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EXPLORATION OF MUSLIMS' EXPERIENCES OF MENTAL HEALTH SERVICES AND SPIRITUAL ABUSE

Section A: A Systematic Review and Thematic Synthesis of Muslims' Perceptions and Experiences of Accessing Mental Health Services

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بِسْمِ ٱللَّهِ ٱلرَّحْمَٰنِ ٱلرَّحِيمِ

Bis-millah-hir Rahman-ir Raheem

In the name of God, the Most Compassionate, the Most Merciful

The Prophet Muhammad (peace be upon him [pbuh]) said, "Help your brother, whether he is an oppressor or he is an oppressed one. People asked, "O God's Messenger! It is alright to help him if he is oppressed, but how should we help him if he is an oppressor?" The Prophet (pbuh) said, "By preventing him from oppressing others." (Sahih al-Bukhari, 2444)

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To my wonderful husband, thank you for your endless love and support, I couldn't have done this without you.

Summary of Major Research Project

Section A: This systematic review examined Muslims' perceptions and experiences with professional mental health services. Twelve qualitative studies were identified through a systematic search and analysed using thematic synthesis. Three key themes emerged: *Therapy's Not for Us: Barriers*, *Relationship Between Therapy and Islam*, and *Therapy Can Be Helpful: Facilitators*. The findings highlight the need for services to address barriers faced by Muslims by collaborating with the Muslim community and faith leaders to provide more culturally sensitive and faith-informed care. Clinical implications and recommendations for future research are also discussed.

Section B: This study explored British Muslims' lived experiences of spiritual abuse (SA) within interpersonal relationships. Semi-structured interviews were conducted with eight participants and analysed using interpretative phenomenological analysis (IPA). The findings were organised into four group experiential themes: *Power and Control, Feeling Trapped, Impact,* and *Healing*, with additional sub-themes explored. The study emphasised the need for mental health professionals to better understand SA and the importance of collaborating with Muslim survivors and faith leaders to provide person-centred, culturally and faith-sensitive support. Recommendations for future research are also discussed.

Section C: This section contains appendices with supporting information.

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Section A:

A Systematic Review and Thematic Synthesis of Muslims' Perceptions and Experiences of Accessing Mental Health Services

Word Count: 7,992 (9)

Abstract

Background: Muslims tend to access mental health services significantly less than the general population and experience significantly worse outcomes than other religious groups when they do access services. Previous reviews have only focused on Muslims' perceptions and beliefs about accessing services which have highlighted various cultural and systemic barriers.

Aim: This systematic review aimed to synthesise and analyse qualitative papers, from around the world, to explore Muslims' experiences as well as perceptions of accessing professional mainstream mental health services.

Method: A systematic search of PsycINFO, Web of Science, Medline and ASSIA yielded 12 papers. The CASP framework was used to assess the quality of the papers. A thematic synthesis was conducted to address the research questions.

Results: Using thematic synthesis, three themes were derived: *Therapy's Not for Us: Barriers*, *Relationship Between Therapy and Islam*, and *Therapy Can Be Helpful: Facilitators*. There were nine subthemes. Clinical and research implications include recommendations of co-production with Muslim communities and faith leaders, enhancing cultural and religious competence within services, and expanding research on the integration of mental health services in existing religious structures such as mosques.

Keywords: Muslim, Mental health, barriers, facilitators, Islam, culturally sensitive, faith-informed, therapy

Introduction

Background and Context

Islam is one of the world's major religions, with a global Muslim population expected to grow from approximately 1.6 billion to 2.2 billion by 2030 (Grim & Hsu, 2011). In the UK, Muslims are the largest non-Christian religious group, comprising 2.8 million people, or 4% of the population (Ali, 2015). Given these demographics, mental health professionals (MHPs) are increasingly likely to work with Muslim clients during their careers.

The mental well-being of Muslims is particularly vulnerable in today's socio-political environment, which is marked by rising discrimination, refugee crises, and negative portrayals of Muslims in Western media (Khan & Ecklund, 2013; Altalib et al., 2019). These challenges have significant impacts on Muslim mental health (MH) (Ali, Liu, & Humedian, 2004; Sheridan, 2006), yet MH services often struggle to effectively meet the needs of Muslim clients (Weatherhead & Daiches, 2010).

In line with the Race Relations Act 2000 and the Government's Delivering Race Equality in Mental Health Care policy (Department of Health [DoH], 2005), the British government and the frameworks of the National Health Service (NHS) have developed initiatives in an attempt to address MH inequities of minoritised ethnic populations by creating services that are more suitable, engaging, and sensitive to their needs (DoH, 2005; Hamid & Furnham, 2013).

However, research in the United States indicates that, despite a rise in MH issues, these often remain unnoticed within ethnic minority communities (Sue et al., 2012). Similarly, British ethnic minority groups are less likely to present at primary MH care

services but more likely to become known to crisis services or enter the criminal justice system. People from ethnically minoritised backgrounds tend to have less awareness about available MH care services and are less likely to be referred for psychotherapy but more likely to be become sectioned and medicated (Bignall et al., 2019).

Much of the research exploring MH inequities among ethnically minoritised groups is valuable, yet it has notable limitations. A common issue is the tendency to treat ethnically diverse populations as homogeneous, leading to a "one size fits all" approach by services and professionals. This is particularly problematic when studies focus on specific ethnic groups but overlook religious identity. For instance, classifying a group as ‘South Asian’ may include Sikhs, Hindus, and Muslims, without accounting for the unique characteristics of each religious group. While Muslims may share cultural similarities with others in the same ethnic group, they also have unique religious features that distinguish them (Musbahi et al., 2022).

This creates a dichotomy, as Muslims are a heterogeneous group with diverse cultural and religious practices, yet many still identify as part of a unified global community, the "ummah", bound by shared religious beliefs (Khan, 2014). These beliefs play a significant role in how psychological distress is understood, expressed, and managed, influencing perceptions and attitudes towards accessing MH support (Abdel-Khalek, 2011; Padela et al., 2012). As such, efforts to engage Muslims with MH interventions that neglect the integral role of Islam in their lives can lead to poor outcomes or result in individuals favouring alternative coping mechanisms (Abu-Raiya & Pargament, 2011).

Muslim MH Outcomes

Research indicates that Muslims receive fewer referrals and are underrepresented in therapy services, with those who do access services experiencing significantly worse outcomes compared to the general population (Mir et al., 2019). During 2021-2022, of the 45,999 Muslims referred to NHS Talking Therapies England, merely 2.6% completed their treatment course. In contrast, 18.4% of Christian patients and 38.9% of individuals identifying with no religion completed their treatment (NHS Digital, 2022). Of those who complete NHS Talking therapies treatment, Muslims have the lowest recovery rates among people from all religions and none, with a Muslim recovery rate of 44% compared to that of Christians (55%) and Jews (53%) (Baker & Kirk-Wade, 2023).

There's a considerable gap in research concerning the Muslim community's perceptions and understandings of MH, highlighting the need for further study in this domain. A survey involving 1,071 Muslims aged 16–30 revealed a range of MH issues, such as suicidal thoughts (32%), anxiety (63%), and depression (52%) (Muslim Youth Helpline, 2019). Despite these figures, many would still refrain from accessing MH services for professional support (Ayub and Macaulay, 2023).

Barriers

Existing research on Muslims living in the West has identified the following barriers to accessing MH services: lack of culturally sensitive and faith-informed services (Arday, 2018; Hammad et al., 2020); lack of identification of and provision for MH needs of Muslims (Hammad et al., 2020; Mind, 2013a); lack of consideration of the interaction between therapy and the client's religious or spiritual beliefs (Hammad et al., 2020; Mind, 2013a); language barriers and limited awareness of MH issues and the services available (Hammad et al.,

2020); worries about confidentiality (Hamid and Furnham, 2013); a general mistrust towards institutions, power imbalances between service providers and users (Hammad et al., 2020), and fear of misinterpretation by healthcare providers leading to reluctance in disclosure (Inayat, 2005), feeling discriminated against by service providers (Alhomaizi et al., 2017); and shame and stigma linked to MH issues (Pilkington et al., 2012).

In a recent study comparing young British Muslim's attitudes towards MH to their non-Muslims counterparts, Musbahi and colleagues (2022) found that the Muslim participants were less likely to accurately recognise signs of MH difficulties. The researchers also found that stigma and lack of awareness continue to be significant barriers for Muslims. One in three Muslims would consider discontinuing medication if a religious leader recommended it. Additionally, nearly half of the Muslim respondents showed a preference for seeking help from a MH service that was designed specifically for their ethnic or religious group.

While survey research has been instrumental in highlighting disparities in MH care access for Muslim communities, quantitative studies often lack the depth of data provided by qualitative methods. This may overlook crucial subtleties in understanding the therapeutic relationship, both individually and systemically.

Rationale and Aim

In summary, despite the rising prevalence of MH issues amongst Muslims communities, there remains a notable underutilisation of MH services by this demographic (Alharbi et al., 2021; Ibrahim and Whitley, 2021). Research has revealed some of the systemic and individual barriers that Muslims face when accessing MH care (Inayat, 2007). However, evidence also indicates that a substantial majority of Muslims opt not to seek

treatment for MH difficulties from mainstream services (Muslim Youth Helpline, 2019; Salaheddin & Mason, 2016). This highlights the need for deeper exploration of Muslims' attitudes towards and experiences of MH services. While existing studies have predominantly focused on Muslims' perceptions of MH services, this review uniquely seeks to review both the lived experiences of Muslims accessing these services, as well as their perceptions. The current review aims to do this by systematically reviewing qualitative empirical research on Muslims' perceptions and experiences of accessing professional MH support.

Methods

Eligibility Criteria

Aligned with the objectives outlined in this review, papers were considered for inclusion if they contained information exploring Muslims perceptions or experiences of MH support in any region of the world, provided they were published in English. Papers presenting integrated findings from various ethnically marginalised perspectives were excluded. The eligibility criteria are detailed in Table 1 below.

Table 1

Eligibility Criteria

Category	Inclusion Criteria	Exclusion Criteria
Sample	• Studies focusing on Muslims perceptions and experiences of accessing professional mental health services and/or receiving professional mental health support from any region worldwide • Studies which included participants who are adults and self-identified as Muslim • Published in English	• Studies that collected data from multiple marginalised groups including Muslims but did not specify which quotes were from Muslims • Studies focused on Muslims participants that were younger than 18 years old • Papers not available in English

Phenomena of interest	• Perceptions and experiences of mental health support	• Studies that focused on healing generally and not mental health specifically • Studies that explored experiences of Muslims without focus on mental wellbeing
Design	• Focus on qualitative studies including but not limited to phenomenology, grounded theory, narrative, ethnography	• All other designs
Evaluation	• Studies focusing on Muslims' experiences or perceptions of psychological support	• Studies focused on staff experiences of working with Muslims
Research type	• Peer reviewed journal • Qualitative or mixed methods studies • Primary/empirical research studies	• Dissertations • Unpublished theses • Systematic reviews

Systematic Search Strategy

A systematic search of the literature was carried out in October 2023. Due to the paucity of research on this topic, there were no criteria applied regarding the year studies were published. A search was conducted in four databases: PsycINFO, WebofScience, Medline and Applied Social Science Index and Abstracts (ASSIA). The selection of these databases was based on their reputability and relevance to the research question. Medline and WebofScience, recognised for their large number of psychology journals, were chosen along with PsycINFO and ASSIA, which allow access to pertinent articles in psychology and the caring professions. The search criteria were restricted to studies published exclusively in the English language. The search strategy employed is outlined in Table 2.

Table 2

Boolean Search Terms used across PsycINFO, Medline, WebofScience and ASSIA.

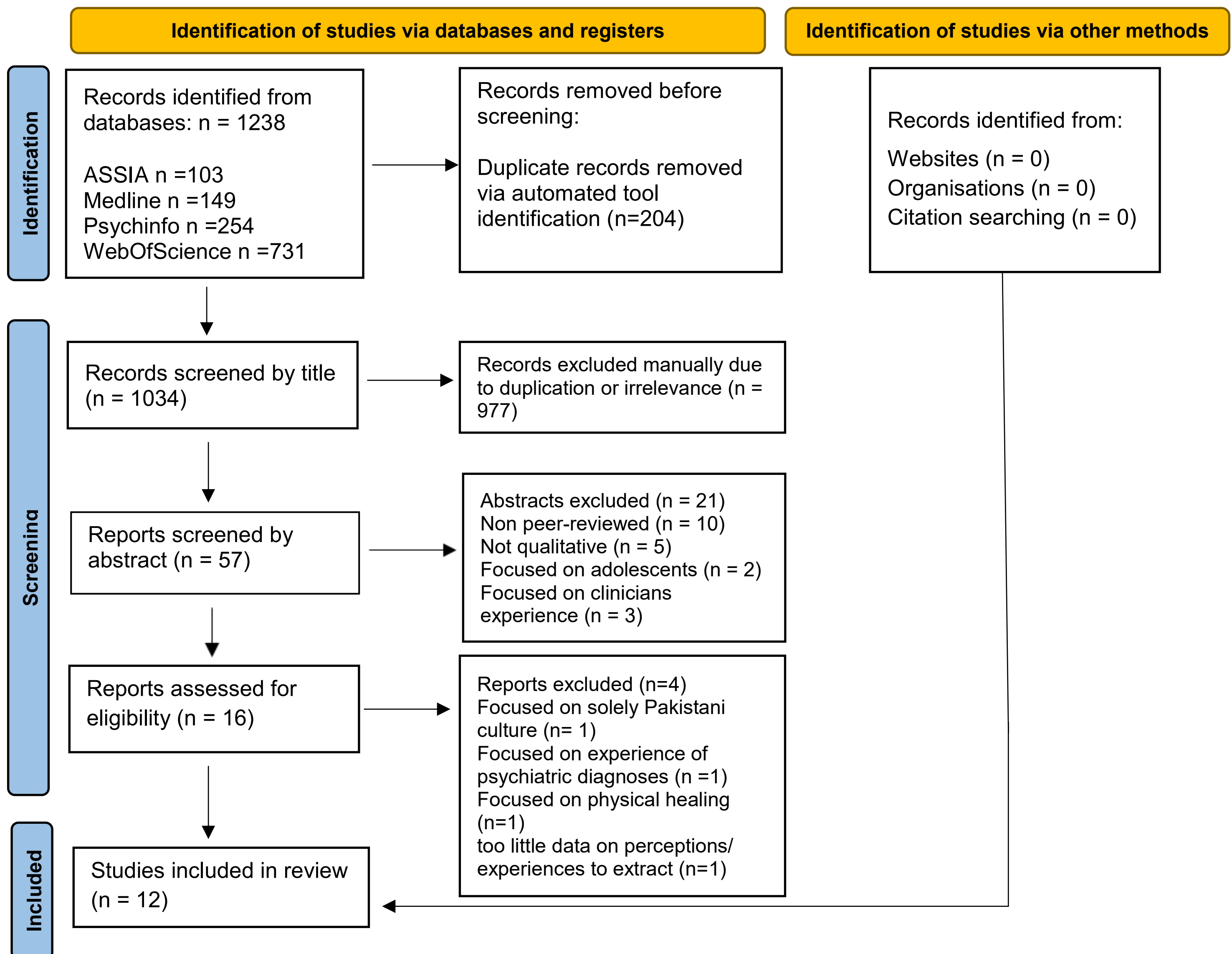
Boolean Operator	Search Terms	Field(s)
AND	Muslim*	All fields
AND	Therap* OR CBT or CMHT OR IAPT or talking therap* OR mental health OR psychology* OR counsel* OR help-seek* OR psychotherap*	All fields
AND	Qualitat* OR thematic analysis OR IPA OR grounded theory OR Discourse analysis OR narrative analysis OR content analysis OR mixed method* OR interview* OR phenomenology OR phenomenological OR focus group OR ethnography	All fields
AND	Perceptions OR attitude OR experience* OR view* OR thought* OR feeling* OR perspective* OR view OR belief*	All fields

Search terms were determined by scoping existing literature through Google Scholar and reading existing papers. The "SPIDER" approach (Cooke et al., 2012), guided the delineation of search areas. This identified the sample (Muslims), phenomenon of interest (therapy/psychology/mental health support), design (qualitative research type e.g. thematic analysis or IPA), evaluation (perception/experience), and research type (qualitative). Broader terms like 'help-seeking' and 'attitude' were included due to the scarcity of existing papers.

An automated tool removed exact duplicates, after which titles and abstracts were screened for relevance based on criteria in Table 1. Full texts were then assessed for eligibility. Backward searching involved reviewing references, and forward searching identified later works citing the selected papers. However, no new papers were found. The systematic search process, following PRISMA guidelines, is illustrated in Figure 1.

Figure 1

PRISMA diagram of Search Strategy



Study Selection

Studies were organised using RefWorks, with duplicates removed via its duplication tool. Additional duplicates were manually eliminated during the title screening phase, and papers related to Muslims' perceptions or experiences of MH support were retained. Abstracts were then screened based on inclusion criteria, with unclear cases moved to full-text screening. Papers failing to meet criteria during full-text review were excluded.

Quality Appraisal

NICE (2013) recommends using the Critical Appraisal Skills Programme (CASP) framework to evaluate qualitative research. While CASP is a useful tool, Long et al. (2020) note that quality assessments in qualitative research are inherently more subjective compared to quantitative studies. Due to the inherent subjectivity and experiential nature of qualitative research, it is important to apply a reflexive approach when utilising the CASP framework. To enhance the validity of appraisals, the author of this this review discussed uncertainties about appraisals with a colleague whilst bracketing preconceptions and biases.

Data Synthesis Approach

After critical appraisal, data was synthesised using thematic synthesis, in accordance with the three stages proposed by Thomas and Harden (2008). See the 'thematic synthesis' section for a detailed outline of this process.

Results

Overview of Studies

Upon screening, 12 studies were deemed to meet the criteria for this systematic review. Among the studies included, only one directly explored Muslim's perceptions of psychological services. Most studies explored Muslims' MH experiences and coping more broadly and three investigated Muslims' experience of a specific therapy model or intervention. Three papers also explored the role of faith in Muslims' coping and attitudes towards therapy and one explored the influence of Muslims' religious and cultural beliefs on the relationship with their therapist. Eight papers were based in western countries whilst the

remaining four were based in the Middle East. See Table 3 for a comprehensive summary of the studies.

Table 3

Summary of Selected Studies' Characteristics

	Author and Year	Study Aim	Participants & Demographics	Recruitment	Design and Analysis	Key Findings
1	Al-Dousari and Prior (2020)	To explore how counselling clients negotiated accessing counselling in the context of their communities, culture and faith	3 Female Muslim Kuwaiti counselling clients. Age range 28-39 years.	Recruited via WhatsApp groups and emails. All participants had experienced over a year of counselling	Qualitative. Semi structured interviews. Thematic analysis	Participants experienced stigma and shame when accessing MH support. Faith is a facilitator to accessing support. Refuted conception that MH difficulties are due to a lack of faith. Prayer and counselling are compatible. Muslims have a religious obligation to seek help. Understanding oneself strengthens faith.
2	Alnaji et al. (2023)	To explore postpartum Syrian refugee women's experiences and perceptions of postpartum depression (PPD) in a refugee camp in Lebanon	8 Syrian Muslim refugee females in Lebanon who experienced PPD	Recruited through social workers who worked with women at risk of poor mental health	Qualitative. Semi-structured interviews. Colaizzi's (1978) descriptive phenomenological analysis.	Superordinate themes included cultural perceptions of mental health help-seeking and coping with negative emotions. Participants used faith as a coping mechanism.

3	Bahattab and AlHadi (2021)	To examine the acceptance, feasibility, and clinical impact of Acceptance and Commitment Therapy (ACT) in a group format for Saudi Muslim women who struggle with depression and anxiety disorders.	8 Saudi Muslim females with Anxiety and/or depression	Recruited via psychologists or psychiatrists working at a Saudi university medical centre	Qualitative. Thematic analysis	Three superordinate themes: participants' perceptions of ACT; ACT in Saudi Culture and Islamic Society; Benefits of ACT.
4	Cinnirella and Loewenthal (1999)	To explore how religious beliefs impacted beliefs about MH difficulties, including the degree to which religious beliefs and practices were perceived to be a factor in interactions with professionals.	52 female participants of various religious backgrounds of which 13 were Pakistani Muslim	Recruited via contacting religious worship sites in London using a 'snowball' approach	Qualitative. Thematic analysis	Themes included: community stigma, prayer as a treatment for MH difficulties, pros and cons of seeking a professional of the same race or religion and, views on seeking help from religious figures.
5	Eltaiba and Harries (2015)	To explore how Muslim men and women perceived the causes of their mental health problems, sought help and how they experienced recovery.	20 Arab Muslims. Males (n=10) age range 24-45 years. Females (n=10). age range 21-50 years.	Recruited from the national centre of mental health in Jordan	Qualitative. Semi-structured interviews. Specific method of analysis is unclear.	Core themes included: the centrality of religion in participants' reflections on recovery, causation of MH difficulties and the link to coping and recovery and barriers to recovery.

6	Hammad et al. (2020)	To understand and address barriers of British Middle East and North Africa (MENA)-origin Muslims in accessing mental health services. To coproduce a culturally appropriate therapeutic group intervention. To assess the impact and participant experience of a coproduced culturally appropriate faith-informed therapeutic group intervention	16 Muslim Middle Eastern North African British females. Age range 36-84 years.	Recruited via collaborations between NHS MH services and third sector community organisations to support those affected by Grenfell Tower fire.	Qualitative. Focus groups. Thematic analysis.	Themes included: barriers to accessing MH services and therapy, shame and stigma attached to seeking MH support and barriers to support such as language barriers, formal delivery of therapy, mistrust, and cultural and religious insensitivity of therapists and/or services.
7	Pooremamali et al. (2012)	To explore the experiences and perceptions of Muslim clients who received occupational therapy as part of their MH care in Sweden.	11 Muslim middle Eastern MH clients (5 male, 6 female). Age range 22-67 years. All participants had been living in Sweden for over 5 years.	Recruited via occupational therapists working in MH services	Grounded theory	Core category found was ‘desiring a union’ which comprised three categories: desiring relationship, desiring affiliation and desiring affirmation. Participants highlighted topics like sameness and difference in the therapeutic relationship, the need for respect and relational issues that arise when trying to making sense of things using the therapeutic relationship.

8	Rayes et al. (2021)	To explore faith-based coping strategies among Arabic-speaking refugee adults seeking MH services in Germany. To explore how positive faith-based coping strategies can be utilised from a MH service-delivery and broader integration perspective.	17 Arab Muslim refugee adults (6 females, 11 males) seeking MH support in Berlin. Age range 22-47 years.	Participants were recruited from a MH clinic for refugees in Berlin.	Qualitative. Semi-structured interview. Grounded theory.	Four themes: 1) faith-based coping methods during fleeing, 2) changes in faith practices upon arrival, 3) faith-based coping methods to cope throughout integration, and 4) recommendations for MH providers.
9	Tarabi et al. (2020)	To explore Pakistani Muslim men's experiences of CBT and how they perceived the fit between Islam and CBT.	6 second-generation Pakistani Muslim men (SGPMM) who had completed individual weekly CBT in the UK	Recruited from Asian community charities in the UK. Sessions attended range (10-16).	Qualitative. IPA	Three superordinate themes: 1) pre-CBT difficulties, 2) the process of CBT, and 3) the interaction between CBT and Islam. The paper focused on the second superordinate theme and

		To support practitioners in being responsive to, and potentially tailoring their interventions to better meet this community's needs.	provided by qualified MH professionals. Age range 20-45 years.			its four sub-themes: experience of therapeutic dialogue, experience of therapist matching, and benefits of CBT and limitations of CBT.
10	Vandekinderen et al. (2022)	To explore cultural aspects and dynamics that affect the help-seeking process of Muslim and Turkish and Moroccan migrant women in Belgium.	12 Muslim females of Turkish or Moroccan background with MH difficulties.	Recruited via contacting women's refugee centres, welfare organisations, community health centres and MH services, general practices, psychologists and psychiatrists.	Qualitative. Semi-structured interviews. Content analysis	(1) negotiating gendered taboo in complex perceived communities; (2) restrictions and agency in education, employment, and finances; and (3) religion as meaning making.
11	Weatherhead and Daiches (2010)	To explore how a heterogenous group of Muslims in the UK conceptualise mental health and how MH distress should be addressed.	14 Muslims living in North-West England (7 males, 7 females). Age range 28-77 years. Participants had a range of ethnic backgrounds (10 first generation migrants, 4 second generation)	Recruited via the University of Lancaster Islamic Society and local Muslim organisations.	Qualitative. Semi-structured interviews. Thematic analysis	Seven operationalising themes: 1) causes, 2) problem management, 3) relevance of services, 4) barriers, 5) service delivery, 6) therapy content and 7) therapist characteristics.

12	Whittaker et al. (2005)	To explore individual and collective understandings of mental wellbeing among young Muslim Somali asylum-seeking and refugee women in living in northern England.	5 asylum seeking or refugee Muslim women born in North Somalia that entered the UK as children or adolescents and lived in the UK for over a year. Age range 17-25 years.	Recruited via voluntary sector Somali training and community centre in northern England.	3 focus groups. 5 individual semi-structured interviews. Qualitative IPA.	Three superordinate themes: 1) resilience and protection with sub-themes of 'getting on with it' approach and 'support', 2) Identity and beliefs with sub-themes of 'conflict and convergence', 'navigation and acculturation' and 3) concealment, secrets and distancing with sub-themes of 'concealing concepts and emotions' and 'secrets'.

Quality Assessment

Quality assessment of the selected papers will be outlined in sub-sections that correspond to the applicable parts of the CASP tool. See Table 4 for CASP ratings.

Research Aims and Design

All papers directly or indirectly outlined their research aims. A qualitative research design was suitable for the research aims of all the included studies. The most used methodology was thematic analysis (Al-Dousari & Prior, 2020; Bahattab & AlHadi, 2021; Cinnirella & Loewenthal, 1999; Hammad et al., 2020; Weatherhead & Daiches, 2010). Two studies used interpretative phenomenological analysis (IPA) (Tarabi et al., 2020); Whittaker et al., 2005). Al-naji et al., (2023) specified using descriptive IPA.

Two papers used grounded theory (Pooremamali et al., 2012; Rayes et al., 2021), and one used content analysis (Vandekinderen et al., 2022). Only one study did not clearly outline its research design (Eltaiba & Harries, 2015) and only stated that they used semi-structured interviews and produced themes. Another study only partially met the CASP criterion for appropriate research design as it did not provide justification for the selected design (Al-Dousari & Prior, 2020).

Recruitment and Participants

All 12 papers had robust recruitment strategies apart from Eltaiba and Harries's (2015) study which reported demographic information of their participants but did not detail the recruitment process. Three studies used purposive sampling (Alnaji et al., 2023); Rayes et al., 2021; Tarabi et al. 2020), two used snowball sampling (Al-Dousari & Prior, 2020; Cinnirella & Loewenthal, 1999) and one was used theoretical sampling (Pooremamali et al.,

2012). The remaining studies did not explicitly state their sampling strategy but from their description it was likely purposive (Bahattab & AlHadi, 2021; Hammad et al., 2020; Vandekinderen et al., 2022; Weatherhead &Daiches, 2010; Whittaker et al., 2005).

Eight studies recruited Muslim participants living in the following Western countries: England (Loewenthal, 1999; Hammad et al., 2020; Tarabi et al.,2020; Weatherhead and Daiches, 2010; Whittaker et al.,2005), Sweden (Pooremamali et al., 2012), Berlin (Rayes et al., 2021) and Belgium (Vandekinderen et al., 2022). The remaining four studies recruited Muslim participants living in the following Middle Eastern countries: Kuwait (Al-Dousari and Prior, 2020), Lebanon (Alnaji et al., 2023), Saudia Arabia (Bahattab &AlHadi, 2021), and Jordan (Eltaiba & Harries, 2015).

All studies appeared to recruit Muslims from a specific ethnic background except for Weatherhead and Daiches (2010) who recruited Muslims from a range of ethnic backgrounds. Most studies reported on participants' migrant status whether that was refugee, first or second-generation migrants. Al-Dousari and Prior (2020) and Bahattab and AlHadi (2021) did not report migrant status as they recruited participants in their respective home countries (Kuwait and Saudia Arabia). Cinnirella and Loewenthal (1999) did not report migrant status though they recorded ethnicity.

Seven studies recruited exclusively female participants, whilst only three studies demonstrated an equal distribution of male and female participants (Eltaiba and Harries, 2015, Pooremamali et al., 2012; Weatherhead and Daiches,2010). The exceptions to this were Rayes and colleague's (2021) who recruited male participants at a ratio twice that of female participants and Tarabi et al., (2020) who recruited exclusively males.

Three studies exclusively examined Muslims' perceptions of accessing MH support (Alnaji et al., 2023; Cinnirella & Loewenthal, 1999; Whittaker et al., 2005) whilst five studies covered Muslims' experiences of accessing MH services and receiving the following intervention: counselling (Al-Dousari and Prior, 2020), Acceptance and Commitment Therapy (ACT) (Bahattab and AlHadi, 2021), culturally appropriate faith-informed therapeutic group (Hammad et al. (2020), Cognitive Behavioural Therapy (CBT) (Tarabi et al., 2020); occupational therapy (Pooremamali et al., 2012); stepped outpatient MH care (Rayes et al., 2021); and psychiatric outpatient care (Eltaiba and Harries (2015). Two studies recruited a mixture of participants; some who had not accessed MH services but reported their perceptions, and others who had accessed them and reported their experiences (Vandekinderen et al., 2022 and Weatherhead and Daiches, 2010).

Data Collection

Most studies had robust data collection strategies with two studies only partially meeting the CASP criteria as they did not justify their chosen data collection method: semi-structured interview (Al-Dousari & Prior, 2020) and semi-structured focus groups (Hammad et al.,2020). Ten studies provided some level of detail about the questions employed during data collection. Five studies reported the topic areas explored in interview questions (Al-Dousari & Prior., 2020; Alnaji et al., 2023; Cinnirella & Loewenthal, 1999; Vandekinderen et al.,2022; Whittaker et al., 2005) and a couple included sample questions (Hammad et al., 2020; Pooremamali et al. ,2012). Two papers included interview schedules in appendices (Rayes et al., 2021; Tarabi et al., 2020) and one study included the interview schedule in the body of the paper (Bahattab & AlHadi., 2021). Two papers did not provide any detail about the contents of their data collection strategies apart from the interview was peer reviewed and piloted (Eltaiba & Harries, 2015) or the interview was developed according to relevant

literature (Weatherhead & Daiches, 2010). This lack of transparency makes the quality assessment of these studies' data analysis and findings more difficult.

Only one study discussed data saturation (Pooremamali et al., 2012), leaving it unclear as to how other studies determined whether their results were representative of Muslim communities' perceptions and experiences.

Data Analysis and Findings

Ten out of 12 studies were deemed to have sufficient data analytic rigour due to their in-depth description of their analysis process and clear outline of how themes and categories were produced from the data. One study only partially met the CASP criterion due to a lack of in-depth description of the analysis process (Al-Dousari & Prior, 2020). The analysis and theme development method in the remaining study (Eltaiba and Harries, 2015) were unclear, as the researchers only mentioned that NVivo was used for coding. However, they presented sufficient participant interview excerpts to support their themes, including contradictory perspectives. Due to the lack of clarity regarding this study's analytical rigour, its findings will be interpreted with caution.

Out of eight studies which used thematic analysis or IPA, all bar one had an appropriate number of participants according to the research design. The exception for this, Al-Dousari and Prior (2020), only had three participants and employed thematic analysis, which some may consider too small a sample for this method (Clarke & Braun, 2013).

Findings

All papers explicitly stated their findings and discussed these in the context of their original research question(s) and in relation to the relevant literature. All studies evaluated the

implications of their research, bar two papers which failed to offer discussion on implications or recommendations for subsequent research and practice (Cinnirella & Loewenthal, 1999; Eltaiba & Harries, 2015). All studies discussed their limitations except for two (Bahattab & AlHadi, 2021; Eltaiba & Harries, 2015).

Eight studies were found to have satisfied the credibility of findings criterion by employing more than one analyst. Of these eight, four studies explicitly addressed credibility and met them in the following way: cultural informant validation (Alnaji et al. ,2023); triangulation (Rayes et al., 2021; Whittaker et al. ,2005); respondent validation (Tarabi et al., 2020; Weatherhead and Daiches. 2010). Eltaiba and Harries (2015) did not provide information regarding data analysis methodology or process used, making it difficult to appraise the credibility of their conclusions.

Reflexivity and Ethics

Inherent to qualitative research is the understanding that the creation of knowledge is inherently subjective and that researchers cannot separate their data analysis and interpretations from their own personal values and life experiences (Groenewald, 2004). Therefore, reflexivity is a critical component of qualitative research (Lazard & McAvoy, 2020).

Of the 12 studies, seven considered the relationship between researcher and participant. Five of these studies used the following methods to address this: discussion of positioning and potential impact (Alnaji et al., 2023); research journal for bracketing (Whittaker et al., 2005); discussion of positioning and having researchers from different backgrounds (Pooremamali et al. , 2012); discussion of positioning, potential bias and use of research supervisor to quality check procedures and findings (Tarabi et al. 2020); critically

discussed personal, epistemological and ontological positioning (Vandekinderen et al., 2022). Two studies only partially met this CASP criterion as they mentioned their positioning and the relationship between researcher and participant but could have expanded on this and discussed the methods used to facilitate this reflexivity (Hammad et al., 2020; Rayes et al., 2021). It was unclear whether Weatherhead and Daiches (2010) met the criterion as they mentioned the researchers' context but did not provide information on how this might influence or bias their research. Four studies did not mention reflexivity at all (Al-Dousari & Prior., 2020; Bahattab & AlHadi, 2021; Cinnirella & Loewenthal, 1999; Eltaiba & Harries, 2015). It is unclear whether bias, and to what degree, has affected these studies. Therefore, the credibility and findings of these studies should be approached with caution.

All studies clearly considered ethical issues except for one (Cinnirella & Loewenthal, 1999). Four studies did not provide information on participant confidentiality and right to withdraw (Alnaji et al., 2023; Eltaiba & Harries, 2015; Rayes et al., 2021; Weatherhead & Daiches, 2010). All studies declared no conflict of interest except for two (Cinnirella & Loewenthal, 1999; Eltaiba & Harries, 2015).

Value of Research

According to the CASP framework, research is considered valuable if the researcher outlines the study's contribution to existing literature, highlights potential research directions, or discusses how findings can be applied to other populations. All the studies satisfied at least one of these criteria, usually by outlining the contribution of the study's findings to existing research.

Summary

All 12 studies were included in this thematic synthesis, despite some receiving poorer quality appraisals. For instance, Eltaiba and Harries (2015) did not state their data analysis method, a key component of a research paper's credibility and robustness. The lack of clarity also made it difficult to appraise other components of the study. However, the inclusion of this paper was warranted, given the limited research in this area and the importance of considering even lower-quality studies. Despite its unclear rigour, the study provided valuable direct quotes and personal accounts, contributing to the thematic synthesis. Despite this, careful consideration was given during the analysis to ensure that the inclusion of less robust studies did not distort the final themes.

Table 4

CASP Quality Checklist Results

Author & Date	Clear statement of the aims of the research?	Qualitative methodology appropriate?	Research design appropriate to address aims of the research?	Recruitment strategy appropriate to the aims of the research?	Data collected in a way that addressed the research issue?	Relationship between researcher & participants adequately considered?	Ethical issues been taken into consideration?	Data analysis sufficiently rigorous?	Clear statement of findings?	How valuable is the research?
Al-Dousari and Prior (2020)	Yes	Yes	Can't tell	Yes	Partially	Partially	Yes	Yes	Yes	Yes
Alnaji et al. (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bahattab and AlHadi, (2021)	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes
Cinnirella and Loewenthal (1999)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Eltaiba and Harries (2015)	Yes	Yes	Partially	Yes	Yes	No	Yes	Can't tell	Partially	Yes
Hammad et al. (2020)	Yes	Yes	Yes	Yes	Partially	Partially	Yes	Yes	Yes	Yes
Pooremamali et al. (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rayes et al. (2021)	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes
Tarabi et al. (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Vandekinderen et al. (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Weatherhead and Daiches (2010)	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes
Whittaker et al. (2005)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Thematic Synthesis

Thematic synthesis was used to aggregate existing qualitative research findings (Thomas & Harden, 2008). This method involves the analysis of included studies' results, which are systematically coded to identify themes across the data. This review considered all data within the studies' results sections including participant quotes and researcher's interpretations. An inductive strategy was utilised, allowing the data to guide the analysis, rather than relying on established research or theoretical frameworks.

To begin, the researcher became familiar with the studies under review. The studies' results sections were then imported into NVivo, a software used for qualitative data analysis, for line-by-line coding that closely aligned with the original data. This produced 123 initial raw codes which were grouped according to similarity in meaning and content to produce descriptive codes. Themes and sub-themes were then developed by comparing descriptive codes. A colleague with research training reviewed a randomly chosen subset of three papers to validate the coding accuracy. The codes were examined, and consensus was reached. The studies' results sections were re-read and codes were revised with new codes introduced and existing ones discarded. Subsequently, descriptive themes were revised with some being collapsed and re-created. This led to the formulation of interpretive themes with the relevance and frequency of each being considered to determine the final analytic themes.

The final thematic analysis produced three themes and nine subthemes (Table 5). A distribution of themes is presented in Table 6. See Appendix A for themes, sub-theme, code examples and illustrative quotes.

Table 5

Thematic Synthesis Themes and Subthemes

Theme	Subtheme
Therapy's Not for Us: Barriers.	Stigma
	Causal Beliefs
	Lack of Appropriate Services
	Alienation
Relationship Between Therapy and Islam	Therapeutic Value of Practicing Islam
	Islam and Therapy Go Hand in Hand
Therapy Can Be helpful: Facilitators	Culturally Sensitive and Faith Informed services
	Therapist Characteristics
	Perceiving Accessing MH Care as a Religious Obligation

Table 6

Theme Distribution

	Therapy's Not for Us: Barriers				**Relationship Between Therapy and Islam**			**Therapy Can Be Helpful: Facilitators**	
	Stigma	Causal Beliefs	Lack of Appropriate Services	Alienation	Therapeutic Value of Practicing Islam	Islam and Therapy Go Hand in Hand	Culturally Sensitive and Faith Informed Services	Therapist Characteristics	Perceiving Accessing MH Care as a Religious Obligation
Al-Dousari and Prior (2020)	✓	✓				✓			✓
Alnaji et al. (2023)	✓				✓				
Bahattab and AlHadi, (2021)						✓	✓		
Cinnirella and Loewenthal (1999)	✓	✓			✓			✓	
Eltaiba and Harries (2015)	✓	✓			✓	✓			✓
Hammad et al. (2020)	✓	✓	✓	✓	✓	✓	✓	✓	
Pooremamali et al. (2012)	✓		✓	✓				✓	
Rayes et al. (2021)		✓	✓		✓			✓	✓
Tarabi et al. (2020)	✓		✓				✓	✓	
Vandekinderen et al. (2022)	✓	✓	✓	✓	✓	✓		✓	
Weatherhead and Daiches (2010)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Whittaker et al. (2005)	✓	✓	✓	✓	✓	✓	✓	✓	✓

Therapy's Not for Us: Barriers

Stigma

Stigma was noted in all but two studies. Some participants labelled those accessing MH services as "*mad*," "*crazy*," or "*psycho*," highlighting strong negative connotations surrounding MH care and its frequent association with severe MH issues.

> *"I wouldn't go and ask for help . . . I feel embarrassed and ashamed to ask for help." (*Hammad et al., 2020)

Participants reported social consequences of having MH issues, such as rejection from their community.

> *"if people know about it [MH issues] they will not accept them and they'll be laughed at and would be completely shut off." (*Cinnirella & Loewenthal, 1999)

MH care was viewed as so taboo that seeking professional support was seen as betraying the community. Participants had to navigate tensions between cultural values of family care and secular concepts of professional care.

> *"they'll have to put her into a homecare. . . the community will say… You're kind of, abandoning her… they'll say that you disown your own blood. So… they're going to disown you as well."* (Whittaker et al., 2005)

Muslims were found to experience multiple layers of stigma, compounding fear and ostracisation.

> *"One Muslim participant felt that the white community has rejected her community,*

*and that this leaves Asians especially concerned not to be rejected by their own community as well, and thus may reduce the likelihood that they seek help. This suggests that where ethnic minorities feel stigmatized by the majority group, then this might make fear of community stigma especially intense." (*Cinnirella & Loewenthal, 1999)

Participants' attitudes toward seeking MH support were influenced by their cultural values and experiences from their countries of origin.

When we are growing up back home it is taught that we should not talk about our family problems to anybody outside the house. (Cinnirella & Loewenthal, 1999)

Causal Beliefs

This theme highlights participants' beliefs about the causes of MH difficulties, which can hinder access to professional support. Some viewed their MH issues as part of a destiny ordained by God, believing that recovery should rely solely on patience and prayer.

*"The illness is Allah's will. Allah says "And when I am ill, it is He Who cures me" (26:80). We have to be patient... We can do nothing except making Dua [prayer]." (*Eltaiba & Harries, 2015)

Lack of faith or sinfulness as a causal belief was also reported by participants either as a belief they identified with or suffered the stigmatising consequences of.

"People link accessing counselling to the strength of your faith. They would say… of course… she's sinful. That's why she goes to counselling." (Al-Dousari & Prior, 2020)

Some participants believed that MH issues were the will of God and that only divine intervention could help. They felt that Muslims could directly ask God for assistance, rendering professional help unnecessary.

> *"…Whatever happens is from Allah, and so a creation of Allah cannot help"* (Weatherhead & Daiches, 2010)

> *"….in our religion we can talk to God directly, we don't need help from anyone. . ."* (Cinnirella & Loewenthal, 1999)

Four studies identified jinn (spirit) possession as a causal belief for MH difficulties. Some participants believed that spiritual doctors could treat this possession using religious scripture and practice.

> *"I went to a doctor in the village who uses Quranic verses to heal you... to discover whether there are evil spirits..."* (Vandekinderen et al., 2022)

However not all participants believed that MH difficulties are due to spiritual problems and attributed these beliefs to a lack of education.

> *". . .{if their family} back home is like that and they believe in holy man and things like that. . .but educated people will avoid this."* (Cinnirella & Loewenthal, 1999)

Lack of Appropriate Services

Participants reported that MH services often failed to consider their cultural and religious contexts, causing them to find therapy irrelevant and unrelatable.

> *"I didn't feel like I could relate to her [therapist] and like she could understand my culture."* (Hammad et al., 2020)

Participants were frustrated by services that overlooked their cultural values of collectivism and family interdependence, instead prioritising Western notions of independence.

> *"[It's] important that they… understand Arab culture…happiness comes from a societal perspective... family is one of the most important pillars of happiness"* (Rayes et al, 2021)

There was a desire for MHPs to respect and support their cultural and religious coping mechanisms.

> *"... I do not think it is realistic that people from all over the world must follow the same norms and rules.... if I am happy to do this activity let me do this in my own way."* (Pooremamali et al., 2012)

Participants felt a mismatch between what MHPs considered valuable and what they valued as Muslims. They believed that Western services overlooked the role of faith in their lives, making mainstream interventions feel meaningless.

> *"The Swedish therapist does not understand my thinking and beliefs ... by going to mosque and praying I try to find a balance and meaning of life"* (Pooremamali et al., 2012)

Participants found it challenging to engage with MHPs due to the formal nature of interactions. This formality seemed to reinforce a power dynamic and may have intensified stigma and shame.

"I would prefer that the therapist is not formal, and they are not in a position where they are the professional, and we are like a sick person." (Hammad et al.,2020)

The lack of MH support in participants' native language created communication barriers, leading to reluctance to engage with services and limiting their effectiveness.

"If, doctors or… nurse came… they're still talking to her, I don't think she understood what they were saying" (Whittaker et al., 2005)

Some participants stressed the importance of linguistic connection in therapy, noting that some emotions could only be expressed in their native language, raising doubts about a non-native-speaking therapist's understanding.

"... I cannot talk about my soul… with someone who does not speak my language ... therefore there is always a feeling of insecurity" (Pooremamali et al., 2012)

One participant found therapy ineffective due to frequent interpreter changes with different dialects. This hindered communication and disrupted the development of safety and trust.

Alienation

Participants described feeling "isolated" by MH services unsure of how to access them and questioning whether these services were designed for or welcoming to them.

"…We thought that service was… only for, you know… white community and not for us." (Whittaker et al., 2005)

Participants feared Islamophobia and negative stereotypes would also be present in

MH services, making them feel unsafe to be authentic in therapy (Pooremamali et al., 2012; Weatherhead & Daiches, 2010).

> *"I am…worried to be considered different, therefore I pretend to be another person"* (Pooremamali et al., 2012)

Relationship Between Therapy and Islam

The relationship between participants' religion and their attitudes to and experiences of MH support was present in all studies.

Therapeutic Value of Practicing Islam

Five papers highlighted Islam's key role in participants' lives, with faith providing comfort and enhancing psychological well-being during MH challenges.

> *" Reading or hearing Quran cools (calms) the nerves."* (Rayes et al., 2021)

> *"[practicing Islam] gives peace of mind"* (Weatherhead & Daiches., 2010)

Participants saw Islam as a therapeutic tool and their first response to psychological distress, describing it as "*like a medicine for life*" (Whittaker et al., 2005). The principle of *"submission to the will of Allah"* helped them accept and manage difficulties (Weatherhead & Daiches, 2010), with additional benefits from religious ceremonies, supplications, community support, and guidance from faith leaders.

> *"when we have a problem, we concentrate on it and talk to Allah about it and ask for help from Him. When someone has faith in Allah… it lifts all sorrow and gloomy moods because the person is sure that Allah knows they have asked for help, and He*

will help them. It brings positiveness in life." (Cinnirella & Loewenthal, 1999)

Quranic scripture and Islamic principles provided comfort, helping participants find meaning in their struggles and focus on a greater purpose.

"*To believe in Allah, to know, that everything stems from Allah. I know that he protects everyone. When bad things happen to me, it doesn't mean that He doesn't love me, but that He wants to protect me from other things… We are put to a test in this world to decide if we go to paradise or to hell."* (Vandekinderen et al., 2022)

Islam and Therapy Go Hand in Hand

Seven papers highlighted that participants viewed Islam and MH support as complementary, with therapy aligning with Islamic values by improving self-awareness, well-being, and religious practice.

"Faith and counselling are two parallel lines that work together not against each other… Just like when you have an illness like cancer, you can't be strong enough to pray and fast and worship God, as strong as when you're fully healthy. So, the same applies for your psychological state!" (Al-Dousari & Prior, 2020)

Participants noted that Islamic teachings align with therapy models like ACT, with Islam's emphasis on acceptance reinforcing therapeutic principles (Bahattab & AlHadi, 2021).

"*…we were given therapeutic strategies and concepts that we have already practiced and believed."* (Bahattab & AlHadi, 2021)

Therapy Can Be Helpful: Facilitators

This theme captures participants' views that accessing professional psychological support can be helpful with certain conditions.

Culturally Sensitive and Faith Informed Services

Many participants expressed wanting services to understand their cultural and religious background and go beyond this by incorporating these into interventions.

> "*The therapist needs to understand and include my religion otherwise I wouldn't be able to relate*." (Hammad et al., 2020).

Incorporating Islamic principles and prophetic stories helped participants adopt a positive outlook on their struggles, normalising psychological distress and reducing shame and stigma (Hammad et al., 2020).

> *". . . the prophets had a hard time before us… this makes us feel accepting of our problems and have more sabr (perseverance)"* (Hammad et al., 2020).

Participants valued collectivist healing practices like group drumming, singing, and cooking, finding them enjoyable, relaxing, and effective for emotional expression, particularly for those lacking the language to convey their feelings (Hammad et al., 2020).

> *"When you share food with someone, it's very close like your family and you respect them, you feel happy and you trust."* (Hammad et al., 2020)

Group interventions alleviated feelings of isolation among Muslims, providing a sense of connection that is particularly valuable for migrant Muslims living in Western countries,

where they may be separated from their extended families

> *"This group has given me what I miss in my life, because in this country we are isolated… The group was similar to the family life I had."* (Hammad et al., 2020)

Therapist Characteristics

A significant subtheme across studies was the desired characteristics of a MH clinician. In four studies, participants preferred therapists who shared their cultural or religious background, believing that such clinicians would better understand their social, religious, and cultural contexts without needing extensive explanation (Rayes et al., 2021). Participants felt these contexts were integral to their MH challenges, necessitating a clinician who inherently grasped them.

> *"I think our depression is different to a white person because our circumstances are different. Our personality is different, our family background is different."* (Cinnirella & Loewenthal, 1999)

> *"I feel like you get me, I don't have to explain my culture and religion to you."* (Hammad et al., 2020)

Some participants believed that having a Muslim therapist would allow for the integration of religious scripture and teachings into therapy, resulting in an optimal combination of secular and religious approaches.

> *"It is good to take… a counsellor with the same faith, because he will give you tips on both ways."* (Weatherhead & Daiches, 2010)

Not all participants shared this view. Some felt torn between wanting a Muslim therapist's understanding and fearing that their familiarity with the community might compromise confidentiality.

> "*Although they will be able to talk to such a person, at the same time they will be afraid of him, so reassurance of confidentiality is very, very important*" (Cinnirella & Loewenthal, 1999)

Another challenge of having a Muslim therapist was participants' belief that discussing taboo topics conflicting with religious or cultural beliefs was unacceptable. This mirrored the stigma they faced from their community, leaving them unable to fully express their concerns or seek guidance without fear of judgment (Weatherhead & Daiches, 2010).

> *"I was talking about sex and…she said… professionally what you're saying to me is fine. Personally… my heart kind of bleeds for you with everything you're doing, and I just thought how can you say that?"* (Tarabi et al., 2020)

Some participants felt that a therapist's religious background was irrelevant as long as they possessed essential skills, such as approachability, empathy, and transparency (Weatherhead & Daiches, 2010).

Participants wanted therapists to respect their religion and show curiosity, believing this would lead to more relevant and helpful questions (Pooremamali et al., 2012).

> *"…they (therapists) need to show that they really really respect our religion."* (Weatherhead Da&iches, 2010)

'Participants asked that non-Somali people "*learn a little about their culture"'*

(Whittaker et al., 2005)

Perceiving Accessing MH Care as a Religious Obligation

In five studies, participants saw seeking professional MH support as a "*religious obligation*" (Eltaiba & Harries, 2015), in line with Islamic teachings on self-care.

> *"Not accessing help is against faith. If you are genuinely practising the teachings of Islam, then it says, "Do not throw yourselves with your own hands into destruction." You need to take all possible means to be better. Our religion encourages us to ask for help." (*Al-Dousari & Prior, 2020)

Some participants emphasised that fulfilling religious duties for psychological well-being requires actively seeking professional support, not just relying on prayer.

> "*That's why I came to the clinic. We have to make efforts to improve."* (Eltaiba & Harries, 2015)

> *If I am sitting at home and wait for God to treat me. God will not send us treatment in an envelope."* (Rayes et al., 2021)

Discussion

The aim of the current review was to systematically review qualitative literature on Muslims' perceptions and experiences of accessing MH services. Thematic synthesis of the findings of 12 empirical studies produced three themes and nine subthemes.

The theme **Therapy's Not for Us: Barriers** revealed that Muslims encounter various systemic, institutional, cultural, and conceptual barriers to accessing MH services. The first

subtheme, shame, is well-documented in the literature. Pilkington (2011) notes that British South Asian Muslims often experience high levels of **shame**, reducing their likelihood to seek MH services. This barrier is also present among individuals of Middle Eastern and North African (MENA) descent in the West (Aloud & Rathur, 2009) and within the MENA region itself (Rayan & Jaradat, 2016). Youssef and Deane (2006) suggest this may stem from cultural taboos against disclosing personal or familial issues outside the community.

Consistent with the literature, Muslims' **causal beliefs** about MH difficulties can also act as a barrier to accessing MH services. Research suggests that many Muslims associate MH issues with supernatural elements, leading them to seek help from religious leaders and healers instead of MH services (Algahtani et al., 2019; Khalifa et al., 2011; Naeem et al., 2016).

Research indicates that beliefs in Jinn (spirit) possession are common among Muslims regarding MH, irrespective of their residence in Muslim-majority or Western countries, particularly for more acute MH symptoms (Al-Adawi et al., 2002; Hamid and Furnham, 2013). However, these beliefs vary by community, with up to 80% of UK Muslims endorsing them compared to only 17% of Saudi Muslims (Hussein, 1991). Evidence also suggests that younger and more educated Muslims are less likely to hold these supernatural beliefs (AlKrenawi et al., 2000; Alharbi et al., 2023).

Other common causal beliefs amongst Muslims frame MH challenges as divine interventions, either as punishment for moral failings or tests of endurance and faith (Aloud & Rathur, 2009; Heath et al., 2016; Padela et al., 2011). This review corroborates existing research showing that such beliefs often foster coping strategies emphasising independence and privacy, which can heighten feelings of shame and reduce help-seeking (Fakhr El-Islam,

2008). Further support for causal beliefs as a barrier is found in Fakhr El-Islam's (2008) work, which discusses how the belief in predestination, seeing all events as God's will, can lead some Muslims to think that MH symptoms arise and resolve solely through divine will. This perspective may hinder proactive problem-solving efforts.

This review produced similar findings to the literature with regards to the **lack of appropriate services** for those from ethnic minorities generally (van Loon et al., 2013) and Muslims more specifically (Arday, 2018; Mental Health Foundation, 2018; Woods-Giscombe et al., 2016). Many Muslims believe that conventional MH services fail to be culturally or religiously sensitive, rendering them irrelevant (Hammad et al., 2020). Numerous studies have found that Muslims want services that understand their religion and culture and requested their Islamic beliefs to be integrated into psychological treatments (e.g., Gilbert & Parkes, 2011; Yamada et al., 2019).

The formality of mainstream MH services was perceived by some as culturally inappropriate due to the power dynamics it creates (Padela et al., 2012). Research by Memon et al. (2016) and Arday (2018) found that ethnic minority clients in the UK view the healthcare provider-service user relationship as characterised by power imbalances, creating further barriers to MH services. Similarly, Hassan et al. (2016) noted that many Muslim Syrian clients felt marginalised by the authoritative approach of MHPs.

Language barriers can also be a significant barrier to some Muslims accessing MH services. Hammad et al. (2020) found that some Muslims felt uncomfortable with therapy conducted in English or even through interpreters, as dialect differences and inconsistencies among interpreters often failed to bridge this gap. This corroborates existing literature on the difficulties some Muslims face when expressing emotions in English compared to their native

languages (Abu-Ras, 2003; Arday, 2018; Inayat, 2005; Memon et al., 2016).

The subtheme **alienation** highlights Muslims' feelings of isolation from mainstream MH services. Many report distrust of services (Arday, 2018; Hammad & Hamid, 2021; Youssef & Deane, 2006) and concerns about confidentiality (Youssef & Deane, 2006). Government-led counter-radicalisation initiatives, like Prevent, have increased surveillance on Muslims, even in healthcare settings, creating further barriers to care (Younis & Jadhav, 2019; Heath-Kelly & Strausz, 2018). Muslims' fears of negative stereotyping and cultural misunderstandings are likely worsened by these initiatives and political rhetoric, further deterring access to MH services (Erickson & Al-Timimi, 2001).

The theme **Relationship Between Therapy and Islam** includes two subthemes: **the therapeutic value of practising Islam** and **Islam and therapy go hand in hand**. Islam is central to many Muslims' psychological well-being, with research showing its protective role in MH (Dein et al., 2018; Dein & Illaiee, 2013). Tedeschi (1999) found that religion aids meaning making, reducing psychological distress and fostering resilience. Studies show using examples from the Qur'an, hadith and prophets reduces Muslims' distress and negative religious coping whilst enhancing optimism, resilience, personal growth and emotional expression (Azhar et al., 1994; Azhar & Varma, 1995; Mir et al., 2015). This may explain why Muslims often turn to traditional coping mechanisms, such as prayer and religious healers, instead of mainstream MH services (Aloud & Rathur, 2009; alHarbi et al., 2023).

Whilst many Muslims grapple with the tension between secular approaches and religious approaches to MH (Sheikh & Gatrad, 2002; alHarbi et al., 2023), some express that these are not mutually exclusive and that in fact **Islam and therapy go hand in hand**. Al-Habeeb (2003) discusses how Islamic teachings support integrating contemporary

psychological treatments with Islamic approaches, a view increasingly endorsed by Muslim scholars and practitioners (Haque et al., 2016; Keshavarzi & Haque, 2012; Rothman & Coyle, 2018; Skinner, 2018).

The third theme, **Therapy Can Be Helpful: Facilitators**, included three subthemes, with the first being **culturally sensitive and faith-informed services**. Muslims who access culturally adapted and faith-informed interventions demonstrate significantly better outcomes compared to those using mainstream MH services that lack cultural or faith-based approaches (Hammad et al., 2020; Naeem et al., 2015). For example, Mir et al. (2019) found that culturally and faith-adapted behavioural activation interventions significantly improved recovery rates for Muslims. Adaptations included integrating religious beliefs and values beneficial to clients, such as: using Islamic teachings to frame hardships as tests for acceptance; emphasising God's merciful characteristics to enhance self-compassion; and reframing Islamic principles such as patience from merely enduring hardship to seeking help while being patient. Many Muslims come from collectivist cultures where communal practices enhance psychological well-being (Mohammed et al., 2010). This review's findings support existing literature highlighting the psychological benefits of communal activities, such as singing (Daykin et al., 2018), cooking and food-sharing (Mundel & Chapman, 2010), and drumming (Núñez, 2016).

The second subtheme **therapist characteristics** outlines the traits Muslims seek in therapists to improve engagement with MH services, with many preferring therapists of the same faith. Studies indicate that Muslims prefer therapists of the same faith, believing they have a deeper understanding of clients' needs, especially in minority settings where non-Muslim practitioners are common (Cinnirella & Loewenthal, 1999; Khalifa et al., 2011). A therapist well-versed in Islam is thought to better integrate religious beliefs into treatment,

emphasising religious practices that provide solace alongside psychological therapy (Cinnirella & Loewenthal, 1999; Khalifa et al., 2011; Weatherhead & Daiches, 2010).

The review found contrasting views regarding the therapist being Muslim, due to concerns about judgement and confidentiality. This tension is reflected in the literature on religious matching in therapy. For example, McLaughlin et al. (2022) found that their sample of American Muslims had mixed feelings about the ethnic or religious background of their therapist. However, those experiencing higher levels of Islamophobia and U.S.-born participants tended to prefer a Muslim therapist. The authors suggest this preference may stem from the perception that a Muslim therapist would be more relatable and aligned with their faith, reducing concerns about religious discrimination.

The third subtheme **perceiving access to mental health care as a religious obligation**, highlights how viewing MH support as a religious duty can facilitate help-seeking among Muslims. Rooted in Islamic teachings on self-care and balancing responsibility with trust in God, the concept is often illustrated by the phrase "tie your camel". This principle encourages Muslims to seek practical solutions like professional care while maintaining faith that the outcome is in God's hands. By doing so, Muslims fulfill their religious duty of self-care, combining proactive action with spiritual trust (Rassool, 2016; Ypinazar & Margolis, 2006).

Clinical Implications

Findings from this review underline several strategies to reduce stigma and improve MH service accessibility for Muslims. Integrating MH services into primary care settings and non-clinical spaces, such as community centres and mosques, can enhance accessibility and engagement (Brunelle et al., 2013; Rowan et al., 2021). Collaborations with Imams and

religious leaders as cultural consultants can build trust and bridge gaps in understanding (Ali, 2016; British Psychological Society [BPS], 2018).

Community engagement and co-production are crucial for tailoring services to community needs. Partnerships with mosques and grassroots organisations can foster culturally relevant interventions that integrate creative arts, faith, and collectivist practices. Activities like food-sharing and group therapy provide informal, supportive spaces that reduce isolation and encourage emotional expression (Hammad et al., 2020; Lane & Tribe, 2010; Mustafa et al., 2017).

In therapy, acknowledging and integrating Islamic beliefs is essential. Educating practitioners about these beliefs and incorporating Islamic teachings and prophetic stories into treatment can reduce stigma, enhance resilience, and improve outcomes for Muslim clients (Algahtani et al., 2019; Sabki et al., 2019). Service providers must prioritise cultural inclusivity through mandatory training in anti-racism and culturally sensitive care. Recruiting a diverse workforce reflective of the community and offering ongoing support for marginalised staff are critical for systemic change (Hammad & Hamid, 2021).

Future Research

Future research should explore the development of collaborative initiatives between mainstream professional MH services and Muslim faith leaders, such as joint clinics pairing MHPs and religious leaders (Musbahi et al., 2022). Research should also focus on documenting and evaluating culturally and faith-adapted therapeutic interventions to ensure their replicability and effectiveness (Hammad et al., 2020).

Further research is needed to investigate how key aspects of Muslim psychological well-being such as faith-based coping, spiritual healing, and communal support can be integrated into therapeutic models. Given the diversity within the Muslim community, studies should also investigate how culturally relevant interpretations of MH and various indigenous healing practices can be integrated into faith-informed interventions, expanding beyond Western and Eurocentric frameworks.

Finally, outcome measures must be developed to evaluate the effectiveness of community-based interventions rooted in the intersection of culture and faith (Hammad et al., 2020; Haque & Keshavarzi, 2014).

Strengths and Limitations

This review explored both Muslims' perceptions and experiences in accessing MH support due to the paucity of research. However, its broad scope may limit its applicability, as perceptions can shift after interacting with MH services.

The review’s findings were based on studies that used a range of qualitative methodologies. Knafl and Breitmayer (1991) suggest that employing larger sample frames and a variety of methods can improve the validity of qualitative reviews by helping to mitigate the limitations associated with relying on a single qualitative analysis approach.

The qualitative nature of this review offers valuable insights into the issues deemed important by this sample. However, it is important to note that the findings cannot be generalised to the entire Muslim population. This review included studies based in both Eastern and Western countries, which at times produced differing results based on the samples’ distinct contexts. For instance, migrant Muslims may contend with issues such as

racism and culturally and religiously insensitive services whilst Muslims in their native land are able to practice their culture and religion as a norm and may have wider cultural and religious support. The lack of differentiation between first and later-generation migrants Muslims is a further limitation.

The transferability of results across Muslim communities in different countries may be limited, as the review only included studies published in English. This excludes potentially relevant research on Muslim communities published in other languages. Finally, this review included only published studies, potentially omitting valuable data from grey literature, such as Muslim MH charity reports (Pappas & Williams, 2011). This may limit diverse perspectives, underrepresent community insights, and contribute to publication bias (Franco et al., 2014).

Conclusion

This review sought to examine Muslims' perceptions and experiences of accessing professional MH support. The findings highlight that Muslims encounter various barriers however, their Islamic beliefs can also facilitate help-seeking. Future research is required to demonstrate how mainstream MH services can collaborate with Muslim communities to co-create more accessible, culturally relevant and faith-sensitive provisions.

References

Abdel-Khalek AM (2011). Religiosity, subjective well-being, self-esteem, and anxiety among Kuwaiti Muslim adolescents. Mental Health, Religion & Culture 14, 129–140. https://doi.org/10.1080/13674670903456463

Abi- Hashem, N. (2006). The agony, silent grief, and deep frustration of many communities in the Middle East: Challenges for coping and survival. In P. T. P. Wong & L. C. J. Wong (Eds.), *Handbook of Multicultural Perspectives on Stress and Coping* (pp. 457–486). Spring Publications. https://doi.org/10.1007/0-387-26238-5_20

Abu-Raiya, H. (2014). Western psychology and Muslim psychology in dialogue: Comparisons between a Qura'nic theory of personality and Freud's and Jung's ideas. Journal of Religion and Health, 53(2), 326-338. https://doi.org/10.1007/s10943-012-9630-9

Abu-Ras, W. (2003). Barriers to services for Arab immigrant battered women in a Detroit suburb. Journal of Social Work Research and Evaluation, 1, 49–65.

Al-Adawi, S., Dorvlo, A. S., Al-Ismaily, S. S., Al-Ghafry, D. A., Al-Noobi, B. Z., Al-Salmi, A., ... & Chand, S. P. (2002). Perception of and attitude towards mental illness in Oman. *International journal of social psychiatry*, *48*(4), 305-317. https://doi.org/10.1177/002076402128783334

Al-Dousari, Mounira, and Seamus Prior. "Islamic faith as a facilitator for accessing counselling: the experience of three Kuwaiti clients." *British Journal of Guidance & Counselling* 48, no. 6 (2020): 757-767. https://doi.org/10.1080/03069885.2019.1651823

Algahtani, H. M. S., Almulhim, A., AlNajjar, F. A., Ali, M. K., Irfan, M., Ayub, M., & Naeem, F. (2019). Cultural adaptation of cognitive behavioural therapy (CBT) for patients with depression and anxiety in Saudi Arabia and Bahrain: A qualitative study exploring views of patients, carers, and mental health professionals. *The Cognitive Behaviour Therapist*, *12*, e44. https://doi.org/10.1017/S1754470X1900028X

Alharbi, H., Farrand, P., & Laidlaw, K. (2021). Understanding the beliefs and attitudes towards mental health problems held by Muslim communities and acceptability of cognitive behavioural therapy as a treatment: systematic review and thematic synthesis protocol. *BMJ open*, *11*(6), e044865. https://doi.org/10.1136/bmjopen-2020-044865

Alhomaizi, D., Alsaidi, S., Moalie, A., Muradwi, N., Borba, C. P. C., & Lincoln, A. K. (2017). Abstract from 9th annual Muslim mental health conference an exploration of the help- seeking behaviors of Arab- Muslims living in the US: A socioecological model. Journal of Muslim Mental Health, 11(1), 61–63. https://doi.org/10.3998/jmmh.10381607.0012.102

Ali, O. M. (2016). The imam and the mental health of Muslims: Learning from research with other clergy. *Journal of Muslim Mental Health*, *10*(1). https://doi.org/10.3998/jmmh.10381607.0010.106

Ali, S. R., Liu, W. M., & Humedian, M. (2004). Islam 101: Understanding the religion and therapy implications. *Professional Psychology: Research and Practice, 35*(6), 635–642. https://doi.org/10.1037/0735-7028.35.6.635

Ali, S. (2015). British Muslims in numbers: A demographic socioeconomic and health profile of Muslims in Britain drawing on the 2011 census.

Altalib, H. H., Elzamzamy, K., Fattah, M., Ali, S. S., & Awaad, R. (2019). Mapping global Muslim mental health research: analysis of trends in the English literature from 2000 to 2015. Global Mental Health, 6, e6.

Aloud, N., & Rathur, A. (2009). Factors affecting attitudes toward seeking and using formal mental health and psychological services among Arab Muslim populations. Journal of Muslim Mental Health, 4(2), 79-103. https://doi.org/10.1080/15564900802487675

Alnaji, N. A., Tippens, J. A., & ElRayes, W. (2023). Syrian Refugee Women's Maternal Mental Health Perceptions, Coping Strategies, and Help-Seeking Practices in Lebanon. *Journal of Transcultural Nursing*, *34*(4), 270-278. https://doi.org/10.1177/10436596231163876

Arday, J. (2018). Understanding mental health: What are the issues for black and ethnic minority students at university? Social Science, 7(10), 1–25. https://doi.org/10.3390/socsci7100196

Ayub, R., & Macaulay, P. J. (2023). Perceptions from the British Pakistani Muslim community towards mental health. *Mental Health, Religion & Culture*, *26*(2), 166-181. https://doi.org/10.1080/13674676.2023.2215168

Azhar, M. Z., & Varma, S. L. (1995). Religious psychotherapy as management of bereavement. Acta Psychiatrica Scandinavica, 91(4), 233–235. https://doi.org/10.1111/j.1600-0447.1995.tb09774.x

Azhar, M. Z., Varma, S. L., & Dharap, A. S. (1994). Religious psychotherapy in anxiety disorder patients. Acta Psychiatrica Scandinavica, 90(1), 1–3.

Bahattab, M., & AlHadi, A. N. (2021). Acceptance and commitment group therapy among Saudi Muslim females with mental health disorders. *Journal of Contextual Behavioral Science*, *19*, 86-91.

Baker, C., & Kirk-Wade, E. (2023). Mental health statistics: prevalence, services and funding in England https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf [Accessed 15th January 2024]

Bignall, T., Jeraj, S., Helsby, E., & Butt, J. (2019). Racial disparities in mental health. *London: Race Equity Foundation*. https://raceequalityfoundation.org.uk/wp-content/uploads/2022/10/mental-health-report-v5-2.pdf [Accessed 20th February 2024]

Braun, V., & Clarke, V. (2013). Successful qualitative research: A practical guide for beginners.

British Psychological Society (BPS) (2018) Guidance for psychologists on working in partnership with community organisations. Retrieved from https://explore.bps.org.uk/binary/bpsworks/00ee0d053df6cd2b/c65ddc68e61aa63862b70687d636a5b4d785613a2acfe97d3ba3ea50be76db97/rep121_2018.pdf [Accessed 26th January 2024]

Brunelle, J., & Porter, R. (2013). Integrating care helps reduce stigma. *Health Progress*, *24*, 26-29. https://www.chausa.org/publications/health-progress/archive/article/march-april-2013/integrating-care-helps-reduce-stigma [Accessed 17th January 2024]

Carroll C, Booth A, Lloyd-Jones M. 2012. Should we exclude inadequately reported studies from qualitative systematic reviews? An evaluation of sensitivity analyses in two case study reviews. Qualitative Health Research 22: 1425–1434. https://doi.org/10.1177/1049732312452937

Chesner, S. P., & Baumeister, R. F. (1985). Effect of therapist's disclosure of religious beliefs on the intimacy of client self-disclosure. *Journal of Social and Clinical Psychology*, *3*(1), 97-105. https://doi.org/10.1521/jscp.1985.3.1.97

Cinnirella, M., & Loewenthal, K. M. (1999). Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. *British Journal of Medical Psychology*, *72*(4), 505-524. https://doi.org/10.1348/000711299160202

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: the SPIDER tool for qualitative evidence synthesis. *Qualitative health research*, *22*(10), 1435-1443. https://doi.org/10.1177/1049732312452938

Daykin, N., Mansfield, L., Meads, C., Julier, G., Tomlinson, A., Payne, Victor, C. (2018). What works for wellbeing? A systematic review of wellbeing outcomes for music and singing in adults. *Perspectives in Public Health*, 138(1), 39–46. https://doi.org/10.1177/1757913917740391

Dein, S. (2018). Against the stream: Religion and mental health— the case for the inclusion of religion and spirituality into psychiatric care. BJPsych Bulletin, 42(3), 127–129. https://doi.org/10.1192/bjb.2017.13

Dein, S., & Illaiee, A. S. (2013). Jinn and mental health: looking at jinn possession in modern psychiatric practice. *The Psychiatrist*, *37*(9), 290-293. https://doi.org/10.1192/pb.bp.113.042721

Department of Health. (2005). Delivering race equality in mental health care. Department of Health.

Eltaiba, N., & Harries, M. (2015). Reflections on recovery in mental health: Perspectives from a Muslim culture. *Social Work in Health Care*, *54*(8), 725-737. hhttps://doi.org/10.1080/00981389.2015.1046574

Erickson, C. D., & Al-Timimi, N. R. (2001). Providing mental health services to Arab Americans: recommendations and considerations. *Cultural diversity and ethnic minority psychology*, *7*(4), 308. https://doi.org/10.1037/1099-9809.7.4.308

Fakhr El-Islam, M. (2008). Arab culture and mental health care. *Transcultural psychiatry*, *45*(4), 671-682. https://doi.org/10.1177/1363461508100788

Franco, A., Malhotra, N., & Simonovits, G. (2014). Publication bias in the social sciences: Unlocking the file drawer. *Science*, *345*(6203), 1502-1505. https://doi.org/10.1126/science.1255484

Gatrad, A. R., & Sheikh, A. (2002). Palliative care for Muslims and issues before death. *International journal of palliative nursing*, *8*(11), 526-531. hhttps://doi.org/10.12968/ijpn.2002.8.11.10894

Gilbert, P., & Parkes, M. (2011). Faith in one city: Exploring religion, spirituality and mental wellbeing in urban UK. Ethnicity and Inequalities in Health and Social Care, 4(1), 16–27. https://doi.org/10.1108/17570981111189551

Grim, B. J., & Hsu, B. (2011). Estimating the Global Muslim Population: Size and Distribution of the World's Muslim Population. *Interdisciplinary Journal of Research on Religion*, *7*.

Groenewald, T. (2004). A phenomenological research design illustrated. *International journal of qualitative methods*, *3*(1), 42-55. https://doi.org/10.1177/160940690400300104

Hamid, A., & Furnham, A. (2013). Factors affecting attitude towards seeking professional help for mental illness: A UK Arab perspective. Mental Health, Religion & Culture, 16(7), 741–758. https://doi.org/10.1080/13674676.2012.718753

Hammad, J., El-Guenuni, A., Bouzir, I., & El-Guenuni, F. (2020). The Hand of Hope: A coproduced culturally appropriate therapeutic intervention for Muslim communities affected by the Grenfell Tower fire. *Journal of Muslim Mental Health*, *14*(2). https://doi.org/10.3998/jmmh.10381607.0014.202

Hammad, J., & Hamid, A. (2021). Migration and mental health of Arabic-speaking communities. In *Mental health, mental illness and migration* (pp. 271-302). Singapore: Springer Singapore. https://doi.org/10.1007/978-981-10-2366-8_37

Hassan, G., Ventevogel, P., Jefee- Bahloul., H., Barkil- Oteo, A., & Kirmayer., L. J. (2016). Mental health and psychosocial wellbeing of Syrians affected by armed conflict. Epidemiology and Psychiatric Sciences, 25, 129–141. https://doi.org/10.1017/S2045796016000044

Haque, A., Khan, F., Keshavarzi, H., & Rothman, A. E. (2016). Integrating Islamic traditions in modern psychology: Research trends in last ten years. *Journal of Muslim Mental Health*, *10*(1). https://doi.org/10.3998/jmmh.10381607.0010.107

Heath, P. J., Vogel, D. L., & Al-Darmaki, F. R. (2016). Help-seeking attitudes of United Arab Emirates students: Examining loss of face, stigma, and self-disclosure. *The Counseling Psychologist*, *44*(3), 331-352. https://doi.org/10.1177/0011000015621149

Heath-Kelly, C., & Strausz, E. (2019). The banality of counterterrorism "after, after 9/11"? Perspectives on the Prevent duty from the UK health care sector. *Critical Studies on Terrorism*, *12*(1), 89-109. https://doi.org/10.1080/17539153.2018.1494123

Hussien, F. M. (1991). A study of the rate of unorthodox treatment of psychiatric illness. *The Arab Journal of Psychiatry*, *2*(2), 170-184.

Ibrahim, A., & Whitley, R. (2021). Religion and mental health: A narrative review with a focus on Muslims in English-speaking countries. *BJPsych Bulletin*, *45*(3), 170-174. https://doi.org/10.1192/bjb.2020.34

Inayat, Q. (2007). Islamophobia and the therapeutic dialogue: Some reflections. CounsellingPsychology Quarterly, 20(3), 287–293. https://doi.org/10.1080/09515070701567804

Inayat, Q. (2005). Psychotherapy in a multi-ethnic society. *Psychotherapist*, 26,7.

Keshavarzi, H., & Haque, A. (2012). Outlining a psychotherapy model for enhancing Muslim mental health within an Islamic context. *International Journal for the Psychology of Religion,* 23(3), 230–249. https://doi.org/10.1080/10508619.2012.712000

Khalifa, N., Hardie, T., Latif, S., Jamil, I., & Walker, D. M. (2011). Beliefs about Jinn, black magic and the evil eye among Muslims: age, gender and first language influences. *International Journal of Culture and Mental Health*, *4*(1), 68-77. https://doi.org/10.1080/17542863.2010.503051

Khan, M., & Ecklund, K. (2013). Attitudes Toward Muslim Americans Post-9/11. *Journal of Muslim Mental Health*, *7*(1). https://doi.org/10.3998/jmmh.10381607.0007.101

Khan, Z. (2014). An exploratory study of therapists' practices with Muslim clients: Building rapport and discussing religion in therapy (PhD). The State University Of New Jersey. https://doi.org/ 10.7282/T3C53HZ4

Knafl, K., & Breitmayer, B.J. (1991). Triangulation in qualitative research: Issues in conceptual clarity and pur- pose. In J.M. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (rev. ed., pp. 226-239). Newbury Park, CA: Sage. https://doi.org/10.4135/9781483349015.N26

Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. ISRN Psychiatry, 278730, 1–33 https://doi.org/10.5402/2012/278730

Lane P, Tribe R (2010) Following NICE 2008: a practical guide for health professionals on community engagement with local black and minority ethnic (BME) community groups. Diverse Health Care 7:105–114

Lazard, L., & McAvoy, J. (2020). Doing reflexivity in psychological research: What's the point? What's the practice?. *Qualitative research in psychology*, *17*(2), 159-177. https://doi.org/10.1080/14780887.2017.1400144

Levy, Y., & Ellis, T. J. (2006). A systems approach to conduct an effective literature review in support of information systems research. *Informing Science*, *9*. https://doi.org/10.28945/479

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31-42. https://doi.org/10.1177/2632084320947559

McLaughlin, M. M., Ahmad, S. S., & Weisman de Mamani, A. (2022). A mixed-methods approach to psychological help-seeking in Muslims: Islamophobia, self-stigma, and therapeutic preferences. *Journal of consulting and clinical psychology*, *90*(7), 568. https://doi.org/10.1037/ccp0000746

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: A qualitative study in southeast England. BMJ Open. doi:10.1136/bmjopen-2016–012337 https://doi.org/10.1136/bmjopen-2016-012337

Mental Health Foundation. (2018). Black, Asian and minority ethnic (BAME) communities. https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minorityethnic-bame-communities [Accessed 13th February 2024]

Mind. (2013a). We still need to talk: A report on access to talking therapies. https://www.mind.org.uk/media-a/4248/we-still-need-to-talk_report.pdf [Accessed 3rd September 2023]

Mir, G., Ghani, R., Meer, S., & Hussain, G. (2019). Delivering a culturally adapted therapy for Muslim clients with depression. The Cognitive Behaviour Therapist, 12(26), 1–14. https://doi.org/10.1017/S1754470X19000059

Mir, G., Meer, S., Cottrell, D., McMillan, D., House, A., & Kanter, J. W. (2015). Adapted behavioral activation for the treatment of depression in Muslims. Journal of Affective Disorders, 180, 190–199. https://doi.org/10.1016/j.jad.2015.03.060

Mohammed, E. N. F., Unher, M., & Sugawara, M. (2010). Psychological well-being: A comparative study between Japanese and Egyptian students. *Psychologia*, *53*(2), 68-85. Mohammed, E. N. F., Unher, M., & Sugawara, M. (2010). Psychological well-being: A comparative study between Japanese and Egyptian students. *Psychologia*, *53*(2), 68-85. https://doi.org/10.2117/PSYSOC.2010.68

Mundel, E., & Chapman, G. E. (2010). A decolonizing approach to health promotion in Canada: the case of the Urban Aboriginal Community Kitchen Garden Project. *Health Promotion International*, *25*(2), 166-173. https://doi.org/10.1093/heapro/daq016

Musbahi, A., Khan, Z., Welsh, P., Ghouri, N., & Durrani, A. (2022). Understanding the stigma: a novel quantitative study comparing mental health attitudes and perceptions

between young British Muslims and their non-Muslims peers. *Journal of Mental Health*, *31*(1), 92-98. https://doi.org/10.1080/09638237.2021.1952951

Muslim Youth Helpline. (2019). Muslim youth: What's the issue? https://myh.org.uk/wp-content/uploads/2021/03/MYH-Research-Report-Muslim-Youth-Whats-the-Issue-1-2.pdf [Accessed 23 January 2024]

Mustafa, Y., Baker, D., Puligari, P., Melody, T., Yeung, J., & Gao-Smith, F. (2017). The role of imams and mosques in health promotion in Western societies—a systematic review protocol. *Systematic reviews*, *6*, 1-5. https://doi.org/10.1186/s13643-016-0404-4

Naeem, F., Habib, N., Gul, M., Khalid, M., Saeed, S., Farooq, S., ... & Kingdon, D. (2016). A qualitative study to explore patients', carers' and health professionals' views to culturally adapt CBT for psychosis (CBTp) in Pakistan. *Behavioural and Cognitive Psychotherapy*, *44*(1), 43-55. https://doi.org/10.1017/S1352465814000332

Naeem, F., Saeed, S., Irfan, M., Kiran, T., Mehmood, N., Gul, M., ... & Kingdon, D. (2015). Brief culturally adapted CBT for psychosis (CaCBTp): a randomized controlled trial from a low income country. *Schizophrenia research*, *164*(1-3), 143-148. https://doi.org/10.1007/978-3-031-27003-1_7

NHS Digital (2023) Detentions under the Mental Health Act. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures#:~:text=In%202023%2D24%3A,by%20changes%20in%20data%20quality. [Accessed 28 July 2023]

NHS Digital (2022) psychological therapies, annual report on the use of IAPT services, 2021-22. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2021-22 [Accessed 18th January 2024]

NICE. (2013) The social care guidance manual: Process and methods. Available at: https://www.nice.org.uk/process/pmg10 [Accessed 27th January 2024]

Núñez, S. (2016). Medicinal drumming: An ancient and modern day healing approach. *NeuroQuantology*, *14*(2). https://doi.org/10.14704/NQ.2016.14.2.939

Padela, A., Gunter, K., & Killawi, A. (2011). Meeting the healthcare needs of American Muslims: Challenges and strategies for healthcare settings. *Institute for Social Policy and Understanding*, *6*.

Padela AI, Killawi A, Forman J, De Monner S, Heisler M (2012). American Muslim perceptions of healing: key agents in healing , and their roles. Qualitative Health Research 22, 846–858. https://doi.org/10.1177/1049732312438969

Pappas, C., & Williams, I. (2011). Grey literature: its emerging importance. *Journal of Hospital Librarianship*, *11*(3), 228-234. https://doi.org/10.1080/15323269.2011.587100

Pilkington, A., Msetfi, R., & Watson, R. (2011). Factors affecting intention to access psychological services amongst British Muslims of south Asian origin. Mental Health, Religion & Culture, 15, 1–22. https://doi.org/10.1080/13674676.2010.545947

Rassool, G. H. (2015). *Islamic counselling: An introduction to theory and practice*. Routledge. https://doi.org/10.4324/9781315694993

Rayan, A., & Jaradat, A. (2016). Stigma of mental illness and attitudes toward psychological help-seeking in Jordanian university students. *Research in Psychology and Behavioral Sciences*, *4*(1), 7-14. https://doi.org/10.12691/rpbs-4-1-2

Rayes, D., Karnouk, C., Churbaji, D., Walther, L., & Bajbouj, M. (2021). Faith-based coping among Arabic-speaking refugees seeking mental health services in Berlin, Germany: an exploratory qualitative study. *Frontiers in psychiatry*, *12*, 595979. https://doi.org/10.3389/fpsyt.2021.595979

Rothman, A., & Coyle, A. (2018). Toward a framework for Islamic psychology and psychotherapy: An Islamic model of the soul. *Journal of Religion and Health*, 57(5), 1731–1744. https://doi.org/10.1007/s10943-018-0651-x

Rowan, A. B., Grove, J., Solfelt, L., & Magnante, A. (2021). Reducing the impacts of mental health stigma through integrated primary care: an examination of the evidence. *Journal of Clinical Psychology in Medical Settings*, *28*, 679-693. https://doi.org/10.1007/s10880-020-09742-4

Sabki, Z. A., Sa'ari, C. Z., Muhsin, S. B. S., Kheng, G. L., Sulaiman, A. H., & Koenig, H. G. (2019). Islamic integrated cognitive behavior therapy: a shari'ah-compliant intervention for muslims with depression. *Malaysian Journal of Psychiatry*, *28*(1), 29-38.

Salaheddin, K., & Mason, B. (2016). Identifying barriers to mental health help-seeking among youngadults in the UK: A cross-sectional survey. British Journal of General Practice, 66(651), e686–e692. https://doi.org/10.3399/bjgp16X687313

Sheridan, L. P. (2006). Islamophobia pre- and post-September 11th 2001. Journal of Interpersonal Violence, 21(3), 317–336. https://doi.org/10.1177/0886260505282885

Skinner, R. (2018). Traditions, paradigms and basic concepts in Islamic psychology. *Journal of Religion and Health.* https://doi.org/10.1007/s10943-018-0595-1

Sue, S., Cheng, J. K. Y., Saad, C. S., & Chu, J. P. (2012). Asian American mental health: A call to action. The American Psychologist, 67(7), 532–544. https://doi.org/10.1037/a0028900

Tarabi, S. A., Loulopoulou, A. I., & Henton, I. (2020). “Guide or conversation?” The experience of Second-Generation Pakistani Muslim men receiving CBT in the UK. *Counselling Psychology Quarterly*, *33*(1), 46-65. https://doi.org/10.1080/09515070.2018.1471587

Tedeschi, R. G. (1999). Violence transformed: Posttraumatic growth in survivors and their societies. *Aggression and Violent Behavior*, *4*(3), 319-341. https://doi.org/10.1016/S1359-1789(98)00005-6

Thomas, J., Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, *8*, 1-10. https://doi.org/10.1186/1471-2288-8-45

Vandekinderen, C., Rondelez, E., Bracke, S., Bracke, P., & Roets, G. (2022). How to make sense of cultural difference in mental health care: analyzing biographies of diasporic Muslim women with mental health problems. *Social Theory & Health*, *20*(4), 416-437. https://doi.org/10.1057/s41285-021-00168-y

van Loon, A., van Schaik, A., Dekker, J., & Beekman, A. (2013). Bridging the gap for ethnic minority adult out patients with depression and anxiety disorders by culturally adapted treatments. *Journal of Affective Disorders*,147(1), 9–16. https://doi.org/10.1016/j.jad.2012.12.014

Weatherhead, S., & Daiches, A. (2010). Muslim views on mental health and psychotherapy. *Psychology and psychotherapy: Theory, research and practice*, *83*(1), 75-89. https://doi.org/10.1348/147608309X467807

Webster, J., & Watson, R. T. (2002). Analyzing the past to prepare for the future: Writing a literature review. *MIS quarterly*, xiii-xxiii.

Whittaker, S., Hardy, G., Lewis, K., & Buchan, L. (2005). An exploration of psychological well-being with young Somali refugee and asylum-seeker women. *Clinical Child Psychology and Psychiatry*, *10*(2), 177-196. https://doi.org/10.1177/1359104505051210

Woods-Giscombe, C., Robinson, M. N., Carthon, D., Devane-Johnson, S., & Corbie-Smith, G. (2016). Superwoman schema, stigma, spirituality, and culturally sensitive providers: Factors influencing African American women's use of mental health services. *Journal of best practices in health professions diversity: research, education and policy*, *9*(1), 1124.

Yamada, A.- M., Lukoff, D., Lim, C. S. F., & Mancuso, L. L. (2019). Integrating spirituality and mental health: Perspectives of adults receiving public mental health services in California. Psychology of Religion and Spirituality. Advance online publication. http://dx.doi.org/10.1037/rel0000260

Yavuz, O. (2022). Building a Bridge Between Spirituality/Religion with Acceptance and Commitment Therapy. *Spiritual Psychology and Counseling*, *7*(2), 179-200. https://dx.doi.org/10.37898/spc.2022.7.2.174

Younis, T., & Jadhav, S. (2020). Islamophobia in the National Health Service: an ethnography of institutional racism in PREVENT's counter-radicalisation policy. *Sociology of Health & Illness*, *42*(3), 610-626. https://doi.org/10.1111/1467-9566.13047

Youssef, J., & Deane, F. P. (2006). Factors influencing mental-health help-seeking in Arabic-speaking communities in Sydney, Australia. *Mental Health, Religion & Culture*, *9*(1), 43-66. https://doi.org/10.1080/13674670512331335686

Ypinazar, V. A., & Margolis, S. A. (2006). Delivering culturally sensitive care: The perceptions of older Arabian Gulf Arabs concerning religion, health, and disease. *Qualitative health research*, *16*(6), 773-787. https://doi.org/10.1177/1049732306288469

Section B:

"*They Use Religion Like a Stick to Beat You With*": Muslims' Experiences of Spiritual Abuse Within Interpersonal Relationships

Word Count: 7,999 (587)

Proposed Journal: Trauma, Violence, & Abuse

Abstract

Background: Spiritual abuse (SA) involves the manipulation of religious beliefs or practices within religious contexts to exert power and control. SA can affect a victims' spirituality, sense of identity, emotional wellbeing and relationships. This is particularly concerning for Muslims, who face multiple barriers to accessing mental health (MH) services and often seek support from their faith and religious leaders during emotional distress. While there is a growing body of research on SA in Christian contexts, no studies to date have explored how Muslims experience SA within interpersonal relationships.

Methods: Semi-structured interviews were conducted with one male and seven female Muslim survivors to explore their experiences of SA and its impact on their emotional wellbeing, spirituality, relationships and their experience of seeking support. Data was analysed using Interpretative Phenomenological Analysis.

Findings: Four group experiential themes were developed from the data: *Power and Control, Feeling Trapped, Impact* and *Healing*. Sub-themes were also explored.

Conclusions: Muslim survivors of SA endure significant psychological, spiritual, and social challenges, often grappling with reconciling their faith and the abuse. Healing can be facilitated through regaining autonomy and relearning the religion through a compassionate lens, as well as accessing person-centred, culturally sensitive and faith-informed therapeutic support. Implications for clinical practice and recommendations for future research are explored.

Keywords: Spiritual abuse, Muslim, mental health, culturally sensitive, faith-informed

Introduction

The adverse effects of the major recognised groups of abuse (physical, sexual, emotional, neglect) on psychological wellbeing have been well documented (Carlson & Dalenberg, 2000; Follette et al., 1996; van der Kolk et al., 2005). However, the psychological impact of spiritual abuse (SA) remains under-researched, with no universally agreed definition. Some definitions describe SA as the misuse of power and authority by religious leaders "*to coerce, control or exploit a followe*r" (Blue, 1993, as cited in Fernandez, 2022), while others propose it is a misuse of power "*within a framework of spiritual belief to practice and satisfy their needs at the expense of others*" (Hall 2003). Swindle (2017) categorises SA into three main types: abuse by religious leaders, abuse by religious group or their representatives, and abuse involving a religious or spiritual element. This study focuses on the latter and will use Oakley et al.'s (2018) definition: *"Spiritual abuse is a form of emotional and psychological abuse characterised by a systematic pattern of coercive and controlling behaviour in a religious context."*

Research has identified several harmful psychological effects of SA, including post-traumatic stress disorder (PTSD), low self-esteem, diminished trust in others, and negative impacts on mental health (MH) (Cashwell & Swindle, 2018; Oakley et al., 2018; Oakley & Kinmond, 2014; Ward, 2011). Victims of SA also face spiritual crises, often grappling with their faith or relationship with a higher power, particularly when they conflate their abuser with God or associate the abuse with religion (Cashwell & Swindle, 2018; Hurcombe et al., 2019). This is particularly concerning as it undermines the protective role that spirituality often plays in psychological well-being (Hill & Pargament, 2008; Salgado, 2014). Religion can provide a sense of identity, social support, and a framework for coping with existential issues and stress (Bottoms et al., 2004; Garssen et al., 2021). When trauma occurs within a

spiritual context, it can doubly affect victims, both through the abuse itself and the additional trauma of losing spirituality as a source of coping (Koch & Edstrom, 2022).

From a theoretical perspective, social constructivism posits that reality, including religious beliefs and power structures, is shaped through social interactions and shared meanings (Andrews, 2012). In the context of SA, power is not merely imposed but also legitimised through cultural narratives that define authority and submission within religious frameworks (Dreher, 2016). This aligns with Foucault's (1980) concept of disciplinary power, where individuals internalise dominant discourses, leading them to accept abusive religious authority as divinely sanctioned (Hall, 2001). By manipulating theological interpretations, perpetrators reinforce ideological power (Bourdieu, 1991), making resistance feel like spiritual failure.

The literature on SA primarily focuses on Christian contexts, with only six studies examining the lived experiences of survivors, three of these being peer-reviewed studies (Oakley, 2009; Oakley et al., 2018; Ward, 2011), and three are non-peer-reviewed theses (Bilsky, 2013; Crocker, 2021; Krueger, 2018).

These studies reveal that SA is multi-faceted, involving the misuse of spiritual authority (Ward, 2011), manipulation of scripture (Oakley, 2018) and intersections with other forms of abuse (Ellis et al., 2022). Ward (2011) found that victims often viewed religious leaders as representatives of God, creating a power imbalance that stifled independent thought and led to conditional acceptance based on obedience. This dynamic caused internal tension between personal beliefs and lived experiences, resulting in psychological distress, spiritual crises, and physical illness. Oakley et al. (2018) similarly identified SA was characterised by coercion, control, and scripture misuse in Christian settings, leading to

significant emotional distress. Krueger et al. (2018) highlighted cognitive dissonance from the conflict between religious beliefs and abuse, as well as "second victimisation" from the church's response, a theme echoed by Swindle (2017). Bilsky (2013) noted that abusers often used threats of divine punishment, such as abandonment by God or eternal damnation.

There are currently no studies examining the lived experiences of SA survivors in Jewish contexts and only one study examining the experiences of Muslim SA survivors. Chowdhury et al. (2022) conducted a pioneering study on Muslim victims abused by religious authority figures such as Imams or faith teachers, identifying two key themes: t*oxicity of silence* and b*arriers to acknowledging abuse*. The authors found that participants experienced long-term trauma, self-blame, and isolation, often remaining silent for years due to the manipulation and control exerted by religious figures and the difficulty in recognising SA. Survivors' attempts to disclose the abuse were met with dismissiveness, victim-blaming, and resistance from the community, further compounding their trauma and deepening their disconnection from both faith and community. Whilst groundbreaking, this study only addressed child abuse within religious contexts and did not explore other forms of SA, such as those occurring within interpersonal relationships.

SA within interpersonal relationships can be understood through the Duluth Model's Power and Control Wheel (Pence & Paymar, 1993), which was originally designed to understand the dynamics of intimate partner violence but can also be applied to SA. SA is seen as a form of psychological and emotional abuse (Oakley et al., 2018), where perpetrators misuse religion to gain power and control over their victims (Sajed, 2021). Alkhateeb (2011) adapted the Duluth model to the Muslim context by creating the 'Muslim Wheel of Domestic Abuse' (Figure 1), which highlights how religion and culture can be weaponised to perpetrate abuse.

Figure 1. *Muslim Wheel of Domestic Abuse*

Although SA is often associated with domestic abuse in religious contexts, it can also occur outside these settings, such as within extended family relationships or interactions with individuals who do not live in the same household (Oakley et al., 2018). What distinguishes SA from other forms of abuse is the use of scripture and religious authority to control victims. Perpetrators may use ‘divine rationale’ to justify abuse, threaten spiritual consequences for

non-compliance and position themselves as beyond question or reproach, thereby exerting control through a supposed divine mandate (Koch & Edstrom, 2022).

Intersectional theory helps explain how overlapping social identities can create unique forms of discrimination or privilege (Crenshaw, 1991). British Muslims face multiple barriers when seeking support for abuse or accessing MH services, including cultural stigmas, racism, and Islamophobia (Chowdhury, 2021). The negative portrayal of Muslims in the media (Ahmed & Matthes, 2017) and the securitisation of healthcare through policies like Prevent (Younis & Jadhav, 2020) have contributed to distrust in mainstream services. As a result, many Muslims turn to faith leaders for support during emotional or psychiatric difficulties (Ali et al., 2004; Ali et al., 2005).

For Muslims who experience SA, the trauma can be compounded by the loss of spiritual support, which is often considered a protective factor (Chowdhury et al., 2022). In addition, the marginalisation faced by Muslims in wider society and within mainstream services further deprives them of other crucial resources. This underscores the need for research focused on the impact of SA on the psychological well-being, identity, and religious coping of British Muslims. Such research can enhance cultural and religious competence among mental health professionals (MHPs) and guide the development of policies for more culturally sensitive, faith-informed MH services that can effectively address SA disclosures.

Aims

To the authors' knowledge, no published research has yet examined Muslims' experiences of SA within interpersonal relationships. This study, therefore, aims to explore the following questions:

a. How do Muslims make sense of their experiences of SA in interpersonal relationships?

b. What psychological, social, and relational impacts do Muslims experience as a result of SA?

c. How does experiencing SA affect Muslims' relationship with their faith?

d. What experience of support seeking for SA do Muslims report?

e. What support do Muslims think would be helpful after experiencing SA?

Method

Design

This study used a qualitative design with semi-structured interviews, enabling participants to share detailed accounts of their experiences of SA. Data was analysed using Interpretative Phenomenological Analysis (IPA), as it is well-suited for exploring individuals' experiences and meaning-making of specific events (Smith et al., 2021). IPA focuses on subjective experiences, viewing participants' accounts as reflections of their inner thoughts and feelings rather than objective reality. It employs a 'double hermeneutic,' where participants interpret their own experiences, and researchers then interpret these accounts, leading to co-constructed findings (Smith, 2017).

IPA's idiographic approach prioritises in-depth exploration of a small, purposefully selected group from relatively homogenous backgrounds (Smith et al., 2021). In this study, eight participants' experiences allowed for both individual analysis and cross-participant comparisons (Smith, 2017).

Epistemological Position

This research was carried out from a critical realist position (Bhaskar, 1975), which aligns with IPA as it acknowledges that while an individual's reality exists, it can only be accessed and understood through the individual's interpretation of that reality (Shaw, 2010). Critical realism also suggests that lived experiences are interpreted through the interaction between the participant and the researcher, with the researcher applying their own perspective in the process (Smith & Osborn, 2015).

Participants

Purposive sampling was used to recruit British Muslims that had experienced SA, according to inclusion and exclusion criteria (Table 1). IPA studies typically have smaller sample sizes, with six to ten participants recommended for doctoral research (Smith et al., 2022). Eight participants were recruited for this study through snowball sampling, initiated by circulating a research poster (Appendix B) in community Facebook and WhatsApp groups that British Muslims frequent to share information and community resources.

Table 1

Inclusion and Exclusion Criteria

Inclusion	Exclusion
• Aged 18 and above	• Currently experiencing abuse
• Currently living in the UK	• Experiencing significant mental health difficulties or where participation in the study may significantly exacerbate this distress

- Self-identifies as Muslim
- Self-identifies as having experienced spiritual abuse in an interpersonal relationship
- Have at least a 6-month period since their experience of spiritual abuse ended
- Has a sufficient level of English proficiency to participate in an interview.

Table 2

Participant Demographics

Pseudonym	Age	Sex	Ethnicity	Employment Status	Relationship to Spiritual Abuser	Accessed Therapy post SA?	Reported Abuser? *
Layla	33	Female	British Bangladeshi	Full-time	Former friend	Yes	Yes
Khadijah	63	Female	White British	Unemployed	Ex-husband	Yes	Yes
Salma	45	Female	Mixed British Egyptian	Full-time	Ex-husband	Yes	Yes
Noor	30	Female	British Pakistani	Full-time	Parents	Yes	No
Samira	27	Female	British Pakistani	Part-time	Mother	Yes	No
Yusuf	20	Male	British Pakistani	Student	Uncle	Yes	No

Amina	68	Female	White British	Self-employed	Ex-husband	Yes	Yes
Hanna	44	Female	British Iraqi	Part-time	Mother-in-law	Yes	No

Note. * *Participants who reported their abuser did so for abuse not identified as SA at the time.*

Procedure

Interested individuals emailed the researcher and were provided with an information sheet (Appendix C) and the opportunity to ask any questions. Those who wished to proceed, were contacted for an initial call to ensure they met the inclusion criteria. Of the 12 individuals who expressed interest, four did not meet the criteria for one of the following reasons: not having had at least six months pass since their last SA experience, were not residing in the UK, or described discrimination occurring in a workplace setting, or SA occurring in an institutional setting rather than an interpersonal context. Those who met the inclusion criteria were sent a consent form (Appendix D) which they returned before a video-call interview was arranged. Participants were offered £15 for participating.

Data Collection

Semi-structured interviews were conducted using the interview schedule (Appendix E) as a flexible guide. Open-ended questions were employed to encourage detailed responses, with follow-up prompts used to gather further information as needed. Before the interview began, participants were reminded that it would be recorded and of the limits to confidentiality. Interviews lasted 60-90 minutes and were audio recorded.

Data Analysis

Data were analysed using IPA procedures outlined by Smith et al. (2021). The lead researcher transcribed the interviews and read through each transcript multiple times to

immerse in the data. Exploratory notes were made on each transcript, noting descriptive, semantic and initial interpretative observations. These notes were then organised into Personal Experiential Themes (PETs) and sub-themes. After analysing each transcript individually, the PETs were compared across participants to identify convergences and divergences, which led to the development of Group Experiential Themes (GETs). This process involved renaming, reordering, or discarding certain PETs to best reflect the dataset as a whole.

Reflexivity and Quality Assurance

Researchers conducting qualitative studies should recognise how their own values, interests, and expectations may shape the research process, including its analysis and interpretation (Elliot et al., 1999). The researcher engaged in researcher reflexivity that encourages awareness of the researcher's thoughts, feelings, and assumptions, which are then acknowledged and explored (Biggerstaff & Thompson, 2008).

The lead researcher was a trainee clinical psychologist who identified as an Arab British Muslim female and was visibly Muslim. The researcher did not have direct experience of SA but had family members who had experienced it. Recognising the potential influence of this on assumptions and expectations of the data, the researcher completed a bracketing interview with another trainee psychologist. Reflections from this (Appendix H) were revisited throughout the research process to mitigate potential influence of the researcher's preconceptions and biases on data collection and analysis (Tufford & Newman, 2012). Supervision and a research diary (Appendix I) were used to consider the researcher's position and its potential impact on interviews, participant responses, and analysis (Jootun et al., 2009). Three coded transcripts, along with drafts of the analysis and theme development,

were reviewed with supervisors to ensure inter-coder agreement and that themes stayed grounded in the data (Yardley, 2008).

Ethics

This study received approval from the Salomons Ethics Board (Appendix G). All participants provided informed consent and were informed of their right to withdraw from the study at any time up to one week after their interview, before analysis began. Participants were informed that their data would be anonymised and kept confidential, except in cases of safeguarding concerns, where it would be shared with the research team and, if necessary, other bodies. Participant data was stored in password-protected files to ensure security

Considering the sensitive and potentially distressing nature of the interview, steps were taken to mitigate harm. During the initial call, the researcher confirmed that participants had not experienced SA in the past six months. Participants were made aware of the topics that could arise, and the possibility of sensitive issues being discussed. To further reduce the risk of harm, the researcher asked participants if they felt that discussing their SA experience might cause significant distress or re-traumatisation; all participants indicated that they did not believe it would.

Participants were made aware that they did not have to discuss anything that made them uncomfortable and that they could skip a question, pause or end the interview at any time. The researcher discussed how participants might indicate that they were struggling with the interview and was attentive to any signs of distress. In the event of a participant becoming distressed, the researcher responded with empathy, offering a break, providing reassurance, and confirming whether the participant wanted to continue.

Participants were offered a verbal debrief after the interview to discuss any issues that may have arisen. Additionally, all participants received a written debrief sheet (Appendix F) containing further support resources if needed and contact information for any concerns.

Findings

Findings were organised into five group experiential themes (GETS) and 13 sub-themes (Table 3).

Table 3

Group Experiential Themes and sub-themes

Group Experiential Themes	Sub-themes
Power and Control	Weaponised Islam
	Conditioned to View Abuser as a Spiritual Authority
	Gendered Oppression
	Multiple Forms of Abuse
Feeling Trapped	Fear & Shame
	Community Response
	Protecting the Religion
Impact	Psychological
	Spiritual
	Social
Healing	Relearning
	Reclaiming Faith
	Culturally & Faith Sensitive Support

Power and Control

Participants' narratives revealed that power and control were central to their experiences of SA.

Weaponised Islam

All participants described experiencing Islam being weaponised against them by their spiritual abuser.

> *"They use religion as, like a stick to beat you with"* – Khadjiah

> *"… it's like a tool that gets used, especially when it comes to wanting people to do…what's culturally acceptable"* - Noor

> "*…he used religion as a humiliation tactic*" - Yusuf

Words such as "*stick*", "*tool*" and "*tactic*" gave the sense that Islam was used as an instrument or strategy to exert power and control or enforce cultural conformity.

Other participants described how religious principles were used to instil fear and "*shame and guilt you so you're put you in your place*" (Hanna). Religious threats such as "*you're going to hell*" (Salma) and "*you're betraying God*" (Samira) were also reported to coerce and control participants.

Yusuf spoke about the weaponisation of specific religious principles:

> *"…Islamically speaking, you have to keep the [family] ties… [it's] a very common vehicle or mechanism for abuse, because it's a great way of silencing people or*

making them just have to put up with something because apparently it's Islamic, and it's obligatory for you to interact." – Yusuf

Salma described the sanctity of religion being perverted to legitimise oppression, implying that what was once a source of comfort became a means for harm.

"[I felt] devastated that something as beautiful and as personal as your religion could be used in a manipulative way to keep you in relationships that are oppressive and toxic, abusive" – Salma

Conditioned to View Abuser as a Spiritual Authority

Many participants described feeling like they could not say no or question their spiritual abuser due to a power dynamic. For Noor and Samira this power dynamic was created by the weaponisation of parents' high status in Islam.

"*It was like my mum was this all-knowing, all-powerful person… I understood that if I upset Mum, I'm upsetting God, and if I'm upsetting God, I'm gonna go to hell*" – Noor

"*I treated my mum's word like it was gospel. So, I never, like, questioned anything out loud*." – Samira

Words like "*Gospel"*, "*all-knowing*", "*all-powerful*" implied that participants' Islamic beliefs were exploited to the point of equating their mothers to divine authority.

Salma and Khadijah described an unspoken expectation to comply with certain roles and behaviours without challenging their abusers, driven either by an ingrained belief that it would please God or by an implicit power imbalance.

"…because I was so conditioned to just toe the line… if I wanted to please Allah, then this was the role that I needed to play" – Salma

"… the power dynamics was such that I wouldn't have turned around and said to him, well… what about you? Are you praying? … that's how it was skewed… where I wouldn't speak back" - Khadijah

Other participants described a power imbalance due to being younger and perceiving their abuser as more religiously knowledgeable.

"he's older…he knows more obviously than I do" - Yusuf

Gendered Oppression

All seven female participants spoke about intersecting experiences of SA with gendered oppression.

Khadijah described how many interpretations of religious texts were "*a part of patriarchy"* because "*the whole thing is run by men*", referring to how male-dominated leadership in Islamic spaces leads to interpretations that favour men and disadvantage women.

Similarly, Samira referred to her experiences of men manipulating and distorting religious teachings to justify harmful behaviour.

"*… men just really take using Islam to their advantage… just completely rewriting the book in their heads… and using it as a way to get away with really dangerous and toxic behaviors.*" – Samira

Layla spoke about her experience of being groomed by someone who held strict beliefs on hijab which starkly contrasted with his disregard for her modesty in private.

"…[He] was very like, controlling in his religious views about hijab, but okay to see my body naked… Somebody used religion to get me to that place that was enjoyable for them" – Layla

Khadijah shared similar frustrations with gendered double standards:

"*…the irony was that I did have to somehow be this perfect wife when he wasn't doing the very basics."* – Khadijah

Salma described experiencing sexual assault in a marriage already broken by physical and emotional abuse, through the weaponisation of a hadith (religious text). She described that it was easier to comply than challenge the manipulation of the hadith, despite the abuse invalidating its conditions.

"I had said no multiple times… then I was quoted many times the same Hadith, like, a woman who doesn't say yes will be cursed by the angels… it was used to pressure me into a situation that I did not want…. And eventually I just stopped saying no, because it… caused so much problem. But I also wasn't saying yes" - Salma

Patriarchal interpretations seemed to not only oppress women in interpersonal contexts, but also at a more systemic level:

*"... he's taking advantage of a system that doesn't support w*omen. *It's much harder for us to get a [Islamic] divorce, even though it shouldn't be*" – Khadijah

Multiple Forms of Abuse

All participants spoke about experiencing other forms of abuse alongside SA. There was a sense that SA perpetrators employed other forms of abuse to enforce their power and control and that religious manipulation "*was just one aspect of it*" (Yusuf).

Amina spoke about experiencing frequent physical, emotional and psychological abuse by her ex-husband.

> *"…once he punched me right in the middle of my nose … then he sort of grabbed both of their [child's] hands, and was pointing at me and telling him, oh, laugh, doesn't mummy look funny"* - Amina

Layla described being groomed by someone who used tools other than religion to gain her trust and manipulate her.

> "*…what did he do to me to get me to that vulnerability… it wasn't just religion, it was like all of these other aspects of grooming, of like using his academic credibility and his, you know, he's Doctor*" – Layla

Other participants described experiencing emotional abuse alongside SA. Hanna spoke of enduring "*lots of guilting and shaming*" and attacks on her character and motherhood. Not only were other forms of abuse used to reinforce SA, but spirituality was also used to justify other types of abuse:

> "*… why are you, like, you know, doing this to [hitting] your wife? Oh, Allah has given me the right to do that*" - Samira

Feeling Trapped

This theme captures participants' feelings of entrapment in the abuse, highlighting various factors that made it challenging for them to escape.

Fear and Shame

Participants' fear and shame contributed to feeling stuck. Salma expressed this through her fear of "*going against our religion*":

> "*I was definitely trapped, because I was, at the time, very practicing. So I also had this guilt, like religious guilt, that if I stepped away … you also believe that you are going to face punishment for the rest of your eternal life because of these things, it brings you back to that place of hopelessness*" – Salma

Salma's identity as a "*very practicing*" Muslim intensified her shame, making her fear that challenging or escaping the abuse would make her a 'bad' Muslim, with the added fear of divine punishment.

Layla likened her experience to a "*scam*," grappling with whether her vulnerability was due to her own religious shortcomings or the predatory nature of her abuse. She reflected on how a Muslim might equate victimisation with personal morality, blaming themselves for being deceived.

> *"… I'm the one who consented to being tricked…Or is it because… you the person who did get trapped was more vulnerable… if we fixate on making it analogous with being a good Muslim, you didn't fall for the scam because you're a good Muslim and person. And you fell for the scam because you're a bad Muslim?"* – Layla

Protecting the Religion

Many participants spoke of their desire to protect the religion from facing more negative attention from non-Muslims:

> "*I don't want to say that this is my Muslim husband that bashed me like this… to tell the system that somebody who is supposed to be the same religion that I have embraced is doing this harm to me… that was partly because there was a lot of Islamophobia going on at that time*" – Amina

It seemed that Amina'a status of being a convert may have heightened her fear of disclosing abuse, as it could have cast doubt on her decision to embrace Islam.

Hanna described being trapped by the broader societal context of racism and Islamophobia.

> *"…we have been vilified by the press, and probably also, to some extent, the government… when you look at narratives around domestic violence… it's weaponised against the Muslim community and that does a double disservice, because it puts us on the defensive… people don't want to come forwards because they fear that these support services are going to, you know, vilify the people around them, and it's not going to be fair"* - Hanna

Salma used the metaphor of an "*autoimmune disease*" to illustrate the idea that after enduring many external threats, it can be challenging to accept that harm can come from within the community as well.

"We have been under attack from so many different places externally that it then feels very difficult to accept that there is internal attack happening as well. It's like we it's like Muslims have an autoimmune disease. You know, we just have to accept that sometimes it's coming from within ourselves as well." - Salma

Community Response

Participants spoke about the response they received from other Muslims.

Layla voiced her frustration with the community's responses to her experiences. While she noted that "*people are very sympathetic towards my childhood sexual abuse experience, because I was a child*," she observed a stark shift in attitudes when she was groomed as an adult, with reactions becoming blaming and unsympathetic.

"*... even if you say like, oh, I don't really feel that this sexual experience was particularly consensual, they'll say, well, the third person is Satan, and when you're an adult, it's zina*[1]" – Layla

Some community responses seemed to worsen harm rather than provide relief. Layla described feeling exploited during Ruqya (Quran recitation), where her PTSD was dismissed and reframed as a spiritual issue, rather than a need for psychological care.

"I was going to Ruqya every two weeks. I actually thought that was more of a form of spiritual abuse, because they were just taking my money but not doing anything… and they were gaslighting me. So even when I said I had PTSD, they said it was Satan

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[1] Zina is an Islamic legal term that refers to unlawful sexual relations, such as adultery, extramarital sex, and premarital sex.

reminding me of my trauma." – Layla

Several participants shared that family members and the community lacked understanding of MH, often responding to expressions of distress with religiously shaming and punitive remarks.

"Why would you want to commit suicide? You're going to burn in hell." – Layla

Similarly, Samira experienced dismissive attitudes which seemed to rely solely on spiritual solutions, neglecting practical and emotional support that may have been needed.

"...she was like, oh just pray, just pray, and you'll be fine." - Samira

For Salma, attempts to seek support were met with minimising responses that left her feeling at fault for struggling with what was deemed "*normal*" behaviour.

"... [I] was very quickly shut down… this was very normal, these behaviours, like I was the one that needed to, like, try again… And now, when I reflect on that, I think it's because it's so ingrained within that community that that is acceptable behaviour, that the people that I went to believed that that was ok"- Salma

Many female participants shared that when they sought help, family, community members, and even religious leaders often quoted religious texts on patience, implying that enduring abuse was virtuous.

"When you can't take it anymore, and you go to somebody for advice, they say, have patience." – Khadijah

The community's response was experienced as an additional layer of punishment to

existing abuse.

> *"The fact that nobody else saw that there was anything wrong… that was the punishment"* - Salma

Impact

This theme relates to how participants were affected by their experiences of SA.

Psychological

All participants spoke about the profound psychological impact of their SA experiences. For Layla her adult spiritual abuse experience triggered and compounded old psychological wounds, making her a "*high-risk suicide"* and requiring psychiatric admission.

Other participants described feeling "*alive, physically, but dead internally*", consistent with dissociation.

> *"… I just existed. I was in a constant state of disconnect. My body and my mind were not connected in any way. I just lived, just hoping that like death would come."* – Salma

> *"[like] a fly and it's stuck on that paper. You're like that. You're sort of alive, but you're just… existing*." – Khadijah

Khadijah's metaphor of being a fly "*stuck on paper*" captures a sense of mere existence, stripped of agency or vitality, reflecting how SA and the community response left her feeling immobilised and helpless. Salma's longing for death highlights the depth of her

despair and hopelessness.

Many participants reported experiencing self-doubt and diminished self-esteem which seemed to erode their sense of self, leading them to question their own judgment, identity and religiosity.

"... you start thinking… am I going crazy? Because in the end, you cannot tell what is truth, what is fantasy? … it's as if you start to believe their narrative" – Amina

Participants also experienced feelings of shame, self-blame, and self-criticism. Salma, for example, blamed herself for allowing the abuse to occur, reflecting an internalisation of responsibility for the harm she endured.

"I had embodied shame so much that I berated myself. Like, how could I be so naive? How did I not see it?... Why did I allow this to happen?" – Salma

Many participants reported that their psychological and emotional distress was so intense that it manifested as physical symptoms as well.

"I got flu several times within the space of a few weeks. I was covered in a rash. I had a kind of lump on my back." - Hanna

"… my little physical heart was like paining severe pain… And they [cardiologist] said, there's a crack showing in your heart and then they said… do you have any like, severe stress in your life?" - Amina

Spiritual

Many participants spoke about the detrimental impact of SA on their spirituality.

Some described employing spiritual "*defences*" (Salma) and "*rejecting anything to do with religion*" (Noor) due to the negative associations they had made between Islam and their experience of SA or their relationship with the perpetrator.

> *"It pushed me away from the religion because I believed that was what the religion represented… [it was] very difficult to reconcile, like, the idea that spiritual faith is something positive"* - Salma

> *"… when I was really young, I would I blame religion… and then when I grew older… it kind of almost merged into me being close with my mum" - Noor*

Samira explained that she "*stopped praying for a period of time*" after reaching a point where she questioned *"why am I worshiping someone that hates me".* Samira's belief that she was condemned to divine disfavour seemed to make it difficult for her to find meaning in prayer.

Layla's experience of SA deeply impacted her spirituality, leading her to conclude that "*religion is a bad thing*," as it was used to "*abdicate responsibility*" for harm. She described how her trauma caused her to "*conflate one bad thing with another*," further eroding her faith. Religious practices, like prayer, became triggering for her, and she viewed her decision to stop praying as both "*a result of trauma*" and "*a way of protest*".

> *"God doesn't protect me… maybe God just doesn't exist. Because if you did exist, why would he allow somebody to use religion to mess with my head?... why should I pray to a God who's like, constantly traumatising me, punishing me, making me feel unsafe? Why would you let this happen to me?... where is the safeguarding from Allah…?"* – Layla

Unlike other participants' retrospective reflections, Layla's struggle with reconciling faith after SA appeared to be more alive as she tried to process her feelings of abandonment and betrayal. Her momentary switches from speaking about God in the third person to addressing him directly with "*if you did exist*" and "*why would you let this happen*" reflects the depths of her internal conflict suggesting she is still wrestling with her faith and her trailing off at the end may imply that she is still awaiting a response from God.

Only one participant said that their spirituality was strengthened during their SA experience, but this was bittersweet due to the desperation she felt and threats she faced.

> *"…that is the closest that you ever feel to Allah, when… your life feels in danger"* – Khadijah

Social

Many participants reported significant social impacts, particularly a deep distrust of the community and religious people.

> *"It made me want to leave the community and leave the family and not have any part of it… it was hard to get close with people as well because… it made me feel different to them… It made me not trust a lot of people in my community"* – Noor

> *"I kind of became really wary and quite distrustful of religious people… so the option of going to an Imam, for example, was totally off the table."* – Yusuf

Salma felt similarly and longed for a more personal, transcendent connection to religion, free from the controlling and judgmental dynamics she had experienced.

> *"I became very like, isolated from the community… I wanted to distance myself from*

the human aspect of the religion but pull myself closer into the ethereal aspect of the religion." – Salma

Healing

This theme encapsulates participants' journey to healing from their SA experiences.

Relearning

Many participants spoke about being exposed to new ways of understanding and practicing the religion that allowed them to gain new perspectives. Samira described discovering a Muslim women's podcast that challenged her existing beliefs on Islam which prompted her to start exploring her faith independently.

> *"Muslim women making apps, Muslim women like reciting the Quran out loud… this has never been something that I have ever seen or experienced…. So I was like… I need to actually understand what my religious texts say and what I learned was very different from what I'd been taught."* – Samira

Similarly, Yusuf described experiencing *"a different reality"* after being exposed to a new Muslim community after moving out for university.

> *"When I was younger what I was experiencing was the only reality, right? ...whereas now my eyes have been opened… I know that this is just one person, and that for every one person like this, there's dozens more people who… actually embody the religious values that they claim to know about"* – Yusuf

The phrase "*my eyes have been opened*" conveys a sense of awakening, implying that his healing journey had led him to recognise the distinction between the misuse of religion

and its true values.

Participants spoke about how relearning the religion helped them re-define their relationship with God and the religion from one based on fear and punishment to connection and compassion.

> *"I was relearning my faith through the lens of compassion rather than of fear… it's not just… fear pushing me into obedience… it's about really connecting to the words in the Quran"* – Salma

For Yusuf, "*gaining [Islamic] knowledge*" was empowering, helping him distinguish cultural practices from authentic Islamic teachings and providing him with "*certainty*" and reassurance in fulfilling his Islamic obligations.

> *"…you can't be religiously manipulated if you yourself know your religion… I can bring the receipts if someone decides to bring a Quranic verse or Hadith, I will bring one too. I can play the reverse card and just, you know, play that card back at them."* – Yusuf

Yusuf's use of phrases like "*bring the receipts*" and "*play the reverse card*" may reflect how his knowledge now serves as a shield against those who weaponise Islam.

Reclaiming faith

Creating physical distance from their perpetrators and moving to a new environment played a key role in many participants' healing journeys. For Noor, leaving her family home allowed her to reclaim autonomy over her faith and align it with her own values and beliefs.

> "*… leaving the environment is what supported me massively… I was able to still live*

the life I wanted and practiced my religion in the way that I wanted to" – Noor

Layla spoke about "*exercising choice*" in how she connects with her faith as praying remained a trigger for her. Choosing an alternative regular form of worship seemed to help her regain a sense of control and agency over her spiritual practice.

"It's my own choice [reading Quran daily] of everything from the religion... just because I want to connect, and that's it." - Layla

Salma also spoke about reclaiming authority over her spiritual understanding, trusting her own judgment and abilities instead of relying on others.

"*I don't need another person telling me what is right or wrong at this moment, like I have good linguistic capabilities, I can read, I can listen, I can research myself."* - Salma

Culturally and Faith Sensitive Support

Several participants spoke positively about therapy helping them process and make sense of their SA experience.

"... I started to discuss all these issues [in therapy], I think just saying the words out loud made me think... then I started to connect the dots." – Salma

Participants appreciated support from therapists who "*listened non-judgementally*" and "*believed*" them. They especially valued therapists who understood their cultural and religious contexts and offered advice that respected religious values, like maintaining family ties.

"*… she [therapist] she was Indian… She could relate to the dynamics… so she was able to give practical tips that were more likely to work"* – Yusuf

"…if it's not making you happy to cut your mum off, find other ways to keep boundaries" - Samira

Layla found it difficult to trust her non-Muslim therapist's perspective, as she thought she wouldn't fully understand her religious context.

*"it was really hard for me to even believe... when *non-Muslim therapist* said it [was grooming], it was like, she's not Muslim, what does she know?"* – Layla

She found working with a private Muslim therapist who offers "*psychotherapy from a faith perspective*" helpful as it allowed her to discuss the nuances of her SA without having to explain religious concepts.

"… when I'm trying to process all these feelings about religion, it's been really helpful to process it with somebody who is Muslim" – Layla

Amina expressed a desire for faith-based support but noted its limited availability due to barriers such as lack of funding, regulation, and awareness.

"I never sought support specifically for the spiritual side of things. One of the reasons is, who do you go to? I think faith support isn't very well publicised. Whether or not you trust it, feel that it's good quality. I think a lot of it probably isn't well funded either… a lot of the time you have to pay"– Amina

Those who had not accessed faith-based therapy shared hopes for future support for SA survivors. Yusuf emphasised the value of a religious approach, suggesting access to

someone "*religiously trained*" to help survivors "*re-establish a positive and healthy relationship with religion*". However, he also acknowledged that many SA survivors can be wary of religious figures.

Samira expressed a desire for a therapeutic approach that integrates both "Western" therapy models and Islamic spirituality.

> *"...something that brings the two together... sort of like Western mindset of therapy, but doing it in a way that makes us think about Allah [God]"* – Samira

Hanna felt it important that MH support should be integrated into mosques by training religious leaders and ensuring this resource is accessible within the community.

> *"... really mosques should be advertising what mental health training Imams and people within mosques have… there needs to be funded structures"* – Hanna

Some participants expressed a desire for more "*tangible*" and "*physical support"* for situations such as homelessness when fleeing abuse or getting divorced. Peer support played an important part in Khadijah and Hanna's healing journeys, which they hoped organisations and services would incorporate more.

Hanna stressed the need for clear pathways connecting religious, legal, and social services, while addressing concerns about trust, safeguarding, and the balance between sensitive support and awareness of biases or false allegations, particularly in communities with mistrust of institutions.

> "*… how do you interface with the police? How do you interface with the council?... you've got to safeguard people, but at the same time… we know that police and legal*

systems have behaved in ways that are institutionally racist" – Hanna

Discussion

This study explored the experiences of Muslim survivors of SA within interpersonal relationships, examining the impacts of SA and participants' experiences of seeking support. Four GETS were developed: Power and Control, Feeling Trapped, Impact, and Healing.

Participants described how Islamic teachings were weaponised to exert power and control, with the religious texts being manipulated to legitimise abuse as divinely sanctioned. This aligns with literature on SA in Christian contexts, where misuse of religious authority was used to control and induce fear (Krueger, 2018; Oakley, 2018; Swindle, 2017; Ward, 2011). Participants described a power dynamic that made them feel powerless to challenge the abuse, as non-compliance with the abuser seemed equivalent to displeasing God. This corroborates existing literature where abusers presented themselves as spiritual authorities, making any disagreement seem like defiance against God, which reinforced victims' sense of powerlessness (Ward, 2011). These findings support Herman's (1992) theory that power imbalances are often present in dynamics that result in complex trauma.

All female participants highlighted an intersection between SA and gendered oppression, attributing this to patriarchal structures and male-dominated leadership in Muslim spaces. This supports Isgandarova's (2018) suggestion that these dynamics can result in interpretations of Islamic teachings that disadvantage women both interpersonally and systemically. Walby's (1989) concept of private and public patriarchy explains this, with private patriarchy operating in the home and public patriarchy systemically oppressing women through societal institutions. This aligns with findings on African American Christian women, where SA reinforced sexist norms and coerced them into staying in abusive

relationships (Bent-Goodley & Fowler, 2006). Similarly, Bagwell-Gray et al. (2021) found 20.5% of women reporting domestic violence also experienced SA, highlighting its bidirectional relationship with other abuses.

Participants expressed feeling trapped in abusive relationships due to fear of divine punishment and internalised shame, leading them to believe that challenging their abuser would make them "bad Muslims." This echoes Krueger's (2018) findings, where Christian SA survivors internalised guilt and fear of divine retribution, intensifying their sense of entrapment.

This can be understood through Cognitive Dissonance Theory (Festinger, 1957), which suggests that conflicting beliefs create psychological distress. Pre-spiritual abuse, participants generally believed in a just and compassionate God, yet SA in the name of God contradicted this belief. To resolve this dissonance, individuals may adopt self-blaming narratives, such as believing that resisting their abuser would make them "bad Muslims", to reconcile their suffering with their faith (McGrath, 2017).

Many participants were reluctant to report abuse due to concerns about reinforcing Islamophobic stereotypes. This created a dual entrapment, with one participant describing the tension between protecting her community from scrutiny and feeling unsupported by that same community. Chowdhury et al. (2022) similarly found that Muslim survivors of SA by religious leaders faced community disapproval for "tainting the image" of the religion, and concerns about contributing to Islamophobia often inhibited Muslim women's reporting of Muslim men's violence (Chowdhury, 2021). The compounded impact of Islamophobia has been found to create a "double stigma" for Muslims when help-seeking (McLaughlin et al., 2022). Structural Islamophobia, such as Prevent policies, contribute to state-sponsored anti-

Muslim bias (Hargreaves, 2018) and deepens mistrust between Muslim communities and authorities, further marginalising Muslims (Qurashi, 2018).

Participants described how their communities often minimised or normalised the abuse, shifting blame onto them by emphasising personal responsibility and citing religious texts that encouraged patience. Some were also told they had placed themselves in vulnerable situations. Victim-blaming intensified their trauma; these findings are consistent with the literature, where survivors frequently report that community minimisation, victim-blaming, and marginalisation contribute to secondary trauma (Chowdhury et al., 2022; Ellis et al., 2022; Krueger, 2018).

Psychological impacts were significant. Many participants described dissociation, depression, and self-doubt because of SA, which is consistent with existing research on the psychological impact of SA (Nobakht & Dale, 2018; Johnston, 2021; Swindle, 2017). Some participants also reported physical manifestations of stress, such as frequent illness and cardiovascular issues, aligning with findings from SA survivors within a Christian setting (Crocker, 2021).

Spirituality was profoundly affected, with most participants initially distancing themselves from their faith due to difficulty reconciling their religious beliefs with the abuse they had experienced in the name of religion. This echoes findings from both Muslim and Christian survivors, who often conflated their abusers with their perception of God, eventually leading to cognitive dissonance and spiritual disillusionment (Chowdhury et al., 2022; Crocker, 2021; Ward, 2011). Participants also reported social isolation stemming from a distrust of religious people and communities, reflecting research that links SA with community alienation and a loss of social support (Crocker, 2021; Shupe, 2008).

Using attachment theory (Bowlby, 1979), SA can be seen as disrupting the formation of a secure internal working model (IWM) of a relationship with God. Victims may internalise negative self-perceptions and view God as punitive, leading to an insecure attachment marked by fear and confusion (Kirkpatrick & Shaver, 1990). This can result in survivors distancing themselves from their faith and struggling to trust religious communities, causing social isolation and alienation.

Participants described key factors in their healing journeys, including exposure to diverse viewpoints and alternative ways of practicing religion, which helped them gain new perspectives on God and faith. Many shifted from seeing God as punitive to viewing Him as loving and compassionate, often through independently relearning their religion. Participants also highlighted the importance of distinguishing between cultural practices and religious teachings, which empowered them to resist religious manipulation. This echoes findings from SA survivors in Christian settings, where hearing alternative narratives about God and the church aided healing (Swindle, 2017), and from Muslim female domestic violence survivors, who reported that increased religious knowledge was crucial to their recovery (Chowdhury, 2021).

Healing from SA also involved reclaiming faith by reclaiming autonomy. Many participants described distancing themselves from their abusers, which allowed them to regain control over their faith. Some reclaimed authority over their understanding of Islam, no longer relying on others for interpretation. This supports Krueger's (2018) observation that most survivors of SA in Christian settings, after a period of distance from their faith, either returned to their pre-abuse faith level or strengthened their connection to God.

These findings align with Herman's (2015) theory that trauma recovery occurs in three stages: safety, remembrance and mourning, and reconnection. Most participants achieved safety and autonomy by physically distancing themselves from their spiritual abuser. Their efforts to process and come to terms with the abuse, such as seeking therapy, reflect the remembrance and mourning phase. Survivors' reclaiming and relearning their faith on their own terms corresponds to the reconnection phase.

All participants had accessed MH support after experiencing SA and had mixed views on therapy. Some found mainstream therapy helpful for making sense of the abuse, and developing self-compassion, consistent with trauma literature (Steger & Park, 2012). Most participants emphasised the need for culturally sensitive and faith-based therapy, with one example being receiving practical advice on setting boundaries with spiritually abusive family members without severing ties. Muslims' preference for therapists who are also Muslim has been documented (Kelly et al., 1996; McLaughlin & Ahmad, 2022).

Some participants expressed frustration at the difficulty of finding quality faith-based therapy and voiced concerns about its regulation. Several called for a combination of Western therapy and Islamic spirituality in treatment, while others suggested that imams and religious leaders should receive MH training. This supports existing evidence on Muslim's positive perception of imam collaboration within therapy settings (McLaughlin & Ahmad, 2022), though some participants acknowledged that this may not be suitable as SA survivors are often wary of religious figures.

Participants also identified the need for practical support, such as help for those at risk of homelessness, which reflects the basic needs highlighted in Maslow's hierarchy of needs (McLeod, 2007). Others mentioned the challenges of navigating community distrust and

concerns about false allegations, pointing to a need for organisations to balance cultural sensitivities with protective interventions.

Strengths and Limitations

This study is the first qualitative exploration of Muslims' experiences of interpersonal SA, contributing valuable insights to a limited evidence base.

IPA methods provide in-depth understanding of a small, homogenous group, but findings may not be broadly generalisable. All participants identified as Muslim, so the experiences of those who no longer identify as Muslim after SA are not represented. Additionally, the study focused on British Muslims, which may limit the transferability of findings to Muslims in other countries, where cultural contexts and religious interpretations may differ. All participants were female, bar one, which could reflect either a skewed perspective or the higher vulnerability of women to SA. The study also did not examine Muslims' experiences of SA within religious institutions or by religious leaders so findings may not be representative of this group. Furthermore, the researcher's identity as a visibly Muslim woman may have influenced what participants felt comfortable sharing. Finally, the study used purposive recruitment, so participants self-selected and had all accessed therapy after experiencing SA. This could mean they had received more support in processing their experiences and were therefore more willing to share, which may limit the representativeness of the wider Muslim population.

Clinical implications

This study highlights a significant gap in recognising SA, with many participants unaware of the concept even after accessing therapy. Training in religious and spiritual

competencies is critical for MHPs to identify SA's characteristics and impacts, explore it sensitively, and address its intersections with other forms of abuse (Oakley et al., 2024; Vieten & Scammell, 2015; Sajed, 2021). Since survivors often lack the language to describe their experiences, therapists should initiate discussions about SA where appropriate (Swindle, 2017).

Given the powerlessness associated with SA, building trust and safety in therapy is essential. MHPs should empower survivors by prioritising their choices, ensuring transparency in safeguarding procedures, and respecting their autonomy (Herman, 1998; Oakley & Kinmond, 2013). Therapists must also respect the role of religion in survivors' lives in a person-centred way, whether through integrating religious concepts, collaborating with religious leaders, or avoiding religion entirely, depending on the survivor's preferences (McLaughlin et al., 2022). Ongoing reflexivity and supervision are essential to mitigating MHPs' implicit biases (Oakley et al., 2024).

To address social isolation and community rejection, MHPs should support survivors in rebuilding relationships and fostering belonging through therapeutic group spaces and alternative safe community resources. Psychoeducation is key to normalising responses to abuse, building resilience, and promoting help-seeking (Bridges et al., 2015).

Recognising SA as a form of abuse, policies must provide clear guidelines for disclosures, safeguarding measures, and addressing coercive control (Krueger, 2018; Oakley et al., 2018). However, statutory agencies must respect survivors' religious practices while ensuring protection from SA (Sajed, 2021). Collaboration among MH services, faith leaders, community organisations, and safeguarding bodies is essential to prevent and sensitively address SA.

Given participants' tension between protecting Islam and escaping abuse, services must train MHPs to address Islamophobia and its impacts, whilst promoting inclusivity and diversity in the workplace (Rashid, 2024). MHPs should reflect on their perceptions of Muslims to reduce bias (Samuels et al., 2021), initiate conversations about Islamophobic microaggressions with clients (Haque et al., 2019), and advocate for systemic change (Jordan & Seponski, 2018). Policy reform is essential to reduce institutional Islamophobia and ensure accessible support for victims (Younis & Jadhav, 2019).

Future research

Given the limited research, future studies should examine Muslims' experiences of SA in diverse contexts, including different interpersonal relationships, abuse by religious leaders, and within religious institutions. Including participants who no longer identify as Muslim will capture a broader range of experiences. To increase generalisability, quantitative research with larger sample sizes could use questionnaires based on themes identified in this study.

Since existing SA questionnaires (Keller, 2016; Kock & Edstrom, 2022) have been developed on SA in Christian contexts, developing a tool tailored to accurately measure SA in Muslim contexts is important. Research should also explore the factors that lead some SA survivors to conflate their abuse with God and leave their religion, while others retain their faith. Further investigation into factors that influence recovery, such as religious coping and post-traumatic growth would be valuable.

Co-production with Muslim survivors, religious leaders, and MHPs should be prioritised to explore how religious leaders can contribute to therapeutic interventions for those who desire such support. This collaboration could inform staff training programs and guide the development of culturally sensitive and faith-based therapies. Finally, pilot studies

of adapted individual and group interventions should be evaluated for their effectiveness in supporting Muslim SA survivors.

Conclusion

This study examined Muslims' experiences of SA, revealing psychological, spiritual, and identity-related impacts. Participants faced isolation and a lack of community understanding, emphasising the need for supportive spaces. Many initially struggled to reconcile their faith with the abuse carried out in its name but healed through relearning and regaining autonomy. MHPs must adopt culturally sensitive, faith-based approaches to support survivors in a person-centered way. Future research should develop MHP training to address SA in Muslims and explore collaboration between survivors, MHPs, religious leaders, and safeguarding services for holistic support.

References

Ahmed, S., & Matthes, J. (2017). Media representation of Muslims and Islam from 2000 to 2015: A meta-analysis. *International communication gazette*, *79*(3), 219-244. https://doi.org/10.1177/1748048516656305

Ali, S. R., Liu, W. M., & Humedian, M. (2004). Islam 101: Understanding the religion and therapy implications. *Professional psychology: Research and practice*, *35*(6), 635. https://doi.org/10.1037/0735-7028.35.6.635

Ali, O. M., Milstein, G., & Marzuk, P. M. (2005). The Imam's role in meeting the counseling needs of Muslim communities in the United States. *Psychiatric services*, *56*(2), 202-205. https://doi.org/10.1176/appi.ps.56.2.202

Alkhateeb, S., (2011). From http://projectsakinah.org/FamilyViolence/Understanding-Abuse/The-Muslim-Wheel-of-Domestic-Violence Last accessed 09.12.2024 [Accessed 24th November 2024]

Andrews, T. (2012). What is social constructionism?. *Grounded theory review*, *11*(1).

Bagwell-Gray, M. E. (2021). Women's experiences of sexual violence in intimate relationships: Applying a new taxonomy. *Journal of interpersonal violence*, *36*(13-14), NP7813-NP7839. https://doi.org/10.1177/0886260519827667

Bent-Goodley, T. B., & Fowler, D. N. (2006). Spiritual and religious abuse: Expanding what is known about domestic violence. *Affilia*, *21*(3), 282-295. https://doi.org/10.1177/0886109906288901

Bhaskar, R. (1975). Forms of realism. *Philosophica*, *15*. https://doi.org/10.21825/philosophica.82713

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative research in psychology*, *5*(3), 214-224. https://doi.org/10.1080/14780880802314304

Blue, K. M. (1993). *Healing spiritual abuse: How to break free from bad church experiences*. InterVarsity Press.

Bottoms, B. L., Nielsen, M., Murray, R., & Filipas, H. (2004). Religion-related child physical abuse: Characteristics and psychological outcomes. *Journal of Aggression, Maltreatment & Trauma*, *8*(1-2), 87-114. https://doi.org/10.1300/J146v08n01_04

Bourdieu, P. (1991). *Language and symbolic power*. Harvard University Press.

Bowlby, J. (1979). The Bowlby-Ainsworth attachment theory. *Behavioral and brain sciences*, *2*(4), 637-638.

Bridges, A. J., Karlsson, M., & Lindly, E. (2015). The effect of brief, passive psychoeducation on knowledge and ratings of intimate partner violence in the United States and Argentina. *Journal of Interpersonal Violence*, *30*(2), 272-294. https://doi.org/10.1177/0886260514534775

Carlson, E. B., & Dalenberg, C. J. (2000). A conceptual framework for the impact of traumatic experiences. *Trauma, violence, & abuse*, *1*(1), 4-28. https://doi.org/10.1177/1524838000001001002

Cashwell, C. S., & Swindle, P. J. (2020). When religion hurts: Supervising cases of religious abuse. In *Trauma-Informed Supervision* (pp. 180-203). Routledge. https://doi.org/10.1080/07325223.2018.1443305

Chowdhury, R. (2021). *Understanding domestic violence and abuse in the UK Muslim population* (Doctoral dissertation, Brunel University London). https://bura.brunel.ac.uk/bitstream/2438/24710/1/FulltextThesis.pdf

Chowdhury, R., Winder, B., Blagden, N., & Mulla, F. (2022). "I thought in order to get to God I had to win their approval": a qualitative analysis of the experiences of Muslim victims abused by religious authority figures. *Journal of sexual aggression*, *28*(2), 196-217. https://doi.org/10.1080/13552600.2021.1943023

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299. https://doi.org/10.2307/1229039

Crocker, S. C. (2021). *Persevering Faith: A Qualitative Exploration of Religious Trauma and Spiritual Resilience in Sexual Minority Christians* (Doctoral dissertation, Regent University). https://www.proquest.com/openview/a352d17664b80892a3099f1ebf6328bc/1?pq-origsite=gscholar&cbl=18750&diss=y

Denney, A. S., Kerley, K. R., & Gross, N. G. (2018). Child sexual abuse in Protestant Christian congregations: A descriptive analysis of offense and offender characteristics. *Religions*, *9*(1), 27. https://doi.org/10.3390/rel9010027

Doyle, T. P. (2003). Roman Catholic clericalism, religious duress, and clergy sexual abuse. *Pastoral psychology*, *51*(3), 189-231. https://doi.org/10.1023/A:1021301407104

Dreher, J. (2016). The social construction of power: Reflections beyond Berger/Luckmann and Bourdieu. *Cultural Sociology*, *10*(1), 53-68.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British journal of clinical psychology*, *38*(3), 215-229. https://doi.org/10.1348/014466599162782.

Ellis, H. M., Hook, J. N., Zuniga, S., Hodge, A. S., Ford, K. M., Davis, D. E., & Van Tongeren, D. R. (2022). Religious/spiritual abuse and trauma: A systematic review of the empirical literature. *Spirituality in Clinical Practice*, *9*(4), 213. https://doi.org/10.1037/scp0000301

Fernández, S. (2022). Victims are not guilty! Spiritual abuse and ecclesiastical responsibility. *Religions*, *13*(5), 427. https://doi.org/10.3390/rel13050427

Festinger, L. (1957). *A theory of cognitive dissonance.* Stanford University Press.

Follette, V. M., Polusny, M. A., Bechtle, A. E., & Naugle, A. E. (1996). Cumulative trauma: The impact of child sexual abuse, adult sexual assault, and spouse abuse. *Journal of traumatic stress*, *9*(1), 25-35. https://doi.org/10.1002/jts.2490090104

Garssen, B., Visser, A., & Pool, G. (2021). Does spirituality or religion positively affect mental health? Meta-analysis of longitudinal studies. *The International Journal for*

the Psychology of Religion, *31*(1), 4-20. https://doi.org/10.1080/10508619.2020.1729570

Hall, S. (2001). Foucault: Power, knowledge and *Discourse theory and practice: A reader*, *72*.

Hall, S. 2003. Spiritual Abuse. Singapore: Youthwork, pp. 32–35.

Haque, A., Tubbs, C. Y., Kahumoku-Fessler, E. P., & Brown, M. D. (2019). Microaggressions and Islamophobia: Experiences of Muslims across the United States and clinical implications. *Journal of marital and family therapy*, *45*(1), 76-91. https://doi.org/10.1111/jmft.12339

Hargreaves, J. (2018). Towards a cure for prevent? Building resilience to religious and political forms of violence within British Muslim communities. *Journal of Muslims in Europe*, *7*(2), 190-210. https://doi.org/10.1163/22117954-12341372

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of traumatic stress*, *5*(3), 377-391.

Herman, J. L. (1998). Recovery from psychological trauma. *Psychiatry and Clinical Neurosciences*, *52*(S1), S98-S103. https://doi.org/10.1046/j.1440-1819.1998.0520s5S145.x

Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence--from domestic abuse to political terror*. Hachette uK.

Hill, P. C., & Pargament, K. I. (2008). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. https://doi.org/10.1037/1941-1022.S.1.3

Hurcombe, R., Darling, A., Mooney, B., Ablett, G., Soares, C., King, S., & Brähler, V. (2019). *Truth Project Thematic Report: Child sexual abuse in the context of religious institutions*. Independent Inquiry Child Sexual Abuse. https://www.iicsa.org.uk/reports-recommendations/publications/research/csa-religious-institutions.html

Isgandarova, N. (2018). *Muslim women, domestic violence, and psychotherapy: Theological and clinical issues*. Routledge. https://doi.org/10.4324/9780429469701

Johnston, C. L. (2021). *The predictive relationship of religious trauma and spiritual abuse on meaning-making, trust, and depression*. (PhD Thesis, Northcentral University). https://www.proquest.com/docview/2582791499?pq-origsite=gscholar&fromopenview=true&sourcetype=Dissertations%20&%20Theses

Jootun, D., McGhee, G., & Marland, G. R. (2009). Reflexivity: promoting rigour in qualitative research. *Nursing standard*, *23*(23), 42-47. https://doi.org/10.7748/ns2009.02.23.23.42.c6800

Jordan, L. S., & Seponski, D. M. (2018). “Being a therapist doesn't exclude you from real life”: Family therapists’ beliefs and barriers to political action. *Journal of Marital and Family Therapy*, *44*(1), 19-31. https://doi.org/10.1111/jmft.12244

Keller, K. H. (2016). *Development of a spiritual abuse questionnaire*. (PhD thesis, Texas Woman's University). https://twu-ir.tdl.org/server/api/core/bitstreams/f591874a-dd01-4883-8363-3f76499cde98/content

Kelly Jr, E. W., Aridi, A., & Bakhtiar, L. (1996). Muslims in the United States: An exploratory study of universal and mental health values. *Counseling and Values*, *40*(3), 206-218. https://doi.org/10.1002/j.2161-007X.1996.tb00853.x

Kirkpatrick, L. A., & Shaver, P. R. (1990). Attachment theory and religion: Childhood attachments, religious beliefs, and conversion. *Journal for the scientific study of religion*, 315-334.

Koch, D., & Edstrom, L. (2022). Development of the spiritual harm and abuse scale. *Journal for the scientific study of religion*, *61*(2), 476-506. https://doi.org/10.1111/jssr.12792

Krueger, M. (2018). *Clergy Nonsexual Misconduct in Protestant Churches: A Mixed Methods Study*. (Doctoral project, California Southern University). https://www.proquest.com/docview/2401981826?pq-origsite=gscholar&fromopenview=true&sourcetype=Dissertations%20&%20Theses

Langone, M. (1995). Secular and religious critiques of cults: Complementary visions, not irresolvable conflicts. *Cultic Studies Journal*, *12*(2), 166-186. https://www.prem-rawat-bio.org/academic/langone.html

McGrath, A. (2017). Dealing with dissonance: A review of cognitive dissonance reduction. *Social and Personality Psychology Compass*, *11*(12), e12362.

McLaughlin, M. M., Ahmad, S. S., & Weisman de Mamani, A. (2022). A mixed-methods approach to psychological help-seeking in Muslims: Islamophobia, self-stigma, and therapeutic preferences. *Journal of consulting and clinical psychology*, *90*(7), 568. https://doi.org/10.1037/ccp0000746

McLeod, S. (2007). Maslow's hierarchy of needs. *Simply psychology*, *1*(1-18).

Nobakht, H. N., & Yngvar Dale, K. (2018). The importance of religious/ritual abuse as a traumatic predictor of dissociation. *Journal of interpersonal violence*, *33*(23), 3575-3588. https://doi.org/10.1177/0886260517723747

Oakley, L., Kinmond, K., & Oakley, L. (2013). *What is spiritual abuse?* (pp. 7-22). Palgrave Macmillan UK. https://doi.org/10.1057/9781137282873_2

Oakley, L., & Kinmond, K. (2014). Developing safeguarding policy and practice for spiritual abuse. *The Journal of Adult Protection*, *16*(2), 87-95. https://doi.org/10.1108/JAP-07-2013-0033

Oakley, L., Kinmond, K., & Humphreys, J. (2018). Spiritual abuse in Christian faith settings: Definition, policy and practice guidance. *The Journal of Adult Protection*, *20*(3/4), 144-154. https://doi.org/10.1108/JAP-03-2018-0005

Oakley, L., Kinmond, K., & Blundell, P. (2024). Responding well to Spiritual Abuse: practice implications for counselling and psychotherapy. *British Journal of Guidance & Counselling*, *52*(2), 189-206. https://doi.org/10.1080/03069885.2023.2283883

Office of Public Sector Information (OPSI) (1998). The Data Protection Act https://www.legislation.gov.uk/ukpga/1998/29/contents

Pence, E., & Paymar, M. (1993). *Education groups for men who batter: The Duluth model*. Springer Publishing Company.

Qurashi, F. (2018). The Prevent strategy and the UK 'war on terror': embedding infrastructures of surveillance in Muslim communities. *Palgrave Communications*, *4*(1), 1-13. https://doi.org/10.1057/s41599-017-0061-9

Rashid, M. (2024). Investigating Institutional Islamophobia in the National Health Service: The Voices and Lived Experiences of Muslim Clinicians (Doctoral dissertation, University of Leicester). https://figshare.le.ac.uk/articles/thesis/Investigating_Institutional_Islamophobia_in_the_National_Health_Service_The_Voices_and_Lived_Experiences_of_Muslim_Clinicians_/27877110?file=50682903

Sajed, E. (2021). *Spiritual abuse:* Reconceptualising coercive control in religious contexts. The Muslim Women's Resource Centre, University of Strathclyde. https://mwrc.org.uk/wp-content/uploads/2023/03/amina-resources-Spiritual-Abuse-2021.pdf

Salgado, A. C. (2014). Review of Empirical Studies on Impact of Religion, Religiosity and Spirituality as Protective Factors. *Journal of Educational Psychology-Propositos y Representaciones*, *2*(1), 141-159. https://doi.org/10.20511/pyr2014.v2n1.55

Samuels, E. A., Orr, L., White, E. B., Saadi, A., Padela, A. I., Westerhaus, M., & Gonsalves, G. (2021). Health care utilization before and after the "Muslim Ban" executive order among people born in Muslim-majority countries and living in the US. *JAMA Network Open*, *4*(7). https://doi.org/10.1001/jamanetworkopen.2021.18216

Shaw, R. (2010). Interpretative phenomenological analysis. *Doing qualitative research in psychology: A practical guide*, 177-201.

Shupe, A. (2008). Rogue clerics. *The Social Problem of Clergy Deviance. New Brunswick: Transaction Publishers*.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5(1), 9–27. https://doi.org/10.1080/17437199.2010.510659

Smith, J. A. (2017). Interpretative phenomenological analysis: Getting at lived experience. *The journal of positive psychology*, *12*(3), 303-304. https://doi.org/10.1080/17439760.2016.1262622

Smith, J. A., Larkin, M., & Flowers, P. (2021). Interpretative phenomenological analysis: Theory, method and research.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British journal of pain*, *9*(1), 41-42. https://doi.org/10.1177/2049463714541642

Steger, M. F., & Park, C. L. (2012). The creation of meaning following trauma: Meaning making and trajectories of distress and recovery. https://doi.org/10.1037/13746-008

Swindle, P. J. (2017). A twisting of the sacred: The lived experience of religious abuse. (PhD dissertation, The University of North Carolina at Greensboro). https://libres.uncg.edu/ir/uncg/f/Swindle_uncg_0154D_12186.pdf

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative social work*, *11*(1), 80-96. https://doi.org/10.1177/1473325010368316

Van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress: Official Publication of the International Society for Traumatic Stress Studies*, *18*(5), 389-399. https://doi.org/10.1002/jts.20047

Vieten, C., & Scammell, S. (2015). *Spiritual and religious competencies in clinical practice: Guidelines for psychotherapists and mental health professionals*. New Harbinger Publications.

Walby, S. (1989). Theorising patriarchy. *Sociology*, *23*(2), 213-234. https://doi.org/10.1177/0038038589023002004

Ward, D. J. (2011). The lived experience of spiritual abuse. *Mental Health, Religion & Culture*, *14*(9), 899-915. https://doi.org/10.1080/13674676.2010.536206

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Eds.), 84 Qualitative psychology: A practical guide to methods (pp. 235-251). Sage.

Younis, T., & Jadhav, S. (2020). Islamophobia in the National Health Service: an ethnography of institutional racism in PREVENT's counter-radicalisation policy. *Sociology of Health & Illness*, *42*(3), 610-626. https://doi.org/10.1111/1467-9566.13047

Section C: Appendices of Supporting Material

Appendix A: *Themes, Sub-themes, code examples, and illustrative quotes*

Theme	**Sub-theme**	**Code examples**	**Illustrative quotes**
1. Therapy's not for us: barriers.	1.1 Stigma	'Community judgement of faith due to MH issues' 'Community isolation due to MH issues'	"Lots of people would question your faith, if you seek help, which is total nonsense" (AlDousari & Prior, 2019) "Our people do not {go to the Doctor when depressed}, in fact they hide it because they think that if people know about it they will not accept them and they'll be laughed at and would be completely shut off because there is this prejudice" (Cinnirella and Loewenthal, 1999)
	1.2 Causal beliefs	'MH issues are God's will so human interventions will not work'	"The illness is Allah's will. Allah says "And when I am ill, it is He Who cures me" (26:80). It is a trial. We have to be patient and keep making Dua to Allah. We

			can do nothing except making Dua.” (Eltaiba & Harries, 2015)
		‘Direct relationship with God renders professional help useless’	In our religion we don’t need a person to take our religious responsibilities, nothing like the Pope, or Archbishop, or Brahman, or Rabbi. Every one of us is responsible to learn whatever we can by ourselves, and are answerable to God for it. . .in our religion we can talk to God directly, we don’t need help from anyone” (Cinnirella and Loewenthal, 1999)
	1.3 Lack of appropriate services	‘Mainstream therapy not reletable’	“Some expressed the interventions on offer by mainstream mental health services and therapists in general as lacking an understanding of their culture and religion, therefore they did not consider therapy

		'Need for professionals to respect and support cultural difference'	as relevant or relatable to them." (Hammad et al., 2020) "...I do not think it is realistic that people from all over the world must follow the same norms and rules.... For example, if I am happy to do this activity let me do this in my own way.... They must know I am not Swedish..." (Pooremamali et al., 2012)
	1.4 Alienation	'Can't be authentic self' 'Services not designed for us'	"I am embarrassed in front of a Swedish therapist and worried to be considered different, therefore I pretend to be another person" (Pooremamali et al., 2012) "I'm sure there's, there's young girls or young boys who are having difficulty in their own family and they do, they don't know where to, actually to go to really. . .. We thought that service was for, was only for, you know what I mean, for white community and not for

			us." (Whittaker et al., 2005)
2. Relationship between therapy and Islam	2.1 Therapeutic value of practicing Islam	'Faith is comforting'	"Religion helps those who understand it. Reading or hearing Quran cools (calms) the nerves. Sometimes I make supplication in order to ask for help, and I cry. You feel a weight on your body, that nothing in this world is worthwhile. When you read Quran or pray, you feel comfort all over your body, God makes you feel this sense of calm." (Rayes et al., 2021)
		'Faith provides meaning & purpose'	"To believe in Allah, to know, that everything stems from Allah. I know that he protects everyone. When bad things happen to me, it doesn't mean that he doesn't love me, but that he wants to protect me from other things. We also believe in life after death. We

			are put to a test in this world to decide if we go to paradise or to hell." (Vandekinderen et al., 2022)
	2.2 Islam and therapy go hand in hand	'Professional MH support enhances Muslims' spiritual growth' 'Islam and therapy are congruent'	"Having counselling is one of the blessings in my life. Islam calls for being professional and encourages each person to have a specialty in life, like counsellors and other helping professions are essential to help us understand ourselves and consequently strengthen our faith rather than relying on unprofessional support." (Al-Dousari & Prior, 2020) "Prayer can enlighten you, similar to the yoga or meditation that I follow. The Quran also describes how you can relinquish troubles. The imam tells stories about what people have experienced. You also can find such stories on YouTube, they are very supportive.. In fact, it's the same with the imam but he relies on different methods. (…) My psychotherapist

			says: "If you have troublesome people in your life, just throw them away." That is also in the Quran: try to extract troublesome people from your life in a respectful, polite, and friendly manner." (Vandekinderen et al., 2022)
3. Therapy can be helpful: facilitators	3.1 Culturally sensitive and faith informed services	'Faith integrated therapy' 'Religious practice as part of MH interventions'	"The therapist needs to understand and include my religion otherwise I wouldn't be able to relate." (Hammad et al., 2020) "They also stated the necessity for the therapist to pay attention to an intervention that took account of their cultural preferences and values in their intervention plan. A client said: "... the therapist must understand why I refused to go to the Fountain House and preferred to go to the mosque." (Pooremamali et al., 2012)

	3.2 Therapist characteristics	'Advantages of therapist from similar background' 'Same faith therapist can provide psychological & spiritual benefits'	"The advice was very much tailored to me, and it was tailored to me because my therapist understood what background I came from because my therapist was from a similar sort of background" (Tarabi et al., 2020) "It is good to take counselling with religion, like going to a counsellor with the same faith, because he will give you tips on both ways. They are very interlocked and make sense together" (Al-Dousari & Prior, 2020)
	3.3 Perceiving accessing MH care as a religious obligation	'Professional MH support as religiously encouraged medicine'	"I mean, in, in our book it says use the medicine as well, which it says in the Qur'an you have to use it. Because it's like medicine is, is the professional so you have to go and, and talk to them as well. So it's both ways really." (Whittaker et al., 2005)

		'Islam promotes proactive help-seeking'	"God said, "For everyone who tastes, there is medicine. "God says, "Ask for help [my worshipper], and I will help you," if you want to seek treatment, and I will help you find it through your prayer. I will make the heart of the doctor feel for you, the pharmacist will help you. If I am sitting at home and wait for God to treat me. God will not send us treatment in an envelope." (Rayes et al., 2021)

Appendix B: *Research poster*

MUSLIM PEOPLE'S EXPERIENCES OF SPIRITUAL ABUSE

RESEARCH OPPORTUNITY

My name is Fatima Elashry. As part of my Doctoral degree in Clinical Psychology, I am conducting a study on **Muslim people's experiences of spiritual abuse (SA).**

WHO CAN TAKE PART?

Adults, living in the **UK** that identify as **Muslim,** who:

- **Have experienced spiritual abuse,** with at least 6 months **since** their **last spiritual abuse** experience
- **Are able to reflect** on their experience **without being caused significant distress**

WHAT WILL IT INVOLVE?

You will be invited to attend an individual 60-90 minute online interview with me to discuss your SA experience.

WHAT IS SPIRITUAL ABUSE?

For the purpose of this research, SA is understood as: ***the misuse of power within a framework of spiritual or religious belief to coerce, control or exploit.***

PARTICIPANTS WILL BE OFFERED £15 AS A THANK YOU

To take part or for more information, email **f.elashry300@canterbury.ac.uk**

Canterbury Christ Church University

This doctoral research study has received Canterbury Christ Church University ethical approval.

Appendix C: *Participant Information sheet*

Information about the research

Understanding Muslim people's experiences of spiritual abuse

Hello. My name is Fatima and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?
This research aims to explore the experiences of Muslims who have faced spiritual abuse. Spiritual abuse is not spoken about often and lots of people are unsure of what is means exactly. In this research, spiritual abuse is understood as the misuse of religious beliefs or religious scripture to exert power and control over someone. Spiritual abuse can happen in religious organisations or in personal relationships. Spiritual abuse can happen in any religious group, but most existing research is on the experiences of Christians. Learning more about Muslim people's experience of spiritual abuse can help professionals and services learn more about what it is and how to better support those affected.

Why have I been invited?
You have been invited to take part because you responded to an advertisement asking for Muslim people who have experienced spiritual abuse to participate.

Do I have to take part?
No, it is up to you to decide whether to join the study. In other words, this is entirely voluntary. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What does taking part involve?
You will be invited to take part in an interview with me in which I will ask questions about your experience of spiritual abuse. This will take around an hour, depending on how much you decide to share. You will also be able to take breaks during the interview, if you would like to.

The interview will be audio-recorded to make sure that information about your experiences are recorded accurately. Only my supervisors and I will have access to this recording and these will be stored safely and securely. I will analyse the interview discussion using a method that explores the meaning of experience. Then, I will summarise the themes of your interview.

After the interviews have been analysed, the recordings will be permanently deleted. All information taken from interviews will be completely anonymous, apart from your age, gender and whether your experience was within an organisational setting or a personal relationship.

We will only meet once for a single interview, after which I will offer a verbal and written debrief to you, immediately after the interview. I will also offer a follow up 1 week after the interview for another debrief, if you would like. This is to check in on your emotional wellbeing after participating in the interview.

Expenses and payments
You will be offered £15 as a 'thank you' for participating.

What are the possible disadvantages and risks of taking part?
You may experience some distress during or after the interview since the topic of spiritual abuse can bring up some difficult feelings. I will check in with you during and after the interview and remind you that you can take breaks. You can also let me know if want to stop the interview or withdraw at any point. If you think that talking about this topic will cause significant distress, we'd recommend that you don't participate.

What are the possible benefits of taking part?
You may find it beneficial to be able to share and reflect on your experiences in an open and non-judgemental space. Your contributions to this research may also help improve professionals' awareness and understanding of the unique experiences and challenges of Muslims who have faced spiritual abuse. This may help professionals and services to improve the support provided to Muslims affected by spiritual abuse.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will information from or about me from taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be kept strictly confidential and anonymous. You have the right to check the accuracy of the data held about you and you have the right to correct any unlikely errors. You can contact me to ask for access to the information held about you if you would like to.

Exceptions to confidentiality
The only time I would have to break confidentiality is if you shared something with me during the interview that raised concerns about your current safety or the current safety of others e.g., the ongoing abuse of a vulnerable person. If this happened, I would let you know, where possible, that I will have to break confidentiality and we would discuss the appropriate people I need to report it to.

This completes part 1.
If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?

You are free to withdraw at any time, without giving a reason. If you withdraw from the study, I would like to use the data collected up to your withdrawal.

What if I have any concerns or wish to make a complaint?

If you have any concerns about any aspect about how you have been treated during your participation in this research, I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number 01227 927070. Please leave a contact number and say that the message is for me Fatma and I will get back to you as soon as possible. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology –fergal.jones@canterbury.ac.uk

What will happen to the results of the research study?

Findings from the study will be summarised and written about in a report that is submitted to Canterbury Christ Church University. The report may also be published in academic journals and will be published on the University's website. You will be provided with a summary of the final report and you have the option of requesting a copy of the full thesis once it is complete. Anonymised quotes from the interviews may be used but you will not be identified in the report or publication.

Who is sponsoring and funding the research?

This research is being funded by Canterbury Christ Church University.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by The Salomons Ethics Panel, Salomons Institute for Applied Psychology, Canterbury Christ Church University.

Support

NHS psychological therapies can be accessed for free via your GP. Whilst spiritual abuse is not commonly spoken about in the UK, existing forms of therapy can support you with the difficulties that can arise from other types of abuse. You may wish to take a copy of this information sheet with you if you feel that it is relevant.

Inspirited Minds (https://inspiritedminds.org.uk) and MindWorks (https://mindworksuk.co.uk/) are Muslim Mental Health organisations that offer low cost therapies for people who are experiencing financial hardship.

Contact

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 01227 927070. Please say that the message is for me Fatima and leave a contact number so that I can get back to you. You can also contact me at fm300@canterbury.ac.uk

THANK YOU

Appendix D: *Consent form*

Ethics approval number:
Version number: 1
Participant Identification number for this study:

CONSENT FORM

Title of Project: Muslim people's experiences of spiritual abuse
Name of Researcher: Fatima Elashry

Please initial box

1. I confirm that I have read and understand the information sheet dated 26/05/22 (version 1) for the above study. I have had the opportunity to consider the information and understand limits to confidentiality regarding safeguarding. I have had the opportunity to ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw from participating at any time without giving any reason. I understand that I am free to withdraw my data until transcription begins, without giving any reason.

3. I understand that data collected during the study may be looked at by the research team (Dr Carmel Digman and Dr Jeyda Hammad). I give permission for these individuals to have access to my pseudonymised data.

4. I understand that my participation will be audio-recorded, transcribed and analysed, with possible use of (anonymised) verbatim quotation.

5. I understand that participating in this interview may be potentially distressing.

5. I agree that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings.

6. I agree for my anonymous data to be used in further research studies involving researchers from this team

7. I agree to take part in the above study.

Name of Participant____________________ Date________________

Signature ___________________

Name of Person taking consent ______________ Date_____________

Signature ____________________

Appendix E: *Interview schedule*

Introductory questions:

Thank you for agreeing to participate in today's interview. Before we start, I would just like to remind you to only share as much as you feel comfortable to do so. We can stop or pause the interview at any point if needed.

Have you read the participant information sheet? Do you have any questions? Do you understand the limits of confidentiality with regards to safeguarding?

Please can you being by telling me how you understand/define spiritual abuse? What does it mean to you?

Main Exploration

1. Please can you tell me about your experience of spiritual abuse?

Prompts:

- How did it begin? How long did it last? What happened?
- What was your relationship with the perpetrator like? Which setting did it occur in?
- What was your understanding of your experience at the time? What's your understanding now?

2. How did the experience of spiritual abuse affect you?

Prompts:

- How did it impact your sense of self/ identity?
- How did it affect your spirituality/faith?
- How did it impact your mental health / relationships / social activities?

3. What was it like to realise that what you had experienced was spiritual abuse?

Prompts:

- What was your process of realising? How did you come to know?
- What helped you realise that it was SA?
- What was your understanding of SA?
- What thoughts / feelings came up for you then?
- What thoughts / feelings come up for you now?

4. What was your experience of seeking support during or after your experience of SA?

Prompts:

- What was the process of support like?
- How did you feel about seeking support?
- Where did you seek support from?
- What was helpful or unhelpful when seeking support?
- How understanding were others/services?
- How effective was the support?
- What were your expectations? How did these compare to reality?

5. How did your Muslim identity (Muslim-ness) or spiritual beliefs affect your attempts to seek support?

Prompts:

- What was it like to seek support as a Muslim or someone with spiritual beliefs?
- What was it like trying to explain your experience to others?
- What would you hope to be different?

Closing questions:

Before we finish, I just want to check in on how you're feeling after today's interview, as I'm aware that we've spoken about some sensitive content.

How did it feel for you? How are you doing now?

(If needed)

- Do you have a supportive person you can chat to?
- How are you going to look after yourself for the rest of your day?

Thank you for your time today. I really appreciate it.

*(*Provide PDF of mental health and wellbeing resources*)*

Appendix F: *Debrief sheet*

DEBRIEF SHEET

Title of Project: Muslims' experiences of spiritual abuse

Name of Researcher: Fatima Elashry

Thank you for participating in this study, it is very much appreciated. This project hopes to understand Muslims' experiences of spiritual abuse. It is hoped that the results of this project will help improve understanding of the support that is required for Muslims who have experienced spiritual abuse.

Data Storage & Withdrawal

Your data will now be securely stored and will be destroyed when no longer needed, as outlined in the information sheet provided to you. You have the option to withdraw from the study within one week of your interview, after which your data will be included in the analysis. If you wish to withdraw, please contact me via the email below.

Contact Details

If you wish to contact me after participating in this study, you can leave a message on a 24-hour voicemail at 01227 927070. Please mention that the message is for me, Fatima Elashry, and provide your contact number so I can return your call. Alternatively, you can email me at fm300@canterbury.ac.uk. Should you require additional support after the interview, I recommend reaching out to your GP or one of the support services listed below:

Further Support

If you require further support for your mental health or emotional wellbeing following today's interview, you may wish to contact another organisation. Whilst there are no specific organisations that offer support exclusively for those who have experienced spiritual, existing forms of therapy can support you with the difficulties that can arise from abuse.

Muslim Mental Health organisations

Muslim Women's Helpline

- National specialist, faith and culturally sensitive helpline and counselling service
- Offer confidential and non-judgemental information, support and guidance to those who have experienced abuse or mental health issues
- Provide support to women and men of faith and no faith
- Contact by phone 10am- 4pm (Mon-Fri) on 0800 999 5786
- Text 10am-4pm (Mon-Fri) on 07415 206 936
- Website: https://www.mwnhelpline.co.uk/

Muslim Youth Helpline

- A Muslim mental health charity that provide faith and culturally sensitive support to Muslims in the UK
- No age limit to those who can access support
- Provide support 4pm-10pm, 365 days a year
- WhatsApp on 0808 208 2008
- Webchat: https://myh.org.uk/how-we-can-help/chat-with-us/#
- Website: https://myh.org.uk/

Inspirited Minds

- A Muslim mental health charity that aims to provide spiritually and culturally sensitive psychological support
- Provide telephone/video and face-to-face services
- Accept reduced rates for those enduring financial hardship
- Webiste https://inspiritedminds.org.uk

MindWorks

- Muslim mental health charity that provides low-cost, faith-sensitive psychological support
- Provide counselling, psychotherapy and faith-based therapy
- Website: https://mindworksuk.co.uk/

Mental Health Charities

Samaritans

- A mental health charity that provides emotional support to anyone in emotional distress
- 24 hour helpline free from any phone: 116 123
- Website: https://www.samaritans.org/

Mind

- A mental health charity that provides advice and support to anyone experiencing mental health issues
- Call 9am-6pm (Mon-Fri) on 0300 123 3393
- Website: https://www.mind.org.uk/

NHS Psychological Support

- You can ask your GP to refer you to Talking Therapies
- Directly contact your local Talking Therapies service. Use this website to find your local service: https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/nhs-talking-therapies/

If you are experiencing significant distress or feel that you are unable to ensure your own safety, we recommend going to your nearest A&E department for immediate assistance.

Concerns & Complaints

If you have any concerns regarding any aspect of the research, please feel free to contact me, and I will do my best to address them. You can reach me by leaving a message on the 24-hour voicemail line at 01227 927070. Be sure to mention that the message is for me, Fatima Elashry, and provide a contact number so I can respond promptly.

If you are still dissatisfied and wish to file a formal complaint, you may contact Dr. Fergal Jones, Research Director of the Clinical Psychology Programme at the Salomons Institute for Applied Psychology, via email at fergal.jones@canterbury.ac.uk.

Sharing of Project Results

If you have agreed to be contacted regarding the study's findings, I will reach out to you once the project is complete to share the results.

Thank you once again for your participation.

Appendix G: *Ethical approval*

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Appendix H: *Extracts from bracketing interview*

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Appendix I: *Abridged research diary*

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Appendix J: *GETS, sub-themes and related PETS*

Group Experiential Theme	**Sub-theme**	**Examples of Related Personal Experiential Themes**
Power & control	Weaponised Islam	'Religious manipulation to facilitate grooming' 'Religion twisted to subjugate' 'Religion used to control'
	Conditioned to view abuser as spiritual authority	'Abuser perceived as spiritual superior' 'Equating Abuser's commands with God's will' 'Inability to question spiritual abuser"
	Gendered oppression	'Patriarchal religious interpretations" 'Gendered abuse via Islamic manipulation' 'Justifying gendered oppression'
	Multiple forms of abuse	'Overlapping types of abuse' 'Co-occurring forms of abuse' 'Intersecting forms of abuse'
Feeling trapped	Fear & shame	'Internalised stigma and self-blame' 'Afraid of being a bad Muslim' 'Fear of displeasing God'
	Community response	'Shamed and blamed by community' 'Family and community response' 'Abandoned by community'
	Protecting the religion	'Fear of contributing to islamophobia' 'Fear of tainting the religion' 'Fear of conversion being undermined by SA'
Impact	Psychological	'Emotional detachment' 'Anxious & paranoid'

		'Suicidal'
	Spiritual	'Negative perception of God' 'Religious worship acts are triggering' 'Religion associated with abuse'
	Social	'Isolated' 'Alone' 'Distrustful of people perceived as religious'
Healing	Relearning	'Exposure to different ways of practicing' 'New perspectives on God and religion' 'Relearning the religion independently'
	Reclaiming faith	'Regaining autonomy' 'Regaining control over religious practice' 'Reconnecting to faith on own terms'
	Culturally & faith sensitive support	'Culture & faith sensitive support is valuable' 'Distrust of non-faith-based perspectives' 'Desire for accessible faith-based therapy'

Appendix K: *Salma's coded transcript exported from Nvivo*

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Appendix L: *Salma's PETs, sub-themes and experiential statements*

Personal Experiential Theme	**Sub-theme**	**Experiential statement**
Weaponised Islam	SA throughout life	*I was made to believe that I was inadequate as a child and I was rebellious and I wasn't worthy of being loved* *just how that [SA in childhood] influenced the rest of you know, my childhood and and the years after* *I went through it [SA] again later on in life, when I got married* *what you learn as a child is the behavior that then becomes acceptable. I accepted behaviors because I didn't know anything else you know.*
	Imbalanced power dynamics	*I was so conditioned to just toe the line, like I was just so conditioned to fall into line* *they are the elders, and they all have far greater like religious knowledge than I do,* *it was very much on the like I was a naive child, and they were the older caregivers,*
	Control	*the Islamic context of like the hell fire…was used to keep, keep us in line* *the Quran was twisted, in my opinion, to instill fear* *very quickly get like the spiritual quotes to like, the religious quotes to like, bring me back to my place.*
	Co-occurring forms of abuse	*[SA] perpetuated and reinforced with physical abuse as well* *other other forms of abuse start to take place as well. So there was definitely, like emotional abuse*
	Justifying gendered oppression	*the relationship broke down completely, like we had very little emotional or verbal communication, but there was still an expectation of like…a sexual relationship… I had said no multiple times…then I was quoted many times the same Hadith… a woman who doesn't say yes will be cursed by the angels, like, like the whole night… it was used to, like, pressure me into a situation that I did not want to be involved in… eventually I just stopped saying no, because it was so it caused so much problem. But I also wasn't saying yes*

Trapped	Fear	*if I wanted to please Allah, then this was this, you know, was the role that I needed to play* *you also believe that you are going to face punishment for the rest of your like, eternal life because of these things, it brings you back to that place of hopelessness* *my fear of punishment kept me trapped in a situation that was abusive far longer than it needed to*
	Shame	*I was definitely trapped, because I was, at the time, very practicing. So I also had this guilt, like religious guilt, that if I stepped away, or if I stepped out of this, because I only knew, like the punishing side of our religion, I felt like, if I stepped away from it, after these people had told me to stay… then I would be like, going against our religion* **Interviewer** What do you think stopped you from seeking professional help at the time*?* **Salma** *Shame. That I was doing something against our religious views.*
	Community and family response	*because I sought help, at least four or five times, and was very quickly shut down, that this was very normal, these behaviors, like I was the one that needed to, like, try again* *because as a Muslim woman, the correct way to leave your marriage is with the support of the male member of your family, and I didn't have his support.* *the fact that nobody else would kind of saw that there was anything wrong, meant that I now had to just live with that. That was the punishment, you know.* *that intergenerational trauma that says I've been through this, put up with it, you know*
	Protecting religion	*We have been under attack from so many different places externally that it then feels very difficult to accept that there is internal attack happening as well.* *It's like we it's like Muslims have an autoimmune disease. You know, we just have to accept that sometimes it's coming from within ourselves as well.*
	Lack of supportive systems	*I had grown up in a European country, and with European like western ideals and understanding, I guess, and with there are also sets of rules and regulations that are safeguarding regulations set to protect people. But I was now living in a country where those didn't exist, that I was aware of. There*

		were, they, they did not exist in the same way that they did the country that I've been raised in. *I just had no idea where I could seek help, because my genuine understanding was that there was nowhere.* *you just don't know where to get help basically*
Impact	Emotional & psychological	*I had very low self-esteem, um, really low self-esteem* *I became stripped of just every piece of personality that I had that I suddenly felt like a very unintelligent* *I really dissociated often. I think I I just wasn't connected to who I was, just as an individual. I was very fearful* *I felt very demotivated. I was incredibly depressed* *I began to question, like, just my own sanity as well* *If you could be alive, physically, but dead internally… I just lived, just hoping that like death would come.*
	Physical	*[Stress from SA] manifested in like physical symptoms as well* *I was experiencing physical manifestations of stress, like I was having, like, I regularly had outbreaks of, like, hives. I was really, like, struggling physically. I was just exhausted all the time*
	Spiritual	*it pushed me away from the religion because I believed that was what the religion represented* *difficult to reconcile, like, the idea that spiritual faith is something positive* *I am still a practicing Muslim, but I practice the faith in a private manner*
	Social	*I became very like, isolated from my other from the community* *I don't like being part of the main Islamic community. I'm, you know, that I'm a part of, because I'm very fearful of people starting to like, judge or comment* *I wanted to distance myself from the human aspect of the religion, but wanted to pull myself closer into the ethereal aspect of the religion*
Healing from SA	Making sense of SA experience	*when I entered into my own therapeutic journey and I started to discuss all these issues, I think just saying the words out loud*

		made me think, oh, hang on a second. And then I started to connect to the dots *like reading books and hearing other people's experience, not necessarily from the Muslim community, but from other religious communities as well* *years of, I guess, just exploring what actually happened,*
	Relearning faith	*I'm learning religion all over again* *I was re-learning my faith through the lens of compassion rather than of fear* *Having compassion for myself has helped me to re-learn the religion for myself in a compassionate way* *it's about really connecting to the words in the Quran and listening to like their beautiful meaning, and finding the beauty rather than only hearing the fear and the punishment, it is definitely a new way of of of learning I think*
	Reclaiming agency	*my religious belief is not dependent on how other people view me and how other people view my religious practice* *my religion is my spiritual belief, and that is my connection to a higher being, rather than to other people around me* *I don't need another person telling me what is right or wrong at this moment, like I have good linguistic capabilities. I have- I can read, I can listen, I can research myself, and that is the capacity that I have at the momen*
	Hopes for future support	*that somebody would offer some advice that was tangible* *show me that what I was experiencing was unacceptable* *hope that a dialogue will begin that just sets something in motion, that Muslims within our community, whether that's male or female, can have a conversation openly about abuse that they are experiencing, and it be acknowledged and it be accepted and it be listened to.*

Appendix M: *Feedback report for ethics panel*

Research Summary

Title: Muslims' Experiences of Spiritual Abuse: An Interpretative Phenomenological Analysis

Background: Spiritual abuse (SA) involves the coercive use of religious beliefs or controlling behaviour within a religious context to exert power and control. While increasingly recognised in Christian settings, its occurrence within Muslim communities remains under-researched. SA can have profound psychological, spiritual, and social impacts, particularly for individuals whose faith is central to their identity and well-being. This is especially concerning as Muslims often encounter intersecting barriers to accessing mainstream mental health (MH) services and may prefer faith-based support, potentially leaving them without adequate avenues for help. Existing studies in Christian contexts highlight themes such as power imbalances, manipulation of religious texts, and long-term psychological effects. However, no research has specifically examined Muslims' experiences of SA in interpersonal relationships.

Aims: This study aims to explore the lived experiences of Muslims who have experienced SA, addressing the following research questions:
a. How do Muslims make sense of their experiences of SA in interpersonal relationships?
b. What psychological, social, and relational impacts do Muslims experience as a result of SA?
c. How does experiencing SA affect Muslims' relationship with their faith?
d. What experience of support seeking for SA do Muslims report?
e. What support do Muslims think would be helpful after experiencing SA?

Method: The study employed semi-structured interviews with eight adult Muslim participants who identified as having experienced SA. Interpretative Phenomenological Analysis (IPA) was chosen as the methodology, allowing an in-depth exploration of participants' lived experiences and the meaning they ascribe to them. IPA is well-suited to this research as it prioritises the subjective experiences of individuals while situating these within broader social and cultural contexts.

Analysis: Data analysis resulted in the development of five group experiential themes, with corresponding sub-themes derived from participants' narratives:

- **Power and Control:** Explored how participants experienced Islam being weaponised to manipulate and control them, how participants were conditioned to view their abuser as a spiritual authority, the use of Islamic concepts to justify gendered oppression and the co-occurrence of multiple forms of abuse.

- **Feeling Trapped:** Highlighted the sense of entrapment participants experienced in SA, often reinforced by fear, shame, and the community response.
- **Impact:** This theme relates to the various impacts of SA that participants experiences including: psychological, spiritual, and social.
- **Healing:** This theme explored participants' journeys of healing, such as learning new ways of relating to God and religion, reclaiming autonomy over faith, and the importance of culturally and faith-sensitive therapeutic support.

Conclusion: The findings of this study highlight the profound psychological, spiritual, and social impacts of SA, including dissociation, internalised shame, negative perceptions of God and religious individuals, and social isolation. Despite these challenges, participants described pathways to healing, such as relearning religion through a lens of compassion, reclaiming agency over their faith, and accessing therapeutic support. They also emphasised the critical need for culturally and faith-sensitive mental health (MH) services. These findings underscore the importance of training mental health professionals (MHPs) to recognise SA, its distinct characteristics, and its intersections with other forms of abuse. Collaboration between MHPs, Muslim communities, and faith leaders is vital to develop person-centred, faith-informed approaches to support survivors. Future research should prioritise enhancing MHP training, fostering survivor-led collaborations with religious leaders and safeguarding services, and evaluating tailored interventions for diverse Muslim populations.

Appendix N: *Feedback report for Participants*

Research Summary

Title: Muslims' Experiences of Spiritual Abuse: An Interpretative Phenomenological Analysis

Background: Spiritual abuse (SA) involves the coercive use of religious beliefs or controlling behaviour within a religious context to exert power and control. While increasingly recognised in Christian settings, its occurrence within Muslim communities remains under-researched. SA can have profound psychological, spiritual, and social impacts, particularly for individuals whose faith is central to their identity and well-being. This is especially concerning as Muslims often encounter intersecting barriers to accessing mainstream mental health (MH) services and may prefer faith-based support, potentially leaving them without adequate avenues for help. Existing studies in Christian contexts highlight themes such as power imbalances, manipulation of religious texts, and long-term psychological effects. However, no research has specifically examined Muslims' experiences of SA in interpersonal relationships.

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Analysis: Data analysis resulted in the development of five group experiential themes, with corresponding sub-themes derived from participants' narratives:

Group Experiential Themes	Sub-themes
Power and control	Weaponised Islam

	Conditioned to view abuser as spiritual authority Gendered oppression Multiple forms of abuse
Feeling trapped	Fear & shame Community response Protecting the religion
Impact	Psychological Spiritual Social
Healing	Relearning Reclaiming faith Culturally & faith sensitive support

- **Power and Control:** This theme explored how participants experienced Islam being weaponised to manipulate and control them, how participants were conditioned to view their abuser as a spiritual authority, the use of Islamic concepts to justify gendered oppression and the co-occurrence of multiple forms of abuse.
- **Feeling Trapped:** This theme highlighted the sense of entrapment participants experienced in SA, often reinforced by fear and shame, wanting to protect the religion from further islamophobia and the community's response.
- **Impact:** This theme relates to the various impacts of SA that participants experienced including psychological, spiritual, and social.
- **Healing:** This theme explored participants' journeys of healing from SA, such as re-learning religion through a lens of compassion rather than fear, reclaiming autonomy over how they practiced their faith, and the importance of culturally and faith-sensitive therapeutic support.

Conclusion: The findings of this study highlighted how Islam can be weaponised to exert power and control, with victims conditioned to view their abuser as a spiritual authority. SA was found to occur alongside other forms of abuse and was used to justify gendered oppression. The study found that victims experienced significant psychological, spiritual, and social impacts of SA. Despite these challenges, pathways to healing were reported, including relearning the religion through compassion rather than fear, reclaiming autonomy and control over religious practice, and having therapeutic support to process their SA experiences. The need for culturally and faith-sensitive therapeutic support was highlighted. Future research should explore the experiences of survivors that no longer identify as religious and evaluate the effectiveness of tailored interventions for SA survivors.

Clinical implications:

- MHPs should receive training in religious and spiritual competencies to identify and sensitively address SA

- Therapists should initiate conversations about SA, as survivors may not have the language to describe this
- MHPs must respect the role of religion in survivors' lives, tailoring approaches to include religious concepts, collaborate with faith leaders, or avoid religion entirely, based on individual preferences
- Addressing social isolation is critical, therapeutic group spaces and alternative safe community resources can help survivors rebuild relationships and foster belonging
- Collaboration between MH services, faith leaders, community organisations, and safeguarding bodies is vital to effectively prevent and address SA
- Policies should recognise SA as a form of abuse, with clear guidelines for disclosures, safeguarding, and addressing coercive control, while respecting survivors’ religious practices.

Thank you for taking part in this research. If you would like to discuss the findings or obtain a copy of the full report, please feel free to contact me.