Exploring the Clinical Experiences of Muslim Psychologists in the UK When Working With Religion in Therapy

Sara Betteridge

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"THE CURE OF THE PART SHOULD NOT BE ATTEMPTED WITHOUT TREATMENT OF THE WHOLE. NO ATTEMPT SHOULD BE MADE TO CURE THE BODY WITHOUT THE SOUL. LET NO ONE PERSUADE YOU TO CURE THE HEAD UNTIL HE HAS FIRST GIVEN YOU HIS SOUL TO BE CURED, FOR THIS IS THE GREAT ERROR OF OUR DAY, THAT PHYSICIANS FIRST SEPARATE THE SOUL FROM THE BODY"

PLATO

(trans by Jowett, 1982)

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UEL University of East London

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Abstract

Objectives: The research on working with religion in therapy in the UK has gained momentum over the last few decades however continues to be significantly less than its American counter-parts. Studies on religions, other than Christianity, in therapy are also significantly small. The following thesis looks at the experiences of Muslim Psychologists when working with religion in therapy and how the religious beliefs of Muslim psychologists impact upon their therapeutic approach with religious clients.

Design: Qualitative research methods were chosen and used from a critical realist philosophical framework.

Method: The Grounded Theory method was chosen to analyse the interviews of six Muslim psychologists' experience of religion in therapy.

Results: The analysis showed a model of Congruence in working with religion from the psychologists' perspectives. Congruence of religion in therapy was influenced by five high-order categories; *Religious Journeys in Therapy, Therapeutic Approaches, Therapeutic Relationship, Therapists' Identity, and Context of Therapy,* and a further nineteen low-order categories. Each category is clearly explained by using participant extracts and the links between each category is explored.

Conclusion: Overall, the Muslim psychologists interviewed believe faith is an important aspect of their identity which has an impact on therapy and can be integrated into therapy when necessary. They appear more comfortable to work with issues of religion in therapy in a secular setting in comparison to studies involving peers from different faiths. A critical evaluation of the study follows looking at strengths and weaknesses, limitations, validity and a personal reflection by the author is given. Recommendations for future research are made.

Glossary

For the purpose of this study the following terms will be defined as:

Religion:

"...2. *A particular system of faith and worship."* (Compact Oxford English Dictionary - AskOxford.com). It refers to the structures, rules, regulations or obligations one adheres to when submitting themselves to a higher power, such as God.

Faith:

"...3. *A conviction of the truth of certain doctrines of religion*." (Collins Modern English Dictionary, 1987). It refers to the confidence of the individual of their religious belief. Therefore a person can practise certain aspects of *religion,* but have varying amounts of belief or faith in what they practise. A person can also hold strong beliefs (or have faith) in a religion without necessarily carrying out specific rituals or practises relating to that religion.

Different Faith Client:

For the purpose of this study a different faith client refers to a person of a different faith to their therapist, in this instance someone who is not of the Islamic faith.

Hadith:

The teachings of the Prophet Muhammad (peace be upon him).

Islamic Psychology:

This term relates to all aspects of Islamic teaching from the Holy Qur'an, Hadith and Sunnah which directly mention or relate to aspects of the human psyche, with particular emphasis on maintaining a healthy mental state or causes and treatments of an unhealthy mental state.

Muslim Psychologist:

A psychologist who may be identified as Muslim by openly expressing a belief in Islam and its teachings.

Religiosity:

This term has been coined to describe the overall understanding for how much one believes, practises, and feels connected to a religion. It encompasses the holistic nature of having a belief and that that it entails and may be used when referring more generally to a person's actions with regards to a religion.

Spiritual Experiences:

Refers to situations in which a person feels a qualitative difference between experiences of this world and those of another world in which a higher power resides.

Sunnah:

The practises of the prophet Muhammad (peace be upon him).

The Holy Qur'an:

This is the final scripture sent by God (after the Torah and parts of the Bible), it was revealed through the Prophet Muhammad (peace be upon him) and is believed by Muslims to be the word of God.

Therapist/Psychologist/Practitioner/Clinician

These terms are used interchangeably throughout the thesis. Even in sections which explicitly talk about the research findings in relevance to Counselling Psychologists, it is felt

that the implications of such research are applicable to any professional who offers psychotherapy as part of a governed and accredited body.

Abbreviations

PBUH: Peace be upon him.

CBT: Cognitive Behaviour Therapy

UPR: Unconditional Positive Regard

GT: Grounded Theory

CCA: Constant Comparative Analysis

NHS: National Health Service

DoH: Department of Health

NICE: National Institute of Clinical Excellence

RCoP: Royal College of Psychiatrists

UEL: University of East London

Notes on Style

During sections which are naturally more informal such as the introduction, and parts of the methods sections when describing research process and reflexivity, the researcher speaks in the first person. All other parts of the thesis are written in the third person.

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1: INTRODUCTION

1.1: Background to the Study

"If animals don't have a soul, then they can't go to heaven when they die. How can that be? It just doesn't make sense, and it is one more thing that's making me lose my faith."

This, in essence, is where my research began. As a new trainee, I sat in front of an elderly gentleman who had been a practising Christian all his adult life. After suffering a stroke which left him unable to walk, he lost his faith, an extremely important part of himself that had previously given him light, hope, and joy in his life. I felt the enormity of his dilemma on my young inexperienced shoulders and simply didn't know what to say.

Despite having a psychologically based formulation and understanding of this client's needs, he continued to bring[1] his religious beliefs as a major part of therapy, bringing in religious poems he had written and prayers he used to recite; it became difficult to talk about anything else. I realised that his faith was intrinsically linked to his psychological state, and that I had to embrace discussions around it if I wanted any progress to be made in therapy. There were a number of difficulties and questions that arose when I decided to do this. Firstly, many of the issues he was struggling with in therapy were in conflict with my own beliefs and I found it difficult not to challenge them. Having an alternative religious belief to his meant that I was able to answer his dilemma for myself and wanted to share this insight with him. I began to wonder in what other ways would my personal beliefs impact upon my contribution to the therapy; consciously and subconsciously. Secondly, if I did enter into these discussions, what would I say? He was clearly being very explanatory about his beliefs and views, was it

[1] In this context the term 'bring' as in 'to bring to therapy' is a semi colloquial counselling term which refers to when a client raises a particular topic (in this case religion) during a therapy session.

enough for me to just continue to be curious? How appropriate would it be to challenge religious beliefs? I began to wonder whether certain types of therapy should be avoided with religious clients, for example those which seek to pathologise religion, such as Psychoanalysis (see chapter two for a more detailed discussion of religion vs. therapeutic modalities). If so, did that mean that there were therapeutic modalities which *would* be better suited to working with religious clients such as Humanistic or Person-Centred approaches?

1.1.1: To be or not to be?

At the beginning of my search for answers to some of the questions above, I was primarily faced with the differing attitudes of psychologists and therapists working in the NHS. They appeared to be divided as to whether they would ask a client about religious or spiritual beliefs: some felt that it was essential, and without it you would not get a holistic view of a person, and others felt it was not a subject pertinent to therapy and should only be discussed if brought up by the client. There is no formal teaching of Religion and Spirituality in Psychology on the Doctoral course I am attending, and my peers expressed mixed emotions about the topic, with a great deal of uncertainty and trepidation about approaching the subject with clients. Even if eager to engage in the topic trainees were left asking questions such as; *how*, *when*, *what's appropriate* and *how much.*

Alongside these informal experiences in clinical and academic settings, were my experiences in a personal environment. As an individual with obvious religious beliefs (a practising Muslim woman wearing associated religious clothing) and at the time receiving personal therapy, I was beginning to wonder how much of my faith to bring to therapy, how my therapist would react to the religious content of my dialogue, and whether I felt the beliefs of my personal therapist mattered and/or should be disclosed.

1.2: Aim:

I was fascinated by both the discrepancy of views on this topic by clinicians, and by my own personal therapy. These early experiences in my training allowed me to begin to explore a number of questions. I was interested in knowing how often is religion a therapeutic issue for practitioners? If it is, what makes the practitioner feel comfortable or confident enough to incorporate it? How is the practitioner able to use it therapeutically (or not)? What are the fears (if any) of the practitioner if their client brings religious practises or beliefs to therapy? How much does a practitioner's religious belief influence their interventions with a religious client?

1.2.1: Client versus Therapist Perspective:

Initial examination into the literature revealed a tendency to examine only the client's perspective of bringing religion into therapy (Worthington et al, 1996). There appeared to be far fewer studies looking at therapists' perspectives and types of therapy used when working with religious clients (this will be examined in more detail in the literature review). Whilst as a client I identified with many of the outcomes of such studies, and understood the need for therapists to understand the client perspective, I wanted to know more about what these issues brought up for therapists within themselves, what personal and professional training would they employ or utilise in this situation?

Quite early on, I felt that getting psychologists' experiences of religious clients would not only help me to develop greater understanding of religion within therapy, but by analysing therapists' accounts it would also give a deeper knowledge of how religion impacts upon psychological formulations/theory, therapeutic process and different models of therapy.

1.2.2: Religion and Culture:

As will be explored below, much of the existing research in this field covers the Christian perspective (of clients and therapists) and mainly emerges from North America (Worthington et al, 1996). Naturally the cultural differences between North America and the UK are an important issue to consider, America overall has a more religious population in comparison to the UK and figures suggest that all Christian denominations in America make up 79.5% and within the UK make up 59.3% of the overall populations (Wikipedia, 2013). US studies have also tended to focus on the religious affiliations of mental health professionals who appear to have a lower percentage of religious belief than the general population (Pelechova et al, 2012). Both countries have a lack of research into religions outside of Christianity and Judaism (Dein, 2004) and therefore focusing on a religion which is pertinent in a country which has a lower level of religiosity than previous studies (Islam in the UK), would be a valuable contribution to Counselling Psychology literature adding to; psychological theory, understanding Muslim Counselling Psychologists, and what practitioners feel might be more appropriate ways of working with Muslim clients.

In research mentioned further on, the country of origin is identified if it is felt valuable to the understanding of the material presented.

1.2.3: Religion versus Spirituality:

I believe there are important similarities that can be shared across faiths, such as a sense of spirituality and a connection to God. However I am also acutely aware of differences, both within faiths and across faiths. From the very obvious differences such as the explanations and meanings a religion makes of a person's psychological wellbeing or mental ill health, to

the more practical and ritualistic differences like how to pray or belief in other beings such as Angels for example. Conducting a study across faiths would on the one hand give an insight into similarities and differences shared, however the large degree of variation would make results difficult to generalise and use effectively with a wider population. We may gain knowledge of the overall processes at work with regards to religion in a therapeutic setting but it would not give us the finer details of how a person's religious beliefs can be used in a helpful and effective way by any practitioner, as the hypothesis is that it may be different across faiths. Therefore, by focussing on a particular religion, it will enable the study to provide a more detailed examination of what is occurring for therapists and clients within that faith. Subsequently the study concentrates on Islamic practises and beliefs.

1.3: Research Questions

A combination of personal experience and an initial exploration into the literature enabled me to arrive at two very important questions:

1) How do Muslim psychologists trained in the UK experience religion in a therapeutic setting and what does it mean to them?

2) How do the religious beliefs of Muslim psychologists in the UK impact upon their therapeutic approach with religious clients?

I feel that these questions look at my main interests which are; what experiences and issues do practising Muslim therapists need to be aware of when working with clients who bring religion to therapy? And subsequently what would be the most appropriate way to work with those issues?

1.3.1: Why Muslim Psychologists?

There were various considerations when thinking about looking at Islam and therapy. One of the options for research would have been to interview Muslim clients about their experiences of therapy. This would give insight into the successes and challenges clients faced and how they felt about receiving psychotherapies derived from western traditions. Another option would have been to randomly select psychologists from *any* background and interview them on working with Muslim clients. This would have given information on the issues that arise when working with this client group. It may even have given information on what therapeutic modalities those therapists found useful when working with Muslim clients. However, although these clinicians would have knowledge of psychological theory they would perhaps lack a deeper understanding of how the Muslim faith does or does not conflict with that.

Therefore interviewing Muslim psychologists would give both an understanding of the faith alongside knowledge of psychological theory. Interviewing them about Muslim and other faith clients should give an insight into Muslim specific issues (if any) in comparison to when working with other faiths.

1.3.2: Rationale:

As a trainee counselling psychologist, practising in an ever diverse population, and in an age where Equality and Diversity policies are prominent in most work places, I was struck by how religion appeared on the periphery of most work practises, including therapy. We study age related issues, social, cultural, race issues, sexual orientation issues, physical health

issues, and many more, but religion appears to either be a sub-category under 'culture' or 'race' (Badri, 2000) or is simply omitted.

In a report carried out by The Pew Research Centre (2010) entitled 'Muslim Networks and Movements in Europe' the population of Muslims in the UK is estimated at 2.869 million. At 4.6% of the overall population, it represents a group that should be studied and understood not least within the realms of Counselling Psychology.

"*If mental health workers are to develop a deeper understanding of ways of life and death, they need to incorporate into their western scientific professional knowledge base some respect for the spiritual sanctions or maps that are being generated within the cultures of the people they care for.*" (Inayat, 2005, p. 3).

In order to encourage growth and diversity in the field of counselling psychology, there needs to be a development of understanding, empathy, and sensitivity towards the beliefs of this client group in order to be able to work more effectively with them in therapy.

"*Spiritual principles and values need to be closely explored if mental health professionals are to really appreciate and work creatively with the richness of a community in all its facets.*" (Inayat, 2005, p. 3).

It is clearly stated in the Professional Practice Guidelines of the Division of Counselling Psychology (DoCP), Section 3; **Practitioners' responsibilities and obligations to self and society**:

"*Practitioners must consider...all contexts that might affect a client's experience and incorporate it into the assessment process, formulation and planned intervention...*
Make themselves knowledgeable about the diverse life experiences of the clients they work with...challenge the views of people who pathologise on the basis of such aspects
as sexual orientation, disability, class origin or racial identity and religious and spiritual views." (The BPS, 2005, p.7).

Also;

"*Counselling psychologists will consider at all times their responsibilities to the wider world. They will be attentive to life experience, modes of inquiry and areas of knowledge beyond the*

immediate environs of counselling psychology and seek to draw on this knowledge to aid communication or understanding within and outside of their work." (The BPS, 2005, p.7).

Research on religion in therapy has grown in importance in the UK over the past few decades (Crossley and Salter, 2005; Baker and Wang, 2004) and appears to be in favour of incorporating a person's religious beliefs in therapy. With the number of existing Muslims in Britain and their growing families, Muslims who chose to migrate to the UK, Muslims who have sought refugee status, and those who are converting to Islam everyday in the UK, this population is one that is set to continue to grow rapidly. It is therefore an apt time to begin to incorporate a broader context of ideologies and philosophies into counselling and psychology in line with the diverse communities they serve. The subject of religion in therapy is a complex one that would benefit from more focussed and in depth research, the main aim of this research is to provide valuable information on the experiences of Muslim Psychologists who are already part of the Counselling Psychology and Clinical Psychology communities. It is an opportunity for their experiences to be expressed and analysed using a rigorous scientific method and creating a valuable contribution to the literature. It is also thought that through their experiences some insight will be gained into working with Muslim clients.

1.4: Epistemological Position:

Muslim psychologists trained in the UK are a relatively small population. By exploring their experiences and the meanings they attribute to them, a subjective reality can be hypothesised, from which we can base assertions and formulate theories about this population. Acquiring information in this way fits with a relativist philosophy and lends itself to be gathered and

analysed robustly using a qualitative approach, allowing for much greater depth and meaning to be derived from the data, of a smaller number of participants. However, the researcher, participants, and clients in discussion all have a faith and a belief in one reality created by God. This belief tends to be more in line with a realist perspective and thus creates a dilemma in the philosophical viewpoint of this research. A critical realist[2] stance has been adopted in an attempt to incorporate both of these viewpoints and a methodology which means to bridge this epistemological divide - the Grounded Theory Method (Glaser and Strauss, 1967) - was chosen. This method reflects a meeting of quantitative and qualitative epistemologies in its philosophy as its method seeks to uncover underlying theory in experiential data. It offers a comprehensive and systematic framework for data collection and analysis, inductively building theory from the data.

1.5: Outline of Thesis:

Having now been introduced to how the research questions were formulated, a review of the relevant literature follows. It covers the historic relationship between religion and psychotherapy and how this has evolved over time, and then reviews studies involving religion in psychotherapy but more specifically 1) those conducted with therapists and 2) those focussing on Islam. An introduction to Islamic Psychology is then given. The methodology section explores the epistemological stance of critical realism in the light of religion, the choice to work at a qualitative level and the decision which led to the implementation of the Grounded Theory model. An in depth review of the analysis method is

[2] It should be noted that the difficulty of adopting a single epistemological position described above has the effect of some parts of the text further on shifting from critical realism to naive realism.

discussed with issues of reflexivity explored. The results section sets out the findings of a core theme, five distinct high order categories and nineteen low order categories including comprehensive excerpts from participants' transcripts. The final discussion section offers a 'grounded theory' from the data looking at how Muslim psychologists experience religion in therapy, how their religious beliefs impact upon the therapeutic process and indications for working with Muslim clients. The summary consists of a critical analysis and reflections of the study and recommendations for further research.

2: Literature Review

The following section places the concepts of the research mentioned above into the context of the wider literature. The history of religion and psychology is explored and an explanation of Islamic psychology is introduced. The literature presented in this section has been collected using 1) PsycINFO and PsycARTICLES databases acquired through the EBSCO host network. The key search terms used were: Religion and Psychology, Religion and Psycho/Therapy/Counselling, Islam/Muslims and Therapy/Counselling, Grounded Theory methods and Therapy/Counselling, Christianity and Therapy/Counselling. 2) A search in the University of East London's library facilities of texts on Religion and/or Psychology and Therapy was also conducted. 3) Islamic sources of literature were attained through the Markfield Institute of Higher Education Islamic library and independent booksellers. 4) Courses attended by the researcher on Islamic Psychology and Counselling Muslims in the west provided another source of references. 5) The National Health Service (NHS) library facilities were also utilised to access NHS, Department of Health (DoH) and National Institute of Clinical Excellence (NICE) documentation on Religion in health settings. 6) A general internet search of grey literature on Islamic Psychology and Religion and Psychotherapy using the Google search engine also yielded results.

2.1: Religion and Psychology - The History

In the past few decades, the importance of the consideration and study of religion in therapy has begun to mushroom. The British Psychological Society's publication The Psychologist

recognised this and dedicated an issue of the journal (April 2011) to Psychology, Religion and Spirituality. Key research findings in the field of Religion, Culture, and Mental Health, how to work with religion, and questions such as why study religion? were critically discussed and reflected upon. An article in the publication by Hall, Francis, and Callaghan (2011) reflected that the relationship between religion and psychology, in essence, goes back to the beginning of recorded religion, as religion has always purported to have an understanding of the workings of man, human nature and the human soul. However, the link was not to remain harmonious and as modern day science began to emerge, a splitting ensued between psychology and religion. The divide mirrors that of the more general sciences versus religion split, with religion/faith/belief in the unseen being viewed as un-scientific in nature and therefore not worthy of study (Strawbridge and Woolf, 2003). The desire of psychologists to be seen as scientist-practitioners, respected, and valued in the world of science meant an abandoning of any previous alliances with religion and theology (as the contemporary world of natural science had already done).

However Religion did not disappear altogether and although science was beginning to explain the biological, psychological, and sociological inner workings of man, it was unable to offer proof that a soul or God did *not* exist (Miovic, 2004, p. 107-108). Over time, the literature and research has made a distinction between religious (or pastoral) psychology and the psychology *of* religion. Religious psychology has predominantly been used by clerics to merge theological theories with psychological ones for the betterment of both subjects. The psychology of religion views religion as a subject to be investigated and examined using rigorous scientific methods, in order to look at the purpose and effect religion has on its followers and the wider world. Both offer different views on the nature of reality, the former believing in the reality of a spiritual world and the latter preferring to believe that because a spiritual world cannot be proven to exist, it should be managed with scepticism and viewed as

a person's *perception* of reality (Miovic, 2004), but nonetheless both now view religion as an important topic to study.

The relationship between religion and psychology has also varied greatly depending on the country and current political context of the time. This is explored in an article by Kugelmann and Belzin (2009) which looks at the historical intersections between religion (Christianity), psychology, and politics in; Spain, Netherlands, UK, and USA. They concluded that overall despite political differences of opinion, psychology and religion were able to form a relationship with each other, becoming a subject that has developed its own right in each of the countries identified. America, being the most religious country of those studied has always been at the forefront of research producing most of the literature on religion and psychology to date.

In psychoanalytic psychotherapy, this historical 'split' is also played out between Sigmund Freud and one of his colleagues Carl Jung (Miovic, 2004). Freud's tendencies were to pathologise religion and view it as an illusion - a social neurosis (Fayek, 2004), but Jung who eventually parted from his mentor, saw the absence of religion as the chief cause of adult psychological disorders (Hall, Francis and Callaghan, 2011). The nature of reality is again brought into question; Jung felt that the soul was a fact, based on reality, whereas Freud felt it was a 'phantasy' and only a reality for the patient. Despite the split, and developments of movements such as Behaviourism which also stifled the 'religion-psychology' interface, later theorists in psychotherapy began to develop models such as Humanistic and Person Centred approaches (Abraham Maslow and Carl Rogers) which did not choose to pathologise religion, but instead allowed room for its exploration and expression. A more detailed exploration of western models of psychology and their relationship with religion is explored further on. The world of psychology slowly begun to realise it was somewhat lacking if it chose to remain a purely natural science; Norager (1998) criticises psychology by saying that:

"*Experimental psychology and behaviourism have lived up to the standards of science, but as soon as psychology extends beyond these two positivistic realms, the 'repressed past of philosophy and metaphysics immediately returns'* ". Norager, 1998 (cited in Haque, 2001, p. 244).

In the 1980's, psychologists such as Allen Bergin begun writing prolifically on values of psychologists being predominantly negative towards religion and that it was difficult for psychologists to be completely value free. The body of work and research that has come from both the UK and abroad has been predominantly of the Judeo-Christian faiths, and certainly in the UK and America there is a significant relationship between Christianity and Psychology. The UK has two major research centres that 'apply psychological theories and methods within the framework of theological and church-related concerns ' at the University of Cambridge and the University of Wales (Hall, Francis and Callaghan, 2011).

It is evident from the current literature available that religion and psychology are once again becoming a popular topic (Kugelmann and Belzen, 2009; Miovic, 2004; Haque, 2001) and perhaps one might say are inevitably bound to return to each other because of the correlations they share in trying to understand human nature and alleviate mental ill health, which will be explored further in the following sections.

2.2: Religion and Mental Health

With regards to the literature on religion in mental health, it is the field of psychiatry and other health professionals that have been at the forefront of research. The relationship between religion and mental health is as tumultuous as the one between religion and psychology described above. It has consistently vacillated between being a positive helpful

relationship to a negative and punishing relationship over time (Koenig and Larson, 2001), and is still seen today as a somewhat apprehensive relationship. Contrary to popular assumption, research suggests that religious guilt does not play a causal role in mental health problems but rather is an arena within which mental health problems can be expressed (Lowenthal and Lewis, 2011). In Koenig and Larson's (2001, U.S.) paper they systematically reviewed studies specifically looking at the relationship between religion and mental health over the past century and found that 20% of the one hundred most relevant studies showed a low level of religiousness correlated with low well-being, as opposed to 80% of studies which showed higher religiousness to be associated with better well being:

"...religious involvement is generally associated with greater wellbeing, less depression and anxiety, greater social support, and less substance abuse." (Koenig and Larson, 2001, p.75).

Koenig (2010) conducted a further review of similar studies. It continued to show that depressed patients who a) recovered more quickly, b) had a better success rate six months later or c) who coped more effectively with their illness, were those who were more spiritually or religiously active. In studies looking at anxiety however, the results were more mixed and results showed that *level* of spiritual/religious involvement mattered. Those with no beliefs and those with strong beliefs did well, but those with moderate beliefs (i.e. had faith in a higher being but did not practise or take part in any spiritual practises) anxiety levels remained high (Koenig, 2010). It also confirmed the strong correlation between substance abuse and spirituality; people with high levels of spirituality were significantly less likely to develop addictions or abuse substances. There is a caveat in the substance abuse-spirituality relationship though, in that people who come from religious backgrounds that do not allow any substance use, who then become addicted, often go on to develop severe patterns of abuse and dependence. Possible reasons for this effect might be from

withdrawing from spiritual activity due to guilt and shame, which then leads to isolation and a worsening of symptoms (Koenig, 2010).

Mental health professionals often find the religious and spiritual beliefs of patients with severe mental health problems to be a concern:

"These concerns flow from a number of sources: the not infrequent religious content of delusions and hallucinations; a sense that the metaphoric nature of spiritual ideation may have a negative impact on symptoms of disorganization and confusion; the involvement of religious language in self-injury (e.g. taking literally the injunction to pluck out the eye if it offends) or violence to others (e.g. killing demons seen in another person); and the perceived rigidity of religious beliefs and rituals, rigidity that may worsen symptoms and preclude acceptance of treatment recommendations." (Fallot, 2001, p.110).

Fallot, in this (U.S.) paper explores why mental health professionals may find it difficult to discuss this topic with patients but also their concerns around working with negative religious material and the fear that they may make the illness worse by focusing on what appears to be a contributing factor. However, there is a growing body of evidence which suggests that this should not be the case and has led various departments across the UK to produce documents, guidelines, and support in dealing with patients' religious and spiritual needs, including the NHS. In a document produced by NHS Scotland entitled '*Religion and Belief Matter: An information resource for healthcare staff*', it clearly documents what religious and spiritual needs are, who should respond to them and how, the current research on the link between religion and health, and issues on human rights and equality. It sates:

"A consensus is emerging in the literature that evidence exists to support the provision of spiritual care in healthcare settings" (NHS Scotland, 2007, p. 35).

Research in psychiatry has found that in comparison to the general population, psychiatrists tend to be individuals of little or no religious belief, with their patients conversely often among the most religious (Dein, 2004). Many Psychiatrists view religion as:

"Primitive, guilt inducing, a form of dependency, irrational and having no empirical base." (Dein, 2004, p. 287).

Dein (2004) suggests that the topic of religion plays a small part in a psychiatrists' training due to the above views, which may lead to the profession being chosen by those less religious (or not religious at all) than the population they serve. The growing interest in the religion-mental health debate however is being observed by psychiatry, and the Royal College of Psychiatrists now has a special interest group on religion and spirituality and has published recommendations for psychiatrists on spirituality and religion in 2011.

The evidence within the literature of religion in health care seems overwhelming that it is an individual's basic human right to have a religious belief and to be allowed to practise should they wish, allowing them to do so will usually lead to an improvement in health, and that it is the responsibility of all health care staff to ensure that this is possible. Why then, is the taking up of this view very slow and sporadic? Post and Wade (2009, U.S.) postulate that:

"That the majority of psychologists believe in the positive relationship between religiosity and mental health, however, does not mean that they necessarily have the knowledge and skill to work with religious clients effectively." (Post and Wade, 2009, p. 133).

Overall, in terms of religion and mental health although a number of the studies mentioned in this section are from the U.S. they discuss the issues faced by mental health professionals when working with religion in this field, and could be used as a baseline for issues which can be transferred to mental health professionals practising in the UK, although their perspective and opinions may vary slightly. It is also evident that the topic has been an important issue in the UK as a number of Department of Health and NHS official policies and guidelines have been created to advise practitioners on this topic.

2.3: Religion and Therapy

The current literature establishes that *all* healthcare professionals should incorporate a person's beliefs into their care. But how does this impact upon therapists, the psychotherapeutic process, and therapeutic modality? In an American paper by Miller (1992) four types of therapists are outlined (by Quackenbos, Privette, and Klentz, 1986), a religious one, an atheist, a neutralist, and a religious counsellor who does not discuss their religious affiliation:

"The first view is the Orthodox view. This view involves a religious position that is typically based in traditional religions such as Roman Catholic. The Orthodox view, represented by Mowrer, views mental problems as guilt from sinning. In this view the church is encouraged to provide counseling for its parishioners. The second view is termed the Atheistic view as typified by Ellis. Within this view, people make mistakes, need not feel guilt for their mistakes, and need not live their lives as though God exists. The third view is the Neutralist viewpoint, in which therapists do not get involved in religious arguments. As modeled by Rogers (1951,1980), therapists do not advocate a religious point of view. Fourth, the Moderate view, as represented by Oden (1966), states that therapists may have religious orientations, but they should not push them on clients." (Miller, 1992, p. 114).

The four types of therapists outlined above represent a somewhat narrow view of what in reality is a far more complex array of therapists' beliefs, but they all illustrate and in fact encourage therapists not to work with religion in therapy, indicating the difficulty of the task of integration and thus advocating separateness.

A ten year review of empirical research on religion and psychotherapeutic processes and outcomes was conducted by Worthington et al (1996, from the U.S.), which looked at one hundred and forty eight articles from 1984-1994. During this time period the majority of empirical research in this area was being conducted in America, although the review does not stipulate that it only reviewed American articles. Worthington et al (1996) highlighted that it has become increasingly acceptable and seen as greatly needed to talk about and explore the role of religion in therapy. The paper found that religious interventions in counselling have

mainly been techniques imparted from formal religious traditions and used as adjuncts to more traditional counselling practises.

A major drawback to the research is that there is a distinct lack of empirical data, with literature being predominantly theoretical. This means that although it is now being acknowledged that religion is helpful and should be used in therapy, there is little to suggest how this might happen. They also commented on the lack of research focusing on the effect on therapists when clients bring religious beliefs, that it is limited to mainly Christian (and some Jewish) denominations and that research has been rather neglectful of other types of belief systems. They recommend that:

"Relative to the 10 years of research we have reviewed, agreed-on definitions must be used more often in research, populations must be more clearly delineated, standardized measures must be used more often, and hypotheses must be more specific." (Worthington et al, 1996, p. 480).

Post and Wade (2009, from the U.S.) reviewed research that investigated more specific spiritual/religious interventions in therapy, such as mindfulness based Cognitive Behavioural Therapy (CBT), spiritual interventions with addictions, eating disorders, and sexual abuse. Their review showed positive outcomes in the use of religious/spiritual techniques for all the studies examined. Although the efficacy of such techniques in comparison to non spiritual interventions overall indicates encouraging results, this area of research is still in its infancy and knowing exactly *what* works and *how* would require an increase in formalisation of techniques. A minority of clients felt that religious issues should only be dealt with by religious leaders and preferred to keep them separate from therapy, but those who did want their spirituality included did not necessarily feel the therapist had to be of the same belief system, only that they be open, non judgmental and genuine.

Hook et al (2010, from the U.S.) reviewed studies specifically looking at empirically supported religious and spiritual therapies. They assessed levels of efficacy, specificity, maintenance, clinical significance, and client matching characteristics. The studies covered a wide range of presenting problems but also included a wider spread of spirituality than previously found including, Christianity, Islam, Taoism, Buddhism, and a more general sense of spirituality. The results were varied mainly because studies were small scale and had not been replicated many times. Although overall results appeared in favour of spiritual based interventions, most of the studies looked at incorporating spiritual ideas into existing secular therapies; therefore outcomes meant that *overall* therapy was successful and it is still difficult to ascertain how much impact the spiritual additions had. It suggests that currently, the use of spiritual/religious therapies is just as effective as non spiritual ones, and including faith issues is dependent on client preference and therapist comfort; it recommends that future studies on efficacy need to be far more scientifically rigorous to be able to make broader and more generalisable conclusions.

It is clear however, that mental health professionals must be prepared to work with these issues (Collicut, 2011; Dien, 2004; Koenig and Larsen, 2001). The National Health Service and Royal College of Psychiatry have produced substantial guidelines to help practitioners integrate spirituality into their work, but as yet, no such specific documents appear to exist for counsellors, therapists, and psychologists.

2.3.1: Client Perspective

It is perhaps of utmost importance to consider the view of the client when thinking about whether to include spirituality in therapy, which may be why this position has taken preference in research. As mentioned earlier, simple initial questions can ascertain whether

spirituality is important to the client and whether they would like to incorporate it into therapy. So far, we have established that therapists need to be open and comfortable to these issues in order for clients to feel able to bring the topic. An American study by Rose et al (2001) on client perceptions found that clients believed it was appropriate to bring religious concerns to therapy (whether they were religious or not) and those who were religious had a preference for doing so; 60% of the psychologists reported their clients used religious language to describe their personal experiences.

Hielman and Witzum (2000) examined three cases of orthodox Jews from Jerusalem. The first case illustrates how the patient uses his religious beliefs to think about and describe his problems, the second and third cases explores the patients using religious structure to create meaning to life, which in turn helps them to cope with their pain. This paper illustrates the highly effective coping and protective mechanisms religion/belief/spirituality can serve when people are experiencing extreme distress (in these three cases psychosis), however it also illustrates the benefits of when religiousness is being taken into account by professionals, leading to greater compliance with non religious treatments such as medication; the patient is more likely to comply because they are being viewed holistically and their beliefs are seen as equally important.

Research suggests that therapy which incorporates religious/spiritual ideas work best for highly religious clients and has varied results the less religious a client is (Post and Wade, 2009). Gregory et al (2008) suggest that disclosure of a therapists' religion to the client too early on in therapy could have an impact on the client deciding to continue with that therapist, more specifically highly religious clients reported preferring to see a therapist affiliated with a major faith rather than someone of no faith.

Issues for clients on this topic include deciding whether to bring their beliefs to therapy, the religious/spiritual beliefs of the therapist, how much of their beliefs should dominate therapy and whether to seek faith based therapy. The research suggests that clients need to feel comfortable and in an environment in which they feel they can choose to bring their beliefs to therapy, and this atmosphere should be facilitated by the therapist. This can be initiated by the therapist but there appears to be a more positive outcome if the client feels able to initiate these conversations. Some religious clients would like to keep faith separate to therapy, but the majority who are very practising would like, and benefit from, their faith being involved (Worthington et al, 1996).

Although most of the research papers mentioned in this section are from America, and as we have established America has a generally larger religious population than the UK, the research focuses on what people who *are* religious want from therapy. Therefore we can at least hypothesise that the people who are religious in the UK may have similar issues. However, there does remain a cultural difference, and religious people in a country that is more religious may feel more comfortable to express their religious needs, but religious people in a less religious country may feel less comfortable to express their religious needs.

2.3.2: Therapist Perspective:

We now turn to literature looking at the experiences of therapists in this field. An American study by Bilgrave and Deluty (1998) investigated therapists' religious beliefs and therapeutic orientations and found that 66% believed in the transcendent, 72% believed their religious beliefs influenced their practise of psychotherapy and 66% claimed their practice of therapy influenced their religious beliefs. With such a high rate of acceptance and acknowledgment of therapists' own beliefs having an impact, it could be hypothesised that the effect of clients'

spirituality would have a similar impact. However the literature suggests that in the UK Psychologists feel less religious than their American counterparts, and difficulties remain in integrating the two concepts. Smiley (2001) conducted a UK study on the attitudes and clinical practises of psychologists regarding religion. Overall, there was a greater level of hesitancy in comparison to the American counter parts (Bergin and Jenson, 1990; Shafranske and Malony, 1990) in discussing religious issues, psychologists did not tend to routinely enquire about religion, and a minority would not pursue religious elements even when brought by the client. Of two hundred and forty seven participants, 18% reported affiliation to a formal religion, 38% claimed an 'informal affiliation' and 68% declared a 'non-traditional spirituality'. Although it is encouraging that the majority of participants associated themselves with a sense of spirituality, it did not seem to correlate with being able to incorporate an understanding of that in their client work.

Clement and Warren (1973) describe five problems of integrating religion into therapy in an article by Miller (1992). They suggest that 1) psychology and religion use different languages to describe human suffering (e.g. behaviour is sinful versus diagnosis of behaviour as an illness), 2) both domains undervalue each other or consider their own domain to be more relevant, 3) 'ultimate truths' held in religions tend to alienate psychology, 4) there are not many individuals in both areas who are interested in integration and finally, 5) those who are interested in integration may not know enough about both domains. Although since 1973 there has been considerably more written about integration of the two domains, some of the above points appear to remain valid, and help to explain why therapists may feel uncomfortable to discuss religion in therapy. A lack of discussion on integration of religion in therapy within training courses may render a therapist unsure about how to use a client's faith effectively in therapy. Therapists may feel they do not know enough about a client's religion to be able to use it in a helpful manner and may be concerned that it has a negative

impact on the therapy, which they will be unqualified to resolve. The different language used in religion may (to an uninformed therapist) at first appear at odds with the 'person centered', 'empathetic' language of therapy. Overall, if a therapist is not religious themselves and does not know anything about a client's religion, it would be a daunting task to allow another set of rules, understanding of human distress, language, and resolutions into the therapy room.

In a UK study conducted by Crossley and Salter (2005) clinical psychologists were interviewed from different (spiritual and non spiritual) backgrounds. They found that despite the growing acknowledgement of the importance of a person's spirituality in therapy psychologists felt unsure of what to do, primarily due to a lack of training and discussion on the topic:

"...the findings of this study indicate that there is considerable diversity and understanding in clinical approach to the issue of spirituality amongst clinical psychologists...it is a diverse and difficult topic that is not rigorously engaged with within training and professional debate" (Crossley and Salter, 2005, p. 307).

The results found that psychologists were divided as to whether to ask clients about spirituality, relying on personal choice rather than clinical judgement to inform their decision. Greater need for debate on the topic was seen as essential and a weakness of the study was that it spoke about religion, spirituality, and culture in their broadest senses, often using the words interchangeably. It seemed to ignore the differences between the three concepts, and that there are definable spiritual practises that could have been taken into consideration. The study found that the word spirituality itself was an issue; as participants did not have a clear understanding of the concept, interpretations varied greatly thus causing them to avoid it with clients due to the lack of knowledge or approach a psychologist could/should take. It perhaps would have been important to define these terms with participants or narrow the research area to certain types of spirituality that are known and can be studied:

"The importance of religiosity for many clients requires a careful re-education of therapists whose conceptual/clinical framework have room only for secular and naturalistic constructs. Bridging this cultural gap should prove rewarding, not only to the therapist who makes the effort to enter into this sphere of the clients experience, but also for the large number of clients who are hungry for help that is friendly and not foreign to their way of thinking." (Bergin and Jensen, 1990, p. 6).

Post and Wade (2009) reviewed empirical studies on religion and spirituality in psychotherapy with the aim of informing practitioners about effective ways to incorporate it in clinical work. One such study analysed therapists who were given three case vignettes to discuss, one on Catholicisim, one on Mormonism and one on Nation of Islam. The results showed that therapists were more likely to pathologise religious/spiritual beliefs if they came from faith systems that they knew little about. Nation of Islam was viewed as least mainstream and most pathologised, Catholicism was seen as most mainstream and least pathologised.

The general consensus appears to be that a therapist should treat spirituality as an integral part of therapy, to the degree dictated by the client. However Post and Wade (2009) point out that:

"Psychotherapists who are not religious or who practice a spirituality that differs greatly from that of the majority of their clients may feel uneasy with the recommendation to use religious/spiritual interventions in treatment." (Post and Wade, 2009, p. 142).

Shafranske and Malony (1990) had similar findings suggesting that therapists (whether they adhere to a faith or not) are less likely to use highly religious techniques in a secular setting.

Baker and Wang (2004) conducted a grounded theory study with 23 Christian clinical psychologists (all belonging to the UK Network of Christians in Psychology - UKNCP) about the impact of their values on their clinical work. They used a repertory grid to ensure ideas were being construed by participants and not researchers, and developed three main categories and two subcategories. What they found was that the identities of being a

Christian and a Psychologist fluctuated depending on the circumstance and was a multidimensional complex relationship:

"What our participants were trying to put across, was that their sense of identity as Christian psychologists - the experience of 'the connections' between work and religious commitment - was one of fluctuation, rather than of static position. Far from being viewed as problematic, a shifting sense of personal identity may indeed be the ordinary outcome of the intersection of two major and potentially competing roles" (Baker and Wang, 2004, p. 134).

This highlights the major work that still needs to be done in the field of religion in therapy and indicates that the research only highlighted further questions rather than give definitive answers. It was also only carried out with Christian psychologists and Baker and Wang (2004) admit that one of the ways of improving category saturation would be to include Christians who are not members of the UKNCP and psychologists from other faiths.

Religion and spirituality remain issues that therapists are unsure of and in the majority of papers reviewed it is felt that education and training are the key missing components. Aten and Worthington (2009) recommend more clinically useful definitions of religion and spirituality, more rigorous research on employing western and eastern religious practises into therapy, the need to carry out clinically focussed assessments of faith and spirituality, and a greater working alliance between therapists and faith representatives.

2.3.3: Client-Therapist Matching

'Client Therapist Matching' is a term that traditionally refers to both the client and therapist coming from the same racial/ethnic background and has since developed into representing any significant similarity in client and therapists' backgrounds. Although this study is not primarily interested in the outcomes of client therapist matching, this research requires Muslim psychologists to discuss their experiences with religious clients including those who are Muslim. It is also asking these psychologists (who have identified themselves within a

religious framework) about their work with religious clients, so there are potentially two levels of client therapist matching that could have an impact on the current study: 1) religious psychologists working with religious clients and 2) Muslim psychologists working with Muslim clients. It would therefore be beneficial to briefly discuss some of the literature on client therapist matching.

In a meta-analytic review of racial/ethnic matching of clients and therapists in mental health services by Cabral and Smith (2011), a succinct description of theories on the topic is given. It states that the predominant view over the past few decades has been based on evidence from the field of social psychology, the presumptions that have been extrapolated include the assumption that matching client and therapist in race/ethnicity would lead to a better therapeutic relationship as:

"People typically associate with those they perceive to be similar to themselves" (Newcomb, 1961 cited in Cabral and Smith, 2011, p. 537).

A further assumption can be made that if the therapeutic relationship is enhanced by matching this should lead to better therapeutic outcomes (Cabral and Smith, 2011; Mollersen et al, 2009; and Flicker et al, 2008). The reality however, has shown that even if the client and therapist share racial/ethnic matching, this alone does not necessarily foster a bond of similarity as it does not take into account factors such as religious beliefs, socio-economic status, having the same race/ethnicity genetically but not sharing a similar cultural upbringing, gender, age, level of education etc (Cabral and Smith, 2011). It is also stated that *differences* in the client and therapists' backgrounds can produce curiosity and insight which can help to abandon preconceived ideas and aid the client to re-frame their situation. They state that the research is so varied that it has been proposed that clients benefit equally

regardless of ethnic/racial matching, but with little evidence it is also hard to support this view (Cabral and Smith, 2011).

Overall, client *preferences* were mainly for a racially/ethnically matched therapist (although clients are likely to imagine a match in age/gender/world views as well as race/ethnicity). Client *perceptions* then begin to acknowledge more variables such as the skill and competence of the therapist as being of importance over race/ethnicity, and client *outcomes* generally show very little difference between matched and non matched clients, though the exact reasons for this remain unknown as the variables increase dramatically when measuring outcomes and cannot be confined to race/ethnicity matching alone (Horst et al, 2012; Cabral and Smith, 2011; Mollerson, 2009). A study conducted by Mollersen et al (2009) looked at ethnic matching in therapy for Sami and non-Sami Norwegians in mental health services. The results showed that ethnically matched clients attended more sessions and were given more sessions by their ethnically matched therapists, but showed little difference in outcome of therapy. In an American study on Hispanic and Anglo adolescents and substance abuse (Flicker et al, 2008) it also showed a better rate of attendance but also an improvement in outcome for the Hispanic matched adolescents, but no improvement for the Anglo matched clients. The difference in findings for different race/ethnicity groups was also replicated in the Cabral and Smith (2011) study, in that African American's showed a slight improvement when matched, leading to the notion that successful therapeutic outcomes associated with matching is dependent on individual ethnic groups and their political and historical backgrounds.

A more appropriate measure seems to be one of matching 'world views' and a move towards this is suggested in Zane et al (2005) who looked at the effects of cognitive matching. Their results showed more positive treatment outcomes when client therapist cognitive matching is done prior to commencement of therapy. Often clients are dissatisfied with therapy when

their ethnically matched therapist shows different world views and opinions, and are pleasantly surprised when a non-matched therapist shares similar world views (Cabral and Smith, 2011). Specific research on matching appears to be predominantly North American and none of the studies mentioned thus far have included religion when thinking about client therapist matching. However, the literature on religion in therapy does discuss issues of religious matching and a few are detailed below.

The prevalent view with regards to religious matching is that highly committed religious individuals would rather seek help from faith leaders or highly committed religious therapists, but individuals who are religious or belong to a faith would prefer to seek help from someone outside that faith (Greenidge and Baker, 2012). In a study by Mayers et al (2007 cited in Post and Wade, 2009) prior to therapy, religious clients indicated a fear that secular therapists would be insensitive to their religious needs, but that their actual experience of therapy with a secular therapist was positive. There was a mixed opinion about whether therapists should be matched to their religious beliefs, but they felt that the therapeutic alliance was strongest when therapists simply accepted and respected their beliefs. A minority said they wished not to discuss religious beliefs in therapy preferring to speak to clergy or feeling that it wasn't connected to their issue. Religious clients appear to suggest that although they would prefer to have therapy with a therapist who has a faith as opposed to an atheist, this is where the similarity ends because as long as therapists are open, accepting and respectful of beliefs, they do not need an in depth knowledge of the clients' faith (Gregory et al, 2008).

2.4: Islamic Psychology - The Fundamentals

Please see Glossary and Abbreviations for definition of terms.

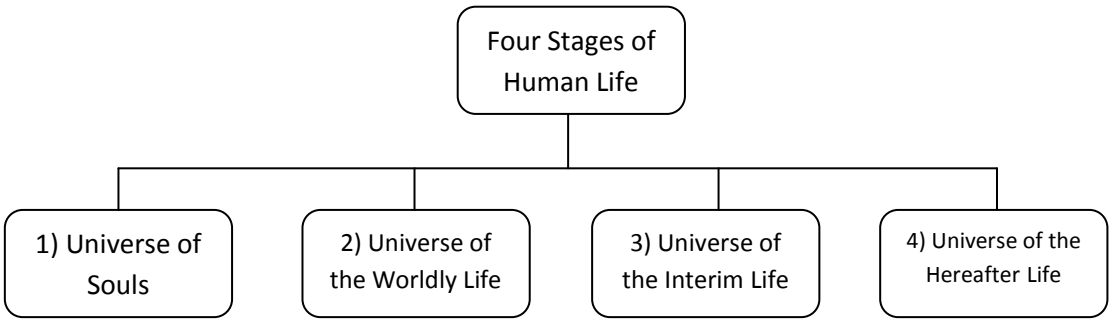
In order to begin to understand how Islam may have an impact on a person's psychology and therefore their mental well being, it is important to understand some basic tenets of the faith and some basic concepts affecting the self, beliefs and emotions. Traditional models of Islamic therapeutic approaches are still alive in mainstream Islamic cultures however, due to language barriers and slow and modest translations of Arabic texts in this field, it is a relatively new phenomenon to be explored in the West.

Muslims follow the word of God (Allah), which has been revealed through the Prophet Muhammad (peace be upon him – pbuh), culminating in the creation of the *Holy Quran* (a holy scripture believed to be the unaltered word of God). Concurrently, they also follow the teachings and practices of the Prophet Muhammad (pbuh), which is known as following the *Hadith* (his teachings) and *Sunnah* (his practices and actions as narrated by his closet companions). 'Islamic Psychology' therefore, is the umbrella term used for all aspects of the human psyche; psychological, spiritual, and social, that is explained or mentioned in the Holy Quran, the Hadith, and Sunnah. These form the fundamental principles of Islamic Psychology upon which one can outline a model and propose practical applications for therapy. They are also the sources against which one can measure whether a psychological theory or method is in some way incongruent to the belief structure of a Muslim. The fear of therapy being contradictory to religion is one which prevents many Muslims from seeking therapy from the outset (Jafari, 1993). As well as the human condition being discussed within these doctrines, methods of relieving symptoms or indeed cures are given.

Though there are a number of divisions within Islam, the explanations detailed below are taken from the predominant or mainstream view, sometimes referred to as Sunni (literally

meaning from the *Sunnah* - see glossary). Muslims believe that there are four stages of human life:

Figure 1: Islamic Stages of Human Life



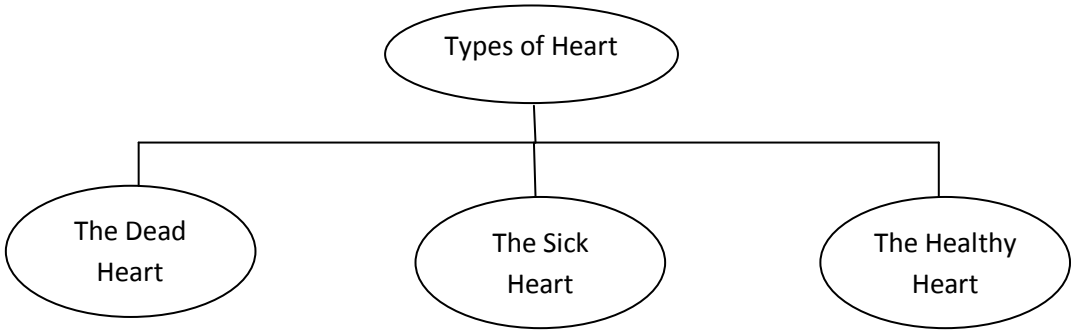
God creates souls before this life and a soul is placed into the foetus at about four months gestation. Human beings are sent to this world as a test, in which the condition of our souls and hearts will be greatly important, as it is this life which will judge how and where we are to spend our eternal life in the hereafter (heaven or hell). The 'interim life', is the life in the grave between a person's death and the Day of Judgement. Similarly here, this will either be a pleasant experience or not, depending on our actions in the worldly life.

Humans are made up of essentially two parts that experience this life; a body and a soul. Within this, there are three concepts central to the structure of personality in Islam; the physical and spiritual heart (*Qalb*), the drives within the soul (*Nafs*) and the mind/intellect/reasoning (*Aql*).

The heart contains a person's 'God consciousness' and 'divine potential' (*Fitra*); Islam proposes that human beings are born in a state of *Fitra* which means they have a natural disposition towards God and good. The heart has three states (see figure 2), 1) the 'dead heart', is when it has lost connection to or has no faith in God. It follows all lusts and desires and is purely concerned with the worldly life. 2) The 'sick heart', is when it has some faith

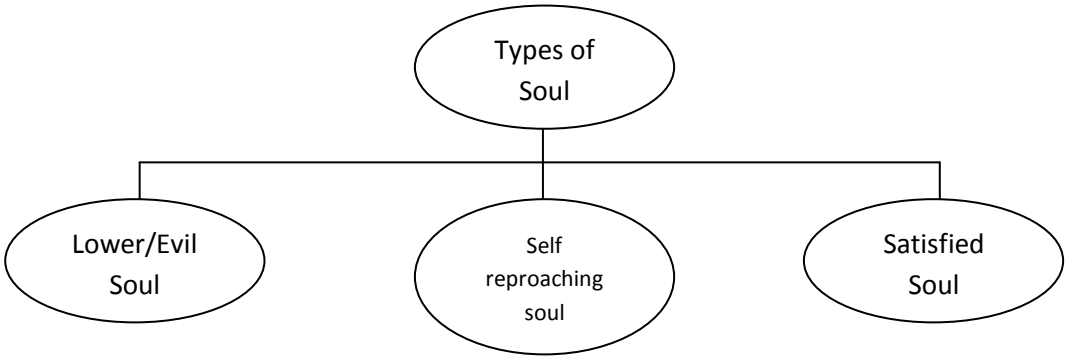
and follows whichever idea manages to dominate at the time, i.e. sometimes God conscious and at other times follows worldly desires (this is seen to be where most people are) and 3) the 'healthy heart', which has a strong faith and is free from most worldly desires. When the environment or circumstances take a person from their *Fitra*, it can create a 'dead' or 'sick' heart, which can then lead to physical or psychological ill health. The heart is also the physical link or connection to the soul (*Ruh*).

Figure 2: Islamic Concept of the Heart



When the soul is in its form outside of the body it is referred to as *Ruh*, when it is inside the body and directly connected to the heart and mind it is referred to as *Nafs*. It also has three states, (see figure 3), 1) the evil/lower soul, which attracts the attention of Satan, is pre-occupied with amusements from the worldly life, 2) the self-reproaching soul, who has faith, recognises and blames self for sin which leads to repentance and seeking spiritual comfort from God [this is where most people are seen to be] and 3) the satisfied soul, which finds peace in faith, Quran, prayer, remembrance, worship and good deeds.

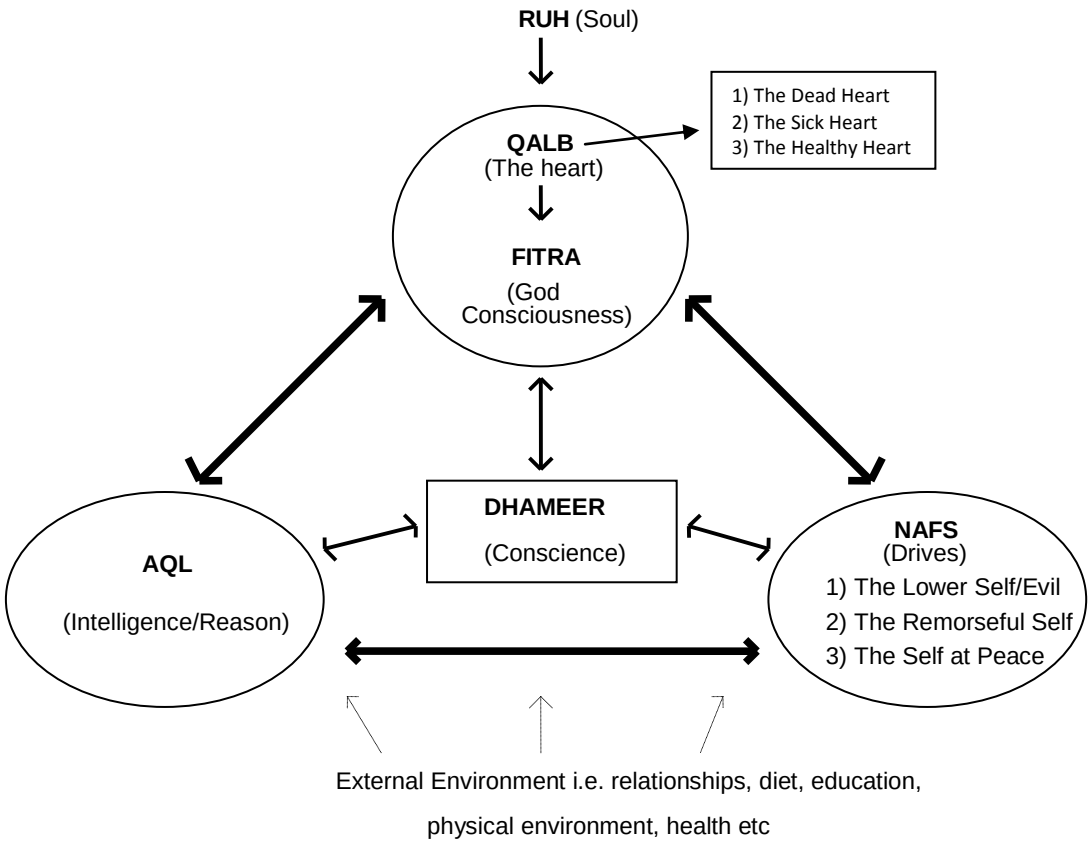
Figure 3: Islamic Concept of the Soul



Finally, humans have been given an intelligent mind or *Aql*. This is so called because out of all of God's creations he has blessed human beings with the highest level of intelligence. Our intelligence and reasoning is fed through our five senses of sight, hearing, touch, taste and smell and similarly is affected by what goes into the body and soul through these senses.

The aim for 'good' Muslims is to spend their lives constantly travelling on a journey towards a healthy heart and a satisfied soul. Having a 'dead' or 'sick' heart, an evil or self reproaching soul can then lead to experiencing psychological (and physical) distress in almost infinite ways. The relationship between the soul, the heart and the mind would determine a person's emotional and psychological well-being (see *Figure 4*).

Figure 4: The Islamic concept of The Self:



The information on the Islamic concepts of the heart, mind, and soul has been interpreted from Anam (2011). Many Muslims seeking therapy will not necessarily have an in depth knowledge of any of the above, however people in distress often feel unbalanced spiritually and turn to their faith first in search of answers. Understanding their problems in relation to their faith could create positive results on a spiritual as well as psychological level.

2.4.1: The Purpose of Life

The previous section has briefly reviewed an Islamic view of the Self, and touched upon areas which may impact upon psychological well-being. It is also important to consider the Islamic perspective on human suffering of any nature, if it is to be incorporated into a therapeutic formulation. Most forms of human distress can be viewed in three ways: 1) a test

of either patience or gratitude; Muslims believe that this world is a test of faith in God, the more you are tested (by loss of wealth or death of a loved one for example) the more God loves you, as He is giving you many opportunities to turn to Him and remember Him, which if you do guarantees a good after life. 2) A punishment and expiation of sin; Muslims believe that it is better to be punished for a sin in this world than be punished in the hereafter and believe that no hardship passes without it expiating sin from that person, hardships are seen to be highly beneficial for a person's afterlife. 3) A temptation from Satan; the dead and sick heart, and the lower and remorseful self are likely to be influenced by evil, Muslims believe this is likely to be the case if you have strayed from God and religious practices which are seen to protect you from Satan (Badri, 1996).

Other important areas of Islam which have an impact on a person's psychological state are the role of Prayer, Thikr (God consciousness and worship) reading the Qu'ran, Fasting, giving to Charity and of course, being a righteous person. These practices among other things, offer methods of purifying the heart and soul, they offer tranquility and fulfillment and thus also cure from psychological distress. A therapeutic model or models that can not only incorporate, but also effectively, use all of the above beliefs (and many more) to alleviate a persons' psychological and emotional distress could be broadly termed 'Islamic Psychology' (Badri, 1996).

The study of the Islamic concept of the self and purification of the heart and soul are complex multi faceted topics, and can require many years of academic study to master. What is presented here is a simple overview to help the reader begin to understand the complexities within Islam of the self and main ideas which need to be born in mind when thinking about psychological theories and practises.

2.5: Islamic Psychology versus Western models of Psychotherapy

There appear to be differing views on using western psychotherapies with religiously practicing Muslim clients. Some practitioners believe that most western based psychotherapies are essentially secular and largely ignore the role of the soul which is central to Islam (Penny, 2006). Badri (1996) reflects on the emergence of western counselling and psychotherapy models in the light of freedom from religious dogma and persecution:

"The renaissance came with explosive anti-Catholic and anti-religious ardour which pushed the pendulum to the extreme of secularization, the sexual revolution and the 'liberation' of Western man from any sacred or spiritual authority." (Badri, 1996, p. 163).

Others feel that it is the theological nature (or limited theology) of the religions being discussed which has caused problems in past discussions between religion and psychology. Islamic theology can be said to incorporate a wider view on human nature and the self, and therefore does not immediately necessitate a split from psychotherapy (Arshad, 2007).

Thus far, this chapter has briefly mentioned the similarity between religion and psychology as sharing the desire to understand, and therefore answer, mans psychological distresses. In this section a critical review of three different models of psychology are compared and contrasted to religious models of human difficulty, and more specifically to Islamic psychology.

2.5.1: Psychoanalytic/Psychodynamic Psychotherapy

Philosophically, at first glance psychoanalysis appears to be the therapy most at odds with Islamic psychology primarily due to Freud's well known beliefs about religion; he felt that religion was born out of an adult's need for a continuous 'father figure' and in a paper entitled 'The Ego and the Id' (1923) he explains;

"Religion, morality, and a social sense- the chief elements in the higher side of man- were originally one and the same thing. According to the hypothesis which I put forward in 'Totem and Taboo' (1912-13) they were acquired phylogenetically out of the father-complex: religion and moral restraint through the process of mastering the Oedipus complex itself…" (Freud, 1923, p. 460).

It is clear that Freud saw God and religion as something fabricated by people to satisfy the need for parental love when making the transition into adulthood, but he also describes how other elements of religion, such as an after-life, have been designed to help manage mental functions such as the 'pleasure principle';

"But the endopsychic impression made by this substitution has been so powerful that it is reflected in a special religious myth. The doctrine of reward in the after-life for the voluntary or enforced- renunciation of earthly pleasures is nothing other than mythical projection of this revolution in the mind. Following consistently along these lines, 'religions' have been able to effect absolute renunciation of pleasure in this life by means of the promise of compensation in a future existence; but they have not by this means achieved a conquest of the pleasure principle." (Freud, 1911, p. 514).

As noted earlier, the principle of a greater reward in the next life is a fundamental one in Islam and many Muslims' actions, and thoughts about their actions, will be related to this goal. To interpret an after-life in any way other than the truth or reality for that person could have an impact on the congruence in therapy and therefore the therapeutic relationship, and may even lead to a rupture[3] in the therapeutic alliance.

Kirsner (2006) says of Freud's view on religion:

"Religion brings about hallucinatory emotional satisfaction and misguided comfort whereas science is the long-term winner" (Kirsner, 2006, p. 359).

It has been suggested that particular types of therapy developed in times and circumstances so far removed from Islamic tradition, such as psychoanalysis, may not be appropriate to use (Koenig, 2010).

"Is belief in God a sickness? Is it a manifestation of transference-a concept of our parents…? Or to put it another way, is such a belief a form of primitive or childish thinking

[3] The term 'rupture' is a semi-colloquial counselling term which refers to when the relationship between the therapist and the client is threatened in some way; such as by a disagreement or a misunderstanding.

which we should grow out of as we seek higher levels of awareness and maturity?" (Peck 1990, cited in Badri 1996, p. 165)

Freud believed our sexual life begins at birth and that it is innately biological, as his theories on the psychosexual stages of development convey. Although the Islamic view incorporates basic instinctual 'drives' it does not view them as sexual in nature nor does it view them to be the only forces at work, the mind or 'aql' for example is a separate entity (see figure *iv)*:

"At the core of the Freudian model, we find drives to be the primary, motivational force. As we have seen, the mind is believed to be driven primarily by instinctual derivatives of the biological body. Human beings are motivated by the pursuit of pleasure contingent upon the discharge of the drive." (Lemma, 2003, p. 24).

Also, from an Islamic perspective, man is born in a state of 'Fitra' (see figure *iv*), which means having an innate God consciousness and a natural disposition towards good (Penny, 2006). The Islamic Psychology model proposes that a person may experience psychological/spiritual distress when his 'nafs' (drives) and/or his environment cause him to stray from this natural state, rather than being purely driven by biological forces.

Similarly Melanie Klein's theory on infant phantasies poses the same dilemma. Klein believed that infant phantasies were innate and of a sexual and aggressive nature, which is a difficult concept to fit with an Islamic perspective of 'Fitra':

"She postulated that the pre-verbal infant was born with innate knowledge about sexual intercourse (in rudimentary form), the penis and the vagina. She believed that these innate phantasies formed the basis of the baby's rich unconscious phantasy life and interacted with external reality." (Lemma, 2003, p. 33).

Dr Malik Badri, a practicing Muslim clinical psychologist and professor of psychology, has written in detail about the difficulties of applying western models of psychotherapy with Muslim clients (Badri, 2000; 1996; 1979; 1976) particularly with regards to Freudian Psychoanalysis and Behaviorism. As well as some of the issues raised here, Badri reflects on

the existence of 'good' and 'evil' within a religious framework, which was a framework Freud deliberately moved away from:

"*According to Freud, there is no such thing as evil or good from the ethical or religious point of view, because man is essentially selfish and aggressive by nature. If he is by nature evil, and is driven by unconscious impulses over which he has no conscious control, then he is not to be blamed for all the immoral behaviour which religion and society condemn...If he thinks that he is doing good deeds he is in fact fooling himself by the distortions and denials of his ego's defense mechanisms such as rationalisation and sublimation. These defenses, according to Freud, satisfy sexual and 'id' impulses by distorting and denying the reality of their true unconscious impulses."* (Badri, 1996, p. 172).

Psychoanalytic psychotherapy has since been through many alterations and transformations and produced a multitude of therapeutic strategies since its early Freudian roots, many moving away from some of the concepts mentioned above. Carl Jung, for example, moved away from Freud's theories believing that religion could be a helpful tool in aiding psychological well-being and that dismissing it as part of a neurosis did not make sense:

"In this respect our age is afflicted with a blindness that has no parallel. We think we have only to declare an accepted article of faith incorrect and invalid, and we shall be psychologically rid of all the traditional effects of Christianity or Judaism. We believe in enlightenment, as if an intellectual change of front somehow had a profounder influence on the emotional processes or even on the unconscious. We entirely forget that religion of the past two thousand years is a psychological attitude, a definite form and manner of adaptation to the world without and within, that lays down a definite cultural pattern and creates an atmosphere which remains wholly uninfluenced by any intellectual denials." (Jung, 1913-35, p. 53)

He believed that the soul resided in the unconscious and it was through the unconscious that we have a connection to 'God'. He also believed in a two part consciousness, one part a 'personal' consciousness and the other a 'collective' consciousness (Eliason et al, 2001).

"[Jung broke with Freud]…Not only did Jung articulate the spiritual dimension of the psyche and limitations of ego, he stressed a relational -he called it dialectical- paradigm of analysis. Jung's model of the psyche added to Freud's by including a substratum of a collective unconscious, a place of commonality and spirit, "beneath" Freud's "personal unconscious." This distinction is useful in discriminating between childish longings for an all-soothing parent (personal unconscious material to be reductively interpreted) and mature longing for an internal connection to the commonality of underlying psychic structure we all share (archetypes from the collective unconscious)." (Maaske, 2002, p. 780).

Lemma (2003) provides a concise overview of the history of psychoanalysis, she states that the shifts have predominantly been associated with the object-relations theory and moving on from the notion of pre-existing libidinal drives to real early experiences of relationships with caregivers. For example, Heinz Kohut's self -psychology postulates:

"In contrast to the object-relations theorists, who emphasise the internalised relationships between representations of self and objects, self psychology is interested in how external relationships help develop and maintain self-esteem." (Lemma, 2003. p. 43).

The British Independent School became an umbrella term for psychodynamic practitioners who did not want to be seen in the light of any particular theorists (i.e. Freudians or Kleinians) and who although have an eclectic mix of practises, agree on the importance of the infants earliest relationships and their impact on the developing psyche. The work of developmental researchers and attachment theorists propelled these ideas into the future, in particular John Bowlby and his work in the 1960's and 1970's on attachment theory and styles. His work has helped transfer the focus of psychodynamic theory from the phantasy into the real world;

"In traditional theory the processes described are often referred to in terms of 'internalising a problem' and the misattributions and misperceptions ascribed to projection, introjection or phantasy. Not only are the resulting statements apt to be ambiguous but the fact that such misattributions and misperceptions are directly derived from previous real-life experience is either only vaguely alluded to or else totally obscured." (Bowlby, 1977, p. 209).

He goes on to say that he believes that there are different types of measurable attachment styles between infant and parent (caregiver) which each produce different early childhood experiences. These experiences correlate to later life presentations of the self in relationships and can also influence emotional and psychological wellbeing. Although the view of early life experiences impacting a person's adult life, do not oppose an Islamic view and could certainly explain reasons behind a 'deadening' of the heart, an Islamic view would also

incorporate a spiritual level of understanding of why a person may be going through a difficulty/test/punishment etc and incorporate a spiritual element of patience and gratitude to help with recovery.

The main difference between psychodynamic psychotherapy and other types of counselling is that it seeks to use unconscious processes (such as transference and counter-transference) to understand the patient and the nature of their problem (Symington, 1986). Transference is the analysis of the interaction of the therapist and client beyond what is happening on the surface, Symington (1986) feels that it is emotionally the most difficult aspect of therapy and is not something that can be taught in training programmes.

Other techniques such as a client's 'defenses' and their potential resistance to therapy or to change, may require a deeper interpretation from the therapist of processes which are being hidden (like transference) and that the client is finding difficult to acknowledge. Mainstream Islam does not have a strong tradition of using altered states of consciousness within its history, in fact substances which alter a person's state of consciousness (including alcohol) are prohibited for that reason, and the full use of a person's mind (cognitions), body and soul are required for prayer (Badri, 1979). Therefore methods such as hypnosis or meditation are viewed with extreme caution if not prohibited altogether. Dealing with the unconscious in therapy therefore may prove more difficult to justify and its efficiency and efficacy may be brought into question. Real-world theories as opposed to phantasy-world theories may help to make it more applicable to the Islamic perspective, however interpretations on the unconscious workings of the client and the therapy would need to be more transparent in order to ensure they remain congruent with an Islamic perspective.

"...Sorenson noted the lack of attention to issues of spirituality in the transference and countertransference" (Maaske, 2002, p. 778)

Overall, early theories of sexual and aggressive drives, working with the unconscious, transferences, and the lack of inclusion of a spiritual element make psychodynamic theory a difficult one to use directly with Muslim clients, although later dynamic theories on early real-life events and their impact on adulthood do not necessarily oppose an Islamic view and may be beneficial in understanding early 'outside influences' on the self. Uncovering defenses and underlying resistance to change can also be invaluable to making progress in therapy, but it would be essential that the interpretations of such do not oppose Islamic beliefs.

2.5.2: CBT

Cognitive Behaviour Therapy (CBT) is often set at the other end of the therapeutic spectrum to Psychoanalysis (Sanders and Wills, 2005). Its early reputation was for being a very rational, unemotional, and an intellectual technique that does not engage in unconscious processes, as opposed to the relational, personal, and interpretative nature of other therapies. This reputation was due in part to the behaviourist influences in the CBT model. Behaviourism and behaviourist ideals were seen as a natural counter-argument against previous psychological theories and to the concepts of religion, the soul, and human freedom (Eliason et al, 2001).

"Possibly the easiest way to bring out the contrast between the old psychology and the new is to say that all schools of psychology except that of behaviorism claim that "consciousness" is the subject matter of psychology. Behaviorism, on the contrary, holds that the subject matter of human psychology is the behavior or activities of the human being. Behaviorism claims that "consciousness" is neither a definable nor a usable concept; that it is merely another word for the "soul" of more ancient times. The old psychology is thus dominated by a kind of subtle religious philosophy". (Watson, 1925, cited in Eliason et al, 2001, p.86).

Albert Ellis, the founder of Rational Emotive Behaviour Therapy (an earlier form of therapy that amalgamated cognitive and behaviourist approaches) also believed that devotion to a superhuman entity can lead to unhappiness for the client (Carter and Rashidi, 2004). Badri (1996) discusses the clear challenges faced by a religious person when using behaviourist techniques and again suggests that it is a lack of morality and 'good' versus 'evil' that would be the main difficulty:

"According to behaviourism, mans nature...is fully dependent on his environment...man's nature is neutral; a tabula rasa...Thus 'good' and 'evil' and man's responsibility for doing good and avoiding evil become an unattainable mirage. Here again, man is seen as a helpless being who should not be responsible for any sexual or other 'unacceptable' behaviour which irresistible environmental influences cause him to practise.' (Badri, 1996, p. 173).

However Arshad (2007), states that elements of behaviourism can be subscribed to without necessitating an abandonment of faith. CBT has been an amalgamation of Behaviourist and Cognitive theories, and proposes that human experience is made up of four components; physiological, emotional, behavioural, and cognitive processes (Woolf et al, 2003). Aaron. T. Beck developed CBT in the late 1970's (Beck, 1976 and Beck et al., 1979):

"...and is built on the assumption that thinking processes both influence and are influenced by emotional difficulties...it therefore aims to modify thinking processes in an experimental way to see whether this may have a positive effect on the client's emotions, behaviour or underlying problems." (Sanders andWills, 2005, p. 3).

The root of maladaptive thoughts (and therefore how people develop psychological distress) is thought to be assumptions made from early life:

"...core beliefs, so called 'early maladaptive schema', are long standing, enduring beliefs about the self, others and the world, often formed from early experiences, and often unhelpful." (Sanders and Wills, 2005, p. 137).

Modern day CBT has no elements which directly contradict an Islamic framework, in fact it's more holistic view lends itself to the Islamic model, allowing room for an intelligent mind (or 'Aql') to have an impact on psychological functioning.

"...Cognitive therapies fit well with the beliefs and values of the Muslim population, ***as long as the counsellor can work comfortably within the religious perspectives of the client"*** (Carter and Rashidi, 2004, p. 156).

As with the Psychodynamic approach however, CBT's lack of including a spiritual component means that it is left to clinicians to make a choice on whether and how to incorporate a client's soul or their belief in God, and what impact that may have on psychological distress and recovery. Subsequently, over the past ten years there has been an increase in the number of studies (mainly Christian but some Islamic) looking at incorporating religion (or a fifth spiritual element) into the CBT framework in a more direct way (Hodge, 2011; Vasegh, 2011; Naeem et al, 2009; Hamdan, 2008; Andersson and Asmundson, 2006; Khalid, 2006; D'Souza and Rodrigo, 2004);

"In recent years, efforts have been made to integrate religiously based concepts and beliefs in the context of a cognitive-behavioural therapy approach. This involves replacing damaging beliefs and attributions about the self, others, and the world with more positive religiously based beliefs and attributions, as well as utilizing various other cognitive approaches" (Hamdan, 2008, p. 101).

Overall, it appears that CBT could potentially work well with a Muslim client, but it relies heavily on the therapist being comfortable with incorporating a persons' spirituality and sometimes discussing in detail their thoughts around that. Early behaviorist approaches are too simplistic for the Islamic model and by incorporating ones reasoning, emotions, social situation and spirituality, a more holistic approach is attained.

2.5.3: Humanistic/Person Centred Approaches

A third type of therapy emerged in the 1940's, as a response to the two most dominant therapies (psychodynamic and behaviourist) as a challenge to their over-deterministic viewpoints. The fundamental aspect of humanistic approaches is the underlying theory of 'self-actualisation'. If the psychodynamic model is one of self conflict and the behaviourist model is one of problem solving, then humanism is one of growth and realising ones full potential (Mcleod, 2003 cited in Woolfe et al, 2003). Abraham Maslow believed that in most humans there is an active drive towards health, growth, and actualization of the human potential:

"Maslow advanced a general theory of human motivation which emphasized a concept of needs. Maslow characterized humans as perpetually 'wanting creatures', always possessing some type of unfulfilled need. He further explained that these needs arrange themselves in a hierarchical order, with 'lower levels' of needs being met prior to the advancement of 'higher levels' of needs. In other words, as basic human needs (e.g. food and water) become sufficiently satisfied, another category of needs soon emerges to take their place. Then, as those needs are satisfied, they too fade into the background and are replaced by still other needs . . . and so on. Only after the lower level needs are met, however, will the individual be motivated to satisfy the subsequent categories of needs" (Oleson, 2004, p. 83-84).

These different levels of needs are known as 'Maslow's Hierarchy of Needs' and have been used internationally across many different disciplines such as education, business, and social psychology fields. Maslow's hierarchy of needs consists of five main levels; 1) physiological needs, 2) safety and security needs, 3) love and belonging needs, 4) esteem needs, and 5) self actualisation. Self actualisation refers to reaching one's full potential to its greatest extent possible. After studying Maslow's major works, Sumerlin (1995, cited in Oleson, 2004) reported 11 optimal functioning features common in Maslow's descriptions of a self-actualizing person. These features were autonomy, purpose in life, movement towards capacity, openness to experience, courage, comfort with solitude, democratic character, self-acceptance, curiosity, lack of fear of one's own greatness (Jonah complex), and an ability to

live in the moment while integrating experiences and future goals (time integration) (Oleson, 2004).

Another famous proponent of the humanistic model was Carl Rogers. His works in the 1950's and 1960's led to person-centred therapeutic approaches. This approach alongside the humanistic philosophy focuses on the relationship between the therapist and the client and proposes that it is the therapeutic relationship that is the catalyst for positive change. There are three conditions which are necessary within the therapeutic relationship for it to be successful and these are; 1) Unconditional Positive Regard for the client {acceptance}, 2) Empathy {to be accurate and understanding} 3) Therapeutic Genuineness {using active listening and being congruent} (Josefowitz and Myran, 2005). Purton (1998) discusses how 'unconditional positive regard' (UPR) is the most controversial of the three conditions as it is not a naturally occurring emotion (as are empathy and being genuine), but is something which needs to be 'created' by the therapist. Although other words such as, acceptance, respect, and warmth are often used to describe UPR, these are often qualities that have their own meanings and don't fit completely to mean UPR:

"One surely has positive regard for things which are seen as in some way good or appealing, negative regard for things bad or unlikeable. 'Unconditional positive regard' seems to mean positive regard for things whether they are good or not, which seems either incomprehensible or to involve a sort of mad sentimentality ...so we are led to the uncomfortable thought that UPR may not be so much a vague or indeterminate phrase like 'loose adjective', but more of a contradiction in terms, 'like square circle'." (Purton, 1998, p. 24).

Purton argues that the only way UPR is possible is to view the client in *spiritual* terms; he states that it is only really possible to be unconditionally positive about good things, and that a persons' desire to change their 'bad' behaviour is the part that we can be unconditionally positive about. He suggests that humans differ from animals in the sense that they have the ability to have a second set of desires which think about and reflect on a primary set of desires (i.e. a person may be addicted to a drug {the addiction is a response to a primary

desire} but have the ability to know that they don't want to be addicted to it and want to make changes {the desire to change being the secondary desire}). His argument suggests that in order to have UPR about a person's secondary desires we have to believe they have the capacity to change beyond the realms of this world and into the next:

"The most it can show is that if we adopt an attitude of (unsentimental) unconditional respect towards a human being then we are ipso facto seeing them as having an essential self of which their empirical self is a distorted form; and if the last bit of the argument is valid what also follows is that we are ipso facto seeing their essential self as unlimited by the temporal confines of their present life." (Purton, 1998, p. 35).

This view would appear to fit with an Islamic view of the self, as Purton argues we have a) the ability to 'reason' and have a view over our base desires and b) that there are fundamentally good and therefore bad or evil acts, which cannot be unconditionally accepted by the therapist. Islam states that a) Allah (God) has given human beings an 'Aql' or intelligent, reasoning mind (which He has not given to animals) b) that there are universal good acts as well as bad ones which are stipulated in religious doctrine and need to be considered when dealing with human distress, including within therapy.

Setting aside Purton's view (as this is not necessarily a mainstream humanistic view) and going back to the original philosophies of humanism, Malik Badri (1996) felt that the main concept of self actualisation was a problematic one from a religious viewpoint;

"Self actualisation is a key concept in humanistic psychology. It is a process of continuous growth to realise ones potentials irrespective of traditional ethical standards or religious mores. For example, sex, which is greatly constrained and sanctioned by the commandments of all religions, is liberally viewed as one of the major unrestrained means of attaining this actualisation." (Badri, 1996, p. 174.)

He suggests that the theme running through all western psychotherapies is one which abandons the notions of 'good' and 'evil' in any moralistic sense and describes the 'gods' of psychoanalysis and behaviourism to be abstract unconscious impulses and environmental stimuli and that even more despairingly the 'god' of humanism to be the individual himself.

"Accordingly, Western psychotherapy, in order to ride the scientific wave, has strongly adopted the secular position of no 'evil' or 'good' in order to support three positions- no religious conceptions in science, no moralisation or judgementalism, and no human responsibility...These, briefly and simply, are the most important philosophical and methodological justifications of counselling and psychotherapy in adopting a value free approach and in rejecting evil and human moral responsibility. When moulded into practical psychotherapeutic and counselling techniques, these philosophical conceptions will be translated into rules and principles such as empathy and unconditional value-free regard for the client..." (Badri, 1996, p. 177).

He proceeds to describe the Islamic view of 'good' and 'bad' and that it is split into five parts; 1) Fard, good deeds and obligatory religious duties, 2) Mustahabbat, good deeds which are not obligatory, 3) Halal, actions which are neither forbidden nor necessarily rewarding, 4) Makhru, deeds that are frowned upon, and 5) Haram, tabooed and clearly evil actions. He suggests that it would be:

"...regretful if we as Muslim therapists blindly follow the western 'no evil, no good' paradigm and throw away our rich psycho-spiritual morally refined ethics which can be a very helpful process in therapy." (Badri, 1996, p. 178).

Badri mentions that there are also many western therapists who also question the validity of unconditional positive regard and value free therapy such as Peck (1993) and as described earlier Purton (1998).

At the opposite end of the spectrum Carter and Rashidi (2004) feel that the person centred approach does fit well with Muslim clients and that its basic tenets of genuineness, congruence, unconditional positive regard, acceptance, accurate empathy, understanding and active listening fit in an Islamic framework. Muslim clients are:

"...presumed to be predisposed to self-preservation, growth, happiness, loving and being loved, communion with others and self actualisation" (Carter and Rashidi, 2004, p. 158).

They suggest that a therapist can apply the conditions of person centred therapy to help a client with their religious beliefs, even if the therapist is not of that faith and doesn't necessarily agree with the rules of the faith the client may be wanting to follow, by having an

unconditional positive regard, empathy and congruence they should follow the lead of the client and accept their views and beliefs in order to help them reach their full potential.

Another issue which has been raised previously is one of individualism versus collectivism, an 'I' versus 'We' identity:

"Attempting to reveal unconscious content and promoting self-actualization may be counterproductive for clients who come from collectivistic cultures." (Dwairy, 2009, p. 199).

The notion here is that western society places a higher value on individualism and eastern (or non western) societies place a higher value on collectivism:

"Eastern mentality fosters group work, networking, and community support...based on piety, human-heartedness, empathy, and benevolence. In contrast, Western mentality is based on individuality, autonomy, individual decision making, and taking responsibility." (Carter and Rashidi, 2004, p. 154).

This connects to the idea that self-actualisation is one which would not be compatible with a collectivist culture and therefore an Islamic one. However, it could be argued that many non-western *cultures* may prioritise a 'collectivist' philosophy, but that an Islamic (*religious*) view is more balanced and incorporates both an 'I' and a 'We' into self identity:

"Counselling and psychotherapy theories have tended to focus on individual aspects of self; for example cognitive psychology focuses on thoughts, psychoanalysis on the unconscious and behavioural psychology on behaviour. In the humanistic tradition Carl Rogers characterised inner growth as 'becoming a person', while Abraham Maslow (1908-1970) termed it 'self actualisation'. With regard to the notion that self-development involves freeing oneself from Egocentric defensive and counter-productive attitudes and behaviours, there appears to be agreement between the Islamic and Western traditions. However, an Islamic approach would emphasise the importance of developing noble and spiritually dynamic qualities in the self. Hence an Islamic perspective of understanding self includes insight into the spiritual aspect of self, and connects more closely with the true meaning of psychology." (Khalid, 2006, p. 1).

2.5.4: Summary

Frager, 1999 (cited in Inayat, 2005) stated that:

'Major differences exist between Western and Islamic psychology'. (Inayat, 2005, p. 1).

Although these differences exist there appear to be major discrepancies emerging around what is appropriate or not when working with Muslim clients. The main divide can be divided into two parts; that of the philosophical nature of the therapy versus that of the methodological implications of it in therapy. Many of the reasons why western psychotherapy may not be appropriate with Muslim clients is due to the philosophical nature of the therapy (such as importance of self, lack of 'good' and 'evil' ideology, lack of inclusion of a soul), but that there are certain practical techniques such as counter-transference (psychodynamic), cognitive restructuring (CBT), or acceptance and empathy (person centred), that are regarded as useful tools when working with Muslim clients and don't necessarily render a persons' beliefs as inappropriate or unacceptable in therapy.

2.6: Therapy with Muslim Clients

Research on Islam in the therapeutic setting is gradually becoming a more popular theme amongst trainees, perhaps as the number of Muslim trainee's rises, but it is still a vastly under researched area. Inayat (2005) highlights the pitfalls of western medicine as that which:

"...lacks any detailed understanding of how Muslim patients' religious beliefs influence their thinking about health, illness, and treatment" (Inayat, 2005, p. 1).

And that although psychotherapeutic practises have evolved over the years, progress still needs to be made in working with black and ethnic minority groups. Clients are often seen in isolation of their religious beliefs and Inayat (2005) states that traditionally;

"...the part religion plays in understanding the meaning of human suffering is of little value in helping us understand the origins of human distress" . (Inayat, 2005, p. 1).

The literature suggests that clients are also very aware of this discrepancy as many do not access services for this reason, and also fearing that the experience will conflict with their beliefs (Inayat, 2005; Jafari, 1993). Conflicts may also arise when clients and practitioners differ in religious beliefs, particularly if therapists view the inclusion of religious material as less important than their clients, Bergin and Jensen (1990) state that this difference:

"*...begs to be bridged, for in their deepest moments of self comprehension and change, many clients see, feel, and act in spiritual terms."* (Bergin and Jensen, 1990, p. 3).

Muslims, (as perhaps with other religious groups) place a substantial emphasis on their faith when thinking about and understanding mental health, and the role faith has when processing the experience and expression of mental distress has been well documented (Inayat, 2005; Badri, 2000; Ansari, 1992; Hussain, 1992). An emerging 'modern' understanding of Islamic Psychology is also gaining importance within Western literature, in which writers are explaining for the first time what the 'psychology' of a Muslim is, alongside descriptions of how this can be applied to psychotherapy and creating an 'Islamic Counselling' (Penny, 2006; Inayat, 2005; Inayat, 2001; Belkeis, 1996).

Another issue in the literature is that the term ‘culture’ has often been used synonymously with 'religion' or 'faith' and psycho-spiritual writers in this field feel that this has added to the under-valuing of the religious paradigm (Badri, 2000). Badri believes that too much value is placed on social, cultural and physical difference and states that it is the belief systems that underpin a culture that should be given greater prominence.

Ali et al (2004) reviews the practical aspects of the religion and some preliminary explanations of the Islamic concept of the self, Islamic Psychology and counselling, and how it may impact on therapy. It provides a case vignette detailing issues such as eye contact, attending with family, prayer and working with the opposite gender. It recommends that crucial to the therapeutic approach with this client group is establishing rapport and suggests using the Empowerment Model (McWhirter, 1997) which integrates collaboration, context, critical consciousness, competence and community, into the work.

Carter and Rashidi (2004; 2003) give an in-depth account of the tenets of the faith and propose an 'Integrated psychotherapy approach for Muslim women'. This model uses client centered and cognitive models from western psychotherapies together with Islamic values and beliefs on the spirit, soul, body and emotion, whilst accounting for practical therapy issues such as prayer, eye contact, counsellor/client match and family involvement. These articles are promoting awareness and encouraging practices that are more appropriate and reduce potential ruptures. However, they acknowledge their weakness by stating that it:

'*…is limited because we address only the behaviours and philosophy of life, but we suggest no techniques for implementation. Future studies may be crucial to develop and test techniques…'* (Carter and Rashidi, 2003, p. 411).

Inayat (2001) sets forth a proposal which aligns Islamic counselling to that of Integrative counselling. The similarities between the two methods are highlighted such as, humility of the therapist, compassion and collaboration between client and therapist, for the therapist to have an open mind and be able to utilise the most appropriate method or technique for that client, as well as being aware of the limitations of each method - and the therapists' own limitations. The main difference in the Islamic model is the connection to a Divine source for both the therapist and the client, and the added goal of personal growth with the express aim of becoming closer to the Divine.

All the articles reviewed under this section are theoretical in nature, they offer practical solutions for practical issues, such as being aware of arranging a session during prayer times, or that less eye contact may be a religious issue as opposed to one which signifies a reluctance to engage in therapy/with the therapist, but they lack empirical evidence to support their claims and practical advice in terms of the clinical issues that may arise in therapy and manage those in an Islamically appropriate way. Carter and Rashidi (2003) also make a comment about the counsellor being able to work comfortably with the religious perspectives of the client, but do not elaborate on why the counsellor may not be able to do so, and what issues may make them feel *uncomfortable*.

Common misperceptions of the faith by non-Muslim therapists may be a contributing factor towards the therapist feeling uncomfortable and since the September 11th terrorist attacks in 2001, there has been a large increase in writings to help de-mystify and quash common misunderstandings of Islam, in both North America and the UK. The extensive media coverage highlighted the inaccuracies in beliefs and Ali et al (2004) state that due to the increasingly negative media view of Muslims after incidences as such as September 11th;

"...assumptions and misunderstandings may affect the work of non-Muslim psychologists and mental health professionals with Muslim American clients. Therefore, it is important for psychologists to understand who Muslim Americans are, the service and practice implications for psychologists in working with Muslim clients, and how to provide culturally congruent mental health services to this community." (Ali et al, 2004, p. 635).

The event itself also had many Muslims seeking counselling in a bid to deal with the backlash which for some Muslims was resulting in a crisis of faith (Inayat, 2005).

Having reviewed the literature it appears there is little evidence to enable practitioners to develop a thorough understanding of how a Muslim client may raise religious issues, its impact upon therapy and how to deal with it effectively:

"The time is right for a shift in emphasis that empowers therapists and clients to build a bridge of open communication so that commonalities can be shared and differences can be celebrated". (Inayat, 2005, p. 3).

The current literature is so varied, and new, that it appears Muslim and non Muslim therapists are working with Muslim clients in a variety of different ways. There are a number of ideas about what should and should not be used therapeutically with Muslim clients but little clinical examples or quantifiable research to produce evidence and confirm the theories. As mentioned in earlier sections, the UK in comparison to America has slightly lower levels of religiousness in both clients and therapists, but what of Muslim therapists trained in the UK? How does their sense of spirituality impact on their work, does the lack of training in religion and spirituality leave them in similar levels of confusion as their colleagues, or does their faith allow for greater exploration? Being in a minority faith and working in a field which has its struggles with religion, are they more or less likely to think about and engage in faith related work?

2.7: Rationale for Present Study

This research has a two-fold aim; 1) to investigate the clinical experiences of UK trained Muslim psychologists when working with religious issues in therapy 2) to gain a better understanding of how their beliefs may impact the therapy; in their choice of therapeutic modality for their religious clients, and more specifically any therapeutic issues that may arise with their Muslim clients.

A review of the literature has revealed that the need to focus on one religion is of key importance, thus making the literature clearer, reduce the amount of variables and to be more

able to generalise results to the client group being studied (Worthington et al, 1996). Islam has also been identified as under researched in this field and is of personal interest to the author. The discussion around Islamic Psychology may suggest an integrative approach as more suitable for this client group and research needs to be carried out to develop more detailed theories on integrated methods. It is hoped that by investigating current practises of Muslim therapists working with Muslim clients in the UK, we can begin to analyse the methods being used and look at their advantages and disadvantages. Interviewing Muslim practitioners allows for the double effect of having knowledge on Islam and psychotherapy. It allows us to look at the processes for this group of clinicians, and the impact both their processes and knowledge of the faith may have on the client. By concentrating on what common themes arise, what difficulties are being faced and how they are being overcome, the areas that appear to be beneficial and areas that need developing, it is hoped that a theory will emerge from the data.

3: Methodology

The following chapter will describe the philosophical assumptions and subsequent choice of research method for this study. It will then explain the methodological implications for procedures for recruiting participants, data collection, data analysis, and interpretation of the data. Much of this section is written in the first person for ease of reading, but this is also a more common-place practise for qualitative research (Banister et al, 1994).

3.1: Research Paradigms

"The paradigm selected guides the researcher in philosophical assumptions about the research and in the selection of tools, instruments, participants, and methods used in the study" (Denzin and Lincoln, 2000, cited in Ponterotto, 2005, p.128).

To understand a piece of research in its fullest sense, it is important to understand the philosophical underpinnings both of the researcher and information being examined. Understanding the context in which research is conducted is essential to realise assumptions which may have been made about the nature and source of the data, and allows for a thorough critical analysis of the work to be conducted.

It also helps us to impose some order on the material as Filstead (1979 cited in Ponterotto, 2005) suggests that paradigms are,

"...a set of interrelated assumptions about the social world which provides a philosophical framework for the organised study of that world." (Filstead, 1979, cited in Ponterotto, 2005, p. 127).

3.1.1: Paradigmatic Considerations:

There are two main paradigmatic considerations to note with this study. Firstly, and perhaps most importantly from an ontological perspective, is the religious aspect of the study. The

researcher has a religious belief and adheres to the principles and practises of an organised religion; the participants also identify themselves as belonging to a religion, and the content of the interviews will be based on clients who also have a belief in God and may follow a religion. It is therefore considered that Religion will have an influence on the nature and construction of reality within this study. Secondly, it is assumed that the beliefs and world view of the researcher will inevitably colour the research material. This study is primarily concerned with the *experiences* of Muslim Psychologists and the *meanings* they attach to those experiences when working with clients who have a religious faith. It is believed that the experiences of individuals are subjective in nature, and the interaction between therapist and client, is one which is considered unique and individual. Therefore the beliefs of the researcher as well as the researched will need to be carefully considered in the context of the results of the study.

3.1.2: Ontological Position:

It is important to note that the views purported in this study are the researcher's own and may not be shared by the participants or indeed philosophical Islamic scholars. However, to have faith and be part of a religious framework is to believe in a 'reality' that is created and depicted by God. This reality is conveyed to humanity through His 'word', which comes in the form of Prophets (people chosen by God bearing his message) and Holy texts or scriptures. These phenomena (to those who have a belief) are 'real' and can be seen in various forms in the modern age (the Quran, the Bible, and the Torah etc). Part of faith is also to believe in a reality which cannot be seen, e.g. belief in a soul and an afterlife.

3.1.3: Epistemological Position:

This 'religious' view could be said to lean towards an epistemological position of Realism, due to believing in one true reality that is or can be separate from human experience. Guba and Lincoln (1994) explain that Realism is an:

'…apprehendable reality…driven by immutable natural laws and mechanisms.' (Guba and Lincoln, 1994, p. 109).

Macintosh (1940) states that religious knowledge can be viewed from realist philosophies because;

"'…in religion at its best there is valid experience of divine reality, making possible religious judgments which can reasonably claim to have knowledge value.' Within the limits of what is psychologically and logically possible in view of accessible facts there can be knowledge of God supplemented by a body of religious belief." (Macintosh, 1940, p. 390).

However, within this 'divine reality', are the individual human encounters, which are often vastly subjective, and create many different experiences. This begins to shift the purely realist epistemological stance stated above, moving further along the continuum towards Relativism (see Denzin and Lincoln, 1994). Another point which develops this view is that most religions assert that human beings have been created as fallible. When considering the meaning of this for the world of research, it could signify that any investigation (performed by human beings) of their environment or experiences, is fundamentally limited to a certain point, as the information is being analysed and interpreted by fallible human beings. It is unlikely therefore, that the results of any research (about religion but outside of religious doctrine) can be stated as 'perfect', 'pure' or 'absolute' fact, because of the nature of the observer.

Relativists, the opposite end of the philosophical spectrum to Realists, purport that there is no one true reality but that there are many realities relative to the actions of the individual. Sciarra (1999, cited in Ponterotto, 2005, pg 129) states:

"*…you cannot partition out an objective reality from the person (research participant) who is experiencing, processing, and labelling the reality."*

However, as stated above, having faith that there is an ultimate reality created by God is essential to religious individuals and means that this study would perhaps not be best suited to a relativist philosophy.

Therefore due to an assumption of a reality created by God, but of a belief that knowledge can be created both by God and by human experience, this study seems to best lend itself to a post-positivist , critical realist philosophical paradigm. This paradigm assumes that a 'reality' does exist, but that we have to be critical about our findings because as humans we are flawed, and therefore any knowledge we acquire will not be 'perfectly' true. Harper (2006) states that critical realists believe that:

"Although we cannot be directly aware of the material objects in the world, nevertheless our perceptions do give us some kind of knowledge of them". (Harper, 2006, p.4).

This not only challenges positivism, but also challenges a social constructionist position as it acknowledges material objects in the world outside of our creation.

3.1.4: Criticisms of Epistemology:

As mentioned earlier, adopting a single epistemological position came with its difficulties. The author believes that a researcher has a significant impact on the participants, data collection, and data interpretation, much in line with a social constructionist view. However, as this research needs to retain the view of 'a' reality within the context of religion, it cannot

accept the social constructionist view of multiple realities created through interactions or discourses (Ponterotto, 2005). Critical realism does begin to acknowledge that it is difficult for the researcher and the researched to remain completely separate, and that researchers should aim to acknowledge this openly and be as objective as possible, (Guba and Lincoln, 1994, cited in Denzin and Lincoln, 1994).

This view is further highlighted in Murken and Shah (2002) where they discuss a 'religion-based epistemology' when conducting research in Islamic psychology. Part of a Muslim's belief is that God and Religion form the basis or beginning to all other things in the earth:

"In a specifically naturalistic and secularised model of western epistemology, society is conceived as being the result of interacting subsystems, each with its own structure and internal logic - for example economics, politics, science, and religion...Religion, in this case, has no privileged position. In contrast, in a model of religion-based epistemology, religion is not one cultural subsystem among others but is instead the basis and framework of everything else, in particular...of doing research in Islamic Psychology." (Murken and Shah, 2002, p. 240).

3.2: Choice of Methodology

Having confirmed the epistemological position of a critical realist philosophy, the method chosen to gather the research data can now be addressed. A traditional critical realist stance could be said to fit more naturally with a quantitative methodology. However, this research aims to explore the experiences of Muslim Psychologists when working with clients who have faith; it is interested in the thoughts, feelings, and behaviours of Muslim Psychologists when faced with religious issues within a therapeutic setting. It is also interested in the impact a Muslim Psychologists' beliefs may have on therapy and/or the client, and what they believe are relevant issues for a Muslim client in therapy. This information would initially be

most effectively sort through an in-depth interview and therefore a qualitative research design.

As most qualitative research designs lend themselves to predominantly relativist philosophies, a method which could incorporate the post-positivist aspects of this research needed to be chosen. Grounded Theory (Glaser and Strauss, 1967) appeared the most suitable option to marry the epistemological and methodological implications stated above. Grounded Theory (GT) as a qualitative method is a notably flexible method which has many positivist underpinnings (Fassinger, 2005).

'The adaptability of the GT approach positions it uniquely as a paradigmatic bridge between post positivist ... [and] ... constructivist ... approaches to qualitative research" (Fassinger 2005, p.157).

Along with 'bridging the gap' there are two other main reasons for its use in this study; 1) GT is best used when the microcosm of interaction in particular settings is to be observed and all related aspects need to be explored (Grbich, 2007). The broader, contextual issues, that are shown to influence the phenomenon under study, are given due recognition in the development of theory. The study hopes to make every effort to acknowledge and incorporate these broader impacting issues. 2) GT is useful when there is little or no prior knowledge of an area and can tease out the elements of the operation of a setting or the depths of the experience (Grbich, 2007). As previously mentioned, research into the experiences of UK Muslim Psychologists and the exploration of religion in therapy is limited. Once a theory has been identified using Grounded Theory methodology, it can pave the way for other qualitative, quantitative or even mixed methods to be employed on the subject matter, to test, verify, or extend the qualitative hypotheses that emerge from this initial research.

3.2.1: Grounded Theory:

A Grounded Theory is one that is developed through systematic data collection and analysis of data pertaining to a particular phenomenon (Strauss and Corbin, 1990). Grounded Theory (GT) has taken on many forms since its conception by Glaser and Strauss (1967). As GT can be used by different epistemological philosophies, there are a number of versions ranging from constructionist stances (Charmaz, 2006) to more realist stances (Rennie, 1988) which have emerged. On the whole GT is a qualitative method which initially sought to detach itself from the constructivist perspective as it saw the role of researcher, though inevitably biased, as having a greater control of passivity when receiving data. It also sought to develop more methodical and systematic data collection and analysis procedures (than current qualitative methods of the time), wanting to gain the precedence set by quantitative methods.

In this instance the phenomenon under study is 'Islam' with the focus on developing theory about how it impacts on therapists and clients in a therapeutic setting. The emphasis is on theory generation as opposed to theory verification, and Fassinger (2005) explains some components of the GT method as; 1) an appropriateness to build (versus test) a theory in a relatively unknown area, and 2) the capacity for the method to capture subtleties and allow a fresh creative look at a phenomenon with as few preconceptions as possible. It gives the opportunity to answer the research questions by identifying abstract core concepts *grounded* within the data, around which the theory is built. The accurate and methodical application of this strategy will ensure that the theory to emerge is one of good science which can be described as; generalisable, reproducible, precise, rigorous, and verifiable (Fassinger, 2005).

In the years after its conception Glaser and Strauss separated on views relating to collection and analysis of data. The Glaserian approach to GT is more in line with this study as it is closer to field-based, hermeneutic qualitative research with lesser emphasis on a coding

paradigm (Grbich, 2007). This also implies that the study will be more unfolding in nature as the questions can be tailored to the information being found and subsequent interviews can then be modified to increase the relevant information to ensure more adequate theory generation.

Grounded Theory generation is to do with the understanding of the semantics of the text which are presented in the form of categories and the relations which appear among them. The analyst is the main investigator for the research and is seen to already have a 'sense' of the data to begin with; this previous knowledge along with increasing knowledge gained from the data gathered and through transcription of the data is known as the hermeneutic cycle. Rennie (2000) suggests that by using an inductive approach to hermeneutics when analysing the data in a GT study, it can resolve the realism/relativism dichotomy.

"The upshot is that grounded theorists' efforts to contain biases by being reflexive in various ways eventuate in a middle ground between realism and relativism." (Rennie, 2000, p. 486).

The data collection and analysis of this study has drawn upon philosophical ideas and practical applications of Rennie (1988:2006), and these will be explained in more detail further on.

3.2.2: Criticisms of the Grounded Theory Method:

Some drawbacks of this method which need to be considered are; 1) it is labour intensive, 2) it draws heavily on the conceptual skills of the researcher and 3) it requires explicit acknowledgment of researcher biases (Woolley, Butler and Wampler, 2000, cited in Fassinger, 2005, p.164). One of its great advantages of being able to straddle the philosophical divide could also be a weakness as it could receive criticism from both sides for

missing the fundamentals of either philosophy. However, Rennie (2000) explains that due to the discovery-orientated objective of GT, the researcher is encouraged to be reflective and 'bracket' their anticipations, hunches, hypothesis in a research log in the interest of objectifying the understanding of the phenomenon of interest. This ultimately leads to a middle ground between realism and relativism.

Another criticism is that too much fragmentation of the data (during analysis) can lead to loss of the 'wider picture' (Grbich, 2007). This would need to be anticipated and prevented by knowing the original data well (listening to interviews and reading transcriptions numerous times) and comparing data across subjects, to ensure the 'wider picture' is seen.

3.3: Procedures:

This section looks in detail at the procedures involved in participant selection, data collection, and data analysis with regards to the current Grounded Theory Study. It aims to provide enough detail to be able to reproduce the study to enhance reliability of the research and follows the methods used by Rennie (1988; 2006).

3.3.1: Procedures of Grounded Theory:

Grounded Theory studies often use textual data, using either existing written documents or those created by the transcribed interview. The data was collected through a process of 'theoretical sampling' which means concurrently collecting, coding, and analysing data in an ongoing process. Results from the initial analysis of data lead to more specific and focused

questioning in subsequent interviews. The explanation for each procedure will be described below alongside how the research was conducted.

3.3.2: Selection of Participants

Participants recruited for this study were Psychologists who identified themselves as Muslim, are registered with the British Psychological Society, and have been qualified for two or more years. It was felt appropriate to suggest a post qualification baseline in order for the participants to have had adequate time post qualification to have worked with clients bringing religious material. Participants were collected via three main sources, 1) through advertisements in *The Psychologist*, the Division of Clinical Psychologists' and the Division of Counselling Psychologists' mailing lists (appendix A), 2) advertisements with the Islamic Association for Muslim Psychologists in Europe (IAMPE) and the Ethnic Health Initiative group and 3) an advertisement email was sent to all Clinical and Counselling Psychologists with names that appeared Muslim after a systematic search of registered psychologists listed on the British Psychological Society website, with an information sheet as an attachment (appendix B). Although there were many Psychologists listed who did not practise the faith and/or those who had Arabic names but who were not Muslim, method three was by far the most successful. The researcher was cautious not to offend those that did not meet the criteria by careful wording of the advertisement email (appendix C). A snowballing strategy was also used whereby the researcher was introduced to other members of the relevant population by initial participants.

Another important factor for consideration was how 'practising' the participant was in their faith, or their level of *religiosity*. This issue received much consideration, and it was decided that due to a lack of research in this area, any Psychologist who responded to the research

advert for a 'Muslim Psychologist' would meet the criteria. This meant that we recruited people who viewed themselves as Muslim, which was deemed as sufficient for this study. Future studies may benefit from assessing the beliefs and practises of the participants and this issue is explored further below.

Once a participant agreed to take part in the study, a participant information sheet was sent out to them (appendix B) and an interview was arranged.

3.3.3: Saturation:

The number of participants needed for a grounded theory study is variable and depends on 'category saturation'. Saturation means to collect data until the information being gathered no longer produces new concepts, categories or relationships between emerging themes (Strauss and Corbin, 1998). However, in many cases of research, it is not possible to gather data continually until saturation occurs, but rather the number of participants needs to be decided before commencing data collection. Little evidence-based research exists to inform the researcher of adequate participant numbers to ensure category saturation. Guest et al (2006) conducted a study which analysed sixty in depth interviews of women across two West African countries, the study intended to operationalise 'saturation', and the paper concludes with recommending sample sizes for interviews. They identified that after twelve interviews enough data had been collected to be able to saturate the four main themes the study produced. However, they suggest that even after six interviews eighty percent of data was present across the four main themes and after twelve interviews it began to level off at ninety percent. They also suggest that if you are interviewing a population who are 'experts' in their field, and if the aim is to describe a shared behaviour among a relatively homogenous

group, then smaller numbers of participants can produce accurate information (with high confidence levels).

"If we are more interested in high-level, overarching themes, our experiment suggests that a sample of six interviews may have been sufficient to enable development of meaningful themes and useful interpretations." (Guest et al, 2006, p. 78).

The above research also appears to fit with the suggestion given by Rennie (1988) whose methods this study aims to replicate;

"It also becomes clear that categories saturate which means that the analysis of additional protocols reveals no new categories, properties or relationships among them. Saturation often occurs after 5-10 protocols." (Rennie, 1988, p. 143).

3.3.4: Characteristics of the sample

With these issues of category saturation in mind, the sample for this study consists of seven Muslim Counselling and Clinical Psychologists, trained and working in the UK. It was felt that this number would go a considerable way to meeting the 'category saturation' standards described above and gain a good grasp of the emerging themes. To ensure reliability all participants were registered with a governing body (British Psychological Society and Health Professions Council) and had been practising for a minimum of two years. One participant was discounted after the interview as although she had been qualified for just over two years, she had been practising for one year and had very minimal client experience, thus bringing the total participant number to six.

The participants consisted of two men and four women, four of whom were clinical psychologists and two counselling psychologists. Their years of post-qualification (PQ)

experience ranged from thirty-five years to three years, and their cultural backgrounds covered England, Pakistan, Turkey, Palestine, and Kashmir. Their religious beliefs, which were collected qualitatively as part of the interview ranged from 1) being a practising Muslim with a high level of Islamic knowledge, 2) to having sound knowledge of the faith with varying degrees of practise and, 3) not practising mainstream Islam, but having some personal knowledge of it. The participant who described themselves as a non-practising Muslim, grew up in a Muslim country but was brought up within a sect of Islam that is quite different from mainstream Islam and is specific to that particular area. This case was considered to add to category saturation by providing data from a 'negative case' of a 'non-practising Muslim' and incorporating it into the analysis provided richer data.

Table 1: Participant Demographics;

Participant Pseudonym	Gender	Age	Country of Cultural Origin	Therapy Practice Setting	Years of PQ Experience
Rehana	Female	32	Pakistan	NHS	3
Salma	Female	33	Kashmir	NHS	5
Sherizad	Female	36	Turkey	NHS/Private	6
Hassan	Male	36	Palestine	NHS	10
Quraat	Female	52	Pakistan	NHS/Private	14
Raffick	Male	60	England	NHS/Private	35

3.3.5: The Interview

All interviews took place in a suitable room at the participants' place of work. Prior to the interview the researcher sent each participant an email asking them to think about some cases, in which religion had been a significant aspect of therapy (appendix D). This was to enable them to be prepared with a few case examples that they could discuss in the interview, preferably at least one Muslim case and one case from a different faith. The interviews were

conducted in person and audio taped to maximise quality. Interviews lasted between sixty and ninety minutes. Following each interview, reflective notes were made about process, content, and ideas including the intrapersonal experience of the interview.

In line with a critical realist stance, it was felt that semi-structured interviews would be most appropriate. This allowed for the subjectivity of the participants to emerge, whilst still maintaining some structure around the research topic. It was suggested that the use of case vignettes may be applicable to this study and would entail providing case studies involving religion and presenting them to the participants for their analysis of the case. However, after careful consideration it was decided that participants' own experiences should provide richer data and allow them to explore their feelings on a much deeper level. A pilot study was conducted with a Muslim trainee psychologist in order to assess the effectiveness and results of the initial interview schedule. During the pilot it was decided to split the interview into two sections; 1) asking the participant about their experiences with different faith clients and asking for case examples which portray positive and negative experiences and 2) asking the participant about their experiences with same faith clients and giving case examples of positive and negative experiences. Then, during the two sections the interview questions (see appendix E for final interview schedule) would be asked at appropriate points in discussions about the case examples. This appeared to work well, giving participants the opportunity to discuss a wide range of issues, and also allowed more fluidity into the interview, as the questions were modified depending on the content of the interview, enabling better theoretical sampling (see below). Asking them to discuss different faith clients first was also deliberate, as it allowed for general thinking and discussion about religion in therapy before focusing on to Islamically related issues.

Recorded interviews were transcribed using a Word computer programme. Transcripts were marked with their participant pseudonym and were numbered by line and page. This

facilitated locating sections of interviews, and the location and identification of the meaning units during the analysis. Initial interviews were transcribed by the researcher which helped with becoming immersed in the data. Subsequent interviews were transcribed by a professional transcribing service due to time limited resources. The transcribed texts formed the basic data for analysis however the audio recordings were listened to throughout, as this helped to not lose site of the overall picture, and for further indicators to category formation and theory generation.

3.3.6: Theoretical Sampling:

Theoretical sampling in GT is when initial transcripts of data are analysed to begin to examine arising themes, initial categories begin to take shape, and subsequent interviews will be based on this preliminary analysis. Interview questions thus change slightly in order to either focus on an interesting/important element of the data or to ensure category saturation. Two participants were selected randomly to conduct the first round of interviews, producing an initial body of data about the widest possible range of issues associated with the phenomenon under study. The structure and content of subsequent interviews were then decided after the data analysis process had started and questions were adapted accordingly. The subsequent interviews were used to gather data about known concepts that were developing and also to continue to gather new data (Chalmers 2005, in Punch 2005).

3.3.7: Ethics

An ethics application was submitted to the University of East London ethics committee and approval was granted (appendix F). The British Psychological Society's code of ethics and

conduct (2009) was adhered to throughout, ensuring an overall ambience of respect, competence, integrity and responsibility at all times. There were no elements of deception in this research. At the beginning of the interview participants were required to give full signed consent (appendix G) and were informed that they could withdraw from the study at any time, they were also asked to fill out a brief background information sheet (appendix H). At the end of the interview participants were debriefed and allowed to ask the researchers any questions relevant to the topic; a debriefing form was given (appendix I) which indicated further reading and advocated speaking to a supervisor if necessary.

Transcripts were made anonymous by using a code for each participant and removing any identifiable information (place of work, names etc) from the transcript documents. Transcript audio and data files were kept in a password protected computer file and print outs of the transcripts where kept in a locked filing cabinet. All information pertaining to the research data will be destroyed in the appropriate manner once the information is no longer required.

Participants were not recruited through the NHS and also spoke about clients from private clinical practise; it was therefore deemed that the UEL ethics approval was sufficient.

3.4: Data Analysis

The analysis follows the methods of Rennie and colleagues' interpretation of Grounded Theory (2000; 1994; 1988). This method employs the use of Meaning Units (MUs), Categories, Constant Comparative Analysis (CCA), and Memos to create a theory that is grounded in the data. This is a circular process going back and forth between data collection and data analysis and each of these elements will be explored in detail below.

3.4.1: Meaning Units:

Initial analysis of the text requires data to be broken down into 'meaning units' (MUs). MUs are words, lines, or sections of the text that can be said to describe a point the participant is making or a phenomenon they are describing;

"In this procedure, the text...is broken into passages or 'meaning units'. In deciding what constitutes a meaning unit, the analyst is alert to the main point or theme of a given passage." (Rennie, 2006, p. 67).

In line with Rennie's method (2006), each meaning unit was cut out from a printed version of the transcript. The MU was then pasted on to an index card which consisted of; 1) The number of the MU overall (from all data transcripts), 2) the initial of the author of the MU, 3) the place of the MU from the transcript it was taken and 4) the categories to which the MU is assigned. An example of a meaning unit is shown in figure 5:

Figure 5: Example of a Meaning Unit:

2Q2
"so the fact that someone is a Muslim doesn't necessarily mean that erm they're interested in experiencing therapy from a religious perspective"
Categories: 1) Being Client Led; 2) Therapy from a Religious Perspective

The above MU was the second MU in the overall analysis, and it came from Quraat's interview. It was the second MU to come from Quraat's transcript and was placed into two Categories of 'Being Client Led' and 'Therapy from a Religious Perspective'.

"For the early stage in the analysis, it is recommended that category generation be descriptive, so that the name of the category closely reflects the language used by the respondents. This procedure serves as a check against straying from the substance of the data. (Rennie 1988, p. 143).

Initially each meaning unit is made into a category. When similarities in the data begin to appear meaning units can be subsumed into the appropriate category, i.e. if a meaning unit matches the properties of an existing category it can be placed in that one and does not need to create a new category.

3.4.2: Constant Comparative Analysis:

Once initial categories begin to form a technique called Constant Comparative Analysis (CCA) can be used. This technique involves:

'*...the meaning of a given fragment of text (or meaning unit) is constantly compared with the meaning of other units.'* (Rennie, 2000).

By using a process of constant comparative analysis, MUs can be assigned to as many categories as is relevant to its meaning:

"An important feature of Grounded Theory Method is that the given unit of text is assigned to however many meanings are seen in it." (Rennie 2006, p. 64).

This means that each new MU is then compared to all existing categories and placed in any that match its properties; it can also create a new category if it has a new property that is not met by any of the other categories.

"Once conceptualised, the category is indexed and the analyst proceeds to the next meaning unit...If the meanings of this meaning unit overlap with the meanings of previous meaning units, then the new meaning unit is assigned to the categories already formulated. Alternatively there may be new meanings in this meaning unit, calling for the conceptualisation of one or more new categories. New categories are indexed, after which the analyst proceeds to the next meaning unit, repeating the process. As the analyst proceeds, there is a decreasing need to conceptualise new categories because the meaning of the new meaning unit is already accounted for by existing categories." (Rennie 2006, p. 67).

In the example above (figure 1) the meaning unit was made into two categories of 'Being Client Led' and 'Therapy from a Religious Perspective'. The next meaning unit would then be compared to those categories and placed in them if they fit and/or create a new category if there is a new dimension to the text.

3.4.3: Categorising:

The first set of meaning units will form the initial categories. The example above is of the second meaning unit from the whole analysis and one of the initial categories created from it is titled 'Therapy from a Religious Perspective' which comes directly from the words used in the text by the author. In early stages of analysis, it is common for categories to remain fairly descriptive, often using the language of the author, thus staying very close to the data.

"The meaning unit is studied carefully, and every meaning that we interpret is represented by a category. Categorising in this way, we found, allows for the meaning of the text to 'hang together' in terms of themes and their properties." (Rennie 2006, p. 67).

As the analysis moves forward and categories become larger, rather than using the language of the participants it becomes clear that more interpretative titles need to be assigned to account for themes appearing in the data. As an example, 'The Relationship between Religion and Mental Health' category was created and incorporates both helpful and unhelpful aspects of faith mentioned by the client. If clients found practises such as prayer improved their mental health, it was entered into this category. If clients found they had an unresolved religious issue and praying was reminding them of that and making them feel worse, it was also included in this category. However, no participants specifically labelled these occurrences as 'the relationship between religion and mental health'.

New files were created to hold 'Categories' which consisted of condensed meaning units and a code to identify the exact location of the meaning unit in the data transcript. A condensed

meaning unit consists of the salient points of a meaning unit condensed into one line, it is often highly abbreviated but due to the in depth knowledge of the researcher of the data in the transcripts, it allows easy access to all meaning units that belong to that category. The researcher is able to use the category cards as a reference guide to accessing all relevant meaning units, across transcripts. It should be noted that at no point does the analysis of the meaning of the data happen from these condensed meaning units, they simply act as an effective and efficient way to categorise the data providing easy access to large amounts of text. Categories consist of meaning units from all participants.

An example of a category card is given below:

Table 2: Category Card; Being Client Led[4]

MU Code	Condensed MU (Category one liner)
1Q1	T feels therapy is client led; just because C Muslim doesn't mean they want therapy from religious perspective
2Q2	T will discuss and then try to intimate if client would find religious dialogue useful and use it with clients who would
3Q3	Even if from same religion there still could be huge differences in belief, T should work at the religious level of C

The three condensed meaning units given in the example above all reflect how the therapist is being led by the religious and therapeutic needs of the client. These condensed meaning units also have other meanings within them and have been placed in other relevant categories.

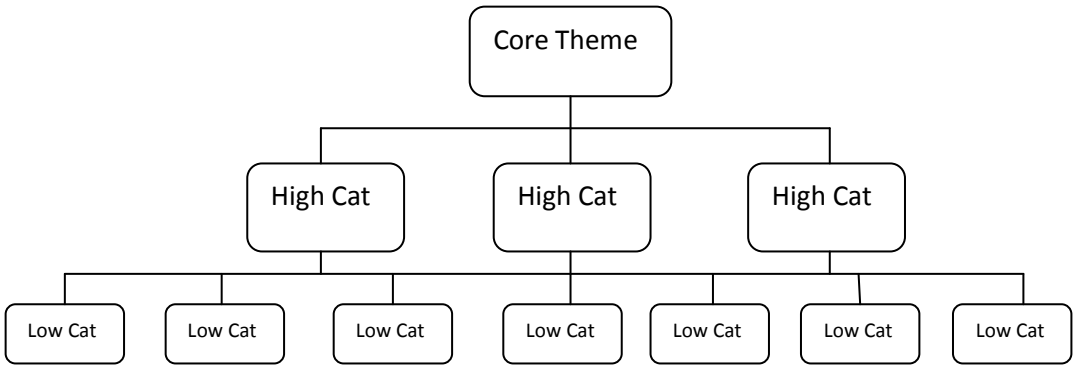
Because meaning units are compared to as many categories as possible and are put into as many categories as is relevant, this is known as *open coding.* Open coding is the standard format used for the Glaserian approach and this consists of finding several properties within a category or subcategory and looking for data to dimensionalise or show extreme possibilities on a continuum of the property (Creswell, 1998). Categories themselves also remain 'open'; for example the category of 'Therapy from a Religious Perspective' includes examples of participants who do want a religious perspective and those who do not. This allows for richer data and category saturation.

[4] In the example given T stands for therapist and C stands for client.

As analysis progresses, often smaller more descriptive categories with similar dimensions can be subsumed by a larger, more interpretative category. This occurs regularly in the early stages of data analysis when category saturation has not yet occurred, for example the category 'Client as Expert' was eventually subsumed into the category 'Being Client Led'. When this happens the smaller categories become known as 'properties' of larger categories. Thus Categories are made up of smaller categories known as properties.

"Categories subsumed by high order ones are called 'properties' of the later. The result is a hierarchical structure of categories, with each level gathering together the categories in the level below it. Eventually a 'core' category is conceptualised that is interpreted to subsume all other categories. Thus, the initial categories are grounded in the text, and higher order categories are grounded in those they subsume. This structure applies to phenomena that appear relatively stable over time. Alternatively if the phenomenon of interest is a process then the categories and relations among them should represent the process." (Rennie 2006, p65).

Figure 6: Model of Category formation:



Data analysis continues in this way until no new properties of categories were found, which is known as 'Saturation' and will be explored further below.

3.4.4: Memoing:

The process of creating meaning units and developing categories by using CCA, also involves the use of Memos. Memoing occurs alongside data collection and analysis and

serves as a reminder of the researchers' thoughts and ideas about categories, their properties, and meanings. It aids with the development of theoretical and conceptual links of the data and the relationships within these links which are made as you proceed through the analysis (see appendix J for an example).

"These memos have several functions. They help the analyst to obtain insight into tacit, guiding assumptions. They raise the conceptual level of the research by encouraging the analyst to think beyond single incidents to themes and patterns in the data. They capture speculations about the properties of categories, or relationships among categories, or possible criteria for the selection of further data sources. They enable the researcher to preserve ideas that have potential value but which may be premature. They are useful if gaps in the relation of theory to data arise, for they provide a record of the researcher's ideas about the analysis and can be used to trace the development of a category. They are used to note thoughts about the similarity of the emerging theory to established theories or concepts. Finally, as shall be seen below, they play a key role in the write-up of the theory." (Rennie 1988, p. 144).

3.4.5: Category Saturation and Category Structuring:

As discussed previously (see section 3.3.3: Saturation) category saturation occurs when no new meanings or themes appear to arise from new data being collected. In terms of qualitative analysis after approximately six interviews the majority of codes and overarching themes have become apparent, with no completely new themes occurring.

Once saturation has occurred the next stage is to look at the relationships between the categories and how they relate to one another (Rennie, 1988). As low-order categories become subsumed by high-order categories and relationships begin to form between categories, those that have little relevance or fewer connections to the developing structure can be dropped or subsumed into other categories.

"Some categories are deemed central because they have links with many other categories as a result of the multiple categorization of items (as illustrated above). It becomes apparent that the network of linked categories forms a hierarchical structure in which central categories subsume lower-order categories. Depending on the conceptual nature of the

categories, the structure can have several levels, with the categories in each level serving as properties of the category or categories at the next highest level." (Rennie, 1988, p. 144).

The next part of the process is to continue to refine categories until a 'core' category emerges from the data:

"As part of the process of developing central categories, effort is directed toward determining the most central, or core category. This is the category that is most densely related to the other categories and their properties. It is typically an abstract category but it is not vague. It is clearly defined by its properties, which are the categories it subsumes. It is sensitive to new information in the analysis because it is associated with many other categories. It is thus the last category to saturate and usually emerges late in the analysis." (Rennie, 1988, p. 144).

3.4.6: Theory Generation:

A Grounded Theory is thus formed by the development of categories grounded in the data and the interpretation of the relationships and meanings of the properties within them. A major part of theory formation in Grounded Theory is the use of memos as described earlier. Whilst the research analyses the categories emerging and decides which categories should be made larger and which can be subsumed, the relationships between the categories becomes further more prominent. The researchers' ideas about these initial relationships and what they mean are documented thoroughly in memos. Once initial analyses of all transcripts are completed and initial memos have been examined, further memos are created on the basis of the initial analysis;

This conceptual material is the basis of the grounded theory. During this advanced stage of the analysis, the research memos are sorted, and new memos are created in response to the insights and speculations produced by initial memo sorts. Additional memoing contributes to the generation of the core category and the specification of the structure of its properties and the relationships among them. This meaning system provides the organizational structure for the write-up of the theory." (Rennie, 1988, p. 145).

There are four criteria that should be met by any 'Grounded Theory' and they are; 1) It should be a plausible explanation of the data to the reader, 2) It should not omit large or important parts of the data and should form a comprehensive account, 3) It should be grounded in terms of following the appropriate procedures and therefore inductively tied to the data and 4) It should be applicable and lead to hypothesis and further investigation. (Glaser, 1978 in Rennie, 1988 p. 145).

In terms of the philosophical nature of theory, there are many different descriptions and explanations of *what* theory is and *how* theory is developed. Constructivist theory construction would purport that theory is derived purely from the shared experiences of the researcher and the participants, a positivist theory construction would treat the data as 'absolute truth' with little concern to the processes of construction or influence of the researcher (Charmaz, 2006). However, as this study originates from a critical realist stance, theory is viewed as being constructed by the participants and interpreted by the researcher, but also contains elements of an absolute reality (pertaining to God and religious doctrine).

It seeks to develop a theory, grounded in the data, using the above methods to hypothesise how Muslim Psychologists experience religion in a therapeutic setting, what it means to them, and how it impacts on their therapeutic work.

3.5: Reflexivity

This study takes the view that the interaction between the researcher and the participant is not a passive one but an active one. It is believed that all interactions between people are influenced by those people present, and that a research interview is no different. Therefore it

is seen as highly important for the researcher to be as reflexive as possible, sharing their views on how they may have had an impact on the participant, thus the data, and therefore the results. Reflexivity is achieved by acknowledging and documenting assumptions, presuppositions and observations of data collection and interviews. An attempt to gain an awareness of where ideas may have come from, reflecting on personal, professional and academic background will be made. Keeping a research diary (particularly during data collection and analysis) and using supervision to identify and discuss biases, are methods which were employed to enhance reflexivity. Once an optimum level of reflexivity is achieved and maintained, the researcher needs to set aside as much theoretical supposition as possible in order to allow the analytic, substantive theory to emerge (Creswell, 1998). It is also important for readers to have a better understanding of who the researcher is, and can therefore judge the results accordingly (Fisher and Rennie, 1999).

I am a thirty one year old female, currently studying for a Doctorate in Counselling Psychology. I was born and raised as Muslim, in a predominantly White affluent part of Southern England. My parents are of a Muslim Asian heritage but did not follow the fundamental practices of Islam as I was growing up. About six years ago I began to learn about and adhere to the obligatory and recommended principles of Islam including the dress code. I was aware that my gender, cultural background, dress code and my own beliefs about Islam, and its impact in a therapeutic setting would not only influence some of my questions at interview, and my interpretation of results, but might also influence the way in which participants responded to me.

In order to limit the amount of bias that may appear in the research, I enlisted a number of methods to help manage this. I engaged in regular supervision (with a White British, non-Muslim supervisor) to discuss these issues and monitor my possible biased interpretations. My research data was also analysed by peers (from different religious and cultural

backgrounds to me) for similar purposes but also to assess if my interpretations fit the data. I kept a research journal of my thoughts and feelings on the topic which greatly aided in keeping perspective and making links, particularly the notes on process of the interviews when I had felt that my dress code had had an impact on the participant. Talking through my thoughts, feelings and assumptions, and writing them down allowed me to make them real and begin to separate them, as much as possible from my analysis.

I am aware that despite striving to maintain an unbiased position of enquiry, that my thoughts around this area of research could not be value free. As a practising Muslim, I am aware that my hopes are predominantly to find positive experiences of how Islam can be integrated into modern (western) psychological therapies.

3.6: Other Relevant Issues

1) The initial title of the research included the term 'non-Muslim' when referring to clients of a different faith to the therapist. It was reflected to the researcher that people are not 'non' entities and that this title may appear objectionable to some, the term 'clients of a different faith' was then adopted.

2) The recruitment of participants was identified early on as a possible area for concern. It was initially hoped to interview between eight to ten participants which proved difficult. The population of this study is a relatively small one and getting access to registered Muslim psychologists and encouraging them to participate had its limitations. Possible solutions to this are explored in the Discussion (section 5.4.3 and 5.6).

3) Being a trainee psychologist interviewing qualified psychologists did have an impact on the researcher - interviewee dynamic. At times a number of the participants attempted to educate me or explain what should be done rather than focus on their experiences and what they actually did. The impact of this is explored further in the Discussion (section 5.4.3).

4) Wearing a headscarf also had an impact on the majority of participants. I was immediately perceived as a religious individual with a high level of religiosity. This had a double impact, for the female participants who did not wear a headscarf, they were initially very wary of my aim, believing that I might advocating a 'Muslim only' therapy situation. Conversely however, it seemed to 'allow' most participants to feel very comfortable in explaining some of the deeper connections with religious clients and some of the more religious interventions they had used in therapy - possibly interpreting that I would not have any objections to their actions and 'understand' why they did it. These issues will also be explored further in the Discussion (section 5.4.2).

4: RESULTS

4.1: Introduction

In the following chapter, the data collected from six Muslim Psychologists on their experiences of religion in therapy will be presented. A model of the theory has been included on the following page (see figure 7) to show the hierarchical nature of the theory and the links between categories. Excerpts from transcripts will be used to illustrate categories, and quotations will be presented alongside a reference code consisting of participant pseudonym, the page number, and the line number at the end of each quote e.g. Quraat; 12:23.

The hypothesised model has been constructed in a way which denotes an interaction between all of the high and low order categories, as it is felt that this flow and connection between topics is present in the data. However, it is acknowledged that the representation of connections could have been made in various ways, and this will be explored in more detail in the Discussion section.

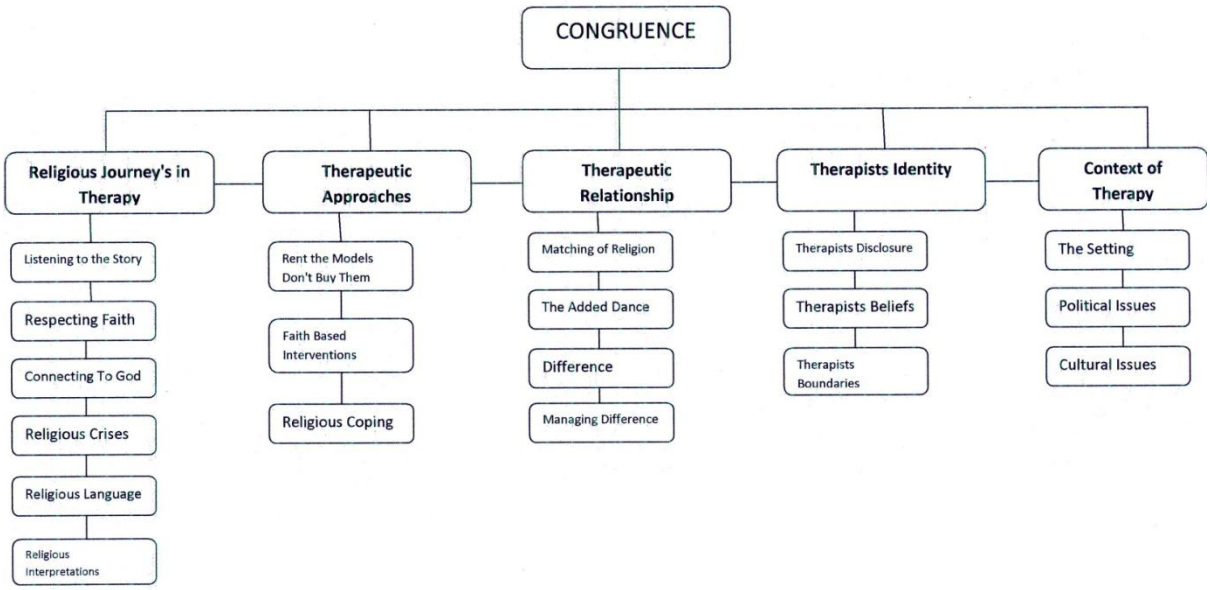
4.2: Overview of Results

A total of; one core theme, five high order categories and nineteen low order categories emerged from the data. Therapists discussed; the types of religious issues clients brought to therapy (Religious Journey's in Therapy - section 4.4), how they worked with them (Therapeutic Approaches - section 4.5), the impact religion had in therapy (Therapeutic Relationship - section 4.6), how the therapists felt about working with religion in therapy

(Therapists Identity - section 4.7), and the external issues which had an impact on religion in therapy (Context Of Therapy - section 4.8). A core theme of Congruence (section 4.3) was found to permeate all categories and its presence or lack thereof, appeared to have an impact on the therapists' experiences of religion in therapy.

Figure 7: *A model of the theory of how Muslim psychologists experience religion in a therapeutic setting*

Figure....: A model of the theory of how Muslim psychologists experience religion in therapy



4.3: Core Category: CONGRUENCE

Congruence is defined as being in harmony with an environment or situation. To be congruent is to be in agreement, to be seamless in action, and to produce a flow which is in time and connected. Within therapy this can mean being congruent with the client, being congruent with the therapeutic model in use, and being congruent with the issues the client

brings to therapy. It appeared that when working with religion in therapy, therapists felt that congruence was of even greater importance than usual because it impacted their own spiritual beliefs. The more congruent the therapists were, the better religion and religious issues seemed to flow in therapy. Difficulties were often associated with a lack of congruence around having religion in therapy, different beliefs between therapist and client, or a therapeutic model that is not congruent with the client's religious framework.

"...I think what I've started to learn is, erm, people they make sense of things by themselves and I need to make sense of this by myself, you know, and so I've started to step back and think actually, wait a minute, you know, erm, the way he'll make sense of it is going to be influenced by his training, his journey in life and, you know, erm, but what do I think about the Qur'an and Islam? and what resonates, fits with me? and I think probably that's why I draw on solution focussed more, whereas that, that particular supervisor doesn't...I think one of the, erm, one of my goals would actually in doing the systemic course is trying to actually work out how I can map some, you know, western psychotherapies with my Islamic framework and how to make it more congruent. I think I would be very much in the sort of early middle stage of that and I can't wait until I've worked it out..." ***Rehana, 23:2 & 23:37.***

"...it's more enriching I think when it is faith based and it's more comfortable because it intuitively fits better with my underlying philosophies, and my underlying philosophy to my clinical work is not CBT, it's not psychodynamic, it's not attachment, it's none of those things, I think they are useful ideas but I think there are fundamental issues with them in terms about I don't like this thing about theorising about people and I think I yea, I don't, I don't, it doesn't really work for me, that, kind-my brain doesn't work in that way or naturally I don't fit and see or approach people's difficulties in that way, and if it's a lot more obvious faith based discussion then I think well this fits naturally to my spiritual ideas which erm inform a lot of my clinical ideas..." ***Salma, 5:21.***

4.4: High Order Category 1: RELIGIOUS JOURNEY'S IN THERAPY

One of the initial aspects for therapists was ascertaining whether religion was a meaningful issue for the client and if it was something which needed to be considered within the

therapeutic context. Therapists varied as to whether they asked directly or waited for the client to raise it as an issue for discussion, however, the majority of therapists were 'listening out' for cues to indicate its importance. Once it was ascertained that the client's religious beliefs *were* to form a part of the therapeutic encounter, it was felt that respecting faith and feeling comfortable with its presence in therapy was essential to help clients on what can often be a journey back to God.

4.4.1: Low Order Category: Listening to the Story

"...So like I said it's often they don't bring it, it's often I yeah I've asked the question. Erm and I think it's back to that thing of, is this something helpful to you? Not helpful to you? how important is it?...Listening to the story to work out where does your thinking fit and then I kind of test the water and sort of say would your faith have something to say on this? Or do you have a faith? Do you go to church or the mosque or something like that and then erm, and again it's just working out is this useful to you or a hindrance in your problem, where does this fit?..." ***Salma, 5:3.***

"...so that's kind of one of the first things that I have a discussion about or try to intimate from what they are saying so that the clients I do bring a religious element into with are the ones that actually want that..." ***Quraat, 1:14.***

Therapists felt that asking direct questions or following up with client cues if they mentioned religion, allowed the client to feel that therapy was a valid space to be able to discuss this aspect of themselves.

"Yeah I certainly think one of the things that's helped him come, and he is coming, is because he can speak about his faith and spirituality, it's been a major factor for him, erm that he can come and talk about dilemmas...I believe is that we need to invite actively people to talk and it, it might be that I did more of that as well as a general engagement, with him has helped." ***Rehana, 2:11.***

It is important for the therapists to be congruent in picking up religious cues, then exploring how important the topic is to the client. This allows the client to feel comfortable with exploring religious issues further if relevant, not allowing them to do this (or being incongruent) could cause future difficulties in therapy.

4.4.2: Low Order Category: Respecting Faith

Once therapists had created an environment in which the client felt able to discuss their spirituality, the therapists themselves had to be comfortable with them doing so. Feeling comfortable about this topic means respecting and valuing the importance religion has in the client's life:

"Yeah, automatically the respect for faith and not fearful to kind of talk about it, or erm, yeah, I think that really helped, that just, I recognised that this can be an area of importance for somebody, so having faith itself was helpful to then talk about faith." ***Salma, 11:6.***

"...and she was saying 'yes but you seem to understand some of the concepts I'm talking about and you seem to be comfortable with them so it kind of feels like I've got the privilege or the pleasure [I think she said] of sharing more of my religion with you...but it also feels like it is acceptable to talk about this' so we did actually..." ***Quraat, 4:29.***

It was suggested that therapists who do not have a religious belief may find it difficult to work in this way, as it would not form part of their repertoire:

"...my experience of what happens when people don't - because we have our model of the self and some of us believe we're body and emotions and mind, and some of us believe we're body and emotions and mind and soul, and if we don't have the soul bit we just don't go there, these are all models you know we can only be truthful to what we are so my experience is that like my colleague referred her to me when they feel that there's just something that's not quite connecting then they'll send them to people who have a different model for working with the self." ***Quraat, 11:13.***

The therapists all felt that having faith allowed them to be more congruent with respect to understanding the beliefs of the client. The respect for faith was automatic due to personal religious convictions and this was seen as a positive element. A number of therapists questioned whether this was truly possible with a therapist that didn't have a faith, and hoped that the client would be referred to someone with a better understanding of their faith should difficulties arise.

4.4.3: Low Order Category: Connecting to God

Once an assessment has been done, and it is ascertained that religion is an important aspect for discussion; the therapist has to then understand the context of the client's religious beliefs within their psychological issues. For most religious people the two are inextricably linked:

"...but I could see that in this case that theology was vital that you know a) that his faith needed to come back that was the major cause of distress, there is a bereavement reaction of a complex sort, but there is this cognitive element to it, like a belief, his whole view of the world has been shattered..." ***Raffick, 5:1.***

"...the way that religion is coming into his therapy is, he suffered a traumatic loss and he's suffering PTSD, erm, and one of the things that he really wants to achieve is making sense, and he wants to work out if there is a God, and that his loved ones are ok." ***Rehana, 1:19.***

Disconnection from God was often a theme in therapy for clients with a faith, and the journey towards God could become a therapeutic goal:

"...whatever would happen she would say 'don't worry, you know, Allah's {God's} in control, Allah knows' and when her son was first taken ill she said 'it's ok, you know, Allah knows better' and she's really, she feels as though she's lost that connection and she really wants that old her back, erm, so in session I sort of, I could feel her begging me 'how do I get that connection with Allah, how can I know that'..." ***Rehana, 18:32.***

"...this is a therapeutic endeavour and I'm here essentially to support my client so that's what I do and although I don't fully understand I do my best to understand and I understand more as time goes on, I really don't feel conflict, this is their path they're on it, they wanna reach God, that's fantastic do it in whatever way feels comfortable to you..." ***Quraat, 10:30.***

When therapists were discussing a clients' reconnecting to God there was a real sense of congruence because they understood what, to some extent, the journey towards God is like. That level of congruence felt valid and helpful, even if they didn't share the same beliefs or the therapist hadn't been through the same life experiences as the client.

4.4.4: Low Order Category: Religious Crises

As well as losing a connection to God, the therapists mentioned a number of other religious issues that can affect a person's psychological wellbeing, such as feeling angry at God for negative life experiences (such as loss and death) or needing to seek forgiveness from God:

"...what was interesting was that she talked a lot about going to church where it was unhelpful to her, and there was this conflict that she was saying life's unfair, God's unfair, He's not listening to me and I'm unhappy with Him..." ***Salma, 3:1.***

"...the whole issue of forgiveness was very big for her because she felt very guilty that now she perceived that the death of her husband had been a test that she felt she had failed...she says 'you know I can forgive myself but I don't know if God will forgive me'." ***Quraat, 4:7 & 5:22.***

When religious issues are presented in a negative manner i.e. anger at God or needing forgiveness from sin, therapists without a faith can often presume that religion itself is an unhelpful aspect for the psychological well being of the client. The majority of the therapists

interviewed did not feel this was the case, and really tried to engage with the client to find out how they could redress the situation with God, and how they could use their faith to do so. This level of congruence around faith greatly benefitted the therapy, allowing the client to feel that their religious crisis was a valid one which needed care and attention from the therapist. This ultimately led to a greater connection between the client and the therapist.

4.4.5: Low Order Category: Religious Language

One of the obvious differences in therapy that incorporates a person's religious beliefs is the use of religious language in the sessions. Most of the therapists felt comfortable listening to and using religious language, which is often about things that cannot be seen such as; God, prophets, angels, the soul, heaven/hell etc:

"... when she used to do her rosary beads, that for her the differentiation was that God was absolute purity and absolute light, and like light in the physical world if your eyes see it too brightly it can actually damage you, and whereas Jesus had died for her so he'd been able to connect with humanity and she felt that he was very close ...for her the grace of the holy spirit was something that filled her ..." ***Quraat, 6:18.***

"...I was able to address his issues, so first of all the issue that this prayer is valid, you know that it is not an illusion, nor the experience he has of feeling this sort of inner impulse or prayer for someone specific is not delusional." ***Raffick, 1:41.***

"...we know we're on the same wavelength...I understand his spirituality and his belief in life after death and his belief in paradise...I can try and draw on some of those...I ask him to talk about his definition of paradise, what heaven meant for him, what people would look like there, to really bring that alive..." ***Rehana, 6:16.***

In a similar vein to the category 'religious crises', the ability to engage in and feel comfortable using 'religious language' felt like an important aspect which aided the flow and congruence

of the sessions. This level of religious dialogue may be difficult for therapists who do not naturally have this vocabulary.

4.4.6: Low Order Category: Religious Interpretations

Religious interpretations came up as a difficulty in therapy for most of the therapists. Particularly, clients' erroneous interpretations of religious doctrine that was negatively impacting their mental health:

"...the problem with this case is, Islam provides a number of models of explanations for events and this is somebody who has had two things go badly wrong for her family, she has a son...in a vegetative state...and the problem essentially is that she as the mother now in her seventies feels a total responsibility for caring for the son...won't accept any help...the underlying interpretation of these events are that it is a punishment from God and therefore she has to punish herself in a way by doing all these things, now that is a narrow interpretation..." ***Raffick, 7:21.***

The difficulty can *increase* if the therapist is from the same faith and disagrees with the interpretation of the client:

"...I think it is that thing about interpretations of faith, so sometimes I think yeah that, that can be really difficult because if it's somebody who is Catholic then I feel it's easier to be able to say what, so you're understanding is this and question that, and erm assume like an alternative more helpful understanding, but I think if it's Muslim then I, they're starting from an unhelpful position then I really worry I'm imposing my interpretation on it..." ***Salma, 11:33.***

Seeking advice from the therapists' own religious leader can cause uncertainty if it contradicts the client's view:

"And then we got stuck...discussion is a good thing and I know a couple of people so I said I'm stuck and I don't know what to do, there is this mawlana (religious teacher) who is saying

doing the Tasbih (rosary) is wrong...what is your take on it and he said well he's obviously an idiot!...And I thought well that won't work either!..." ***Quraat, 20:16.***

All therapists agreed that this was a difficult aspect to manage and that when deciding how much religion to engage with in therapy, and which aspects could be worked on and how, an element of flexibility was essential:

"...it's so complex, sometimes it happens in fact the persons theology changes, indeed it did in - case, sometimes you have to send to somebody else to deal with it, sometimes it doesn't change and your left with, well, you're doing first aid really you can't get to the root of the problem." Raffick, 13:35.

Although this was a difficult aspect, by remaining congruent i.e. by acknowledging within themselves that this may be an issue, or by working towards being more congruent with the clients' views, or by discussing the situation with the client and telling them about the dilemma, ruptures could be alleviated, managed or repaired.

4.5: High Order Category 2: THERAPEUTIC APPROACHES

The therapists appeared to discuss three ways of working with religious clients. One way was to use the models they were trained in and adapt them to fit with the client and their religious beliefs, the second was to use explicitly religious strategies to help clients with their current situations, and the third was to identify what religious strategies had been helpful in the past and encourage a reconnection to those.

4.5.1: Low Order Category: Rent the Models Don't Buy Them

The therapists all used different therapeutic models including; Jungian, CBT, Person-centred, Integrative, Acceptance, Mindfulness and many more. All therapists incorporated the client's belief in God into those models:

"I think that different therapies and modalities give you different models of the human being and different techniques and strategies for working with them so I think any one of them can be useful...I think each model has advantages and disadvantages...rent the models don't buy them...chose the one that's going to work for your client." ***Quraat, 26:1.***

"...I find...Jungian useful, I suppose I'm trained in that system but erm it's pretty close in my view it certainly, I suppose Islamic understanding is a bit fuller than Jung's but none the less, Jung does describe spiritual processes, erm er understands dreams and different levels of dreams, has a structure of the self which I suppose I would say complies with the Islamic understanding of the self, so erm I would tend to work through that system." ***Raffick, 2:34.***

"...I think solution focussed is more of a main model that I think fits so wonderfully with Islam...because it's about hope, it's about you can change, it's about trying, it's about persevering, it's about not seeing it all as negative, you know, there are wisdoms in difficult times and all that for me fitted really well." ***Rehana, 13:9.***

The model was adjusted according to the client's beliefs, which were given greater importance:

"...I have to say you have always to be sensitive with that because you know the religious beliefs always has a bit of kind of superiority and something you can't reach and you have to work around..." ***Hassan, 21:33.***

In order to achieve this you need a good understanding of religious beliefs as otherwise its importance could be missed:

"Depends on the presentation, I mean if there's a, even if you're dealing at a cognitive level then religion is important, if the person has a strong religious belief then that's a key part of

their cognition so you need to recognise that either you can deal with it yourself, or recognise that somebody else has to deal with it...even if you're working within a simple CBT level you know how Muslims are gonna think about life events...if you don't understand that as a cognition well your gonna miss entirely the CBT." ***Raffick, 5:39 & 6:11.***

Each therapist took what was most useful in the therapeutic models they used whilst trying to remain congruent to the client's religious beliefs. They were conscious of this decision, and omitted parts of models they felt might not 'fit' with the client's beliefs. This level of congruence takes good knowledge in both the therapeutic model and the religious framework being used.

4.5.2: Low Order Category: Faith-based Interventions

Therapists used specific religious practises as therapeutic interventions for alleviating psychological distress. This was done by negotiating treatment plans with clients and discussing how a joint approach may work best. All but one therapist described utilising practises such as rosary beads, listening to and reciting holy scriptures, pilgrimages, and specific prayers.

"Yes, for him these voices and this woman that he sees in his flat goes away completely when he hears Quran, so for me he gave me exactly you know he gave me nice coping strategies with his hallucinations no matter what all the science says, so what we agreed to do we provided him with CD player just he puts it beside him and just press it every time he feels that the voices are coming or that woman is coming, the moment he does things clear up and he's fine, so that's very powerful for that patient..." ***Hassan, 13:1.***

"...I just suggested to him and I did say I want your advice, I suppose this was one of those cases where you might say I don't feel qualified, but do you want me to give it? You know it's sort of upon yourself um you know I'm not acting with authority I'm giving you advice, it occurred to me the only way of undoing the bayat {membership to a religious order} was to go higher than that at the level of the sheikhs - so I suggest you do Umrah (pilgrimage) a visit to Madina um he did it took his wife on Umrah and came back cured" ***Raffick, 10:39.***

"...between us I guess we agreed that what had been most powerful for her was the rosary beads, they have some kind of prayers or beads that they say quite late at night and that she'd found this facilitating sleep but actually really really useful for her, so we agreed that would she want to start these? And she said she was quite keen to start doing some kind of rosary beads and I think it was Hail Mary's that they originally started with..." ***Quraat, 6:28.***

Seeking advice and guidance from religious sources outside therapy was also seen as an important aspect in therapy if the client agreed that it would be of benefit. Therapists felt happy to make this suggestion and if taken up by the client were happy to facilitate this:

"...I think in the beginning it was really, she felt really positive that I was Muslim...And that she could talk about her faith that she really, really, desperately wanted to see someone of religion. So I referred her to see a sheikh who works at a local mental health organisation...she wanted me to accompany her...I thought it would be useful to see what he says and how she would receive that...she found that really useful..." ***Rehana, 16:35.***

"...I mean you can see, I think I understand the bones of it, I know how I would address it but I can't myself or it's very difficult, I can't get through that language barrier I um she needs, if there was a good Imam I would do that, a Shiia Imam who would have the authority to change the cognition, to say this belief is too limited it was a wrong belief and this is the correct way of looking at it." ***Raffick, 8:34.***

There was also a sense of responsibility in which the therapists wanted to make sure that the client and their needs were empathetically dealt with by any outside involvement:

"...I found a Catholic priest that was recommended and had a quick chat with him to make sure, I always have this fear whenever I'm talking religion, any religion, is that you have people in it that are quite rigid in their ways in the way they express things and when it's a therapeutic relationship I didn't want her crushed with any kind of doom and gloom stuff I guess essentially or any un-forgiveness stuff..." ***Quraat, 5:42.***

An improvement in psychological well-being by achieving a closer connection to God should be celebrated as a success in therapy:

"...it felt important to celebrate what he was achieving and reaching and erm, I don't know whether other psychologists, therapists would be able to celebrate it...and give him that feedback that I knew he wasn't getting from his family...you know because they didn't quite understand and so that sort of connection, as you would give feedback to someone who was achieving on their hierarchy of, I don't know, exposure to something..." ***Rehana, 14:37.***

The therapists felt that having a faith was an advantage when using faith based interventions. These methods required the therapist to have good working knowledge of both; religion *and* therapeutic models, to be able to help the client create their own unique therapeutic interventions. They could also genuinely acknowledge, encourage, and praise religious 'successes' which may be difficult for a person of no faith to do congruently.

4.5.3: Low Order Category: Religious Coping

The therapists identified a number of helpful religious coping strategies that are more general than the ones mentioned above, such as suicide prevention.

"...I had a Muslim patient where you know because in Islam you shouldn't, or kind of ending up your life is taboo, you don't go there, no matter how awful you feel in life that's a protective factor, so for me patients that brought that into therapy was quite good because you know that's a big protective factor that actually causing me to relax a little bit because they're not going to do it because of their strong beliefs in God." ***Hassan, 2:10.***

"...even though she'd OD'd in the past but she wouldn't now because of her belief system, which I thought was fantastic...we, you know briefly went into how helpful it is, you know how often she actually thinks about God, how praying is helpful..." ***Sherizade, 9:23.***

"I feel king of your know thank God! Because they are so risky population with a huge massive issues that sometimes I think to myself you know they have all the reasons really to think badly about life erm so I said God help really to keep them going and when they say that I just get fascinated actually you know how much people really hold these beliefs that keep them going..." ***Hassan, 11:27.***

Therapists also found it useful to discuss previously helpful strategies used by the client, and what might be preventing the client from accessing them and using them again in their current situation:

"I think, and also that you can very clearly see that something that's been useful for part of their life for a long time no longer is, so I think that, oh it's a shame, there's this added loss and I want to try and restore that a little bit..." ***Salma, 3:9.***

"...we started talking about values and things that were important to him, erm, and he talked about faith coming in his life quite strongly and how it was a very powerful force, erm, in the past it helped him overcome the depression..." ***Rehana, 9:19.***

Sometimes when at a loss in life and in therapy, a client's faith can provide a sense of hope that things will get better:

"...to look at the akhira, do you know the akhira? The second life, um and say things will be good...for these patients they are holding big time this hope...even later in that life that things might shift because God will help them to, so it's like with InshaAllah (God willing) things will change so then when I see that it gives me hope as well to shift them in therapy..." ***Hassan, 12:7.***

Religious coping appears to be a category which doesn't necessarily require the therapist to have faith, because it is purely using coping mechanisms that the client has used in the past, and encouraging its use again. The congruence in this category is about listening to the client and accepting and encouraging previously helpful religious strategies - being client led.

4.6: High Order Category 3: THERAPEUTIC RELATIONSHIP

Most therapists felt that having a good relationship with the client made a difference to therapy overall, but in terms of working with religious beliefs, it meant that any differences

could be managed well and any similarities were beneficial and used effectively. Without a good therapeutic relationship both similarities and differences could cause ruptures.

4.6.1: Low Order Category: Matching of Religion

The therapists felt that sharing a belief in God (regardless of religion), alongside a good therapeutic relationship was a sufficient match to work well, although they did talk about the advantages of also sharing the *same* faith.

"...the people of the book are to be respected and I see no reason, and I mean I think we should respect everyone anyway because we don't know their journey and Allah [God] does and no-body's here without His blessing. For me it was just such a privilege to see someone connect with God in whatever expression makes sense to them..." ***Quraat, 7:31.***

"...I think it's still that thing it's still about connection because you automatically still respect somebody who is using their faith or has this belief and I share that so I'm still, on a similar journey to her, I'm still looking above me above my life above meaning, I'm looking for a greater meaning and she is..." ***Salma, 10:33.***

Having knowledge of the same faith can enhance interactions and understanding of clients issues:

"I have to say I feel I'm more familiar with them and that familiarity gives me kind of a blessed working alliance that's been dealt without meeting them...I feel that I'm already connected with them in some level that might with one of my colleagues take five six sessions to develop, so I don't need that because it's already there..." ***Hassan, 17:23.***

"I think it's much, it's much easier, it's not about spirituality or faith, it's much easier and there's always a sense of 'ahh' (sigh)...I think for me I feel as though I can, I will be able to make connections much quicker, I'll be able to draw on things that will be helpful to them, erm quicker. There will be less, erm, I think otherwise the, it tends to take more working out..." ***Rehana, 7:10.***

"There's all this stuff in therapy literature that you don't need to share that experience, but I think it would be very hard to prove that if you had shared that experience it doesn't add something...I think undoubtedly in some areas it's a benefit." ***Salma, 16:32.***

Some therapists felt that with same faith clients, they may be able to provide alternative ways of thinking on unhelpful religious interpretations due to their personal knowledge of the faith. They suggested that this may be better received if it comes from a therapist with the same faith.

"...When it's faith based it's much easier because I think I remember reading that passage or I remember thinking that... I have an interpretation and a view of it and you have yours of it and it's both of ours are entrenched in our cultural practises, upbringing as well, so I don't know if who's right or wrong or the truth, but it's, it's what's most helpful to you, and I guess I know the faith, the view she's having is not helpful to her, so I'm trying to give her an alternative questioning..." ***Salma, 6:44.***

The difficulties noted of sharing the same faith were; 1) over-identifying with the client and revealing too many personal thoughts and views, 2) personal difficulties with the faith that may impact the therapeutic encounter and 3) clients may not be able to share difficulties they have with their faith for fear of what the therapist may say:

"...but what I, when I started to sort of understand that maybe that's not what he wanted to talk about when I, it's a reminder for myself that his spirituality, you know, isn't the same as mine...I think it could be really easy to slip into a 'yeah, we both share a faith' you know what it's like..." ***Rehana, 3:17.***

"...as far as she was concerned every right was against her, it was on his side, and so I find this immensely problematic on religious, on human grounds, on political grounds, on all kinds of grounds, but I just, but it was, you know, it was her cultural and her religious view, and I really, I remember thinking, now what should I do with this, do I go and find a copy of the Quran and then we go through it and look at it, how am I going to tackle this with her..." ***Salma, 12:18.***

"It, it just all seemed so easy that it felt that, have I missed something?... is he pleasing? Is this even genuine? You know..." ***Rehana, 15:26.***

It was clear that the majority of therapists felt an understanding of faith was beneficial when working with religious clients, but that it was not necessary to have the same faith in all circumstances. The congruence therefore appeared to be about the belief in God, in a higher power, in an after-life, and in living a life that God would be pleased with. How clients chose to do that (i.e. which religion they were) was less important to remaining congruent.

4.6.2: Low Order Category: The Added Dance

When both the therapist and client had a faith, when the therapeutic relationship was good, and when there were no obvious differences/potential areas for rupture, it appeared that something special happened. It happened with those of a different faith, and then to a higher intensity with those who shared the same faith.

"I guess where that is that soul element is a part of the journey, it just feels more energised, I guess I mean I do love therapy, I really love therapy, but there's just that added little dance to it because to me the spiritual journey is very important and when I'm sharing that journey with somebody it feels great." ***Quraat, 28:16.***

"I guess I'm getting better at trying to find integration or taking the risk a bit more, and so being able to do that, it feels stronger, very I think it will like when it's Ramadan, you know if you are seeing a Muslim person and you are both fasting, it's it is a really nice feeling to know, it's that equality thing I think which is important to me in clinical work, I really wish there was ways of doing that across the board, feel an equal footing with somebody that it's just very humbling when you are sitting there with a Muslim patient where you're both fasting and so sorry for my stomach grumbles or something and it's just it's nice to have that connection and then to move on I guess to their difficulties..." ***Salma, 8:41.***

"I think the connection is probably higher with the Muslim client, erm, yeah, I think there would probably be a feeling of Iman (faith) rush through me, erm, and that will have a lasting effect probably for a couple of hours or whatever..." ***Rehana, 23:20.***

This category combines all aspects of congruence for religion in therapy and could therefore be seen as the most positive aspect of this research. The therapist is 1) congruent with the client in their relationship, 2) congruent with the religious aspect of therapy, and 3) congruent with their chosen method of working. Due to the impact on spirituality and the deeper spiritual connection this kind of congruence allows for in both the client and the therapist, this category becomes truly special and as a rare therapeutic encounter.

4.6.3: Low Order Category: Difference

A major element of 'difference' is how the differences are perceived by both the therapist and the client. If the differences are perceived favourably, the above categories ('Matching of Religion' and 'Added Dance') apply, and the outcome was usually positive. However, if the differences are perceived in a negative light it could cause ruptures in therapy, this applied to being from different faiths as well as being from the same faith.

"...it's um it's different but it's mixed, I mean I have had people who are Christian particularly of the born again variety who I know are suspicious, I only think one possibly pulled out of therapy even though the therapy was going well and was really a concern of the husband but I have a feeling that the minister told them they are not to go the Muslim particularly as I was a convert...people are quite dogmatic about things, most people aren't actually but if you are then it's a problem..." ***Raffick, 12:23.***

"...she always kind of implied , um, that well of all she assumed I'm Jewish because she knew I'm from Israel, so she already built in her mind an idea about Judaism...she asked me what my religion is, and I said you know what, I'm gonna be authentic, real about it, I'm not gonna lie about it, although I said to her it's something personal to start with but she said I was just curious...I said to her well actually I'm Muslim...and we have kind of a rupture at that moment..." ***Hassan, 3:25.***

"...I seen an orthodox Jewish gentleman, and err, when I saw him I was like ahhh! Took a deep breath..." ***Sherizade, 7:12.***

The therapists felt that negatively perceived differences with same faith clients could be even more challenging:

" I think it is that thing about, interpretations of faith, so sometimes I think, yeah, that that can be really difficult because if it's somebody who is catholic then I feel it's easier to be able to say what, so you're understanding is this on this and question that, and erm assume like an alternative more helpful understanding, but I think if it's Muslim then I, they're starting from an unhelpful position then I really worry I'm imposing my interpretation on it..." ***Salma, 11:33.***

The three female therapists interviewed who did not wear Islamic clothing all commented on being judged negatively about this by Muslim clients, and the female therapist interviewed who did wear Islamic clothing also commented on being judged negatively by both clients who were Muslim and those who were not:

"...most people have a different belief system to mine, I think sometimes I struggle with Muslim people, on one hand, I, quite like the fact that they are, they are covered, they are actually able to embrace erm, and I think sometimes I'm conscious that I'm not covered so I don't know how they will see me coz you know, if-if, knowing that I'm Turkish they will assume that I am Muslim, and-and probably assumptions that I might make about them as well, umm, I sometimes you know find that difficult, if somebody is Muslim and covered, a lot of assumptions from both parties, err then somebody from a totally different religion then I kind of feel I have the freedom to ask..." ***Sherizade, 7:4.***

" ...with Muslim women it is very much how, because we make a lot of judgements within the first 30 seconds or so depending on who we see and what we see so I have short hair, I'm wearing a skirt I'm wearing tights and my mother would kill me, actually yeah, she doesn't know I'm wearing them, so immediately there's, I know there's a whole said of conceptions and preconceptions that are set up in the other person a lot of which are quite negative...you're not Muslim enough" ***Quraat, 12:28.***

"Erm, I think sometimes like shared assumptions or yeah, judgements, I guess, so I think often people sort of say when I've met a Muslim person they, whether they're wearing, sometimes if they're wearing the headscarf, but sometimes they're not necessarily wearing the headscarf, I pick up that they're Muslim but they don't with me, and so they will, but that's throughout my life, I find that people often judge me on my appearance they're very quick to say, she's not a good Muslim, or she's not a Muslim, and so I find that quite erm, that tricky to negotiate, that whatever their assumptions or judgements or questions of me are, I've just got to let them be, and erm, yeah." ***Salma, 13:7.***

"...someone who I assessed, she was a convert, and she spoke about religion and faith, erm that then didn't come again to the next session...And that was really interesting because she came into the session, she saw us wearing a scarf and said 'I'm a convert' and let her talk about all her journey, talk about so much, erm, that it felt like it was a really good session for her...But then when she didn't come, I was like it's something there which maybe just felt uncomfortable about afterwards, erm, so, I think we can't make generalisations about it but on the whole, erm, people who want to talk about religion and spirituality..." ***Rehana, 7:25.***

Therapists can also sometimes have negative perceptions and assumptions of their clients which can damage the therapeutic relationship:

"...where you know Iraq you think everyone is Muslim which it's not but I ended up with um Christian patient and that was tricky, I was assessing him and somehow I just assumed again, we are all humans, I said to him 'so are you religious?' and then he said 'no but I used to go to church' and I missed that bit and then I went on and then I said 'so when you go to the mosque' he said 'I didn't say mosque I said church' so I had to apologise but in my mind because I deeply so much I assumed that that's his background...so it was kind of a bit unpleasant situation yeah but er yeah so that's one of the mistakes it's just that your assumptions sometimes are so strong..." ***Hassan 9:18.***

"So I had this one client who was wearing the Niqaab (cover over the face except the eyes)...my understanding of Islam is that if its two women in a room there's no reason why she can't take her niqaab off, so I guess we didn't start off on a good footing cause I couldn't understand why she couldn't take the niqaab off...that was immediately putting us into a defensive-defensive position and I knew it as I was doing it but I thought, I need to know...So erm I think there was a real rupture in our communication...her niqaab now represented something to me erm and who and what I was really represented something to her..." ***Quraat, 13:1.***

This category represents a lack of congruence between the therapist and the client. If either party holds negative or inaccurate assumptions about the other it is likely to cause some difficulty. Outward appearance such as name or attire could provoke immediate assumptions.

4.6.4: Low Order Category: Managing Difference

Therapists had various ways of managing these differences in order to avoid possible ruptures and the theme of being congruent appeared. It involved naming and discussing differences early on in therapy, being transparent, seeing the client and therapist as equal partners in therapy, and being willing to refer on if necessary:

"Absolutely yeah because I think to me religion is very much a part of diversity and diversity is there regardless of whether you're talking about religion and spirituality or not so if two people are sitting in a room there are quite often inevitable differences and I like to own those differences fairly early on in the therapy just to see is this an issue for either of us? If it's not you can let them go, but by not owning them it erm creates that silent message in the room that's not being attended too." ***Quraat, 2:20.***

"Yeah, I did, I raised that when it, when we were going through the early engagement period I raised the issue of me being a Pakistani Asian woman with a hijab and how that made him feel...When we started talking more about religion I raised that I'm Muslim and he could see that from the way that I dress and I know that he's studied Islam but it's one of the religions he's not carried on with...or he's worried about what I might be thinking and how that might impact on us... Erm, I am aware of that, erm, and I think ... I would invite him again to talk about it if he wants to..." ***Rehana, 2:19.***

"...These differences need to be negotiated in a way that feels supportive to the client and any ruptures or misunderstandings are dealt with as you would in any therapy..." ***Quraat, 1:20.***

Working on building a good therapeutic relationship, being humble and equalising the relationship were all techniques that could be used to manage differences:

"I think it is, it's being really careful, it's being really careful not to, because automatically when something clashes I guess you'd think coz they must think in any debate or discussion, that I have the better view (laughs) so I think it's automatically putting that to one side and not jumping in, and really trying to kind of listen, keep listening and staying with their story and break yours up, and then bring it in, in little bits and accept their views first, are you really listening to them? Before you're charging in there with, you've got an alternative..." ***Salma, 13:7.***

"yeah it is different case by case but I do emphasise as well the therapeutic alliance you establish because that makes it more confident that patient can trust you more they can rely on you and I think it will facilitate big time..." ***Hassan, 23:10.***

"I really like this idea of collaboration with people, but I think we're often not very true to that...but when I talk about faith...we're going to have a discussion about something that's far greater than me and so I'm automatically humble so that sense of...powerfulness is gone and we're both equalled because we're both Muslims and we're both talking about a struggle and I relate a lot more then to that struggle." ***Salma, 6:33.***

The therapists felt that therapy was not an avenue for their beliefs to dominate and it was the clients' opinion that mattered. They should aim to work at the level of the client and be prepared to refer on to someone with more religious knowledge. Having good supervision played a role in monitoring and managing difficulties but was only mentioned by two of the therapists.

"... the patient's ideas don't match with the therapist ideas that they can, I think that's when there can be a real clash but I think even then, is it not about some kind of shared goals or shared perspectives...it's a session about are the views this person has helpful or unhelpful to them ... but I don't, because again my view of my faith is that it's not just about tolerating other faiths or differences, it's about seeing what can be done together that ok you have this view on it, I have this view on it, they're different, what can we do together?... it's not about converting somebody to your frame of mind, it's about what's a helpful frame for you to have and what resonates with you?" ***Salma 9:35.***

"...maybe I'm not the best therapist for you if you need a person whose expressing their Islam in a different way, then I can refer you and I'm more than happy to do that but I want you to be comfortable with what we have the reality of what we have..." ***Quraat, 12:42.***

"I think, major thing really, erm, and there's two aspects to that, one is, erm, competent supervision in religion and spirituality, the second is multiple models because I don't think the one model, erm, is congruent enough for, you know, Islam's spiritual framework" ***Rehana, 22:15.***

The therapists felt that by redressing the congruence i.e. talking about the difficulties and being open and honest was the key to managing difference. This may mean acknowledging when a difference is irresolvable and will have too much of a negative impact on therapy. When this was the case therapists were happy to refer on if the client also felt this would be beneficial.

4.7: High Order Category 4: THERAPISTS IDENTITY

How the therapist felt about religion in their own lives appeared to have an impact on how they managed religion in therapy.

4.7.1: Low Order Category: Therapist Disclosure

The issue of whether to disclose their faith had a mixed opinion amongst the therapists. Quraat and Rehana shared a similar approach of being comfortable to disclose to all clients, but Rehana was clear that she felt it should be kept to a minimum.

Raffick and Hassan assumed clients would know their faith either because of their name or their prominence in the local community, and would only usually disclose if and when asked. Similarly Salma would disclose to Muslim clients but not to clients of another faith. Sherizade felt strongly that disclosing her personal beliefs was not an option she would consider.

"...I think to me difference is a big part of being transparent in therapy so any differences I generally like to kind of at least comment on very early in the therapy and to me the religious spiritual types of dialogue are very much part of the difference dialogue...So we discussed that and how she felt now and whether it was an acceptable subject to be talking about and within that dialogue I said 'I'm really curious you're talking about Christianity to a Muslim how does that feel?'" ***Quraat, 2:36 & 4:26.***

"...it doesn't concern me I have to say, you know I feel very comfortable about it and let's say a patient put me in a light where he's not happy that I don't practise, but generally what I do if it's like very kind of, it depends who's talking to me you know the familiarity with your patient, you know who you can answer you know who you can't. Like when sometimes I, when a patient of mine asked erm I was thinking twice should I answer that? so actually said 'you know it's personal thing that I wouldn't be comfortable to share unless you are concerned about that,' they said 'no no no' that wasn't a concern for her, but I kept it to myself, it's just because I just thought it is going to be an issue although she said it's not but it is going to be an issue, but later on we just got over it and things were fine because we just focussed really in the problem, so somehow I did, very rarely don't answer when it's kind of tricky situation..." ***Hassan, 10:23.***

"...it's interesting because with non-Muslim patients and we've talked about faith, I've never said 'oh I'm Muslim' I've just talked about Christianity or Catholicism, which I know less about, so I've had to ask more, but with Muslim patients I've always said, you're Muslim, I'm Muslim and just said it, it's been much easier, that I fear that less...I don't think I fear anything, but I just think it's not relevant to them, like for them I make that assumption that they're not interested in me being Muslim or not Muslim they they're not, errm, yeah, I don't know why I make that assumption, but I feel like to them, it matters less, whereas I guess with somebody who is Muslim then I am talking with more confidence or certainty about erm, faith I guess and how we might see it." ***Salma, 4:6.***

Being congruent in terms of disclosing ones faith seemed to vary, particularly when it came to clients from a different faith, as most assumed generally that it would be of benefit to disclose to Muslim clients. Often, not disclosing was due to a fear that it might be unhelpful to the situation and that the client would see it as a negative, or that the client was not interested in the faith of the therapist. It was difficult to decipher what impact this lack of congruence has in therapy, however during the interview those that did not disclose began to question themselves about it as it appeared to be a topic they had not consciously thought about before. It was also obvious that those that did disclose, even in situations in which it was initially perceived negatively, the honesty of disclosure (and working through any rupture that may have been caused by this) led to an increase in the therapeutic alliance and felt like an important aspect of therapy had been worked through.

4.7.2: Low Order Category: Therapist Beliefs

Despite differences about disclosure of faith, the majority of the therapists understood that their beliefs had some form of impact on the way they worked. They also saw their work as part of their relationship with, and connection to, God. This allowed them to be more sensitive, and have a deeper understanding for their clients' own journey towards God, and felt privileged to be sharing that journey.

"God knows best so as far as I'm concerned this is the way it is, God is the only one with all the answers ... and I think Allah is present in all our interactions and He deals with the rest of it, so if I make a mistake then He's going to sort it out, which is great, a great strategy... Islam says that intention is everything and I'll make my intention to serve Allah with the skills that I have to the best of my ability and if my intention is as pure as I can make it then Allah really will sort out the rest and I totally believe that." ***Quraat, 17:13.***

"I think with all clients there's an element of growth and expansion for the therapist or there should be, umm the way I would understand it is that Allah (Glory be to Him) always sends

our 'Rizak' (growth, development, wealth) almost always through our trade, so each person in that trade is enriched by it, so somebody comes to me for something that I have, this is their Rizak erm but by transferring it, by giving it I'm enriched in the process, I'm expanded, and with some people this is more obvious than others, I mean that's a case where I did feel my own understanding and growth had happened through him." ***Raffick, 3:39.***

"...so if I see somebody and they've just got this awful history throughout their life I will kind of leave thinking of having a conversation with God about that, it's incredible that that person's life has had so much and I've not had one of those things, how do I understand that, how do I, how do you make sense of that, how do you weigh that up and you just realise that you know so little" ***Salma, 18:24.***

"... because I think we use our own frameworks to make sense of what other people might be doing as well and, erm, whether we like it or not our own values and the way that we see things does seep through and if there's someone I'm seeing who doesn't have spiritual or religious framework, erm, you know, sometimes I can wonder, erm, how did they make sense of, of this? You know, is it, is it really hard for them? Yyou know, especially if I don't know them well, erm, and then I've got to then try and work out how things would, you know, fit together and their world... Yeah, yeah, I'd go home sort of buzzing and really, really pleased ...it just felt this is why I wanted to help people, you know, erm, and that links to my own beliefs about why I wanted to be a psychologist, you know, my own making sense of a religious framework, my own making sense of, erm, you know, helping people deal with purpose of life and things like that..." ***Rehana, 7:2 & 14:3.***

The two therapists who found it most difficult engaging with in religion in therapy were Hassan and Sherizade. They were the only two participants not born in this country, Sherizade described herself as not Muslim in the traditional sense and Hassan described himself as not practising, and both struggled with religious issues in therapy:

"...you try to push them away, especially one of my big challenges maybe inapplicable to your research it's just coming from different country as well where you coming to western society where you have to be aware that your value is, big time shouldn't intervene with your work, you know I mean I am, I'm sure of I am practising psychology in Islamic culture the whole situation will be different, I don't know if it's for good or for bad but will be definitely different ... well what my, kind of my beliefs would kick in more, more than here because here I am in a state of mind where I'm saying I'm in a western society I'm practising in this

country, I am foreigner no matter what coming to this country and I will do my best to adapt myself and my values to this culture." ***Hassan, 5:21.***

"I was quite angry about it and it was actually funny because I was um found myself and I'll be true with you, I found myself putting my, the Quran, which is for me you know, I'm not gonna explain to you what is Quran to us but, for me the Quran is kind of peace that you don't just put it second, and I felt I am for the sake of the patient I'm actually putting my values and the Quran which is always up there, I'm just putting it aside and just all of a sudden looking at it as the reminder that brought all these bad things so I felt really bad inside it's kind of, I know that sounds weird but it's kind of I sinned, for the sake of a human being which of course as a professional I know sensibly that that shouldn't be the case I shouldn't deal with it that way it has nothing to do with my beliefs but at that moment I was kind of frustrated that I had to deal with it that way just removing the Quran and put it away because my way of dealing with stress is reading Quran. So how on earth I'm just actually helping someone under stress and removing the Quran from him..." ***Hassan, 14:26.***

"I think, erm, I came over here 15 years ago, so when I was you know, in my very early 20's and err you know, almost you know going through the third individuation and finding myself, my identity, erm, and the majority of Turkish population comes from eastern part, err, it is quite a deprived, you know socially, err, because you know emotionally, you know very deprived, erm, background, so...the pain and everything is very externalised, somatised, erm, I kind, I think probably I was quite probably prejudice towards the population I kind of felt, you know the only commonality I have with that group is you know, we're from the same country, that's all... , being an ignorant, an ignorant pig I guess in some sense, so I think that really probably me over the years, erm getting in touch with my Turkishness..." ***Sherizade, 13: 30.***

"...I think I've got an internal conflict about it, and I've got conflict in the room..." ***Sherizade, 6:20.***

"...probably I'm becoming much more tolerant of difference, whether it be err, coz I think I've got a lot of erm, erm, prejudice towards Islam, errr, I think maybe because it was forced..." ***Sherizade, 5:33.***

"...I didn't deal with it kind of in a personal level you know that will, from me like as a Muslim or whatever cause I tried as much as I can to push my values, my ideas my upbringing to push it away which was a challenge it was not easy you know to be kind of tempted to, to say I know where that comes from you know just I can't shift it myself you know sometimes we just get into that corner where you say my God I don't know how I'm changing

that with that person I can't change it in me, so that was a bit tricky about the religion thing with her..." ***Hassan, 4:42.***

The therapists who felt they were able to be congruent about their beliefs by including and involving them in therapy whether that was implicitly or explicitly, found their faith a source of joy and fulfilment in therapy. Those who felt they had to hide it or push it away, struggled to remain congruent with their clients.

4.7.3: Low Order Category: Therapist Boundaries

Linked closely to the above category (but discussing wider issues) were a number of boundaries that therapists felt they needed to adhere to with religiously themed therapy. There was careful consideration over how much they shared their own personal views and most felt this was entirely dependent on each client and their presenting problem. This included talking about their beliefs, values, or their own religious dilemmas:

"...I felt it was useful to be fallible I wanted to show her that I was fallible but also that actually I believed in the namaaz [prayer] as a really important precept and I said I do pray and I totally enjoy praying erm but I've never managed fajr [dawn prayer], she said oh yeah I see what you mean so, I said I like staying up late and then I can't get up in the morning so I think the fallibility helped her that you know you can be connected to Islam but actually not get it 100% right..." ***Quraat, 22:32.***

" ...Yeah, so it's been much more, erm, boundaried myself and, erm, been focussed on, on his spiritual framework, in doing that...I think it's remembering my professional role, erm, because, well we work with really complex clients, erm, we can slip into different ones sometimes so, ... So, boundaried in the sense of, erm, being careful of the sorts of things I might share about my religion and spirituality or my world view or my sort of morality. I think there's always going to be that flow of values, you know, and you can't always, you can't actually, you know, control that, erm, but I think I was, I, I'm being much more careful in why I'm sharing, erm, knowing that he might be hesitating, you know, at some level because he doesn't want to offend me as a Muslim as well..." ***Rehana, 4:5.***

"...I'm sure of I am practising psychology in Islamic culture the whole situation will be different I don't know if it's for good or for bad but will be definitely different ... my, kind of my beliefs would kick in more, more than here because here I am in a state of mind where I'm saying I'm in a western society I'm practising in this country, I am foreigner no matter what coming to this country and I will do my best to adapt myself and my values to this culture..." ***Hassan, 5:24.***

"...Oh fundamentally, because I think, I think it's not one of those things that I can say I put in a box and I cut off there and this is me without my faith and this is me with my faith. I'm always with my faith, but it's relevance to different situations can vary and so it's erm, I guess if I'm on a pilgrimage, if I'm meditating if I'm reflecting, if I'm praying it's dominant, it's the most dominant thing, if I'm in a therapy session being somebody's support is the most dominant thing, and then faith might influence that, psychotherapy might influence that, being a woman might influence that, lots of things might influence that, so it becomes one of many, it's not the most dominant thing, but it's always present so, my ideas and how I approach things and who I aspire to be, I don't know if that, I don't believe in this idea that you are an objective therapist you cut off all those aspects of yourself so I guess they're always there..." ***Salma, 11:10.***

Identifying when to seek outside help and knowing the boundaries to their own knowledge and experience felt important and was mentioned frequently by the therapists:

"...so if I have a question that I'm consciously aware of, obviously I can't deal with the unconscious too much, but I will try to seek advice as much as possible and I'm very closely involved with the department of spiritual and cultural care we have a chaplain there, a lady, and from time to time I'll get her to find people to work with clients from a Muslim faith if I for whatever reason don't want to do that. So I'll get advice as much as possible, I'm totally confident about my therapeutic relationship but if I'm not confident about the precepts of either Islam or anything else then I get advice and try to do that really quite consciously and to be fully aware that if I'm not at all sure and even if I think I'm sure I'll say this is my understanding of it I can give you the names of people you can go to and double check that because what I'm sharing with you is the therapeutic encounter and the rest of it sits as a scholarly activity beyond, I'm not a scholar I'm not claiming to be and we will seek advice where necessary..." ***Quraat 27:41.***

"Yes I hope I was aware of my limitations in fact what I told him to do was go and find a vicar, a vicar he felt confident with..." ***Raffick, 4:39.***

"And that she could talk about her faith, that she really really desperately wanted to see someone of religion. So I referred her to see a sheikh who works at a local mental health organisation..." ***Rehana, 17:2.***

The impact of a therapist's identity in therapy is a topic which all the therapists acknowledged as being important. However, the extent of their beliefs about its impact varied greatly, and understanding why this was the case is unclear. It may be due to how comfortable therapists were about their faith in their own lives. The more comfortable and congruent they were with it for themselves, the more they understood their impact on the therapy. It could be about how much they believed religion itself should be included in therapy, i.e. the more comfortable they were with it in therapy, the more comfortable they were with exploring it from both perspectives in therapy. It could be due to their perceptions about clients knowing they are Muslim. This needs further exploration and will be looked at in the discussion. Due to this, it becomes unclear how the role of congruence affects this category. However the four therapists most comfortable with their own spirituality (Quraat, Raffick, Salma and Rehana) had a level of congruence with their clients and the therapy, which was not seen in Hassan or Sherizade's accounts, the former also reported less negative encounters with religion in therapy.

4.8: High Order Category 4: CONTEXT OF THERAPY

All of the previous categories were in some way affected by the context in which therapy took place. The most apparent was whether therapy happened in an NHS or private setting. Initially, the therapists did not make this distinction but it soon became clear that those discussing private therapy clients simply had more *time* to discuss religious issues. Due to the research being conducted in the UK, a high proportion of Muslim clients whose cases were discussed were not from this country, therefore cultural background played an important role in therapy, and also for the two therapists who were not born in the UK. Finally, possibly due to high media coverage at the time of research, political issues such as terrorism, 'Islamaphobia', and the conflicts in the Middle East particularly between Muslim's and Jew's did appear a number of times in the data.

4.8.1: Low Order Category: The Setting

Work varied greatly depending on where therapy took place. In the private setting there were no restrictions on 1) length of therapy 2) amount of religion discussed in therapy and 3) therapeutic modality. Within an NHS setting there were restrictions on all three, mainly due to therapy being time limited and the choice of therapy for most NHS settings being CBT.

"I think I try and make sense of that as we're in a professional context and my role has been defined as facilitating them within their own frameworks and if they've come with a framework then I need to use the western psychotherapy frames that I'm trained in to help, so that I can guide them towards their own decisions. And as a Muslim I, I can't share things or guide them or direct them, erm, I could only use any of that if it was in their best interests so it would have to come from them first. Erm, so it really is a professional context my job is to facilitate them to find their own answers from, from their own resources, erm, and can only use the sorts of psychotherapies that this professional context would formally allow. Erm, so that helps to give that distance from that really. Erm, I think there's times where I'd like to work outside the NHS in more faith based organisations..." ***Rehana, 5:33.***

"I think it's really difficult because we we're based in primary care, so it's very much, short term therapy, so it's about 20 sessions maximum, and it is very much recovery oriented so nothing becomes, like there's never one key thing continued to talk about ... I wouldn't say religion or spirituality hasn't been a key part of the work, I think nothing, no one issue has ever been a key part in therapy..." ***Salma, 1:13.***

"...its sound rules for clerking if you ask about faith and it's an idea and certainly there's pressure from the NHS at the moment to just cut to the bone um and after all most cases you're dealing with at a simple level probably with something like CBT and um you know you don't need to go into it um but I think it's good practise" ***Raffick, 5:25.***

Part of having a flexible approach (as mentioned in the category 'Managing Difference' section 4.6.4) is knowing what the issues are *and* what can realistically be dealt with in the time and space available:

"...sometimes it happens in fact the persons theology changes, indeed it did in layards case, sometimes you have to send to somebody else to deal with it, sometimes it doesn't change and your left with, well, you're doing first aid really you can't get to the root of the problem..." ***Raffick, 13:34.***

One therapist mentioned a slight anxiety around colleagues in the NHS setting over-hearing the religious content of sessions and perceiving it negatively:

"...I think it, it was sort of 'oh, that's great' and on the other side it's like 'oh no, I hope no one else is listening to this'...I think the fear is that people don't understand and they will see it as, pushing faith and it really is the ignorance of not understanding of how we work with someone's belief systems, and how religion is seen as something historically as always being pushed as well, I think there is, there is a spectrum of what people believe and within clinical psychology there a spectrum of people who really think we should never speak about religion, people who think 'it's their framework, then you should', you know, so there's a real sort of mix and, ignorance about it, you know, whereas a, a psychotherapy can be seen as a belief system. You could be pushing that, you know, but it's, I think it's that lack of understanding around what it really means to work with someone and what they bring, you know..." ***Rehana, 11:31 & 12:5.***

Being congruent to the setting of therapy could often mean a lack of congruence with the client and their issues. Therapists seemed to deal with this challenge pragmatically; particularly if it was something they had little control over, and whilst acknowledging their setting, would do their best to work with the presenting issues.

4.8.2: Low Order Category: Political Issues

A number of political issues were mentioned by therapists, mainly Muslim extremist views, the current media coverage of Muslim's in the West and Terrorism, and the conflicts in the Middle East with regard to the relationship between Jews and Muslims.

"...there's so many questions at the moment about Islamic interpretations and people you know killing themselves over interpretations that they have and killing other people, so it's, just requires a lot more thinking and dialogue..." ***Salma, 19:42.***

"...my you know outside world was coming into the therapy room, coz I think there has been you know current conflict between Israel and Turkey, and, and I didn't, don't know whether he knows if I'm Muslim or not, but you know I was aware of that you know this history between erm two religion I guess..." ***Sherizade, 7:35.***

"...but when you are having these kinds of discussions it is very hard because then I could tell this person was interested in knowing am I Jewish or Muslim and he was unsure about that and I steered it away so that he wouldn't ask that question and so I think and I don't know how that would have gone if he knew I was Muslim rather than erm Jewish which I think he felt there might have been better affinity there, if that was the case ... but I didn't say on what side of a divide I was, and then I wondered 'oh dear' where might this conversation go, and if, would you be accepting of me or not. In my experience actually in Israel when I'd been there once people found out I was Muslim they weren't accepting of me and so, I I think maybe I was carrying some of that and worrying..." ***Salma, 3:31.***

The outside world coming into therapy and affecting the dynamics between the therapist and the client is a difficult situation to manage. Most therapists acknowledged it, but very few

addressed it in therapy, as the political world usually had a negative connotation to it. Similar to the category 'The Setting' - 4.8.1, congruence (in terms of discussing such issues and how it may impact therapy) in this category was low, even though it could potentially be these political issues that initiate therapy services e.g. with refugee's.

4.8.3: Low Order Category: Cultural Issues

Issues such as cultural background, language, and age also appeared to have an impact on how religion was dealt with in therapy. There are many issues which are cultural rather than religious in nature. This can be difficult for the therapist and the client to work out in terms of which views can be shifted and which beliefs cannot.

"*...And I think it is really difficult with religious beliefs where culture entwines with that, and people in lots of cultures where literacy is not high and things, and I think that it's a cultural ideas and stories can form how they practice religiously more and so then it's really hard to untangle that for people because that's generations, that's kind of down my whole village does this, my whole community does this, you know just around deaths and births and weddings, what they think is religious and I often wonder is that the religion or is that culture and they won't see a separation of that, and erm and that's where I think you can clash a bit..."* ***Salma, 12:40.***

"...I think one of the challenges is perhaps depending on what generation of Muslims you are working with, erm, and their sort of journey of acculturation, erm, you know, if they've come from abroad for example, erm, or if they've come from a very quite sort of traditional family, one of the challenges has been the emphasis on collaboration and, erm, you know, which almost comes in opposition to their bare need for wanting a directive doctor pill, doctor patient, tell me what to do approach..." ***Rehana, 20:32.***

"...it's almost like well, a sort of sense of personal impotency I suppose, you know I feel can understand the case but the language prevents me getting deeper and what I have decided in fact is to work entirely through the daughter, and it's obvious if there is family dynamics involved and the daughter speaks good English and maybe that's a way of dealing with these sorts of family dynamics by dealing with the daughter..." ***Raffick, 8:14.***

In some instances an over-identification can happen between the therapist and client on cultural/religious grounds which can lead to possible difficulties.

"...so sometimes, and again I think this might be an older, you know, so, erm, erm, there's one lady who said something like 'I want to tell you this but, you know, you don't need to tell every, anyone else' and I say 'I do' because I'm, you know, professional and she's says 'why, why, you know, you're a Muslim, errr', you know, it's like 'no' I've got to and it was a child protection issue, anger a lot, erm, and also the older non-speaking women, erm, you know, calling you 'daughter' and things, so those sorts of, you know, erm, invited me for a cup of tea, things like that. Even though, those, that's different isn't it, I think that's to do with context and expectations of, you know, the different generations kind of, that, that's ok. I think it was more, well there was another lady as well who, erm, 'can't you just do this, can't you just refer me there, can't you just do this letter', you know, that sort of thing, 'you, you're Muslim, you know what our communities like', erm.. So there has been a little bit of that as well..." ***Rehana, 21:34.***

All the categories mentioned within the high order category 'Context of Therapy' were only briefly mentioned by the therapists and not explored in great detail. It is difficult to hypothesis therefore how congruence may have played a part in this category; however with issues such as language it is clear that being congruent is more beneficial. In terms of discussing outside events and how this impacts therapy, this is not covered in the scope of this research.

4.9: Summary

Overall, the Muslim therapists interviewed were aware and adept at dealing with religious issues in therapy. They understood its meaning for the client and its importance to be incorporated into their therapy, however they acknowledged that due to time constraints it

was not always possible to fully incorporate faith. A variety of psychological approaches were used and adapted to incorporate religious beliefs and practises. The therapeutic relationship and remaining congruent were highly significant, particularly in managing differences (of same faith and different faiths clients). There appear to be advantages and disadvantages of the therapist and client sharing the same faith, however when the therapeutic relationship was strong and similarities were high, an extra level of connection between therapist and client was achieved. If the therapeutic relationship was weak and the similarities were perceived negatively, therapy was usually unsuccessful. Therapists overall felt their identities were crucial to how they practised therapy, particularly when the client was also religious and were mindful of the impact faith could have on both parties. They all noted outside factors which could have an in influence therapy, with particular regard to influencing religion in therapy.

5: DISCUSSION

This chapter will briefly summarise the findings of the study by discussing how they have answered the research questions. The findings will then be reviewed in relation to the literature and the position taken by the researcher. This will be followed by a critical analysis of the research including; limitations, validity and reflections. The terms 'therapist' and 'participant' are used interchangeably in this section when discussing the participants of the current study.

5.1: The Research Questions

The aim of this study was to provide answers to the following two research questions:

1) How do Muslim psychologists trained in the UK experience religion in a therapeutic setting and what does it mean to them?

The results of the research were clearly split into two parts; Muslim psychologists who were born in this country and those who were not. Four therapists (Raffick, Salma, Quraat and Rehana) where born in the UK and identified themselves as practising Muslims. For these participants it was clear that if a client raised religious issues in therapy they would 1) understand, validate and encourage its importance in therapy, 2) be comfortable about dealing with religious issues in therapy, 3) incorporate religious strategies/solutions into therapy, 4) assess, acknowledge and discuss client-therapist 'differences' in therapy, and 5) feel a connection to God through being a therapist, this connection is increased when helping clients with their own connection to God.

The two therapists who were not born in the UK (Hassan and Sherizade) felt considerably more conflict with religion in therapy. Both discussed a process of acculturation when studying and working in the UK, and the need to acclimatise to a British culture. They felt that their religious beliefs should also be inhibited during this process and both mentioned that they were 'trained' to believe that it is not 'professional' or 'scientific' to discuss religion in therapy. Although Sherizade was born in a Muslim, country she did not follow mainstream Islam. She disclosed personal struggles with spirituality, and described herself as a 'Humanist'. Hassan was also born in a Muslim country and described himself as 'not very practising'. However, he acknowledged that his morals and values come from an Islamic background and are still extremely important to him, and in turn they must have an impact on his practise, but that he feels the need to consciously inhibit them.

Hassan and Sherizade's interviews acted as negative case studies adding to the data and increasing the richness of the results. It was useful to be able to compare their data to Muslim therapists who did not have these struggles. It provided additional information on; 1) different levels of 'religiousness' and how personal struggles with faith could have an impact on how therapists felt about dealing with religion in therapy, 2) due to a process of training and acculturation they initially felt that religion should not form a part of therapy because it was not 'scientific' in nature, (this appeared to support the views of the other therapists that practitioners or institutions that did not value faith may not accept its presence in therapy), 3) that both therapists after a process of time, by gaining experience, developing as a person, and becoming more confident as a therapist, concluded that it *is* important to accept the presence of religion in therapy and incorporate a person's beliefs, and to some degree use their own spirituality to aid this process. Over time, they felt less constrained by secular authorities and more interested in using what was meaningful and important to the client.

2) How do the religious beliefs of Muslim psychologists in the UK impact upon their therapeutic approach with religious clients?

Similarly, the results for this question are also split into two parts. The four therapists who identified themselves as 'practising Muslims' showed that they had all thought about the impact of their faith on their chosen model of working to some extent. They were able to discuss which parts of their chosen approaches fit well with their religious beliefs, and which parts may be conflicting. They were then able to use this information to think about how their chosen models may be best used with religious clients, based on their personal experiences. They all described being drawn to particular methods due to its apparent fit with religion: Raffick to Jungian psychoanalysis, Salma to Mindfulness and Acceptance principles, Quraat to Person Centred approaches and Rehana to Solution focussed Therapy. The issue of the need to use CBT within an NHS context was raised. This had mixed reactions as some therapists felt there was an increased likelihood of missing important spiritual information by using this method rigidly, but others felt able to continue to incorporate the client's faith albeit with a less rigid model of CBT.

Sherizade described herself as a 'humanist' and therapeutically was inclined to use mindfulness based interventions. She acknowledged that this was in line with her own sense of spirituality and that it did impact on her approach, but this was with all clients (not just religious ones) and was not from an Islamic perspective.

Due to actively suppressing his religious and cultural heritage in order to be more culturally congruent with British clients, Hassan adhered most to the framework in which he was expected to work (CBT). He initially felt therefore that it was not an option for his religious beliefs to impact his therapeutic approach. This changed over time to a more relaxed stance

in which he felt able to move outside the boundaries of his setting and utilise his religious knowledge and skills in a helpful way for the client.

5.1.1: Summary of the findings:

Muslim psychologists have a rich and diverse experience of religion in a therapeutic setting and show that they are actively thinking about religion and its implications. All therapeutic encounters enhanced their relationship with God, but this was more intense and meaningful when it was with a person of faith, and even more so if it was a successful encounter with a person from the same faith. It appeared that they adapted their chosen therapeutic approaches to accommodate their own and their clients' religious beliefs, but had difficulties with constrictions of time and organisational expectations. These results were severely impacted when the therapist was not born and raised in the UK, and differed depending on the level of their religious practise.

Overall, the more congruent a therapist was to their own and clients' spirituality in therapy, and to their chosen therapeutic method, the more successful the therapeutic encounter was likely to be. The less congruent a therapist was in the aspects mentioned above, the more likely they were to have difficulty with incorporating religion in therapy.

5.2: Findings in Relation to the Literature:

The following section places the findings of the present study within the literature of religion and therapy, and the wider literature of congruence, the therapeutic relationship, therapists disclosure, client-therapist matching and different therapeutic approaches.

5.2.1: Congruence

The core theme described in the results is that of Congruence. Congruence means to be in agreement, in harmony or compatible with. Within therapy it is a term most associated with Carl Rogers' (1957) approach to therapy, as he described three core conditions necessary for Person-Centred therapy; 1) Unconditional Positive Regard for the client {acceptance}, 2) Empathy {to be accurate and understanding} 3) Therapeutic Genuineness {using active listening and being congruent}. All conditions should be present to allow for maximum effect and are all fundamentally important (Klein et al, 2001). Within the context of this study there were a number of levels of congruence. Firstly, there is the ability of the therapists to be congruent with their own personal beliefs, to acknowledge what they believe and how it could impact on therapy, positively or negatively. Secondly, is the ability to be congruent with the clients' beliefs, to accept the presence of their beliefs in therapy and to be open to working with them. Thirdly, is the ability to be congruent with the therapeutic modality, to ensure that it does not conflict either with the beliefs of the therapist or those of the client. Having a high degree of congruence across these points appears to lead to a very positive experience in therapy for client and therapist. A lack of congruence in any of these areas appears to affect therapy in a negative way. If therapists were 1) genuine about their own religious beliefs, 2) were genuinely interested in their clients religious beliefs, 3) genuinely thought about how the model of therapy they were using may impact on beliefs,

then even if mistakes are made, the genuineness and honesty of the therapist was enough to repair the rupture. This overall congruence of the therapist allowed for a better working alliance and a positive experience. When the therapist was not genuine about their beliefs, did not follow up with the client about their religious beliefs, or did not think about the impact of the therapeutic modality on religious beliefs, there were likely to be ruptures or blocks in therapy.

Klein et al (2001) reviewed studies which looked at the concepts of Congruence and Genuineness and outcome in therapy. Historically, studies showed some improvement in outcome of therapy but largely no difference (and no negative outcomes). However, they state that the quality of the research is low and there is enough empirical and theoretical evidence to promote the use of congruence and advocate a revival of research in the area. They describe congruence to be a relational quality;

"Congruence or genuineness has both intrapersonal and interpersonal facets. It can be seen as a personal characteristic (intrapersonal) of the therapist as well as a mutual, experiential quality of the relationship (interpersonal). Congruence may also arise as an issue that patient's raise in therapy when, for example, they directly question the therapist's genuineness (interpersonal and intrapersonal mixed). In our view, congruence or genuineness should be recognized as a key psychotherapy treatment parameter and a potent change process". (Klein et al, 2001, p. 398).

This multi faceted view of congruence matches that of the present study, they go on to describe the feature of congruence as:

"...self-disclosure of personal information and life experiences. They may also entail articulation of thoughts and feelings, opinions, pointed questions, and feedback on client behavior. Genuine responses require mindful attention and self-reflection. Congruent responses are honest. Genuine responses are not disrespectful, overly intellectualized, or insincere although they may involve irreverence. They are authentic and consistent with the therapist as a real person with likes, dislikes, beliefs, and opinions. Congruent responses are flexibly guided by normative therapist role behavior and yet they are not rigidly role bound. Genuine therapist responses are cast in the language of personal pronouns..." (Klein et al, 2001, p. 398).

Studies on congruence focus heavily on the therapist's ability to be self reflective (Omylinska-Thurston and James, 2011, Klein et al, 2001, Tudor and Worrall, 1994). The terms congruence and empathy derive from the person centred model, but have been likened to counter-transference (the therapists understanding of themselves within the relationship) from the psychodynamic model, as (Omylinska-Thurston and James, 2011). Worrall (1994) identified four requirements needed when using congruence: (1) that the therapist is aware of the flow of feelings and sensations within (self-awareness); (2) that the therapist is able to be and to live these experiences (self-awareness in action); (3) that the therapist is able and willing to communicate that awareness in the immediate moment of the relationship with a client (communication); and (4) that the therapist evolves coherent and ethical criteria for assessing when it may be appropriate to share that awareness (appropriateness).

These four requirements link heavily with the results of this study and describe how 'congruence' is woven into categories such as Therapists Beliefs, Therapists Disclosure, Therapists Boundaries, Therapeutic Relationship, Respecting the Faith and Faith Based Interventions.

5.2.2: Religious Journeys in Therapy:

This category is comprised of what therapists felt they need to do or accept in order to incorporate a clien's' faith in to therapy. Although a number of points were raised, six themes appeared; 1) listening and being attentive to the client's story and pursuing any cues from the client about their faith and religious practise, 2) having a respect for the client's beliefs and being comfortable with them, 3) accepting that therapy may involve helping a client to re-connect with God, 4) accepting that therapy may involve a religious crises for the client, 5) to be comfortable around religious language and 6) to be accepting of clients having religious interpretations of their problems.

The above points appear to support Post and Wade's (2009) review which examined how more experienced psychologists dealt with religion in therapy, in which they found they needed to be accepting and comfortable with religious material; they also suggested that the degree of religion in therapy should be dependent upon the client, which was clearly supported by this study.

It was recognised that religious clients do not always want to talk about their faith in therapy, but as well as it being due to a concern about the therapist's beliefs (Mayers et al 2007, in Post and Wade, 2009), or fear that the therapist is not religiously qualified to discuss religious issues (Jafari, 1993), participants interpreted that it could also be because they simply wanted to be treated with compassion and unconditional positive regard over their problems or they were deliberately avoiding more religious interpretations/solutions. In comparison to the psychologists interviewed in the Crossley and Salter (2005) study, four out of six of the present study's participants were more willing, and most were eager, to engage in conversations of a spiritual nature with their client. It was also evident from the data that a proportion of clients clearly want to discuss their religious beliefs in therapy.

However, when it is clear that a client would like their faith incorporated, therapists believed that having a good understanding of faith ensures a better ability to be genuine and less likely to pathologise religious beliefs (Post and Wade, 2009).

Although this was not specifically mentioned by the participants, they all shared the ability to understand and use highly religious language. Bilgrave and Deluty (1998) suggest that the different language used in religion may (to an uninformed therapist) at first appear at odds with the 'person centered', 'empathetic' language of therapy. In this study, it appears that due to the therapists being 'informed' in this sense, it had a positive impact on therapy and in fact increased the level of empathy and person-centeredness with the client.

5.2.3: Therapeutic Approaches:

This category discusses the therapeutic methods used by the therapists when working with religious clients and what issues need to be taken into consideration. There were three themes that emerged from the data; 1) adapting western models to fit with religious beliefs, 2) using faith based interventions, and 3) making use of pre-existing religious coping strategies.

An important finding of this research is therapist's views on therapeutic modality when working with religious clients. Four of the six participants advocated the points outlined below:

1) They used a wide variety of methodologies including those covered in the literature review; psychoanalysis (Jungian), person-centred, CBT, and others. They felt that there was no single method that fit all aspects and needs of a religious person, but equally found no method that could not be used.

2) They all chose to use methods that they felt the most comfortable with from their perspective. They described this as being a method in which they trained in initially or one that fit with their morals and values and was able to incorporate their own beliefs. Herron (1978) in his paper on therapist's choice of psychotherapy, outlines a number of reasons for why therapists choose a method. He postulates that a) it's largely dependent on how much exposure a therapist has had to a model i.e. training or personal interest, b) how successful a method is, when used by the therapist, c) how adaptable the therapy is in order to include varying interpretations of a problem, d) personality type of the therapist, e) a phenomenon which Herron describes as 'a truth which the therapist likes best' as opposed to another therapy which is also true but which the therapist may not like as much, f) it needs to keep the therapist interested by being at the appropriate level of intricacy, g) have an emotional satisfaction for the therapist, and finally h) what the larger society is demanding from

services. All of these points were present in the data of this study and suggest that choice of therapeutic modality is an individualised choice by the therapist based on many factors.

3) They tended to have a 'main' model (see point 1) which guided the structure of the sessions to which they then could incorporate clients' religious beliefs and practises. Quite often this could take on an 'integrative approach' which allowed for more flexibility in incorporating religious beliefs and can be seen in category 4.5.1: 'Rent the Models Don't Buy Them'. For example, one of the therapists working from a person-centred perspective incorporated a CBT style behavioural experiment to test out a religious assumption. This type of working is suggested in a paper on integrated working with Muslim clients by Inayat (2001) and appears to be supported by the results of this study. In a paper by Hook et al (2010) which reviewed studies using religious interventions it found that:

"In fact, in many cases, the scenario that develops is as follows. An investigator modifies a secular treatment by including R/S [religious] elements..." (Hook et al, 2010, p. 67).

They suggest that further research needs to look at how (if at all) do modifications benefit therapy and that a therapists' preference for a certain type of therapy (with or without religious modifications) could be the reason for improvement in therapy. Although this study does not look at therapy outcomes, the question of validity of incorporating religious interventions is important and should be taken into consideration.

5.2.3.1: Psychodynamic:

The use of psychodynamic psychotherapy was used by two participants, one participant rooted in the Jungian philosophy and the other under more recent 'liberal' developments of the tradition. As mentioned in the literature, review Jung's view of the self and religion fit well with a religious client and this was supported by the therapist's account. The therapists both felt that they were able to make good use of the practical aspects of the method without

needing to invest in original underlying philosophies. The suggestion of psychodynamic work not being applicable (Koenig, 2010) was not congruent with what the participants felt. One of the aspects considered possibly conflicting was that of transference and counter-transference but this was also not raised as an issue in this study. It is interesting to note that the literature of congruence in therapy describes transference as the aspect of congruence within psychodynamic therapy (Omylinska-Thurston and James, 2011). It is possible that the therapists who were using psychodynamic psychotherapy felt that congruence with their client and any religious issues were in fact enhanced by the use of transference.

5.2.3.2: CBT

All the therapists interviewed had experience with using this method. CBT produced the largest amount of mixed results of all the methods discussed. The two participants who had the most difficulty with religion in therapy, (the negative case studies) used this method more stringently in comparison to the other participants. The other four participants used elements of this method, but found they needed to incorporate other methods to meet the needs of the client. The most common issue with CBT was the cognitive aspect. If a religious client had a negative/unhelpful/erroneous religious view or 'cognition' that was severely impacting their lives, often the CBT model would either miss the validity of the religious belief and simply attempt to 'modify' the cognition, or if it did accept its validity was too rigid to be able to produce any helpful change. On the contrary the behavioural aspect of CBT was seen to be very effective in incorporating religious beliefs, by using behavioural experiments to test out religious practises and how helpful they are, or to develop practical religious coping strategies. What was most apparent was that therapists that were confident with using religion in therapy were confident to use the CBT in an adaptable way i.e. using it when it fit and abandoning it when it did not. This study seemed to support the view of Carter and Rashidi (2004) that;

"...Cognitive therapies fit well with the beliefs and values of the Muslim population, ***as long as the counsellor can work comfortably within the religious perspectives of the client"*** (Carter and Rashidi, 2004, p. 156).

Even difficult religious cognitions could be challenged in an effective way but it needed sound knowledge from the therapist of both religion and CBT, and the confidence to work with it.

5.2.3.3: Humanistic

One participant used person centred counselling as their main approach however all participants described using person-centred techniques in their work. The most commonly described was being client led, empathetic, genuine, accepting, and congruent. The two main difficulties with this approach with religious/Muslim clients discussed in the literature review were 'unconditional positive regard' and 'self-actualisation'. These concepts in their original form pose a difficulty for religious clients as, at first, there appears to be little room for God, accountability, and good versus bad behaviour. However, what the participants described was being able to use these concepts *within* a religious framework, i.e. being the best person you can be is also the desire for a religious person, although the intention may be to do it for God, and thus using religious processes to self actualise (Khalid, 2006). The unconditional positive regard was used by therapists when discussing the client's problems but because both the client and the therapist had a faith they were able to congruently discuss what the client's faith may say about the issues and acknowledge the impact of that. This meant the therapist would not be making judgements on the client's actions but could still acknowledge the religious issues within them.

Overall, it was felt that the participants of this study took incorporating religion into therapy seriously. They actively worked it into the formulation, worked on building a good therapeutic alliance, and had marked success with integrating religion into their therapeutic

modality of choice. The differences between philosophical and practical applications of different therapeutic modalities are clearly identified in this study. It can be argued that from a philosophical perspective many fundamental points of western models of therapy conflict with religious beliefs and a religious way of life. However, in the practical application, many of the methods have useful techniques that can seemingly be used separately to their original philosophies, and be interpreted and adapted by religious therapists for religious clients, which was supported the participants in this study. It is also evident that the therapists favoured using an integrative approach tailored to the needs of the client.

5.2.3.4: Faith-Based Interventions:

All participants felt the inclusion of faith based methods such as the use of rosary beads, praying, going on pilgrimages, reading/listening to holy texts, mindfulness, and acceptance were all appropriate to incorporate into therapy. These were normally added onto the therapist's modality of choice. This contradicts Shafranske and Malony's (1990) findings which suggested that therapists (whether they adhere to a faith or not) are less likely to use highly religious techniques in a secular setting. Five out of six of the participants felt comfortable to suggest seeking outside religious guidance when necessary and felt that it could potentially lead to progress in therapy. Therapists differed as to whether they would refer the client to seek advice separate to therapy or be an active part in this process. In Hook et al (2010) review of faith based interventions; the overall results appeared in favour of spiritual based interventions. However, most of the studies looked at incorporating spiritual ideas into existing secular therapies; (as does the present study) therefore outcomes meant that *overall* therapy was successful and it is still difficult to ascertain how much impact the spiritual additions had. It suggests that currently, the use of spiritual/religious therapies is just as effective as non spiritual ones. It also adds that including faith issues is dependent on

client preference and therapist comfort; which the present study appears to support, but that it is not an indicator of therapy outcome.

5.2.3.5: Religious Coping Strategies

All therapists felt it was important to ascertain what had been helpful previously to the client with regards to their faith and what might be stopping them from accessing those things now. Therapists believed that if faith had been an important and helpful aspect to a client in the past that it would be beneficial to restore it. Identifying pre-existing helpful coping strategies is a simple starting point in therapy and participants were not afraid to ask about religious ones. They felt religion had the ability to help people to cope in situations of extreme distress, providing support during and after therapy. Faith can give hope for a better future, it can also sometimes be used to access helpful religious communities. It also has the ability to act as a protection against extreme self harm or suicide. These findings appear to correlate with Heilman and Witzum's (2009) findings that faith provides incredible protective and coping strategies when in extreme pain.

5.2.4: The Therapeutic Relationship:

Participants felt that the quality of the therapeutic relationship was an important factor in how they experienced religion in therapy. The results suggest that if the therapeutic relationship is good, any difficulties or issues in therapy (to do with religion specifically) could be worked out, but if it was not good, it would be difficult to overcome those difficulties. The literature on the therapeutic relationship and its impact on therapy outcome and repairing ruptures in therapy is extensive (see Taber, Leibert and Agaskar, 2011; Martin, Garske, and Davis, 2000; Horvath and Symonds, 1991; Gelso and Cater, 1985). It is well known that good therapeutic

alliance transcends therapeutic modality and type of client problem (Taber, Leibert and Agaskar, 2011). The humanistic and person centred traditions (Carl Rogers) have promoted the importance of the therapeutic relationship, emphasising the need for genuineness, realism and congruence in an effective therapeutic alliance (Watson, 2011). The importance of the therapeutic relationship with Muslim clients is also highlighted in Ali et al (2004). However the research concerning *how* to attain a good therapeutic alliance is much smaller (Castonguay, Constantino, and Grosse-Holtforth, 2006). Within the present study participants talked about good therapeutic alliances with a wide variety of clients of different faiths and also of no faith. They agreed that the therapeutic alliance could be formed on a number of different levels such as sharing a similar world view, having similar characteristics, cognitive level or other areas of shared interest, not necessarily from a shared faith, which is a view supported by Zane et al, 2005.

The aspect of how much the therapist and the client shared in common leads into the literature on client-therapist matching. The results of the present study are explored below:

5.2.4.1: Sharing a Faith:

Advantages:

Five out of the six therapists felt that having a faith was beneficial to the working alliance with religious clients but that they did not have to share the same faith. Participants felt that having a shared understanding of faith created a deeper connection between individuals and more spiritually satisfying sessions for both therapist and client. Having a personal understanding of faith and an attitude of belief, acceptance, and respect was enough of a match to build a good therapeutic relationship. This appeared to support the results from Mayers et al (2007, in Post and Wade, 2009) and Gregory et al, 2008, who found the same when interviewing more experienced therapists.

Disadvantages:

If the client perceived the difference of faith in a negative way, e.g. the therapist is too religious, not religious enough or not from the same religion and wouldn't understand the client's views, this could lead to a rupture in therapy. It should be noted here that with a good therapeutic relationship participants felt that this could be overcome.

5.2.4.2: Sharing the Same Faith:

Advantages:

Similar to sharing a faith, this connection could be even deeper with someone of the same faith, the level of understanding would be greater, and the spiritual connection for both the therapist and the client was much stronger. Participants reported that shared faith often led to an equalling of the therapeutic relationship as power and control is taken from the therapist and put with God, therefore both faced each other as humble human beings. This is seen as an advantage by Harrison (2013) in which she states that it is the responsibility of a counselling psychologist to reflect upon, and reduce or remove power imbalances to equalise the relationship.

Disadvantages:

The negative aspects of sharing the same faith are again similar to sharing a faith. The client could perceive the therapist as too religious or not religious enough. Also with same faith clients, there was a concern that if an over identification happened with the therapist, the client may then feel unable to explore concerns or difficulties with the faith. Again it appears from the data that when these issues appeared with the same faith client they were experienced as more intense (more negative) than with a different faith client.

5.4.2.3: Not Having a Faith:

Advantages

Religious clients may not always want their faith included in therapy.

Disadvantages

The participants unanimously felt that not having any faith at all was seen as being too different from the client and could potentially cause ruptures or that the therapy would not incorporate a major aspect of the client successfully.

The results suggest that matching of client-therapist religion is not always necessary and does have disadvantages, but is an individual choice or preference that should be decided by the client. Overall, participants felt that having some matching elements was better than not having any; Raval (1996) suggests a similar finding when working with interpreters. It was acknowledged however that some clients may choose to see therapists who do not have faith or who do not share a faith, but that this choice was dependent on the needs and perception of the client. Post and Wade (2009) also concluded that rather than client-therapist matching, it was the client's perception that the therapist was open and respectful and willing to use religiously congruent (to the client) interventions. Perceptions (particularly negative ones) that the client and therapist had of each other were identified as the largest obstacle in therapy in the present study. Cabral and Smith note a similar phenomenon:

"For instance, clients who enter therapy with a therapist of another race/ethnicity than their own may presume worldview dissimilarity and thus be pleasantly surprised when it does not occur. Conversely, clients who specifically request a therapist of their own race/ethnicity but then encounter divergent worldviews with this therapist may have unmet expectations detrimental to the therapeutic alliance." (Cabral and Smith, 2011, p. 545).

Having negative perceptions of one another with regards to religious views was the area most likely to cause a rupture:

5.2.4.4: Difference

1) Any differences, whether from a different faith or the same faith, perceived negatively would lead to difficulties in therapy. This can be alleviated if there is a good therapeutic alliance and if differences or ruptures are discussed openly early on in therapy. If there is not a good therapeutic alliance it is likely therapy will not be successful. *This negative difference appears exaggerated in the data for clients from the same faith.* It is hypothesised that because they share the same faith, and the therapist has a different view of the situation it could become difficult for the therapist to accept the client's un-shifting problematic view. Generally, therapists felt that if their clients brought something that was in direct contradiction to their beliefs they found it easier to detach if it was a *different* faith client than if it was a same faith client. This idea fits with Baker and Wang's (2004) view that the religious part of a therapists identity can fluctuate as and when necessary.

2) If the differences are perceived positively, it was generally a good therapeutic experience. With the added advantage of a good therapeutic relationship, the results were very positive experiences of religion in therapy. *Similarly this positive experience appears exaggerated for same faith clients* (See appendix J for a full description).

The results appear two fold. Primarily the therapists all agreed that having an understanding of faith was enough of a match and that sharing the same faith was not essential. However, they also explained that if you shared a faith, and that was perceived positively by both the client and the therapist, and there was a good therapeutic relationship, the resulting therapeutic experience was an incredibly wonderful encounter and was termed 'The Added Dance' (category 4.6.2) by one of the participants. This is similar to the phenomenon termed 'Added Value' in Baker and Wang's (2004) study of Christian psychologists. The therapists mentioned a number of ways to deal with differences including; openly naming and

discussing differences early on in therapy, being congruent, empathetic and honest, and acknowledging when it might be appropriate to refer on if the differences could not be managed. Two participants also mentioned having good supportive supervision to help manage differences, and one participant mentioned seeking supervision with a religiously competent supervisor which supports Ali et al suggesting that good 'religious friendly' supervision is important.

Cabral and Smith (2011) discuss an issue termed 'internalised racism', this is when client and therapist come from the same ethnic background, but are at odds with each other. The example given in the paper, is a client perceiving a therapist from the same race to be 'better' than them because they have become a therapist. Two participants in the current study described such a phenomenon, when working with clients of the same religion and cultural background. The first participant described working in a refugee service (where she was able to offer therapy in her native language) and described difficulties in interacting with refugees from her native country as these would never have been people she would have ordinarily associated with. The participant felt ashamed but acknowledged feeling an internal sense of racism which needed to be worked through. Another participant described not being able to work with a female Muslim client who refused to remove her face veil, the participant (also a female Muslim) wore western clothing and her understanding of the religious ruling regarding 'covering' was that women could 'uncover' in front of other women. This issue led to a rupture in therapy as the therapist recognised that she would not be able to work congruently with the client and it was mutually agreed to refer her on.

When working with Muslim clients specifically Ali et al (2004) mention eye contact, prayer times, working with the opposite gender, and Carter and Rashidi (2004: 2003) mentions counsellor-client match and family environment. The present study did not identify any of these issues as significant factors when working with Muslim clients. The most significant

Islamic issue raised by the therapists (female - four out of six participants) was the female Muslim dress code. Three participants wore western clothing and one participant wore Islamic clothing. The three participants in western clothing commented on being judged 'not religious enough' by Muslim clients and it being a concerning factor in the therapeutic relationship. The participant in Islamic clothing discussed concerns over clients of the same faith, a different faith, or no faith perceiving her to be too religious, and it having a negative impact on the therapeutic relationship. Three of the four participants felt that discussing this issue early on in therapy with the client was the most appropriate and effective way of dealing with it. Therapists also judged clients on their dress code with similar assumptions, the most problematic being Muslim female clients dressed in full Islamic attire being too religious for the therapist, or the therapist feeling daunted that they may not be able to meet the religious needs of the client. This issue comes under the remit of *perceptions* mentioned earlier, if the difference in dress code was perceived positively e.g. a religious female client in Islamic clothing wanting to see a therapist who was not as religious or not Muslim may be happy that the therapist is not dressed in the same way, then this was not an issue. However, if the difference in dress code was perceived negatively then this would lead to a rupture, if not dealt with.

5.2.5: Therapist Identity:

Five out of six participants acknowledged their belief had an impact on therapy, which supports the view postulated in Fayek, 2004. Where appropriate, participants would disclose their faith and actively use their faith identity in situations that would be beneficial to the client; they would also use their identity to help challenge unhelpful religious beliefs if they possessed a more helpful alternative view and had a genuine understanding of what the client

was experiencing. This also helped to increase congruence between the client and therapist (Harrison, 2013 and Klein et al, 2001). Ziv-Beiman, (2013) reviews the literature on therapists disclosure and concludes that it is a valid therapeutic method that can be highly valuable when used in the correct manner. The paper briefly discusses the history of therapist disclosure in relation to therapeutic modalities in which it was forbidden in early psychoanalytic models but later acknowledged as inevitable. The majority of models such as person-centred and the cognitive-behavioural approach highly advocate the use of disclosure as a way to enhance the therapeutic relationship which will ultimately enhance therapy outcome. Watkins (1990) proposes four models for explaining the rationale behind the use of self-disclosure: mutuality, modeling, reinforcement, and social exchange. The mutuality hypothesis suggests that one party's disclosure induces disclosure by the other. The modeling hypothesis maintains that patients learn to open up and expose themselves in therapy by imitating the therapist's disclosure. The reinforcement model proposes that therapists employ self disclosing interventions in order to reinforce patient self-disclosure. Finally, the social exchange model views the reinforcing nature of the therapist and patient's mutual sharing as serving as a beneficial norm guiding the therapeutic interaction.

"*Other reasons adduced for self-disclosure include demonstration, strengthening the therapeutic alliance, suggesting alternative modes of thought and action, validating the patient's perception of reality, and granting a sense of normality and universality to the patient's experiences*" (Ziv-Beiman, 2013, p.63).

The participants mentioned a number of the above reasons for disclosing their faith.

For some participants the decision to disclose was removed as their identity was obvious due to their name or dress code. Of these participants, some chose to discuss their identity early on in therapy and some did not. For those whom religion was less obvious, the choice to disclose was more difficult, particularly with different faith clients; they felt the need to think carefully about the client, the situation, and what benefit would come from disclosure before

doing so. If they decided that it would be helpful, they also thought about timing and extent of disclosure (Ziv-Beiman, 2013). Therapists felt that over disclosing personal religious thoughts/practises could blur professional boundaries, and the client may begin to relate to them on a more personal level. Therapists highlighted concerns of client expectations moving beyond the therapeutic process/room to other areas of their lives (such as attending the same faith events etc). Two therapists prominently preferred not to disclose their faith and the lack of congruence appeared to affect the therapeutic relationship and subsequent discussions about religion with their clients.

Participants had responded to an advertisement for Muslim psychologists and clearly identified themselves as such. The length of time they had been qualified and the amount of experience they had also seemed to have a direct impact on their ability to work with their identity successfully in therapy (as reported by the participants). As their experience of therapy grew and the confidence in their ability to deliver good therapy developed, so too did their ability to accept and deal with religion in therapy. Initially, most participants accepted that it was a difficult domain, because they either had not had any formal training in it, or the training they had had, indicated that religion should not be part of therapy. Over time, the participants themselves concluded that it was usually beneficial to include a client's faith when appropriate and became much more confident and comfortable in doing so.

Five of the six therapists felt that the role the therapist had in the client's life, the effectiveness of therapy, and change in the client, was ultimately the responsibility of God. This notion appeared to match that of Baker and Wang's 'Added Dimension', whereby God is the external locus of control. Shafranske and Malony's (1990) 'ideology' scale also appears to have similar dimensions. Therefore their religious identity is fundamentally crucial to their therapeutic identity and the two are inextricably linked. This aspect also linked into the category 'The added dance' (section 4.6.2) which identified same faith clients and therapists

with a good therapeutic relationship and a positively perceived match, to have a much deeper spiritual connection and greater therapeutic experience.

Baker and Wang (2004) describe a phenomenon they call 'Integration- the inner pleasure and pain' about psychologists reconciling their dual identities of being a Christian and a psychologist. Elements of this theme were reflected in the category of *therapist's identity,* however overall, participants felt that their religious identity was a positive aspect rather than a negative one when used appropriately. The Baker and Wang (2004) participants also felt a distinct dichotomy between being religious and being a psychologist. This didn't appear in the current data set; participants spoke more about their 'trade' i.e. the ability to provide therapy being a gift from God and another source of connection to Him. They felt their skills were God given to provide a living and avenue for personal and spiritual growth.

Participants felt they needed to be aware of their limits in terms of religious knowledge, and know when it was appropriate to encourage the client to seek 'outside' religious guidance. Participants were clear that they did not want the client to believe the therapist was a religious authority (even if they had a lot of religious knowledge) and wanted to remain in the role of therapist.

Of the two participants who found it more difficult to integrate religion into therapy their reasons for not doing so are supported by Hamdan (2008):

"...1) dual relationships (professional and religious) 2) imposing religious values on clients, 3) informed consent issues, 4) professional competency issues, 5) violating the therapeutic contract by focussing on religious rather than therapeutic goals, 6) obscuring the boundaries that are important for the therapeutic relationship to be maintained 7) assuming religious authority and performing these functions when referral to religious leaders may be warranted and 8) applying only religious interventions to problems that may require medication or other treatments..." (Hamdan, 2008, p. 102.)

The literature and the other four therapists resolved these dilemmas by:

"... a) thorough assessment of religious and cultural issues to determine appropriateness of spiritual integration b) a strong therapeutic alliance should be established and and proper informed consent proceedures followed c) clinician should avoid imposing religous values on the client and maintain flexibility throughout the process..." (Garzon, 2005, in Hamdan 2004 pp 102.

Two participants said they would be prepared to refer on if they felt that a client's religious views were in complete contradiction to their own however these were hypothetical statements as it had not actually happened to either participant. They had however referred on if both they and the client agreed it would be beneficial to see someone more religious. In comparison to Smiley's (2001) study participants appeared overall more religious and more willing to work with religious issues.

5.2.6: Context of Therapy:

Although this did not feature as a significant part of the data, participants did discuss variations between working in NHS settings and private settings. There appeared to be more time and flexibility within private settings and no restrictions on how much religion to incorporate into therapy. In NHS settings, there were restrictions on time and sometimes method (many required to use CBT) and a concern over what colleagues would make of the amount of religion they were incorporating into therapy and how appropriate it was. This seemed to reverberate with Baker and Wang's (2004) 'Speaking Out' category and the disclosing of personal faith to psychology colleagues. The concerns about colleagues could also be supported by Shafranske and Malony's (1990) findings, suggesting that therapists (whether they adhere to a faith or not) are less likely to use highly religious techniques in a secular setting.

The impact of the client's cultural background and current political climate was mentioned as having an impact on religion in therapy. Cooper (2009) states six principles that counselling psychologists should adhere to and the sixth principle is:

"An understanding of the client as a socially- and relationally-embedded being including awareness that the client may be experiencing discrimination and prejudice (versus a wholly intrapsychic focus" (Cooper, 2009, p. 120).

Psychologists have a moral and ethical obligation to recognise that a client lives in a social world and this world is full of power dynamics that affect the client (Harrison, 2013). Due to the nature of the current study, areas outside of religion in therapy were not examined in detail, but they are acknowledged as being influential and should be taken into consideration. Harrison says of cultural influences:

"*Cultural norms are also affected by power and therapists need to ensure they do not make assumptions about a client's thoughts, emotions and behaviour. The therapist needs to take care and be aware that their views and beliefs are not the clients. All clients will not share 'Western' individualised culture, power and agency can be held within the wider family and/or in their religious beliefs and these may have a stronger pull. Therefore, to label a behaviour or an emotion without understanding the broader cultural aspects of the specific world the client inhabits can lead to misunderstandings and a power imbalance." (*Harrison 2013, pg. 111).

All outside influences that can affect the client and the therapy should be explored with the client, creating an environment of openness and congruence:

"...despite a continued focus by counselling psychology on equality and I would argue that it is better to acknowledge that there are power dynamics, rather than trying to eradicate them completely." (Harrison, 2013, p. 112).

5.3: Implications of Findings and Relevance to Counselling Psychology:

This is the first study to look at the practises and beliefs of Muslim psychologists in the UK and as such, adds a valuable contribution to the field of counselling psychology. As the number of Muslims in the UK rise, it would be justified to expect a rise in the number of

clients and practitioners, and it is hoped that this study begins to explore the nature of Islamic beliefs and its impact in a therapeutic setting, to help develop a more informed understanding of their potential colleagues' value systems and potential clients' religious nature and how to incorporate it in therapy.

The results of this study suggest that Muslim psychologists embark upon a journey post-qualification to find a therapy that best suits them and their beliefs and adapt it to incorporate religion when necessary. The participants overall did not struggle working with clients from a different faith, but instead enjoyed the spiritual connection. Therapists were comfortable with seeking outside religious guidance when necessary. The differences between Muslim psychologists in comparison to other researched religions (mainly Christianity) is much smaller than anticipated which will hopefully lead to practitioners who are not Muslim being less concerned about working with Muslim clients. It would be highly beneficial if research of this nature could help practitioners not to pathologise religions which they are unfamiliar with.

The Muslim psychologists in this study felt their identity of faith was important to them and can be successfully integrated into their work. There were many challenges noted in this process but most were dealt with as any other challenge in therapy (i.e. developing a good therapeutic relationship, respect, active listening, being honest and congruent with issues). They felt it was appropriate to incorporate religious tasks in to therapy and to seek outside religious guidance to supplement therapy when necessary. The above findings appear to fit with research conducted on the connections between values and practise of religiously committed Christian psychologists in the UK (Baker and Wang, 2004). This would suggest that in terms of personal faith, and incorporating a client's faith in therapy, Christian and Muslim psychologists in the UK share similar processes. This study's participants though,

did seem to feel a little more comfortable about their religious identity and in discussing religion with clients overall.

A major theme that is highlighted in most of the literature and also in this study is lack of training. In Crossley and Salter's (2005) study, due to lack of training it appeared that therapists asked questions pertaining to faith because of personal choice as opposed to clinical judgment, which also appeared to be the case in this study. A brief inquiry into the topic of religion in course content on three Counselling and three Clinical Doctoral programmes across the UK revealed that, at most, there was one session on spirituality (not necessarily including religion), if not then it was incorporated into teaching on working with difference. Two of the programmes had none of the above (email correspondence see appendix L).

Considering the practical aspects that come with working with religion in therapy (as opposed to a more general sense of spirituality), and the need to remain open minded and genuine and not to pathologise beliefs; the lack of the inclusion of religion on training courses is a cause for concern. It is hoped that this is one more study that points to the necessity of the consideration of religion and spirituality becoming a more formal part of training.

5.3.1: Findings in Relation to Islamic Psychology:

Islamic psychology as described in the literature review (section 2.4) was not discussed explicitly by the participants. The therapists did not use the Islamic concepts of the heart, soul, or self to inform formulations, but did focus explicitly on an Islamic journey towards God and how the client could achieve a successful journey.

5.4: Critical Evaluation and Limitations

The following section discusses the issues for consideration with the results of the present study.

5.4.1: Epistemology, Methodology and Design

This study was conducted from a critical realist stance and the results can only be interpreted as such. For example, more constructivist views on discourse and use of language are not fully taken into consideration. It is suggested that a deeper look into discourse and language use would be highly informative, as there was a level of religious language being used that was not able to be fully analysed in this study. It is also acknowledged that the interpretations of the results were subjective (and in line with a critical realist stance) and could be viewed differently by a different researcher. However, although the model of the theory could have been constructed in a different way, it is felt that the main theme and the high order categories are nevertheless prominent parts of the data.

This study was not necessarily looking at current cases and was therefore retrospective in nature. It is difficult to ascertain how accurate therapists' accounts of what they did are; it also did not look at therapy outcomes and although participants felt that there was a better connection with spiritual clients and that positive experiences had led to successful therapy, this was not a measurable factor in this qualitative study.

This study is a small scale qualitative study and results will be difficult to generalise. Generalisability is not the main aim for grounded theory, but inductively building theory from the data is. This should be done by reaching category saturation, which is achieved when no new categories are being generated from new data. This is a fairly abstract concept

and researchers arrive at different levels of category saturation dependent on their interpretation of it. There are no measurable guidelines about when categories become saturated and it would be unwise to suggest that another new piece of information would never bring anything new. It is therefore theorised that category saturation was reached, but that this is certainly an area that is ambiguous and is often subject to constraints of time.

5.4.2: Researcher-Participant Matching

There were some interesting comparisons to be made between the literature presented on client-therapist 'matching' (in section 2.3.3) with researcher-participant matching. Cabral and Smith (2011) suggest that the results are mixed and there are advantages and disadvantages in having an exact match. This also appeared apparent when considering the match between the researcher and participant. From a negative perspective participants could assume researcher knowledge and not explore experiences in enough detail:

"...inside I was quite angry about it and it was actually funny because I was um found myself and I'll be true with you I found myself putting my, the Quran, which is for me you know I'm not gonna explain to you what is Quran to us but..." **Hassan, 26:14.**

Another area of client-therapist matching mentioned in section 5.4.2.4: Difference, is of female therapists and clients perception of each others' dress code. From appearance a judgement could be made of level of religiosity (too religious vs not religious enough) with varying results, depending on whether the difference was perceived positively or negatively.

This appeared to be mirrored in the interview between researcher and participant as the researcher wore Islamic attire (covering the head and hair) and three of the female participants did not. Early on in the interviews, all three participants mentioned being

perceived as not religious enough due to their dress code and two of the participants aired further concerns of the current research having an ulterior agenda in trying to advocate for faith based therapies. In an article by Collicutt (2011) she noted that the psychology and religion UK network identified a number of challenges when working with religion and psychology, one of those being:

"Trustworthiness: Psychologists who study religion may be suspected of having a hidden agenda of trying to make converts." (Collicutt, 2011, p. 251).

This was an interesting theory, considering none of the advertisements or information provided had mentioned specialist services. The participants appeared concerned that their data may be used to support such a movement and it is hypothesised that they may not have made this assumption if the researcher was not from the Muslim faith and been perceived as more religious than them by dress code. This would also make an interesting area for study as the rationale for their reservations about faith based services were not matched by their positive experiences with same faith clients.

The results of this study, if conducted by someone of a different faith or no faith, would be equally as interesting and informative. It would help to reduce researcher biases, and would perhaps enable more curiosity and questioning around areas that may otherwise be taken for granted, such as language and understanding of underlying religious beliefs (Cabral and Smith, 2011).

As an advantage however, participants perhaps felt more comfortable to explore difficult situations, or situations in which they may fear being judged by non religious peers (Baker and Wang, 2004):

"...[I'll be true with you] for me the Quran is kind of peace that you don't just put it second, and I felt I am for the sake of the patient I'm actually putting my values and the Quran which

is always up there, I'm just putting it aside and just all of a sudden looking at it as the reminder that brought all these bad things so I felt really bad inside it's kind of, I know that sounds weird but it's kind of I sinned, for the sake of a human being which of course as a professional I know sensibly that that shouldn't be the case I shouldn't deal with it that way it has nothing to do with my beliefs but at that moment I was kind of frustrated that I had to deal with it that way just removing the Quran and put it away because my way of dealing with stress is reading Quran". **Hassan, 29:14.**

It was felt that the nature and extent of this disclosure was intensified due to the researcher sharing the same faith as the participant.

5.4.3: The Participants

There were a number of potential participants who responded by saying they were Muslim but not practising, or that they didn't feel their faith impacted upon their work and therefore did not want to be interviewed. Not interviewing this population of Muslim psychologists has certainly impacted upon the results. It may be that these individuals struggle more with integrating their faith and felt uneasy about discussing it. It may also mean that the participants who came forward and were subsequently interviewed represent a population of Muslim psychologists who generally felt more comfortable about their spirituality and discussing it with clients (and the researcher). The data may then appear overly positive if this is the case. It may be that we are missing the information described by Baker and Wang (2004) as the 'pain of integration'. Perhaps a more general research topic on religion which purposefully included Muslim practitioners from a wide range of backgrounds may lead to a wider perspective on this population.

This was a study conducted on psychologists about themselves in the therapeutic setting. It therefore does not give us any usable insight into how their clients felt about therapy and

whether they found the interventions helpful or not, or what they thought about the balance between therapy and religion in the sessions.

Being a trainee psychologist also had an impact on the researcher - participant dynamic. Occasionally the participant would slip into 'teaching' me what they felt was the right way to do something or indeed tell me that I shouldn't be advocating faith based services. Being interviewed by a researcher or a qualified psychologist may have provided slight differences in the exploration of process and the information provided.

As mentioned earlier, issues specific to Islam such as; Islamic model of self, male and female interactions, black magic, eye contact, prayer etc (Ali et al, 2004) did not form a significant part of the data and the topic of Islamic Psychology was not brought up. This study therefore does not give us an insight into how widely used the concepts of Islamic psychology currently are in the UK, or as to what other contexts outside of counselling and clinical psychology it may be being used.

5.5: Validity:

Validity and reliability in a qualitative study can take many forms. Making the reader aware of researcher perspective and possible biases, being open about philosophical stand points and being as reflexive as possible by using supervision and keeping a research diary are all part of that process. Grounding categories with examples, situating the sample population and providing a clear and coherent account of how the research was carried out, verifying findings with others and providing a detailed critical analysis of the study are all ways to validate the research. Although the researcher is aware that personal ideas may have

influenced both data collection and analysis, it is hoped that by grounding the categories in the data with numerous examples, having the analysis checked and verified by peers who are not Muslim, and keeping a reflexive diary will all show the attempts made to bracket off researcher biases and produce more reliable results.

An account of the above points has been mentioned in various sections throughout the thesis. Some further reflections on the study follow below.

5.5.1: Reflections:

The researcher notes the similarities between the researcher and participants. All are practising Muslims who have trained as Psychologists in the UK. Four of the participants were also born in the UK (as is the researcher). The researcher's personal interests were to find out how the participants were grappling with similar difficulties as the researcher, regarding faith in therapy. It was hoped that some insight would be gained into how best to deal with religious dilemmas, both of the practitioner and the client. The researcher thought that participants would have chosen particular therapeutic methods to work with religious clients and was surprised to find the opposite was happening. The researcher also thought that Islamic psychology had been more widely thought about and incorporated amongst Muslim practitioners working with Muslim clients and was again surprised at the results. The researcher was also expecting to find greater difficulties working with clients of a different faith; this was not the case and the link of a faith was sufficient, however a couple of participants felt they knew when it would be appropriate to refer on, if that ever was the case.

Due to these expectations by the researcher it is probable that many biases and assumptions were shared, and that the researcher may have missed opportunities for further exploration of

categories due to assuming a level of understanding with the participants. As mentioned earlier, there was a level of shared religious language which also meant clarification of ideas and meanings could have been missed.

5.6: Further Areas of Research:

A major consideration for future research is the inclusion of accredited psychotherapists, counsellors, and family therapists. The decision to only include psychologists was one of practicality and homogeneity. However, after more careful understanding of the grounded theory approach it is often recommended to gather data from the widest range of sources possible to allow for greater category saturation. It is therefore considered to be in line with the current method employed, to have included a wider range of practitioners. This would also greatly increase the number of participants willing to participate and generate better category saturation.

A separate study into the understanding and application of Islamic Psychology is also considered to be a valuable contribution to the literature and would possibly give Muslim psychologists another avenue to explore with their clients. This study looked at how Muslim psychologists' identity impacted on therapeutic approaches but not on therapy outcome. Another area for further research would be on Muslim psychologists' integration of religion in therapy and therapy outcomes. One hypothesis as to why Islamic psychology didn't come up specifically is due to the secular environments in which the research took place, conducting research with therapists that practised in a Muslim counselling service may yield different results.

The level of religiosity of therapists was not measured and appeared to have an impact on the results. The two participants who identified themselves as not practising struggled the most with integrating religion into therapy. A study which measured participant level of religiosity would be a valuable addition to the literature. The scope for possible research in this field at present is almost limitless. There is so little research in the UK with Muslims in therapy that quantitative studies on outcomes and interventions, more qualitative studies on other areas such as Muslim clients working with therapists of a different faith, and mixed methods studies looking at specificity and efficacy are all viable options.

5.7: Summary and Concluding Comments:

An attempt has been made to answer the research questions stated above using a qualitative grounded theory method from a critical realist stance. The participants in this study indicated that as Muslim Psychologists their faith and identity is fundamentally important to them and can impact upon therapy in many ways; overall positively but there are negative aspects too. They seem more likely and more comfortable than the average psychologist to include faith in therapy and tended to use the therapeutic modality they were most comfortable with and adapted it to fit with additional religious issues. They did not appear to have too many difficulties when working with clients of a different faith (it seems difficulties were more likely to arise with same faith clients), however when all aspects of therapy were congruent the experience could be very spiritually rewarding, even more so with a client of the same faith. The researcher has attempted to account for issues of bias, validity, and reliability and it is hoped that the results from this study lead the way to many more studies involving Islam in therapy, and Muslim clients, and practitioners, as the scope for research in this field is endless.

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Appendix A:

Advertisement placed in The Psychologist Magazine and WebPages:

I am a fourth-year trainee studying for a Professional Doctorate in Counselling Psychology at the University of East London. **I am investigating the clinical experiences of Muslim Psychologists when working with the Muslim client population.** I am being supervised by Professor Rachel Tribe. If you are a Muslim Psychologist who has trained in the U.K. and this topic interests you or you have conducted research in this area I would be eager to hear from you.

Sara Betteridge
Email:***
Tel: ***

Appendix B: PARTICIPANTS INFORMATION SHEET

Aim of the study and brief overview:

Thank you for your interest in this study. My name is Sara Betteridge and I am currently completing a Professional Doctorate in Counselling Psychology at the University of East London. I am looking to gain a better understanding of how Psychologists experience religion in the therapeutic setting and more specifically what therapeutic methods are being employed by Muslim Psychologists when working with Muslim clients.

What are the benefits of taking part in this study?

This would be an opportunity for you to inform your own practise by exploring what it is like to work with clients from the same faith and clients from a different faith to yourself. It is also hoped that the information gathered from this research will help towards informing best working practises for all clinicians when working with the Muslim client population.

What will I have to do if I take part?

If you chose to take part in this study you will be asked to complete a consent form and answer some background information questions. Participants are then required to participate in a semi-structured interview lasting approximately 60-90 minutes. Interviews will take place with myself at a location convenient to you.

Confidentiality:

I will ask for your permission to record the interview using a digital audio recorder. All interview information will be anonymised and stored in a locked location and will only be used by myself and my research supervisor Professor Rachel Tribe at the University of East London. Should you wish to, the thesis will be available for your viewing and comments prior to submission. Please note that you may withdraw from the study at any time.

Snowballing:

If you know of any other Muslim Psychologists trained in the UK who may be willing to participate in this study I would be very grateful for their contact details so that I can forward them the relevent information.

My contact details:

If you are interested in taking part in the current study or would like to discuss further details regarding the study, please do not hesitate to contact me on: [email] or [mobile number].

THANK YOU FOR YOUR TIME

Appendix C: An example of a recruitment email

From: Sara Betteridge <email address>
Date: Sat, 22 May 2010 10:36:35 +0000 (GMT)
To: <@***>
Subject: Muslim Psychologists needed for Doctoral Research Project

Dear Ms ,
my name is Sara Betteridge and I am a 3rd year trainee counselling psychologist at UEL. I am currently recruiting for my research project which is looking at how Muslim Psychologists experience religion in a therapeutic setting and asking them about therapy with Muslim clients.
I have tried to identify Psychologists who may be Muslim through the BPS list, my apologies if you are not, however if you are Muslim and have been qualified for more than two years I would greatly appreciate your participation in this project,
I attach the participant information sheet and look forward to hearing from you soon,
thank you in advance for your time,
Sara Betteridge

Appendix D: Example of pre-interview email

Dear ***
I'm emailing to confirm our meeting this Friday at 2 pm at the address which appears below your name.
I also wanted to ask you to have a little think about certain cases in preparation for the interview if you had a few spare moments. If you are able to do this it would be helpful for you to think about a case/s with a Muslim client who has brought religion as part of the dialogue in therapy and any positive and/or negative aspects that may have arisen for you from this situation.
and also of a case/s in which a client of a different faith has brought issues of their religion to therapy and the positive and negative aspects this raised for you.
many thanks and look forward to meeting with you on Friday
kind regards
Sara

Appendix E: Interview Schedule

It is hypothesised that the following set of questions may guide the initial stages of the interview but will need to remain flexible:

Firstly ask the participant to think about a few clients from a different faith that have brought religion into therapy and ask:

1) How do you experience the therapy session when a client from a different faith brings religion to therapy?

2) What meanings do these experiences have for you?

3) How much do you think your own faith has influenced this perception?

4) Does your own faith help or hinder the experience?

5) When working with clients of faith what therapeutic methods do you employ? Which do you avoid?

Then ask the participant to think about a few clients from the same faith that have brought religion to therapy:

6) What are your experiences when clients of the same faith as you discuss religion?

7) What meanings do these experiences have for you?

8) Do you integrate your knowledge of your faith when working with same faith clients? Is it a help or a hindrance?

9) What is your understanding and use (if at all) of Islamic Psychology?

10) When working with Muslim clients - what therapeutic methods do you employ? Which do you avoid?

Appendix F: Ethics Approval

UEL
University of East London

Rachel Tribe
Psychology School, Stratford

ETH/11/86
23 February 2010

Dear Rachel,

Application to the Research Ethics Committee: Exploring the clinical practises of Muslim psychologists (in the UK) when working with the Muslim client population: A grounded theory study. (S Betteridge)

I advise that Members of the Research Ethics Committee have now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Simiso Jubane
Admission and Ethics Officer
s.jubane@uel.ac.uk
02082232976

Research Ethics Committee: ETH/11/86

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed: ..... Date: 23.2.10

Please Print Name: SARA BETTERIDGE

Appendix G: Consent Form

University of East London

Research Ethics Committee
Debbie Dada (Committee Secretary)
The Graduate School
University of East London
Docklands Campus
4-6 University Way
London
E16 2RD
Tel: 0208 223 2976
Fax: 0208 223 2826

Informed Consent form

Introduction

You are being invited to participate in a research study titled 'Exploring the clinical practises of Muslim psychologists in the UK when working with the Muslim client population: A Grounded Theory Study.'

This study is being conducted by Sara Betteridge under the supervision of Professor Rachel Tribe in the School of Psychology at the University of East London, Stratford Campus.

Volunteer status and confidentiality

Your participation in this study is completely voluntary and confidentiality is assured in all published and written data resulting from the study. You have the right to refuse to answer particular questions. You may elect to withdraw from this study at any time and the information we have collected from you will be destroyed. If you decide to participate the information you provide will be used only for the completion of this study.

Purpose

The purpose of this study is to first gain an understanding of how clinicians experience therapy when a client brings religious material and secondly what methods are currently being used by Muslim practitioners when working with Muslim clients, in order to develop ways of working with this client group for all practitioners which are congruent with their religious beliefs, whilst also utilising appropriate western psychotherapies.

Procedure

Participants are required to meet with the researcher who will conduct a semi structured interview on your experiences of working with Muslim clients. Participants will be met at a time and location convenient to them.

Time Commitment

Your participation in this study will take approximately 60-90 minutes.

Risks

There are no known risks to participating in this research.

Benefits

There is likely to be no direct benefit to you for participating in this study, but it will help us and others to gain a better understanding into more religiously congruent ways of working with Muslim clients. It aims to produce techniques and methods of implementation for both Muslim and non-Muslim practitioners to benefit from.

Payment:

You will not be paid for participating in the study.

Ethical clearance:

This study has received ethical clearance from the Graduate School Research Ethics Committee at the University of East London, Docklands Campus.

For Further Information

Any questions that you may have about this study can be answered by Sara Betteridge at [email address] or for out of hours queries [mobile number].

Before You Sign This Document

By signing below, you are agreeing to participate in a research study. Be sure that any questions have been answered to your satisfaction and that you have a thorough understanding of the study. If you have further questions that come up later, please feel free to ask the researcher. If you agree to participate in this study, a copy of this document will be given to you. Please also be aware that some of the data from the interviews may be used in a published study.

Participant's Signature:

Date:

Print name:

Researcher's Signature:

Date:

Appendix H:

BACKGROUND INFORMATION SHEET:

Qualification:

Year of Qualification:

Place of Qualification:

Age:

Gender:

Country of Origin:

Appendix I:

Debriefing Form

This form should be used in addition to a personal debriefing which would normally be given to participants after they have acted as research participants.

Purpose of research
The purpose of this study is to first gain an understanding of how clinicians experience therapy when a client brings religious material and secondly what methods are currently being used by Muslim practitioners when working with Muslim clients, in order to develop ways of working with this client group for all practitioners which are congruent with their religious beliefs, whilst also utilising appropriate western psychotherapies.

Procedure
Participants are required to meet with the researcher who will conduct a semi structured interview on your experiences of working with Muslim clients. Participants will be met at a time and location convenient to them.

If you were upset, disturbed or distressed by participation in this study or found out information about yourself that is upsetting, disturbing, or distressing, we encourage you to make contact with one the following agencies or individuals:

Your Supervisor

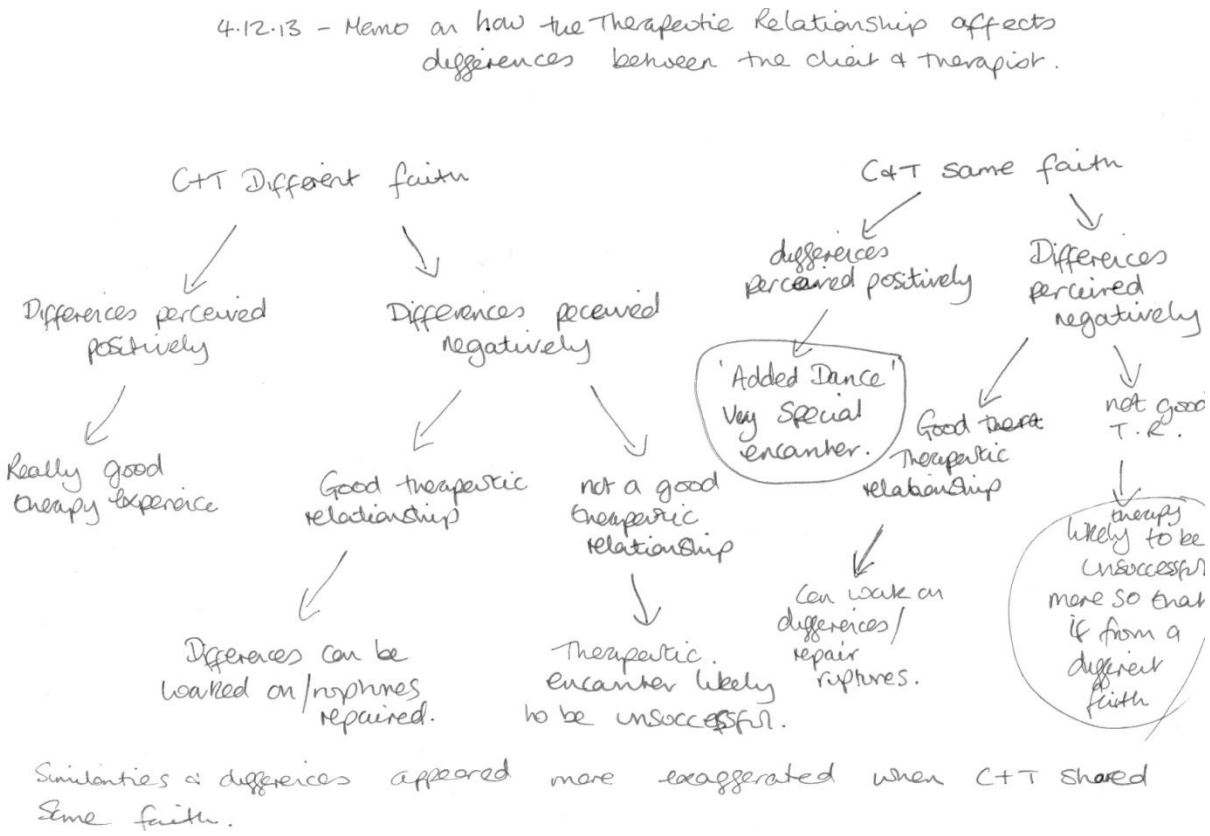
In the event you would like to read more about these and related topics, here are several authors which you might find interesting.

Qulsoom Inayat
Malik Badri

Also, if you have any questions or concerns about this study, you are encouraged to contact Sara Betteridge at [email address] or [mobile number]

Thank you very much for your participation.

<u>Appendix J:</u> Example of a Memo



<u>Appendix K:</u> Turn it in Receipt

Statement of Originality: Turn-it-in receipt details

Paper title: Doctoral Thesis

Paper ID: 16069513

Author: BETTERIDGE, SARA

Appendix L:

Example of email sent to Psychology Doctoral Programmes and their responses:

From: Sara Betteridge [mailto:email address]
Sent: 18 December 2011 12:14
To: ***@city.ac.uk
Subject: syllabus enquiry

Dear Dr,

I am a psychology doctorate trainee currently conducting research in religion and psychotherapy. I would be very grateful if you could inform me as to whether 'religion and psychology' forms part of the formal teaching syllabus at city uni for the counselling psychology doctorate programme,

many thanks

Sara

Dear Sara,

There are aspects of an discussion between the concepts, but I am not sure if I respond to your question with that.

Dear Sara

I have been asked to respond to your question as one of the programme directors of the doctorate in counselling psychology.

We have a short explicit focussed input on spirituality (one day) on our programme. the issue of the way that individuals construct meaning does however flow throughout the programme (and links to the ethos of reflexivity help by the programme). The focused input sits in a section of the programme about working with difference.

It may also be useful to know that we have a staff member (William West) who undertakes a lot of research in this area. This means that trainees may gravitate towards him for their thesis too.

I hope that helps

Dear Sara

Thank you for your enquiry. We do a session on spirituality but it is not part of our core delivery.

Hope this helps.

Regards

Hi Sara,

The issue of religion and psychology does tangentially come into our curriculum, in a number of ways.

Firstly, when working with people suffering psychosis, delusional (fixed, distressing) beliefs sometimes centre around religious themes. Prof. David Kingdon has written about this, and how we work with such beliefs within a cognitive behavioural framework.

Secondly, some of the psychological therapies which we teach have a spiritual, if not religious dimension, depending on the practitioner involved. For example mindfulness has been adapted from Buddhist practice, and is making a big impact on recurrent depression.

Lastly, my colleague Isabel Clarke has written extensively on spiritual aspects of psychosis and psychological therapy and has two books published. She teaches on the course, bringing her approach to bear to cognitive theories.

Hope this helps,

All the best

Dear Sara
Thank you for your email. We do not have any focus on religion as such, although several of our lectures (particularly within Older Adults teaching) do consider the role of spirituality in mental health.
Best wishes.

Hi Sara,

We have had sessions on Spirituality but not on Religion.

hope this helps