How do clinicians respond to the faith identity of young Muslims in a London Child and Adolescent Mental Health Service (CAMHS) clinical context? An interpretative phenomenological analysis.

Rachel Abedi

A thesis submitted for the degree of Professional Doctorate

in

Psychoanalytic Child and Adolescent Psychotherapy

Department: Tavistock & Portman NHS Trust

University of Essex

Date of submission for examination: September 2020

Contents

Abstract 4

Introduction 6

Literature review 9

Methodology 34

- Interpretative Methodological Analysis
- Why focus on Muslims?
- Research setting
- Ethics
- Selection of research participants
- Subjectivity and researcher's identity
- Presentations and feedback
- Advisory Groups
- Interviews
- Data analysis process

Interview data 56

- Overview
- Free coding
- Recurrence of themes
- Super-ordinate themes

• A: What difference stirs up
• B: The clinician as 'other'
• C: Tension around knowledge

Discussion 79

- Super-ordinate themes

• A: What difference stirs up
• B: The clinician as 'other'
• C: Tension around knowledge

- Concluding discussion
- Limitations

Conclusion …… 101

Acknowledgements …… 106

References …… 107

Appendices …….. 116
- Appendix 1: Trust ethical approval emails (including approval of change to study)
- Appendix 2: Public facing documents
- Appendix 3: Advisory Group report summary
- Appendix 4: Interview Schedule
- Appendix 5: Sample of data analysis process
- Appendix 6: Thematic tables
- Appendix 7: Participants' suggestions
- Appendix 8: Media Context

Abstract

This research project explores how a multi-disciplinary group of CAMHS clinicians in a diverse London borough think about the faith identity of their Muslim patients, and how this might affect the therapeutic relationship. The researcher focuses on what the clinician brings to the room, both consciously and unconsciously, rather than locating issues of difference solely in the patient. This is important because the clinician is a participant in an inter-subjective process, rather than a neutral, objective observer. The researcher acknowledges the impact of her own identity as a Muslim on the research process.

Following a literature review bringing together relevant papers from psychoanalytic literature and beyond, the researcher notes the lack of qualitative and quantitative research in this area. The researcher argues that CAMHS engagement with Muslims deserves further thought, particularly in the current socio-political climate, and discusses why the area of faith identity in general, and Muslim faith identity in particular, might be difficult to explore in the therapy room.

In order to reflect the concerns of young Muslims in the interview schedule, the researcher consulted focus groups (Advisory Groups) of Muslim adolescents. The data from the subsequent interviews with clinicians, analysed using IPA, is presented here. Three overarching themes are selected for detailed exploration: what difference stirs up, the clinician as ‘other’, and tension around knowledge. The researcher seeks to understand how far clinicians’ responses are specific to working with Muslim patients, or reflect wider tensions around working with difference, in the context of the relationship between generalities and specificities in clinical work.

The eventual objective of this research is to contribute to enhanced engagement with Muslim families and young people in CAMHS. Possible areas for improvement in training and service delivery are suggested, and potential areas for further research.

Introduction

This research project aims to explore how a small, multi-disciplinary group of CAMHS clinicians working in a diverse London borough think about the faith identity of their Muslim patients, and how this might affect engagement. This aspect of the therapeutic relationship - what the clinician brings to the room, both consciously and unconsciously - is important because it is often not considered when thinking about working with diverse populations. Rather, issues related to difference are usually located in the patient, as if the clinician is a neutral, objective observer, rather than a participant in an inter-subjective process. We need to acknowledge difference in order to arrive at appropriate theoretical formulations (Davids, F. 1998). However, this not only involves learning something about the 'other', but requires an effort to become aware of our own response to 'otherness'.

Of course, there are likely to be many areas of difference between clinicians and patients, the most obvious being age and power, but also including class, ethnicity, culture, faith, gender and sexuality; this project focuses on Muslim faith identity.

It is not known how many Muslims work in CAMHS, or how many Muslim patients are referred to CAMHS and receive treatment. In the mental health Trust in which the research was carried out, the percentage of Muslim employees (5%) was less than half the percentage of Muslim patients (12%) (Morgan-Valentine, M. and Menia, J. 2018). It is likely that this discrepancy is even greater for CAMHS, as 33% of British Muslims are under 16 and 50% are under 24, compared to 19% and 30% respectively of the UK population as a whole[1].

[1] Based on 2011 ONS census figures.

Among Association of Child Psychotherapy members, those describing themselves as having no religion (53%) is higher than the national average (25%)[2] (ACP report to AGM, 2020), which is itself on an upward trend. This drift away from faith identity, if this is representative of other CAMHS professions, makes it even more likely that Muslim faith identity will be an area of difference between clinician and patient, yet it is one that is rarely explored in the research literature.

By analysing data gathered from eight interviews with CAMHS clinicians, this study seeks to tease out how far clinicians' responses are specific to working with Muslim patients, or reflect wider tensions around working with difference, and what happens to thinking when what we think we know about Muslims meets the individual Muslim in the room. Is this comparable to the way in which clinicians balance the generalities of their training with the specificities of individual experience, and how do they influence each other?

A further aim of this study is to discover whether an analysis of the participants' experiences and thinking suggests that this area requires further thought in terms of CAMHS training and service delivery. The eventual objective is that a reflective process will lead to enhanced engagement with Muslim families and young people in CAMHS.

The impact of the researcher's identity is also considered. Having a psychoanalytic background, the researcher is interested in conscious and unconscious aspects of her own and the participants' responses, and the interplay between them. Being a Muslim CAMHS clinician, the researcher has a personal as well as professional interest in the

[2] Based on 2011 ONS census figures.

research question, which can be said to have advantages and disadvantages for the research process, which will be explored.

Literature review

This study looks through a psychoanalytic lens at the response of CAMHS clinicians to a particular aspect of patients' identity: faith. Faith is an integral part of identity for many, but also a marker of difference, especially when a particular faith identity is in the minority. However, much of the key psychoanalytic literature concerning difference explores how we respond to difference in race, ethnicity, culture, class and gender, rather than faith. There is obviously a significant degree of intersectionality involved in these aspects of identity, as their interaction creates particular and complex human experience:

> "The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways." (Hill Collins, P. and Bilge, S., 2016).

Given this complexity, and the lack of space here to do justice to a full review of literature on various forms of difference and their intersections, the researcher has narrowed the scope of this literature review to focus on areas most relevant to the study, namely:

1. Psychoanalytic ideas concerning how we respond to difference (including in a clinical context).
2. Psychoanalysis and religion.
3. Thinking about Muslims (mentions of Muslims and Islam in psychoanalytic literature).
4. The impact of prejudice on young Muslims (in psychoanalytic literature and beyond).
5. Muslims and mental health (including barriers to accessing mental health services).

Exclusions

The emphasis here is on psychoanalytic literature, although not exclusively so. The researcher has also focused primarily on literature exploring the above areas in the British context, as this is where the researcher has lived and trained, and is the setting for the research project. However, where there is little empirical research set in Britain, examples from other countries (in English) have been referenced, when considered potentially relevant to the British context.

There was significant literature available exploring Muslim communities' cultural constructions of mental illness, the development of alternative models of mental health treatment for Muslims, and the particular mental health needs of refugee children. While these are undoubtedly interesting areas, they are more relevant to a study of how Muslim populations might experience mental health treatment, so are not included here.

This review focuses on literature more directly pertinent to the research question, which explores how mental health clinicians experience their Muslim patients and their families.

Psychoanalysis and difference

Much psychoanalytic understanding of how we respond to difference, and how this permeates the way we behave, draws on Melanie Klein's theory of object relations (Klein, M. 1946). This describes the unconscious process by which infants create a secure sense of self and manage persecutory anxiety through splitting their object, introjection of good psychic experiences and projection of those perceived as bad. This primitive state of mind,

described by Klein as the paranoid schizoid position (Klein 1946), is designed to protect the self by attributing frightening or unwanted experience to another. It populates the infant's internal world with phantasy figures (I use the term phantasy to denote unconscious mental activity) drawn from fragments of the self and other, both imagined and real. Usually, children eventually learn that people are not only 'goodies' or 'baddies.' However, we may often revert to the paranoid schizoid position throughout life as a response to anxiety. As such, phantasy remains a feature of ordinary adult mental life, and "facilitates prejudicial, excluding and racial thought processes where the other can take on an emotional resonance reserved for the bad object." (Clarke, S. 2003)

Michael Rustin (1991) questions why the 'empty concept' of race (being externally and socially constructed) appears to have such psychological significance, and finds answers in Kleinian theory, namely the pervasiveness of schizoid mechanisms. "Dichotomous versions of racial difference are paranoid in their structure", with splitting resulting in idealization and denigration. He argues that conventional anti-racist responses which castigate all white people for their inherent racism ignore the universality of this scapegoating mechanism. Dalal (2008) agrees that being subject to prejudice and assumptions about others is universal, that racism is "born of the human condition" (p.14).

This human propensity to attribute unwanted parts of the self to the other, who can then be viewed as fundamentally and negatively different from the self, is amplified across groups (Segal, H. 1999 p.19), for example ethnic and cultural groups, creating barriers to understanding. Kareem and Littlewood (1992) describe how the resulting stereotypes can compromise clinicians' thinking, and emphasise the need to know something about the patient's cultural context in order to understand his experience.

Jenny Daly's (2016) reflective exploration of the emotional encounter between social workers and Irish Travellers in UK child safeguarding cases helpfully highlights how the unconscious defences triggered in professionals working with unfamiliar groups can impact relationships and outcomes. In this sense, it is highly relevant to this research dissertation, Muslim beliefs and cultures being unfamiliar to many psychotherapists. Daly raises concern about how pervasive societal disapproval towards Travellers may be absorbed by practitioners, at the expense of a curiosity about historic marginalisation, the contemporary cultural and social context and a recognition of the strengths of the community.

Pérez Foster, R., Moskowitz, M. and Javier, R. A. (1996) find that the "Euro-American ethnocentric bias in psychoanalysis […] is responsible for the discipline's difficulties in reaching across boundaries of class and culture." As psychoanalytic therapies reach a relatively small number of people from ethnic and cultural minority backgrounds, they are viewed as systemically, albeit unconsciously, biased against these groups. Patients coming from a different backgrounds may have different meaning systems, and due to their minority status might feel subtly pressurised into disowning those systems to obtain therapeutic support.

Inge-Britt Krause (1998) also points out the influence of Euro-American philosophy on the training of therapists, and the significance of power on prioritisation of knowledge. She warns against the reification of culture (p.167), arguing that therapists need to understand that, just as their patients "live their lives in relational frameworks and that the ethos, outlook and norms of these frameworks may vary" (p.173), therapists themselves are

embedded in a similar process. Therefore, they may imbue what they see with their own meanings, so that “what they observe is not only other persons, (but) […] sometimes solely, themselves” (p.173). The Nafsiyat Intercultural Therapy Centre[3] was the first psychotherapy service in the UK with the specific task of offering psychodynamic psychotherapy to Britain’s black and ethnic minority population was the in North London. It recognised the importance to the therapeutic relationship of thinking about the cultural background of both the patient and the therapist (Ababio, B. and Littlewood, R. 2019).

Psychoanalyst Fakhry Davids (1998), in his review of Pérez Foster et al, argues that the problem lies not in psychoanalytic theory itself, but rather in its application by clinicians “to avoid difficult issues arising in cross-cultural treatment”. For example, the clinician’s guilt about his ignorance of a patient’s cultural background, including the culturally-specific meaning of psychological dysfunction, might prevent him from being curious, and instead lead him to adopt a ‘we are all the same’ approach. This reluctance to acknowledge difference, leading to lack of sensitivity, makes it impossible to reach an appropriate theoretical formulation and can leave the patient feeling unheard and judged.

Foster (2006) observes that the psychoanalytic profession is “full of white, middle-class people, something that is particularly striking in London where the resident community, unlike the psychoanalytic community, is so mixed both racially and culturally.” (p.6) Like Davids, he fears that therapists’ possible shame about their ‘inner racist’ being revealed “inhibits our ability to empathise and limits our effectiveness in the therapeutic endeavour.” (p.13) The denial (or ignoring) of the the unequal power relationship between black and white people, which saturates all aspects of society including psychoanalytic

[3] Established in 1983 by psychotherapist Jafar Kareem.

training, is criticised by Helen Morgan (2008). This ‘colour-blind’ position can freeze our curiosity and prevent us from having ordinary conversations about the external and the internal divides caused by racism.

Similarly, acute anxieties can be mobilised when racism is identified as something an organisation needs to tackle (Cooper, A. 2010). In his examination of how racism affects institutions, Cooper notes how difficult it can be for organisations to deal with difference: “It is easier to grasp the ‘sameness’, the universality; harder to really work with and face the differences, the particularity, the idiosyncratic, especially when it is alive, dynamic, and potentially destructive.”

Clarke (2003) seeks to add a psychoanalytic dimension to sociological studies of racism, which do not account for the intense hatred involved, and the speed with which societies can be swept into states of racial hatred. Dalal (2002) argues that, although racism may appear to have an internal origin (hatred of difference stemming from hatred of parents), it reflects powerful processes of racialisation originating in external world power relations, that have been deposited deep inside us. This echoes psychiatrist and philosopher Franz Fanon’s analysis of race relations in the 1950s (2008 translation). He describes how psychiatrists, having internalised the messages of colonialism and slavery, perpetuated the interpretation of aggressive responses to oppression and domination as pathological, rather than a justified expression of anger. Furthermore, white people have an often unconscious vested interest in maintaining the status quo by ignoring issues of racism: “if it does not exist in the first place then it cannot be changed.” (p.219) Fifty years on, Blackwell (2005) describes how internalised power imbalance rooted in the post-colonialist historical context inevitably affects the therapeutic relationship between refugees and

counsellors. He considers psychotherapy a political activity because “the construction of intersubjective meaning always has political implications and cannot escape ideological influences”, but this is usually “ignored or denied within the psychotherapeutic discourse.” (p.30)

Further exploring the internal mechanisms of post-colonial racism, Davids (2011) describes how the ‘racial other’ provides a container for the split-off and projected unwanted aspects of the psyche. The paranoid schizoid ‘solution’ of early infancy continues to operate alongside the normal integrating processes of development. As a child grows, their ‘circle of goodness’ is expanded first to include the father, then others in the family, then strangers in contrast to out-groups. This occurs at about the same time[4] as the child forms an identification with wider ethnic, religious or national groups. Responses to out-groups later in life involve a return to the latent primitive level of infantile experience, and have the effect of ‘freezing’ thinking. In the internal racist organisation, which operates on an unconscious level, an apparently ordinary network of fixed internal object relationships is created including the object identified as ‘different’. The racist structure only becomes apparent when the object acts outside the role prescribed by the internal racist organisation. When a person then becomes aware of his internal racist, they experience unbearable guilt which cannot be processed mentally, leading to repetition. Davids argues that the internal racist organisation is universal and part of the ordinary mind, but is pathological in that it defends tenaciously against intense anxiety by asserting dominance and control.

[4] Around 7 years old.

Lennox Thomas (2013) returns to the damaging intergenerational legacy of colonialism, and examines how British society's pride in a 'golden age' affects both therapists and people who use therapy, particularly when under the intense pressure of the transference when at least two cultures and backgrounds are in the room. He argues that, although therapists might be confident enough to engage with issues of cultural difference, "deeper analysis involving transferential matters would be taking a greater personal risk that might implicate them."

Keval (2018) also examines how the intense emotion of the transference reveals the racial and racist fantasies that are deeply embedded in psychic life and functioning. He explores the challenges of engaging with the racist states of mind which are universally present in contemporary culture as well as the therapy room. Keval outlines a primary function of racist thinking as a defence against the experience of separateness. Racist states of mind operate by attacking the potential fusion of parental objects in the mind which remain highly anxiety provoking because they recall the experience of separateness and difference from the mother.

Frank Lowe (2014) acknowledges that conscious and unconscious prejudices about race, culture, and diversity are extremely difficult to think about in a non-judgemental yet emotionally truthful way, which can lead to a superficial approach to discussions of diversity. Adding to Davids' conceptualisation of ethnic minorities as containers for unconscious projections, Lowe describes how overtly racist people function as containers for the unconscious racism of others, so that the latter can continue to ignore any problems at a conscious level (presentation at the Tavistock Clinic, 2016).

The difficulty of exploring difference (in the context of Work Discussion Seminars at the Tavistock Clinic) is also examined by Crehan and Rustin (2018). They propose that heightened levels of anxiety generated when reflecting on difference are evoked by learning that threatens existential security and a stable sense of identity. They suggest that this epistemic anxiety prevents us from adequately examining issues of ethnicity and difference in our therapeutic work.

Psychoanalysis and religion

Despite the range of literature examining aspects of difference such as race, culture and class, and how it affects the therapeutic encounter, there is a dearth of material exploring faith difference. While psychoanalysts have challenged the blind eye we turn to difference due to the discomfort this causes, this thinking is less frequently applied to faith identity. Perhaps by ignoring faith as a relevant category of difference (although inevitably intersectional with other factors), and treating it merely as a form of cultural practice, it becomes possible to avoid potentially thorny existential issues of difference its exploration might provoke.

One of the few papers mentioning what is stirred up in professionals as well as patients when working with faith groups is by Judith Edwards (1998). She briefly explores what people project into religious frameworks, in the context of her work with children and families through a Catholic organisation.

This omission, or unconscious avoidance, might reflect the traditional psychoanalytic stance based on Freud's view that religion is an unhealthy, wish-fulfilling illusion, and the

parallels he drew between obsessional neurosis and religious practice. For Freud, the “strange private ceremonials and rituals of the obsessional neurotic” echo those that accompany religious practices (Bell, D. 1999 on Freud, S. 1907); both centre on the need to separate good and bad (sacred and profane), and both involve strong feelings of guilt and ways of managing it. Religion is thus regarded as a psychic defence against anxiety based on splitting. Interestingly, the way in which this internal mechanism is described makes it similar to that of racism, except that in Freud’s view of religion, bad parts are projected into the idea of evil, and good parts are idealised as divine.

In his examination of the interface of contemporary psychoanalysis and religion, Black (2006) finds that Freud’s view of religious phenomena as analogous to psychopathology, has led to an assumption that psychoanalysts are hostile to religion. However, contributors suggest a shift away from simply interpreting religious experience in psychoanalytic terms, and towards an engagement with theological ideas and viewing aspects of religious experience as valuable in their own right. Black argues the case for a ‘contemplative position’ in the mind, in the same vein as Klein’s paranoid-schizoid and depressive positions.

The classical Freudian and Kleinian view of religion has been criticised for being just as subjective as a religious viewpoint, in that it substitutes faith in psychoanalytic explanations for faith in God. For example, Trevor Dobbs (in Black 2006), suggests that religion could represent the ‘other’ of psychoanalysis (p.32). He accuses the psychoanalytic movement of being “unable to master its own counter-transference of religiosity and instead critiques this internal object through a projective identification with traditional religion.” (p.28)

Fakhry Davids (also in Black 2006) explores within an object relations frame whether a realm of God may be said to exist in the mind, as understood by classical Islamic scholars. He points to Prophet Muhammad's advice to "first tether your camel" as an example of religion directing man first to ordinary reality then to trust Allah, and the efforts of Sufism to overcome the worshipper's self-interested projections onto God.

Contributors to Moodley and Palmer (2014) examine how cultural diversity, including spirituality, affects the therapeutic relationship. In her paper[5], Judith Mishne notes the incongruous omission from publications and training of Jewish issues, which she thinks might be due to a mistaken perception of the prevalence of Jewish therapists and clients. She argues that "the place of religion and/or cultural identification is a critical question in working with Jewish clients" (p.218), but that many clinicians avoid religious clients or dismiss issues of religion due to ignorance of religious beliefs, conscious or unconscious bias. Mishne argues that clinicians must be aware of their feelings about the client's minority group, as well as their own conflicted or negative feelings about their own personal identity. However, she points out that a matched therapeutic dyad is no guarantee for successful ongoing work, as there will remain a fear of judgement that the therapist will be too Jewish or not Jewish enough. Significantly for the focus of this research dissertation, Mishne argues that thinking about faith identity must be included if we are to provide "culturally competent, sensitive empathic clinical interventions, which avoid the errors of generalisations and stereotypes." (p.225)

Kizilhan (2014) acknowledges that it was only after the 1980s that researchers started dealing with religion as a supporting potential, realising that patients' value systems and

[5] "Cultural identity and spirituality in psychotherapy"

world views can be important for psychotherapeutic success and that they must be taken into account in a culture-sensitive manner. This has stimulated a new relationship between psychotherapy and religiosity/spirituality, with some calling for the biopsychosocial model of mental health to be expanded to include the religious-spiritual dimension.

Thinking about Muslims

Like people of other faiths, Muslims are not a homogeneous group which fits neatly into a single category of race or culture. Thinking about and working with Muslims involves consideration of the intersectionality of religion, culture, ethnicity, class and gender, in addition to the impact of colonialism, intergenerational trauma, ongoing prejudice and media narratives about current events. Furthermore, Islam is not a separate part of the individual's identity, but one which is integral to and influences all aspects of Muslims' lives, with an internal intersectionality as well as external.

The pervasive socio-psychological context which shapes attitudes towards Muslims might well influence the clinical setting. In this respect, Muslim faith identity can be said to be similar to race, in that both might be difficult aspects of an individual's identity to think about (Lowe 2014), because our thinking and responses are characterised by defences resulting from anxiety. Hannah Segal[6] (in Bell 1999) observes that these defensive manoeuvres are intensified in groups, for example nations. She describes how, after the end of the Cold War, the West needed to find another enemy, and so Saddam Hussein was rapidly transformed into the required "evil monster" (p.19). Subsequent wars against Muslim countries and terrorist attacks further entrenched an already existing trope of the

[6] "Hiroshima, the Gulf War and after"

threatening Muslim other, given symbolic geographical form by US President George W. Bush as the 'axis of evil'[7], in a phrase suggestive of Segal's "manic triumphalism" (p.19)

Fakhry Davids provides a psychoanalytic understanding of psychological responses to Muslim minority populations in the UK. Following 9/11, Davids (2002) remarked on the power of racist frames of mind to reduce complex, anxiety-provoking situations to more straightforward, black-and-white accounts that sharply differentiate good from bad. This paranoid solution to intense anxiety "makes us feel that we know where we are… and can further justify actions designed to make us feel better, rather than to face the real problem." The form of prejudice against Muslims that has grown since 9/11, in which "the term terrorist has elided all too easily into fundamentalist, into Muslim", is underpinned by the specific dynamics of internal racism, involving the use of an existing difference for the purpose of massive projective identification. In "Internal Racism, Anxiety and the World Outside: Islamophobia Post-9/11" (2006), he further examines the impact of external political events on the primitive anxiety which characterises the internal world, resulting in Muslims being seen by some as the ultimate 'other'.

Referring to parallel reports by the Runnymede Trust in the 1990s into discriminatory practices faced by Jews and Muslims in Britain, Davids (2009) compares anti-Semitism and Islamophobia. He quotes Edward's Said's observation that "Malicious generalisations about Islam have become the last acceptable form of denigration of foreign culture in the West" (Said 1997, p.xii), in that general aspersions cast about Muslims or Islam cannot now be made about other cultures in mainstream discussion.[8] Linking the terms 'terrorist',

---

[7] Following the 9/11 terrorist attack in 2001.

[8] Although the recent debate about antisemitism in the Labour Party suggests that anti-Jewish prejudice is still thriving.

’fundamentalist’ and ‘Islamic’ creates a paranoid construction that identifies the Muslim as enemy. Davids argues that, to sustain this belief in the face of contrary facts, Islam must be seen to have something that sets it apart from other religions; the notion that Islam has a fundamentalist core fulfils this function.

Unsurprisingly, this prejudice is also found in psychoanalytic writing. Aggarwal (2011) surveys the psychodynamic literature on suicide bombers to demonstrate a publication bias against Arabs and Muslims. He concludes that, while scientific literature aspires toward an objective universalism, it is actually embedded within a particular social, political moment.

The impact of counter terrorism initiatives in the UK is considered by Carter (2017). He argues that they can reinforce and increase perceptions of real and imagined difference between Muslim and anti-Muslim groups, leading to the Muslim ‘other’ becoming an ascribed category in the UK. He warns of the ‘soft harms’ done to ‘suspect communities’, and the ensuing social and community polarisation and isolation. He remarks on how little research has been done to investigate the impact on British Muslims.

Writing in the aftermath of the Westminster Bridge terror attack, David Morgan (2019) uses psychoanalytical concepts to understand fundamentalist religious and economic terrorism. He acknowledges that there are “whole cultures that feel aggrieved by the perception that their lives, experience and belief systems are marginalised.” (p.131) He considers how “terrorism perpetrated by Western colonialism and economic expansion” (p.127) has resulted in transgenerational trauma and an accumulation of grief, humiliation and legitimate grievance. This has led some to feel driven to “evacuate pain, loss and

humiliation into the other" (p.124) through acts of terrorism. Morgan suggests that, through a process of "inflammatory projective identification", the terrorist forces victims to bear their traumatic fragmentation and fear, born of "the threat to faith and fundamentalist thinking that is threatened with disintegration in the face of secularism" (p.122). Unfortunately, Morgan's ridiculing of jihadists' belief in a "pie in the sky" (p.119) heavenly reward (disputed translation of virgins/raisins), while surely intended as an amusing anecdote, might also be a subtle example of anti-Muslim prejudice creeping into his attempt to make sense of terrorism.

Anna Fleming's research (2020) confirms that the child psychotherapy profession is not immune to the current socio-political situation. Her interview data shows Muslims portrayed as bad objects, with violence, perversion and resulting disturbance "*always* attributed to Muslim families." (p.176)

The definition of the term Islamophobia is itself political and contested. A report by the All Party Parliamentary Group on British Muslims (2018) proposed the following working definition: "Islamophobia is rooted in racism and is a type of racism that targets expressions of Muslimness or perceived Muslimness" (p.50). Despite being adopted by the Labour Party and Liberal Democrats, this definition has (to date) not been adopted by the Conservative party. Abdal Hakim Murad[9] (2020) queries the definition of Islamophobia as a form of racism, arguing that it requires an intersectional definition (p.44).

Murad discusses the particular position of British Muslims, and rising Islamophobia in Europe, with Muslims "viewed by increasing numbers as a Dark Other fit only to be

[9] Also known as Timothy Winters, an English Professor of Islamic Studies, Director of Theology and Religious Studies at Wolfson College, Cambridge, and Dean of Cambridge Muslim College.

scrutinised and stigmatised" (p.4). He explores how the archaeology of faith identity has contributed to this, arguing that the European 'sense of self' is historically rooted in defensive opposition to Islam/Saracens from 7th century (p.13). Europeans today, "constantly quarrelling with ourselves over definitions of belonging" (p.12), seek to recreate a solid identity by again self-defining against its "significant and negated Other: the Saracenic and Turkish realms, now identified with the problematic principle of religion itself." (p.18-19). For example, the UK's "Brexit convulsion" was fuelled by claims that Turkey would join the EU, stoking fears that "a tsunami of migrants would overwhelm British health and social services." (p.21). Murad also notes that the "liberal religion of progress" (Enlightenment, civil society, democratic institutions and human rights codes) "finds it difficult to respect dissidents" (p.12), and so Muslims have fallen victim to "this coercive-liberal definition of European authenticity." (p.25).

Murad's arguments echo a Kleinian understanding of paranoid-schizoid functioning, for example perceptions of the Muslim other as monolithic are seen as a defence against vulnerability: "Muslim atavism is true because anxious Western self-definition requires it to be true; it is a structural meta-truth unassailable by mere factual dissent" because "even to acknowledge that Islam has internal disparities and graduations might be a reminder of the Same's own internal divisions and hence, implicitly, its vulnerability." (p.51) On a contemporary note, and further illustrative of the paranoid-schizoid response to anxiety, Murad suggests that the Covid-19 pandemic is likely to increase Europe's sense of unease over demographics and difference, "as nations retreat into themselves and conspiracy theories bloom." (p.20)

Impact of prejudice on young Muslims

There seems to be little psychoanalytic literature about the impact of prejudice on young British Muslims. However, Rabia Malik (2006), a systemic psychotherapist and lead at the erstwhile Marlborough Cultural Therapy Centre[10], draws on her experience of working with young Muslims in a UK mental health context, and uses psychoanalytic concepts to illustrate how the dominant social discourses of the external world can structure the internal world and sense of self. She argues that the current construction of British Muslims is based on simplistic dichotomous positions. This fixes and limits what young Muslims can be, "by either demonising them as 'bad Muslims' who are politicised or appropriating them as 'good Muslims' who relegate their 'difference' to the private realm." (p.103) She argues that the therapeutic space "can act as a nodal point where social and personal processes come together" but will only be an empowering space for marginalised groups in a context which recognises the broader socio-political processes and their impact on identities." (p.91) Mental health practitioners need to "be conscious of how their own identity is structured by, and embedded within, a matrix of social relationships". They will otherwise be unable to "tolerate the tensions of working with difference and take an inter-subjective, as opposed to colonising approach to young Muslim clients." (p.104)

Similarly, in their report for the National Youth Agency, Malik, Shaikh and Suleyman (2007) argue that faith is a key identity indicator in appreciating welfare needs of young British Muslims, and that mainstream service providers need to use models of practice "that

[10] A specialist culturally appropriate family therapy service for the south Asian and Arab communities in northwest London.

understand the socio-cultural, faith and psychological dimensions of the lives of Muslim young people."

Suleiman (2015) makes particular observations about the response of young Muslims to Islamophobia. He argues that targets of prejudice experience a lowering of self-esteem, resulting in a reaction to elevate self-esteem, for example through isolation, assimilation or retaliation (violent or non-violent), depending on social situation and context. As part of their non-violent retaliation, young people may adopt Islam as an oppositional identity. Young dissenters might choose a form of Islam separate from their parents' generation, or display reactive religiosity to make themselves more visible in defiance of prejudice, for example by wearing the hijab.

In "Student or suspect?" (2015), the author (anonymous) examines the impact of Islamophobia on students' mental health in the context of anti-radicalisation measures taken by UK government, and fears that "Muslim students, feeling scrutinised or under suspicion, may be less likely to access counselling for fear that what they disclose may be used later as evidence against them." The author compares this situation to how Irish people were treated on the British mainland in the 1970s. Others consider the impact of UK government counter-terrorism measures on professionals. For example, Stanley and Guru (2015) point out the difficulty for social workers of becoming pawns in an ideologically driven moral panic in the context of child radicalisation risk, and Rizq (2017) examines the impact of Prevent/WRAP on psychotherapists and other mental health professionals.

Although there appears to be nothing published about the impact of anti-Muslim prejudice on children in the UK, there are a few examples from other countries. For example, in “Growing Up Muslim: The Impact of Islamophobia on Children in a Canadian Community” (Elkassem et al, 2018), the authors analyse interviews with Muslim children in Canada. They find that these children feel continually judged and stereotyped, partly due to negative portrayal of Muslims in the media. They feel that many non-Muslims “not only feared them but hated them, even though they were still only children.” (p.14-15) This uncertainty about how they are perceived leads some to be cautious with non-Muslims, creating a challenge for participation in social and community relationships. If this is at all representative of the UK context, this research has clear implications for British Muslim children’s engagement in mental health services.

This is borne out by the findings of the 2007 Social Mobility Commission and Sheffield Hallam University report (Stevenson et al), which paints a disturbing picture of the challenges faced by young British Muslims. They are found to be excluded, discriminated against and failed at every stage, from school onwards. Many young Muslims, anticipating possible negative perceptions of them, avoid asking for help, fearing that they will be misunderstood. Again, this has obvious implications for whether CAMHS is perceived by young Muslims as a source of support.

In his work with an adolescent girl of Muslim Bangladeshi heritage, Sean Junor-Sheppard (2019) acknowledges the impact of the UK’s ‘hostile environment’, including post-colonial ideas and beliefs and Islamophobia, on the therapeutic relationship. He interprets the resistance shown by his patient as a fear that CAMHS would replicate the prejudice

experienced in wider society, and warns that the therapist can become drawn into enacting the patient's defensive positions.

In relation to refugee children, the majority of whom are Muslim, Alayarian[11] (2017) argues that there is "intentional and unintentional neglect of and discrimination against children and young people of refugees and other migrants through denial of social and cultural differences" (p.xvii). The author questions whether CAMHS has the resources "to provide intercultural interventions and facilitate environmental forces that are positive and healthy for children of refugees." (p.115)

Muslims and mental health

There is considerable research literature in the US about working with Muslims in a mental health context. For example, a research project by Abu Raiya and Pargament (2010) used a combination of qualitative and quantitative research to develop a Psychological Measure of Islamic Religiousness (PMIR) and apply it as a basis for clinical recommendations when working with Muslim clients. They recommend that mental health clinicians should educate themselves about basic Islamic beliefs and practices, and should directly address and utilise the place of religion in the client's life.

There has been less published in the UK, despite evidence that British Muslims already underutilise mental health services (Patel et al 2000). Although it is difficult to know, due to the lack of published data, the little research there is for the UK suggests that Muslim children receive psychotherapy in CAMHS proportionately less than non-Muslims. For

[11] A psychoanalytic psychotherapist and founder of the Refugee Therapy Centre.

example, a small qualitative study by Kam and Midgley (2006), based on a single CAMHS team, found a “significant underrepresentation of children from Arabic/Asian background referred for individual psychotherapy.” (p.30) Whether this is representative of the situation across the UK is unknown. Furthermore, the data is based on extrapolation from stated ethnicity, rather than stated faith identity[12]. Given that there is faith diversity within Arab or Asian ethnic groups, and that 8%[13] of Muslims classify themselves as “white”, ethnicity is not an accurate gauge of Muslim faith identity. However, Muslims do account for 32%[14] (or 1 in 3) of the British BME population.

Inayat (2005) examines barriers to utilisation of mental health services by Muslim clients, and finds that six areas have significant impact: mistrust of service providers; fear of treatment; fear of racism and discrimination; language barriers; differences in communication; issues of culture. Inayat later (2007) calls for counsellors working in multicultural settings to be sensitive to the many factors that affect the therapeutic alliance, as “Muslim clients may be feeling particularly vulnerable in the current political climate in Britain.” (p.292) Inayat emphasises the importance of identifying and avoiding false assumptions concerning Muslim beliefs (p.288). One way for therapists to combat such barriers is by learning about Islam and its impact on Muslim daily life and expression of distress.” (p.289)

The qualitative research of Weatherhead and Daiches (2010) uses thematic analysis to explore how a heterogenous group of 14 British Muslims understand the concept of mental health and how mental health distress can be addressed. They identified 7 themes:

---

[12] Faith identity is not routinely recorded on CAMHS referral forms.

[13] Census 2011.

[14] Census 2011.

causes, problem management, relevance of services, service delivery, therapy content and therapist characteristics. The results highlighted the “interweaving of religious and secular perspectives on mental distress and responses to it.” (p.75) In a later review of the available literature (in English) pertaining to therapy with Muslim families (2015), they discuss the key issues to consider, namely self, family dynamics, causation, coping strategies, and roles of religious leaders and mental health services. They call for empirical research to investigate the role of these themes, and warn therapists not to “fall into the trap of presumed homogeneity” of Muslims.

Dabbagh et al (2012) also note the paucity of research on Muslim mental health, especially adolescents. Their quantitative study investigates whether psychological distress is greater in Muslim adolescents in comparison with their non-Muslim counterparts, and whether distress is associated with level of ‘Westernisation’, sense of ‘Britishness’ and perceived discrimination. Their survey of 14-16-year-olds in two comprehensive schools finds that, contrary to expectations, Muslim students have lower levels of psychological distress than all other religious groups at a statistically significant level. They conclude that faith identity may have protective effects on mental health, possibly due to aspects of the religious community (social cohesion, family structure and support) or of the religion itself. However, they concede that this is a limited exploratory study and further research is required.

Another quantitative study by Pilkington, Msetfi and Watson (2012) examines factors that affect intention to access psychological services in a sample of British Muslims of South Asian origin. They find that shame (*izzat*) and length of time living in Britain are significant predictors of intent for migrant participants, whereas higher levels of acculturation and

education predict greater intention for those born in the UK. This has implications for Muslim children and young people, who are more likely to have been born in the UK.

Tommis-Cardo (2019) also examines perceived reluctance amongst British Muslims to access mental health services. Reviewing literature on the subject published between 2000-2014, she finds evidence of mistrust in mental health services and the practitioners who deliver them, due to a lack of education on both sides which contributes to the stigma and stereotypes attached to Muslims and mental health attitudes. She argues for further research on the perceived demoralisation of Muslim populations and the effect of stereotypes.

British Muslims often respond to the onset of mental ill-health by turning to their faith leaders, rather than to mainstream mental health services. In their quantitative study of 41 UK-based imams, Meran and Mason (2019) explore how Muslim faith leaders manage encounters with individuals meeting DSM-IV criteria for depression or schizophrenia. They were found to exhibit low stigma, provide substantial informal counselling, and routinely refer individuals to mainstream mental health services. They simultaneously embraced environmental, biological, and religious causes for mental illness. Muslim faith leaders emerge as potential allies in efforts to improve mental health outcomes for British Muslims, by challenging community stigma and collaborating with mental health professionals to deliver holistic care.

Many religiously committed Muslims do not seek psychotherapeutic services because of assumptions that psychotherapists will not engage with their religious values in an informed and open way (Rothman and Coyle, 2020). This has led to a growth in the area

of Islamic psychotherapy, an approach that explicitly values Muslims' religious orientations and commitments and integrates these into clinical practice.

What's missing?

As mentioned above, there is a dearth of research (quantitative and qualitative) exploring the impact of faith difference on the therapeutic relationship, and the impact of prejudice on young British Muslims. There also appears to be a lack of research into the mental health needs of children from minority cultures in the UK, and even less to into the needs of UK-born Muslim children. Approaches focussing on refugees are not necessarily applicable to this population, even if they are to the parents' generation.

The McPin Foundation, a London-based mental health research charity whose purpose is "to transform mental health research by putting the lived experience of people affected by mental health problems at the heart of research methods and the research agenda" (Onions 2019), recently identified the ten most pressing unanswered questions about children and young people's mental health. They argued that all ten needed to be considered in the light of the question ranked 11th in the list: how can the number of effective culturally appropriate approaches available in children and young people's mental health services be increased, particularly for ethnic minority groups? They called for the Association of Child Psychotherapists to consider a joint research project. Such projects might go some way to addressing Muslim children's needs, if the ethnic group in question happens to be a Muslim-majority one. However, the significance of faith identity would also need to be encompassed in such a project, if it is adequately to reflect Muslim children's experience.

In terms of the specific context of this dissertation's research question - working with Muslim children and young people in CAMHS - there is no published research, other than Junor-Sheppard's single case study (2019). Quantitative and qualitative research is lacking in four key areas:

1) numbers of Muslim children referred to CAMHS and presenting issues
2) treatment pathways and outcomes for Muslim patients in CAMHS
3) Muslim patients' experience of CAMHS treatment
4) how CAMHS clinicians conceptualise and respond to difference (including faith).

This research study aims to explore the latter area, albeit in a limited way.

Methodology

Interpretative Phenomenological Analysis

Data was collected by interviewing eight CAMHS clinicians and analysing the qualitative data using Interpretative Phenomenological Analysis (IPA). This method of analysis is appropriate for this project because IPA enquires into the particular nature and meaning of the lived experience of a small number of participants. By identifying then analysing the groupings, recurrence and connections between themes in participants' responses, IPA attempts to elucidate the unconscious aspects of participants' responses. This is particularly helpful when the area of the research question is felt to be anxiety-provoking, potentially making participants "defended subjects" (Holloway and Jefferson 2013). It is important to understand both conscious and unconscious responses; the unconscious informs the conscious, and is perhaps more likely to have an effect on the therapeutic relationship in the form of transference. The advantage of a small sample size is that data acquired from interviews can be analysed in greater detail, the intention being to raise further questions and stimulate useful ongoing exploration, rather than to provide a definitive, generalisable answer.

An important aspect of IPA for the purpose of this project is that it uses the "double hermeneutic" (Smith, Flowers and Larkin 2009 p3) of the participants' understanding of their experience, and of the researcher's interpretation. So, in this case, both the clinicians' understanding of their experiences with Muslim patients, and the researcher's interpretation of the resulting data is examined. This method attempts to acknowledge the impact of the researcher's identity on the research process, thereby mitigating to some

extent the inevitable subjectivity more obviously associated with qualitative research methods than with quantitative ones.

In addition to acknowledging the impact of her own identity on the process, the researcher has added a further element to the IPA methodology, in the form of Advisory Groups to inform the creation of the interview schedule. The Advisory Groups were one-off reference groups of Muslim adolescents with whom the researcher discussed issues relating to mental health and faith identity, and interaction with services. The inclusion of Advisory Groups has three benefits:

1. It allowed for some measure of service user population involvement in the project, which in itself could benefit Muslim young people's engagement with CAMHS by demonstrating an interest in their experience and opinions.
2. It enabled the researcher to learn more about what young Muslims think about mental health and contact with professionals, and to incorporate their preoccupations and concerns in the interview schedule.
3. This meant that the interview schedule did not solely reflect the preoccupations and concerns of the researcher, thereby further reducing the level of subjectivity and making the results more relevant.

Further details of this part of the process are given in **Ethics** and **Advisory Groups** below[15].

[15] See Appendix 3: Advisory Group report summary.

Semi-structured interviews were used to collect data, in order to allow the researcher to modify her initial questions in the light of participants' responses and to pursue whichever interesting areas arose. The researcher originally intended to re-interview a small number of participants in the light of initial findings and record responses to this and ongoing thinking. However, this was not possible due to time constraints and the quantity of data collected from the eight interviews.

Why focus on Muslims?

The researcher chose to focus her study on responses to Muslim young people for four reasons: evidence that fewer Muslims use CAMHS; a need identified for greater understanding of the welfare needs of young Muslims; current negative perceptions of Muslims; and evidence of young Muslims' fear of negative response.

Fewer Muslims using CAMHS

Muslims make up 6% of the UK population, but this is far higher in many areas. It is the UK's second largest faith group. Most significantly for CAMHS, 50% of Muslims are under 25 years old. Despite this, it appears that fewer Muslims use CAMHS by proportion of local population. It is difficult to know the actual figures and reasons behind them, as many CAMHS referrals do not include an indication of faith identity, even if a space is provided to do so on the referral form. There could be various explanations for this, for example a sense that faith identity is not relevant to mental health referral, that it might unduly influence the referral, or that the patient might not wish this information to form part of the referral. This might be an interesting area for further research. In existing research, there is

some evidence that Muslims already underutilise mental health services (Patel et al 2000), and psychotherapy in particular. For example, Kam and Midgley (2006) found a “significant underrepresentation of children from Arabic/Asian background referred for individual psychotherapy.”

Need for understanding

Despite this apparent discrepancy, a need for understanding of the welfare needs of Muslims has long been identified. A report funded by the National Youth Agency over ten years ago recommended that “mainstream service providers must begin using faith as a key indicator in appreciating welfare needs of young British Muslims.” It also underlined the need for services and models of practice “that understand the socio-cultural, faith and psychological dimensions of the lives of Muslim young people.” (Malik, Shaikh and Suleyman 2007). Since this report, there seems to be an absence of published research into Muslims’ engagement with CAMHS services.

Negative perceptions

Twenty years of negative media coverage concerning Muslims, particularly since the attack on the World Trade Centre, has taken its toll. There has been a strong negative public discourse concerning Muslims, for example with regard to media coverage of radicalisation and terrorism, refugees and immigration, controversies over Muslim practices in schools (for example hijab, fasting) and even resentment at Muslim foster carers caring for non-Muslim children[16].

[16] See Appendix 8: **Media Context** for news stories related to Muslims during the research period.

The anxiety provoked by acts of terrorism has provoked a polarised phenomenon of 'us and them' (the West versus Islam), a defensive splitting reaction resulting in Muslims being seen by some as the ultimate 'other' (Davids 2008, 2011). This pervasive socio-psychological context might well influence the CAMHS clinical setting. In this respect, Muslim faith can be said to be similar to race, in that both might be difficult aspects of an individual's identity to think about (Lowe 2014), because our thinking and responses are characterised by defences resulting from anxiety.

Fear of negative response

A recent report by the Social Mobility Commission and Sheffield Hallam University (2017) painted a disturbing picture of the challenges faced by young British Muslims. They were found to be excluded, discriminated against and failed at every stage, from school onwards. The report found that many young Muslims, anticipating possible negative perceptions of them, avoid asking for help, fearing that they will be misunderstood. This could have an impact on their potential engagement with CAMHS.

This combination of factors has obvious implications for our engagement with this significant portion of our service user population. It also provokes wider questions: is CAMHS a service in which young Muslims and their families can feel understood, and if not, what can we do to improve this?

The research was designed to find out more about what happens in a CAMHS clinical setting if negative perceptions of the other (as described above) meet an expectation of

not being understood. Could this be creating particular problems for engagement that need further exploration? The reasons for apparent poorer engagement of Muslims with CAMHS are undoubtedly complex, and may well include interrelated factors of faith, culture, race, class and gender. However, if we focus solely on these, we risk locating the problem entirely in 'the other', rather than asking whether there is anything getting in the way of *our* relating to Muslim young people and their families, and exploring whether we as clinicians might be unwittingly responding to Muslim patients in ways prompted by anxiety about the other, as well as about external factors.

Research setting

The geographical focus of the study is a CAMHS service in a diverse west London borough. The area served by the clinic is ethnically diverse; 55% of the borough's population identifies as an ethnic group other than white British, which is similar to the London average but significantly higher than the average for England (19%). The most recent census indicates that 10% of the borough's population is Muslim, which is slightly less than the London average but double that of England and Wales (almost 5%). The number of Muslims in the borough has risen by over 61% since the previous census in 2001, and is likely to rise exponentially by the next census in 2021[17].

Although there are no official figures for referrals to CAMHS by faith, an informal audit of referrals to the clinic (undertaken by the researcher to provide statistical context to the research study) indicated that over 22% of referrals in 2018 (up from 16% in 2017) were of Muslim young people. This high referral rate could be due to the high percentage of young

[17] Figures from 2011 ONS Census.

Muslims in the borough (33% UK-wide are under 16, and 50% under 25, compared to 19% and 30% respectively of the wider UK population). It is difficult to know more because:

a) the figures might not be accurate (current referrals do not require faith identity to be specified, so the researcher made a conservative judgement about faith identity according to the surname of the young person referred), and

b) it was beyond the scope of the audit to examine reasons for referral and treatment pathways, for example to see if there are fewer referrals to psychotherapy within multi-disciplinary teams. This area would require a separate research study.

Ethics

Ethical approval for the project was received from the Tavistock Research Ethics Committee (TREC), the Health Research Authority (HRA), and from the Research and Development department of the Trust in which the data collection took place[18].

Initially, it was planned to invite solely Child & Adolescent Psychotherapists from all three CAMHS clinics in the Trust to participate in the research study. However, their small number meant that their anonymity would be compromised. Recruiting Child & Adolescent Psychotherapists as research participants from outside the Trust would have complicated the ethical permissions process and delayed the study. In consultation with the researcher's service supervisor, it was therefore decided to widen the pool of potential participants to include all Tier 3 clinicians from the Trust's largest CAMHS clinic, which is

[18] See Appendix 1: Trust approval.

also where the researcher was training. This change was agreed by the HRA and by the Trust.

Participants were given information about the research project when they expressed interest following an initial email from the researcher[19]. Having agreed to participate, they were given a copy of the interview questions so that they could give some thought to relevant cases they had worked with, in preparation for the interview. At the start of the interview, participants were given a further copy of the Participant Information Sheet, invited to ask any questions about the interview process, then asked to sign the Informed Consent Form[20]. Interviews were recorded, anonymised, and the data kept securely and separate from the list of participants.

The ethical implications of the addition of Advisory Groups to the research process were carefully considered at each stage of the project. While their contribution was important for informing the interview schedule, the young people involved in the Advisory Groups were not interviewed. As such, they were not considered research participants, so further ethical approval was not required. The Advisory Groups were entirely voluntary, anonymous (names not taken by the researcher), and were not recorded. Responsible adults were present at all Advisory Groups (parents and/or teachers), but as observers rather than active in the discussions.

---

[19] See Appendix 2: **Public Facing Documents**.

[20] See Appendix 2: **Public Facing Documents**.

Selection of research participants

The CAMHS clinic where the research took place houses Tier 2 and Tier 3 teams, consisting of a range of professional backgrounds and trainings, including Psychiatry, Clinical Psychology, Counselling Psychology, Psychotherapy, Family Therapy and Specialist Nursing. Recruiting from Tier 3 of the multi-disciplinary team allowed for data to be gathered from a range of professionals, all of whom were specialists with experience of longer term work on complex cases. On reflection, involving multi-disciplinary participants also gave the research project broader relevance; working with difference, particularly harder to reach communities, is something that clinicians across professions can struggle with, and so is equally applicable to all CAMHS professions.

Participants were selected using purposive sampling, in that the researcher chose which colleagues to approach with a request to be interviewed, rather than randomising the selection within each main professional group. The researcher's intention in making her selection was to include colleagues who had previously indicated a particular interest in the research area, while ensuring a relatively even spread of the key modalities represented in the multi-disciplinary team. All those invited to participate accepted, although there were some concerns voiced about anonymity being maintained; this is perhaps not surprising, given the sensitive nature of the enquiry and the fact that participants work together in the same team. A total of eight participants were recruited, including clinicians from most of the professional backgrounds represented at the clinic.

Subjectivity and the researcher's identity

The convention when writing a research paper is to use the third person when referring to the researcher. However, in this section I am writing using the first person, because the alternative feels disingenuous, implying an objectivity that does not sit comfortably, particularly when discussing the impact of my own identity.

In accordance with IPA methodology, I have attempted to acknowledge the potential influence of my own identity throughout the research process, from my initial interest in the subject, through selection of participants and interviews, to analysis and discussion of the data.

There are personal, academic and professional reasons for my interest in the research topic, and my uncertainty over the order in which to present these perhaps illustrates some of the complexity and tensions which arise when thinking about Muslim faith identity in relation to a secular training and mental health service. All these motivations are relevant to my choice of study, yet it feels as if acknowledging a connection with my personal identity as an English Muslim might be perceived to undermine the premise of the research; might the importance of faith identity to me lead me to wrongly assume that faith identity might be significant to others? Even so, an exploration of whether perceptions of faith identity might affect engagement between clinicians and Muslim patients, perhaps getting in the way of relating, seems important, regardless of my own faith identity.

In order to mitigate to some extent the unavoidable subjectivity, it was important to acknowledge my own feelings about doing this particular research. IPA methodology

attempts to address the impact of subjectivity through the Free Coding stage, in which the researcher attempts to consciously acknowledge his/her feelings about the research area, recording as data his/her emotional responses prior to analysing the interviews[21]. Although the Free Coding stage does not set aside subjectivity, it does to some extent acknowledge and identify it, in an albeit limited way.

In fact, I had frequent misgivings during the development stage over the field of research, including fear of the reaction it might provoke from professional and academic colleagues. I think that this repeated 'crisis of faith' in my own research stemmed in part from recognition of negative perceptions of Muslims, and fear of negative response described above. My assumptions about dismissive, even hostile, attitudes towards faith identity in a secular setting were also significant; in this as in other areas, I acknowledge that I am as much subject to prejudice and assumptions about others as anyone else, this being part of the human condition (Dalal 2008). As a relatively inexperienced trainee, I was also concerned that I was somehow not doing 'proper' child psychotherapy research, as my focus was on clinicians rather than on patients or families, which sometimes felt presumptuous.

There were several things that kept me going in the face of this persecutory anxiety. These included the encouragement of my clinical supervisor and research supervisor, the active interest of colleagues and my research group, the opportunity to reflect with others at the Tavistock's Difference and Diversity Workshop and Frank Lowe's Thinking Space, and feedback from academic presentations (e.g. the ACP conference 2018). Crucially, I was also discovering the work of Fakhry Davids, which explores responses to Muslims in

[21] See **Free Coding**.

particular, and how this gets into the consulting room. However, my position as a lone researcher meant that it could be difficult to recognise my potential blind spots, such as selection of participants.

The selection of participants through purposive sampling is obviously subjective. It is possible that my fear of a hostile reaction influenced my selection, and in choosing participants who had shown a lively interest on the area, I was also actively *not* choosing those I thought might be hostile to it, to avoid potential 'attack' on my own identity. In this sense, perhaps my own anxiety was causing a split in my mind between 'good' potential participants and 'bad' non-participants.

It is important to recognise the dynamics of the relationship between interviewer and interviewee, and their significance for the production of data (Holloway and Jefferson 2013). For example, I had worked with every participant for between one and three years as a junior colleague, which will have affected how I related to them and how they responded to me. This perhaps made it hard to be reflexive and notice transference and counter-transference dynamics. However, the fact that we had good, established working relationships also meant that participants were more able to trust me to treat their responses with professionalism and respect, and the resulting data was therefore remarkably candid. It is also significant that the participants were aware of my faith identity, as I wear a headscarf. This might have made their responses more guarded lest they offend me, and potentially added to the anxiety already felt by participants due to the focus of my research.

It was also important to include young Muslims' thinking about the research question, so that the interview schedule could reflect their priorities and preoccupations, not just my own. For this reason, consulting with the Advisory Groups and incorporating their views and concerns in the interview schedule was a key part of the project[22]. However, my not recognising this stage as a piece of research in itself, and therefore omitting to consider ethical issues relating to Advisory Group members (e.g. the impact of being asked about some quite challenging areas such as mental health and experience of discrimination), is possibly another subjective blind spot. Perhaps I assumed that they, as Muslims 'like me', would be enthusiastic about considering these questions, and not adversely affected. It is also possible that being white and therefore not having experienced the intersection of racism and anti-Muslim prejudice, I did not consider the potentially painful impact on them of my questions.

Presentations and feedback

The researcher presented preliminary thinking about the research idea at the Association of Child Psychotherapists annual conference in 2018, which focussed on "Relating to the Other." Although this was not included in the research project application, it was useful because a broad consensus emerged from the workshop that Child Psychotherapy colleagues were uncomfortable about the potential impact of unconscious prejudice on engagement with Muslim patients, and wanted to look further at what could be done to improve this. The researcher was encouraged that others in the profession recognised

[22] See **Advisory Groups**.

some of the difficulties in this area, and were willing to take part in further exploration. It is also significant that the topic of how we respond to difference was the focus of the conference, indicating that this is a subject which currently preoccupies many people.

Many of these concerns were prescient in that they flagged up concerns subsequently raised by research participants during the interviews. This suggests that the anxieties around working with Muslim faith identity are widespread, and it is therefore even more important that this area be explored and better understood.

Advisory Groups[23]

In order to ensure that issues relevant to Muslims in the service user population were represented in the interview schedule, the researcher arranged a series of one-off reference groups (here called Advisory Groups), comprised of Muslim adolescents, to discuss the research study. Reference groups have been used in the context of previous child psychotherapy research. For example, Mercieca and Jones (2018) identified the potential of reference groups as a participative and co-reflexive activity which can inform research design.

The aim of the Advisory Groups was to incorporate the views and concerns of young Muslims into the interviews. This was eventually achieved in consultation with three groups of young Muslims aged 13 to 19, some from the local area. It was initially intended that all Advisory Groups would consist of young Muslims from secondary schools and community organisations in the area of the CAMHS clinic from which participants were drawn.

---

[23] Also see Appendix 3: **Advisory Group report summary**.

However, it was only possible to form one Advisory Group in the local area; the other two consisted of young Muslims from a secondary school and a Muslim community centre in another diverse London borough.

It was also hoped to include an Advisory Group of former service users. Ethical considerations meant that only former service users could be contacted, rather than Muslim patients currently receiving CAMHS treatment. However, it was only possible to include one former service user.

The researcher approached several local secondary schools in the same borough served by the participants' CAMHS clinic, inviting them to host Advisory Group meetings of Muslim students, for example through their Islam societies or as part of current national curriculum activities relating to mental health and wellbeing. Of the schools contacted, the majority did not reply, and the researcher was left wondering why this might be. An informal conversation with a member of staff from one of the schools revealed, in that case, that the school was unwilling to promote events for Muslim students only, for fear of being perceived as "divisive." They were proud of being a diverse school, and felt that in the current climate it would undermine their multicultural ethos to host an event focussing on one minority.

It was disturbing to hear that an initiative designed to improve understanding in the context of diversity would be thought of in this way, and an apparent tautology that diversity should be supported by avoiding an exploration of difference, rather akin to a frightened child hiding his eyes so that the monster 'disappears.' The school's reticence was perhaps an indication of the anxiety stirred up by an exploration of attitudes to Muslim difference, and

the resulting fear of retaliation this might provoke. This theme of anxiety and fear of retaliation/aggression is one that runs through the research data. It could be that other schools contacted felt the same, so did not reply.

It is also possible that schools in the borough where the research was based were particularly sensitive to questions involving the Muslim population. Three of the four so-called ‘Beatles’, who left the UK to join ISIL in Iraq and were linked to high-profile terrorist atrocities on Western captives, had links with this borough[24]. It is also possible that the schools approached were so busy with everyday pressures that involvement in the research project was a low priority.

In order to recruit former service users to form an Advisory Group, the researcher contacted several young Muslims (recommended by colleagues) who had expressed interest in the research area while they were involved with CAMHS. Most did not respond. Of those who did, only two young people were willing and able to form an Advisory Group to discuss the research project, and in the event, only one attended. The difficulty in forming this group is perhaps less surprising than the reticence of the schools to be involved. Former patients might prefer not to return to CAMHS once their treatment has ended, perhaps wishing to ‘move on’ or simply having other priorities. One who was willing to participate had moved out of borough for university. Another agreed to participate then did not attend. While there might have been practical reasons for this, it might also have felt too exposing to meet with the researcher and another former service user to discuss their experience of mental health treatment.

---

[24] See Appendix 8: **Media Context**.

The former service user was 19 and unaccompanied. With other Advisory Groups, there were adults present at all group discussions: a teacher at each of the school-based groups, and a community youth leader plus a parent at the Muslim community organisation-based group. While this might have inhibited the young people's participation, it did not appear to do so. The parent was included as an observer in the community centre group due to the anxiety of parents in that community about what the researcher - a Muslim but from outside their community and perhaps representing a non-Muslim approach to mental health - might be saying to their children. The researcher was concerned that her presence might prevent the young people from expressing their opinions. This is perhaps an illustration of the anxiety and suspicion which can be found in all parties when engaging with difference, and the need to explore this to find some common ground.

Members of the Advisory Groups were welcomed then introduced to the research premise by the researcher. They were divided into sub-groups of 5-6, and each group asked to discuss the following four questions:

1. Is it sometimes important that professionals (teachers, GP, CAMHS etc) know that you are Muslim? Please give your reasons.
2. Is it important that professionals (teachers, GP, CAMHS etc) know something about your faith/culture? Like what?
3. Have you ever felt uncomfortable or misunderstood because of your faith/culture? Please give examples.
4. Do you think that being Muslim, whatever that means to you, makes any difference to your emotional health? Can you say why?

They were then invited to share their answers with the plenary group, and to discuss further. At the end, Advisory Group members were given certificates to acknowledge their contribution to the research project.

In all Advisory Groups, there was lively discussion and disagreement about the significance of faith identity, how Muslims relate to non-Muslims, whether being Muslim made any difference to their mental health, and if so how. Some felt an “unspoken barrier” between themselves and clinicians, feared being categorised, and hoped to be met with genuine curiosity rather than a tick-box approach to diversity. One of the most hotly debated issues was whether health professionals should even need to know that they are Muslim. On balance, their view was that it would be helpful for clinicians to know this, but only if the clinician explored what that actually means to the individual. It was sobering to discover that all the young people involved in one Advisory Group had been verbally abused in public because they were visibly Muslim, or knew someone who had. This perhaps explains in part their uncertainty about whether they wanted clinicians to know about their faith identity; due to fear of prejudice or negative response as described above.

Areas discussed in the Advisory Groups impacted the research interviews in two ways. Firstly, it enabled the creation of interview questions[25] reflecting some of the Advisory Groups’ preoccupations. For example, Question 5 invited participants to think about their impressions of beliefs in the system about Muslims, which led them to consider their awareness of assumptions, prejudice and how this might impact engagement. In Question 3, participants were asked to comment on how they felt Muslim service users perceived

---

[25] See Appendix 4: **Interview Schedule**.

them, in order to encourage them to see themselves through the eyes of the young person, and explore their response to this.

Secondly, some of the opinions expressed and debated in the Advisory Groups were directly communicated to the participants to provide context for the questions. For example, preceding Question 4 about how young people might view the relevance of faith identity to their mental health, the researcher described some of the Advisory Groups' responses to this. In Question 6, participants were asked to comment on the fact that there was a debate in the Advisory Groups about whether clinicians should know something about Islam.

The influence of Advisory Group discussion on the interviews was important because it indicated to participants that the questions were not only relevant but actively debated by Muslim young people, and encouraged participants to think about engagement from the young people's perspective, as well as their own.

Interviews

The semi-structured interviews took place at the CAMHS clinic in February and March 2019. Interviews took 60-90 minutes, depending on how far participants wanted and were able to discuss matters arising from the interview questions.

The interviews covered the following areas:

1. What were your initial thoughts and feelings when you became aware of the Muslim faith of a young person/family? What were your first impressions on meeting the young person/family?

2. Think of 1 -3 Muslim young people/families you have worked with int he past 2 years. Could you say something about how you felt their faith identity was relevant (or not)? Could you say something about how you felt their faith identity influenced clinical decision-making (or not)?

3. Can you say something about how you think Muslim young people/families might perceive you as a non-Muslim or in terms of other forms of difference?

4. *The researcher will give a brief description of her recent workshops with Muslim adolescents.* What are your thoughts about how young Muslims might view the relevance of their faith identity to their mental health?

5. Research studies have suggested that there might be something in the system that gets in the way of relating between Muslim young people/families and CAMHS. Is that your experience? If yes, what are your thoughts about what gets in the way and how? What is your perception of the beliefs in the system regarding Muslims?

6. In my workshops with you Muslims, there was a debate about whether or not it is necessary for professionals to have some knowledge of Islam when working with Muslim young people/families. What do you think about about this?

During the interviews, participants made several interesting suggestions of ways in which engagement with Muslim young people and their families might be improved.[26]

Data analysis process

Interview data was transcribed by the researcher. Prior to analysing the interview data, the researcher's concerns and preoccupations related to undertaking the research project were recorded and analysed using Free Coding, to produce themes. The purpose of this was to acknowledge the possible influence of the researcher's personal feelings about the research on the analysis process, and thereby mitigate the issue of subjectivity. The interview data was then analysed (interview by interview) using IPA in three stages: transcript annotated[27], annotations examined for themes, themes transposed and examined for relationships with each other. Numerous themes were identified within each interview, related both to ideas explored in participants' responses and to specific

---

[26] These will be considered in the **Discussion** section, and are listed in Appendix 7.

[27] For an example of an annotated section of transcript, see Appendix 5.

vocabulary used. Observable anxiety was also noted, for example some participants' nervous laughter when discussing difficult issues such as prejudice.

The researcher then organised themes from all eight interviews (plus Free Coding themes) into a table to identify whether themes occurred across interviews. A note was made of which themes occurred in at least half the sample, and how this related to the Free Coding data.[28]

Using this information, and the researcher's sense of how frequently certain themes recurred in each interview as well as across interviews, the researcher chose three super-ordinate or overarching themes to discuss in further detail.[29] It was clear that these overarching themes are very much interrelated, and this is reflected in the **Discussion** section.

It was never intended to differentiate between the responses of clinicians of different professional backgrounds. The small sample size meant that such differentiations could not meaningfully be generalised. However, the language used by participants to describe their cases might indicate their modality.

---

[28] Appendix 6: **Thematic Tables** - Themes present in >/= half the sample

[29] Appendix 6: **Thematic Tables** - Super-ordinate themes

Interview data

Overview[30]

The multi-layered complexity of participants' thinking in relation to Muslim young people and families is apparent from the interview data. Participants describe this as shaped by several factors: their personal experiences of difference (for example belonging to some sort of cultural, linguistic or faith minority); a sense of the young person's awareness of difference 'in the room'; ordinary adolescent issues and intergenerational dynamics; and the influence of a societal response to difference (for example prejudice). This perhaps echoes the multi-faceted nature of our identities, whether at home, school, peer group, workplace, community or country.

In identifying and grouping themes, the researcher has included those relating directly to the participants' thoughts and feelings, and also to thoughts and feelings attributed to Muslim patients by participants (for example participants' recollections of how young Muslims have addressed issues of difference in therapy). Where differentiation is relevant, the origin of these themes is identified. However, the researcher has largely treated such data as part of the individual participant's response, as it forms part of how they makes sense of their experience. For example, the theme **Impact of (faith-related) prejudice, stigma, judgement, hostility** encompasses the impact (as explored by the participant) on the Muslim patients and families with whom he/she has worked, on the participant him/herself, on the therapeutic relationship, on the Muslim community and on the non-Muslim public. Similarly, the theme **Danger, fear, threat, risk, death** refers not only to the

---

[30] For tables showing themes by interview (and Free Coding), and how they recur across interviews (and in Free Coding), see Appendix 6: **Thematic Tables**.

participants' feelings, but to its occurrence in the interview (related to the feelings of a patient, their family, the professional network, the community). Their relevance as themes is that they are part of the participant's thinking about cases involving Muslims patients, and as such form part of their conscious and unconscious response to the interview questions.

Free Coding

Three of the themes which occurred in all or most of the interviews also appear in the free coding undertaken by the researcher prior to data analysis:

- Influence of clinician's own difference (experience of, perceptions of, positive/negative transference due to perceptions of, shared)
- Fear (of being misunderstood)(of asking), anxiety, tension, defensive, safe/unsafe, uncomfortable
- Complexity (of difference)(vs blunt/concrete)(vs stereotype)

As discussed earlier, it should be acknowledged that the researcher's awareness of her own difference, specifically being visibly Muslim (wearing *hijab*), both in relation to her team and to her experiences of wider socio-political narratives, might have made her more sensitive to these aspects of the participants' responses during data analysis. In psychoanalytic terms, this could be understood as an example of the researcher projecting her own anxieties and preoccupations onto the research participants. Interestingly, *all* the participants felt that their own 'difference' - they all felt that some aspect of their identity

belonged to a minority - had an influence on how they respond to Muslim identity of young people and families. This perhaps illustrates how we use our own experiences to understand the other, hence how unavoidably subjective our understanding is.

The researcher experienced significant anxiety in relation to the area of research while undertaking this project, sometimes felt as uncertainty about the project's relevance, sometimes linked to feared negative response from colleagues. While this may have been due in part to the researcher's position as a Muslim trainee and a relatively inexperienced researcher, it might also reflect participants' struggle to know whether faith identity is relevant to mental health (just over half of participants stated that it is).

Recurrence of themes

Using IPA analysis, it is possible to identity a number of themes particular to individual participants which are also shared by others in the participant group and represent super-ordinate themes (Smith, Flowers and Larkin p101). The researcher examined the extent to which themes recurred across data sets, and found that ten of the themes identified in individual interviews were present in over half the sample:

- Influence of clinician's own difference (experience of, perceptions of, positive/negative transference due to perceptions of, shared) (8/8)
- Fear (of being misunderstood)(of asking), anxiety, tension, defensive, safe/unsafe, uncomfortable (7/8)
- Political climate (Islamophobia, racism, negative media coverage of Muslims/Islam), Prevent, terrorism (7/8)

- Impact of (faith-related) prejudice, stigma, judgement, hostility (on young person, family, clinician, relationship, Muslim community, faith leaders, non-Muslim public) (6/8)
- Need for change to service/training/resources (re Muslim faith identity, diversity and mental health) (6/8)
- (Clinician's) wish to understand (individual, difference), wish to know more, curiosity (5/8)
- Complexity (of difference)(vs blunt/concrete)(vs stereotype) (5/8)
- Barriers (to treatment, to thinking, to relating, to engagement e.g. language) (5/8)
- Faith identity is relevant to mental health (positive and struggle, core relevance) (5/8)
- [Link between anxiety and laughter?] (5/8)

A further eight themes were present in half the sample:

- Danger, fear, threat, risk, death
- Search for similarity, safety, belonging, assumptions re shared difference
- Ignorance, not knowing (clinicians' fear/anxiety/discomfort/tension of)
- Knowledge as positive (for understanding)(some basic knowledge)
- Individuality of young person (Yp as expert in their faith identity, choice/agency of yp), therefore need to ask young person
- Intergenerational conflict, tension (and dilemma of clinician)
- Hijab, niqab (signifiers of difference)
- Sexuality (significant in case, stigma in Muslim community, Western values narrative)

The recurring nature of these themes across professional backgrounds was significant, suggesting that they are common preoccupations for CAMHS clinicians regardless of modality.

Super-ordinate themes

The researcher formed three super-ordinate themes by identifying connections across recurring themes, using subsumption where themes could clearly be included under one umbrella (eg search for similarity, safety, belonging), polarisation (eg safe/unsafe) and by abstracting certain ideas (eg split, conflict, battle, struggle). The super-ordinate themes are not exhaustive or prescriptive, but are interrelated and untidy. In some cases, it has been difficult to decide where themes from individual data sets most comfortably nest, and could be argued that some are not discreet super-ordinate themes at all; this reflects the huge complexity of the task and of the issues discussed. However, they represent overarching areas reflecting the emphasis given by the participants as they described their experience of thinking about and working with Muslim young people and their families. There is ample material in the data to form additional super-ordinate themes such as complexity, barriers to engagement and clinicians' struggle concerning the relevance of faith identity. However, there is not space here to explore these, so the researcher has focused on the following:

A: What 'the other'/difference stirs up in us

B: The clinician as 'other'

C: Tension around knowledge

I have indicated where themes occur in half or more than half of interviews.[31]

[31] For a full list of themes in each group, see Appendix 6: **Thematic tables**.

A: What 'the other'/difference stirs up in us

It is relevant to note here the anxious initial responses of many participants when first approached for interview. Some expressed nervousness about the subject matter, others trepidation about the significance of their contribution - that their thoughts would "mean something" - as part of a research project. This nervousness is perhaps reflected in the fact that most of the participants (5/8) exhibited anxious laughter during their interviews.

By far the most frequently recurring emotion referred to by participants when discussing attitudes to difference, specifically Muslim difference, was fear. References to fear in various degrees and manifestations (such as anxiety, discomfort, tension, defensiveness, safe/unsafe) were made by 7/8 participants, for example:

- anxiety rooted in assumptions about Muslims:

> "We spoke … earlier about the anxieties around you know a clinician holding a referral or you know Choice or someone coming through here of Muslim background, they have preconceived ideas, you know, things that they are expecting." (2.6.1)

> "I think… there's quite a negative perception, widely. I think there's a kind of fear. Um, I think… there is a sort of… um… idea that- that there's aspects of the Muslim faith that are bad and are dangerous and are… um… I think, yeah, I think… more so than other faiths, so it feels like it's put into the Muslim faith particularly." (5.5.6)

> "I think we have a position about religions nowadays, and I think it's one… of judgement. I don't think we have a position of 'OK we're going to try to understand.'" (8.6.4)

- fear of appearing ignorant, offending, or getting it wrong:

  “Whether that gets in the way, whether people do feel ignorant therefore they feel frightened, I think fear is a lot… of you know… saying the wrong thing… offending, making a mistake, so people are quiet rather than curious sometimes.” (4.5.5)

  “But I think it’s out of fear that people probably wouldn’t ask” (4.6.5)

- discomfort about being perceived as not understanding by Muslim patients and families:

  “I kind of think that must be the family’s experience of the whole service, actually, ‘We’re bringing our child here, and is anyone really gonna get what, you know, is part of our life… or understand the complexities around this?’ Yeah maybe it might have been sort of uncomfortable.” (3.3.5)

  “I was wondering what she may, whether she felt… that I was too different, that I’m not going to understand their world and their experiences. So that was definitely there in that session where I kind of wondered “What does mum think?” Does she feel that um… I suppose I always wondered does she feel that this service can help my child or help me?” (5.1.9)

- fear perceived to belong to Muslim patients (for example in relation to stigma, fear of not being understood, fear of prejudice):

  “The kind of fear that… they may be judged, externally, in their community or their family, for coming to this services, the stigma around mental health” (6.5.3)

  “I had… two to three Muslim families… and their anxiety about relating to a CAMHS service that didn’t understand their faith, and the importance of faith to them. And [they] perceived that the CAMHS clinicians would not be able to really understand their faith and their culture… and so there was an anxiety before attending. An understandable anxiety about possibly a lack of understanding by therapist clinicians.” (7.5.1)

> “There is a sense that comes from the families that they really feel uncomfortable” (8.1.4)

> “I feel there is an element of [the family] feeling uncomfortable, but… I never know where that comes from. Does it come from the fact that I am not Muslim? But they are and um… but there [are] degrees of uncomfortability… I have [Muslim] families that… are really uncomfortable. They really feel… targeted as a family” (8.3.1)

The themes of power relations, political climate, FGM, Prevent can be linked to this sense of fear, whether described as anxiety, tension or discomfort, as they form one of the contexts of the participants’ and the patients’ lives. Almost all participants referred to the political context of ‘Islamist’ terrorism, either by mentioning specific attacks which had taken place around the time of their work with a Muslim patient or family, for example:

> “I saw her during the London Bridge attacks, or soon after the Westminster attack, and I think it made her very conscious of how she looked to other people” (1.2.1)

Or by referring to the impact on patients and clinicians of media-stoked Islamophobia particularly in relation to fears of terrorism, for example:

> “I think there’s a lot that’s gone on in the world, particularly around terrorism… and… it’s left a narrative of bigotry… paranoia… fear, and a lot of other things… so there is a perception that that sense of belongingness and identity, all those issues are meshed into that, which… aren’t very helpful, and the system isn’t seen as one that is sympathetic to Muslims in that way, because you are stigmatising them and seeing them in a particular way, and judging them without having to have an understanding of who they are… the position of the system, I guess, before even mentioning something they are assuming ‘Are you sympathetic to terror ideas?’ [laughs] and all those kind of things, before you even have that conversation.” (2.5.6)

> “I think also at the moment all the Islamophobia out there… I wonder if it makes it harder for [clinicians] to enter that territory… If they ask the wrong question and are perceived to be racist, or you know, I wonder if that makes it harder, especially in the current climate.” (4.2.2)

> “… particularly since 2011, where Islam is portrayed in the media as a hostile faith, an aggressive faith.” (7.5.1)

Some discussed the impact of Prevent training; for example:

> “I think it then conflates two very different things, um, you know, sort of faith and… extremism, which I don’t think are necessarily all that related, actually.” (3.5.9)

The implications of power dynamics for the political context was also noticed:

> “The discrimination is much more, you know, wider… how they are positioned in kind of dominant discourses as potentially dangerous.” (6.2.2)

> “I always feel that we are trying to make everybody Western [laughs].” (8.3.3)

Participants were also concerned about the way in which these narratives and risk-related imperatives can affect our thinking, and interfere with engagement:

> “You’re constantly sort of thinking about the risk, and monitoring and assessing the risk, and that might get in the way of doing the work… cos you’ve got to focus on the immediacy. […] I would imagine that, well maybe for mum, that experience of feeling “People don't trust me” would be, was very hard.” (5.2.2)

> “There is something about perceptions by clinicians, and I would say negative perceptions, of Islam. Um… whereas behaviours and belief systems that would be sort of experienced by all young people, if they’re experienced or presented by a young person of maybe an Islamic faith, may be understood in a particular

> way, as opposed to a young person just struggling with conflict and development and sexuality. And I think then that's about the society and prejudices that one holds without being conscious of them, and how labels are attributed, and behaviours pathologized, when actually this is a developmental process and a child in conflict working through normal pathways." (7.5.1)

> "I have families for example that come from Somalia and they are Muslims, and… I always wonder if there is a bit of hyper-vigilance around the families… because we are so trained about female genital mutilation and [asked] to be vigilant about that. And […] I think it does effect the way [we] are thinking, not necessarily position ourselves, I mean thinking." (8.2.3)

This tension regarding Muslim faith identity (viewed by participants as present in society and therefore in themselves) is linked by participants to a struggle to explore or even think about difference and faith identity in the room:

> "There is something around people's experience of dealing with things that are hidden, you know whether it's about facial features or whether it's about practices that you know remain sort of hidden from other people or that are just too different, you know sometimes it's about sort of cognitive dissonance really… You know, the difference that's too far, … it's difficult to bridge the gap." (1.5.5)

> "I think when I've talked about cases where there's just Muslim faith, I think people tend to be sensitive, sometimes overly sensitive and kind of don't know how to think about it in an ordinary way… but when I talk about cases where there's been… increasing observance, I think there's been a bit of scepticism, there's been… suspicion around that I think wasn't warranted." (3.1.17)

> "I think that makes it very hard to kind of, work out what relationship do I have with this person? Are they safe or not?" (5.5.7)

However, participants' awareness of the tension can also make them more determined not to let it interfere with engagement:

> "I am kind of aware that the people with Muslim faith have to negotiate their identity within a lot of discrimination. And… I am mindful of how my engagement [should] not repeat that discrimination." (6.2.1)

B: The clinician as '**other**'

All participants referred to their own personal experience of difference, for example how their minority status has been perceived by others including patients, and their thoughts about the impact of this on the transference, whether positive or negative. Several participants emphasised the importance of reflexivity, acknowledging both the impact of clinicians' difference on patients, and the relevance of the clinician's experience of difference for how they think about patients' difference. For example:

> "I think it's very important to own the privileges of being white middle class in this country, and to put that out there actually… this is an awareness that I have with young people, whether they are different from me in race or culture or religion or you know in any way… age as well, so… I think it always important to highlight differences and how that can sort of influence us, but it's better to have it there on the table than to sort of not talk about it." (1.3.1)

> "I think… you do bring yourself to the room." (3.3.1)

> "So I suppose for me it was about […] how I would be received as a therapist, and how I would understand then the presentation, bearing in mind my own um background? […] How I would relate to them and how they would relate to me." (7.1.1)

> "My clinical experience is… I am always 'other'" (7.6.2)

> “I look very Western, and then there is that sort of [idea] would I be able to understand them as parents as well? Um, and, would I be able to respect their views?” (8.2.1)

Participants also acknowledged how difficult this can be to speak about with patients:

> “I think we come to this work with a personal lens, and I think that, for me, it’s become easier, both because I’m more aware of it, and also I worked in a very, very systemic place before here, we always talked about race, religion… and sort of privileged that over… some of the talking therapies. But I think for a lot of people who are less familiar with it, it’s extremely hard.” (4.2.2)

While being aware of the significance of difference, some participants also noticed Muslim patients’ search for similarity:

> “It’s a question I get asked a few times by Muslim families when I may see them, that ‘Are you Muslim?’” (2.3.1)

> “On some level I’m certainly aware if I’m noticeably different to my patients in some way, some significant way, but I don’t necessarily bring it in unless it’s somehow showing itself in the work… Like when my patient kept trying to bring up our similarities, and was sitting there when we are visibly and culturally and religiously and age-wise, very different” (3.4.11)

Participants recognised the positive impact on engagement when patients perceived common ground with the therapist by making assumptions about shared difference. This can enable the patient to talk about their own experience of difference:

> “I think that they think that we are both different… therefore… that’s something in common… You know and that I can relate to them, or we can talk openly or freely… about you know their experience or what they are feeling.” (2.3.5)

> “The positive transference of being perceived… to have some sort of… shared understanding enables the other to feel less criticised or judged, and allows the other to be less defended, and therefore be able to speak to you a bit more openly” (7.2.4)

However, one participant noted that patients’ assumptions about shared difference with the clinician can also lead to negative transference, for example if the clinician is assumed to be Muslim and the patient has an experience of being criticised by other Muslims.

> “They then find it difficult to… have open conversations with you for the fear of judgement. So… it works both ways.” (7.7.2)

C: Tension around knowledge

Participants mentioned a wish to understand the place of faith in their Muslim patients’ identity, and expressed various ideas about the place of knowledge in relation to achieving this understanding. These ideas were not only in response to question 6 (whether it is necessary for professionals to have some knowledge of Islam when working with Muslim young people/families), but ran through the whole interview:

> “If their faith is very important to them and it is a very key part of their life, how much [do] they feel they are able to think about that here? Because you would think that it would have a close connection with their emotional wellbeing, their sort of mental health, that those two things would be sort of, going along in parallel, you know, and so how does that work? How does that weave through? How is that understood?” (5.3.1)

> “I probably would not understand very well because I don’t know very much about their faith, beliefs and how they function in that, what does that mean for them? I think it’s much more complex than just faith, I think it’s about them as a

> culture and community and that I'm not raised in that […] Will I be able to understand where they're coming from?" (8.1.3)

For some participants, the *niqab* (veil covering face) represented a barrier to understanding Muslim faith identity (*hijab/niqab* mentioned by half of participants):

> "I think there's maybe not enough understanding I think about what the faith is about, and how it works […]. I saw a lady the other day who had literally just her eyes, like, just her eyes […] I find that hard to make sense of. I find it hard when I see it, visually, and I think she could only see out of that tiny… window, and I, and I can't imagine how that might be… and I can't understand it, and I don't know enough about, I don't know enough about how she came to that decision and what it means to her […] I think it's an ignorance, probably, on my part, you know of not knowing, not understanding, and it being alien a bit to me." (5.5.6)

Half of participants thought that, in order to understand Muslim patients, it was important to have some knowledge, at least to a basic level, of Islam and its practice. Most (5/8) specifically wanted to know more about how faith difference affects the Muslims they work with. The majority (6/8) felt that engagement with Muslim young people could be improved through specific training for mental health clinicians working with Muslim families, better information resources available to clinicians and improved links with external Muslim faith organisations in the community:

> "Shouldn't we be trained more into this? […] We all go to the mandatory training, but I've never felt satisfactory to be very honest [laughs], and I don't know, I didn't find that it's addressing, er, I mean it's talking about of being respectful and embracing diversity and equality, but it doesn't actually talk about diversity and mental health." (8.5.1)

Some acknowledged their confusion between cultural and faith practices:

> “Some cultures may have different [slight laugh] beliefs around you know… depression or anxiety, […] but I don’t know about Muslim religion per se. I can talk more about […] different cultural beliefs […] but I’m not sure in terms of religion… To be honest, it’s a good question, and I don’t know enough.” (4.4.3)

Others acknowledged the positive impact of having some knowledge, both on the clinician’s confidence in seeking engagement, and on the patient’s perception of being understood:

> “If I have an understanding of their faith, I can have that confidence to have that conversation with them, and also give them confidence that I have an understanding of their faith, and I think that will go a long way in encouraging them to seek help, in you know establishing that good rapport with them.” (2.6.2)

Whereas inadequate knowledge (and the perception of this by patients) can lead to tensions in the therapeutic relationship, and create a barrier to engagement:

> “If they don’t believe that I understand their religion, then I will come across as if […] I haven’t got an understanding of what they are. […] So I would have done my job, tick-box, I’ve done some psycho-education, I’ve told them about the medication, but they’ve not had confidence in me that I really understand what they are talking about, what their religion says about these kind of things.” (2.6.3)

> “I think there might well be a perception… you know, of not understanding, or ignorance, you know, or possible perception of racism” (4.3.1)

> “I don’t think we are trained enough to understand and to have a different way of approaching and formulating things, and […] what we are trying to manage […] from our cultural standpoint. […] and I think that’s where the clashes and the tension come up.” (8.5.10)

This situation can be exacerbated by Prevent training, which is the only mandatory training that does involve thinking about Muslims:

> "We're not taught very much in trainings about sort of cultural sensitivity or religious sensitivity or how to understand things, but we are then sort of given that very jarring [Prevent] training, and I wonder if that's kind of in the mix somewhere… and I wonder if that's a two-way street, I wonder if Muslim families perhaps don't feel it's a particularly receptive service." (3.5.9)

Participants gave clinical examples of occasions when they had been struck by their lack of knowledge about Muslim faith identity. For example, one described how her assumption about Muslim faith and sexuality was confounded on meeting a Muslim girl with gender identity issues yet wearing headscarf:

> "Perhaps I realised then that I didn't know enough about what it's like to navigate adolescence whilst from an observant Muslim family, in a way that maybe would've been quite helpful for me to know." (3.1.1)

Anxiety and knowledge

Linked to participants' acknowledgement of lack of knowledge and wish to know more, was a pervasive sense of discomfort and helplessness[32] about not knowing.

> "I think people might feel uncomfortable, I think for some people… and including me, sometimes having an ignorance of, not knowing enough about, so I feel I don't know enough about Muslim practices and culture" (4.2.2)

Participants described a fear of appearing ignorant or 'getting it wrong' and thereby damaging empathy, yet also fear that asking might be intrusive or 'othering', faith identity being a sensitive area, both 'loaded' and complex (links to A and B):

---

[32] which I link to anxiety, see **Discussion**

> “But I wonder whether actually some people may feel that their lack of knowledge could sort of be a barrier to them asking questions about someone’s faith.” (4.2.2)

> “There’s something always about ‘How much shall I ask you about this?’, or whether it feels like it’s intrusive. Sometimes, I feel like it might be quite a private thing, and so, it’s not something that I’m not interested in, but […] I’m a bit unsure about how much.” (5.2.7)

Despite wishing to know more, some participants felt that the requisite knowledge is somehow unattainable. This was expressed through a sense of being overwhelmed by faith difference (links to A):

> “If it’s not your religion and there’s [slight laugh] so many different religions, you can’t hold it all in mind, you know, about all the different festivals, about what their religion means, you know, about how they practice that religion. […] and then you’re like, woah! It’s just too much!” (5.6.1)

There can then be a pull towards denying difference:

> “I think sometimes we have this kind of approach to supporting these kind of families or young people with ‘one size fits all’ kind of approach, which isn’t always the best idea” (2.5.1)

Some participants questioned the value of acquiring some knowledge, fearing that it might even be counter-productive. They were concerned that it could make clinicians feel that they knew enough so stifle curiosity and thinking:

> “There is a need to enquire into each person’s journey of faith or significance of faith, rather than have some kind of blanket education and therefore run the risk that you know it all” (1.6.1)

> “It kind of feels very tokenistic, you know… You don’t want it to become like a box-checking exercise where people feel they’ve got to ask about certain things, or where people do ask about certain things because they feel like they’ve learned about it and that’s sort of a blind-sighting.” (3.6.5)

This combination of anxieties related to knowledge about an ‘other’ perceived as very different creates tension, an uncomfortable place for the clinician to be:

> “We are caught in that kind of sense of not knowing.” (6.5.5)

The way in which anxiety can sometimes hamper clinicians’ thinking about Muslim patients and their families was noted by participants:

> “A lot of the times, what’s seen first is their religion before their problems. And that in itself become a hindrance in then delving into the real issues” (2.3.8)

> “I think we didn’t really know how to think about or talk about her questioning [her faith] or explore, is that a safe thing to allow her to do or to work with her in doing? […] I think ordinary thinking got a little bit squashed” (3.1.3)

Most participants (5/8) emphasised the importance of the individual patient’s experience of faith identity, the need to be curious about this and to ask the young person. For some, this seemed to obviate the wish to seek knowledge through training, while for others, both routes of seeking understanding were desirable. There was agreement that some knowledge about Islam/Muslim beliefs and practice is important, yet is no substitute for asking the individual patient about what being Muslim means to them:

> “It’s not good to be completely ignorant, but […] some knowledge should never replace curiosity or the need to investigate or enquire into complexity, because it’s too simplistic otherwise.” (1.6.1)

> “I do ask the families themselves about their own experiences and how religion plays a part in their lives. So I learn from the young people as experts.” (4.2.2)

> “I think the most interesting thing is to hear the young people themselves” (6.5.4)

Assumptions versus curiosity

Participants acknowledged the danger of making assumptions about patients, including about their faith identity:

> “I think all the time we’re sort of, you know [light laugh], making judgements and perceptions sometimes non-accurate.” (4.3.2)

If a patient has an apparently Muslim name, assumptions are made about his/her faith identity from the referral stage. Participants described how their assumptions are often challenged by their experience on meeting and getting to know the patient:

> “I think names always conjure up you know certain expectations, rightly or wrongly,… so I was quite surprised to see them not wearing a headscarf… and talking about going to church” (1.1.4)

> “The name is imbued with so much. But over time what they’re looking at, what is sitting in front of them, doesn’t quite add up to their experience.” (7.3.2)

Participants also noted how these initial assumptions about Muslim faith identity can be negative rather than neutral, in contrast to a more positive experience of the patient/family on meeting:

> “So definitely I think from the referral […] there was more of a negative potential, I suppose. But on meeting with them, I felt that, yes, I can work with this family, and felt very positive towards them.” (5.1.5)

Participants described the need for respectful curiosity to counter assumptions:

> “Often it’s about asking the questions but in a respectful way, and it’s about not making assumptions.” (1.3.2)

> “I think it’s all about [the young person] thinking, ‘Can you understand enough about where I come from and my values and beliefs, to actually be able to work with me?’ And I think if you ask the right type of questions, and actually are curious to learn, then… that’s why I think it’s not been a barrier.” (4.3.3)

> “The two main critical things for me is an openness of mind, a curiosity, […] But it’s a curiosity of mind which is crucial.” (7.6.2)

Yet participants acknowledged that assumptions made about Muslim faith identity in particular, due to key indicators such as name and style of dress (e.g. *hijab/niqab*), can shut down such curiosity:

> “So I suppose with Muslim faith it’s more obvious, so you might do less enquiry.” (1.1.1)

There was a sense that making assumptions about the other is not only something that affects clinicians, but patients too, so reinforcing the barrier to understanding:

> “Because this goes both ways, doesn’t it? […] [There] was a Muslim family who […] perceived that the CAMHS clinicians would not be able to really understand their faith and their culture, and so there was an anxiety before attending. […] But, on the other side, from the perspective of the professional system, […] I believe we all make assumptions, we all have stereotypes, and we all have prejudices, whether we’re conscious of them or not. Some of us have had space to really sit down and think clinically about how we may be experienced by another, and how we experience the other, a space for self-reflection. Others have not.” (7.5.1)

Participants described trying to find a balance between taught knowledge, assumed knowledge and curiosity, between knowing (or assumed knowledge) and not knowing (so needing to ask):

> "I think generally a bit more information is always helpful. I'm aware that people get too caught up in things like religion, in terms of how they view the family and thinking about that a sort of mental block can happen, and will it help or hinder that? It might help to sort of dismantle some of that. But, I guess I also wouldn't want too much importance being put onto religion to the detriment of actually just looking at a patient in a more organic way, and kind of learning about them. I mean, given we have things like Prevent and other trainings, it sort of seems noticeably absent, and even just a bit of rudimentary information would be helpful, actually" (3.6.1)

For another participant, having some knowledge of other faiths enabled constructive conversations with Muslim patients:

> "What I've learned over the years is, when I'm working with difference, is to look into it a bit, to find out a bit of knowledge about different faiths, […] just so I have a basis, some basis for an understanding, […] rather than constantly asking out of ignorance. So I would say it's useful to have some understanding, because I think my experience has been that young people get irritated if they constantly have to explain something, it becomes annoying. And even though I think it's helpful for young people to unpick their thoughts and processes… to a point, to a point." (7.6.2)

There was acknowledgement that, although it is not possible to know everything about Muslim faith and practice, it is important to know something:

> "I think I need to have some knowledge, but I'm probably not going to be able to have the knowledge of everything, but I think I have to have an understanding what that means, not necessarily what that means Islam, […] what that means for the community, what that means for the family, the relevance of that, how important, […] what drives what's going on in the family." (8.6.1)

The participant goes on to express how it can be a difficult process to understand the other, but that the clinician needs to make some effort (by acquiring knowledge) towards this:

> “I would probably struggle to understand certain things, so I will have to come, I will have to meet them somewhere to understand.” (8.6.1)

Knowledge and power

Participants recognised that the way in which different sorts of knowledge are prioritised can reflect the power inequality between clinician and patient. There was an acknowledgement that CAMHS clinicians’ practices are “very much located in Western, middle class, white culture” (6.5.2) If we disregard the significance of Muslims’ social and faith context, and unthinkingly privilege Western ways of thinking, we are repeating the power imbalance:

> “We tend to colonise people with our practices” (6.5.3)

> “Like there’s this expectation, ‘You have to do this way, because, and if you’re not doing it this way’ - which is very much a Western culture way of doing that - ‘then there’s something wrong with you as a family.’ And I always wondered about that, about do we, do we really try to meet and understand?” (8.3.4)

Some participants felt that curiosity about the individual could help mitigate the power imbalance:

> “There are different positions around power, but I think by being curious and not-knowing or enquiring, you can shift the power relationship and ask them to explain and educate you in a sense.” (1.3.1)

Others emphasised the importance of being aware of the power dynamics of the therapist-patient relationship, and of addressing this by encouraging service user participation, rather than relying on taught knowledge about Muslims:

> "I think it's more than to have a knowledge that I have read about what Muslims believe in, I would think more that as clinicians we need to […] open our eyes to name oppression, our voice when we may be witnessing something that is oppressive or something that is silenced, […] it's how we make choices, when we bring this conversation forward, […] that reflexivity, inviting people to be part of those decisions, and seeing that they are part of our work." (6.6.1)

Others reflected on contemporary Western society's position regarding religion, and how this can create a barrier to understanding. For example, the absence of a request for faith identity information on referral forms was viewed by one participant as power-related, as it privileges a Western secular position that does not consider faith as important as, for example, ethnicity:

> "But is religion on the form? [R: No] Oh gosh, so…[omission request]… it's political." (4.2.5)

> "I think we have a position about religions nowadays, and I think it's a position of judgement. I don't think we have a position of 'OK we're going to try to understand.'" (8.6.4)

Discussion of super-ordinate themes

A: What 'the other'/difference stirs up in us

> "I suppose what I'm talking about is internal prejudice, really." (3.6.7)

One of the most striking things about the interview responses was the sense of unease when thinking about work with Muslim patients and families. This ranged from discomfort, anxiety and tension, to references to dilemmas, struggle, conflict and danger related to difference. Fear appears explicitly in the material in terms of fear of being misunderstood. Linked to this, there is a recurrent theme of trust/distrust, protection/threat, and what is safe/unsafe, with 'ordinary' being safe and 'other' or difference being unsafe. The discomfort is not solely described as coming from the participants, although this was frequently acknowledged. It is symptomatic of how we deal with difference, particularly when the 'other' is not known (ordinary, safe). This may link to the paranoid schizoid state of mind developed in infancy to manage persecutory anxiety by projecting unbearable experiences into the other (Klein 1946), cemented as the child develops and responds to unfamiliar people and groups (out-groups) with distrust and fear (Davids 2011), and returned to at times of anxiety in adult life.

Furthermore, both participants and patients are inevitably aware of, so influenced by, the prevailing socio-political discourse around Muslims (as discussed by Davids 2006, Inayat 2007, Stevenson et al 2017, Junor-Sheppard 2019 and others), often anticipating that it will be present in the relationship with the other. This is perhaps why these feelings are so

prevalent in my sample, almost all of whom mentioned the impact of Islamophobia and the repercussions of terrorism.[33]

More than one participant pointed out that the only official CAMHS discourse concerning Muslim young people is negative, as it is focussed on training about our professional obligations concerning vulnerability to FGM and suspected terrorism involvement (Prevent). While child protection considerations are paramount, a focus on FGM and Prevent inevitably gets into clinicians' thinking about and relationship with Muslim patients, thereby reinforcing perceptions of difference (Carter 2017). This can increase a fearful so potentially insensitive and marginalising approach to Muslim young people and families. The impact of these policies on an already negatively-charged sense of the other may be hard to quantify, but would be unwise to ignore:

> "I wonder if we've started thinking too quickly about somebody [who]… has strong beliefs… I wonder if we've now started quickly thinking [that they are] extremist." (8.6.5)

Participants were very aware of the impact of faith-related prejudice on the young Muslims they see, on their families, on clinicians themselves. Faith-related judgement, stigma and hostility were described as affecting relationships outside the room, including between young people and their families, families and the community, families and the non-Muslim public. This was seen as affecting relationships in the room because the young person might arrive with an expectation of prejudice from the clinician, as described in the literature (Inayat 2005 and 2007, Tommis-Cardo 2019). This was seen as a barrier to treatment in some cases:

---

[33] For an overview of terrorist attacks in the UK and other relevant stories in the news media, see Appendix 8: **Media Context**.

> “I think conversations I've had with young people, who haven’t quite worked out what I am but give me this benefit that I may have a better understanding than most, speak of an anxiety around prejudice.” (7.5.1)

To complicate things, participants were aware that some Muslim young people face stigma from within their families or the community regarding mental health (also sexuality). They might come to the clinic for help with this aspect of their identity, yet might also be wary of prejudice from clinicians towards the Muslim aspect of their identity. This could place the clinician in a difficult position; some participants describe struggling to know where to position themselves in relation to the young person and the family. This in turn was felt to exacerbate conflictual inter-generational aspects of some cases. The young person might feel part of a stigmatised community, and stigmatised within that community because of his or her mental health issues or sexuality. This raises the question of whether they can find a safe place in CAMHS and trust the clinician, or whether they anticipate facing further prejudice due to difference of faith and culture.

Participants were very much aware of these tensions in what the young person was bringing concerning their identity (i.e. the young person’s perception of and fears about difference in the clinician), but also aware of being part of an organisation with policies that might increase the young person’s fear of prejudice and indeed influence their own focus in the room, and of being educated within a Western discourse concerning mental health and sexuality. Three participants reflected specifically on the impact of the narrative of ‘Western values’ on their relationship with Muslim patients, and linked this to Western clinicians’ “problem with faith.” While participants echo Davids (2011) and Lowe (2014) in acknowledging that it is hard to think about difference of any kind in the room, which is perhaps not surprising given the levels of anxiety that accompany the subject, this seems

to be particularly so with faith difference. This could be due in part to the dominant influence of Western philosophy in mainstream therapy training (Krause 1998).

Thinking about Muslim faith difference could give rise to particular discomfort given the influence of social prejudice in the form of negative media coverage and Islamophobia.[34] The impact of the political climate (including racism as well as specifically anti-Muslim prejudice) was pointed out by half of the participants. A reticence to ask the young person about the place of Muslim faith in their identity was explained by one participant as the clinician's concern not to make the young person feel 'other' by asking. While this might show sensitivity to the Muslim patient and an acknowledgement of the mental pain experienced by minorities due to the projections of the majority (Akhtar. S, 2014), it might also indicate the projection onto the young person of the participant's own anxieties around difference, for example those pertaining to Muslims as the ultimate other (Davids 2006). It might also be evidence of the participant's empathy, having experienced othering themselves (see super-ordinate theme B).

As such, this response is perhaps also evidence of a powerful wish for similarity which appeared in the data, and is explored in section B. This could be thought of as perhaps preferable to unconscious and conscious fear of difference, a wish for integration in the face of splitting. Fear of being misunderstood, and its flip-side fear of asking (lest the other be provoked) is also related to the theme of tension around knowledge which appeared in several interviews (see super-ordinate theme C).

---

[34] See Appendix 8: **Media Context**.

The appearance of themes relating to splits, conflicts, struggles and battles regarding difference brings to mind the risk of not finding common ground on which to build a relationship; perhaps a fear that the acknowledgement and exploration of difference will create an insurmountable barrier to understanding, which is another notable theme in the data. These themes also brings to mind unpalatable aspects of European history in relation to Muslims in the form of the Crusades, now distant so easier to disown, but nevertheless still occasionally part of the political narrative, and, according to Murad (2020) integral to Europe's sense of self. Indeed, the recent Brexit campaign, with its war-ridden imagery and anti-immigration narratives, and the less recent but equally potent rhetoric about a Western 'crusade' against an 'axis of evil' consisting of mainly Muslim countries, illustrates how effective it still is to refer to this narrative.

Some participants referred to the impact of power difference on their ability to discuss faith identity with Muslim young people. Unequal power relations, inextricably linked to the legacy of colonialism, are acknowledged to have a significant effect on the transference, yet are risky for the clinician to explore lest this reveal their own prejudice (Lennox 2013). It could be that the confluence of these differences in the room, with the clinician seen to hold all the power, (professional power, power of widely accepted Western narratives around not only mental health but spiritual/cultural issues, socio-political power as a non-Muslim) creates a particularly difficult area to address in the room: the place of Muslim faith identity in the context of mental health. This discomfort might be exacerbated by other mutually influencing differences, such as race, age, class and sexuality, which also affect perceived and unconscious power imbalance. (Hill Collins and Bilge 2016) The complex impact of intersectionality perhaps led participants to question how they should position

themselves in relation to the patient and family in response to the multiple tensions which arise.

These dilemmas also appear to lead to anxiety-provoking cognitive dissonance, perhaps due to the experience of "epistemic anxiety" (Crehan and Rustin 2018) in relation to difference, evoked by learning that threatens existential security and a stable sense of identity.

> "I think when I've talked about cases where there's just Muslim faith, I think people tend to be sensitive, sometimes overly sensitive and kind of don't know how to think about it in an ordinary way." (3.1.17)

B: The clinician as 'other'

> "I myself reflecting how I deal with my own difference in this culture, as a foreigner" (6.6.1)

Significantly, every participant referred to their own experience of difference in order to understand the experience of young Muslim patients. It was not until this common thread became apparent that the researcher realised that every participant identified with a minority in at least one respect: cultural, ethnic, religious or linguistic. This both added to the complexity of the therapeutic relationship and helped participants to negotiate it. This acknowledgement by participants of their own 'otherness' was undoubtedly influenced by interview question 3: "Can you say something about how you think Muslim young people/ families might perceive you as a non-Muslim (or in terms of other forms of difference)?" However, participants' references to the impact of their identity on their thinking about Muslim young people and families was not restricted solely to their answer to this question.

Participants' use of the otherness in their own identity as they seek to understand Muslim patients was in relation their personal experiences, and, linked to this, in relation to their sense of how Muslim patients and families might perceive them. Most commonly, participants described an increased empathy with Muslim patients stemming from an understanding of what it meant to be other/belong to a minority. Some spoke of the personal impact of belonging to a minority, using those feelings to try to understand how a Muslim young person coming to CAMHS might feel. Those who had experienced prejudice as a result of their minority identity, from within and outside their community, found that this helped them understand the impact of prejudice on their Muslim patients.

Participants also spoke of both positive and negative transference due to their perceived difference, or perceived shared similarity. One participant felt that it made it easier for the patient and family to expect understanding of their own difference because they could hear that the clinician had a foreign accent. Others described the same effect of increased warmth towards and anticipation of empathy from the clinician due to perceived ethnic and cultural similarities.

If the clinician was perceived by the young person as Muslim (regardless of their actual faith identity; participants cited examples of this and attributed the assumption to their perceived race/culture), he/she sometimes encountered an expectation of empathy through a perception of shared faith. As noted by Mishne (in Moodley and Palmer 2014), a perceived matched therapeutic dyad could occasionally lead to awkwardness, with the young person unsure whether a shared faith might lead to judgement by the clinician. This was experienced in the transference, reflecting the way that the young person had

experienced judgement from family members or the community, especially in cases involving questions of sexuality. However, participants most often felt that a sense of shared experience of difference (even if the differences themselves were not shared) led to increased empathy and engagement in the therapeutic relationship.

This echoes another common theme in the data, the search for similarity, a safety in belonging, which perhaps lends itself to young people making assumptions about shared difference with their clinician. The search for similarity is perhaps not surprising, as it can be thought of as a core part of clinicians seeking to relate to, understand and encourage engagement from their patients, as well as a way in which Muslim patients, facing an uneven power scenario as described earlier, yet hoping to receive a level of understanding from contact with CAMHS, might find some relief in discovering some common ground with their clinician. The search for similarity points to the sense of safety in feeling understood, particularly in times of vulnerability, and is perhaps felt as preferable to the anxiety and danger of difference (described above). In reality, even if a clinician were Muslim, there would be no guarantee of their thinking the same way as the patient on issues relating to their mental health. This leads the researcher to wonder whether the search for similarity to facilitate empathy by both clinicians and patients might be an attempt to avoid the discomfort, fear and shame which is part of our response to difference (Davids 1998, Foster 2006, Morgan 2008, Cooper 2010, Lowe 2014).

Finding the balance between using our own experiences in order to find similarity/empathy, and letting ourselves acknowledge difference, is perhaps linked to participants' struggle to find the right closeness/distance in relation to their Muslim patients. It might also affect how clinicians position themselves in relation to parents, with whom the young person

might be in conflict, but for whom the clinician might have different things in common leading to a conflict of empathy.

Some participants discussed reflexivity as a valuable part of their thinking about difference, including in relation to Muslim patients. This was acknowledged by family therapist participants as being an integral component of systemic family therapy training and supervision, in which clinicians are expected to explore the therapeutic relationship in terms of the “social GGRRAAACCEEESSS” (Burnham, J. 2012). This approximate acronym encompasses many forms of difference: gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation and spirituality. However, this focus on complex individual identities in the therapeutic relationship has been criticised for neglecting the role of wider social and institutional discrimination (Krause in Ababio and Littlewood, 2019). Indeed, Malik (2006) argues that an awareness among clinicians of how their identity is formed by this wider picture is essential if they are to become aware of their internal biases and take an inter-subjective rather than a colonising approach to Muslim patients.

Some participants described the impact on them of particular referrals (due to issues of difference stirred up by the patient’s Muslim faith identity), and others described the impact of the research interview on them, as the questions caused them to examine their responses to this particular type of difference. They found the interviews thought-provoking and challenging, which links to self-reflexivity, and our capacity as clinicians to both appreciate and deny or avoid difference:

> “It’s very interesting doing this, actually, scary but interesting!” (3.7.5)

C: Tension around knowledge

While all participants mentioned the importance of understanding for engagement, there was a difference in emphasis about how this understanding might be acquired. Once difference is acknowledged, it can seem to create an unbridgeable gap. Participants expressed a wish for knowledge of the other to 'fill the gaps', in order to 'connect' with Muslim patients:

> "I feel like I know a little bit, but I feel I'm ignorant in other areas, and it's knowing who you can go to… to know more. Does that make sense? To fill the gaps." (4.7.1)

> ""How do I connect with you?"" (5.5.9)

What might be within the gap that is so anxiety-provoking could be the idea that the other is just too different to be understood, and therefore a threat, the dangerous 'other' unconsciously defended against by the internal racist (Davids 2011). This might explain the anxiety behind participants' sense that there is too much to know, and that even some knowledge could be dangerous.

Participants explored how to learn more about Muslim faith identity, including consideration of improved training, assumptions versus curiosity, and what kind of knowledge is desirable or attainable. A tension seems to emerge around whether knowledge might help or hinder us as we seek to understand and engage with Muslim patients and their families. Most participants thought that learned knowledge/training about Islam or Muslims would allay clinicians' anxiety and correct misconceptions, as advised by Inayat (2007 p.289); as such, knowledge is seen as an enabling factor in the relationship with patients. However,

some expressed a concern that learned knowledge/training about Islam or Muslims might shut down curiosity about the individual patient's experience; as such, formally-learned knowledge might become a limiting factor, whereas knowledge about the meaning of faith to the individual gained in the context of the therapeutic relationship is seen as more valuable. Participants wrestled with both ideas, sometimes privileging one over the other, sometimes recognising a need for both.

It is possible that the stifling of curiosity is linked more to the guilt and shame felt on becoming aware of one's inner racist (Davids 2011): "It is fear of such shame which freezes our curiosity about each other and prevents us from having ordinary conversations about the reality of the external and the internal divides caused by racism." (Morgan 2008) Absence of curiosity precipitated by the acquisition of knowledge about Islam/Muslims suggests that the underlying anxiety remains.

Alongside an acknowledgement of lack of knowledge and wish to know more, was a sense of anxiety about not knowing. Clinicians understandably fear appearing ignorant or 'getting it wrong' and thereby damaging empathy. Furthermore, there was a recognition that ignorance lies behind assumptions about the other, in this case Muslims. This was highlighted by participants' reflections on question 1, which encouraged participants to compare their thoughts and feelings on receiving the referral of a particular Muslim patient (or on first hearing about them) with their thoughts and feelings on first meeting that patient.

On the one hand, it was recognised that prejudice is based in ignorance and flawed assumptions about the other. On the other, it was also felt that more information is not in

itself enough to remedy attitudes underlying false assumptions. Although 6/8 participants voiced a need for change to CAMHS services backed by training and better information resources about Muslim faith identity and more generally in diversity and mental health, participants were also wary of this creating an artificial sense of security in ‘knowing’ about the other, at the expense of real curiosity about and openness to the patient’s individual experience. This seems to lead to the tautology that seeking some knowledge about Muslims might kill off the necessary (and less comfortable) awareness of ignorance that drives a wish to know more.

Linked to this, participants voiced a concern that the level of knowledge (of Islam/Muslims) they might acquire through a typical day/half-day of training would inevitably be inadequate, and therefore risked being “token” and therefore harmful, in that it could bypass further curiosity. This sense of some knowledge about Muslim faith identity being potentially harmful was quickly compounded by an exasperated sense that there is just too much to know - if we learn about Islam, then what about the faith and culture of others in the service user population? How could one possibly learn enough about every faith and culture? - as if the already large task becomes compounded by the burden of our ignorance of every kind of other, and the sheer magnitude of the task makes it overwhelming, impossible. It is almost as if ‘the other’ looms enormous and unknowable in our imagination. For example, one participant described an enormous diversity manual covering a wide range of faiths and cultures containing far too much information to absorb in a meaningful way. This could be an example of defensive splitting when faced with the anxiety of not knowing; after all we are highly trained professionals with serious responsibilities to the children and families with whom we work. While a wish to know might make the other feel less threatening, it might also make clinicians feels less

inadequate in the face of difference, the acquisition of knowledge functioning as a defence against not knowing.

None of the participants who expressed a wish for further training about Islam were suggesting that clinicians need to be experts in Islam in order to work with Muslims. However, they shared the sense that some knowledge is important, yet is no substitute for asking the individual patient about what being Muslim means to them. This is in accord with the opinions expressed in the Advisory Groups, where young people wanted clinicians to know something about their faith (which they felt could be helpful in practical ways), but also feared clinicians making assumptions about them. They wanted clinicians to ask them about the place of faith in their individual lives.

Assumptions, which are fundamentally unconscious and generalised in nature (even if they are thought of by the protagonist as specific 'knowledge'), seem to be particularly evident around visual difference. This perhaps echoes our primitive need to assess the risk of danger at first sight. It is therefore no surprise that anxiety is particularly stirred up by visible difference, such as skin colour and style of dress. The confluence of these two visible markers of difference perhaps creates a particularly emotive focus on the dress of Muslims, especially women (perhaps due to intersectionality with sexism). The wearing of *hijab* (headscarf) or *niqab* (covering of head and face except for eyes) is subject to many assumptions and prejudices; indeed during the period of this research it was subject to ridicule by the current Prime Minister (then Foreign Secretary).[35] Several participants reflected on the meaning they derived from Muslim patients' wish to wear or eschew the *hijab*, in addition to other 'surface' indications of difference such as name and skin colour.

---

[35] See Appendix 8: **Media Context**.

This might reflect the clinician's inner tension between how much is known and unknown, between what is on the surface (so available) and what is concealed and unknowable without intrusion.

This may link to participants' uneasiness about asking Muslim patients about the place of faith identity in their lives, a reluctance to intrude on private matters, also expressed as a fear of making the patient feel 'othered' (also see section A). Significantly, for one participant, the *niqab* seemed to embody the barrier to understanding the Muslim 'unknowable' other. Perhaps the observer's own fear and aggression is projected into the veiled Muslim woman, making the latter a withholding, even hostile, entity.

This is perhaps echoed in a theme within the data placing sensitivity in opposition to thinking/openness. Sensitivity is described as "a basic of psychoanalytic technique" (Davids 1998); without sensitivity to difference (based on openness), it is impossible to reach an appropriate theoretical formulation. However, when sensitivity is placed in the Muslim other, it often means that he/she is defensive of his/her faith identity and traditions, and closed to understanding other perspectives, such as that of the CAMHS clinician.

It is worth noting that the researcher wears *hijab*. None of the participants mentioned this during the interviews, even when discussing their feelings about Muslim women's dress. This could have been due to a conscious wish not to cause offence to the researcher, who was also a colleague. However, the researcher's sense was that she was not being thought of in the same 'bracket' as the *hijab*- or *niqab*-wearing women being discussed. This might be because the researcher was a professional colleague and/or possibly

because she was white; in both cases, she was perhaps perceived as less 'other' than the patients being discussed. This might reflect an unconscious attempt by participants to ignore the researcher's faith difference, perhaps because it provoked anxiety.

Most participants expressed dissatisfaction with the diversity training currently available, particularly in relation to working with Muslims, a point also made in the literature (Inayat 2007 p.292). This echoes the sense of knowledge being either too little (token, inadequate) or too much (overwhelmingly huge, complex impermeable), perhaps an expression of the split that occurs when faced with the anxiety of the unknown other. Even so, participants made several interesting and practical suggestions as to how to improve the current service provided to Muslims by CAMHS.[36]

One participant pointed out that the NICE guidelines on cultural competence training recommend that "this training should take into consideration the impact of the patient's *and the healthcare professional's* (my italics) racial identity status on the patient's depression." (CG28 2005[37] quoted in 1.1.2.3) The participant noted that the guidelines recognise the significance of difference in both the patient and the clinician, making clear the importance of the clinician being able to reflect on the impact of his/her own identity. The participant felt that this reflexivity should also apply to other areas of difference, not only race (also see B above for the importance of reflexivity), but also felt that current training does not prepare clinicians to fulfil either aspect of this recommendation.

---

[36] See Appendix 7: **Participants' suggestions**.

[37] This guidance has since been updated and replaced by NICE guideline NG134, published 25 June 2019, 1.1.8, but wording is the same.

Some participants' perception of Muslim faith as an obstacle to understanding and being understood, places faith in opposition to knowledge. This tension between the concepts of (Western) knowledge and (Muslim) faith perhaps reflects the post-Cartesian split between the head and heart, between intellect and spiritual belief:

> "Religion was often brought up as possibly being a barrier to the parents' understanding of the difficulties, and I don't think that it was, I don't think it was about that, I think it became a bit sort of blunt, maybe a bit like the headscarf, that interfered with people's perception of what was going on. I don't think religion was really that big a, was front and centre of why this family weren't getting on, but it certainly was a big part of what was talked about." (3.2.16)

The anxieties around knowing about the other, the sense that difference based on faith identity is a particular barrier to understanding, and the way in which this seems to make it difficult for clinicians to think (so they become 'unknowing'), all seem to point towards epistemic anxiety (Crehan and Rustin 2018) (also see A). Perhaps identity based on (Muslim) faith is perceived as a threat to the philosophies and assumptions upon which modern secular Western culture is based; the data certainly suggests that participants perceive it as at odds with the models on which CAMHS clinicians' trainings are based. As with other forms of anxiety, epistemic anxiety might be disowned by the subject and projected into others. One participant describes how Muslim families are thought of as unable to understand and adapt:

> "There's an idea they're just not going to get it, not going to be able to make the sort of emotional changes necessary to accommodate this [CAMHS recommendations] in their family." (3.2.21)

This also reflects the link between knowledge and power, specifically the hierarchy of knowledge in which the clinician's (medical/Western) 'knowledge' trumps the other's (faith/cultural/traditional) 'opinion.' Several participants expressed concern about the impact of

the way in which their training privileged Western knowledge/values over other forms of knowledge/values which may be held by service user families.

This recognition of the culturally-specific nature of Western mental health trainings (Krause 1998), and the potential impropriety of deploying them in a multi-cultural context (Morgan 2008), adds another layer of complexity:

> "I don't know what it says in the Quran about mental health, so I don't have enough knowledge. What I do know is we adopt a very Western model of understanding mental health here, so if I was working with families of different cultural backgrounds, who may be Muslim, you know… certain constructs of mental health would be seen very differently by different cultures." (4.4.3)

> "Mental health is so cultural […] I think it [working in diverse London] is a challenge, […] it's more than just put in the dime and understanding some symptoms." (8.6.6)

Concluding discussion

There is so much more that could be discussed from the rich and detailed material within the interview data, but space here is limited. It is striking how much more space is given in both data and discussion sections to super-ordinate theme C, which focuses on aspects of knowledge in relation to the other. This might reflect a sense that knowledge is a safer area to discuss, both for participants and for the researcher. Perhaps it is less painful to dwell on than the shame, guilt and fear stirred up by difference, as described in super-ordinate theme A. Perhaps concepts of learning and training can be more comfortably expressed than the feelings around personal difference and awareness of bias provoked

by the reflexivity of super-ordinate theme B. The researcher might also be guilty of a ‘retreat into knowing’ in her more fulsome coverage of super-ordinate theme C.

The extent to which clinicians made practical suggestions to improve engagement with Muslim patients might also indicate a degree of defensiveness, a refuge in knowing rather than being at a loss. CAMHS clinicians will be familiar with the pull to offer helpful solutions rather than feel helpless, facing the anxiety of what might seem like irreconcilable difference and our internal response to the other.

At a presentation and discussion of the research project, the researcher was again reminded what nerve-wracking territory the exploration of difference can be. One senior clinician, reluctant to be the first to speak and girding herself to make a comment, prefaced her remarks by exclaiming, “I’m gonna risk it!” This revealed what a dangerous area this can seem, when commenting on Muslim difference feels like exposing oneself to attack.

The data is peppered with evidence of the fear and anxiety stirred up by difference, in particular Muslim difference. It appears that the anxiety associated with acknowledging and thinking about difference, whether primarily internal in origin or external, is all the more acute when thinking about Muslims, due to the socio-political perception of Islam/Muslims. The traditional reluctance in psychological trainings to treat faith identity as anything other than a manifestation of culture at best, a psychopathology at worst, has perhaps made it more difficult to explore attitudes to faith identity, whether in clinical meetings or in the therapy room. Given the anxieties inherent in the current media discourse about Muslims, mentioned by every participant (Prevent, terrorism, Islamophobia), thinking about Muslim faith identity specifically might be even more difficult.

However, Jewish people might feel that their faith identity, which is also a minority identity in the UK and linked to assumptions about ethnicity and socio-political issues, is equally difficult to think about in a clinical context, in that negative stereotypes abound, and have done so for centuries. However, if there were a similar study of responses to Jewish faith identity, while it might suggest some tension or anxiety in response to difference, the 'other' might feel less alien, and less imbued with elements of fear.

Personal reflection

My Muslim identity has played an important part in driving my interest in this area of research. Just as the participants used their personal identification with a minority to relate to their Muslim patients, I have used my identification with a minority (as a Muslim) and a majority (as a white person) to explore the relationship between the two. I am aware that, while my interpretations of the data are those that make most sense to me, alternative interpretations might be made by a non-Muslim researcher, or by a non-psychotherapist researcher.

I also acknowledge the occasional tension inherent in my identity as a Muslim psychotherapist. For example, when reading David Morgan's paper[38], I felt absorbed by his description of inflammatory projective identification, yet mildly offended by his jocular comments about Muslim beliefs, which were intended to apply to terrorists, but I felt were making Muslim beliefs fair game for ridicule. Conversely, I have heard psychotherapy

[38] See **Literature Review**.

ridiculed in certain Muslim circles, and regarded as incompatible with Islam; in that context, I found myself feeling defensive of my psychotherapy training, and simultaneously anxious. Similarly, listening to a participant struggle with thinking about a patient's motivation for wearing the *hijab*, I felt conscious of my own headscarf, and how that might be perceived.

When I presented my research at the international Muslim Mental Health Conference (MMHC)[39], I was struck by the absence of a need to justify my focus on Muslims; it was widely felt to be a relevant and necessary area for research. This was in contrast to my earlier presentations to audiences containing few (if any) Muslims, when I felt I needed to persuade attendees of the relevance of thinking about this group. Furthermore, at the MMHC, I was in a minority as a white delegate (and presenter), and became acutely aware of my lack of real perspective on the impact of racism in the area of Muslim mental health.

Limitations

Sample size

Although this research project is based on interviews with a very small sample of CAMHS clinicians, the interview data does produce an array of complex and interesting themes. This study has focused on certain thematic areas reflecting both the degree of participants' responses and the interests of the researcher. As such, the specificities of individual participants' responses may not be generalisable to other CAMHS clinicians in other

[39] July 2020

services, but provide a snapshot of some CAMHS clinicians' thinking about Muslim faith identity, elements of which are reflected in the literature and so may well be more widely relevant.

Selection of participants

Participants were purposively rather than randomly selected, according to their previously declared interest in diversity-related issues. In this sense, they were 'self-selecting'; as they all identified with an area of difference, they had all thought deeply about issues of difference. This influenced the data, one of the main themes being the extent to which participants try to use minority aspects of their own identity to understand their Muslim patients. If the participants had been selected randomly, the data might have led to different super-ordinate themes.

Relationship with researcher

The researcher was fortunate to work in a supportive team who encouraged her research and gave their time and trust to be interviewed. It is significant that none of those approached refused. However, the researcher being a junior colleague of the participants might have influenced her interview style and the participants' responses.

Researcher's identity

The researcher's Muslim identity has had benefits and drawbacks.[40] For example, knowing that the researcher was Muslim, the participants might have subtly adjusted their responses to avoid causing perceived offence. However, being Muslim also gave the researcher a particular interest in and sensitivity towards the research area as a result of

[40] Also see **Subjectivity** section in Methodology.

being both inside (as a *hijab*-wearing Muslim woman) and outside (as a white middle-class professional) the sphere of anti-Muslim prejudice and projections. As such, her Muslim identity is part of the specificity of the research project rather than a limitation.

Research setting

The diverse metropolitan setting of the research is likely to be significant. Had the research taken place in a less diverse, more rural setting, the emphasis of the results might well have been different.

Advisory Groups

The presence of adults (teachers, parent) at the Advisory Groups might have had an impact on how the young people responded. For example, they might have toned down what they wanted to say, omitted aspects of their experience altogether, or made exaggerated responses to impress the adults.

Conclusion

In hindsight, perhaps the most challenging thing about this research project has been to unpick the impact of the researcher's subjectivity throughout - as far as this is possible. This is a particular challenge for a lone researcher, albeit with supervision and peer support. However, if it were not for this subjectivity, which brings with it a passion for the area studied and a commitment to seeing it through despite frequent persecutory anxiety, the project would not have happened at all.

The researcher found that fear - be it in mentions of danger, threat and risk, or couched in terms of anxiety and discomfort - is a pervasive theme in the interview data of all participants when talking about working with Muslim young people and families. While this is a common feature of our response to difference, as mentioned in the literature, it has a particular flavour due to the contemporary socio-political perceptions of Muslims and Islam. Participants all mentioned the contemporary political environment in various ways, referring to Prevent and concerns about radicalisation, terror attacks, Islamophobia and the impact of this on young people. It is to be expected that concerns of this nature infiltrate how Muslims are thought about in CAMHS, and it is therefore not surprising that it appears so clearly in the data. As mentioned in the scarce research published about working with Muslims young people in CAMHS (most recently Junor-Sheppard 2019, Fleming 2020), it is crucial that we acknowledge the influence on us as professionals of the social and political climate, recognise the dynamics at play in engagement with your people and families, lest our fear lead to us being insensitive and even discriminatory in our work.

Just as the impact of the external world on clinicians must be acknowledged, so must the impact of the researcher's identity (as a Muslim, as a trainee) on the interview encounter. The extent to which participants expressed such thoughtful and benign views about Muslims could reflect the fact that purposive sampling has its flaws, as previously mentioned. Similarly, it is possible that fear was such a prominent theme in the data partly due to projection of the researcher's own persecutory anxiety. For example, could this explain the relatively few examples of positive engagement with Muslims described by participants?

Just as particular aspects of the researcher's own identity inevitably influenced every stage of the project, every participant attempted to understand their Muslim patients by using their personal experience of minority aspects of their own identity. This perhaps made them particularly sensitive to prejudice, so able to acknowledge both their own assumptions about Muslims and the impact on their Muslim patients of the external socio-political climate. This search for similarity appeared more an attempt to find common ground than to smooth over disagreeable feelings provoked by difference, but it is possible that both are present.

In their responses, participants attempted to balance the generalities of their knowledge of Muslims, with the specificities of their experience of the individual Muslim patient. This perhaps mirrors the experience of clinicians with any patient, as they seek to apply a framework of knowledge acquired through training to the particularities of a case. However, given the majority of participants' professed (and lamented) lack of knowledge about Islam and Muslims, the framework clinicians take into the room can often consist of assumptions and unconscious bias, rather than knowledge. It is probable that this shapes

how we experience the individual Muslim patient, and, being largely unconscious, is harder for us to detect and challenge.

Despite the anxieties associated with thinking about Muslims, participants expressed a keen wish to know more, or rather to understand better. They agreed that training should be improved, but struggled to decide whether more knowledge about Muslims would be helpful or might stifle curiosity. This might be evidence of our difficulty in holding the tensions of difference in mind. However, participants agreed on the importance of genuine curiosity about the complexity of the individual patient's experience:

> "I think the interface between a person, their experiences, their cultural background, their family experiences and faith is enormous and complex and I think it's far more interesting, it's far better to enquire into that complexity as opposed to making assumptions about what it's like" (1.6.1)

A core part of the learning from this research is that it is impossible to escape our subjectivity, be it as a researcher or as a clinician, both roles in which we like to imagine we can be objective or neutral. Like it or not, we carry with us the influence of our upbringing, our professional training, our socio-political context, and the histories associated with our identities. The current debates around racism and the Black Lives Matter movement underline this. What this means for CAMHS engagement with Muslims is significant, and concerning. The findings of this project are that significant anxieties are stirred up in CAMHS professionals when thinking about their work with Muslims. There is an awareness of not knowing enough, and an acknowledgement that we cannot study our way out of this, because curiosity and personal reflexivity are crucial. It is sobering to reflect on the limited potential for meaningful engagement, when the anxieties of clinicians

are met by the fear of many young Muslims that their faith identity will not be properly understood by professionals. What can we do about this?

Firstly, there is clearly a need for further training in regard to working with Muslims, which should include training in reflexive practice to help us acknowledge our own assumptions and prejudice, as well as ways in which aspects of our identities might help us to be more open to difference, together with examples of how not doing so can lead us to marginalise Muslim young people and families.

Secondly, specific consideration of how we work with Muslims should be built into ongoing, regular reflexive practice spaces/sessions in CAMHS clinics. As with the experience of the lone researcher, in complex work it can be very difficult to identify when one's own subjectivity is leading to splitting and projection, without the help of other minds. These sessions are often best when facilitated by an outside consultant (as with Frank Lowe's Thinking Space).

Thirdly, more research is needed into whether and how young Muslims are engaging with CAMHS. For example, what are their perceptions and experience of CAMHS? How can CAMHS better respond to the current mental health crisis recently identified by Muslim Youth Helpline?[41] Is this dramatically increased need reflected in more referrals to CAMHS? If not, why not? What can we learn from working with Muslim community organisations and imams? There is currently no quantitative data on how many Muslims are referred to CAMHS, which makes it impossible to measure not only referrals, but data on treatment pathways and outcomes. This failure to acknowledge the significance of faith

[41] The helpline has seen a 313% rise in calls since March 2020, with many young people struggling with suicidal thoughts, depression, anxiety, panic attacks, and religious guilt.

identity is shockingly negligent, given the level of need, and perhaps says more about our dismissal of faith as an important part of identity than about anti-Muslim prejudice. Either way, we do need to know the figures in order to know to what extent we might be failing to provide support for young Muslims. The collection of such data is not without its challenges. For example, Muslim families might be wary of being asked about their faith on referral forms, due to a history of prejudice and Prevent narratives. However, without this, we cannot know whether the research project's objective - that reflective processes within CAMHS will lead to enhanced engagement with Muslim families and young people - has been reached.

This research has explored the pressing questions of whether attitudes towards Muslims require particular attention within CAMHS, and whether there is a difficulty with thinking about faith identity in general, perhaps particularly for psychotherapists. The percentage of ACP members describing themselves as having no religion is more than twice the national average. This aspect of child and adolescent psychotherapists' identity is likely to have an impact on how they think about the faith identity of their patients. It might not occur to the non-religious majority that faith identity deserves further thought, other than as a facet of cultural difference; could this be akin to a white majority espousing 'colour-blindness' rather than acknowledging their privilege? This is a shame because psychotherapy training gives us the tools of working in the transference and recognising countertransference, and both these are likely to be compromised if we do not acknowledge our own assumptions and prejudices about religious belief, and particularly about Muslims. If religion is the 'other' of psychoanalysis (Dobbs in Black 2006), perhaps only greater diversity within psychotherapy professions will enable us to address this fully, by challenging thinking and provoking debate about an under-researched area.

Acknowledgements

I have been fortunate to work in a supportive CAMHS team who have encouraged my research, with committed colleagues who have generously given their time and trust to be interviewed. Heartfelt thanks to those who encouraged me to develop the research idea and its implementation, especially my service supervisor Kate Robertson, research supervisor Margaret Lush, research groups led by Jocelyn Catty and Brinley Yare, my tutor Ilana Inspector, and the Tavistock's Difference & Diversity workshop facilitated by Krisna Catsaras and Geraldine Crehan. Further thanks are due to Rabia Malik, for encouraging the tentative seed of an idea that grew into this project. I also appreciate my Trust's commitment to supporting my research.

References

Ababio, B. and Littlewood, R. (2019) *Intercultural therapy : challenges, insights and developments*. 1st edn. Routledge. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=cat04005a&AN=tavi.43309&authtype=shib&site=eds-live (Accessed: 7.8.20)

Abu Raiya, H. and Pargament, K. (2010) “Religiously Integrated Psychotherapy With Muslim Clients: From Research to Practice.” in Professional Psychology: Research and Practice Vol 41 (2), American Psychological Association

Aggarwal, N. K. (2011) ‘Medical orientalism and the War on Terror: Depictions of Arabs and Muslims in the psychodynamic literature post-9/11’, Journal of Muslim Mental Health, 6(1), pp. 4–20. doi: 10.3998/jmmh.10381607.0006.102

Akhtar, S. (2014) ‘The Mental Pain of Minorities’, British Journal of Psychotherapy, 30(2), pp. 136–153. doi: 10.1111/bjp.12081

Alayarian, A. (2017) “Children of Refugees. Torture, Human Rights, and Psychological Consequences” Karnac, London

All Party Parliamentary Group on British Muslims (2018) “Islamophobia Defined: report on the inquiry into a working definition of Islamophobia/anti-Muslim hatred” Available at: https://appgbritishmuslims.org/publications (Accessed 27.8.20)

Association of Child Psychotherapists (ACP) (2020) report to the AGM on the initial findings from the diversity and equality monitoring form, July 2020

Bell, D. and Tavistock Clinic (1999) Psychoanalysis and Culture : A Kleinian Perspective. London: Routledge (Tavistock Clinic Series). Available at: http://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=367131&authtype=shib&site=eds-live (Accessed: 4.8.20)

Beshara, R. K., (2019) “Decolonial Psychoanalysis. Towards Critical Islamophobia Studies” Routledge, Abingdon

Black, D. M. (2006) *Psychoanalysis and religion in the 21st century. Competitors or collaborators?* (The new library of psychoanalysis). Available at: http://search.ebscohost.com/login.aspx?direct=true&db=cat04005a&AN=tavi.11869&authtype=shib&site=eds-live (Accessed: 15.8.20)

Blackwell, D. (2005) Counselling and psychotherapy with refugees. Jessica Kingsley. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=cat04005a&AN=tavi.11147&authtype=shib&site=eds-live (Accessed: 2.8.20)

Burnham, J. (2012). Developments in Social GRRRAAACCEEESSS: visible-invisible and voiced-unvoiced. In Krause, I.-B. (Ed.) *Culture and Reflexivity in Systemic Psychotherapy: Multiple perspectives*. (pp. 139-160) London: Karnac

Carter, D. M. (2017) ‘(De)constructing difference: a qualitative review of the “othering” of UK Muslim communities, extremism, soft harms, and Twitter analytics’, *Behavioral Sciences of Terrorism & Political Aggression*, 9(1), pp. 21–36. doi: 10.1080/19434472.2016.1236142

Clarke, S. (2003) *Social theory, psychoanalysis, and racism*. Palgrave Macmillan. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=cat04005a&AN=tavi.42119&authtype=shib&site=eds-live (Accessed: 12.8.20).

Cooper, A. (2010) “Institutional Racism; can psychotherapy change?” in *British Journal of Psychotherapy,* 26 (4)

Crehan, G. and Rustin, M. (2018) “Anxieties about knowing in the context of work discussion: questions of difference” *in* Infant Observation 21(2):1-16

Dabbagh, N. *et al.* (2012) ‘Muslim adolescent mental health in the UK: An exploratory cross-sectional school survey’, *International Journal of Culture and Mental Health*, 5(3), pp. 202–218. doi: 10.1080/17542863.2011.594246

Dalal, F. (2002) “Race, Colour and the Process of Radicalization: New Perspectives from Group Analysis, Psychoanalysis and Sociology” Brunner-Routledge, Hove

Dalal, F. (2008) “Against the Celebration of Diversity” in *British Journal of Psychotherapy,* 24(1)

Daly, J. (2016) ‘Thinking About Internal Prejudice And Anti-Oppressive Practice In Child Safeguarding Social Work With Irish Travellers In The UK’, *Journal of Social Work Practice*, 30(4), pp. 335–347. doi: 10.1080/02650533.2015.1116438

Davids, M. F. (1998) ‘Reaching Across Boundaries of Culture and Class: Widening the Scope of Psychotherapy edited by Rose Marie Pérez Foster, Michael Moskowitz and Rafael Art. Javier. Published by Jason Aronson Inc., London and Northvale, New Jersey, 1996; 275 pages’, *British Journal of Psychotherapy*, 15(2), pp. 258–262. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=pph&AN=bjp.015.0258a&authtype=shib&site=eds-live (Accessed: 4.8.20).

Davids, M. F. (2002) ‘September 11th 2001: Some Thoughts on Racism and Religious Prejudice as an Obstacle’, British Journal of Psychotherapy, 18(3), pp. 361–366. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=pph&AN=bjp.018.0361a&authtype=shib&site=eds-live (Accessed: 7.8.20)

Davids, M. F. (2006) “Internal Racism, Anxiety and the World Outside: Islamophobia Post-9/11” in Organizational and Social Dynamics, 6 (1)

Davids, M. F. (2009) ‘The Impact of Islamophobia’, Psychoanalysis and History, 11(2), pp. 175–191. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=pph&AN=pah.011.0175a&authtype=shib&site=eds-live (Accessed: 7.8.20)

Davids, M. F. (2011) “Internal racism: A psychoanalytic approach to race and difference” Palgrave Macmillan, Basingstoke

Edwards, J. (1998) “Holding the Child in Mind: Work with Parents and Families in a Consultation Service”, Journal of Child Psychotherapy 24 (1)

Elkassem, S., Csiernik, R., Mantulak, A., Kayssi, G., Hussain, Y., Lambert, K., Bailey, P., Choudhary, A. (2018) “Growing Up Muslim: The Impact of Islamophobia on Children in a Canadian Community”, Journal of Muslim Mental Health, 12(1)
DOI: http://dx.doi.org/10.3998/jmmh.10381607.0012.101

Fanon, F. (2008) Black Skin, White Masks. (C. L. Markmann, Trans.) London: Pluto Press

Fleming, A. (2020) “Child psychotherapists’ fantasies about working with ‘cultural difference’”, Journal of Child Psychotherapy, 46 (2)

Foster, A. and London Centre for Psychotherapy (2006) *Difference : An Avoided Topic in Practice*. London: Routledge (Practice of Psychotherapy Series). Available at: http://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=367086&authtype=shib&site=eds-live (Accessed: 4.8.20)

Freud, S. (1907) *Obsessive Actions and Religious Practices*. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=pph&AN=se.009.0115a&authtype=shib&site=eds-live (Accessed: 15.8.20)

Freud, S. (1927) *The Future of an Illusion*. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=pph&AN=se.021.0001a&authtype=shib&site=eds-live (Accessed: 15.8.20).

Hill Collins, P. and Bilge, S. (2016) *Intersectionality*. Chicester: Polity (Key Concepts). Available at: http://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=1362329&authtype=shib&site=eds-live (Accessed: 7.8.20).

Hollway, W. and Jefferson, T. (2013) *Doing Qualitative Research Differently : A Psychosocial Approach*. London: SAGE Publications Ltd. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=775817&authtype=shib&site=eds-live (Accessed: 21.8.20)

Inayat, Q. (2005) “Psychotherapy in a multiethnic society” Psychotherapist May 2005

Inayat, Q. (2007) ‘Islamophobia and the therapeutic dialogue: Some reflections’, Counselling Psychology Quarterly, 20(3), pp. 287–293. doi: 10.1080/09515070701567804

Junor-Sheppard, S. (2019) “The ‘hostile environment’ and the therapeutic journey of an adolescent girl” Journal of Child Psychotherapy 45 (3)

Kam, S.-E. and Midgley, N. (2006) “Exploring Clinical Judgement: How Do Child and Adolescent Mental Health Professionals Decide Whether a Young Person Needs Individual Psychotherapy?” in *Clinical Child Psychology and Psychiatry* 2006 11:27

Kareem, J. and Littlewood, R. (Eds) (1992) “Intercultural Therapy: themes, interpretations and practice”, Blackwell Scientific Publications, Oxford

Keval, N. (2018) *Racist states of mind : understanding the perversion of curiosity and concern*. Routledge. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=cat04005a&AN=tavi.43184&authtype=shib&site=eds-live (Accessed: 6.8.20)

Kizilhan, J. I. (2014) ‘Religious and cultural aspects of psychotherapy in Muslim patients from tradition-oriented societies’, *International Review of Psychiatry*, 26(3), pp. 335–343. doi: 10.3109/09540261.2014.899203

Klein, M. (1946) Notes on some Schizoid Mechanisms, in *International Journal of Psycho-Analysis* Vol 27 pp99-110

Krause, I.-B. (1998) *Therapy across culture*. Sage.
Available at: http://search.ebscohost.com/login.aspx?
direct=true&db=cat04005a&AN=tavi.6035&authtype=shib&site=eds-live (Accessed:
3.8.20)

Lowe, F. (2014) *Thinking Space : Promoting Thinking About Race, Culture and Diversity in Psychotherapy and Beyond*. London: Routledge (Tavistock Clinic Series). Available at:
http://search.ebscohost.com/login.aspx?
direct=true&db=nlebk&AN=648135&authtype=shib&site=eds-live (Accessed: 7.8.20)

Malik, R. (2006) “British or Muslim: Creating a Context for Dialogue” in Youth and Policy, No.92

Malik, R., Shaikh, A. and Suleyman, M. (2007). “Providing Faith and Culturally Sensitive Support Services to Young British Muslims”, National Youth Agency, Leicester

Malik, R., Fateh, R. and Haque, R. (2009) ‘The Marlborough Cultural Therapy Centre’, in Fernando, S. and Keating, F. (eds) Mental health in a multi-ethnic society: A multidisciplinary handbook., 2nd ed. New York, NY: Routledge/Taylor & Francis Group, pp. 174–186. Available at: http://search.ebscohost.com/login.aspx?
direct=true&db=psyh&AN=2008-07685-013&authtype=shib&site=eds-live (Accessed:
3.8.20)

Meran, S. and Mason, O. (2019) “Muslim Faith Leaders: De Facto Mental Health Providers and Key Allies in Dismantling Barriers Preventing British Muslims from Accessing Mental Health Care”, Journal of Muslim Mental Health, 13(2)
DOI: http://dx.doi.org/10.3998/jmmh.10381607.0013.202

Mercieca, D. and Jones, P. (2018) ‘Use of a reference group in researching children’s views of psychotherapy in Malta’, *Journal of Child Psychotherapy*, 44(2), pp. 243–262. doi: 10.1080/0075417X.2018.1481130

Moodley, R. and Palmer, S. (2014) Race, Culture and Psychotherapy : Critical Perspectives in Multicultural Practice. Hoboken: Routledge. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=778559&authtype=shib&site=eds-live (Accessed: 6.8.20)

Morgan, D. (2019) *The Unconscious in Social and Political Life*. Bicester: Phoenix Publishing House (The Political Mind). Available at: http://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=2460983&authtype=shib&site=eds-live (Accessed: 16.8.20)

Morgan, H. (2008) “Issues of ‘race’ in psychoanalytic psychotherapy: whose problem is it anyway?” in *British Journal of Psychotherapy* Vol 24 (1)

Morgan-Valentine, M. and Menia, J. (2018) Equality and Diversity Demographic Report, West London NHS Trust

Murad, A. H. (2020) “Travelling Home. Essays on Islam in Europe” The Quilliam Press, Cambridge

Muslim Youth Helpline blog (September 30th 2020), myh.org.uk (Accessed: 14.3.21)

Onions, C. (2019) McPin report 2019: Report for ACP Scientific Development Committee Meeting 8.2.19

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Matitani, A., Miller, A. and Nadirshaw, Z. (2000) “Clinical Psychology, ‘Race’ and Culture: a training manual”, The British Psychological Society, Leicester

Pérez Foster, R., Moskowitz, M. and Javier, R. A. (1996) *Reaching across boundaries of culture and class: Widening the scope of psychotherapy*. Edited by R. Pérez Foster, M. Moskowitz, and R. A. Javier. Lanham, MD: Jason Aronson. Available at: http://search.ebscohost.com/login.aspx?

direct=true&db=psyh&AN=1996-98395-000&authtype=shib&site=eds-live (Accessed: 4.8.20)

National Institute for Health and Care Excellence (NICE) (2005), Depression in children and young people: identification and management. Clinical guideline CG28. Published date: 26 September 2005

Pilkington, A., Msetfi, R. M. and Watson, R. (2012) 'Factors affecting intention to access psychological services amongst British Muslims of South Asian origin', *Mental Health, Religion & Culture*, 15(1), pp. 1–22. doi: 10.1080/13674676.2010.545947

Rizq, R. (2017) "'Pre-crime', Prevent and practices of exceptionalism: psychotherapy and the new norm in the NHS." in Psychodynamic Practice (Oct 2017) Vol 23 (4)

Rothman, A. and Coyle, A. (2020) 'Conceptualizing an Islamic psychotherapy: A grounded theory study', Spirituality in Clinical Practice. doi: 10.1037/scp0000219

Rustin, M. (1991) *The good society and the inner world. Psychoanalysis, politics and culture*. 1st ed. Verso. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=cat04005a&AN=tavi.15326&authtype=shib&site=eds-live (Accessed: 14.8.20)

Said, E. W. (1997) "Covering Islam: How the Media and the Experts Determine How We See the Rest of the World" (revised edition), Vintage Books, Random House, New York

Smith, J. A., Flowers, P. and Larkin, M. H. (2009) *Interpretative phenomenological analysis: Theory, method and research*. SAGE. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=cat04005a&AN=tavi.21717&authtype=shib&site=eds-live (Accessed: 21.8.20)

Stanley, T. and Guru, S. (2015) "Childhood Radicalisation Risk: An Emerging Practice Issue", Practice, 27:5, 353-366, DOI: 10.1080/09503153.2015.1053858

Stevenson, J., Demack, S., Stiell, B., Abdi M., Clarkson L., Ghaffar F., and Hassan S. (2017) “The Social Mobility Challenges Faced by Young Muslims”, Social Mobility Commission and Sheffield Hallam University

Suleiman, Y. Ed. (2015) “The Role of Self-Esteem in Understanding Anti-Semitic and Islamophobic Prejudice” in “Muslims in the UK and Europe I” Centre of Islamic Studies, University of Cambridge

Thomas, L. (2013) ‘Empires of mind: Colonial history and its implications for counselling and psychotherapy’, *Psychodynamic Practice*, 19(2), pp. 117–128. doi: 10.1080/14753634.2013.778484

Tommis-Cardo, G. (2019) “The Mental Health Needs of British Muslims”. www.academia.edu/37447370/The_Mental_Health_Needs_of_the_British_Muslim

Weatherhead, S. and Daiches, A. (2010) “Muslim views on mental health and psychotherapy.” in Psychology and Psychotherapy: Theory, Research and Practice, 83 (1)

Weatherhead, S. and Daiches, A. (2015) “Key issues to consider in therapy with Muslim families” in Journal of Religion and Health Vol 54 (6)

“Student or suspect?” (2015) *Therapy Today*, 26(4), pp. 4–5. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=108982389&authtype=shib&site=eds-live (Accessed: 16.8.20)

Appendices:

- Appendix 1: Trust ethical approval emails (including approval of change to study).. 117
- Appendix 2: Public facing documents …….. 119
- Appendix 3: Advisory Group report summary ……. 122
- Appendix 4: Interview Schedule …… 125
- Appendix 5: Sample of data analysis process ……. 126
- Appendix 6: Thematic tables …….. 132
- Appendix 7: Participants' suggestions …….. 146
- Appendix 8: Media Context …… 147

Appendix 1: **Trust ethical approval**

From: Maria Tsappis
Sent: 10 July 2018 16:03
To: Rachel Abedi
Subject: 237291 - Authorisation to proceed in West London Mental Health Trust
Importance: High

Dear Ms Abedi

Study Title: How do child and adolescent psychotherapists respond to the faith identity of young muslims in a London CAMHS clinical context? An interpretative phenomenological analysis
IRAS reference: 237291

I am pleased to confirm that the above study has now received authorisation to proceed in West London Mental Health Trust.

We would like to take this opportunity to wish you every success with your project.

Yours sincerely

Maria

Maria Tsappis
Research Co-ordinator
(Mon, Tues, Thurs pm)
Tel: 020 8354 8734
Fax: 020 8354 8733
Maria.Tsappis@wlmht.nhs.uk

West London Mental Health NHS Trust
Research & Development | Ground Floor | Wing C
1 Armstrong Way | Southall | Middlesex | UB2 4SD

From: Maria Tsappis
Sent: 19 November 2018 17:15
To: Rachel Abedi
Cc: Rubina Choudhry
Subject: 237291 - Confirmation of receipt of change to study at West London site
Importance: High

Dear Rachel

Re: Clinicians' responses to Muslim patients in CAMHS
IRAS Ref: 237291
REC Ref: 18/HRA/2002
Amendment: Change to participant population
Amendment Date: 17 October 2018
Site Name: West London NHS Trust

Please accept this email as R&D acknowledgement of the change to your study.

Best wishes

Maria

Maria Tsappis
Research Coordinator
Tel: 020 8354 8734

Research & Development
West London NHS Trust
Trust Headquarters
Ground Floor
1 Armstrong Way
Southall
Middx UB2 4SD

Appendix 2: **Public facing documents**

Email to potential participants:

Email to potential research participants:

[Subject] Invitation to research interview

Dear …

How do clinicians respond to the faith identity of young Muslims is a London CAMHS clinical context? IRAS Project ID 237291

As you may know, I have been preparing the above project for my ProfDoc for some time, and am now ready to start interviews.

I would like to invite you for an interview to explore your experience of working with Muslim young people and their families in CAMHS. The interview will last about one hour and will take place here at CAMHS during working hours. If you are happy to participate, I will send you the questions in advance. Please also see the attached information sheet.

I envisage that most of the interviews will take place during the week beginning 18th February 2019 (half term week). If this is not convenient for you, but you would still like to participate, I will try to offer an alternative time.

I look forward to hearing from you.

Best wishes,

Rachel

Rachel Abedi
Child & Adolescent Psychotherapist in Doctoral Training
Hammersmith & Fulham CAMHS
020 84831979
(Mon, Tue, Thu, Fri pm)

Consent form:

The Tavistock and Portman NHS NHS Foundation Trust | West London Mental Health NHS NHS Trust

Informed consent form
IRAS Project ID 237291

ProfDoc research project:

How do clinicians respond to the faith identity of young Muslims in a London CAMHS clinical context?

Investigator: Rachel Abedi

1. I confirm that I have read the information sheet which provides details of the nature of the research and how I will be asked to participate. I have had the opportunity to consider this information and ask any questions that I might have.

2. I understand that my interview will be recorded, transcribed and analyzed for the purposes of the study.

3. I understand that my agreement to participate is voluntary and that I am free to withdraw it at any time without giving a reason, up to two weeks after my interview.

4. I understand that any identifiable information linked to my participation in this project will be anonymized and held securely by the researcher. I will not be identified in any resulting publications, papers or presentations produced for the professional doctorate.

5. I understand that, due to the limited pool of potential research participants (Hammersmith & Fulham CAMHS clinicians), other participants might be aware of my participation.

5. I confirm that I have understood what is required of me and consent to participate in this study.

Participating clinician's name (BLOCK CAPITALS):

Signature:

Date:

Investigator's name (BLOCK CAPITALS):

Signature:

Date:

Thank you for agreeing to take part in this study. Your contribution is very much appreciated.

Participant information sheet:

The Tavistock and Portman NHS West London Mental Health NHS
NHS Foundation Trust NHS Trust

Participant Information Sheet
IRAS Project ID 237291

How do clinicians respond to the faith identity of young Muslims in a London CAMHS clinical context?

Thank you for expressing an interest in participating in the research study, which will form part of my professional doctorate. The aim of the research is to learn from clinicians working in a CAMHS clinic (Hammersmith & Fulham) about the significance of Muslim faith identity in their recent work with children, young people and families.

What is the purpose of this study?

The purpose of this research is to understand more about how we as clinicians respond to Muslim patients, in order to identify how this might be relevant to our work with these young people and their families. For example, might it affect therapist-patient engagement, the dynamics of our relationship, our clinical formulations, and so on?

What will participating in this study involve?

If you agree to participate, I will arrange a convenient time to interview you about your experience of working with Muslim families and young people in CAMHS in the past two years. Interviews will be in a semi-structured format, will last about one hour, and will take place between January and March 2019. I will give you a copy of the interview questions ahead of the interview to give you time to consider your responses. The interviews will be recorded and transcribed. If possible, I will request a 'time 2' interview with some participants, depending on availability, to explore any further thinking relating to the research question.

A transcript of your interview will be produced from the recording. Your name will be kept separately from the transcript, and any identifying details removed from the transcript. Any extracts quoted from your interview will be entirely anonymous.

The data generated in the course of the research will be retained in accordance with the University of Essex Data Protection Policy.

Participation in the study is entirely voluntary. However, your contribution would be invaluable. If you do agree to take part, you can change your mind without giving me a reason up to two weeks after the initial interview.

What will happen to the results of the study?

The results of this study will be used in my thesis for the professional doctorate, academic papers and presentations.

If you have any questions about the study, please do not hesitate to ask. My contact details are:

Rachel Abedi, Trainee Child & Adolescent Psychotherapist, Hammersmith & Fulham CAMHS
Tel: 020 84831979 Email: Rachel.Abedi@wlmht.nhs.uk

This research has received formal approval from TREC. If you have any queries regarding the conduct of this research, please contact: Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock & Portman NHS Trust, email: academicquality@tavi-port.nhs.uk

Appendix 3: **Advisory Group report summary**

Questions:

1. Is it sometimes important that professionals (teachers, GP, CAMHS etc) know that you are Muslim? Please give your reasons.
2. Is it important that professionals (teachers, GP, CAMHS etc) know something about your faith/culture? Like what?
3. Have you ever felt uncomfortable or misunderstood because of your faith/culture? Please give examples.
4. Do you think that being Muslim, whatever that means to you, makes any difference to your emotional health? Can you say why?

Former service user

Setting: CAMHS

Group composition: 1 female (as the other confirmed invitee DNA), aged 19

Views: non-Muslims have restrictive, de-humanising, 1-dimensional perceptions of Muslims (dynamics of spirituality, culture, history, politics and economy not understood); hopes to be perceived as a “normal person”; unspoken barrier results in feeling she can’t open up as much; ‘othering’ is uncomfortable (e.g. assumptions made by non-Muslims due to her wearing *hijab* create distance); problem is categorisation without understanding (e.g. people confuse ethnicity with Islam); importance of recognising the cultural history of psychological categories; include question about religiosity (not religion) on referral forms; clinicians should ask more directly about patient’s and parents’ faith identity, communicate more to reduce patients’ anxiety; harness faith as a positive force, not just a problem (e.g. clinician could create a path to communication about faith between parents and children); but see yp as individual, with separation between faith and treatment depending on patient; Muslim clinician might present a problem for Muslim patients due to fear of judgement.

Advisory Group 1

Setting: secondary school in London.

Group composition: 31 young people aged 13 - 18, mixed. Teacher present.

Views: can be helpful for professionals to know that yp is Muslim (e.g. for medical reasons, and to understand importance of aspects of religious practice), but fear of being categorised/discriminated against; concern about being judged rather than understood (e.g. when fasting); concern about misinformation about Islam/Muslims in wider society; emotional impact of discrimination and anti-Muslim hate crime; professionals' ignorance about basics of Islam causes discomfort; intergenerational issues (e.g. parents might not understand pressures on young Muslims, can be hard to ask for help when parents tell you to "Trust in Allah"); conversely, faith can be a source of emotional strength and support; British Muslim identity and struggle to belong: can be harder to connect with non-Muslim peers, and simultaneously harder to connect with parents (e.g. being labelled both 'too religious' and 'not religious enough'); stigma of mental health issues in some Muslim families; issues for mixed heritage young people; dislike of term 'liberal' which feels judgemental; Prevent seen as focussing on Muslims, so contributing to a xenophobic, Islamophobic rhetoric.

Advisory Group 2

Setting: secondary school in London.

Group composition: 5 young people aged 15 - 16, all female. Teacher present.

Views: can be helpful for professionals to know that yp is Muslim (e.g. for medical reasons, and to understand importance of aspects of religious practice) but knowledge of other faiths is equally important; needs associated with Muslim identity should be considered, but being Muslim should not lead to discrimination; intergenerational issues: parents might

not acknowledge mental health problems because not physical; feel misunderstood due to misinformation/Islamophobia in the media; unsettling impact of daily micro-aggressions and open prejudice in public (e.g. hostile stares at *hijab*-wearing girls on bus); benefit of faith to deal with stress (e.g. saying prayers); wrong assumptions can be made by Muslims and non-Muslims (e.g. about yp's political or faith-related opinions); wish for professionals to as sincere questions before forming an opinion.

Advisory Group 3

Setting: Muslim community centre in London.

Group composition: 18 young people aged 13 - 19, mixed. Youth leader and one parent present.

Views: can be helpful for professionals to know that yp is Muslim (e.g. for medical reasons, and to understand importance of aspects of religious practice), but it depends on reason for contact and how close yp feels to them; some fear that professional might judge the yp knowing they are Muslim; yp appreciate it when professionals understand something about their religious practice; feel uncomfortable when professionals confuse Muslim faith and cultural issues; proud of faith identity, yet afraid to state some opinions due to fear of judgement; feel particularly judged/misunderstood concerning views on sexual relationships, marriage; fear of deportation is significant for some; negative impact on emotional health of feeling continually judged and misunderstood; comfort and peace in turning to faith for emotional support (e.g. reading Qur'an); yet anxiety can be raised by pressure from parents about observing religious practice (e.g. prayers, memorising Qur'an, and religious messages of judgement and hellfire).

Appendix 4: **Interview schedule**

1. What were your initial thoughts and feelings when you became aware of the Muslim faith of a young person/family? What were your first impressions on meeting the young person/family?

2. Think of 1 - 3 Muslim young people/families you have worked with int he past 2 years. Could you say something about how you felt their faith identity was relevant (or not)? Could you say something about how you felt their faith identity influenced clinical decision-making (or not)?

3. Can you say something about how you think Muslim young people/families might perceive you as a non-Muslim or in terms of other forms of difference?

4. *The researcher will give a brief description of her recent workshops with Muslim adolescents.* What are your thoughts about how young Muslims might view the relevance of their faith identity to their mental health?

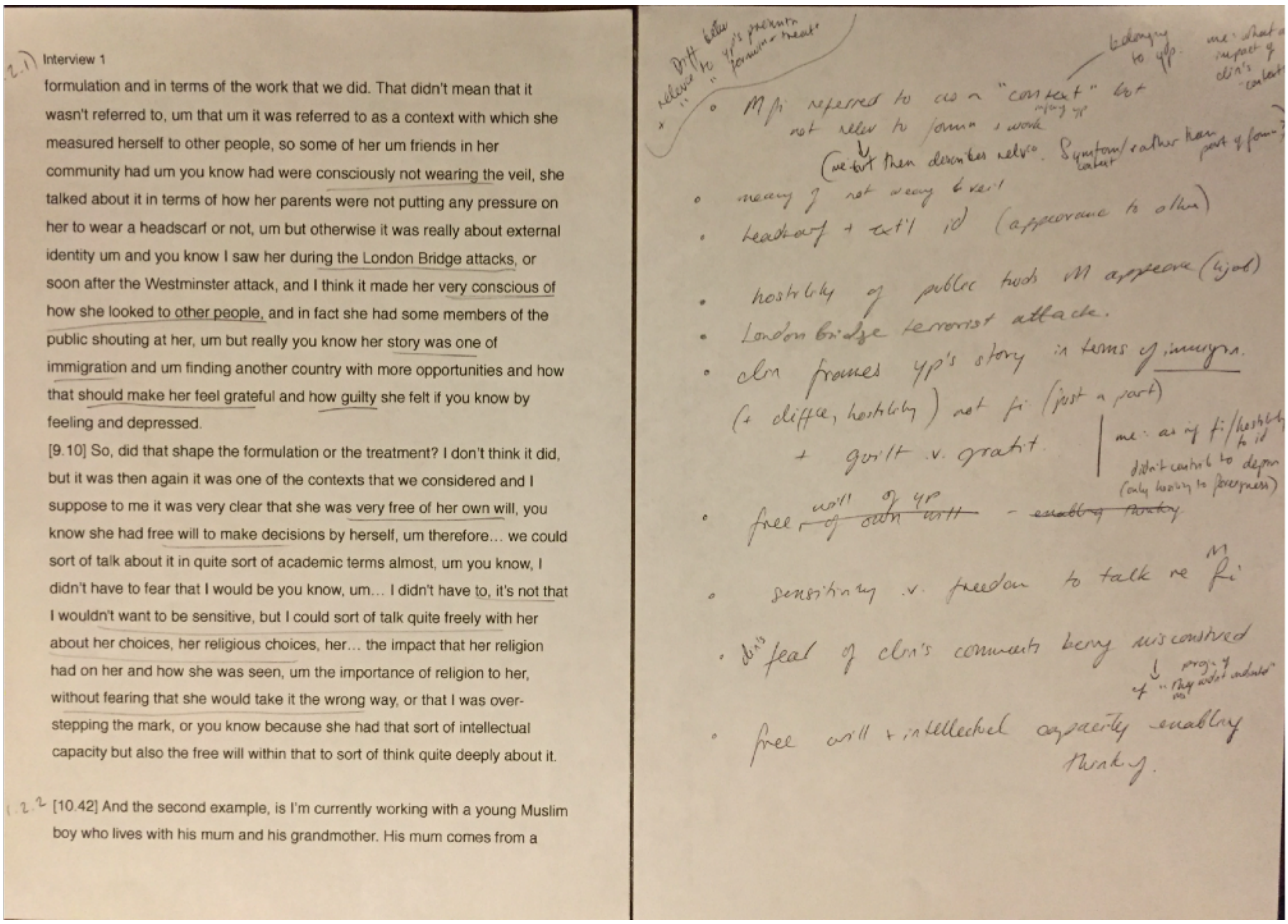
5. Research studies have suggested that there might be something in the system that gets in the way of relating between Muslim young people/families and CAMHS. Is that your experience? If yes, what are your thoughts about what gets in the way and how? What is your perception of the beliefs in the system regarding Muslims?

6. In my workshops with young Muslims, there was a debate about whether or not it is necessary for professionals to have some knowledge of Islam when working with Muslim young people/families. What do you think about about this?

Appendix 5: **Sample of data analysis process**

To show how the researcher approached the task of coding, creation of themes and super-ordinate themes, an example is given from the transcript of interview 1. Two codes are followed here, relating to the theme **Fear (of being misunderstood)(of asking), anxiety, tension, defensive, safe/unsafe, uncomfortable**.

1. Transcript of interview 1, question 2, paragraph 1, showing code "fear of being misunderstood" in my notes:



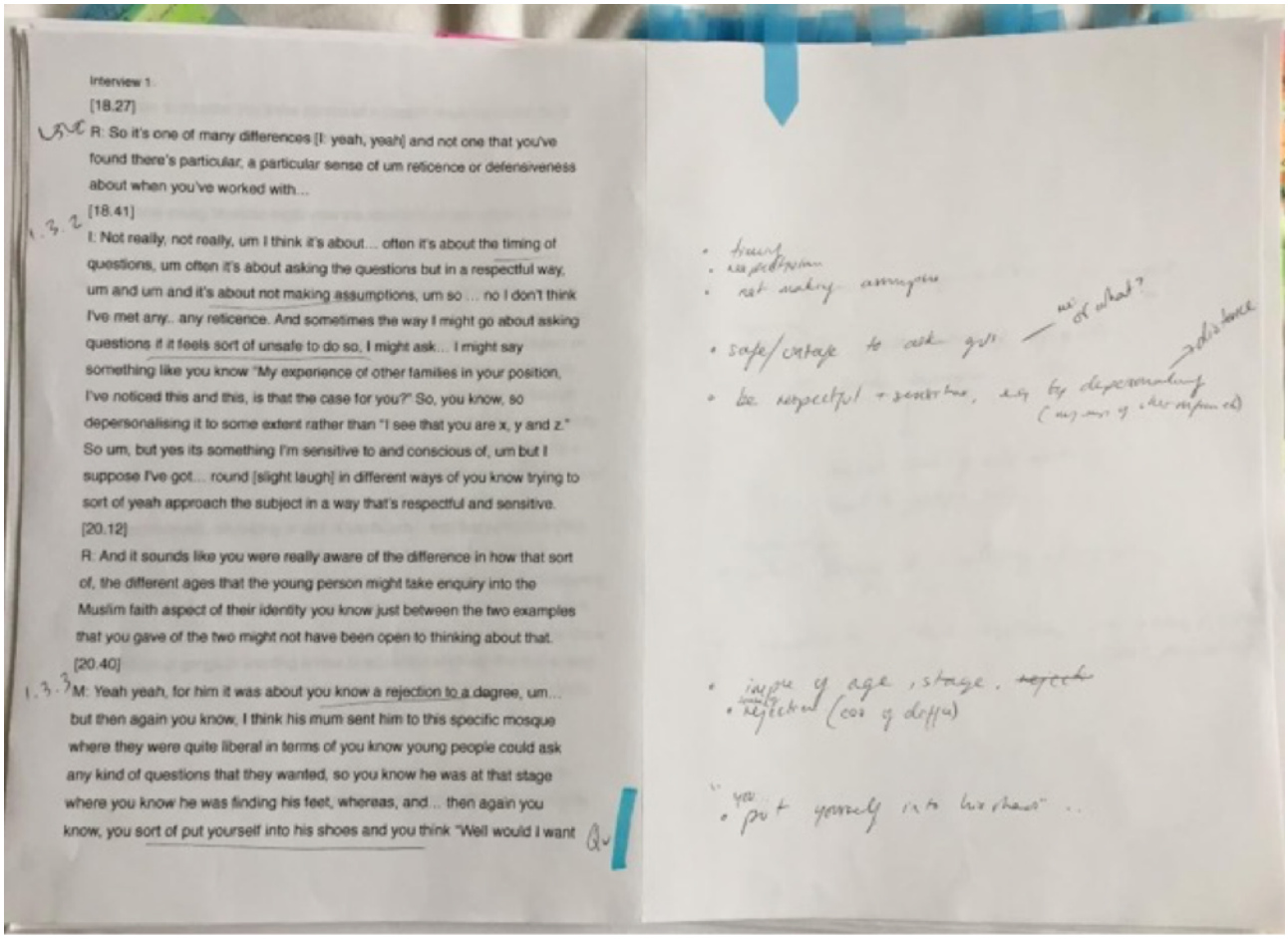
2.1) Interview 1

formulation and in terms of the work that we did. That didn't mean that it wasn't referred to, um that um it was referred to as a context with which she measured herself to other people, so some of her um friends in her community had um you know had were consciously not wearing the veil, she talked about it in terms of how her parents were not putting any pressure on her to wear a headscarf or not, um but otherwise it was really about external identity um and you know I saw her during the London Bridge attacks, or soon after the Westminster attack, and I think it made her very conscious of how she looked to other people, and in fact she had some members of the public shouting at her, um but really you know her story was one of immigration and um finding another country with more opportunities and how that should make her feel grateful and how guilty she felt if you know by feeling and depressed.

[9.10] So, did that shape the formulation or the treatment? I don't think it did, but it was then again it was one of the contexts that we considered and I suppose to me it was very clear that she was very free of her own will, you know she had free will to make decisions by herself, um therefore… we could sort of talk about it in quite sort of academic terms almost, um you know, I didn't have to fear that I would be you know, um… I didn't have to, it's not that I wouldn't want to be sensitive, but I could sort of talk quite freely with her about her choices, her religious choices, her… the impact that her religion had on her and how she was seen, um the importance of religion to her, without fearing that she would take it the wrong way, or that I was over-stepping the mark, or you know because she had that sort of intellectual capacity but also the free will within that to sort of think quite deeply about it.

2.2 [10.42] And the second example, is I'm currently working with a young Muslim boy who lives with his mum and his grandmother. His mum comes from a

2. Transcript of interview 1, question 3, paragraph 2, showing code "safe/unsafe" in my notes:



Interview 1

[18.27]

R: So it's one of many differences [I: yeah, yeah] and not one that you've found there's particular, a particular sense of um reticence or defensiveness about when you've worked with...

[18.41]

I: Not really, not really, um I think it's about... often it's about the timing of questions, um often it's about asking the questions but in a respectful way, um and um and it's about not making assumptions, um so ... no I don't think I've met any.. any reticence. And sometimes the way I might go about asking questions if it feels sort of unsafe to do so, I might ask... I might say something like you know "My experience of other families in your position, I've noticed this and this, is that the case for you?" So, you know, so depersonalising it to some extent rather than "I see that you are x, y and z." So um, but yes its something I'm sensitive to and conscious of, um but I suppose I've got... round [slight laugh] in different ways of you know trying to sort of yeah approach the subject in a way that's respectful and sensitive.

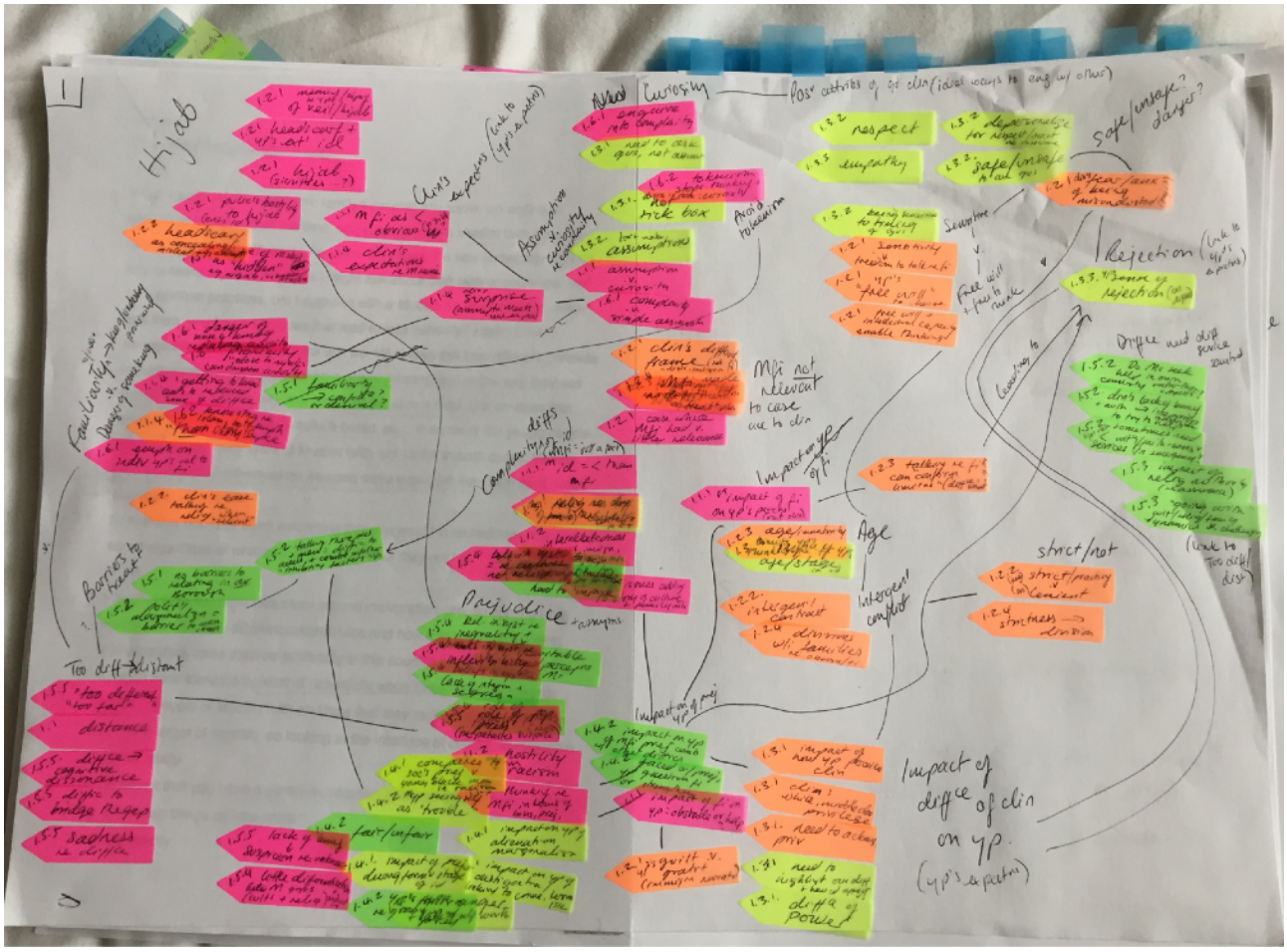
[20.12]

R: And it sounds like you were really aware of the difference in how that sort of, the different ages that the young person might take enquiry into the Muslim faith aspect of their identity you know just between the two examples that you gave of the two might not have been open to thinking about that.

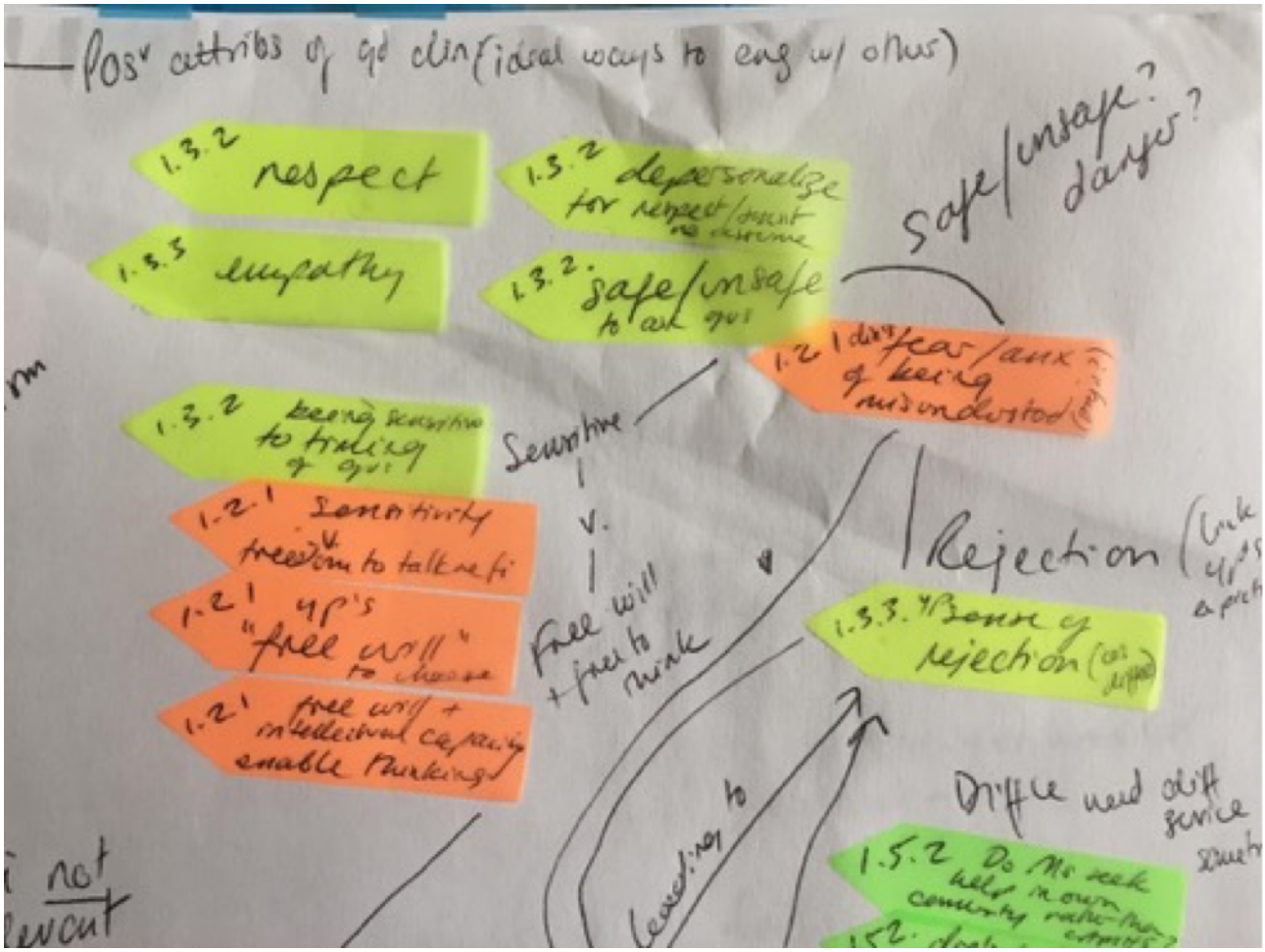
[20.40]

M: Yeah yeah, for him it was about you know a rejection to a degree, um... but then again you know, I think his mum sent him to this specific mosque where they were quite liberal in terms of you know young people could ask any kind of questions that they wanted, so you know he was at that stage where you know he was finding his feet, whereas, and... then again you know, you sort of put yourself into his shoes and you think "Well would I want

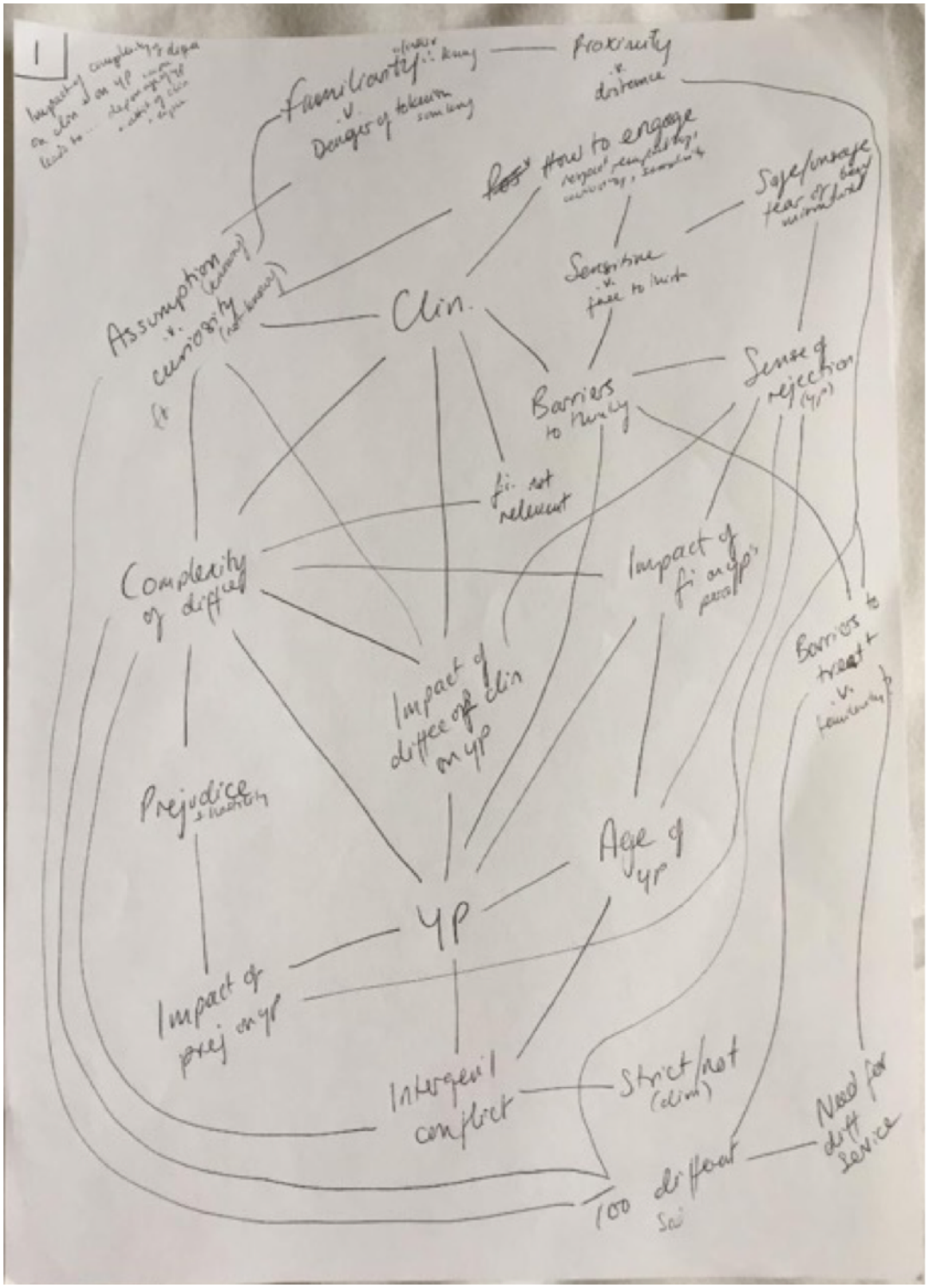
3. The researcher tagged the codes with a post-it note marked with the code and location. Once the whole interview and been coded, the post-it notes were transferred to an A3 page to group into interrelated themes:



4. Detail of the above page showing position of codes "fear of being misunderstood" and “safe/unsafe”:



5. The researcher then tried to understand how the interview's themes related to each other, and represented this in a rough diagram:



6. The researcher then created a table of all themes (created from codes from all interviews), in order to see which ones recurred and how often (see Appendix 6 Thematic tables: Identifying recurrent themes). The theme "Fear (of being misunderstood)(of asking), anxiety, tension, defensive, safe/unsafe, uncomfortable" occurs in 7/8 interviews, as well as in the Free Coding section.

7. The researcher then created a superordinate themes table, using the most commonly recurring themes and grouping other themes around them as seemed relevant (although this process has plenty of overlap) (see Appendix 6 Thematic tables: Super-ordinate themes). The theme Fear etc is grouped under super-ordinate theme **A What** '**the other**'**/ difference stirs up in us.**

Appendix 6: **Thematic tables**

Themes by interview:

Free Coding:

fear & anxiety/defensive/aggression

pain

trust/protection

splitting vs wish for integration/understanding

self-doubt

influence of own identity

complexity

1:

Overall theme: Impact of complexity of difference on clinician and yp.

Familiarity with individual vs danger of tokenism (inadequate knowledge).

Proximity vs distance.

Barriers to treatment, barriers to thinking.

How to engage (respect, empathy, curiosity, sensitivity).

Safe/unsafe (fear of being misunderstood).

Families as sensitive vs free to think.

Assumption (‘knowing’) vs curiosity (‘not knowing’).

Faith identity not relevant.

Yp’s sense of rejection.

Complexity of difference.

Impact of faith identity on yp’s perceptions.

Impact of clinician’s difference on yp.

Prejudice and hostility, impact on yp.

Significance of yp’s age.

Intergenerational conflict.

Strict/not strict.

Sadness of feeling too different.

Need for different service.

2:

Relationships influenced by stigma, assumptions and judgement vs supportive relationships: yp, family (parents and extended), community, faith leaders, CAMHS, clinicians, non-Muslim public.
Change through empathy via shared experience, and understanding via education.
Need for mandatory training.
Impact of stigma re faith identity.
Impact of stigma re sexuality.
Complexity.
Impact of clinician's personal experience of difference.
Compassion, non-judgement.
Anxiety, fear.
Importance of understanding for engagement.
Need for collaboration.
How CAMHS could improve.
[Link between anxiety/discomfort and laughs?]

3:

Overall theme: hard for yp to develop, and hard for clinician to think: dual process.
Clinician's personal experience of difference (eg faith)
Tension, anxiety (e.g. of not knowing, of yp)
Something missing.
Assumptions of clinician, of yp, of others.
Surprise, startling, jarring.
Prejudice.
Wish to know, curiosity (vs suspicion).
Engagement.
Yp's adolescent development (including exploration and anxiety).
Training.
Hard to think about difference.
Faith identity is difficult to explore in the room.
Complexity vs blunt/concrete.
Development and change (of yp and clinician).

‘Ordinary’ (safe).
Search for similarity, safety, belonging.
Barrier, concrete, rigid, stuck.
Sensitivity (insensitivity, over-sensititivity).
Sexuality.
Race.
Hijab.
Observance.
Freedom vs constraint.
Appearance (surface vs hidden).
Danger, threat, risk.
Split, battle, conflict.
Prevent.
Division between yp and parents.
[Link between anxiety/discomfort and laughs?]

4:
Overall theme: wish to assimilate yet wish to be understood; wish to understand (difference); knowledge as positive.
Tension between yp and parents, clinician’s dilemma (whether to ally with yp or parents).
Wish to assimilate.
Wish to understand/be understood.
Narrative of Western values/liberalism re sexuality, drugs/alcohol/sex, Western model’s shortcomings.
Stereotype.
Yp as expert re own faith identity, need to ask yp.
Complexity.
Clinician’s own experience of difference.
Barriers to engagement/to coming to CAMHS (what does CAMHS represent?).
Political climate (Islamophobia, racism).
Stigma of mental health in Muslim community.
Vicious circle of clinician’s ignorance and fear vs being unsure but curious/open.
Need to seek consultation, use resources in the team and community.

Training to acquire at least some knowledge.
[Link between anxiety/discomfort and laughs?]

5:
Impact of prejudice, negative perceptions of Muslim faith identity.
Support becomes threat, distrust.
Terrorism.
Power relations.
Ignorance, not knowing.
Clinician's position in conflict/tension.
Can yp feel understood at CAMHS (therefore talk), or do they feel 'the only one'?
Impact on clinician of referral.
Good CAMHS practice.
Clinician not understanding
Clinician's wish to understand individual yp and to know more re Muslim faith identity (and wish for resources re Muslim faith identity).
'Too much' knowledge vs knowledge as helpful.
Clinician's uncertainty (fear?) re asking.
Relevance of Muslim faith identity (positive and struggle).
Family and faith identity, family as resource.
Meaning of visual/appearance (assumptions) (e.g. re *hijab/niqab*).
Impact of interview on clinician.
[Link between anxiety/discomfort and laughs?]

6:
[Thoughtful, long time considering replies, interviewer talked a lot (conversation more than interview), no anxious laughter.]
Relevance of Muslim faith identity to mental health.
Faith identity and mental health treated as separate (by yp, by CAMHS).
Tension re Muslim faith identity (e.g. contrast between referral and first meeting).
Sexuality.
Yp's wish to belong.
Clinician's role to help yp navigate identity.

Signifiers of difference.
Western model vs other cultures.
Impact of discrimination/prejudice.
Prevent.
Power relations.
Safety/danger.
Clinician's experience of difference, reflexivity.
Barriers to CAMHS.
Anxiety re not knowing.
Curiosity.
Importance of learning, understanding.

7:

Overall theme: perceptions of difference, positive and negative impact, shared or not, understood or not.
Need for understanding (e.g. some basic knowledge).
Importance of curiosity (respect vs anxiety about asking).
Engagement and development, barriers to relating.
Assumptions about difference based on appearance/name (by clinician and yp) (e.g. ignorance of/assumptions about Islam)
Assumptions of shared difference therefore perceived understanding..
Assumption vs reality.
Clinician's difference.
Fear of not being understood.
Importance of yp's choice/agency/individuality re Muslim faith identity.
Core relevance of faith identity.
Negative transference from family/yp towards clinician due to difference.
Faith/culture and difference (not just Muslims).
Conflict of difference.
Impact of negative media coverage of Muslims/Islam.
[Also see post-it note diagram]

8:

Faith and culture as different but complex.

Need more knowledge re faith and mental health (e.g. lack of training re diversity and mental health).

Yp's wish to choose.

Fear of prejudice/being judged.

Fear of not being understood.

Intergenerational tension.

Impact of being a minority.

Power.

FGM and suspicion.

Western clinician's problem with faith.

Relevance of faith identity.

Impact of feeling prejudice/judged.

Impact of interview on interviewee.

Hard to talk about difference, struggle, uncomfortable.

Language barrier (e.g. problems with interpreters).

Not understanding (fear of).

Impact of shared difference (with clinician) (clinician's personal experience of difference).

Need for reflexivity.

[Link between anxiety/discomfort and laughs?]

Appendix 6: **Thematic tables**

Identifying recurrent themes:

Theme	1	2	3	4	5	6	7	8	**>/= half**	F C
Fear (of being misunderstood)(of asking), anxiety, tension, defensive, safe/unsafe, uncomfortable	Y	Y	Y		Y	Y	Y	Y	**Y**	Y
Pain										Y
Trust/distrust, protection/threat					Y					Y
Splitting vs (wish for) integration										Y
Self-doubt										Y
Influence of clinician's own difference (experience of, perceptions of, positive/negative transference due to perceptions of, shared)	Y	Y	Y	Y	Y	Y	Y	Y	**Y**	Y
Complexity (of difference)(vs blunt/concrete) (vs stereotype)	Y	Y	Y	Y				Y	**Y**	Y
Value of knowledge vs danger of tokenism (having enough/too much/not enough knowledge)	Y				Y					
Proximity vs distance	Y									
Barriers (to treatment, to thinking, to relating, to engagement e.g. language)	Y			Y		Y	Y	Y	**Y**	
Qualities needed for engagement (respect, empathy, curiosity, sensitivity)	Y						Y			
Defensive sensitivity vs freedom to think	Y									
Assumptions (of clinician, yp, others) vs curiosity	Y		Y							
Faith identity not necessarily relevant to mental health	Y									
Sense of rejection (yp's)	Y									
Impact of yp's faith identity on yp's perceptions	Y									
Impact of (faith-related) prejudice, stigma, judgement, hostility (on yp, family, clinician, relationship, Muslim community, faith leaders, non-Muslim public)	Y	Y	Y		Y	Y		Y	**Y**	
Empathy via shared experience		Y					Y			

Intergenerational conflict, tension (and dilemma of clinician)	Y		Y	Y				Y	**Y**	
Sadness (of feeling too different)	Y									
Need for change to service/training/resources (re Muslim faith identity, diversity and mental health)	Y	Y	Y	Y	Y			Y	**Y**	
Judgemental vs compassion, supportive relationship		Y								
Understanding via education/training		Y				Y				
Sexuality (significant in case, stigma in Muslim community, Western values narrative)		Y	Y	Y		Y			**Y**	
Need for collaboration/consultation (with yp, Muslim community, CAMHS team)		Y		Y						
[Link between anxiety and laughter?]		Y	Y	Y	Y			Y	**Y**	n/a
Something missing			Y							
Ignorance, not knowing (clinicians' fear/anxiety/discomfort/tension of)			Y		Y	Y		Y	**Y**	
Surprise, startling, jarring (of difference)			Y							
Suspicion/ignorance vs curiosity, wish to know, exploration, openness despite being unsure			Y	Y		Y				
Importance of engagement		Y	Y							
Yp's adolescent development (including exploration, anxiety, impact on engagement)	Y		Y				Y			
Faith identity is difficult to explore (in the room), hard to think/talk about			Y					Y		
Search for similarity, safety, belonging, assumptions re shared difference			Y	Y		Y	Y		**Y**	
Barrier, concrete, rigid, stuck			Y							
Sensitivity (insensitivity, over-sensitivity)			Y							
Significance of difference (positive and negative, perceptions of)			Y			Y	Y			
Race			Y							

Hijab, niqab (signifiers of difference)			Y		Y	Y	Y		**Y**	
Observance: freedom vs constraint	Y		Y							
Significance/meaning of appearance/perceived difference (visible surface vs hidden, assumptions by clinician/yp about, eg hijab, EFL, name, race)			Y		Y		Y			
Danger, threat, risk			Y		Y	Y		Y	**Y**	
Split, conflict, battle, struggle (related to difference)			Y				Y	Y		
(Yp's) wish to be understood (vs wish to assimilate/belong)(vs pain of feeling "the only one', different)				Y	Y			Y		
(Clinician's) wish to understand (individual, difference), wish to know more, curiosity				Y	Y	Y	Y	Y	**Y**	
Knowledge as positive (for understanding) (some basic knowledge)				Y		Y	Y	Y	**Y**	
(Narrative/shortcomings of) Western values, liberalism, Western model vs other cultures, Western clinicians' problem with faith				Y		Y		Y		
Stereotype vs individual experience				Y						
Individuality of yp (Yp as expert in their faith identity, choice/agency of yp), therefore need to ask yp				Y	Y		Y	Y	**Y**	
Political climate (Islamophobia, racism, negative media coverage of Muslims/Islam), Prevent, terrorism	Y	Y	Y	Y	Y	Y	Y			
Conflation of extremism and Muslim religious observance								Y		
Mental health (stigma in Muslim community)				Y						
Yps' perception of CAMHS (what does it represent/have to offer?)				Y						
Power relations					Y	Y		Y		
Reflexivity						Y	Y	Y		
Clinician's position in conflict (tension of)					Y					

Impact of referral on clinician (difference)					Y					
Good CAMHS practice					Y					
Faith identity is relevant to mental health (positive and struggle, core relevance)					Y	Y	Y	Y	**Y**	
Significance of family (in faith identity, family as resource)					Y					
Impact of interview of clinician					Y			Y		
Faith identity and mental health not linked by yp						Y				
Faith identity and mental health not linked by CAMHS						Y				
Tension re Muslim faith identity (clinicians', society's, therefore struggle to talk)			Y			Y		Y		
Assumptions (of clinician re referral/Islam) vs reality (eg on meeting)						Y	Y			
Clinician's role in helping yp navigate identity						Y				
Ignorance, assumptions about, negative perceptions of Islam							Y			
Faith/culture and difference (don't conflate, not just Muslims)							Y	Y		
Significance of being a minority								Y		
FGM and suspicion (impact of policy on relationship between clinician and yp/family)								Y		
Language barrier, problems of working with interpreters								Y		

Appendix 6: **Thematic tables**

Themes present in >/= half the sample:

Theme	?/8	also in FC?
Influence of clinician's own difference (experience of, perceptions of, positive/negative transference due to perceptions of, shared)	8/8	Y
Fear (of being misunderstood)(of asking), anxiety, tension, defensive, safe/unsafe, uncomfortable	7/8	Y
Political climate (Islamophobia, racism, negative media coverage of Muslims/Islam), Prevent, terrorism	7/8	
Impact of (faith-related) prejudice, stigma, judgement, hostility (on yp, family, clinician, relationship, Muslim community, faith leaders, non-Muslim public)	6/8	
Need for change to service/training/resources (re Muslim faith identity, diversity and mental health)	6/8	
Complexity (of difference)(vs blunt/concrete)(vs stereotype)	5/8	Y
Barriers (to treatment, to thinking, to relating, to engagement e.g. language)	5/8	
(Clinician's) wish to understand (individual, difference), wish to know more, curiosity	5/8	
Faith identity is relevant to mental health (positive and struggle, core relevance)	5/8	
[Link between anxiety and laughter?]	5/8	
Intergenerational conflict, tension (and dilemma of clinician)	4/8	
Sexuality (significant in case, stigma in Muslim community, Western values narrative)	4/8	
Ignorance, not knowing (clinicians' fear/anxiety/discomfort/tension of)	4/8	
Search for similarity, safety, belonging, assumptions re shared difference	4/8	
Hijab, niqab (signifiers of difference)	4/8	
Danger, fear, threat, risk, death	4/8	
Knowledge as positive (for understanding)(some basic knowledge)	4/8	

Individuality of yp (Yp as expert in their faith identity, choice/agency of yp), therefore need to ask yp	4/8	

Appendix 6: **Thematic tables**

Super-ordinate themes:

A What 'the other'/difference stirs up in us:

- Fear (of being misunderstood)(of asking), anxiety, tension, stigma, defensive, safe/ unsafe, uncomfortable [7/8] (links to B, C)
- Impact of (faith-related) prejudice, stigma, judgement, hostility (on yp, family, clinician, relationship, Muslim community, faith leaders, non-Muslim public) [6/8] - links to B
- Ignorance, assumptions about, negative perceptions of Islam - links to C
- Tension re Muslim faith identity (clinicians', society's, therefore struggle to talk)
- Prevent ((impact of policy on relationship between clinician and yp/family), terrorism
- FGM and suspicion (impact of policy on relationship between clinician and yp/family)
- Power relations
- Political climate (Islamophobia, racism, negative media coverage of Muslims/Islam)
- [Link between anxiety and laughter?] [5/8]
- Danger, threat, risk [4/8]
- Surprise, startling, jarring (of difference)
- Ordinary (ie not different) as 'safe'
- Trust/distrust, protection/threat
- Split, conflict, battle, struggle (related to difference)
- Proximity vs distance (links to B, C)
- Clinician's position in conflict (tension of)
- Pain
- Sadness (of feeling too different)
- Hard to think/talk about difference (faith identity) - links to C

B The clinician as 'other':

- Influence of clinician's own difference (experience of, perceptions of, positive/negative transference due to perceptions of, shared) [8/8]
- Empathy via shared experience
- Search for similarity, safety, belonging, assumptions re shared difference [4/8]
- Reflexivity
- Impact of referral on clinician (difference)

- Impact of interview of clinician

C Tension around knowledge:

- (Clinician's) wish to understand (individual, difference), wish to know more, curiosity [5/8]
- Knowledge as positive (for understanding)(some basic knowledge) [4/8]
- Need for change to service/training/resources (re Muslim faith identity, diversity and mental health) [6/8]
- Ignorance, not knowing (clinicians' fear/anxiety/discomfort/tension of) [4/8] - link to A
- Assumptions (of clinician, yp, others) vs curiosity
- Assumptions (of clinician re referral/Islam) vs reality (eg on meeting)
- Suspicion/ignorance vs curiosity, wish to know, exploration, openness despite being unsure
- Significance/meaning of appearance/perceived difference (visible surface vs hidden, assumptions by clinician/yp about, eg hijab, EFL, name, race) - links to D/assumptions
- Value of knowledge vs danger of tokenism (having enough/too much/not enough knowledge)
- Self-doubt (FC only?) - link to tension of not knowing, and link to clinician's awareness of own difference
- Defensive sensitivity vs freedom to think
- Understanding via education/training

Appendix 7: **Participants' suggestions**

Training

- Expand Trust diversity training to include more training about Islam (practicalities), not just as part of a 1-day event on all religions, which is too much information to process.

In-house

- Faith identity should be addressed in supervision
- Regular reflective event/forum to talk about difference.
- Academic slot about Islam.
- Eid decorations in the clinic waiting room.
- Posters in the waiting room to reflect diversity.
- Include a leaflet with the Choice letter sent to Muslim families, eg stating awareness that medication should be halal, instructions in case of fasting, etc.
- Muslim therapists in the service could offer consultation to colleagues.
- Researcher should join the clinic's Youth Forum (adolescents).
- Researcher should give feedback to clinicians about the Advisory Groups.

Making links

- Find out and share information about different organisations with knowledge of different cultures.
- Make list of relevant reading material as a resource for families and clinicians.
- Make links with local Muslim organisations as a resource for families and clinicians (including e.g. local imams with an interest in psychological therapies)

Appendix 8: **Media Context**

Included below are some of the news stories involving Muslims covered by mainstream UK media outlets before and during the research period. They are significant in that they form part of the social context of the researcher, the research participants, the clinicians who work with them and the families and young people who use the service.

2001 Terrorist attacks on New York and Washington, subsequent ‘War on Terror’ and ‘Axis of Evil’ narrative.

2005 London bombings (killed 56, injured 784), subsequent counter-terrorism policies (e.g. Prevent).

2011 Refugee crisis resulting from the war in Syria. Fear about mass immigration of (Muslim) refugees stoked by some political parties.

2015-19 Intermittent stories about the so-called “Beatles”, a group of four British Muslim ISIL supporters responsible for atrocities against western hostages in Iraq and Syria.

2016 Brexit referendum resulting in a vote to leave the EU. Part of the ‘Leave’ campaign message appeared to be anti-immigration, including anti-Muslim. The campaign reflected the social and political impact of economic austerity, which also encouraged Far Right political movements around Europe, including the UK.

March 2017 Terrorist attack: five people killed in a combined vehicle and knife attack at Westminster, London.

May 2017 Terrorist attack: suicide bomber killed 22 people at an Ariana Grande concert at Manchester Arena.

June 2017 Terrorist attack: van deliberately driven at pedestrians on London Bridge, then the three occupants stabbed people in and around Borough Market. 11 people killed (including the perpetrators) and 48 injured.

August 2017 Controversy over Christian child 'forced' to live with Muslim foster carer in Tower Hamlets, London. Complaint over coverage by Times newspaper upheld by Ipso.

January 2018 St Stephens Primary School, east London, banned wearing of *hijab* and fasting. This was seen by many Muslims as an act of oppression, taking away responsibility from parents to decide what is the best way to introduce their children to their faith. Backlash against the decision resulted in resignation of Chair of Governors.

March 2018 "Punish a Muslim Day" leaflet widely distributed. This received very little publicity, raising the question of whether, if it had been directed against a different minority group (perhaps one perceived as less threatening, less deserving of punishment), it might have caused more widespread outrage.

August 2018 Boris Johnson's 'letter-box' remark in his Daily Telegraph column compared Muslim women in burqas to letter boxes. This lead to a significant spike in Islamophobic incidents, according to anti-racism organisation Tell Mama.

February 2019 "ISIS Bride" Shamima Begum, a British-born Muslim who had left the UK aged 15 to join ISIL, had her British citizenship revoked, thereby rendering her stateless, against international law. Her case resulted in a public debate about the handling of returning jihadists. The Court of Appeal later ruled that she should be permitted to return to the UK, so that she could fairly contest this decision.

March 2019 Demonstrations outside schools in Bradford by Muslim parents protesting against their children being taught that homosexual relationships are on a par with heterosexual relationships.

June 2019 YouGov poll revealed scale of Islamophobia in the Conservative Party.

September 2019 Aggressive attack on two women wearing *hijab* in west London, amid a steady increase in Islamophobic hate crime in London (1323 attacks reported in 2018-19).

November 2019 Conservative Party decide not to hold an independent inquiry into Islamophobia. Subsequent controversy over this, as they supported an inquiry into anti-Semitism in the Labour Party.