The Whisperings of the Devil:

Muslim Individuals' Experiences of *Waswaas*

Sameera Ishaq

Submitted in fulfilment of the requirements for the degree of:

Doctor of Psychology

Department of Psychology

City University, London

September 2016

Table of Contents

Acknowledgements

I would like to thank Dr Julianna Challenor for her support and encouragement.

Also, a big thank you to all the participants who were kind enough to take part in this study, for giving their time and sharing their experience.

To those who suggested the topic to begin with, this may never have got off the ground if it wasn't for you, and thanks to everyone else who has contributed to this process in some way.

Lastly, I would like to thank my family and friends for all their support and encouragement.

And most of all to my husband, thank you for everything.

Declaration

I hereby grant powers of discretion to City University London to allow the thesis to be copied in whole or in part without further reference. This permission covers only single copies made for study purposes, subject to the normal conditions of acknowledgement.

Introduction to the portfolio

This section will introduce the three components of the Doctoral portfolio, comprising of a research study, clinical case study and literature review. The central theme of the portfolio concerns the importance of working with difference or diversity, with the therapeutic alliance being a key component in the therapeutic process.

The first part of this portfolio focuses upon how the phenomenon of *waswaas* is understood and experienced. The second part of this portfolio is a clinical case study, which focuses on the trauma of rape. The third part examines some psychological interventions developed to work with young refugees. Whilst each of these pieces are separate, they are tied together with a common thread that seeks to explore the importance of the therapeutic relationship when working with issues to do with trauma and/or difference, and whilst remaining open to the subjective experience of the individual and to validate it.

The psychological interventions described in the literature review may be understood to see how one can work with groups of people whose voices are not often heard, whilst respecting differences, with the ultimate aim of meeting their needs. This I believe represents the overall theme of this portfolio.

Part 1: The Research

The qualitative research project explores in depth Muslim individuals' lived experience of the phenomenon of *waswaas*. It offers an appreciation and understanding of a different belief system, and provides an alternative explanatory model of mental health. Data was collected using semi-structured interviews and analysed using Interpretive Phenomenological Analysis (IPA). From the data three superordinate themes emerged: The *Qareen*, The Impact and Content of *Waswaas*, and Therapy can be an Asset. Findings of the study are discussed in relation to existing literature and psychological theories, and the implications for the practice of Counselling Psychology, limitations and future research are explored in the discussion.

Part 2: Professional Practice

A piece of clinical work in the form of a case study using trauma-focused cognitive behavioural therapy is presented to demonstrate clinical competence in the therapeutic model. The study focuses on the development and evaluation of therapy, and emphasises just how instrumental I believe the therapeutic alliance to be in the therapeutic process, especially when working with someone whose control was taken away from the act of rape and whose voice was seen to have been silenced for some time as a result.

Section C: Critical Literature Review

I already had an interest in working with difference, such as different belief systems and different cultures, and wondered how as counselling psychologists we could do work with, it might be argued, some of the most vulnerable people in society. The critical literature review explored the psychological interventions that are being developed to meet the needs of working with young refugees, whilst taking in to account how to work with some cultures in which talking about one's feelings and thoughts may not be the norm. This highlighted to me the importance of the therapeutic alliance in which one can respect and validate another's subjective experience, allowing one to work collaboratively and accept difference. Through this piece of work, I believe the central theme of this portfolio grew.

Section A: Research Study

The Whisperings of the Devil:

Muslim Individuals' Experiences of *Waswaas*

Abstract

There is limited research generally in Western nations exploring Muslim explanations regarding mental health. One such explanation is something called *waswaas*, and the very little research there is on *waswaas* is quantitative. However, there is no clear explanation readily available from the Western literature describing what *waswaas* is and how it might impact upon formulations of the psychological distress of Muslim clients who may present to psychological services. In response to the dearth of research, this qualitative study aims to investigate Muslim individuals' experience of *waswaas*.

The study is conducted using semi-structured interviews with 8 Muslim participants and is analysed using interpretative phenomenological analysis (IPA). Three superordinate themes emerged from the data: 'The *Qareen*', which captures participants' understanding and experience of there being another being whom they believe is responsible for the *waswaas*, which are unbidden thoughts, and the methods this other being employs to do the whispering. The second superordinate theme 'Impact and Content of *Waswaas*' explores some of the different ways participants experience *waswaas* and other areas that *waswaas* might impact on. The third superordinate theme 'Therapy can be an Asset' refers to coping mechanisms which might be employed to help deal with the *waswaas*.

The findings suggest a number of implications for Counselling Psychology, including a need for multicultural awareness amongst counselling psychologists, enabling them to work more effectively with Muslim groups, whilst working collaboratively with clients and respecting their subjective experiences and meanings they give to them. The subjective and diverse ways in which participants made sense of *waswaas* has provided new and richer insights in to the phenomenon and contribute further to the limited knowledge base of Muslim explanatory models for mental health. Both the findings and the limitations of the study are discussed, along with suggestions for future research.

Introduction

This research explores Muslim individuals' experiences of *waswaas* or whisperings of the devil (Al-Issa, 2000; Besiroglu & Agargun, 2006; Utz, 2012). In this section I will present the rationale for investigating this topic and its research aim, and highlight the major research gap that this study seeks to address. I will explore the importance of researching minority groups, and then move on to the significance of discussing Muslim individuals' religious views in psychological therapy and the mental health explanations they may hold, including the topic of *waswaas*. I will also briefly touch upon religion and obsessive-compulsive disorder (OCD), and what this study may overall contribute to counselling psychology. The method interpretative phenomenological analysis (IPA) used to conduct this study will be discussed in the methodology section, as well as issues of reflexivity.

Background and Rationale

Amongst the proposed definitions given, *waswaas* has been described as whisperings of the devil (Al-Issa, 2000; Besiroglu & Agargun, 2006; Utz, 2012), but further information as to what precisely this means and how it is experienced by individuals is lacking. It is suggested that the devil matches one's own voice, which is the internal voice that one hears in one's head, and one then experiences certain thoughts that one thinks are one's own but actually are from the devil (Zaidg, 2008). These thoughts pop in to one's mind and tend to focus on the areas of lust, harm, and blasphemy. It is suggested that the devil whispers to someone in order to cause the individual pain and anguish (Zaidg, 2008), to misguide the person or to distract the person from fulfilling acts of worship (Utz, 2012). Yet there is no clear explanation readily available from the Western literature describing what *waswaas* is and how it might impact upon formulations of the psychological distress of Muslim clients who may present to psychological services.

There are many justifications for why it is important to review the phenomenon of *waswaas* and I will focus on two that are pertinent to current practice as described below.

The British Psychological Society (BPS), in the Division of Counselling Psychology Practice Guidelines (2006), stipulates that counselling psychologists must consider 'all contexts that might affect a client's experience and incorporate it into the assessment process, formulation and planned intervention' (p.7). Alongside this, it stipulates that counselling psychologists must 'make themselves knowledgeable about the diverse life experiences of the clients they work with' (p.7), and to draw on this within their work, whilst challenging such views in which spiritual and religious beliefs are pathologized. However, some Muslims tend to shy away from Western facilities for mental health services and one of the reasons given is because they believe that such services are not always appropriate as they do not accommodate their religious beliefs (Weatherhead and Daiches, 2010; Keshavarzi and Haque, 2013). This study therefore seeks to explore how Muslim individuals understand and experience *waswaas* to add to the literature on Muslims' explanatory models of mental health.

The BPS (2009) acknowledges that Black and Minority Ethnic (BME) groups greatly underutilise psychological therapies. For this reason, it has been advocated that the psychological needs of wider communities should be addressed, rather than just the individual. Indeed, Huppert, Siev and Khushner (2007) state that when treating individuals from different cultures or faith, clinicians must have sufficient understanding of the norms of those communities in order to effectively develop and adapt treatment approaches. In order to increase equality to services for all, the BPS (2009) states that services should work collaboratively with communities, and that all staff are 'trained and competent in equality and diversity awareness and cultural competency skills and knowledge' (p. 26). By exploring how Muslim individuals experience *waswaas* it is hoped this study will add to the multicultural awareness of counselling psychologists and contribute to the cross-cultural psychology literature, enabling clinicians to work more effectively with Muslim groups.

It is important therefore to work with mental health explanations that Muslim clients may identify with, based on their understanding of their faith, but there is a lack of literature which has explored this. By understanding the phenomenon of *waswaas* it is therefore hoped that a more holistic approach to formulating a Muslim client's experience would be adopted. This in turn would promote a healthy liaison between alternative sources of help that such a client may utilise, whilst encouraging the use of psychological services when needed.

Literature Review

Religion and Mental Health

Although there are 2.7 million Muslims in the UK (Office for National Statistics, 2011), Hussain (2009) points out that in the mental health literature, figures regarding specific religious groups is sparse. She goes on to say that research specifically focusing on Muslims is limited, although a number of small studies do focus on the South Asian population, who in the main are usually Muslim. Ahmed and Amer (2012) also highlight that the literature has often conflated Arab communities and Muslims or stressed the experiences of refugees and immigrants. The Muslim community is very multicultural, as it includes Muslims born in the West, those who have converted to Islaam, as well as people from different ethnic groups. Bhui and Morgan (2007) highlight that some religious groups are distinctive, not because of ethnic or cultural factors, but rather, because their lives are guided by their religious or spiritual beliefs, more so than other religious groups. Sheikh (2007) stresses that for many British Muslims the key defining characteristic for them is their religious identity, through which they interpret and understand the world.

Spiritual and religious issues have gained more acknowledgement in clinical practice in recent years. Utz (2012) highlights that religion and spirituality hold a greater role in psychotherapy and spiritual interventions have begun to be integrated into treatment with clients. Smith, Bartz and Richards (2007) state that *spirituality* is often defined as an individual's understanding of God, whereas *religious* refers to institutional beliefs, rules, practices and rituals of spiritual creeds. They argue that individuals can be both religious and spiritual, mainly religious but not that spiritual, or mainly spiritual but not religious.

Koenig and Shohaib (2014) reviewed literature focusing on the impact spirituality and religion have on mental and physical health. They found that overall, religion and spirituality play a protective role in both the physical and mental health of Muslims, leading to positive outcomes. For instance, they found that Muslims have a greater sense of optimism, a greater sense of purpose and meaning in life, experience fewer depressive symptoms, have lower rates of anxiety, and engage in less substance abuse. Koenig and Shohaib (2014) state that spirituality is a common coping method that people utilise for guidance and support in dealing with life difficulties. Yet despite this, many clinicians avoid discussing religion or

spirituality with clients. By adding a spiritual dimension to the therapeutic process, clinicians can utilise the hope and solutions spirituality brings to difficulties their clients face. Koenig and Shohaib (2014) found that many Muslims felt less sad, less anxious, less worried and more relaxed because their Islamic faith and practices helped them to cope better.

Utz (2012) states that Muslims often use religion to help them cope during stressful times and with tribulations, a view supported by the findings of Bhui, King, Dein, & O'Connor (2008). They found that Muslims, more so than other religious groups, used their religion to help them cope with difficulties. They propose that this may be because Islaam has more of an encompassing role in people's lives as it is a 'total philosophy of life' (p. 149) determining everything Muslims do. Bhui et al., (2008) state that an approach that supports religious coping may improve and promote recovery and resilience. Kuyken, Padesky and Dudley (2009) argue a similar point. They state that clients possess strengths that they utilise in order to cope effectively, and by incorporating these strengths into the formulation, this will help build resilience and relieve distress, as well as providing a better understanding of the person as a whole and not just their difficulties.

A meta-analytic review of religious and spiritual adaptions to psychotherapy by Smith, Barts and Richards (2007) suggests that such approaches are indeed beneficial and effective. They state that 'religious-spiritual' adaptions to therapy can address a client's 'religious-spiritual' concerns and incorporate interventions and language that demonstrate a respectful attitude. Such treatment approaches they argue are more compatible with a client's values and utilise the existing coping methods present in the client's spiritual and religious belief systems. It's also worth noting, as Morris (2012) points out that some 'Third Wave' approaches use philosophical ideas and religious techniques, such as Buddhist ideas found in Mindfulness and Acceptance and Commitment Therapy, and are more readily being used in Western societies. This suggests therefore that it is worth exploring with Muslim clients their understanding of distress and difficulties and what coping methods they use based on their faith, which may in turn be incorporated in to the therapeutic work.

Inequalities in Mental Health Services

Williams, Turpin and Hardy (2006) question whether clinical psychology as a profession is ethnically diverse and may be universally applied. They list a number of points, including that the profession is inherently ethnocentric and Eurocentric. They criticise it for not being relevant, sensitive, nor respectful to the cultural, religious and ethnic needs of the diverse societies in the UK. Morris (2012) echoes similar views regarding clinical psychology in representing a 'predominately white western workforce delivering western psychological models' (p. 34). Indeed, Fernando (2005) argues that despite Britain being a multicultural society, mental health services remain uni-cultural.

Although the arguments made by Williams et al. (2006) and Morris (2012) are aimed at the clinical psychology profession, it can be argued that all of their points may equally be applied to the profession of counselling psychology. Indeed, in suggesting that the discipline of counselling psychology has not been able to carve out its own identity, Moller (2011) argues a very similar point. She argues that the profession of counselling psychology in the UK should follow the lead of its counterpart in the US and become just as strong and active by focusing on issues to do with diversity and multiculturalism.

It is clear that the inequitable access of ethnic minorities to psychological services must be addressed. Some of the reasons given for this lack of access are: institutional racism (Fernando, 2005); lack of bilingual professionals, lack of professionals from within the ethnic minority communities, and previous negative experiences of services (Williams et al., 2006). There may also be a mismatch between psychological models based on individualistic ideals and collectivist ideals held by some ethnic minorities, and different explanations for the causes of mental distress (Morris, 2012). In many communities (including native Western communities) mental health issues have a stigma attached to them, there are also communication and language barriers, as well as a lack of awareness regarding current services and what they offer. Some people experience fear and shame regarding mental health issues, some want to keep matters within the family, some individuals prefer to turn to spiritual leaders or religion to help cope with difficulties, and some believe that professionals hold certain assumptions or stereotype communities (Rethink, 2007; Keshavarzi & Haque, 2013). Other reasons for the low uptake of mental health services by ethnic minorities include concerns regarding

the cultural insensitivity of services (Keshavarzi and Haque, 2013) and being expected to conform to practices ethnic minorities may disagree with.

Due to mainstream services deemed culturally and religiously insensitive, and to help with issues surrounding stigma, a number of third sector services have been established to meet the various needs of the Muslim population in the U.K. These include services like Nafsiyat, an intercultural therapy centre (http://www.nafsiyat.org.uk). Nafsiyat places an emphasis on offering a culturally sensitive therapy service as well as helping explore effects of racism and was established in 1983. The Muslim Youth Helpline (https://www.myh.org.uk), piloted in 2001 and then launched officially in 2002, offer a faith and culturally sensitive service. The Muslim Community Helpline (http://muslimcommunityhelpline.org.uk) originally ran as the Muslim Women's Helpline for 19 years. They too offer a faith and culturally sensitive service and credit themselves as being amongst the first to offer Islamic counselling. Another service which purports to offer Islamic counselling is Sakinah Muslim Counselling (https://sakinahcounselling.com/), established in 2004. However, neither of these two latter services explicitly state what Islamic counselling is and hence what they are offering. There is also the Lateef Project (http://www.lateefproject.com) which is an Islamic telephone counselling service and is run in partnership with the National Health Service (NHS). It is for the Muslim community in Birmingham, plus for those who are not Muslim but have relatives who are Muslim or are thinking about becoming Muslim themselves. They provide a brief explanation as to what they mean by Islamic counselling and say their faith-based service uses a model of therapy derived from the teachings of the Qur'aan, the Sunnah (teachings) of Prophet Muhammad and from the field of Islamic science which looks at the self, which they term nafsiyah, using a philosophy of self-transformation. They state that if one's spiritual needs are not met, this leads to internal conflict and prevents a person from moving forward, so their counselling approach incorporates a spiritual focus based on Islamic teachings.

Cross-Cultural Psychology

Keith (2011) reviews several definitions of culture. These range from information sharing among a group of people to the use of tangible objects (food, architecture, etc) and subjective human elements such as social, religious, political, and economical practices. Keith (2011) states that culture is a "group of shared behaviors, values, and beliefs that are passed from generation to generation" (p. 4). Cultures can be complex, diverse (multicultural), consisting of subcultures or homogenous. He concludes that culture may be understood as a characteristic within a person, including all psychological processes, or it can be outside of the person.

Cross-cultural psychology attempts to test knowledge about human behaviour by comparing it with two or more cultures, which Tonk (2014) argues aims to quantify culture as an objectively definable variable. It seeks to explore universal and unique behaviours to see how culture affects individuals. Similarities and differences across cultures are sought to develop explanatory theories and knowledge as well as explanations for specific variations (Tonk, 2014). Cross-cultural psychologists use either an etic approach whereby they study the similarities between different cultures, seeking universal transcultural characteristics, or an emic approach which focuses on the differences between cultures, seeking unique local cultural features (Tonk, 2014). There has also been a focus on ethnocentrism, whereby one's own culture is used as a standard to judge and evaluate other cultures by. An individual would judge what is 'normal' by using the understanding of one's own culture, which might lead to viewing cultural differences as negative or abnormal and influence how people interact with others from different cultures, without realising how one's own culture is influencing one's behaviour. This leads to a biased perspective lacking objectivity in assessing specific phenomena and behaviour in other cultures (Tonk, 2014).

Cross-cultural psychology therefore seeks to determine any shared behaviours and mental processes across cultures, whilst cultural psychology views human behaviour as being dependent on one's own unique culture. It seeks to explore behavioural characteristics within a specified culture to see how culture influences individuals' behaviours and mental processes; culture is viewed as being essential in understanding psychological processes (Keith, 2011). Cross-cultural psychology on the other hand compares characteristics from one culture to another, thereby

evaluating cultures (Tonk, 2014), but often times no clear explanation is given as to how the similarities or differences have arisen (Keith, 2011). The two branches differ on philosophical and methodological grounds: cross-cultural psychology is rooted in the positivism movement whilst cultural psychology is rooted in hermeneutics (Tonk, 2014). Christopher, Wendt, Marecek, and Goodman (2014) state that hermeneutics is an interpretive practice focused mainly on understanding everyday lived experience, and that all forms of knowledge production are based on cultural assumptions and values. Hermeneutics provides ways of exploring how culture shapes experience and thus all forms of psychology too.

Heine (2016) states that people from diverse cultures differ in their psychology and that psychological processes are shaped by cultural experiences. As cultures vary in terms of practices, values and beliefs, people from diverse cultures will then differ in how they feel, think, and act. Actions are laden with meaning and meanings are derived from cultural experiences. Christopher et al., (2014) highlight that every form of psychology is indigenous as it is embedded in, and is a result of, the surrounding culture and societal conditions. Henrich, Heine, and Norenzayan (2010) found that most psychological knowledge is based on participants who are "WEIRD", that is, they are from Western, educated, industrialized, rich and democratic societies. Heine (2016) argues further that such samples are not generally representative of Western individuals at large, as usually participants tend to be recruited from undergraduate psychology classes, suggesting that Western psychologists are prone to generalize from a narrow set of data. He adds that this then weakens the ability to generalise from such studies to all other cultural populations. Christopher et al., (2014) point out that U.S. psychological textbooks for instance tend to make universal claims which are in fact particular to the U.S. Such claims presume that issues related to gender, family and societal structures for example, are universally shared, whereas they argue that the cultural specificity of their evidence base needs to be acknowledged, thereby increasing cultural awareness.

Ventriglio, Ayonrinde, and Bhugra (2015) state that culture influences how emotional distress is experienced and perceived, how it is expressed and understood, and where help is then sought from. Culture therefore determines what idioms of distress are used. They refer to the term 'culture bound syndrome' and argue that its premise was based on the belief that certain emotional distress or psychiatric syndromes were confined to specific cultures. These 'syndromes' were

seen as exotic and alien, appearing in cultures deemed to be uncivilised. Bhugra, Sumathipala and Siribaddana (2007) argue that as a result of imperialism and colonialism 'new' clinical diagnoses and categories were created and imposed on others through the lens of a Western diagnostic system, disregarding any links between emotional distress and culture, environmental stressors and the social environment. Therefore, issues which were frequently accepted and tolerated in a social-cultural context were suddenly medicalised and indigenous methods of medicine became suppressed in many places. Ventriglio et al., (2015) state that this led to existing indigenous health-care systems being discounted, including idioms of distress and therapeutic interventions.

Ventriglio et al., (2015) point out that the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V) has replaced the term 'culture-bound syndrome' with 'cultural concepts of distress'. Although these concepts of distress have diverse characteristics, they argue that they share common features too, such as that they do not easily fit in to established international diagnostic categories, and they are initially described as being present in a particular cultural area or population group and will then be associated with this culture or community. They highlight that the DSM-V emphasises that culture frames all mental distress and that diverse groups have their own cultural ways of communicating distress, explanations of causality, help-seeking behaviours and coping methods, and also that the number of 'syndromes' listed in the DMS-V have been reduced. Ventrglio et al., (2015) suggest that this demonstrates that the presentation of these 'syndromes' may be changing. They argue that due to globalization and industrialisation, various cultures are now being influenced by others, leading to social and economic changes, and they question whether certain idioms of distress are only present in specific cultures and argue that some are present in other cultures too and so are not exclusive to one particular group. They add that due to increasing globalization, 'culture bound' cases are being seen by clinicians in different geographical areas and cultures.

An example of cultural psychology in which a specific culture influences and shapes individuals' psychological processes from within that culture and therefore its idioms of distress also, is the Japanese cultural concept of distress known as *hikikomori*. Its core feature is isolation or social withdrawal and it is prevalent mostly amongst adolescents and young adult men, wherein they withdraw from having contact with family and friends, don't attend school or have a job, and become recluses for

months or years (Tea, 2010). It has been suggested that social factors may result in someone experiencing *hikikomori*, such as a decrease in desire and motivation in young adults; a sense of the value of work having declined due to economic comfort; and childrearing becoming less strict, as well as traumatic childhood experiences, such as bullying at school (Tea, 2010). Tea (2010) explains there is a wide spectrum regarding the isolative behaviour, in which some never leave their room, and relieve themselves in empty cans and don't bathe, whereas others do emerge to shop for essentials; some during the day and others at night when they are less likely to encounter people. There are also some who may display violent behaviour. Tea (2010) states that traditionally the young live with their parents until marriage, and so those who are unemployed and experiencing *hikikomori* are able to get by due to parental support.

Tea and Gaw (2010) argue that many of the *hikikomor*i cases fit under a variety of existing psychiatric 'disorders' but there are some cases which do not meet the criteria for any established psychiatric 'disorder', and so they suggest that *hikikomori* is a cultural concept of distress. They highlight that although it shares some similarities with another cultural concept of distress known as *taijin kyofusho*, there are some distinguishing features between them. For instance, the core feature of *taijin kyofusho* is a fear of hurting or offending others through a perceived physical defect (such as body odour, eye contact, or blushing) or through awkward social interaction, whereas they believe that *hikikomori* may be an intensification of specific Japanese concerns regarding the quality and quantity of the individual's social interactions. However, it is worth noting that a case of *hikikomori* has been identified outside of Japan too, for instance in Oman. Sakamaoto, Martin, Kumano, Kuboki, and Al-Adawi (2005) suggest that this may be due to the social environments of Japanese and Omani societies which lead to behaviour suggestive of *hikikomori*.

Christopher et al., (2014) argue that even the meaning of a suicide is culture specific and not necessarily psychopathological. They illustrate this by describing that in the Indian subcontinent suicide and suicidal behaviour, usually committed by individuals who have a low social status, are often a means of redressing grievances, or evading or protesting unwelcome demands. They argue that the motivating force is not depression but rather anger, with the intention to shame the wrongdoer. Likewise, they claim that suicides in rural China have also been linked to familial grievances with the desire to publicly avenge a wrong by disgracing the transgressor, and so suicidal behaviour in the Indian subcontinent and in China is

not perceived as an immediate sign of psychiatric disturbance. They highlight that the diagnostic manual of the Chinese Society of Psychiatry even states that most Chinese individuals who commit suicide do *not* have a mental illness. Ventriglio et al., (2015) also point out that the development of other culturally specific diagnostic systems, like the Chinese Classification of Mental Disorders, may indicate a shift in some cultures from a universal classification of mental 'disorders' to one which is more culture-specific. Christopher et al., (2014) further add that India and China cannot be viewed as 'exotic exceptions', as together they constitute over 36% of the global population. They argue for instance that as the United States comprises only about 4% of the global population, it could be proposed then that it's medicalised view of suicide is the 'exotic' exception, and that the concept of suicide is a local and historical one rather than a transcultural principle.

Christopher et al., (2014) argue that Western psychologists have often dismissed non-Western psychologies and view them as culture specific, but they urge that once it is acknowledged that Western psychology is also culture specific, this will help to remove the barrier between a "them" and "us" mentality. They advocate for psychologists to be open to learning *about* and *from* other psychologies to aid in reassessing or revising their own understandings. They argue that cultural practices and systems to help alleviate psychological distress are often not explored or are even dismissed, but by engaging with other psychologies this may lead to other ways of practice which may not consist of medical or health orientated frameworks. They warn that in not doing so this risks pathologizing or dehumanising people from other cultures.

Matsumoto and Jones (2009) highlight that one of the dangers faced in cross-cultural research is that it may be used to reinforce stereotypes of certain cultural groups, particularly if researchers are unaware of stereotypes they themselves hold and how these may affect their research unconsciously. They caution that findings from cross-cultural comparisons may even be used to oppress certain groups. Also, any interpretations made of the findings will be bound by the researcher's cultural bias and thus reflect one's values. Cross-cultural research has also been criticised for the use of Western instruments in non-Western cultures, including inadequate translations and using Western norms in other cultural contexts (Tonk, 2014). There is also a concern that a drive for a single universal psychology may result in a loss of emic knowledge of other cultures (Tonk, 2014). Despite this, Matsumoto and

Jones (2009) stress the importance of cross-cultural psychology in order to test the knowledge of American (and European) 'monocultural research of the past' (p. 326) to see whether the observations and ideas actually do or don't apply to other cultures, as Tonk (2014) argues some common ground between emics may still be discovered.

This current study can add to the literature on cultural psychology as it is exploring Muslim individuals' experiences of the phenomenon of *waswaas*, which is shaped by their Islamic beliefs and values. The Islamic culture they adhere to will have an influence on their psychological processes and experiences, as well as on the meanings they then derive from their experiences and how they understand them. This study is therefore seeking to explore how Muslim individuals experience and perceive *waswaas*, how it may be expressed and understood and any resulting help-seeking behaviours they may engage in. It can also lend itself to cross-cultural research however in exploring similarities and differences between Western cultural views on mental health and Muslim cultural views, shaped by their Islamic beliefs. This latter point seems pertinent, especially as in the limited Western literature available on *waswaas* (see below) it is suggestive that *waswaas* may be similar to obsessive-compulsive disorder (OCD), yet there are no studies exploring how Muslim individuals themselves understand and experience it. This study will therefore also aim to seek any similarities and differences between how Muslim individuals experience *waswaas* and how it is described in the sparse Western literature.

Despite calls for Muslim clients' religious beliefs and practices being incorporated in clinical work, there still remains a dearth of research which adequately explores whether this is done and how it is done. Concepts of mental health, including mental ill-health and treatment, must be understood alongside cultural and religious factors, which may be influential components in understanding and treating Muslim individuals within psychological services.

Muslim Mental Health Explanations

Utz (2012) argues that there is little research in Western nations on Muslims' explanations on mental illness. Through exploring an individual's worldview, Bhui and Bhugra (2004) say this helps both practitioner and client to negotiate differences, and at times acknowledge that they can agree to differ, as long as it's not in a confrontational and antagonistic manner. They state that clinicians should respect their clients' views, just as they would like them to respect theirs. However, they argue that some clinicians don't understand or value other worldviews and see them as being exotic and unscientific.

A qualitative study using thematic analysis by Weatherhead and Daiches (2010) found support for this. Their research looked at how a sample of Muslim individuals understand mental health and how they perceive mental distress should be responded to. It was found participants felt that mental health services did not understand their culture, most notably their faith. Some said that Western and Islamic beliefs could both be used in therapeutic work, whereas others stressed that there should at least be an understanding and respect for their religious beliefs which would help bolster the therapeutic relationship. Utz (2012) posits that clinicians would need to have an awareness of Muslim cultural beliefs in order to assess whether beliefs and/or behaviours are seen as acceptable within the religious or cultural context. Indeed, Hussain (2009) stresses that mental health professionals not only need to increase their understanding of culturally diverse concepts of mental health, but also religiously diverse concepts too.

Like all individuals, Muslims vary in their levels of religiosity, so practitioners should explore the role of Islaam for each individual client. Haque and Kamil (2012) highlight that information regarding a client's worldview may be gained through understanding the client's spirituality. Haque and Kamil (2012) posit that through understanding the beliefs of Muslims, practitioners may formulate a client's difficulties more adequately, as well as choosing the relevant treatment plan. They also state that by becoming familiar with a client's terminology and incorporating it in to the therapy, such as *waswaas* for instance, this would strengthen the therapeutic alliance, whilst giving valuable insight in to the client's difficulties and issues.

Khalifa, Hardie, Latif, Jamil, and Walker (2011) describe an explanatory model to mean how people from different cultures understand illness, its consequences, and the most appropriate way it should be treated. Williams (2005) advises that if such explanations are not explored in therapy, then for some Muslim clients, their underlying frame of reference, which is their religion, may be missed, thereby making the therapeutic process incomplete for them.

The following section explores some of the explanatory models of mental health that some Muslims hold, bearing in mind that they may adhere to a few simultaneously.

Biological, Psychological and Environmental Factors

In Weatherhead and Daiches (2010) thematic analysis study with 14 Muslim individuals, one of the dominant common themes across participants was that the cause of psychological difficulties or mental health difficulties are due to life-events, such as stress. However, some participants did give other reasons too, such as people may develop psychological problems as a punishment from God or because of the *Jinn*, and some gave multiple reasons as causes. It was found that participants used both religious and secular ways of coping with difficulties, and some said they would access mental health services. However, a number of barriers were identified. For example, some participants felt they were treated differently because of their faith by mental health practitioners and did not feel their views were understood. They recommended that practitioners should have an understanding of their culture and faith and wanted their beliefs to be respected. There was also shame and stigma attached for some in accessing services. Some of the participants also spoke about psychosomatic symptoms and believed that G.P.s should provide more information on mental health.

This is a very illuminating study, but it does have some limitations. Amongst these are that the participants were all first-generation migrants, and some of their beliefs may not be shared by non-migrant Muslims. Another possible limitation is that both the researchers were non-Muslims. It might be that some participants therefore gave responses which they thought were socially desirable. Despite this, the study gives useful insights in to the views of some Muslims in accessing mental health services and the causes of mental health issues.

Jinn

The topic of the *Jinn* and possession is beginning to receive more attention in the health field within the West. Khalifa and Hardie (2005) explain that the *Jinn* are another form of creation, alongside humans, and share some similarities, such as choosing to do right or wrong, but their origin is different as they are created from a smokeless fire. The devil/satan/*shaytaan* is the father of the *Jinn,* and the *Jinn* can cause physical and mental harm to humans. They give the example of possession as being a type of harm they can inflict on people. Utz (2012) lists some of the symptoms that may be attributed to *Jinn* possession, such as voice changes, or the person suddenly having unusual strength, or speaking in an unfamiliar language. She also mentions that sometimes there may be spiritual changes, such as somebody reacting negatively when they hear religious phrases being recited.

Sheikh (2005), in response to Khalifa and Hardie's (2005), paper provides a commentary summarising some beliefs regarding the *Jinn* that he believes might aid healthcare professionals working with Muslim patients, alongside offering some insights based on his experience treating such patients. He highlights that some symptoms attributed to *Jinn* possession are 'commonly manifestations of a mental health disorder that may benefit from medical treatment' (p. 339) and that individuals and their families may have misinterpreted the symptoms. He says that in cases where the individual or the family may not wish to adhere to a medical or psychological treatment, he has encouraged them to continue with any spiritual treatment they are utilising, alongside completing the medical or psychological treatment, as this may be the best way to keep them engaged. Sheikh ends his commentary by saying 'Lastly, there is a need for humility since, despite all our scientific developments, the symptoms and experiences of patients commonly remain medically unexplained' (p. 340).

Magic *(Sihr)*

Utz (2012) states that magic can occur through written or spoken incantations, or actions that affect the heart, mind or body of an individual. This can take place through sorcery or witchcraft, or through the *Jinn* who choose to do bad acts. She says that some Muslim individuals may believe that their psychological difficulties are caused by people doing acts of magic against them. Magic was another reason

given for causing mental health difficulties by some Pakistani Muslims in the study carried out by Rethink (2007).

Evil Eye (*al-^Ayn* or *Nazr*)

Utz (2012) states that this is when the envious glance of a person can cause harm to another person, mainly due to envy or because the person desires what the other has. In a thematic analysis study by al-Solaim and Loewenthal (2010), it was found that 15 young Muslim women in Saudi Arabia who had a diagnosis of Obsessive Compulsive Disorder (OCD) attributed its primary cause as due to the evil eye. Al-Solaim and Loewenthal (2010) state that the evil eye is not necessarily caused by an evil intention but because someone admires something that another person has. They say it occurs when someone does not recite a particular religious phrase 'in the moment of admiration which would have prevented the evil eye' (p. 175).

Participants also believed that religion did not cause the OCD but rather the OCD showed in their religious activities, and OCD seemed particularly related to their prayers. It was also found that they used religious coping mechanisms, not just with the OCD but in all areas of their life. The women in the study also mentioned that they would first seek help from a faith-based healer and psychiatric help as a last resort, and that they would prefer to see a Muslim mental health professional who used Islamic religious statements as they believed that would help establish a better therapeutic alliance.

Although this study helped to understand what the women believed to be the cause of their OCD symptoms it does have a number of limitations. Firstly, it is difficult to transfer findings to the broader Muslim community due to the small sample size of 15 women. Another limitation which is acknowledged by the researchers is that the participants were all female. They admit that males in Saudi Arabia have more independence than the women there and this may affect where a male would go to seek help because he would not necessarily need to consult his family. Also, it's a communal obligation for Muslim men to pray 5 daily prayers in congregation, whereas this isn't an obligation for Muslim women, and they wondered how this may affect any OCD symptoms a male may experience in his prayers. The researchers also admit that there is a selection bias as the women who participated were all recruited from mental health clinics, which meant they had some trust in them, even

whilst seeking traditional methods. Therefore, it is possible that those who experience OCD symptoms but do not seek medical or psychological help may understand their OCD symptoms differently and may not believe that they need to access mental health services.

In a quantitative study conducted by Khalifa et al. (2011) in the UK, they found that many of the 111 Muslim participants believed in the existence of the *Jinn*, the evil eye and magic, and that these can cause both physical and mental health problems. Khalifa et al., (2011) admit this may not be surprising as beliefs in the *Jinn*, evil eye and magic are mentioned in the Islamic faith. Many of the participants said those who would be best suited to treat afflictions caused by the *Jinn*, evil eye and magic would be religious figures, although some of them also said that treatment could be sought from other professionals if they work collaboratively with religious leaders. This may support the view that some Muslims use two explanatory models simultaneously and so will access help from religious sources as well as non-religious sources.

A few of the participants expressed concerns regarding mental health professionals who aren't aware of the above concepts, that they would misdiagnose people as mentally ill, or would be seen as 'backwards' and superstitious. Khalifa et al. (2011) advise that clinicians who do not share such beliefs need to remain open to religious perspectives that their clients hold, without having to see themselves as 'colluding' with explanations that differ from their own. They suggest that in the interest of the client, this can be done collaboratively and if necessary, 'in the context of disagreement' (p. 74).

There are some limitations to the study, including the fact that participants were all recruited from one city, so it may be that individuals in other parts of the UK have different views on these matters. Also, the participants were from first generation, as well as second and third generations of descendants of immigrants, so it may be that there are generational differences in the findings which haven't been described. For a small number of participants, verbal translations of the questionnaire were provided in their languages and it may be that things were lost in translation. The researchers themselves acknowledge that they had a lack of information regarding people's education and history of contact with mental health services. They also admit that there may have been a response bias, in that those who are religious

may give responses congruent with the Islamic faith, whereas others may have given more socially desirable answers for fear of being viewed as superstitious.

Waswaas

Another explanation for the cause of mental health issues is *waswaas.* However, there is a lack of research exploring exactly what it is and what it means to those who experience it. Utz (2012) describes *waswaas* as a means through which the devil whispers to humans and affect their thoughts and feelings. She explains that the whispering aims to make people avoid acts of worship and to participate in 'negative behaviours' (p. 19), although she does not clarify what these are.

Al-Issa (2000a) states that *waswaas* is not seen as an illness requiring treatment, but rather it is seen as a religious experience whereby the devil/*jinn* distract Muslims from fully or correctly engaging in their religious duties. For instance, Utz (2012) explains that symptoms of OCD may be attributed by some Muslims to whisperings of the *Jinn*. Besiroglu and Agargun (2006) argue that the perception of OCD as a disorder is made complicated when it is seen instead as a religious obsession, which they term *waswaas*, and so it may negatively affect health care seeking behaviour in OCD. This opinion is shared by Ghassemzadeh, Abai, Khamseh, Ebrahimkhani, Issazadegan and Saif-Nobakht (2000); and Karadag, Oguzhanoglu, Ozdel, Atesci, Amuk (2006). Interestingly, although al-Issa (2000b) states that *waswaas* is not an illness, he describes it as a 'culture-specific obsessive-compulsive syndrome' (p. 113).

Ghassemzadeh et al., (2002) state that in the context of an Islamic religious practice, the term *waswaseh* may refer to doubting excessively about whether one has completed a religious practice properly and in an orderly manner. They argue that it is not uncommon to have occasional doubts, but it is when these doubts become excessive in nature or begin to interfere with activities in one's daily life, that they are seen as abnormal and as *waswaseh*. This is when these excessive doubts are attributed to the whisperings or temptations of the devil. Although Ghassemzadeh et al., (2002) state that religious teachings exist that instruct individuals how to cope with these excessive doubts, they do not state what these are and how they are employed.

Although the study conducted by Ghassemzadeh et al., (2002) looked at the content of symptoms of OCD in a sample of Iranian patients, and the study by Karadag et al., (2006) examined the clinical characteristics and cultural factors of OCD in a Turkish sample, neither quantitative study fully explored the phenomenon of *waswaas* and how their samples experienced it. By having used qualitative methods, it is possible that with more detailed information, their results may have led to other conclusions. It is therefore not clear whether there is an overlap between *waswaas* and OCD. Indeed, Yorulmaz and Işik (2011) appear to suggest there is not. They claim that the principles of cleanliness and purity in Islaam, alongside religious doubts, which they term as *waswaas*, may share some 'superficial similarities to some characteristics of OCD' (p. 142), yet they give no further explanation as to what it is. Due to the ambiguity as to what *waswaas* is, and the lack of research exploring how it may be experienced, it was therefore decided to investigate what it is in this current study.

However, a famous Muslim scholar named al-Hafidh Abul – Faraj ibnul Jawziyy, wrote a book called *Talbees Iblees* (The Devil's Deceptions) in which he touches upon *waswaas*. It is not known when exactly he wrote this piece of work, but he was born in the year 1087 of the Gregorian calendar and died in the year 1175. Ibnul Jawziyy (n.d.) explains that *waswaas* occurs when someone is doubtful about a matter. He states that the devil influences people as much as he can, depending on how vigilant, knowledgeable, ignorant and negligent they are, and the strongest way that the devil influences people is through their ignorance. Ibnul Jawziyy (n.d.) states that the devil is able to take advantage of people through their ignorance because, despite doing acts of worship, these people have not sought the religious knowledge which would help them in these matters. He continues to say that once the devil has deceived people to leave aside seeking religious knowledge, he then starts to deceive them through acts of worship.

Ibnul Jawziyy (n.d.) gives the example of a person who wants to make *wuduu'* (ablution) and then the devil convinces the person to repeat the intention for the ablution again and again. However, Ibnul Jawziyy (n.d.) says that this is due to ignorance, because the intention takes place in the heart, so the person does not have to utter it verbally, and it does not need to be repeated. He goes on to say that such a person may become so preoccupied by doing this, to the point that one misses praying the prayer altogether, or misses the beginning of the prayer, or misses praying in congregation. He mentions the devil is able to do this because he

convinces the person that he is performing an act of worship which he needs to do correctly in order to make his prayer valid.

Ibnul Jawziyy (n.d.) gives a similar example regarding the intention but this time in relation to prayer. He mentions that some people, when they stand to pray, repeat their intention for the prayer over and over again. He reminds people that the intention for the prayer is already made in the heart by the mere act of standing for the prayer, so there is no need to verbalise the intention anyway. He again mentions that the reason people do this is out of ignorance. He likens this situation to a hypothetical scenario in which, out of respect, a person stands up for a scholar when he enters a room, whilst this person says that he intends to stand up out of respect for the scholar who has entered the gathering. Ibnul Jawziyy (n.d.) says that if a person was to do something like this, then this person would be seen as being silly. The fact that this person stood up to begin with has made his intention clear. Likewise, ibnul Jawziyy (n.d.) says that when a person stands to pray, this itself is the intention, as there is only one reason why a person would be standing to pray. He gives further examples through which the devil deceives people concerning the prayer, such as some people repeating certain words in the prayer or overstressing certain words to ensure they are pronouncing them correctly, and thus the devil preoccupies people in this way.

As ibnul Jawziyy (n.d.) has stated that it is through a lack of religious knowledge that a person can experience the whisperings of the devil, this was one of the aims of the current study, to explore how Muslim individuals understand what causes *waswaas.* Ibnul Jawziyy (n.d.) recommends that one way people can deal with the whisperings is through learning the Islamic religious knowledge, and so this study aims to explore how people manage the whisperings when they experience them.

OCD, Mental Health or 'Illness' and Diagnosis

As this study is investigating the experience of *waswaas*, which may or may not share similarities to OCD or scrupulosity, it will use the definitions set out in diagnostic manuals or in the literature. However, in doing so, it must be clear that this study is making no judgment as to whether OCD or scrupulosity are categories of mental disorder, or indeed are mental disorders at all. By using such terms this study does not intend to pathologize these experiences, and it is important to bear in mind the implications such terms may have.

The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V) defines obsessive compulsive disorder (OCD) as being characterised by a presence of either obsessions or compulsions or both (American Psychiatric Association, 2013). Obsessions are persistent and recurrent thoughts, images or urges experienced as being unwanted and intrusive but are recognised as originating in an individual's mind and not from an external agency (NICE, 2008). An individual may attempt to suppress, ignore or neutralise such thoughts, images or urges with another thought or action, such as performing a compulsion. Compulsions are mental acts or repetitive behaviours that one is driven to carry out in response to either rules that have to be rigidly applied or to an obsession. The mental acts or behaviours are meant to prevent or reduce distress or anxiety, or prevent a dreaded situation or event from occurring, but there is no realistic connection to what it is they are aimed at preventing or neutralising. The individual usually acknowledges that the obsession(s) or compulsion(s) are excessive or unreasonable, cause significant distress or impact upon the individual's occupational and/or social functioning, or are time-consuming (American Psychiatric Association, 2013).

It appears that intrusive unwanted thoughts, urges or images are present in the general population and the content of them found in people who experience 'OCD' and in the general population are pretty much similar (Murphy & Perera-Delcourt, 2012). It is proposed that the difference between obsessional thoughts and 'normal' intrusive thoughts is the meaning the person experiencing OCD gives to the thought and/or its content, such as believing that these urges and thoughts are immoral or dangerous and that the individual is responsible for preventing harm occurring to oneself or to someone else (Berman, Fang, Hansen and Wilhelm, 2015). It is not clear however what causes intrusive thoughts, though Clark and Rhyno (2005) suggest based on Klinger's view (1996) that it is important to understand what the

individual's current concerns are, even if they are latent or dormant, alongside cues that will elicit an emotional response from the individual. They also propose Horowitz's (1975) formulation that certain parts of the memory storage may experience conscious intrusions and the repetition of unwanted information, and that unwanted intrusive thoughts may be a result of a 'failure to integrate new information of external events with existing internal working models of the self and world' (p. 23).

Current cognitive-behavioural models of OCD propose that it develops and is maintained due to specific cognitions the individual holds. These include the individual overestimating the sense of threat, such as believing that negative events are more likely to occur; having a sense of inflated responsibility so the person believes that he/she can cause a negative outcome, and/or has the duty to prevent it; giving a sense of over importance to the intrusive thoughts, so believing that having the thought means that the thought is significant; having the belief that one needs to control the intrusive thoughts; having a sense of perfectionism, so that imperfection and mistakes are intolerable); and being unable to tolerate uncertainty, so that one has to be 100% convinced that a negative outcome won't occur. So one might develop OCD when one misinterprets the intrusive thoughts or doubts, images and urges through the cognitive factors mentioned. This in turn creates anxiety and one is then compelled to reduce the anxiety by performing rituals for instance (Berman et al., 2015).

Another feature of OCD is rumination. This is when an individual experiences uncontrollable prolonged thinking continuously on the same topic, and includes intrusive thoughts, usually in the form of doubts or questions, as well as repeatedly trying to get an answer. Rumination involves the obsession in the form of doubts or questions, as well as the compulsive thinking which accompanies it in order to try to find an answer to the question (NICE, 2006).

It is important to note however that discourses shape how we attempt to understand difference, and this leads to classificatory systems in order to impose order, and make sense of that which is unfamiliar, distressing and frightening (Douglas, 2010). Indeed, the term 'disorder' in 'obsessive compulsive disorder' would therefore classify it immediately as a mental 'illness'.

It is argued that distress has become medicalised and that there appears to be an acceptance of terms such as ‘diagnosis’ and ‘disorder’ as absolute truths and the norm, rather than being historical, social and cultural constructs (Douglas, 2010). Previously, in Western societies historical constructs of psychological difficulties were explained as being caused by spirit possession, witchcraft or demons, which serves to demonstrate that what is ‘normal’ and ‘abnormal’ can change over time (Milton, Craven & Coyle, 2010). Such constructs are still prevalent in other parts of the world to this day and are considered as ‘normal’ or ‘truths’, whereas in the West such belief systems may become pathologized and deemed in need of ‘treatment’.

The concepts of mental health and mental illness have been challenged by various writers who have claimed that ‘madness’ was used as a method to exclude an undesirable societal group and thereby suppress them, as well as to explain away problems by locating them in the individual, rather than looking at social, cultural or interpersonal factors that may contribute to psychological distress (Milton et al., 2010). For instance, Douglas (2010) points out that the ‘social construction of the feeble-minded as a group was both mirrored in, and developed by, the emergence of the eugenics movement’ (p. 31), which legitimised the discourse of segregation and containment. She also highlights an aspect of psychological history by stating that due to such views intellectual functioning tests emerged to highlight weak-mindedness, meaning that the origins of such tests ‘are inseparable from the socio-political context in which a discourse of protection of society from invisible menace was privileged’ (p. 31).

Fernando (2011) also emphasises how the concept of diagnosis was used historically as a form of suppression by giving an example of those who were freed slaves or escaped from slavery being labelled as ‘mad’, and that any sign of aggression, insanity or social conflict was seen as a pathology within the individual. Milton et al., (2010) highlight that classificatory systems, like the DSM, may be used to define behaviour, thereby reinforcing cultural views and ideologies, and constraining and influencing people’s behaviour, in order to validate a power hierarchy and to preserve the status quo. Thus, Newnes (2010) argues that by observing the less powerful, mental health professionals define both abnormality and normality.

Milton et al., (2010) state that Emil Kraepelin’s classification of mental diseases in 1883 is still evident today as it is the basis of current classificatory systems. The medical model of mental distress still seems to be the dominant model in use in the

mental health profession, with the DSM as one of the most prevalent diagnostic manuals being used, despite there being little evidence to support psychiatry's claim that many disorders are a result of brain abnormalities and chemical imbalances (Rapley, Moncrieff and Dillon, 2010; Douglas, 2010). Larson, Brooks, & Loewenthal (2012) state that the DSM seemed to justify the existence of both the psychiatry and psychology fields as it secured their place in the medical world and ensured them respectability and funding. As a result, Moncrieff, Dillon and Rapley (2010) argue that 'mental distress' became to be seen as the exclusive territory of specialists and something beyond the understanding of lay people.

Rapley et al., (2010) claim that 'mainstream psychology' actually supports psychiatry's stance of codifying distress in to diagnostic categories. They argue that instead of 'disorders' being seen as simply understandable reactions to life difficulties, they are instead de-contextualised and given a diagnostic label. Thus, the focus of mainstream psychology and psychiatry is to study decontextualised individuals whose emotions, cognitions and behaviours are understood generally in reference to their minds and brains (Boyle, 2010). This results in an underlying message that one has an internal pathology and one's deficiencies are both the causes of one's distress and also the targets for intervention, putting the onus on the individual to take responsibility and demonstrate the will to improve (Dillon, 2010).

As a result, the social circumstances that contributed to the person's distress remain unexamined or unchallenged, implying that context is irrelevant in explaining distress, and that a person's life experiences and social context shouldn't be targeted for intervention (Boyle, 2010). This diverts attention from one's lived experience, as well as from those responsible for creating, contributing to, or maintaining the individual's distress. Dillon (2010) argues that there are much further reaching consequences of this, such as colluding in protecting abusers from being held to account for what they have committed and from preventing society in dealing effectively with these issues. Boyle (2010) argues that the context of emotional distress then may be seen in relation to power, and by avoiding social context, this obscures the operation of power and protects powerful groups from being scrutinized.

Boyle (2010) suggests any evidence indicating that social context and life experiences are inseparable from emotional distress poses a threat to psychiatry and the DSM, as their foundations lie in the medical model, which is rooted in the

belief that ‘symptoms’ are a sign of internal pathology and hence why a medical framework is needed to make sense of them. Boyle (2010) also takes aim at the vulnerability–stress hypothesis, put forward by Joseph Zubin in the 1970s. It suggests that people become ‘mentally unwell’ as a result of an interaction of environmental stressors and pre-existing vulnerabilities. Yet no real explanation of the nature of these vulnerabilities, how they arise and how the environment interacts with them to produce distress has been given. Although it acknowledges the role the environment may have in causing and shaping one’s distress, Boyle (2010) argues that life experiences or context are then nullified as it is implied that adverse experiences are not innately stressful but due to pre-existing vulnerabilities people then experience distress; the implication being that those without such pre-existing vulnerabilities would manage to cope.

Smail (2010) argues that Freud essentially denied the harmful influences of a person’s real lived world and proclaimed the causes of an individual’s distress to be imaginary, and that one is morally responsible for the difficulties they experience. He goes on to describe how Freud early on discovered that the ‘neurotic symptoms’ of his generally young female patients appeared often to be related to sexual traumata they had experienced in childhood, with the emerging understanding that the psychological distress experienced in later life most likely was due to what had happened in earlier life. However, when Freud discovered that this was an unpopular view he completely revised his theory, instead positing that the sexual assaults behind his patients’ distress were in fact the results of their wishful fancy, so rendering them guilty of wishing for such events to happen, and denying the abuse and the abuses of power that they had encountered.

Regarding religion, Smail (2010) argues that although Freud criticised it as a means of disciplining and controlling people, he ended up ‘replacing’ and competing with it by offering psychoanalysis as the ‘scientific’ alternative. Smail (2010) claims that Freud proffered a psychotherapeutic ideology whose foundations underlie subsequent therapeutic approaches, which he summarises as the following: that distress is a result of fantasies, desires, and ‘faulty’ cognitions of the individual rather than due to the harm caused by one’s social and material environment, and thus the person is viewed as being ‘responsible’ for their own distress.

The premise of traditional cognitive behavioural therapy (CBT) holds that unhelpful assumptions about oneself and the world are developed due to negative childhood experiences. These are reactivated later in life by critical incidents and are mediated

by ‘negative’ automatic thoughts that a person may not even be aware of. Although past events are acknowledged, the focus is mainly on the present. Such unhelpful thought patterns create negative affective states like depression, anxiety and so on. Boyle (2010) criticises the sorts of CBT textbook examples generally given regarding triggers, such as being ignored by a friend, rather than more serious environmental issues some people face, such as repeated racial abuse.

Milton, Craven and Coyle (2010) are critical of various forms of therapy, such as psychoanalysis, CBT and Rogerian therapy (in which a client is encouraged on a journey of self-fulfilment and accept one’s real self), as they claim a client’s narrative is either incorporated in to or even replaced by the therapist’s account of it. They argue that by attempting to categorise and diagnose distress in an attempt to achieve universality, little is said then about historical and cultural influences and factors. This results in similar formulations developing across clients who now experience the ‘same’ disorder. They state that these versions may be suitable for some clients in helping them to draw out distinctions which fit them and help them to think of alternative possibilities, but in the worst case the therapist is attempting to find a disorder he/she hypothesises to fit and then imposes this on the client in way of ‘intellectual colonialism’.

Rapley et al., (2010) call for the placing of matters, which are essentially political and moral, back at the heart of understanding human distress, though they acknowledge the enormity of such a task. Boyle (2010) adds to this that in order to make distress meaningful in social context, good theory is needed. For instance, she argues that the mental health profession needs to go beyond simply stating that ‘ethnicity is linked to psychosis or that gender is linked to depression’ (p. 42) but needs to further clarify just how power, social structures, economic and social policies, etc, manifest themselves in certain contents and forms of distress; precisely the theories she argues that psychiatry and mainstream psychology have been reticent to develop. Alongside this, Boyle (2010) proposes a change in language; she highlights how life experiences are generally described as symptoms, vulnerabilities, disorders and deficits, with an absence of words such as power, inequality, and resistance.

It may be argued that the DSM gave clinicians a common language to communicate with regarding mental ‘disorders’ and diagnosis. Yet Douglas (2010) argues that the role of therapy should not be in ‘curing’ disorders but via the therapeutic relationship, an account of the client’s distress can be built and constructed, and so it can be

shared and validated by the therapist, in keeping in line with the values of counselling psychology and without pathologizing the individual. 'Symptoms' and distress should be recognised as manifestations of injustices that need to be witnessed, heard and publicly acknowledged, and thereby, Patel (2010) argues, research and therapy need to be committed to bearing witness to atrocities and suffering, whilst challenging and exposing injustices, and indeed one of the values of counselling psychology is social justice (Kagan, 2015).

Counselling psychology addresses many of the criticisms mentioned above regarding psychiatry and mainstream psychology. It is based on humanistic values and pluralistic practice, and focuses on the therapeutic relationship, challenges the medical model and emphasises well-being and growth instead of pathologizing and diagnosis (Konstantinou, 2014). Wilk (2014) argues that pluralism enables counselling psychologists to respond to different clients with different explanations and approaches at different points of time whilst embracing ambiguity and seeking effective therapy, which Konstantinou (2014) states enables them to be responsive to clients' needs and wishes. She asserts that counselling psychology values the potential use of all therapeutic modalities, recognising that none are superior. Both Konstantinou (2014) and Wilk (2014) argue that using a pluralistic framework is important when working with diverse clients, and Steffen, Vossler, and Joseph (2015) posit that it serves to address clients' own needs and preferences for a certain therapeutic modality rather than one imposed by the clinician.

Konstantinou (2014) states that counselling psychology training involves critical inquiry, which includes examining an issue from different perspectives and providing potential alternatives as well as alternative therapeutic options. A pluralistic framework would seek to understand and incorporate how factors such as religion and spirituality, cultural identity, different coping mechanisms, and intercultural communication patterns differ and shape clients' beliefs and values, and by having an awareness of alternative interventions a pluralistic clinician may check to see how they may be used alongside more traditional Western ones if clients wish for these to be included in their treatment. Konstantinou (2014) proffers that by welcoming different worldviews, including intercultural understandings, this would help to strengthen the therapeutic relationship and collaboration, and enable deeper appreciation of clients' phenomenological understandings, which are core values of counselling psychology.

The professional identity of counselling psychologists is that of scientists-practitioners in that they produce research and research in turn informs their practice. Konstantinou (2014) states that the pluralistic philosophy of counselling psychology regarding practice and research enables the profession to engage with various methodologies and to concentrate on research that validates subjective experiences and highlights the complexities of the therapeutic endeavour. She stresses that the discipline however needs to focus more on research, and by doing so, alongside practice, counselling psychology will have a more active and involved role in shaping the mental health field, the health care system and services. She advocates for further research to explore how effective a pluralistic framework is in working with and supporting intercultural and religious diversity.

Steffen et al., (2015) argue however that in recent years counselling psychology practice has moved away from its focus on health and wellbeing to focusing more on 'disease' and distress due to healthcare settings which tend to centre on deficits and symptom reduction. They call for the field to reaffirm its identity and shift its practice back to human flourishing by re-focusing on its humanistic roots and cultivating strengths. Kagan (2015) also argues that there needs to be a shift in counselling psychology and for it to incorporate more of the action orientation values of community psychology. For instance, she argues that counselling psychologists can contribute to policy development and analysis through insight gained from practice, rather than just witnessing how social policies affect clients.

This current study seems relevant to counselling psychology on many fronts. It is hoped that by exploring and understanding Muslim individuals' experiences of *waswaas* this well help the field re-affirm its practice on validating and understanding subjective experiences without a diagnostic and pathologizing approach. Counselling psychology's pluralistic stance should enable it to respond to the needs and preferences of clients who come from a Muslim background and to work with the diverse mental health explanations they may employ, whilst choosing appropriate alternative therapeutic interventions if desired. Whilst working alongside intercultural and religious understandings, clinicians can provide a more effective therapy service for such clients who may feel marginalised in accessing services that do not support their beliefs.

Ade-Serrano and Nkansa-Dwamena (2016) point out that issues to do with difference are still prevalent in how black and ethnic minorities are treated in the

mental health field today. They highlight that mainstream services are not able to meet the needs of such individuals adequately, thereby resulting in them accessing these services less; that black men and women are more likely to be misdiagnosed; and that black men are more likely to be admitted to inpatient wards than white individuals. Ade-Serrano and Nkansa-Dwamena (2016) state that Eletheriadou (2014) suggests that once individuals from black and ethnic minorities are given a psychiatric label, issues to do with race and culture may be ignored. This thereby discards the roles played by these individuals' cultures in influencing and interacting with their psychological difficulties and how these are understood and expressed, and as such their difficulties are therefore perceived and understood only from a Western culture instead.

It is also important for mental health professionals to note how the current socio-political climate may also be affecting the mental well-being of Muslim individuals. Due to the acts of a few, who claim to be acting in the name of Islaam, the Muslim community as a whole has come under greater scrutiny. Yet an important point made by Haque and Kamil (2012) is often ignored, which is that 'the influences of personalities, local customs, and cultures may lead to practices that are often in violation of Islamic laws' (p. 11).

Williams (2005) highlights that in the West, the focus on Islaam tends to typically be on perceived threat and danger, fundamentalism, war and suppression. This also extends to the misconceptions of the role of women in Islaam, gender equity, and dress codes. Media portrayals have also helped to further fuel negative attitudes towards the community, resulting in misinformation and stereotyping. It is important to look at how Muslims are described and understood from the various discourses around, as this will have an impact on how they identify themselves, as well as how they are perceived at a societal level. Williams (2005) cautions that clinicians need to have an awareness of any false assumptions that they may make about Islamic beliefs and practices. She advises that the 'worst kinds of assumptions are those which are out of our awareness, hidden and never challenged in our reflective thinking processes' (p. 126).

Haque and Kamil (2012) point out that the rise in Islamophobia has led to an increase in discrimination, including employment discrimination (Dobson, 2014), hate crimes and profiling. Experiences of discrimination are worth exploring with

clients, particularly as some have found others to be dismissive of their experiences and have been referred to as being 'paranoid' (Sheridan, 2006).

It may be argued then that if Muslims are being discriminated against and are in a position of less power and autonomy, with their religious identity also under greater scrutiny, they are more vulnerable to having other identities and meanings imposed upon them, which may not reflect their genuine experience as it is not theirs. Rather, such an experience is going to be an account of others' perceptions of them, rather than a true reflection of these Muslim individuals. Some Muslims may feel ignored and isolated, possibly increasing the risk of any psychological difficulties they may be experiencing, whilst at the same time not having their psychological needs met. It is easy to see how then they may be labelled as experiencing some kind of 'disorder', though this is not to say that their difficulties are not genuine, but rather, they may be as a result of different factors, including societal, financial, and interpersonal. In light of this, this study aims to provide Muslim individuals with a voice, by exploring how they understand and describe their own experiences of *waswaas.*

Religion and OCD

Although it is not certain whether there is an overlap between *waswaas* and OCD, Huppert et al., (2007) state that obsessions with religious and ritual themes are a common theme in OCD, although they highlight that the few studies which have investigated the direct relationship between OCD and religion have failed to show an association between the two. Religious themes are apparent in the presentation of OCD in religious individuals, and reflect the religion's beliefs, rituals and practices. Huppert et al., (2007) highlight that this is typical, as OCD tends to manifest in important areas in an individual's life.

Huppert et al. (2007) therefore caution that clinicians should not demonstrate an attitude in which they hold religion responsible for OCD symptoms, particularly if the topic of religion is to be addressed in treatment. Huppert et al., (2007) suggest that if it is conceptualised that religion is the cause of the OCD, the clinician may hold the assumption that the influence of the individual's religion must be reduced or controlled for treatment purposes. Holding such an attitude, they warn, may have a

detrimental effect on treatment, reducing empathy and trust, and leading to conflict. However, by recognising that OCD can manifest itself in religious individuals by way of religious compulsions and obsessions, rather than an individual's religious beliefs causing the OCD, they suggest this will foster rapport and treatment compliance. Rahiem and Hamid (2012) also caution that a clinician should have an awareness of how one's own beliefs and world-views influence how one engages with a client. It is hoped that this current study exploring Muslim individuals' experiences of *waswaas* would contribute to the multicultural awareness of counselling psychologists, thereby fostering rapport and enabling both clinician and client to work more effectively together.

Scrupulosity

Huppert et al., (2007) state that a pronounced example 'of a disorder that is inherently and inextricably linked to a patient's value system is that of scrupulosity in obsessive–compulsive disorder (OCD), which often is manifest within a particular system of religious observance and beliefs' (p.926). Although they argue that scrupulosity is a subtype of OCD, in which an individual's obsessions and compulsions are based on religious or moral issues, Miller and Hedges (2008) claim that because there is not enough known yet about scrupulosity, it might even be a completely different disorder, though within the 'obsessive–compulsive spectrum' (p.1043). Although it may be argued that the research on scrupulosity is not yet comprehensive and perhaps still in its infancy, the debate around the uncertainty of what kind of a 'disorder' scrupulosity is, helps to illustrate what Douglas (2010) has said about the importance of critically appraising the 'concept of disorder as discrete entity' (p. 28).

In scrupulosity, obsessions may be centred on, for instance, sins/sinning, distressing blasphemous mental images and thoughts, and fear of going to Hell, and compulsions may include repeating religious practices and reassurance seeking (Huppert, et al., 2007; Rosmarin, Pirutinsky, and Siev 2010). Huppert and Siev (2010) point out that themes vary between religious groups. For instance, the obsessions of Christians tend to focus on blasphemous thoughts and devil-worshipping, whereas Jews experience obsessions about violating laws to do with diet, prayer, and ritual purity (Siev, Baer and Minichiello, 2011).

Siev et al., (2011) state that scrupulosity has been under researched. They highlight the complicated relationship between religious observance and scrupulosity. They state that scrupulous individuals may perceive their compulsions as worthy or successful attempts in avoiding sin. However, compulsions cause distress and are driven by fear, and may disrupt religious practices and reduce the fulfilment individuals may have achieved otherwise. Indeed, in their quantitative study they found that the majority of participants felt that their symptoms of scrupulosity interfered with their religious experience, although a few believed they facilitated their religious observance. Huppert and Siev (2010) mention that some individuals may not perceive their symptoms as a disorder but rather of a religious nature. They suggest that individuals may distrust secular clinicians and believe that such clinicians do not hold any authority over religious issues.

Summers and Sinnott-Armstrong (2015) argue scrupulosity shares many features with OCD, such as beliefs about being responsible for controlling the intrusive thoughts, and contamination fears. Its features also involve chronic doubt (involving intolerance of uncertainty and doubt regarding the religious or moral status of oneself and one's acts), moral perfectionism (involving high religious or moral standards, and heightened sensitivity when the standards are not met), and thought-action-fusion, though Summers and Sinnott-Armstong (2015) acknowledge this is not well understood yet. Thought-action fusion (TAF) consists of two types: moral thought-action fusion (having a thought about something immoral is equal to having the intention to do it or is equal to actually carrying it out); and likelihood thought-action fusion (the belief that having certain thoughts increase their chances of actually happening). Summers and Sinnott-Armstrong (2015) state that these three features can be interconnected and influence the other. Berle and Starcevic (2005) point out that TAF is not just associated with OCD but also in other anxiety 'disorders' and with depressive 'symptoms' and in eating disorders.

Millers and Hedges (2008) give a brief outline of some of what they claim are the identifiable and apparent features of scrupulosity. For instance, they claim that a key feature of scrupulosity is when individuals may experience moments of confusion or doubt which can be disabling, centring on possible morality violations. As a result, the ability to engage in rational behaviour and thought, and the ability to function is impaired. Because of the cognitive distortions involved in scrupulosity, Miller and Hedges (2008) state this leads to poor insight and a lack of awareness,

as individuals may become overwhelmed with religious and moral issues to the extent that they cannot fully process their thoughts.

They also posit that scrupulosity often results in engaging in long periods of moral rumination which is deeply distressing. They state that scrupulosity involves an individual becoming consumed by and fixated on religious issues, resulting in severe anxiety to the extent that individuals cannot enjoy every day activities or relax. They claim this results in an excessive usage of mental energy, thereby impacting on other cognitive demands and may lead to 'symptoms' of depression and other types of anxiety. Another feature of scrupulosity that they highlight is a sense of depersonalization or derealisation, or a loss of attachment with personal identity or reality.

Millers and Hedges (2008) also state that scrupulosity involves a sense of personal responsibility and extreme sense of guilt which is most notable in the moral thought-action fusion feature. However, they point out that the moral thought-action feature has been found to trigger unwanted thoughts in a number of anxiety based disorders, so this is not necessarily unique to scrupulosity.

Besiroglu, Karaca and Keskin (2014) point out that some belief systems, like Protestantism, do view certain thoughts as being sinful, so it might be that Protestant individuals in this regard may well be correct in seeing themselves as sinful for having certain thoughts based on the belief system they profess to follow. However, Besiroglu et al., (2014) state this isn't the case in the Islamic faith, and highlight an Islamic text which demonstrates that having an intrusive immoral thought isn't the same as having carried out this thought. They therefore point out that moral thought-action fusion isn't compatible with the Islamic belief, nor is thought-action fusion likelihood, nor beliefs about perfectionism, again by highlighting Islamic texts. Yet they do acknowledge that obsessive-compulsive 'symptoms' can be found in Muslim populations, for which they propose several explanations, such as that some Muslim individuals might not be familiar with Islamic teachings that state that having an intrusive immoral thought is not the same as actually performing it. They also highlight that obsessive-compulsive 'symptoms' are present in many cultures, suggesting that religion may not be responsible for the occurrence of such 'symptoms', though it may shape them. For instance, they suggest that if one is experiencing obsessive-compulsive 'symptoms' and practices a faith, then these 'symptoms' are more likely to occur in a religious context.

This highlights that what is assumed to be known in one culture (i.e. in this context Western culture) is not easily applicable to other cultures. By claiming certain features influence scrupulosity, like thought-action fusion, this hides the nuances and divergences of features in other cultures and whether what is termed as scrupulosity is even indeed present in other cultures. By trying to 'diagnose' something as a mental health issue, this perpetuates the sense that this exists as an 'illness' in a recognisable form, and therefore is an objective feature of reality, when rather it is something which is generally socially constructed (Larsson, et al., 2012). The human experience is varied and is intricately linked to the culture in which it exists, and Thomas and Bracken (2011) remind us that even medical, and psychological, understandings and practices are also full of cultural values and assumptions. Indeed, Allmon (2013) points out that the DSM is 'a cultural document based on western assumptions that may result in culture-bound syndromes and be less applicable for non-western clients' (p. 544).

It must be understood then that which is labelled as OCD or scrupulosity is entangled in discourses around culture, religion, ethnic minorities, mental health and illness, as well as diagnosis. These areas intersect with one another and have an impact on how Muslims are viewed in society, as well as affecting discussions on mental health. The concept of a diagnosis may deprive people from understanding issues in a way that makes sense to them and allows them to find their own methods of dealing with them (Moncrieff, Dillon and Rapley, 2011). This present study therefore focuses on investigating the phenomenon known as *waswaas* by exploring how Muslim individuals themselves understand their experiences of it.

Working with Religious Beliefs in a Therapeutic Setting

There may well exist a tension between the need to ensure that psychological services are made accessible to diverse groups while also ensuring that services aren't colluding in harmful or unhelpful beliefs and practices (Utz, 2012). Some psychologists and service providers may have concerns about accommodating certain practices and beliefs (Khalifa et al., 2011). However, any discussion exploring this should be done in a respectful manner, in the context of a healthy debate, as Utz (2012) argues that clients may be hesitant in discussing Muslim explanations for mental health with a clinician who is not Muslim. However, it is important that these beliefs are explored, because not only may key information be missed, but because these beliefs may also impact upon the therapeutic process, as well as the treatment outcomes.

Utz (2012) advises that if a clinician is unsure about a client's presentation, it is best to consult with either a Muslim clinician who has the relevant religious/cultural knowledge, or with a religious leader, such as an Imam or a shaykh who has an understanding of mental-health issues. In this way, counselling psychologists can begin to better meet the needs of Muslim clients by providing culturally appropriate services. This may also raise awareness regarding psychological interventions within communities who may not otherwise access psychological services, and reduce the fear, shame and stigma that may be associated with mental health difficulties.

Huppert, et al., (2007) also argue that religious leaders should be consulted during treatment to ensure that clinicians have a clear understanding of religious norms and so treatment can be tailored appropriately. They state that such treatment should be framed within the community norms to prevent conflict between religious and secular values. They add that specific sayings and teachings within the religion can be applied by clinicians so as to promote collaboration. They emphasise that adapting treatment approaches for individual clients is consistent with treatment protocols, and demonstrates efficient, evidence-based practice.

However, it is also important to recognise that perhaps some people from ethnic minority groups may not wish to access Western psychological services, not simply because they don't feel that they will adequately meet their needs, but perhaps because they believe they have no need for them. Indeed, Bhui and Morgan (2007)

state that some individuals will eschew psychological services in favour of approaches that are seen as more culturally congruent or which they understand better. They point out that certain rituals, like prayer, may alleviate mental distress for these individuals without them having to come in to contact with mental health services. Indeed, Morris (2012) suggests that it may be useful to deconstruct Western notions of mental well-being. Fernando (2005) also states that some professionals hold the attitude that the knowledge and methods of Western psychiatry and psychology are superior over the knowledge and ideas of non-Western cultures, which he terms as professional arrogance. It is important to understand the religious and/or cultural beliefs of ethnic minority groups, rather than imposing upon them culturally insensitive or limiting perspectives and treatment options. It therefore seems pertinent to explore and understand how Muslim individuals cope with any difficulties they experience, how effective such strategies are, and whether they would seek professional help.

Western Models and Muslim Models of Treatment

There are a number of treatment options available in predominately Western societies for those dealing with mental health issues. These range from using medication, complementary and alternative therapies, electroconvulsive therapy and ecotherapy, which helps people connect with nature by doing outdoor activities to help improve their mental and physical well-being (Mind, 2015), as well as talking therapies. Yet, Haque and Keshavarazi (2014) point out that many psychological theories stem from a Eurocentric framework and the treatments are generally designed for European-American societies. Hussain and Hodge (2016) highlight that the 'Enlightenment' movement in Europe composed certain assumptions about human existence and these in turn lay the foundations of Western therapeutic approaches. Religious systems were replaced by rationalism and belief in scientism, and other beliefs, such as the belief in the supernatural were dismissed, and so much of Western modern psychology is now based on a secular framework in which spiritual values are often ignored.

During times of distress there are a number of practices Muslim individuals might use to help them manage or treat their distress, including those mentioned above.

Alongside these they may also recite the Qur'aan, as well as ask religious leaders to perform *ruqyah* for them, in which Qur'anic verses are used for healing or protection purposes (Utz, 2012). Skinner (2010) also highlights that certain physiological and psychological difficulties might be seen as a result of homeostatic imbalance, so the aim would be to correct the imbalance and restore stability. Muslim individuals might also make supplications (*du^aa*), and ask God for forgiveness and mercy, or to protect them from certain matters that they fear may occur or are the causes of their anxiety or distress. This can help provide relief and help them deal with their worries. Haque and Keshavarzi (2014) point out that ill health in Islaam may be viewed on a continuum in which most people seek to achieve congruence between Islamic beliefs and their actions, and thus such 'spiritual' interventions are not solely for a clinical population but are a way of healing and an act of worship for Muslims in general.

Certain aspects of modern psychology (such as models of the self) were already evident in the Islamic 'world' centuries ago, as well as elements of certain modern Western therapeutic approaches (Haque and Keshavarazi, 2014). Psychological models and therapeutic interventions that can be applied to Muslim clients have even recently continued to emerge, evolve and develop, though they are still very much in their infancy. Certain Western therapeutic approaches have also begun to incorporate Islamic knowledge and understanding when working with Muslim clients. For instance, there are a few studies that indicate several beliefs and cognitions within the Islamic faith can be integrated into CBT (Haque and Keshavarazi, 2014). Islaam recognises and encourages the importance of healthy cognitions in promoting psychological well-being (Hussain and Hodge, 2016). Cognitions or statements which focus on the blessings provided by God, trusting and relying on God, belief in life after death, what the Islamic belief is regarding the purpose of distress or finding meanings in suffering may be used with clients who feel hopeless or overwhelmed to counteract unhealthy cognitions, and thus help them develop spiritually too.

There is a form of scientific discipline in Islaam known as tassawuf which focuses on nourishing the soul. This is done by reforming one's life spiritually, experientially and behaviourally in order to achieve congruence between the Islamic belief and the practice of it (Keshavarzi and Haque, 2013). A famous Muslim scholar called al-Ghazaliyy provided a conceptualization of the soul in which the spiritual identity is formed from 4 aspects: the *nafs, ^aql, ruh* and *qalb*. Keshavarzi and Haque (2013)

have used this conceptualisation of the self to offer an outline of a psychological therapeutic framework within an Islamic context.

The nafs are further broken down in to different types and are even mentioned in the Qur'aan. The *nafs* may be seen as similar to the Freudian idea of the id but it is not seen as intrinsically bad. Rather, if it acquires good habits then this helps serve the individual but if it acquires bad ones then this can create a barrier to growth (Keshavarzi and Haque, 2013). There are a number of ideas from the psychoanalytic/psychodynamic approach that contradict the Islamic faith. For instance, classic Freudian theory views humans as being driven by unconscious sexual and destructive urges, whereas Islaam views humans as generally rational beings with an intellect that influences their behaviour (Amer and Jalal, 2012). Also, the view that children enter psychosexual stages are also incompatible with the Islamic faith. People are seen as autonomous beings, possessing free will, intentions, choices and are responsible for their actions.

The ^*aql* is the faculty of rationalism, logic, intellectual beliefs and reason. The *ruh* is commonly viewed as being the 'soul' or the spirit' and the *qalb* is the heart, which some may refer to as the self or even the soul (Keshavarzi and Haque, 2013). It is argued that the effects of the ^*aql, ruh, and nafs* manifest in the heart, and if there is a sickness or something bad in the heart, then it is seen as if the whole body is seen as being sick/bad. For instance, the heart may experience jealousy, envy or pride, as a result of the evil inclinations of the *nafs,* or the soul may be lacking in nourishment due to a lack of saying *dhikr* for instance, or a person may not use one's intellect properly or their *nafs* may be more dominant than the intellect. And so to remove the sickness of the heart, these would then have to be tackled, such as modifying the inclinations of the *nafs* to that which is good, to feed the soul/spirit through *dhikr,* and to restructure or acquire more helpful thoughts from within the Islamic faith (Keshavarzi and Haque, 2013).

Keshavarzi and Haque (2013) state that a clinician would intervene at either one or at all three levels in order to make the heart healthy again, as each level impacts the other, so intervening at one level will cause a change in others. They suggest that if the clinician does not know the Islamic faith very well nor these methods, then one should gain appropriate training, even from a Muslim religious leader or refer clients to Muslim religious leaders, and the clinician's task then would be to reinforce and help monitor that the client adheres to these practices. Keshavarzi and Haque

(2013) acknowledge that they haven't provided a treatment manual as such and nor have they described how the interventions may be implemented for various 'clinical disorders'. However, they have offered a tentative outline as to how to work with Muslim clients who wish to access psychological services which incorporate spiritual interventions.

Relevance for Counselling Psychology

As indicated in the above research, some Muslim individuals believe that psychological services do not understand nor respect the religious belief of Muslims, which may be one reason as to why some are not accessing mental health services (Rethink, 2007; Weatherhead and Daiches, 2010). An aim of this current study is therefore to understand how the term *waswaas* is understood in an Islamic context. By doing so, it is hoped that this will also contribute to the knowledge base of counselling psychologists as well as lend a contribution to cross-cultural psychology. It is folly to assume or to expect a client to cast aside his/her cultural and religious belief systems, but rather, it is important to explore such beliefs in the therapeutic process, just like one would do with other areas of diversity. As the above research has indicated that many Muslims' perceptions of mental health issues and their methods of coping is influenced by their religion, it is therefore imperative that counselling psychologists use this understanding to provide effective psychological services to this group. By doing so, it is hoped that they will thereby be able to show that psychological therapy is a space where religious beliefs can indeed be explored in a respectful and sensitive manner.

The aim of the study

This study seeks to develop a greater understanding of Muslim individuals' experiences of *waswaas*, thus contributing to the limited UK multicultural counselling psychology literature, and cross-cultural psychology literature, by expanding the research base on Muslim understandings of mental health. By using a qualitative method to focus on the subjective and lived experiences of Muslim individuals, this may help capture and shed further light on the phenomenon of *waswaas*. It is hoped that this will contribute to the development of multicultural awareness amongst counselling psychologists (and other mental health professionals), so that they can work more effectively with minority groups, and thereby making psychological services more accessible to Muslim groups.

The general research question to be explored in this study is:

1. How do Muslim individuals understand and experience *waswaas*?

Chapter 2

Methodology

Outline

Below, the rationale for selecting the qualitative paradigm and the chosen methodology is presented. This is followed by an overview of the methodology and its philosophical underpinnings. The researcher's epistemological standpoint is then presented, as well as a discussion on how issues of reflexivity and validity will be addressed throughout the research, in order to discuss the present study's justified methodological rigour. This is followed by an outline on the study's procedures, elaborating on: sampling; participants; materials; the interview process; ethical considerations; and the analytic strategy.

Research Design

This study used a qualitative methodological approach to explore Muslim individuals' experiences of *waswaas*. Semi-structured interviews were conducted to gather data and were analysed using Interpretative Phenomenological analysis (IPA).

Rationale for a qualitative study

There is a gap in the psychological literature in exploring and understanding Muslim individuals' subjective lived experiences and perceptions of *waswaas* according to their own personal accounts. This study therefore seeks to address this gap with the aim of exploring and conveying their lived experience. It is hoped that this will help illuminate and add to the existing literature on the phenomenon, whilst also contributing to the knowledge base of counselling psychologists in further understanding Muslim explanations on mental health.

A qualitative approach was chosen because the study aims to understand how Muslim individuals conceptualise their knowledge and experience of *waswaas*. Finlay (2006) states that qualitative research is concerned with understanding how people make sense of the world and how they experience events. Willig (2008) adds

that qualitative research is interested in meanings participants themselves attach to events. That is, how they interpret and describe their experiences, so as to provide depth of understanding (Willing, 2012). She states that qualitative research does not tend to use 'variables' which are defined by the researcher as this would lead to the researcher imposing his or her own meanings of the phenomenon being investigated. Willig (2008) also states that this therefore allows participants to challenge a researcher's assumptions regarding the relevance and meaning of categories and concepts. This seems suitable to this study as the literature that has been cited earlier regarding *waswaas* does not clearly explain what it is, yet some have suggested it may be a form of OCD (Utz, 2012; Besiroglu and Agargun, 2006). Using a qualitative approach will enable participants to speak in their own terms about their lived experience, and allow more light to be shed on the phenomenon of *waswaas*. This will be different to previous quantitative research on *waswaas* which suggests that *waswaas* might be a form of OCD, without this being explored further or even challenged perhaps, and in which the meanings or variables have been defined by the researchers themselves and not by the participants.

Draper (2004) states that quantitative research is rooted in the positivist tradition, so it's concerned with understanding and describing the world through observing physical phenomena, with an emphasis on objectivity and empirical data that can be measured. Its focus tends to be on making causal statements or supporting claims about phenomena. Nelson and Quintana (2005) state that in quantitative research the responses of participants are controlled by the researchers as it is they who determine the 'operational definitions of construct' (p. 345), which can prevent a more nuanced and closer examination of the phenomenon under study. Swift and Tischler (2010) add that quantitative research is unlikely to produce data that generates explanations or provides detailed descriptions. Nelson and Quintana (2005) summarise that a quantitative approach is more about confirmation, whereas a qualitative methodology is more focused on discovery, and fewer assumptions are made prior to commencing research (Brocki and Wearden, 2006). Finlay (2011) adds that qualitative research is exploratory and inductive, whilst quantitative research attempts to 'prove' and explain. Therefore, as there is very little known about *waswaas*, a qualitative approach rather than a quantitative one seems more suitable for this study so as to understand how individuals themselves experience it.

Willig (2008) states that qualitative research is concerned with the texture and quality of human experiences and their meanings to individuals. It aims to explain and understand individuals' beliefs and behaviours within the context in which they occur, and allows for complexity to be explored (Brocki and Wearden, 2006). There is an emphasis on examining the individual's explanation, meaning, and understanding. Finlay (2006, 2011) adds that findings in qualitative research are always tentative and partial, and open to multiple subjective interpretations. She states that the social world is too uncertain and chaotic to be represented in a clear-cut, unambiguous, objective way, or in a manner of cause and effect, unlike what the quantitative approach seeks to do.

The little research there is on *waswaas* is of a quantitative nature and does not examine the experience and meaning of the individuals' accounts. Due to this lack of literature on how individuals experience *waswaas* and make meaning of their experiences, it was deemed that a qualitative approach, rather than a quantitative one, was most appropriate for this study. This is because, as Draper (2004) states, qualitative research aims to describe and understand patterns of behaviour through discovering the intentions, beliefs, motives, attitudes, values and rules that individuals attach to them, thus making the behaviours and actions more meaningful, as well as understanding how particular problems develop.

Interpretative Phenomenological Analysis

Utz (2012) has argued that there is very little research exploring Muslims' mental health explanations, and some Muslim individuals are concerned that their beliefs are not understood (Weatherhead and Daiches, 2010). It was deemed important therefore to give Muslim individuals a voice, and thus for them to provide an insider's perspective on *waswaas*. One such methodology which does just this is interpretative phenomenological analysis (IPA). Todorova (2011) states that IPA values the subjective experiences and voices of individuals who are otherwise silenced or ignored, as it urges us to listen and understand them collaboratively through the participant and researcher.

Smith (2011) states that IPA is concerned with an examination of personal lived experience, the meaning of the experience to participants, and how they make

sense of that experience. It portrays, in a rich and detailed manner, personal experience in its context, which is influenced by the historical, linguistic and social milieu. Montali, Frigerio, Riva and Invernizzi (2011) state that IPA highlights the socio-cultural elements of individuals' reported experiences and is also useful when investigating topics in which the self, identity, and the construction of meaning are important. Finlay (2011) posits that IPA focuses on the meanings of experiences, including the existential, embodied and cognitive-affective aspects.

The theoretical underpinnings of IPA are phenomenology, hermeneutics and idiography. Shinebourne (2011) states that phenomenology is a philosophical approach influenced by people such as Husserl, Heidegger, Sarte and Merleau-Ponty. The approach highlights the individual as embedded and embodied in the world in a specific cultural, social and historical context, and how to understand and examine an individual's lived experience. Finlay (2011, p. 21) provides a summary of the key ideas of some phenomenological philosophers, such as Heidegger, Sartre, Merleau-Ponty, regarding their views on human existence:

> They argue that we all have an *embodied sense of self* which is always in *relation to others*, while our consciousness is shared with others through *language, discourse, culture and history*. We experience *time* in our recollection of past joys and trauma. We also anticipate what is to come in the future. We are placed into a matrix of *spatial relations* in the world surrounded by things which have *meaning* while we engage with ideas and activities which become our *projects*. We are thrown in to the world in order to live: we act, make choices, strive, become. And ultimately we die.

Smith and Osborne (2008) state that IPA is phenomenological as it explores participants' lived experiences in detail and how they make sense of those experiences. Smith (2011) states that IPA acknowledges though that there is no direct route to experience. IPA is based on a phenomenological view, proposed by Husserl, who was interested in the examination of the world as it is experienced by individuals within particular contexts. His aim was to capture the essence of conscious experience through an analysis of consciousness as it appears in experience. Husserl stated that consciousness is intentional, as it is always directed towards something, 'consciousness is consciousness of something' (Finlay, 2011, p. 45). Finlay (2011) states that in the context of research this means that the researcher studies participants' experiences of phenomenon.

Phenomenology is concerned with 'the lived world of everyday experience' (Finlay, 2011, p.10), that is, connecting immediately and directly with the world as it is experienced. It is attentive to the embodied lived experience and to the meanings attached to the experience. There is an interest in descriptions of a phenomenon via people's everyday experiences of it, as it appears and what it means, rather than producing an objective account of it. Finlay (2011) explains that phenomenological research provides insight and understanding regarding the human condition through individual experiences, and such research gives individuals 'the opportunity to be witnessed in their experience and allows them to 'give voice' to what they are going through' (p. 10). In phenomenology there is no dualist distinction, so therefore the world is not separate from people's perceptions but rather it is part of it, it is intertwined. As Finlay (2011, p. 21) states 'It is only in the world that we can come to know ourselves'.

Phenomenology focuses on understanding how an individual subjectively experiences objects, so that reality is then dependent on the perception of the individual, rather than through objective means. Depending on an individual's subjective view, the meaning of an object can therefore change, and this suggests that multiple realities can exist. Heidegger stated that each individual would see the same phenomenon in a different way, dependent on the person's lived experience, background and understanding (Finlay, 2003). Heidegger stated that human beings can be conceived of as 'thrown into' and immersed in a world of objects, relationships, languages, history and culture.

Based on this, the focus in IPA is on exploring individuals' perspectives of their lived experience and the interpretation of meanings that the experience holds for them. Larkin, Watts and Clifton (2006) state that although the aim of IPA research is to try to understand a participant's world it has to be acknowledged that an authentic first-person account cannot be achieved, as the participant's account is constructed along with the researcher. Willig (2008) states it is the participant's account of the phenomenon that the researcher engages with. The aim therefore is to try and get as close as possible to the participant's view.

Husserl also advocated for a reduction and epoché, that is, that we should 'bracket' or place aside our previous knowledge and understanding so that we may see and appreciate the phenomenon in its essence as it appears and as it is experienced. Finlay (2011) argues that often this idea of 'bracketing' is misunderstood by some

researchers to mean that one has to remain objective. Rather she states it means that one's assumptions are left aside temporarily so that one is able to focus, remain open and be attentive to the phenomenon or data, whilst continuously being engaged in managing one's preconceptions from intruding. This is because the focus is on the psychological reality of a participant's lived experience. Finlay (2011) argues that researchers should accept participants' accounts of their experience as their 'truth' and focus on the meanings participants have attached to their experience.

Smith and Osborne (2008) state that IPA is linked to both interpretation theories and hermeneutics. This is because the researcher has an active role in the research process, in which the researcher's conceptions are involved in the process of interpretative activity. Golsworthy and Coyle (2001) state that IPA is heavily influenced by symbolic interactionism in which meanings that individuals attribute to events are of central significance to the researcher. The researcher tries to make sense of how the participants try to make sense of their world through a process of interpretation and engagement. IPA therefore involves a double hermeneutic between the participant and the researcher. Willing (2008) states that in order for a researcher to understand a participant's lived experience, this requires the researcher to interpret the participant's account via the researcher's own conceptions and assumptions. Therefore, the knowledge that IPA produces is reflexive as it is dependent upon the researcher's stance.

IPA is idiographic rather than nomothetic in that it comprises of an in-depth analysis of various case studies or a single case study, rather than making generalisations for larger populations. That is, the researcher is engaging in understanding the phenomenon from the perspective of particular participants in particular contexts (Finlay, 2011). Smith and Osborne (2008) claim that an idiographic approach should also be applied to the analysis of the interview transcripts. A single interview is analysed in detail before moving on to other interviews, looking at specific examples, such as of convergences and divergences, before slowly moving on to more general claims. Finlay (2011) states that the researcher may use the analysis of people's accounts to provide a suggestive general description of the phenomenon.

IPA was chosen for this study, rather than another approach, because it seemed to fit the research aims. For instance, Smith (2011) highlights that in IPA, analysis on what participants say is done in order to understand how they make sense of their experience, whilst in discourse analyse, focus of the analysis is in order to understand how participants construct accounts of their experience. Finlay (2011) points out that in discourse analysis the emphasis is on the linguistic resources and conversational features that people use to account for and construct their experience. As Todorova (2011) stipulates, IPA is sensitive to language, but its focus is on personal meanings and experiences. It therefore does not view language as the sole source of data to analyse, but it also assumes that what participants say offers psychological insights into their worlds and into how they make sense of their experiences. Due to the limited research on *waswaas*, IPA seemed more appropriate to shed further light on how *waswaas* is experienced. Eatough and Smith (2006) state that certain matters have significance to people because of the meanings they give to events which shape a person's lived experience. Finlay (2011) adds that in IPA the focus on what is said is not just to learn about how people make sense of their experiences, but to also learn about connections with embodied emotional responses.

Another approach that was briefly considered was grounded theory. Charmaz (2012) states that grounded theory can be used to investigate diverse processes, and Burck (2005) states it is used for areas which are under-theorized to develop theory about 'processes and to develop conceptual analyses of social worlds' (p.245). Grounded theory was developed initially by Glaser and Strauss, who were trained in symbolic interactionism and quantitative sociology. At the time quantitative methods rooted in positivism were dominant. Positivistic beliefs in scientific objectivity, logic and truth had reduced human experiences to quantifiable variables, leading to a divide between theory and research. New theory construction seldom occurred, as hypotheses that were testable were deduced from existing theory (Charmaz, 2012). Willig (2008) states that Glaser and Strauss argued that there was a need for new theories and that these could emerge from the data they were grounded in, rather than relying on variables or categories from existing theories. Grounded theory is therefore both the process through which categories are identified and integrated from the data, and its product as it provides a theoretical framework to understand the phenomenon being investigated. Willig (2013) states however that although grounded theory highlights categories and

concepts participants use to understand their experiences, it does so in a descriptive manner, making it actually difficult to develop a theory.

Grounded theory traditionally takes a realist position, in that the data gathered reveals something about an objective reality. IPA however states that a participant's experience is not directly measurable, and it will always be interpreted by the researcher who is influenced by his/her own thoughts and assumptions (Willig, 2013). Thus the researcher's role is considered necessary when developing an understanding of the experiences of the participants, yet in grounded theory the role centres more on witnessing observations made and being cautious in not allowing one's own assumptions to influence the data (Willing, 2013).

However, the current aim of this study is to explore the lived experience of *waswaas* and how it is understood and made sense of because this is lacking in the literature, and as such IPA was deemed as a more suitable choice than grounded theory as this study is not concerned with contesting existing theories or constructing a theory of social processes (Starks and Trinidad, 2007). This study focuses on a small number of Muslim individuals' experiences of *waswaas*, not a theoretical account of them, and grounded theory has been criticised in its ability to address questions of experience over social processes (Willig, 2013).

Narrative analysis was also considered. There has been debate as to what a narrative is (Freeman, 2015), ranging from simply an account with a beginning, middle and end (Emerson and Frosh, 2004) or as Freeman (2015) proposes that it is understanding human reality from a historical view. That is, with retrospection, consisting of a historical chronicle of knowing what happened when, alongside how experiences and events might be related, a plot is formed, 'a constellation of meaning that holds together, in some semblance of unity, the disparate threads of the past' (p. 28). Narratives are part of a meaning making process, helping to make sense of a somewhat chaotic world and restoring a sense of order (Willig 2013). Narratives help people organise events in their life, by ordering them over time and locating them within a cultural and historical context. This then allows the individual to understand themselves and others, within the context of their world.

Narrative analysis is similar to IPA as it too is concerned with subjectivity and the experience of individuals. Yet, there are significant points of divergence, like in the kind of research question each addresses. IPA is interested in the experience of the phenomenon under study (Willig, 2013), whereas narrative methodologies

generally focus on how individuals make sense of their experience through the narratives they use and there is a heavy focus on the content of the narrative (Crossley, 2007). Typically, narrative research deals with issues of identity and self-construction (Crossley, 2007). An individual's choice of narrative can be relevant in both the construction and preservation of one's identity, and an individual may have different narrative identities dependent upon their social relationships and circumstance (Willig, 2013). Crossley (2007) stated that it is through the telling of stories that we establish our identities and sense of self. IPA however tends to focus on the 'texture' of experience and seeks to address questions such as 'what it is like' to live in a particular situation or moment (Willig, 2008). As this study focuses on how Muslim individuals make sense of their lived *experience* of the phenomena of *waswaas*, rather than how individuals construct or reconstruct their identities, IPA was deemed as being more suitable.

Epistemology

As has been described previously, IPA focuses on individuals' subjective experiences and understandings of a phenomenon, whilst acknowledging that gaining direct access to experience is not possible and requires interpretation, although we may be able to glimpse something of a participant's life-world. IPA is influenced by symbolic interactionism as it gives importance to meanings that people ascribe to things, and recognises the individual in his/her wider context, including the socio-cultural, psychological, historical, and linguistic elements.

IPA is aligned with social constructionism (Smith et al., 2009), and it is also aligned with critical realism. Critical realism assumes that reality cannot directly be known and neither does the data directly reflect reality, rather the data has to be interpreted (Willig, 2012). Smith and Osborn (2003) state that IPA accepts a real world, alongside acknowledging the complexity of portraying this reality due to narrow links between cognition, language and the body. Eatough and Smith (2006) state that it is impossible to directly access a participant's lived experience as there is no 'clear and unmediated window' (p. 118) into his/her lifeworld. Therefore, in attempting to understand a participant's experience and meaning-making, it requires an interpretative activity.

The epistemological stance for this study is therefore within a critical realist paradigm as I accept as Fade (2004) states that there are 'stable and enduring features of reality that exist independently of human conceptualisation' (p. 647). She goes on to say that 'Differences in the meanings individuals attach to experiences are considered possible because they experience different parts of reality' (p. 647). This study seeks to explore individuals' subjective experiences and understanding of *waswaas*, whilst acknowledging that their experiences are embedded in the wider context of their psychological, socio-cultural, and historical worlds. Participants' lived experiences may not be directly accessed but it is hoped that the process of interpretation may shed light on the phenomenon of *waswaas* according to the meanings participants have given it.

In the context of the current study, holding a critical realist position means that during data collection and analysis, the narratives that will emerge will be based on the lived experiences of Muslims and their views on *waswaas*. These will be derived from the meanings they attach to their experiences of reality and how they perceive the world (French, Maissi, Marteau, 2005). As Harper (2011) points out individuals may not always be fully aware of all the various factors that have influenced their experience, but it is their meaning-making process and how participants have made sense of their experiences that are the focus of this study. I recognise that in order to understand their experience, this will require me to engage in the process of interpretation, as well as continuing to be reflexive to explore my own experience and understanding of *waswaas*.

Reflexivity and role of researcher

An integral part of qualitative research is reflexivity, and unlike quantitative research, the view that a researcher can be a detached and independent observer is rejected. Willig (2008) highlights that in regards to the phenomena being studied, the researcher must examine how he or she may have influenced the research process and its findings. This is because Willig (2012, p. 6) states that 'meaning is always given to data and never simply identified or discovered within it' and so the researcher's beliefs, assumptions and experiences will shape one's own interpretation of the data or, as Finlay (2003) points out, may even block insights. Finlay (2003) states that researchers need to acknowledge their own involvement in their studies. This is because our perceptions are based on our pre-judgements

and understandings which influence our interpretations when we are trying to access experience. Finlay (2011) argues that findings emerge from within a constantly dynamic, evolving and co-created relational process involving the participant and researcher. Finlay (2003) posits that one must examine their own experience in an effort to bracket it, as well as to understand participants better, as well as the impact of the relationship between participant and researcher. According to Finlay (2011) 'bracketing' helps the researcher to remain alert to how one's own ideas, experience, values and assumptions may influence the description and identification of the phenomenon. She states that it is not enough to simply identify our previous understandings and attempt to bracket them, but rather researchers should be engaging reflexively throughout the research in order to see how they impact the research process and findings.

My epistemological standpoint, which I have stated above, explicates that I see myself as being implicated in the research process. This is because my background influences how I have conducted the research, how I have helped create the data and interpret it, in ways that I may not even be aware of or necessarily understand. Due to this, throughout the research process I have had to explore, examine and reflect on my own beliefs and assumptions concerning *waswaas*. I have kept a reflexive research diary which contains the various beliefs and struggles I have encountered throughout the whole research process. It has also helped me to reflect on how my ideas and beliefs have been shaped and have evolved over time.

Willig (2001) posits that there are two main areas of reflexivity. One is epistemological reflexivity and this comprises a detailed reflection on the assumptions a researcher holds about the nature of knowledge and the world. The second is personal reflexivity and it is concerned with the beliefs, values and interests of the researcher and how these are related to the research study. In the following section, both types of reflexivity shall be reflected upon and how these have influenced my decision to study *waswaas* as a research project.

Epistemological standpoint

In order to explore my epistemological reflexivity, I have had to reflect upon assumptions I hold about the world and my views regarding how knowledge may be drawn from it. One of the most important areas in my personal life is my Islamic faith and my identity as a Muslim. I believe there is a real world and much of it may not be known to me, but I may be able to learn about certain aspects of it through religious teachings for instance. In regards to my professional life my years of working as a psychological therapist and as a Counselling Psychologist in Training are also important. Both of these facets of my life influence how I understand myself and others, and will likely influence how I conceive 'knowledge' in this study.

In regards to my professional clinical work the kind of 'knowledge' I use in order to relate to and understand my clients has developed into an integrative approach. At the core of my work is the importance of the therapeutic relationship between client and therapist and has a humanistic underpinning. For many years my main therapeutic approach has been Cognitive Behavioural Therapy (CBT) and to a large extent, it still is. However, during my training as a Counselling Psychologist and the clinical work I have undertaken, my therapeutic approach has evolved to incorporate a psychodynamic and systemic perspective too. The latter two I have utilised particularly in helping to form my understanding of clients who come from diverse backgrounds, have severe difficulties in relating to people, and whose issues stem from a wider social and political context. Such an integrative approach has helped enrich my formulation of clients' difficulties, particularly those who have experienced trauma and torture.

Each of the therapeutic approaches I employ I believe strengthen and make my therapeutic work more holistic and robust. Placing the client in their wider context, in which for instance they may have experienced some form of persecution and have had their integrity as an individual violated through acts of torture, validates and respects the client's experience and narrative. The dynamics that are played out in the therapeutic relationship (in which I have to be mindful of my own experience, feelings and thoughts too and explore these for myself), can aid in developing an understanding of the client and what he/she is experiencing and trying to communicate to me, thereby deepening therapeutic insights. Understanding a client's thoughts, beliefs, fears and behaviour can uncover the meanings they ascribe to situations and events.

This notion of understanding and unravelling knowledge through a therapist and client's interactions is a similar process to what occurs during qualitative research. Indeed, Finlay (2011) argues that therapy practice and skills are transferable to the research field and vice versa. In both one is remaining open to hearing and exploring a narrative, with the aim of leading to some kind of growth or new understanding and insights, through uncovering meanings of an individual's experiences. I do believe that I have utilised many of my therapy skills throughout the research process. For instance, whilst conducting the semi-structured interviews, I have had to remain open, interested and empathic; at times asking the interview questions felt akin to being Socratic; I have had to be mindful of my internal state and the participant's external state. Also, throughout the research process I have had to remain reflexive, just as I would have to be in therapy: examining what it is that I am bringing to the situation; what is influencing me; having an awareness of the dynamics between myself and participants; and how I am interpreting what is being said and how I am understanding it.

My therapeutic practice has grown into a more integrative approach in order that I may better understand and I believe, work more effectively, with my clients, particularly those whom have been severely traumatised. This in turn, alongside personal therapy, has allowed me to develop insights into my own internal world as well. This has led me to wonder how the participants in this study and I have changed and grown during our interactions and how we have influenced the other's understanding of *waswaas*. For instance, I was able to witness how some of the participants really took their time to reflect and respond as fully as they could, as they engaged with their thought processes out loud. One participant even noted a few things down for himself after the interview as he said the interview process had made him think of questions regarding *waswaas* that he personally would like to seek answers to. One participant contacted me after the interview to say that he was becoming even more aware of when he was experiencing what he believed to be *waswaas*.

I have also been able to reflect on how my identity as a Muslim has helped shape this research and influence the interactions I have had with participants. I have been acutely aware that we have a shared language of the Islamic faith and that there are certain aspects of our realities that we share and accept as our truths. I do believe and accept in the beings which are the *Jinn* and the *qareen*, as these are

part of my Islamic belief. It has made me wonder whether the participants would have been as open with someone from a non-Muslim background, and whether they would feel that they would have to censor or explain further certain concepts relating to the Islamic faith or certain aspects relating to their experiences. Although we may not know the direct reality of *waswaas*, we are able to learn and know some things about it through our subjective experiences, our interactions with others, and within our religious identity as Muslims, which fits in with my epistemological stance in this research. This has meant that I have had to fully engage in reflexivity in order that I may continue to remain present with the participants as they have described their experiences. I have had to temporarily leave aside my own experience, knowledge and assumptions about *waswaas* and any psychological explanations that may go alongside it, in order to explore meanings participants themselves give to it.

Personal reflexivity

My interest in pursuing this research topic was a result of many different factors. These were mainly due to discussions I have had with individuals within the Muslim community, as well as a realisation, built through the process of my training as a Counselling Psychologist, of a lack of multicultural awareness within the profession of counselling psychology and due to my interactions with some mental health practitioners. I acknowledge that although there seem to be more members entering the profession of counselling psychology from diverse backgrounds, as can be witnessed in training programmes for instance, I believe however more needs to be done to further attract individuals from a variety of backgrounds.

Over the years I have had many Muslim individuals approach me to recommend a Muslim therapist they could see. They have expressed certain fears centred on being misunderstood or judged negatively by someone who is not of a Muslim background, and an interest in seeing someone who has a shared Muslim background so they do not have to explain or justify certain matters. Some of these fears have been mentioned in this study's literature review.

As a Muslim myself I can relate to this. When I was searching for a therapist from whom I could receive personal therapy, as part of the requirement of my doctorate course, I was initially searching for a Muslim counselling psychologist. I felt a Muslim practitioner would be better able to understand my background, mainly my religious

beliefs and values. I was dismayed when I couldn't find a Muslim practitioner but then I found someone who shared a similar cultural background. This was useful because I felt this practitioner would at least have an idea of my cultural community and some of its beliefs and values. And this did prove to be very helpful at the time.

When I moved location and had to find another therapist, I again tried to find either a Muslim counselling psychologist or someone who shared a similar cultural background. However, I wasn't able to find anyone nearby so I had to settle on finding a therapist who wasn't similar to me in neither my religious nor cultural background. I found my therapy to be very useful but I think this was due to the attitude of my therapist, in the sense that she was very open and willing for me to talk about religious and cultural issues. I did have to explain certain matters, but I knew that I would have to, as otherwise my therapist wouldn't necessarily understand what I was referring to. I therefore do believe it is important that counselling psychologists are willing to explore religious issues with clients, particularly if this is an integral part of one's identity and it is something which the client would like to speak about. I feel this would help foster the therapeutic alliance and show that the therapist is respecting the client's wishes and identity by exploring this within the therapy.

The reason I chose to explore people's experience of *waswaas* was due to numerous discussions I had with Muslim individuals. Many of them said they knew people who experience it but were reluctant to seek psychological help when they felt they were struggling because they were worried that a non-Muslim practitioner would not understand what *waswaas* is or would advise them in ways that may not be compatible with their faith. Many individuals encouraged me to explore it as a research topic to raise awareness around it and to see if there would be any findings that may have wider implications and could be used to further help the Muslim community.

When I worked as a High Intensity Therapist, during a supervision session once, a colleague described a Muslim client who was constantly repeating his *wuduu'/*ablutions for the prayer. Although the case was being discussed as if the client had symptoms of Obsessive Compulsive Disorder (OCD), I didn't believe it was a clear-cut case and believed the client was lacking some basic knowledge regarding the ablution. I therefore encouraged my colleague to speak to the client about *waswaas* and to check with him if he had acquired the Islamic religious knowledge which would help him realise how to perform *wuduu'/*ablution correctly

and would also tell him whether he had invalidated the *wuduu'*/ablution, in which case he would have to perform it again. Otherwise, if he hadn't invalidated it, he did not have to listen/act on these thoughts because he would know then that he has performed a valid *wuduu'*/ablution and he would recognise when it has been invalidated, rather than acting on doubts. Brief feedback later from my colleague suggested that this discussion with her client had helped him and he had reduced the number of times he was repeating the ablution.

At this stage I would say I had a little understanding of *waswaas* and had occasionally experienced it myself in the form of thoughts centred on the religion and acts of worship. For instance, I have had what seem like doubts as to which cycle of prayer I am in, and I understand that the *waswaas* is trying to confuse me, but as I have learnt religious information as to what to do in this case, I am able to dismiss the *waswaas* and assume I have done one less cycle of prayer and so will add another one. I have also had *waswaas* regarding the Islamic belief which would usually be viewed as blasphemous. However, in such cases I recognise this is a *waswaas* due to the horror I experience at thinking that I would have thought such a thought, and as such I am able to dismiss it as I recognise then that this is not my own thought but a *waswaas*. As I embarked on this study, my developing thoughts, understandings and impressions on *waswaas* began to change and deepen. I have attempted as much as I can through my reflexivity, to question and explore my own views and understanding of *waswaas* so that I can, as much as possible, be open to and appreciate the unique and individual experiences of each participant.

Reliability and Validity

Due to dissatisfaction regarding qualitative research being assessed using the same criteria to assess the validity and reliability of quantitative research, some guidelines have been produced to assess the quality of qualitative research. Smith et al., (2009) recommend Yardley's (2000, 2008) guidelines due to its pluralistic and sophisticated stance and it's these guidelines that were applied to assess the quality and validity of this study. Yardley (2000) provides a framework in which a valid piece of qualitative research will show sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Presented below is a demonstration of how these guidelines have been adhered to and how they have been applied to this current study.

Yardley (2008) stipulates that the researcher should show sensitivity to existing literature on a particular area in developing a research topic and question. In this present study, a lot of time was spent in sourcing information on the topic of *waswaas*. Although there was not much information available in English or in the West, there is a possibility that there is more information on the topic in other languages, particularly in Arabic and in the Middle East. However, due to the researcher having limited Arabic language skills and resources or contacts, what was available in the medium of English has been used in regards to existing theoretical and empirical literature. The few studies which do exist on *waswaas* are of a quantitative nature and do not explore the personal lived experience of the individual and how one make sense of their experiences. This study can highlight how this particular group of participants understand, define and experience *waswaas* and give voice to a particular group of people, that is, Muslims, who are not adequately represented in mental health research (Hussain, 2009). This study aims to add to the existing literature and also inform practice, whilst providing the participants with an opportunity to speak on a phenomenon that they have experience of and are thereby experts on, and adding also to the multicultural awareness of practitioners.

In regards to sensitivity to the socio-cultural context, participants were interviewed at a place and time that was convenient to them, and this was at Islamic centres. The semi-structured interview which contained open-ended questions allowed participants to talk at their own pace, to express what was central for them and to share their lived world and experiences.

In regards to demonstrating commitment and rigour, the sample of participants was purposively selected and was homogenous to ensure their appropriateness and representativeness in meeting the criteria of the investigation. A sensitive and careful analysis of each case will be conducted to ensure the essence of what each individual said is captured whilst bearing in mind that the researcher is interpreting what each individual is interpreting about their lived experience. This will be done through an in-depth engagement and personal commitment to the analysis and the topic, whilst engaging in supervision and peer supervision to ensure that the data stays close to the voice of each participant.

In relation to transparency and coherence, the aim has been to provide a coherent and structured piece of work to demonstrate why there is a need for this research to be carried out, to detail the research process whilst keeping in line with the underlying principles of IPA. This is also emphasised through the use of a paper trail and a transparent analysis to show the basis of the analytic interpretations. A reflexive journal was kept throughout, and issues of reflexivity have been considered to consider how the researcher's background and interests may have influenced the study.

Yardley's last principle is impact and importance, and this has been a focal feature throughout the entire process of the study, from its conception, to the end goal, which is to shed further light on the topic of *waswaas* and add to the existing literature, and to give Muslim individuals a voice to talk about their lived experience of it, and contributing to multicultural awareness amongst practitioners.

Procedures

Sampling and Participants

As IPA is concerned with the detailed examination and understanding of personal lived experience, samples are purposively selected (Smith et al., 2009). This means that the research question may be of significance to participants so that they may offer insight into the particular experience. The participants in this study were recruited via opportunities (Smith et al., 2009), that is, as a result of the researcher's own contacts, and through snowballing, in which participants referred other people. Smith et al. (2009) recommend that IPA studies are based on small sample sizes due to detailed accounts of individual experiences which warrant a concentrated focus, and they suggest a sample size of between four to ten participants.

During the research I had begun to compile a list of Islamic centres and Mosques in the U.K. whom I would be contacting to discuss the research with and to see whether they would agree to distribute information to potential participants after knowing the details of the study, its purpose and procedure. However, during the course of people hearing about the research and enquiring about it, I found that either people were putting themselves forward or were recommending that I speak to particular individuals who they believed would be willing to participate. Each time

I was given a name I would either directly speak to the person then and there to give them further information about the study or after having received people's contact details, such as a phone number or email address, I would then contact the individual to explain the research and to see whether they were interested in participating, and to also assess their level of English. I explained that all information they gave would be anonymised, that they did not have to say anything they did not feel comfortable to say, and if they agreed to take part, they would have to sign a consent form (see appendix D).

Through this means ten individuals agreed to participate. However, it became problematic to arrange a convenient time and place to meet two of them, as they had other commitments that seemed to get in the way or were not always in the country. It was therefore discussed and agreed with them that it did not seem feasible for them to participate in the study at present and they were thanked for their willingness to take part. Some individuals also recommended contacting individuals outside of the U.K. but after some consideration it was decided to only recruit participants from within the U.K. due to practicalities and because of the possibility of further ethical clearance being sought in which time the study may have to be placed on hold.

Eight Muslim individuals, aged between thirty and fifty-three years of age, comprising of five men and three women, agreed to participate in the research. Only participants with an understanding and lived experience of *waswaas* and who had a good grasp of the English language were recruited. All participants self-identified as Sunni Muslims and only one participant had had prior contact with mental health services.

Participants were asked to record their ethnic origin in the demographics form (see Appendix E). Although all participants identified themselves as British, just over half of the participants had an Arab background, whilst one participant declined to share her ethnic origin. A particular ethnic group of Muslims was not selected prior to the study, so as not to exclude anyone who wished to participate, particularly as there is very little known about the lived experience of *waswaas*. Although this is a purposive homogenous sample to whom the research question is meaningful (Smith et al., 2009), it also has a degree of heterogeneity, allowing for a diversity of backgrounds, experiences and meanings across the group. This seemed appropriate to gain access to the perspective of Muslim individuals' experiences of

waswaas, whilst also granting the possibility of convergence and divergence within the group (Smith et al., 2009).

The demographics form (appendix E) provided information regarding participants': gender, age, ethnic group, occupation, level of education and any prior contact with mental health services. The latter two were included as it was cited as a limitation in a study exploring Muslim individuals' beliefs about *Jinn*, black magic and the evil eye by the authors themselves (Khalifa, Hardie, Latif, Jamil and Walker, 2011). It was decided therefore to include this information in this study in order to help to contextualise participants' responses and perhaps add greater depth of meaning. One participant however declined to give his occupation.

Table I below displays participants' demographic details. Pseudonyms have been provided to preserve anonymity.

Name	**Age**	**Nationality**	**Level of Education**	**Occupation**
Ismail	36	British Arab	Bachelors	Teacher
Tariq	38	British Arab	PhD	*Declined to fill in*
Maria	35	*Declined to fill in*	PhD	Lecturer
Mansur	37	British Pakistani	MBCHB, BSc	G.P. and religious lecturer
Zakariya	53	British Arab	NVQ	Gas Engineer
Sarah	30	British Arab	Masters	Marketing
Nida	48	British Arab	Secondary education	N/A
Abid	34	British Indian	MBBS, BSc	Doctor

Ethical Considerations

Full ethical approval was granted for this study by the Ethics Committee of City University. Ethical consideration was also given to the implications of the research in accordance with the British Psychological Society Code of Human Research Ethics (2010).

At the beginning of each interview both oral and written informed consent was obtained from each participant to ensure that the aims and purposes of the research were understood. Participants were informed that they did not have to answer any questions they did not wish to, nor did they have to reveal any personal information or answers. The written consent form (see Appendix D) provided information relating to the purpose of the research, the researcher and supervisor's contact details, the right to terminate the interview at any time and the right to withdraw data given. It also stated that verbatim extracts from the interview may be included in the final write up. All signed materials provided by participants are kept securely in a locked cabinet at the researcher's home

Participants were also asked to give consent to allow the interview to be audio-recorded. Each interview was recorded using a digital recorder and stored anonymously on a password-protected computer in the researcher's home. Participants were made aware that the audio file would be transcribed and analysed using IPA. Participants were informed that audio recordings and all signed materials would be destroyed once the study was fully completed.

At the end of each interview time was set aside for a debrief with each participant and to discuss any issues that may have arisen during the interview, although it was not anticipated that any adverse risks would be raised for participants during the interviews. Participants were given a written debrief form (see Appendix F) containing information relating to the purpose of the study, the researcher and supervisor's contact details, as well as information regarding support services, if required, following the interview.

Each interview was transcribed by the researcher and anonymised so that no individual would be identified. All potentially identifying details, including names of participants and any other names they gave, were changed during this time. This excluded the names of Muslim scholars whom participants referred to, to either

support their claims or whom were used as references regarding certain matters. The transcriptions included the words ‘um’ or ‘er’ and pauses were also indicated, as well as laughter, coughs, and clearing of throats noted.

Interview Procedure

Interviews were conducted by the researcher at a place and time convenient for the participants and took place in Islamic centres. The semi-structured interviews allowed participants to offer detailed accounts of their experiences freely and reflectively in their own words. Some participants requested seeing the interview schedule at the start of the interview and any concerns they had prior to the interview starting were discussed with them. Participants were encouraged to talk as freely and openly as they wished and were reminded that all data would be anonymised. It was also explained to them that some questions they may be asked may appear simple to them and which they may think that the Muslim researcher should be aware of already, but they were encouraged to respond with as much detail as they wished and to imagine they were speaking to someone who was not aware of the Islamic faith.

The interview schedule (see Appendix C) contained some general and open-ended questions to facilitate discussion on the topic of *waswaas*, with more specific questions acting as prompts. The questions were exploratory and focused on processes and meanings (Finlay, 2011), and were informed by the research question. The interview guide provided a framework, but also provided the flexibility to explore novel issues as they arose and enabled the researcher to formulate questions impromptu, allowing participants to talk freely about their experiences. As Smith and Eatough (2007) point out, the researcher has an area of interest to pursue with some questions, yet there is a desire to enter as much as possible the social and psychological world of the participant. In this regards the participant is active in shaping the interview process as he or she is seen as the experiential expert and should be given as much opportunity to tell one’s own story.

With one particular participant, the interview guide was abandoned at times as the researcher followed the concerns of this participant, whilst making a note of key words and topics the participant referred to, to follow up on later and eventually re-

introducing the interview schedule. Smith et al., (2009) emphasise that the participant is the expert in the topic being discussed and so at times it may well be necessary for the interviewer to move away from the schedule and follow the participant's concerns. Smith and Eatough (2007) highlight that these unanticipated avenues can be valuable, as they have been unprompted and may be of some significance to the participant.

A pilot study was conducted on the first two participants who volunteered for the research in order to review the interview process and to reflect on relevance and appropriateness of the interview questions. After both of these interviews it was noted that neither participant had mentioned anything about the devil nor the *Jinn*, although it is claimed that this is from whom the whispering or *waswaas* originates. Due to this, it was decided to add a further prompt. Both participants had mentioned that people who experience *waswaas* have thoughts, so a prompt was added to the interview schedule 'Where do these thoughts come from?' to see what responses this might elicit. However, subsequent to this prompt being added to the interview guide, it was not used as all the other participants openly spoke about the *Jinn* and the devil of their own accord. These two pilot interviews have been included in the data.

Analytic Strategy

The transcripts were analysed using IPA developed by Smith (1996). Although there is not a prescriptive method of working with the data, analysis is described as an iterative and inductive cycle (Smith et al., 2009) and some guidelines have been suggested. Smith et al., (2009) highlight that the researcher is engaging reflectively with a participant's account and so the analysis is a joint product because of the double hermeneutic, that is, the analyst is trying to make sense of how the participant makes sense of his or her experience. Therefore, the analysis will be subjective and tentative.

As IPA is influenced by idiography, each transcript is worked through individually first before moving on to the next. Smith et al., (2009) stipulate that the researcher must be fully immersed in the transcripts, reading them again and again whilst engaging in a line by line analysis of each participant's account. They recommend

that the researcher use the left-hand margin of the manuscript to note anything interesting or striking that they find in what a participant has stated, such as initial interpretations, questions, metaphors, summaries, and themes. Then the researcher will begin to identify emergent themes within each individual transcript that capture the essence of participants' experiences, and then later across all the transcripts, particularly with issues of divergence and convergence. The researcher then begins to interpret the data using one's psychological knowledge in trying to understand what these concerns might mean for participants in such a context. Themes which bear a connection will be clustered together and then each cluster will be given a descriptive label which represent superordinate themes (Smith and Osborn, 2008). The themes will constantly be checked against the transcript data to ensure they are reflective of the participant's experience. The superordinate themes are then organised into a table with their constituent themes with quotation references to show where each theme can be found in the transcript. This same procedure will be repeated for each individual transcript. These themes will be integrated throughout the transcripts through a cross-analysis and then a summary table will be produced which consists of the superordinate themes and their constituent themes.

Smith et al., (2009) stipulate that all of the material should be organised in a format that allows for the data to be traced throughout the entire analytic process, from initial comments, to initial clustering and thematic development, to the end structure of themes. They advocate the use of supervision and collaboration throughout the process to test and develop the plausibility and coherence of the interpretation. A narrative account will then be produced, using extracts from the participants' accounts in the transcript, along with the researcher's interpretation of them, to help guide the reader through the interpretation. They encourage the researcher to engage in a continuous process of reflection in terms of one's processes, perceptions and conceptions throughout.

Summary

This section reviewed the methodology and method used in this study. A qualitative research approach, IPA, which examines how people make sense of their lived experiences was chosen. The manner in which the research was conducted was also discussed, including sampling, data analysis, reliability and validity, reflexivity in qualitative research, and ethical considerations.

Chapter 3

Analysis

In regards to data analysis an interpretive phenomenological approach was employed with the aim of exploring in depth eight Muslim individuals' lived experience of *waswaas*. A detailed analysis of the data provided access to each individual's world for a short time based on their own unique and subjective experience of *waswaas*, yet it became clear that some of the themes that began to emerge were shared by some of the participants. In this chapter the aim is to share insights and discoveries which have emerged through the analysis process, and to shed light upon the participants' experiences of *waswaas* and the meanings and implications it has for them.

Three superordinate themes emerged from the analysis: *The Qareen,* Impact and Consequence of *Waswaas*, and Therapy can be an Asset. The first superordinate theme 'The Qareen' captures participants' understanding and experience of there being another being who is responsible for the *waswaas*, which are unbidden thoughts, and the methods it employs to do the whispering. The second superordinate theme 'Impact and Content of *Waswaas*' presents an account of some of the different ways participants might experience *waswaas* and other issues experiencing *waswaas* might lead to. The third superordinate theme 'Therapy can be an Asset' refers to coping mechanisms which might be employed to help deal with the *waswaas*.

Attention must be drawn to an important concept that ran through the participants' narratives, which is that participants spoke about the fact that an individual may experience thoughts or 'voices' from different routes, and this was further broken down in to voices that one does have control over, i.e. their own inner voice which they are in control of, and another two which they are not in control of. This distinction between the types of voices appears to be important as participants described the issue of accountability being closely tied in to whether it is a type of voice/thought one has control over or not, and whether one then acts on that thought, as this will have a consequence for the Muslim individual in the Hereafter. All of the participants mentioned that *waswaas* is a type of thought that is not initiated by them, so they do not have control over it. What is of concern though is what they do with this whisper, for this is when they will now become accountable for acting on or rejecting this whisper, and it is this which is of significance because

this is what will have an impact on their situation in the Hereafter. Participants also spoke about their belief that *waswaas* occurs to everyone, so they understand *waswaas* to be something which is universal, which occurs to every individual human being (apart from Prophets), regardless of their age, background, culture and belief system.

Overview of Emergent Themes

The themes are depicted in the below diagram. The diagram is just one illustration of the themes rather than a comprehensive representation of them, and they are clustered in this way for the sake of clarity. Therefore, the themes should not be deemed as existing in isolation but as being interrelated.

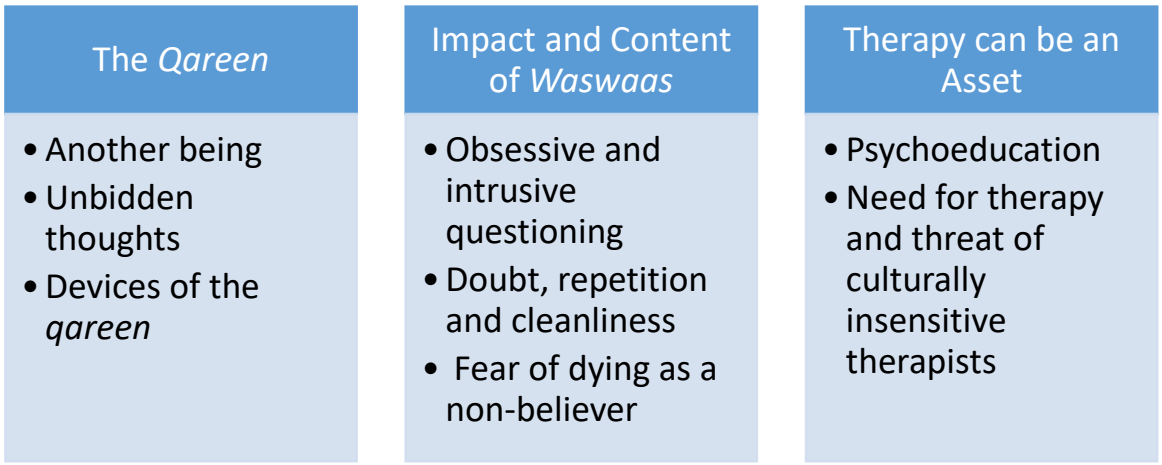


Figure 1. List of themes and subthemes

The participants' own words will be presented as extracts from the transcribed interviews along with interpretations of the text, and the participants' quotations are referenced by page and line number, in accordance with the original transcript. Some participant quotes have been omitted and are represented by '…'. This was done in order to improve fluency for the reader and only when words were felt not to be essential to the overall meaning conveyed by the participant, such as false starts or hesitations.

Superordinate theme one: The *Qareen*

The first superordinate theme captures how many of the participants' experience and make sense of the *waswaas* as something that is separate from them, and occurs from not their own volition but from another being called the *qareen*. This other being is able to place thoughts and images in to their 'minds' over which they have no control. Many of the participants described various ways the *qareen* operates in making people experience *waswaas*, as well as when or who the *qareen* is more likely to target. As a result, three subthemes capturing this will be presented: Another being, Unbidden thoughts, and Devices of the *qareen*.

Subtheme 1: Another being

The first subtheme aims to capture many of the participants' experiences of another being that is independent from them and who is responsible for the *waswaas*. The narratives portray that such an understanding of the existence of another being emanates from their religious beliefs as Muslims. Nearly all of the participants explained the Islamic belief of another creation known as the *Jinn*, which generally are not seen. They spoke about some of the similarities they share with humans, such as that some of them are also Muslim and some of them are not. It is the non-Muslim *Jinn* that are referred to as devils and the ones who are responsible for the *waswaas* are known as the *qareen*.

Before attempting to understand what *waswaas* is Mansur explains that there is something else which needs to be understood first, as he begins speaking about the *Jinn* and the *qareen*:

> From if you like a modern science perspective it is also understood there are things for example from radio waves through to other signals that are known to exist even though we cannot actually physically see them. Islaam recognises that concept that there are things that we know about their existence, although we cannot physically actually see them, that is, with the … naked eye. (Mansur: 1, 10-14)

Mansur appears to be aware that the notion of the *Jinn* may seem strange to those who have never heard of such beings or who easily dismiss such beliefs. This is evident in his attempt to place such a belief in context so that it may seem more palatable and less odd by drawing similarities to other notions in the realm of science which are widely accepted as facts, though they too cannot be 'seen'. There is a sense that he is appealing for people who do not share similar beliefs to be open-minded and to be open to other cultural views. At the same time, it appears as if Mansur is revealing about himself that just as he is able to easily accept scientific ideas without seeing a representative physical entity, so too it is easy for him to accept religious ideas about the unseen and that the two are not mutually exclusive, but rather science and religion can go hand and hand and co-exist.

> this *Jinn* is referred to as a *qareen*, which literally means a companion. And in general the *Jinn* that accompanies human beings, because it is a … non-Muslim *Jinn*… they are referred to as a *shaytaan* … or one amongst the *shayateen*. (Mansur: 2, 23-27)

Mansur describes the *qareen* as literally meaning a 'companion', which suggests a being who is loyal to one and is constantly by someone's side.

Many of the participants spoke about the *qareen*, including Sarah:

> the *qareen*, which …in Arabic it means … your follower … who is from this category, which is the *Jinn*, the devil, who follows you since you are born." (Sarah: 4, 28-31)

Here Sarah reveals that her understanding of the *qareen* is 'your follower'. This suggests that each individual has this invisible being who is always with a person following them since the day they came in to existence.
Nida too refers to the *qareen*:

> And every human Allaah has created the *qareen* for him, stays with him all his life (Nida: 1, 11-13)

Nida's words that the *qareen* stays with one 'all his life' sounds somewhat ominous. This coupled with the translations of Mansur and Sarah of the *qareen* being a 'companion' and a 'follower' gives the impression that one is stuck with the *qareen* and not able to break away from it.

Zakariyah too mentions the *qareen* as something that is with someone and has been with one since the individual was born and he mentions that the *qareen* 'stays with him and whispers to him' (Zakariyah: 1, 6-7). Zakariyah and many other participants expressed that their understanding is that it is the *qareen* that whispers the distressing thoughts. What it whispers and why will be looked at in the following sub-themes.

Subtheme two: Unbidden thoughts

For the majority of participants their initial attempts at understanding *waswaas* focused on describing another being known as the *qareen*. After the initial religious explanations as to what the *qareen* is, participants then began to address what they understand *waswaas* to be, and their attempts at trying to explain who the *qareen* are became clearer. The majority of the participants explained that the *waswaas* actually comes from the *qareen* itself, so it is the *qareen* that is the cause of the *waswaas*. The words 'whispers', 'thoughts' and 'voices' were used interchangeably by participants in reference to *waswaas*, and as such will be used throughout this chapter. The *waswaas* is a whisper or thought that one receives from the *qareen* and which causes one distress.

Although Tariq did not mention the *qareen* in his interview he described the *waswaas* as the following:

> Essentially… it would be like involuntary thoughts… A thought that might come to a person without him wanting it to occur to him, without intending to do something… a thought that might come to him to do a certain thing that he doesn't want to do." (Tariq: 1, 6-10)

This suggests that when he experiences *waswaas* he is resisting but despite his attempts such thoughts force themselves unto him and find a way through his 'defences'. This thought focuses on something he does not wish to do but perhaps feels compelled to do.

Abid elaborates on the nature of the thought:

> something that interferes with a person's thinking that causes them distress. So it's like thoughts … but thoughts that cause distress (Abid: 1, 2-3).

Abid's use of 'interfere' suggests there is a form of communication or line of thought which is clear and fine and then all of a sudden there is a form of static which meddles with the line of thought, disrupting it and disturbing him. This 'static' i.e. whisper is something he is forced to listen to and think about.

Maria defines *waswaas* as a 'whisper':

> "*Waswaas* originally in Arabic it means a whisper… it's something that creeps in to your mind, something that you hear, and obviously the issue with *waswaas* is that people have the impression that it's coming from them… when really we define it as an involuntary thought, that's what *waswaas* is. It's a thought that is in their mind but it's an involuntary one…It's a thought which is not initiated by you. (Maria: 1, 2-6)

Maria's understanding is that *waswaas* is a whisper that she can hear and stealthily enters her mind. Her use of the word 'creep' suggests a bogeyman character that sneaks up on someone unexpectedly and scares them. And perhaps this is what Maria is saying, that the *qareen* is something scary, something which whispers and disturbs her. It is interesting that when she mentions that the *waswaas* makes people think that it is they who have initiated these distressing thoughts themselves, she goes on to explain however that 'we' understand them to be involuntary and not in one's control, perhaps referring to the Muslim community as a whole.

Zakariyah talks about where the whispering actually occurs:

> *Waswaas* is like whispering in somebody's chest from the *shaytaan*' [devil] (Zakariyah: 1, 2)

He goes on to explain that 'a person next to him can't hear it' (Zakariyah: 1, 5-6) and this is so 'because this is something private' (Zakariyah: 2, 14). This may sound unusual as typically when one pictures someone whispering, it is of someone whispering in to the individual's ear, but here Zakariyah's understanding is that the *qareen* whispers to an individual's heart. This understanding was shared by many

of the participants, who also stressed that the whispering is a private matter, done only to the recipient of the whisper and no other is privy to it.

Abid, a medical doctor, highlights how little is actually known about the heart and the mind:

> according to the Muslims, … the belief and things like that occur in the heart. So the heart has got its physical and its spiritual aspect … and the mind is something different from what I understand … well, even in Western thought they don't quite know where to position the mind, so the brain and the mind are different. So likewise the heart and its physicalness and … otherwise, are different as well, so I don't quite know what the mind means, even in a Western point of view… so the *waswaas* enters through the heart, because it's through the heart that thoughts, and intentions and beliefs take place (Abid: 2, 21-26)

'Even in Western thought' suggests that Abid is trying to show that the concept of the 'mind' is something which is also elusive in Western thinking and does not have a specific location, although it is seen as a different entity to the brain. Abid later repeats this phrase 'even in a Western point of view' suggesting that he straddles both a religious Islamic worldview as well as a Western cultural worldview, but that his primary point of reference is his religion.

Mansur also talked about the heart and the mind and where the whispers are located:

> …so in essence it appears like a voice on the inside uh and this is where the word *waswaas* literally means one that whispers to the hearts of the human beings. And if you wanted to consider that in general terms, you would say whispers to the minds of the human beings. (Mansur: 3, 42-44)

'If you wanted to consider that in general terms' suggests that Mansur is stating that indeed the mind is where the heart is, that either they are the one and same entity or that they share some purposes. Mansur also appears to be suggesting that the whisper is experienced as a voice, not just merely as an unspoken thought, which is heard by the person whom the *qareen* is attached to.

All of the participants spoke about *waswaas* as being whispers and thoughts, and Sarah also mentioned that they can occur in another form as well 'They can occur as images or … like sayings, like, just as how we think.' (Sarah: 2, 25-26). She later

elaborates on this and talks about a mother who experiences unwanted 'ideas' about killing her own baby:

> Who would think such a thing (laughs), like, kill your own baby? These are ideas, so if the mother is thinking that it is coming from her, she would start believing that she is a horrible mother, she is terrible…And then she will- this idea would keep coming to her. Like, she would even see pictures or, or scenes of her killing her baby, or she would see a knife and this idea would come to her. (Sarah: 5, 75-81)

Sarah sounds incredulous that any mother would have such thoughts intentionally and her laugh suggests that such a notion for her is further proof that this is a *waswaas*, a 'horrible' idea planted by the *qareen* and not by the mother's own volition. However, because the mother is unaware that these in fact are not her own thoughts she starts to believe that this is what she genuinely wants to do and that she must harbour desires to harm her child, and so she ends up believing about herself that she is a 'horrible' and 'terrible' mother. I wonder though if this is her own experience and by using the third person 'she', whether Sarah is creating a distance between the material she is relaying and the fact she is talking about herself.

Abid speaks about when the distinction between one's own thought and a *waswaas* is no longer easily made that this is when problems may arise:

> So the problem occurs when the boundaries blur and you become so engulfed in it that you no longer can confidently tell what's you and what's not you anymore. That's the bit that's distressing, not the mere fact of getting the *waswaas*. Like I, when I used to get *waswaas* when I was a bit stronger, then at that point erm I didn't like it but I could ignore it, because I was like well, it's not me so why should I be bothered about it? But when you can no longer confidently make that distinction, that's when it gets very distressing. (Abid: 9, 118-122)

Abid points out that when he receives a *waswaas* that in itself is not 'distressing' but rather when he can no longer make the distinction between the *waswaas* and his own thought. His description of things becoming blurry and losing confidence in his ability to distinguish between his own self and another, and being 'engulfed' in such a state does indeed sound distressing. It appears that when he experiences *waswaas* when he is 'stronger' although he does not like it, he can easily shrug it

off and not be affected by it because he knows it's not his own thought. But it seems that when he loses his own self or the ability to know his self and separate or disentangle his self from the *waswaas*, this is the 'distressing' element, leaving him in a confused and powerless state. When asked to clarify what he meant by 'stronger' Abid explained: 'By stronger I just meant being able to tell the difference between different types of thoughts' (Abid: 10, 128). By having a clear distinction between his self and the *waswaas* Abid is able to avoid such an overwhelming internal confusion, but when he loses his sense of self and feels invaded or infiltrated by the *waswaas*, a sense of terror and anxiety is evoked within him.

Subtheme Three: Devices of the *qareen*

Many of the participants spoke about their understanding of the reasons why the *qareen* whispers to people, such as to misguide people by getting them to listen and then act on the *waswaas* in order to do something which goes against the teachings of the religion of Islaam (such as to commit an 'evil' act or to leave out an obligatory act of worship) or ultimately to make them commit blasphemy and leave the religion of Islaam so that they are no longer Muslim.

All of the participants spoke about the fact that someone is likely to experience *waswaas* because either the individual is lacking in religious knowledge to do with certain issues or because the person is already experiencing mental health issues which make one more prone to the *waswaas*. Regarding the lack of knowledge though participants differentiated between one who has no interest in learning and remains ignorant about matters, compared to the one who is learning but still does not have enough knowledge yet. There is a sense that the *qareen* will also target those who are seen as vulnerable or have a weakness in a certain respect, and that it has many ways by which it targets an individual and will adapt its methods if needs be.

Abid explained about having weakness in knowledge by giving an example of someone who is unsure whether they have done the ritual washing properly:

> if they had the knowledge of what constitutes erm the conditions and the erm steps involved in doing this wash, then they'd know erm whether that was done or not, like there wouldn't be a grey area. So, and the more they learn, they'd even understand the grey areas. For example, if they thought that they left a step

> out, what do they have to do? Do they have to start all over again or do they just leave off from where they think they stopped, or you know? So it helps to have that knowledge because if you don't have that, then you probably, someone might probably do what he thinks is acting by precaution and then overdo it, and then each time successively overdo it even more, just as he might call it to cover himself. But if someone has the knowledge then they don't go through those steps and that laboriousness. And the more knowledge they have the more they know about how to handle different scenarios from a religious point of view. (Abid: 12-13, 156-163)

Abid suggests that a lack of religious knowledge is a major chink in one's armour so to speak. It appears that by arming oneself with religious knowledge there are no gaps for the *waswaas* to come through from because one is defending oneself from as many areas as one can, including the 'grey' areas. By having religious knowledge on certain matters it appears that Abid is suggesting one is more confident in handling certain situations. His use of the word 'labouriousness' is quite striking and suggests the tiring process one undergoes when one lacks this information and doesn't know how to proceed. His repetition of the words 'overdo it' suggests this may lead to an extremity in one's behaviour with the belief one is trying to protect oneself from all angles.

Ismail elaborates on this further:

> My own experience because of a lack of knowledge... when I first started learning, I didn't understand particular issues properly through a fault of my own. I didn't spend enough time to review certain things and understand them properly. So therefore because of the lack of understanding, I developed... I wouldn't say a serious form of *waswaas* but... it caused me anxiety... and I would go through like phases. But it was tackled by then addressing these issues and learning more and understanding issues more. So therefore I tackled it. (Ismail: 6, 64-68)

His use of the word 'tackle' seems to suggest that he grappled and wrestled with the *waswaas* that he was experiencing. He notes that his experience of *waswaas* wasn't a 'serious' form of it but he adds that nonetheless it did cause him anxiety. It is unclear if he is downplaying his experience of *waswaas* or whether he is pointing

out that although it wasn't serious compared to other cases of *waswaas* that he may know of, it was still a distressing experience for him.

Zakariyah also speaks about that prior to learning, due to his lack of knowledge he wasn't 'bothered' by the *waswaas*:

> before I learnt, when I had the *waswaas*, because I didn't know the knowledge and I didn't know the difference between what's good, what's bad… this one didn't use to bother me. Because of being ignorant and you don't care about whether you're doing good or bad, this doesn't bother you. Like, if you are… trying to be good and carry on in the right path, and ... when you have a *waswaas* of evil things, you want to get rid of it, to keep it away, because you know this is ... not good thing. But when you are ignorant and you don't know the difference between good and bad, it might not ... bother you in a way ... that you listen to it ...and the *shaytaan* is happy, the devil is happy that you are - whatever he says you don't disagree. (Zakariyah: 11-12, 123-129)

It seems that before Zakariyah started learning religious knowledge having some kind of moral compass was of no real interest to him. Therefore, it appears that he is saying that in such a situation he was more inclined to pay attention to the *waswaas* and perhaps even act on it, which in turn makes the devil or *qareen* happy because he isn't then battling it. Whereas if he makes a conscious effort to be good and do the right thing, this is when he would be more troubled by the *waswaas* perhaps and actively tries to find ways to keep such thoughts away. The change in the first person to the second person suggests that Zakariyah is stating that this isn't just his situation but actually applies also to others more generally.

Maria also picks up on this thread that the *shayateen*/devils don't disturb someone who is ignorant about the religious knowledge and is not interested in learning it, but rather it is when someone starts learning that this is when one is more likely to experience *waswaas*. This is something that other participants also shared in their accounts. Maria refers to something that a religious scholar has mentioned to explain this, by offering a vivid comparison to illustrate this:

> the *shayateen* [non-Muslim *Jinns*/devils] are like thieves; they do not go to empty houses…Because when the person hasn't learned, they're already misguiding themselves, they're already doing things which are wrong, but they don't care because they don't- they're ignorant anyway so where's the chance of them

> doing something correctly? If they're ignorant it's all wrong...So the *shayateen* [non-Muslim *Jinns*/devils] don't really need to help that person go astray because they're already straying themselves... so they're like an empty house, and thieves wouldn't go to empty houses. But… when you start acquiring precious items, and there's nothing more precious than your knowledge about the religion, then that's when… they start having an interest you, and they literally assault you with thoughts and you know doubts and whether you should carry on and etcetera, etcetera, etcetera. And they do it really strongly, especially at the beginning, for that reason. (Maria: 16, 186-197)

'They literally assault you' gives the sense of an individual experiencing a pounding, a psychological beating so to speak from the *qareen*, who use an onslaught of 'thoughts' and 'doubts' as their arsenal to weaken a person's resolve to continue to acquire religious knowledge.

Ismail and some other participants mentioned that some people who are aware of *waswaas* become scared that if they start to learn religious knowledge, they will start to experience *waswaas* but that this shouldn't put someone off from learning:

> there are those who haven't learnt - and that's a fear that sometimes er people just think that, I don't know if I want to say this … but the issue of you know, they might wrongly think that if you learn then this is what will happen to you, or if you become religious then you will have- and that's not the case ... It's not, in fact if you learn properly you open your mind and you don't have these issues. Through a fault of my own I suffered through this because I … didn't continue with what I should have continued to learn my religion properly and apply it. (Ismail: 8, 83-87)

His hesitancy, reluctance or unease in wanting to bring up this issue demonstrates his concern that maybe someone may misunderstand and believe that it is indeed the case that if one learns religious knowledge they will experience *waswaas* more. Ismail cuts himself off at one point to stress that in actual fact this won't happen and his strength of conviction is reinforced when he links back to his own experience and lays the blame within himself. He made himself 'suffer' and it almost seems as if he is warning people not to do what he did, which is that he didn't learn the 'religion properly and apply it'. His conviction that one won't receive *waswaas*, along with his reassurance, is shown when he advises one to 'learn properly' so that one's mind

becomes more ‘open’. It would have been useful to have explored this further with him as to what exactly he meant by this.

Sarah talks about how persistent the *qareen* can be by returning to the example of the mother receiving whispers about killing her child:

> He can give her these ideas of killing her baby, and she would just ignore it and she wouldn’t show anything on her face or in her behaviour or anything that would make him think that she’s not following him, and then he would just leave her, just leave this idea. He would try something else, but this idea he would leave it because he sees that it doesn’t work. (Sarah: 9, 93-96)

She suggests that if someone remains stoic in the face of the whispers by not showing that one is being bothered by them, this will deter the *qareen*. Initially Sarah says that the *qareen* would leave the mother, but then it becomes clear that he will ‘leave this idea’, not the mother. Rather he would try a different angle and come back to whisper to her again, a point made by other participants too. This fits in with her definition of the *qareen* as being ‘your follower’, so although he may change tactics he still does not leave one alone but continues to ‘follow’ one. It is interesting that she uses the same word to talk about the mother not ‘following’ the whispers, suggesting the dynamic between an individual and the *qareen* in that they both end up ‘following’ each other if someone pays attention to the whispers.

Many of the participants mentioned that the *qareen* also tries to confuse someone as to what are their own thoughts and what might be *waswaas*, so that the individual might believe that they themselves actually initiated the thought that is bothering them. Mansur explains this when he uses his own example of when he has had what is a distressing thought for him regarding the Existence of God:

> And the devil though as I was mentioning before doesn’t stop with one thing; he would then follow that up. And I’ve also experienced that, which is that uh the devil would say uh “that was *you*, that’s *you* doubting, it’s you yourself. This is your active thought; you are the one who is actually doubting.” (Mansur: 49, 644-646)

It is easy to see how quickly one might become confused and lost if an individual keeps experiencing a thought which is telling him/her that this really is one’s own

thought and not a *waswaas*. This brings to mind what another participant Abid had said earlier that when the boundaries between *waswaas* and his own thoughts are blurred that this is when it becomes a distressing experience. It does indeed sound frightening to imagine being in a state in which one can no longer trust what are one's own thoughts and what is *waswaas*, almost as if one is starting to lose grip on their own reality, their own mind, their own being.

Superordinate theme two: Impact and Content of *waswaas*

Many of the participants pointed out that it's not always easy to know whether someone has *waswaas* unless they say so directly themselves but there are indications which may suggest the person is experiencing *waswaas*. Participants gave many examples of *waswaas*, although they seemed to centre mainly around issues to do with whether something was blasphemous; doubt about whether something has been done properly and so one repeats it, and making sure something is clean; and someone continuously asking questions of a religious nature.

Subtheme one: obsessive and intrusive questioning

Many of the participants said that if a person repeatedly asks questions, this is a sure indicator that the person may be experiencing *waswaas*. For instance, Abid stated:

> if a particular topic is being talked about or, or discussed they might get fixated on a particular aspect of that, erm and ask questions, in a way that it might make you think whatever answer you give, they're going to have a comeback because something else has occurred to them. And then they just keep asking and asking ... in a way which doesn't necessarily show that they're just being inquisitive but more uh maybe obsessive. (Abid: 4, 47-50)

It seems that Abid is suggesting that someone might hone in on a certain issue, almost as if they are stuck or somehow attached to it, and repeatedly ask questions. Abid's use of the term 'comeback' conjures up an image of a game of tennis where the individual is quick to volley question after question in an 'obsessive' manner.

Maria also highlighted that the types of questions that are asked are very specific and not because the person is curious or is eager to learn more, but because the *waswaas* will make a person continuously ask questions:

> The questions, they seem- if they seem far-fetched, erm you say to them something and they, now they don't know anymore. Like they come to you with something, they ask you a question, you give them an answer, and then they go like, actually no my case was something else. And then you answer that but then they say actually no, and it's like that, and it goes on and on and on… there can never be a definite answer. Or you say to them and they're like oh but actually even what I told you I'm not even sure it happened like that, maybe it was this other thing. And then you yourself don't have the answer to that. And then it just carries on and on and on. (Maria: 8, 88-93)

There is a sense of frustration that comes across as a result of the 'far-fetched' questions Maria has been asked and a sense of futility in answering questions when her responses don't seem to satiate the individual, but rather lead to further questions. It is interesting to note that she repeated the phrase 'on and on and on' later and perhaps this suggests how fed up she is of such situations. What also comes across again is the confusion and a sense of being lost in one's head as the individual experiencing the *waswaas* appears to figure out what their actual question is or how the situation relates to them. This again gives the sense that one who is experiencing *waswaas* becomes lost and shackled by it.

Tariq discloses his irritation regarding being asked such questions:

> Sometimes, the question itself, er from one point of view, annoys you because you know this person's just getting these thoughts to say what if, what if. You know it's not them wanting to learn, er it's not something that they're genuinely, some might say genuinely asking. You can see, you can notice that, sometimes they're just looking, what if, and then staring in thin air, and they're saying what if, what if, what if. It is- it's annoying in some cases. (Tariq: 9, 93-96)

It appears that if someone was sincere in asking their questions because they want to know the answer Tariq may not be annoyed by this and wouldn't mind responding, but perhaps it is the disinterest or ambivalence that irks him and maybe which he even resents. His description makes me think of a robot or someone who is detached and is just blank and emotionless, asking questions with no real interest

in the answer, nor any understanding or awareness of how they might be affecting the other person.

Ismail spoke about asking questions himself due to his own experience of *waswaas*:

> I didn't make it so apparent for people to know, so it was like a silent suffering as such (laughs). It wasn't- people didn't know about it, unless they were experienced and then they picked up certain things from my questions. When I questioned and I behaved in a particular way, …erm, it took me a while to do certain things, I asked questions in a way that it indicates alarm bells that this person is not asking a question because he wants to learn, he's asking questions because he's got paranoia, he's paranoid about certain things, so that's how they picked it up. (Ismail: 8, 88-92)

Ismail's experience of *waswaas* wasn't so obvious to people and as a result he suffered in silence. The sense of pathos evoked by those words are almost concealed by his laugh, as perhaps Ismail is creating a distance between himself and his painful experience or perhaps because he wishes he had made it more 'apparent' to people so that he could have been helped earlier and his laugh is masking his regret for not having done so. Ismail had to endure his suffering alone and kept his inner turmoil private and hidden from others. Ismail is also echoing what the other participants have mentioned, that if one is experienced in dealing with *waswaas* they are able to realise that someone might be experiencing it through the manner of questions they are asking and through their behaviour. Ismail points out that the manner of his asking questions seemed to act as a warning signal to alert people to the fact that he wasn't asking due to a desire to learn but rather because he was experiencing *waswaas*. It would have been helpful to have explored with Ismail what he meant by 'paranoia', as it would have been interesting to see whether what he meant was something similar to what Abid had said, that someone becomes 'fixated' on an issue, or did he mean something different altogether?

Subtheme two: Doubt, repetition and cleanliness

Some of the participants spoke about individuals repeating acts of worship because they doubted the validity of what they had done. Some of them also spoke about an individual being concerned whether something was clean or not and then acting on the urge to clean it.

Sarah spoke about an individual that she knew of who would experience *waswaas* when performing ablution in order to pray:

> for example, in the ablution, washing the face is an integral. So there are boundaries to the face. So she would double-check and double-check and double-check one hundred times that she is uh reaching the boundaries of the face. (Sarah: 12, 122-124)

Sarah emphasises the word 'double-check' which suggests initially that one wants to be cautious and so to be safe one repeats the action, but Sarah then follows it up with 'one hundred times' which implies this is now an extreme reaction and the person has now gone beyond the limits of wanting to be cautious, giving the sense of a loss of control. She continues to say:

> Or having the intention to do the *wuduu'*, the ablution, is something, uh is an integral, and it has to be made at a certain time whilst washing the face. So she would think, she would be washing her face, and she would be thinking that she didn't do the intention whilst washing her face, she didn't intend to do the ablution whilst washing the face. Although when you would ask her, why did you wash your face? She would say because I wanted to do my ablution. So this is an intention, she intended to wash her face. Why? Because she wanted to do the ablution. But the other way round, it wouldn't work for her (laughs). This is *waswaas*. She kept thinking she forgot to intend to perform *wuduu*' whilst washing her face. (Sarah: 12, 124-130)

Sarah mentions a similar thing would happen regarding one's intention when the individual would be washing her face, though Sarah highlights that by simply washing the face, this itself is the intention. She points out, and even her laugh suggests, the absurdity of the situation by saying that when the individual is asked why she washed her face, she clearly states it was because she had wanted to do

her ablution which encapsulates the intention of doing the act. Yet this way of rationalising the act didn't appear to be effective for this individual, and for Sarah this summarises what *waswaas* is; not being able to rationalise one's doubts. She states that seeing someone repeat the acts of worship makes one think that such a person is 'crazy':

> And I saw these cases… when you see it you would think the person is crazy, you would really think this. The person might become insane, because when you keep doing like this, you can become insane. I used to have a neighbour. I could hear him from - he is Muslim - I could hear him from, from the wall because the wall was very thin. And I would hear him. He would want to start praying. So when we want to start praying, we say *Allaahu Akbar*. We would hear him 10 times, 10, 11, 12. He would say *Allaahu Akbar, Allaahu Akbar, Alllaahu- Allaahu Akbar*, and he would repeat, repeat, repeat. (Sarah: 14, 140-144)

Sara expresses what might be seen as one extreme outcome of the *waswaas*, that of someone losing their sanity. Her phrase 'you would really think this' implies she's saying that this is almost like a fact, that without any hesitation or doubt that even *I* and others might be convinced that such a person is acting 'crazy' or is 'crazy'. I wonder what else Sarah may have felt towards her neighbour for disturbing them through the walls with his continuous repetition of the opening statement of the prayer, did she feel annoyed or even pity for him for instance?

It's not just in the acts of worship in which *waswaas* manifests itself but in other areas of one's lives too, as Tariq highlights:

> it comes in different shapes and sizes as some people might say. Sometimes- sometimes even *waswaas* comes in the form of did I lock that door or not? … I guess what some people might call OCD in some cases…I've noticed some people even having *waswaas* in illnesses… they would hear about someone having cancer, and it's usually cancer, and they would say what if we have it? Maybe I have it. And then they start looking at their skin and go Oh, is this- what- what is this? And a lot of them go and google and they start googling what if this happens to you, and what if this happens to you, what does that mean? That is a form of *waswaas* as well. (Tariq: 10, 103-109)

Here Tariq himself explicitly uses the term 'OCD' and suggests that someone might develop symptoms of obsessive compulsive disorder as a result of *waswaas*. He

also mentions what sounds like someone experiencing health anxiety and worrying that they may have cancer for example, and suggests this is another type of *waswaas*. When I asked Tariq to clarify what he meant, for instance whether he was suggesting that symptoms of OCD and health anxiety are forms of *waswaas*, Tariq initially replied by saying:

> I don't know if you would call them various forms, but various topics let's say that these involuntary thoughts might involve. So some people might get it a lot in terms of illnesses, or one's health that is. Other people might get it a lot in did I erm turn the oven off or is it still on, after leaving home? Erm and other people might get it in the forms of those what if questions I was telling you about. That's what I've noticed, that there are several- I don't know if those would be called manifestations, but several of those. (Tariq: 11, 118-121)

Tariq seems unsure or uncomfortable to say here whether *waswaas* comes in various forms, though it appears this is indeed what he is suggesting. He goes on to say that *waswaas* covers various topics and areas. So for Tariq, his understanding is that the *waswaas* or involuntary thoughts seem to revolve around issues where someone has doubt about something, whether they may have an illness, whether they have turned something off, and also is demonstrated by asking 'what if' questions. Although Tariq had initially seemed hesitant to say whether he believed OCD was a form of *waswaas*, he seems to have developed his understanding further when he goes on to say:

> Maybe you could say OCD is a form of *waswaas*. Erm, because- I don't know, I'm not technically very familiar with what OCD really is, technically. But if you think of it as someone constantly scrubbing and washing because they're afraid that there might be some bacteria there or there might be some bug that would kill them, you would think that this is a thought they are constantly getting- there is something, there is something, there is something. So that's why it's being manifested in them washing a lot, or cleaning a lot, or doing something which would be called OCD. (Tariq: 12, 123-127)

Tariq's repetition of the word 'technically suggests that Tariq wants to make it clear that he's not claiming to be an expert on OCD, yet the example he gives demonstrates that he does have some understanding of it. When he says 'Maybe you could say OCD is a form of *waswaas*', this suggests that Tariq's understanding of *waswaas* was developing and perhaps shifting during the interview and that he was becoming more confident in his sense-making of *waswaas*.

A few of the participants spoke about someone with *waswaas* being focused on making sure things are clean. For instance, Nida became animated when she began to describe a woman who she believed to be experiencing *waswaas* and due to the *waswaas* the woman began to clean excessively:

> I know a woman she got to a point, if someone in her house is talking, she would be watching his mouth while he's talking. Did a tiny spit, you know, from his saliva come out? (Gasps). If something comes out (gasps), she would become breathless, she would become very clean. She's worried about that. She would clean that. If someone is eating, oh my God. As soon as they go to the toilet, she would move the couch, she would move everything, wash it, clean it. They come back saying "What's going on?" As if the woman - like she'll wash the walls every couple of days, she'll wash every- she'll wash it, just wash it. She's sick. She becomes skinny and sick, she doesn't care about anything, because, because the thoughts, he could, he could really find a door to, to bother her with this. (Nida: 8, 96-102)

Nida's description and acting of this woman, in particular the gasps and the exclamation of "Oh my God", indicates the fear and horror the woman experiences if someone's spit comes out from their mouth or likewise if they are eating. However, it is not clear whether this is because this woman is worried about germs and so she feels the need to clean or if it is for some other reason, but Nida indicates that the *qareen* has found a gateway in which to exploit the woman's fear. There is a sense of bewilderment though at how other people experience such behaviour, which is demonstrated by Nida explaining when someone returns to find things have been moved around, washed and cleaned, they ask "What's going on?" This bewilderment highlights that this woman's behaviour is unusual, which is emphasised by Nida's repetition that this woman is 'sick', although it is not clear from Nida's example whether this woman views herself as being such. However, her being 'skinny' stresses that not only has the *waswaas* affected her mentally but physically too, to the point that perhaps she is not eating well and perhaps is neglecting herself, as she is so consumed by the *waswaas*. So it seems that Nida is conveying that the torment of *waswaas* is not only intolerable but indigestible too.

However, some of the participants pointed out that *waswaas* can occur in other issues too. Ismail for instance mentions how *waswaas* isn't just related to religious issues:

> a person who doesn't know me in a religious context, they wouldn't know that I had this issue because it's not a - for me it wasn't a psychological issue as such, it didn't reflect in other aspects of my life. It was just linked to this, to the issues of the acts of worship, and that's where it kind of developed. (Ismail: 9, 93-95)

He suggests that if his *waswaas* was due to 'psychological issues' then it would have been more apparent to others that he was experiencing it. However, because his *waswaas* was just centred on religious issues, Ismail seems to have kept this part of his life secret and compartmentalised from the other areas in his life and from other people too, apart from those who knew him in a 'religious context.'

Sarah initially mentioned that she was experiencing *waswaas* in regards to other people and later revealed it was actually in regards to her husband specifically, in which she would feel hurt by certain comments he would make but then she had begun to realise that a lot of it was based on her misinterpreting what he was saying:

> So sometimes I might face this because he might say something and I might take it for something which is completely different. And I would be like how come he can say this? ... Actually it is lately that I identified it as being *waswaas*. Because uh these ideas, usually I'm not the kind of person who has these ideas. And it keeps coming and comping and coming, so this is a completely different issue. It deals with, not like an ideology but it deals with concrete relations and it affects the relations. (Sarah: 20-21, 217-221)

Sarah explains that it's only recently that she's realised that the reason she is getting upset with her husband is because of *waswaas* and usually she does not have such thoughts, so this is how she has identified the thoughts as being of *waswaas*. Sarah goes on to explain that these kinds of thoughts only occur with her husband:

> This is actually another interesting thing that the same situation might happen with another person, I wouldn't even care. I wouldn't even feel nothing. Like any idea would come or nothing, it would go like a train … going (laugh). But especially with my husband it happens, this is silly. It's really silly because it's

> the closest person to you, so it shouldn't happen. So this is not, it's not a normal situation. (Sarah: 22, 233-237)

This again highlights what was emerging from many of the participants' accounts that the *waswaas* focuses on something which is of central importance to someone, in Sarah's case her relationship with her husband. She states that even when *waswaas* occurs with other people, she is aware of the thoughts but they mean nothing to her and she remains unaffected by them. Her words conjure up an image of a fortress for me, offering security, surrounding and protecting her relationship with her husband, yet the *waswaas* still finds a weak spot from which to sneak in and target the relationship. Initially Sarah is talking in the first person possessive pronoun 'my husband' but then switches to the second person pronoun 'closest person to you', perhaps signalling a warning to others to be careful and to be more attentive than she has been.

Sarah's repetition of this being 'silly' highlights how nonsensical it is and perhaps suggests some disbelief that the *waswaas* can affect the relationship with the person who is most close to her. When she says this is 'not a normal situation' it emphasises what she said earlier, that she does not normally have such thoughts, so for her this is abnormal and it is not typical for her to be facing this in her marriage. However, when she says 'it shouldn't happen' it seems that Sarah might be expressing her disappointment with herself that she should know better and should have recognised that this is *waswaas* that she is experiencing in regards to her husband and so should not have let it affect her relationship with him. Perhaps she sees this as a personal shortcoming or failure that she left her relationship unguarded and unprotected from the *waswaas* and did not take precautionary measures to secure her marriage against it.

Maria talks about the uncertainty as to whether her self-doubt regarding her ability to teach may be *waswaas* or not:

> I'm lecturing, I'm teaching, and then you get this creepy feeling that maybe they shouldn't take from me, they should take from others. But then again, is it really a *waswaas* or is it more to do- because I read something to do with the imposter syndrome which is apparently er quite common in females who have - (laughs). Reading that I was like oh that's me… So you know when you feel like someone's going to come and say get out (laughs) you are incompetent… so when I read that I was thinking so that's more that than anything else. Erm, things like that.

> Things like trying to discourage you from teaching because you get this feeling that but no I'm not really that knowledgeable for me to sit in front of crowds and teach them. (Maria: 12, 139-145)

Maria suggests that perhaps it's not always clear-cut for her to identify something as *waswaas*. Regarding her own situation when she is teaching, she suggests the doubts she experiences might be due to 'imposter syndrome' instead rather than *waswaas*, because of her insecurities that she is not competent enough to teach. It would have been interesting to have discussed this further with her to see precisely how she was separating this out from being something other than *waswaas*, rather than this being an area specific to her that the *waswaas* is focusing on.

Subtheme three: Fear of dying as a non-believer

When participants spoke about their own experiences of *waswaas*, interestingly enough for nearly all of the participants the *waswaas* seemed to centre on their fears that they may have committed blasphemy and therefore were no longer Muslim.

As Mansur and I were talking, Mansur revealed he was experiencing a *waswaas* then and there:

> (Pause) I mean you asked me about uh you know (laughs) have I experienced uh *waswaas*, I mean I feel that I'm experiencing it right now speaking to you. Erm some of the things I'm saying I'm getting a type of a whispering in the background that's trying to uh distract me from saying what I'm wanting to say. And, and for me, that again would be a, a strong indication that that's *waswaas* and not just a *khawaatir*, a spontaneous thought, because the devil, I can understand, is bothered massively by what I'm saying. So my devil would be bothered by that and would want to distract me. So along the way he's start- trying to make me doubt about some of what I'm saying, trying to whisper different things to me in that regard along the way. He even just whispered to me that maybe that thing that you said it could mean this and that would have a *kufr* [blasphemous] meaning. Right, so I experienced one of those whispers just now as I was speaking to you. (Mansur: 56, 729-737)

I wonder if the pause was because Mansur was listening to the *waswaas* or whether he was debating whether to share with me that he was hearing it? He refers to the whispering as being *waswaas* rather than another type of thought/whisper because he believes that the *qareen* would be annoyed or alarmed even that he is talking openly and freely about it, exposing the *qareen* and *waswaas* in general. It seems that Mansur believes the *qareen* is trying to stop him from talking about this topic and scare him in to believing that he may have said something blasphemous. Mansur spoke about how he was dealing with the *waswaas*:

> amongst the ways that I dealt with it was I ignored it in a way that I can hardly even recall to you what was the whisper. I, I didn't allow myself to take it and follow it through and I just pushed myself to keep talking and to concentrate on what- rather than responding to this internal whisper of the devil, I, I pushed myself to concentrate on you know what I'm saying and to continue down uh that route. Erm the whisper then didn't have its uh have its effect (Mansur: 52, 737-741)

One of the ways Mansur employed was by ignoring the *waswaas* and concentrating on what he wanted to say to me, pushing the *waswaas* away and not paying attention to it or acting on it. As a result, Mansur could barely recollect the detail of the *waswaas* because he chose not to respond to the *qareen*'s whispering. As the interview continued, Mansur told me that he was still experiencing the *waswaas*:

> the *shaytaan* [devil] doesn't just come in one way, you know even right now he's trying to play at this in different ways. And so that I'm not going to waste my time, I'm not even going to pay much attention to what's happening with the *waswaas* right now in the background (Mansur: 56, 743-745)

Mansur believed that the *qareen* was still trying to him to stop talking about the topic at hand and was using different ways of getting him to stop. But Mansur seemed to be determined not to be distracted or become upset by the content of the *waswaas*.

Nida speaks about when she first experienced *waswaas*, regarding certain 'bad' words that kept repeating themselves for a long time over many years, though at the time she was not aware of *waswaas*:

> I had *waswaas* when I was, I don't know how old, but very little. I was in nursery. Uh I remember the teacher was, was saying, and I was so young, so young… I'm talking maybe three years or something. So young, three, four years, something like that… but someone said something very bad and the teacher said "We don't say these words, we don't say these words, we don't do that." Then while she's saying "We don't say that, we shouldn't say that … polite people don't say such things", and when she's saying not to say it, and in my head I hear it. I was so young; I didn't know there was something called a whisper. All I thought was I'm thinking about that, I'm saying this in my head. I was so upset with myself, and I didn't want to say it, but it kept on with me, the same words, just these words, and I'm sure it showed on me. And I didn't have *waswaas* about other things, it's these words, what, what the woman taking care of those children told us not to say. It stayed with me for many years. (Nida: 14, 177-185)

Nida stresses again and again how young she was when she first experienced *waswaas* and this portrays the sense of helplessness that she must have felt when she was assailed by these disturbing words. There is a sense of horror that Nida must have experienced as a young child who, despite not wishing to have such thoughts, they continued to plague her. This horror seems to have intensified for her when she believed that she somehow was responsible for these thoughts and deeming them as her own thoughts rather than as *waswaas*, particularly as she mentions a few times that it was 'these words', the 'same words' and not any other words which were being repeated. There's a deep sense of sadness and the continued sense of helplessness when Nida states that the words stayed with her for 'many years', indicating that she had to endure this 'abuse' and was unable to find a way to relieve herself from the words for so long. Nida speaks further as to how the words affected her:

> I used to cry at night. I went to sleep and those words are running through my head. And I don't want to say it, and I get more upset, and it gets more and more. And uh then I thought, because I'm too young, I'm like weak and stupid, I don't know how to control my thoughts. (Nida: 15, 187-189)

There is a sense of Nida being a victim, bullied by these unwanted words that continued to taunt and abuse her, despite how she much she desperately wanted them to go away and leave her alone. It seems there was no respite for her as even at night, when she was trying to sleep, the words would come to her. And the more upset she became the more the words would come, and thus a vicious cycle. As she did not understand why she was experiencing such thoughts and believed she was not in control of them, she blamed herself and began to see herself in a negative way. Nida told me of various ages as she was growing up that she thought she would be able to 'control' her thoughts and thereby stop experiencing these words:

> Anyway, it stayed with me, there's no maybe, maybe. I passed eighteen until I was like over twenty. But I never admit to the bad words coming to my head. All my life when the thoughts come and tell me bad words about the Creator I never accepted it. That's why I was bothered, since I was a few years old until over twenty, it used to really bother me. And I- no one taught me, I didn't learn about religion by then, no one taught me to get busy but it happened, that when I'm busy with something, that it's better…I only understood it when I started learning about religion. That was after I passed twenty (laughs). That was late. I found out, when I found it, it was (gasps and snaps fingers) so easy, just like this to get rid of. (Nida: 15, 196-202)

Nida finally reveals that these bad words were something to do with God, although she never believed in those words, but this is why it seemed to bother her even more so that she couldn't stop them coming to her. Nida explains that she finally found her own way of coping with the *waswaas*, which was to get busy, though it was once she started learning Islamic knowledge that she finally understood what she had been experiencing. Her laugh that it was when she was past twenty that she finally was more in control of her experience of *waswaas* might be a way to express the frustration and long struggle she faced all her life. This is highlighted by when she acknowledges that when this finally happened when she was past the age of twenty 'that was late', so her desire to be relieved of these words and their grip on her was a lifelong struggle for her up to that point. Her relief though when she finally figured out what she was experiencing and how she could manage it is evident and palpable by her loud gasp and clicking her fingers. I was left with the impression of someone who has been drowning at sea and who is finally able to

break through the water and frantically takes in their first gulp of air, finally able to breathe again, or someone who has been shackled for so long and is finally liberated.

Abid spoke about his experience which also started at a young age:

> I think with me it's happened in several different ways. So I remember it even from a child erm and it's been various different things. So usually when a particular topic has been what's been bothering me, it goes on for a while and then when I somehow resolve it, erm I'm fine for a little while and then a new topic springs up and then that's what preoccupies me. So I remember that actually since when I was eleven or twelve, or maybe even younger. Erm and it's usually been to do with the religion (Abid: 8, 99-103)

In contrast to Nida's experience of her *waswaas* being the same repeated phrase, Abid's *waswaas* has been to do with 'various things' from a young age but which are all linked to the religion. It would have been interesting to have explored with Abid whether he had already understood from a young age that this was his experience of *waswaas* or whether at a later stage he understood it to be this and how had he come to that understanding. His use of the word 'somehow' sounds like even he is not quite sure what it is that he has done to help him deal with the *waswaas* or may suggest that his attempts may not always have worked effectively or fully, as he goes on to say that he can never resolve the *waswaas* completely as it keeps springing up again in various other topics. His description gives the impression of a firefighter who is constantly having to put out fires started by the *waswaas*; when one is put out, another one starts up elsewhere which he then has to contend with.

> Even if I've got thoughts about other things, I've usually kind of just said to myself 'Oh, oh what's the worst that could happen?' and I kind of just let it go like that, thinking ok even if that was the case whatever I was thinking, I'd always be able to think, 'Oh, it can't be that bad.' Whereas if it's with relation to religion, like the ultimate thing would be erm potentially eternal punishment and then you would, even if you asked yourself 'Oh, what's the worst it could be?', well, yeah you don't want that to happen so that doesn't quite work here. (Abid: 8, 103-107)

Abid discusses how he generally deals with his fears or anxieties regarding certain issues which seems quite a helpful approach and allows him to relax and release them. However, when he has anxieties or fears to do with the religion the worst result would be 'eternal punishment', which sounds terrifying, and Abid explains that

his normal attitude dealing with difficulties therefore isn't effective here as eternal punishment *is* his biggest fear. Abid speaks about how his whole experience of *waswaas* has always been terrible:

> The whole, all of it has always been a bad experience. Erm like it relates, it links a lot with how I'm feeling most of the time, erm so yeah it's quite debilitating. (Abid: 9, 110-11)

Abid's *waswaas* affects his mood and emotions too and sounds as if it leaves him feeling quite crippled and crushed by it.

Sarah mentioned that her *waswaas* was also due to a lack of not understanding certain religious issues well. She spoke about her first experience of *waswaas* when she was by herself and crying because she had a question but was unable to get an answer for it straightaway:

> Let's imagine that because I didn't know the judgement I would die as a non-believer. This was my uh big fear, it's to die as a non - believer. So yeah this was my biggest fear. And I think this is how *waswaas* comes, it comes like this. He checks what is your biggest fear and, and he keeps working on that. (Sarah: 18, 197-199)

As a result of not knowing the religious judgment about a particular issue Sarah was no longer sure whether she was still classified as a Muslim, as she may have committed blasphemy. Her fear was intensified as she had to wait to receive a religious judgment about her case and she fretted that she could die before she'd received the answer, and therefore if she had committed blasphemy, she would die as a 'non-believer'. Sarah reconfirms what she has said earlier, that she believes this is how the *qareen* works; he finds out what an individual's biggest fear is and continues to whisper on that topic, heightening one's fears. It is interesting to note that Sarah uses the past tense and then this quickly changes to the present tense 'This was my big fear, it's to die as a non-believer', which reveals that in fact this might still be a real fear that she still has.

> I was so scared. It's really, when I remember it - (laughs). Yeah I was crying because this thought used come to my mind 'What if you die now?' Somehow I knew this *waswaas* wanted to lead me somewhere else, and because I was

> fighting it and because it was hard for me to fight it, I was crying because it was hard to fight it. (Sarah: 24, 259-262)

Sarah's terror at the thought of dying as a non-believer is perhaps something that she still experiences when she is recollecting the incident, as indicated by her laugh. It sounds as if she was engaging in some kind of battle with the *waswaas* and struggling to fight it off and get away from it. It is unclear what her words that it 'wanted to lead me somewhere else' mean exactly but what is clear is that Sarah was not prepared to be taken there. Perhaps one can wager that the *waswaas* wanted her to commit blasphemy, as at this moment she was not sure yet whether she had or not, but now it was pulling her in that direction more strongly. Her repetition of the words 'hard', 'fight' and 'crying' reveal how distressed and what a desperate situation she was in and that she must have had to use perhaps all of her resources to continue to defend herself from the *waswaas*. Despite how fragile and weak she may have felt, it seems that her resolve did not waver to keep battling and ultimately, she did not succumb to the *waswaas*.

Mansur went on to explain that the *qareen* tries to engage the person in a kind of discussion with it, so that instead of the person using their time more effectively by doing religiously beneficial things, the individual end's up wasting their time as the person tries to figure out whether this is *waswaas* or their own thought:

> So here the devil's trying to waste my time, number one. Two: he's trying to make me feel anxious, and as a believer, as a Muslim, clearly I am anxious about the idea of potentially going to Hellfire. So he's playing to something that is there and he knows it's a type of uh vulnerability within me, and he's trying to use that against me… because I am worried about after I die, in the Hereafter, am I going to be amongst the people of Paradise, that is, on the Day of Judgement, or am I going to be amongst the people of Hellfire? (Mansur: 51, 667-671)

Mansur succinctly states his understanding of how the way the *qareen* works, that is by wasting his time and producing a state of anxiety in him by stoking his biggest fear and 'playing' with that. His use of the word 'clearly' after having spoken about being a 'believer' and 'a Muslim' suggests that he believes that his fear of going to Hellfire is one that all believers or all Muslims experience, not just solely him. In fact, this fear of being in Hellfire was one that nearly all of the participants disclosed and

relates to the Islamic belief that there will be a Day of Judgement, in which people will be judged for the actions they did in this life, after which people will either enter Paradise or Hellfire for eternity. It seems that many of the participants believe the *qareen* know that this is something these participants feel vulnerable about and hence why the *waswaas* they say they experience are related to them fearing they will become non-believers and will therefore enter Hellfire rather than be in Paradise.

Superordinate theme three: Therapy can be an Asset

This third superordinate theme explores methods participants have used to deal with their own experiences of *waswaas* or suggestions they have given to others. The first subtheme 'Psychoeducation' refers to the fact that all of the participants agreed that first one needs to be educated about *waswaas* itself so that people are able to differentiate between what is their own thought and what is a *waswaas*, which will help alleviate the anxiety and other things *waswaas* causes, as one realises that this thought is not one's own. All of the participants stated that people who were struggling with *waswaas* should seek psychological help, yet at the same time some also voiced concerns about seeking such help, and this is explored in the subtheme of 'Need for therapy and threat of culturally insensitive therapists'.

Subtheme one: Psychoeducation

Those participants who spoke in their interviews about the *qareen* mentioned that one needs to know about the existence of the devil or the *qareen*, and all participants mentioned that one needs to know about *waswaas* itself, as the first step, such as Mansur, who is a medical doctor:

> You know, I am not speaking without knowledge, it is something that I know and understand, and it would be akin to what another professional might provide in the form of CBT. Uh I'm making them knowledgeable and aware about what is *waswaas*, who is the devil, what he's trying to do, how he might harm us, and teaching them ways by which they can protect themselves from the harm of the

> devil. So if you're saying professional psychological help I would believe that a lot of what I'm saying falls in to that category. (Mansur: 66, 865-869)

Mansur is making it clear that he is not ignorant or making things up, but rather *waswaas* is something that he knows about and understands well, just like any professional does about their particular field. His conviction in this is demonstrated by his saying 'I am', 'I know', and 'I'm making'. Mansur reasons that he would psycho-educate someone about *waswaas* similar to how psychoeducation is carried out in cognitive behavioural therapy, that is educating someone about the 'symptoms' they're experiencing, as well as providing coping strategies.

> one of the things that I've tried to counteract is almost if you like illogical thinking. And uh I might use certain explanations based upon a religious reality that I believe is a lot more uh detailed and structured and systematic in way of explaining what's going on relative to what my broad understanding, if you like, of Western medical explanations are. (Mansur: 70, 911-914)

Mansur believes that his religious understanding of *waswaas* is more comprehensive and detailed than his understanding of current 'Western medical explanations'. He uses knowledge from both cultures whenever he deems that one is necessary and more appropriate. This way perhaps he feels he caters to the needs of both types of patients: those who wish to have a religious understanding and those who don't.

Maria also touches upon the importance of possessing religious knowledge in order to 'combat' the *waswaas*:

> In Islaam we teach people that your best weapon against *waswaas* is knowledge. So there have been situations where I was badly doubting about, I don't know, things which are, would appear simple for others, whether this is blood of menses or whether this or that. But then you just sit down, you look at the facts, you either calculate or go through that fact you're aware of and then you find the solution. It's like in one sense yeah it was a bad experience in the sense that you were doubting but then for me, if I sorted it out through the classes and through what I've learnt, then I've sorted it out. So it's not really that much of a bad experience. A bad experience I would describe as someone who you know can't even achieve- can't even finish their *wuduu'* [ablution] or can't finish their prayers, or

> is driven mad, that would be a bad experience. But I haven't had so far, *alHamdulilaah* [praise be to God], things like that. (Maria: 14, 160-167)

Maria uses the word 'weapon' and indeed throughout the narratives of many of the participants it seems that they see themselves at war with the *waswaas* and the *qareen* and have developed ways to combat it. Maria again highlights that the *waswaas* clouds her judgement and ability to think clearly and what may seem 'simple' to others, no longer is for her and she has to find a way through the haze in her mind. Her approach in doing so seems very level-headed and pragmatic by resorting to 'facts' and going back to what she *does* know in order to ground and anchor her so that she can work her way through the confused and puzzled state the *waswaas* has thrown her in. Maria points out that when she has experienced *waswaas* like this it is a 'bad experience' for her, but then seems grateful when she acknowledges that it isn't, by comparing her experience to those of others.

Nida describes her palpable relief when she started learning religious knowledge and found out about *waswaas*:

> It helped me that it's not me thinking about this. It's thoughts, and it's not me. And I was so happy that, oh right, all these years I thought I'm thinking about this but I'm not admitting that and I don't believe those words coming in my head, as if someone is talking. I don't believe that, I don't like this. I never liked it, I never liked the words that come to my head. I was happy that I never accepted it, and I never followed it, I never believed it. And I was happy because oh, it's not me! Get out of here. When it comes, oh that's not me, that's just whispers. Get out. So I felt much better. (Nida: 16, 209-213)

There is a sense of joy conveyed in Nida's account when she realises that despite having 'those words' in her head for years, these actually weren't her own beliefs but it was 'as if someone' else had been 'talking' and putting them in her 'head'. This also perhaps demonstrates a sense of guilt though that she must have carried around with her as it seems she may have blamed herself for having such thoughts when she says 'It helped me that it's not me thinking about this'. It seems however that she was able to absolve herself of such blame once she understood *waswaas*, and this is highlighted by the numerous times she mentions that she 'never liked the words' and 'it's not me'. It seems that having such knowledge and realisation has helped her mark a stronger boundary around her own psychological self and

that of *waswaas* and has empowered her to be bold and threaten the *waswaas* and *qareen* by saying back 'Get out.' This is also highlighted in her following extract:

> Very quickly, very quickly. But it doesn't mean that the person he would be, that's it, he would never have a whisper, it always comes back. When it comes back, I sometimes talk with the voice, like (laughs mockingly) "Hahahaha, you're whispering this? Get out of here." (Laughs). "You think I'm going to listen to you, you're going to bother me? Get out of here." And it really goes, but tries again. And then it goes. (Nida: 16, 204-207)

Once the 'victim' for many years of the whispers and the *qareen*, Nida is now strong enough to face and stand up to such 'bullying'. By making sense of her experience and understanding it as *waswaas* she has become courageous and emboldened and fights back by mocking the *qareen* and ordering it to leave her alone. Despite the years of 'abuse' she endured in the form of whispers, as soon as she learnt about *waswaas*, she admits it went then 'very quickly' and she was able to rid herself of it. However, she highlights what many of the other participants also conveyed that the *waswaas* is relentless; despite being given its marching orders, it will find a way back to try to torment her, again giving the sense that she is never entirely free of it.

Sarah also shares in her account that by knowing about *waswaas* this helped her to deal with it:

> It didn't last for such a long time *alHamdulilaah* [praise be to God], because I identified it for what it was, as *waswaas*, and I just refused to, to follow it, because I knew what it was. I heard about it before, and I just refused to follow it. So what I did is that I started learning more and more and more, and reviewing and memorising. And by this it just went, because I really was able to really master this, especially these topics of blasphemy. In such a point that even today I don't have, *alHamdulilaah* [praise be to God], I don't have *waswaas* in regards to this. (Sarah: 19-20, 204-209)

Sarah's prior understanding of *waswaas* allowed her to identify and make sense of her experience as such, and by doing so she did not allow herself to be bullied or manipulated in to 'following' it. By educating herself further on it and learning about

other religious matters, specifically issues to do with blasphemy, she was able to become more powerful and refused to be a 'slave' to the *waswaas* by 'mastering' the areas in which she had previously been weak in and thereby mastering the *waswaas* itself. However, Sarah's statement of 'I don't have *waswaas* in regards to this' reveals that although she has banished or overcome experiencing *waswaas* in issues related to blasphemy she still experiences it in other areas, which she has already highlighted previously when admitting to experiencing *waswaas* in her marital relationship.

Subtheme two: Need for therapy and threat of culturally insensitive therapists

This final subtheme explores the openness that all of the participants share about engaging with psychological services but at the same time, for some of them, this was coupled with concerns too.

It seems as if Nida wishes she had had the opportunity to have accessed psychological services when she was younger:

> when I was little, I didn't trust myself, I thought oh I'm different than other children, I'm weak, I'm this. If a person feels better about himself, then he becomes stronger… this psychological way is very important (Nida:18, 228-231)

Due to her experience of *waswaas*, it is clear that Nida mistrusted herself and felt there was something wrong with her and that she was 'different' to the other children, like an outsider not fitting in and belonging. It seems as if Nida is saying that if she had had access to psychological therapy this would have helped perhaps normalise the experience for her, and help build her inner resources and resilience. She stresses that accessing this kind of help is 'important' and it seems that she would have liked to have received it so that would have been 'stronger' to fight the *waswaas* and be more confident in trusting herself.

Abid is also supportive of accessing psychological services but also denotes that the 'professional' needs to know their own limitations:

> I would say anyone who wants to see someone should see someone, erm and then the professional can tell them whether they think what the person is presenting with is something that they can help them with… I wouldn't tell anyone not to go and do something if it wasn't against the religion in principle. I mean,

> why would you? Because different things help different people. (Abid: 17, 214-216)

It seems that Abid is suggesting that the mental health professional has to be confident and competent, and has to recognise whether *waswaas* is something they can understand and work with or not. It seems he is placing an onus on the professional to own up to that. It also seems that Abid believes that seeking help and working with a professional is compatible with religious principles. When he says 'I mean, why would you?' it seems as if he is challenging those who might think otherwise, and perhaps he is asking people from the Muslim community to keep an open mind. Conversely, it seems as if he is saying the same about the psychological community to be open to other belief systems and working with them.

For Mansur, a medical doctor, he states about himself that if a 'patient' came to his surgery, there would be a number of factors which would influence whether he would refer someone for psychological treatment for *waswaas*. Mansur recognises limitations though as he demonstrates that he is aware that not everyone is open to the Islamic view about *waswaas* or even the phenomenon itself. As mentioned previously, all of the participants believe that even people who aren't Muslim experience *waswaas*. Mansur illustrates that he is able to detect this in some of his non-Muslim patients:

> As soon as they started to speak, I immediately knew that a lot of this was *waswaas*. And erm when I've said a few things they've looked at me strange, in a way that they've said something to the effect that as though you know exactly what's going on in my head and I've hardly told you much. And that's because I know how the devil whispers; a) through personal experience, and b) through religious learning. But … in their situation, I'm generally not able to uh give them religious advice, and invariably I have to direct them towards some level of medical help, and that's partially because I do not believe they would be uh receptive to any religious advice that I would be giving them. (Mansur: 64, 839-845)

As a result, Mansur seems to recognise a sense of amazement or bewilderment in his non-Muslim patients when he informs them about things that they've not mentioned but shows that he understands what they are experiencing, due to a combination of his own experience of *waswaas* and also through his religious knowledge. Despite having different belief systems, Mansur demonstrates that

there are commonalities shared. He talks further as to when else he will refer someone for psychological treatment:

> Some people because they've been bothered by it so much so, affected by lack of sleep.. feelings of worry and guilt… they sometimes can start to develop low mood and depression as part of that… and that, often you would get a sign that this low mood and depression is not just uh the intermittent uh feeling uh down that any one of us might experience at one particular point in our lives, but this is something more uh deeper and protracted than that. So they at the very least require some sort of uh medical intervention in terms of dealing with their depression. So I suppose it depends on what I personally if you like find in terms of the types of things that this individual is saying and how I sense it's been affecting them and how long it's gone on for. (Mansur: 65, 856-860)

As a result of the *waswaas*, Mansur states that an individual might develop psychological difficulties which may necessitate medical treatment and may not be treated by religious guidance alone. This demonstrates that Mansur is aware that each culture and support system has its own role to play.

During the interview Ismail acknowledged that he did not think his experience of *waswaas* was severe but if it had been, he would have accessed psychological support:

> If there's a clear understanding, I think, in terms of mental health professionals, they would be an asset to help resolve this issue, more than me. They are more qualified in terms of certain aspects of how to deal with behaviour and so forth, which I lack the knowledge. (Ismail: 18, 201-203)

For Ismail, it is important that his experience is understood by a mental health professional and if it is, this would encourage him to access such support. In recognising his own limitations and having awareness that he cannot help himself but does need help from someone who is qualified to do so, he recognises and values the skills such a professional would possess. Such support and help would be an 'asset' for him, a valuable resource that he may benefit from.

Maria suggests that psychological therapy might be helpful if religious coping strategies aren't effective:

> If they're professionals then you can't rule out the advice that they might give, you can't do that, especially if the person is desperate and the *du^aas* [supplications] and the *dhikrs* [religious statements asking God to protect one] and the things, all the good things you've asked them to say didn't work, then obviously you don't want to leave the person like that. It makes sense to seek professional help but my main concern would be, how well equipped are they anyway to deal with that? (Maria: 20, 242-245)

Initially it appears that Maria is supportive of accessing psychological therapy. Her repetition of 'you can't' comes across as if she is setting a boundary and insisting on accessing professional help, as if it is an obligation to do so. However, Maria and some other participants did express concern though regarding accessing psychological services. This was predominately due to fears of being misunderstood, labelled as 'crazy' or even given tools or information which contradict the participants' values and beliefs:

> I'm not sure if I would advise them to seek professional help. Firstly, because- obviously your study seems to be one of a kind, but I'm not aware how much understanding there is out there about *waswaas* anyway. Also, my concern would be either they might be classified as lunatics, for believing in spirits and other creatures (Maria: 20, 237-239)

Maria demonstrates that she is aware that there is a lack of knowledge and understanding regarding *waswaas*, and by saying 'out there' it seems as if she is implying in the Western psychological community. This limitation was a grave concern for some of the other participants also.

Ismail shared his concerns if he was to access psychological support in which *waswaas* was generally not understood:

> They might give me the wrong advice. Or they might say something that is… blame it on things that are not- that I believe are dear to my heart, like the religious-and worry that they'd advise me to stop learning or stop you know. And if… I'm vulnerable at the time and I'm not thinking straight then I would fear that they would influence me in a negative way, to something that I- I believe is important to me- the religious- that's, that's what worries me. So therefore if they don't have enough understanding of where I'm coming from, then they might give the wrong advice, which doesn't actually help, but would just add to the problem. (Ismail: 19, 215-219)

Ismail's fears centre around being advised incorrectly as to how to deal with the *waswaas*, as well as something that he treasures and values and is of central significance to him, such as his religion, being held responsible for his difficulties. It is almost as if Ismail is pleading for his subjective experience of *waswaas* to be understood, whilst his religious beliefs are also respected, without feeling like they are under attack. If this was to happen, then for Ismail this would worsen his problems.

Sarah speaks about her previous experience of seeking psychological treatment:

> There are a lot of things I used to tell her, and she used to say to me such weird things. I used to find them weird. And I didn't follow her because if I followed her I would have become worse (laughs). Like she was telling me some things that would push me to be more stubborn, to be more thinking of myself that I am always right. (Sarah: 33, 355-357)

Her laugh suggests that despite seeking help because she had wanted to get better and improve, if she had followed through on some of the therapy recommendations, she would have 'become worse', which would be an undesirable, and in fact, the opposite outcome she had been hoping for. It seems that some of the therapy process was not compatible with her values and personality, yet she felt a 'push', as in she was being forced into changing in to someone she wasn't and didn't want to be.

> When you have someone who comes and says something like this, and it goes the opposite way of what you believe, and of what you see from your parents, from religion, from many things you know, it disturbs you just because it's the opposite. And it doesn't make sense for you (Sarah: 35, 376-379)

Sarah's experience of therapy was 'disturbing'. The experience was incomprehensible for her, 'it doesn't make sense', as the therapist was saying things which contradicted her beliefs, her family upbringing and religious values, amongst other things which have helped shape her and hold a significant value for her. It seems that instead of respecting her views and finding ways to work together, the therapy was at odds with who she is as an individual and wasn't the right fit for her. It could be understood that Sarah is asking for therapists to respect and honour their clients' beliefs and principles, without imposing their own on them.

Summary

The analysis reveals that this particular group of Muslim individuals make sense of their experiences of *waswaas* in ways that were specific, complex and diverse, whilst also sharing similarities. This section demonstrated the main themes that emerged during the analysis. Participants identified their understanding of where the *waswaas* originates from and the various ways it takes place, and this is illustrated in the first superordinate theme: 'The *Qareen*'. Participants also described several ways that the experience significantly affected their daily lives, as well as psychologically, and the impact on relationships, captured in the superordinate theme 'The Impact and Content of *Waswaas*'. Lastly, participants identified a number of important elements that contributed to getting support and help, which is encapsulated in the third superordinate theme 'Therapy can be an Asset'.

Chapter 4

Discussion

This research study aimed to investigate how Muslim individuals understand and make sense of their experience of *waswaas*, and to use any resulting insights to increase the multicultural knowledge base of counselling psychologists and to add to the cross-cultural psychology literature. It was hoped that the present research would shed further light on this phenomenon of which very little is presently known in Western literature, by providing a voice to Muslim individuals and thereby gaining a deeper appreciation and understanding of their lived experience. The little that is known is through the use of quantitative methodologies and thus the understanding, and meaning-making of the lived experience of *waswaas* is generally still unexplored. However, this study has strived to provide an opportunity to capture rich descriptions of the lived experience of *waswaas* for this group of Muslim individuals, and the narratives reveal similarities, differences, and diversity in their experience. The analysis of the data aimed to provide an interpretive account of participants' description of their experience, and its findings will now be explored in the content of wider literature.

This will be followed by a critique of the study, considering the strengths and limitations of the methodology. I will discuss personal reflexivity and provide suggestions for how the study could be improved. A discussion regarding the implications of the study for the practice of counselling psychology and suggestions for future research will conclude this section.

Discussion of Superordinate Themes

Three superordinate themes emerged from the analysis and were presented in the findings, and they were: *The Qareen*, Impact and Content of *Waswaas*, and Therapy can be an Asset.

The Qareen

Many of the participants' narratives focused on the Islamic belief that there is another being called the *qareen* which is a non-Muslim *Jinn* and is with each human from birth until we die, and there was a prevailing sense that it is this other being that is responsible for the *waswaas*. All of the participants described *waswaas* as an involuntary intrusive thought that generally causes them distress as it focuses on one of their vulnerabilities, i.e. that being generally their biggest fear. The participants described numerous ways the *qareen* is able to carry out the *waswaas* and who is more likely to be at risk of experiencing *waswaas*.

Another being

Nearly all of the participants spoke about the Islamic belief of another creation called the *Jinn*. Their descriptions of the *Jinn* were very similar to what Khalifa and Hardie (2005) and also Sheikh (2005) described. This suggests that the participants were accessing preformed schema regarding the Islamic teachings about them.

There was a sense however that some participants felt they had to justify such beliefs by drawing parallels to scientific concepts which cannot be seen but are generally accepted as being in existence. However, some of what the participants mentioned is found in other belief systems too. For instance, the notion of a being named Satan is found in the Christian and Jewish worldviews too, and in the Islamic faith he is seen as the head or the father of the *Jinn*. So such a concept may not sound too strange to those who are already familiar with such concepts.

What is of note though is that many of the participants spoke further about the *Jinn* and highlighted that the non-Muslim *Jinn* are the ones called devils and from amongst them there is a *Jinn* or devil called the *qareen*, and that it is the *qareen* that does the whispering. This distinction was not mentioned in the descriptions of

the *Jinn* by Khalifa and Hardie (2005) or Sheikh (2005). During the course of the interviews it became clear that participants viewed the *qareen* as an enemy and they believe it is with one from birth until death, making it a lifelong enemy, with which they were in a constant battle or struggle with.

This suggests the importance of incorporating such knowledge in multicultural training for counselling psychologists so that they are aware that such beliefs are deemed as normal and an important aspect of the Islamic faith.

Unbidden thoughts

Participants described various types of thoughts they believe people have, and these were split in to thoughts one has control over (such as our own inner voice), and those that participants believed people don't have control over, one of the latter being *waswaas*.

Understanding *waswaas* as unwanted intrusive thoughts was a view shared by all the participants. Although participants initially began talking about *waswaas* by firstly explaining what the *Jinn* and the *qareen* are, they then began to talk more about *waswaas* itself and described it as something which is done by a *Jinn* (which is known as the *qareen*). This understanding of theirs matches the little which is known in the literature about *waswaas,* such as by Utz (2012), and al-Issa (2000a), although they do not specify that it is this *Jinn* in particular that does the whispering.

Participants used various words to describe the *waswaas,* such as it being intrusive thoughts, whispers or a voice which matches their own. Initially the descriptions of the *waswaas* as being unbidden thoughts or images that happen outside of their control, may sound very similar to a description of intrusive thoughts experienced in obsessive-compulsive disorder (OCD) (American Psychiatric Association, 2013). However, what is of note though is that unlike in OCD where it is believed that this is the person's own intrusive thought (NICE, 2006), the participants expressed them as coming from an external agency, and that being the *qareen*. Some of the participants described the *qareen* as also 'mimicking' their own inner voice, which agrees with what was mentioned by Zaidg (2008). This is in contrast to the vague propositions highlighted by Clark and Rhyno (2005) as to why people experience intrusive thoughts to begin with.

So the participants believed it is the *qareen* which is responsible for the intrusive thoughts that they experience, and because it can mimic their voice, this can confuse them and make them doubt whether this is actually their own thought or a *waswaas*. The findings of this study therefore do not fit with current Western psychological understandings of OCD or what it is that is responsible for intrusive thoughts. This is something that counselling psychologists will need to be aware of when they are conceptualising a client's difficulties who shares the same views as these participants. Having this understanding of how these participants understand *waswaas* as they use this as an explanatory model for mental health may help to develop a more comprehensive formulation and facilitate a better therapeutic alliance.

What was also interesting was that some participants situated the whispering to occur in the 'mind' which they placed in the heart, thereby rejecting the Cartesian dualism of there being a separation between the mind and the body, and suggesting that the thoughts are experienced in a more holistic manner. Although this may not be in line with the Western biomedical model, this does seem to be consistent with contemporary understandings of psychosomatic symptoms, which are also prevalent in other cultures. Indeed, Szasz (2010) has argued that the illusion that the mind is the brain must be discarded, and with it the belief that mental 'disease' is the same as brain 'disease', in order for the genuine discovery and understanding of human behaviour to begin. So even in contemporary Western views there is such a notion that the mind is not the same as the brain and that they are two separate entities.

A common belief shared amongst all participants is that everyone (other than Prophets) experiences *waswaas*. If participants were able to recognise that an intrusive thought was *waswaas* then this did not really affect them. However, it was when they could no longer distinguish whether a thought was their own or that of *waswaas*, that participants described becoming confused and distressed. This was apparent in Abid's description of things becoming blurry and confused as a result of losing this distinction, the extent of which was emphasised when he said "You can no longer confidently tell what's you and what's not you anymore." This seems to share similarities with Millers and Hedges (2008) description of one of the features of scrupulosity being when someone experiences a sense of disabling confusion, as well as a sense of depersonalization or derealisation, or when someone loses touch with their own personal identity or reality.

Sarah gave the illustration of the *waswaas* appearing in image-form when she described a mother experiencing intrusive images of harming her baby. Hudak and Wisner (2011) state that during the first three months after delivering, a mother is at increased risk of developing mental health issues. They say that a lot of attention has been given to postpartum depression but not enough to other 'disorders', such as OCD. As a result, they claim that women may be given differential diagnoses, as intrusive thoughts during the immediate postpartum period are common in both major depression and OCD. Uguz, Akman, Kaya, Cilli (2007) found some differences between women who experience postpartum OCD compared to those who develop OCD independent of childbirth, such as that they experienced more aggressive obsessions more frequently but had less severe obsessive-compulsive symptoms. Hudak and Wsiner (2011) claim that women are also at risk of developing postpartum psychosis with hallucinations, but if a woman finds the intrusive thoughts or images distressing, then this is an indication that this is not psychotic but rather an obsessional thought. They urge for further work to be conducted in this area and for women to be more educated about the nature and occurrence of obsessional thoughts during childbearing. What is clear from what Sarah described though, was that she has an awareness that a mother is likely to develop intrusive thoughts and images after having given birth but she attributes these to *waswaas*.

Devices of the *qareen*

Participants spoke about the various reasons and ways they understood the *qareen* whispers to people. Their reasons included that the *qareen* wanted people to listen to it and thereby act on the whispers, particularly as the whispers would be encouraging someone to do something against the teachings of Islaam, which is supported by Utz (2012) and the participants mentioned that the ultimate aim of the *qaree*n is to make someone blaspheme and to leave the religion of Islaam, which ibnul Jawziyy (n.d.) also mentioned.

One of the key things all of the participants spoke about is whether someone is knowledgeable about the teachings of Islaam or not. By having knowledge, it seemed as if the participants were saying one was able to better protect oneself from the whispers. This leaves then no room for the *qareen* to whisper things that will make them doubt about whether they have done something correctly or not. By

possessing religious knowledge there was a sense that participants were more confident and would not be swayed by doubts that the *qareen* would whisper to them, making them repeat acts of worship again and again. Many of the participants spoke about if one is not already learning and practising the knowledge then the *qareen* is less likely to whisper to such a person because the person is already misguided. Rather it is the person who is learning and who has not fully grasped certain religious issues, that is more likely to fall prey to the whispers of the *qareen*. Indeed, ibnul Jawziyy (n.d.) mentioned that it is through one's ignorance of certain religious matters that the *qareen* is able to take advantage of people and whisper to them.

This was a concern raised by some participants who acknowledged that some people may have this fear that if they were to learn they would be 'assaulted' by whispers from the *qareen*. Ibnul Jawizyy (n.d.) has said that this is actually one of the ways the *qareen* deceives people so that they may stop learning religious knowledge. However, participants mentioned that although this may happen, it is through pushing oneself to continue to learn that one becomes stronger and better able to deal with the *waswaas*, as with having more knowledge, there are less areas in which the *qareen* can try and confuse someone and make them doubt about things and therefore get them to repeat matters.

Another tactic the participants described was the *qareen* trying to confuse one in to believing that the intrusive thought that they had was actually their own thought and not a *waswaas*. It seems that these doubts that they experience are very debilitating because they can't differentiate what thought belongs to them and what doesn't. Besiroglu et al., (2014) point out thought action fusion does not explain 'symptoms' of OCD or scrupulosity in Muslim individuals. It seems however, that what is distressing for the participants is whether this thought is theirs or not. This view is not one which is present in any of the current cognitive behavioural models of OCD however, and in particular none of the models accommodate the belief that another being is the one who is responsible for the thoughts to begin with.

It may be argued though that some participants do give a sense of over importance to the intrusive thoughts but this is in the sense that they are trying to figure out if it is theirs or not. But the belief that one needs to be in control of the thoughts, as highlighted by The Obsessive-Compulsive Cognitions Working Group (TOCCWG, 1997), does not apply either, as the participants believe that *waswaas* is not a

thought that they are in control of. It seems to be that when there is this confusion as to where the thought has originated from, some of the OCD models do not apply. Yet it seems, when one has lost this distinction altogether and is convinced that this is one's own thought, the features then become very similar to OCD/scrupulosity and the same psychological theories might then be applied.

Impact and Content of *Waswaas*

Participants described various ways *waswaas* affects them and how it manifests. This included people asking repetitive religious questions, fears around whether they had committed blasphemy or not, doubting whether something had been done correctly or not, leading them to repeat the action again, and worrying whether something was clean or not, and thus cleaning it. However, what was clear was that *waswaas* affected people in a number of ways, some of which cannot be easily packaged to say they fall under particular categories. For instance, it seemed that sometimes it is not clear whether someone is experiencing *waswaas* or if it is their own self-doubt, perhaps linked to self-esteem issues or some other 'disorder'. And *waswaas* also appeared to materialise in relationships, making people become upset with those who are closest to them. Despite this, the participants believe the *waswaas* targets an area which is special to someone, which is their vulnerability and a therefore a weakness of theirs that the qareen tries to exploit.

Obsessive and intrusive questioning

Participants spoke about people experiencing *waswaas* repeatedly asking questions of the same nature, in an obsessive manner suggesting they have become fixated on this issue. There was a real sense of frustration that such people are not sincere in wanting to know the answer when they ask questions but as if they are stuck in a loop, coming up with more and more questions. This led to feelings of irritability and being fed up by participants who described being asked such questions.

This sounds very similar to what has been described as rumination (or obsessions) which occurs in OCD (NICE, 2006). Rumination has been described as when someone thinks continuously for a prolonged time about the same topic and experiences intrusive thoughts which come in the form of questions or doubts, as

well as the compulsive thinking that occurs in trying to find an answer. Rumination is a method of responding to distress by passively and repetitively focusing on the distress symptoms and the possible causes and consequences of them (Brozovich, Goldin, Lee, Jazaieri, Heimberg, and Gross, 2015). Yet rumination doesn't lead to any change though because the person is unable to actively problem solve. Rather, the ruminating person becomes fixated on their feelings and on the issue without taking any action.

It may be that such people are seeking reassurance, similar as to what happens in OCD or scrupulosity, and yet the reassurance effect from any answer given is short-lived, because the person either has further intrusive thoughts or thinks of a rationale to reject the response given, and so asks again to get further reassurance (Greenberg and Shefler, 2008).

There was also a sense of confusion and being lost that came across regarding the person experiencing *waswaas* whose thoughts appear to be jumbled and who cannot think clearly, and has no awareness of how they are affecting other people by asking continuous questions of them. As Miller and Hedges (2008) have said this might be because of cognitive distortions which leads to poor insight and a lack of awareness, so that individuals become overwhelmed with religious and moral issues to the point that they're unable to process their thoughts properly.

There was also a sense of 'silent suffering', as Ismail described it, as he chose to keep it hidden from others that he was experiencing *waswaas*. Despite this though, participants highlighted that the nature of such questions alerts people who are knowledgeable and have experience of dealing with *waswaas*, that this person asking such questions might indeed be experiencing *waswaas*, even if the person does not share this about themselves or has no awareness that this might be their experience.

Doubt, repetition, and cleanliness

Participants spoke about how sometimes the *waswaas* might make them doubt whether an act of worship was performed correctly and thus repeating it, and typical examples given were to do with ablution or the prayer. Bonchek and Greenberg (2009) state that typically Jewish people who experience OCD symptoms in regards to prayer would hesitate before they start the important parts of the prayer, as they fear they're not properly concentrating, or they may repeat important parts of the prayer a few times. They have given various cognitions which may cause someone to do this, such as they 'may fear that they were not concentrating, had not said the words correctly, had lewd thoughts, or did not believe in God at that moment' (p. 398).

There was an apparent loss of control involved as participants described excessively repeating things as they kept experiencing strong doubts about the validity of the action they had performed. In this regard, the doubt and repetition was centred on religious activities, but participants understood this to be the case because the *qareen* knows that the religion is an integral part of their identity and they actively choose to practise it, and hence it might be seen as an area of vulnerability for them. Thus this is why the *qareen* targets them specifically in this area by whispering to them and making them doubt about their actions. In fact, Huppert and Siev (2010) talking about OCD 'symptoms' propagate this same belief, that 'OCD attaches itself to each individual's most important or core values, but is not caused by those values' (p. 385). Thus, they argue this way such people will experience scrupulosity over other obsessive-compulsive symptoms.

Participants made distinctions between *waswaas* manifesting itself in their religious practises and how it also affects them psychologically. In other spheres of one's life some participants said other people may not have realised that they were experiencing *waswaas* unless these people knew the participants in a religious context, which gives the impression that outside of the religious sphere participants may be functioning well and no one would be the wiser. The experiences of *waswaas* however seem to be on a continuum and when it is quite distressing it might lead to other psychological difficulties, which then might become apparent to others that this person is not psychologically well nor physically well, as Nida mentioned in her example of the 'skinny and sick' woman. It seems that the ability to rationalise the doubts may be lost, and at the severe/extreme end, as Sarah pointed out people may be seen as being 'crazy'.

Many participants stated that they do not believe *waswaas* is OCD but rather that OCD can occur as a result of *waswaas*. For Tariq, it was clear that his understanding of this crystallised during the course of the interview. It seemed that the participants believed that the intrusive thoughts might result in someone experiencing symptoms which are similar to some 'disorders' or might actually be classified as these 'disorders'. The typical 'disorders' referred to included: depression, OCD and health anxiety, where Tariq for instance gave the example of someone becoming anxious that they may have cancer. Compulsions mentioned by the participants included, checking, washing, and cleaning.

Health anxiety or hypochondriasis consists of someone becoming preoccupied with fears that they either may have a medical illness or that they are at risk of developing one, based on misinterpreting bodily sensations (Rachman, 2012). The person misinterprets benign physical signs and symptoms believing that they have a serious illness or are at risk of one, which creates anxiety. As a result, certain cognitions will then serve to maintain this issue. A person might interpret something which confirms their fears, and will be selective in which information they attend to and recall. The person will then keep checking their body, will start avoiding certain things and seek constant reassurance from family and friends, including their doctor and ask for repeated tests.

Although it may seem so far that *waswaas* may have some similarities to OCD and scrupulosity, it seems that participants believed that *waswaas* can present itself in many different ways and once again targets the areas that are most important to someone. For instance, Sarah described experiencing *waswaas* in regards to her husband and there was the sense that she believed the *qareen* tries to cause problems between people who are dear to one. There was a sense that even if the *waswaas* occurs with other people who aren't close to one, then the *waswaas* doesn't affect the individual, and the individual can easily dismiss it. One of the ways Sarah described that she realised this was *waswaas* was because she acknowledged that she doesn't normally have such thoughts about people. Therefore, by recognising that these aren't typical thoughts one usually has, this is how people may be able to identify that these thoughts are not actually their own thoughts, but those of *waswaas*.

What then of 'negative' thoughts when perhaps they might be justified? There was a sense from the participants that if one is able to rationalise their thoughts and see that there is a justification to feeling upset, then such thoughts may not be deemed

as *waswaas*. However, the experience of *waswaas* becomes problematic when one loses this ability to rationalise.

There was also a sense that sometimes it might not be clear whether something is *waswaas* or not. For instance, Maria spoke about having self-doubts but was unsure whether that may be linked to 'Imposter syndrome' rather than *waswaas*. So it appears that in certain matters all of the participants were clear that such intrusive thoughts and images are *waswaas* but this distinction was less clear for Maria in other areas. Imposter syndrome refers to someone who has achieved a level of success but believes they have done so through deception and have fooled people around them. They believe that they do not deserve such success or the position that they have and fear that they will be found out, experiencing feelings of fear, psychosomatic symptoms, anxiety and doubt. They may even avoid certain situations to avoid being 'found out'. The 'syndrome' appears to be linked to high levels of perfectionism, low self-worth and doubting in one's own ability (Kananifarl, Seghatoleslam, Atashpour, Hoseini, Habil and Danaee, 2015). It seems that *waswaas* may lead to feelings of low self-worth and low self-esteem. This suggests that perhaps *waswaas* covers a number of different areas, and it seems that this may be an explanatory model of mental health that some Muslim individuals use to understand some psychological difficulties.

So how does one separate what is *waswaas* and something else? Participants suggested that the *qareen* will target someone if someone is doing something good, like the fact that they are practising the religion, learning the religious knowledge, thinking well of people and having close intimate relationships with them, because the *qareen* is trying to deter someone from fulfilling these religiously good acts and to misguide him/her. In regards to relationships, it might be said that it is trying to sow seeds of discord amongst a couple, be it husband and wife, two friends, a parent and child, to break up the relationship, and cause disharmony, as having good relations with people is also a key tenet of Islaam.

Fear of dying as a non-believer

Mansur believed he was experiencing *waswaas* during the course of the interview, as he believed the *qareen* was alarmed that he was exposing it by talking about it and about *waswaas,* and that was why he was receiving whispers in order to stop him from talking and to distress him. He believed the *qareen* was doing this by whispering to him that perhaps he had just said something blasphemous, which would be a distressing thought for a practising Muslim to experience. Siev et al., (2011) claim this is a typical intrusive thought in scrupulosity for religious people. For some of the participants this still seemed to be a real fear for them. However, this does not necessarily mean having such a fear is part of scrupulosity for them, but rather it is a genuine fear based on their faith that they do not wish to go to Hell.

Participants explained that even children can experience *waswaas*. This was particularly true for Nida and Abid, who described their experiences of receiving intrusive thoughts which they later understood to be *waswaas* once they were older. It seems it was perhaps a more difficult and distressing experience to have as a child, particularly for Nida, as she was not aware of something known as *waswaas* and was convinced this was her own thought, even though she said she didn't believe or accept the content of the thought. In this case, it is easy to see how some of the important belief domains in OCD, such as inflated responsibility and beliefs about the controllability of one's thoughts may have matched her experience as a child (TOCCWG, 1997). It has been found that many adults who have OCD report that they first experienced it in childhood (Kenyon and Eaton,2015).

There was a sense that if the *waswaas* is not dealt with effectively, it might come up again in a different topic, even if it shares similarities. However, it also seemed that participants believe *waswaas* to be something that one will continue to experience, as the *qareen* continues to try to find the person's vulnerability. So the sense was that one cannot necessarily get rid of *waswaas*, but rather, if one recognises it for what it is, then it does not have a distressing effect on the person. But then this will lead the *qareen* to keep trying again and again as it tries to find their weak spot so to speak.

It may be argued that this might be the case for these participants because they haven't accessed psychological treatment to help them manage with their psychological difficulties. Yet, if we are to stick for now with the 'symptoms' of OCD, Murphy and Perera-Delcourt (2012) point out that around 30% of people don't

respond to cognitive behavioural therapy (CBT), although it is the proposed therapeutic model of choice for OCD (NICE, 2006). This is inclusive of those who don't engage with it, those who don't improve and those who drop out of treatment. They add that the figure increases to 55% at follow-up due to relapse. However, this might be because generally the studies on the efficacy of CBT conceptualise individuals with OCD as a homogenous group, and have not paid much attention to how its subtypes respond to treatment.

Therapy can be an Asset

All of the participants spoke about the importance of someone being educated about *waswaas*, which for some meant that one would also have to be educated about the *qareen*. They all also spoke about using religious coping methods first, which included supplications and religious statements asking God for protection. Alongside this, all of the participants were positive and welcoming of seeking professional help in the form of psychological therapy, either alongside the religious coping mechanisms, or if they felt they needed more input and the religious coping mechanisms weren't enough. However, many of the participants expressed concerns about seeking psychological help, which were centred on their fears about being misunderstood and labelled as being 'crazy', or their faith being blamed as the cause of their psychological difficulties, as well as being given interventions which weren't compatible with who they are or didn't fit with their religious values.

Psychoeducation

Some of the participants stressed that by understanding that unwanted intrusive thoughts are not one's own thought this helped alleviate the anxiety and guilt that they'd experienced when they believed that it had been their own actual thought. Understanding the aims of the *qareen* helped them to understand better as to why they are receiving these intrusive thoughts. There was a sense of relief that participants can understand their experience through religious explanations. It seemed this allowed them to build a stronger psychological boundary around one's self and the *waswaas*, and made people more courageous to stand up to the *qareen*. At the same time, it seemed that participants weren't entirely free of the *waswaas* as it would try and come back at some point but perhaps targeting a

different area. However, there was a sense of triumph that at least the participants knew what was happening this time and were able to make sense of their experience in this way.

There was a sense of participants having a better understanding of their experiences through a religious frame rather than current western medical ones, which suggests that the current understandings of Western mental health issues, like OCD and scrupulosity don't match their experiences, and therefore don't fully answer any questions they may have about their experience. This again suggests that it is problematic to apply one cultural belief system or cultural assumptions to another culture (Allmon, 2013). Throughout the interviews it was clear that the participants straddled both their Islamic and Western cultures but that their worldview is mainly shaped by their religious identity, which supports what Sheikh (2007) has posited is the case for many British Muslims.

For many of the participants there was a sense of a battle between them and the *waswaas* and in them trying to orientate themselves without being engulfed by the doubts and the ensuing confusion this causes. The *waswaas* seemed to cloud their judgements, which resulted in some of them unable to think clearly. As a result, Maria would resort back to facts and what she already knows in order to ground herself and work through the doubts and confusion.

This may be in contrast to current Western psychotherapeutic models, particularly the 3rd wave CBT models, in which not knowing and being able to tolerate certainty are privileged. For instance, although still in its infancy, research is emerging at how Acceptance Commitment Therapy (ACT) may be used as a treatment for OCD, and the findings seem to be promising. ACT for OCD teaches people to accept the thoughts and feelings, learning to disempower them by not giving them significance and learning mindfulness techniques (Dehlin, Morrison, Twohig, 2013). However, it seems that for many of the participants the uncertainty of not knowing was too unbearable for them. Yet Sarah mentioned that when she has *waswaas* with people other than her husband, it does not affect her and rather the intrusive thoughts 'would go like a train … going.' It sounds as if Sarah engages in mindfulness, which allows one to see the thought not as a fact but through developing awareness that 'thoughts are just thoughts' that one doesn't have to respond to (Hershfield and Corby, 2013). It seems that the participants use different strategies to help them deal with the uncertainty caused by *waswaas*.

Need for therapy and threat of culturally insensitive therapists

All participants were open to receiving psychological therapy if they were struggling with psychological difficulties. There was an acknowledgment that both cultures and their support systems have their own role to play, without meaning one can't access help from the other. Participants recognised that clinicians have a skill set, so accessing psychological services if one was struggling was seen to be an 'asset', by Ismail in particular.

For Nida it seemed that receiving psychological help would normalise the experience of *waswaas*, help build inner resources and resilience, thereby making one more confident in one's self. It could be understood that she was implying that this would help build a stronger awareness of one's own self that one can then separate from the influence of *waswaas*. The study of Khalifa et al., (2011) showed that some of their participants are also open to working with mental health clinicians, especially if they worked collaboratively alongside religious leaders. Indeed, Ahmed and Amer (2012) have said that in the West there are more Muslims increasingly now accessing psychological services. They put this down to people struggling to cope with acculturation difficulties, stressors as a result of the socio-political climate, and an increase in mental health awareness. Despite this, there was a strong sense that participants want clinicians to respect their views, particularly their mental health explanations, and not to impose their own views on them.

There was a belief amongst some participants that professionals need to recognise their own limitations and to be honest with themselves whether they can work with other belief systems. Some of the participants believed that simply having different beliefs shouldn't stop one from accessing help, but that both parties need to acknowledge their differences and be willing to work with them and in a collaborative manner. There was a sense that even if the mental health explanations might be different, there might still be some commonalities shared which could be worked with.

Many of the participants however did express concern about accessing help due to fears of their belief systems not being understood or respected and labelled as 'crazy'. There was also a concern that they would be advised 'incorrectly' as to how to deal with the *waswaas*, feeling that their religion is being blamed. Some others expressed the belief that therapy may be incompatible with their values, contradicting what they believe and they may feel forced to change in a way they don't wish to. This was particularly true of Sarah as a result of her previous therapy

experience which she found ‘disturbing’. These were similar to the beliefs found in the study conducted by Khalifa et al., (2011) and by Weatherhead and Daiches (2010).

Reflections on the use of IPA.

As the aim of the study was to explore Muslim individuals’ lived experience of *waswaas* IPA was chosen as it was considered to be the most appropriate method to focus on the subjective experience of the participants. It also gave the opportunity to expand on the meaning making of participants, which has allowed for more insight into the phenomenon. This rich and detailed data may not have been possible if instead a quantitative method had been used.

However, IPA has been criticised on several fronts, and these have been summarised succinctly by Willig (2008). She argues for instance, that IPA depends on the representational validity of language, meaning that what is said accurately captures our experiences. Yet Willig (2008) argues that the manner in which we talk shapes and constructs our experience, rather than just simply describing it. However, this study aimed to explore the meaning that participants give to their experience of *waswaas* and not to look at the role of how they talk about it. However, it may be that participants chose to construct their experience in a way that could be understood by both themselves and the researcher, and drawn on religious terms based on their prior knowledge instead of using language that was more reflective of their direct subjective experience. Despite this, the transcripts are still their accounts and allow us to get closer to their experience.

Willig (2008) also questions whether participants are successfully able to convey the richness of their experience and describe the nuances and subtleties of their emotional and physical experiences through IPA. Although it may be argued that some participants may struggle to articulate the intricacies of their experience, this did not seem to be the case for the participants of this study. It may be that they are able to articulate their experiences because of the active roles they play in the Muslim community and may have already had the opportunity to reflect on their experiences through talking about them with others in the community, as well as

engaging with the accounts of others who have confided in them about their own experiences also.

Willig (2008) makes a final point against IPA, in that it focuses on how things are experienced rather than why participants experience these things, which she says limits further understanding of the phenomenon. Although this is valid, IPA is concerned with the nuanced and detailed analysis of a lived experience and an approach like grounded theory may be more suitable to give a conceptual understanding of a phenomenon instead.

Limitations and suggestions for further research

A critique will now be offered regarding certain key elements of the research design. One such element is concerning the sample size. Typically sample sizes in qualitative studies are smaller than in quantitative ones to provide more breadth and depth of understanding. As Smith et al., (2009) have stated that a sample size of 4 to 10 participants is adequate, for this study a sample size of eight participants was chosen. This would allow for detailed interviews to be carried out, as well as an in-depth analysis of the data, and allow any convergence and divergence to be identified across the sample, whilst still allowing participants to express themselves individually.

The homogeneity of the sample group comprised of participants with an understanding and lived experience of *waswaas* and who spoke a sufficient level of English. Due to these being the only restrictions to recruitment, this allowed for a diversity in experience amongst the participants. Having further criteria may have made it more difficult to recruit an adequate number of participants within the time frame. However, in order to make the group more homogeneous and to improve generalisibility of the findings, similar research may explore the lived experience of *waswaas* of Muslim individuals who come from the same ethnic, educational, or professional backgrounds.

Due to the idiographic nature of IPA, this study was focussed on a thorough analysis of the particular, in order to capture in detail, the views and understandings of the Muslim individuals in this group. As participants were not recruited from a specific ethnic group or from one particular region in the UK, it may be argued that the

diversity found within the sample increased its representativeness, and therefore the generalisability of this research to a larger population of Muslim individuals, who themselves are a very multicultural group. Further to this, the relative convergence of experiences found amongst the broadly homogenous sample of participants suggests that the findings may indeed also be transferred to a larger group. Willig (2008) points out that although one cannot generalise from small-scale qualitative research, the particular experience that has been investigated, at the very least is then known to be available within a society or culture. Also, although Smith et al., (2009) acknowledge that an IPA study reports details about a perspective from within a particular group, without claiming the same for all groups, they do state that further studies may add to it, so more general claims may be made gradually, each based on a detailed examination of a set group. In this way IPA studies may allow for theoretical transferability, that is to see whether the accounts of the participants may be transferred to other similar contexts (Smith et al., 2009).

Focus should also be given as to how participants were recruited. During the course of hearing about the research participants either volunteered themselves to participate, or were recommended by others who then agreed to take part. All the participants mentioned they interact with members of the Muslim community in some kind of educating/teaching role, and have engaged with people whom appear to have experienced *waswaas* also. This may suggest that some participants have had time to understand and process the experience and meanings given to *waswaas* more sufficiently, not only from their own perspective but also through their interactions with others. Therefore, they may have a better grasp of their understanding of *waswaas* than someone in a different capacity and this should be borne in mind in regards to the findings. This is important to bear in mind as Muslims differ as to how practising and knowledgeable they are about their faith. It might be for instance, that some Muslims may not even know about the phenomena of *waswaas* at all, or even about the Islamic belief that there is a particular *Jinn* known as the *qareen*. This might well be the case, as one of the participants in this study had mentioned that she had only learnt about *waswaas* when she was in her twenties through acquiring the religious knowledge, and so was able to make sense of her experience in this way.

It is possible that participants presented a certain account of their experience which may not fully reflect their actual experience of *waswaas*. Participants may have felt vulnerable or exposed during the interview or may have worried about being judged.

Many of the participants were encouraging about others coming forward and talking about their experiences, so it may be that the experience of *waswaas* is something that perhaps not everyone is comfortable to speak about. It might be that participants may have not shared their experience of *waswaas* in its entirety, yet I do believe that participants were candid, honest and open in their accounts. I believe this is evident in the data as it reveals a variety of experiences and meanings that participants disclosed in their narratives of *waswaas*.

The double hermeneutic involved in IPA must also be acknowledged, and that is that the researcher's role is significant throughout in making sense of the participants' attempts of making sense. Finlay (2011) states that such acknowledgement recognises the relationship between the researcher, participants and their social worlds, and that the researcher is aware of one's integral role in co-constructing the tentative data. Therefore, it must be recognised that had a different researcher carried out this study, then the interview process, the analysis and interpretation of the transcripts and emergent themes would have been different. However, it is hoped that throughout the paper there is acknowledgement and recognition of my role in the research whilst still remaining open to the lived experiences of the participants. It may also be important to remember as Finlay has stated (2011) that despite the meanings articulated in research, there is much more which is unsaid and therefore findings will always be partial, emergent and provisional.

Consideration may also be given to the fact that bar one participant, none of the other participants said they had had previous contact with mental health services, and therefore had never engaged with psychological therapy before. It would be interesting to explore further how participants who have engaged with therapy as a result of experiencing difficulties with *waswaas* have found their experience of therapy. What was their experience like? Did they feel comfortable to speak about their views on *waswaas* and how they believed that was affecting their psychological difficulties? Did they find helpful methods of dealing with *waswaas* as a result of the therapeutic work? Did the process of therapy change their understanding of *waswaas* at all, or change their understanding of the psychological difficulties that they were facing which prompted them to access therapy in the first place?

It would also be interesting to explore how Muslim psychologists themselves understand *waswaas*. How do/would they explore it with clients and whether they

incorporate it in to their formulation of a client's difficulties? What are their views on working with *waswaas* in therapy? How have they worked with *waswaas*, or have they felt it was not appropriate for them to address it in the therapeutic work?

Another angle to look at might be a longitudinal study. This is so because the participants in this study said that they experience *waswaas* again, every so often, as it comes and go. So perhaps a longitudinal study would provide deeper breadth to the phenomena of *waswaas* and how participants have experienced it at different parts of their lives.

A further area of interest might be for more research to be done with Mindfulness and ACT to see how effective these are with Muslims experiencing *waswaas*, to see how well Muslims are able to tolerate the uncertainty and doubts caused by it.

Personal reflexivity

In phenomenological research reflexivity should be occurring throughout the research process. This has already been touched upon in the methodology section but I will return to it again to give an overview of the progression of my reflexive stance during the research study.

I was very mindful from the literature that I had read that there appeared to be suggestions that there might be an overlap between *waswaas* and OCD, and indeed, sometimes in discussion with strangers who wanted to know about my research, one or two people as soon as they heard the word *waswaas* immediately responded by saying it was OCD. I was intrigued by this because I was still unsure what I fully understood *waswaas* to be and what it's relationship, if any, was to OCD. Keeping a reflective diary helped me to track my own ideas, thoughts and underlying assumptions that I may have had about the phenomenon being investigated. I began to notice that my ideas began to focus more on the whispers, rather than the content of them, and how these might relate to Western psychological theories about the inner voice we all experience.

It is also interesting to note that when I explained the research study to some non-Muslim individuals, how difficult it was for some of them to grasp the notion of the *Jinn*, which is part of the Islamic faith. Indeed, some non-Muslim psychologists

whom I spoke to seemed only to be able to understand the being of the *Jinn* as some kind of delusion or a variance of hearing voices which may be labelled as falling under the umbrella term of 'schizophrenia'. This made me reflect on how much multicultural awareness training there still needs to be, and that perhaps some of the participants in this study are correct in having concerns about accessing some psychological services in which their views and experiences may not be fully understood.

Despite this, there are many individuals in the mental health field who are open to working with difference and accepting other worldviews. I am therefore grateful to my team at the organisation where I have been seeing clients during the process of this research study, who have continued to show interest in it and have allowed me the opportunity to talk about it, whilst sharing their own experiences of working with other cultures and belief systems. This has continued to allow me to straddle, just like for many of the participants in this study, both my Islamic and Western cultures, which both shape my identity and worldviews, and has allowed me to remain open to the accounts of the culturally diverse clients I work with there, as well as to the experience and accounts of the participants in this study. As Fernando (2011) states 'if we are to reach out for an understanding of human beings that is universal, multicultural and nonracist, we must draw from a plethora of world cultures' (p. 52).

I have had to adopt a very reflective stance when talking to others and during the interview process itself, to see how others' experiences and understanding have influenced my own. The use of a reflexive diary and the use of reflexive notes after each interview have helped to highlight my views and what has contributed to them, whilst creating enough distance to hear the narratives of others and to attempt to capture their views.

It is important to also acknowledge that in the analysis process there were numerous decisions taken, for instance which quotes to use to represent the themes that emerged from the data, during my making sense of the participants making sense of their experience. This was something that I really struggled with, as I wanted to represent the participants' accounts as best as I could, albeit admittedly having been shaped by my interpretation of them. Although I repeatedly checked themes against the data, it may well be that another researcher may emphasise different facets of the phenomenon of *waswaas*, despite using the same data.

It must also be acknowledged that despite aiming to remain reflexive, my role as the interviewer may still have impacted upon the interview process, as well as on the interaction I had with participants during it. For instance, I do wonder how the accounts of the participants of the topic may have been shaped if the interviewer was a non-Muslim individual. I was also aware that we shared a common Islamic language and how this may have influenced their assumptions about what they believed I understood and knew about the Islamic faith. It is also possible that the questions I asked from the interview schedule or as follow ups to their statements may have also influenced the data.

Implications for Counselling Psychology

This study contributes to the understanding of how Muslim individuals experience the phenomenon of *wawaas*, when currently there is a paucity of research in this area. The aim was to give these individuals a voice and to describe their subjective experiences and to also enable clinicians to provide more effective services for their needs. As such the implications for counselling psychology will now be explored.

One of the key findings from this study is the concerns that participants expressed of accessing psychological services, which they fear may be unresponsive to their needs. The narratives suggested that participants were concerned that they would not be heard and would not be responded to appropriately, but rather would be labelled as being 'crazy', would be misunderstood, and their values and religious beliefs would not be respected. Although it is understood that certain beliefs may seem unusual to some and thereby pose a challenge, these participants were very receptive to receiving psychological help.

As Counselling Psychologists, we are well suited to work with issues of difference and to attend to the subjective experience of individuals, without having to pathologise such difference. A key tenet of our work is based on the emphasis given to the therapeutic relationship, through which The British Psychological Society (BPS), in the Division of Counselling Psychology Practice Guidelines (2006) states that we are to engage with beliefs and values, intersubjectivity and subjectivity and 'to respect first person accounts as valid in their own terms' (p.1) and 'not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing' (p.2). Working collaboratively, the therapeutic relationship lends itself to a

process of mutual discovery and shared exploration, providing a voice to those who often aren't heard in psychological services and who may be in positions of lesser power in society.

It is important for clinicians to understand what Muslim clients want from therapy so as to create a safe place for them to speak about issues they may be reticent about and devise interventions to help them reach their aims in an ethical manner. Clinicians can incorporate Muslim mental health explanations and offer a more holistic and comprehensive approach which is more congruent with clients' faith values, whilst taking in to consideration the current socio-political context and how that might be affecting their well-being too. With an emphasis on subjective experience and validation for the individual, counselling psychologists can continue to challenge the terms 'mental illness', 'diagnosis' and by token, the medical model. Providing a therapeutic service which incorporates a psychological and spiritual space and reflects a client's cultural and religious context can help foster the therapeutic alliance and may increase access in services and reduce rates of drop-outs.

There are already a few services which cater towards the psychological needs of Muslims, and this appears to have arisen due to their needs not being met by mainstream services. It may be that clinicians in recognising their own limitations may refer clients to such services. However, it is important to note that the participants in this study all seemed to wish to engage with mainstream services as long as they respect their Islamic beliefs and incorporate them in to the therapeutic work. Therefore it is imperative for clinicians to recognise this and use both Western and Islamic traditions in order to work effectively with Muslim clients. It seems that one of the main findings from this study is that participants wish to dispel the supposed dichotomy between Islaam, Muslims, and the West and urge for a positive dialogue and engagement to work effectively and collaboratively. This suggests that further exploration in to Muslim mental health explanations is needed, and may contribute towards both the development of counselling psychology practise and research, and cross-cultural psychology.

It is apparent that the participants see their selves in a complex, dynamic relationship with this other being the *qareen.* Although there are perceived boundaries of the self, sometimes these would become blurred, and it would be helpful for counselling psychologists to open this dialogue with Muslim clients to see

how to help them manage these boundaries, whilst at the same time collaborating with Muslim religious leaders if needs be to further understand Islamic concepts and what are seen as religious norms and what are not. Muslim clients therefore won't need to conceal, deny or hide parts of their beliefs if they believe they will be understood and respected as an integral part of the therapeutic process.

Another key finding from this study was that Muslim individuals who believed the intrusive thoughts were *waswaas* and could distinguish this from their own thoughts, did not appear to struggle so much with them. It might be that using this knowledge of the *qareen* and *waswaas* counselling psychologists may be able to use this information with Muslim clients who are struggling with intrusive thoughts, by psycho-educating them that if it is an unwanted intrusive thought, then it is not in one's control and therefore one does not have to pay attention to it, which is what some of the participants said helped them deal with theirs. This may help some who are struggling with intrusive thoughts feel that they do not therefore have to control such thoughts and nor are they responsible for them. It is necessary for counselling psychologists to expand their multicultural knowledge base, which can be offered through training, personal development programmes, personal therapy, reflexive work and specialised supervision. Also, by developing a shared vocabulary with Muslim clients this may help foster the therapeutic alliance further (Haque and Kamil, 2012).

It may be argued based on the participants' accounts that they do not see the phenomenon of *waswaas* itself as a mental illness or a disease, but rather as an explanation of unwanted intrusive thoughts on a continuum which may impact on someone's subjective well-being, which may lead to psychological distress. Counselling psychologists should explore with clients any spiritual, cultural and social factors which may underpin their experiences, in order to add these to the conceptualisation, whilst being cautious not to impose their own assumptions and beliefs.

The findings of this study may even have implications for other health professionals, such as G.P.s when seeing Muslim individuals in surgeries or clinics with 'symptoms' that may seem similar to the experiences of the participants described in this study. This would help facilitate an open dialogue at a community level, and normalise the situation for Muslim individuals, thereby removing any stigma there may be around their psychological difficulties and in seeking helping. In the study

of Weatherhead and Diaches (2010) participants recommended that G.P.s should have more knowledge on mental health issues and psychosomatic symptoms.

This study has offered empirical evidence on Muslim mental health explanations, of which there is little, and namely on *waswaas*. It suggests that possessing a knowledge base on such issues may influence the therapeutic alliance and treatment. This study highlights the need for further discussions and reflections on exploring religious and spiritual issues within counselling psychology and other mental health professions when working with Muslim clients.

Conclusion

This study aimed to explore Muslim individuals' understanding and lived experience of *waswaa*s using an Interpretative Phenomenological Analysis (IPA) approach. There is currently very little known about *waswaas*, particularly from a qualitative perspective. Eight Muslim individuals participated in semi-structured interviews, which were then analysed by using the IPA approach.

Although the participants gave their own individual accounts of their world and their lived experience, the research identified some shared understanding of the phenomenon of *waswaas* and three superordinate themes emerged from the analysis. These themes were: The *Qareen*, Impact and Consequence of *Waswaas*, and Therapy can be an Asset. It appeared that participants understood *waswaas* to be a form of unwanted intrusive thoughts from an external agency which may be used as an explanatory model for mental health.

It is hoped that by giving a voice to people who are often not heard in psychological research, this will help contribute to the development of multicultural awareness amongst counselling psychologists, in order that they can work more effectively with the Muslim population and thereby make psychological services more accessible to them.

References:

Ade-Serrano, Y., & Nkansa-Dwamena, O. (2016). Voicing the uncomfortable: how can we talk about race? *Counselling Psychology Review, 31* (2), 5-9.

Ahmed, S., & Amer, M. M. (Eds.). (2012). *Counseling Muslims: Handbook of mental health issues and interventions*. New York: Routledge.

Al-Issa, I. (2000a). Religion and Psychopathology. In I. Al-Issa (Ed) *Al-Junun: mental illness in the Islamic world.* U.S: International Universities Press, Inc: pp. 3-42.

Al-Issa, I. (2000b). Culture and mental illness in Algeria. In I. Al-Issa (Ed) *Al-Junun: mental illness in the Islamic world.* U.S: International Universities Press, Inc: pp. 101-120.

Allmon, A.L. (2013). Religion and the DSM: from pathology to possibilities. *Journal of Religion and Health*, 52, 539-548.

Amer, M. A. & Jalal, B. (2012). Individual Psychotherapy/Counseling. In S. Ahmed & M. M. Amer (Eds.) *Counseling Muslims: Handbook of Mental Health Issues and Interventions*. New York: Routledge, pp.87-117.

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders-V (DSM-V). Washington, DC: APA.

Al-Solaim, L., & Loewenthal, K. M. (2010). Religion and obsessive-compulsive disorder (OCD) among young Muslim women in Saudi Arabia. *Mental Health, Religion & Culture, 14*, (2), 169-182.

Berle, D. & Starcevic, V. (2005). Thought-action fusion: review of the literature and future directions. *Clinical Psychology Review*, 25, 263-284.

Besiroglu, L., & Agargun, M Y (2006). The correlates of health care seeking behaviour in obsessive compulsive disorder: a multidimensional approach. *Turkish Journal of Psychiatry, 17* (3), 1-9.

Besiroglu, L., Karaca, S., & Keskin, I. (2014) Scrupulosity and obsessive compulsive disorder: the cognitive perspective in Islamic sources. *Journal of Religion and Health*, 53, 3-12.

Bhugra, D., Sumathipala, A., & Siribaddana, S. (2007). Culture bound-syndromes: a re-evaluation. In D. Bhugra and K. Bhui (Eds) *Textbook of Cultural Psychiatry*. Cambridge: Cambridge University Press, pp. 141-156.

Bhui, K., & Bhugra, D. (2004). Communication with patients from other cultures: The place of explanatory models. *Advances in Psychiatric Treatment, 10*, 474-478.

Bhui, K., King, M., Dein, S., & O,Conner, W. (2008). Ethnicity and religious coping with mental distress. *Journal of Mental Health, 17* (2), 141-151.

Bhui, K., & Morgan. N. (2007). Effective psychotherapy in a racially and culturally diverse society. *Advances in Psychiatric Treatment, 13*, 187-193.

Boncheck, A., & Greenberg, D. (2009). Compulsive prayer and its management. *Journal of Clinical Psychology, 65* (4), 396-405.

Boyle, M. (2010). Making the world go away, and how psychology and psychiatry benefit. In M. Rapley, J. Moncrieff & J. Dillon (Eds.) *De-medicalizing Misery: Psychiatry, Psychology and the Human Condition.* Hampshire: Palgrave Macmillan, pp. 27-43.

British Psychological Society. (2005). Professional practice guidelines. Division of counselling psychology. Retrieved from http://www.bps.org.uk/sites/default/files/documents/professional_practice_guidelines_-_division_of_counselling_psychology.pdf

British Psychological Society. (2006). Division of Counselling Psychology: Professional Practice Guidelines. Retrieved from http://www.bps.org.uk/sites/default/files/documents/professional_practice_guidelines_-_division_of_counselling_psychology.pdf

British Psychological Society. (2009). Psychological health and well-being: a new ethos for mental health. Retrieved from

www.bps.org.uk/sites/default/images/psychological_health_and_well-being_-_-a_new_ethos_for_mental_health.pdf

British Psychological Society. (2010). Code of Human Research Ethics. Retrieved from http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf

Brocki, J.M. & Wearden, A.J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health, 21* (1), 87-108.

Brozovich, F. A., Goldin, P., Lee, I., Jazaieri, H., Heimberg, R. G.; & Gross, J. J. (2015). The Effect of Rumination and Reappraisal on Social Anxiety Symptoms During Cognitive-Behavioral Therapy for Social Anxiety Disorder. *Journal of Clinical Psychology, 71* (3), 208-218.

Burck, C. (2005). Comparing qualitative research methodologies for systemic research: the use of grounded theory, discourse analysis and narrative analysis. *Journal of Family Therapy*, *27*, 237-262.

Charmaz, K. (2012). *Constructing Grounded Theory: a practical guide through qualitative analysis.* London: Sage Publications Ltd.

Christopher, J.C., Wendt, D.C., Marecek, J., & Goodman, D.M. (2014). Critical cultural awareness: contributions to a globalizing psychology. *American Psychologist, 69,* (7), 645-655.

Clark, D.A. & and Rhyno, S. (2005). Unwanted intrusive thoughts in nonclinical individuals: implications for clinical disorders. In D. A. Clark (Ed.) *Intrusive Thoughts in Clinical Disorders: Theory, Research and Treatment.* New York: Guildford Publications, pp. 1-29.

Crossley, M. (2007). Narrative analysis. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology*. London: Sage, pp. 131-134.

Dehlin, J.P., Morrison, K.L., & Twohig, M.P. (2013). Acceptance and commitment therapy as a treatment for scrupulosity in obsessive compulsive disorder. *Behaviour Modification, 37* (3), 403-490.

Dillon, J. (2010). The personal is the political. In M. Rapley, J. Moncrieff & J. Dillon (Eds.) *De-medicalizing Misery: Psychiatry, Psychology and the Human Condition.* Hampshire: Palgrave Macmillan, pp. 141-157.

Dobson, R. (2014, November 30). British Muslims face worst job discrimination of any minority group, according to research. *The Independent.* Retrieved from: http://www.independent.co.uk/news/uk/home-news/british-muslims-face-worst-job-discrimination-of-any-minority-group-9893211.html

Douglas, B. (2010). Disorder and its discontent. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.) *Handbook of Counselling Psychology.* London: Sage, pp. 23-43.

Draper, A.K. (2004). Workshop on 'developing qualitative research method skills: analysing and applying your results': the principles and applications of qualitative research. *Proceedings of the Nutrition Society, 63*, 641-646.

Eatough, V. & Smith, J.A. (2006). I feel like a scrambled egg in my head: an idiographic case study of meaning making and anger using interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice, 79*, 115-135.

Emerson, P., & Frosh, S. (2004). *Critical Narrative Analysis in Psychology: A guide to practice.* London: Palgrave.

Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: a practical guide. *Proceedings of the Nutrition Society, 63*, 647-653.

Fernando, S. (2005). 'Ethnic issues' in the mental health field: Is psychiatry racist? Retrieved from http://www.narrativepractice.com/Articles.htm#'Ethnic issues' in the mental health fi

Fernando, S. (2010). Cultural diversity and racism: an historical perspective. In M. Rapley, J, Moncrieff & J. Dillon (Eds.) *De-medicalizing Misery: Psychiatry,*

Psychology and the Human Condition. Hampshire: Palgrave Macmillan, pp. 44-52.

Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research, 2* (2), 209-230.

Finlay, L. (2003). Through the looking glass: intersubjectivity and hermeneutic reflection. In L. Finlay & B. Gough (Eds.) *Reflexivity: a practical guide for researchers in health and social sciences*. Oxford: Blackwell Science Td, pp. 105-119.

Finlay, L. (2006). 'Going exploring': the nature of qualitative research. In L. Finlay and C. Ballinger (Eds.) *Qualitative research for allied health professionals: challenging choices.* West Sussex: Whurr Publishers Limited, pp. 3-8.

Finlay, L. (2011). Phenomenology for therapists: researching the lived world. West Sussex: Wiley-Blackwell.

Freeman, M. (2015). Narrative as a mode of understanding: method, theory, praxis. In A. D. Fina & A. Georgakopoulou (Eds.), *The Handbook of Narrative Analysis.* West Sussex: John Wiley & Sons, Inc, pp. 19-37.

French, D.P; Maissi, E., & Marteau, T.M. (2005). The purpose of attributing cause: beliefs about the causes of myocardial infarction. *Social Science & Medicine, 60*, 1411-1421.

Ghassemzadeh, H; Mojtabai, R; Khamseh, A; Ebrahimkhani, N; Issaadegan, A-A, and Saif-Nobakht, A. (2002). Symptoms of obsessive-compulsive disorder in a sample of Iranian patients. *International Journal of Social Psychiatry, 48* (1), 20-28.

Golsworthy, R. & Coyle, A. (2001). Practitioners' accounts of religious and spiritual dimensions in bereavement therapy. *Counselling Psychology Quarterly, 14* (3), 183-202.

Greenberg, A., & Shefler, G. (2008). Ultra-orthodox rabbinic responses to religious obsessive-compulsive disorder. *The Israel Journal of Psychiatry and Related Sciences, 45* (3), 183-192.

Harper, D. (2011). Choosing a qualitative method. In D. Harper and A. Thompson (Eds.) *Qualitative research methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners*. West Sussex: John Wiley & Sons, Ltd, pp. 83- 98.

Heine, S. J. (2016). *Cultural Psychology (3rd ed.)*. New York: W.W. Norton & Company, Inc.

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences, 33,* 61–83.

Hudak, R., & Wisner, K. L. (2011). Diagnosis and treamtnet of postpartum obsessions and compulsions that involve infant harm. *The American Journal of Psychiatry, 169* (4), 360-363.

Huppert, J.D., Siev, J., & Khushner, E.S. (2007). When religion and obsessive-compulsive disorder collide: treating scrupulosity in Ultra-Orthodox Jews. *Journal of Clinical Psychology, 63* (10), 925-941.

Huppert, J.D., and Siev, J. (2010). Treating scrupulosity in religious individuals using cognitive-behavioural therapy. *Cognitive and Behavioural Practice 17,* 382-392.

Hussain, F. (2009). The mental health of Muslims in Britain. *International Journal of Mental Health, 38* (2), 21-36.

Hussain, A. & Hodge, D. R. (2016). Islamically modified cognitive behavioural therapy: enhancing outcomes by increasing the cultural congruence of cognitive behavioural therapy self-statements. *International Social Work, 59,* (3), 393-405.

Ibn al-Jawziyy, A. F. (2014). *Talbees Iblees* / *The Devil's Deception*. (A. Khalid, Trans.). Birmingham: Dar as Sunnah. (Original work published between 1087-1175). Retrieved from https://ia802501.us.archive.org/31/items/TheDevilsDeception_201406/TheDevilsDeception.pdf

Kagan, C. (2015). Community psychological perspectives and counselling psychology. *Counselling Psychology Review, 30*, (3), 12-21.

Kananifarl, N., Seghatoleslam, T., Atashpour, S.H., Hoseini, M., Habil, M.H., & Danaee, M. (2015). The Relationships between Imposter Phenomenon and Mental Health in Isfahan Universities Students. International Medical Journal, 22, (3), 144-146.

Karadag, F; Oguzhanoglu, N.K; Ozdel, O; Atesci, F.C; Amuk, T. (2006). OCD symptoms in a sample of Turkish patients: a phenomenological picture. *Depression and Anxiety*, *23*, 145-152.

Kenyon, M. K. & Eaton, W. O. (2015). Age at child obsessive-compulsive disorder onset and its relation to gender, symptom severity, and family functioning. *Archives of Scientific Psychology, 3,* 150-158.

Keshavarzi, H. & Haque, A. (2013). Outlining a psychotherapy model for enhancing Muslim mental health within an Islamic context. *The International Journal for the Psychology of Religion, 23,* 230-249.

Khalifa, N & Hardie, T. (2005). Possession and Jinn. *Journal of the Royal Society of Medicine*, *98*, 351-353.

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.

Koenig, H. G. and Shohaib, S. (2014). *Health and Well-being in Islamic Societies: Background, Research and Applications.* New York: Springer.

Konstantinou, G. (2014). The relationship of counselling psychology training with CBT: implications for research and practice. *Counselling Psychology Review, 29,* (3), 43-54.

Kuyken, W., Padesky, C. A., & Dudley, R. (2012). *Collaborative case conceptualization: working effectively with clients in cognitive-behavioural therapy.* New York: The Guildford Press.

Larson, P., Brooks, O., Loewenthal, D. (2012). Counselling psychology and diagnostic categories: a critical literature review. *Counselling Psychology Review, 27* (3), 55-67.

Lyons, E. (2007). Analysing qualitative data: comparative reflections. In E. Lyons & A. Coyle (Eds.) *Analysing Qualitative Date in Psychology*. London: Sage Publications, Ltd, pp.158-175.

Matsumoto, D. & Jones, C. (2009). Ethical issues in cross-cultural psychology. In D. M. Mertens, & P. E. Ginsberg (Eds.) *The handbook of social research ethics.* Newbury Park, CA: Sage Publications Ltd, pp. 323-336.

Miller, C.H. & Hedges, D.W. (2008). Scrupulosity disorder: an overview and introductory analysis. *Journal of anxiety disorders, 22*, 1042-1058.

Milton, M., Craven, M., & Coyle, A. (2010). Understanding human distress: moving beyond the concept of 'psychopathology'. In M. Milton (Ed.) *Therapy and Beyond: Counselling Psychology Contributions to Therapeutic and Social Issues.* West Sussex: Wiley-Blackwell, pp. 57-72.

Mind (2015). Ecotherapy. Retrieved from: https://www.mind.org.uk/information-support/drugs-and-treatments/ecotherapy/about-ecotherapy/?o=31233#.WmDKFahl82w

Moller, N. (2011). The identity of counselling psychology in Britain is parochial, rigid and irrelevant but diversity offers a solution. *Counselling Psychology Review, 26* (2), 8-14.

Moncrieff, J., Dillon, J. & and Rapley, M. (2011). What is to be done? In M. Rapley, J, Moncrieff & J. Dillon (Eds.) *De-medicalizing Misery: Psychiatry, Psychology and the Human Condition.* Hampshire: Palgrave Macmillan, pp. 256-258.

Montali, L., Frigerio, A., Riva, P., & Invernizzi, P. (2011). 'It's as if PBC didn't exist': the illness experience of women affected by primary biliary cirrhosis. *Psychology and health, 26* (11), 1429-1445.

Morris, C. (2012). How accessible and acceptable is clinical psychology to black and minority ethnic clients? *Clinical Psychology Forum, 230,* 31-35.

Mulder, R.T. (2008). An epidemic of depression or the medicalization of distress*? Perspectives in Biology and Medicine, 51* (2), 238-250.

Murphy, H. & Perera-Delcourt, R. (2012). 'Learning to live with ocd is a little mantra I often repeat': understanding the lived experience of obsessive-compulsive disorder (ocd) in the contemporary therapeutic context. *Psychology and Psychotherapy: Theory, Research and Practice, 87,* 111-125.

National Institute for Clinical Excellence (2006). *Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder.* The British Psychological Society and the Royal College of Psychiatrists.

Nelson, M.L. & Quintana, S.M. (2005). Methodological article: qualitative clinical research with children and adolescents. *Journal of Clinical Child and Adolescent Psychology, 34* (2), 344-356.

Newnes, C. (2010). Toxic Psychology. In M. Rapley, J. Moncrieff & J. Dillon (Eds.) *De-medicalizing Misery: Psychiatry, Psychology and the Human Condition.* Hampshire: Palgrave Macmillan, pp. 211-225.

Patel, N. (2010). The Psychologization of torture. In M. Rapley, J. Moncrieff & J. Dillon (Eds.) *De-medicalizing Misery: Psychiatry, Psychology and the Human Condition.* Hampshire: Palgrave Macmillan, pp. 239-255.

Rachman, S. (2012). Health anxiety disorders: a cognitive construal. *Behaviour Research and Therapy, 50,* 502-512.

Rahiem, F.T. & Hamid, H. (2012). Mental health interview and cultural formulation. In S. Ahmed & M. M. Amer (Eds.) *Counseling Muslims: Handbook of mental health issues and interventions*. New York: Routledge, pp. 51-70.

Rapley, M., Moncrieff, J., & Dillon, J. (2010). Carving nature at its Joints? DSM and the medicalization of everyday. In M. Rapley, J. Moncrieff & J. Dillon (Eds.) *De-medicalizing Misery: Psychiatry, Psychology and the Human Condition.* Hampshire: Palgrave Macmillan, pp. 1-9.

Robinson, O.C. & Smith, J.A. (2010). Investigating the form and dynamics of crisis episodes in early adulthood: the application of a composite qualitative method. *Qualitative Research in Psychology, 7* (2), 170-191.

Rosmarin, D., Pirutinsky, S., & Siev, J. (2010). Recognition of scrupulosity and non-religious ocd by Orthodox and non-Orthodox Jews. *Journal of Social and Clinical Psychology, 29* (8), 930-944.

Salkovskis, P.M. (1999). Understanding and treating obsessive-compulsive disorder. *Behaviour Research and Therapy*, 37, 29-52.

Sakamoto, N., Martin R.G., Kumano, H., Kuboki, T., & Al-Adawi, S (2005). Hikikomori, is it a culture-reactive or culture-bound syndrome? Nidotherapy and a clinical vignette from Oman. *International Journal of Psychiatry in Medicine, 35,* (2), 191–198.

Seybold, K.S., & Hill, P.C. (2001). The role of religion and spirituality in mental and physical health. *Current Directions in Psychological Science, 10* (1), 21-24.

Sheikh, A. (2005). Jinn and Cross-Cultural Care. *Journal of the Royal Society of Medicine, 98*, (8), 339-340.

Sheikh, A. (2007). Should Muslims have faith-based health services? *British Medical Journal, 334,* 74.

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

Shinebourne, P. (2011). The theoretical underpinnings of interpretative phenomenological analysis (IPA). *Existential Analysis, 22* (1), 16-31.

Siev, J., Baer, L., & Minichiello, W. (2011). Obsessive-compulsive disorder with predominately scrupulous symptoms: clinical and religious characteristics. *Journal of Clinical Psychology, 67* (11), 1188-1196.

Smail, D. (201). Psychotherapy: Illusion with no future? In M. Rapley, J. Moncrieff & J. Dillon (Eds.) *De-medicalizing Misery: Psychiatry, Psychology and the Human Condition.* Hampshire: Palgrave Macmillan, pp. 226-238.

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

Smith, J.A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.) *Qualitative psychology: a practical guide to research methods*. London: Sage, pp. 51–80.

Smith, J.A. & Eatbough, V. (2007). Interpretative phenomenological analysis. In E. Lyons & A. Coyle (Eds.) *Analysing Qualitative Date in Psychology*. London: Sage Publications, Ltd, pp. 35-51.

Smith, T.B., Bartz, J., & Richards, P.S. (2007). Outcomes of religious and spiritual adaptations to psychotherapy: a meta-analytic review. *Psychotherapy Research, 17* (6), 643-655.

Smith, J.A. (2011). Evaluating the contributions of interpretative phenomenological analysis. *Health Psychology Review, 5* (1), 9-27.

Starks, H., & Trinidad, S.B. (2007). Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17* (10), 1372-1380.

Steffen, E., Vossler, A., & Joseph, S. (2015). From shared roots to fruitful collaboration: how counselling psychology can benefit from (re)connecting with positive psychology. *Counselling Psychology Review, 30*, (3), 1-11.

Summers, J.S. & Sinnott-Armstrong (2014). Scrupulous agents. *Philosophical Psychology, 28* (7), 947-966.

Swift, J.A. & Tischler, V. (2010). Qualitative Research in nutrition and dietetics: getting started. *Journal of Human Nutrition and Dietetics, 23*, 599–566.

Szasz, T. (2010). Coercion as cure: a critical history of psychiatry. London: Transaction Publishers.

Teo, A.R. (2010). A new form of social withdrawal in Japan: a review of hikikomori. *International Journal of Social Psychiatry, 56,* (2), 178-185.

Teo, A.R. and Gaw, A.C. (2010). Hikikomori, a Japanese culture-bound syndrome of social withdrawal? A proposal for DSM-V. *The Journal of Nervous and Mental Disorder, 198* (6), 444-449.

The Obsessive-Compulsive Cognitions Working Group (1997). Cognitive assessment of obsessive-compulsive disorder. *Behaviour Research and Therapy, 35* (7), 667-681.

Thomas, P., & Bracken, P. Dualisms and the myth of mental illness. In M. Rapley, J, Moncrieff & J. Dillon (Eds.) *De-medicalizing Misery: Psychiatry, Psychology and the Human Condition.* Hampshire: Palgrave Macmillan, pp.10-26

Tonks, R.G. (2014) Cross-Cultural Psychology, Overview. In: T. Teo (Ed.), *Encyclopedia of Critical Psychology*, pp. 334-341. New York, NY: Springer. Retrieved July 7th, 2017, from https://0-link-springer-com.wam.city.ac.uk/content/pdf/10.1007%2F978-1-4614-5583-7_370.pdf

Uguz, F., Akman, C., Kaya, N., & Cilli, A.S. (2007). Postpartum onset obsessive-compulsive disorder: incidence, clinical features, and related factors. *Journal of Clinical Psychiatry*, 68, 132-138.

Utz, A. (2012). Conceptualizations of mental health, illness and healing. In S. Ahmed & M. M. Amer (Eds.) *Counseling Muslims: Handbook of Mental Health Issues and Interventions*. New York: Routledge, pp.15-32.

Ventriglio, A., Ayonrinde, O., & Bhugra, D. (2015). Relevance of culture-bound syndromes in the 21st century. *Psychiatry and Clinical neurosciences, 70*, 3-6.

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

Wilk, K. (2014). Using a pluralistic approach in counselling psychology and psychotherapy practice with diverse clients: explorations into cultural and religious responsiveness within a western paradigm. *Counselling Psychology Review, 29,* (1), 16-28.

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.

Williams, P.E., Turpin, G., & Hardy, G. (2006). Clinical psychology service provision and ethnic diversity within the UK: a review of the literature. *Clinical Psychology and Psychotherapy,* 13, 324-338.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham, UK: Open University Press.

Willig, C. (2008). *Introducing Qualitative Research in Psychology*. Open University Press: England.

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In. H. Cooper (Ed) *APA Handbook of Research Methods in Psychology, Vol 1: Foundations, planning, measures, and psychometrics*. Washington, Dc: American Psychological Association, pp. 5-21.

Willig, C. (2013). Introducing qualitative research in psychology: 3rd edition. Maidenhead: McGraw-Hill Education Open University Press.

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

Yardley, L. (2008). Demonstrating Validity in Qualitative Research. In J. A. Smith (Ed) *Qualitative Psychology: a practical guide to research methods.* London: Sage Publications Ltd, pp. 235-251.

Yorulmaz, O., & Işik, B. (2011). Cultural context, obsessive-compulsive disorder symptoms, and cognitions: a preliminary study of three Turkish samples living in different countries. *International Journal of Psychology, 46* (2), 136-143.

Zaidg [the miracle of the Quran]. (2008, May 11). Curing obsessive-compulsive disorder (OCD) in 3 steps [Video file]. Retrieved from

https://www.youtube.com/watch?v=D9FPidUVS9E

Appendix A

Recruitment Material

Dear

I am writing to you about some research that I am conducting as part of my doctoral training in counselling psychology. I am a third year Counselling Psychologist in Training, at City University in London, supervised by Dr. Pavlos Filippopoulos, Counselling Psychologist.

I am recruiting Muslim individuals who have experienced *waswaas,* as there is a dearth in the psychological literature in Muslims' explanations of mental health. The study consists of a qualitative research design using Interpretative Phenomenological Analysis (IPA), which aims to look at the data and analyse the recurring themes that emerge. It is hoped that the findings of the study will provide some understanding of the term *waswaas*, which may help to develop more culturally appropriate psychological services for the Muslim population.

If you wish to participate you will be provided with an information sheet to read and you will be asked to give informed consent. I will contact you to arrange an appropriate time and place to conduct an interview. I will give you a form to sign to state that you are giving consent to participate, as well as consenting to record the interview. The semi-structured interview will take approximately one hour to complete, and will later be transcribed. All the material you provide will be confidential and your name will be changed so that you will remain anonymous.

Your participation is not expected to involve any risks of mental or physical harm any greater than those involved in your daily life, and you will be debriefed fully at the end of the interview. I will ask you how you found it to participate in the interview and will provide you with some information regarding where to get support should any difficulties have arisen as a result of the interview.

I will provide you with my contact details and those of my supervisor so that if you wish to withdraw your consent and participation from this study at any time, you may do so. There will be no penalty for withdrawing your participation and I will destroy any recordings or data related to you.

I hope that this information is enough to give you some idea of whether you would like to participate in this research. Your participation will be invaluable and much appreciated. If you would like to volunteer, or if have any questions or require any further information, please do not hesitate to contact me or my supervisor. I can be contacted on either email: [redacted] or Tel: [redacted], and my supervisor Dr. Pavlos Filippopoulos can be contacted at the address at the top of this letter or by email [redacted]).

Yours sincerely

Sameera Ishaq

Counselling Psychologist in Training

Appendix B

Participant Information Sheet

Study Title: An Interpretative Phenomenological Analysis: Muslim individuals' experiences of *waswaas*

Thank you for considering taking part in this research project. Please take the time to read the following information about the study to decide whether you would like to consent to take part and what the study involves. You are welcome to talk to others about the study if you wish.

What is the purpose of the study?

The project is titled "Muslim individuals' experiences of *waswaas*". It is an investigation into how Muslim individuals understand and experience *waswaas*. It is hoped that the study will increase our understanding of Muslim explanations of mental health, and provide useful implications for making psychological services more accessible and culturally more appropriate for Muslims.

How do I take part?

If you decide to participate in this study you will need to sign a consent form, and you will also need to consent for our interview to be recorded. I will contact you to arrange a suitable time and place to conduct a semi-structured interview. During this interview I will ask you some questions about your experience of *waswaas*. The interview should last approximately 1 hour and it will be recorded using an audio-recording device. The tapes will then be transcribed and the data will be coded to ensure anonymity.

Your participation is not expected to involve any risks of mental or physical harm any greater than those involved in your daily life, and you will be debriefed fully at the end of the interview. We will explore your experience of participating in the interview, and I will provide you with some information regarding where to get support should any difficulties have arisen as a result of the interview.

Any information that may identify you will be taken out. You may also withdraw from the study at any point and do not have to give a reason for this. All information you

give will remain confidential. There will be no penalty for withdrawing your participation and I will destroy any recordings or data related to you.

What happens after?

This research is being conducted as part of the thesis requirement for a Doctorate in Counselling Psychology and may later be published, but all participants' names and any identifying information will be removed. If you would like a copy of the completed study, I would be happy to provide you with one.

If you have any questions about this research or would like further information, please contact me on [redacted] or at [redacted]

Yours Sincerely,

Sameera Ishaq

Counselling Psychologist in Training

Appendix C

Semi-Structured Interview Schedule

1) How would you explain what *waswaas* is to someone who has never heard of it?

Prompt- What do you understand by paranoia?
Prompt- What causes the thoughts? Where do the thoughts come from?

2) What would tell you that someone is experiencing *waswaas*?

Prompt- What might you be looking for in a person which will help you recognise that they are experiencing *waswaas* from the following?
-Behaviourally
-Cognitively
-Emotionally
-Spiritually
Prompt- Are there any other domains in which waswaas manifests itself?
Prompt- What might be the reason or reasons for someone with *waswaas* to ask the kind of questions that they do?

3) Would you mind telling me about your own experience of *waswaas*?

Prompt- If you had a particular bad experience, would you tell me a bit about that?
Prompt- In what way, if any, did others react?
Prompt- How did it affect your relationship with others, if at all?

4) What would somebody with *waswaas* do that would help them cope with it if they found it to be distressing?

Prompt- What did you do?
Prompt- What was most helpful for you?
Prompt- What is the aim of stopping the person with *waswaas* asking the questions that they do?

5) At what point, if any, would you tell such a person to seek professional psychological help?

Prompt- What might be your reasons for not advising them to seek professional psychological help?
Prompt- What might be your reasons for advising them to seek professional help?
Prompt- What might encourage you to work with a psychologist?

6) Is there anything that I have not asked you that you would like to share?

Appendix D

CONSENT FORM

Please sign the below form at the end to indicate that you have consented to each point.

I consent to participate in the project entitled: “Muslim individuals’ experiences of *waswaas*” conducted by Sameera Ishaq, Counselling Psychologist in Training at the Department of Psychology at City University, London. The project is supervised by Dr Pavlos Filippopoulos at the Department of Psychology, City University London, Northampton Square, EC1V 0HB. Email: ([redacted]).

I confirm I have understood the information sheet provided for this study and I understand what this study involves. I have had the opportunity to ask questions and discuss the study, and I have received satisfactory answers to all my questions.

I understand the purpose of the study is to investigate Muslim individuals’ understanding and experiences of *waswaas*. I understand that the only requirement from me is to be interviewed by Sameera Ishaq for approximately one hour.

I understand that the interviews will be audio-taped and transcribed. I consent to my interviews being recorded and my data to be used as verbatim quotation in the research study.

I understand that the results of this research will be confidential, and any information relating to me will be anonymised and that I will be given a pseudonym. The key that lists my identity and pseudonym will be kept securely and separately from the research data in a locked file so that my identity will not be attached to the information I contribute. Once the research is completed it will be destroyed.

I understand that the research project is expected to provide further information on Muslims’ explanations on mental health, and from this is it hoped that this will help to make psychological services more accessible to Muslims and more culturally appropriate.

I understand that the results of this research may be published in psychological journals or otherwise reported to scientific bodies, but that I will not be identified in any such publication or report.

I understand that this project is not expected to involve any risks of harm greater than those involved in everyday life, and that all possible safeguards will be taken to minimise any potential risks.

I understand that my participation is voluntary and that I am free to leave and withdraw my consent and participation from the study at any time, without giving reason, and that there is no penalty for doing so. I understand that if I withdraw my consent and participation, that my data, including any recordings, will be destroyed.

If I have any questions about any procedure in this project, or wish to withdraw my participation at any time, I understand that I may contact the researcher Sameera Ishaq at email: [redacted] or Telephone: [redacted], or her research supervisor Dr Pavlos Filippopoulos at email: [redacted].

Name of Participant (Block Capitals):

Signature:

Date:

Appendix E

Demographics

1. Please state your gender:
2. Please state your age:
3. Which religious group do you affiliate yourself with?
4. What is your nationality and ethnicity?
5. Level of education:
6. Occupation, if any:
7. Any prior contact with mental health services:

Appendix F

Debriefing for Participants

Thank you for taking part in this research project.

The project is titled "Muslim individuals' experiences of *waswaas*". It is an investigation into how Muslim individuals understand and experience *waswaas*. It is hoped that the study will increase our understanding of Muslim explanations of mental health, and whether there are any useful implications for making psychological services more accessible and culturally more appropriate for Muslims.

If you have any questions regarding the research or if you wish to withdraw your consent at any time, you may contact me directly at: [redacted] or by Telephone: [redacted]. If you prefer, you may contact my supervisor instead if you have any issues or queries regarding the research, or the conduct of the interview itself that you may not wish to share with me. The contact details of my supervisor are: Dr Pavlos Filippopoulos at the Department of Psychology, City University London, Northampton Square, EC1V 0HB. Email: [redacted].

At the end of the interview, you were asked about your experience of participating in the research and any feelings you may have had after the interview. If, after the interview, you have experienced or are experiencing feelings such as sadness, emotional distress, embarrassment, or any feelings that you are uncomfortable with, below are some details of organisations that you may like to contact in order to get some support. I hope these might be useful if issues have arisen for you during or after the interview, which you would like to discuss with someone.

You may like to see your GP, or you may wish to contact either the BACP for information regarding finding a counsellor or the BPS regarding a psychologist.

Samaritans
Confidential emotional support day and night for anyone experiencing feelings of despair or distress.
Tel: 08457 90 90 90.
Website: www.samaritans.org

The British Association for Counselling and Psychotherapy:
BACP House,15 St John's Business Park, LE17 4HB.
Tel: 01455 883300.
Website: www.bacp.co.uk

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester, LE1 7DR.
Tel: 0116 254 9568.
Website: www.bps.org.uk

Muslim Youth HelpLine (MYH)
2ND Floor, 18 Rosemont Road, London, NW3 6NE
Helpline:08080 808 2008
Email: help@myh.org.uk
Website: www.myh.org.uk
The core service is a free and confidential counselling service available nationally via the telephone, email, internet and a face to face befriending service in the Greater London area.

The Lateef Project- Islamic Counselling
Tel: 0121 301 5392 or 0121 301 5393
Website: www.lateefproject.com
The service is open to any Muslim in Birmingham over the age of 14, it is a non-judgmental counselling service. Volunteers are trained in Islamic counselling.

Nafsiyat- Intercultural Therapy Centre
Unit 4, Clifton House, 42-43, Clifton Terrace, London, N4 3JP
Tel: 020 7263 6947
Email: admin@nafsiyah.or.guk
Website: www.nafsiyat.or.guk
Intercultural psychotherapy and counselling

Appendix G: Ethics form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

D.Psych

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

An Interpretative Phenomenological Analysis: Muslim individuals' experiences of *waswaas*

2. Name of student researcher (please include contact address and telephone number)

Sameera Ishaq
[redacted]

3. Name of research supervisor
Pavlos Filippopoulos

4. Is a research proposal appended to this ethics release form? Yes

5. Does the research involve the use of human subjects/participants? Yes

If yes,

a. Approximately how many are planned to be involved? 8

b. How will you recruit them?

Through Islamic centres and Mosques

c. What are your recruitment criteria?
(*Please append your recruitment material/advertisement/flyer*)

8 adult Muslim individuals who have experienced *waswaas* will be recruited through Mosques and Islamic centres. If they wish to participate, participants will be sent information sheets and will be asked to give informed consent. Thereafter, I will contact them to arrange an appropriate time and place to conduct a semi-structured interview.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? No

d1. If yes, will signed parental/carer consent be obtained? NA

d2. If yes, has a CRB check been obtained? NA
(*Please append a copy of your CRB check*)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

In a semi-structured interview, participants will be asked questions about their experiences the phenomenon of *waswaas*. It is anticipated that the interview will last approximately one hour. The interviews will be arranged at a time and place which is convenient for them. Participants do not have to answer any questions they do not wish to and they will be free to withdraw at any time if they should so wish.

7. Is there any risk of physical or psychological harm to the subjects/participants?
NO

If yes,
a. Please detail the possible harm?

b. How can this be justified?

c. What precautions are you taking to address the risks posed?

In the information sheet provided for participants it is stated that the interview will not pose any risk greater than those involved in their daily life. Participants will be debriefed at the end of the interview. I will ask them how they found the interview and will provide them with some information on counselling services should they feel they would like extra support for any difficulties that may have arisen from the interview.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research? Yes

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Audio-tape recordings of the interviews will be kept that will later be transcribed, and I will also be making memos

12. What provision will there be for the safe-keeping of these records?

All records will be kept in a securely locked filing cabinet

13. What will happen to the records at the end of the project?

They will be destroyed

14. How will you protect the anonymity of the subjects/participants?

Any identifying information will be removed and the data will be coded so as to ensure anonymity.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Participants will be given the opportunity to debrief after the interview and if they require further psychological support, they will be encouraged to speak to their G.P or I will give them details of counselling services if they would like further support.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher: Sameera Ishaq Date: 29.05.2014

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal
Recruitment Material
Information Sheet
Consent Form
De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? No
If yes,

a. Please detail possible harm?

How can this be justified?

What precautions are to be taken to address the risks posed?

ction C: To be completed by the research supervisor

ease pay particular attention to any suggested research activity involving minors or nerable adults. Approval requires a currently valid CRB check to be appended to this m. If in any doubt, please refer to the Research Committee.)

ase mark the appropriate box below:

ical approval granted X

er to the Department's Research and Ethics Committee

er to the School's Research and Ethics Committee

nature [redacted] --------- Date 27/2/15

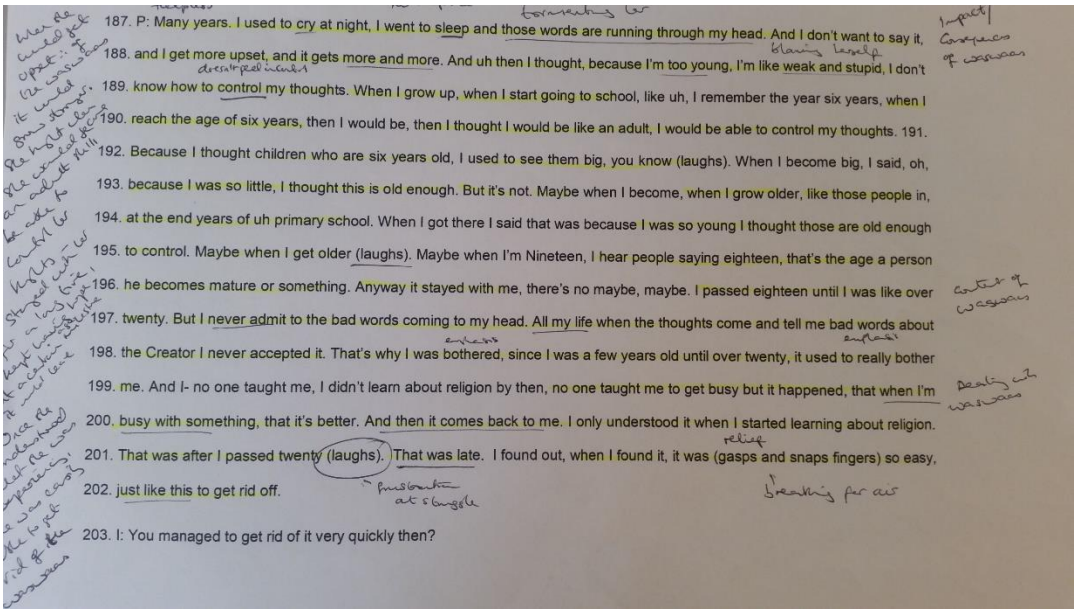
ction D: To be completed by the 2nd Departmental staff member

*ease read this ethics release form fully and pay particular attention to any answers on form where **underlined bold** items have been circled and any relevant appendices.)*

gree with the decision of the research supervisor as indicated above

nature [redacted] ---------- Date 27/02/2015

Appendix H: Transcript for Nida



187. P: Many years. I used to cry at night, I went to sleep and those words are running through my head. And I don't want to say it,
188. and I get more upset, and it gets more and more. And uh then I thought, because I'm too young, I'm like weak and stupid, I don't
189. know how to control my thoughts. When I grow up, when I start going to school, like uh, I remember the year six years, when I
190. reach the age of six years, then I would be, then I thought I would be like an adult, I would be able to control my thoughts. 191.
192. Because I thought children who are six years old, I used to see them big, you know (laughs). When I become big, I said, oh,
193. because I was so little, I thought this is old enough. But it's not. Maybe when I become, when I grow older, like those people in,
194. at the end years of uh primary school. When I got there I said that was because I was so young I thought those are old enough
195. to control. Maybe when I get older (laughs). Maybe when I'm Nineteen, I hear people saying eighteen, that's the age a person
196. he becomes mature or something. Anyway it stayed with me, there's no maybe, maybe. I passed eighteen until I was like over
197. twenty. But I never admit to the bad words coming to my head. All my life when the thoughts come and tell me bad words about
198. the Creator I never accepted it. That's why I was bothered, since I was a few years old until over twenty, it used to really bother
199. me. And I- no one taught me, I didn't learn about religion by then, no one taught me to get busy but it happened, that when I'm
200. busy with something, that it's better. And then it comes back to me. I only understood it when I started learning about religion.
201. That was after I passed twenty (laughs). That was late. I found out, when I found it, it was (gasps and snaps fingers) so easy,
202. just like this to get rid off.
203. I: You managed to get rid of it very quickly then?

Appendix I: Emergent Themes for Sarah

The Qareen

Another being/ Separate identity

Waswaas is unbidden thoughts

Psychological disorder/mental health issue/ Waswaas versus a psychological issue

Control and accountability

How the qareen works

Vulnerability to waswaas (checks for vulnerability and observes people, including being alone)

The aims of the Qareen

Impact/consequence:

Driving a person crazy/ Appears crazy or becomes crazy

Waswaas can lead to psychological issues/mental health issues

Hard to battle the waswaas

Impact on self: petrified

Engaging with thoughts

Acting on it

Content of waswaas

Waswaas manifesting in religious practice

Repetitive checking/O.C.D./ Cleanliness

Asking questions of a religious nature

Blasphemy/ Biggest fear to die as a non-believer

Manifesting in relationships

How to deal with the waswaas

Psycho-education

Learn/acquiring religious knowledge

Ignore ideas/qareen/ Refuse to engage with the thoughts/

Mindful of the thought but not to engage with it

Don’t react outwardly/ Do the opposite

Defiance/mindset/ Fight it

Traditional herbal Arab medicine

Dhikr

Talk to others / Support from others

Therapy: When waswaas is problematic

Wouldn’t understand, label someone as crazy, in conflict with someone’s own beliefs and values

Appendix J: Final Themes for all

	A	B	C	D	E	F	G	H
Another being/ Separate identity			✔	✔	✔	✔	✔	✔
Waswaas is unbidden thoughts (what waswaas is)	✔	✔	✔	✔	✔	✔	✔	✔
Devices of the qareen			✔	✔	✔	✔	✔	
Obsessive and intrusive questioning	✔	✔	✔	✔	✔	✔	✔	✔
Repetitive checking/O.C.D./ Cleanliness/health anxiety		✔	✔		✔	✔	✔	✔
Biggest fear to die as a non-believer	✔			✔	✔	✔	✔	✔
Psycho-education	✔	✔	✔	✔	✔	✔	✔	✔
Therapy can be an asset	✔	✔	✔	✔	✔	✔	✔	✔

The Professional Practice Component of this thesis has been removed for confidentiality purposes.

It can be consulted by Psychology researchers on application at the Library of City, University of London.

Section C:

Critical Literature Review

Are Psychological Interventions Effective in Treating the Mental Health Needs of Young Refugees?

Introduction

The 1951 Geneva Convention states that for an individual to be granted refugee status, he/she must have left his/her own country and be unable to return to it because of 'a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion' (United Nations High Commission for Refugees (UNHCR), 2007). The UNHCR stated that at the end of 2015, there were 65.3 million people who were forcibly displaced worldwide, including asylum seekers, refugees, internally displaced persons, stateless people and returnees. Refugees constituted about a third of the figure, and almost half were children under the age of 18 (UNHCR, 2015). More than half of the world's refugees were from Syria, Afghanistan and Somalia. However, due to the recent ongoing persecution faced by the Rohingya people in Myanmar it is possible that the figure of 65.3 million people who have been forcibly displaced worldwide may increase. The top 5 countries that hosted the largest number of refugees worldwide in 2015 are Turkey, Pakistan, Lebanon, Iran and Ethiopia respectively (UNHCR, 2015).

For the purpose of this review, the term *refugee* will include: asylum seekers (those applying for refugee status); those given humanitarian protection or discretionary leave to remain; and those given indefinite leave to remain (full refugee status). The term *young refugees* will be used for children and adolescents.

Many young refugees have experienced various forms of trauma, including war-related trauma, bombings, fear of safety, as well as experiencing hunger, poverty, homelessness and displacement (Marshall, Butler, Roche, Cumming and Taknint, 2016), and may have even lived in a refugee camp (Hadfield, Ostrowski and Ungar, 2017). They may have been tortured, raped or have witnessed family members experience these. They may have seen family members murdered, taken away or imprisoned and have become separated from their families. They too may have been arrested, detained, or even tortured, and they may even have been forced to

commit certain acts of violence (Lustig, Kia-Keating, Knight, Geltman, Ellis, Kinzie, Keane and Saxe, 2004).

Young refugees have had to flee their homelands, possibly alone or via traffickers (Fazel, Reed, Panter-Brick and Stein, 2012), and may be vulnerable to exploitation. They may have traversed through several countries in dangerous conditions to get to a country of safety, and risk the possibility of death along the way, or even once arriving at a country where they believe they will be safe, they may well actually be deported (Hebebrand, Anagnostopoulos, Eliez, Linse, Milovancevuc and Klasen, 2016).

Those who are accompanied by parents or relatives may find that the adults experience difficulties in responding to them due to their own trauma. It has also been argued that trauma experienced by parents may be 'transmitted' to their children (Rezzoug, Baubet, Broder, Taieb and Moror, 2008). The long-term ramifications of trauma and persecution on health and mental well-being may persist through several generations of refugee families (Bjorn and Bjorn, 2004). Children of torture victims often experience more emotional difficulties and psychosomatic symptoms, even if they have not experienced torture themselves. Therefore, such children should also be assessed for the effects of torture (Campbell, 2007).

Chronological phases of experiences that refugees have undergone are those of: preflight, flight and resettlement, and each phase consists of its own stressors (Lustig et al., 2004). All these experiences can compound psychological distress and increase the risk of psychiatric disorders (Hodes and Tolmac, 2005), such as Post Traumatic Stress Disorder (PTSD), depression and anxiety. However, alongside mental health needs, young refugees also have significant physical health problems (Fazal and Stein, 2002), which means that young refugees have a diverse range of both psychological and physical needs.

Once in the new host country, young refugees still face many stressors which can continue to affect their psychological well-being, and this is increasingly being referred to as "secondary trauma" (Fazal and Stein, 2002). For instance, they may be experiencing ongoing grief as a result of separation from their family and their homeland, a loss of belonging and of their culture (Marshall et al., 2016). Young refugees who do not know the whereabouts or fate of their relatives experience more distress than those who know that their relatives are dead. This is because

they are unable to undergo the grieving process and engage in necessary death rites (Hodes, 2002). Young refugees may also experience feelings of guilt due to family members still remaining abroad in difficult circumstances, whilst they have managed to escape (Kaplan, 2009).

Other stressors may include racism, bullying by peers, culture shock, adapting to a new culture, and learning a new language. They may be unable to identify with the culture of the host country, and they may also feel that their cultural identity is attacked if their home culture is generally discriminated against in the host country (Marshall et al., 2016). Some may also struggle to find a balance in adapting to the new culture whilst maintaining a connection to their own. Key family members may also be missing, creating a new family dynamic, in which the children may have to adapt to new roles and responsibilities.

Some issues may also cause intergenerational conflict. For instance, young refugees may find it easier to assimilate and adapt to new societies than their parents (Marshall et al., 2016). By attending school, young refugees can become fluent in the main spoken language of the new society, whereas parents may find it harder to adapt to the new culture. These intergenerational problems may result in parents losing their authority and influence over their children, creating conflict (Marshall et al., 2016).

It is important to note that young refugees are a very diverse group, with different needs and experiences. There is a propensity to generalise the refugee population as a homogenous group, which can lead to stereotyping and misunderstanding individual needs. There is also a growing view within psychology that psychological disturbance is a rational and justifiable response to the experiences that many young refugees have faced. Many young refugees are resilient and not all will require psychological treatment, due to a mix of individual, familial and community strengths (Marshall et al., 2016). This has resulted in much controversy of the diagnosis of PTSD being applied to the refugee population. This is because young refugees have faced multiple traumas, but also have strengths that tend to be ignored by the concept of PTSD.

There is also concern that the notion of PTSD itself is a very Western one, which may not be easily applicable to other cultures, as certain symptoms may signify something completely different in some cultures. Murray, Davidson and Schweitzer

(2010) claim that there has been a shift away from focusing on the symptoms of PTSD and instead a more holistic approach is being taken to help foster strength and resilience in this population group. They argue that different cultural belief systems should be honoured instead of pathologized, and so clinicians should acknowledge and work with cultural differences and the meanings and understandings people give to distress.

International agreements now recognise that war severely affects children and that there is a duty to alleviate its effects on the mental health of these children. Indeed, the needs of young refugees have been addressed in some of the United Nations Charters, such as the UN Convention on Refugees, and the Universal Declaration of Human Rights. Despite this, there are some countries who do not wish for refugees to enter their borders (Hebebrand et al., 2016).

The United Nation's Convention on the Rights of the Child (Office of the UNHCR, 1989) declares that every child deserves care and protection, and that the best interests of the child must be the primary principle behind any decision or action related to him/her. It states that governments must ensure that children develop healthily and are able to survive. This consists of helping the child to develop mentally, physically, morally, spiritually, and socially. It is clear that many young refugees and their families require health care and some form of psychological support. Yet, despite UN conventions, many receiving countries are unprepared in responding to their needs. Research has shown the negative effects that detention centres can have on the mental health of young refugees (Davidson, Murray and Schweitzer, 2008). A lack of service provision also appears to be critical for unaccompanied minors, and in the UK, this may be because only a few statutory requirements stress the health care need of this group (Raval, 2005).

Many GPs do not assess for mental health needs due to the lack of appropriate referral services (Hargreaves, Holmes and Friedland, 2003). The treatment needs of young refugees often appear overwhelming and can involve liaising with different professionals and organisations, including interpreters and schools. This means the use of more resources and time. Indeed, The Guardian (Carvel, 04/06/2002) has reported some psychologists have refused to work with refugees for these reasons.

Harris (2002) however, argues that it could be unethical not to offer counselling as an intervention to refugees and states that counselling psychologists are in a

position to work with this group as they have the relevant knowledge regarding how humans function whilst employing a humanistic, holistic stance in understanding people. By holding an attitude of belief, rather than the common disbelieving one that the Home Office and the like adopt when engaging with refugees, this can result in an encounter which is therapeutically powerful. The therapist can provide the extremely beneficial role of an empathic witness and validate the individual's life experiences. However, Harris (2002) does caution that counselling psychologists have the responsibility to ensure that they can meet the needs of this population, and if not, then to be cognisant of other options that might be available.

However, young refugees already underutilise mental health services. This may be because parents/caregivers may not recognise psychological disturbance in children, and also, because of their own emotional distress, they may be unable to adequately respond to their children and get them appropriate help. They may not share the same conceptualisations regarding mental health issues as the host country (Ellis, Miller, Baldwin and Abdi, 2011), and may not differentiate between psychological and physical symptoms and that separate services will then be needed. Parents may give other factors immediate priority, such as ensuring that basic needs are met first, such as having adequate food and housing, and if these are not met, these factors themselves may well be affecting a child's development and mental well-being (Ellis et al., 2011).

There are also practical problems, such as finding their way to a service and language difficulties, as services may not be available in languages they are fluent in (Marshal et al., 2016). There may also be fears that services may not be confidential, particularly if they are still waiting to find out if their asylum claim has been successful. Also, clinical interviews may be seen as a form of interrogation, and some may distrust government services as such services were the ones responsible for causing them harm in their own countries (Ellis et al., 2011). There is also a stigma attached to mental health in some cultures.

Despite the need for young refugees to receive psychological treatment, research in evidence based interventions is still not established. There is much evidence now to support different forms of cognitive behavioural treatment (CBT) for the treatment of PTSD in children, as well as eye movement desensitisation and reprocessing (EMDR) (NICE, 2005). However, not all refugee children will develop PTSD, and some will have co-morbid disorders. Young refugees tend to experience repeated

and prolonged trauma, and they also come from and face different environmental, sociocultural and political contexts.

Tyrer and Fazel (2014) have argued that services need to address these diverse range of factors and offer a broad range of services to young refugees, yet the evidence-base for this remains weak. Cognitive behavioural therapy (CBT) appears to be the most studied and effective intervention for adult refugees and other traumatised children (Tyrer and Fazel, 2014). However, studies evaluating psychological treatments for young refugees remain scarce (Unterhitzenberger, Eberle-Sejari, Rassenhofer, Sukale, Rosner, & Goldbeck, 2015), although Tyrer and Faezl (2014) argue that research in this area has begun to be intensified in order to find effective interventions which can be conducted in different settings. Tyrer and Fazel (2014) conducted a systematic review of mental health interventions that had been evaluated in school or community-settings for refugee and asylum-seeking children, and found limited evidence available for school and community interventions. It is therefore that this paper will be focusing on current psychological treatments for young refugees.

Psychological Interventions

Trauma-Focused Cognitive Behavioural Therapy

Unterhitzenberger and Rosner (2016) describe a case report of a 17-year-old unaccompanied refugee minor girl (URM) known as Amina, using a manualised trauma-focused CBT (TF-CBT) short-term approach for PTSD in an out-patient setting in Germany. They adapted the manual of Cohen, Mannarino, and Deblinger (2006) and the treatment consists of 12 sessions of 45-50 minutes (normally with the child and the same number with the caregiver, who is usually a parent). It involves 8 modules known as PRACTICE and consists of psychoeducating the child and caregiver and teaching positive parenting skills; relaxation skills; affective modulation and emotion regulation; cognitive processing; a trauma narrative; and if necessary in vivo exposure; a joint session where the child and caregiver share the trauma narrative; and working on future safety. Unterhitzenberger and Rosner (2016) point out that TF-CBT has been tested in different cultural settings and each module is culturally sensitive.

They provide some background history of Amina, such as that her and her family had to flee their home several times to a camp, and on one occasion she saw a

young girl raped and killed in the camp; she saw the corpses of 3 of her siblings who were killed; and as she was fleeing to Europe with her aunt, her aunt drowned in the sea, but Amina was rescued and reached Germany. Unterhitzenberger and Rosner (2016) mention that Amina had been in Germany for 2 years and lived in a residential setting with 8 other adolescents in a youth welfare institution. She had no prior schooling but was attending a preparatory class in German and Maths for secondary school and her German was deemed proficient for therapy work. They report some of her symptoms, such as: recurring nightmares, intrusions, aggressive behaviour, panic reactions, self-harm, no emotional regulatory skills; avoidance of going out by herself; and separation difficulties from her key caregiver in the residential setting.

Unterhitzenberger and Rosner (2016) list a number of inventories that Amina was assessed on, such as the Clinician Administered PTSD Scale of Children and Adolescents; the University of California Los Angeles PTSD Reaction Index; and the Children's Depression Inventory; Screen for Child Anxiety Related Disorders and the Schedule for Affective Disorders and Schizophrenia for School-Age Children. Some of these tests were also completed by her caregiver. The tests were given by a trained administrator who was blind to the treatment condition, at pre, post and at the 6 month follow-up. Although at pretest Amina's scores were elevated, Unterhitzenberger and Rosner (2016) state she only met the diagnosis of PTSD. They also add that the German outcome measures have good psychometric properties but do not mention their validity when applied to refugees. They mention that her caregiver also filled in outcome measures but do not report whether she met any diagnostic criteria.

Unterhitzenberger and Rosner (2016) describe some of the modifications for the modules in their work with Amina. For instance, it was discovered that Amina did not know the names of different emotions in her native language so the therapist used pictures of emotional facial expressions and Amina would practice the names of the emotions. Also, 6 sessions were spent on the trauma narrative instead of the usual 4, and it was found that in vivio exposure was not necessary as Amina showed no severe avoidance of stimuli. Unterhitzenberger and Rosner (2016) state that at posttreatment and follow-up Amina no longer met the diagnosis of PTSD and all of the measures showed marked improvement. However, they add that her caregiver's outcome scores showed less improvement. They suggest this may be because before the follow-up Amina turned 18 and there were concerns regarding her being deported or having to leave the residential setting, and so the caregiver was not

able to separate out these real fears from trauma related ‘symptoms’ when filling out the questionnaires on her own. They suggest Amina was able to separate them out however as she filled them out with the administrator.

As this TF-CBT study reports on a single case study, only limited conclusions can be drawn. Unterhitzenberger and Rosner (2016) suggest that it may be that Amina’s cultural background was particularly suited to the treatment. They also mention that Amina was motivated and did the work between sessions and received a lot of support from her residential group. It would be useful to see how effective the treatment would be with young refugees who do not have an adequate support system and who may not have adequate language skills and may need the assistance of an interpreter. This study does however show that a ‘Western’ evidence based approach for PTSD can be used with young refugees who may have limited language skills and come from another cultural background.

Although more research is needed to see if the treatment would need to be culturally adapted for other groups of young refugees, this study does demonstrate that no major modifications were made to the manual. The minor additions that were made, Unterhitzenberger and Rosner (2016) state were as a result of tailoring the treatment to the individual rather than due to cultural issues, something which is generally done in therapy anyway. As it is a skills based short-term approach it also seems that it would be more appropriate for those who wish to learn and implement such skills rather than a less directive and exploratory treatment approach.

Tree of Life Narrative Group

Hughes (2014) describes ‘Tree of Life’ groups for parents and children run in schools by The Child and Family Refugee Service at the Tavistock Centre in London. The groups use a strength based narrative methodology, using a tree as a creative metaphor, by which parents and children are able to develop empowering stories about their lives, rooted in their social and cultural histories. Hughes (2014) mentions that practitioners from refugee communities are employed to help bridge gaps between the communities and the mental health service, and services are offered in accessible locations, such as schools and community centres to help remove stigma.

Hughes (2014) states that the service has attempted to develop culturally congruent models incorporating resilience, unlike standard models which focus on trauma and loss. The Tree of Life groups she states therefore help develop alternative narratives, whilst respecting cultural differences. The groups recognise and build on the strength and resilience of refugees, and focus on coping methods that are culturally congruent, whilst acknowledging injustices people have faced.

Hughes (2014) mentions that the first Tree of Life group began by offering parenting workshops to Afghani mothers who were struggling to manage and support their children effectively, at the request of a primary school. After this, the team delivered further workshops in secondary schools with refugee children from a range of backgrounds, such as Congolese, Afghani and Arabic-speakers. The Tree of Life is a narrative method developed by Ncube (2006) in collaboration with David Denborough, to help people move forward from their traumatic life histories. Concerned that Western based counselling methods weren't suitable for bereaved children whose parents had died due to HIV/AIDS, the Tree of Life was developed to help the children re-build a sense of safety, so that they may talk about their experiences without being re-traumatised. Children were able to talk about their dreams and hopes for the future, and this helped create a safe environment in which they could talk about their trauma and losses.

The Tree of Life is a creative metaphor using a tree on which people can pan out their lives. This consists of writing or drawing their social and cultural histories in the roots, family origins, religious roots and so on. The ground shows elements of people's current lives, such as where they live and what they are doing now with their lives. On the trunk of the tree people's strengths and abilities are placed whilst talking about how these were developed. In the branches hopes and dreams regarding the future are put, with names of significant people from both the past and present placed on different leaves, and the tree's fruits are gifts people have received. Narrative questioning is used to help people develop detailed life descriptions, to identify skills and resources and how these developed and how they can guide the person to their hopes and dreams. Then people share their trees with others in the group, as well as sharing how to deal with ongoing difficulties in ways that fit their cultural values. People can also share their trees with those who are important to them and this is done by either writing letters to them or inviting them to events celebrating their work where group participants are handed certificates to acknowledge their achievements and strength (Hugh, 2014).

Hughes (2014) highlights that similar themes would emerge amongst the groups regarding problems they faced around their refugee experiences, such as racism, learning a new language and adapting to a new culture, and uncertainty about the future. Hughes (2014) states that with the young refugees structured outcome measures were used, so at the start they were asked to identify their aims from attending the group and using a scale to rate how near they were to achieving these goals. At the end of the group, they re-rated these and were also asked further information regarding what else they may have gained from the group. Hughes (2014) claims that the evaluations consistently demonstrated that the children had developed pride in their cultural heritage, their self-confidence had increased, and they had developed responses to everyday stresses and difficulties. Teachers, family and friends were invited when certificates were awarded. Teachers who may have viewed some children as disruptive were later reported to have noticed improved behaviour in them after they had attended the groups. However, Hughes (2014) does not state how teachers reported their feedback and what precisley the improved behaviour was.

There are a number of limitations from what Hughes (2014) has described regarding the Tree of Life, making it difficult to replicate the study and it is also hard to draw certain conclusions. For instance, there is no mention regarding how long the children had been in the U.K. when they participated in the groups, and so whether they had had time to settle and adjust or if they were recent new arrivals. The study also doesn't mention if any of the children were asylum-seekers and if so, whether they faced uncertainty about being sent back and how that affected their well-being and shaped the process of their trees. It is uncertain how the children were referred to the groups and what the inclusion or even exclusion criteria to join a group, if any, were. Diagnostic criteria aren't referred to at all in the study and nor any validated outcome measures. It is unclear how old the children were in the groups, how many were in a group, how long the sessions lasted for and over what period of time.

It is also uncertain whether interpreters were used, yet Hughes (2014) does point out that information can be conveyed through imagery as the Tree of Life is a visual method, so it is useful for those who are not fluent in English or who possess limited verbal communication. It is difficult to say how effective the Tree of Life is as there's no mention of a control group and also how effective it is compared to other treatment models. It would be useful also to follow up the children in a few years'

time to see if they have managed to achieve their dreams, how effectively they tackled the problems they were facing and how resilient they have remained when facing new difficulties.

Despite these limitations however, the Tree of Life groups seem very promising and present a more holistic approach in treating young refugees, by incorporating their strengths and resilience. By producing a tree, a personal document is produced which can be shared with others so they are witnesses to the experiences of this person. Hughes (2014) states that there is a storytelling element to the process which is an important tradition of some refugee communities. The Tree of Life helps roots people in their past and present community, which Hughes (2014) states can be very powerful for those who have experienced traumatic losses, and it also helps people recognise past hopes and resources which they may begin to implement again. Hughes (2014) also highlights that the process enables people to understand their traumatic responses and not see them as a weakness or something shameful. There is also a sense of empowerment and being true to one's cultural identity and working out one's own path forward as the young refugees negotiate with British life. That is, they do not have to replace their own cultural understandings of their experience with Western ones which may not seem congruent.

"Writing for Recovery" for Bereaved Young Refugees

Kalantari, Yule, Dyregrov, Neshatdoost, and Ahmadi (2012) conducted an experimental and controlled group study with 61 Afghani young refugee pupils in a school in Iran, who were recently affected by the war in Afghanistan, in conjunction with the Children and War Foundation. The intervention used was an expressive writing manual developed by the Children and War Foundation for adolescents who have experienced trauma, and was then adapted for children who have also experienced bereavement (having lost one or both parents during the war in Afghanistan). It consists of both structured and unstructured writing and can be administered in either an individual or group setting in a school over 3 consecutive days. In this study it was administered in an experimental and control group, and during the 3 consecutive days consisted of two 15minute sessions. It is mentioned that the children were all Farsi speakers (their first language) and could read and write in Farsi. Although it is not mentioned explicitly in the study, it is assumed the study was undertaken in Farsi.

A Farsi version of the Traumatic Grief Inventory for Children (TGIC) was used to screen 88 war bereaved children. Kalantari et al., (2012) state that children experience a trauma event, and coupled with the trauma and loss of losing a parent, they may experience 'complex elements of grief and trauma that make ordinary recovery from bereavement difficult' (p. 141). They claim that the TGIC is used to 'measure maladaptive symptoms of grief in children and adolescents' (p. 145) and that the Farsi version showed good internal consistency, yet they do not mention its validity for a refugee population. 64 children who were found to have the highest TGIC scores were then randomly allocated to the experimental and control groups. However, only 29 from the experimental group attended all 3 consecutive days, meaning that only 61 children participated in the actual study. The groups were further split almost equally between boys and girls, with the girls participating in the Writing for Recovery intervention in the morning and the boys in the afternoon.

The sessions began with unstructured writing exercises regarding feelings and thoughts about their traumatic event or loss and moved to more structured writing regarding reflections on advice they would give to another in their situation. Then they were asked to envision 10 years having passed, and looking back, to reflect on what they may have learned from their experience. They then placed their written pieces in a blue box at the end of each session and after a short break resumed the next session.

Kalantari et al., (2012) acknowledge that it is still not yet clear how exactly writing can improve one's psychological well-being but highlight certain elements from both CBT and narrative exposure therapy (NET) which may be instrumental in this. For instance, they briefly touch upon imaginal and in vivo exposure, and cognitive restructuring regarding trauma-related cognitions in CBT and suggest that 'exposure through writing may involve the same mechanisms' (p. 143). They add that emotional disclosure in the unstructured writing may aid the cognitive reappraisal and 'benefit-finding' in the more structured exercises, hypothesising that writing about traumatic experiences will result in a decrease in negative feelings and thoughts related to the trauma.

Other than not being a bereaved young Afghani refugee person and not reaching a high score on the TGIC scale, it is unclear what other exclusion criterion were applied. A week after the last day of the intervention, the post-test was conducted. The post-test results showed that the experimental group experienced reduced

‘maladaptive symptoms of grief’ (p. 145), (average score fell from 56.30 to 44.9), whereas there was a slight increase in the control group (49.9 to 53.9). Kalantari et al., (2012) suggest therefore that writing about traumatic experiences may alleviate grief symptoms amongst children who experience traumatised grief. They claim that the intervention can be used for large groups with a maximum time of 90 minutes only invested. They call for more research on the Writing for Recovery intervention to further check its efficacy so that it may be used to reduce psychological difficulties following large-scale disasters. Also, as the intervention is manual based, there is a possibility for non-mental health professionals to be able to deliver it, including teachers themselves at schools.

A 6 months follow-up was planned but the authors said it was not possible to carry it out in the end. They mention that after the post-test there was a 3 month school break, after which the school faced problems regarding re-opening, which was a new stressor for the young refugees, and some of them had to leave school in order to work due to their social-economic situation.

The results of this study have to be treated with caution as no long-term effects were assessed. Kalantari et al., (2012) highlight that the socio-economic situation may continue to affect the psychological well-being of young refugees. They also point out that the young refugees in their study were supported by a religious charity, so findings cannot be generalised to those who do not have some form of support. This study was conducted in a school setting, and although Kalantari et al., (2012) point out that the school had poor air-conditioning, was noisy, overcrowded, and that the pupils said they had to sit on the floor as there were no tables in the classrooms, there is no acknowledgement as to how these conditions may have had an impact on the wellbeing of the participants and their participation in the study itself.

Although this study shows support for a brief writing intervention for young refugees experiencing traumatised grief, it has a number of limitations and only further research on the efficacy of the intervention will suggest how effective it really is. The findings of this study are specific to one group of refugee children and so cannot be generalised to young refugees who come from other ethnic backgrounds, nor to those who are experiencing traumatised grief, such as the loss of a loved one family member who is not a parental figure. Also, the study does not indicate how many children had lost only one parent and how many had lost both. This is surprising as

Kalantari et al., (2012) do acknowledge that how young refugees cope with stressors, including death of loved ones, are influenced by the reaction of the surviving parent and community, and as such 'poor quality parenting' (p. 141) and a lack of support is a risk factor for the child's mental well-being. Also as the authors briefly mention CBT interventions such as imaginal and in vivo exposure, cognitive restructuring, and even NET, it would be useful to compare the Writing for Recovery intervention with these other approaches to see which is more effective. This study also raises the question as to how ethical it is to not provide treatment to the control group when these participants also scored highly on the TGIC scale.

Summary

Psychologists can play a pivotal role by providing support to young refugees and their families by working in collaboration with other organisations. Counselling psychologists have a plethora of generic skills that can be employed in the community and schools, providing support which is accessible, culturally appropriate and non-stigmatising, to a vast number of refugees (German and Ehntholt, 2007). Harris (2002) states that counselling psychologists can create a safe and trusting place for refugees, in which they can be unquestioningly accepted and which will help lessen some of the negative effects of being in a society that holds an attitude of disbelief towards them. Psychologists can form genuine relationships with refugee clients, act as witnesses to the injustices they have suffered, help empower them, and act as advocates for social change.

It appears that one of the most imperative roles for counselling psychologists is to undertake further research into psychological interventions which can be effectively used to meet the mental health needs of young refugees. Many young refugees experience mental health difficulties as a result of traumatic experiences and a range of losses they have faced, as well as due to the ongoing stressors they face in the country of settlement. Very little research involving randomised controlled trials or large scale studies have been conducted in this area. From the small scale studies that have been done, the treatments mentioned, such as TF-CBT and Tree of Life Narrative groups seem promising and may meet the needs of some young refugees.

It is argued that refugees should not simply be seen as victims who require help, especially as they have found ways to survive their ordeals (Chan, Young and Sharif, 2016). Therefore, treatments should be innovative and flexible in order for them to be appropriate and effective for young refugees. It is also important that young refugees have access to emotional and psychological support, which is non-stigmatising and culturally appropriate, whilst acknowledging that not all young refugees will need this support.

Conclusion

Young refugees are a heterogeneous group, who have faced a diverse range of trauma sequelae. Research concerning treatment interventions for young refugees is extremely inadequate. The little research that has been done consists of many limitations. Different outcome measures have been used in some of the studies to measure PTSD symptoms. There may be a need for a general outcome measure to be developed specifically for young refugees, which accounts for the variety of trauma experiences they face and which can be culturally adapted for different refugee groups. However, there is a concern that young refugees experience other symptoms, such as depression, and researchers need to be mindful when conducting research with young refugees of co-morbid disorders. The outcome measures that have been used have not been validated in refugee populations, so there is an urgent need for this in order to effectively evaluate interventions.

Different psychological interventions have been used so it is difficult to compare the studies and to evaluate which interventions are more effective. There is also a need for these studies to be replicated on a larger scale. Some of the studies lack control groups. Control groups are needed to evaluate the effectiveness of interventions, but this raises the question as to how ethical it would be to deprive a group of young refugees potential benefit and relief from distress. There is also a need for long-term, longitudinal studies to be conducted in order to investigate how short-term interventions affect young refugees' distress and mental health needs in relation to long-term outcomes, as well to evaluate the effectiveness of the interventions.

It is clear though that a variety of different treatments, including individual, group, family, and school based interventions need to be established in order to meet the mental health needs of young refugees, from which an evidence base can then be

developed. Some of the studies have addressed social and political experiences of the young refugees, but there is a need for more holistic treatments which can meet the needs of both mental health and practical problems whilst also incorporating their cultural values. Counselling psychologists need to gain further knowledge about the diversity of cultural beliefs in order to make treatments more culturally acceptable and accessible to young refugees.

Although psychological interventions do appear to effectively meet some of the mental health needs of young refugees, it is difficult to answer the question definitively because current studies are not comprehensive enough due to their limitations discussed above. A pilot study could be conducted in a primary school with young refugees who have full refugee status, using The Tree of Life group intervention which can be compared to a similar group of young refugees who are using a TF-CBT treatment approach in order to see which intervention is more effective in treating PTSD 'symptoms'. A longitudinal study could then reassess the children in 5 years time, perhaps in secondary school, to see if the treatments' effects are maintained.

References

Berman, R.N. (2001). Children and war: Current understandings and future directions. *Public Health Nursing, 18* (4), 243-252.

Bjorn, G. J., & Bjorn, A. (2004). Ethical aspects when treating traumatized refugee children and their families. *Nord J Psychiatry, 58* (3), 193-198.

Campbell, T.A. (2007). Psychological assessment, diagnosis, and treatment of torture survivors: A review. *Clinical Psychology Review, 27,* 628-641.

Carvel, J. (2002). Mental care denied to refugees: NHS psychologists refuse to treat 'traumatised asylum seekers'. Guardian Unlimited. Retrieved 05 May 2009 from http://www.guardian.co.uk/society/2002/jun/04/asylum.immigrationasylumandrefugees

Chan, J. K., Young, M. Y, & Sharif, N. (2016). Well-being after trauma: a review of posttraumatic growth among refugees. *Canadian Psychology, 57* (4), 291-299.

Cohen, J. A., Mannarino, A. P. & Deblinger, E. (2006). Treating trauma and traumatic grief in children and adolescents. New York: The Guildford Press.

Davidson, G. R., Murray, K. E., & Schweitzer, R. (2008). Review of refugee mental health and wellbeing: Australian perspectives. *Australian Psychologist, 43* (3), 160-174.

Ehntholt, K. A. & Yule, W. (2006). Practitioner review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of Child Psycholody and Psychiatry, 47* (12), 1197-1210.

Ellis, B. H., Miller, A. B., Balwdin, H., & Abdi, S. (2011). New directions in refugee-youth mental health services. Overcoming barriers to engagement. *Journal of Child and Adolescent Trauma,* 4, 69-85.

Fazal, M and Stein, A. (2002). The mental health of refugee children. *Arch Dis Child, 87*, 366-370.

Fazel, M., Reed, R. V., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *The Lancet,* 379, 266-282.

German, M and Ehntholt, K. (2007). Working with refugee children and families. *The Psychologist, 20* (3), 152-155.

Hadfield, K., Ostrowski, A., & Ungar, M. (2017). What can we expect of the mental health and well-being of Syrian refugee children and adolescents in Canada? *Canadian Psychology, 58,* (2), 194-201.

Hargreaves, S., Holmes, A., & Friedland, J.S. (2003). The United Kingdom's experience of providing health care for refugees: time for international standards? *Journal of Travel Medicine, 10*, 73-74.

Harris, K. (2002). The importance of developing a culture of belief amongst counselling psychologists working with asylum seekers. *Counselling Psychology Review, 17* (1), 4-13.

Hebebrand, J., Anagnostopoulos, D., Eliez, S., Linse, H., Miolvancevic, M. P. & Klasen, H. (2016). A first assessment of the needs of young refugees arriving in Europe: what mental health professionals need to know. *European Child & Adolescent Psychiatry,* (25), 1-6.

Hodes, M. (2000). Psychologically distressed refugee children in the United Kingdom. *Child Psychology and Psychiatry Review, 5* (2), 57-68.

Hodes, M. (2002). Three key issues for young refugees' mental health. *Transcultural Psychiatry, 39* (2), 196-213.

Hodes, M and Tolmac, J. (2005). Severely impaired young refugees. *Clinical Child Psychology and Psychiatry, 10* (2), 251-261.

Hughes, G. (2014). 'Finding a voice through the tree of life': a strength based approach to mental health for refugee children and their families in schools. *Clinical Child Psychology and Psychiatry, 19* (1), 139-153.

Kaplan, I. (2009). Effects of trauma and the refugee experience on psychological assessment processes and interpretation. *Australian Psychologist, 44* (1), 6-15.

Leavey, G., Hollins, K., King., M., Barnes, J., Papadopoulos., C., & Grayson, K. (2004). Psychological disorder amongst refugee and migrant schoolchildren in London. *Social Psychiatry and Psychiatric Epidemiology, 39*, 191-195.

Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D., Keane., T & Saxe, G. N. (2004). Review of Child and Adolescent Refugee Mental Health. *Journal of the American Academy of Child and Adolescent Psychiatry, 43* (1), 24-36.

Marshall, E. A., Butler, K., Roche, T., Cumming, J., & Taknint, J. T. (2016). Refugee youth: a review of mental heath counselling issues and practices. *Canadian Psychology, 57,* (4), 308-319.

Murray, K., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: best practices and recommendations. *American Journal of Orthopsychiatry, 80* (4), 576-585.

National Institute for Clinical Excellence (2005). *Post traumatic stress disorder: The management of PTSD in children and adults in primary and secondary care.* The Royal College of Psychiatrists and British Psychological Society.

Ncube, N. (2006). The Tree of Life Project: Using narrative ideas in work with vulnerable children in Southern Africa. *The International Journal of Narrative Therapy and Community Work*, *1*, 3–16.

Office of the United Nations, High Commissioner for Human Rights. (1989). *Convention on the Rights of the Child*. Retrieved 13 June, 2009, from http://www.unhchr.ch/html/menu3/b/k2crc.htm.

Raval, H. (2005). Being heard and understood in the context of seeking asylum and refuge: Communicating with the help of bilingual co-workers. *Clinical Child Psychology and Psychiatry, 10* (2), 197-216.

Rezzoug, D., Baubet, T., Broder, G., Taieb, O., & Moro, M.R. (2008). Addressing the mother-infant relationship in displaced communities. *Child and Adolescent Psychiatry Clinics of North America, 17* (3), 551-568.

Smith, P., Dyregrov, A., Yule, W., Gupta, L., Perrin, S., & Gjestad, R. (1999). *Children and Disaster: Teaching Recovery Techniques.* Bergen, Norway: Foundation for Children and War.

Tyrer R. A., & Fazel, M. (2014). School and community-based Interventions for refugee and asylum-seeking children: a systematic review. *PLoS ONE 9 (2):* e89359.

UNHCR. (2007). *Convention and Protocol Relating to the Status of Refugees*. Retrieved May 21, 2009, from http://www.unhcr.org/3b66c2aa10.html

UNHCR. (2015). *Global Trends Forced Displacement in 2015.* Retrieved July 16, 2017, from http://www.unhcr.org/576408cd7

Unterhitzenberger, J., Eberle-Sejari, R., Rassenhofer, M., Sukale, T., Rosner, R., & Goldbeck, L. (2015). Trauma focused cognitive-behavioral therapy with unaccompanied refugee minors: a case series. *BMC Psychiatry,* 15, 260.