecting her to the point she required time off work. She found it difficult to engage in conversation with others in the initial stages of her illness:

“I didn't really know what was going on during this time, who I was anymore, what I was suppose to do” (P10, Female Pakistani).

The same participant was probed further and asked if these negative thoughts continued. She responded by describing regaining her strength by reflecting upon her religious belief and understanding that (a) she would receive help from God who would relieve her pain and (2) there being a purpose behind her suffering which would result in blessing:

“is a strength that helps me get through. Allah swt is there for me, listening to me and the belief that when you are going through a difficult time...turn to Allah and remember Him and this is the true purpose of life, worship Him...this give me the hope and sense of peace, feeling at rest” (P10, Female Pakistani).

The data reported benefits and challenges for participants. This is important to consider as people might feel close or distant to their faith at times of mental health difficulties. Despite this, a sense of belonging to the Muslim faith overall was accepted as a source of strength, helped individuals to reinforce their identity, facilitate their sense of meaning and purpose in life and regain control in their lives. Faith also appears to be interwoven with the outlook to life discussed in chapter 154.

8.2.1.2 Sabr and other transformational concepts relating to faith

Participants not only shared their experiences with their faith in a general sense. Another level to the discussion was a more specific dimension to faith. This dimension can be understood as individual concepts that were used during their help seeking journey, grouped as transformational. These appeared to help Muslims justify their thoughts and behaviour and allowed them to draw

strength from their faith, through developing these positive emotions. These were therefore termed as transformational as corresponds to developing change and seeking help based on these traits.

Sabr²⁴ emerged as the primary concept from the interviews; being used directly in the participant's interviews. This stood out ahead of the other concepts discussed here; the others were only reported in minority of participants. One of the participants brought up the concept of *ridhaa* (contentment), and subsequent interviewees were asked about it. The others concepts were borne out of discussions with scholars and developed in the topic guide; the participants were subsequently asked directly about them but still not commonly discussed by them. This could be explained by the close connection of 'sabr' with the notion of being tested, a commonly held universal Muslim view. This theme has been presented on page p290. What could be understood is that there are concepts that exist in Islam pertinent to faith but there are varying level of awareness surrounding them whereby not everyone will be able describe them or use them as part of coping strategies.

Sabr was not simply understood as patience in the face of adversity but being proactive and finding a way forward in tackling their issues as suggested here:

"we should be patient and at the same time we look for solution to our problem" (P2, Female Tunisian).

Even although sabr was discussed by majority of the participants, there was little description provided by participants:

²⁴ Sabr refers to patience. This is further discussed on page 289.

“Sabr should be in everyone” (P1, Female Pakistani).

“I pray to Allah that he give me sabr in this matter” (P4, Male Somalia).

This could be because the concept is frequently used among Muslims and the participants may not have expected the need to explore the concept in detail.

Another thing that transpired was that not everyone had the same understanding of sabr. A minority believed exercising the state of patience alone was sufficient rather than taking any steps to change or seek help:

“Bear it, just bear the worry. You should bear me, it better to do sabr” (P11, Male Indian).

This participant suffered from Schizophrenia and continued to complain of symptoms which he struggled with.

This understanding could potentially lead people to suffer in silence by not seeking further help.

A similar concept to sabr that emerged was ridhaa. This is ‘contentment’ with what God has decreed. Despite the similarity, the point that ridhaa was only discussed by a minority of participants could be explained by the understanding ridhaa follows process of sabr, and requires a higher level of spirituality. Participants described how contentment provided a sense of satisfaction with what God has decreed upon them, no matter how little or how much. This seemed to help participants during their difficulties:

“Satisfied, this is my time to phone my Allah. I should be content, this is truly a feeling you cannot buy. I have nice house, things we can buy, look at the noise in the house, grandchildren running about, I have big family mashallah [God willed]” (P3, Female Pakistani).

One participant, who suffered from psychosis shared her experience. She had migrated from a country where life was difficult. Following the migration, she became content with her life despite having suffered a period in the past when she was a victim of isolation and had experienced significant distress:

“Content, means be happy with what you have, be happy for that present moment. Accept, accept whatever is with your life. Accept it and be happy with it” (P6, Female Malaysian).

The importance of having certainty²⁵ was discussed by these participants where they highlighted importance of possessing this trait, without going deeper in its meaning:

“Through this heartache yes, real conviction in Allah has helped, belief, because how I learned that you focus” (P6, Female Malaysian).

“Well in so far as I have recovered somewhat, we need to have this yaqeen [certainty]” (P8, Male Kenyan).

Another concept, contemplation (tafakkur)²⁶ could help people self-reflect through what God has created:

“The creation of Allah, we should do tafakkur...we can see how fortunate we are, we can see the amazing things Allah has created like this. There are so many good things Allah has made for us. Amazing. So much. We become closer to Him and we remember Him” (P4, Male Somalia).

The process of contemplation seems to encapsulate a deep spiritual understanding of the marvels of creation around the person and to lead them to think of the Creator.

25 Yaqeen (certainty) is sometimes used to synonymously with iman; Iman relates to beliefs, principles of faith (see page 38). Yaqeen is a stronger and firmer level of conviction of those beliefs.

26 Tafakkur is an arabic word which means to ponder deeply and reflect on the creation of God, the heavens and the earth in order to understand and become closer to Him (Badri, 2000).

Tafakkur being discussed by only a small number of participants could be explained by people requiring more awareness or effort to be involved in self-reflection. This position might be contested by people themselves.

Tawbah is the concept of repentance. This was not brought up by participants and it was only discussed when they were asked directly about it. A minority asked for forgiveness for their shortcomings and sins. The act of repentance was perceived as an opportunity to become closer to God and might develop a sense of hope among people:

“Like tawbah, somebody who did repent sins from very bad things and want Allah, that Allah will accept him after his redemption, so maybe they do...we are fortunate Allah has given us the opportunity...to do tawba, so this will give me more peace as Allah does not want to punish us as He is giving us a chance after chance” (P2, Female Tunisian).

Seeking forgiveness requires someone to acknowledge their shortcomings and part of their spiritual journey and looking for success in the after-life. This is not necessarily linked with mental health but relate to the person as a whole. This is explored with scholars on page 246. This might not necessarily be understood or accepted by the person. Also a person who engages with repentance might equate their mental illness with punishment for their sins whereas mental illness being related to a type of punishment was explained by scholars not to be the case, on page p243.

8.2.1.3 Inspirations and solace

Some of the participants came out with expressions that correlated with either a verse from the Qur'an and reference from hadith, which were inspirational and created a feeling of solace for them when they were able to relate them to their own experiences.

Where the expression seemed familiar to Islamic sources, the participants were asked if these were from the Qur'an or hadith to which they confirmed this or not.

This participant described the comfort of having God close to her during a time where she felt isolated. She had left her home country of Tunisia and only had very few friends. She expressed the comfort God has close to her spiritually:

“Allah swt is always there, I do not feel alone, closer to us than jugular vein the Qur'an says” (P2, Female Tunisian).

The same participant also mentioned the feeling of not being overburdened:

“the examination will be to an extent that somebody can bear, not even more”

(P2, Female Tunisian).

This idea comes from a Qur'anic verse. The same experience was shared by another participant:

“you can only carry the burdens you can bear, I did feel like that, I got to the point where I could bear no more so the burdens were taken away from me” (P10, Female Pakistani).

Another phrase a participant described remembering God in their hearts:

*“If we remember Allah, Allah will remember us. You know he is happy”*²⁷ (P5, Female Indian).

This ties with the idea of spiritual growth mentioned in page 148.

²⁷ The quotation is used a second time due to its relevance, on page 148

One of the issues to consider here is whether a person resorts to spiritual resources to avoid dealing with issues emotionally. This is discussed by Scholar 17 on page 340.

8.2.2 **Beyond me: connection with the community**

The previous section explored areas relating to a person's faith at an individual level. Participants reported contact with the wider community for advice and support. This was coupled with hindrances. Consultation with scholars and imams also took place. The understanding from the data lends to the idea of coping strategies and support mechanisms going beyond the individual level and connecting at a community level.

8.2.2.1 Contact with scholars and imams

Participants confided and sought advice from imams and scholars²⁸ as part of the help seeking process:

"I go to Mosque and see Imam, I know this area...I not know where to go for help with this problem except go to Imam I trust... he gives me prayers to read...he has good knowledge from Quran and Hadith and give advice for me to get better" (P11, Male Indian).

This participant seemed more willing to see someone for religious support who they were familiar with and able to forge a trusting relationship with. He was well acquainted with his local mosque and seemed oblivious to where else he could go for help.

The previous participant accessed help from the Imam at least a year before the GP and explained the Imam was easily accessible:

²⁸ The distinction between imams and scholars is described on page 106.

“They are in the mosque and easy to contact and get time easy anytime. I can speak with them over the phone anytime...it was long time, cannot remember, maybe a year or two”²⁹ P11, Male Indian).

This participant seemed to appreciate the support he received from fellow congregants when he went to the mosque:

“there is satisfaction going to the Mosque for regular prayers...the fact that I go to the Mosque sometimes, the people there I talk to so that has been a help. Helps me think better. I used to go there recently because my mother is not very well, I have not been” (P8, Male Kenyan).

Another participant spoke about the Imam being a key figure who accessed by his friend as well, stating contact was made with the Imam 6 or 7 months before the GP:

“before I went to the GP. My friend also go to Imam. Imam is very important man and we go and see him... maybe 6,7, months” (P4, Male Somalia).

Despite this support, more participants however described their experience of contact with Imams as not so positive. Some reported Imams were dismissive of the existence of their mental illness:

“young and old Imams, they are dismissive about mental illness, not have that understanding and 'empathy', they don't even understand the word. Our Muslim community is already fearful of people with mental health issues” (P10, Female Pakistani).

²⁹ Part of this quote has been used a second time due to its relevance.

Lack of empathy was also discussed:

“Empathy, some Imams are not educated properly, what is empathy, you should ask them this question, they are so far away from empathy, it is so sad” (P6, Female Malaysian).

Some who were referred to as 'imams' were regarded as unqualified and fraudulent. This could be a barrier to accessing religious figures for advice and support due to the fear or perception they may be not be credible:

“some of them are not proper scholars and have little knowledge. They say they can help but they just want power, politics” (P2, Female Tunisian).

“Obviously there are charlatans out there who are money making” (P10, Female Pakistani).

There seemed to be the idea that people who project themselves as religious authorities may involve themselves in politics and capturing positions of power.

8.2.2.2 Being part of the community and social support

A number of areas were identified relating to being part of the community, community involvement and social support. Even although are not necessarily distinct to the Muslim faith, this was found to be a key area of discussion by participants.

8.2.2.3 Belonging to the community

This participant spoke positively about belonging to the Muslim community:

“This gives me a stronger sense who I am, that I belong to this community, I feel happy”
(P9, Male Bangladeshi).

However, participants reported primarily negative experiences being part of the Muslim community and suffering from mental illness.

Contact with the community seemed to be a hindrance to seeking help. Individuals with mental illness were called 'mad' or a 'fool' (referred to as 'pagal' in Urdu) from within the community in a stereotypical attitude, making it more difficult for mental health to be discussed more openly:

“our kind of culture people used to say pagal that she is pagal you know because that time, you know, I did not want to be like that, I did not want to be pagal...Some people do not understand and say who’s that pagal? Who’s that pagal?” (P5, Female Indian).

This participant seemed to project the views of others of being ‘pagal’ onto themselves and said she did not want to be one of them. Her expressions were emphasised through her repetitive words and non-verbal emotion of distress. This relates to self stigma which is discussed on page 356.

There were also cultural factors that emerged from the data, namely Izzat (family honour) and shame. These will be described in the next chapter, on page 411.

8.2.2.4 Community involvement and charity

Community involvement either through helping others or giving charity was suggested by this participant as a way of bringing contentment to oneself and appreciation of one's situation. She said helping others would bring with it, help from God:

“giving whenever possible some money to charity, helping other people that will make me feel happy because you are solving a problem and you are helping people in need...there are people worse off than me, less happy. I have had big problems but now alhamdulillah better now. I need to

help others and will get even more satisfied and Allah will help me more” (P2, Female Tunisian).

This view was not supported by others, who were found it difficult or negative being involved in community activities:

“I find big problem, feel I [am] tired, sleep on bed this day, that day, big problem my depression is like big, so I not do anyone any help...I want to do help to people, there [was] day where they do cake and sweet, and people speak and happy, me no, me at house” (P15, Female, Yemeni).

The impact of mental illness could also hinder an individual becoming involved with the wider community. Individuals might also take the stance that they would get themselves well first, before they got involved with others.

The other challenge to consider is for the community to be more accessible for individuals with mental illness. This participant found it difficult to be involved:

“no one care, they don’t get involved with other people, you see it is not easy this, to get with others working in the Muslim community, where [are] the activities for people, like me with my same problems” (P16, Male, Syrian).

Furthermore, if someone is more critical of others not being open, this could create more distance between the individual and the ‘others’.

8.2.2.5 Social support

Seeking help through family and friends appeared to be another strategy people adopted and utilised to cope with their mental illness:

“My friends have been fantastic and said no we are not going to let you stay at home you will just come out with us, we will go somewhere where it is not busy, it is just a combination of everything” (P10, Female Pakistani).

Despite this, the same participant seemed to be critical of her family:

“I am the eldest grandchild...everyone would ring me...I know my Aunties are probably whinging about me saying she has not been round, she has not been and looked after mum, she has not done this and she has not done that...I have had to step back” (P10, Female Pakistani).

When this participant described support from family, she was then asked about whether they saw family before health professionals, to which she responded:

“My family understand...I told my family few months before” (P1).

Another participant described support from her aunt who visited regular. She had obsessive compulsive disorder and was fearful of being given an injection by her GP and being misunderstood:

“my Aunts used to come down and one of my Auntie's she used to go see these people like with depression and she used to tell me, so one day I told her that I do a lot of things, I repeat a lot of things, am I alright or is there something wrong with me...I did not go to the doctor...my Auntie and my Cousin's sister came down and she said she got a friend in her work who had got a problem and they gave her this kind of, I don't know what they do but they give her injection, I don't know what they give her right, or something on her head, I don't know what they do. She was having that so she said to me that, because my doctor does not understand” (P5, Female Indian).

There was still the issue of confiding in friendships; this participant who experienced a failed marriage, could not bring herself to trust her friends and discuss her depression with them:

“between me and people, it is not easy for me to trust anybody, even friends, especially after my experience with failed marriages and all these things...it’s not easy, it’s very hard” (P15, Female, Yemeni).

Overall, the data borne out from participants in relation to contact and involvement with the community was a negative and challenging one.

8.2.3 Relationships

The data reported participant’s closeness and distance with God. There were also various dimensions to this where participants spoke more frequently about some aspects over others. They also drew parallels with the life of Prophet Muhammadﷺ. The experiences of participants brought out significance and meanings for them based on their relationship with God and Prophet Muhammadﷺ.

8.2.3.1 Connection with God

This section concerns the many different facets to the relationship a Muslim might have with God, which may or may not help them through times of difficulty. The most frequent concepts emerging here were the remembrance of God, reliance in Him (tawakkul) and gratitude to God (shukr). These three concepts were expressed from the participants through open questioning. The data reported the relevance of the other concepts in a minority of participants; these included hope in God (raja), sustenance and provision from God (rizq) and God consciousness (taqwa). They

emerged from discussion with scholars and developed in the topic guide questioning. It therefore seemed pertinent to explore these with the participants.

The remembrance of God included prayer, acts of worship and remembering God:

“Worship yes, 5 namaz [prayer in urdu], love your children, read your Quran. Allah gets happy when I do this, and then I get happy. This gets me strong. [smiled]. If we remember Allah, Allah will remember us. You know he is happy” (P5, Female Indian).

Remembrance of God could occur at any time and performed through a number of ways, including the use of the tongue and heart, which could explain the frequency with which this emerged.

The majority of the participants also described tawakkul, reliance in God, having the confidence that God has the ultimate control of affairs of man and will be there to help in difficult times:

“My belief and trust in God has helped me face my problems, fighting against all odds that I faced and my mother also faced, with (pause as tearful), so now I am here” (P10, Female Pakistani).

This participant became emotional when she remembered her recent past which she had recovered from and pointed to trusting God in the midst of her depression and wider family stressors.

There were varied views among a minority of participants, who believed the meaning of tawakkul was relying in God and not requiring to exerting themselves:

“I just need to trust Allah, not need to do anything else, not tablets, not doctor, not nurse” (P13, Male Palestinian).

This participant did not feel he needed to seek professional help for his schizophrenia. This stance could stop people from accessing help where required.

Hope in God³⁰ appeared to give participants a sense of confidence that they would gain the mercy and help from God. One participant talked about this feeling of carrying a heavy load, struggling through the difficulty and on the brink of letting go. However, the expectation of something changing for the better helped her rationalise through her problems:

"I have come close with so many problems and Allah gives a problem, Allah yes we had to believe, believe Allah will not burden us with so much" (P9, Male Bangladeshi).

Another said if it were not for her faith and hope, her depression would have worsened; she was able to speak about this more clearly, when she was well:

"I don't think I would have been as well as I am now. I think when you don't have that hope or faith or belief you will fall further and further down" (P10).

Another feature connected to the relationship with God related to rizq, where all sustenance and provision came from God - as suggested here:

"is from Allah's power we say rizq, it is Allah who give us this or we prefer to say it is up to him so we should not worry too much about this, it is something which is not in our hands it is in Allah's hands" (P2, Female Tunisian).

This participant however said rizq was not necessarily the first thing that came into her mind when she was depressed:

30 Hope in God is a peaceful condition of the heart which awaits for something that is precious to them (Farid, 1993).

“Allah has provided, everything that we need is there. It is just about being open to that and recognising the support like the rizq and it will be provided, like it there is a time when we are going without, there will be a time when we will have things. It isn't easy and not the first thing I would say that comes into your mind when you are without anything” (P10, Female Pakistani).

Accepting one's situation as part of rizq against background of difficulties might be difficult as they might not recognise it or the impact of mental health difficulties could make the person more negative.

This participant described how she felt some comfort knowing she was not isolated during her difficult times and God was always present. She also described being conscious of God (taqwa)³¹:

“Allah swt is always there, I am aware of Him and that is peaceful for me, I try and do good, my prayers and remember Him...taqwa we always be aware...I do not feel alone, closer to us than jugular vein the Qur'an says” (P2, Female Tunisian).

Shukr or gratitude is exalting and elevating the One who is providing blessings. The majority of participants talked about shukr with what God has provided them. Even when this participant was out of work and unable to work and consequently found it difficult to financially support his family due to his depressive illness, he was thankful to God:

“I could not do work, find a job...thanking Allah the way actually I am there is no problem there is no worry, happiness in the world” (P9, Male Bangladeshi).

31 Taqwa is the concept of God consciousness or described as the continuous awareness of God's presence and reminder to safeguard His commands (Farid, 1993).

This participant was grateful with what God had given to him:

“it helps us remember what He has given to us, ears, eyes you know. So we thank him in one hand and other He gives us more. Maybe in after-world he gives us. Satisfied with what Allah has given me. Look I have small house, alhamdolilahi [All praise is to Allah]. Things could be worse for me, people worse off than me” (P4, Male Somalia).

Developing gratitude might help people reflect on their own situation and compare their difficulties to others who were worse than them.

The relationship with God overall appears to be a helpful one. Another thread to the relationship was one of disconnection and negative thoughts towards God, identified through a smaller number of participants. This participant was concerned with what people may think and was asked in the interview if he felt on his own. He responded not only did he feel isolated, but also distant away from God:

“This is big thing, upset you. I prefer to stay in house and see family now...sometimes, like feel alone, Allah is far away...sometime try and get help from family, don't know” (P11, Male Indian).

Negative emotions such as God being unfair, anger and blame towards Him were also apparent:

“I want to pray and then 'no no because Allah has not been kind to me He has taken my husband away so why should I pray...everything you blame God” (P6, Female Malaysian).

This participant who looked after her husband with dementia, felt a lot of anger towards God when she lost her husband and started to question aspects of her faith such as prayer.

The negative feelings appeared to be less evident when she was able to reflect on her thoughts and when she felt stronger spiritually:

“the Almighty is fair to everybody if you understand religion, before you get happiness you got to have pain” (P6, Female Malaysian).

What seemed important was when she was interviewed, her husband passed away a few years before and she remarried and able to move on with her life. This improved her depression.

The idea of ‘punishment’ from God was raised by a minority of participants. This has been discussed in earlier on page 205. This participant for example felt he was distant from his religion and consequently was being punished for this:

“it is definitely a punishment. I think the punishment was running away from the Religion. For my sins” (P8, Male Kenyan).

8.2.3.2 Prophet Muhammad ﷺ

In addition to their relationship with God, the majority of participants described their relationship with Prophet Muhammad ﷺ. Participants shared their experience where they drew strength from his life experiences. Participants considered him a source of inspiration and drawing parallels from the hardships he underwent:

“We learn his example, his way, how to live in hard times, we learn everything...Muhammad rasullah sallahu wasalam had Sabr [patience]” (P1).

This could be relevant to be aware of as even although Muhammad ﷺ was a prophet, he was not immune to pain and hardship.

Some talked about how the Prophet Muhammad’s ﷺ was a role model for humanity, whose behaviour and actions were an example for others to follow. This participant was able to relate

Prophet Muhammadﷺ difficulties to be trials of life and in another part of her interview, discusses being tested in life (on page 146):

“he has had a lot of very difficult times and he coped with certain things...and it came to a point where he could no longer cope with things as it was...so it helps you realise you know take you an alternative route...he went through these things, he was tested...an important role model to learn from” (P10, Female Pakistani).

Others found solace by praising Prophet Muhammadﷺ and found him as a source of comfort when they were experiencing difficulty;

“Send praise to Prophet Muhammad sallallahu alaihi wasalam [peace and blessing be upon him] after prayers, in our duas. He was our example and send for guidance to mankind, to help us, guide. We feel connected to him” (P10, Female Pakistani).

8.2.4 Religious practices I do or cannot do

Participants described activities, either at an individual level or congregation which they found played a role in their coping strategies. These have been understood as religious practices and summarised as recital of the Quran, prayer, performing supplication (dua), mosque attendance and fasting. There were also challenges for the participants where they were not able to do religious practices. There was also mention of additional contact with complementary therapies. This is how the concept ‘religious practices I do or cannot do’ was developed. The questioning discussed related to these areas were developed in the topic guide, following review of the literature and refined as the interview progressed.

8.2.4.1 Qur'an

Reading the Quran was identified to be as a source of healing and protection and a means of being closer to God:

“it makes you closer to God and listening to the Quran is good, it is healing” (P4, Male Somalia).

This participant seemed to attribute her recovery to the Qur'an rather than input from mental health professionals:

“I read the Quran...all the time heal and I pray. I think what protected me, was not the psychologist or anyone like that. What protected me was the Quran...I feel very good mood (P2, Female Tunisian).

Recital of the Qur'an seemed to provide participants with a sense of tranquillity and relaxation:

“Sakoon, sakoon [tranquillity] comes from faith, comes from Quran, from Allah...if I don't read the Quran I feel all my life is upside down. These things make me feel safe and self confident and I even feel a type of relax after them all the time” (P2, Female Tunisian).

It is important to acknowledge a person's spiritual journey, which might be different from another persons. This participant drew from her experience in her younger years when she said she was not particularly inclined towards religion and did not keep regular to her religious practices:

“As children we went to the Mosque to recite the Quran and learn Islamic studies so it has always been part of my life, but I was not very practicing myself, when I was younger it was always nagging at me saying it is time to read your prayer go and read your prayer”
(P10, Female Pakistani).

8.2.4.2 Prayer (Salah)

Prayer was also seen as a comfort and way of helping with anxiety for some participants:

“to perform the prayers...makes the day go by it is a blessing” (P6, Female Malaysian).

The impact of mental illness may however impede some people from carrying out their prayers.

This participant experienced guilt:

“The day I can't do it I am a bit upset...when you don't do it, it is at the back of your mind...I am thinking about not praying, makes me, I get upset and worried, guilt that I have not yet prayed, this is back of mind” (P6, Female Malaysian).

Related to guilt was the feeling of regret experienced by some who had not prayed regularly in the past:

“life is sad you know, I regret not having been a regular, you know doing prayers before that, had I been doing it I think I would have been happier” (P8, Male Kenyan).

8.2.4.3 Supplication (Dua)

Performing dua³² was described by the majority of participants as one of the practices Muslims might use when in distress. This may be because it can be performed in a number of ways and without any time restriction:

³² Supplication (dua) has numerous meanings including a form of worship, seeking help, a request, a call and praising God (Qadhi, 2003).

“I have a routine dua, I call it...when I am sitting there and at that time I will say to Allah swt please can you help me I am feeling like this, please can you give me the strength to deal with this and get through this” (P10, Female Pakistani).

Slightly more participants believed that duas are always responded to by God:

“either this dua will be answered and that dua will be answered in this way...Allah will always give one way or another” (P9, Male Bangladeshi).

This participant believed duas were answered in one form or another. This was not mentioned by the other participants so it cannot be said that others would necessarily agree with this. They may hold expectations that their prayers are answered in a way they expect.

A small number disagreed with the view that all the duas were answered; this might lead to a sense of feeling unsettled.

“Not all of them...this is how I feel. Difficult” (P8, Male Kenyan).

Scholars hold contrasting views to this. This will be considered on page 312.

8.2.4.4 Attending the mosque

Attendance at the Mosque, the place of worship for the Muslim community seemed to be an integral part of life for participants who suffered from mental illness:

“to be close to the Mosque and go there. Mosque is part of our life” (P4, Male Somalia).

However the experience in the mosque was not always seen as positive. Participants talked about the disrespect they experienced in the mosque:

“Sometimes there are some people who make jokes about mental health and things like that and this makes me feel no good at all. They do outside and in Mosque” (P4, Male Somalia).

Another participant felt judged by fellow congregant members when he visited the mosque and preferred to stay at home:

“they do and they judge...prefer to stay home then, and get upset” (P8, Male Kenyan).

8.2.4.5 Fasting (ramadhan)

Ramadhan, the month of fasting for Muslims, is one of the pillars of Islam. Muslims may look to this month as a period of solace. This participant described the atmosphere of happiness (called roniq in Urdu) during this month:

“But like the think I like I really like ramzan [Ramadhan in urdu] it is very nice and like it is roniq, it brights up the house...Its the roniq in the house. I get happy and I forget about all, all my problems. Mashallah” (P5, Female Indian).

However, her depression made it difficult to regularly fast:

“you know to be honest I can't keep that much roza [fast in urdu], I will tell you the truth and even my doctor says no” (P5, Female Indian).

Similar to other domains of religious practices, a person's religious activities could be hindered due to the impact of their own mental health difficulties. This may cause an additional level of distress depending on their closeness to their faith.

8.2.4.6 Complementary therapies

Complementary therapies were utilised by some of the participants to help alleviate their level of

distress. Participants described this less often than other strategies. One discussed the use of amulets (taweez) which contains writing from the Quran or names of God in a locket. He also reported taking dates and honey for medicinal purposes to alleviate stress:

“I have been given a taweez in the past. They give it to me. I have had it for 6-7 years...I like to take honey, dates that I feel better, good...stress, cupping helps with stress, this is something that was done by Prophet Muhammad (saw) and feel less stress, less anxious about things” (P11, Male Indian).

Cupping was also described:

“Cupping can help, give clean blood, this is sunnah [practice] of Prophet Muhammad (saw) and help with relax muscles, give less stress” (P9, Male Bangladeshi).

Cupping is one of the alternative forms of traditional medicine, found not specific in Muslim history but in others like the Chinese tradition. It involves a local suction on the skin to help promote healing.

8.3 Scholars' views

This section will examine the analysis from a scholarly perspective on how Muslims cope or do not cope with mental illness, under the following themes, which emerged from the data:

- Transformational concepts relating to faith and character
- Connection with the community
- Relationships
- Exercise, diet and connecting with nature
- Religious practices
- Emotional support
- The process of change in recovery

8.3.1 Transformational concepts relating to faith and character

The participants primarily discussed sabr (patience) as one of the main concepts related to developing positive emotions. Scholars were asked to discuss any related concepts to sabr that could be relevant however when participants were queried about them, they were not discussed frequently. These findings were then probed further with the scholars, to explain why certain concepts may not be familiar to people or discussed in a limited way from their perspective.

Sabr was the key concept described by all the participants. Scholars also frequently discussed it.

Sabr was connected with the essence of reward and benefit for the person:

"having patience that when you do have difficulty...and although that is difficult for you are getting rewarded for it...reward, ease Allah will make it easy for you and not burden the person who is patient" (Scholar 5).

"As the Prophet (saw) says that the condition of a believer is strange, at times of good he gets rewarded because he is grateful at times of misfortune he still gets rewarded because of his patience" (Scholar 8).

These two examples also tie sabr with the idea of inspirations and solace developed from the participants data (discussed on page 266).

What was borne out among the participants was the difference in whether sabr simply equated to state of 'patience' or whether this entailed a person being active in seeking help. The scholars were of the view sabr encompassed practical actions. The view of the participants could be explained by this scholar who reported differing views were related to an individual's level of understanding, which was evident in certain cultures:

"it kind of percolates through certain cultures, where you just submit yourself to whatever happens and accept it but then also become very apathetic to being active after that thing has happened"
(Scholar 2).

A similar word to sabr, *istibar* (endurance in patience) was asked directly with scholar 2:

"Istibar is sabr that is known will be required for an extensive or unending period of time".

This appears to give the idea of occupying oneself with sabr that is perpetual.

This scholar was asked directly about the concept *ihitab*³³. He suggested a lack of this may lead to depression:

³³ *Ihtisab* is where one waits in state of patience for Gods reward or benefit out of their situation (al-Jibaly, 2000).

"when you do something waiting for outcome or reward and does not come it is one of the losing hope, it is one of the main causes of depression because he found the shop closed, why you are so because the girl said no to him after the marriage proposal, why this because the interview they said no you have not got the job and so on" (Scholar 10).

This scholar went as far as suggesting loss of hope was one of the main causes of depression, which could be related to social stressors.

Ridhaa was mentioned related to being content with what God has provided; where expectations were not met, this was suggested to lead to depression:

"Ridhaa, that is being happy whatever Allah has ordained for you be happy with that...people expect one thing in life and get another and this mindset, this disappointment can lead to depression" (Scholar 9).

Ridhaa was also related to a peaceful state:

"there is a comfort in this that we look for, contentment that we look for and that settled, peace of heart" (Scholar 3).

As mentioned on page 266, Ridhaa was only discussed in minority of participants. This could be explained by the view of this scholar who felt this was lacking in the community:

"One thing I think is really missing from the modern Muslim is the context of Ridhaa, contentment, being content with what Allah has given you" (Scholar 5).

All the scholars who participated in the study discussed the importance of seeking appropriate help. One view discussed by a scholar was the circumstance (which may be accepted as plausible) where a highly spiritual elevated individual may refuse medical support or treatment. This related to the

person being content with their difficulties. It was also suggested most people would not be at this spiritual level:

“A person says ‘well I am going to live with this cancer and I don't want any treatment and I submit myself to God’ that is one way of looking at it, it is a way of being content and saying okay it's over. That is not what I would recommend but I could understand that if the person has that kind of spiritual state, quite heightened spiritual state, but if a person is not then he will seek to get treatment, and it is the same with mental illness as well. Most people however will not be at this level and would recommend for everyone to seek help” (Scholar 2).

Scholars spoke about conviction in Allah, yaqeen; being absolutely sure in Allah's power, His promise and His Mercy amongst other things. This is encouraged to say as part of a dua (supplication):

“we should have firm belief in Allah, today you have been inflicted with this problem, you will see better days...Allah says after hardship there comes ease, and with the ease you forget about all the hardship. This is the dua we are encourage to do to pray, make dua for certainty that the difficulties will be made easy” (Scholar 9).

Yaqeen appears to be informing us that a person should only have reliance upon God and not upon any other.

This scholar described people might talk about having yaqeen but this had to developed from within the person:

“Having yaqeen, yaqeen is very interesting because people say it a lot but saying it isn't enough. In other words in English we have it as well, ‘Actions speak louder than words’ ” (Scholar 3).

Furthermore, it was suggested:

“nurture certainty, how do you nurture certainty, through dhikr [remembrance of God] and another thing, resistance, every single time you have a reason to fear something, need to have certainty to face it” (Scholar 2).

Yaqeen is having a firm conviction of beliefs and this could explain why participants did not discuss this frequently.

The deep reflection of the creation of Allah, contemplation or tafakkur was seen as a way of appreciating what one has been given in their own lives and helps them live a more spiritually lifting manner. Tafakkur was seen as a means of:

“Contemplation, it is really sitting down with them and talking to them, thinking about Allah swt creation, around you, being grateful, wonderful creation of Allah swt...how magnificent it is and looking at ourself and our place, Tafakkur looking at the amazing things and this helps” (Scholar 3)

“to help the mind think and contemplate Allahs swt creation and bounties and things is spiritual is very nourishing and uplifting to the soul” (Scholar 7)

Tafakkur, similarly was rarely discussed by only a small number of participants. This was suggested by one scholar to be related to a lack of self-reflection in the Muslim community:

“to help the mind think and contemplate Allahs swt creation and bounties and things is spiritual is very nourishing and uplifting to the soul...It requires self, self-reflection which not many people do or I would say, not able to do” (Scholar 7).

There were also factors that may help refine a person’s character.

Repentance and forgiveness in front of Allah were encouraged as a way of looking at one's shortcomings and acknowledging that you are in need. This could be seen as an opportunity to remember Allah who in turn will remember the individual:

"I would say that the Prophet (saw) who was the most perfect human being who was sinless, he used to ask for forgiveness a 100 times a day and that is an example to us that no matter what you think you are, you are always in need. Forgiveness, part of forgiveness is the fact that Allah wants you to remember you are in need of him so you are asking him for forgiveness you are asking him to overlook you because no matter what you do in life there is going to be deficiencies... turning away from fault, doing tawbah [repentance] and going back, returning to Allah" (Scholar 5).

"Tawbah, is constantly going back, referring back to Allah, refocusing or reorienting oneself back to Allah, always going towards or moving away, that is nature of creation" (Scholar 17).

This scholar was probed directly on whether repentance was related to mental illness:

"There is doing tawbah, for the person overall, whole life and their spiritual development and this is connected with the success in hereafter...when you have asked about whether or not, it is related to mental illness, no it is not" (Scholar 16).

It is suggested that it is more useful understanding repentance being related to the person as a whole rather than specifically linking it directly with mental illness. This is important to consider particularly in the initial stages when a person presents with distress, otherwise a person might develop guilt and distance themselves from others.

A more positive reframing of understanding forgiveness was suggested here:

“our forgiveness, asking Allah to forgive our shortcomings, on how little we understood things, that is a healthier expression of feeling, asking for forgiveness, rather than I am flawed, people who are prone who to mental issues, need to be careful about this, see that a lot in our community, so it is a healthier expression to see that, Allah forgive me, astounded how limited my perception at that situation, Allah forgive me for that and after forgiveness, mercy, mercy giving you an opportunity after that to grow, constantly we are doing that...we are flawed in our perception and constantly growing in our perception, but the problem is of this, we still have to assert things to move forward, and so it is a paradox, we are in a perpetual state of asking for forgiveness, not because we are flawed in terms of ultimate sinful or tainted or impure, obviously tainted in terms of perception but limited, but not tainted in terms of evil grossness about you, that I sense sometimes in community in terms of upbringing, massive impact and not being accepted, that is healthier way of explaining forgiveness, that is istighfar [forgiveness], covering of my faults” (Scholar 17).

It was suggested this approach related to understanding one’s limited perception and growing in that perception rather than being preoccupied on sin, which may negatively impact on a person’s mental health.

Forbearance and kindness were other qualities that were recommended to be exercised:

“Allah is kind and loves kindness, people to be kind in their lives...the Prophet Muhammad (saw) displayed the quality, the virtue of forbearance when faced with situations” (Scholar 15).

He was further probed about these characteristics. He responded by:

“There are things which help build the character of the person, refine the character and includes generosity, wishing good for people, this gives benefit for the person as well, humbleness, being humble, forgiveness”.

Scholar 12 was asked about opposites to these characteristics, to which muhlikat (vices) was explained; munjiyat (virtues) were additionally described:

“there are things that perish the person, riya [ostentation], arrogance, deceit, being angry, these are the downfall of the person. Al-Ghazali [Muslim scholar of the past] describes how to counter this, through sincerity, mercy, compassion, also sacrifice, the munjiyat will treat this, al-Ghazali provides a methodological solution for the muhlikat”.

These related to granting health to the heart (qalb) or averting sickness.

Another description of muhlikat was as follows:

“[they are] diseases of the heart. The states of greed, anger, etc are emotional illnesses when they are out of balance or extreme” (Scholar 4).

Similar to the nafs, there seems to be a struggle between muhlikat and munjiyat.

Here is another example of where the purpose relates to the Muslim outlook of life; a type of spiritual awakening is suggested (previously discussed on page 159):

“If Allah wants good for a servant Allah shows them their faults and they undergo difficulties so the servant then becomes aware of their own shortcomings, to come back on track” (Scholar 7).

The spiritual dimension of health and its ailments has been described by participants and scholars on page 209. Another aspect to this is ‘tazkiyah’³⁴. Scholars described this, the process of purifying and refining a person:

34 Tazkiyah or the ‘purification of the heart’ examines the “*nature of the human and his spiritual ailments and diseases with which they are afflicted. The ultimate aim of tazkiyah is perfection in worship and adoration of God*” (p55, Mohammed, 2016a).

“tazkiyah which is purify and basically it is that interaction of the body and soul which leads to ego or the Nafs, that imbalance leads to the desire to clean it out or purify it so it is not imbalanced anymore” (Scholar 2).

Spiritual imbalance has been presented on page 220.

The same scholar went on to describe one of main diseases of the heart, heedlessness (ghaflah) and how this is cured by its opposite, seeking refuge in God/fleeing to God. Also the idea of sharing stories and experiences with others and in the company of others was described:

“spiritual ailments are cured by the opposites, awakening of the state of ghaflah requires the person to sit with others, in good company, pondering over death and life to come...really the spiritual diseases, cure of these is seeking refuge in God, al-firar ila Allah, fleeing to God, turn to God for help, our shortcoming, all of them cannot be cured with God’s help. The ideas of developing spiritual states is through sitting with other people, scholars, sharing, learning from their stories, many experiences” (Scholar 2).

The idea of tarbiyah emerged from some of the scholars data. Tarbiyah is the process of spiritual development. This was in response to questions relating to ways to manage one’s nafs. This scholar was asked to explained the difference between tazkiyah and tarbiyah:

“tazkiyah means to purify to cleanse, tarbiyah means to grow and develop. These are two important concepts in Islam which are linked with mental health. So tarbiyah is something which we all need to do, we need to grow as human beings” (Scholar 4).

Participants did not discuss these areas. This could be because it is a journey, which requires a greater degree of determination and awareness compared with other strategies.

The data reported participants differed in how to practiced aspects of their faith. The manner in which individuals might vary Islamic practice could also be explained by the level of spiritual conviction, as explained by this scholar:

“the heart is mentioned as a metaphor for actions since it is the place where an increase or decrease of actions is felt... in terms of conviction in the heart - the centre of spiritual conviction”

(Scholar 2).

In comparison to participants, it appears scholars placed more emphasis on different dimensions of transformational concepts.

8.3.2 **Connection with the community**

The same sub-theme is carried from the participants data and explored with the scholars.

8.3.2.1 Community involvement and charity

Participants did not commonly discuss community involvement and doing charitable acts. When scholars were asked about this, they seemed to describe the importance of this area, in particular giving charity and volunteering. Community activities were encompassed the concept of ‘khidmat’ (khidmah in Arabic) by this scholar, which means to ‘serve others’:

“giving charity and volunteering, this is like a sadaqah [charity] and help others, khidmat and indirectly will help people themselves, make them feel better” (Scholar 9).

Scholars spoke about the importance of giving which in turn helps people feel better in themselves:

"That sense of giving out to help others in fact we are helping ourselves, benefiting ourselves, where the left hand does not know what the right hand is giving. In Islam, we are reminded that our wealth does not decrease but in fact increase. This gives a happy thought to the person, sense of fulfilment and reaching out and helping someone who is worse off than yourself. This gives people perspective on their own situation when they are in difficulty themselves when looking at others and being thankful" (Scholar 8).

Another scholar not only highlighted volunteering and charitable work but went as far as stating his view that majority of people with ‘mental illness’ (from his perspective) could be helped through these means including social interactions. However not everyone partakes in this:

"I think most of the kind of cures and ways of rectifying these are social responses to them. I think a lot of it is to do with people being very kind of secluded in their own lives. That is one of the main problems I kind of see in people that I deal with. You would probably get them to do more work in the Community or change their environment, change their company, do charity or voluntary work, you know to get out and see other people in more difficult situations than themselves. I think the majority of what I consider to be mental illness or abnormalities would be curable through social interaction, voluntary work, using company" (Scholar 2).

This is explored further on page 330.

8.3.2.2 Social support

Overlapping with community involvement, is social support. The idea of social support and interaction was further highlighted by this scholar:

“one remedy for spiritual illnesses whatever the illness is which is constant, isolation is a vulnerability, is to keep good company, to be in the company of good people...imbalances, is very much related to the environment as well, the environment a person keeps and the company a person kept as well” (Scholar 2).

The same scholar who was of the view that majority of people with mental illness could be cured through community and social means, gave the example of good company (suhba saliha) to taking amoxicillin:

"A lot of those responses are to do with company and environment because one of the things I noticed when I looked at spiritual treatises is that there is one remedy for spiritual illnesses whatever the illness is which is constant, isolation is a vulnerability, is to keep good company, to be in the company of good people...to be in the company of good people which for me is like, almost like the amoxicillin, in the Middle East if you ever had anything wrong with you, you would be given amoxicillin, even if you had dandruff. In Islamic Spiritual Sciences it is very similar this idea of keeping good company. So it shows that there idea of imbalances, is very much related to the environment as well, the environment a person keeps and the company a person kept as well...It seems to be very closely tied in with the way, the way the spiritual sciences would work that they would say to keep good company" (Scholar 2).

One of the scholars described one of the root meanings of ‘man’ (insan in Arabic) related to affection. He suggested the core trait for humans is to develop relationships and avoid isolation:

“insan [man] is [from] uns which means affection or opposite of loneliness. Humans have a need for affection and don't like isolation, hence the need for interaction, social relationships” (Scholar 5).

8.3.2.3 Role of scholars and imams

Participants accessed religious support from scholars and imams. This has been described on page 276 where participants sought involvement before engaging health professionals. The role of the scholars involved outreach work and supporting people with their emotional and mental health problems as well as spiritual difficulties:

“There is a responsibility with people who have got religious training that they are not just their sitting like a shop and expect people to come to them. Once they are in the Community they are interacting with people and there is a degree of responsibility on them as well to look out for the wellbeing of the person” (Scholar 2).

“People will get worries, stress, things going on in their mind and one of ways is to ask scholars for advice, to help with their problems, pain. The scholars can support people” (Scholar 12).

One scholar considered that their role in helping an individual with mental health difficulties was based primarily in describing the problem from a spiritual perspective rather than giving a person a diagnoses that is related to mental health. They would then focus on a solution to help the individual. This is described by the following scholar who gave the example of someone who was not able to pray due to obsessive thoughts:

“We would just look at in terms that it was a practical problem for the person who wants to pray and this is the way to get round it, to give them a diagnosis and tell them what to do, problem

solve...you try and diagnose what type of imbalance that person might have...Maybe it is a mental health issue that is bringing this to the fore, but again, I would not diagnose it” (Scholar 2).

The role of the imam/scholar is to understand the context a person finds themselves in and to factor this when considering matters such as legal ones:

“Role of imam, scholar depends on how religious conscious person is as well, the imam may be first port of call, depends on set up on the community to be honest, so it is important that they have tools to verify what the this person needs, and when person comes, and this often happens, they come with a fiqh [Islamic jurisprudence] question, often more than not, instead of answering the question directly, if a husband utters 3 divorces, is that binding, obviously there is a situation where this has happened, so before answering the question, I want to know what has happened, does this couple have a generally happy marriage, or is it an abusive relationship, so scholars have to be taught first and foremost, when a legal matter is brought before them, they are taught the context” (Scholar 17).

The role of imam/scholar was suggested to be important as they could be the first point of contact for a person in difficulty.

The same scholar emphasised that the role of the imam/scholar is to signpost the person to professionals:

“how to ask further, to understand context and does this person need some sort of counselling, or support beyond the question, and if that is not within the capacity within the imam, that he be networked with counsellors, and services, where he can channel the person”.

Some of the scholars were asked about the experience of other scholars who deal with people with mental illness. Some of the scholars also concurred with participants that there were unqualified scholars who were dealing with people with difficulties:

“as they [scholars] are not proper ones out there who do not have the experience, knowledge in dealing with people’s problems, call them what you want” (Scholar 3).

Scholars could be involved in a number of ways such as marriage counselling and family work:

“scholars are grounded in traditional knowledge and can help in many ways, I see lots of people who need help with their marriages, they need marriage counselling, involved in mediation, family, situation within the family which is causing stress” (Scholar 5).

Scholar 5 described involvement in marriage counselling. Another scholar highlighted the need of the imams, scholars to be trained in the relevant area of counselling they are working in:

“marriage counsellors, these things, imam can’t deal with these roles, imams, scholars need to specialise some form of counselling, therapy, does not need to be in depth, each imam, scholar can direct person to another imam or counsellor if they do not have the capacity and no way an imam can deal with all these things, so this is a community obligation” (Scholar 17).

Another role and responsibility of scholars was to re-direct the person to other religious figures or counsellors who are more experienced in dealing with the persons problems.

Effects of other realities has been discussed in chapter 7. It was suggested that scholars are in a position where they can facilitate accessing religious practitioners who specialise with such cases:

“there are situations where the person is affected by Jinn, effects and this needs to be dealt with by qualified individual, these genuine people are difficult to find, and the scholars may know where to find these people, know them” (Scholar 17).

It was indicated here that these individuals are difficult to access.

Friday sermons are conducted weekly in the mosque. This was regarded as a platform where imams, scholars could deal with educating people on basic matters relating to mental health:

“The other thing, khutbahs [Friday sermon] is a place, practical issues which affect people, but what I have felt, is what I sense...is got to be based in Islamic sources so people feel its grounded, and be conscious and aware of terms that may be triggering for people such as trauma, so forth, some people may be adverse to this sort of lexicon, because in our community, there is the idea in community...putting up with things, attitude of being strong, need to be taught vocab to use, in religious language so people more likely to accept this, for khutbahs really important” (Scholar 17).

The scholar put forward the need for imams to be trained to deliver the sermon in a more sensitive manner.

Scholars spoke of other challenges they faced when dealing with patients with mental health difficulties and illness. One scholar stated his view there is lack of training in mental health for scholars. He went on to share his view that wider experience helps scholars deal with issues such as depression or people with suicidal thoughts:

“most of the Imams are trained in are so different from people’s lives and are so focused on books. Scholars don't have experience in mental health, there is no exposure in their training either. Know if somebody comes to me and says that they are feeling depressed or someone

turns up and says I am feeling suicidal, I know what they are talking about because I have experience of the same feelings, either through personal experience or experience of people around me committing suicide or attempting to commit suicide” (Scholar 4).

In this part of the conversation, he spoke about his own personal experience; through his body language, it seemed there was a deep concern this scholar projected about helping people and done so with appropriate experience.

8.3.3 Relationships

8.3.3.1 Connection with God

In comparison to participants, the scholars reported more dimensions relating to the connection with God. Scholars were asked directly from the topic guide about the relationship with God and as the interviews progressed, this expanded to other concepts being explored. Also, what emerged from the data was that some of the participants described blame towards God and doubts about their faith. Scholars were subsequently asked about the challenges and whether people were able to embody the concepts spiritually and practically.

Remembering God including *dhikr*, specific devotional acts which involves mentioning verses from the Qur'an/praising Allah or general, where one things about doing good work with the remembrance of Allah, for example making supplication (dua) or giving in charity.

Remembering God was discussed to be related to a settled state of heart and mind; in the situation where things seem difficult and remembering God will make the pain easier then are made easier:

"through the remembrance of Allah you get contentment of the heart after difficulty there comes ease, sakoona [peaceful state], it all sort of encourages a person and gives a person the idea that they have not come to the end of the road that Allah will cure will always cure, as all the duas are listen in one way or other" (Scholar 8).

Trust in God (tawakkul) was also frequently discussed by scholars. Scholars suggested the importance of continuing to trust Him even when circumstances are difficult and uncertain:

"Now in Islam you have complete reliance on Allah swt that ultimately only Allah can cure a person of physical and spiritual illnesses so that gives hope it builds a positive mentality that actually there is a way out, there is light at the end of the tunnel, so that in itself instigates the cure in a person, where they make a firm resolution, so now that is one, second Islam encourages that you make a firm resolution" (Scholar 8).

Reliance is the dependence of the person's heart on Allah to provide and sustain their needs. This is an ultimate reliance. This scholar argues that if there is reliance other than in God, this could lead to distress:

"Having tawakkul in Allah, when a person relies in Allah then they are given protection from worry, distress but what I can say, is relying on someone else and not Allah, then this lead problems, the person is worried about things, that is provided for ultimately by Allah" (Scholar 12).

The idea of tawakkul seems to point to the importance of the individual making the resolution not to wait for help to automatically come but to anticipate it will arrive, coupled with action. The tying of the camel in the hadith mentioned in the following quote implies this. This is where a Bedouin Arab leaves his camel and was asked to tie his camel and then trust in God. This scholar also

suggested this was not the understanding found within the Muslim community:

“There is a general misunderstanding here of the terms, cultural interpretations particular in certain communities of what these mean...tawakkul [reliance in Allah], we have the hadith [words & actions of Prophet Muhammadﷺ] about tying the camel. There is a disconnect sometimes in the understanding” (Scholar 3).

Another term discussed was tafwid. This was briefly mentioned by this scholar when asked directly about tawakkul, a related term:

“tafwid, the delegating of all future affairs to the will of Allah almighty” (Scholar 15).

Hope in God (raja) is a peaceful state of the heart. This is where a person awaits for something that is precious to them:

"Islam teaches that you have hope and turn to Allah, tawakkul that you become whatever you made a target of and you expect it happening, you have hope in Allah that it happens, if it does not happen then taqdeer [destiny] every good and bad happens from Allah and it happens for a reason. May be that was not good for you and that was why you did not progress in that" (Scholar 9).

The idea is linked back to idea of destiny by this scholar where situations occur, the goodness should be understood from that. A person may not always share this same realisation.

One scholar argues that faith always brings with it, hope and suggested this was an immediate effect:

“Where a person does not have a hope, so when faith comes in, hope will come in immediately...when faith comes in then hope comes in so it is a way out for a person who is feeling down because Islam will give that” (Scholar 8).

This viewpoint may not hold true for some people and a person may find this stance pejorative.

Hopelessness in God was recognised by others. This is referred to as ‘al-ya’s’ in Arabic. This has been described on page 180.

Allah is the one who gives rizq, meaning provision and sustenance to people, animals and plants.

This was regarded as an essential part of coping as discussed by the scholars:

"our belief that Allah swt will provide and sustain, He is the provider, He is the sustainer. The people need to have the yaqeen in this and this will help peoples well-being. This is part of the belief of every single Muslim to believe Allah swt will provide" (Scholar 7).

This also highlights one of the names of Allah is ar-Razzaq, the Provider.

Another scholar highlights the names of God and connects it to yaqeen (discussed on page 292):

“Allah, when we say Allah, every single perfection comes to mind...Allah as a name, contains the most of perfect names, when we say Allah, all of His names are contained in this, connotation of this...increasing this quality of yaqeen” (Scholar 2).

God has the power and authority over all events and His creatures. Al-Qadir, the Powerful was used here to reflect this:

“Qadir, He has qudra [power] over everything, so can take you out of depression- so there is hope”
(Scholar 5).

In addition to mentioning another name of God (Al-Rahman), it was indicated that a person could find the names of God useful by personalising the relevant names to their own lives:

“Al-Rahman, all encompassing, Merciful, He provides for everyone, even if they obey Him or disobey Him, I translate rahman as compassion, rather than mercy as compassion more encompassing word, rahman sometimes has nuance done something wrong and Allah let you off but that’s not what rahman is talking about, it is about nurturing and providing, so compassion far better word...using names that resonate with them, in positive way and useful thing to do and look at their life where it is manifested, so like a resource” (Scholar 17).

Another aspect highlighted here is the consideration of the usefulness of the strategy for the person:

“You have to look at the client or patient, their standing, like how religiously focused they are, if they bring in religious language into the actual work, then I will work with that, if it is a resource for them, contemplating names is useful then I will do that in our work...all relative to the circumstances” (Scholar 17).

This could relate to all aspects of coping strategies rooted in Islamic approaches.

Taqwa or God consciousness was discussed by a smaller number of participants. According to this scholar’s perspective, taqwa is a spiritual level that requires persistence and greater effort:

“this is a process, develop through this taking time and effort...some people may not have developed, that is something lacking I would say” (Scholar 7).

This scholar talked about taqwa being an important facet to the relationship with God and helps to strengthen other aspects of one's faith like patience and worship:

"This develops sabr, develops yaqeen. The person might do his dhikr hours days pray in the Mosque or dua but if he does not have taqwa Allah he does not have anything...you can almost say is synonymous it's because a person does it for Allah swt, they either do it out of fear or out of extreme love, and that is the next level you start with fear and then it develops into extreme love and love can be of different levels of course" (Scholar 7).

The idea of love of God, which emerged from the data was asked subsequently with some scholars.

This appears to relate to drawing closer to God:

"To love Allah and His messenger is in the heart, this love is the basis of doing good. This is reality of faith without which faith is tasteless. Whoever loves to meet Allah, Allah loves to meet them. The striving in our faith, in our life, worship is to come closer to Allah. Allah whom He loves, gives them good and closeness, honour to Him. To love Allah and have hope in His Mercy for all the situations we are in, the pain, loss, family problems" (Scholar 12).

The love of God could be an expression of a person's faith. A person who is suffering from pain and hardship, may however develop the notion they are not being loved by God and therefore God's Mercy is not showered over them in their times of difficulties.

Building a relationship with God at a higher spiritual level appears to be presented here, where a person worships God, as if they are seeing God and if they are not able to, to pray as if God is watching:

“we remember Allah swt at all times, standing, sitting, night or day at all times and in all worship, worship Him as if you see Him and the other part is, if you do not see Him, then understand God sees you” (Scholar 12).

This relates to the idea of Ihsan (discussed on page 37), relating to spiritual excellence or perfection. This is the constant awareness of God’s presence and the person remaining on the path of achieving excellence in spirituality. It may be not everyone will attain this.

Muslims become closer to Allah through gratefulness to Him (Shukr), as a way of not just appreciating good times but also difficult times where one considers oneself fortunate for what has been given by Allah:

"sometimes you don't acknowledge it and give gratitude for it and it is only when you are in difficulty that you realise the situation of happiness and ease is one that you should ask for in God and you ask God to give it to you because He gave it to you in the first place and He is the person who will take the darkness away from you as well. So a lot of it is to do with your relationship with God. This is one of the ways you find out who you are so it is like self discovery, to go through a difficulty, being grateful and also it is how to discover, remember God...acknowledge His blessings" (Scholar 2).

It seems a person needs to be connected to God, to acknowledge the blessings provided to them is from God. If this is not the case, then they could be oblivious to the blessings received and find themselves reacting to a situation differently to another person who is able to acknowledge blessings around them.

This connection involves a person recognising God. This was referred to as ma’rifah:

“about the hadith recognising God in times of prosperity and He will recognise you in times of adversity, ma’rifah, can be recognition of God” (Scholar 17).

The challenges or negative thoughts may occur due to loss of attachment with God:

“that connection isn't there with Allah swt, that dependence...really everything you have comes directly, indirectly from Allah swt, when a person realises this then there is greater appreciation, hope” (Scholar 3).

This scholar further explained how negative thoughts such as doubt may be explained by the person's understanding of Islamic knowledge or level of spiritual conviction in the heart of the individual towards their faith:

“Where does the doubt come from, towards our faith? In my experience it comes from knowledge, lack of knowledge, power of knowledge gives us conviction and belief...iman [faith] level is down, low so when the tidal of challenges comes, we fall over, when this happens people move away from their faith” (Scholar 3).

This scholar draws on the idea of the oneness of God (tawhid³⁵), suggesting this could help individuals. This brings together other discussions that have taken place, on the mention of trusting God, in whatever situation a person may find themselves in, that they rely in God and believing that what occurs in life, will only take place at God's Will (described on pages 168):

“Knowing the existence of God and His Oneness, there is no power except His power, that nothings occurs without His will, He provides. And, looking at this, God has all the qualities of perfection, nothing can be compared to Him, none like Him, really thinking about this, to know the Oneness of

35 Tawhid literally means divine oneness. It expresses the central belief that there is no god but God. It negates the possibility that whatever is conceived by the intellect and imaginations of the mind is God (Maghnisawi, 2007).

God, there is the realisation of responsibility morally and also that a person places his trust in God, this can free a person of those anxieties, the uncertainties he may have” (Scholar 2).

“Tawhid, seeing oneness in everything, holistic awareness, everything part of something greater and broader, something they say, some of parts that are not equal in the whole seeing beyond that. That is tawhid, oneness of everything, which is act of God” (Scholar 17).

The idea of oneness of God relates is not restricted to the belief in one God without any partner, but also His attributes, the qualities of perfection and nothing among His creation can be compared to Him.

There are a number of facets to the connection with God. The relationship is one of trust, gratitude and love. This seems to be signify that a person’s life is intrinsically connected with God.

8.3.3.2 Relationship with Prophet Muhammad ﷺ

This was an area where the analysis of data from the scholars was similar to the participants. Scholars spoke about the life and character of Prophet Muhammad ﷺ, his experiences, difficulties and how he responded to them:

"a person's life who constantly comes up against adversity and then constantly triumphs over adversity. From Muhammad’s (saw) younger life as an orphan to being in the custody of different people and being in the commissions of the prophet and going through all the difficulties and surpassing the difficulties. Seerah [biography] is actually a window into a person who triumphs through difficult situations...It also shows how he did that and how people around him learned from that as well...how he coped emotionally with the difficulties...So people around him actually took on that way of dealing with difficulties as well, or found a way of dealing with them which was

based upon his" (Scholar 2).

This suggests there are examples from Prophet Muhammad's ﷺ or controlled he where life managed his emotions and how he interacted with others and for others to learn from.

He was seen as in learning example for Muslims today to help them through difficulties and illness: *"we look at health as a gift of God...his prophetic sunnah to be followed...practiced by the Prophet Muhammad (saw) through his life he was a health keeper, health presenter for everyone from his time in the last day, the way he slept, the way he ate, the way he walked...so in brief health is a great gift to be maintained" (Scholar 10).*

Here the idea of health is regarded as a gift from God and is suggested to encompass wider facts such as exercise, diet, sleep hygiene. There is also the indication on how this was practiced through the sunnah.

As well as learning from the life of Prophet Muhammad, sending praise to him was seen as a path to a sound heart; the idea of a peaceful heart being described on page 211:

"Praising our blessed Prophet (saw), who was sent as a mercy to this world, for an example for all of us for all time. Praising him, there is a comfort in this that we look for, contentment that we look for and that settled, peace of heart" (Scholar 3).

8.3.4 Exercise, diet & connecting with nature

Diet and exercise were not a set of questions from the topic guide. Some of the scholars brought up the importance of regular exercise. Parallels were further drawn from activities Muslims performed at the time of Prophet Muhammad ﷺ:

“all sports are prophetic along as according to guidelines of Islamic shariah, not just wrestling, swimming, which were common to Prophet (saw), might be football, running” (Scholar 15).

“Do you do exercise, do you walk, do you ride a bike, do you swim...There were sports that were played, there was wrestling, there was sword sports, there were running, the prophet (saw) raced himself...it boosts the confidence and confidence is a good reliever of mental ill health” (Scholar 7).

“physical activities happen at the time [of Prophet Muhammadﷺ], horse riding, archery” (Scholar 8).

Dietary advice was also suggested to be beneficial; the example given here was looking at the way Prophet Muhammadﷺ balanced his diet:

“If you look at the life of Prophet [Muhammad] (saw) and how much he ate and how much he did not eat...the amount of food he eats there was a balance in what he eats, so his life is for us to follow as well and will see the benefits not just physically but mentally” (Scholar 8).

Looking at ones diet was seen as an important piece of advice given by some of the scholars:

“I personally approach it as first of all I would look at the persons, if the depression has been long, I would look at the persons diet first, so what are you eating, I don't know much about, but I know diet has a big impact on a person's mental abilities, resilience” (Scholar 7).

This scholar felt diet played a significant role in a person’s mental health.

Scholar 15 asked about outdoor activities and he suggested connecting with nature helps one’s wellbeing:

“Connecting to nature is very important, the Qur’an is replete with verses, it is a direct commandment to look at the creation, the alteration of the day and night, Allah says travel through the earth, we know the messenger of Allah used to go to the cave hira to get away from things, reflecting...that can be retreats, mountain walking, gardening, this is done, keeping busy which will help with well-being” (Scholar 15).

8.3.5 Religious practices

Participants discussed practices relating to Islam, which they were able to fulfil or found difficult to perform. Scholars were asked directly about these practices, with a focus on examining what factors that may enhance the practice or aspects that may be challenging for the person and an explanation why this could be.

8.3.5.1 Supplication (Dua)

Dua or supplication was seen as an important way of coping with difficulties. There were varying views from participant’s perspective, whereby some were of the view not all duas were answered. This was explored with scholars. Scholars reported that all duas are accepted by God however were not automatically answered directly and some may be responded in another way that was seen as better by God. It was suggested that God is always listening to a person’s dua and is not linked with place or time of prayer:

“He [God] always accepts the duas, he is always listening and sometimes peoples mentality is that it is only in the masjid only when the person prays only when I am offering salah will Allah listen to me whereas that is not the concept, if a person comes to me and says Oh I need to speak to you, I need to speak to Allah I need to converse with Allah at all times that in itself gives a person hope

Allah is always with you Allah is always listening to me, Allah always accepts by dua then that gives a person so much hope now whatever misfortune if you call it, whatever mentally illness you may call it then a person has got that hope and that path that yes I have got a way out now” (Scholar 8).

This might leave a person being more positive if they feel their duas are being answered rather than unsettled, which was the feeling of those participants who felt their duas were not always answered.

This scholar spoke further how dua being a type of worship, was strengthened by dedication and sincerity. This scholar said in his view, how some Muslims might not understand its true essence: *“Dua is first and foremost is accepted with a degree of sincerity and dedication...a dua that is a recitation, a dua is from here (points to heart). So people need to understand that...Duas are accepted if they are done with conditions and sometimes specific dua not given but another given which is better”* (Scholar 3).

One of the supplications mentioned by scholars was to seek refuge in God from illness:

“the prophetic dua is something we read every single day and I took refuge from hamm, which is concerns” (Scholar 5).

It was suggested what was important was the level of certainty associated with the dua:

“nothing takes place except God’s permission, the dua, it is not the saying of the dua itself but the degree of certainty behind it, striving to place in the heart the nature of belief” (Scholar 2).

Scholars discussed use of supplication and recitation of Qur’an. This scholar was asked effects from Satan and he discussed use of specific verses from the Qu’ran or supplications, in order to cast

away Satan. This is referred to ruqya, which is a type of spiritual healing (also used to deal with other realities such as sihr, nazr):

“It can be doubts, or like; in the Quran there is a verse surah [chapter] an-nas is telling you seek protection from whispers of Satan” (Scholar 9).

Satan and other realities have been outlined in previous chapter on page 219.

8.3.5.2 Prayer (Salah)

Salah, one of the five pillars of Islam is one of the starting points where a Muslim builds himself up and developing strength through patience and enable them to face difficult times:

"The prayer is one of the foundations which helps people connect with Allah swt and is able to manage their time rather than time managing them and brings it the sense of peace, peace of mind. We remember Allah swt in the prayers and Allah swt will then remember us in our difficulties. It spirituals help lift oneself and helps build hope and strength and patience. This in turn helps people face those difficult times and time of gratefulness, giving thanks to Allah" (Scholar 3).

The prayer in Islam appears to be argued not just a ritualistic action but one that was spiritually internally and connected to outwardly good action:

“Actions speak louder than words...there were many people saying pray salah but they forget it is not just here they have to take it out...they [people] pray but then they drink wine outside, they cheat, lie and deceit...people think because they are doing salah that is enough, you can't be deceived more than that...there is imbalance there” (Scholar 3).

It also seems that the essence of prayer is connected to purpose and spiritual balance, which has been described on page 174.

8.3.5.3 Qur'an

Participants spoke about the benefits of reading the Qur'an; this was similarly highlighted by scholars such as developing hope and a source of comfort. The Qur'an was also viewed as possessing healing powers:

"We know the reward of reciting the Quran and how the Prophet (saw) said it is like a citrus fruit which is good in taste and smell. The Quran has healing effects and comforts people through their worries" (Scholar 3).

The same scholar went further and described the salience of understanding its message:

"the stories in the Quran are so profound that they can be applied to any situation as long as you know the story... not just reading the Quran" (Scholar 3).

Furthermore, there appears to be use of stories in the Qur'an. For example, pain and suffering was relayed through stories of the past, relating to either Prophet Muhammadﷺ, or other Prophets as a way to bring out the experience of difficulty and distress and how people should try and deal with them. An example given in the Qur'an was the period when Prophet Muhammadﷺ had not experienced any revelation for six months and had become distressed and anxious at this; the chapter Surah ad-duha was revealed relating to this. This is a specific verse relating to Prophet Muhammadﷺ but is relevant in the general sense to how people may feel in the morning and night as explained by this scholar:

“surah ad-duha, starts with morning brightness looking at start of day and end night covered with darkness, sense of comfort, hope that Allah swt is there...giving that hope looking forward in morning for day and end for comfort, what we can say is that it is specific to an individual, rasulullah sallallahu alaihi wasallam [Muhammad, peace and blessing be upon him] in difficulty” (Scholar 2).

This scholar was asked about the usefulness of stories from the Qur’an:

“I often do this if client religiously focused, if I think I can use something Quranically or religiously to sort of correct a misunderstanding for example and therefore Religious knowledge resourcing for them, I will do that, that will be useful, for example the prophet (saw), he touched into grief rather than disassociate himself from it and saying ‘we should be content’ however the prophet (saw), he touched into grief, is that a matter of contentment, and I will correct certain misconceptions” (Scholar 17).

This may be helpful in situations where the person is able to reflect and possess the strength and insight to draw lessons from the Qur’an and relate it personally to their situation. This could be hindered by extreme distress and impact of mental illness.

Another level discussed was the pondering of the meanings contained in the Qur’an. This field is called tadabbur, which involves deep reflection and pondering. Here it relates to pondering over not just the words but underlying meanings of the Quran. Tadabbur also extends to the creation: *“Tadabbur is an important subject where people ponder the Quran in such a way that will help people think and make them appreciate and feel better in themselves. This connects the heart, the thinking facility to the Quran and in that process is comfort and hope for people in difficult times,*

sadness, depression. Reflecting on this, we can learn lessons and reminders to help change ourselves, give us hope" (Scholar 7).

"Tadabbur seeing things from broader perspective" (Scholar 17).

What appears to be understood is the value of fostering a deeper understanding behind acts of worship such as praying, reading the Qur'an can help individuals develop a more insightful level of spirituality and connection with Allah:

"One of the important aspects as I have mentioned which is missing in many people or not understood in the community is these things like prayer, reading Quran etc are not just rituals that are done so ticked off in the checklist but these are acts of worship, which serve the purpose of remembrance, connecting with Allah...There needs to be understanding behind the arabic words, what they do mean. It is difficult to become closer to Allah, connect with Him without this" (Scholar 3).

In addition to understanding, there could be an opportunity for people to reap more benefits from the acts of worship they perform through sincerity and humility:

"there is the reminder that reciting the Quran is for reflection and humility. Through understanding these acts, with sincerity then people then are able to get out, gain more fruits from what they do... being sincere, humble this are the inside internal aspects that help people when they are praying, asking, the connecting with Allah swt asking for help" (Scholar 3).

8.3.5.4 Attending the mosque

Visiting the mosque was described as beneficial:

“we see people, interact and meet at the mosque. This is important part” (Scholar 10).

However, most of the data from the scholars was negative. The negative views some of the participants faced in the mosque was echoed by scholars. People suffering from mental health difficulties might find it difficult to engage with representatives from the mosque:

“So I think there is a lack of confidence from the leaders, a lack of knowledge from the leaders. I think a lot of the masjids [mosques] the committees especially are not very open, they don't face up to things, some judge others and don't show much empathy, put yourself in his kind of boots, shoes” (Scholar 3).

The importance of showing empathy and understanding people's emotions was described by the same scholar:

“There is just one Bengali Uncle who come to the Mosque, nobody ever talks to him, he just comes and prays and every time I see him, I open the door for him, I smile at him even if it is just being nice, showing empathy, good relationships. I will give him my place and say you go forward and things like that. Now he has opened up to me and is telling me things about the history of Bangladesh and I am learning so much from him” (Scholar 3).

8.3.5.5 Hajj and zakat

Two of the pillars of the Islamic faith came out from the participants and scholars data, the obligatory daily prayers (salah) and month of fasting (ramadhan). This scholar was asked directly

about the other pillars and how they were relevant for a person's mental health. He suggested conducting the hajj and paying zakat as beneficial:

“The pilgrimage, is a very spiritual journey, people do benefit, change, there is something about going to those blessed places, soul is nourished, person remaining in worship, that has an effect of the soul, strengthening connection with Allah swt” (Scholar 15).

“We believe in spiritual realities, unseen realm, every single action in physical realm has a reaction in spiritual realm, when we give zakat, even although financial transaction, we believe there is benefit spiritually, purifying the soul, obviously there is benefit from well-being point, feel positive, feel good factor” (Scholar 15).

8.3.6 Emotional support

Only a small number of scholars discussed recognising and managing one's emotions. This is in contrast to religious forms of help, which was discussed more. Emotional expressions have already been discussed on page 181.

This scholar were asked directly about examples of emotional support in the Islamic tradition:

“There are many examples about emotions, Prophet (saw) saying that the tears comes from the merciful and they are not a complaining against the actual decree, this is when he was grieving over his son. I mentioned the quote, the eye sheds tear, the heart feels pain, we do not say anything that displeases our Lord, so it's about accepting emotions and processing them before we allow them to take course, before fully processing them cognitively” (Scholar 17).

Another example from the life of the Prophet Muhammadﷺ expressing emotions is provided here:

“Prophet (saw) after battle of Uhud, was grief stricken with Hamzah, death of Hamzah, and even after, he saw face of Wahshi [person who killed Hamzah]. He didn’t want to see him [Wahshi], trigger to bring grief, cognitively he accepted things but even he found it difficult, whenever he saw his face, reminded him of Hamzah’s martyrdom” (Scholar 17).

Recognising one’s emotions was highlighted by same scholar:

“Ask your heart, hadith, context of hadith, there is secondary meaning here. Person asking if he gets two different opinions than what he asked what shall I do. Prophet (saw) said consult your heart, and you take from that, if heart telling you something, and you need to listen to it, even if brain, your brain saying something else” (Scholar 17).

Scholar 17 suggested people tended to use spiritual practices for example quotes from the Qur’an or spiritual uplifting messages to avoiding dealing with emotional problems. None of the other scholars spoke about this:

“there are these verses in the Qur’an, like ‘do not be sad’, these verses are there for solace, it is not forbidding someone from doing something. When someone says ‘do not be sad’, it is not saying don’t be sad.

People are ignoring emotions, stuck in their heads, lose what I call their internal compass, dismiss emotions and go beyond them and not process them. Prophet (saw) recognised these [emotions] as natural things.

People try and cognitively understand, fully understand them before they process them. Typical example [is] baby loss, people say, it is from Allah. First step is to just be there, towards healing, be there for them, be present for them, so they can go through process of grief, and then later can have a greater expansion, awareness around the event, that is more embodied, more integral and

just simpler than using the cognitive process to dismiss what they are feeling. Person will say 'I know it's from God but they can't shake it, God taketh, God giveth, deep down emotions still tingling them' (Scholar 17).

He further elaborated on this by providing an example about anger:

"Attributing emotional issues to spiritual ones, I think that is difficult sometimes as I think the traditional model have identified as spiritual and I think it is emotional thing, like controlling anger, and the spiritual solution to that is sometimes, I have to control my anger, no matter what, and to be angry is unspiritual, and sometimes that can dysfunctional for people, like repression...If someone in dorsal vagal shutdown response, it will be difficult for them to open up, curious, be aware of what is around them, that is important process for them to start being aware of it...polyvagal theory important for anyone doing therapy" (Scholar 17).

It is suggested that in some cases, a spiritual explanation or approach is taken and avoidance of dealing with emotional issues. Use of a conventional approach (polyvagal theory) was also mentioned here.

Scholar 5 described the different layers to the heart earlier on page 210. In his description, one of the layers relates to emotions:

"Pointing to nature of heart changing constantly, such as emotions and decisions undergo change. This changing of the heart is a normal state of the heart...So referring to how much a burning heart is inflamed with emotions, like emotional cover...the emotional, psychological side cannot be ignored".

It was not just the domain of spirituality that needs expressing but also the emotional area as highlighted here:

*“It is opening yourself up, emptying yourself out emotionally and spiritually, to speak your heart and every desire you want and everything you want rectifying...you are about to sink, you can't swim nobody can save you so you turn towards the power that can save you, that is a tadaru’”*³⁶

(Scholar 2).

Scholar 4 suggested the following explanation as to why scholars in Islam were not familiar with emotional concepts in the Qur’an or hadith:

“The scholars who are concerned with ilm al-nafs tend to be spiritual guides/sufis. Very few of them managed/ manage to break from the theological interpretations of emotional and mental health/ ill health and see the connection with the physical body and societal pressures. This is the reason why al-Balkhi's work is so important and why its influence on mental hospitals in Baghdad at a time when they were not even imagined in the West was so significant” (Scholar 4).

Scholar 17 was also asked why scholars in the study discussed this area of emotional support less frequently, and also asked about scholars in general. He was also asked to provide his view on why this was, considering the expressions of emotions found in the Qur’an and Hadith (as indicated on page 180):

“The Islamic approaches and other approaches should be integrated. Disconnect with the richness in the Islamic tradition and scholars, what is practiced...disconnect comes from in my view, Islamic approaches to knowledge became codified, spirituality became more, there was a struggle with

³⁶ This has been used a second time due to its relevance.

spirituality at some point in Islamic history, where they wanted to make an orthodox model, which was codified by Imam Ghazali [Muslim scholar of past], after Ghazali, now I am making huge generalisations, books built upon the ihya [book written by Imam Ghazali], to codify, thing is you cannot codify managing emotions, what is book called, DSM, explaining what they are but not how to deal with them is completely with them. Advice traditionally, when dealing with them, rather than getting some healing from them, in a way, do this and do that. Emotions is subjective experience, you cannot do that with emotions” (Scholar 17).

On page 282, participant 6 expected to undergo the feeling of pain and sadness in order to understand the opposite emotion of happiness. This is similarly highlighted by scholar 15:

“In Islamic poetry, [in Arabic] meaning things are known by their opposites, in the Qur’an there are many contrasts, [Arabic] hardship and ease, so one expects these experiences, to be tested. Understanding emotions is important for the person, emotions, there is sadness and happiness” (Scholar 15).

8.3.7 The process of change in recovery

This area which came from the scholars data, can be conceptualised as the ‘process of change in recovery’. This area was understood with some of the scholars using the word ‘change’ or placing an emphasis on this word:

“We should focus on how to deal with it and how to alleviate it which is to look at what they can do to change that situation” (Scholar 2).

"Allah (swt) will not change the people until the people change themselves" (Scholar 7).

These factors emerged from the interviews where the scholars were probed further about coping strategies and steps of change in recovery. The questions in the topic guide were modified as the interviewed progressed to ask scholars of areas that would either enhance coping strategies or hinder the recovery process. Scholars were also asked directly about some terms. This is further mentioned on page 418, highlighting the role of the researcher on data generation and analysis. This was pertinent to examine deeper as participants, even although they resorted to coping strategies relating to their faith, there were still periods where they were still struggling with their mental illness and road to recovery. Different individuals may be at different stages in their readiness to change.

There was use of specific arabic words for the description of these factors. What seemed important was the emphasis placed on these factors and indicated to be pertinent to a person's help seeking journey and recovery, which was intertwined with the Islamic concepts already discussed. For example, an individual might not necessarily believe they have the capacity to change or feel they need to exert effort; this could be related to their understanding of concepts such as 'sabr', 'tawakkul' and 'qadar' (described earlier on page 277 and 153).

Having an awareness of one's mental health difficulties could be considered a starting point in the process of change. It has been described as introspection (wa'y):

"Introspection, difficult to get a word to capture fully this, wa'y would be the closest word, indicating a general awareness, self-awareness, awareness of yourself, context around you"

(Scholar 2).

Scholar 2 was asked directly about the term, awakening (sahwa). He responded that this related to someone on a spiritual path:

“arousing yourself, there is awakening at beginning of spiritual growth, spiritual path, it is looking at own worth and breaking yourself from the shackles of heedlessness, this relates to a purely spiritual journey...sahwa, awakening, arousing from neglect” (Scholar 2).

The idea of contemplation or tafakkur, where one reflects on the creation of God and the heavens and earth is described on page 268. Closely related to this is tathakkur (re-membering):

“Tathakkur, this is reflection upon on the past as if you are re-membering [as vocalised as scholar] something, interestingly re-membering semantically, ie. Putting different membranes together to create a whole, whilst in Arabic, it’s tathakkur, to remember, active exertion in remembering things, things already taken in divine knowledge and trying to piece these things together, to go forward, whilst tafakkur is taking 2 new pieces of information to arrive at a result” (Scholar 17).

The idea of tathakkur appears to be not just recalling the past but involves deconstructing past meanings, remembering the past purposefully to ponder over it and understand the wisdom behind it occurrences and arrangements.

It could be through contact with other people, advice is given. This is referred to as shura (consultation with others):

“to do shura when you have a problem, asking other people” (Scholar 3).

“sharing and consulting others and trying to solve a situation” (Scholar 2).

Following this, it seems the next stage to consider is intention (niyyah³⁷). The importance of intention was suggested to play a role in a person making that decision to take steps to recover from their difficulties:

“actions are according by intention, niyyah is in the heart, spiritual affair in the heart, intention can be in anything, to do intention to get help” (Scholar 15).

“intent to engage” (Scholar 2).

Scholar 15 mentioned once a person makes the intention to change, they need to then have the ‘will’ to carry it out (called ‘irada’). Though he mentioned, this may be difficult for some people:

“Irada, which follows, is about have the will then to do something, actively deciding to go out and perform the action. On the other hand, this might be difficult as people might be avoiding dealing with issues, they might be in despair” (Scholar 15).

As part of change in the help-seeking process, it seemed the next steps involved a determination and effort to make change happen. They pointed out it was not enough just to wait about and do nothing:

“Irada is like the will, so for example if you want something, want or willing something and then moving up, ‘azm [determination] is making the decision, like that's it I am going to do it, I want this now, I want this, yes, then once you are wanting it, because you can want it and not do anything.

‘Azam is like you saying, (thumps table) okay, time for action, I am going to do it now, you have finally made that decision” (Scholar 5).

“determination and effort, you can't just sit at home and expect food to come to your table, you have

37 Niyah is the resolve in the heart to do something (Farid, 1995).

to make effort for it, you have to toil for it, only then will you get the food on the table" (Scholar 3).

‘Azm was further elaborated as:

“making the decision, having the determination to act then, this is ‘azm” (Scholar 2).

The merit of deliberation (‘*anah*) was suggested here, to enhance clarity and giving due consideration before decision taken and acted upon:

“Haste is a state that infiltrates the heart where a person wants immediate response. When people make decisions, the cure is to wait and do this at right time, that of the process of ‘anah, deliberation, consideration, this gives clarity. This is not the same as putting things off but being thoughtful and doing the right things in due time...when you choose to do something, do it at a certain time rather than previous time, think about better now or better later, delaying it, implementing it at a certain point, a right moment...differing from when procrastinate people may do, that delays or stops decisions” (Scholar 2).

Deliberation does not equate to indecisive behaviour and avoiding doing something unnecessarily through procrastination.

A person works towards setting goals on their road to recovery, though the Arabic version was seen as a modern version of the word ‘objective’:

“Objective is a general term to refer to the outcome you are working towards in an action, so words such as hadaf is the modern equivalent” (Scholar 2).

Similar to determination is qasd as suggested by same scholar:

“Qasd is a strong intention, a resolve at point of doing something. Following deliberation, niyyah, intention can waver however this is stronger, a firm resolution, more emphatic. Study and deliberation and resolve, following up something, focus on resolve” (Scholar 2).

This was described in another way, involving a focus or goal but explained where the experience of the journey was important and not necessarily the endpoint:

“the intent, qasd, goal is fundamentally Allah, in Fatiha [chapter of the Qur’an] we ask to be guided onto straight path [Arabic] guide me to something but preposition ‘to’ not used, guide me to the path, on the path, guide me towards the destination, guide me with your presence, the preposition ‘to’ being left out leaves it ambiguous, for those nuances to come out about treading on a path.

Interesting you are not guided to a path, guided to a destination, destination is not actually mentioned, what I understand is that we should be focused on each step on the path towards a goal, and it’s not about just longing for the destination, but rather enjoying the journey, or seeing the significance of the journey as part of the actual destination in itself, and that has helped me in my journey, we are usually focused on the goal but that leaves you frustrated, like a horizon, that you can never reach, but rather focus on where u have come, and where your feet are, and where they are directed towards and taking each step at it comes” (Scholar 17).

This could help people with distress who might become frustrated or preoccupied at not being able to achieve the end point of their recovery. Each step or occurrence in life could be perceived as reflective or learning opportunity for the person.

Scholar 17 was asked about the words *istibsar*, seeking clarification and *nathar*, gaining insight/scrutiny:

“istibsar, considering things with contemplation and basirah, fair comment...istibsar comes from root basara, holding something together something firmly, which is something larger, which is gathered together, and stretched out, or knowledge attained through eye of heart, it has concept of real focus of something, really scrutinise something...nathar, gazing on your eye and scrutinising it and arrive at some sort of conclusion”.

As indicated on page 154, it was suggested that in the process of recovery, people need to have the knowledge that they have the power and choice to change things, this is referred to as *kasb*:

“people being aware they have the volition and choice to change things, kasb, this goes against the fatalistic view”³⁸ (Scholar 2).

A person may need to make the decision to seek help or not, as understood by the term *isti’anah*, help-seeking/aid:

“to seek help, that may be professional help, not just God’s help. Person needs assistance that is isti’anah” (Scholar 2).

Once someone has made the determination and resolve to act, taking action (or *‘amal*) to recover is identified as the next imperative stage:

³⁸ This has been used a second time due to its relevance.

“Really there has to be the practical aspect which is the ‘amal [action] of the person which has to continue. The two things important, which is important is ‘amal and dua [supplication]” (Scholar 7).

This was suggested to be rooted to being practical and problem solving for tackling problems (alongside other aspects such as supplication):

“We would just look at in terms that it was a practical problem for the person...we should focus on how to deal with it and how to alleviate it which is to look at what they can do to change that situation” (Scholar 2).

There was the idea of ‘taking the means’ as indicated here, pointing to taking action based on what is available and possible at the person’s level:

“akh’dh bil asbab [taking the means] is to acknowledge that change can not happen without steps being to undertaken that act as evidence of a person’s intention to change. If God had wanted, there would be no asbab, and this miraculous method would discard the human act of conviction and intent” (Scholar 2).

The idea of adapting to situations is discussed by another scholar who also brings in the term himma, which relates to spiritual resolve:

“himmah the spiritual ambition to drive yourself...there is many hadith looking at the trials, situation you will face and often talked about is remaining steadfast and firm. We look at the life of rasullah (saw) and he solved a lot of problems, being able to cope with all that was thrown at him from all sides, changing to face those challenges, crisis, the problems...adapting to the situations in Makkah, Madina, with the people who were against him” (Scholar 7).

The idea of resilience is also described by this scholar, being able to adapt and recover from ill health:

"making the mind healthy and doing exercises to build up the resilience against potential illness, remaining steadfast...when you are in a state of health to build up a bank of skills, of coping strategies for when you are not well...to be able to adapt to those situations so by building up your resilience then you are able to face those situations" (Scholar 4).

Himma is further explained by scholar 2 relating to resilience:

"once in situation, seeing through it to end, like you are in the middle of your PhD, and when in action, himma sees you through it, way to do it to completion. Resilience, himma, it's a motor inside the person, why are you resilient, it's because of your himma. This can be low resolve and high resolve" (Scholar 2).

Furthermore, the importance of perseverance (sabr) in the face of pain and suffering and adapting to life circumstances was highlighted. Scholars also used related words such as steadfast and firmness during the time of difficulties:

"it is about small steps slowly but they need to be steadfast, standing firm and they need to be constant...if you look at any way of rectifying oneself it is not something that happens overnight...you keep that going... It's the perseverance of doing things to get better, carrying on despite the problems" (Scholar 8).

"situation you will face and often talked about is remaining steadfast and firm" (Scholar 7).

"There are different kinds of sabr, this is closest thing to perseveration, sabr when something happens, sabr in action, tribulations in faith, sabr, pathway to continue persevering" (Scholar 2).

The same scholar used dawam to signify perpetually doing something in a continuous manner:

“Dawam is closest to the idea of being perpetual in a continual manner, even if what is done is small and is used to indicate being persistent in an action to affect change” (Scholar 2).

Steadfastness (istiqâmah) used earlier by the scholar 2 was explained further:

“this can be looked at holistically, being on the straight, ie. having clarity, and not veering off so could have psychological, use it in psychological realm, istiqamah, these are generic words that have developed religious connotations, but they can be used more broadly. Straight, upright, solid, balanced, so forth, and use sort of symbolism with my clients, feeling the sense the core feeling uprightness, feel there is straight string that is holding them down to their spine” (Scholar 17).

Similarly, what seems important is tadarruj (making small steps of change):

“It is not about doing loads of things...it is about small steps slowly” (Scholar 8).

Maintaining good company is highlighted here (explored on page 299):

“linked with practical, problem solving, good company. This is very important in Islam” (Scholar 7).

Scholar 15 was asked about the term muraqabah (observation):

“Muraqabah, taking note of your actions, observing your actions, moment, doing something positive. Different scholars have understood this in different ways” (Scholar 15).

Following muraqabah is the idea of muhasabah, which a more active process:

“Take account, write something, muhasabah. Muraqabah, to observe something, first process is this, muhasabah is result of that” (Scholar 17).

Muhasabah or evaluating one’s action was put forward as a responsibility for the individual:

“One of the thing we do at end of the day is to take account of ourself, to do muhasabah. Take yourself to account before you are taken into account, this is from hadith about taking personal responsibility and helping yourself and Allah swt will help you only when you help yourself” (Scholar 3).

Scholar 2 took another view, understanding muhasabah as a difficult process for the individual and advised to focus on being engaged with activities such as volunteering:

“take yourself to account for it and that will be done muhasabah and you sit down and you look at what you have done and then take yourself to account for that is important. But it is a very small group of people who would be able to do that it is quite a rigorous process of self evaluation. I think there is very limited scope for that...it is a difficult path to correct spiritual imbalances...generally engross yourself in good actions and not take yourself to account but just to get on doing good, and that process of getting in just doing good which is why I mentioned doing social work and volunteering, because it is something you can do collectively and it covers the problems of large group of people very quickly.....strenuous process, applies to people on top of the game, spiritually elevated. In times of stress, adversity, it is very difficult” (Scholar 2).

The impact of mental illness may also make it difficult for the person to do muhasabah.

Scholar 17 also suggested muhasabah was challenging and not always appropriate:

“Take account, write something, muhasabah...if u live life like that, muhasabah, life experience is a code, some of the spiritual community think like that and live like that, by the book, life is not like that, as life gets more complex, they live life like a code, but life not like that. Need to live by principles and adapt according to circumstances, and broader outlook to life. Can be susceptible to outlook to life if being too narrow. Need common sense and see things broader perspective, awareness of social sciences, we are not machine and fall into certain way”.

Scholars described taking a balanced, holistic approach to help:

"There has to be, everything has to be taken in context and not in isolation...this is what we have to do during our difficulties when getting help" (Scholar 7).

"balance in our approach, in our mental health, in what we do, think about and not to go to the extremes" (Scholar 8).

This is referred to as i'tidaal :

“the balance approach, general balance, i'tidaal is generally the middle ground, taking into consideration difference scenarios, understood as holistic, the other word close to it is wasatiyyah” (Scholar 2).

This was reflected by not necessarily one linear approach being suggested by scholars and also not restricted to religious practices being performed but wider areas such as social strategies. This is further discussed on page 396.

Personal responsibility (mas'uliyya) is put forward here as important aspect of change and long term thinking (basirah):

“When thinking about person getting help, taking those steps, personal responsibility is obviously important...this is called mas’uliyya” (Scholar 2).

“Basirah, this is relevant, related to long term thinking, perspective” (Scholar 2).

Scholars described even although there are pain and suffering in life, a person should be see the good in situations; this sense of optimism (tafa2ul) is reflected in the following two examples:

“even the slightest difficulty that comes upon a believer, so that if he was just pricked by a thorn that is an expiation for his sins” (Scholar 1).

“the Prophet (saw) was optimistic, taking good omens, looking positively at something” (Scholar 17).

“the condition of a believer is strange, at times of good he gets rewarded because he is grateful, at times of misfortune he still gets rewarded because of his patience” (Scholar 8).

This is similar to the inspirational quotes described by participants on page 270.

Scholar 2 was asked about the meaning of ittihad (union), which represents the unification of individual parts or union. The word suggests the bringing together of different aspects of a person:

“Ittihad is for the person to approach an issue on the premise that all aspects of what make them who they are is being represented in their behaviour, whether it is their cultural, religious, spiritual, physical or emotional inclinations” (Scholar 2).

Scholars were also asked about steps to consider when someone is presenting with aspects relating to their spirituality. One approach is proposed here:

“The spiritual path is one which entails ilm [knowledge], ‘amal [action] and haal [state]. To give an example, we know that patience is beneficial, and when the person is in the situation when they

are tested, tested then it comes into practice, it is practiced and then a person comes into hal, becomes patient and that confirms the ilm and person does not worry as much” (Scholar 4).

Knowledge was described here, linking it with aspects of mind and being and developing intuition. It was suggested a person’s judgement may be affected by trauma and this was one example where adhering to sound knowledge was viewed as important:

“it is important mind, knowledge and being mentioned by others like Peter Levine...when you are traumatised, your judgement is skewed, so important to balance it, mind, knowledge and being with those three fall into place...when it conforms to real knowledge then you have intuition...different stages to firasa [intuition], some say it as a spiritual intuition, everyone has some sort of intuition” (Scholar 17).

It may take time for the person to develop their level of spirituality. In addition to ilm and ‘amal, another scholar described sulook (behaviour). He was asked to explain salook:

“One needs to learn knowledge and this is ilm, then act upon it through ‘amal and finally sulook...this includes character and ongoing self improvement and inner purification. Salook is the path to getting closer to God, normally done by following a spiritual path” (Scholar 5).

Scholar 2 indicates the importance of spiritual change through the following way:

“Spiritual change is turning towards God sincerely and prerequisite of this change is through tawba, this is heart of spiritual change, understood through the conditions of three R’s of tawba: removing oneself from the prohibited acts, having remorse over past behaviour and then resolve, whereby not to go back to the past ways. If there is also wrong action towards creation, then another condition is rectify, rectify any issues which can be reasonably done” (Scholar 2).

What can be understood from the concepts emerged such as tawakkul (reliance in God) and raja (hope in God), is the importance that a person focuses on the purpose of pain and suffering and journey of recovery rather than the outcome or end-point.

8.4 Similarities and differences between the two groups

This section deepens the analysis by exploring the similarities and differences within each group and between the two groups. Areas that were given emphasis or distinct by one group over another will be highlighted. The importance of understanding these views from within the groups and between the two groups is explored. This will be drawn out using the themes emerged from the data.

Relating to faith

Three concepts were developed through the analysis, namely belonging to the Muslim faith, inspirations and solace and transformational concepts. The first one emerged distinctly from the participants data in comparison to the scholars. This could be explained due to the nature of discussion (developed initially from the topic guide) focused on exploring the actual experience of suffering of mental illness and belonging to the Muslim faith, at a real and deeply personal level.

The analysis showed participants reported different facets to 'belonging to the Muslim faith', which examined the role and meaning of faith. The aspects of faith related to a sense of belonging to the community, Muslim identity, sense of meaning and purpose in life and control in their lives. There were varying views among the participants. A closer exploration at these facets highlighted that belonging to Muslim faith, even although was overall positive, was also challenging. Furthermore,

people might feel close or distant to their faith at times of pain and suffering. Lastly, faith was inseparable from the outlook to life. These levels of understanding were insightful and captured from the analysis of data.

In relation to transformational concepts, both participants and scholars commonly discussed the idea of 'sabr'. There was similarity regarding the emphasis of importance of this area. Sabr is closely related to the idea of life being full of trials and tribulations, which is commonly held world-view (discussed on page 270), which could provide an explanation why sabr was frequently discussed by both groups. Between participants, there was not a consistent understanding of sabr. A minority took the view that sabr only entailed a state of patience without necessarily taking practical steps to seek help.

One distinction brought out in the analysis found that a minority of participants only discussed the other transformational concepts in comparison to the scholars. The concepts emerged were ridhaa (contentment), yaqeen (certainty), tafakkur (contemplation) and tawbah (repentance). Additional new areas discussed by scholars included Ihtisab (waiting in patience for Gods reward) and tazkiyah (purification). The comparison of findings between the two groups highlighted that even although concepts are described in Islam, there needs to be a consideration that there are differing levels of awareness and understanding around them. There were some possible explanations for this. For example, an interpretation of the scholars data indicated more effort and self-reflection might be required for tafakkur; a greater level of spiritual awareness needed to develop ridhaa. These judgements might be contested by participants themselves and needs further exploration.

Relating to the connection with the community

The two areas discussed in the analysis were ‘contact with scholars and imams’ and ‘being part of the community and social support’.

The participants data showed there were mixed views towards how helpful imam and scholars were, with majority reporting a negative experience. Also, participants found it difficult being part of the community and social support not always positive.

The findings showed similarity with the scholars data. The only distinction was the importance of community involvement such as charity, volunteering and social interaction being emphasised by scholars in coping strategies at a community level. However this was not congruous with views of participants who found it difficult to engage in these activities. What seemed of value to scholars to partake in, participants found challenging. This gap was borne out from comparison of the two groups.

Relating to relationships

Two strands were uncovered from the data: relationship a person has with God and connection with Prophet Muhammad ﷺ.

In relationship to God, there were diverse dimensions to this relationship. There was some commonality between the two groups: remembering God and gratitude to God. There was varying views between the understanding of tawakkul, reliance in God. Some participants felt reliance in God did not require any effort on their behalf. This is in contrast to the views of scholars. The other concepts were found discussed less frequently among participants in comparison to scholars: hope in God (raja), sustenance and provision from God (rizq) and God consciousness (taqwa).

Participants also reported negative emotions such as God being unfair, anger and blame towards

Him. This was also born out of scholar's data as well, such as hopelessness and relying on other than God.

The comparison of the two groups highlighted the relationship with God encompasses a number of layers with the strategies not being mutually exclusive. This seems to indicate that developing and strengthening the relationship with God requires a person being on a journey of spiritual development.

Participants shared their experience of inspiration and strength from the life of Prophet Muhammad ﷺ. These findings were similar to the scholars.

Relating to religious practices

The practices described by participants were similar to the scholars. There were some distinctions, the main one being the challenges in carrying out religious practices; this was evident in the participants data. In relation to supplication (dua), there was varying understanding on whether this was always responded to by God. A small number of participants highlighted complementary therapies. The comparison between the two groups seems to indicate the importance to acknowledge a person's spiritual journey, which might be different from another persons.

Relating to emotional support

The majority of scholars did not discuss this area of emotional support. Examples were provided from the life of Prophet Muhammad ﷺ where he expressed and managed his emotions. It may be that people resort to attributing difficulties to spiritual causes rather than emotional ones.

Relating to process of change

This area was developed from the analysis of the scholars data. This could be explained by the fact the focus was examining ways of enhancing coping strategies and required a deeper level of probing. The findings demonstrated there were generic strategies, some of which were rooted in Islamic description that could be useful for a person's recovery.

8.5 Summary

In the journey of recovery and resolution of symptoms of mental health difficulties and illness, Muslims adopted coping strategies specific to their faith. The findings show a greater degree of insight with new areas described.

This encompasses strategies at multiple levels and it is multi-faceted. There does not seem one prescriptive approach but one that has many avenues. At an individual level, a Muslim looked inwardly spiritually, to their faith, and gained strength and meaning through this most of the time. There were however periods in a person's life where he or she experienced the impact of suffering from mental illness negatively. There were also transformational concepts evident that helped participants during their time of distress and hardship. These strategies were not mutually exclusive with their relative importance varying among the participants. The usefulness of the strategy may need to be considered for the person. The findings also show social strategies used by Muslims which were shaped by a religious outlook. Despite the indication that standard mental health approaches and Islamic approaches to mental health can be intertwined, only a small number of scholars highlighted conventional approaches to mental health and emotional forms of support. It was also suggested that people may use religious practices to avoid dealing with emotional issues.

The relationship with God was seen as an important axis around which a Muslim life revolved.

This has been outlined in relation to outlook to life on page 152. There were however times in the lives of a small number of participants where they developed negative thoughts towards God.

There also seemed to be contrasting views between participants and scholars. Some of the scholars discussed this to be related to level of knowledge and understanding of Islam for those individuals.

Other factors that they thought might explain this were lack of self-reflection and level of spiritual conviction.

Contact with religious figures was viewed as positive however there were also challenges to accessing qualified imams and scholars with experience of dealing with mental health issues. A Muslim might engage with religious activities which brought with it comfort however suffering from mental illness could impede some of the practices such as prayer, leading to distress when this seemed to be difficult. Despite mosque attendance being described as beneficial, more unhelpful experiences were highlighted. Scholars also highlighted factors that might need to be considered during their recovery which are deeply rooted within the Islamic tradition as outlined on page 277.

The findings in this chapter indicate the manner Muslims cope with their mental illness. The way they rationalise their understanding of mental illness cannot be separated from their perspective of the bigger picture as to why things happen in life from a religious perspective. This is connected with their outlook to life such as predestination, life as a test and balancing this temporal world versus the after-life, discussed on page 145 and 151. A continuous thread woven through all these themes is the position of God as highlighted earlier.

The next chapter will explore how Muslims access mental health care and treatment.

9 Chapter 9 - Contact with services: the level of accessibility and experience of Muslim participants

9.1 Pathway for Muslims

The main themes from the first three results' chapters have been summarised under the headings of philosophy of life, understanding of health and well-being, perceptions towards causes of mental illness and coping strategies. These come together in this chapter where it becomes evident how they affect a person's access to care and treatment.

This chapter maps the experiences of Muslim participants in accessing formal mental health care and examines the experiences that are distinct to this faith community, rather than addressing general issues that are common to all communities. Cultural factors will be highlighted where significant findings have been found within the data. It will begin with theoretical discussion relating to access to healthcare.

There will be a focus specifically on the experience involving Muslim scholars and perspective from Muslim scholars who might be consulted. This seemed pertinent as it was highlighted on page 271 that they play an influential role in the Muslim community. They seem to hold a position of legitimacy and validation of their views. There can be an analogy drawn with the authority of doctors over their patients.

Where there is similarity to previous concepts described, this will be referenced to the source page.

9.2 Access to healthcare

Access to healthcare has been discussed earlier using the Goldberg and Huxley model on page 27. However, it can be further understood for ‘hard to reach’ populations in terms of the concept of ‘candidacy’ (Dixon-Woods et al., 2005). Candidacy illustrates how access to healthcare is outlined through a dynamic process and interaction between the individual and health services. The individuals identify themselves that they are a suitable candidate for healthcare. The theoretical framework is defined as:

“ways in which people's eligibility for medical attention and intervention is jointly negotiated between individuals and health services” (Dixon-Woods et al, 2006, p7).

According to the model, eligibility for health-care and treatment is *negotiated* between the individual and services. The authors of this model argue that the key to understanding services is conceptualising them as being encapsulated by membranes: individuals need to pass these membranes to enter the health services. This is a similar concept to the filters described by Goldberg & Huxley (1980). Membranes can be more permeable in places such as the A&E department and General Practice. Such settings are more accessible and may have shorter waiting periods and therefore individuals may enter into the service more easily. However, there are more barriers and resistance in less permeable membranes, such as outpatient clinics and interventions performed in hospital.

Integrating this concept of candidacy along with concordance and recursivity, an analytical model was developed by Kovandzic et al., (2011). In this framework, concordance is seen as the basis that service users and practitioners work collaboratively on decisions relating treatment choice (Stevenson & Scambler, 2005). A service user’s future demand for services and help-seeking

journey is influenced by contextual factors such as past experiences and beliefs about healthcare.

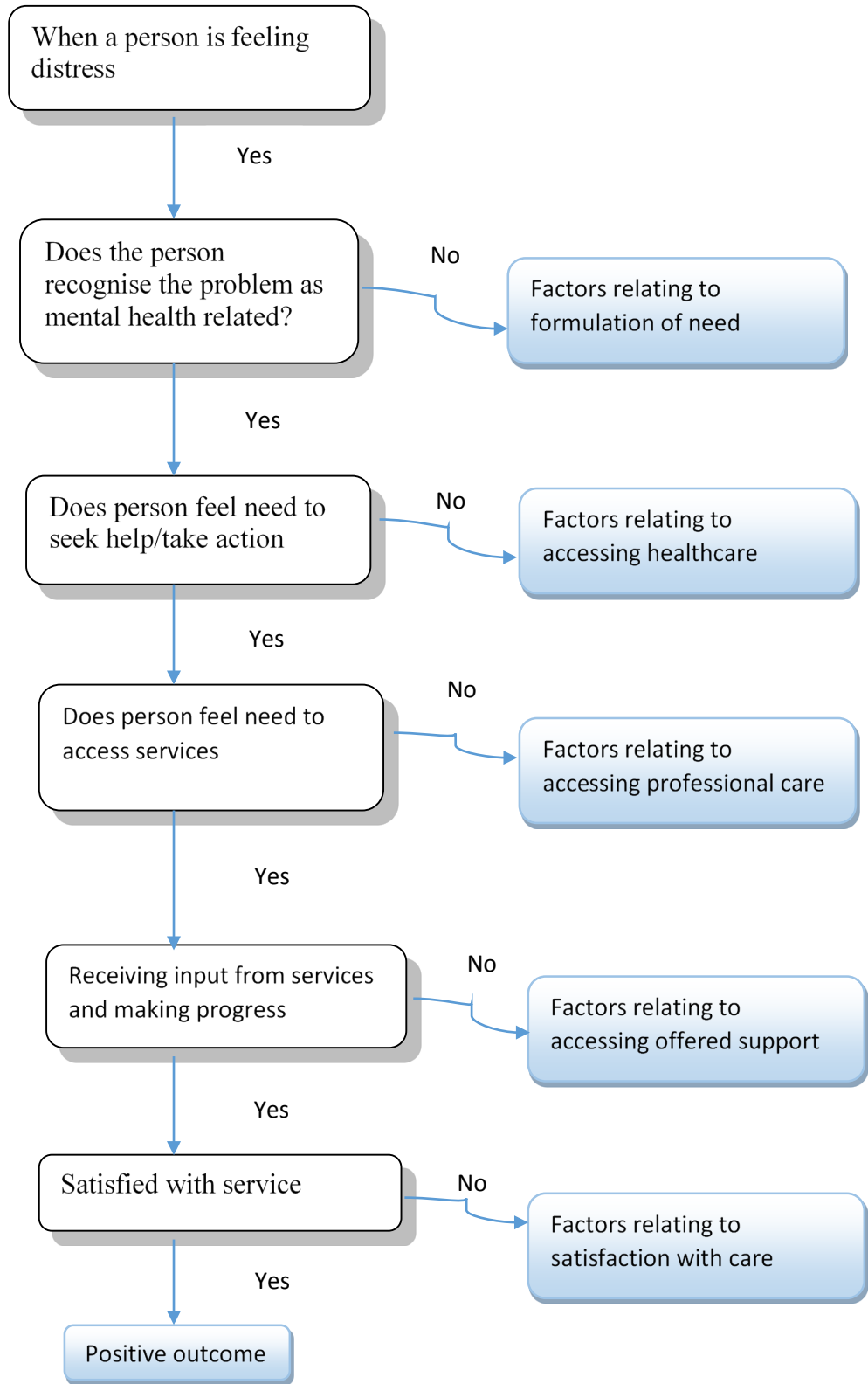
This is captured under the concept of recursivity (Rogers, Hassell, & Nicolaas, 1999).

This model by Kovandzic et al. (table 10) was selected as an organisational framework for the findings here since it represents a more inclusive model encapsulating recursivity and concordance.

A good degree of fit was observed between this model and themes emerging from the analysis process with regards to the pathway to care.

Diagram 11: Patient in distress: pathway for accessing mental health care in primary care

(adapted from Kovandzic et al, 2011).



**Table 10: Access to mental health care in primary care
(adapted from Kovandzic et al, 2011)**

Stage 1	Why a person may or may not formulate their experiences of need into a mental health problem?
Stage 2	What may prevent, or facilitate, the demand for healthcare even if symptoms are formulated as a mental health problem?
Stage 3	What may prevent or facilitate a contact with a health professional once an initial act of help-seeking is performed?
Stage 4	What may prevent or facilitate a prescription/allocation and uptake of a mental-health-supportive intervention once the relevant professional is reached?
Stage 2	What may prevent or facilitate positive outcomes and user's satisfaction with care even if a mental-health-supportive intervention is allocated and accepted?

Factors governing access to mental health care in this study will be described under these five stages.

Further insight that emerged which gave relevance to accessing care and treatment, will also be presented. Where there is similarity with or contrasting views with the data from scholars, reference will be made back to the relevant section.

9.3 Why a person may or may not formulate their experience of suffering into a mental health problem?

Access to mental health care through primary care level services could be affected depending on how a Muslim person may, or may not, envisage their experience of suffering as representing a mental health difficulty. Where a person does not view their pain as mental health related, there is no basis for candidacy to be *assumed* since there are barriers to a person recognising that their difficulties may require professional or medical attention. This section is further discussed in the next chapter, on page 366.

A number of concepts emerging from the data that might explain this as described below.

9.3.1 Muslim philosophy of life, pain & suffering

9.3.1.1 Difficulty as part of a test

As indicated, the majority of participants tended to conceptualise their pain and suffering as a test from God; this concept is discussed in detail on page 145.

9.3.1.2 Spiritual growth and wisdom

In addition to this idea of life as a test, participants discussed a number of other reasons behind pain and suffering and their mental illness. A Muslim may assume one's experience of mental health as being part of spiritual growth and wisdom, discussed on page 160.

9.3.2 Understanding of mental health and illness among participants

The topic guide contained questions exploring mental health and illness. Only a small number of the participants were able to understand the meaning of this term. For example, this participant equated mental illness to an illness affecting the mind:

"Mental breakdown in the brain, there are times some nerves have gone you are normal but there are times when you subside, brain does not function, there is some illness there" (P6, Female Malaysian).

In one interview, despite translating the words in Urdu, one of the participants responded saying mental illness (zehni bemari) was the same as mental health (dimaghi sehat) and associated the word with madness (pagal in Urdu). She found it challenging to rationalise why she was facing adversity:

"This is same as dimaghi sehat. Pagal, u know. I do not know but people want to stay away from these people. They stay home. You find them. Maybe they are pagal...I don't understand myself...I don't understand why it happens, everything is fine, taking medicine but the pain is not going away" (P3, Female Pakistani).

This was similar to another participant who perceived mental illness was the same as mental health. These questions were asked directly to her. She reported mental illness was a life-long experience and made people 'different' to others.

"This is same as mental health I mean. Mental illness that is something that is not going to go, it is going to stay with you until you die. It is not going to go away, you are not going to be, like you

know I could say "I wish I could be like her", you are not going to be like her you are you and she is another person. Because that is always going to bug you in your head" (P5, Female Indian).

A different way of understanding their experiences could affect a person recognising their difficulties as mental health related and hinder accessing mental health help.

9.3.3 Understanding of 'mental health' and 'mental illness' among scholars

Chapter 6 detailed how mental health and mental illness is conceptualised from a scholars perspective. There was a varied level of understanding towards these concepts. This is important to consider as the findings have shown (on page 160) that people access scholars for mental health advice and support. Where a scholar lacks an understanding of mental illness, this may hinder a person recognising their difficulties as mental health related.

9.3.3.1 Another dimension: spiritual health

As presented on page 183, a Muslim might see their difficulties as part of a struggle with their nafs or diseases of the heart. Furthermore, the person could also find the balance of living in this world against preparing for the after-life challenging. This area can be conceptualised as a spiritual dimension of health.

When faced with pain and distress, a Muslim might see their experience through this prism of spiritual health rather than mental illness itself. One cannot ignore the possibility it could be both. It could be from a person's perspective, they do not necessarily require to access formal professional help but spiritual support.

9.3.3.2 A different model of mental health

Chapter 7 (on page 184) points to a Muslim perceptual framework relating to causes of mental health difficulties, which differs from other faith groups and professionals. This was described under ‘other realities’, encapsulating causes which were non-natural and external to the person. The data reported the idea of Jinn, sihr and nazr. The beliefs around Satan was also explored (page 204).

For those participants who have mental illness, holding different perceptions towards their mental illness could affect their level of awareness and hinder accessing formal professional help where required. There has to be the consideration that a person could suffer from a mental illness and simultaneously experience the effects of other realities such as Satan. They also could be experiencing psychological difficulties as a result of these other realities.

9.3.3.3 Punishment from God and being a weak Muslim

The analysis in chapter 7, (page 208), highlighted some of the participant’s perception of mental illness was linked as punishment from God or weakness in faith. People might construct their distress within a framework of what professionals view as ‘illness’. This could act as a potential barrier.

It is important to understand such issues in the broader Muslim community. Muslims from the general public might judge individuals to be weak Muslims or receiving God’s punishment. This form of prejudice may result or contribute to those individuals feeling isolated and deter them from coming forward to seek medical intervention.

9.3.4 Expressions of emotional distress

The analysis of the findings showed there were individual concepts mentioned in the Qur'an and Hadith which appear to primarily reflect expressions of emotional distress and mental health difficulties rather than as medical categories or medical diagnosis as understood by psychiatrists. In contrast to the spiritual aspects of health discussed on page 209, scholars were less familiar with concepts. This area has been explored on page 208.

It appears from the data that these expressions were not classified as a category or overarching area. People may not necessarily accept this as a hinder to accepting professional help as they have a different way of expressing their distress and make the decision to seek help through religious means and a religious figure.

In summary, the data suggested that Muslims may not formulate their problems as mental health difficulties due to utilising a different conceptual framework. Furthermore, they apply a specific outlook on life, engrained in spiritual tradition to explain their difficulties. The perception of some participants related mental illness to the concept of punishment and being a weak Muslim.

9.4 What may prevent, or facilitate, the demand for health services even if symptoms are formulated as a mental health problem?

The second stage described by Kovandzic et al (2011) is whereby a person might not access services even when their difficulties are formulated as being related to mental health.

9.4.1 Understanding of Islamic concepts

An apparent difference in understanding of specific Islamic concepts emerged which might be considered as facilitators or barriers to care depending on participants and advice taken from scholars.

The concepts qadar (predestination), tawakkul (reliance in God) and sabr (patience) have already been discussed from a participant and scholarly perspective (see page 153, 304). 'Help' is here understood as encompassing wider support, either from family or friends, local religious figures and not just professional help.

Based on the interviews with scholars, the Islamic concepts of 'qadar', 'tawakkul' and 'sabr' of should not be an impediment to the individual seeking care through mental health services and primary care. However, it seemed to be the understanding and interpretation of such concepts by lay people which could deter a Muslim coming forward to seek help rather than being a facilitator to treatment.

9.4.2 Cultural factors: Izzat (honour/respect) and shame

A number of cultural factors emerged from the study; namely Izzat (family honour)³⁹ and shame. These do not have a direct connection with the Islamic faith, however, affects individuals from the Muslim community- particularly women. Muslims may decide to lead their lives according to their faith but this may be in conjunction with their own understanding of other factors, such as cultural issues which are important. Even though the primary area of this study is from a religious perspective, certain cultural factors affected individuals to a degree that affects their behaviour and attitudes cannot be ignored.

The preservation of izzat (family honour) was indicated to be relevant. For example, the feeling of shame, fuelled by community gossip not only applied to the individual but also the family, which stopped an individual from speaking with others:

“what do we have then without this? Izzat is very important, this is our culture. Everything we do, get married, moved here, working is connected to izzat...our family are important. Shame is worse than a black dot. You do not then feel like speaking with anyone” (P3, Female Pakistani).

Shame or beizzati in Urdu was experienced by some of the participants. One participant suggested that he would rather stay in the four walls of their house than leave and mix with others. Another stated that the fear of shame stopped him asking for help. Isolation was preferred as a way of avoiding the shame of mental illness:

³⁹ Izzat is a term too simplistically to be understood under one meaning but is primarily used to signify family honour in the South Asian community (Gilbert et al, 2004).

“this is big thing and stop you from going to ask for help. Also, not speak about your problem...Sometime worry about gossip and sometimes stay in house” (P9, Male Bangladeshi).

“It is very difficult and beizzati [shame], to make company with people, so I stayed by myself mostly. So worry for this” (P1, Female Pakistani).

Shame may also be projected onto family:

“I feel ashamed myself as I could not do work, find a job, this is shame and my neighbours friends are working, so what are they saying about me...I would never talk about this as this is shame like on my family, my wife. What are they going to say outside? So this is like best not to speak about this” (P9, Male Bangladeshi).

Family honour and shame was primarily discussed by participants of South Asian background. This was also experienced by smaller number of Muslim participants from other ethnic groups:

“If I go to the Mosque I will never tell them that I am suffering from depression and taking medication...honour, of course it will affect me” (P2, Female Tunisian).

“there is this (shame) problem. I would not say to everybody that I have a mental health problem” (P4, Male Somalia).

Izzat was suggested by the majority of participants to be part of their cultural background:

“Izzat is very important, this is our culture” (P3, Female Pakistani).

One participant however, placed emphasis that izzat in her life was part of her religion:

“this is our religion, our izzat, our family izzat” (P1, Female Pakistani).

One of the scholars stated that the concept of shame and honour appeared to be influenced by family and cultural factors rather than being guided by Islamic principles:

“that suffering from any problem, mental health, physical brings no shame and people have no right to judge and this izzat, this is common in Asians, Pakistanis...people are worried about family honour but in Islam, religion the well-being, health of someone is precious, a gift from Allah swt, the people are thinking about their family, their culture, things they think are right but infact this is not Islamic” (Scholar 4).

These issues seem important and cannot be dismissed as they could hinder people from accessing help:

“There are people with bipolar and all kinds of disorders in the community and they are not getting help because of the shame it would bring on their family, worried about their family honour”

(Scholar 4).

9.4.3 **Stigma**

These cultural factors play an important part in maintaining the stigma of mental illness. Stigma however is not exclusive to people of the Muslim faith and common to all who have contact with mental health services. It can be argued that people belonging to the underserved and marginalised communities have a number of factors which affect stigma in multiple ways (Kovandzic et al, 2011). Some of the issues have been highlighted here. Cultural issues such as honour and shame

exacerbate stigma in the Muslim community. The findings here are extended in the discussion chapter, on page 370.

This participant brought up the idea of shame and then was asked stigmatising attitudes

“if there are any of my friends who are silently suffering I want them to know that don't be ashamed lets talk about it and get the help...I think it is at the whole wider society's view that, especially depression, is seen as you are weak, you are not able to handle what life has thrown at you so you are weak...that worries me. If I am introduced to somebody I don't introduce myself as “Hi I am(name mentioned) I have mental health problems” I don't think I ever would because I think people especially a woman they see her as you know she is not going to be a strong partner, she is not going to be a strong daughter-in-law, she is not going to be a good mother to the children”

(P10, Female Pakistani).

She was worried about identifying herself with mental health problems due to the potential label being given to her. She reported what may be understood as perceived stigma when applying for future job opportunities or affecting her marriage prospects:

“Because I don't want it on my medical record, because I thought if it was on my medical record and my employer ever asked to see my medical record, or in the future if I ever wanted to adopt”.

Actual stigma was experienced here where this participant felt she was treated differently:

“I do feel cut off, isolated from the other ladies. I go to the Mosque sometimes and see the way they treat me and talk about me” (P6, Female Malaysian).

As outlined in the previous chapter, on page 304, this participant described the views of others who held people with mental illness were 'pagal' (mad or fool in urdu) and then internalised this:

"I feel in situation, where I think this or that, and I feel pagal. I did not want to feel this" (P5, Female Indian).

This scholar reinforces the stigma evident in the community:

"They don't understand, mental health is almost like er, somebody can be almost perfectly normal, work have a family but they have a mental problem and that word 'mental problem' is a bit strong. So the stigma is still there. I would never use the word 'mental', 'mental problem', people from mosque, Imams, local people misunderstand and say this and that about others, say they are mad and not right in head, don't fit in" (Scholar 7).

A small number of participants from minority cultural groups also described being treated differently and judged by the majority cultural group in the UK (Pakistani). It is difficult to draw on why this may be but might be related to the manner relationships are formed across cultural groups and whether there might be discriminatory behaviour across communities from within the same faith group:

"I don't know they laugh like that, talk behind me, see me strangely...other Pakistanis...I think, they think they maybe look at me in different way and don't don't understand me, think different" (P4, Male Somalia).

9.4.4 **Alternative pathways of support**

There was also use of informal support mechanisms and lay advice in addition to formal support.

This has been discussed in the previous chapter on page 276.

Participants accessed the mosque for help and contact from scholars and imams. There was no need for referrals. This relates to permeability which will be discussed later on page 411.

Belonging to the Muslim faith also gave access to scholars and imams where they confided and sought advice as part of the help seeking process. The analysis showed some of the participants accessed friends and family and religious figures before approaching health professionals.

However, what is challenging is the negative experiences described overall (discussed on page 236) with Imams and negative experiences in the mosque.

A Muslim who formulates their difficulties as mental health might still not access professional help. This does not mean this is unfavourable as they might choose another form of help.

9.5 **What may prevent or facilitate a contact with a health professional once an initial act of help-seeking is performed?**

When an individual recognises they are a candidate to use mental health services, their route to accessing specialist service is influenced by their knowledge of what services are available and where it is provided. This stage is similar to the route to entry into mental health service termed as navigation by Dixon-Woods et al (2005). Four areas were identified in this stage, relating to gender preference, haya, purdah and media perception.

Gender preference was suggested by some of the participants. This can be found in other cultures: *“when I go out. I worked with [female names mentioned]. These three people so I prefer to go out with a lady. People are understandable, I think they understand modesty because they usually ask and tell me it is up to you...for me as I told you just going out I feel comfortable to go with a lady, but at home, since they, Dr (name) are just going to ask me questions only about medication, I don't see it is very big deal and they don't usually stay long so okay, don't feel uncomfortable. With (female name mentioned) I can speak more personal things and open about anything”* (P2, Female Tunisian).

The focus on medication could adversely affect this person's future experience with services. This participant also had female mental health workers come to her house. She preferred to be supported by them when going outdoors and could openly discuss more personal issues with females.

Gender preference does not necessarily equate to preference to see same gender professional. This female participant, when asked about seeing her psychiatrist who was male, responded: *“I was not bothered”* (P3, Female Pakistani).

Purdah is the appropriate covering in front of opposite gender. It can also refer to segregation of the genders, a curtain or partition between them. The concept of purdah is found in South Asian cultures. Another concept emerged from the data was 'haya', an Islamic concept which means modesty or shyness. This participant was questioned about it from the topic guide:

“I am just personal I would prefer a female, haya [modesty] should be there where I can be personal and comfortable...the purdah is quite important, where we are relate, interact male female and modesty there” (P10, Female Pakistani).

Another area seemed to be related to be media perception of Muslims being called ‘radicals’ highlighted by one of the participants. This may be fuelled by media coverage and misperceptions which appeared to cause some reluctance to discuss issues openly or contact with health professionals. It could also create a sense of not being confident to discuss relevant areas of their faith:

“Worried about all of this stuff, staff may think of radicals, watching news, all muslims are radicals...scared sometime to speak some stuff to them” (P7, Male Caucasian).

These areas may facilitate or hinder contact with professionals.

9.6 What may prevent or facilitate a prescription/allocation and uptake of mental-health -supportive intervention once the relevant professional is reached?

No themes specific to Islam emerged under this section from participants. Cultural factors however played an important part for a small number of participants once they had reached a professional. For example, family were sometimes involved in decision making and were not necessarily in favour of complying with accepting medication as they believed would not be beneficial:

“Family also say no help from medication” (P11, Male Indian).

One area of relevance emerged from one scholar, was the use of medication that may contain products that may not acceptable to Muslims such as capsule coating containing non-halal ingredients:

“well this needs to be looked at, the use of other ingredients, pork, things not halal and looking options, are there other options, the capsule coating and needs to ask about the tablets, does the person seeing you need to take the tablet? What the doctors saying, why?” (Scholar 15).

He suggested when making the decision in taking medication, to consider alternatives and necessity in taking the medication.

9.7 What may prevent or facilitate positive outcomes and user's satisfaction with care even if a mental-health-supportive intervention is allocated and accepted?

Kovandzic et al (2011) suggested that this stage of 'making it work' includes considering treatment that is considered holistic, not from just from a professional viewpoint but also the patients perspective. Some of the participants felt their faith mattered but professionals did not fully explore these religious factors that may impact on their mental illness:

“I would not have minded them asking me questions to say that “Oh you are talking about your wider responsibility where does that come from, help us understand” but they didn't I don't know if they felt that it was not right for them to be asking questions about my religious or cultural belief” (P10, Female Pakistani).

Even when an individual had accessed mental health services, the understanding of Islamic concepts relating to mental health appeared to be important to individuals. This could lead to some not discussing aspects of their faith with them:

“My care-coordinator does not understand this, I don't even discuss this with him. I do not discuss heaven and hell with him. I just speak generally with him and my medication” (P11, Male Indian).

“I don't think they were able to understand my problems, they don't understand” (P3, Female Pakistani).

Where there might be a clash between therapy and Islamic values, this could negatively impact on the level of satisfaction. This was described by this participant who described the conflict she experienced during her counselling session and her religious values:

“I think what difficulty I have is when I saw the Counsellor in the past...they have no understanding of my religion and religious obligations...their attitude would be very much turn your back on people, its all about you...Like an attitude, because they don't understand they are not helpful in looking at solutions...a lot of the solutions they were talking about were not solutions for me.... little awareness about Islamic values” (P10, Female Pakistani).

This relates to the concept ‘recursivity’ discussed earlier on page 277, where past experience affects future decisions and access to care.

9.8 Summary of factors relevant to accessing mental health care

It seems relevant that the analysis comparing both participants and scholars data, brought out pertinent areas relating primarily to stage 1 and 2. The factors were commonly discussed and could be seen as either facilitators or hindrances. For the same individual, depending on their level of understanding and perceptions held, a particular factor may change between being a facilitator to hindrance (or vice versa). There were fewer factors described in stages 3-5, which seemed to be related more towards barriers to care.

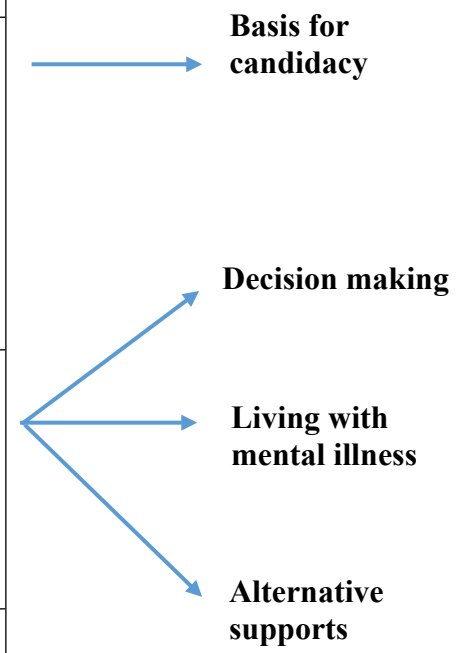
Furthermore, the analysis showed a specific factor could be a hindrance for one individual and not be a barrier for another. There were variations within the participants group and between participants and scholars. These have been presented in the relevant sections.

The summary of the factors that have emerged from data will be presented in following table 11. Also, the implication of these findings will be described and this examined further in the discussion chapter.

Table 11: Barriers and facilitators to accessing mental health care

Main implication of findings

Research sub-question (adapted from Kovandzic et al, 2011)	Findings: Barriers and facilitators to accessing help
1) Why a person may or may not formulate her/his experience of suffering into a mental health problem?	<ul style="list-style-type: none"> ➤ Muslim philosophy of life, pain & suffering ➤ How mental illness is understood among participants ➤ Understanding of ‘mental health’ and ‘mental illness’ among scholars ➤ Another dimension: Spiritual health ➤ A different model of mental health ➤ Expressions of emotional distress ➤ Punishment from God ➤ Weak Muslim
2) What may prevent or facilitate placement of demand to health services even if problem is formulated as related to mental health?	<ul style="list-style-type: none"> ➤ Understanding of Islamic concepts ➤ Cultural factors: Izzat (honour/respect) and shame ➤ Stigma ➤ Alternative pathways of support <ul style="list-style-type: none"> Family and friends Contact with mosque and support from religious figures
3) What may prevent or facilitate a contact with a health professional once an initial act of help-seeking is performed?	<ul style="list-style-type: none"> ➤ Gender preference ➤ Haya and purdah (modesty, shyness) ➤ Media perception
4) What may prevent or facilitate a prescription/allocation and uptake of mental-health -supportive intervention once the relevant professional is reached?	<ul style="list-style-type: none"> ➤ Views of family ➤ Medication containing non-halal ingredients
5) What may prevent or facilitate positive outcomes and user's satisfaction even if a mental-health -supportive intervention is allocated and accepted?	<ul style="list-style-type: none"> ➤ Lack of exploration and understanding of Islam



9.9 Summary

This chapter identifies barriers and facilitators to pathways to care. It describes specific issues relating to how the Muslim community may access mental health care and treatment. Several factors emerged that might influence the pathway but there were two important stages: firstly, where a Muslim may not formulate their suffering as a mental health difficulty. This might be related to Muslims holding a different model of mental health or another dimension amongst other reasons described. There is no basis for candidacy to be identified. Chapter 7 provides a deeper description of this area. The discussion chapter discusses this further (on page 406).

Secondly even if the problem was viewed as a mental health problem, an individual's understanding of Islamic concepts affects a person's decision to access care. Living with mental illness brought with it the impact of stigma and the role of cultural factors. Chapter 6 and 8 outline these areas. Alternative support such as the mosque, community and access to scholars has been presented on page 276. The involvement and influence of scholars cannot be ignored as it appears they play a significant role in a person suffering from mental illness. Scholars however had little understanding in mental health.

The most salient findings have implications which are covered under the four areas (basis for candidacy, decision making, alternative support and living with mental illness). These will be explored in the discussion chapter.

It seemed to be important to understand the nuances based on contextual factors. The understanding of Islamic concepts might differ between scholars and participants. Furthermore, other factors might influence a person's interpretation of the Islamic concepts.

It is important to consider each factor could be a facilitator for some people and barriers to others. This depends on the perspective a person takes which may differ from a scholarly stance. Another layer to consider is the pathway simply highlights access to care. This does not signify that a person who recognises their difficulties as another explanation needs a medical diagnosis. Also, a person who does conceptualise their experiences as mental health might still not access health services and this does not necessarily mean this is unfavourable as the individual might choose another form of seeking help rather than professional help. These are issues to be considered with the individual.

The chapters 6-9 have detailed the findings of the study. These will be developed further in the discussion chapter.

10 Chapter 10 - Discussion

10.1 Introduction

This section now moves on to consider and summarise the key findings from the research, in the light of both the original objectives and the literature review. By way of introduction to the discussion, the main themes and sub-themes will be outlined in diagram form. In setting out these findings some of the *key Islamic concepts* that emerged will be explained further in the context of Islamic literature and scripture where the existing literature is scarce. The discussion will also include a consideration of the strengths and weaknesses of the research; specifically addressing reflexive issues such as the role of the researcher in data generation and analysis. Finally, recommendations for clinical practice, policy and future research are offered.

Objectives in relation to summary of findings and literature

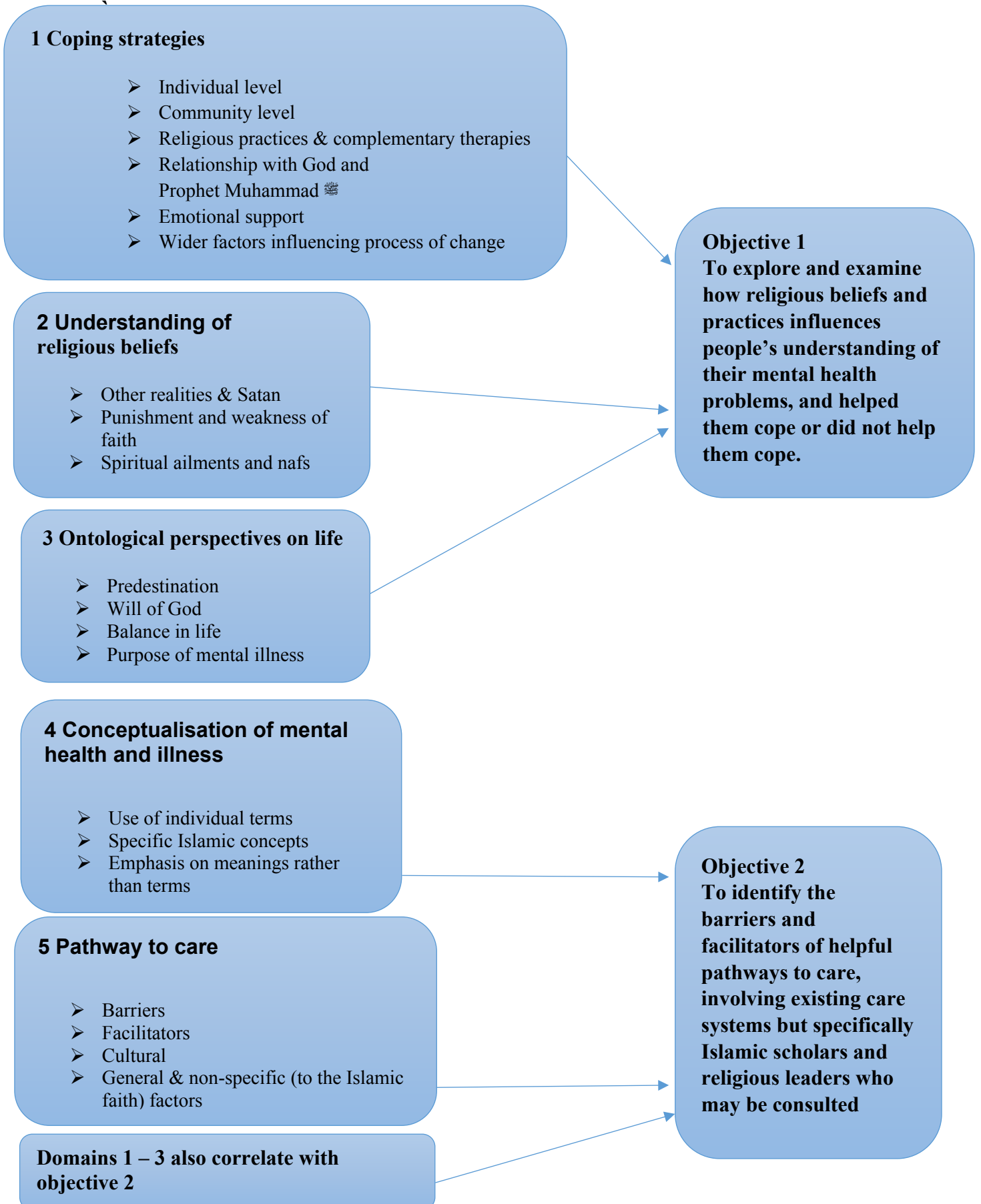
The findings are summarised under each of the study objectives as outlined in diagram 12. Each theme is examined in relation to the existing literature, highlighting what is already known in the subject area and drawing out similarities or distinctions with these study findings, exploring the gaps in the literature and what this research adds. The conflicting and similarities between views of patients and scholars are explored throughout the discussion.

Diagram 12 details the themes correlating with objective 1 which also have implications for objective 2, on pathway of care. In discussing the second objective, there is

description of the literature on pathways to care followed by highlighting the relevant stages of the Kovandzic et al., (2011) model in relation to barriers and facilitators.

Where the theme has previously been discussed, reference will be made back to the relevant section. The last area discussed under objective 2 is connecting pathways of care with explanatory models. This is done to deepen the discussion and indicate how the findings can be organised under an explanatory model framework.

Diagram 12: Objectives in relation to themes/sub-themes outlined in the findings



10.2 Objective 1

The first objective of this study was to explore and examine how religious beliefs and practices influence people’s understandings of their mental health problems, and helped them cope or did not help them cope.

This study set out to examine the interface between aspects of the Islamic faith in relation to mental health and well-being that were pertinent to Muslims suffering from illness. The work also sought out to explore views from Muslim traditional scholars who were engaged with Muslims who experienced pain and suffering and mental health problems. Overall, the salient concepts and themes were grouped under four key areas summarised as follows: the Muslim outlook on life and their understanding of pain and suffering, conceptualisation of well-being, mental health and illness in the Islamic tradition, perceptions towards causes of mental health difficulties and illness and coping strategies.

10.2.1 Muslim outlook on life

Marinoff (2013) considered that at various stages in life- human beings go through different experiences and emotions with specific questions arising around the purpose and meaning of life. Sometimes, the process involves making sense of events that have already happened; are happening and which are likely to occur in the future. This process of inquiry and seeking wisdom is the philosophical approach to life. A part of this philosophy is *theodicy*, which is appreciating why “*God's power and goodness are compatible with the fact of suffering*” (Green, 1987, p431).

There are however many contrasting opinions to the Islamic ontological perspective such as that proposed by Aristippus, the founder of the Hedonism school of Philosophy, one of the followers of Socrates. He believed in pleasure as the core of life, where people should not think about future rewards or pleasures and focus on immediate gratification (Laërtius, 1853; cited by Gordon, 1997).

In relation to the Muslim outlook on life, four main themes emerged from the data: *the idea that everything is predestined, Will of God, the concept of balance in life, and the purpose of mental illness*. The findings here allow a greater understanding of the centrality of these four concepts in Muslim life. The study identified a simple, but meaningful, finding that each of the concepts could not be understood on their own, but were intertwined with each other.

It is difficult to compare findings with existing medical literature in respect to some of these themes as according to the author, traditional scholars views have not been examined in relation to outlook on life, pain and suffering.

10.2.1.1 Predestination

The first concept described in the findings was *predestination*, the fundamental belief that everything in life is predetermined. This has been extensively mentioned in the literature (Hussain, 2006; Ypinazar & Margolis, 2006; Zafar et al, 2008; Hussain and Cochrane, 2003) however most studies did not include views of people who suffered from mental illness or no details of mental disorder was described. As outlined on page 59, in the Hussain (2006) study, the participants included 33 older Muslim Pakistanis in

England but did not detail if participants suffered from mental disorder or accessed mental health services. This study confirms the significance of destiny described in literature where participants have suffered from mental illness. Hussain and Cochrane (2003) included 10 Asian women who suffered from depression, described the significance of belief in 'kismet' (urdu for destiny) where people passively accepted their depression as part of their destiny and waited for God's help.

Muslims believe that God brought into existence the whole of creation and that everything that will happen, be it in this world or the hereafter, is already known to God. The following verse from the Qur'an highlights the belief of qadar (predestination), God's knowledge of everything before its creation:

"Verily, We have created all things with qadar" (Qur'an 54:49).

This study reported contrasting views among participants on whether predestination could be changed, or whether it was fixed. This is contrast to one study, where all ten participants reported illness as a predetermined fate that could not be altered (Ypinazar & Margolis, 2006). Distress was understood as fixed and furthermore, to take measures to control it was viewed as sinful, that could lead to further distress or punishment (Hussain, 2006). This could be related to participants developing a feeling they are going against God's decree if they attempt to take steps to change. Similar findings were replicated in the current study. There is a lack of development of understanding the central relevance of this concept for Muslims in the literature and how it might affect help seeking for mental health problems. This study detailed how the views of

participants was either associated with seeking help or taking a more passive stance and accepting their illness as a final fate.

From a scholarly perspective, the idea of predestination emerged as a more complex and nuanced concept than the other ideas related to the Muslim outlook on life. This has not been uncovered in the medical literature. The different layers to the concept related to freedom of choice, capacity to change one's destiny and practical effort required in this. An individual can take decisions freely. Furthermore, a person has the ability to change his destiny by carrying out actions such as praying, reforming one's character and seeking medical intervention or treatment. It is indicated that attaining a detailed understanding of predestination was not possible. The value in comparing the data with participants reported that not all participants shared the same understanding of this concept.

Another level of understanding is gained from the author reading the Islamic literature, that God's decree is described as either absolute (destiny that cannot change) or conditional, dependent on what a person does (Mohammed, 2017c). Scholars recruited in the study have discussed these points.

How does this fit with the notion that an individual's destiny is influenced by the choices made in life and actions? This is explained by knowing that most of what is recorded by God is the conditional decree rather than absolute decree. The individual's actions are therefore dependent on his circumstances and choice they make rather than it

being imposed upon them. The scholars in Islam have further explained the divine knowledge of God as descriptive rather than determinative. This means that even though God is already aware, a human being is still able to exercise his free will and make choices, as God's knowledge does not influence an individual's decisions and actions he takes. This is the majority view of scholars in Islam. There have been sects that have emerged in Muslim history holding opposing views on this issue of predestination (Mohammed, 2017c), namely the libertarians or dualists (the Qadariyah) including the Mu'tazilah group who believed that they were completely free to make choices and act without any aspect of predestination. They refused to acknowledge God's Power and Will had any influence on their decisions and actions. The other side of the spectrum was the fatalists (the Jabariyah) who were of the view that a person's destiny could not be changed and any actions were of no bearing. They correlated it to "*a feather blowing in the wind*" (p119, Mohammed, 2017c).

The discussion on this theme can be further extended by the distinction, drawn from Islamic literature on contentment, between the decree of God and what has been decreed (Mohammed, 2017d). Contentment with God's decree is considered an obligation whereas this does not extend to being content with the thing that has been decreed. In practical terms, a person with mental illness may accept their pain and suffering as part of God's decree and a test but this does not mean the person should accept their pain and suffering as an unchangeable condition. If this distinction is blurred, then this could provide another explanation why people may not seek help or the way they react to difficult circumstances.

Predestination is argued to be a complex concept to grasp and cannot be fully understood (Maghnisawi, 2007). At an elementary level, one has to appreciate the idea may be difficult for some to conceptualise.

Theories regarding locus of control have significance in considering this theme of predestination and also of God's Will (the next theme discussed). An internal locus of control is defined where a person perceives that their behaviour will determine the outcome and the external locus is defined where others will have impact on outcome. External locus of control has been linked with positive outcomes in people with depression (Roy-Byrne et al., 1992). A perceived sense of control has an influence on how individuals cope or do not cope with mental illness. Loss of control could signify sense of powerlessness (Compas et al., 1991). Feelings of powerlessness were reflected in the data where participants felt they could not change their destiny and could occur where a person feels they do not have free-will. Skinner (1995) argues reactions may be negative and maladaptive in situations which are deemed uncontrollable (for example chronic illness), leading to frustration. The findings here indicated that from a Muslim perspective, a person has both an element of internal control, within a certain boundary but overall accepts that God is the external locus of control. These were not seen as incompatible from a Muslim perspective.

10.2.1.2 Will of God

The description of God's Will exists in previous studies (Al-Krenawi, 1999; Zafar et al, 2008). This belief provided a sense of comfort for participants of the Muslim faith that their suffering was not meaningless and could be related to a spiritual reason (Cinnirella & Loewenthal, 1999). Participants from the Al-Krenawi study were recruited from a psychiatric clinic where almost one third of the study believed God's Will caused their mental health symptoms. In this study, participants rarely discussed this theme. The findings built this theme with a scholarly perspective, extending the understanding of God's Will. The theme was linked with predestination, encapsulated the idea that recovery (shifa) comes from God and other avenues such as medication/role of doctor are intermediaries and lastly, clarification provided that this does not clash with a person's own will. The distinction between God's Will and predestination has been discussed on page 169.

This concept is seen here in the Qur'an:

"Allah blots out what He wills, or He establishes (what He wills)" (Qur'an 13:39).

In order to gain clarity on whether there is a clash between God's Will and a person's own will, one has to refer to the Islamic literature. This is clarified by being aware there are two types of Will (Maghnisawi, 2007). The first one is the 'creative decreeing Will'. This relates to God's creation, by which God has created creation and His decree on a person's life and death. The second type is the 'legislative Will', which is linked to His love and approval. God wills something and lets the person decide, so the will is

conditional on being accepted or left by the person. This will be like a guidance or discretion for the person to either take it or leave it.

10.2.1.3 The concept of balance

The review of the existing literature did not place emphasis on the importance of beliefs concerning *spiritual and natural balance*. This study highlighted the relevance of the concept of ‘fitrah’, the natural balance where a Muslim becomes close to God through good actions. Fitrah has been similarly described in the literature, where a person is regarded as intrinsically good and seeking a tendency towards God (Keshavarzi & Haque, 2013; Haque, 2004) but no evidence of systematic research or appropriate research methodology applied in these studies.

Capturing a patient’s world-view and how this encapsulates their illness understanding, enables greater insight in terms of meaning attached to their illness and recovery (Bhui & Bhugra, 2002).

This can relate to this sub-theme of balance in this world and life as a test. Spiritual balance was described where a Muslim viewed their worldly life as short, temporary and a gateway to eternal life. These findings explained why a Muslim might place importance in discussing their health, their outlook on life, and both ponder on their journey in this life and look forward to another life.

10.2.1.4 Purpose of mental illness

The last concept that emerged on the topic of ‘outlook on life’ encapsulated the

understanding of the *purpose of mental illness* from a spiritual perspective. An Islamic outlook on life could be categorised as (1) life was a test, (2) suffering was an opportunity for spiritual growth and (3) suffering was connected to spiritual wisdom. This connects to the wider purpose of life, as presented on page 147.

In common with previous studies (Abu-Ras, 2008; Weatherhead & Daiches, 2010; Hussain, 2006), it was apparent that ‘life as a test’ was a commonly held Muslim belief. Mental health problems were seen as God’s test, and to be patient (*sabr*) would result in God’s favour and reward (Hussain, 2006).

In this study, as presented on page 156, the findings showed more detail, bringing out the significance of how this concept is understood. The centrality of this concept, ‘Divine trial’ provided an understanding why participants discussed this frequently during their experience of mental illness.

In addition to ‘Divine trial’, the other key ideas connected with *purpose of mental illness* were ‘spiritual growth’ and ‘spiritual wisdom’. These areas, examined on page 159, have not previously been discussed in literature focused on mental health and illness where systematic research has been conducted.

The findings indicate that religious counsel should be tailored to the person. There is the acknowledgement that not everyone will experience the same views about spiritual growth and wisdom as the scholars. It requires on part of the scholar, an element of

judgement, not a simple one, to make on a person's level of insight. There is also a power discrepancy between the scholar, the expert who has Islamic knowledge and the patient, who is ill and discloses their symptoms. This relationship between the scholar and the individual is a complex one and the power imbalance cannot necessarily be eliminated. It is a situation where the scholar needs to engage the individual and build a trusting relationship; also provides advice and support in an empathic manner and considers options where applicable with the individual.

Parallels can be drawn with the doctor-patient relationship where there is a power imbalance (Lysaught et al. 2012). Doctors talk about what normal judgement is with their patients, where the doctor makes a claim on their formed opinion. Patients may also be categorised according to the professional interest of the clinicians (Hillman et al., 2013). Moral evaluations are made, where staff members draw on their experiences of social life, characterising them to facilitate judgments being made regarding patients (Roth, 1972).

Sabry & Vohra (2013) argue the role of Islam is to prevent psychiatric disorders. However, the findings from this study did not concur with this. There might be situations where difficulties can be prevented through gaining strength from faith but overall, Islam was not necessarily understood to be about preventing mental illness. Contrasting views, albeit in the minority, emerged from this study. Islam was perceived as a prism through which those suffering from mental health problems might understand their difficulties.

Another discussion to consider relates to the idea of 'resilience'. While there is no consensual opinion on the definition and facets of resilience (Luthar et al. 2000), one preferred definition is "*an outcome of successful adaptation to adversity*" (p42, Zautra et al. 2008). The findings showed elements of perseverance and adapting in the face of suffering. This supports the idea of developing a 'spiritual bank' for the person, where they generate and grow a capacity of positive emotions and thoughts and transformational factors, rooted in Islamic principles and conventional strategies. This confers resilience, understood through concepts such as sabr, himma and the Divine trials and tribulations (outlined on page 156, 267, 328). Parallels can be drawn to the work by Cornwell (1984) and Rutter (1985) on facing challenges in face of adversity and inequalities.

Another possible way this could be understood is through the development of capacity through spiritual intelligence (Emmons, 2000) though this is a contested concept (Gardner, 1999; Mayer, 2000).

The areas relating to the Divine trials and tribulation, spiritual growth and spiritual wisdom help towards understanding theodicy from a Muslim perspective, why God allows suffering to occur. This is the idea of maturing the body and soul to a point of spiritual fruition, through episodes of tests.

In summary, the findings showed relevant concepts in relation to outlook on life encapsulated four main areas: predestination, purpose of mental illness, balance and

Will of God. There were variations in understanding and level of awareness between participants and between participants and scholars. It is pertinent these nuances are considered.

10.2.1.5 Nature of man

The data covered a number of dimensions to this area. A key concept related to the use of the word 'insan'. This could mean forgetful, affection or perceiving things through interaction. The nature of man connects with God, where the soul yearns for presence of God and developing a greater meaning of life. Man is also created with a lack of fulfilment in this world from an Islamic perspective.

10.2.2 **Conceptualisation of well-being, emotional and mental health in the Islamic tradition**

A Muslim outlook on life is closely linked with this theme. There were three areas identified from the findings: *use of terminologies, use of specific Islamic concepts* and *emphasis on meanings rather than terminologies in Islamic tradition*. These have been outlined on page 188.

10.2.2.1 Use of terms

The terms 'well-being' and 'health' have been well recognised in Islamic history and described by scholars. This is in contrast to the terms 'mental health' and 'mental illness'.

The concept of 'afiyah' (well-being) encompasses a number of facets from an Islamic perspective, including social, physical and psychological aspects and not merely the spiritual side of the individual. This can be understood using the description by Al-Jibaly (2003), who suggest that 'afiyah' covers security and protection for the individual and both worldly matters and religious affairs.

Although scholars discussed at length the concept of well-being, a study conducted by Dodge et al (2012) confirms that there is no agreed consensus for the meaning of 'well-being'. It can however be broadly measured in four ways- domains of life satisfaction (Diener et al, 1999, Bradburn, 1969), self-appraisal (Ryan et al, 1999), mental illness and physical health.

Health has also been described by scholars in a number of ways. It was explained as a blessing and gift from God. This has previously been discussed on page 175.

The findings highlighted scholars have a limited awareness and understanding of the terms 'mental health' and 'mental illness' in contrast to the concepts of 'health' and 'well-being'.

A study conducted by Hussain (2006), found the term 'mental health' as problematic and similarly viewed as a western concept by Muslims of Pakistani origin.

The interface between Islam and mental illness in relation to terms and concepts may give rise to areas of agreement or disagreement when compared with other models.

According to Fernando (2002), understanding terminologies and concepts in regard to health and illness is of paramount importance as it varies across cultures.

10.2.2.2 Use of specific Islamic concepts

New areas have been described in respect to this sub-theme. The findings indicated that individual concepts alluding to emotional and mental health difficulties are conceptualised in a distinct manner that does not fit with the traditional western medical model.

The findings point to a number of terms which could be categorised into three groups:

(1) spiritual dimension of health, (2) sadness or emotional distress, (3) terms suggestive of more severe symptoms. There is evidence of use of diagnosis in Muslim culture.

With respect to these three groups, the findings showed scholars had a good awareness of the spiritual dimension of health in contrast to the other groups where only a small number were familiar. This could be explained by the fact that the area of mental health is a specialist area that not studied by scholars and there is lack of understanding and experience among Muslim scholars. There were no overarching term used for emotional health in the past despite individuals expressions being used in the Qur'an and Hadith.

These have been outlined in the earlier chapters on pages 188.

10.2.2.3 Emphasis on meanings rather than terminologies in Islamic tradition.

In respect to understanding mental health concepts in Islam, the final area identified was that the scholars described the idea that there was less reliance on terminologies relating to mental health and greater emphasis on understanding these concepts. These are narratives that are understood through use of emotional states, expressions, stories and

meaning. What was apparent was the clear mis-match between these concepts and the understanding of emotional and mental health found within the traditional western medical model. Some of these concepts are not necessarily viewed as being related to mental illness. According to Bhugra and Mastrogianni (2004), each society and culture possesses their own distinct emotional lexicon. It can also be argued this extend to distinct faith groups such as the Islamic faith.

10.2.3 Understanding of religious beliefs

Experiences of distress are explained in a number of ways, attributing cause ranging from social problems, relationship difficulties to sorcery or witchcraft (Weiss, 1997). Lay beliefs about mental illness has been widely described over the last three decades (Furnham, 1988; Herzlich, 1973; Helman, 1990; Pill & Scott, 1982). Lay belief cannot be ignored as they can greatly contribute to the understanding of how, why and when a patient presents with their problem and engages with treatment (Fitzpatrick, 1984; Furnham, 1994; Kleinman, 1988). The literature has shown a transition away from a biomedical model toward a holistic understanding of and approach to health and illness (Conrad, 1990; Lawton, 2003). One view is that there are two ends of the spectrum, lay beliefs of health and illness and traditional medical model and examining this gap can contribute towards addressing pertinent health inequalities and issues (Popay & Williams, 1996; Popay et al., 1998). Another perspective is that there is a parallel process whereby the medical model informs lay beliefs and lay beliefs informs the medical model. This study focused on religious variation in beliefs about mental illness.

10.2.3.1 Other realities & Satan

This study supports and re-affirms the existing literature, which describes religious beliefs about the causes of mental illness (Dein et al., 2008; Leavey et al., 2007; Hussain & Cochrane, 2002).

Areas relating to Jinn, sihr, nazr and Satan are developed further, particular in relation to views between participants and scholars.

This study provides additional explanations why people may hold certain perceptions towards mental illness. These have been described under 'other realities' in this study (referring to Jinn, sihr and nazr) and Satan. Existing literature highlighted that these non-natural explanations could be reported where there was no other cause found or where someone was in denial of suffering from mental illness (Hussain & Cochrane, 2002; Laher & Khan, 2012). Similar findings were found in this study. The participants in this study came from diverse backgrounds. This in contrast to the majority of the existing literature conducted in the UK, which was based on South Asian participants. Furnham (1994) found people rejected supernatural forces played a role in health and illness. This is contrast to this study's findings.

Other explanations why people may hold perceptions about Jinn being a cause for mental health difficulties and illness have been explored in this study. These have been discussed on page 225. This indicates that a person's assessment should be extended to considering wider aspects, including socio-cultural and psychological factors.

The idea of possession is not unique to Islam, as similar beliefs are evident in other religions including Judaism (Greenberg & Witztum, 2001), Buddhism (Gaw et al., 1998) and Hinduism (Halliburton, 2005).

Most of the studies in the existing literature included faith healers, Imams, and religious leaders. However, the findings of this study were restricted to the views to traditional Muslim scholars alongside participants suffering with mental illness.

All scholars held some form of belief in relation to mental illness. Scholars held religious and medical/psychological beliefs concurrently. This is not unsurprising as there are historical accounts of Muslim scholars dating as far back as the 9th to 12th centuries who integrated both sacred and psychological knowledge (Haque, 2004). However there is a gap identified here as only a small number of scholars discussed the importance of formulating a number of diagnosis and not necessarily dismissing one underlying reason over another. The findings by Dein et al., (2008) indicate local Imams in London perceived depression to be related to a biomedical cause and where there was no resolution Jinn possession was considered (Dein et al., 2008).

The study highlighted contrasting views of patients and scholars on the concept of jinn as to; (1) how common Jinn are, (2) how Jinn influence human behaviour and (3) the degree of their power on an individual. In relation to the first point, scholars felt that such non-natural causes were rare. This is in contrast to the views held by participants. Under the second point, there was discussion how Jinn may affect people. Unlike the

findings of Dein et al., (2008) where most of the Imams believed Jinn primarily possessed people over influencing people externally, the scholars in this study believed the reverse. This study findings also do not agree with Dein & Illaiee (2013) who state that the possibility of Jinn possession is accepted by most Islamic scholars. The findings also brought out further discussion relating to point 3, on differing views among participants about whether the influence of Jinn could control individuals or not. This was relevant as people might feel helpless where they believed they were being affected fully by Jinn. The role of God was emphasised by participants where the effects of external non-natural causes would only occur at His will. For some participants, as outlined on page 225, it was also evident their beliefs about Jinn delayed accessing medical treatment. Participants were found to be reluctant to discuss their beliefs about Jinn due to a fear of being misunderstood. An interesting finding was participants believed in the effects of Jinn in others rather than themselves. This is considered a type of heuristic fallacy which has been discussed on page 198.

Varying views between participants and scholars towards the control of Satan also existed.

Scholars illustrated three salient points in the findings (relating to other realities and Satan on page 198, under the section 'understanding other realities'), which could be understood as a practical framework to work with: firstly, scholars discussed factors, whereby a person might be more vulnerable to these effects. These aspects should be considered in the assessment of individuals presenting with these specific concerns.

Secondly, when an individual presents with these complaints, there should be the approach of not taking a polarising stance of dismissing one type of diagnosis over another or formulating only one diagnosis as the root cause. An assessment involving both religious practitioners and mental health professionals needs to be considered. In the last point, following an assessment by relevant practitioners, treatment options should not be restricted to religious practices but extend to other forms of help including physical wellbeing, psychological and social aspects. Data to support these points emerged only from a small number of scholars.

The following points need to be considered when working with people presenting with beliefs relating to Jinn or sihr: 1) This relates to exploring whether the beliefs are true or not true. There may be alternative explanations explaining the person's presentation or true cases which requires specialist religious treatment; 2) Assessment on whether the beliefs are useful or not useful. It may be useful, where the person is empowered through their beliefs and seen as a coping mechanism or not useful where there is a delay in treatment of mental illness and not used as a coping strategy; 3) The impact of the beliefs on a person's emotional health.

10.2.3.2 Punishment and weakness of faith

This study reported mixed views from participants suffering from mental illness, where slightly fewer felt that mental illness was a result of divine punishment. The findings from the participants' data were similar to the widely described literature (Ypinazar & Margolis, 2006; Muga & Jenkins, 2008; Weatherhead & Daiches, 2010).

From the authors' review of existing literature little was found on the area of punishment (and also weakness of faith) from a traditional scholarly perspective.

Scholars who took part in the study perceived that pain and suffering should be framed as spiritual growth rather than punishment. Members of the Muslim community may not arrive at this the same conclusion.

As examined on page 247, the findings from the scholars data indicate the idea of 'perceived punishment' and 'self-punishment'. Perceived punishment can be understood as a public perception that mental illness is related to punishment. A person may develop a personal response in a manner where they feel they are being punished by God at an emotional or behavioural level, this can be referred to as self-punishment. This could act as an exacerbating factor during a period of relapse. In the case where a person has the free will to make decisions and acts accordingly, and consequently affects negatively their mental health, a more apt way to frame this is personal responsibility (where capacity is also retained) rather than punishment.

The majority of participants felt that a weakness of faith was not a cause of mental illness. There were contrasting views amongst some participants who felt their suffering was due to a lack of faith and their distance from Islam.

From a scholarly perspective, the findings also show that mental illness *should not* be associated as a sign of weakness in faith. Weakness of faith did not correlate with punishment.

It is difficult to define the concept of ‘weakness of faith’. Firstly, one has to define what is meant by ‘faith’? Is this being used in a general sense, as a synonym for religion or more specifically, refer to ‘Iman’ (see page 38). Furthermore, ‘faith’ has been explained in the literature in a number of technical and lexical meanings (Maghnisawi, 2007; al-Jifri, 2012a).

The second point of difficulty in defining ‘weakness of faith’ is there is no consensus in the literature, on whether faith can fluctuate. The 11th Century Muslim scholar, Abu ’l-Ikhlās al-Shurunbulālī described it is the actions that fluctuate rather than faith itself: *“Faith itself does not increase or decrease; thus, the increase of faith mentioned [in the Qur’an and hadith texts] refers to an increase in its fruits and the illumination of its light [that dawns on the believer].”* (Al-Shurunbulālī, 2010, p37).

The other view is that faith does change:

“When action is included in the meaning of the word ‘faith’, the fact that it increases and decreases is obvious” (al-Jifri, 2012b, p27).

Another level to understand is a person themselves might introspectively consider their own relationship with their faith in terms of closeness or distance and formulate themselves a view about their level of faith. This however was argued to be a matter between the person and God.

10.2.3.3 Spiritual ailments and nafs

Further concepts discussed in this study related to the spiritual heart and internal

struggle against the self/ego (nafs). The findings showed these areas were described more commonly by scholars than participants. These have not been described previously in the medical literature except from opinion papers, historical accounts given from Islamic tradition, theoretical models explored and Islamic frameworks proposed in the literature (Deuraseh & Abu Talib, 2005, Carter & Rashidi, 2003. Haque, 2004; Keshavarzi & Haque, 2013, Haque et al., 2016). As mentioned on page 378, there was no evidence of systematic research employed in these studies, involving patients or traditional scholars.

For Muslims, the heart was a source of comfort and positive mental health. It was understood that the nature of the heart would be of a turbulent nature, changeable to being tested. The heart undergoes a spiritual struggle (page 210). The findings showed the significance of semantics in the usage of the term 'heart': there were many words to express the 'heart', and also to represent the concept of a sound heart and tranquil one. There are ailments (or diseases of the heart) that affect the heart spiritually, including jealousy and anger.

The scholars highlighted that they perceived a lack of awareness and understanding in the Muslim community relating to these concepts. This was interesting given how scholars offered a perspective from faith about ill health and the way they arrive at these judgements. Spiritual and life imbalances were also described by the scholars. This encapsulates areas relating to this world versus the after-life, imbalance of spiritual elements and spiritual wellbeing.

In the literature, Mohammed (2017d) summarised that there are two primary sources of the spiritual ailments relating to the heart (referred to as 'diseases of the heart') - shubuhah and shahawat. This is indicated in the data on page 213. Shubuhah refers to the belief of when someone neglects their true goal of life, moving away from the worship of God in their daily lives and possessing an impaired understanding of one's beliefs; such as not appreciating the blessings given by God and having hope and reliance on others except for God. The second ailment, shahawat relates to the base desires inherent in humans where the desires surpasses the natural state and individuals lead their lives to fulfil these desires. Examples originating from this ailment included anger, lying, arrogance and backbiting.

Nafs was seen as a struggle against oneself. The findings also demonstrated nafs being used in different ways that initially may appear confusing. There were also three levels mentioned in the data. The findings indicated there was the comparable use of nafs as the lowest level of the soul and psychology understanding of 'drive'.

The idea of a struggle is similarly seen with the muhlikat (vices) versus the munjiyat (virtues).

Utz (2011) discusses the concept of Nafs in more detail and describes a hierarchy of three types of souls in the descending order, this being (3) the commanding soul, (2) the reproachful soul and (1) the tranquil soul. The lowest level appears to be the commanding soul, which urges individuals towards evil actions and following ones

desires without obedience and ethical behaviour. The reproachful or self-blaming soul refers to the level where the individual recognises the sinful deeds and is remorseful and repents to God. The highest level referred to as the tranquil soul is where the person loves to do good deeds and resents wrong-doing, achieving a sense of peace in his or her life.

In addition to the nafs and the heart, the findings indicate the intellect and the soul as other spiritual elements of the individual. Mohammed (2016a) highlighted that although these are four distinct elements, the terms are used interchangeably as they can also imply one spiritual force.

Participants discussed external causes such as Jinn, sihr and nazr more commonly than those considered internal causes, namely the ailments of the heart and nafs.

Externalisation of aetiology, rooted in religious beliefs is found in other studies (Grover et al., 2012; Patel, 1995).

10.2.4 How Muslims cope or do not with mental illness

Finally, with reference to the first objective, the third theme which emerged from the findings, was how *Muslims cope or do not cope with mental illness*. The key findings are summarised under six headings: 1) Strategies used at individual level; 2) Community level; 3) Religious practices and other strategies; 4) Relationships with God and Prophet Muhammadﷺ; 5) Emotional support; 6) wider factors influencing process of change.

Individual strategies

This study throws light on a number of key ideas relating to individual strategies, relating to transformational concepts relating to faith and character.

Firstly, with respect to belonging to the Muslim faith, participants described this as a source of strength principally. Participants developed a sense of belonging and greater meaning and purpose in their lives. A purpose in life has been reported in the literature to contribute to positive mental health and well-being (Nicholls, 2006; Hill et al, 2016). Also, people who gain a sense of meaning from religion have higher levels of optimism and self-esteem (Krause, 2003).

The study also showed participants enhanced their identity and regained a degree of control in their lives through their faith. Keyes & Reitzes (2007) reported depressive symptoms reduced and levels of self-esteem increased as religious identity increased. Religious identity in this study was viewed as someone who was more confident and competent as a religious person.

Even although the majority of participants in this study reported strength from their faith, the findings here also highlighted periods of negative experiences such as loss of purpose in life and identity loss and doubts towards God. It was interesting how some people struggled with aspects of their faith in times of crisis then were able to rebuild the strength within them. This is presented on page 264.

It is also worth considering that depending on a person's expectation of faith, they may

feel guilty about not carrying out religious practices and turn to be an exacerbating factor during times of crisis.

In comparison to existing medical literature, the strategies at individual level were further developed with new areas discussed in this study. Sabr is the only concept that has been commonly discussed in existing literature (Hussain, 2006). A number of concepts discussed by patients helped them rationalise their thoughts and affected their behaviour. These have been referred to as ‘transformational concepts’ (described on page 265) related to faith and character which are connected to developing positive emotions. It is significant to appreciate that people acknowledge and utilise the concepts are varying levels.

Secondly, the transformational concepts described cannot be separated from other Islamic notions such as being tested, a commonly held universal Muslim view and the connection with God. The idea of life as a test is highlighted by the following Qur'anic verse which appears to signify people will be tested in a number of ways with good news given to those who are patient:

“And We will surely test you with something of fear and hunger and a loss of wealth and lives and fruits, but give good tidings to the patient” (Qur'an 2:155).

There is description of developing one’s character through morals and strengths such as kindness, forbearance, generosity. This is understood as tahdhib al-akhlaq or refinement of character.

Folkman and Lazarus (1985) draw out a distinction between problem focused and emotional focused coping. This was found in this study where some of the scholars also described approaching difficulties through problem solving as outlined on page 327.

In order to achieve a greater understanding between scholars and participants, it is important to draw out that there were concepts present in Islam and discussed by scholars that are not considered at all or discussed less frequently by participants. Some of these ideas included yaqeen (conviction) and tazkiyah (purification of the heart) as presented on page 292 and page 295. Engagement of individuals by scholars need to factor in the varied awareness and understanding of concepts. This is also important for professionals who understand the implication of concepts practically for people.

Emotional support

There was discussion highlighting the richness of concepts relating to emotional health in the Qur'an and Hadith. Only a few scholars were able to describe this area in detail. Furthermore, there is a disconnect here where only a few scholars described understanding and managing one's emotions and receiving support for this. People may also use spiritual ideas to avoid tackling emotional difficulties. This can be understood as spiritual bypassing (Welwood, 2000).

Community support, religious practices and other strategies

In relation to the areas of community support and religious practices, the findings were consistent with the existing literature. The existing literature contains a greater wealth of findings in the area of social and community support in contrast to this study. This includes the stigma associated with mental illness and cultural factors evident. Previous findings have shown Muslims place a greater focus on religious strategies compared with other groups (Bhui et al., 2007; Loewenthal et al., 2001). Religious practices included recitation of the Qur'an and prayer was found to be useful. This gave perspective to one's difficulties (Bhui et al., 2007). Prayer was also reported by participants to help with feelings of helplessness by placing trust in God (Cinnirella & Loewenthal, 1999).

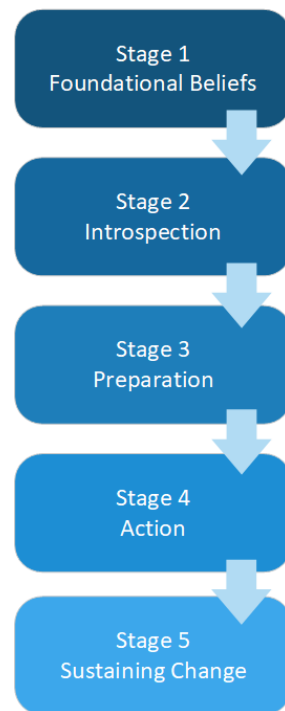
Religious practices are not always positive (Pargament et al., 2001; Kendler et al., 2003). This study included challenges faced by Muslim participants when undertaking religious practices. In the findings from scholars, the areas of religious practices have been expanded upon such as prayer being spiritual connected, understanding the meaning contained in the Qur'an, whether supplication (dua) is accepted or not and factors which strengthen dua such as sincerity and humility. Additional included social strategies used by Muslims, which are influenced by a religious outlook, described on page 332. The Islamic approaches to mental health also entailed consideration of standard mental health approaches however only a small number of scholars highlighted emotional support as a way of coping.

There is a gulf of understanding, almost a tension, between what the scholars suggested to be helpful and what was reported to be valuable by participants. This related to community involvement, charitable acts and volunteering. A number of points need to be considered here: the impact of mental illness could hinder involvement with the community and volunteering, person might not be in the situation to give charity or involved in charitable acts and stigmatising attitudes present towards those suffering with mental illness. There is also discussion on other domains to observe such as exercise, diet and connecting with nature. This has been highlighted on page 310.

Process of change

Furthermore, there were factors described related to change which are considered relevant to a Muslims road to recovery (described on page 321). The stages have been developed here as follows:

Diagram 13: Process of change



This model represents an overview on the stages a Muslim with emotional difficulties may go through to change their behaviour and situation.

The terms and principles highlighted can help understand how and why a person may change, the need for change and factors that facilitate progress in that road to recovery.

The model is not understood to be a prescriptive guide but offers an overview of salient concepts and principles that can facilitate change. The steps or process of change

recognises that individuals may be different stages in their recovery and readiness for change. The steps unfold over time, in a gradual approach. There are also barriers to change which need to be considered.

At the basis of the change are the foundational beliefs a Muslim holds. Muslims hold a distinct ontological belief system which brings a perspective on their outlook to life in relation to pain and difficulties. This stage is integral, bringing a sense of meaning and purpose to the person and why they should change. These core beliefs are fundamental for a person to refer back to and to facilitate strength and stability in the journey ahead.

Following this is the introspection stage, where the person is contemplating and not yet decided on whether action is required. In the contemplating stage, the person is trying to understand the experienced situation and obtain an awareness about the nature of the problem and need for change. Once a person decides change is required, they begin to immerse in the preparation stage. This leads to the action stage where the person gets involved in the planned modifications to instigating change. There are factors that will sustain this change and enable success longer term for the person in their road to recovery. Another set of factors were further identified that were not specific to one stage but considered to be facilitators to change (in stages 2-5).

Some of the terms and principles are not exclusively restricted to the Islamic faith but display significant meaning and usage within the Islamic sciences literature. These have not been presented as a described process of change in previous medical literature.

Parallels can be drawn with cycle of change model developed by Prochaska & DiClemente (1983).

These have been summarised in table 12

Table 12: Stages of change in recovery

Stage of change	Components of change	Factors more relevant to spirituality
Foundational beliefs	Concept of predestination (qadar) Natural belief in God (fitrah) Divine trial (ibtīlā') Divine Oneness (tawhid) Idea of not being burdened beyond what one can bear Concept of life being a journey, moving onto an after-life	
Introspection	Awareness (wa'y) Contemplation/introspection (tafakkur) Presence ('hudur) Seeking clarification (istibsar)	Awakening (sahwa)
Preparation	Intention (niyyah) Irada (will) Determination ('azm) Strong intention (qasd) Gaining insight/scrutiny (nathar) Deliberation ('anah) Volition and choice (kasb) Help-seeking/aid (isti'anah) Pondering (tadabbur) Consult others (shura) Concept of taking the means (akh'dh bil asbab)	
Action	Practical action ('amal) Resilience (himma) Re-membering (tathakkur)	
Sustaining change	Perseverance (sabr) Endurance in patience (istibar) Being persistent in action, perpetual (dawam) Small steps of change (tadarruj) Steadfastness (istiqāmah) Maintaining good company (suhba saliha) Consulting others for advice (shura) Balanced, holistic approach (i'tidaal) Observation (muraqabah) Long term perspective (basirah)	Self-evaluation (muhasabah) for someone who is well and on a spiritual path.
Factors relevant to all stages	Personal responsibility (mas'uliyya) Optimism (tafa2ul) Ittihad (union) Managing one's emotions (shu'ur/feeling, subtle intuition; awatif/emotions).	Tazkiyah (purification of the heart). Spiritual path involving ilm (knowledge), fi'l /'amal (action) and haal (state), and sulook

	<p>Understanding where notions/thoughts come from. Gaining insight around different degrees of thinking.</p> <p>Factors relating to connection with God (reliance on God/tawakkul, hope in God/raja, conviction/yaqeen, provision from God/rizq). Recognition of God (ma'rifah).</p> <p>Spiritual transformational factors (contentment/ridhaa, waiting for reward/ihtisab, sabr/perseverance).</p> <p>Refinement of character (forbearance, kindness, gratitude, forgiveness, sincerity, generosity, humility). Repentance (tawbah).</p> <p>Managing wider challenges/barriers to change such as procrastination, notions about punishment and weak faith, stigma, heedlessness, spiritual bypassing.</p>	<p>(behaviour).</p> <p>Spiritual change relating to tawba (repentance): removing, remorse, resolve, rectify.</p> <p>Tarbiyah (spiritual growth and development).</p>
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Relationship with God and Prophet Muhammadﷺ

The last area that emerged with regards to coping strategies was the relationship a Muslim has with God and the Prophet Muhammadﷺ. The belief in God is discussed in previous research papers (Hussain and Cochrane, 2003; Penny et al, 2009) including holding trust that God will listen to prayers, which was viewed as comforting (Cinnirella & Loewenthal, 1999). People have a belief that the success of treatment comes from God (Hussain and Cochrane, 2002).

The current findings provide greater insight in this relationship such as hope in God (raja), provision from God (rizq), God consciousness (Taqwa) and gratitude to God (shukr). The strategies relevant to the relationship with God were not mutually exclusive, with their relative importance varying among the participants. Furthermore,

not all the participants shared a similar understanding of these concepts. The relationship with God was one that was supportive overall, but it also highlighted that a small number of participants felt brief moments in their lives where they felt disconnected from God, developing negative thoughts such as isolation and blame. In relation to Prophet Muhammadﷺ, participants drew lessons from his life and strength for their own experiences.

The data appear to mirror and support Islamic literature, where it is described sending praise to Prophet Muhammadﷺ is considered a form receiving blessing from God:

“Who invokes a blessing on me [Prophet Muhammadﷺ] will receive ten blessings from Allah” (Sahih Muslim 4: 0747).

Strategies are used at a number of levels by Muslims during their recovery journey.

These needs to be considered and explored further on how these can be developed as an approach which considers support being delivered in the most appropriate manner.

10.3 Objective 2

The second objective set out to identify the barriers and facilitators of helpful pathways to care, involving existing care systems but specifically Islamic scholars and religious leaders who may be consulted.

10.3.1 Pathways to care

The existing literature contains a substantial body of evidence, identifying pathways to care including barriers and facilitators and improving access to care and treatment, in particular for people of Black and Asian ethnic minorities (Bhui & Bhugra, 2002; Bhui et al., 2003; Gask et al., 2012; Kovandzic et al., 2011). The information from the literature is briefly discussed here to bring out its the relevance of the current work.

In chapter 1, on page 27, the Goldberg & Huxley (1980) pathway was presented however this is considered too simplistic. It is known that for people of Black and Asian ethnic minorities access to and utilisation of treatments in mental health differs from people of White background (Lloyd & Moodley, 1992). People belonging to the Muslim faith are similarly less likely to seek professional help compared to people who had no religious affiliation (Sheikh & Furnham, 2000).

Gillam et al. (1989) reported that consultation rates with the GP for mental illness were lower among ethnic minorities, in this study South-Asians complained more frequently of non-specific symptoms and respiratory infections and were less likely to be provided

a follow-up appointment compared to White British. In a study of GPs in Birmingham, Commander et al., (1997) found South-Asians were less likely to be referred to specialist services, and that White people were more likely to be diagnosed with mental illness by the GP compared to South-Asians. Koffman et al., (1997) found in a study of 3978 psychiatric inpatients in London that Black people were less likely to have a GP (Black included 'Black African', 'Black Caribbean' and 'Black other').

In a sample of 42 black people (Afro Caribbean) people presenting with first episode psychosis in Nottingham, there was a longer delay in seeking psychiatric help compared to non-Caribbean patients (Harrison et al., 1989). There was also a greater proportion of black people (40%) compared to general patients (2%) who had contact with a helping agency (including GPs, members of religious organizations, nurses, social workers) the week before psychiatric contact.

Police involvement was more likely in Asian and particularly black people in psychiatric admissions (with non-affective psychosis) compared to white counterparts (Commander et al., 1999). The authors also found black and Asian patients were less likely to recognise they had mental health difficulties and more likely to be dissatisfied with the admission process.

There are variations to pathways to care and more complicated for black and Asian ethnic minorities patients (Bhui et al., 2003). This study focused on the barriers and facilitators

that could be specific to Muslims in this pathway. Other factors, such as cultural ones were identified due to their prominence in the findings.

Barriers and facilitators in this study

As presented on page 343, ‘candidacy’ is a collaborative process between patients and professionals and may explain why some people engage with health services in varying ways (Dixon-Woods et al., 2006). This requires the person to see themselves as candidates for healthcare. Methley et al., (2016) have summarised how the concept of candidacy has contributed towards the understanding of sociological processes such as identification with the sick role (Parsons, 1951), normalisation of illness (Bury, 2001) and illness identity (Sulik, 2009).

This study examined the pathway to care for Muslim participants, exploring facilitators and barriers to accessing mental health care, specifically looking at factors relating to being Muslim and also involvement from religious scholars. This has been described in chapter 9 and summarised on page 343.

In light of existing literature, the first two stages described by Kovandzic et al., (2011) were deemed the most relevant for participants in this study. The implication of the findings from these two stages can be grouped under four headings (as presented on page 347):

Basis for candidacy, decision making, living with mental illness and alternative supports. The latter two areas are discussed in the next section.

Basis for candidacy

The findings highlighted specific issues that need to be considered when a Muslim presents with distress. Muslims might themselves hold differing views and not formulate their experiences as related to mental health. This has been presented under objective 1, earlier in this chapter on page 348 and earlier in chapter 9, on page 351. In this situation, there is no basis for candidacy to be formed.

Specifically it is proposed that factors relating to spiritual understanding need to be considered when beginning to understand explanatory models of illness and distress for Muslims. This will facilitate better engagement and communication between the individual and professional.

Other considerations need to be taken factored when exploring the model described by Kovandzic et al., (2011). One needs to consider that a person may hold a specific outlook to their problems such as a different model of mental health or spiritual health and still formulate their problems as mental health related. The two are not mutually exclusive. The symptoms of mental health and spiritual health may be inter-linked and as a consequence of the other.

Also, a person who does not view their problems as mental health related is not necessarily an issue. Based on the person's explanation of their difficulties, they may

still use coping strategies that help them manage their emotional symptoms (Dinos et al., 2018).

Furthermore, formulating emotional difficulties into a medical condition is not always appropriate or beneficial (Dowrick, 2009).

The pathway discussed here simply outlines access to mental health care is affected by differing expressions of distress and explanatory models.

Decision making

Even if a person viewed their difficulties as relating to a mental health problem, a person still must make the choice to access services. This study suggests that this is based on a person's understanding of Islamic concepts, which consequently impacts on the decisions they make. The factors that affect access to care at this stage (see diagram 11, on page 345) may either be a facilitator or hindrance to accessing care and requires to be explored with the person.

There are two other concepts which build on candidacy, that are relevant in decision made by individuals. The concept 'recursivity' was relevant in the findings discussed earlier on page 344, where past experience can affect future decisions and access to care (Rogers, Hassell, & Nicolaas, 1999). In this study's findings, one example was around a negative experience with counselling – such past experience can shape choices of service to access (Hunter et al., 2013).

Another example that emerged from the findings related to exploring options with the patient and not restricting treatment to medication. This relates to concordance, one of the foundations of working collaboratively together in decision making (Stevenson & Scambler, 2005).

10.3.2 Linking pathways of care with explanatory models

Kleinman et al., (1978) introduced the term ‘explanatory model’ four decades ago. The disease and illness distinction was drawn from this discourse; whereby disease was understood from a medical paradigm and illness represented what affected the patients and their personal reactions to the disease, that is - how they viewed their problem.

Explanatory models can be defined as “*culturally determined beliefs that individuals hold about misfortune, suffering, illness and health*” (Dinos et al., 2017, p106).

A shared understanding of the individual’s explanatory model is a crucial component to collaborative working and ensuring patients’ concerns are addressed. Explanatory models are dynamic and changes over time (Mathew et al., 2010). William and Healy (2001) propose the term ‘explanatory map’ as a reflection of the complexity of belief systems.

Linking the pathways of care with explanatory models can be done by using the framework Barts Explanatory Model Inventory, self-report checklist (BEMI-C) (Rudell

et al., 2009). This indicates how salient findings from this study can fit in and be understood in an explanatory model framework. The five areas identified in this checklist (identity, causes, timeline/course, consequences and preferred interventions) will now be discussed.

In relation to identity, the findings indicated there were complaints and perceived symptoms relating to somatic/physical, mental and behavioural symptoms. This in line with existing literature (Rudell et al., 2009; Baarnhielm & Ekblad, 2000; Yeung & Chang, 2002). The findings from participants' data can be summarised as follows: tiredness, unexplained pain when person was relaying her views about black magic; headaches when complaining of Jinn and sleep problems. Mentally, there were number of complaints relating to feeling low, scared, worry, feel lonely, obsessive thoughts and annoyance. In respect to behaviour aspects, staying at home, not meeting people, not working and unable to do tasks in house, and affecting roles in the house.

Secondly, perceptions of the identity of distress can overlap with perceptions of its cause (Rudell et al., 2009). Psycho-social and physical causes were mentioned in the data; however the focus of the study was to examine religious beliefs and perceptions. As presented earlier in the chapter, these have been grouped under a number of headings: other realities (Jinn, sihr, nazr), Satan, spiritual ailments and nafs, punishment and weak faith and spiritual and life imbalances.

The third area related to the timeline/course of illness. There were reports some of the participants delayed access to treatment. The idea of life as test was seen not as episodic but a continuous event. Also, the course of an illness was determined by God's Will and predestination so could be seen as acute or episodic. The cure of illnesses came from God. These are discussed earlier on page 153 and 377.

In terms of consequences, the main impact of living with mental illness was manifest through experiences of stigma and modified by cultural factors. This study's findings supports the existing literature. Stigma is a symbol of discredit or disgrace creating a distinction between that person from others- them and us (Byrne, 2000). It has been defined by Goffman (1963) as a sign "*deeply discrediting*" and moves someone from being normal to a "*tainted discounted one*" (Goffman, 1963, p3).

The findings indicated the negative impact of mental illness on the individual and their families. Participants experienced discriminatory behaviour and negative attitudes from community members. Other challenges participants found was finding a job and suitable spouse.

Similar to the literature (Brohan, et al., 2012; Corrigan & Rao, 2012), the three aspects of stigma have been found in this study. These are perceived stigma, where there is an expectation or fear that others will behave in a discriminatory manner; experienced stigma, which is actual stigma a person has been exposed to; and self-stigma where a person internalises the negative stereotypes. These have been presented on page 358.

Izzat and shame were described by participants, particularly of South Asian background. Izzat is a term too complex to be understood under one meaning but is primarily used to signify family honour in the South Asian community (Gilbert et al, 2004). It can sometimes be translated as personal honour or pride and used as to mean 'trust' (Soni, 2012). It has also been used as 'respect' (Gilbert et al, 2004). Members of the family have to therefore abide by a set of principles to preserve the name and reputation of the family and their status in the community. Izzat is enhanced through perceptions that the family is virtuous, generous, returning favours, participation in community events and arranged marriages (Hussain, 2006). Any action that may affect izzat will be dishonour and fear of being disowned by not only the family but also wider community.

Shame was found to be reported by participants and also projected onto the family. This is a fear of causing shame to others, referred to as '*reflected shame*' (Gilbert et al, 2004).

The last area relating to this model explores preferred interventions. Participants accessed informal supports such as mosque, community and social support. There are also alternative supports more formally available via religious figures like imams and scholars. This has already been discussed earlier in the chapter on page 258. This relates to the idea of 'permeability', described by Dixon-Woods et al. (2006) where there is a direct access for the person to their local community, mosque and religious figures. There is no need for referrals or waiting lists.

The results from this study showed evidence that Muslims *would* contact scholars when experiencing mental health issues. The findings show some of the participants approached Imams before approaching the GP. This was similar to the Cinnirella & Loewenthal (1999) study, where religious figures were sometimes the first point of contact for individuals suffering from psychological distress. Scholars were involved in outreach work, supporting individuals with their emotional difficulties and their families. They played a significant role as gatekeepers as first point of contact for Muslims. The findings appeared to be supportive of the previous literature involving religious figures of other faith groups (Larson et al., 1998; Mollica & Streets, 1986).

As outlined earlier in chapter 8, a number of coping strategies were used by the participants. This related to religious practices, role of God, transformational factors. Scholars also reported doing volunteering work and involved in charitable works. Complementary therapies were also discussed such as use of honey and cupping.

In relation to community support, some of the participants discussed their difficulties with friends before involving the GP. The complexity is the solution itself can also present as a challenge due to concerns around confidentiality within the community (Hussain and Cochrane, 2003). There was description in the study of the negative experiences and challenges faced when consulting scholars. This study found some participants reported scholars were dismissive of mental illness and lacked empathy. Some scholars were also considered as fraudulent and unqualified.

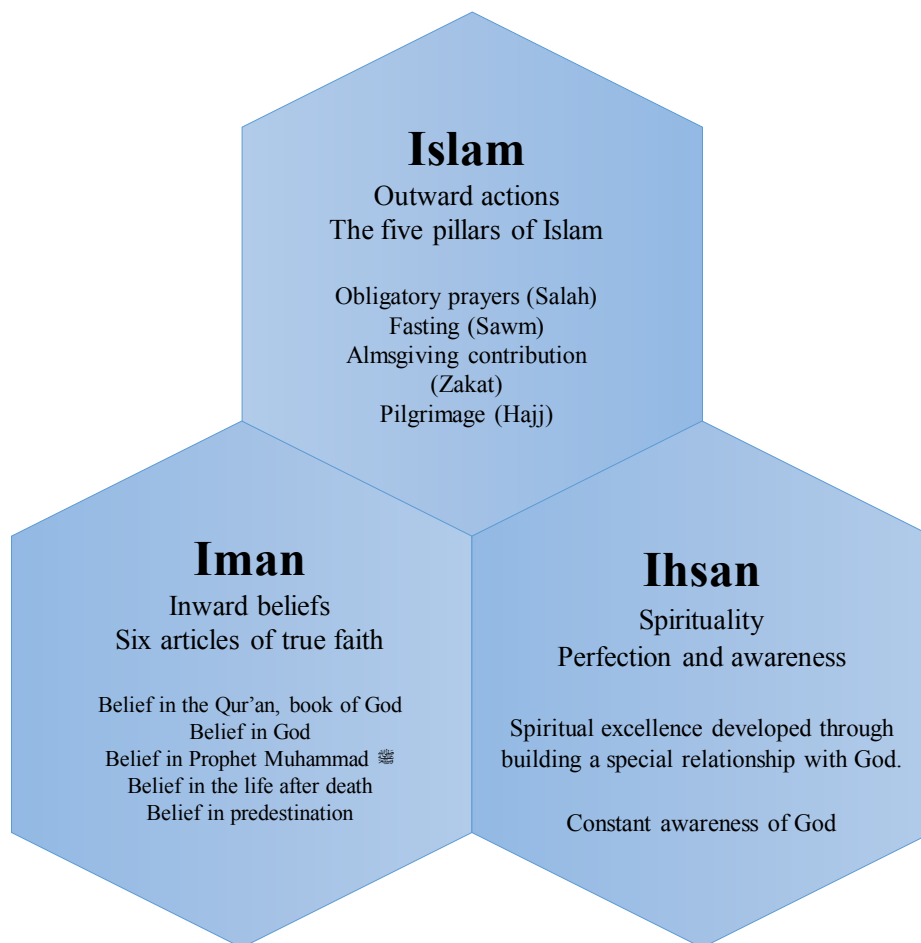
10.4 Linking study findings with frameworks in the Islamic tradition

One way of bringing the findings together is considering two overarching areas: Hadith Jibreel and the spiritual elements of the individual, which have been described extensively in Islamic tradition. Based on these frameworks, there can be a greater understanding of the self, mapping out key concepts and ideas and allowing the person to navigate through their issues. On this basis, clinical approaches can be developed. This area requires further exploration and could incorporate conventional principles as well.

As presented on page 36, the familiar report called 'Hadith Jibreel', concisely sums up a cornerstone of Islam: the concepts of *Islam*, *Iman* and *Ihsan*.

Some of the broad headlines from the study findings correlates to this succinct summary of Islam as outlined in the table 1 (page 38). It connects to the first objective in terms of outlook on life as discussed on page 371 and has implications on the pathway to care (second objective) where a person may not formulate their difficulties as mental health related and also a person may use alternative support mechanisms. This indicates understanding these concepts are one of the foundations to begin to understand Muslim beliefs and a recommendation given to this framework when thinking about clinical application of care.

Diagram 14: Correlation of summary findings with domains of Islam, Iman and Ihsan



One approach that could be considered is as follows: this model in practice looks at an individual working holistically in all these areas, carrying out religious practices outwardly, internally looking on one's beliefs and taking means to facilitate change and spirituality building a strong connection with God where God is central to one's life.

The manner this framework could be explained from a psychological perspective as follows: 1) Islam is how people behave, physical aspect of the person, relating to the

body; 2) Iman is how people think, conceptualise themselves, the world and God, mental aspect of the person, relating to the mind; 3) Ihsan is a sense of God in a person's life and that impacts on how a person acts, is an experience and a sense of feeling, emotional/spiritual aspects of the person, relating to the heart.

This framework also corresponds to the major disciplines in Islam: 1) Islam corresponding to Fiqh (Islamic Jurisprudence); 2) Iman corresponding to Aqeedah (Islamic Creed); 3) Ihsan referring to Tazkiyah (Purification of the heart).

Another area that connects to the two objectives and can form a basis for drawing principles is the understanding of the composites of the individual described by the Muslim scholar Al-Ghazali and as outlined on page 210: heart (qalb), nafs (ego/self), 'aql (intellect) and the soul (ruh) (Mohammed, 2016d; Ali, 2013). These spiritual elements provide a description of how Muslims present with a spiritual dimension of health and alternative explanation of their symptoms. Nafs also encapsulates mental and physical aspects to it and just restricted to a spiritual entity. These elements are understood as distinct entities and also interchangeably to signify the same spiritual force within a person (table 13):

Table 13: Spiritual elements of the individual

Qalb (heart)	State of sound heart (settled emotional state) and nature of the heart as turbid and changing and reaching spiritual tranquillity. Diseases/ailments affect the heart (heedlessness, envy, jealousy). Qalb described as seat of emotions, place of reflection and divine guidance. Can overcome the ego. Nurturing of personality traits.
Nafs (ego/self)	Three levels described: commanding nafs, self-blaming nafs, tranquil state. The ' <i>ego</i> ' or ' <i>lower self</i> ' has the tendency to follow desires. Nafs are aspect of self, which requires spiritual purification.
'Aql (intellect)	Relates to cognition. Thinking, logic (common sense), reason, knowledge, beliefs. Restrict destructive tendency of the ego.
Ruh (soul)	Propensity towards good, spirituality. Dreamlike states, visions.

The four spiritual elements are not exclusive in nature. As seen previously, some of their functions may overlap, and their qualifying terms may be used interchangeably.

The qalb and the 'aql can be seen as control mechanisms. The qalb is assessing things according to its state, and that assessment is executed by the 'aql.

The qalb is influenced by the nafs, (through its carnal impulses, and has tendencies of the ego and can go through various stages of development) and the ruh (which is akin to an upward system, gives inspirations to the heart and has propensity towards good).

Similar to the qalb, the ‘aql can also overcome the nafs (though from a different angle/level).

The nafs can be described as the very essence of a human being, referred to as the soul. This encapsulates all the spiritual elements of the person. Another usage is understanding the nafs as an individual element, understood as the human needs. The nafs appears to be of a compound nature, and therefore does not adhere exclusively to good or evil. It can veer towards the basic carnal desires or towards elevated states of self-control and spiritual realisation. Thus, it is plunged into a perpetual strive aiming at reaching an equilibrium between these positions.

As for the ruh, it appears as a more obscure and mysterious component of the self with regards to both, its nature and function(s). It is described as an essential element for existing, it is considered as a pure and good motivational entity, highly inspired by the divine.

In relation to the spiritual elements of the individual, there has to be the consideration of a person’s level of spiritual development, usefulness for the person and connection with

emotional and physical health. These have been described on page 296 and 318. The impact of a person's mental health cannot be ignored.

In considering the application of this model, one approach could consider the following: a person begins to understand their self and attempts to self-rectify themselves by curing spiritual ailments by doing the opposite. However, this might be difficult due to the impact of their difficulties or distress and the person could gain support in the company of others. The presence of another person could be supportive and being with others may create a sense of belonging with engagement in activities and volunteering; this could be in parallel with guidance from traditional scholars. In situations where a person has a greater need spiritually and able to engage in more structured sessions, then input from a qualified practitioner who has specialised in the area of Islamic spirituality could be considered. This however might be challenging for someone who suffers from a mental illness of increased severity, someone with emotional dysregulation or someone who has a traumatic background and unable to confide in others. In this situation, there may be use of conventional approaches.

These are two conceptual frameworks described in the Islamic tradition to begin to consider in peoples' explanation of their beliefs and perceptions towards their experiences.

10.5 The role of the researcher in data generation and analysis

Subjectivity and reflexivity has already been discussed in chapter 5, in table 9 (page 125-130), where potential bias was considered and how this was managed.

The reaction of scholars during the interviews may have been influenced by the researcher's role as a psychiatrist. This potentially could have impacted on the development of the data. For example, when scholars were asked about causes of mental illness or treatments, their responses may be a result of trying to match the researcher's own background.

Scholars asked the researcher about his background, his affiliation with Muslim organisations, mosques and scholars he knew personally or were connected with. This occurred either prior to the interview or during the interview. Some of them also asked about his level of Islamic knowledge and whether he had studied Islamic sciences formally.

The researcher is currently enrolled on an Islamic studies programme and previously attended Islamic seminars and spent time with scholars. This level of Islamic knowledge could influence data generation and analysis. This has been discussed under 'subjectivity and reflexivity' on page 121 and also table 14 (page 419).

The identity of the researcher impacts of the interviews as the interpretative nature of reality is a co-construction between the researcher and the participant in the research process (Charmaz 2006).

The researcher's role as a psychiatrist could have impacted on the participants response. This has been previously discussed on page 128.

Consideration of reflexive issues allows the evaluation of subjectivity and the researcher's impact on data collection and analysis (Finlay, 2002).

Table 14: Impact of subjectivity on data collection and analysis

Researcher's approach to subjectivity	Impact of this
<p>Researcher understood there were a number of semantic meanings to the word 'heart' in Arabic.</p>	<p>Researcher probed to elicit deeper meanings in the scholars' interview. Otherwise, all the interviews with participants and scholars, the word heart was used rather than its Arabic form. In the results sections, the word heart was used instead of qalb.</p>
<p>Researcher was aware of concepts relating to emotional distress and mental health in the Qur'an and Hadith.</p>	<p>In the first instance, the researcher asked open ended questions about concepts in the scholars' interview. He then explored this area further by asking direct</p>

	questions about specific concepts and terms he was familiar with.
Researcher was aware there were varying views on how Jinn affected a person.	In interviews with scholars, researcher asked openly about Jinn and then in closed manner, if there were alternative opinions.
The idea of weak faith was suggested not to be linked with mental illness but researcher was aware there were other views on this.	Researcher asked participants what their views were and probed scholars to ask if weak faith was a possibility.
In interviews with scholars, some of them indicated mental illness was not linked with God's punishment. Researcher was aware this was a prevalent view in the Muslim community.	Researcher asked scholars further questions on possibility of God's punishment. This was considered more closely during the interpretation of data.
The view that Jinn is considered common among the Muslim community was known by the researcher.	Researcher queried with scholars why Muslim community would hold these views and detailed in the analysis.
Scholars described number of ways a Muslim would cope in distress. Researcher was aware of the impact of mental illness on the individual.	Researcher explored with scholars what is challenging and in their experience, why people found it difficult doing religious practices.

<p>Researcher was aware there were differing views on whether Satan and Jinn could control a person.</p>	<p>Researcher asked both groups directly whether Satan and Jinn could take control of a person.</p>
<p>There were differing views on whether one's destiny could be changed was known by the researcher.</p>	<p>Scholars were asked by the researcher what their views were and why people may hold contrasting views.</p> <p>This was drawn out in the interpretation with use from Islamic literature in the discussion section.</p>
<p>The researcher was aware of various diseases of the heart.</p>	<p>The researcher asked directly how these were grouped and understood, ensuring the views of scholars were reported.</p>
<p>The researcher was aware there were factors that may influence the process of change for an individual.</p>	<p>The researcher probed the scholars directly about factors that may facilitate or hinder recovery, making sure that the views of scholars were considered.</p>

This second table (table 15) details how some of the researcher's view changed throughout course of the study.

Table 15: How researcher’s views have changed

View of the researcher before study	How the researcher’s view changed
<p>Researcher was of the view that role of Islam was to prevent mental illnesses</p>	<p>Islam has a role to play in prevention, but other factors have to be considered- the context, person’s understanding and application of their faith. The role of faith is to give perspective to one’s difficulties and mechanism to deal with them.</p>
<p>Researcher held the opinion that weak faith was not linked at all with mental illness</p>	<p>This was explored deeper in study where it was considered it was matter between the person and God.</p>
<p>Researcher understood coping strategies in terms of religious domains.</p>	<p>Researcher became aware that social strategies were integral component of coping and connected with the Islamic tradition.</p>
<p>The researcher was aware of terms and concepts relating to emotional distress and mental health in the Qur’an and the Hadith before the commencement of the study.</p>	<p>The researcher gained a deeper insight of some of the underlying nuances behind the Islamic concepts, that were not known to him prior to the research.</p>

10.6 Strengths

This study was able to bring together and carry out a fine grained analysis of beliefs and concepts found in the Islamic tradition relating to the experience of mental distress and pathways whereby Muslims may seek to access mental health care. The findings helped contextualise the concepts in relation to the individual and the meaning it brings to them, their lives and their struggles with mental health. The richness of the data allowed a greater and new insight gained in the field of Islam and mental health which has not been evident previously in the literature where systematic research conducted or appropriate methodology has been applied. The description of Islamic concepts was also limited in the existing literature.

The employed methodological process was transparent and robust with a diverse range of participants. Patients had received a range of different diagnoses. In the existing literature, one of the weakness in studies found was majority of participants did not suffer from mental illness and were of South Asian background. This has been addressed here where this study was successful in recruiting participants with mental illness from diverse ethnic backgrounds. To the knowledge of the researcher and with a degree of literature searching, this is the first study in mental health literature where the views of qualified traditional scholars have been considered on how mental illness is understood in Islamic tradition. There was also inclusion of female scholars for the first time in this area which can be seen as a major breakthrough in this field of study.

10.7 Limitation of findings

The background section only included literature papers published in the English language. This decision was made by the author due to ease of understanding the literature in the same language. This limits the search by excluding papers of other languages, which can be considered in future work.

Religion is practiced in a varying manner by the respective faith communities, depending on their level of understanding and conviction. One therefore cannot attribute norms to the whole group and consideration must also be given to the connection and importance an individual has to their religion. This is a qualitative study and the findings detailing views of participants of Muslim background and scholars cannot be generalised to the wider community.

People have been reported to access community organisations for support more than the family (Beliappa, 1991). This is in contrast to the findings that majority of issues are managed within the family structures (Ineichen, 1987). Capturing views from community organisations is important. In this study, recruitment of participants only took place from mental health services and primary care. All the interviews took place in English. These weaknesses can be addressed by recruitment from third sector and non-English communities.

Muslims also access other key figures as alternative support such as pirs and healers. They were not included in the study due to the objectives of the study. This can be addressed by different objectives and inclusion criteria.

Muslim Scholars came from a diverse range of ethnic communities. Even though ethnicity has been argued to be a '*contested classification*' (Bhui et al, 2007, p149), it has been used for purpose of research. Furthermore, they can be sub-divided into socio-political groups and institutions where they may have obtained their Islamic education. It is therefore difficult to draw any inferences based on any socio-political groups, education or ethnicity. A larger study and more team members can overcome this.

Cultural aspects where relevant have been highlighted however these was not a focus of this study. Another area which may be relevant in future work is examining role of gender role in expression of distress and how this may impact on coping.

10.8 Implications (clinical practice, service development, research).

10.8.1 Clinical practice

From a clinical perspective, a number of points need to be considered when interviewing and engaging Muslim patients. This study indicates a reconnection with a phenomenological approach to psychiatry (Jaspers, 1959). Awareness will be needed of the distinct views Muslims hold in relation to; (1) pain and suffering, (2) perceptions of mental illness, (3) spiritual dimension of health, and (4) religious strategies Muslim utilise. An assessment could be argued to be incomplete without considering these areas. It is considered good practice to have basic understanding of cultural and religious issues and include this during psychiatric/psychological assessments. There needs to be collaborative working between professional, patient and Muslim scholar, ensuring a shared understanding of a person's explanatory model.

This however may be challenging as highlighted in a recent study of twenty-two Psychiatrists in the UK (Durà-Vilà et al, 2011). The same authors reported that none of the psychiatrists routinely included religious aspects of care as part of their mental health assessment. A clinician is not expected to have detailed knowledge in the field of Islam and mental health but they are required to be an expert in considering a person's narrative and their interpretation of it. A person's personal faith is likely to be part of this story and therefore as a starting point it would be important for the clinician to try to establish the patient's religious and cultural beliefs. One approach to this may be to understand the views of the family and whether these align with the patient's views.

Another challenge for practitioners in routine clinical practice is having clear boundaries in the therapeutic relationship between practitioner and patient when considering religious issues (Poole, Cook & Higgo, 2018).

In areas where clinicians have a high clinical workload managing Muslims patients, they will need to consider undertaking continued professional development programme learning further about religious issues. In more complex cases, they will need to look at tapping into local resources. For example, contacting the local NHS chaplaincy department for advice or accessing available resource material. Clinicians may also explore if there are other clinicians who have a specialist interest in Muslim mental health. They will also need to enquire with the patient if there is a community Muslim scholar who can be approached to attend a multi-disciplinary meeting with involvement from family.

Consideration needs to be given for consulting both professional and Muslim scholar in individuals presenting with specific concerns and mental health difficulties. In the assessment and treatment phase, there has to be the inclusion of a holistic, integrated approach of biological, psychological, social and religious domains.

A proposed development from this study could be the development of training modules for piloting.

10.8.2 Service development

In the area of policy, Naylor et al (2012) have highlighted interventions rooted in the wider community and linking with lay and voluntary networks. Development of a

community based intervention, which involves working closely with Muslim community, local Muslim organisations and Mosques will need to be delivered. In majority of scholars interviewed in this study, it was evident mental health and mental illness was understood. The subject area of mental health was seen as a specialist area, not necessarily studied by scholars. Furthermore, a training programme that is evaluated and a toolkit for Scholars and Imams in the area of mental health will need to be considered. Another approach could be delivering a package involving psychoeducation and Islamic approaches to mental health to the Muslim community.

10.8.3 Direction of research

There are research questions that remain unanswered and would be important to understand before one considers studying specific religious interventions. There needs to be a larger scale study looking at Muslims from different socio-political groups and a greater number within each distinct ethnic groups. Also, to explore deeper whether there are acculturation factors that might affects views of Muslims.

Furthermore, it will be useful to obtain views from service providers in meeting the needs of Muslim mental health patients and to determine what response is required from the UK healthcare system to ensure the needs of people of a Muslim faith who have mental health problems are addressed. It will be insightful to interview mental health professionals to assess their understanding of the needs of Muslim patients. It will be

important to interview Muslims who do not speak English to determine whether they hold differing views or not.

11 Chapter 11 - Conclusion

In conclusion, this study provides valuable new insights into the field of Islam, mental health and well-being. It highlights those aspects of religion that are important to people of the Muslim faith with mental illness. Central to this, is the universal ontological perspective Muslims possess, which is specific to their faith.

The research also indicates health, well-being and mental health is conceptualised in a distinct manner in the Islamic tradition. The Islamic paradigm encompasses a holistic outlook with a strong spiritual dimension of health and relationship with God, which does not match with the traditional western medical model or existing secular frameworks. In relation to aetiologies of mental illness, integral to the Islamic framework is understanding the perceptions sensitive to the Muslim religious beliefs. Islam facilitated a sense of meaning and purpose of life. The analysis of the data indicates specific issues that affect how a Muslim accesses mental health care. These barriers and facilitators to accessing mental health care primarily related to whether a Muslim formulates their distress as a mental health problem and even if their difficulties are understood as mental health related, there may still be factors that hinder or facilitate care. Muslims use scholars and attending the mosque as an alternative pathway of support. There were also barriers to accessing mental health care identified such as stigma and cultural issues. The manner by which Muslims adopt coping strategies is demonstrated in a number of levels. Conventional approaches and the Islamic framework are not mutually exclusive and may be seen as complementary.

One of the key strengths of the study include the methodological process of the study. Participants recruited came from a number of ethnic backgrounds and had a number of diagnosis. The study was successful in recruiting qualified Muslim scholars as well as female ones, of various ethnic backgrounds.

Furthermore, there is evidence of a greater depth of analysis of Islamic concepts in relation to mental health in this study. The study contextualises these concepts in connection to the individual. There was diversity of views not only between individual themselves but also between participants and scholars. For each individual there appears to be an interplay between the understanding of Islamic concepts rooted in Islamic tradition, the views of the individual, spiritual conviction of the person and how he or she practices their faith. This is further complicated by the impact on the person of their mental illness.

With regards to limitations, the study did not consider wider socio-political groups during the recruitment of the scholars. No interviews took place in other languages except English. There were no participants recruited from the third sector.

The study concludes with recommendations for future practice including future research direction, collaborative working and training.

12 Chapter 12 - References

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13 Summary of papers

Modified version of template suggested by Noyes & Lewin (2011).

Author Title	Context/setting/research question & participants (sample size, demographic)	Study design and methods used (theoretical frameworks or foundations, data collection, analysis)	Findings & recommendations
<p>Abdul Kadir, N.B. & Bifulco, A. (2010).</p> <p>Malaysian Moslem Mothers' Experience of Depression and Service Use.</p>	<p>Johor Bahru, Malaysia</p> <p>To explore symptoms of depression and attitudes and beliefs towards mental illness In Malaysians.</p> <p>61 Malaysian Muslims with depression.</p>	<p>Qualitative and quantitative</p> <p>Semi-structured interviews</p> <p>This was part of a wider study with use of questionnaires.</p> <p>Contact names of potential participants were provided by a single mother association and local community leaders.</p> <p>Participants who scored greater than five on the GHQ-30 screening tool were included in the study. The SCID was used. Themes were identified.</p>	<p>Barriers were identified in accessing mental health services. Most of the participants were not aware of local mental health services with same number holding negative perceptions towards psychiatric hospitals. 75% of those who received treatment had also seen a faith healer with the use of psychiatric help being viewed as a last option. Most people stopped taking anti-depressants due to fear of being addicted to the medication or experienced side effects. They also reported that medical treatment was unable to cure their mental illness.</p> <p>Respondents used words to express distress such as disappointment, stress and sadness. They also expressed their feelings and distress through cultural proverbs. Somatic complaints were also reported such as feeling in the stomach, weight upon the heart and physical pains.</p>

<p>Abu-Ras et al (2008).</p> <p>The Imam's role in mental health promotion: A study at 22 mosques in New York City's Muslim Community.</p>	<p>New York, United States</p> <p>To investigate the role of the Imam prior and post 9/11 and congregant's perceptions towards mental health services.</p> <p>102 Muslim Congregants 22 Imams</p> <p>1/2 congregant members were Arab and 1/3 had a college or graduate degree.</p>	<p>Quantitative</p> <p>Use of questionnaire. Invitation letter sent to all Mosques in New York.</p> <p>Univariate and bivariate analyses used.</p>	<p>Closed questions used. Descriptive presentation of data. Little discussion of themes</p> <p>Majority of respondents believed mental illness was related to devil. They also reported 98% was a test of one's faith. 95% of the sample perceived mental illness could be cured by the Quran and Hadith solely. The majority of them (86%) however believed in parallel treatments, using the Quran and psychotherapy with 80% agreed with the use of medication for people with mental illness.</p> <p>One third of the respondents who reported emotional difficulties, only 14% actively sought help out with the Imam and Mosque. For those who sought help, it was primarily from family doctor with only 3% seeing a mental health professional.</p> <p>Most of the twenty-two Imams had no formal training in mental health.</p>
<p>Al-Adawi et al (2002).</p> <p>Perception of and Attitude towards Mental Illness in Oman.</p>	<p>Muscat, Oman</p> <p>To explore whether social factors are related to persons attitude towards people with mental illness (PWMI).</p>	<p>Quantitative</p> <p>The public members were recruited from one of the neighbouring town and students from the University. Relatives who accompanied</p>	<p>When asked about causal factors, the participants reported genetics was not linked with mental illness. The majority of students and public believed spirits caused mental illness in contrast to relatives who did not.</p> <p>Forty percent of the participants felt mentally ill people could tell the difference between right and wrong</p>

	<p>The three groups selected were medical students, relatives of psychiatric patients and members of the public. In total, 226 males and 242 females participated (468).</p>	<p>patients to outpatient clinics or hospital were asked to take part.</p> <p>A revised version of the Attitude Towards Mental Illness Questionnaire (ATMIQ) was used (Well & Grunes, 1988).</p>	<p>however a large proportion of relatives disagreed with this. The majority of relatives believed people with mental illness were not able to form a true relationship. <i>Most of the public respondents believed psychiatric hospitals should be distant from residential areas.</i></p>
<p>Ali et al (2005).</p> <p>The Imam's Role in Meeting the Counselling Needs of Muslim Communities in the United States.</p>	<p>US</p> <p>To explore the role of the Imam in counselling needs</p> <p>62 Imams.</p> <p>Most of the imams were Arab American followed by South Asian and African American/Sub-Saharan/Caribbean.</p>	<p>Cross-sectional survey</p> <p>79 item questionnaire.</p> <p>The forms were sent out to 730 mosques in the United States using the North American Muslim Guide but there was only an 8% return rate.</p>	<p>There were a number of reasons of consultation with an Imam, the common reasons being religious or spiritual guidance, marital difficulties, parenting and death and dying. However, the study highlighted their work goes further in seeing people with depression, anxiety, odd thoughts and suicidal thoughts. The author's reported Imams are less likely to have formal training in counselling compared to other clergy.</p>
<p>Ali, O.M. & Milstein, G. (2012).</p> <p>Mental Illness Recognition and Referral Practices Among Imams in the United States.</p>	<p>United States</p> <p>To examine whether Imams could recognise symptoms of mental illness and assess their referral patterns.</p> <p>62 Imams</p>	<p>Quantitative</p> <p>Use of a survey and vignette (displaying symptoms of depression and possible risk of suicide).</p> <p>Self-reported survey. Recruitment from Mosques.</p>	<p>Most of the Imams were able to recognise the vignette reflecting the seriousness of the mental health difficulties. Imams were likely to continue seeing people and refer onto a mental health professional rather than advising referral to professional only. 60% of Imams reported making contact/referred members of their congregation to the family doctor and 46% of the Imams contacted another Imam who was more familiar with dealing with</p>

		Responses to vignettes were given on 4 point likert scale. Statistical analysis included calculation of standard deviations, means and Pearson-Rho values.	people with mental health issues. 46% of the Imams referred to a psychiatrist or psychologists. Less than half of them had not received any formal training in counselling or mental health.
Al-Krenawi, A. (1999). Explanations of Mental Health Symptoms By the Bedouin-Arabs of the Negev.	Negav, Israel To explore explanations of mental health difficulties. 60 Bedouin-Arab Muslim, 36 female and 24 male.	Interviews Semi-structured interviews with open ended questionnaires Participants were recruited from a psychiatric clinic.	Patients explained their difficulties resulting from God's Will, sorcery or evil spirits. It was seen as God's punishment for sin they had committed. None of them attributed a medical cause to their difficulties. The majority of the sample was diagnosed with neurotic illness and smaller number with psychosis. Unemployment was high among the participants with all female and half of the males not working. Low educational level. Males who perceived their symptoms related to God had received up to ten schooling years whilst males who had less education attributed their difficulties to evil spirits. Majority females who related their experiences to sorcery had not attended formal schooling. Half of the participants defaulted from treatment and their contact with mental health services.
Al-Krenawi et al (2004). Cross national study of attitudes towards seeking professional help: Jordan, United Arab Emirates (UAE) and Arabs in Israel.	United Arab Emirates, Jordan and Israel examined attitudes towards seeking help	A questionnaire based survey convenience snowball sample Recruited from University.	Younger participants and single women held less positive attitudes towards seeking help from mental health services compared with older participants and married women. There were no significant differences between nationalities.

	262 female Arab Muslims Majority were below age 31.	Orientation for Seeking Professional Help Questionnaire (OSPH) (Fischer and Turner, 1970). Hierarchical multiple regression analysis took place.	
Ally, Y. & Laher, S. (2008). South African Muslim Faith Healers perceptions of mental illness: understanding, aetiology and treatment.	Johannesburg, South Africa To explore the perceptions of Muslim faith healers toward mental illness. 6 Muslim faith healers, born in South Africa, Indian background. The healers all had minimum five years experience and four studied in an institution gaining the formal qualification of a Maulana, a religious scholar.	Qualitative approach Semi-structured interview schedule used. Recruited performed by convenience sample. Analysis done by thematic analysis.	Underlying aetiologies included black magic and evil eye as well as biological and social reasons given. Using plants was believed to help with black magic according to the healers. The existence of Jinn, unseen supernatural creature can also cause black magic. The healers reported this could lead to fear and hallucinations. The healers also cited the 'evil eye' could lead to sleep and appetite disturbance and tiredness. They used natural ingredients in treatment as well as reading the Holy Qu'ran. All the healers were in favour of close working relationship with professionals as they acknowledged biological factors as one of the possibilities.
Aloud, N., & Rathur, A. (2009). Factors affecting attitudes towards seeking and using formal mental	United States To explore attitudes towards seeking help and accessing	Quantitative	The study indicated that Arab Muslims utilised informal methods before accessing formal mental health services. They also held less positive attitudes towards seeking formal help. Possessing stronger traditional beliefs was

<p>health and psychological services among Arab Muslim populations.</p>	<p>mental health services in the US</p> <p>285 respondents primarily students and community members.</p>	<p>questionnaires were distributed to Muslims of Arab background through Islamic organisations</p> <p>Use of attitudes towards seeking help using the Orientations for Seeking Professional Help Questionnaire (OSPH) (Fisher & Turner, 1970)</p> <p>Data analysed by SPSS</p>	<p>linked with a greater perception of shame associated with accessing mental health services. Low levels of knowledge and little familiarity with mental health services affected individuals decision to seek professional help.</p> <p>Respondents were likely to access help for mental health difficulties firstly from the family practitioner (33%), and then family (21.6%) followed by the scholar (19%).</p>
<p>Al-Rawi et al (2012). Traditional healing practices among American Muslims: perceptions of community leaders in southeast Michigan</p>	<p>Southeast Michigan, US</p> <p>To explore traditional healing practices in American Muslim Community Leaders</p> <p>12 Community leaders</p>	<p>Qualitative study</p> <p>Semi-structured interviews</p> <p>Participants were contacted through community organisations. Purposive sampling.</p> <p>Interviews were recorded and transcribed. QSR Nvivo was used for coding. Framework coding structure used.</p>	<p>Three main areas of practices undertaken by the healers. Examples cited included use of Islamic text as a source of spiritual healing. Dietary advice, use of olive oil and honey, wet cupping (Hijama) and specific herbs such as black seed was reported.</p> <p>Secondly, worship practices were mentioned believed to have healing qualities such as prayer and dua (supplication).</p> <p>Lastly, there was mention of healing practices not considered Islamic and originating from cultural heritage. Examples given were use of herbs such as sunflower found among the Lebanese and sage tea used in Syria. The community leaders described how these traditional practices were used if conventional medicine had not worked or where there was no available practitioner Muslims could engage. The leaders reported using the</p>

			combined treatment of conventional and traditional practices as the last option.
Al-Solaim, L. & Loewenthal, K.M. (2011). Religion and obsessive compulsive disorder (OCD) among young Muslim women in Saudi Arabia.	Saudia Arabia To examine their experience OCD and influence of Islam. 15 women with OCD, aged 14 and 30.	Qualitative approach Semi-structured interviews took place. Analysis performed by thematic analysis, identifying codes to categories and between categories then themes emerged.	All the women consulted a faith healer prior to professional help. They believed their symptoms were caused by nazr (evil eye). The healers were involved in reading specific verses from the Quran, giving the women Zamzam (holy water to drink) and giving oil to be poured over the body.
Bhui et al (2007). Ethnicity and religious coping with mental distress.	London, UK To explore what is entailed in religious coping and examine patterns across diverse ethnic groups. 6 ethnic groups (Pakistani, Indian, Irish, Caribbean, Bangladeshi & White British). 116 people were interviewed, 40 of whom were Muslim, primarily South Asian in origin	Qualitative in-depth interviews Respondents invited who had taken part of larger study, EMPIRIC (Quantitative in nature). Interviews recorded and transcribed. Used framework analysis. Clinical Interview Schedule Revised used to measure the severity of a common mental disorder. 57% scored more than 12 and 59% scored less than 12.	The study highlighted that Muslims and Black Caribbean Christians used religious coping more often than other groups. Practices such as prayer, using beads, reciting verses from the Quran and listening to tapes helped Muslim participants. Muslim participants reported less distress, being able to clear one's mind and help solve problems when using religious coping.
Chew-Graham et al (2002).	Manchester, UK	Qualitative approach using focus group discussion	Self-harm was a coping strategy against wider pressures and social isolation. Izzat was given precedence over the happiness of children in some families. This could be

<p>South Asian women, psychological distress and self-harm: lessons for primary care trusts.</p>	<p>To examine psychological distress and self-harm in South Asian women in the UK.</p> <p>Participants involved in 4 focus groups.</p> <p>All but one were Muslim (one was Sikh). Majority were Pakistani.</p>	<p>4 groups</p> <p>Existing women groups were contacted.</p> <p>Analysis was performed through identification of themes and framework analysis (Ritchie & Spencer, 1994) (content analysis method).</p>	<p>misused to coerce females remaining silent. This led to high expectation of the women being wives, mothers, daughters and daughter in laws, creating an environment where the women felt controlled. The women were aware that this was not accepted within Islam and it was being misused by the community to reinforce stereotypical roles of woman. This view was also fuelled by the media as perceived by the women. Within the community, rumour and gossip was present and this led to a fear of disclosing their problems. Racism was also experienced in the community from outside the community. There was also the preference to speak to someone from the same background. Women spoke about the concern of being judged by professional agencies.</p>
<p>Cinnirella, M., & Loewenthal, C. (1999).</p> <p>Religious and ethnic group influences on beliefs about mental illness: a qualitative interview study.</p>	<p>London, UK</p> <p>To explore key differences in belief systems about mental illness among diverse groups. To examine impact of religious beliefs on causation and treatment of mental illness.</p> <p>52 females,</p>	<p>Qualitative approach</p> <p>Snowball and convenience techniques used. Interviewers approached individuals at places of worship and contacts made through networks</p> <p>In-depth recorded interviews which were transcribed. Questions</p>	<p>Possible underlying cause of depression was lack of faith but the majority of participants felt schizophrenia was related to an organic problem and religion played a less vital role.</p> <p>They found participants of the Muslim faith reported religious practices as helpful with their Schizophrenia and depression. The participant talked about prayer being helpful and relying on God's help. They spoke about God's Will which was seen as comforting.</p>

	<p>White Christian, Afro-Caribbean Christian, Orthodox Jewish and Indian Hindu, Muslim.</p> <p>13 Muslim</p> <p>9 volunteers reported about their personal experience of depression and 31 participants knew someone who had depression.</p> <p>Unclear how many Muslims suffered from mental illness.</p> <p>None of the participants indicated experience of symptoms of schizophrenia but 25 participants knew someone who had schizophrenia.</p>	<p>followed a funnelling approach (Guba & Lincoln, 1981). Analysis performed by thematic analysis, grounded theory.</p>	<p>Muslims may be 'doubly stigmatized' where they are excluded from their own community and also by the wider community for being from a certain ethnic group. Seeking professional help may be viewed as a symptom of weakness by community members and may affect the family honour and reputation. They also reported that even although there was the preference to see professionals from the same cultural background, there was still some ambivalence is seeking as this created fear of the community finding out and associated stigma as a result.</p>
<p>Dein, S. & Sembhi (2001). The Use of Traditional Healing in South Asian Psychiatric Patients in the U.K.: Interactions between Professional and Folk Psychiatries.</p>	<p>London, UK</p> <p>To explore the use of traditional healers among the South Asian population in the UK</p>	<p>Qualitative approach</p> <p>Interviews guided by theme list, applying an explanatory model (Kleinman, 1980).</p>	<p>Seven people (28%) had contacted a healer during their psychiatric illness and five consulted healers for non-psychiatric illness. Six people used herbs or traditional medicines. Patients used folk treatments alongside psychiatric medication. Patients less than the age of 40 years were more likely to resort to help from a healer compared to above the age of 40. Gender, country of</p>

	25 patients, 14 were Muslims, 2 Christian, 4 Hindu, 4 Sikh, (one unknown). South Asian background.	Recruited through community psychiatric nurses.	origin or religion did not have a significant association with seeking help from a traditional healer. Some thought healers were useful but others found them to be charging excessive amounts of consultation fees and were suspicious of them.
Dein, S., Alexander, M., Napier, A. D. (2008). Jinn, Psychiatry and contested notions of misfortune among East London Bangladeshis.	London, UK. To explore the understanding of misfortune in relation to Jinn among Bangladeshis. 40 Bangladeshis (18 female, 22 male)	Qualitative Ethnographic interviews. Used snowballing techniques, participants were recruited from the community, including people attending a community centre, mosque, local businesses, health professionals and restaurant workers. Unclear how analysis was undertaken.	Muslim Bangladeshi reported the influence of Jinn as causing misfortune, dramatic changes in behaviour, low mood, chaotic behaviour, unfaithfulness in marriage, stealing and unexplained physical symptoms. Use of traditional healers is common.
Eneborg, Y.M. (2013). Ruqya Shariya: Observing the rise of a new faith healing tradition amongst Muslims in east London.	London, UK To investigate Ruqya Shariya, a form of faith healing in Muslims 40 Muslims. All but one were Somalian.	Participant observation & semi-structured interviews. A list of faith healers was compiled and one was selected from the list (The study mentions he was selected due his position in the local community). The faith healer	Faith healers are also contacted after patients have accessed services. Most of the 40 participants had sought help from health services prior to seeing the faith healer. The faith healer specialised in ruqya shariya, a type of treatment using incantations with roots in the Quran. The faith healer diagnosed black magic in most cases followed by influence from a Jinn. All the individuals received the treatment, ruqya shariya and were given a course of herbal medicine.

		<p>was observed over a period of five weeks seeing people.</p> <p>Forty people came to see the faith healer, 34 were seen separately following the consultation by the researcher.</p>	
<p>Gilbert et al (2004)</p> <p>A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby</p>	<p>Derby, UK.</p> <p>South Asian women</p> <p>To explore South Asian women's meaning of shame, entrapment, izzat & subordination and how this is linked mental health difficulties and help-seeking behaviour</p> <p>3 groups consisted of different age groups- group 1- 16-25, group 2- 26-40, group 3- 41+ (last group took place in Punjabi).</p>	<p>Focus group discussion</p> <p>Groups recruited from and ran in a women's project, Karma Nirvana.</p> <p>Sessions recorded and transcribed.</p>	<p>Shame, entrapment and subordination were linked with the central concept of Izzat which played an important role in women's experience. This affected help-seeking behaviour due to fear of discovery and confidentiality.</p> <p>The women complained of low mood, created a sense of failure and low self-esteem further leading to difficulties talking to others.</p>
<p>Greenwood et al (2000)</p>	<p>London, UK</p>	<p>Qualitative interviewing</p>	<p>The term 'Asian' was seen as problematic as participants came from diverse backgrounds. Negative experiences</p>

<p>Asian in-patient and carer views of mental health care. Asian views of mental health care</p>	<p>To explore the understanding of participants of Asian background with mental illness and treatment and experience in services.</p> <p>14 Asian (current or recent inpatients), of which 10 were Muslims and 10 Carers interviewed. Average age of participants-40. More than half were born outside UK and two-thirds lived in UK over 20 years.</p> <p>Diagnosis of patients- psychosis (5), Schizophrenia (5) and Depression (3).</p>	<p>Patients recruited from hospital lists.</p> <p>Carers were identified by the patients. in-depth interviews using open-ended questions. Topic guides were modified regularly. 2/3 interviews were in English, rest in other languages.</p> <p>Sessions recorded and transcribed.</p> <p>Analysis was performed by hand, using steps from Miles & Huberman (1994) and involved grounded theory (Strauss & Corbin, 1998). Categories and themes were developed.</p>	<p>mentioned food, privacy, washing facilities and communication. Stigma was also mentioned as a barrier.</p> <p>Respondent preferred to use terms such as depression rather than mental illness and used traditional methods such as herbal medicines and religious help.</p>
<p>Haj-Yahia, M. (1999) Attitudes towards Mentally Ill People and Willingness to Employ Them in Arab Society.</p>	<p>East Jerusalem</p> <p>To examine attitudes toward mentally ill with particular focus with regards to employment.</p> <p>262 Muslim employers</p>	<p>Survey</p> <p>Recruitment from directory and from family and community leaders. Sample of 1701 were accessed and stratified random sample of 262 employers studied.</p>	<p>Muslims from a traditional background were more likely to perceive mental illness as a consequence of an inadequate relationship with God, divine will and punishment. The results showed the greater the view of divine punishment, then the higher likelihood of negative attitudes being present toward mentally ill people.</p>

		A 7-item measure of 'traditionalism' was developed. Factor analysis used. The questionnaire was pre-tested among smaller sample of 14 respondents.	However the findings did not support the hypothesis that traditionalism influences attitudes and rejection. The negative attitudes and rejection were predominately present in the moderate group rather than the more orthodox Muslim group.
Hamid, A. & Furnham, A. (2012). Factors affecting attitude towards seeking professional help for mental illness: a UK Arab perspective.	UK To examine factors affecting attitudes towards help-seeking behaviour. 100 Arab Muslims and 104 Caucasians	Quantitative Questionnaire were self-administered and online. Recruitment took place at London Universities, social network sites and Arab groups. Use of questionnaire assessing attitudes towards seeking help using the Orientations for Seeking Professional Help Questionnaire (OSPH) (Fisher & Turner, 1970), Mental Distress Explanatory Model Questionnaire (MDEMQ) (Eisenbruch, 1990) and Attitude towards Mental Health Problems (ATMHP) Questionnaire (Gilbert et al, 2007)	The Arab Muslims held stronger supernatural beliefs towards mental illness compared with British Caucasians. The Arab sample were found to hold less positive attitudes towards seeking help compared with British Caucasians. A higher level of education, old age indicated a more positive attitude in seeking help. There were concerns about confidentiality which affected access to services.
Hussain, F. & Cochrane, R. (2002).	Birmingham, UK	Qualitative method. Topic guides utilised. Categories and themes were identified and	The women reported evil eye, black magic and possession by Jinn as causes of depression. The Jinn was perceived to cause sadness, withdrawn behaviour and physical illness. Number of strategies was employed by

<p>Depression in South Asian women: Asians Women's beliefs on causes and cures.</p>	<p>To explore beliefs of Asian women relating to causes and cures of depression.</p> <p>6 Muslim women, 4 Hindu, 2 Sikh women.</p> <p>All women suffering from depression.</p> <p>Also 3 carers interviewed.</p>	<p>used theoretical sampling. Used grounded theory. Field diary kept.</p> <p>Describe use of guidelines by Elliott et al (1999) and constructivist perspective.</p> <p>Data collected in English, Urdu & Punjabi.</p> <p>All the women were recruited from mental health services in Birmingham.</p>	<p>the participants, formally and informally. The most common cited was the religious coping such as prayer, reading the Quran and supplication. Herbal remedy was used. The participants also used talking therapies which helped them explore issues within the community and confidential concerns. They accessed support groups within voluntary organisations and directly with friends. Religious healers were accessed.</p>
<p>Hussain & Cochrane (2003).</p> <p>Living with depression: coping strategies used by South Asian women living in the UK, suffering from depression.</p>	<p>Same study as Hussain, F. & Cochrane, R. (2002).</p>		
<p>Hussain, N. (2006).</p> <p>Culturally determined care goals and the efficacy of statutory services.</p>	<p>England, UK</p> <p>To assess the reasons for poor engagement with services in sample of distressed participants.</p>	<p>Qualitative</p> <p>Participants were recruited through community care programmes. The clients of traditional hears came through one of the local religious leaders.</p> <p>Narrative-pointed questioning used to bring out narratives in particular</p>	<p>Kismet or predetermination was a central belief underlying mental illness. They saw milder forms of mental health difficulties such as depression or anxiety as spiritual disorders rather than a mental problem. The participants held the view that mental illness was a punishment for sinful acts. The participants described mental illness could also be part of the test sent by God in this world where success in the after-life was attained through being patient during difficult times.</p>

	<p>First-generation Pakistani Muslims presenting with distress- 16 males, 17 females.</p> <p>All except 2 accessed a traditional healer or used mental health services.</p> <p>All above 55 age.</p>	<p>themes. Interviews were recorded and transcribed.</p> <p>Categories and themes were developed.</p> <p>Used a Constant Comparative Method Silverman (2000).</p>	<p>Izzat or family honour was a reflection of the family status in the community and any threat to this position created distress. Most of the participants were reluctant to engage with service as they voiced their concerns about GP's confidentiality and the belief GP's did not understand the concept of izzat. The participants did not find using mental health services useful and some felt it worsened their difficulties as they were given the idea they were 'mentally ill'.</p>
<p>Javaheri, F. (2006).</p> <p>Prayer healing: An experiential description of Iranian prayer healing.</p>	<p>Tehran, Iran</p> <p>To examine prayer healing in Iran.</p> <p>14 healers, 170 patients who use healers</p>	<p>Qualitative</p> <p>In-depth interviews and participatory observation.</p> <p>Healers selected through contacts.</p> <p>Patients who were referred to centres for healings were randomly selected.</p>	<p>The role of the healer varied in contrast to the specific roles of doctors. In addition to healing through prayer, they would also help in problem solving and act as social workers. Most of the healers met their clients in person but it was not limited to this interaction. Some healers would work with clients by letter or arranging for someone else to be present with the client rather than the healer themselves. Healing took place in mosques, the street, and people's home. Clients spoke about hope, peace and happiness and the sense of belonging with a sacred environment.</p>
<p>Javed et al (2006)</p> <p>Attitude of the university students and teachers towards mentally ill, in Lahore, Pakistan.</p>	<p>Lahore, Pakistan.</p> <p>To measure attitudes of general public (university teachers and students) towards individuals who are mentally ill.</p>	<p>Survey</p> <p>Based on questionnaire by Crisp et al (2000). Scale used different levels of agreement.</p>	<p>Most people had negative attitudes such as danger to others, unpredictable, hard to talk to towards people with schizophrenia, depression and substance abuse.</p>

	194 respondents completed survey forms, 66% were female.	Survey was randomly given to teachers and students using prepaid envelopes.	
Johnsdotter et al (2011). Koran reading and negotiation with jinn: strategies to deal with mental ill health among Swedish Somalis.	Sweden To examine perceptions of mental illness among Swedish Somalis. 20 Somalian Muslims	Qualitative study & focus group. Recruitment performed through snowballing and contacting Somali associations. Identifying codes and themes were involved in the analysis (Brenard, 1996) and use of naturalistic inquiry (Lincoln and Guba, 1985).	Political conflict was reported as one of the main reasons leading to difficulties. Concern about their relatives back in Somalia and break-up of the family were other reasons cited. A number of concepts on a spectrum of severity (rather than categories), ranging from a mild form Dhimir referring to mental ill health and Muruf which referred to feeling low and worry. A more severe form of mental illness was described as Buufi. These concepts were present alongside the notions of Jinn and evil eye. Community support was seen integral to this where people talked to others about their problems. Reading the Quran in the company of family, friends and scholars was seen as helpful where the Quran was seen as having healing powers.
Kadri et al (2004). Stigma impact on Moroccan families of patients with schizophrenia.	Casablanca, Morocco To examine whether relatives of patients with Schizophrenia suffer from stigma and to explore their views towards the patients.	Survey Recruited at the Psychiatric hospital and outpatient clinics. Data analysis using Epi info.	Out of 100 families, just over 60% did not ask the patients to undertake important tasks due to mistrust or they viewed them to be handicapped. A small number reported they treated the patients as if they were 'mad' and with feeling of rejection. Some perceived Schizophrenia was not curable and should be locked away to help them. Most family members suffered from discrimination and

	100 family members		stigma. Most of them reported they had difficult lives and reported poor sleep pattern and relationship difficulties. The families also experienced mockery, maltreatment and mistrust. One third of the respondents also reported they felt neglected from the neighbours and feeling that people were afraid of them.
Khalifa et al (2011). Beliefs about Jinn, Black Magic and Evil Eye among Muslims: age, gender and first language influences.	Leicester, UK. 111 Muslim participants To examine beliefs towards jinn, black magic and evil eye and whether it can cause mental and physical health problems. The majority were born outside the UK, married, belonged to 18-30 age group and first language was English.	Use of questionnaire Respondents were recruited where Muslims gathered such as shopping areas, the mosque and Islamic centres. Questionnaire was tested on a small sample of 12 participants and self-completed by respondents.	Most common supernatural belief held by Muslims living in Leicester was Jinn followed by influence from the evil eye and black magic. The participants also believed the supernatural causes could cause physical illnesses such as high blood pressure, bruises and fever. More than 40% reported both religious figures and doctors should be involved in the treatment of evil eye, black magic and jinn.
Khan, Z. (2006) Attitudes toward counseling and alternative support among <i>Muslims</i> in Toledo, Ohio	Toledo, Ohio To examine attitudes towards counselling among Muslims.	Cross sectional study Self-reported questionnaire	The results reported most people were positive towards counselling. Even although 15.7% of the sample indicated a need for counselling, a smaller number did not access mental health services in the preceding 2 years. Most of the Muslims who had this unmet need were

	<p>459 Muslims (119 South Asians, 240 Arabs, 44 African Americans, 56 Others).</p> <p>Most of the sample were well educated and young (25-44).</p>	<p>Use of Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Farina, 1995).</p> <p>Participants were recruited from Mosques and Islamic centres</p> <p>Analysis use of odd ratios & chi-squares.</p>	<p>females. Muslim men had more negative attitudes towards seeking psychological help. Most of the sample sought help from reading the Quran, prayer and family as an alternative form of support.</p>
<p>Laher, S. & Khan, S. (2011). Exploring the influence of Islam on the perceptions of mental illness of volunteers in a Johannesburg community based organization.</p>	<p>Johannesburg, South Africa</p> <p>Explore perceptions of mental illness in Muslim Volunteer counsellors.</p> <p>8 individuals of Indian Muslims</p>	<p>Qualitative approach</p> <p>Recruited from a community organisation</p> <p>Semi-structured interviews.</p> <p>Schedule was piloted on 2 psychology students.</p> <p>Thematic content analysis used.</p>	<p>Perceptions of mental illness were related to a number of reasons rather than one cause, for example stress, genetics, trauma, chemical imbalance, family and social problems. They also held religious beliefs as a cause such as a test from God. Community members do not necessarily acknowledge the existence of mental health difficulties and mental illness. Members of the community showed little empathy towards people with mental illness which in some cases led individuals to complain more of physical complaints rather than mental health difficulties. The respondents also highlighted community issues and associated stigma was related to cultural upbringing rather than Islamic values. People would rather speak about problems such as jadoo (black magic) rather than mental illness as this was more acceptable in the local community.</p>

<p>Laher, S. & Ismail, A. (2012).</p> <p>South African Muslim Psychologists' Perceptions of Mental Illness.</p>	<p>South Africa</p> <p>To examine the perceptions of mental illness in Muslim Psychologists.</p> <p>10 Muslim female Psychologies</p>	<p>Qualitative</p> <p>Semi-structured interviews, questions were piloted on 4 participants.</p> <p>Recruitment - convenience sample took place.</p> <p>Thematic content analysis (Braun and Clark, 2006) was utilised.</p>	<p>Respondents reported that mental illness was someone primarily struggling to cope with life. 4 of the respondents said their personal religious beliefs influenced their opinion about therapy. All respondents were open to collaboratively working with faith healers. Respondents talked about Islam being a resource for well-being.</p>
<p>Leavey et al (2007).</p> <p>Finding Help: Turkish-speaking Refugees and Migrants with a History of Psychosis.</p>	<p>London, UK</p> <p>To examine illness narratives of Turkish patients.</p> <p>9 Turkish Muslims (8 male, 1 female).</p> <p>Participants presented with first episode Psychosis.</p>	<p>Qualitative</p> <p>Participants were identified through a previous study.</p> <p>Interviews were transcribed.</p> <p>Use of software NUD.IST to code and analyse data.</p>	<p>Reports of the concept of fate, beliefs about evil eye and magic (referred to as buyu) being related to mental illness.</p> <p>There was concealment of symptoms with friends or family who encouraged help to be sought for the person affected. The respondents suffered from psychosis prevented their families from contacting mental health services. These patients utilised treatment in combination with traditional healers.</p>
<p>Leavey, G. (2008).</p> <p>U.K. Clergy and People in Mental Distress: Community and Patterns of Pastoral Care</p>	<p>London, UK</p> <p>To explore models of care provided by clergy of Jewish, Christian & Muslim groups.</p>	<p>Qualitative approach</p> <p>Theoretical sampling strategy, recruited through contacted through directories.</p> <p>Interviews recorded and transcribed with use of topic guide.</p>	<p>The Imams raised the important issue of stigma linked to mental health problems more so than the others 2 groups. They reported that in certain circumstances there may be blurring of boundaries between religious and cultural beliefs such as marital problems or misfortune and Imams played a role in exploring this with community members.</p>

	6 Rabbis, 19 Christian ministers and 7 Imams, aged between 37 and 68. 4 of the Imams came from Bangladesh. The rest were from India, turkey and Kenya.	Hyper-research software package was used for coding the data (Hesse-Biber & Dupuis, 2000).	
Loewenthal et al (2001). Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK.	London, UK To examine the perceived benefits to religious activities (coping). 282 participants (Christians, Hindu, Jewish, Muslim and no religion). 33 Muslims	Quantitative Use of questionnaire (114 item) developed on 59 semi-structured interviews reported in previous studies (Cinnirella & Loewenthal, 1999). Administered to volunteers based at the University.	Prayer and faith was found to be most helpful in coping with depression for the Muslim group compared with Christians, Hindu, Jewish and no religion. Other religious activity included study of religious material and attendance of Mosque, place of worship. Limitations were that most Muslims were of the South Asian background.
Mölsä, M. E., Hjelde, K.H. and Tiilikainen, M. (2010). Changing Conceptions of Mental Distress among Somalis in Finland.	Helsinki, Finland To examine expressions, conceptions and treatment of mental distress 27 Somalians living in Finland (20 female, 7 male) and 2 Muslim healers.	2 focus group interviews Recruitment took place from community with help from 2 community activists. Interviews were transcribed and translated. Findings organised thematically.	Expressions of distress were discussed. Concept 'buufis' was expressed to mean sadness and distress, feeling despondent of the isolation and loss of social support that had happened. The men interviewed experienced this emotion more than women as they were seen as the breadwinners. The situation they faced regarding unemployment, language barriers, difficulty integrating in the community, discrimination, financial difficulties, and loss of family ties were seen as leading to buufis. The participants described the concept of qalbijab (referring to the heart) and Niyadjab (referring to the mind, soul, will and thought).

	All participants lived through the colonisation of Somalia and independence, aged between 50-72.		
Muga, F.A. & Jenkins, R (2008). Public Perceptions, Explanatory Models and Service Utilisation Regarding Mental Illness and Mental Health Care in Kenya.	Mombasa, Kenya To examine underlying public views about mental illness. 353 participants, 35% were Muslims.	Questionnaire & interviews 353 participants completed questionnaires. 5 participants also gave 1:1 interviews (unstructured). Sample frame took place and participant's households selected using stratified random sampling. Unclear how data analysis took place.	Households in Kenya hold the view that Schizophrenia was caused by spiritual beliefs and supernatural causes. This was driven by idea that the person is being punished as a consequence of abandoning their faith or human jealousy.
Mullick et al (2012). Beliefs about Jinn, black magic and evil eye in Bangladesh: the effects of gender and level of education.	Dhaka, Bangladesh To examine beliefs about jinn, evil eye, black magic in Muslim participants in Bangladesh. Sample of 320 attendees 195 male, 125 female	Self-completed questionnaire This was translated into Bangla. Muslims recruited from medical outpatient departments attending the University Hospital. Data was analysed using descriptive statistics.	Muslims had higher beliefs towards Jinn possession in contrast to evil eye and black magic. People with a higher level of education were less likely to report jinn possession, evil eye or black magic could cause mental illness. Women reported higher beliefs in existence of Jinn and held the view more strongly and religious figures should play a role in the treatment of black magic and jinn.

<p>Nguyen et al (2013). Mosque-Based Emotional Support Among Young Muslim Americans.</p>	<p>Michigan, United States</p> <p>To examine mosque based support among American Muslims</p> <p>231 participants</p> <p>Over half of the respondents were Arab followed by Asian background (29%).</p>	<p>Quantitative</p> <p>Recruitment took place from the community and University. Use of measures of congregation support (Fetzer Institute and National Institute on Aging's, 1999) and use of likert scale. Tabulations presented using Chi square.</p>	<p>The results indicate there is a positive link between congregational involvement and mosque attendance with giving and receiving emotional support. Muslims who visited the mosque and were more involved with the congregation members received and gave higher levels of emotional support. Women received and gave more support than men.</p>
<p>Farooqi, Y. (2006). Traditional Healing Practices Sought by Muslim Psychiatric Patients in Lahore, Pakistan.</p>	<p>Lahore, Pakistan</p> <p>To examine traditional healing practices used by psychiatric patients.</p> <p>54 females and 33 males participated</p>	<p>Interviews Self-reported schedule (Case History Interview Schedule).</p> <p>Used ex post facto design (Ray 2003). Use of hospital records to gather background information. All had an inpatient stay in hospital and were identified using a purposive sampling technique.</p> <p>SPSS used to analyse the data.</p>	<p>The use of the Muslim healers is prevalent among Muslim Psychiatric patients in Pakistan. Men consulted healers more frequently than women. Possible reasons for this are men travel more and most healers are men which may be a barrier for women consulting them. Females use multiple traditional healing practices more than men. Muslims living in Pakistan find it difficult to discuss their psychological issues outside the family with shame and guilt being a hindrance to accessing help from professionals. In this light, religious healers are often accessed by such patients.</p>
<p>Padela et al (2011). The Role of Imams in American Muslim Health: Perspectives of</p>	<p>United States</p>	<p>Qualitative study</p> <p>Semi-structured interviews</p>	<p>Imams promoted healthy patterns of behaviour through their sermons; undertaking religious activities such as burials, visiting the sick and playing a role as a counsellor</p>

<p>Muslim Community Leaders in Southeast Michigan.</p>	<p>To investigate the views of community leaders towards the role of Imams in health</p> <p>12 community leaders</p>	<p>Community-based participatory study with 4 Muslim organisations. Representatives from the organisations identified participants to be interviewed.</p> <p>QSR Nvivo was used to aid coding and analysis.</p>	<p>or providing alternative therapies; engaging in hospitals and delivering cultural training programmes and advising in decisions pertinent to someone's health.</p>
<p>Penny et al (2009). Whispering on the Water: British Pakistani Families' Experiences of Support From an Early Intervention Service for First-Episode Psychosis.</p>	<p>Birmingham, UK</p> <p>To examine the experience of British Pakistanis families with the early intervention service.</p> <p>11 participants, from 6 families. All the participants cared for a family member who was under the care of intervention service with a diagnosis of Psychosis.</p>	<p>Qualitative</p> <p>In-depth interviews</p> <p>Families under the early intervention service were contacted.</p> <p>Interpretative Phenomenological Analysis too place.</p>	<p>The participants turned to Islam as a way of coping. This helped them make sense of their difficulties and gave them hope for the future. Some of the participants reported a sense of empowerment through their faith and placed their trust in God's help. Family members took part in reading the Quran and regular prayer. They also visited Imams for spiritual support. The carers complained the services were not holistic. Some of the families reported they did not understand some of the information shared with them and were not clear about the type of illness their relatives were suffering from.</p>
<p>Pilkington et al (2011). Factors affecting intention to access psychological services</p>	<p>England, UK.</p>	<p>A cross-sectional survey</p>	<p>The results showed that higher levels of izzat and shame and biological beliefs were linked with a reduced intention to accept help. Acculturation and education</p>

<p>amongst British Muslims of South Asian origin.</p>	<p>To examine intention to use psychological services among South Asian Muslims.</p> <p>94 British Muslims of South Asian,</p> <p>higher level of education levels observed in the sample group compared to the Muslim population living in the UK</p>	<p>The respondents were recruited from Muslim community centres and online sites.</p> <p>Measurements described- Measure of intention to seek psychological help (IASMHS, Mackenzie et al, 2004), the Attitudes Towards Mental Health Scale (ATMHP, Gilbert et al, 2007).</p> <p>Hierarchical block-wise multiple regression used to analyse the results.</p>	<p>levels were related positively to intention to access mental health services.</p>
<p>Qidwai, W. & Azam, S.I. (2002). Psychiatric morbidity and perceptions on psychiatric illness among patients presenting to Family Physicians, in April 2001 at a teaching hospital in Karachi, Pakistan.</p>	<p>Karachi, Pakistan.</p> <p>To investigate psychiatric morbidity and explore perceptions about mental illness.</p> <p>400 patients</p>	<p>Quantitative</p> <p>questionnaire based survey, administered by an interviewer.</p> <p>Participants who attended clinics to see family physicians were recruited.</p> <p>147 patients were diagnosed with a mental illness by a family physician or psychiatrist.</p>	<p>Almost one-third of the sample believed mental illness was caused by spirits or supernatural powers. There was reluctance to seek help from a psychiatrist in 27.3% of respondents, 10.5% perceived treatment of mental illness may be harmful and 74% reported mental illness was a stigma. 27.3% of the patients felt they needed to consult a psychiatrist for treatment but were reluctant to do so in the past. Near 40% of patients showed ambivalence in accepting the diagnosis. 12% sought help from a Hakim (someone who has specialised in Islamic/traditional medicine) and same number consulted a faith healer.</p>

<p>Rashid et al (2012).</p> <p>Muslim faith healers' views on substance misuse and psychosis.</p>	<p>UK</p> <p>To examine views of faith healers towards psychosis and substance misuse.</p> <p>8 Muslim faith healers</p> <p>All except one were South Asian, 7 males</p>	<p>Qualitative</p> <p>Semi-structured interviews with vignettes</p> <p>Faith healers recruited from Nottingham, Birmingham, Leicester using personal contacts at local mosques.</p> <p>Interviews transcribed. Analysis involved grounded theory methods. Line by line coding (Glaser, 1978) and Constant comparative methods were used (Glaser & Strauss, 1967).</p>	<p>Healers cited psychosocial reasons such as major life events or traumatic childhood. They also mentioned possession by Jinn as a cause. The Jinn was perceived to affect individuals when there were low levels of religiosity, revenge or where the Jinn have carnal feeling towards the individual. Religious practices was seen as a protective factor against mental illnesses such as reciting the Quran and praying.</p> <p>Exploring the cause of substance misuse, the healers cited social issues commonly such as adverse upbringing, broken families, and peer pressure and in contrast to the other vignette, religious reasons were rarely mentioned.</p>
<p>Razali et al (1996)</p> <p>Belief in supernatural causes of mental illness among Malay patients: impact on treatment.</p>	<p>Kelantan, Malayasia</p> <p>To assess help seeking behaviour of Malay psychiatric patients.</p> <p>134 Malay patients.</p> <p>Most of the participants were housewives, farmers or semi-skilled workers.</p>	<p>Semi-structured interviews and questionnaire.</p> <p>Semi-structured interviews used to gather information on past treatment and attitudes. Use of 20 item checklist to rate most likely reason of mental illness. Chi-square used.</p>	<p>Over half of the patients of 134 Malaysian Muslims cited possession by evil spirits and witchcraft as causes of mental illness. The participants reported a spell was cast on their food or objects placed in close contact to them. A supernatural cause was found more commonly in patients suffering from psychosis. They reported that patients who accepted supernatural causes compared to others who did not demonstrated poorer medication compliance and less likely to engage at the six months follow up.</p>

		Patients attending from a psychiatric clinic were recruited. Diagnosis made using DSM 3 criteria.	Understanding someone's religious background is important during the treatment of patients.
Razali, S.M. & Najib, M. (2000). Help-Seeking Pathways Among Malay Psychiatric Patients.	Kelantan, Malaysia To examine help-seeking behaviour in new patients attending psychiatric outpatient. 134 Muslim psychiatric patients	Questionnaire based survey. Semi-structured interviews conducted based on a proforma. Questionnaire based survey Patients recruited from outpatient clinic. Patients had diagnosis of mental disorder made according to DSM-3R. Most of the patients primarily suffered from a psychotic illness, bipolar illness or severe depression.	Majority of sample consulted faith healers prior to seeing a psychiatrist. Also they accessed the general medical clinic before seeing a psychiatrist due to the higher fees. They reported a delay in accessing psychiatric help. Other treatments access were acupuncture, herbs or homeopathy prior to seeking professional help at the hospital.
Saeed et al (2000). The prevalence, classification and treatment of mental disorders among attenders of native faith healers in rural Pakistan	Gujarkhan, Pakistan To examine prevalence and treatment of mental illness among attenders who attend faith healers.	Questionnaire A list of faith healers were obtained from the Department of Religious Affairs. The contact between the faith healer and their attender was observed. The participant was then	Participants who saw five Muslim faith healers primarily complaining of Saya (meaning an evil spirit casting a shadow onto the individual), Jinn infliction and Churail possession (a demon who presents as a young woman with the aim of seducing men and thereafter possessing them). The study highlighted a significant number of people accessed faith healers who may be suffering from a mental disorder.

	139 participants, 192 female, 106 male (unclear how many were Muslims).	<p>contacted to agree to take part in the study.</p> <p>Individuals completed the GHQ-12 and PAS. According to the DSM-3 criteria, in total 61% were diagnosed with a mental disorder. The most frequent diagnosis was major depression illness (24%) followed by generalised anxiety (15%) and epilepsy (9%).</p>	
<p>Salem et al (2009).</p> <p>Help-Seeking Behaviour of Patients Attending the Psychiatric Service in a Sample of United Arab Emirates Population.</p>	<p>Al-Ain, United Arab Emirates</p> <p>To examine help-seeking behaviour of new patients attending a psychiatric clinic.</p> <p>106 participants (54 females and 52 males).</p>	<p>Quantitative</p> <p>Use of questionnaire was administered face to face.</p> <p>Recruited from a psychiatric clinic. Diagnosis was given by the psychiatrist in the clinic.</p> <p>SPSS was used for statistical analysis.</p>	<p>44.8% of people consulted a faith healer prior to accessing the psychiatric service. 22.6% of the sample were suffered from a psychotic illness, of the people with remaining primarily being diagnosed with depression (30.9%) and anxiety (34.6%). 33.3% continued to attend the faith healer in conjunction with the psychiatrist. Out of those who contacted faith healers, 45% reported improvements however complained of recurrent symptoms. Near half of the patients reported no improvement.</p>
<p>Shibre et al (2001).</p> <p>Perception of stigma among family members of individuals with schizophrenia and major</p>	<p>Butajira district, Ethiopia</p> <p>To examine perception of stigma experienced by relatives</p>	<p>Quantitative</p>	<p>Stigmatising attitudes towards relatives were common. Three-quarters of the respondents experienced stigmatising attitudes, 42% were anxious about being treated differently by others and 25% perceived they were</p>

<p>affective disorders in rural Ethiopia.</p>	<p>of people with Schizophrenia and mood disorder.</p> <p>178 were included. The majority of respondents were Muslim and remaining Christian (73.6% and 26.4% respectively). The relatives of people who suffered from severe mood disorder or Schizophrenia were interviewed.</p>	<p>Interviews took place at the healthcare centres.</p> <p>The CIDI was used for screening (Sartorius and Janca, 1996). The SCAN was also utilised. SPSS was used to analysis the data.</p>	<p>being blamed for relative's illness. This led to 37% of relatives concealed that fact someone in the household suffered from a mental illness.</p>
<p>Sheikh, S. & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help.</p>	<p>Karachi, Pakistan London, UK</p> <p>To examine relationship between cultural beliefs and attitudes with seeking professional help.</p> <p>67 Muslims in sample of 287 (British Asian, Western European and Pakistanis were investigated). Most were aged between 18-30 years and single.</p>	<p>Questionnaire</p> <p>Use of The Orientations for Seeking Professional Help (OSPH) was used (29 item, Likert format) and the Mental Distress Explanatory Model Questionnaire (MDEMQ). Hierarchical multiple regression analysis took place.</p> <p>In UK, recruitment took place through 2 drop in centres,</p>	<p>Religious beliefs played an important role in predicting attitudes to help seeking behaviour. Muslims were less likely to seek professional help compared to people who had no religious affiliation. Male participants and those who had lower level of education compared to others had a more negative attitude to seeking help. Pakistanis resident abroad compared with British Asians were more likely to perceive supernatural forces as a cause of mental illness.</p>

		In Pakistan, participants recruited from an outdoor stadium and at a school function.	
Shoaib, K. & Peel, J. (2003). Kashmiri women's perceptions of their emotional and psychological needs, and access to counselling.	Oldham, UK To examine the understanding and expressions of mental illness in Kashmiri women. 45 Muslim Kashmiri women	Qualitative and quantitative Recruitment- 10 participants recruited through professionals and thereafter through 'snowballing'. Themes were identified in analysis. No further detail given how analysis took place. Unclear how many of participants have used mental health services	Participants were able to understand mental illness as a psychological frame of mind however the expression of emotional distress referred to relating to the head or heart. Phrases were used metaphorically by Kashmiri women to express their distress. They also cited disability, marital conflict, family conflict, financial issues and intergeneration conflict as causes of mental illness.
Tabassum, R., Macaskill, A., Ahmad, I. (2000) Attitudes Towards Mental Health in an Urban Pakistani Community in the United Kingdom.	Sheffield, UK Deprived, working class area with high levels of unemployment. To investigate the attitudes of Pakistanis towards mental illness 22 males and 52 females. Most born in Pakistan and married. Most received little education.	Interviews Respondents were contacted through the GP, community health care worker, social worker and personal contacts. Interviews took place in either Punjabi, English or Urdu. Only 7 gave permission for interviews to be recorded.	They found although Pakistani Muslims were prepared to interact with people with mental illness, this was only at a superficial level as more than three-quarters were not prepared to develop a close relationship with someone with mental illness. Furthermore less than half would socialise regularly with people with mental illness. All the participants refused to consider marrying someone who had a mental illness. Admission to a psychiatric hospital was seen as a option for the respondents. Language was cited as the main reason why someone would not seek help from the hospital followed by social stigma.

	17 of the participants were born in UK.	An Interview schedule consisting of 21 statements was used. This was translated in Punjabi and Urdu. No information about history of mental illness	Hakims and faith healers were accessed however the treatment of choice was GPs.
Vanaleesin, S., Suttharangsee, W., & Hatthakit, U. (2010). Cultural aspects of care for Muslim schizophrenic patients: An ethnonursing study.	Thailand To examine cultural beliefs of caring in Muslim patients. 13 Carers of Muslim patients with diagnosis of Schizophrenia and 19 general informants (who had understanding of caring needs).	Qualitative In-depth interviews. Ethno-nursing method Using a semi-structured open-ended questions, interviews were recorded, observations notes taken and use of reflections. Unclear how recruitment took placed.	Caring was seen as a means of doing good in the eyes of God and whoever placed barriers to this help, was seen as being sinful. All the participants believed visiting Muslim patients or giving them money or food would help them gain a better place after death. Hating patients with schizophrenia was seen as sinful. They argued this view helped reduce stigma. They also reported the use of Muslim healers in Thailand.
Weatherhead, S., & Daiches, A. (2010). Muslim Views on Mental Health and Psychotherapy.	Lancaster, UK To examine Muslims views of the concept of mental health 14 Muslims took part of diverse backgrounds. Half of the participants belonged to 30-39 age.	Qualitative approach Recruitment from local organisations and electronic mailing lists, Lancaster University. Only three of the participants reported contact with mental health services. Data analysed using thematic analysis, using a coding frame,	Muslims held a philosophical view that life in this world was a test for them. This was seen as an aspect of life to be acceptable with and viewed positively as it was an opportunity to prepare for the after-life. The students were grateful for this opportunity. Jinn, witchcraft and punishment were also cited as causes of mental illness. One participant described their illness being a consequence of their own action and referred to it as a bad thing.

		categories, subcategories (Mark & Yardley, 2004).	
Whittaker et al (2005). An exploration of psychological well-being with Young Somali Refugees and Asylum-seeker Women.	England To investigate how Somali females understand psychological well-being. 5 Somalian females	Qualitative Recruited from voluntary sector Semi-structured interviews 1:1 and group interviews. Themes identified using Interpretative Phenomenological Analysis (J.A.Smith et al, 1999). No information about history of mental health difficulties	Cultural beliefs of zar possession intertwined with religious beliefs. Participants described how there can sometime be a conflict between culture and religion particularly concerning possession and family responsibilities where people may live or follow ideas that are culturally rooted rather than having a basis in the Quran. Psychological distress was perceived as weakness making it difficult to share their difficulties with others. They also reported the family and the wider community as important sources of emotional support, advice and practical help. The Quran was seen as a central point of guidance, enabling individuals to understand and deal with their difficulties.
Youssef, J. & Deane, F.P. (2006). Factors influencing mental-health help-seeking in Arabic-speaking communities in Sydney, Australia.	Sydney, Australia. To investigate factors that influence help seeking behaviour. 35 participants of Arabic speaking community, (Christian, Muslim;18 Egyptian, 16 Lebanese, 1 Jordanian background). At	Qualitative Semi structured interviews Recruitment conducted by snowball technique (Biernacki & Waldorf, 1981). Content analysis used for interpretation of meanings (Mostyn, 2000). Key themes were placed into	Majority of the participants believed mental illness was caused by Satan. Mental illness was not seen as curable. The participants also associated mental illness with majnoon, which means madness in Arabic and believed Schizophrenia referred to a 'split personality'. Arab respondents perceived psychiatric facilities were for patients who are rejected from the wider society and were violent. The word 'mental health' as part of 'mental health centre' was seen negatively which led to some individuals avoiding the place. The title 'Psychiatrist' was also

	<p>least 5 were Muslim participants. Most were professionals.</p>	<p>categories and structured (Silverman, 1997, Miles & Huberman, 1994).</p> <p>No information about history of mental illness</p>	<p>perceived in a derogatory manner. Shame and stigma were barriers to accessing services.</p>
<p>Ypinazar, A.V. and Margolis, S.A. (2006). Delivering Culturally Sensitive Care: The Perceptions of Older Arabian Gulf Arabs Concerning Religion, Health, and Disease.</p>	<p>UAE</p> <p>To determine their understanding and perception of health, illness and the role of their religion.</p> <p>10 Muslims, all above 65.</p>	<p>Qualitative approach</p> <p>Semi-structured, open-ended interviews.</p> <p>Recruitment took place from the community using a database of residents.</p> <p>Focused ethnographic approach (Manns and Chad, 2001).</p> <p>All the interviews were performed in Arabic and then translated into English.</p> <p>Interviews recorded. Analysis took place alongside interviews until saturation taken place. 2 researches independently analysed the</p>	<p>Emerging themes were the concept of health and illness being a predetermined fate and God has the power to provide good health and sickness. Everyone sought help from doctors in illness but viewed the cure ultimately lying at the hand of God. Women preferred not to visit a doctor in the clinic, relating this to their modesty.</p>

		<p>transcriptions to attain triangulation (Patton, 2002). Also, inductive process described, involving repeated readings of transcripts.</p>	
<p>Zafar et al (2008). Perceptions about the cause of schizophrenia and the subsequent help seeking behaviour in a Pakistani population - results of a cross-sectional survey.</p>	<p>Karachi, Pakistan</p> <p>To examine the perceptions of Schizophrenia and help-seeking behaviour.</p> <p>404 participants. 92% were Muslim and there were a high proportion of people who had a bachelor's qualification (62%) with 50% in employment.</p>	<p>A cross sectional survey</p> <p>Questions were based on a case vignette of a man exhibiting behaviour of Schizophrenia.</p> <p>Self-administered questionnaire. Analysis and data management performed by SPSS.</p> <p>Recruited from general outpatient setting.</p>	<p>Participants found superstitious ideas and God's Will to be the most common cause of mental. Interestingly only 22% of respondents characterised the symptoms as mental illness. Another reason noted was punishment of sins. Participants with the least education were more likely to have misconceptions about the causation. Females and the older participants were more likely to believe in mental illness as a cause of the symptoms compared with male participants. People would seek religious or social help or do nothing with only 40% suggesting a psychiatric assessment.</p>

14 Chapter 14 – Appendices

14.1 Appendix 1 Topic Guide

The systematic search undertaken identified emerging themes, which will be incorporated in the semi-structured interview.

The prompts will be used as required.

1.1 Prompts for patient group:

What are the beliefs, knowledge and understanding towards mental health among patients?

- What do you understand by the words 'mental health'? 'Mental well-being'?
- Tell me about your mental health problems?
- How did you recognise you were unwell?
- Who did you speak to first about your problems?
- What do you believe has caused your problems?
- Tell me about your symptoms? The nature of your difficulties?
- How have the doctors explained your diagnosis?
- What is your understanding about your mental health difficulties?

How does religion influence the understanding of mental health problems?

- How important is religion in your life?
- How do you identify yourself primarily? By your faith, country of birth?

- Do aspects of your religion help in understanding your difficulties?
- Have you ever been burdened with difficulties which you cannot cope with?
- Why do you think people become unwell? Where do you think illness and good health comes from?
- How do you think illnesses are cured?
- What are your thoughts on predestination
- What does your religion say about life? Guidance? Being a test? Temporary test?

What is your level of awareness, accessibility and experience of Muslim patients in using mental health services?

- How aware are you of the services locally for the Muslim community?
- Have you been given support to access these services?
- What has been your experience in accessing services?
- Were you given a choice in the treatment?

Do religious views play a role in patient decision-making on treatment

- Who did you speak to when you first experienced mental health difficulties?
- Did you try anything before you accessed mainstream services?
- Do you find yourself going to the mosque more regularly?
- Do you feel reading the Qur'an is helpful?
- What about fasting?
- How does religion help you cope with your difficulties?
- What else helps to improve your mental well-being?

What are the key factors that may affect the understanding and attitudes towards mental health and treatment?

- What role do you think your religion plays in helping you get better? Being part of the congregation? Going to the mosque?
- What particular aspects of religious beliefs or activity have been helpful?
- Does prayer help or reading the Quran?
- What about talking to a religious/pious figure (Imam)?
- Was there anything else that has affected your use of mental health services?
- What role do you think a religious figure could play in helping your mental health difficulties?
- Who would you see first?
- Are you comfortable about seeing both a health professional and Imam?
- Do you feel health professionals respect your views of religion?
- How have you felt about the treatment you have received from your doctor?
- What improvements are needed to improve services?
- Is there anything else you feel would help? Translator? Halal food? Prayer facilities? Quran, prayer mat
- How do you feel having a mental illness has affected your relationship with other people in the community?
- Do you feel people stare at you when you are in the community?
- Have other people felt uncomfortable around you in the mosque?
- Have you felt people talk about you in your absence?
- Have you ever experienced stigma in the community?
- How did that make you feel?
- Do you feel bad?

- Does it want you to meet people again?
- Has it ever stopped you from performing rituals important in your religion?
- Are you able to speak to anyone about it?
- Do you feel professionals may misunderstand you? Do you think services are fair? Respectful?
- Are you scared your friends may find out about your problems? (confidentiality)?
Would you prefer to see someone from your own community?

1.2 Prompts for Muslim scholars:

What is the understanding and attitude of Muslim scholars regarding mental health?

- What is your understanding of mental illness?
- Does mental illness exist?
- How do you think mental health is linked with religion?
- Is mental illness caused by physical problems? Any other cause?

What do Muslim scholars believe are the aetiologies of mental illness?

- What do people suffer from mental illness?
- Could there be any other cause?

What do Muslim scholars think would be helpful in the delivery of treatment and care to patients with mental health difficulties?

- What would be helpful in getting patients better?
- What help should people with mental illness seek?

- What is the role of medication in the treatment of mental illness?
- What is the role of the doctor in treating patients with mental illness?
- What role do you think you play in helping people?
- What part does the community play? Going to the mosque?
- What are the barriers in your community?
- What are the practical experiences of Imams in providing support to mental health patients and agencies?
- What sort of patients do you help?
- How do you help them?
- What training have you had in mental health?
- What resources would you like in helping patients?
- Are you aware of existing services for mental health users and how to access them?

14.2 Appendix 2 Participant Information Sheet

The influence of religion on the understanding of and attitudes to mental health and illness in Muslim patients in UK

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like further information. This information sheet can also be made available in other languages. Take time to decide whether you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

We would like to speak to people of the Muslim faith, aged between 18 and 65, who have had mental health difficulties (low mood, “nerves”) to ask for their opinions about this problem, how it has affected them and the treatment they received. It would be important to ask about their experience related to their faith, Islam. This information will be useful for doctors and nurses who see and treat people of the Muslim faith who experience these difficulties.

2. Why have I been chosen?

Your General Practitioner or other professional involved in your care has identified you as having experienced mental health difficulties such as depression, low mood or “nerves” in the past.

3. Do I have to take part?

It is up to you to decide whether to take part. You will be given this information sheet and invitation letter with a reply slip. If you do decide to take part you will be asked to sign a consent form. If you do decide to take part, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

4. What will happen if I agree to take part?

The practice staff will contact you after seven days of receiving this information and invitation letter unless you have replied refusing to take part in the study. If you have agreed to take part, he will arrange a time to meet up with you. The researcher will spend an one hour and half hour with you and will ask some questions. If you feel an interpreter is required then this can be arranged. This will result in a longer interview. This interview will be recorded onto an audio tape if you are happy with this.

A friend or carer may stay with you during the interview, if you wish. Participants will be given reasonable travel expenses (public transport and parking) if requested (receipts to be produced).

5. What do I have to do?

You will meet the researcher and talk to him about your experiences. He will ask you some questions but will particularly want to hear what you have to say.

6. What are the possible benefits of taking part?

Information you give us may make it easier for health care professionals to understand the influence of religion on the beliefs of people.

7. What are the possible disadvantages and risks of taking part?

Some people can find it difficult or distressing to talk about how they felt when they were depressed. If this happens to you, please let us know. The interviews are being conducted by someone experienced in dealing with distressful situations. Following the interview, you may wish to contact your Psychiatrist, Community Psychiatric Nurse or General Practitioner, or we can contact them at your request.

8. What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.

9. What happens after the interview?

There will only be one interview during the research study.

10. What if something goes wrong?

No harm should come to you by participating in the interview.

11. Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. Computers used for the storage of anonymised information will also be password protected. The recordings of the interviews will be destroyed once the interviews have been transcribed on paper.

12. What will happen to the results of the research study?

The results may be published in a medical journal or presented at a medical meeting so that other doctors and nurses can see them. A summary of the results will be made available to you if you wish. This request can be made directly to the researcher or supervisors at any point. All results will be anonymous so it will not be possible for anyone to identify you. The information gathered from the interviews may also be used in future research work.

13. Who is organising and funding the research?

The research is organised by Dr Imran Ali and supervised by Prof. Linda Gask and Dr Heather Burroughs, University of Manchester. The study has no external funding.

14. What about confidentiality?

All quotations used will be completely anonymised.

15. Who has reviewed the study?

The study has been reviewed by LREC (the local ethics committee) 10/H1011/51.

16. Contact for further information

Dr Imran Ali

0161 787 6003

14.3 Appendix 3 Scholar Information Sheet

Version 2.0 16th September 2010

The influence of religion on the understanding of and attitudes to mental health and illness in Muslim patients in UK

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like further information. This information sheet can also be made available in other languages. Take time to decide whether you wish to take part.

Thank you for reading this.

1. What is the purpose of the study?

We would like to speak to scholars who are have experience dealing with individuals who are suffering from mental illness. It would be important to ask about your experience of dealing with members of the Muslim community, your understanding of mental health and illness, aspects of Islam that relate to this mental health and wellbeing. This information will be useful for doctors and nurses who see and treat people of the Muslim faith who experience these difficulties.

2. Why have I been chosen?

You have been identified as holding an important position in the community and a source of support for people in mental health difficulty. ves” in the past.

3. Do I have to take part?

It is up to you to decide whether to take part. You will be given this information sheet and invitation letter with a reply slip. If you do decide to take part you will be asked to sign a consent form. If you do decide to take part, you are still free to withdraw at any time and without giving a reason.

4. What will happen if I agree to take part?

The researcher will contact you to arrange time to meet up. This interview will be recorded onto an audio tape. The time may vary and can be up to two hours. The interview can be conducted over two meetings if you prefer this. This will be depend on your consent.

5. What do I have to do?

You will meet the researcher and talk to him about your experiences. He will ask you some questions but will particularly want to hear what you have to say.

6. What are the possible benefits of taking part?

Information you give us may make it easier for health care professionals to understand the influence of religion on the beliefs of people.

7. What are the possible disadvantages and risks of taking part?

There are no disadvantages taking part in the study. The interviews are being conducted by someone experienced in conducting interviews in other settings.

8. What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.

9. What if something goes wrong?

No harm should come to you by participating in the interview.

10. Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. Computers used for the storage of anonymised information will also be password protected. The recordings of the interviews will be destroyed once the interviews have been transcribed on paper.

11. What will happen to the results of the research study?

The results may be published in a medical journal or presented at a medical meeting so that other doctors and nurses can see them. A summary of the results will be made available to you if you wish. This request can be made directly to the researcher or supervisors at any point. All results will be anonymous so it will not be possible for anyone to identify you. The information gathered from the interviews may also be used in future research work.

12. Who is organising and funding the research?

The research is organised by Dr Imran Ali and supervised by Prof. Linda Gask and Dr Heather Burroughs, University of Manchester. The study has no external funding.

13. What about confidentiality?

All quotations used will be completely anonymised.

14. Who has reviewed the study?

The study has been reviewed by LREC (the local ethics committee)

10/H1011/51

15. Contact for further information

Dr Imran Ali

0161 787 6003

14.4 Appendix 4 Consent form (Participant)

CONSENT FORM

Title of Project: The influence of religion on the understanding of and attitudes to mental health and illness in Muslim patients in UK.

Name of Researcher: Dr Imran Ali

Please initial box

1. I confirm that I have read and understand the information sheet dated(version) for the above study. I have had opportunity to consider the information, ask questions and have had them answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.
3. I understand that the interview will be audio-recorded. I give my permission for this to happen.
4. I agree that the anonymised written record of my contribution may be kept and used in future research projects.
5. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.
6. I agree to take part in the above study.

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Researcher	Signature	Date

1 form for participant; 1 form for researcher

14.5 Appendix 5 Consent form (Scholar)

CONSENT FORM

Title of Project: The influence of religion on the understanding of and attitudes to mental health and illness in Muslim patients in UK.

Name of Researcher: Dr Imran Ali

Please initial box

1. I confirm that I have read and understand the information sheet dated(version) for the above study. I have had opportunity to consider the information, ask questions and have had them answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.
3. I understand that the interview will be audio-recorded. I give my permission for this to happen.
4. I agree that the anonymised written record of my contribution may be kept and used in future research projects.
5. I agree to take part in the above study.

Name of Participant Signature Date

Researcher Signature Date

1 form for participant; 1 form for researcher

14.6 Appendix 6 Invitation letter (Participant)



Prof. Linda Gask/Dr Imran Ali
Primary Care Research Group
School of Medicine
The University of Manchester
NPCRDC, Williamson Building
Oxford Road,
Manchester M13 9PL
Tel: 0161 275 1848
Fax: 0161 256 1070
docimrankali@yahoo.com

Participation in study:

The influence of religion on the understanding of and attitudes to mental health and illness in Muslim patients in UK

I am writing to ask if you would take part in a small study research that I am conducting.

I enclose some written details about the study.

You have been chosen because you are of Muslim faith and you have experience of mental health difficulties. I believe a professional involved in your care has already spoken to you about this study and you have an interest. I would very much appreciate it if you would be willing to spend an hour and half talking with me about your experience of mental health problems, what treatment you received, and how you felt your difficulties related to your faith. I can see you at home or see you in the Health Centre, whichever is most convenient for you. The interview will only take place once. The interview will be taped, with your permission and all details will be kept strictly confidential.

I will be contacting you in the next week to ask if I can speak with you. If you would rather not take part in the study, please be assured that this will not affect your care in any way. Please return the reply slip below. I have enclosed an information sheet and reply slip. Please do not hesitate to contact me for any further information (0161- 787-6003).

Thank you

Yours Sincerely

Dr Imran Ali

Researcher



The influence of religion on the understanding of and attitudes to mental health and illness in Muslim patients in UK

I would / would not be happy for Dr Ali to contact me regarding the above study.

Name:

Contact:

Please return completed slip to: Dr Imran Ali/Prof. Linda Gask, Primary Care Research Group, School of Medicine, The University of Manchester, NPCRDC, Williamson Building, Oxford Road, Manchester M13 9PL.

14.7 Appendix 7 Invitation letter (Scholar)



Prof. Linda Gask/Dr Imran Ali
Primary Care Research Group
School of Medicine
The University of Manchester
NPCRDC, Williamson Building
Oxford Road,
Manchester M13 9PL
Tel: 0161 275 1848
Fax: 0161 256 1070
docimrankali@yahoo.com

Participation in study:

The influence of religion on the understanding of and attitudes to mental health and illness in Muslim patients in UK

I am writing to ask if you would take part in a small study research that I am conducting.

I enclose some written details about the study.

You have been chosen because you have experience working with clients of the Muslim faith. I would very much appreciate it if you would be willing to spend an hour and half talking with me about your attitudes towards mental health problems, what you feel may cause mental health problems and what you think may be helpful in the treatment of Muslim patients with mental health. I can see you at home or mosque, whichever is most convenient for you. The interview will only take place once.

The interview will be taped, with your permission and all details will be kept strictly confidential. I will be contacting you in the next week to ask if I can speak with you.

I have enclosed an information sheet and reply slip. Please do not hesitate to contact me for any further information (0161- 787-6003, 07779586225).

Thank you

Yours Sincerely

Dr Imran Ali
Researcher

The influence of religion on the understanding of and attitudes to mental health and illness in Muslim patients in UK

I would / would not be happy for Dr Ali to contact me. Name:

Please return completed slip to: Dr Imran Ali/Prof. Linda Gask, Primary Care Research Group, School of Medicine, The University of Manchester, NPCRDC, Williamson Building, Oxford Road, Manchester M13 9PL

14.8 Appendix 8 Copy of ethics approvals



NHS SalfoR+D Director: Professor Bill Ollier
NHS SalfoR+D Associate Director: Dr Lloyd Gregory
ReGrouP Manager: Rachel Georgiou

Enquiries: Email: Salford-Regroup-RD@manchester.ac.uk
Tele: 0161 206 8343
Fax: 0161 206 4205

SalfoR+D web address: <http://www.nhssalfordrd.org.uk/>
ReGrouP web address: <http://www.gmregroup.nhs.uk/index.html>

26th October 2010

Dr Imran Ali
Consultant Psychiatrist
Greater Manchester West Mental Health NHS Foundation Trust
Cromwell House
Cromwell Road,
Eccles
Salford
M30 0GT

Dear Dr Ali,

Study Title: The influence of religion on the understanding of and attitudes to mental health and illness in Muslim patients in UK

REC Reference: 10/H1013/30

R&D Reference: 2010/245

This letter confirms your right of access to conduct research through the following organisation for the purpose and on the terms and conditions set out below:

- Bolton PCT
- Bury PCT
- Manchester PCT
- Oldham PCT
- Trafford PCT
- Stockport PCT

This right of access commences on 26th October 2010 and ends on 1st October 2013 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at the above mentioned NHS Organisation has been reviewed and you do not require an honorary research contract with these NHS organisations. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to the Trust premises. You are not entitled to any form of payment or access to other benefits provided by the Trust to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through the Trust you will remain accountable to your employer but you are required to follow the reasonable instructions of the heads of the relevant NHS Departments in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the PCT's policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with the PCT in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the PCT premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

The Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely



Rachel Georgiou
RM & G and ReGroup Manager

Research & Development
Clinical Sciences Building, SRFT, Stott Lane, Salford, Manchester, M6 8HD

National Research Ethics Service

NORTH WEST 10 RESEARCH ETHICS COMMITTEE – GREATER MANCHESTER NORTH

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Dr Imran Ali
Consultant Psychiatrist
Greater Manchester West Mental Health NHS Foundation Trust
Community Mental Health Team
Cromwell House, Cromwell Road
M30 0GT

04 October 2010

Dear Dr Ali

Study Title: The influence of religion on the understanding of and attitudes to mental health and illness in Muslim patients in UK
REC reference number: 10/H1011/51

Thank you for your letter of 16 September 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Investigator CV		21 July 2010
Protocol	2.0	16 September 2010
CV Academic Supervisor		16 April 2010
Letter to professionals to help with recruitment	2.0	16 September 2010
REC application	3.0	21 July 2010
REC application	3.0 (Info only)	19 September 2010
Covering Letter		19 July 2010
Interview Schedules/Topic Guides	2.0 - Clients	16 September 2010
Interview Schedules/Topic Guides	2.0 - Professionals	16 September 2010
Interview Schedules/Topic Guides	2.0 - Religious Practitioners	16 September 2010
Letter of invitation to participant	2.0 - Clients	16 September 2010
Letter of invitation to participant	2.0 - Professionals	16 September 2010
Letter of invitation to participant	2.0 - Religious Practitioners	16 September 2010
Participant Information Sheet: Clients	2.0	16 September 2010
Response to Request for Further Information	1	16 September 2010
Participant Information Sheet: Professionals	2.0	16 September 2010
Participant Information Sheet: Religious Practitioners	2.0	16 September 2010
Participant Consent Form	2.0	16 September 2010
Evidence of insurance or indemnity		21 July 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H1011/51

Please quote this number on all correspondence

Yours sincerely


pp Dr Peter Stanley Klimiuk
Chair

Enclosures: "After ethical review – guidance for researchers" SL- AR2 for other studies

Copy to: Mr Mohammed Zubair, The University of Manchester