Understanding Muslim Women Clients of Counselling: An Interpretive Phenomenological Analysis

Nadia Rehman Sadiq

A thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol for the degree of Professional Doctorate in Counselling Psychology

Faculty of Health and Social Sciences,
University of the West of England, Bristol

May 2019

Word Count: 36, 987

Acknowledgements

This thesis would not be what it is without the numerous people who've contributed to its creation. Firstly, I'd like to thank my supervisors; Dr. Helen Malson, I'm grateful for your engagement with my process, for challenging and nurturing my perspectives; Liz Maliphant for your warmth and encouragements.

I am indebted beyond words to my family. Mum, dad, your life experiences, along with your unconditional love and belief in me, has been the fuel for all of my studies and work. My brothers and sisters: Saif, Sadia, Saaira and Ayman, thank you for being my net. You've helped me keep my life balanced throughout the wavy, tumultuous and tranquil movements of this experience. Additionally, getting married whilst doing my doctorate was a big but rather breezy transition, for which I want to thank my in-laws for their patience.

A special thanks goes to my husband, Omar. I extend my deepest appreciation to you for being by my side. There were times where I couldn't see the wood for the trees, and where I would trip over my own feet, but you continuously helped to clear the intellectual and emotional muddle and constantly succeeded in holding me and cheering me on.

Thank you to the women who took part in this research; for your trust, honesty and courage. I have great respect for each of you and hope this research honours who you are and your experiences.

Above all, my most essential gratitude is to God; who is constantly unfolding my life in such a blessed way. I hope all my efforts are made with sincerity and humility and can be a source of goodness.

Abstract

Muslims and Islam have become a central feature of global news and often find themselves in narratives associated with national and international terror. These negative representations may have an impact on Muslim individuals' wellbeing through increased fears of discrimination. Amidst this, Muslim women in Britain are showing increased religious identification. They are creating different ways of navigating their national, ethnic and religious cultures. This can be simultaneously liberating and challenging. Additionally, mental health issues, relationship issues and substance misuse are prevalent within Muslim communities. Despite this, recent research has highlighted that Muslims underutilize mental health services. Multiple barriers to counselling have been found including embarrassment and shame, fear of mistreatment, discrimination and being misunderstood, cultural and communication constraints, and lack of familiarity with services. However, previous research is far from giving us insight into Muslims' experiences of counselling. This research specifically explores the subjective lived experiences of female Muslim clients. The presence of ethnic minority and Muslim women in research is a growing area. I intend to extend existing literature and provide a closer look into experiences of a group that is often homogenised, misrepresented and under-researched.

Semi- structured interviews were conducted with ten Muslim women who had engaged in counselling. Verbatim transcripts of the interviews were analysed using Interpretive Phenomenological Analysis (IPA).

Three major themes were identified from the analysis; 1) Constructions of The Self, which explores how participants' self-constructions are dynamically created through relationships with faith, British society and ethnic culture; 2) Self in Relation to Distress, which explores the psychological and emotional impact of experienced difficulties, coping strategies and how these were influenced by mental health stigma and; 3) Therapeutic Relationships in Counselling, which explores the influence of client- counsellors similarities and differences on the therapeutic relationship, and the presence of a relationship with God.

Findings illustrate intricate and parallel connections between, Muslim women clients' experiences of living in Britain and their experiences of counselling. The study highlights the significance of acceptance and faith for this client group. Implications of these findings for clinical training and practice are discussed.

Contents Page

Chapter 1

Introduction

"A personality can never be isolated from the complex of interpersonal relations in which the person lives and has his being" (Sullivan, 1953, p. 10).

Reflecting on the origins of the research

The fruition of this study has been churning away from the beginning of my journey to becoming a counselling psychologist. By the start of my doctoral studies I had become accustomed to being a religious minority within my academic courses. The eradication of religion and culture from my educational and professional life became increasingly striking. My training experiences exposed me to an insubstantial interaction between Western counselling psychology and faith. Some of my experiences brought up feelings of frustration, shame and isolation. One experience of this occurred when a class on religion within a 'Difference and Diversity' module was replaced by a second lecture on sexuality. Experiences of being 'religiously invisible' despite being visibly Muslim, also occurred within personal therapy sessions and placements. Reflecting on some of my supervision sessions I recall a realisation of a fundamental need for clients, and myself, to be met at all levels. Yet this meeting rarely occurred due to lack of engagement with cultural and religious contexts; despite these being central to my worldview. However, I am fortunate to know counsellors and supervisors who have respected and explored the meaning of culture, religion and its presence and absence within counselling psychology. These experiences fuelled my desire to explore this area. By doing so, I hope to fill in some gaps within the field of counselling psychology, cross- cultural and multicultural counselling.

As a Muslim in this profession I often engage in conversations with other Muslims about mental health. I recall a situation that highlighted some, potentially harmful, attitudes towards mental health amongst Muslim communities; one evening myself and five other Muslim women were discussing mental health. Every individual shared a story about their experiences of struggling

with psychological issues, either personally or within their families. Some of the issues they described as depression, eating disorders and schizophrenia. They all commented on silent suffering related to fears of judgement, and a lack of understanding and support. I was struck by the commonalities of neglect and isolation within their accounts. It was common for the women to hear things like “it is Allah’s will,” “just be grateful” and “you should pray more”. I trust that these beliefs can be valuable but they often appear to be tossed around as quick fixes and avoidances. Thus, they can be a catalyst for further guilt, helplessness and psychological anguish for those suffering. I have gathered a catalogue of such dialogues over the years, portraying a dismissive attitude to mental health issues amongst some communities.

I have become increasingly interested in how Muslim individuals relate to psychological and emotional difficulties. This is where my research question originated; Understanding Muslim women clients of counselling. Race and ethnicity research have generally focused on male voices and perspectives, and feminist research has usually voiced concerns and experiences of white, women. Although there will be similarities in experiences of Muslim men and Muslim women, and white women and Muslim women, there will also be significant differences. This piece of intersectional research explores Muslim women’s experiences as thoroughly as possible in a qualitative IPA study with a relatively small sample. Thus, facilitating understanding of a group that can often become overshadowed by other identity dimensions.

Research Framework

I approached this work as a counselling psychologist trainee from a relational psychodynamic framework. Relational psychodynamic psychology has developed aspects of classical psychodynamic theory by introducing the significance of the role of context in the life of an individual. Relationalists believe that the primary human motivation is to be in relationship with others (Greenberg & Mitchell, 1983). Theorising, that relationships are a central tenet of our experiences and impact our emotional, psychological and interpersonal worlds (Greenberg & Mitchell, 1983). This approach embraces many interconnected theories that put relationships at

the centre of understanding life experiences, identities and psychological distress. Object relations theory (Fairbairn, 1958) and interpersonal theory (Sullivan, 1953) were key influences on the relational perspective and comprise a large part of its approach. At the centre of Object Relations theory is the idea that early relationships with significant others, become internalised templates that we use to navigate subsequent relationships (Fairbairn, 1958). Interpersonal theory highlights the role of interpersonal relationships on our sense of self. It suggests that we only understand and manifest who we are within interpersonal positions (Sullivan, 1953). Kohut (1971) added to the relational approach with his personality development theory of self-psychology. As well as a need for relationships, this theory also emphasises a need for the development of an individual self. Attachment theory extended these ideas and emphasised the impact that different types of early relationships can have on an individuals' relational patterns and temperaments. Attachment theory emphasises safety and security as key features of a relationship (Bowlby 1958; 1969). All of these theories are characterised by their ideas relating to the mutual influence that people have on each other. Psychoanalytic ideas, such as transference and countertransference are embedded within the relational approach. Transference is the process of accessing internal and interpersonal worlds of a client through attending to the emotional and psychological landscape of the client- counsellor relationship. Countertransference refers to the counsellor's emotional responses to the transference. The relational shift began to emphasise the contextual nature of human beings. It has also been influenced by Systemic thought (Capra, 1996; Bateson, 1972) and operates within a social constructionist epistemology (Bateson, 1972).

Social constructionism views society and experiences as a product of interactions between people, emphasising the socially constructed nature of life experiences (Garfinkel, 1984). It proposes that meanings of events are made within, and based on, particular contexts (Gottfried, 2008; Bhaskar, 1998; Garfinkel, 1984). This echoes the relational approach discussed above. Similarly, Interpretive Phenomenological Analysis views individuals as being embedded within, and inseparable from, their contexts (Smith, et al., 2009). It explores how meanings are made

from particular perspectives within the contexts that an individual is connected to (Smith, et al., 2009; Pietkiewicz & Smith, 2014). Social constructionist and critical realist positions challenge essentialist understandings that view constructs and concepts to be fixed (Potter, 1998; Bhaskar, 1998). Instead, the world is viewed as an open system, that is fluid (Bhaskar, 1998). This allows concepts, institutions and social systems to evolve and be challenged (Bhaskar, 1991; 1998). At a macro- level, social constructionism has been criticised for the 'death of the subject', taking away the agency of the subject by believing that everything is socially constructed (Burr, 2003). My views are in line with Bhaskar (1991; 1998) who argued for micro- level social constructionism. At this level it is acknowledged that social structures are constructed by people, and their presence then influence a persons' experiences, interpretations, perceptions and behaviours but also recognises that an individuals' actions are not determined by the structures (Bhaskar, 1998). For example, structures of racism can condition behaviour but do not necessarily determine it (Potter, 1998). Structures can also then be challenged and reformed by individuals' agency (Potter, 2003). The position of maintaining human agency whilst acknowledging powers of social structures has been coined as 'subtle realism' (Willig, 1999; Harre; 2002) particularly led by the work of Bhaskar (1978). This type of social constructionism gives credence to scrutinising language that maintains particular stereotypes, discourses and contradictions (Potter, 2003). The critical realist approach of this research allows social, political, religious and cultural structures to be uncovered, scrutinised and challenged; particularly if those structures are oppressive (Bhaskar, 1991; 1998). Strengths of systems and people can also be explored (Houston, 2001).

A belief in intersubjectivity runs through these approaches. It allows for co-construction, de-construction and re-creation of structures and concepts through intersubjective meaning making between people (Bhaskar, 1998; 2002; Willis, 2001). This is shared by IPA in its belief that knowledge and meanings are translated between people to construct particular 'realities' (Willis, 2001). Intersubjectivity and co-construction come together in the hermeneutic component of IPA (Smith et al, 2009). Hermeneutics posits that we only come to know of things

and experiences through interpretation (Heidegger, 1962; Schmidt, 2006; Willis, 2001; Smith et al, 2009). Meaning making is seen as a dynamic process of co- construction between people, i.e. between participant and researcher, where participants are interpreting their experiences and researchers are interpreting participants' interpretations (Smith & Osborn, 2007; Smith, et al., 2009). Social constructionism, critical realism and interpretive phenomenological analysis share the importance of interpretation, a belief in contextual influences on persons' experiences and a belief in co-construction of 'realities' in intersubjective spaces.

Mitchell (2014, p. 107) sums up the importance of context on individual experiences: "the best way to understand persons is not in isolation, but in the context of their relations with others, past and present, internal and external, actual and fanatasised".

Research Aims

This study provides an explorative understanding of Muslim women as clients of counselling. It aims to understand how their identities are constructed, what issues they face and how they navigate through them. I use the qualitative approach of Interpretive Phenomenological Analysis (IPA) to explore this topic. This research intends to provide an understanding of my participants' individual, subjective experiences and provide valuable insights for the field of counselling psychology and beyond.

The following chapter presents a literature review. I begin by contextualizing Muslim women in the UK, exploring our identities and experiences. This is followed by a brief review of mental health amongst Muslim women. I then go on to explore the relationships between minority groups and counselling to set the scene for this research.

Chapter 2

Literature Review

This thesis provides an understanding of Muslim women clients of counselling. It explores their identity constructions, their experienced difficulties, coping strategies and healing journeys. It aims to provide an understanding of the interconnectedness between the self, our contexts and counselling experiences. The research adopts an Interpretative Phenomenological Analysis (IPA) approach (Smith, 1996) to gain an understanding of the women's lived experiences. I hold individual and contextual experiences in mind, adhering to the belief that an individual cannot be separated from their context.

This chapter introduces Muslim women in Britain and their positions within national, ethnic and gendered contexts. I begin by outlining demographics of Muslims in Britain, followed by an exploration of who a 'Muslim' is. Using intersectionality theory, I will provide insight into the position of Muslim women within the systems that they are part of. This theory considers the complex interconnections between identity markers and how the interplay between them can create systems of oppression (Crenshaw, 1989). Particular attention will be given to how Muslim women co-create identities through relationships with their socio- political and ethnic cultures. This will help conceptualize what it means to be a Muslim woman in Britain and provide an understanding of the different systems that we live in along with some of our experiences within these systems. I will then explore literature investigating Muslim women's mental health in the UK and in Muslim countries. This will be followed by research on the relationship between ethnic minority communities, faith communities and mental health services. Here I will explore four areas; minority ethnic group experiences with therapy; collectivism in counselling; faith groups experiences with therapy; and ethnic and religious matching in therapeutic dyads. Following this the rationale for the study will be given.

Statistics on Muslims in Britain

In 2011 the Office of National Statistics distributed its most recent census, which included statistics on religious groups in Britain. After Christians, Muslims were found to be the largest religious group in Britain (59% and 5% respectively) with 2.7 million people identifying themselves as Muslim (an increase of 1.2 million (35%) compared to a decade prior (Census, 2011). Nearly half (48%) of the Muslims were under 25 years old and 88% were under the age of 50 years; this gave them the youngest age profile amongst religious groups. The Muslim population was reported to be the most ethnically diverse religious group in England and Wales with members of the group identifying as Asian/ Asian British (68%), Black/ African/ Caribbean/ Black British (10%), White (8%), Arab, Mixed/ Multiple ethnic groups (4%) and 'other' ethnic group (11%). An increasing number of converts from white and African Caribbean backgrounds is included within this (Brice, 2010). The largest ethnic group within these profiles was that of Asian/ British Asian made up of predominantly Pakistani (38%) and Bangladeshi members (15%). Just over half the Muslims (53%) were born outside the UK and nearly half (47%) were born inside the UK, both almost doubling with a rise of over half a million over the decade. Three hundred thousand Muslims identified as full-time students with 43% of them being women. However, compared to other religious groups Muslim women were 71% more likely to be unemployed. Muslims are disproportionately represented in the most deprived areas of England and Wales with 46% residing in the 10% most deprived areas of the UK and 1.7% in the 10% least deprived areas (1.22 million and 46,000 respectively). Housing issues, low income, health, wellbeing and educational achievement are all factors that need to be taken into consideration with the above information. It is also important to keep in mind that these issues are not solely faced by Muslim communities but occur across all cultures and groups.

Defining 'Muslim'

The translation of the Arabic word 'Muslim' means someone who submits to God or achieves peace through submitting to God (Meer, 2008; Hamdan 2007). This definition is not limited to

any ethnic group, encompassing the diversity that has been found amongst Muslims as described in the statistics. However, there is great variability within the term 'Muslim'.

Firstly, there are numerous approaches to Islam. Hamid (2011) and others (Gilliat- Ray, 2010; Bowen, 2014) discuss some of the different sects of Islam that have formed through differences in beliefs, interpretations and practices, including; Sunni, Shi'a, Salafi, Sufi, Deobandi, Barelvi, Wahhabi and Ismaili sects. There are many theological and philosophical differences between these groups including (but not limited to) differences in beliefs and processes of connecting to God, differences in beliefs about the succession of the caliphate and devotion to the Prophet Mohammed (peace be upon him), and differences in adherence to literal and metaphorical interpretations of religious scriptures. There are also many similarities between these groups (Hamid, 2011; Gilliat- Ray, 2010). Furthermore, some Muslims do not identify with any particular group (Gilliat- Ray, 2010). This highlights the ideological differences amongst Muslims, which have been found to be influenced both by international connections and organisational structures in Britain (Gilliat- Ray, 2010; Hamid, 2011).

Secondly, the term 'Muslim' is sometimes used to refer to individuals who have a Muslim heritage but are not practicing Islam. Studies have identified differences between 'religious' and 'secular' Muslims, with the former having an increased internalised relationship with Islam and the latter viewing Islam as part of cultural traditions (Ali, 2008). More recent research has used the term 'Muslimness' to refer to the spectrum of engagement with Islam (Mohee, 2011; Mirza, 2012). This is in line with earlier research by Jacobson (1997) who observed that religious identities appear on a spectrum from 'devout' to 'non- practicing'. This indicates that identifying as Muslim does not correspond to a person's religiosity or attachment to Islam (Meer, 2008).

Generational changes can also be seen in how Muslims relate to Islam. Earlier generations in Britain used Islam in a functional role of community and family cohesion, with a greater focus on shared rules, norms and practices that hold a culture together (Triandis, 2001; Matsumoto &

Juang, 2004). Whereas younger generations utilise Islam in their identity constructions and day-to- day life from a more religious perspective (Jacobson, 1997, Geaves, 2010; Gilliat-Ray, 2010, Akhtar, 2014). Hutnik (1985) was one of the first to identify changes in assertion of a 'religious' identity by younger Muslims and her results have been reinforced over the decades (Saeed, Blain and Forbes, 1999; Dwyer, 1999; O'Beirne, 2004, Hutnik & Street, 2010). Re- engagement with religion has involved reinterpreting meanings and developing new meanings about Islam and Muslim identities (Traversa, 2012, Bhatia, 2012, Hamid, 2011). This provides support for previous research that has commented on the emergence of a 'new Muslim identity' (Dwyer, 2000) and a 'new Islamic identity' (Brown, 2006): an identity that combines Western perspectives of critical thought, openness and equality, and questions and evaluates cultural traditions e.g. altering gender roles. Other factors including ethnicity, nationality and personal characteristic also contribute to a Muslim's identity (Saeed et al, 1999; Dwyer, 2000; Ali, 2008). Therefore, Muslim individuals ought to be understood as living within a network of intricately connected systems that inform who they are (Ali, 2008).

Social Constructionist Perspective on Muslim Women's Identity

There are numerous ways of theorising identity and experiences in psychological theory and literature. My theoretical perspective is social constructionist; a belief that identities are constructed through social interactions (Garfinkel, 1984; Bhaskar, 1998). Many psychologists have stressed the importance of the social construction of the individual self (Mead, 1934; Festinger, 1954; Cooley, 1902; Blumer, 1980). I also believe that identities and experiences are subjective; each individuals' experiences will have different meanings; thus, individuals construct different social realities. These realities are created between people, not in isolation. The relational psychodynamic approach argues that personality grows from within the network of early relationships with significant figures, both as experienced and imagined (Sullivan, 1953). A social constructionist definition of identity converges with the relational perspective as it emphasises the interplay between oneself and others in the development of personal identity.

Cooley's (1902) theory of identity suggests that a sense of self is developed through social interaction where our perception of others' attitudes towards us, influences how we see ourselves. He called this the 'looking glass self' (Cooley, 1902). This social constructionist perspective emphasizes how a sense of self is a co- construction between the individual and others. These relational ideas posit that identities evolve over time through social interaction, underpinning ideas of hybrid identities (Hutnik, 1991; Hall, 1992). Navigating between two or more cultures and learning to "translate and negotiate between them" is a key feature of hybrid identities (Hall, 1992). As we will see later, research with Muslim women has given examples of their hybrid identities as they negotiate and alter their presentation according to different situations, contexts and timescales. Brah (1996) suggests that these movements transform history in their new ways of 'performing' between different cultural practices. We can see this in the way that Muslim women's gendered identities have shifted over generations, this is explored below.

Dwyer (2000) carried out research exploring how South Asian women in Britain negotiate their diasporic identities; identities that cut through national boundaries, consequently creating new forms of belonging (Brah, 1996). Dwyer's (2000) participants felt their gendered identities were important within their communities as they were expected to carry forward their parental culture. However, they were also resisting passivity. Haw (2010) explored changes in her Muslim female participants' sense of being and belonging from her earlier research (Haw, 1995). She described her participants as "part of an 'in-between' generation" (p. 347) who are positioned varyingly as being British, being Muslim and being British Muslim. Increased independence was present through challenging expectations of dress and marriage (Dwyer, 2000; Brown, 2006). Dwyer (2000) and Haw's (2010) participants were re-constructing and re-evaluating cultural traditions inherited from their parents and the role of religion in British culture to define themselves. Research has suggested that Muslim women are combining different dimensions of identity suited to different contexts (Dwyer, 2000; Werbner, 2004; Haw, 2010). Bauman (1996, p.125) describes identity as "a verb rather than a noun". This fits aptly with the above

considerations and emphasises how identities are continuously interacting and changing with others and the environment. However, this process can be difficult and create conflicts. For example, valuing freedom but also feeling pressure to adhere to cultural traditions (Dwyer, 2000) and identifying with an ethnic minority group but feeling ashamed of this identity (Ali, 2008).

Moving beyond perspectives of identity I will explore different systems that Muslim women are part of and the impact these can have. These include: political systems and Islamophobia, and ethnic cultures and patriarchy. In this section I will draw on intersectionality theory (Crenshaw, 1989). This theory states that different, inseparable, organisational systems and hierarchies such as; ethnicity, gender, class, and other social identities, interact and create oppressive systems of inequality (Crenshaw, 1989). Intersectionality first grew through the knowledge, experiences and interests of black female researchers and scholars, who were concerned with understanding connections in social structures that contribute to systems of oppression, for minority women. I use this theory to explore social inequalities faced by Muslim women. Intersectionality fits with a social constructionist perspective because of the belief that meanings are dependent on social and historical contexts (Gottfried, 2008). For example, different cultures have different meanings attached to gender positions i.e. homemaker- breadwinner, and as cultures change so do the constructs.

The Rise of Islamophobia

Islamophobia has been defined as prejudice toward Muslims, exclusion of Muslims from professional fields, experiences of discrimination within employment, education and health, and experiences of violence and abuse (Inayat, 2007). A high volume of research about Muslims has been carried out citing 9/11 as a turning point for the Western Muslim population, followed by the 7/ 7 bombings in the UK. More recent attacks such as the attack at Charlie Hebdo in Paris (2015), the bombing in Manchester (2016), Westminster and London (2016) and New York (2017) have exacerbated issues for Muslims in Western countries. Vast amounts of research and

reports discuss the rise of Islamophobia. Reports immediately after 9/11 and 7/7 showed an increase in hate crime against members of the Muslim population (Hanes & Machin, 2014). And a greater number of incidents and experiences of racism and religious discrimination (Sheridan, 2006) as well as an increase in perceptions of discrimination towards Muslim women in the UK (Liepyte & Kocaman, 2015). Recent terrorist attacks towards Muslims including Finsbury Park in London (2017), Al- Falah mosque in Manchester (2018) and Christchurch mosque, New Zealand (2019) could be taken as evidence of the rising Islamophobia. A link has been found between negative constructions of Islam, portrayal of the "dangerous Muslim", repetitive associations of Islam and terrorism (Ali, 2008), the spreading of anti- Muslim imagery via media (Moore, 1995; Perry, 2014) and increased fear, hostility and Islamophobic attitudes towards the Muslim 'other' (Hanes & Machin, 2014). This 'other' Muslim community can be seen as an imagined community; a socially constructed group created through media, images and social interactions (Anderson, 1983). Moosavi (2015) suggests that Islamophobia originates from the racialization process of positioning Muslims as the 'other'. Thus, Islamophobia can be seen as a social construct.

The negative impact of terrorism has also been found to cause internal conflicts for some Muslims (Inayat, 2002). Quite immediately after 9/11 some Muslims in the UK experienced identity loss and confusion as they attempted to make sense of sharing the same faith as the terrorists but not wanting to be associated with them (Inayat, 2002). Racism and Islamophobia have been found to have instilled a fear within Muslim individuals; a fear of violence, harassment and of appearing in public (Abu-Ras & Suarez, 2009; Kwan, 2008). It is important to be sensitive to the long- term effects that a fear of Islamophobia can have on individuals. This can include low self- esteem, depression, increased isolation, dejection, hopelessness and suspicion (Inayat, 2002).

Researchers suggest that the majority of Islamophobia manifests in more common subtle forms, which can include verbal attacks, misconceptions and stereotypes (Laungani, 2002; Moosavi, 2015; Larsson 2005; Sheridan, 2006). Some of these Islamophobic attitudes can be seen in

representations of Muslim women in Western media where we are portrayed as passive and submissive (Akhtar, 2015). Researchers argue that since 9/11 Western media has exerted overwhelming preoccupation with 'backward' constructions of Muslim women (Abu-Lughod, 2002) positioning us as an 'oppressed other' (Droogsma, 2007; Sheridan, 2006; Scharff, 2011). This research addresses how Muslim women understand and experience their position within British society. I will explore how the wider contexts in which we live shape Muslim womens' identities and experiences and explore any influence this may have on the therapeutic process for my participants.

Muslim women's dress has been at the forefront of Islamophobic discourses. Researchers may have followed this trend, as there are copious studies on this topic when searching databases for research on Muslim women. It could be argued that this could feed into narratives that reduce Muslim women to their appearance (Abu-Lughod, 2002). However, as this is a large part of current narratives, and has a part to play in identity constructions and everyday experiences of Muslim women, it does need some acknowledgement.

Stereotypically, the hijab[1] and niqab[2] have been equated with subordination and suppression (Scharff, 2011; Akhtar, 2015). Muslim women in UK and Denmark have commented that wearing a veil can contribute to increased feelings of difference, resulting in feeling stigmatised and judged. But can also provide a sense of safety and confidence in other situations (Chapman, 2016). Values and practices for some Muslim women are evaluated in negotiations with family and community, within structures of liberalism and secular, and tradition and religion (Chapman, 2016). New perceptions and positions can be developed in this dynamic process, suggesting that Muslim women are actively involved in negotiating representations of their identity and creating new identities. Some Muslim women have equated an ability to make choices in the way they dress, choice of education and career, with freedom (Traversa, 2012). However, some women

[1] Refers to a head covering worn by some Muslim women
[2] Refers to a face veil worn by some Muslim women

have experienced opposition from family in their decision to wear the hijab or niqab (Haw, 2009), suggesting that choice and agency are not always afforded in an interdependent culture. These studies provide understanding about identity constructions amongst Muslim women, and highlight areas in which they may face resistance when exercising their agency. My research will explore identity constructions of Muslim women specifically in the UK, without an assumed occupation with the veil. My research will also provide a unique perspective on how Muslim women's socially- constructed identities can influence therapy.

From the statistics presented at the beginning of this chapter we can see that ninety three percent of Muslims in Britain are predominantly from ethnic minority backgrounds. In the next section I will explore literature on Muslim womens' experiences within ethnic cultures.

Muslim Women's Experiences within Ethnic-Cultural Systems

Crenshaw (1994) suggests that women of colour have greater risk of gendered violence because of multiple disempowerment experiences within organisational systems that they are part of. Their class, gender, ethnic and, here, religious position, often simultaneously oppress them. However, disempowerment applies across society, for example gender pay gaps between female and male employees and sexual abuse scandals by MP's, celebrities and other groups of men. Additionally, violence against women is not confined to occurring within the Muslim community but transcends all social divisions (Hanmer, 1978), and has been suggested as a way of keeping women 'in their place' (Perry, 2014).

From a South- Asian cultural perspective, research has suggested that young men within the community often use religion as an excuse to behave authoritatively over women (Dwyer, 2000). Dwyer's (2000) respondents stressed how the dominance of patriarchy within their communities created a culture of 'policing': where female individuals are controlled by the assumed authority of male individuals. For example, some women felt their dress choices were being controlled by men. Based on her participants' accounts Dwyer (2000) suggests that observance of "full Islamic dress remains complicit with dominant patriarchal rhetoric of the veil" (p. 484). But other

research has suggested that some women choose to wear the veil with no patriarchal pressue (Traversa, 2012; Mirza, 2012). However, it is questionable how much of this choice is an unconscious response to gender oppression. Macey (1999) examined male violence within Pakistani communities in Bradford. She talked about the control that occurs within the community by male members using the concept of *izzat* (honour). The concept of *izzat* is specific to South Asian cultures (including Bangladeshi, Sikh and Hindu cultures). The women in Macey's (1999) research were aware of oppression and resisted controlling attitudes on a day to day basis. They used religious and cultural practices to gain autonomy in situations where they would otherwise be restricted (Macey, 1999). This included demanding to go to university and deferring arranged marriages. Some research has suggested that Muslim women are exhibiting increased agency (Macey, 1999; Dywer, 2000; Haw, 2010) through creative use of values and contexts (Haw, 2010; Brown 2006), suggesting that forces of resistance are at play on an ongoing basis (Dwyer, 2000; Brown, 2006). Simultaneously then, their positions within different value systems can be potential sources of conflict (Ali, 2008). Previous research presented here does not explore psychological and emotional consequences of living within patriarchal cultures. Yet, the psychological impact of patriarchy should not be glossed over. This research will explore the emotional and psychological impact of difficult experiences on my participants' sense of self. Previous studies have looked at cultural influences in isolation i.e. ethnic groups (Macey, 1999; Dwyer, 2000; Brown, 2006) as opposed to exploring multiple systems of oppression. This research aims to cross identity markers and explore the position and experiences of participants within multiple social systems.

This section has highlighted the significance of viewing social, political and cultural influences on the position of Muslim women in Britain. Identities of Muslim women "have not existed in a social and political vacuum, but have been shaped in dialogue with their context" (Meer, 2008 p.6). The space where gender intersects with ethnic, national and religious identity (a space in which gendered violence and hate crime exist) has meant that the position of Muslim women in society is made increasingly vulnerable (Perry, 2014). Their identities are continuously moving

and shifting amidst the pressures that exist from within their communities and from a wider secular society that stem from Islamophobia, sexism and patriarchy. Having explored the positions that some Muslim women occupy, what impact does this have on their wellbeing? My research seeks to explore this and provide insight into how contextual struggles can impact my participants' mental wellbeing.

Muslim and South Asian Women's Mental Health

In this section I will explore research relating to the psychological health of Muslims and particularly Muslim women. Maynard (2008) surveyed community service providers, imams and voluntary organisations in the UK to gain insight into the nature of issues that Muslims sought support for. Main issues included mental health concerns related to anxiety and depression, conduct disorders, substance misuse, domestic violence, sexual issues and identity issues and relationships. This is not particularly surprising as these concerns are not limited to Muslims. However, measurement tools used in these studies are open to question based on their suitability with these populations.

Hicks & Bughra (2003) carried out a focus group with South Asian women in Britain to look at factors that can lead to suicidal behaviour. The significant themes that came up were marital violence, 'entrapment' in unhappy situations and depression. Similarly, Thompson & Bughra's (2000) research also found that family pressure to conform to traditional values increased suicidal behaviour amongst married, South Asian, women. Maynard's (2008) review of presenting problems amongst Muslims in the UK also found that South Asian women reported a high volume of gender- based violence/ domestic abuse cases as well as other relationship issues. We must be wary of generalising the findings to all South Asian women and keep demographic variability in mind as these studies were conducted across ethnicities, age groups and socio-economic status' with individuals having different levels of education, employment, acculturation and religiosity. South Asian ethnicities include Pakistani, Indian, Bangladeshi, and Sri Lankan, amongst others (Sporston & Nazroo; 2002). Researchers have found varying results

in studies exploring depression amongst different South Asian ethnic groups. Research has suggested that South Asian women, namely Pakistani and Punjabi, tend to have higher rates of depression compared to their white counterparts (Bhui, et al., 2004; Anand & Cochrane, 2003; Williams, et al., 2015). Consistent results have been seen amongst where Pakistani women show greater levels of depression compared to other South Asian groups (Fazil & Cochrane, 2003) including Bangladeshi women (Sporston & Nazroo, 2002). However, acculturation and socio-economic status play a role in the variability of results (Sonuga-Barke & Mistry, 2000).

There is also variation between religious groups with Muslim women showing greater risk to suicidal ideation than Hindu and Sikh women (Creed, et al., 1999). Age group also accounts for some variation, with younger South Asian women being higher risk than older women (Bughra, et al., 1999), but more 'traditional' elders experiencing greater distress when younger generations were becoming 'less traditional' (Gulgani, et al., 2001). However, Anand and Cochrane (2003) have also suggested that South Asian women who had lower involvement with British society and greater affiliation with their ethnic origins were more vulnerable to mental health difficulties. Significant differences have been found between Pakistani and White women in employment, who had lower vulnerability scores to depression compared to Pakistani and White women who were not in employment (Fazil & Cochrane, 2003). These studies suggest that there is a relationship between acculturation and mental health, where differences relating to tradition versus modernity, within families and social systems, can be a potential risk factor (Bhui & Bughra, 2002; Gulgani et al., 2001; Anand & Cochrane, 2003).

Research regarding help- seeking amongst Muslim and South Asian communities has suggested that mental health services are under-utilised (Patel, et al., 2000) and members may use other forms of coping such as prayer and family support (Hussain & Cochrane, 2003; Sheikh & Furnham, 2000). Thus, research does not present an accurate picture of actual experiences of mental health issues amongst South Asian and Muslim communities. In addition to this, Western conceptualisations of mental health do not take into account culture specific conceptualisations

and symptoms of mental health issues, which could impact on how participants understand and respond to data collection methods in these studies (Bhui et al., 2004; Anand & Cochrane, 2003).

My research will expand on these studies, providing in-depth accounts from my participants using a qualitative method to allow for exploration of different influences on participants' mental health. The research presented above has focused specifically on South Asian women, without exploring results amongst religious groups within South Asian samples. My research aims to expand this literature by exploring issues across different ethnicities within Muslim faith groups.

Research in predominantly Muslim countries has also explored Muslim women's mental health and have found gender specific risk factors. These studies have been conducted in Middle Eastern and North African countries (Douki, et al., 2007). Some of these have been linked to women occupying a subordinate position (Douki & Nacef, 2002), high rates of domestic violence, marital conflicts and fertility issues (Yahia, 2000; Kamel & Riskalla, 2001). Results from these studies are impacted by mental health stigma, somatisation of symptoms and the validity of Western measures and constructs used to gather data. Some studies have found higher rates of depression amongst Muslim women compared to men in some countries. For example, a study by Ghuba (2001) with more than a thousand individuals in UAE found that the experience of depression amongst males was 2.5% compared to 10.3% for women. Although they mention experiences of recent and chronic life events their research was quantitative and does not explore any reasoning for these results. Mirza & Jenkins (2004) carried out a systematic analysis of research published relating to risk, prevalence and treatment of depression and anxiety in Pakistan. They found a stark contrast between male and female ratios of prevalence of anxiety and depression, average 21.7% and 45.5% respectively, with great variation. However, they have suggested that although numbers seem high, they are in line with the worldwide average depression ratios for men and women. They also acknowledge the methodological variation and quality of the studies that were reviewed. Eloul, Ambusaidi & Al-Adawi, (2001) suggest that

although roles are changing outside the home within some Muslim countries, roles within the home are not. Changes in value systems in different contexts could be a contributing factor to the difficulties experienced by some Muslim women within these countries.

Looking at cultural influences closer to home; Gilbert & Sanghera (2004) explored the impact of shame, subordination and entrapment on mental health and support seeking amongst South Asian women in Derby. In response to given scenarios participants shared collectivist values and beliefs that influenced their views and decisions about particular problems presented. This included; putting family approval before their own desires, avoiding behaviour that could bring shame to the family and stressing the importance of fulfilling roles and expectations e.g. being a "good mother and a good wife". Some of them expressed a sense of feeling trapped by responsibilities and expectations and equated shame with feelings of failure. This supports research by Gilbert & Sanghera (2004) who suggested that the South Asian culture operates strongly on shame. The women in their study identified as South Asian, not Muslim. Participants were sharing their views in relation to scenarios given by researchers rather than their own lived experiences. Not all participants had experienced mental health difficulties and the majority of them did not have experience of seeking professional support. My research extends previous research by focusing on Muslim women's lived experiences of psychological difficulties and counselling.

These studies highlight the socio-cultural and relational factors that play a part in the creation of pathological symptoms amongst South Asian women. However, we must be wary of linking pathology to particular cultures, due to the danger of reinforcing stereotypes (Anand & Cochrane, 2005; Sproston & Nazroo, 2002). The findings present a social constructionist perspective of South Asian Women's distress. The relational nature of issues experienced could be due to the collectivist nature of different cultures that Muslim women are part of. Having explored some of the mental health research with Muslim women I will now look at experiences of minority and faith groups in the process of seeking professional support.

Minority Groups in Counselling

This section will look at specific group experiences in counselling that are relevant to this research. I begin by providing a definition of counselling, followed by research on experiences of ethnic minority groups in counselling. This will include exploration of individualism-collectivism and counselling, followed by experiences of members of faith groups in counselling. Much of the research found relates to matching based on dimensions of difference. This will be discussed in both sections. At the end of the chapter I will provide a rationale for the research.

Definition of Counselling

Counselling is a 'talking therapy' in which a qualified practitioner facilitates an individual's emotional and psychological growth and development, to overcome particular difficulties and increase life satisfaction (Gladding, 2004). Although I focus on 'counselling' I have used it interchangeably with the term 'therapy' and, where relevant 'psychotherapy', although BACP note that there is no differentiation between them (Gabriel et al, 2007; BACP, 2010). Counselling Psychology refers more specifically to my training and expertise that combines talking therapy with psychological theory.

Ethnic minority group experiences in counselling

In this section I will explore African- Caribbean, East and South Asian individuals' perceptions and experiences of mental health services and counselling, as there is a greater amount of research with these groups.

Ethnic minority groups have shown less usage of mental health support services than their American and White British counterparts (Bhui, et al., 1995, Casas et al., 2002). Studies have suggested that help seeking and engagement with services can be impacted by lack of knowledge, lack of trust and negative attitudes toward services, experiences and expectation of mistreatment in the form of racism and prevalent stigma within society (Thompson, Bazile &

Akbar, 2004; McFarland, 2009). Those who do attend counselling are likely to have a much higher drop- out rate (Sue, et al., 1998; Casas et al., 2002), report lower levels of satisfaction (Atkinson, 1983; 1985; Roach, 1992), and have significantly early termination rates with 50% ending after just one session (Sue, et al.,1998). This has been partly attributed to negative attitudes towards services, mistrust of services (Thompson, et al., 2004; Diala et al., 2000), low cultural competence and lack of engagement with multicultural issues (Sue, 2001). Multicultural competence here includes the counsellor's awareness of their own beliefs, cultural understanding of their client's beliefs and identities, and use of culturally sensitive and appropriate skills and interventions (Sue, 2001).

McLean, Campbell & Cornish (2003) argue that the gap between African- Caribbean communities and mental health services could be understood in terms of experiences of exclusion; social exclusion, cultural exclusion and institutional exclusion. They suggest that feelings of exclusion can be exacerbated through lack of accommodation of ethnic minorities, which can inhibit access to services. This relationship could be a reflection of current and historical events and experiences of particular groups (Aron & McIntosh, 2015).
A recent study by Moller, Burgess & Jogiyat (2016) explored barriers to counselling within South Asian communities in the UK. They suggested that stereotypes held by members of the population around counselling, counsellors and clients, acted as potential barriers. These stereotypes delayed and prevented support- seeking amongst South Asian women. One perception included concerns about counsellors not understanding cultural elements (Moller et al., 2016). Notions of misunderstanding, and concerns about experiences of racism, may not be completely unfounded. A study conducted by Reavey, Ahmed and Majumdar (2006) on practitioners working with South Asian women who had experienced sexual abuse, found that the available models were largely based on individualistic perspectives while their clients held collectivist views.

Collectivism in Counselling

Differences in cultural values may account for differences in openness to counselling. Research with Muslims has suggested that some are reluctant to seek help outside of the family as taking issues from within to the outside would not be accepted (John, 2005) and some may prefer to turn to their family and faith (Weatherhead & Daiches, 2010; Aloud & Arthur, 2009).

Without acknowledging wider situational and contextual implications, or through operating from a strictly individualistic framework, counsellors may misread and misattribute their client's distress (Constantine, 2002). Consequently, interventions that are implemented based on a misjudged assessment would not be in line with the client's worldview and thus result in unethical practice (Sue et al., 1998; Sue & Sue, 2003). Attitudes in collectivist cultures are based on group norms (Triandis, 2001). Elements of Western therapy, that are based on Eurocentric assumptions, may then cause internal and interpersonal conflict for a client from a collectivist culture (Owusu-Bempah & Howitt, 2000). Western therapy risks imposing Eurocentric formulations onto people (Squire, 2000), for example, by promoting self- actualisation and encouraging an individual focus on the self (Dwairy, 2009). One example of this is Maslow's hierarchy of needs, which promotes self- actualisation. Self- actualisation is a western concept and could pose an issue for people from collectivist cultures where selflessness and group harmony are key features (Murray, 2014; Oysernman et al., 2002). Additionally, it could be a problem for someone with a faith, as spirituality is not present in the current model, but for myself, spirituality is a foundation that is woven throughout all stages. Prochaska and Norcross (2003) described different therapeutic approaches, including psychoanalytic, person- centred, cognitive and integrative, and state how they have been developed, practiced and evaluated largely against Western, individualistic values. These approaches can therefore be described as discriminatory as they do not take cultural differences into account (Pilgrim, 1997). However, this is not the case for all Western therapeutic modalities nor for all Western practitioners.

Cultural differences can also affect the therapeutic alliance. Individualistic cultures possess a more direct approach as opposed to indirect (Oyserman, et al., 2002). For example, if a therapist expects direct communication and gives responsibility of communication to the client, who may not be accustomed to such engagement, this could not only create discomfort but also affect formulation of the client's presentation (Sue, et al., 1998; Williams, 2005). Research amongst Muslim individuals, and traditional Asian clients from the Far- East, have suggested that these client groups prefer more direct forms of therapy. Clients from these cultures may hold expectations and preferences for the therapist to take the lead and provide interventions earlier on in therapy (Kim et al., 2001). These findings suggest that psychological processes may be predicted by worldview (John, 2003). However, researchers have not found a clear indication that an individual's cultural position can predict the type of counselling that they are most suited to or will benefit from (Shillo & Kelley, 1997). Oyserman, et al. (2002) found that particular cultures did not fit in their assumed position. These disparities suggest that we would be mistaken to think that all minority groups in the UK operate on collectivist values. We cannot assume that all individuals and families from typically individualist and collectivist countries are individualistic and collectivist. These dimensions are present at varying degrees within cultures and groups. A person's worldview may be much more multidimensional, particularly if living within multiple cultures. Additionally, an individual's personality can also play a part. It cannot be assumed that all Muslims will have strong collectivist positions, as worldview is not predicted by ethnic or national group membership (John, 2003). Nevertheless, ethnocentrism within counselling psychology raises concerns about working with particular groups as it isolates an individual from their context. This also sits far from the idea of intersubjectivity.

Intersubjectivity in psychodynamic perspectives suggests that experiences and shared meanings are constructed between two people in the relationship (Faris & Ooijen, 2012), with both people playing a part in creating those experiences, meanings and understanding and producing knowledge. In counselling the therapist also becomes a participant in a client's life and thus is required to reflect on his or her own subjective influence on the intersubjective and on the

client. However, if individualized approaches are adopted by therapists this closes the therapist's awareness of their own influence on the therapeutic experience for the client. This research pays attention to the processes, communications and experiences that occur in the intersubjective space between Muslim clients and their counsellors.

Ethnic Matching

Roach (1992) found that clients from an African Carribbean background specifically wanted support from a racially similar practitioner. If this provision were in place, they would be more inclined to access services (Roach, 1992). This raises questions around ethnic matching of client and counsellor, and ethnic minority individuals' perceptions of racially different counsellors. Researchers argue that a lack of awareness and acceptance of cultural viewpoints and issues may contribute to high drop- out rates (Flaskerud & Liu, 1991; Roach, 1992; Sue, 1998) and has found a general trend in minority clients having a preference for similar counsellors (Casas et al., 2002). But some research has found ethnic matching to have minimal influence and mixed outcomes (Maramba & Hall, 2002; Shin et al., 2005). However, these studies raise a number of questions; did clients hold matching to be important? How sufficient was the matching? Does the number of sessions attended tell us about client engagement or perceptions of successful outcomes?

A lot of research has been published showing that the qualities of the counsellor are more significant to effective therapeutic work than racial or cultural similarity (Redfern & Dryden, 1993; Shafi, 1998). Shafi (1998) carried out research exploring this very topic by surveying four South Asian women whom she, herself from a South Asian heritage, had counselled. Shafi argues that her participants stressed the importance of qualities such as empathy, warmth, trust and openness over cultural similarity. Shafi (1998) argues that client- counsellor differences are not a hinderance to therapy, and that counsellor qualities are more important than matching. However, three out of four of her participants talked about the importance of having someone similar for ease of understanding, particularly when the problem was related to cultural issues.

This has also been found by other research (Kohatsu, et al., 2000). This suggests that matching may have had a mediating effect. I would argue that Shafi had, maybe unconsciously, overlooked the fact that a shared ethnic background between herself and her clients had a part to play in their experiences. Due to their shared backgrounds this perhaps was a blind spot. Her suggestion that differences do not factor into the therapeutic alliance negates others' experiences of facing negative outcomes as a result of dissimilarity and others' preferences for similar counsellors. It is important to see beyond the issue of matching and to ask questions such as: what are people's reasons for wanting or not wanting someone similar to them? What elements bridge the gaps of visible difference? And had Shafi's participants worked with someone different would they have been aware of other qualities and elements that could facilitate or impede the process? My research will provide some insight into the questions I pose here as my participants experiences include working with both culturally similar and different counsellors. My research also goes beyond cultural domains and explores religious and spiritual elements that are less studied than ethnic dimensions.

Research carried out by Netto, et al. (2001) explored Asian people's perceptions and experiences of counselling. They found that although individuals' generally left counselling with positive attitudes and experiences, dissatisfaction was associated with not feeling understood. This was sometimes attributed to a 'mismatch' in terms of gender and ethnicity. However, South Asian participants in Netto, et al's (2001) study expressed mixed views about ethnic matching. My research expands on these studies as it provides a detailed exploration of the nuances in matched and non-matched therapeutic dyads. It will shed light on the qualities and factors that can impact experiences of therapy and therapeutic relationships.

To summarise, I have explored some attitudes and experiences of counselling of individuals from African Caribbean and South Asian cultures. In this section I have highlighted some of the barriers to counselling associated with power differences, and issues around the ethnocentric foundations of counselling practice. I have also explored importance of ethnic matching versus

qualities of the therapeutic relationship that can be important in shaping ethnic minority experiences of counselling. Multicultural approaches have tended to compartmentalize marginalized people's experiences by addressing cultural variables in isolation from one another. By examining gender, race, sexual orientation, and class separately, the lives of people with different racial and ethnic identities have also been separated into categories. Compartmentalisation does not mirror real life and in some instances privileges some elements over others e.g. gender over race in some cultural feminist theories. It is here that the gap between Muslims and therapy can be seen, as 'religion' as a dimension of difference has often been overlooked in favour of other areas of difference such as ethnicity. My research aims to address this imbalance in multicultural research by providing insight into Muslim individuals' experiences, whilst taking gender and ethnic identities into account. Therefore, providing a broader, yet holistic, and more accurate picture.

Faith group experiences in counselling

This section will focus on religious and spiritual clients' experiences of counselling. The majority of research has been conducted with Christian clients but I will relate findings from these studies to more recent studies with Muslim clients.

A recent report on the current NHS IAPT service by the House of Commons (Baker, 2018) broke down their statistics by various identity markers including religious group. Those identifying as Muslim were least likely to move to reliable recovery (58% compared to the highest score of 68% for Christian individuals) and one of the least likely to experience reliable improvement (39% compared to Jews 54%). However, no information was gathered or disseminated as to why this might be.

Mayers, Leavery, Vallianatou and Barker (2007) carried out research exploring experiences of help seeking and therapy of clients with religious and spiritual beliefs. Their participants were predominantly a mix of six Evangelic and Pentecostal Christians within the Church of England and within black congregations, one participant described themselves as Greek Orthodox and

one Muslim. All of them attributed great importance to their religion and were experiencing a range of diagnosed psychological difficulties. Similar to experiences of ethnic minority groups, participants from these religious groups had concerns about accessing support from secular services due to fear of being misunderstood, concerns that their religious beliefs would be undermined and fear of religious conflict with the therapist. Other research has also found negative views towards secular counselling amongst Christians including; concerns that the counsellor would ignore or misunderstand religious and spiritual concerns, that the counsellor would locate the problem in religious beliefs and would not be able to work effectively and appropriately with their concern or with their religion and spirituality (Worthington & Scott, 1983; Goedde, 2001). A recent study on Christian clients' experiences of secular therapy found that clients often hesitated to open up about their faith because of uncertainty about how their therapist would respond and react (Cragun & Friedlander, 2012). These studies suggest that religion and spirituality are important issues for clients from a faith background, but that they may not always feel comfortable bringing them into counselling due to fear, shame and guilt (Goedde, 2001; Rose, Westefeld & Ansley, 2008; Warwick, 2002; Mayers et al, 2007). However, Christian clients have also reported positive experiences when their counsellor showed openness and curiosity that allowed them to decide when and how they bring faith into the room (Cragun & Friedlander, 2012). Despite participants' hesitancy and preconceptions in Mayers, et al's (2007) study, they concluded that matching was not considered of great important. However, their perspective as white professional clinicians and researchers was focused around the performance of a service in the NHS where their participants were also part of a clinical psychology service and had all received diagnoses. I would question how much their own positions and the 'institutionalisation' of their participants impacted their results. My research on the other hand is less concerned about service performance and more concerned about the individual's identity and their experiences within the therapeutic relationship.

Similar to Christian clients, Muslim clients have been found to hold uncertainty and scepticism about counselling (Netto, et al., 2001; Moller, et al., 2016). Factors contributing to Muslims

underutilisation of mental health services are similar to those discussed above including; shame, social embarrassment, mistrust, fear of treatment, fear of racism and discrimination, fear of being misunderstood, issues of culture, differences in communication, language barriers and a lack of familiarity with the process (Jafari, 1993; Inayat, 2007, Khalili, 2004, in Patel & Shikongo, 2006; Moller et al., 2016). These findings also suggest that clients' perceptions of their counsellor's cultural sensitivity could impact on perceptions of credibility, their experiences and the relationship (Vasquez, 2007; Owen et al., 2011; Assouad, 2014).

Faith based counselling is much more common in USA (Fouque & Glachan, 2000). With these provisions in place some Christian clients have reported preferences for a Christian counsellor (Guinee & Tracey, 1997; Belaire & Young, 2002) but some differ on their views of this (Mayers et al., 2007).

Religious Matching

Committed Christian clients have been able to seek help from professionals who hold similar beliefs due to the emergence of Christian professionals, and Christianity based services, bridging the gap between secular professionals and clergy (Fouque & Glachan, 2000). This maps some of the recent developments amongst Muslim religious professionals, where there has been an increase in Muslim chaplains in prisons and pastoral care allowing those from Muslim faith groups to receive religious and spiritual care (Gilliat- Ray, Ali & Pattison, 2013). Greenidge & Baker (2012) explored why some committed Christians may go down the route of seeking support from Christian professionals. They conducted interviews with four female, and two male Christians (three identified as white British and three as African- Carribbean). Their findings suggested that feeling a greater connection with a Christian counsellor informed some participants' choice of counsellor. This was expressed to be important for increased understanding and ease of dialogue in sessions, and often provided an enhanced form of help (Greenidge & Baker, 2012). But this may be due to levels of religiosity that have also been found to have an impact on Christian individuals' more favourable perceptions of Christian counsellors

than secular counsellors (Guinee & Tracey, 1997). Similarly, research with Muslims has suggested that matching is likely to lead to better understanding especially when it comes to cultural references and religious metaphors (Meer & Mir, 2014). However, some researchers have encouraged the inclusion of religion into mainstream therapeutic approaches when working with Muslim clients and suggest that doing so would allow Muslim clients to receive help that is consonant with their belief systems (Hodge & Nadir, 2008; Meer & Mir, 2014).

Studies have suggested that religious and spiritual clients experience greater ease in therapy with counsellors of a similar religious background (Mayers, et al., 2007; Belaire & Young, 2002). Studies have also found that religious and spiritual clients have a generally positive experience of, and attitude toward, secular counselling once they had experienced it (Mayers, et al., 2007; Belaire & Young, 2002), except in the case of religious clients who felt judged by their therapist or who felt that the therapist imposed his or her own views onto them. In which case clients often left the therapy holding feelings of anger, shame and rejection (Knox, et al., 2005, Cragun & Myrna, 2012). These findings suggest that sensitivity is vital if a counsellor is to build rapport, trust and show empathy. If this is not the case a client may feel misunderstood, invalidated, disrespected and disempowered (Williams, 2005). Previous research has primarily been conducted with Christian clients, or clients who identify as religious or spiritual. My research will focus solely on Muslims, adding a new perspective to literature within this area.

The therapeutic relationship is known to be a significant predictor of effective treatment and outcomes of therapy (Lambert, 2013; Norcross & Lambert, 2014). Empathy is one aspect that Kohut identified as being central to healthy development of the self, which if absent can lead to distress and pathological experiences (Kohut, 1977; 1982). Studies have found that a client's sense of feeling empathy from the counsellor, feeling accepted, respected and understood were significant elements in enhancing the strength of the therapeutic alliance (Redfern & Dryden, 1993; Knox et al., 2005; Mayers, 2007; Belaire & Young, 2002). Similar findings have been published with Muslims clients, where trust, empathy, warmth, respect and care were

considered more important for the therapeutic relationship than a therapist's religious or ethnic background (Shafi, 1998; Meer & Mir, 2014). However, Shafi (1998) also found that counsellors' cultural awareness and understanding of Islamic values was important to some of her participants. This suggests that knowledge of culture is important and that empathy and qualities of good practice may not be enough for positive experiences in therapy (Roland, 2005).

In this section I have suggested that clients from a faith group tend to hold concerns about their faith being judged by their counsellor and thus are hesitant to disclose religious content. Studies have suggested that religious clients prefer working with counsellors from a similar background because of perceived shared understanding and increased safety. However, positive experiences with non- matched counsellor are also present and are largely influenced by the counsellor's qualities of acceptance and empathy. My research will build on the growing research exploring the relationship between Muslims and counselling. A lot of research with Muslims has attended to difficulties around accessing services. Whereas research with Christians has explored experiences within therapy in different ways. This research will provide a new perspective on Muslim clients' experiences within services.

Matching, Further Afield

The fields of genetic counselling and social work have also explored matching between ethnic minority and Muslim service users, services and practitioners.

Genetic counselling provides support to help individuals and families understand and adjust to implications of diseases that have genetic contributions (Resta, et al., 2006). Research within genetic counselling has also found that factors including language, consideration of religious culture and family culture may act as barriers to genetic health care services (Shaw, 2003). Research with Muslims has suggested that matching may be necessary only where language concerns are present. Other than this, effective counselling can be provided across cultures if clinicians develop knowledge and sensitivity to, differences, although matching could facilitate this (Middleton, et al., 2007). However, it is not clear that this knowledge and sensitivity is

present amongst clinicians. For example, research in Amsterdam found that during contact with Moroccan Muslim services users for antenatal screening, thirty percent of practitioners did not pay attention to the religious background of their client (Gitsels-van der wal, et al., 2014). This lack of focus on religious and cultural contexts could be due to lack of confidence and comfort in approaching these areas (Reis, et al., 2007).

Like the gaps between minority groups in therapy, prenatal screening has not been offered at the same rate for Muslim women compared to other minority groups (Modell, et al., 2000). This has partly been due to religious stereotypes and assumptions from healthcare providers (Modell, et al., 2000). However, reduced usage of prenatal health care services could also be due to families' wariness of healthcare providers because of fears of judgement, blame and stigma, particularly associated with consanguinity (Shaw, 2003)

The field of social work is also recognising religious and spiritual needs amongst Muslim service users. Social work has seen shifts in its practice in adoption of 'black perspectives' and more recently 'Islamic perspectives' in response to the cultural pluralism of society (Ahmad, 1992; Singh, 1992). In an effort to bridge theory and practice, a number of authors have sought to present models and frameworks for incorporating religion and spirituality within social work practice (Furness and Gilligan, 2009; Hodge, 2007; and Hodge and Bushfield, 2007). Research relating to the introduction of religion into the field is still emerging. As with other services, such as health care and psychological support, researchers have identified numerous barriers to accessing social care including language barriers and systemic barriers (Graham et al., 2009) or as Butt (2006) calls it 'institutional racism' along with lack of knowledge amongst minority groups about services, lack of appropriate services and staff lacking in effective communication skills and experience to work with diverse groups (Butt, 2006). When working with Muslim clients in social work, Al-Krenawi and Graham (2003) raise the Importance of asking about individuals' fears, concerns, attitudes, experiences and values before doing the work and involving the client fully in interventions. Some research has explored the role and importance

of 'frontline' ethnic minority workers in child welfare, housing and social services in order to support clients from similar backgrounds. Suggesting that matching can influence interactions outcomes (Sowa & Selden, 2003). Graham et al., (2010) suggest that "social services risk becoming another instrument of Western colonialism if they lack awareness, sensitivity and competence around cultural nuances and complexities. It is cultural sensitivity that is of utmost importance" (p.344). This section suggests that sensitivity to diversity is growing in various health and social care services, but there are still large gaps between services, ethnic minorities and religious service users.

This chapter has illustrated the interconnections between contextual and individual factors that contribute to Muslim women's experiences in Britain. I have illustrated the position of Muslim women within contexts of Islamophobia and patriarchy. Some Muslim women acknowledge the constraints they face and challenge them, creating shifts in their positions within their families and communities and wider British society, for example through choosing to pursue education and employment. I have also shed light on the psychological health of Muslim women, which begins to provide an insight into the relational nature of problems. Following on from this I explored ethnic and religious groups' interactions with and experiences of counselling services. This further highlighted the implications of difference on help seeking, suggesting that gaps are present between populations and practitioners but counsellor qualities can reduce this. Research relating to ethnic and religious matching within this section suggested preferences for similarity between client and counsellor dyads, however effectiveness of services could also be based on cultural sensitivity rather than cultural similarity (Sue, 1991; Constantine, 2002).

Rationale for research

Within current multicultural counselling research some ethnic groups and faith groups have been given greater attention than Muslim groups. Although there is increasing research on topics of religion and spirituality within counselling, it has tended to be carried out with (often young) Christian individuals, and predominantly in the USA. Studies carried out with Muslims

has often been based on quantitative methods mainly involving South Asian women. Much of the research is based on barriers and attitudes to services rather than experiences of services themselves. This may be because of the underutilisation of mental health services by Muslims but also because access issues may be a current problem for this particular group. Even so, Muslims do attend services, albeit to a lesser extent than other groups (Patel, et al., 2000)

There are numerous articles published that explore Muslim identities, values and belief systems with the aim of guiding counsellors and therapists on working with Muslim clients (Shariff, 2009; Williams, 2005; Lewis et al., 2009; Ibrahim & Dykeman, 2011; Ali, Lui & Humedian, 2004). Many studies also provide therapeutic techniques to work with Muslims (Hamdan, 2008; Hodge & Nadir, 2008; Dwairy, 2009; Meer & Mir, 2014) and case studies of therapeutic work carried out with Muslim clients (Hamdan, 2007). Some offer a combination of these (Masaud & Wiggins, 2011; Meer & Mir, 2014; Rassool, 2015). I searched through PsycInfo, Science Direct and PsycArticle databases using terms including, but not limited to: Muslim, women, therapy, counselling, spirituality, religion, Islam, multicultural counselling, depression & mental health. Muslim clients' voices are particularly limited when it comes to discussing their subjective experiences of counselling. As illustrated above, issues of multiculturalism within therapeutic encounters are multifaceted and intricate and require greater depth of research.

Taking into account the unique position of Muslim women in Britain and the increased attention to religion in research, I am interested in understanding experiences of Muslim, female, counselling clients. Whilst the literature review presents some understanding of Muslim women and mental health, research has often compartmentalised experiences.

This research aims to foreground Muslim women's lived experiences of who they are and how this interacts with their mental health and their counselling experiences. I will do this through in- depth exploration using Interpretive Phenomenological Analysis (IPA), giving my participants a platform to be understood from within their realities. The growing number of Muslim women in the UK and the increasing visibility of issues they face, points to the importance of this

research. Whilst religion is not a central part of every Muslims identity, Islam is likely to have informed values that many Muslims may have been raised with as it features in social, political, economic and spiritual aspects of a Muslim's life (Ahmed & Amer, 2012). Although this may depend on levels of religiosity, it suggests the importance of religion for the identity and everyday life of a Muslim client; hence a client will bring this into the therapy room. Studies have not explicitly looked at the influence of religion or religious identification on the therapeutic relationship and therapeutic work with Muslims; such research is vital in assisting counsellors, therapists and psychologists to understand, empathise and work more effectively with this client group. Badri (2000) argues that belief systems underpinning a culture are central to religious paradigms. To understand the mental health needs of a community these belief systems need to be given greater importance (Badri, 2000). This research looks to address the lack of dialogue with Muslim women. It intends to explore parallels between Muslim, female, clients' experiences in therapy and wider structures of racism and oppression in society.

Chapter 3

Methodology

This chapter sets out the methodological foundations of the research. I will discuss my research aims and design, giving a rationale for the use of the qualitative approach of Interpretive Phenomenological Analysis (Smith, 1996). This will be followed by the method used to carry out the research. The final part of this chapter comprises of reflections on my own position within this research with a discussion on insider- outsider positionality

Research Question

In relation to the main research questions; 'Understanding Muslim, women, clients of counselling' the following areas were explored using Interpretive Phenomenological Analysis;

- How participants made sense of their identity
- How they experienced, and managed, their struggles

- What their experiences were of seeking and attending counselling
- If, and how, religion played a role throughout their journey

Rationale for Qualitative Approach

Qualitative research moves away from the idea of discovering pre-existing 'truths' (Langridge, 2007) and instead aligns with an in-depth exploration of the lived experiences of particular phenomena (Creswell, 2013). It maintains a degree of flexibility in its data collection and analysis that allow for discovery of 'realities' and creation of knowledge that is translated through meaning making processes between individuals, or through intersubjectivity (Willis, 2001). This is in line with the social constructionist epistemological position of my research. Exploring lived-experiences is a central focus of this research, and as a counselling psychologist my desire to gain insight into lived experiences is a central focus, therefore such concern with individuals' meaning making processes are suited to a qualitative approach. Additionally, qualitative research is most suitable for under-explored areas as it makes it possible to identify new knowledge and findings through inductive processes (Atieno, 2009).

Researchers have argued that the under representation of minority groups in health research may contain issues related to power imbalance and unintentionally contribute to marginalisation (Rugkasa & Canvin, 2011). When researching minority groups, researchers have identified issues of language and cultural disparities, difficulties with recruitment due to issues around trust (Alvarez, et al., 2006; Guiliano et al., 2000; Shavers, et al., 2001) and cultural attitudes towards sensitive topics (Neufeld et al., 2001; Kokanovic, et al., 2009). Neufeld et al. (2001) highlighted the value of using qualitative methods when researching minority experiences. They suggest that adopting a qualitative approach lowers the concerns of language barriers, trust and sensitivity. One reason for this could be because it allows for the relationship to develop, which has been found to be effective in enhancing participation of members from ethnic minority groups (Gillis, et al., 2001; Neufeld, et al., 2001; Eide & Allen, 2005) and allows

time and space to work in ways that enhance cultural sensitivity (Neufeld, et al., 2001; Eide & Allen, 2005).

Principles of qualitative research also overlap with counselling psychology's principles of equality, empowerment, intersubjectivity and the importance of the relationship. Finlay (2011) draws a comparison between phenomenological researchers and therapists, pointing out that criticality, reflexivity and intuitive interpretation are a commonality between the two. A qualitative approach therefore fits well with counselling principles and my research question.

Research Design

My interview questions focus on the lived experiences of ten Muslim women in counselling. It explores contextual, interpersonal and personal influences on the meaning making of this experience. As a complex and under-explored area my research question is well suited to the inductive approach of Interpretive Phenomenological Analysis (IPA) (Atieno, 2009), which allows for generation of new perspectives and knowledge (Gabriel, 2013).

My Research Paradigm

Phenomenology is a foundation of Interpretive Phenomenological Analysis IPA (Smith, Flowers & Larkin, 2009) that stresses the importance of going back to the things themselves (Husserl, 1962; Willig 2013), i.e. re-engaging with the object itself, as opposed to our assumptions about what exists, in order to understand the meanings that are made in relation to and between people and objects (Husserl, 1982; Willis, 2001). Therefore, it aims to articulate important phenomena as closely as possible to the lived experience of the participant through what they articulate and how they articulate it, without inferring or judging, (Smith, 1996; Smith & Osborn, 2007; Smith, et al., 2009). IPA holds an idiographic perspective but also sees individuals as being embedded within, and inseparable from, their contexts. Thus, exploring how meanings are made from particular perspectives within particular contexts (Smith, et al., 2009; Pietkiewicz & Smith, 2014). There are several layers of context involved within my research question and participants; that of being women, being British citizens, being predominantly from ethnic

minority groups, being from a religious minority group and having the experience of being in counselling. All of these dimensions are part of the multi-layered social world (Bhaskar, 1998) of my participants and contribute to the unique social phenomena being explored.

IPA's ideas about co- construction of the research highlights its relational dimension. This allowed me to create space for individual voices, whilst also relating individual experiences to their contexts. Therefore, my research is positioned within a social constructionist epistemology alongside a phenomenological methodology. The employed paradigm is consistent with my own epistemological position that lies between critical realism and social constructionism.

I take a dialectical position where I focus in on individual experiences but also widen my perspective to explore how experiences are co-created within intersecting contexts (Bhaskar, 1998). There are also philosophical overlaps between social constructionism and the epistemological position of IPA through the process of hermeneutics. Hermeneutics posits that it is only through interpretation that we come to know of things (Heidegger, 1962; Schmidt, 2006) and make sense of experiences (Willis, 2001; Smith et al., 2009). In other words, to interpret something we need to look at an experience but for an experience to be understood it needs to be interpreted, so one cannot occur without the other (Larkin & Thompson, 2012); there is a constant relational influence. Therefore, hermeneutics links my phenomenological approach with constructionism. IPA emphasises the co- construction of meaning making of experiences and our understanding of those experiences through double hermeneutics where the participant is making sense of their world and the researcher is making sense of the participants' meaning making of their experience (Smith & Osborn, 2007; Smith, et al., 2009). I believe that my use of this approach enhances my research as it is an example of bringing together phenomenology and intersubjectivity through maintaining a focus on how individual experiences are shaped through interactions with context.

The double hermeneutic process also recognizes that knowledge of, and access to, the participant's inner world is influenced and complicated by the researchers own conceptions. Therefore, acknowledging that social, cultural and historical processes play a key role in

individuals' experiences. It also takes into account that interpretations will be based on each individual's meaning making systems, beliefs and attitudes (Smith, et al., 2009).

Subsequently then, while relying on my participants' articulations and expressions of their experiences, I also recognise that, as an individual in my own context, I have an influence on the co- construction of the research (Creswell, 2013). My own influence is engaged with through reflexive thinking (Creswell, 2013) at the end of this chapter.

Method

Design

In this IPA research a purposive sample of ten Muslim women was recruited to participate in semi- structured interviews. The interviews were audio recorded, transcribed verbatim and analysed using IPA (Smith, et al., 2009).

Participants

Process of Recruitment

Ethical approval for the research was granted by the University of the West of England's faculty of Health and Social Sciences research ethics committee. Part way through recruitment, due to interest and responses from individuals across the UK, I requested a modification to my research to include Skype interviews. This change was approved by the ethics committee. After which, I proceeded to recruit participants.

A recruitment flyer was sent to some of my personal and professional contacts through social media including active members of the local Muslim community (see Appendix 1). The use of community figures or 'gate keepers' has been highlighted as an effective recruitment strategy amongst minority groups (McLean & Campbell, 2003; Eide & Allen, 2005). I found the use of gatekeepers to be helpful as information about my research was spread further afield amongst individuals that others had increased access to. As well as facilitating recruitment, gatekeepers can act as a barometer of trust for research amongst particular communities (de Laine, 2000).

However, researchers have previously raised concerns around power that is afforded to the gatekeeper (Eide & Allen, 2005), their choice in framing the research (Das & McArevey, 2013; Sanghera & Thaper-Bjorkert, 2008), and negotiation of 'trade offs' where gatekeepers are offered something in exchange for participants (Corra & Willer, 2002; Das & McArevey, 2013). Yancey (2006) suggested that incentives may be helpful in ethnic minority research, and some researchers have offered honorariums (Das & McArevey, 2013), however this was not something I adopted.

The flyer contained information about myself, about the research study and a contact e-mail address. I also shared this flyer on a Facebook group called 'Islamic Counselling' that consisted of Muslim and non- Muslim therapists and people with an interest in Islamic counselling. In addition to this I contacted the Muslim Counsellor and Psychotherapist Network (MCPAN) who kindly shared my call for participants in their monthly e-newsletter to its members. Using social media platforms was particularly helpful in recruitment, but I would emphasise consideration of boundaries and confidentiality when using this method. Further to this I contacted two Muslim therapists and provided them with participant information sheets, which they shared amongst their circles. I also left flyers and information sheets at three counselling services who work with Black and Minority Ethnic individuals, a university Islamic Society and a mosque.

The information sheets contained an overview of the research question; aims and rationale; information about participant involvement, including confidentiality, consent and withdrawal; the process of participation; and contact details for my supervisory team and myself (see Appendix 2). Interested individuals were e-mailed a recruitment letter and information sheet. They were requested to confirm their participation after reading this. A suitable day, time and location for the interview was then arranged with those who were happy to participate. I found recruitment to be easier than anticipated, I discuss this in more detail in the reflexivity section of this chapter.

Sampling and Participants

Participants were ten Muslim women from the UK who had engaged in counselling in the UK. Smith, et al., (2009) highlight the fact that sample size is contextual and must be considered on a study-by-study basis. My supervisor and I agreed on higher numbers in order to gather sufficient meaningful data from an underrepresented sample. To partake in the research participants were required to be female, Muslim and have had experience of counselling in the UK. The sample was not homogenized beyond this as I did not hold assumptions about participants' backgrounds and experiences. Consequently, having the potential to capture a better degree of heterogeneity amongst the sample. Smith, et al., (2009) state that a diverse sample can be helpful in obtaining multidimensional and intricate accounts of the phenomena.

The women were between the ages of 23- 44 years and all self- identified as Muslim. They were from a variety of ethnic backgrounds, with seven out ten identifying as South Asian, including self-definitions of Bangladeshi, Pakistani and British-Pakistani. Others self- identified as White, Mixed Race and Black. Nine out of ten self- identified as being British and one as Somali. They were all from inner- city areas of the UK and all, but one, were currently living in the UK at the time of the interview. Six of them were currently in employment. Through disclosures during the interview it emerged that the majority of the women had accessed higher education, or were currently enrolled on further education courses. They all identified as heterosexual. This demographic information gives an insight into the heterogeneity of my participants without my own assumptions of their sexual, ethnic and racial identity markers. I have not provided further demographic information in order to maintain their anonymity. I am also aware that, had my participants demographics been different, my findings would also have been different, I elaborate on this in the discussion section of this research.

Four women had received counselling through the NHS, which included low intensity and high intensity cognitive behaviour therapy, five had been referred by their GP to a counselling service, three of these had also sought private counselling and one had additionally attended a student

counselling service. Two had also sought and attended counselling at a BAME counselling service. One received counselling solely from a student counselling service. Although all of the women received mainstream counselling, not Islamic counselling, it was unclear what therapeutic approaches were used in sessions, particularly for those who did not receive NHS based Cognitive Behaviour Therapy. Some of the women had several sessions with different therapists, others had only one session before beginning therapy with a different therapist, some had NHS prescribed six- sessions, and some had open ended private therapy. One also had previous experience of family therapy. This information was not gathered directly but emerged during discussions of counselling experiences.

Five women worked with white, non- Muslim counsellors. One woman worked with a Muslim counsellor and four worked with both a non- Muslim and Muslim counsellor. Two women who had worked with a non- Muslim had worked with a male counsellor. At the time of interviewing, two women were currently undergoing therapy but had also had experiences of counselling prior to this. Eight had completed and ended their course(s) of counselling.

Data Collection

Interview Schedule

A semi- structured interview schedule was developed in relation to the aims of the research and was used to guide the interviews. This allowed for detailed exploration of each participants' lived experiences through engaging in dialogue via techniques of inductive inquiry (Yardley, 2000). The interview schedule (see Appendix 3) was formed of sixteen open- ended questions to elicit responses in relation to the following:

- How participants made sense of their identity
- How they experienced, and managed, their struggles
- What their experiences were of seeking and attending counselling
- If, and how, religion played a role throughout their journey

Interview Process

Skype interviews were adopted as an alternative method of participation, in addition to face-to-face interviews. Previous research has suggested that having more than one option of participation can increase opportunities for ethnic minority individuals to participate (Das, 2010) therefore reducing barriers to participation (Weller, 2015). Five interviews were conducted via Skype and five were conducted face- to- face. The interviews took place at a location chosen by the participant; 7 interviews were conducted in the participants home (five of these were via Skype, which I carried out from a university counselling room), one was conducted in a room at a counselling service, one at a participant's place of work, and one in a university counselling room. An information sheet was given to participants to read prior to the interview, along with consent and demographic forms (See Appendix 4 and 5). Participants were given an opportunity to ask questions before and after the interview. Interviews lasted between 35- 90 minutes and were audio recorded using a Dictaphone. As well as a Dictaphone, Skype recording software was used to record Skype interviews.

Reflections on Skype interviews

Skype provided an opportunity to widen participation. It allowed greater flexibility for participants to be interviewed at a time and place suitable to them. This was often in the privacy of their homes, reducing travel constraints and increasing privacy. I would argue that this also provided participants with greater control, flexibility and power in the interview process. Research exploring online counselling has suggested that individuals show greater willingness to share their stories (Leibert, et al., 2006), which could be due to greater comfort and feeling less pressure than face-to-face counselling (Schultze, 2006). Deakin and Wakefield (2014) likened the reliability and depth of online interview data to face- to face interviews. I found all my Skype participants to be open and honest and I did not feel that the use of Skype inhibited the establishment of trust in the relationship.

However, two drawbacks of this method were technical issues with video and audio functions and lack of access to non- verbal communication. The technical quality of interviews was dependent on internet connection. Two interviews had several disconnections and lapses in sound. Seitz (2015) suggests that this can cause a loss of intimacy in the interview. Although we experienced breaks in the flow of conversation participants remained engaged.

Each interview was transcribed verbatim. All identifiable information such as names, places of residence and work were changed to protect participants' anonymity. Interview recordings were deleted as soon as they were uploaded to my computer and stored in a password protected file that were only accessible by myself. Extracts from the original transcripts are presented in this manuscript. Employed transcript conventions can be found in Appendix 6.

Process of analysis

Analysis was conducted in accordance with Smith, Flowers & Larkin's (2009) description of conducting IPA. The procedure of analysis was as follows:

I. I began by listening to each individual interview whilst reading the transcript and then re-reading the transcript. This helped maintain an idiographic focus and become familiar with each transcript and each participant's feelings.
II. After becoming familiar with the transcript, I made initial notes in the right- hand margin of the transcript. These included insights, initial interpretations, and comments on language, similarities and contradictions within the transcript.
III. Once this was done, I began conceptualising data at a higher level through noting emergent themes from the initial notes in a separate column to capture the central qualities of the data i.e. participants' thoughts, feelings and experiences.
IV. I then wrote these themes on a paper and looked for connections between them using different colours to highlight connections. This involved 'clustering' (Smith & Osborn, 2008) themes based on similarity. Themes that did not have sufficient extracts to back them up were discarded and others that overlapped were regrouped and re-named. I

cross-referenced each theme with the transcript to ensure that it captured the data. This was done for each transcript individually. The themes for each transcript were then evaluated amongst each other.

V. Extracts from transcripts that illustrated and supported each theme were developed into a word document that was used to evaluate the suitability and richness of each theme. If sufficient support was not garnered from extracts, or a theme did not fit, it was discarded. This ensured that the themes were grounded in participants' accounts (Shinebourne, 2011). Recurring themes, with substantial data to support them, were placed as master themes. Themes that captured common experiences were grouped under subthemes.

VI. A table of Master themes and Subthemes, that most pertinently captured participants' experiences, was produced. The structure of themes was considered to ensure that they related well.

VII. These themes were then presented to, and discussed with, the supervisory team for examination and agreement and were used to form a narrative that shaped the final write up.

Reflecting on Researcher Positionality

Researchers are permanently attached to their way of 'being in the world' (Heidegger, 1962), thus I cannot entirely bracket off my own assumptions. Therefore, it is important for me to own my perspective and reflect on my identity and any influence this had on the research (Yardley, 2000; Eilliot, et al., 1999; Smith, et al., 2009). In this section I will reflect on my position as an insider- outsider researcher and some of its implications.

I am a twenty-seven-year-old, British born, Pakistani, Muslim woman. I am a counselling psychology doctorate student and have engaged in counselling myself as well as providing therapy. As a member of the population that I am studying I can be positioned as an insider researcher (Kahuna, 2000; Asselin, 2003). As a Muslim woman who wears a headscarf, I am visibly identifiable as Muslim. This would influence participants' perceptions of me. However,

there are differences and similarities in age, ethnicity, marital status, roles, values, beliefs and our experiences as Muslim women. Therefore, although we may appear to be similar, the identity relationships between myself and my participants are complex and dynamic (Hayfield & Huxley, 2016). Despite overt similarities of faith- group membership, nuances in identities create different relational positions between myself and my participants (Abbas, 2010). Additionally, I have membership with other groups i.e. academics, researchers and therapists, that my participants may not, thus positioning me as an outsider (Dwyer & Buckle, 2009). Therefore, in this research, I identify both as an insider, and to some extent, as an outsider, occupying 'a space between' (Dwyer & Buckle, 2009).

Researchers have suggested that an insider position can be useful to alleviate barriers to participation arising from mistrust (Yancey, Ortega & Kumanyika, 2006) and that participants are likely to have a greater willingness and confidence to share with those they perceive as being similar to them (Johnson-Bailey, 1999; Neufeld, et al., 2001).

During interviews researchers suggest that an insider position can facilitate rapport, understanding, acceptance, trust and openness (Dwyer & Buckle, 2009). Perceived similarities can also re-address and diminish power differences (Jensen & Lauristen, 2005; Neufeld, 2011; Das & McAverey, 2013). I felt that my participants disclosed openly with me, however I also noticed some hesitancies. Some participants may not have been transparent as they may have viewed me as a "social intruder" and not felt safe to expose particular thoughts to someone similar to them (Abbas, 2010).

Some also suggest that an insider position can increase sensitivity to participants' experiences and facilitate prioritising the participants' voice (Abbas, 2010; Neufeld, 2011). I possessed an understanding of some social norms and patterns that allowed me to be sensitive to non- verbal communications. For example, I was aware of particular rules and taboos within the community around pre-marital relations that allowed me to be sensitive to disclosure of these experiences. When interviewing Jamila discussed her experience with her ex-partner her tone quietened, I

noticed and respected that this was a potentially risky topic to discuss in her home environment and inquire tentatively. My sensitivity extended to awareness of issues of objectivity during interviews when some topics felt 'too close to home' (Kahuna, 2000). I upheld my researcher position through maintaining boundaries and focus. Having had experience of being a client also gives me some affinity with an insider position, but this was not known to any of my participants. One way in which this personal experience could play a part in this research is in the generation of my very question.

Approaching this research as an insider also had some challenges around assumptions and biases. For example, I had initially assumed that it would be difficult to access my participants. This may have been due to my own awareness of the stigma of mental health in the community. It could also have been the influence of previous research that discussed the barriers to counselling for this participant group. Alternatively, it may have been related to my own anxieties and potential risk in sharing parts of myself in my experiences of counselling as a client, practitioner and student, which I may have projected onto others. I was surprised to find that interest far exceeded my expectations with a total of eighteen individuals who enquired to participate. Abbas (2010) identified some challenges that are unique to having a shared religious background. He emphasised the significance of objectivity for the researcher. This was something I experienced through my own process.

I noticed my own resistance to the topic of Islamophobia. When beginning to analyse my data I realised that the subjects of Islamophobia and hijab were present within my participants' accounts but I had unconsciously excluded them from my literature review. I questioned this and recall feelings of frustration when reading literature on Muslims that recurrently centred around Islamophobia. However, my awareness and rectification of this has now shaped my research more subjectively, based on my data.

Another issue with insider positioning is that participants may not fully explain their experiences (Kanuha, 2000; Dwyer & Buckle, 2009). For example, when Halima mentioned 'dhikr' we did not elaborate on what she meant as we both assumed a shared understanding. But I realise there

may be differences in our understanding. Exploring this practice may have produced new information that could have influenced the analysis in a different way. However, she may have felt an ease in not having to elaborate.

Other researchers have also highlighted the potential of role confusion for the researcher when they engage in the research process from a perspective other than that of a researcher (Asselin, 2003). However, I feel that these difficulties could occur as both an insider and an outsider researcher and that the crucial elements of research are an ability to be "open, authentic, honest, deeply interested in the experience of one's research participants, and committed to accurately and adequately representing experience" (Dwyer & Buckle, 2009 p.59).

As a researcher, therapist and trainee counselling psychologist I was also positioned closer to an 'outsider' position. My professional role was vital in establishing credibility and preventing boundaries from becoming blurred (Asselin, 2003). My professional identity also allowed me to analyse the data in an explorative yet critical way. However, as a Muslim woman, researching other Muslim women, I held a sense of accountability throughout, particularly in how the findings were presented. Researching a group that gains significant (often negative) attention, I was mindful of increased scrutiny that my research may be subject to.

During the end of the interviews many of my participants expressed additional information on the research topic such as further comments about stigma within the community and their current struggles. Some requested to be informed of the findings of the research. Some also expressed an admiration and encouragement of myself in researching and working in this field and hoped for the research to create a positive impact. To me, this highlighted the significance of their experiences, the importance of my endeavours and the privilege that I have as a researcher.

Chapter 4

Analysis

In this chapter I present an analysis of the Interpretative Phenomenological Analysis of ten Muslim, women's lived experiences of being Muslim, female, clients of counselling. This includes how they construct their sense of self, their experiences of distress, and their experiences of counselling. Three themes emerged from the analysis. The first theme: Constructions of The Self, will explore the dynamics of context and identity. It will illustrate how my participants' self-constructions were influenced by their relationship with God, British society and ethnic culture. The second theme: Self in Relation to Emotional Distress, will explore how my participants' issues impacted their wellbeing, how they responded to this and how these experiences were influenced by mental health stigma within their communities. The final theme; Therapeutic Relationships in Counselling, explores the influence of client- counsellor differences and similarities and the relationship with God. The analysis has been laid out in this way to show how my participants' external contexts entered the therapy room. All themes will be illustrated via data extracts from the interviews. Transcript conventions are found in Appendix 6.

Table 2. Master Themes and Subordinate Themes

Master Themes	Sub-Themes
Constructions of the Self	Self in Relationship with Allah Self in Relation to British Society Self in Relationship with Family and Community
Self in Relation to Emotional Distress	Experiences of Distress Responses to Distress

	Influence of Cultural Attitudes Towards Distress
Therapeutic Relationships in Counselling	Impact of Client- Counsellor Difference Relationship Between Client, Counsellor and God Impact of Client- Counsellor Similarities

Master theme 1: Constructions of the Self

All participants communicated the complexity of being Muslim women. This theme explores different contextual dimensions that contribute to who they are, prior to accessing counselling. This includes their relationship with God, their relationship with British society and with their families and communities. This theme provides an understanding of my participants' self-constructions and experiences at the intersections of religion, politics, gender, ethnicity and culture.

Sub-Theme 1a: Self in Relationship with Allah

This subtheme explores the significance of God in my participants' identity constructions. When describing themselves as Muslim women, six out of ten of the women made reference to personal qualities of strength that were associated with their religious identity. For instance, during the interview with Shumi she repeatedly used words related to strength to describe herself such as "strong willed", "confident" and "independent":

I feel empowered being a Muslim woman…I'm strong and independent (Shumi)

Shumi described herself with firmness, reinforcing her sense of confidence, which she attributed to the combination of her religious and female identities. This association was also shared by

others. Amy was a convert to Islam. She commented on the changes this brought to her self-confidence:

> *I feel far and away more empowered as a Muslim than I did as a non-Muslim (Amy)*

Amy attributed her confidence and strength to "*having a direction in my life*" and also being treated "*way more respectfully*" by both Muslim and non-Muslim men. These extracts highlight the sense of empowerment achieved through a religious identity. In addition to this, they also felt connected to God. All of the women emphasised that their relationship with God was integral to their Muslim, female identity.

For example, Amal commented that:

> *The main thing for me personally is that connection with God…it's almost like inside…like no one can really know what's in your heart, so it's almost like it's just between you and God (Amal)*

Amal's relationship with God was a central part of her identity. She describes it as an internal, private connection. Amina and Amy also put their relationship with God at the centre of their Muslim identity:

> *Central to it [being Muslim] is my relationship to Allah…but also like trying to establish a very intense, or not intense, but an omnipresent kind of spiritual relationship (Amina)*

Amina explained that she is consciously and consistently creating and maintaining her relationship with God. Amy also commented on the centrality of God to her Muslim identity through having awareness of God in her day to day life:

> *It [being Muslim] is a conscious decision that I've made to live my life with awareness of God and to strive to do everything that I do with that consciousness (Amy)*

This ties in to her earlier quote where she stated that Islam gave her a direction in life. These accounts suggest that having a relationship with God is constructed as spiritual and as part of their religious identity.

These extracts have highlighted the internal aspects of faith for some of my participants, however their relationship to it has variations. This suggests that a person's relationship with God can be a shared element of being Muslim but is also personal and distinct. For example,

Jamila talked about how her views sometimes differed from her parents' and how she managed this:

> *If they [my parents] ever say something that I find that can obstruct my way of thinking in terms of my faith I will just voice my opinion, cos I'm just like well no that's **your** like traditional value thinking (Jamila)*

Jamila's sense of agency came through strongly in her interview and this extract is also an example of that. She differentiated her views from "traditional thinking" suggesting that there are sometimes opposing values within her family culture and her faith. Jamila exhibited a confidence in her ability to defend her opinions and beliefs. A divergence of values has been found by other researchers too who's participants have used religion to create change and opportunities for themselves within their cultures (Brown, 2006, Dwyer, 2000).

The accounts presented in this subtheme have begun to build a picture of the relationship that my participants' have with God and Islam. God and faith were central components in their self-construction as Muslim women and also contributed to their personal characteristics of strength and confidence. It parallels previous findings about Muslim women embodying a spiritual experience that affords them inner strength (Mirza, 2012). I have also suggested that there can be divergences in values and belief systems within families. This will be explored further in subtheme 1c. My participants' accounts in this initial subtheme focused on an internal dimension of their identity, the next section will explore the external dimension of a Muslim identity in Britain.

Sub-Theme 1b: Self in relation to British society

Nine out of ten of the women interviewed were visibly Muslim as they wore a head covering. Their head-covering was an outward expression of their affiliation with Islam. It impacted how they saw themselves within mainstream British society. All of the women made reference to stereotypes and misconceptions about Muslim women that they felt were prevalent in Britain. When Shumi was asked how she made sense of herself as a Muslim woman she positioned herself in contrast to the stereotypes:

> *Muslim women generally come across as oppressed, that's something I'm definitely not. I'm, alhamdulillah[3], a strong, independent woman (Shumi)*

Her initial self-construction was made in reference to the stereotype of Muslim women being "oppressed". She distanced herself from this negative image by rejecting it and asserting her contrasting, positive, personal qualities. Some of the women talked about negative impacts that the stereotypes had on their sense of self. For example, Amina talked about her increased self-consciousness due to negative public perceptions of Muslim women and the impact this had on her over time as a woman who wears the khimar[4]

> *I don't feel as confident in the outside world as I used to just because of the different perceptions within society… I feel like the air's changed, I feel like I'm viewed differently, people treat me differently…I, as a person, I'm actually very very open but now I feel that when I'm in the outside world I actually feel like I have to prove my openness…I feel like in terms of the way I dress even my dress has to reflect a certain casualness (Amina)*

Amina was tentative about naming the changes that she was talking about, suggesting a feeling of insecurity. But her emphasis on 'openness' suggests people in mainstream British society may view Muslim women as being other than open and casual, maybe strict, conservative, close-minded and secluded. Amina expressed a sense of responsibility to reassure others that she is not threatening. Like Shumi, Amina also felt the need to distance herself from the 'other' and construct a positive self- image. She did this through expressions of openness via her dress choice. Whilst distancing herself from the 'other' she is simultaneously positioning herself in closer proximity to a society that she sometimes does not feel included in. Additionally, Amina appears to become overshadowed by the stereotypes, particularly when she leaves the house. This suggests a difficulty in being seen for who she is.

Some participants showed sensitivity to increasing socio-political tensions regarding Muslims amongst British society. Perceptions of this brought up fear, which was seen as contributing to

[3] Alhamdulillah: An Arabic phrase used by people when they wish to praise God, translated to "praise be to God"

[4] Khimar: A covering worm by Muslim women covering the head, neck, shoulders, chest and body at varying lengths

increased self-consciousness in public. Sana's comment about how she feels being a Muslim in Britain illustrates this;

> *In this climate and where I'm living at the moment it's quite hard to go out as a Muslim woman, especially as one who covers their head and is visibly Muslim. Just because I think since 9/11 and since the London attacks there's been a lot of Islamophobia and then the rise of these right-wing groups and all these attacks on Muslims and Muslim women, it's been hard (Sana)*

Sana expressed a self- consciousness stemming from fear of being a target for others' resentment towards Muslims. She expressed a sense of threat due to being visibly Muslim that makes her feel constrained and unsafe to go out in public.

These extracts show how external perceptions of Muslim women significantly influenced how my participants saw themselves as Muslim women in Britain. They possess a double-consciousness as they are viewing themselves "through the eyes of others" (Du Bois, 1903, p. 351). As a result of this, part of their self- constructions stem from their response to stereotypes (Anthias, 2002; Wagner, et al., 2012). Their initial claims of confidence and empowerment contrast with their feelings of insecurity as Muslim women in British society. However, their initial self-descriptors could be a response to stereotypical representations of Muslim women. They can be seen as existing in a dichotomy between being outsiders in mainstream society but also trying to be 'normal'. I would argue that the narratives of terror and subordination surrounding Islam and Muslim women contribute to systems of oppression; such as Islamophobia. The fear and insecurity that my participants felt outside their homes suggests feeling oppressed by Islamophobic attitudes within society. As well as the context of Britain my participants also shared experiences of living within their ethnic cultures. The next subtheme explores how this dimension influenced who they are.

Sub-Theme 1c: Self in relationship with family and community

This theme explores the experiences of my participants within contexts of family and community. Nine out of ten of the women talked about gender inequalities within these contexts and seven out of ten shared first-hand experiences of sexism. I interpreted this as

impact of patriarchal cultural norms, which they separated from their understanding of Islam. Islam was seen as something from which they derived strength and purpose (see subtheme 1a). Some participants' interpretations and practices of Islam were not always shared by those around them.

Jamila talked about her experience of separating religious and cultural values:

> *I've always done things a little bit differently that's the problem. Like I'll go out wearing something and my mum will be like but what will people say? Or for example, I'm with my friends and my parents are fully accepting but they will be like come home at this time, and if I come home later than that it's like wow oh no what are the neighbours going to say?…when you realise how wrong being suspicious is in Islam you'd have a totally different perspective on the culture of what are people going to say (Jamila)*

Jamila's account gives examples of feeling constrained by different values between herself and others in her community. There are tensions in her ability to exercise her freedom as an individual whilst living within her community. This could be seen as a challenge occurring between individualism and collectivism. Her account is evidence of experiences of difficulty in navigating spaces between conventional cultural norms and change (Talbani & Hasanali, 2000). Although she states that her parents are fully accepting, their fear of judgement for her suggest that they may have difficulty in fully accepting some of her choices. It suggests that she could be rejected by others in her community when her choices are outside of the cultural norms. This fear of rejection could also influence her own self- acceptance as she suggests that the problem is due to her being "different". Jamila highlighted how she feels that the culture of judgement within her community contradicts Islamic teaching about suspicion. This suggests that the watchful culture is part of her ethnic community as opposed to stemming from religion. Jamila went on to stress the centrality of gender in some of her struggles:

> *It always comes back to when you're a girl as well. I feel like when you're a girl you can't wear certain things, you can't go to certain places, you can't hang out with certain people, um because it's so and so's daughter but no one hardly ever talks about so and so's son (Jamila)*

Cultural gender rules imposed on Jamila's freedom. This parallels findings by others such as Macey (1999) whose respondents talked about being "policed" by the community, particularly

by men, in order to maintain family and community honour. Jamila's accounts suggest that external pressures are a part of her daily experiences, which contain an element of risk but also courage. This suggests that the same struggles could also be a source of her strength.

Sana also expressed frustration, but resilience, in her difficulty when deciding to separate from her husband:

> *My dad and brother were telling me I should still stick by him [my husband] and that this is what our **religion** tells us to do. When it's not, I don't believe it is our religion that tells us to stick in an abusive marriage (Sana)*

Sana highlights the difference in Islamic interpretations between herself and the men in her family. The dominant message she received was to remain subjugated and not act on her choice. This created pressure for her to conform but her own beliefs helped her uphold her decision. However, she did not receive full support from her mother due to outside pressure:

> *"sometimes she [my mother] would say you should go back you know he hasn't basically punched me yet and sometimes she'd say oh you did the right thing but the community like his family would call my parents and they'd say something to them [my parents] that'll make them go off at me again" (Sana)*

These extracts suggest that Sana's own needs were subjugated by male dominance and cultural expectations of women. In order for her to receive her right to divorce she underwent difficulties with family members, and experienced guilt, shame and blame. Emotional difficulties are not only the result of immediate struggles but also have an additional layer of community involvement. Both Jamila and Sana's accounts suggest that attitudes of others in the community can have a negative impact and create further difficulties associated with shame. Challenges relating to the position of women within ethnic cultures goes beyond the family home. Halima shared an experience of challenging gender inequalities at a community level:

> *"he [the imam] didn't approve of women events where women do speaking so I met with him to try and discuss this…his response to my questions as to why was because 'my sheikh[5] said so' so it was quite closed and when I said you know this isn't from the sunnah[6] to just cut off an entire half of the population because your sheikh said so he*

[5] Sheikh: An honourific title in Arabic, which can be used to mean a "leader"/ "chief," "revered elder," "Islamic scholar"

[6] Sunnah: Record of the teachings, sayings and actions of the Prophet Muhammad (peace be upon him), which provide guidelines on the way of life for Muslims to follow

threatened to preach against anything that I did (laughs) in the area and that women would not come and their husbands would not allow them to come and this kind of thing and that's probably my fault because I didn't know how to engage with that kind of person

The differing religious perspectives between Halima and the imam caused hostility and resulted in her being threatened. Her experience highlights the strength of patriarchy within the Muslim community and the risks involved for women in challenging gender norms. It also points to a lack of openness to discussion of gendered issues, which perpetuates systemic power imbalances. There are attempts of silencing occurring in Sana and Halima's experiences, which can become internalised. This is seen in the above extract where Halima blamed herself for the Imam's response. It appears that some of my participants located issues within themselves to account for others' negative responses and difficulties within their situations.

This subtheme explored female subordination within Muslim communities. These experiences were from women from three different ethnic groups within Muslim communities. I have not included specific ethnicities in order to maintain anonymity. The extracts above have shown different forces of control that are at play in my participants' lives. These include gender rules and norms, patriarchy, sexism and religious manipulation. Power imbalances were apparent and portray a victimisation of my participants as their freedom and agency are sometimes restricted. Victimisation is also seen when the women directed blame toward themselves, taking responsibility for stressful situations and for others' emotions. Such conflicts and experiences had the potential to result in a loss of independence, agency and expression. There is a silencing occurring in their attempts to live according to their own views and rights. My participants real experiences of oppression and inequality within a patriarchal culture, stand in contrast to their initial ideal identifications of being strong and independent. This may be due to denial or dissociation from areas of anxiety. They did not appear to be aware of this contradiction during interviews, further suggesting unconscious dissociation. My participants' experiences could also have generated strength and assertiveness through the process of challenging inequalities and

power figures that attempted to oppress them. The women point to both courage and vulnerability in how they exercise their right to make choices. Their experiences suggest that they are attempting to define themselves apart from cultural traditions but from within family and community structures. They are in a position to challenge and criticize particular social norms and conflicts by reviewing them against their own ideas about their values and futures (Hoare, 1991), but the process is complicated by powerful, social structures.

I started off this theme by highlighting the ways in which the women described themselves in relation to their religious identity. Participants possessed a uniquely personal, and often invisible, internal aspect of their relationship with God. Their religious identity also cultivated empowerment. This may have been a response to negative, oppressed, stereotypes of Muslim women. However, creating more positive self-constructions, in order to move away from stereotypes could be seen as a form of internalised oppression. My participant's identifications with strength and independence could also be a dissociation from cultural issues or may stem from responding to gender inequalities and oppressive experiences. Despite often feeling vulnerable and fearful within their contexts they continue to make decisions that allow them to adhere to their personal values, while discreetly and openly challenging others' expectations. For me, this is evidence of an internal strength that my participants possessed and I would argue that strength and vulnerability coincide. However, the particular combination of contexts that my participants navigate can increase the vulnerability factor as they are challenging overpowering systems of Islamophobia and sexism in everyday situations. In the next theme I will explore some of the issues that my participants experienced.

Master Theme 2: Self in Relation to Emotional Distress

This theme consists of three subthemes exploring how my participants related to their emotional distress. I will firstly summarise some of the issues that led my participants to seek counselling. The summary is intentionally broad in order to maintain anonymity. Following this I will explore the psychological and emotional impact of some of the experienced issues

including depression, loss of confidence, autonomy and faith. I will explore how the women managed their distress and made sense of their experiences including use of faith and online resources. Finally, I will explore how mental health stigma influenced coping strategies and access to counselling.

Five women in this research were experiencing, or had experienced, marital and relationship issues that brought about symptoms of depression. These included; relationship breakup; divorce; conflict of roles in the home; physical, emotional, financial and religious abuse. One reported social anxiety, two experienced work and family related difficulties that led to anxiety and depression, one experienced pregnancy related depression and one reported being depressed but did not elaborate on what was going on at the time.

Sub-Theme 2a: Experiences of Distress

In this subtheme I will provide an understanding of some of the emotional and psychological consequences that resulted from the difficult situations that my participants were facing. These include experiencing symptoms of depression including low self- esteem and confidence, loss of autonomy and power, loss of direction and clarity, and also included spiritual disconnection.

Shumi was struggling with maintaining her independence in an environment where she felt controlled by her in-laws. She had agreed with her counsellor to go for a walk when she was feeling tense at home. However, her in-laws did not approve of this and instructed her to stop. In the extract below Shumi describes what impact this had on her:

> *When that sit-down chat happened everything fell to pot. I broke down, it broke me completely that no matter how much I try I'm never going to win, I'm never going to be my own person again (Shumi)*

Through her constant attempts to maintain her independence, Shumi became fragile to the point of shattering. She felt helpless and hopeless, experiencing despair, defeat and loss. Her living situation contributed to her depression; highlighting a negative impact of cultural gendered expectations. Her experience here is in stark contrast to her self-constructions in theme 1 of being strong and independent. It suggests that her personal qualities came into conflict with more traditional norms.

In the previous theme I also explored Jamila's views on gender inequality within her culture. She talked about an experience of battling this when she ended her long- term relationship:

> *He [ex- boyfriend] would threaten me by saying I'm gonna show your parents this, I'm gonna tell your parents this, that you are this, like every name under the sun. So that obviously got my confidence low…he just kept me in this almost very abusive relationship… so essentially my confidence which was not very existent went like completely down (Jamila)*

The relationship was not known to her family, thus Jamila's ex-partner used cultural manipulation to overpower her. This could have caused feelings of guilt and shame in addition to feelings of worthlessness and helplessness. Shumi and Jamila's experiences suggest that depression can develop and persist through interpersonal difficulties. In these cases, particular difficulties arose due to their position as females within their culture. Their struggles may also stem from differences in their values of independence and freedom versus cultural values of interdependence and traditional gender roles.

Seven women expressed feelings of disorientation and feeling lost. Farah's description of her depression illustrates this:

> *I remember those first few months they were like my darkest days basically (laughs) I don't know where I was, who I was, what I was going through (Farah)*

Farah's account gives a powerful depiction of a loss of self, a loss of direction, a loss of clarity and a confusion about her experience. It was an unfamiliar experience that she struggled to make sense of. Her laughter, just after describing the severity of the situation, suggested an attempt to distance herself from the painful experience.

Sana also expressed a loss of clarity and direction but more explicitly in relation to her spirituality:

> *I was going off rails in the sense that I wasn't praying, my imaan[7] was proper shaken up because of everything that I went through (Sana)*

[7] Imaan: Denotes a believers faith in Islam

Her difficulty had unsettled her spiritually and thrown her off track of her usual religious engagement. Amina also commented on the disorientating impact that her struggle had on her spirituality:

> *I'm feeling that I'm meandering in and out of like a spiritual crisis (Amina)*

Sana and Amina's experiences suggest that depression, and its symptoms, permeated their relationship with their faith, making it difficult to practice Islam. It suggests that a loss of connection with religious practice could be a symptom of depression.

These experiences also suggest that my participants' relationship with their faith and with God was impacted as a result of their struggles. Therefore, changes in religiosity and spirituality can be a sign of mental health issues or an indication of struggling with life circumstances. Later in the interviews Farah, Amy, Jamila, Shireen, Shazia and Halima talked about a re-connection with their faith as a sign of progress and strength in their journey of healing. This suggests that their issues also impacted their spirituality. It could also indicate that spiritual connection and growth was associated with improved mental health. Faith was sometimes also a crucial component of coping, this will be explored below.

Sub-Theme 2b: Responses to Distress

This subtheme draws out some of the ways in which my participants coped with their emotional distress. These include faith, online resources, the GP and counselling. This subtheme illustrates a meaning making process that occurred as the women sought to understand and overcome their difficult experiences. It is important to bear in mind that the process was different for each woman and was not linear.

In the previous theme some participants described a disconnection with their faith as a result of their struggles. Some women utilised faith to understand and cope with their difficulties:

> *I thought to myself what have I done to deserve this? Why am I being tested so much? It's not fair (Shumi)*

Shumi appeared to be looking for an explanation as to why God would allow this. There is a sense of injustice and confusion and self- blame. This parallels how some of the women

internalised cultural conflicts they experienced in subtheme 1.c. Sana also talked about her attitude toward God:

> *There are still days where I'm like why is God doing this to me? (Sana)*

These extracts highlight unhelpful religious coping. In their attempts to seek answers they are sometimes locating a fault within themselves. This suggests that self- blame could be an unconscious, coping mechanism. Through this they are attributing responsibility to themselves for their struggles, even though their problems may have originated externally.

Others utilised religion for support. Amy, who experienced an abusive relationship used her faith to help her cope;

> *…To have that patience to persevere to fight through whatever's going through I'm really really grateful that I had that because if I hadn't I wouldn't be here today sitting and talking... [if I wasn't Muslim] I wouldn't have had the knowledge that I had of Qadr[8], of God's plan, of you know that whatever happens to you is written and it will pass and you will get through it (Amy)*

Faith was a crucial component in Amy's appraisal of the issue, her resilience and ability to cope. Beliefs around patience and perseverance reinforced a positive self- belief that helped her manage. There's an element of hope and strength in her belief that her issue will end. There is also trust in a Divine plan for her life, through this trust she appears to have let go of controlling the situation but allowing it to unfold and pass. Her belief and trust show an optimism for her healing. This type of cognitive appraisal has been termed as 'positive religious coping' (Meer & Mir, 2014).

Faith was also utilised to cope with isolation:

> *When you feel that you are alone and you literally can't speak you know that I think is one of the times you do fully comprehend the fact that only Allah can really understand what's happening with you (Halima)*

Halima's account suggests that her relationship with God substituted the emotional disconnection she experienced from others during her struggle. Turning to God was not a

[8] Qadr: Predestination/ fate: concept of divine destiny, the "decree" of Allah. One of the articles of faith in Islam

replacement for professional support but was often done before, during and after seeking counselling. We begin to get a sense of how the comforting effects of faith brought some of the women closer to God. This was often seen also as a benefit of therapy and a sign of progress, which will be explored later. Faith-based coping suggests that my participants' cognitive appraisals of their problems were strongly influenced by their religious beliefs. However, these could have been impacted by their emotional state, levels of distress, perceived control and support.

Some of the women also utilised forms of psychoeducation to gain understanding of their issues, often prior to seeking counselling. For example, Sana and Halima turned to online resources;

> *I was googling things online about how I been feeling…I didn't realise I was a victim of domestic abuse until I googled things. It just made sense to me why I was feeling the way I was and there was something online that said seek help from your GP and I had an idea that they would refer me to counselling because I read up that they sometimes do refer you to counselling (Sana)*

Sana sounded satisfied and relieved when talking about this. Receiving validating information provided her with a motivation to address her struggles. It also provided her with hope of being able to receive support and information about how to proceed.

Halima also felt empowered through gaining a greater understanding of her situation, which also then led her to seek support;

> *For a long time it was trying to understand what on earth was wrong with me. Then it would be like every time I would read an article or I would see something that was relevant to how I was feeling it would be like a lightbulb, like wow you know, so then I went to see my doctor and they said it sounds like you have textbook generalised anxiety disorder so that was my journey to counselling GP referred me then (Halima)*

Accessing online resources was an important avenue for Sana and Halima to gain understanding about their difficulties. Gaining knowledge about their experiences was extremely enlightening, empowering and significant in their journey to counselling. Their experiences here, accompanied by hope, bring to mind the adage of "knowledge is power". The accounts so far depict a movement from darkness and confusion to light and clarity. This continued through counselling where some women began to regain a sense of control and empowerment. This will

be explored in theme 3. Their use of online resources also suggests that this was a safe and accessible option.

The safety and ease in accessing faith and online resources contrasted with their experiences of accessing counselling. Nine out of ten of the women talked about their situation in a way that suggested that they had endured it for quite some time before seeking help. For example, Shireen felt disconnected from others for many years before seeking professional support:

> *I think I kind of had a problem for a long time, and it kind of just got to a point where I had enough…after years of kind of being isolated and things like that I kind of just got to a point where I thought I needed to seek help (Shireen)*

Her feelings of frustration had built up over time and it was only when she could not tolerate the difficulties of being isolated that she decided to access counselling. Shumi also accessed counselling as a last resort:

> *It was either that or we go forward with a divorce, and I wasn't ready to throw the towel in. So it was either or, one road or the other, and hence why I thought okay let me try (Shumi)*

Shireen and Shumi had gotten to a point where they were pushed to look outside of themselves for support. This raises the question of why they didn't seek help sooner. Delays in help seeking suggest a lack of awareness and understanding of counselling. It also alludes to misconceptions and taboos surrounding counselling that acted as barriers to accessing support.

When Amal was asked what stopped her from seeking support earlier, she pointed to an attitude of self- reliance that hindered her access to counselling:

> *I thought I don't really need it [counselling] I can deal this by myself (Amal)*

Her reasoning suggests that there may be a lack of knowledge about counselling. Her response to her issue may also have come from expectations about how Muslims cope with difficulties. She raised some of these expectations during the interview including: "*you're a Muslim you should be the strong one*" and "*Muslim people should be strong…"* Expectations of strength and self- reliance was echoed by others. This could account for some of the delay in help- seeking. Thus, some of the women may have endured their difficulties in isolation for a considerable amount of time. Suppression of their emotional experiences could signal an internalised

oppression as some of the women turned against themselves and their emotions. Stifling them, rather than accepting and expressing them. This could originate from wider cultural attitudes to mental health, which will be explored next.

This subtheme has provided an understanding about the means of coping that my participants used. Faith was pivotal for some of the women, particularly in appraisal of the problem and coping with isolation. Some of the women questioned religion and God, some felt distant from their faith, some felt resentment, anger and disappointment with God. Others relied on God for comfort, support, hope and safety. This suggests that religious beliefs can influence ability to cope. Online resources were also used to gain understanding of their experiences of mental health issues. Both these avenues were helpful in providing comfort and validation but also suggest a need to conceal their difficulties. Access to counselling was, more often than not, a last resort, suggesting that it may not be an accepted, or safe, means of support. It also indicates that the women endured their difficulties to a great extent, without support from other people. This could have exacerbated their emotional distress. I will now take a look at the cultural context to further understand my participants' experiences of coping with their distress.

Sub-Theme 2c: Influence of Cultural Attitudes Toward Distress

This subtheme explores some of the wider cultural attitudes to counselling that may have influenced my participants' coping strategies and delayed help seeking. It provides an understanding of my participants' experiences of seeking professional support as Muslim women; a process that can often feel unsafe in a culture that stigmatizes mental health. Taking this into account with their experiences of gender inequality we begin to see how intersectionality plays a significant role in Muslim women's experiences of mental health issues and counselling.

Mental health stigma impacted the majority of my participants' experiences as Muslim female clients. Its presence resulted in secrecy and concealment of their issues and their counselling. The stigma around mental health and the lack of knowledge about counselling made it extremely difficult for Sana to talk about her need for counselling with her parents;

*I really strongly believe our community they see counselling as a bad thing. Like they think if someone's getting counselling…there's something really **really** wrong with you…as if it's something bad as if you're psycho (Sana)*

A message that Sana received from her community was that being a client was associated with a sense of deficiency within an individual. It suggests that harsh judgements, critical attitudes and misconceptions may have influenced how Sana perceived herself as a client. It could also contribute to further self- blame.

Halima reflected on thoughts she had about herself as a Muslim client prior to beginning counselling:

I did have that feeling of guilt in some sense, that feeling of you've not been managing this well as a Muslim…that was my reality that I was a failure as a Muslim (Halima)

Halima held beliefs that equated seeking counselling with a sense of failure, which brought about feelings of guilt. These extracts support the existence of unspoken, cultural, expectations of how a Muslim 'should' cope. Such expectations can have a negative impact on evaluations of the self, even if those perceptions are imagined. These became part of the Halima's reality about herself as a failure. Prevalence of negative judgements about oneself often led to concealment of counselling.

Farah experienced fear of judgement from her parents regarding her experience of depression:

My parents they're from back home Pakistan, older generation, I knew that they're not going to understand and that was my biggest worst fear that like you know what do I do? How do I face my parents? Do I tell them that I've got depression? What's going to happen? (Farah)

She was anxious about the consequences of disclosing her depression to her parents. This could be due to their lack of understanding about mental health issues and perhaps her own. Farah talked about how she manoeuvred through feelings of shame, and fear whilst accessing counselling support:

*I used to go to counselling and then walk it to my friends shop and it was really hard. Obviously with my family obviously they know if I say to them can you drop me off to this place they'll be like okay what appointment is this for?…This [counselling] is something really **personal** I didn't know how to deal with it because it's counselling (Farah)*

Farah consciously hid her difficulties and her counselling from her parents to keep herself safe from the potential guilt, shame and embarrassment that she assumed could result from exposure. Her avoidance of the issue, worry and anticipation of a negative outcomes, were an additional stressor whilst seeking support for her depression.

Sana disclosed her counselling to her mother but reframed her reason for attending:

> *I just said to her [my mum] I'm getting counselling because it's going to help me in my court case… cos she didn't really understand why I needed counselling, she didn't know I felt suicidal, she didn't know how low I was at that time (Sana)*

Despite Sana feeling extremely low there is a loss of connection between her and her mother about her psychological health. The lack of transparency expressed in the above accounts is indicative of fear and shame around experiencing psychological issues and counselling. Seven other women also talked about this. Their acts of hiding were a way to protect themselves from others judgments. These are examples of internalised oppression as they are unable to express their experiences. On reflection, the women's issues can be seen as magnifying deeper issues within cultures e.g. subordination of women, abuse, gendered oppression and lack of acceptance of women's rights and freedom of expression. Through stigma, these issues remain undisrupted and harmful expectations of gender identities continue to operate. Their concealment could also be motivated by their avoidance of shame (Goffman, 1963) in order to protect their self- image and collective identity. These extracts involved an element of fear and threat to their safety. Thus, my participants may have been motivated to avoid conflict, despite concealment causing difficulty for themselves.

This theme explored the psychological and emotional impact of problems that my participants were experiencing. Some of the accounts presented here portrayed disempowerment, hopelessness and spiritual disconnection. In seeking to understand and cope with their issues some of my participants utilised faith. This appeared to be an option that was accessible and safe. The women who turned to God for support reported feelings of ease, comfort and reassurance, but it was not enough to overcome the issue. Some also used online resources to understand their experiences and accessed GP service for support. For some women this then

led them to counselling. It was not always clear if and how they could seek outside support and counselling was often a last resort. Beliefs about being a strong Muslim had a role to play in delayed help seeking. This was also fuelled by wider cultural attitudes to mental health issues and a strong, prevalent stigma of mental health and counselling. Fear, shame and guilt resulted from stigma, with the women often concealing their experiences. The stigma increased challenges of accessing counselling, but did not prevent them from attending. The next theme will explore my participants' experiences in their counselling sessions. It is important to highlight that the experiences of distress, coping and accessing support, was not as linear as it appears here. But this theme portrays a movement that was interpreted from the accounts of some of the women.

Master Theme 3: Therapeutic Relationships in Counselling

This theme explores the different helping relationships that were present in my participants' experiences of counselling. I will explore how therapeutic alliances were impacted by socio-political, cultural and religious dimensions in matched, and non- matched therapeutic dyads. I will firstly explore the therapeutic alliance in which client and counsellor were from different ethnic and religious backgrounds. Here I will talk about the impact of Islamophobic attitudes in society and counsellor qualities. Following this I will explore the importance of faith, and the God- relationship, for my participants' healing process. Lastly, I will look at the effects of perceived similarities between client and counsellor including benefits and areas of concern.

Sub-Theme: 3.a: Impact of Client- Counsellor Differences

This subtheme will explore some experiences of working with a non- Muslim therapist. I will explore some of the apprehension experienced prior to attending counselling, followed by experiences within therapy and some of the barriers that were present.

Some of the women had preconceived ideas about their meeting with their counsellor. Halima had sessions with a white, non- Muslim counsellor. Reflecting on how she felt before attending, she responded:

Oh really really nervous, really nervous, and all sorts of things were going through my mind you know. I thought oh they're going to tell me that I should stop praying or (laughs) something you know and I was actually sort of preparing myself to have to defend my faith, that my faith wasn't the reason why I was feeling like this (Halima)

Halima's initial response was of worry and fear stemming from an assumption of Islamophobic attitudes. She was concerned that the counsellor would judge her religion as a negative contributor to her problem and felt protective of it.

Jamila also had concerns about being misunderstood prior to attending counselling;

My whole thing was should I even go to counselling with a non- Muslim counsellor? Because I don't want them to get a skewed image about the culture and Islam, and I was worried about that (Jamila)

Jamila's awareness of negative stereotypes of Islam influenced her decision-making process when seeking counselling. She had some concerns about reinforcing negative attitudes toward her culture and religion. So much so, that she also explained and justified some Islamic teachings that she shared with her counsellor; unconsciously defending her religion. This also suggests that she initially felt unable to relax and be open. Despite these concerns all, but one, participant reported a negative experience.

These extracts suggest that the socio-political position of Muslim women and wider Islamophobic attitudes can affect their attitudes towards their counsellors and their counselling. This can be understood in relation to the first theme in which I explored the impact of the socio-political context in Britain on my participants self-perceptions and sense of belonging.

Sana had therapy with a non- Muslim male counsellor and talked about validation being key factor in her therapeutic experience:

I had my own space and I could say what I wanted and get it off my chest, and because those were my 55 minutes of saying whatever I wanted, if I wanted to just sit there and cry, if I wanted to sit there and complain…I needed that at the time, I needed to go see someone and get things off my chest and you know cry if I had to it made me feel better (Sana)

There's a sense of feeling relief, safety and acceptance in being able to share her distresses with

someone non- judgemental and accepting. Jamila had therapy with a non- Muslim, female therapist and commented on how collaborative exploration helped her gain clarity and confidence:

> She [the counsellor] *really wanted me to break down the little situations and make me understand why I'm feeling the way that I am, to make me realise and make me kind of empower myself to say ah okay this is why (but) I can handle this (Jamila)*

Jamila's account suggests an internalization of her counsellor's voice that helped her reflect on, and manage, her emotions outside of therapy. From an object relations perspective this can be seen as an indicator of healing (Kohut, 1971). These extracts suggest that positive counselling experiences can occur in non- matched dyads where the counsellor exhibits qualities of validation, empathy, warmth and trust.

However, despite these qualities, some women were hesitant to open up around topics relating to their culture and religion. This was sometimes influenced by the counsellors perceived knowledge of Islam:

> *With the ones [counsellors] that didn't really know much about Islam I think maybe it did make me withdraw. Like I didn't want to talk about certain things, or it made me hesitant to talk about certain things (Shireen)*

Shireen felt restricted in sessions where she felt her counsellor did not have an understanding of Islam. There's a sense of recoiling that contradicts the basic principles of counselling of providing a safe, non- judgemental space for clients to open up. It is worth questioning how much of this is due to the client's internal confidence and safety and how much is due to the counsellor's lack of engagement and openness to these topics.

In the interview Jamila talked about prayers that were particularly significant for her. However, she did not share these with her counsellor due to concerns about how she may be perceived:

> *Having to describe…Islamic spirituality to a non-Muslim counsellor it was like I couldn't say things like oh I prayed tahajjud[9] and I felt like this this this, or when I prayed istikharah[10] and this all fell into place…it was such a big deal but then if you look at it in a more practical sense it's just like o-kay then like…you know I don't know what their interpretation of that would be (Jamila)*

Jamila concealed some significant aspects of her journey from her counsellor. There is a dilemma present in these accounts; to self- censor or risk negative judgements. As a result, they were often not able to be fully congruent.

This theme has presented ways in which wider contextual factors of Islamophobia, stereotypes of Muslims and attitudes toward Islam, influenced my participants perspective of their counsellor and their experience of counselling. Withholding of information suggests that they did not feel completely safe. This adds another dimension to contexts of fear, judgement and insecurity for Muslim women. It reinforces the idea that they are sometimes not accepted for who they are, thus feeling oppressed within the context of counselling. Withholding can also be problematic for the therapeutic alliance as clients are not being met authentically. It can also impact the therapeutic work as potential resources are not utilised. Some of this oppression could be unconsciously created by the therapist, some may be intersubjective and some may have been internalised by the women. If they felt unsafe bringing faith into the counselling room, where and how did they engage with it?

Sub-Theme 3.b: Relationship Between Client, Counsellor and God

Seven out of nine of the women who worked with a non- Muslim counsellor did not bring religion into the therapy room. One could argue that their issues may not have been related to cultural or religious aspects but I would argue that these cannot be separated from the individual. This is supported by the fact that six of the women utilized religion in their healing outside of their

[9] Tahajjud: Night prayer. Voluntary prayer offered in the night after the last prayer of the day and before the first prayer

[10] Istikharah: A prayer recited when seeking guidance in decision- making. From the Arabic root word 'khayr' meaning 'all that is good', this prayer is recited to seek guidance towards what is good

counselling sessions. In the subtheme above, Shireen talked about her hesitance in opening up about particular topics around Islam with her non- Muslim counsellors, however her faith was central to her healing:

> *I looked up [American Islamic Scholar], his videos helped me understand a lot more about Islam so that definitely helped. To be honest I think that helped more than like therapy itself…he's always talking about having a good relationship with God so it kind of strengthened that (Shireen*)

Shireen highlights the centrality of religion and God in her life, but neither of these were present in her therapy sessions. For Shireen, having a greater connection with God was a sign of improvement in her wellbeing. Her accounts suggest that the lack of safety in bringing religion into therapy meant that a valuable resource may have been overlooked.

Halima, who worked with a female, non- Muslim therapist, talked about her experience of using religion alongside the mindfulness that she learnt from her therapist:

> *What I found was pairing mindfulness with dhikr[11] became very useful and beneficial…I felt that there would be no healing for me without Allah…it just felt very natural to pair those two things (Halima)*

Halima combined mindfulness from her therapy with a form of mindfulness from Islam. These accounts show creativity in how the women engaged with different avenues of support to help themselves. They talked about nearness to God as something that was fundamental to their healing, but something they engaged with in their own time, outside of therapy. I do question where the gaps are as they could occur from the client's fears and concerns, but also from the counsellor's lack of knowledge or awareness. It also raises issues of conceptualisation of problems and treatment in therapy with Muslim clients.

An exception to this was Jamila's experience with her non- Muslim therapist. As explored in subtheme 3.a. Jamila had initial concerns about discussing religious and cultural issues in therapy. However, her therapist curiously explored her relationship with Islam, which resulted

[11] Dhikr: A devotional practice/ spiritual exercise of the remembrance of God, often involving rhythmic repetition of name's of God or Arabic prayers

in a strengthening of her relationship with God:

> *she would always ask which I found very kind of respectful about religion… I would say a non- Muslim person actually made me indulge **more** into my religion, she'd made me think about it so much more deeply cos she'd said like this must be something so **immense** for you when you felt like giving up on your own life you hadn't given up on the religion and it has saved you from destruction and then I thought wow yeah it really has*

Jamila's counsellor noticed the significance that her faith had in her life. By exploring the role of religion in coping with distress Jamila felt a greater connection to it. Her account suggests that religion might also be something that she may take for granted sometimes. This could also be a reason why other women did not bring it into their sessions. However, this would contradict the previous accounts where other women utilised religion as part of their healing. It may be more accurate to postulate that secular ideas and experiences of therapy may hinder the introduction of faith in sessions. Particularly when working with non- Muslim counsellor. Although Jamila's account shows us there are exceptions.

Faith and God were readily present in therapy with Muslim counsellors. Amina had previous experiences with non- Muslim counsellor but more recently sought a Muslim counsellor to discuss her current issue that was related to her culture and religion. She felt safe bringing these aspects into therapy. Her counsellor also felt confident in working with these areas:

> *It's taken five sessions to reach a point where I can say actually, I'm a bit angry with God…I should be turning to God but there's something within me that's resisting and for her [the psychotherapist] that's like okay ((clicks fingers)) bingo lets address that, and she can understand where I'm coming from in a way that maybe a non-Muslim can't (Amina)*

As well as feeling connected at a deeper level, there's a sense of feeling increased safety in how her counsellor held her and worked with her issue. For four out of five of the women who worked with a Muslim counsellor, sessions sometimes included religious input from the counsellor. These women had consciously sought out a Muslim counsellor to receive this perspective and all four of them stated that they benefitted from this. Amy was amongst these women and she talked about how her counsellor's religious input was significant in helping her

to understand and overcome her situation;

> *She's helped me to see that sort of spiritual manipulation, that religious manipulation, that I was being subjected to I was not at all aware of it until I started seeing her and it was bit of a breakthrough (Amy)*

Her counsellor was able shed a different light on teachings of Islam because she possessed this knowledge. Amy could re- learn some teachings with the help of her counsellor and begin to live her life as a Muslim with more certainty and clarity in her faith. In both of these experiences the counsellor's knowledge of Islam could have hard a part to play. Despite what the issues were, Amina and Amy's faith was implicated as a result of it. So, being able to re-connect with their faith was significant to their healing. This was also the case for Shireen, Jamila, Amina, Farah and Halima. Four out of five of the women who did not see a Muslim counsellor said that they would have liked to because of the idea of receiving religious guidance. This does bring into question how the women see the role of a Muslim counsellor versus a counsellor from a different background. Although there may be greater ease in religious dialogue there may also be a misunderstood idea of the counsellor's role, i.e. the counsellor being a spiritual 'guide' and providing expertise.

This subtheme suggests that God can be a third figure in the therapeutic relationship. But God is not always brought into the room due to concerns about the counsellor's knowledge, openness and understanding about Islam and Muslims. Religion played a central role in the majority of my participants' journeys of healing. This could be as it was central to their identity. Thus, religion can be seen as being embedded within my participants' worldview and day to day life. Feeling unable to bring religion or God into the therapy room can feel disjointed and create gaps in the client- counsellor relationship. Without having space for faith in therapy it may also reinforce ideas of unacceptability of Islam in Western society, thus forcing Muslim clients to conceal a central part of their identity. Additionally, neglect of religion in the room could add to suppression, internalised oppression and a silencing that has also occurred in other areas of my participants' lives. The final subtheme below explores why this might be.

Sub-Theme 3.c: Impact of Client- Counsellor Similarities

This subtheme explores how perceived ethnic and religious similarities between client and counsellor facilitated the therapeutic process and relationship, leading to increased congruence and validation. However, working with an ethnic/ religiously similar counsellor was not always favoured.

Amy and Shazia had self-referred to an organization that employed Muslim counsellors. Amina and Farah had sought private counselling with a Muslim and Shumi was referred to the counsellor at her GP practice who happened to be Muslim.

Amy talked about the advantage that she felt in this;

> *I think one advantage of having a Muslim counsellor was that I can make religious references and she'll immediately know what I'm talking about…so that did make it easier (Amy)*

There was an assumption of a shared understanding of religious teachings and beliefs between herself and her counsellor. Inevitably then, there was an environment of openness about bringing religious content. This openness and understanding meant that the process felt easier, saved time and a relationship was established quicker. For Shumi, having a counsellor of a similar cultural, as well as religious, background was helpful. Shumi felt that her counsellor was better able to empathise with her and understand her difficulties accurately, which influenced her feelings of ease in opening up;

> *Literally everything came spilling out and I think that helped cos she was Muslim and she was Asian (Shumi)*

Shumi's description of self- expression is portrayed as fast and free- flowing. This is in stark contrast to some of the accounts in the prior section where the women felt "*restricted*" (Shireen), "*nervous*" (Halima), and doubtful and hesitant (Jamila) about opening up. For Shumi and Amy there was an immediate feeling of safety present with their Muslim counsellor that allowed them to express themselves without holding back and without questioning what they

wanted to share. The similarity between client and counsellor can be seen as an open gate that allowed them to let their inner world flow out with less of a barrier to overcome.

Amina talked about the impact of working with someone from a similar religious background when she was experiencing a difficulty with her faith:

> *It's a different kind of empathy that you get…it's a different kind of understanding the depth and the multitude of layers of the situation…it's just about that person that therapist being able to relate to you on a multitude of levels and that's important (Amina)*

Amina's account paints a picture of a deep and holistic level of connection that she experienced. This understanding was important for her issues related to religion and culture. There's an increased connection that was influenced by openness and authenticity. All of which are characteristics of relational depth in the therapeutic alliance (Cooper, 2005; Knox, 2008; Knox & Cooper, 2011). Thus, the therapeutic relationship was strengthened by perceived religious similarities.

However, this was not the case for everyone. Halima had reservations about seeing a Muslim counsellor. She felt they may have preconceptions about her and thus not fully explore her issues:

> *I prefer the entirely neutral approach that allows me to inject faith into it when I want to rather than someone who comes from the same faith background and assumes that they already know my experience maybe (Halima)*

Halima's account suggests a preconceived idea that a Muslim counsellor would bring faith into the sessions. She also shows concern about judgement and assuming that a Muslim counsellor would impose their perspective onto her rather than giving her autonomy. This could stem from the judgement that is present within the culture that was explored in subtheme 2.c. There is a hesitation that she may not be given the space to be heard.

Farah had concerns about being judged by a Muslim therapist and being pressured to perform religious duties. She mentioned that she would be more comfortable with a non- Muslim therapist, when asked for elaboration she commented:

> *I'm not going to have that little buggy feeling in the back of mind like oh she's Muslim what is she going to say and obviously with praying it made me a little unsettling like obviously if I speak to a Muslim about it obviously they're going to say do it it's good for you (Farah)*

Her account suggests that she would feel more relaxed with a non- Muslim therapist. There is an assumption that if she were to work with a Muslim therapist she would be judged based on her level of religious practice. This could result in her feeling ashamed and pressured into praying. Both these accounts echo ideas about shame and guilt that were explored in subthemes 1.c. and 2.c. where participants often felt that they were at fault or that they would be judged by others for their difficulties. For Halima, despite choosing a non- Muslim therapist, we saw earlier that she also had apprehensions about being judged for her faith. These accounts suggest that some of the decision making in the counselling process may be based on feelings of security, as participants were opting for a counsellor they feel most safe with, and disclosing what felt safe. Being able to have independence and freedom in voicing their concerns was important, whilst also being validated and accepted. Having a non- judgemental way of working is at the heart of all counselling practice, so it appears that there may be some misconceptions and inaccurate judgements about counsellors, both Muslim and non- Muslim. However, part of this may stem from Islamophobia, which therapists may be unconscious of, and partly from internalised oppression, that my participants may be unconscious of.

This subtheme has also illustrated that religion was more present in sessions with matched dyads, both from the client and counsellor's perspective. This could have been because the clients had specifically sought out Muslim counsellors as their issues were directly related to their religion/ spirituality and culture. However, one could argue that these are not possible to isolate from the person as we have seen that clients who did not seek a Muslim therapist also sought religious input.

This theme has explored the different attitudes and experiences that the Muslim women in this research had with their counsellors. It appears that there are misconceptions about counselling

and counsellors from the perspective of some of my participants but that these may be influenced by cultural attitudes to mental health services, Islamophobic attitudes toward Muslim women and cultures of shame and judgement within ethnic minority communities. This theme has explored counsellor qualities that enhance the therapeutic experience: namely a warm, safe, non- judgemental therapeutic relationship and how this is impacted by the counsellor's engagement with, and knowledge of, religion, or lack of. The findings presented in this theme suggest that without engagement of religion in therapy, counsellors may reinforce negative ideas about Muslims, overlook potentially invaluable therapeutic resources and fall short in providing a holistic experience of counselling. Although Muslim client's experiences with Muslim counsellors was reported to be easier and more comfortable, it was not the case for everyone. Clients also had positive experiences with non- Muslim counsellors. I do not suggest that matching is necessary, but having the option may be helpful. More importantly, there is great scope for practitioners to learn to work with faith in counselling.

Summary of Analysis

This chapter provided an exploration of Muslim women's experiences of being clients of counselling. In theme one of the analysis I suggested that self- constructions of Muslim, female, clients are influenced by internal relationships with their faith and external factors of Islamophobia and sexism. Their self- descriptors of strength and independence contrasted with their, often vulnerable, positions in British society and within their ethnic and religious cultures. However, their strength may originate from their position within oppressive systems of Islamophobia and patriarchy. These positions, although sometimes giving rise to adverse experiences, can also act as a platform from which to assert their values, desires and opinions.

The second theme explored the emotional and psychological impact of their problems, how they coped with these and how these aspects were influenced by mental health stigma. The analysis suggested that relational issues were often a source of distress that led to feelings of depression, loss of autonomy and experiences of spiritual disconnection. In trying to make sense of their

experiences some of the women turned to God and their faith for support, some also used online resources; both of which were safe options. In contrast, counselling was often a last resort. Negative attitudes to mental health and counselling, and cultural expectations of strength may have contributed to delayed help seeking. Cultural attitudes to mental health and counselling also led to concealment of difficulties from family.

The third theme suggested that Islamophobia can impact Muslim clients' preconceptions about their counsellors and how safe they feel to bring their whole selves, including their religion and culture, into the session. Faith and God were a central component to the healing process for the majority of women, but it often did not enter the therapy room with non- Muslim counsellors. This suggests a divide between spiritual and secular worldviews. Hence, participants working with Muslim counsellors felt a greater ease in discussing these topics due to perceived similarities and acceptance.

Throughout all of the themes there was a sense of safety and risk where participants did not feel that they could be accepted for who they were; in British society, within their families and communities and within some of their counselling sessions. There is a sense of withholding parts of themselves in these domains for fear of being rejected, insecurity and lack of acceptance.

The presence of God is also a common thread through the themes; their relationship with God was integral to their identity as Muslim women, their relationship with God was also central to their meaning making and coping processes. It was also something that the majority of the women coveted on their journey of healing, often citing a strong God- relationship as an aspiration. This research suggests that faith is an important part of their lives and thus working with faith alongside, or within, their counselling proved to be effective in their healing. This was in addition to the core counselling qualities of acceptance, non- judgemental attitude and positive regard towards clients (Rogers, 1961). I would also suggest that acceptance is a missing piece across contexts in some of their experiences of being Muslim, female, clients. In the next

chapter I will discuss these findings further in relation to existing literature, theory and counselling practice.

Chapter 5

Discussion

In this chapter I will discuss the findings of my research on understanding Muslim, women, client of counselling. Following this I will discuss implications of my research findings for counselling psychology and beyond. An evaluation of my research will be presented. The chapter ends with personal reflections on my experience of carrying out this research.

Understanding Muslim, women, clients of counselling.

The aim of this study was to understand Muslim, women, clients of counselling. Interpretive Phenomenological Analysis (IPA) was employed to explore this. The main research question was explored with the following questions:

1) How do participants make sense of their identity?
2) How do participants make sense of, and manage, their struggles?
3) What were their experiences of seeking and attending counselling?
4) If, and how, did religion play a part throughout their counselling journey?

Three themes were presented in the analysis: 'Constructions of the Self', 'Self in Relation to Emotional Distress' and 'Therapeutic Relationships in Counselling'. In this chapter I will discuss the findings in relation to the main research question. Answers to the fourth research question are embedded within former sections to reflect client experiences.

5.1 Understanding, Muslim, Female, Identity

This section addresses the first question relating to identity construction. The majority of the women in this research highlighted personal qualities of strength and independence. However,

all participants also experienced vulnerability within their contexts due to their religious, gendered and ethnic identities.

5.1.1 Significance of Faith

A relationship with Allah was central to my participants' identities. Consciousness of this relationship had temporal and individual variability. Amy stated that she maintained awareness of God in all her daily actions. Amina was also mindful of establishing an ongoing connection to God. This suggests that Islam had a central and internal space in their lives. However, my research also suggests that this dimension can easily become eclipsed by a larger focus given to social identities and external contexts. Much of the research on Muslim women's identities in the UK and the West has generally focused on social identities, cultural differences, politicisation of Islam, and outward representations of Islam such as the hijab (Dwyer, 2000; Chapman, 2016). My research adds a valuable layer to discussions about Muslim women's identities as it suggests that an inward component of spirituality is also central to their self- constructions. This area merits further study as God is almost unequivocally absent in discussions of Muslim women's identity constructions.

My participants talked of deriving empowerment from Islam; emphasising a non- material, personal dimension that was detached from social contexts. Jamila acted on her own choices that were not always culturally accepted but were within her religious boundaries. Amy and Sana were able to leave their abusive marriages with the assurance that Islam allowed this, despite pressure to remain by their partners and families. This layer of spirituality parallels Mirza's (2012) articulation of faith as a "second skin" for her Muslim, female, participants. For my participants, Islam acted as a platform from which to gain strength and assertiveness. Brown (2006) and Dwyer (1999) have also suggested that Islam reinforces Muslim, women's rights and provides an avenue to gain independence and strength. My research extends these findings by

providing some insight into the emotional and spiritual aspects of Islam that facilitate increased strength, such as valuing faith and the God- relationship over cultural norms.

5.1.2 Influence of Islamophobia

Stereotypes and negative media representations of Islam led to increased feelings of vulnerability, threat and 'otherness' for some of my participants. All of my participants were aware of negative stereotypes about Muslim women. This has been found by previous research (Meer, 2010; Mirza, 2012; Van-Es, 2017). The double- consciousness and responses to stereotypes is not limited to Muslims, as Du-Boise's (1903) original concept of 'double consciousness' was in relation to African-American's experiences of viewing themselves through the eyes of others. A visible Muslim identity was often a source of anxiety and fear in public. Sana felt threatened going outside as a visibly Muslim women because she felt like a target for others' hostility. This is in line with previous research that has found increased feelings of threat and insecurity for visibly Muslim women in public (Abu-Ras & Suarez, 2009; Kwan, 2008; Kapur, 2002). But this can depend on different areas of residence (Kapur, 2002). Insecurity outside was partly mediated by dress; a representation of being an 'other' (Mirza, 2012; Meer, et al., 2010).

Awareness of negative "oppressed" stereotypes of Muslim women led some of my participants to distance themselves from the stereotype by emphasising their independence i.e. exercising their choices, and defining themselves as "strong" and "empowered". This reinforces their motive to be 'normal'. I would argue that maintenance of a positive self- image could be seen as an unconscious coping mechanism to preserve their sense of self. This could be an occurrence of stereotype threat where my participants felt anxious about confirming a stereotype and thus exaggerate the opposite (Steele & Aronson, 1995). By projecting oppression away from themselves and onto the "Muslim other", my participants may be freeing themselves of the label and affording themselves a more individualised, empowered identity. This parallels the way some western women disarticulate feminism by adopting empowerment for themselves and projecting oppression onto the "other" Muslim woman (Scharff, 2011). Being in a Western

culture could make it easier to adopt characteristics of empowerment (Scharff, 2011). Empowerment could also be adopted to represent Islam and Muslims in a positive light, attempting to eradicate negative stereotypes associated with the religion (Van-Es, 2017). On the other hand, their empowerment could also be seen as a reflection of the strength that is required to respond to Islamophobia and feelings of 'otherness', resulting in development of strong individual identities (Haw, 2009; Jasperse, Ward & Jose, 2012).

My participants were navigating daily life against powerful Islamophobic discourses, which fuelled their sense of difference. Perceiving the self as an outsider raises issues of belonging and acceptance. Van-Es (2017) suggests that Muslim women's self-identifications ought to be held in light of 'the politics of belonging', where boundaries between groups are distorted, created and preserved. My participants were motivated to close the gap between themselves as an 'other' in society and being part of British society. This was sometimes negotiated through dress, such as in Amina's decision making to choose attire that gives a sense of 'normality' whilst being visibly different by wearing a veil. Defiance of, and distancing from 'otherness' can be a form of establishing 'normalcy' (Ryan, 2010; Ryan, 2011). However, preoccupation with stereotypes and Islamophobic discourses can overshadow individual identities. For Amina, her personal identity became lost within the battle to be seen as 'normal'. This supports Haw's (2009) description of a 'mythic feedback loop'. A process by which, wider narratives of Islamophobia and otherness impact perceptions of Muslim women, which in turn impacts their self- constructions and self-image. These findings add to literature on psychological impact of Islamophobia and provides insight into how my participants navigate this context.

5.1.3 Influence of Sexism

It was found that cultural pressures experienced by my participants often led to experiences of oppression and suppression. All of my participants reported gender inequalities within their

families and communities. Some of my participants experienced pressure to conform to traditional expectations of women, a pressure to show obedience to elders and experiences of being overpowered by male figures. This was seen in Shumi's experience of challenging her in-laws' control over her, in Halima's experience of being threatened by an Imam, Sana's experience of pressure to remain in an abusive marriage and Amy and Jamila's experiences of religious and cultural manipulation. The majority of my participants' issues appeared to be a response to sexism and gendered expectations within the context of their communities, families and relationships. This supports previous research that has illustrated the presence of issues along power structures within the cultural and familial structures in Muslim womens' lives (Talbani & Hasanali 2000; Bhugra and Jones 2001; Bhardwaj, 2001).

My findings also suggest that relational factors were primary contributors to emotional distress. Experiences of distress related to situational factors has previously been investigated amongst Pakistani women (Malik, 2000). Experiences of distress often occurred when negotiating between control within their ethnic cultures and their individual freedom. Desire for equality and increased female authority has been found amongst other ethnic minority and Muslim, female participants (Talbani & Hasanali, 2000). However, my research findings suggest that the power dynamics between an individual's choice and larger social norms can be extremely challenging and increase vulnerability to poor mental health. Thompson & Bughra (2000) and Bughra & Jones (2001) also note that conflicts between traditional expectations, "modern attitudes" and a pressure to conform, can give rise to psychological difficulties.

Psychological distress amongst my participants was more strongly related to external cultural pressures. This differs from earlier research with Muslim and South Asian women that suggested depression was linked to migration, acculturation and social isolation (Nazroo, 1997). These findings add to literature exploring some of the difficulties that Muslim women in Britain may face. I would argue that all of the women's issues could be made sense of through a relational perspective. Eagle (2011) brings forth the relational view of Mitchell (1988) in stating that an

individuals' struggles and "difficulties in connecting to others while also maintaining autonomy" are the very essence of being human (p. 174). My participants' often felt dismissed and disregarded when voicing their needs and concerns. Shumi and Halima's experiences mentioned above are an example of the risks associated with confrontation and protest to cultural norms. Their self- expressions were sometimes met with external pressure, emotional blackmail and rejection, leading to suppression of emotions and experiences.

The majority of my participants steered away from open disagreement and confrontation by concealing their difficulties. This could be due to elements of collectivism within the culture, which values group harmony and agreement (Oyserman, et al., 2002). However, indirect communication and negotiation, which are favoured amongst some collectivist cultures (Oyserman, et al., 2002) also did not appear to be utilised. The avoidance of confrontation and negotiation could be due to oppressive cultures of shame and honour (Bhardwaj, 2001). This could support why my participants' struggles were not seen or heard by those around them. Other research has also found an invisibility of difficulties amongst Muslim women (Bhardwaj, 2001; Bughra & Jones, 2001). Consequently, issues continued to negatively impact their wellbeing.

My participants' self- definitions of strength appeared to contradict their vulnerability. This contrast was particularly interesting as it was not acknowledged by any of the participants during the interview, but became evident during analysis. This suggests that there were unconscious processes occurring. Their claims of strength, despite restrictive experiences, could signal a denial of oppression. It could be a protective mechanism to maintain a positive image of their culture and Islam (Van-Es, 2017). Experiences of oppression emerged as the interview progressed. I would argue that all women encounter oppressive experiences at some point. Therefore, participants' experiences can be seen as gendered experiences, rather than a culturally specific phenomenon. The impact of patriarchal culture on women from various backgrounds has been researched; including South African (Frenkel, 2008), Latino and Caribbean

(Pineiro & Carroll, 2012) and Western Cultures (Meharchand, 2016). These have been in many different forms including domestic violence (Tracey, 2007; Bettman, 2009; Piosiadlo et al., 2014) and gender inequalities in occupations (Sojo, Wood & Genat, 2016; Stamarski & Son-Hing, 2015), including within the field of Psychology where men hold a higher number of senior positions (Christidis, Lin & Stamm, 2017; Clay 2017). Rather than being a fixed identity construction, oppression can be seen as an experience within power dynamics. Alternatively, their empowerment could also reflect the strength required to challenge cultural norms on a daily basis.

5.2 Understanding and Managing struggles

This section addresses the second question related to understanding and managing struggles. It is addressed through discussion of; hopelessness, self- blame and spiritual disconnection, coping using faith and managing through concealment.

5.2.1 Hopelessness, Self- blame and Spiritual Disconnection

Almost all of my participants reported experiences of helplessness and hopelessness in response to their struggles. Some of this was due to powerlessness that sometimes led to suicidal ideation and thoughts of self- harm (Jamila, Sana and Amina). This coincides with Bhardwaj's (2001) research with South Asian women, which suggested that powerlessness and helplessness were a catalyst for self- harm and a way of regaining a sense of control.

Self- blame was a response to apparent conflicts and psychological distress. Jamila, Halima, Shumi, Sana and Amal located parts of the problem within themselves, despite being treated unfairly by others. This could be due to lack of acceptance from others that may have been internalised. It could also result from perceived lack of control. Research with women in abusive relationships has suggested that lower levels of perceived control relate to higher levels of self-blame (O'Neill & Kerig, 2000). These findings extend previous research that has explored presentations of depression and self- harm amongst Muslim and South Asian women (Sproston

& Nazroo, 2002; Fazil & Cochrane, 2003; Hicks & Bughra 2003; Thompson & Bughra's (2000) as it suggests that the particular position of women within these populations can increase their likelihood of losing control and power within their relational struggles.

Spiritual disconnection was identified as a symptom of mental health struggles. Some of my participants recognised that experiences of emotional and psychological distress were having an adverse effect on their spirituality. Amina called it a "spiritual crisis". This often occurred alongside mental health struggles. This suggests that spirituality is an important dimension to consider in my participants' presentations of mental health difficulties, as experiences of a spiritual crisis in addition to emotional and psychological distress could increase difficulties. It also contradicts widely held stereotypes amongst Muslims that poor mental health is the result of a lack of spirituality (Weatherhead & Daiches, 2010). Rather it may be more accurate to consider the opposite; that poor mental health can contribute to spiritual difficulties. There is a considerable amount of research that suggests religion correlates with good mental health (Koenig et al., 2009), suggesting that mental health and spirituality may have a bi-directional relationship, where spirituality may facilitate good mental health but also be impacted by mental health difficulties.

5.2.2 Faith- Based Coping

Faith was utilised by the majority of my participants to cope with difficulties. It included the God-relationship, and positive and negative religious coping. Some participants felt anger and confusion within the God- client relationship. For example, Shumi and Sana sometimes felt disconnected from God, and questioned why God was putting them through their difficulties. At other times, and for other participants, beliefs within Islam were helpful coping mechanisms. For example, Amy's belief in pre-destination provided her with hope and the ability to accept her difficulties. These findings suggest that the appraisal of difficulties as tests or punishments can lead to greater symptoms of distress or facilitate optimism (Abu- Ras & Suarez, 2009; Nabolsi

& Carson, 2011). My participants did not attribute other religious causes to their issues, such as demonic possession, black magic and evil eye. This contradicts research that has suggested supernatural causes are often attributed to psychological distress amongst Muslim populations (Loewenthal, et al., 2001; El-Islam, 2008; Khalifah, et al., 2011). This could depend on many factors including migration status, age, educational level and acculturation (Anand & Cochrane; 2005; Pilkington, et al., 2012).

A relationship with God was also helpful in reducing feelings of isolation. Some women talked about turning to God when they were lonely and believing that "God is always with me" and "God is the only one that understands". These findings relate to ideas about God being a compensatory figure when others are not available (Granqvist, 2002). It also points to the centrality of the God-relationship in my participants' modes of coping. Alternatively, it could suggest that faith is an accessible, invisible and safe, means of coping, thus providing insight into why it may be preferred amongst Muslim individuals (Weatherhead & Daiches, 2010; Aloud & Rathur, 2008). However, this could depend on the type of relationship with God; secure or insecure (Pargament, 2002) which could mediate the type of religious coping used and the effects of religious coping.

5.2.3 Professional Support and Concealment

Online resources were used as a means of gaining information and knowledge about mental health issues. These resources pointed Sana, Halima, Shireen, Farah to counselling, often via their GP. The GP as a first point of contact has been found by others too (Weatherhead & Daiches, 2010). Suggesting that this may be more acceptable and more accessible than mental health services.

My participants sought professional support over support from family. The majority of my participants kept their counselling hidden from their families, often feeling unsafe to open up. This contrasts with previous research that has suggested that Muslim clients may favour familial

support over professional support (Sheikh & Furnham, 2000; Weatherhead & Daiches, 2010; Aloud & Rathur, 2009). And challenges findings that mental health is perceived as a "family matter" (Hamdan, 2009). However, despite seeking professional support, counselling was often a last resort, due to fears of judgement and expectations of strength. This supports previous research that has found stigma to reduce help seeking behaviours, particularly for ethnic minority populations (Clement et al., 2015; Abdullah & Brown, 2011) and particularly for Muslims (Weatherhead & Daiches, 2010; Gilbert, et al., 2004).

My findings suggested that feelings of anxiety and shame led to concealment of psychological distress and attendance to counselling. Farah and Sana were concerned about exposing their distress and counselling to their families, they deliberately chose to hide these aspects to avoid negative judgements and prevent further issues. When Farah attended therapy, she would request her family member to escort her near the premises, not directly to it. she would then walk to her friend's house after sessions before returning home in order to give herself time to recuperate. My findings suggest a sense of risk and lack of acceptance, despite some participants experiencing severe depression and suicidal thoughts. Concealment of issues and counselling could be associated with negative attitudes that Muslim and South Asian communities have been found to hold toward mental health issues (Tabassum, Macaskill & Ahmad, 2000; Abu- Ras, 2003; Memon et al., 2016) and towards counselling (Weatherhead & Daiches, 2010; Moller, et al., 2016).

My findings suggest that concealment was an avenue for navigating the stigma due to the shame that mental health issues and counselling could bring. Shame and embarrassment have been found to be a major barrier for Muslim women seeking and accessing mental health support services (Anand & Cochrane, 2005; Gilbert, et al., 2004; Abu- Ras, 2003, Pilkington, et al., 2012). Concealment can also be seen as maintaining a culture of judgement. The deliberate distance created between my participants and their families prevented wider issues within their contexts to come to the surface such as the culture of patriarchy and the minimisation of emotional and psychological distress. Thus, maintaining power structures that contributed to their difficulties.

On exploring the role of shame, Gilbert et al., (2004) suggested that it is a means of maintaining group identity amongst collectivist cultures. These findings help to understand why Muslims may prefer religious coping, why it may be difficult for Muslims to access support, and why Muslims may not be as visible in mental health services (Patel & Shikongo, 2006; Rethink, 2007).

Despite feelings of shame and guilt experienced by some of my participants they did attend counselling. The utilisation and openness to counselling could be because of the demographics of my sample. It could be due to levels of acculturation as my participants had spent the majority, if not all, of their lives in Britain. Previous research has found that the greater the acculturation of an ethnic minority groups the greater their use of psychological support services (Sanchez, et al., 2014). Time spent in the UK has also been found to account for increased openness to mental health services amongst some Muslims (Pilkington et al., 2012; Hamid & Furnham, 2013). The findings from my research could also support the idea that there are intergenerational changes in beliefs about the aetiology of psychological issues; with younger, more educated Muslims moving away from beliefs in supernatural causes (Hamid & Furnham, 2013; Pilkington et al., 2012) contrary to earlier research (Sheikh & Furnham, 2000; El- Islam; 2008).

5.3 Experiences in Counselling

This section relates to the third question regarding my participants' experiences of attending therapy. Threads overlapping with identity and coping are discussed here including Islamophobia and faith. Additionally, I will discuss the importance of authenticity in the therapeutic relationship.

5.3.1 Islamophobia and Therapy

Prior to accessing therapy with non- Muslim counsellors, some of my participants felt anxious about their culture, religion, and consequently their identity, being judged by their therapist. Halima and Jamila felt protective of their faith and did not want to feed into negative stereotypes

about Islam. This supports previous findings discussed in the initial section of the discussion relating to my participants' motivations to appear 'normal' and distancing themselves from negative stereotypes about Muslim women.

My findings suggest that self- consciousness and vulnerability that were present for some of my participants in wider British society were also present when attending counselling. Previous research has mentioned this in relation to lack of support- seeking due a to context of Islamophobia (Weatherhead & Daiches, 2010). However, my findings add to this literature suggesting that the wider context of Islamophobia also impacts perceptions and attitudes towards non- Muslim counsellors. This includes expectations and assumptions of the therapist and feelings of safety in the relationship. Weatherhead & Daiches (2010) and Moller, et al. (2016) also found similar concerns toward mental health professionals amongst their Muslim and South Asian participants. Fears of misunderstanding and concerns of religious and cultural prejudice and discrimination can create particular challenges in accessing counselling for Muslim clients. This reinforces previous studies that have suggested that Muslim minorities underutilise mental health support services due to fear of discrimination, mistrust of services and issues around culture and communication (Inayat, 2005; Moller, et al., 2016; Netto, et al., 2001). My research supports that these concerns are prevalent, and do have an impact on experiences of seeking and attending counselling. My findings also provide an understanding about the origin of such concerns as being embedded in my participants' awareness of Islamophobia. The context presents an additional challenge to accessing counselling, alongside cultural constraints discussed in the section above. However, these constraints do not always prevent access to services.

Projection of anxieties onto the counsellor sometimes prevented my participants from opening up about cultural and religious aspects. Jamila mentioned she did not want to give a "skewed image of Islam", suggesting that she did not want to add to negative stereotypes. Previous research has suggested that some Muslim women adopt positions of representatives for Islam, motivated to show Islam in a positive light to counteract negative stereotypes (Van-Es, 2017).

This research suggests this process can also occur for Muslim women in therapy. My participants' assumptions could be based on their experiences, stereotypes, narratives, relational templates and schemas that they hold (Gilbert & Leahy, 2007). Their perceptions can be seen as a transference and countertransference occurring due to power relations in the room that are influenced by cultural, social and political discourses around Muslims and Islam and their place in Britain, thus the women and their counsellors could be enacting internalised objects.

Islamophobic influences had some Impact on participants' openness and authenticity, with religion sometimes being left outside of the room. This was a common experience when working with non- Muslim counsellors. For example, Jamila engaged in justification and explanations of some of her religious practices. Some women separated religion from their presenting issues, despite it being central to their identity and to their healing. It could also suggest a lack of acceptance that parallels experiences of being Muslim women in Britain, and lack of acceptance that parallels experiences of hiding within their families and communities. It appears that wider issues of oppression and fears of rejection impacted the therapeutic experience. But these may be outside consciousness.

5.3.2 Faith and Therapy

Faith was used to help with healing for the majority of my participants. However, it did not often form part of the work within counselling with non- Muslim counsellors. Halima combined dhikr, a form of remembrance of God, with mindfulness. Shireen spent time learning more about her religion to help her reconceptualise gender rules. And Jamila utilised ritual prayers to help overcome her difficulties. Sana, Jamila and Shumi stated they would like to seek spiritual counselling in the future to gain a different perspective on understanding and managing their issues. My findings suggest that faith was often an important and desired avenue for healing for my participants and supports Maynard's (2008) suggestion that Muslims, particularly after 9/11, are seeking support that is in line with their faith.

Utilisation of faith within counselling was often influenced by the background of the counsellor, perceptions of the counsellor's openness to Islam and feelings of safety in the relationship. Some participants questioned whether their counsellor would understand their religious perspective and experiences. These findings parallel concerns expressed by Christian clients about being judged and feeling unsafe (Goedde, 2001; Mayers, et al., 2007). Faith has been interwoven throughout my participants' experiences, so keeping it outside of therapy feels fragmented. This suggests a disconnection between religion, spirituality and secular therapy and points to assumptions of a lack of acceptance of faith within therapy.

In contrast to the above, faith was utilised to a greater extent within therapy when working with Muslim counsellors. This included exploring the relationship with God, exploring religious expectations and unpicking Islamic and cultural values (Amy & Amina), exploring feelings towards God (Amina), exploring cognitive appraisals of difficulties (Shazia), re-establishing prayer and learning supplications (Farah). This suggests that what some might call 'traditional healing' (where religious and spiritual practices and interventions such as reading of religious scriptures and prayers are used) can be useful today, in the 'modern world', with British Muslims who identify with their faith. This supports previous research that suggested religious coping such as prayer to be important for manging mental health amongst Muslims (Cinnirella & Loewenthal, 1999; Hussain & Cochrane, 2003; Rassool, 2015).

Participants who engaged with Islam alongside counselling reported benefits of an increasing closeness to God. This was identified as a marker of progress. Such effects have been indicated as an attribute of positive religious coping (Pargament, 2002), suggesting that spiritual and psychological wellbeing work alongside one another. However, it can depend on levels of religiosity (Pargament, 2002). Although this was not measured in this research, all participants held their connection with God to be important to their identity and day- to- day activities. Their accounts also suggested that their relationship with God was present before, during and after

their counselling. Although maintenance of a God- relationship may be a characteristic of spirituality (Hill, et al., 2000), my research suggests that this can fluctuate. Therefore, it would not be accurate to make a general claim about my participants' levels of religiosity and spirituality except that these dimensions were important to them. These findings add to previous studies discussing the gap between spirituality, religion and secular therapy but also highlight the importance of connecting the two. Other research with faith groups has also made this point (Mayers, et al., 2007; Weatherhead & Daiches, 2010) suggesting that the gap is bridgeable with hopes of greater cultural competence amongst practitioners. In which case, individuals from faith groups can be met at different levels in holistic and deep therapeutic work that acknowledges and works with their faith. As Jung said "called or not called, God is present" (Jung, 2012; 1975 p. 611).

5.3.3 Authenticity in the Therapeutic Relationship

All of the women who worked with a Muslim counsellor felt a great sense of connection and empathy because they felt met at a deeper level. Amina and Amy felt that having a counsellor from a similar background allowed them to receive a "different kind of empathy" where they were met on a "multitude of layers", which included the cultural and spiritual dimensions of their being. Suggesting that being able to bring spirituality in the room allows for greater authenticity. This parallels Christian clients' feelings of greater connection to a Christian counsellor, and ensuing increased understanding and ease of dialogue (Greenidge & Baker, 2012). My participants valued and benefited from feeling accepted and validated within their sessions with Muslim and non- Muslim counsellors. It is well known that the therapeutic relationship is a crucial component of effective therapy (Gilbert & Leahy, 2007). A client's sense of feeling empathy from the counsellor, feeling accepted, respected and understood have been found to be significant elements in enhancing the strength of the therapeutic alliance (Redfern & Dryden, 1993; Knox, et al., 2005; Mayers, et al., 2007; Belaire & Young, 2002). However, the formation of a facilitative therapeutic alliance is not necessarily dependant on shared

background, but more-so on being met within the client's worldview (Knox, et al., 2005; Mayers, et al., 2007).

My analysis suggested that engaging with Muslim clients' worldviews can enhance the therapeutic relationship. Jamila felt a greater connection with her faith as a result of her (non-Muslim) therapist's engagement with religion. She emphasised how respectful she felt towards her therapist for her curiosity about her relationship with Islam. This suggests that counsellors, with a curiosity and confidence in working with faith, can facilitate openness and authenticity and reduce feelings of anxiety and shame, allowing the relationship to strengthen. Authenticity in the client- counsellor relationship has been found to create long term changes relating to feelings of increased empowerment and better internal and interpersonal connections (Knox, 2008; Knox & Cooper, 2011). This suggests that a counsellor's ability to meet the client at relational depth is pivotal and may be achieved by acknowledging and working with religious and cultural differences. Previous research has highlighted that discussion of cultural issues can be facilitative for the therapeutic relationship (Owen, et al., 2011; Assouad, 2014). Additionally, working with faith can facilitate the therapeutic process for religious clients (Mayers, et al., 2007; Meer & Mir, 2010). This was evident in Jamila's experience, however hers was an exception to the norm. Safran and Segal (1990) suggested that unpacking the therapeutic alliance can "provide new insights into facilitating the alliance and resolving impasses in the therapeutic relationship that impede treatment" (p. 94). In this case it may not always be impasses in the relationship but oversights of differences in the room. However, such authenticity is not common practice particularly amongst non-matched ethnic minority and white majority dyads (Duffey & Somody, 2011).

A large part of positive experiences of counselling were related to the qualities of the therapy including warmth, validation and trust in the relationship. This is important for any therapeutic work (Rogers, 1961). Previous research has suggested that these qualities are more important than client- counsellor similarity (Shafi, 1998). However, based on my research,I would argue

that counsellors' cultural and spiritual competence is of greater value than their shared background and of as equal value as counsellor qualities.

Recommendations for Practice

This research has highlighted multiple factors involved in understanding Muslim, female, counselling clients. It has illustrated areas for consideration for counsellors, counselling psychologists and health and social care practitioners when working with Muslim, female, clients. I will outline some of these considerations in this section. The research has provided insight into some of the gaps in understanding between some Muslim clients and non-Muslim counsellors with regards to religious and spiritual dimensions of their identity. The findings are in relation to my participants and not all Muslim clients.

The majority of concerns experienced by my participants related to their culture. Their culture and religion were also central to their coping. This suggests that, when working with Muslim women, cultural competence is required of the counsellor. By this I mean that he or she can "actively attempt to understand the worldview of his or her culturally different client without negative judgments" while maintaining a "process of actively developing and practicing appropriate, relevant, and sensitive intervention strategies and skills" (Sue, Arredondo, & McDavis, 1992, p. 481). This applies to religious and spiritual differences as well as ethnic, gender and other differences. These aspects cannot be worked with in isolation as my research has suggested that experiences cut across contexts. Therapists need to understand the interplay between different spaces that a Muslim client occupies and the effects these have on the client, their current issue, the therapy; exploring different areas without compartmentalization.

Subsequently, therapists and trainers need to be aware of Western assumptions within theory and practice. Approaches of therapy influence client formulations and treatment interventions. Thus, working with a client with a different worldview requires awareness of these differences and an ability to engage with them in a therapeutic way. Otherwise we risk imposing our

assumptions onto clients, and may create experiences of shame and disempowerment. A therapist's ability to work with diversity primarily depends on the training they embark on. Therefore, I recommend that trainings include religious, spiritual, and cultural aspects of different populations. From my experience there is much potential to develop these aspects of training, teaching and learning within psychological and educational institutions, and within psychological theories and practice. Ignoring cultural differences can spur inequality within treatment through misconceptions and misunderstandings. This is something that Kareem & Littlewood (1992) and Fernando (1988) have written about, explored and discussed extensively. I would argue that training institutions hold themselves accountable for their levels of cultural sensitivity and competence. In light of these findings I advocate religious literacy within training, in the least to assist practitioners in asking the 'right questions' about faith and beliefs.

Cultural sensitivity also needs to be acknowledged by counsellors themselves so that they can challenge their own biases. It is important for counsellors to be aware of their misconceptions about Islam and Muslims, those they hold themselves and those held by society. This awareness will help prevent practitioners from oppressing the people that have come to them for help. I would encourage practitioners to learn about Islam and Muslims through various means, such as attending seminars or workshops or engaging with reading materials. There are numerous papers on understanding different Islamic beliefs and shedding light on misconceptions (Inayat, 2007; Ali, Liu & Humedian, 2004; Inayat, 2005). Case vignettes, which can provide working examples and insights to others, often accompany much psychological research on Islam and Muslim clients but it is important to remember the uniqueness of each person. McMinn, et al. (2011) note that a willingness to learn from clients is also helpful. Williams (2005) also raises important issues around gaining accurate understanding about Muslim clients' beliefs and values to avoid making assumptions and not confusing religious issues with cultural issues. She encourages counsellors to increase their awareness of Islam and engage with reflexivity and learning when working with Muslim clients.

My research could help counsellors think about ways in which religious and spiritual practices may be significant to clients from a Muslim background. For example, in shaping their healing practices to utilise dhikr and prayer, exploring decision making, coping and meaning making, exploring clients' relationship to their faith and culture (both difficult and beneficial aspects) and working with the God- relationship where appropriate and relevant. It would require sensitivity and curiosity and an ability to work with the resources that a client already possesses. However, it is important to note that some clients may be hesitant in discussing sensitive topics associated with religion and culture for fear of 'betraying' their community. Dialogue with Muslim clients could involve exploring clients' attitudes about seeking counselling, clients' perceptions of counselling and the counselling relationship, clients' attitudes and understanding about the process of counselling, the role of the counsellor and the role and importance of religion in their life. Cultural competence could assist in helping counsellors provide increasingly enriching and effective therapeutic experiences, empowering the relationship by engaging in honest and open dialogue that respects the religion and culture of the client. It could also increase counsellors understanding and confidence to work with religion and spirituality therapeutically (Meer & Mir, 2014). I would encourage counsellors to be confident in tentative, curious, inquiry where appropriate and relevant as opening up dialogue is an important stepping stone to meeting any client and engaging in working within the client's own contexts (Carone & Barone, 2001).

I would also encourage counselling psychologists to address transference and countertransference responses within therapy to nurture interpersonal learning. A lack of engagement with religion could reinforce clients' beliefs that parts of themselves are unacceptable to others. Thus, leading clients to hide some parts of themselves, as well as counsellors running the risk of not connecting with their clients (Duffey & Somody, 2011). Other research has found that if a therapist does not address cultural issues and differences their client may feel that they are culturally biased (Day- Vines, et al., 2007) and experiences of prejudice within therapy can deter help seeking contributing to a double- stigma from outside, internalised and within counselling (Gary, 2005). Some may argue that the therapeutic

connection is not entirely the therapist's responsibility and that a client needs to be willing to engage too (Knox & Cooper, 2011). However, if feelings of shame and fear go unacknowledged then as therapists we may be inhibiting the clients' openness.

There is also scope for counsellors to consider collectivist approaches to mental health issues amongst Muslim clients. This is especially important due to the likelihood of a relational nature of presenting issues. This diverges from Western assumptions of counselling that have focus on the individual. Acknowledgment and engagement with context could provide a more harmonious experience of counselling for Muslim clients. However, this will depend on the client's personal values, beliefs, preferences and issues. A lack of confidence in working with religion and spirituality is also prevalent amongst Muslim practitioners (Meer & Mir, 2014) so the above applies to Muslim counsellors as well as non- Muslim counsellors.

As a participant in the relational world of the client, I would argue that the therapist has a responsibility to bring the unconscious into the intersubjective space to allow for new meanings and experiences, and an integration of potentially fragmented parts of identity. Particularly as therapists often hold greater power in the room and thus can instigate change (Sue & Sue, 2003). This does not depend on having a shared background. I am not advocating client- counsellor matching, although it could be helpful to have this as an option for clients. Matching is not straightforward or ever complete as there are many layers of difference between individuals. Even if they appear to be from similar cultural and religious backgrounds, we cannot assume shared understanding, or assume that a shared understanding is always beneficial. Practitioners also cannot assume the level of faith held by a client based on outward factors, but rather it is something that needs exploration through dialogue and communication. Therefore, I encourage cultural, religious and spiritual competence amongst both Muslim and non- Muslim counsellors.

It is important to note here that clients as well as counsellors could hold misconceptions about each other, therefore I would encourage and recommend psychoeducation amongst Muslim communities about psychological issues and support services. Researchers within this field, with

sufficient knowledge can also assist in teaching about Islamic beliefs and principles to assist practitioners in increasing their knowledge of this area (Hamdan, 2007).

In 2017 the British Psychological Society (BPS) published its third edition of practice guidelines. These were the first guidelines with a focus on inclusivity and diversity. It includes a (very small) section on working with faith. It outlines that psychologists respect client values, make use of spiritual beliefs with clients where they could have a positive impact and highlights that some beliefs may be harmful. In light of my own research and the research that has been conducted over the last few decades, these guidelines are disappointing. The British Association for Counselling and Psychotherapy (BACP) has been slightly ahead. They have an established division of spirituality that dates back to the 1970's, formerly known as the Association for Pastoral and Spiritual Care and Counselling (APSCC). This suggests that the division has undergone reorientation over the years but maintained a spiritual focus. Their stance on religion appears ambiguous. In 2018 the British Association for Counselling and Psychotherapy (BACP) published its first Therapy Today issue centred on the topic of race. Although this is not religion or spirituality it is a step in the right direction of acknowledging and working with difference. Having said that, inclusion of topics of religion, particularly Islam, appears very thin. My research suggests that these are very current issues that need addressing within professional bodies in the UK.

This research is also relevant for social workers, trainers, health care practitioners, as well as psychologists and therapists as all these professions work with diverse populations and are discussing cultural issues within their fields.

Quality in Qualitative Research

Yardley (2000) highlights four key areas against which the quality of qualitative research can be assessed, particularly in relation to IPA; sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. I will use these to present the quality of this research.

Sensitivity to context

This refers to sensitivity to theoretical and socio- cultural contexts (Yardley, 2007). Through the literature review I have shown sensitivity to the context in which I situate this research by attending to issues faced by Muslim women. As an insider researcher I possessed sensitivity and awareness of socio-cultural setting of this research. Sensitivity was shown towards my participants and their communities through consideration of my recruitment process, method, during interviews, analysis and write up. Reflexivity throughout the research also shows an awareness of my own position within the research and provides further evidence of my sensitivity to context.

Commitment and rigour

This refers to consistency and thoroughness in engagement with the research at its different junctures, and a dedication to learning knowledge and skills relevant to each phase (Yardley, 2007). My commitment to this research extends beyond the conception of the research question showing prolonged engagement with the topic. It is also exhibited in my ongoing engagement with IPA through reviewing my work and my perspectives in relation to the underpinning philosophical approach. Rigour will hopefully be evident through a sense of completeness of the analysis. However, this is one area in which, as a new researcher, I could have been more thorough.

Transparency and Coherence

This refers to clarity and honesty throughout the period of conducting and writing up the research and a 'fit' of all aspects of the research (Yardley, 2007). The structure and content of this research study are presented in a clear and concise manner exhibiting strengths in my argument. Additionally, my critical- realist perspective frames each chapter of my research, with emphasis on co- constructions of meaning throughout, showing coherence. Transparency also exists in reflexive sections and in the processes of data collection and analysis.

Impact and Importance

Yardley (2000) contends that this criterion is 'decisive' and refers to the usefulness of a piece of research. The literature review, and my participants, highlighted the importance of this research. I hope the findings and implications also attest this.

Evaluation of Research

This research study provided an in-depth exploration of the lived experiences of Muslim women clients of counselling. It included how they experienced themselves within their religious, national and ethnic contexts. An exploration of the struggles they faced within their contexts, how they coped with psychological distress and an exploration of their journey of healing.

It appears to be a unique study delving into the relationship between Muslim clients and counselling. Previous research has explored barriers to counselling (Inayat, 2005; Memon, et al., 2016), attitudes to mental health and counselling amongst Muslims (Rassool, 2015; Moller, et al., 2016); and provided guidelines to working with Muslims (Lewis, et al., 2009; Cook-Masaud & Wiggins, 2011). Some research has explored spiritual and religious clients in a wider sense thus not focusing specifically on Muslim experiences (Mayers, et al., 2007; Loewenthal, et al., 2001). Therefore, a major strength of this study is its provision of valuable new insights into Muslim women clients' lived experiences of attending counselling and recommendations for practice.

I have also upheld reflexivity throughout this research (in the introduction and in Chapters 1, 2, 3 and 5), which evidences good quality qualitative research (Elliot and Fischer, 1991; Yardley 2000). It also demonstrates transparency (Yardley, 2000) and seeks to show a coherence between myself as the researcher and social constructionist underpinnings of this research to demonstrate how I have co-created this research with my participants.

IPA studies commonly consist of smaller sample sizes ranging between three to six participants (Pietkiewicz & smith, 2012). My sample size was on the larger end of the spectrum. Some may argue that this takes away from the idiographic focus that IPA advocates, however I would argue that idiographic commitment does not depend on sample size but on the researcher's ability to engage and interact with the research. Using IPA in this research has allowed me to bring Muslim womens' individual experiences to the forefront, providing a platform for their (often marginalised and invisible) experiences. It has also allowed me to showcase diversity and intricacies within my sample as it included different ethnic groups, age groups and a range of diversity in relation to relationships with faith and God. It has given a platform for a variety of Muslim women's experiences to be heard from their own accounts, allowing them to speak for themselves rather than being spoken about.

Although this research has its merits it also has some limitations. Firstly, as an IPA researcher, I made a conscious effort to keep interview questions open ended and to be flexible in my exploration of relevant experiences during interviews. On reflection, I feel that I could have given my participants more space to open up a deeper explanation of some of their experiences. I would attribute this downfall to being a novice researcher and thus having a lack of experience in engaging in IPA interviewing. It may also be attributed to the difficulties of being an 'insider researcher' as discussed in Chapter 3 where there may have been some assumed understanding from myself and my participants (Nuefeld, et al., 2001; Dwyer & Buckle, 2009). This would have had an impact on the research data and consequently on the analysis.

My experience of using IPA with a social constructionist approach also warrants some critique. I believe IPA's hermeneutic feature fits well with social constructionism, but the phenomenological aspect may be debatable. On one hand, IPA theorists state that phenomenology cannot occur without interpretation (Smith, et al., 2009; Larkin & Thompson,

2012) but on the other hand they emphasise an idiographic approach (Smith, et al., 2009). This appears to be contradictory, but it could also suggest that IPA is a flexible approach, with researchers utilising difference tenets of it to varying degrees as opposed to it being a strict set of procedures. On reflection, my utilisation of IPA has not maintained as much of an idiographic focus as was intended. This could have been due to the nature of the research question or the data. However, it pertinently reflects the difficulties of reconciling relational and collectivist perspectives within individualistic approaches.

Another area of consideration is the recruitment process. The main avenue from which participants volunteered to take part was through social networking sites, with correspondence occurring via e-mail. This may reflect the demographics of my participants who were all English speaking and (at least) second generation migrants. This has implications for the findings as it meant that I did not hear from those who may not use computers or social media, or older, first generation Muslims, and those who may have been harder to reach particularly for this sensitive topic. They may have expressed different experiences and perspectives on psychological issues and help seeking. However, the sample involved could also, faintly, point to intergenerational disparities relating to openness about mental health. Although barriers to professional support are still prevalent.

Further Research

This research included Muslim women who had gone through, or were enrolled in, higher education. The majority of women were also in employment. Thus, it could be argued that they were more integrated into British society and therefore, more open to seeking psychological support. But there are many Muslim women who are not in this position. Such as older generations of migrant women who have not been educated or employed in Britain. It would be interesting and important to explore their experiences of psychological difficulties and how they cope. This could also provide insight into patterns of intergenerational change relating to understanding of, and engagement with, psychological issues and support.

The majority of women in this research had a preference for receiving some kind of religious guidance and input in their counselling in order to improve their wellbeing. The research suggests the positive impact that this had on them, however not everyone had this experience. What is involved from the practitioner's perspective when working therapeutically with religion and spirituality? It would be interesting to explore counsellors' experiences of working with Muslim clients to get some insight into the thought- processes, challenges and benefits that are experienced on the other side of the therapeutic dyad. It would be incredibly useful to hear from counsellors, both Muslim and non-Muslim, who have engaged with (or not engaged with) religion and spirituality in their work with Muslim clients.

The majority of women in this research deliberately shielded their counselling experiences from those they lived with. Further research could then explore experiences of individuals who have opened up to their family about their psychological difficulties and use of counselling. This would shed light on the impact of psychological issues and counselling on the family system within Muslim communities: unpacking interrelatedness of stigma, shame and community that was brought to light in this research. However, as I have established, Muslim communities are diverse (Ali, 2008; Gilliat-Ray, 2010), therefore exploring experiences within specific ethno-religious cultures could also provide different outcomes.

I would also include a need to research further into matching as I believe that if we begin creating different services for specific populations then we potentially perpetuate segregation between populations and services. The very segregation that is problematic for society (Kramer, 1984).

Lastly, future research needs to be conducted to explore and develop empirical methods of combating stigma of mental health and counselling within the Muslim community.

Personal Reflection

I was aware of the importance of this research from the beginning to the end. It was reinforced by the interest I had from participants, conversations that I have had with colleagues and friends,

and my own experiences. Just before submission of this thesis I attended the Keele Counselling Conference on the (apt) theme of Religion, Spirituality and Faith in the Therapeutic Space. During a workshop on exploring religion and spirituality in therapy attendees were swift to deprecate religion, in favour of spirituality. As a visibly Muslim woman this situation caused great discomfort and brought up strong feelings of injustice and judgement from others. After airing my concerns and engaging in essential and, quite special, dialogues, the value of my work was further clarified.

Hearing my participants' stories had an emotional impact on myself, even months after conducting interviews. However, this was combined with an appreciation and gratefulness for being given their stories and a sense of determination to do justice to them. Their experiences also provided me with hope and admiration of their journeys and I am in awe of their courage and creativity in navigating their spaces.

During interviews there was uncertainty from some of my participants regarding the nature of my research and the answers they were providing. For example, four participants showed hesitation before disclosing information that they felt might cause them to transgress particular boundaries i.e. feeling that they may betray someone. I was mindful of holding feelings of guilt and provided reassurance about confidentiality and the non-judgmental nature of the interview. On reflection I soon realized I could highlight these factors more explicitly and proceeded to do so, thus offering more comfort for the following participants. Reflecting on these occurrences, a theme of safety became visible across my participants' accounts and my own self- disclosure within this thesis. i.e. questioning what is safe to share. Throughout the process I have kept a reflective journal that holds many of my own reflections and thoughts, I have incorporated only a very small part of these into my writing. This could be interpreted as fear of judgement from others, however I believe I have brought enough of myself into my work to adequately assist my writing. As a Muslim, female, counselling psychologist, I ought not to feel obligated to expose

myself in the academic field. Doing so would feel like tokenism, something that is not uncommon amongst minority ethnic professionals.

Having said that, I recognise the privilege I have in using my professional identity to help others learn about Muslim and ethnic minority experiences within the counselling profession. On the other hand, airing my personal experiences are not the main concern of this writing. However, I am open to engaging with this in different ways throughout my career in a more natural and progressive way.

Throughout this research process I struggled to place religion and God within my writing. It took much restructuring to incorporate these aspects in a way that paralleled their importance within my participants' experiences. I have also previously mentioned my own experiences of feeling that this field has some lack of acceptance of religion. These experiences highlight the difficulty of bringing faith and counselling psychology together. They also reflect the invisible yet central force of faith in Muslim, women's experiences as clients of counselling. There is much more that can be explored, discussed and shared on this topic and I hope to continue this work in the future.

Conclusion

The purpose of this study was to gain an understanding of Muslim, women, clients of counselling. Interweaving of religion, culture, gender and mental health is very complex and weighty. This research opened up considerations about identity constructions of Muslim women in Britain as well as problems that Muslim women face and the contextual factors that play a role in their experiences of counselling. It brings to light the threat and shame that can be experienced across contexts of society, community, family and therapy. Amongst the movements between secrecy and a need for acceptance, the stand-out message indicates the need for an integration of religious and spiritual beliefs and psychological practice on a personal level for Muslim clients and on a professional level for counsellors and therapists. This research provides insights into how relationships between client and counsellor parallel wider

relationships between Muslim minority groups and mainstream society. This research has suggested that client- counsellor relationships can be implicated by social, political, cultural and individual factors from both the therapist and clients' positions and perspectives. The ways in which some of the women utilised both counselling and faith to facilitate their wellbeing indicates that the two have potential to be integrated.

References

Abbas, T. (2010). Muslim-on-Muslim Social Research: Knowledge, Power and Religio-cultural Identities, *Social Epistemology, 24*(2), 123-136.

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review*, 31, 934-948.

Abu-Lughod, L. (2002). Do Muslim women really need saving? Anthropological reflections on cultural relativism and its others. *American Anthropologist, 104*(3), 783-790.

Abu-Ras, W. M., & Suarez, Z. E. (2009). Muslim men and women's perception of discrimination, hate crimes, and PTSD symptoms post 9/11. *Traumatology, 15*(3), 48.

Ahmad, B. 1992. *Black Perspectives in Social Work*. Birmingham: Venture Press.

Ahmed, S., & Amer, M. M. (2012). *Counselling Muslims: Handbook of Muslim Mental Health*. New York: Routledge.

Akhtar, P. (2014). 'We were Muslims but we didn't know Islam': Migration, Pakistani Muslim women and changing religious practices in the UK. Paper presented at the *Women's Studies International Forum, 47,* 232-238.

Akhtar, S. (2015). Editor's introduction: Challenging the Western caricature of Muslim Women. *International Journal of Applied Psychoanalytic Studies*, *12*(4), 357-358.

Al-Krenawi, A., & Graham, J. (2003). Principles of social work practice in the Muslim Arab world. *Arab Studies Quarterly, 25*(4), 75-91.

Ali, S. (2008). Identities and sense of belonging amongst Muslims in Britain. *Doctoral Thesis.* Department of Sociology, Nuffield College: Oxford.

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.

Aloud, N., & Rathur, A. (2009). Factors affecting attitudes towards seeking and using formal mental health and psychological services among Arab Muslim populations. *Journal of Muslim Mental Health*, *4*, 79-103.

Alvarez, R. A., Vasquez, E., Mayorga, C. C., Feaster, D. J., & Mitrani, V. B. (2006). Increasing minority research participation through community organization outreach. *Western Journal of Nursing Research*, *28*(5), 541-560. doi:10.1177/0193945906287215.

Anand, A.S., & Cochrane, R. (2005). The mental health status of South Asian women in Britain: A review of the UK literature. *Psychology and Developing Societies*, 17, 195–214.

Anderson, B. (1983). *Imagined Communities: Reflections on the origins and spread of nationalism*. New York: Verso.

Anthias, F. (2002). Where do I belong? Narrating collective identity and translocational positionality. *Ethnicities, 2*(4), 491-514.

Asselin, M. E. (2003). Insider research: Issues to consider when doing qualitative research in your own setting. *Journal for Nurses in Staff Development*, 19(2), 99-103.

Assouad, J. P. (2014). The effects of acknowledging cultural differences on therapeutic alliance in cross- cultural therapy. *PCOM Psychology Dissertation*. Paper 293.

Atieno, P. O. (2009). An analysis of the strengths and limitations of qualitative and quantitative research paradigms. *Problems of Education in the 21st Century, 13*, 13-18.

Atkinson, D. R. (1983). Ethnic similarity in counseling psychology: A review of research. *The Counseling Psychologist*, *11*, 79–92. doi:10.1177/0011000083113009

Atkinson, D. R. (1985). A meta-review of research on cross-cultural counseling and psychotherapy. *Journal of Multicultural Counseling and Development*, *13*, 138–153.

Badri M (2000), *Contemplation: An Islamic Psychospiritual Study*. The International Institute of Islamic Thought. Cambridge: Cambridge University Press.

Baker, H. S., & Baker, M. N. (1987). Heinz kohut's self psychology: An overview. *The American Journal of Psychiatry, 144*(1), 1-9. doi:10.1176/ajp.144.1.1

Baker, C. (2018). *Mental health statistics for England*: *Prevalence, services and funding*. Briefing paper 2988. House of Commons library (accessed on February 2019).

Bateson, G. (1972). *Steps to an Ecology of Mind*. New York: Chandler.

Bauman, Z. (1996) in Pillips, C., & Webster, C. (2014). New Directions in Race, Ethnicity and Crime (pp. 125). London: Routledge.

Belaire, C., & Young, J. (2000). Influences of spirituality on counsellor selection. *Counselling & Values*, *44*(3), 189-197.

Bettman, C. (2009). Patriarchy: The predominant discourse and fount of domestic violence. *The Australian and New Zealand Journal of Family Therapy,* 30(1), 15-28.

Bhardwaj, A. (2001). Growing up young, Asian and female in Britain: A report on self-harm and suicide. *Feminist Review, 68*(1), 52-67.

Bhaskar, R. (1978) *A Realist Theory of Science*, Brighton, Harvester Press.

Bhaskar, R. (1991) *Philosophy and the Idea of Freedom*, Oxford, Blackwell.

Bhaskar, R. (1998) 'General Introduction', in Archer, M., Bhaskar, R., Collier, A., Lawson, T. and Norrie, A. (eds.), *Critical Realism*, London, Routledge.

Bhatia, S. (2012). Strategic subversion of the sacred: The cultural psychology of religious identities. *Culture & Psychology*, *18*(1), 60-75.

Bhugra, D., & Jones, P. (2001). Migration and mental illness. *Advances in Psychiatric Treatment, 7*(3), 216-222.

Bhui, K. Christie, Y., & Bhugra, D. (1995). Essential elements of culturally sensitive psychiatric services. *International Journal of Social Psychiatry*, *42*(4), 242-256.

Bhui, K., & Bhugra, D. (2002). Explanatory models for mental distress: Implications for clinical practice and research. *The British Journal of Psychiatry: The Journal of Mental Science, 181*, 6-7.

Bhui, K., Bhugra, D., Goldberg, D., Sauer, J., & Tylee, A. (2004). The prevalence of depression in Punjabi and English primary care attenders: The role of culture, physical illness and somatic symptoms. *Transcultural Psychiatry, 41*(3), 307-322.

Blumer, H. (1980). Mead and Blumer: The convergent methodological perspectives of social behaviorism and symbolic interactionism. *American Sociological Review,* 45(3), 409-419.

Bowen, I. (2014). *Medina in Birmingham, Najaf in Brent: Inside British Islam* Oxford University Press.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psycho-Analysis, 39*, 350–373.

Bowlby. J. (1969). *Attachment and Loss*. Vol 1: Attachment. New York: Basic Books.

Brah, A. (1996). *Cartographies of Diaspora*. London: Routledge.

Brice, K. (2010). *A minority within a minority*: A report on converts to Islam in the United Kingdom. Retrieved from http://faith-matters.org/images/stories/fm-reports/a-minority-within-a-minotiry-a-report-on-converts-to-islam-in-the-uk.pdf (accessed on March 2017).

Brown, K. (2006). Realising Muslim women's rights: The role of Islamic identity among British Muslim women. *Women's Studies International Forum, 29*(4) 417-430.

Burr, V. (2003). *Social constructionism*, 2nd edn. London: Routledge.

Capra, F. (1996). *The Web of Life: A new scientific understanding of living systems*. New York: Anchor Books.

Butt, J. (2006). 'Are we there yet?' Identifying the characteristics of social care organisations that successfully promote diversity. *Race Equality Discussion*, paper 03. London: Social Care Institute For Excellence.

Carone, Jr. D. A., & Barone, D. F. (2001). A social cognitive perspective on religious beliefs: Their functions and impact on coping and psychotherapy. *Clinical Psychology Review, 21*(7), 989-1003.

CENSUS, 2011. *Census National Statistics*. UK: Office for National Statistics (ONS).

Chapman, M. (2016). Feminist dilemmas and the agency of veiled Muslim women: Analysing identities and social representations. *European Journal of Women's Studies, 23*(3), 237-250.

Christidis, P., Lin, L., & Stamm, K. (2017). Psychology faculty salaries for the 2016- 2017 academic year: Results from the 2017 CUPA- HR survey for four- year colleges and universities. *APA Centre for Workforce Studies*.

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*, 505–524.

Clay, A. R., (2017). Women outnumber men in psychology but not in the field's top echelons. *American Psychological Association*, 48(7), 18.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rusch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health- related stigma on help-seeking? Systemic review of quantitative and qualitative studies. *Psychological Medicine*, *45*, 11-27.

Constantine, M. G. (2002). Predictors of satisfaction with counselling: racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Counselling Psychology, 49*(2), 255–263.

Cook-Masaud, C., & Wiggins, M. I. (2011). Counseling Muslim women: Navigating cultural and religious challenges. *Counseling and Values, 55*(2), 247-256.

Cooley, H., C. (1902). "*Human Nature and the Social Order*". New York: Charles Scribner's Sons.

Cooper, M. (2005). Therapist's experiences of relational depth: A qualitative interview study. *Counselling and Psychotherapy Research*, *5*(2), 87-95.

Corra, M., & Willer, D. (2002). The gatekeeper. *Sociological Theory, 20*(2), 180–207.

Cragun, C. L., & Friedlander, M. L. (2012). Experiences of Christian clients in secular

psychotherapy: A mixed-methods investigation. *Journal of Counseling Psychology, 59*(3), 379-391.

Crenshaw, K. (1989). Demarginalising the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. University of Chicago Legal Forum, 1989(1), 139- 168.

Crenshaw, K. (1994) Mapping the Margins: intersectionality, identity politics and violence against women of color, in M.A. Fineman & R. Mykitiuk (Eds) *The Public Nature of Private Violence*, pp. 93-118. New York: Routledge.

Creswell, J. W. (2013). *Research design*: *Qualitative, quantitative and mixed methods approaches* (2nd Ed). Thousand Oaks: Sage

Das, C. (2010). Considering ethics and power relations in a qualitative study exploring experiences of divorce among British-Indian adult children. *Centre on Migration, Citizenzhip and Development*, (working papers) 76, 1-28. Retrieved from https://nbn-resolving.org/urn:de:0168-ssoar-367735 (accessed on January 2017).

Das, C., & McArevey, R. (2013). A delicate balancing act: Negotiating gatekeepers for ethical research when researching minority communities. *International Journal of Qualitative Methods, 12*(1), 113-131.

Day-Vines, L. N., Wood, M. S., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, J. M. (2011). Broaching the subject of race, ethnicity, and culture during the counselling process. *Journal of Counselling & Development, 85*(4), 401-409.

de Laine, M. (2000). *Fieldwork, participation and practice: Ethics and dilemmas in qualitative research*. London, United Kingdom: Sage.

Deakin, H. & Wakefield, K. (2013). Skype interviewing: Reflections of two PhD researchers. *Qualitative Research, 14*(5), 603-616.

Diala, C., Muntaner, C., Walrath, C., Nickerson, K., LaVeist, T., & Leaf, P. (2001). Racial/ethnic differences in attitudes toward seeking professional mental health services. *American Journal of Public Health, 91,* 805–807.

Droogsma, R.A. (2007). Redefining hijab: American Muslim women's standpoints on veiling. *Journal of Applied Communication Research*, *35*, 294–319.

Du Bois, W. E. B. (1903). *The Souls of Black Folk*. New York: Dover Publications.

Douki, S., Ben Zineb, S., Nacef, F., & Halbreich, U. (2007). Women's mental health in the Muslim world: Cultural, religious, and social issues. *Journal of Affective Disorders*, *102*(1), 177-189.

Duffey, T., & Somody, C. (2011). The role of relational-cultural theory in mental health counseling. *Journal of Mental Health Counseling, 33*, 223–242.

Dwairy, M. (2006). *Counseling and psychotherapy with Arabs and Muslims: A culturally sensitive approach*. New York: Teachers College Press.

Dwyer, C. (1999). Veiled meanings: Young British Muslim women and the negotiation of differences [1]. *Gender, Place and Culture: A Journal of Feminist Geography, 6*(1), 5-26.

Dwyer, C. (2000). Negotiating diasporic identities: Young British south Asian Muslim women. *Women's Studies International Forum, 23*(4) 475-486.

Dwyer, C. S., & Buckle L. J. (2009). The space between: On being an insider- outsider in qualitative research. *International Journal of Qualitative Methods, 8*(1), 54-63.

Eagle, N. M. (2011). *From Classical to Contemporary Psychoanalysis: A critique and integration*. London: Routledge.

Eide, P., & Allen, C. B. (2005). Recruiting transcultural qualitative research participants: A conceptual model. *International Journal of Qualitative Methods*, *4*(2), 1-10.

El-Islam, M. F. (2008). Arab culture and mental health care. *Transcultural psychiatry, 45, 671–682*.

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.

Fairbairn, W. R. D. (1958). On the nature and aims of psychoanalytic treatment. *International Journal of Psychoanalysis, 39*, 374-385.

Faris, A., & Ooijen, V. E. (2012). *Integrative Counselling and Psychotherapy*. London: Sage Publications Ltd.

Fazil, Q., & Cochrane, R. (2003). The prevalence of depression in Pakistani women living in the West Midlands. *Pakistani Journal of Women's Studies*, *10*(1), 21–30.

Fernando, S. (1988). *Race and Culture in Psychiatry*. London: Croom Helm.

Festinger, L. (1954). A theory of social comparison processes. *Human Relations, 7*(2), 117-140.

Finlay, L. (2011). *Phenomenology For Therapists*. Oxford: Wiley- Blackwell.

Flaskerud, J., & Hu, L. (1992). Relationship of ethnicity to psychiatric diagnosis. *Journal of Nervous and Mental Disease*, *180*(5), 296–303.

Fouque, P., & Glachan, M. (2000). The impact of Christian counselling on survivors of sexual abuse. *Counselling Psychology Quarterly*, *13*, 201–220.

Frenkel, R. (2008). Feminism and contemporary culture in South Africa. *African Studies, 67*(1), 1-10.

Furness, S., & Gilligan, P. (2009). Social work, religion and belief: Developing a framework for practice. British *Journal of Social Work, 40*(7), 1-18.

Gabriel, D. (2013). *Inductive and Deductive Approaches to Research*. Retrieved from http://deborahgabriel.com/2013/03/17/inductive-and-deductive-approaches-to-research/ (accessed on March 2017).

Garfinkel, H. (1984). *Studies in Ethnomethodology*. Cambridge: Polity Press.

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26*(10), 979-999.

Geaves, R. (2010) *Islam in Victorian Britain*: The Life and Times of Abdullah Quilliam. Leicester: Kube Publishing.

Gilbert, P., & Leahy, L. R. (2007). *The Therapeutic Relationship in the Cognitive Behavioural Psychotherapies*. Sussex: Routledge.

Gilbert, P., Gilbert, J., & Sanghera, J. (2004). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental Health, Religion and Culture, 7*(2), 109–130.

Gilbert, R., J. & Mitchell, A., S. (1983). *Object Relations in Psychoanalytic Theory*. USA: Harvard University Press.

Gilliat-Ray, S. (2010) *Muslims in Britain: An Introduction*. Cambridge: Cambridge University Press.

Gilliat-Ray, S., Ali, M., & Pattison, S. (2013). Understanding Muslim chaplaincy. Burlington, VT: Ashgate Publishing Company.

Gitsels-van der Wal, T. J., Verhoeven, S. P., Mannien, J., Martin, L., Reinders, S. H., Spelten, E., Hutton, K. E. (2015). A qualitative study on how Muslim women of Moroccan descent approach antenatal anomaly screening. *Midwifery, 31*(3), 43-49.

Goedde, C. (2001). A qualitative study of the client's perspectives of discussing spiritual and religious issues in therapy. *Dissertation Abstracts International: The Sciences and Engineering, 61*(9-B), 4983.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon and Schuster.

Gottfried, H. (2008). Reflections on intersectionality: Gender, class, race and nation. *Journal of Gender Studies*, *11*, 23-40.

Graham, J. R., Bradshaw, C., & Trew, L. J. (2009). Addressing Cultural Barriers with Muslim Clients: An Agency Perspective. *Administration in Social Work, 33*(4), 387-406.

Graham, J. R., Bradshaw, C., & Trew, L. J. (2010). Cultural considerations for social services agencies working with Muslim clients. *Social Work, 55*(4), 337- 346.

Granqvist, P. (2005). Building a bridge between attachment and religious coping: tests of moderators and mediators. *Mental Health, Religion & Culture*, *8*(1), 35-47.

Greenberg, J. & Mitchell, S.A. (1983). *Object Relations in Psychoanalytic Theory*. Cambridge, MA: Harvard University Press.

Greenidge, S., & Baker. M. (2012) Why do committed Christian clients seek counselling with Christian therapists? *Counselling Psychology Quarterly*, *25*(3), 211-222.

Guinee, J. P., & Tracey, T. J. G. (1997). Effects of religiosity and problem type on counselor description ratings. *Journal of Counseling and Development*, 76, 65-73.

Guiliano, R. A., Mokuau, N., Hughes, C., Tortolero-Luna, G., Risendal, B., Ho, C. S. R., Prewitt, E. T., Mccaskill-Stevens, J. W. (2000). Participation of minorities in cancer research: The influence of structural, cultural and linguistic factors. *Annals of Epidemiology, 10*(8), S22-34.

Gulgani, S., Coleman, P. G., Sonuga-Barke, E. J. S. (2000). Mental health of elderly Asians in Britain: A comparison of Hindus from nuclear and extended families of differing cultural identities. *International Journal of Geriatric Psychiatry, 15*, 1046–1053.

Hall, S. (1992). The question of cultural identity. In Stuart Hall, David Held, & Tom McGrew (Eds.), *Modernity and its future* (pp. 273–325). Cambridge: Polity.

Hamdan, A. (2007). A case study of a Muslim client: Incorporating religious beliefs and practices. *Journal of Multicultural Counseling and Development, 35*(2), 92-100.

Hamdan, A. (2008). Cognitive restructuring: An Islamic perspective. *The Journal of Muslim Mental Health, 3,* 99-116.

Hamdan, A. (2009). Mental health needs of Arab women. *Health Care for Women International, 30*, 595-613.

Hamid, S. (2011). British Muslim Young People: Facts, Features and Religious Trends. *Religion, State and Society*, 39(2-3), 247-261.

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.

Hanes, E. and Machin, S. (2014). 'Hate crime in the wake of terror attacks: Evidence from 7/7

and 9/11', *Journal of Contemporary Criminal Justice*, *30*(3), 247–67.

Hanmer, J. (1978). *'Violence and the Social Control of Women'* in Littlejohn, G., et al. (eds.) Power and the State, Croom Helm: London.

Harre, R. 2002. Social reality and the myth of social structure. *European Journal of Social Theory, 5*, 111–23.

Haw, K. (1995). Education for Muslim girls in contemporary Britain: social and political dimensions. *PhD thesis*: University of Nottingham.

Haw, K. (2009). From hijab to jilbab and the 'myth' of British identity: Being Muslim in contemporary Britain a half-generation on. *Race Ethnicity and Education, 12*(3), 363-378.

Haw, K. (2010). Being, becoming and belonging: Young Muslim women in contemporary Britain. *Journal of Intercultural Studies, 31*(4), 345-361.

Hayfield, N., & Huxley, C. (2015). Insider outsider perspectives: Reflections on researcher identities in research with Lesbian and Bisexual women. *Qualitative Research in Psychology, 12*(2), 91-106.

Heidegger, M. (1962). *Being and time*. Oxford: Basil Blackwell

Hicks, M. H. R., & Bhugra, D. (2003). Perceived causes of suicide attempts by UK South Asian women. *American Journal of Orthopsychiatry, 27*(4), 455–462.

Hill, C. P., Pargament, I. K., Hood, W. R., McCullough, E. M. Jr., Sweyers, P. J., Larson, B. D., & Zinnbauer, J. B. (2000). Conceptualising religion and spirituality; points of commonality, points of departure. *Journal for the Theory of Social Behaviour*, *30*, 1, 51-77.

Hoare, C. H. (1991). Psychosocial identity development and cultural others. *Journal of Counseling & Development, 70*(1), 45-53.

Hodge, D. (2007). The spiritual competence scale: A new instrument for assessing spiritual competence at the programmatic level. *Research on Social Work Practice, 17*(2), 287-295.

Hodge, D., & Bushfield, S. (2007). Developing spiritual competence in practice. *Journal of Ethnic and Cultural Diversity in Social Work, 15*(3-4), 101-127.

Hodge, D. R. & Nadir, A. (2008). Moving toward culturally competent practice with Muslims: modifying cognitive therapy with Islamic tenets. *Social Work, 53*, 31-41.

Houston, S. (2001). Beyond social constructionism: Critical realism and social work. *British Journal of Social Work, 31*, 845-861.

Husserl, E. (1962). *Ideas: General introduction to pure phenomenology*. New York: Collier.

Hutnik, N. (1985). Aspects of identity in a multi-ethnic society. *New Community, 12*(2), 298-309.

Hutnik, N. (1991). *Ethnic minority identity: A social psychological perspective*. Oxford: Clarendon Press.

Hutnik, N., & Street, R. C. (2010). Profiles of British Muslim identity: Adolescent girls in Birmingham. *Journal of Adolescence, 33*(1), 33-42.

Ibrahim, A. F., & Dykeman, C. (2011). Counselling Muslim Americans: Cultural and spiritual assessments. *Journal of Counselling and Development, 89*(4), 387- 396.

Inayat, Q. (2002). The meaning of being a Muslim: An aftermath of the twin towers episode. *Counselling Psychology Quarterly, 15*(4), 351-358.

Inayat, Q. (2005). Psychotherapy in a multi-ethnic society. Retrieved from: https://www.baatn.org.uk/wp-content/uploads/Psychotherapy-in-a-Multi-Ethnic-Society-1-1.pdf (accessed on February 2016)

Inayat, Q. (2007). Islamophobia and the therapeutic dialogue: Some reflections. *Counselling Psychology Quarterly, 20*(3), 287-293.

Jacobson, J. (1997). Religion and ethnicity: Dual and alternative sources of identity among young British Pakistanis. *Ethnic and Racial Studies, 20*(2), 238-256.

Jafari, M. F. (1993). Counseling values and objectives: A comparison of western and Islamic perspectives. *American Journal of Islamic Social Sciences, 10*(3), 326.

Jasperse, M., Ward, C., & Jose, E. P. (2012). Identity, perceived discrimination, and psychological wellbeing in Muslim immigrant women. *Applied Psychology: An International Review*, 61(2), 250-271.

Jensen, C., & Lauritsen, P. (2005). Qualitative research as partial connection: bypassing the power- knowledge nexus. *Qualitative Research*, *5*(1), 59-77.

Johnson-Bailey, J. (1999). The ties that bind and the shackles that separate: race, gender, class, and color in a research process. *International Journal of Qualitative Studies in Education*, *12*(6), 659-670.

Jung, C. (2012) in called or not called quote- Buck, S. (2004) Home, Hearth and Grave: The archetypal symbol of threshold on the road to self. Retrieved from http://jungiansociety.org/index.php/home-hearth-and-grave-the-archetypal-symbol-of-threshold-on-the-road-to-self. (accessed on June 2017).

Kanuha, K. V. (2000). "Being" native versus" going native: Conducting social work research as an insider. *Social Work*, *45*(5), 439-447.

Kapur, R. (2002). The tragedy of victimisation rhetoric: Resurrecting the 'native' subject in international/postcolonial feminist legal politics. *Harvard Human Rights Journal 15*(1), 1–38.

Kareem, J. (1992). *Intercultural Therapy: Themes, Interpretations and Practice. Oxford:* Blackwell Science Ltd.

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.

Knox. R. (2008). Client's experiences of relational depth in person- centered counselling. *Counselling and Psychotherapy Research*, *8*(3), 118-24.

Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005). Addressing religion and spirituality in psychotherapy: Clients' perspectives. *Psychotherapy Research, 15*(3), 287-303.

Knox, R., & Cooper, M. (2010) Relationship qualities that are associated with moments of relational depth: The client's perspective. Person-Centered and Experiential Psychotherapies, *9*(3), 236–56.

Knox, R., & Cooper, M. (2011). A state of readiness: An exploration of the client's role in meeting at relational depth. *Journal of Humanistic Psychology, 51*(1), 61-81.

Koenig, H. G., McCullough, M. E., & Larson, D. B. (2009). *Handbook of Religion and Health*. Oxford: Oxford University Press.

Kohatsu, E. L., Dulay, M., Lam, C., Concepcion, W., Perez, P., Lopez, C., & Euler, J. (2000). Using racial identity theory to explore racial mistrust and interracial contact among Asian Americans. *Journal of Counseling & Development, 78*(3), 334-342.

Kohut, H. (1971). The analysis of the self. New York, NY: International Universities Press

Kohut, H. (1977). The restoration of the self. New York: International Universities Press

Kohut, H. (1982). Introspection, empathy and the semi-circle of mental health. *The International Journal of Psycho-Analysis, 63*, 395-407.

Kokanovic, R., Furler, J., May, C., Dowrick, C., Herman, H., Evert, H., & Gunn, J. (2009). The politics of conducting research on depression in a cross-cultural context. *Qualitative Health Research*, 19, 708-717. doi:10.1177/1049732309334078

Kramer, B. M. (1984). Community mental health in a dual society in Sue, S., & Moore, T. (Eds). The *Pluralistic Society: A Community Mental Health Perspective*. Pp. 254- 262. New York: Human Sciences Press.

Kwan, M. (2008). From oral histories to visual narratives: Re-presenting the post-September 11 experiences of the Muslim women in the USA. *Social & Cultural Geography, 9*(6), 653-669.

Kwon, P. (2002). Hope, defense mechanisms, and adjustments: Implications for false hope and defensive hopelessness. *Journal of Personality*, *70*(2), 207-231.

Lambert, J. M. (2013). Outcome in psychotherapy: The past and important advances. *Psychotherapy*, *50*(1), 42-51.

Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis in A Thompson & D Harper (eds), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners*. John Wiley & Sons, Oxford, pp. 99-116. DOI: 10.1002/9781119973249

Larsson, G. (2005). The impact of global conflicts on local contexts: Muslims in Sweden after 9/11–the rise of islamophobia, or new possibilities? *Islam and Christian–Muslim Relations, 16*(1), 29-42.

Laungani, P. (2002) Cross-cultural psychology: A handmaiden to mainstream Western psychology, *Counselling Psychology Quarterly, 15*(4), 385-397.

Lewis, Z. S., Ali, S. R., Ackerman, R. S., Jane, J., & Dewey, H. (2009). Religion, ethnicity, culture, Way of Life: Jews, Muslims, and Multicultural Counselling. *Counselling and Values*, *54*(1) 48-64.

Leibert, T., Archer, J., Munson, Jr. J., York, G. (2006). An exploratory study of client perceptions of internet counselling and the therapeutic alliance. *Journal of Mental Health Counselling, 28*(1), 69-83.

Liepyte, S., & McAloney-Kocaman, K. (2015). Discrimination and religiosity among Muslim women in the UK before and after the Charlie Hebdo attacks. *Mental Health, Religion & Culture, 18*(9), 789-794.

Loewenthal, K. M., Cinnirella, M., Evdoka, G., & Murphy, P. (2001). Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK. *Psychology and Psychotherapy: Theory, Research and Practice, 74*(3), 293-303.

Macey, M. (1999). Religion, male violence, and the control of women: Pakistani Muslim men in Bradford, UK. *Gender & Development, 7*(1), 48-55.

Malik, R. (2000). 'Culture and emotions: Depression among Pakistanis'. In Squire, C. (Eds.) *Culture in Psychology*. Routledge; New York.

Maramba, G. G., & Hall, G. C. N. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity and Ethnic Minority Psychology, 8*(3), 290-297

Matsumoto, R. D., & Juang, L. (2004). *Culture and Psychology* (3rd Ed). Belmont, CA: Wadsworth.

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy, 14*(4), 317-327.

Maynard, S. (2008) Muslim mental health: A scoping paper on theoretical models, practice and related mental health concerns in Muslim Communities. Stephen Maynard Associates. Retrieved from https://www.scribd.com/document90324305/Muslim-Mental-Health-Stephen-Maynard (accessed on March 2017).

McFarland, R. (2009). African Caribbean people's experiences of mental health services and factors moderating length of hospital stay. *Doctoral thesis*. Clinical Psychology: University of Sheffield.

McLean, C., & Campbell, C. (2003). Locating research informants in a multi-ethnic community: Ethnic identities, social networks and recruitment methods. *Ethnicity and Health*, *8*(1), 41-61. doi:10.1080/13557850303558

McLean, C., Campbell, C., & Cornish, F. (2003). African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (re)productive of health inequalities. *Social Science and Medicine*, *56*(3), 657-669.

Mead, G. H. (1934). *Mind, self and society* Chicago. University of Chicago Press.

Meer, N. (2008). The politics of voluntary and involuntary identities: Are Muslims in Britain an ethnic, racial or religious minority? *Patterns of Prejudice, 42*(1), 61-81.

Meer, S., & Mir, G. (2014). Muslims and depression: The role of religious beliefs in therapy. *Journal of Integrative Psychology and Therapeutics, 2*(1), 1-8.

Meharchand, R. (2016). A western concept of honour: Understanding cultural differences, realizing patriarchal similarities. *Undergraduate Awards*. Paper 22. Retrieved from https://ir.lib.uwo.ca/ungradawards)2016/22 (accessed on January 2017).

Memon, A., Taylor, K., Mohebati, M., L., 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 Journals*, 6(11), 1-19.

Middleton, A., Robson, F., Burnell, L., Ahmed, M. (2007). Providing a transcultural genetic counseling service in the UK. *Journal of Genetic Counseling, 16*(5), 567-582.

Mirza, S. H. (2012). 'A second skin': Embodied intersectionality, transnationalism and narratives of identity and belonging among Muslim women in Britain. *Women's Studies International Forum, 36,* 5–15.

Mitchell, A. S. (2014). *Relationality: From Attachment to Intersubjectivity*. New York and London: Psychology Press.

Mitchell, J. R., & Baker, M. C. (2000). Religious commitment and the construal of sources of help for emotional problems. *Psychology and Psychotherapy: Theory, Research and Practice, 73*(3), 289-301.

Modell, B., Harris, R., & Lane, B. (2000). Informed choice in genetic screening for thalassemia during pregnancy: audit from a national confidential inquiry. *British Medical Journal, 320*, 337-341.

Mohee, S. (2011). *Young British South Asian Muslim Women: Identities and Marriage*. Doctoral thesis. Centre for Intercultural Studies: University College London.

Moller, N., Burgess, V., & Jogiyat, Z. (2016). Barriers to counselling experienced by British south Asian women: A thematic analysis exploration. *Counselling and Psychotherapy Research, 16*(3), 201-210.

Moore, K. M. (1995). *Al-mughtaribun: American law and the transformation of Muslim life in the United States.* SUNY Press.

Moosavi, L. (2015). The racialization of Muslim converts in Britain and their experiences of Islamophobia. *Critical Sociology, 41*(1), 41-56.

Nabolsi, M. M., & Carson, A. M. (2011). Spirituality, illness, and personal responsibility: The experience of Jordanian Muslim men with coronary artery disease. *Scandinavian Journal of Caring Sciences*, *25*, 716-724.

Nazroo, J. Y. (1997). *Ethnicity and Mental Health*: Findings from a national community survey. London: Policy Studies Institute.

Netto, G., Gaag, S., Thanki, M., Bondi, L.., & Munro, M. (2001). An Asian perspective on counselling. *Journal of the British Association of Counselling and Psychotherapy*, *12*, 13-15.

Neufeld, A., Harrison, M. J., Hughes, K. D., Spitzer, D., & Stewart, M. J. (2001). Participation of immigrant women family caregivers in qualitative research. *Western Journal of Nursing Research*, *23*(6), 575-591.

Norcross, J. C., & Lambert, M. J. (2014). Relationship science and practice in psychotherapy: Closing commentary. *Psychotherapy, 51*(3), 398-403.

O'Beirne, M. (2004). *Religion in England and Wales: Findings from the 2001 home office citizenship survey.* Home Office London.

O'Neill, L. M., & Kerig, K. P. (2000). Attributions of Self-Blame and Perceived Control as Moderators of Adjustment in Battered Women. *Journal of Interpersonal Violence, 15*(10), 1036-1049.

Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy, 48*, 274 –282.

Owusu-Bempah, K., & Howitt, D. (2000). *Psychology beyond western perspectives.* Wiley: Blackwell.

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Re-thinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin, 128*, 3–72.

Pargament K. I. (2002). The bitter and the sweet: An evaluation of the costs and benefits of religiousness. *Psychological Inquiry, 133*, 168–81.

Patel, C. J., & Shikongo, A. E. (2006). Handling spirituality/religion in professional training: Experiences of a sample of Muslim psychology students. *Journal of Religion and Health, 45*(1), 93-112.

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Matitani, A., Miller, A., & Nadirshaw, Z. (2000). *Clinical Psychology: 'Race' and 'Culture': A training manual*. Leicester: The British Psychological Society.

Perry, B. (2014). Gendered Islamophobia: Hate crime against Muslim women. *Social Identities, 20*(1), 74-89.

Pietkiewicz, I., & Smith, J. A. (2012). *A practical guide to using IPA, 18(2), 361-369.*

Pietkiewicz, I., & Smith, J. A. (2014). A Practical guide to using Interpretive Phenomenological Analysis. *Psychological Journal, 20*(1), 7-14.

Pilkington, A., Msetfi, M. R., & Watson, R. (2012). Factors affecting intention to access psychological services amongst British Muslims of South Asian origin. *Mental Health, Religion & Culture*, *15*(1), 1-22.

Pineiro, N. K. C. (2012) Seminar in black studies. The impact of patriarchy on Latin American and Caribbean cultures.

Piosiadlo, M. C. L., Fonseca, S. G. M. R., & Gessner, R. (2014). Subordination of gender: Reflecting on the vulnerability to domestic violence against women. *Escola Anna Nery, 18*(4), 728-733.

Potter, J. (1998) 'Fragments in the Realization of Relativism', pp. 27–45 in I. Parker (ed.) *Social Constructionism, Discourse and Realism*. London: Sage.

Potter J. (2003). *Representing reality: Discourse, rhetoric and social construction*. London: Sage.

Prochaska, J.O. & Norcross, J.C. (2003) *Systems of Psychotherapy – a Trans-Theoretical Analysis.* Pacific Grove, CA: Brooks/Cole.

Rassool, G. H. (2015). Cultural competence in counselling the Muslim patient: Implications

for mental health. *Archives of Psychiatric Nursing*, *29*, 321- 325.

Reavey, P., Ahmed, B., & Majumdar, A. (2006). 'How can we help when she won't tell us what's wrong? Professionals working with south Asian women who have experienced sexual abuse. *Journal of Community & Applied Social Psychology, 16*(3), 171-188.

Redfern, S., & Dryden, W. (1993). Empathy: its effect on how counsellors are perceived. *British Journal of Guidance and Counselling, 21*(3), 300-309.

Reis, M. L., Baumiller. R., Scrivener, W., Yager, G., & Warren, S. N. (2007). Spiritual assessment in genetic counseling. *Journal of Genetic Counseling, 16*(1), 41-52.

Resta, R., Biesecker, B. B., Bennett, R. L., Blum, S., Hahn, S. E., Strecker, M. N., & Williams, J. L. (2006). A new definition of genetic counselling: National Society of genetic counselors' task for report. *Journal of Genetic Counselling, 15*(2), 77-83.

Rethink (2007). *Our voice: The Pakistani community's view of mental health and mental health services in Birmingham.* London: Islamic Human Rights Commission

Roach, F. (1992). Community mental health services for black and ethnic minorities. *Counselling Psychology Quarterly*, *5*(3), 277–290.

Rogers, C. (1961). *On Becoming A Person: A Therapists View of Psychotherapy,* Boston: Houghton Mifflin.

Roland, A. (2005) Between civilisations: psychoanalytic therapy with Asian North Americans. *Counselling Psychology Quarterly*, *18*(4), 287-293.

Rose, E.M., Westefeld, J.S., & Ansley, T.N. (2001). Spiritual issues in counselling: Client's beliefs and preferences. *Journal of Counselling Psychology, 48, 61–71.*

Rugkasa, J., & Canvin, K. (2011). Researching mental health in minority ethnic communities: Reflections on recruitment. *Qualitative Health Research*, *21*(1), 132- 143.

Ryan, L. (2010). Becoming Polish in London: negotiating ethnicity through migration. *Social Identities, 16*(3), 359–376.

Ryan, L. (2011). Muslim women negotiating collective stigmatization: “We’re just normal people”. 45(6), 1045-1060.

Saeed, A., Blain, N., & Forbes, D. (1999). New ethnic and national questions in Scotland: Post-British identities among Glasgow Pakistani teenagers. *Ethnic and Racial Studies, 22*(5), 821-844.

Safran, J. D., & Segal, Z. V. (1990) *Interpersonal Processes in Cognitive Therapy*. New York: Basic Books.

Sanchez, M., Cardemil, E., Adams, T. S., Calista, L. J., Connell, J., DePalo, A., Ferreira, J, Gould, D., Handler, S. J., Kaminow, P., Melo, T., Parks, A., Rice, E., & Rivera, I. (2014). Brave new world: Mental health experiences of Puerto Ricans, Immigrant Latinos, and Brazilians in Massachusetts. *Cultural Diversity and Ethnic Minority Psychology,* 20(1), 16-26.

Sanghera, G. S., & Thaper- Bjorket, S. (2008). *Methodological dilemmas: Gatekeepers and positionality in Bradford. Ethnic and Racial Studies, 31*(3), *543–562.*

Scharff, C. (2011). Disarticulating feminism: Individualisation, neoliberalism and the othering of ‘Muslim women’. *European Journal of Women’s Studies, 18*(2), 119-134.

Schmidt, L. K. (2006). Understanding Hermeneutics. Stocksfield: Acumen Publishing Limited

Schultze, N. (2006). Success factors in internet based psychological counseling. *Cyber Psychology and Behaviour, 9*(5), 623-626.

Seitz, S. (2015). Pixilated partnerships, overcoming obstacles in qualitative interviews via Skype: a research note. *Qualitative Research, 16*(2), 229-235.

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology, 35*, 326–334.

Shinebourne, P. (2011). Interpretative Phenomenological Analysis. In N. Frost (ed). *Qualitative Research Methods in Psychology: Combining core approaches*. (pp. 44-65). Open University.

Shafi, S. (1998). A study of Muslim Asian women's experiences of counselling and the necessity for a racially similar counsellor. *Counselling Psychology Quarterly, 11*(3), 301-314.

Shariff, A. (2009). Ethnic identity and parenting stress in South Asian families: Implications for culturally sensitive counselling. *Canadian Journal of Counselling, 43*(1), 35.

Shavers, V. L., Lynch, C. F., & Burmeister, L. F. (2001). Factors that influence African-Americans' willingness to participate in medical research studies. *Cancer, 91*(S1), 233-236.

Shaw, A. (2003). Genetic counseling for Muslim families of Pakistani and Bangladeshi origin in Britain. In D. N. Cooper, *Encyclopedia of the human genome*. Hoboken, NJ: Wiley. Retrieved from https://search-credoreference-com.ezproxy.uwe.ac.uk/content/entry/wileyhg/genetic_counseling_for_muslim_families_of_pakistani_and_bangladeshi_origin_in_britain/0 (accessed on October 2018).

Sheridan, L. P. (2006). Islamophobia pre–and post–September 11th, 2001. *Journal of Interpersonal Violence, 21*(3), 317-336.

Shin, S., Chow, C., Camacho-Gonsalves, T., Levy, R. J., Allen, I. E., & Leff, H. S. (2005). A meta-analytic review of racial-ethnic matching for African American and Caucasian American clients and clinicians. *Journal of Counseling Psychology, 52*(1), 45.

Singh, G. (1992). *Race and Social Work from 'Black Pathology' to 'Black Perspectives'*. Bradford: Race Relations Unit, University of Bradford.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11*(2), 261-271.

Smith, J. A., & Osborn, M. (2007). Interpretive Phenomenological Analysis in Smith. J. A. (2nd Ed.) *Qualitative Psychology: A practical guide to research methods* (pp 53- 90). London: Sage Publications Ltd.

Smith, J. A., Flower, P., & Larkin, M. (2009). *Interpretive Phenomenological Analysis: Theory, Method and Research*. London: Sage Publications.

Sojo, V. E., Wood, R. E., & Genat, A. E. (2016). Harmful workplace experiences and women's occupational well-being: A meta-analysis. *Psychology of Women Quarterly, 40*(1), 10-40.

Sonuga-Barke, E. J. S., & Mistry, M. (2000). The effect of extended family living on the mental health of three generations within two Asian communities. *British Journal of Clinical Psychology, 39,* 129–141.

Sowa, E. J., & Selden, C. S. (2003). Administrative discretion and active representation: An expansion of the theory of representative bureaucracy. *Public Administration Review, 63*(3), 700- 710.

Sproston, K., & Nazroo, J. (2002). Ethnic Minority Psychiatric Illness Rates in the Community: Quantitative report. London: The Stationary Office

Squire, C. (2000). *Culture in Psychology*. London: Routledge

Stamarski, C. S., & Son-Hing, L. S. (2015). Gender inequalities in the workplace: The effects of organizational structures, processes, practices, and decision makers' sexism. *Frontiers in Psychology, 6*, 1400.

Steele, C. M., & Aronson, J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of Personality and Social Psychology, 69*(5), 797-811.

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist, 29*(6), 790-821.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*(4), 477-486.

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M. & Vazquez-Nutall, E. (1998). *Multicultural counseling competencies: Individual and organizational development*. Thousand Oaks, CA, US: Sage Publications Inc.

Sue, D. W., & Sue, D. (2003). *Counseling the Culturally Diverse*: Theory and practice (4th ed.). Hoboken, US: John Wiley & Sons Inc.

Sullivan, H.S. (1953). *The interpersonal theory of psychiatry*. New York: Norton.

Tabassum, R., Macaskill, A., & Ahmad, I. (2000). Attitudes towards mental health in an urban Pakistani community in the United Kingdom. *International Journal of Social Psychiatry, 46*, 170-181.

Talbani, A., & Hasanali, P. (2000). Adolescent females between tradition and modernity: Gender role socialization in south Asian immigrant culture. *Journal of Adolescence, 23*(5), 615-627.

Thompson, N., & Bhugra, D. (2000). Rates of deliberate self-harm in Asians: Findings and models. *International Review of Psychiatry, 12*, 37–43.

Thompson, S. L. V., Bazile, A. & Akbar, M. (2004). African American's perceptions of psychotherapy and psychotherapists. *Professional Psychology Research and Practice*, 35(1), 19-26.

Traversa, R. (2012). Religion made me free: Cultural construction of female religiosity. *Culture & Psychology, 18*(1), 34-59.

Triandis, C. H. (2001). Individualism- Collectivism and Personality. *Journal of Personality,* 69(6), 907-924.

Van Es, A. M. (2017). Muslim women as 'ambassadors' of Islam: breaking stereotypes in everyday life. *Identities: Global Studies in Culture and Power*. Published online, DOI: 10.1080/1070289X.2017.1346985.

Vasquez, M. (2007). Cultural Difference and the Therapeutic Alliance: An Evidence-Based Analysis. *The American psychologist. 62*, 875-85. 10.1037/0003-066X.62.8.878.

Wagner, W., Sen, R., Permanadeli, R., & Howarth, C. S. (2012). The veil and Muslim women's identity: Cultural pressures and resistance to stereotyping. *Culture & Psychology, 18*(4), 521-541.

Warwick, L. L. (2002). Self-in-relation theory and women's religious identity in therapy. *Women & Therapy, 24*(3-4), 121-131.

Weatherhead, S., & Daiches, A. (2010). Muslim views on mental health and psychotherapy. *Theory, Research & Practice, 83*, 75- 89.

Weller, S. (2015). The potentials and pitfalls of using Skype for qualitative (longitudinal interviews). *National Centre for Research Methods,* Working Paper 4/ 15.

Werbner, P. (2004). Theorising complex Diasporas: Purity and hybridity in the South Asian public sphere in Britain. *Journal of Ethnic and Migration Studies, 30*(5), 895-911.

Williams, C. B. (2005). Counseling African American women: Multiple identities—multiple constraints. *Journal of Counseling & Development, 83*(3), 278-283.

Williams, E. D., Tillin, T., Richards, M., Tuson, C., Chaturvedi, N., Hughes, A. D., & Stewart, R. (2015). Depressive symptoms are doubled in older British South Asian and Black Caribbean people compared with Europeans: Associations with excess co-morbidity and socioeconomic disadvantage. *Psychological Medicine, 45*(9), 1861-1871.

Williams, V. (2005). Working with Muslims in counselling—Identifying sensitive issues and conflicting philosophy. *International Journal for the Advancement of Counselling, 27*(1), 125-130.

Willig, C. (1999) 'Beyond appearances: A critical realist approach to social constructionist work', in Nightingale, D., & Cromby, J. (eds.), *Social Constructionist Psychology*, Buckingham: Open University Press.

Willig, C. (2013). *Introducing Qualitative Research in Psychology* (3rd Ed). England: Open University Press.

Willis, P. (2001) The "Things Themselves" in Phenomenology. *Indo-Pacific Journal of Phenomenology*, 1(1), 1-12.

Worthington, E.L., & Scott, G.G., (1983) Goal selection for counseling with potentially religious clients by professional and student counselors in explicitly Christian or secular settings. *Journal of Psychology and Theology*, *11*, 318-329.

Yancey, A. K., Ortega, A.N., & Kumanyika, S.K. (2006). Effective Recruitment and Retention Of Minority Research Participants. *Annual Review Public Health*, *27*, 1–28.

Yardley, L. (2000) Dilemmas in qualitative health research. *Psychology & Health*, *15*(2), 215-228.

Yardley, L. (2007). Demonstrating validity in qualitative research, in Smith, J. A. (2008). Qualitative Psychology: A practical guide to research methods (3rd Ed.) pp. 235-251. York: Routledge.

Appendices

Appendix 1.

Recruitment Flyer

Participants Wanted

I am a Muslim trainee Counselling Psychologist conducting research to explore Muslim women's experiences of counselling in the UK.
I am interested to hear your perspective and gain an understanding about how counselling felt for you.

If you are a Muslim, female, who has had counselling sessions with a Muslim and/ or non-Muslim counsellor, I would love to hear from you!

You will be asked to discuss your views and experiences with me during a sixty-minute interview. All interviews will take place in quiet rooms in public places and all information, including your participation, will be kept confidential.

To take part, and for more information, please get in touch with me:

Nadia2.Rehman@live.uwe.ac.uk

Appendix 2.

Exploring Muslim Women's Experiences of Counselling in Britain

Information sheet

Invitation

You are invited to consider taking part in a research study, exploring Muslim women's experiences of counselling with a Muslim counsellor. This study is being undertaken by Nadia Rehman, a Muslim from Cardiff, who is a student at the University of West England on the Professional Doctorate in Counselling Psychology programme. Before you decide whether to take part, it is important for you to understand why this research is being done and what it will involve. Please ask if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

Why have I been invited?

You are invited to take part in this study because you are a Muslim women, who has attended counselling in the UK with a Muslim Counsellor/ Therapist

Do I have to take part?

Participation is entirely voluntary. If you do decide to take part you will need to e-mail me to let me know and we will arrange an interview date and time. You will be asked to sign two consent forms; one to be returned to me and one for your own records. You will also be free to withdraw your participation up to a month after the interview has taken place.

What will happen if I take part?

This research project explores Muslim women's experiences of counselling. If you decide to take part you will be asked to take part in an interview for approximately an hour. The interview will be conducted in a non- judgemental environment where you will be given the opportunity to talk about your experience of counselling. Your interview will be audio-recorded and then later transcribed. Your name and any other identifying details will not appear in the transcript. The transcriptions will be used for analysis. I may use quotes from the transcript to illustrate my analysis of Muslim women's experiences. Any quotes from your interview that are used in my thesis or any other publication resulting from this study they will be anonymised to ensure you are not identifiable as a participant in this research.

What if I change my mind about participating?

You will be free to withdraw from this study, without giving a reason, any time up to a month after the interview date. You do not have to answer any questions you do not feel comfortable with, if at any point during the interview, you feel that you do not wish to continue talking about your experience, you are welcome to stop the interview. If at any point, during or after the interview, you feel that you do not wish to participate in the research you are free to withdraw from the study. If you wish to withdraw from the study you can contact me via e-mail to inform me of your intention to withdraw so that I can then destroy your data.

Will my taking part in this study be kept confidential?

All information will be kept confidential and interview data will be anonymised. To protect your data I will store the digital recording on my computer in a password- protected folder, and transcripts will be stored safely in a locked cabinet and destroyed once the research study is finished. All identifying information, such as your name, area of residence, family names etc. will

be removed from the interview transcripts. A false name will be used instead. This way all of your data will be confidential.

The personal information collected in this research project (e.g. on any form/questionnaire/survey) will be processed by the University in accordance with the terms and conditions of the 1998 Data Protection Act. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used/processed as described on this information sheet.

What benefits and / or risks could come from taking part? I would like to take part

I hope to understand Muslim women's experiences, in the UK, of counselling. Your contribution would help in my understanding of this. This research will also add to the growing literature on counselling and religion and I hope other counsellors and therapists will gain an insight into experiences of the Muslim client group. As well as this I hope you feel a personal benefit from taking part in that you may enjoy talking about your experiences with me.
There is potential for distress to occur when sharing your experiences and views about counselling. You are free to disclose as little or as much as you wish, but should you become distressed you do not have to proceed in answering further questions in the interview, and if you prefer not to carry on with the interview you are free to end the interview. If you would like to seek support after the interview I have included contact details of some agencies in the information sheet that you can contact.

I would like to take part

If you would like to participate in this research study please e-mail me, Nadia Rehman, at Nadia2.Rehman@live.uwe.ac.uk

Contact for Further Information

Researcher: Nadia Rehman, Nadia2.Rehman@live.uwe.ac.uk

Supervisor: Helen Malson, Helen.Malson@uwe.ac.uk

Appendix 3.

Interview Schedule

What does being a Muslim mean to you?

What does being a Muslim woman mean to you?

How would you describe the Muslim community in Cardiff? In your view is it similar or different to Muslim communities in other cities in the UK?

Could you tell me something about your experience as a Muslim woman in Cardiff?

Could you tell me something about what led you to seek counseling?

What led you to seek a counselor rather than some other form of help?

How did you decide which counselor (or type of counselor) to choose? How did you go about finding the right counselor?

(Was it important to you that your counsellor was Muslim? Were there any other factors, as well them being Muslim, that were important for you? If so, what and why?)

(Was it significant to you that your counsellor wasn't Muslim? What other factors about th ecounselor were important for you? And why?)

What were your first impressions?

Did your view stay the same or change as you continued your counseling continued? If so, how?

*If you were to seek counselling in the future what factors would be important for you when choosing a counsellor?

Could you tell me about your experience of continuing with your counseling? What was it like to visit them on an ongoing basis?

What did you find helpful about it?

What was difficult or challenging about the process?

What role, if any, did religion/being Muslim play for you throughout your counselling sessions?

Do you have any other experiences of counselling? If so, how do they compare?

Is there anything else you would like to add?

Appendix 4.

CONSENT FORM

Title of Project: Exploring Muslim Women's Experiences of Counselling in the UK.

Name of Researcher: Nadia Rehman

1	I confirm that I have read and understand the Participant Information sheet for the above study and have had the opportunity to ask questions.	
2	I understand that participation in this study is voluntary and that I am free to withdraw at any time, without giving a reason, up to the point where the thesis is submitted.	
3	I understand that the data collected during the study will be analysed and used in the final report and follow up publications. And have been made aware that any identifiable data will be anonymised.	
4	I understand that confidentiality will be breached if I disclose any self-harm or harm to others during the interview, the researcher will seek advice from their research supervisor.	
5	I have been given information on the British Association of Counselling and Psychotherapy (BACP) where I can find the contact details of a qualified counsellor whom I can contact if I feel any distress after participating in the interview.	

Name participant _____

Signature of participant _____

Appendix 5.

Muslim Women's Experiences of Counselling in the UK

Demographic questions

Please consider answering the following questions about yourself so that I can describe the sample of people taking part in my study. If there are any questions you would prefer not to answer please leave them blank.

Pseudonym .....

How old are you? .....

What is your occupation? .....

How would you describe your ethnic identity?

.....

How would you describe your national identity?

……

How would you describe your religious identity?

……

How would you describe your sexual identity or sexual orientation?

.....

How would you describe your social class?

.....

Appendix 6.

Transcript Conventions

Below is a list of the transcript conventions used in the participant extracts.

Word Bold font signals stress on the word

= An equals sign indicates 'latching', where utterances occurred in overlap or without a gap between speakers

… Ellipses signal that part of transcript has been omitted in the beginning, middle or end of the presented extract

(word) words between single parentheses are the closest match to a word that was said but not accurately heard

(laugh) brackets to indicate laughter

(( )) words between double parentheses signal non-verbal gestures such as bodily movements

other sounds 'umm' and 'err' transcribed phonetically