The Experiences of Second Generation Pakistani Muslim Men Receiving Individual Cognitive Behavioural Therapy: An Interpretative Phenomenological Analysis.

A thesis submitted in partial fulfilment of the requirements for the Professional Doctorate in Counselling Psychology of London Metropolitan University.

By

Said Aris Tarabi

Student Number: 12032890

Supervised by

Dr Angela Ioanna Loulopoulou

School of Psychology
Faculty of Life Sciences and Computing
London Metropolitan University

September 2016

Declaration

I hereby declare that the work submitted in this thesis is the result of my own investigations, except where otherwise stated.

Name: Said Aris Tarabi
Date: 16th September 2016

Abstract

Background/Aims: According to the United Kingdom (UK) census statistics (ONS, 2011), Islam represents the second largest religion after Christianity, and the largest group of Muslims in the UK has a Pakistani heritage. Analysis of the existing research suggests that Pakistani Muslim men with psychological difficulties underutilise mental health services in the UK. Several studies (mainly quantitative in nature) have reported that CBT can be an appropriate treatment for Pakistani Muslims, but some authors argue that there are fundamental philosophical conflicts between Islam and CBT. However, there has been no research to date on how CBT is actually experienced by Pakistani Muslim men, and the needs of this under-represented group remain unexplored. In response to this dearth of research, particularly in Counselling Psychology, this study investigated the experiences of Pakistani men who had completed CBT treatment within the last 18 months.

Design/Method: Verbatim accounts of semi-structured interviews were analysed employing Interpretative Phenomenological Analysis. The participants were six Second-Generation Pakistani Muslim men (SGPMM) aged between 20 and 43 who had received individual CBT.

Findings: In the process of analysis three superordinate themes were generated: 'Pre-CBT difficulties' (which refers to the thoughts, feelings and challenges that the participants had encountered prior to CBT), 'the process of CBT for Muslim men' (which discusses what CBT means and how helpful and/or unhelpful the participants found CBT), 'the interaction between CBT and Islam (which explores the significance of religion, and how CBT and Islam complement and/or clash with each other).

Conclusions: The participants emphasised the difficulties and concerns that SGPMM can encounter in therapy as a result of religious and cultural pressures: namely in adhering to collectivist and individualist values, in meeting family and community expectations, and in reconciling differing aspects of Islam and CBT. It is therefore suggested that training programmes and practitioners should consider developing more targeted interventions to better address this group of clients' religious and cultural needs.

Table of Contents

Title Page **1**

Declaration **2**

Abstract **3**

Table of contents **4**

Glossary **7**

Acknowledgments **8**

1 Reflexive Statement **9**

Introduction **13**

2 Literature Review **15**

2.1 Migration of Pakistanis into the UK and their Psychological Wellbeing 15

2.2 Utilisation of Mental Health Services by UK Pakistani Muslim Men 17

2.3 Models of Therapy 20

2.3.1 Individual CBT for Muslims 22

2.4 Empirical Studies of Individual CBT for Muslims 23

2.4.1 Individual CBT for Pakistani Muslims 24

2.4.2 Individual CBT for Pakistani Muslims in the UK 26

2.4.3 Individual CBT for Pakistani Muslim Men in the UK 27

2.5 Summary of the Review and Identified Knowledge Gap 29

2.6 Relevance of this research topic to Counselling Psychology 30

3 Method **32**

3.1 Rationale for a Qualitative Study 32

3.2 Ontological and Epistemological Position 33

3.3 Rationale for Employing IPA 34

3.4 Other Qualitative Methods considered for the current study 35

3.5 Personal and Methodological Reflexivity 37

3.6 Participants 38

3.7 Procedure 39

3.7.1 Recruitment 39

3.7.2 Data collection 40

3.7.3 Pilot Study 40

3.7.4 Materials 41

3.8 Data analysis 41

3.9 Ethical considerations 43
3.10 Research Quality 44

4 Analysis 47
Summary of superordinate and sub-themes with relevant quotes 48
4.1 Superordinate Theme One: Pre-CBT Difficulties 49
4.1.1 Subtheme One: *'The need for help'* 49
4.1.2 Subtheme Two: *'Pakistani Community, stigma and hiding'* 50
4.1.3 Subtheme Three: *'Pakistani men without feelings'* 48
4.1.4 Subtheme Four: *'Being stuck in the middle ground and living in two worlds'* 55
4.2 Superordinate Theme Two: The Process of CBT for Pakistani men 57
4.2.1 Subtheme One: *'Mirror, guide or conversation'* 57
4.2.2 Subtheme Two: *'The Muslim therapist: tailor or taboo'* 59
4.2.3 Subtheme Three: *'Being in a learning environment'* 61
4.2.4 Subtheme Four: *'Lack of space and too difficult'* 59
4.3 Superordinate Theme Three: Interaction between CBT and Islam 65
4.3.1 Subtheme One: *'Personal significance of Religion'* 65
4.3.2 Subtheme Two: *'The need for two knowledges'* 67
4.3.3 Subtheme Three: *'Clash, conflict or complement'* 69

5 Discussion 73
5.1 Research findings in relation to the existing literature and the implications of these findings 73
5.1.1 First Superordinate Theme: *Pre-CBT difficulties* 73
5.1.2 Second Superordinate Theme: *The process of CBT for Pakistani men* 76
5.1.3 Third Superordinate Theme: *The interaction between CBT and Islam* 85
5.2 Application for research and clinical practice 89
5.3 Evaluation and suggestions for future research 90

6 Reflexive Statement Part Two 94

7 Concluding Words 100

8 References 101

9 Appendices 122

Appendix A: Inclusion and Exclusion criteria 123
Appendix B: Recruitment Posters 125
Appendix C: Organisations that displayed the study poster 127
Appendix D: Demographic Details Form 128
Appendix E: Participant Information Sheet 129
Appendix F: Participant Informed Consent Form 133
Appendix G: Interview Schedule 136
Appendix H: Debriefing Form 138
Appendix I: Sensitive Verbal Debriefing 140
Appendix J: London Metropolitan University Distress Protocol 141
Appendix K: Transcription Conventions 143
Appendix L: Extracts from my reflexive diary 144
Appendix M: Ethical Consent Certificate 147
Appendix N: List of useful resources and organisations 149
Appendix O: An example of a participant's annotated transcript (Imran's) 151
Appendix P: An example of the participants' (Imran's) emergent themes 156
Appendix Q: A participant's (Imran's) table of subthemes and superordinate themes 163
Appendix R: Table of superordinate themes, sub-themes and relevant quotes of all the participants 165
Appendix S: The process of developing subthemes and superordinate themes for Imran 167
Appendix T: The process of developing subthemes and superordinate themes for all the participants 168
Appendix U: List of recommendations for research and clinical practice 169
Appendix V: Brief Psychiatric Rating Scale 173
Appendix W: Beck's Scale for Suicidal Ideation (SSI) 174
Appendix X: Reflexivity 179
Appendix Y: Template of e-mail to relevant organisations 182

Glossary

Abbreviation	
BACP	British Association of Counselling and Psychotherapy
BPS:	British Psychological Society
CBT:	Cognitive Behavioural Therapy
DA:	Discourse Analysis
DoH:	Department of Health
GT:	Grounded Theory
HADS:	Hospital Anxiety and Depression Scale
HCPC:	Health and Care Professions Council
IAPT:	Improving Access for Psychological Therapies
LMU:	London Metropolitan University
NHS:	National Health Service
NICE:	National Institute for Health and Care Excellence
NIMHE	National Institute of Mental Health in England
ONS:	Office of National Statistics
PANSS:	Positive and Negative Syndrome Scale of Schizophrenia
PEQ:	Patient Experience Questionnaire
PM:	Pakistani Muslims
REBT:	Rational Emotive Behavioural Therapy
SGPMM:	Second Generation Pakistani Muslim Men
TAU:	Treatment As Usual
UK:	United Kingdom

Acknowledgments

First and foremost I would like to thank Almighty God for all his blessings and for giving me the strength, courage and determination to face all the challenges in my life, including that of the current research study.

I would like to thank all the participants who gave their time so generously to participate in this research study, and without whom this project would not have been possible. I am extremely grateful to them for their willingness to share and explore their experiences with me, and I am honoured to have this opportunity to give their experiences a voice in the literature.

I would like to thank my supervisor Dr Angela Ioanna Loulopoulou for all her support, and wisdom in the construction of this research. She believed in my research idea right from the start and helped me every step of the way. She has provided me with supportive words and with consistently attentive and detailed feedback over the past three years, and for all this I am grateful beyond measure.

I would also like to thank Dr Eva Sykorova deeply for all the help and support that she gave me throughout this research. She is quite simply an amazing friend.

My thanks also go to my initial supervisor Dr Russel Ayling for his invaluable expertise, feedback and encouragement to pursue my research in this area.

Special thanks go to my family, friends, and to my fellow trainees (Anna, Amy, Michelle, Owen, and Raffaello) who have supported and encouraged me all through this long process. They have been a tremendous help and I cannot thank them all enough. I feel very lucky to have them in my life.

I dedicate this research to the loving memory of Susan Mary Phaure, who inspired me to read Psychology and to become a Counselling Psychologist.

1 Reflexive Statement Part One

Reflexivity in research is described by Donati (2016) and Mcleod (2001) as the capacity to direct one's awareness onto one's own self by encouraging and promoting transparency, and self-reflection. This is achieved by making explicit the researcher's role in the process. Willig (2001) and Morrow (2005) argue that reflexivity is essential in that it documents how researchers' values, beliefs and assumptions influence both the research process and themselves. This reflexive statement will thus aim to make clear to the reader my personal, theoretical, ontological and epistemological position in relation to the research topic of exploring the experiences of Second-Generation Pakistani Muslim Men (SGPMM) who have received CBT. It is important for the reader to have an understanding of who the researcher is and to judge the findings accordingly (Elliott, Fisher & Rennie, 1999).

I am a 29 year-old man, born in Afghanistan, and I came to the UK when I was 13 years old. I was brought up in a liberal Muslim household, and Islamic practices such as praying five times a day, not drinking alcohol or smoking, and helping and respecting one's elders, have played a major guiding role throughout my life. Since September 2012 I have worked as a trainee Counselling Psychologist for the NHS where CBT is employed as the primary psychological intervention.

As part of my doctoral training, in my first year I experienced twenty sessions of CBT as a client, and I found the majority of the sessions helpful, directive, and engaging, but also culturally and religiously insensitive at times. For instance, the therapist indicated that my emotional difficulties and core beliefs such as 'not being good enough' were influenced by and related to my unhelpful religious beliefs such as having to please God to feel good about myself, and my cultural expectations and values such as living with and looking after my elders. As a result, I felt misunderstood and anxious because my therapist did not seem to understand my religious beliefs and my collectivist cultural background. I therefore thought that therapy and religion might not go together, and in subsequent sessions I tried to avoid discussions involving family and religious matters. I therefore have rather mixed views about receiving CBT, and perhaps I wanted to find out whether my experiences of CBT were echoed by other Muslim clients. Possibly, I unintentionally wished for my own voice and experience of CBT to be heard. On further reflection, I could also have unwittingly wished for my experiences to be validated and thus to feel good about myself, and to feel that I was not alone in experiencing these difficulties in CBT.

Despite some of my aforementioned negative experiences of CBT, my theoretical stance has very much been informed by my personal experiences of receiving CBT, my clinical experiences of delivering CBT, and my doctoral training. These have led me to favour CBT and Humanistic values in both research and clinical practice. This is possibly because I like the structured nature of CBT, such as the homework, being goal-driven, and being solution-focussed (Greenberger & Padesky, 2016). This structure provides me with a sense of control over the direction and uncertainty involved in the process of therapy. It is possible that this need for structure could come from my upbringing because, whilst growing up, my older brothers always emphasised the importance of structure in everything. Perhaps I have learnt to prefer structure in my life because it gives me a sense of knowing what needs to be done.

Equally, I was aware of the possibility that these feelings and wishes could have hindered the research process and could have influenced the manner in which I constructed my research questions, chose my methodology, and reviewed and critiqued the existing literature. This 'epistemological reflexivity' (Willig, 2013) has encouraged me to think about the implications that such assumptions can have for the research process and for its findings. For instance, I may unintentionally have looked for research studies that supported my assumption that CBT is helpful and suitable for Pakistani men, and I may unwittingly have ignored literature that did not fit in with such views.

From the outset I was aware that there were personal and professional experiences and assumptions that I held with regards to cultural values, religious beliefs, psychological therapies (e.g. CBT can be suitable for Muslim clients), and gender differences (e.g. men needing to be strong and independent based on my upbringing), and these might have influenced my research. 'Personal reflexivity' (Willig, 2013) has thus encouraged me to consider and to be aware of my presuppositions and biases so that I could minimise them and use them during the research process.

I have tried to 'bracket' or put aside my own personal feelings and assumptions with regard to the research topic, and to review the literature from an objective perspective. However, Smith, Flowers and Larkin (2009) and Milton (2010) suggest that it is very difficult if not impossible to be completely objective. In my Literature Review therefore, I have attempted to be open and objective in order to explore the research topic in depth and to formulate a balanced view of it. During the process, in order to minimise the influence

that my own views have on the direction of my review, I have tried to be mindful of my thoughts and feelings and to explore them in my personal 'reflective-journal' (Kasket, 2013). I believe that by talking and writing down my thoughts, feelings and assumptions, and by discussing them openly with colleagues, I was able to separate them as much as I could from my research.

Interestingly, the process of trying 'to bracket' my own beliefs, assumptions and values, and of taking a more open stance, has also improved my clinical practice in that I now help clients to express their needs more openly without interjecting my own beliefs and assumptions into the process too much. However, it is impossible to block out one's own cultural understandings, values and experiences completely, and despite trying hard to bracket my own experiences, I am aware that I have had/I do have/and I will have an influence on the process of therapy with clients and in my research. I therefore agree with Smith et al. (2009) that despite trying to put aside my thoughts and beliefs, I will always to some extent have an influence on the processes of my research and therapy, and IPA recognises this fact. I will therefore try to be aware of how this might impact the research process and I will strive to remain as impartial as possible and to be fair and balanced in my choice of research studies and my critique of them, but obviously my influence on them will be inevitable.

My research interest stems from my clinical placements, where I have worked with a number of Muslim men and developed strong therapeutic relationships with the majority of them. From the feedback that these Muslim men gave me, it would seem that they preferred CBT over other therapeutic approaches. This gave rise to my interest in exploring this area further. My experiences have also motivated me to pursue my interest in CBT for Pakistani Muslim (PM) men because in team meetings in my placements I had heard about the religious, cultural and language difficulties experienced by South Asian men (and mainly by Pakistani Muslim men) in therapy. I was therefore motivated to find out more about their experiences of therapy and to hear their voices rather than to just make vague assumptions about them such as that they may not find CBT helpful.

I was aware that despite trying to maintain an unbiased position of enquiry, my thoughts and motivations around this research topic were not value-free. As a practicing Muslim CBT therapist, my hope has been that the research would guide me to find ways of integrating Islam into Western therapies, and in particular into CBT, so that it could bring

together my different roles and selves. I have always tried to keep my religious beliefs and attitudes separate from my professional work as much as I could. I therefore avoided talking about or paying attention to my clients' religious beliefs in my clinical practice because at times I have been unsure about how religion could be included appropriately in CBT. On a personal level, perhaps I was also hoping that my research would help me to bring together my thoughts, beliefs and attitudes in relation to my personal self (e.g. my religion) and my professional role (as a CBT therapist). I hoped to do this by identifying ways of integrating aspects of Islam into the CBT framework more effectively. This would then enable me to be more holistic in my clinical practice (Garraway, 2016). Possibly it would make me more comfortable because I would not have to switch between my personal and professional selves as much, and I could be just one person with different roles (and this reflexivity is further discussed in the Method and Discussion section).

Introduction

The United Kingdom (UK) has undergone changes and faced considerable challenges due to mass migration and the rapid growth of its immigrant communities (Laungani, 2004; Hutchison, Lubna, Goncalves-Portelinha, Kamali & Khan, 2015). Immigrants currently represent 13% of the UK population (Office for National Statistics, ONS; 2011), and the UK has increasingly become a multicultural society (Moodley, 2007). The dominant immigrant groups in the UK come from former British Colonies, and South Asians (6.3% of the UK population) form the largest immigrant community in the UK with 2.3% from India, 1.9% from Pakistan, 0.7% from Bangladesh and 1.4% from other Asian countries (ONS, 2011). According to Anand and Cochrane (2005) immigrants from South Asia share many commonalities, but there are also many differences between and within the South Asian populations in terms of language, education, religion and cultural values.

The large majority of South Asians living in Britain are Muslims (Hussain, 2009), and Muslims are now the UK's second largest faith community after Christians (ONS, 2011). Islam is a monotheistic religion that worships God/Allah as the creator of the universe (Haque & Kamil, 2012). The followers of Islam (Muslims) believe that the Qu'ran is the revelation of Allah's Will to Muhammad, the last of the prophets, and British Muslims are a diverse community and form an important part of Britain's multicultural society (Inayat, 2007). It is beyond the scope of this review to explore all the Muslim groups in the UK, so the focus of this review will be on Pakistani Muslims (PMs) because they represent the largest group of Muslims in the UK (ONS, 2011). PM men are currently under-represented in the research literature of psychological therapies (Bhui & Bhugra, 2002; Bhui, 2013; Rathod, Naeem & Kingdon 2013), and their needs remain unexplored. This review will thus investigate how PM men utilise UK mental health services for their psychological well-being. It will also explore their experiences of psychological therapies, and of CBT in particular, because CBT is the treatment of choice in the NHS (NICE, 2009).

A comprehensive systematic literature search strategy was employed for the current study. The journals, papers, and articles that were presented and referenced throughout the present study were accessed through the database which included: ScienceDirect, PubMed, PsychINFO, PsychArticles, and EBSCOhost. A varied combination of search terms was employed using words such as 'Cognitive Behavioural Therapy', 'CBT', 'Religion', 'Islam', 'Second Generation', 'Acculturation', 'Ethnic Identity', 'Masculinity', 'Mental

Health', 'South Asian Men', 'Psychotherapy', 'Resilience', 'Stigma', 'Pakistani Men', 'CBT' and 'Islam', 'Men' and 'Therapy', 'CBT and Islam', 'Pakistani Men' and 'Therapy', 'South Asians' and 'Therapy'. Employing the snowballing technique, the journals and papers retrieved from the initial search were utilised through their reference sections to widen the search for relevant and up-to-date peer reviewed papers and journals.

In addition, searches of specific journals and papers were carried out where they were considered to include information relevant to the present study. These included journals such as: 'Journal of Mental Health', 'Psychology and Psychotherapy: Theory, Research and Practice', 'International Journal of Mental Health', 'The Counselling Psychologist', 'Ethnicity and Health', 'Counselling Psychology Review', 'Counselling Psychology Quarterly', 'Journal of Muslim Mental Health', 'Mental Health Religion and Culture', 'Psychology and Religion', 'Religion and Therapy'.

For the purpose of this review, unless stated otherwise, the term 'South Asian' is used to refer to people from Bangladesh, India and Pakistan. The term 'first-generation immigrant' is used to describe people who were born overseas and have migrated to the UK, and the term 'second-generation immigrant' refers to children born in the UK to first-generation immigrant parents.

2 Literature Review

2.1 Migration of PMs into the UK and their Wellbeing

Since the 1960s many PMs have immigrated to the UK following social, political and economic instability in Pakistan. Consequently, the number of PMs in the UK has risen substantially, from 747,285 in 2001 to 1,175,983 (ONS, 2011). PMs who immigrated to the UK have faced considerable challenges such as language barriers, social isolation, identity crises and a sense of being marginalised (Bhugra & Becker, 2005). According to Berry (2005; 2008) high levels of psychological stress can be experienced during and after migration depending on the individual concerned and on the process of acculturation. This involves the personal, cultural and psychological changes that individuals experience following contact between two very different cultures.

PMs in the UK are faced with the difficult challenge of preserving their own cultural standards and principles while becoming acclimatised to Western cultural values. It can therefore be argued that they are caught between two cultures. Anwar (1976) and Lalonde and Giguère (2008) argue that immigrants can experience cultural clashes in the process of acculturation. This cultural clash is even more pertinent for second-generation immigrants because they experience feelings of being torn apart by the two opposing cultural values, norms and expectations (Goodwin & Cramer, 2000; Hutchison et al., 2015). According to Laungani (2005) this cultural conflict arises from the difference between Western individualist perspectives and Eastern collectivist ideology. Laungani (2004) suggests that PMs generally follow a collectivist culture and are connected by membership of the 'Ummah' (Muslim community) which emphasises the importance of collective responsibility, collective achievement, and which prizes a 'we' identity that puts duties and obligations to the community before the rights of the individual. Trubisky, Ting-Toomey and Lin (1991) state that in contrast, the individualistic culture of the UK tends to emphasise the significance of the individual-centred 'I' identity which values the importance of emotional independence, free-will and individual autonomy.

It is pertinent to recognise that generational differences exist within the PM population in the UK where the difficulties faced by first-generation PMs differ considerably from those faced by second and subsequent generation PMs. For instance, in their quantitative study, Furnham and Sheikh (1993) showed that 35 second-generation immigrants of South Asian origin in the UK had experienced significantly higher levels of psychological difficulties

(e.g. stress, depression) compared to 60 first-generation immigrants from South Asia. Although first-generation immigrants experience adjustment and language difficulties, second-generation immigrants face the conflicting pressures of having to conform to their family and traditional Eastern values whilst simultaneously having to fit in with the Western way of life. Similarly, Dhillon and Ubhi's (2003) qualitative study found that this cultural dynamic puts second-generation South Asians in the UK under considerable pressure because they feel unable to affiliate to, and be comfortable with both their own and the host culture. As a result, the participants reported that they did not feel British, Indian or Pakistani, and had difficulties in affirming these aspects of their cultural identities.

Muslims, including Pakistanis in the UK not only have to deal with the universal difficulties of migration and acculturation, but they also face a number of political and relational challenges. For example, the '9/11' terrorist attack in the US, and the '7/7' bombing in London, and recent attacks (in Paris in 2015, and Nice and Brussels in 2016) have caused considerable hostility towards Muslims. This hostility has resulted in Muslims feeling as though they are regarded as terrorists (Ahmed & Amer, 2012). Similarly, Sheridan (2006) drew attention to the fact that the media has played a big role in creating and portraying hostile attitudes and creating misconceptions about Islam. Consequently, there is currently an atmosphere of fear and controversy surrounding all Muslims in the UK (Funke, 2002; Haque, 2004). According to Inayat (2005) and Hussain (2009) Muslims feel unable to openly voice their fears, concerns, and needs including those relating to mental health difficulties. Given this context, Pakistanis like other Muslims, have been vulnerable to the effects of negativity and hostility and are in need of services that are culturally and religiously appropriate. Despite the growing size of the Pakistani community, there has been a noticeable lack of data and research on the needs, demands and utilisation of mental health services by Pakistani people in the UK and in particular by PM men.

2.2 Utilisation of Mental Health Services by UK PM men

Published research concerning the use of mental health services by PMs in the UK is sparse, but several studies have considered South Asians as a whole. Bowl (2007) and Netto, Gaag and Thanki (2006) found that UK mental health services were not able to address adequately the religious needs of South Asian participants, and indicated that this inadequacy requires urgent attention in order to prevent South Asians from experiencing further alienation. In order to address the psychological needs of ethnic minority groups, UK governments have introduced a number of initiatives such as the Social Exclusion Unit (2004) and "Delivering Race Equality: A Framework for Action" (DoH, 2005). These initiatives were introduced to make mental health services appropriate, engaging and responsive to the needs and wishes of ethnic minority communities, and to serve this population with 'confidence and sensitivity' (Department of Health, 2014). However, despite these initiatives, Bowl (2007) reports that South Asian communities under-utilise mental health services, and this under-utilisation is caused by a number of factors such as language barriers and the fear that South Asians have of mental health practitioners and services. In order to address the psychological needs of ethnic minority groups, there has been a rapid expansion of psychological services in the UK such as Improving Access to Psychological Therapies (NICE, 2011). Moreover, according to the ONS (2011) there has been a significant increase in the South Asian Muslim population in the UK from 1.2 million in 2001 to 1.9 million in 2011, and the majority of these Muslims are of Pakistani heritage. Haque and Kamil (2012) suggest that as the Muslim population in the UK continues to grow, the challenge of providing them with culturally appropriate psychological therapies needs to be addressed. It is therefore important to understand how South Asian Muslims and PMs in particular utilise UK psychological services, and how they view and experience psychological therapies.

Bowl (2007) conducted a thematic analysis to investigate South Asian mental health clients' views and experiences of mental health services in the UK. The study included focus groups and individual interviews, and all the participants were either Indian or Pakistani immigrants. From the interviews, Bowl identified a number of themes that acted as major barriers to this population group receiving effective treatment. These included racism, the lack of information being offered to patients regarding clinical treatments, and limited interpreter facilities. However, Bowl (2007) paid no attention to the language, and to the cultural and religious differences of the participants. Furthermore, the focus group

discussions were not audio-recorded and thus were not accessible to the researchers after the event, and this is problematic because relying on one's memory in research can be unreliable. Sabry and Vohra (2013) argue that the majority of Muslims feel uncomfortable about sharing personal details in group settings, particularly if members of the opposite gender are present. Group and gender dynamics might therefore also have influenced the data obtained in Bowl's (2007) study. Moreover, Warr (2005) states that although focus groups can provide rich data, there are other concerns to be aware of such as ensuring non-judgemental interaction in the group.

Netto, Gaag and Thanki (2006) carried out a grounded theory study to examine the accessibility and appropriateness of counselling services for South Asians in the UK. The study employed semi-structured interviews and focus group discussions with 23 female and 15 male South Asian immigrants. It was found that the majority of the clients valued highly the confidential nature of the counselling process and reported that a number of benefits (such as the ability to discuss problems more openly, and the ability to consider problems from a fresh perspective) had been gained from counselling services. The therapeutic alliance between the client and the therapist was considered crucial in ensuring a positive outcome. This echoed the findings of Everall and Paulson (2002), which emphasised the importance of good therapeutic relationships for better therapy outcomes.

Netto et al. (2006) assumed that a commonality exists between South Asian communities, and they did not take into account the heterogeneity of the South Asian population (Anand & Cochrane, 2005). They also did not differentiate between the views of first and second-generation immigrants, nor between those of males and females. There is evidence to suggest that the prevalence of depression and suicide is lower for South Asian men than for South Asian women (Hussain & Cochrane, 2004; Khan & Waheed, 2009), and a higher consumption of alcohol has been reported amongst South Asian men than South Asian women (Bhui & Bhugra, 2002). Gender related expressions of distress thus vary significantly, and Siraj (2010) argues that there are profound differences between the role of men and women in Muslim culture. For instance, Muslim families are largely patriarchal (Al-Hashimi, 2005) with the man being the head of and the authority figure in the family, whereas the woman is the homemaker and is responsible for child-bearing and rearing. Moreover, in South Asian communities, women are not supposed to associate with men outside of the family without supervision, and if women engage in any type of sexual behaviour such as kissing and hugging, then this constitutes a serious breach of family

honour (Goodwin, 2003). How men and women interact with each other and how they engage in therapy is thus profoundly affected by gender differences in Muslim communities (Ahmed & Amer, 2012; Ali, 2013). Arguably, it is therefore pertinent that future research with regards to Muslims should take gender differences into account.

In contrast to Netto et al. (2006), Tabassum, Macaskill and Ahmad (2000) paid attention to the importance of cultural heterogeneity within South Asian groups by focussing on Pakistani families in the UK. A qualitative study was conducted with 52 females (29 first-generation and 23 second-generation) and 22 males (first-generation but no second-generation males) to investigate their mental health issues and psychological needs. The study found that the major barriers to psychological help were language difficulties, religious and cultural practices, and the stigma attached to mental health difficulties. Similar findings were reported by Ciftci, Jones and Corrigan (2013), and Commander, Odell, Surtees and Sashidharan (2004) who reported that the stigma around mental illness and therapy significantly affects the seeking of professional help in Muslim communities. However, in Tabassum et al.'s (ibid.) study the views and needs of second-generation Pakistani Muslim men (SGPMM) were completely absent. In the light of Dhillon and Ubhi's (2003) findings that second-generation South Asian men experience considerably more stress than their first-generation counterparts, this omission is particularly noteworthy. Future research should arguably give this neglected population of SGPMM a voice, and this resonates with Strawbridge and Woolfe's (2010) suggestion that one of the core values of Counselling Psychology is to address the needs of under-represented groups.

More recently, Weatherhead and Daiches (2010) undertook one of the first qualitative studies, a thematic analysis study in the UK to explore Muslim views on mental health and psychotherapy. A group of seven male and seven female Muslim participants were interviewed comprising of ten first-generation and four second-generation immigrants from a wide range of ethnicities. One of the key findings was that for some participants, seeking help from mental health services could be considered to be an indirect rejection of Allah who is believed by Muslims to control the destiny of all human beings. In contrast, other respondents suggested that religious beliefs could actually complement Western psychological therapies. The majority of respondents were able to identify characteristics of both the therapist and the therapeutic context that are required for therapy to be effective and appropriate to their needs. For instance, some participants indicated that it may be beneficial for therapists to respect and acknowledge the religious faith of the clients within

the therapeutic process, so that an important aspect of life is included in therapy. It can therefore be argued that the Weatherhead and Daiches' (2010) study provided useful insights into the needs of Muslims as a client group.

Nonetheless, as was the case in the other studies mentioned above, Weatherhead and Daiches (2010) did not explore the differences in the analysis between the views of males and females, nor between the views of first and second-generation Muslims. Since a large number of the participants were first-generation, the needs of second-generation Muslims were neglected. Another drawback of this study was that some participants had used mental health services and some had not, but no differentiation was made between them when analysing the data. Future research might therefore address some of these limitations by investigating the experiences of specifically second-generation Muslim groups who have utilised mental health services.

Perhaps more crucially, there are over 400 different therapeutic approaches in Counselling Psychology (Cooper & Mcleod, 2007; 2011) with psychodynamic, humanistic and CBT being the three main therapeutic approaches in the UK (Norcross, 2005). However, all the above-mentioned studies omitted to focus specifically on any one particular model of therapy for South Asians or for PMs. In order to draw a meaningful conclusion therefore, it is vital to know what model of therapy is being used for treating PM men so that tailored interventions can be developed for their needs. This is consistent with Strawbridge and Woolfe's (2010) suggestion that the tailoring of interventions to suit clients' individual needs is central to the philosophy and practice of Counselling Psychology.

2.3 Models of Therapy

It is beyond the scope of this review to explore all the Western models of therapy. This review will therefore briefly discuss psychodynamic and humanistic therapeutic approaches, and CBT for PMs in greater detail. It is worth noting that men are less likely to seek psychological therapies than women (Millar, 2003). Ogrodniczuk (2006) states that the development of specific therapeutic approaches for men in a counselling setting is fairly recent. Mahalik, Good and Englar-Carlson (2003) have proposed a range of distinct characteristics (such as independence and self-reliance) that are generally more common amongst men than women. It can be argued that men, with such gender attributes, view

counselling as a last resort (McGoldrick, Giordano & Garcia-Preto, 2005). However, many traditional therapeutic approaches depend on clients being able to express their emotions and being reliant on the therapist's help (Millar, 2003). Self-disclosure can thus be in conflict with men's internalised messages such as being strong, self-reliant, and independent (Hammer, Vogel & Heimerdinger-Edwards, 2013). This can present a special challenge when it comes to men and particularly South Asian men in therapy because of the stigma that exists with regards to mental illness and therapy within South Asian communities (Mahalik, 2001; Mahalik et al., 2003; Bhui, Chandran & Sathyamoorthy, 2002; Lalwani, Sharma, Rautji & Millo, 2004). South Asian men in particular are therefore less likely to seek help or to engage in therapy than are other groups of men in the UK (Ahmed & Amer, 2012).

Berger (2010) however argues that CBT techniques such as psycho-education and problem-solving can be particularly beneficial when working with male clients because such techniques enhance the clients' ability to examine coping strategies. Similarly, Good, Thomson & Brathwaite (2005) have indicated that CBT interventions such as rational problem solving, logical thinking and assertiveness training can be effective in counselling men. Generally, CBT interventions are problem-focussed and directive (Beck, 2011), and men seem to find such interventions suitable because, according to Mahalik (2001), men are more likely to avoid or to terminate therapy as the work starts to focus on their feelings.

Chaudhry and Li (2011) indicate that Muslim clients, and particularly Arab and South Asian Muslim men, seek therapy with the expectation that they will obtain direct advice from an expert (Dwairy, 2006). An exploratory, non-directive form of therapy might thus meet with scepticism from South Asian Muslim clients. There is therefore a growing belief that psychodynamic and humanistic approaches with their non-directive nature may not be suitable for the majority of Muslim clients (Ahmed & Amer, 2012; Haque, 2004). Such clients are therefore more likely to benefit from directive and action-focussed therapy such as those embodied in CBT (Elliott, Watson, Goldman & Greenberg, 2004). In addition, Ali, Liu and Humeidan (2004), and Sabry and Vohra, (2013) argue that individual therapy as opposed to group therapy seems to be more congruent with Muslim clients because Muslims may feel uncomfortable in revealing their personal issues in group settings. Furthermore, the National Institute of Health and Care Excellence (NICE, 2004; 2009) recommends individual CBT as a treatment for all ethnic minority groups. It is therefore important to examine the empirical evidence with regard to the use of CBT for PM men in

the UK. In the light of these findings, individual CBT for Muslims and PMs in particular, will be investigated.

2.3.1 Individual CBT for Muslims

Religious affiliations vary amongst Muslims and there are different Muslim schools of thought and interpretation, but the teachings of Islam lie at the very heart of all of them and govern the lives of Muslims, including Pakistanis (Haque & Kamil 2012). Similarly, Utz (2012) states that Muslims view Islam as a way of life and that they turn to religion for support and comfort. Meer and Mir (2014) have argued that in order to increase suitability and facilitate positive outcomes, it is important to incorporate clients' religious and cultural beliefs into the framework of CBT. Moreover, some researchers have suggested that Islam and CBT can be incorporated well into each other because they share some important similarities. For instance, CBT focuses on reason, education, and rational and logical discussion. Hodge and Nadir (2008) argue that because of this CBT is more congruent with the Islamic belief system than are the other main therapeutic approaches. Cognitive therapy focuses on identifying irrational and dysfunctional thoughts that create emotional distress and unhealthy behaviour, and it seeks to replace these thoughts with others that foster good psychological well-being (Beck, 1976; Beck, 2001). Similarly, the Islamic faith encourages the role of personal reflection, logical analysis, and the seeking of knowledge for positive mental health (Hamdan, 2008). In essence, the key philosophical underpinnings of CBT are arguably congruent with Islamic discourse (Carter & Rashidi, 2004) because both emphasise the importance of rationality.

On the other hand, Beshai, Clark and Dobson (2012) and Beshai, Dobson, Adel & Hanna, (2016) state that there are some fundamental philosophical conflicts between Islam and CBT. For example, CBT emphasises the internal locus of control and the examination of evidence such as challenging un-evidenced religious beliefs that might contribute to distress (Beck, 2011). In contrast, the majority of Muslims believe in external forces such as God and supernatural powers that are not congruent with the tenets of CBT (Carter & Rashidi, 2003). Springer, Abbott and Reisbig (2009) state that Muslims believe that everything that happens is as God wills it (expressed in Arabic as 'Inshallah'). Similarly, Geels (1997) suggests that for the majority of Muslims, the Qur'an is the indisputable word of God. For instance, if the Qur'an stipulates that one should respect and obey one's

parents or that one should not engage in sexual activity outside of marriage, then not complying with such statements is wrong. Islam therefore promotes an external locus of control, which is opposed to CBT's emphasis on people strengthening their positive self-beliefs and self-confidence, and being in control of their own lives (Beck, Rush, Shaw & Emery 1979). In contrast, Haque and Kamil (2012) state that Islam also promotes 'individual free will', which encourages Muslims to engage in the process of change towards improving their lives, and this is consistent with the tenets of CBT.

Hodge (2011) argues that despite some key philosophical differences, there is a growing belief that CBT can be tailored to Muslim client's needs, whereas Beshai et al. (2012) argue that CBT may not be suitable for the majority of Muslims because there are fundamental incongruities between CBT and Islam. However, there appears to be a deficit of empirical support for these claims and future research should address this gap in the literature.

2.4 Empirical Studies of Individual CBT for Muslims

The majority of published research has hitherto focussed on the suitability of CBT with regard to individuals with Western, Judaeo-Christian backgrounds (Pecheur & Edwards, 1984), but there are only a few studies that have examined the efficacy of CBT with regard to Muslims (e.g. Razali, Aminah, & Subramaniam, 1998; Razali, Aminah, & Khan, 2002; Mahr, McLachlan, Friedberg, Mahr & Pearl, 2015; Naeem, Saeed, Irfan, Kiran, 2015; Rathod et al., 2013). This review will therefore focus initially on the effectiveness of CBT for Muslim clients, and then narrow down to focus on its effectiveness for British PM men.

Razali et al. (1998) undertook one of the first ground-breaking studies on Muslims in Malaysia. They evaluated the use of CBT and religiously-based CBT treatment for Muslim clients suffering from generalised anxiety disorders and/or major depression. Clients were randomly allocated to two groups who received either standard CBT, or a religiously modified CBT. The study found that the participants who received religiously modified CBT reported significantly greater reductions in their symptoms than clients in the standard CBT group.

Razali et al. (2002) then conducted another study in Malaysia evaluating the effectiveness of standard CBT and religiously modified CBT treatments for Muslim clients who suffered from generalised anxiety disorder. The study found that the anxiety symptoms of the clients diminished significantly for those who were treated compared to those who were not treated with the religio-cultural psychotherapy. Nonetheless, there are limitations associated with the above two studies, namely that they did not take into account gender differences, and there were insufficient data with regards to the gender balance in the studies. A more robust study would have provided demographic data regarding the participants' age, marital status and the severity and duration of illness. These factors could thus have been correlated against therapeutic outcomes. It would also have been helpful if the authors had provided more information on how the interventions were religiously modified, and then made the modified protocols available to the reader. Finally, it is unclear as to whether Razali's findings would be replicable within a different cultural context such as Pakistani Muslims in the UK.

2.4.1 Individual CBT for PMs

Only a small number of studies have investigated the suitability of CBT for PMs. Naeem, Gobbi, Ayub and Kingdon (2010) interviewed five psychologists using thematic analysis to explore the participants' experiences and views on providing CBT in Pakistan. The study reported that all the five psychologists agreed that CBT in its current form with its emphasis on individualistic values is not suitable for clients in Pakistan who focus primarily on collectivist cultural values. They suggested that the therapeutic techniques that were involved needed modifications and adjustments, yet no suggestions were made as to how this could be achieved. Moreover, it is worth noting that the psychologists were all recruited from one city, and all of them were trained in Rational Emotive Behavioural Therapy (Ellis, 1962) and not in CBT (Beck, 2011). REBT and CBT may share similarities in terms of theory and practice, but they also differ significantly with regards to epistemology, training and delivery (Ellis, 2003; Padesky & Beck, 2005).

Additionally, Naeem, Waheed, Gobbi, Ayub and Kingdon (2011) undertook a randomised controlled trial in Pakistan to evaluate the effectiveness of a culturally adapted CBT for depressed Pakistani primary care attendees. They compared the effect of anti-depressants with a combination of antidepressants and culturally adapted CBT and found that the

clients who received modified CBT in combination with anti-depressants showed a significant decrease in the levels of depression, anxiety and somatic symptoms compared to the group on anti-depressants alone. Culturally modified CBT was thus shown to be effective in reducing the symptoms of anxiety and depression on the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). However, the authors did not provide information on how they had culturally modified the CBT. Additionally, there was no 'standard CBT group', and it is impossible to know how much of the improvement was attributable to the CBT, how much attributable to the cultural modifications, and how much attributable to the anti-depressants. Moreover, 65% of clients in the therapy group were taking their anti-depressants compared to 35% in the control group, and it is possible that this disparity in anti-depressant compliance may have contributed to improved outcomes in the therapy group.

More recently Naeem et al. (2015) conducted a quantitative study to evaluate the effectiveness of brief (six sessions of) culturally adapted CBT for patients with psychosis in Pakistan. The therapy group involved culturally modified CBT with the involvement of the carer, plus one session for the whole family. The study found that the participants in the therapy group reported a statistically significant improvement in all measures such as delusions, hallucinations and the Positive and Negative Syndrome Scale of Schizophrenia (PANSS). The results indicated that culturally modified CBT for psychosis can be an effective treatment when it is combined with Treatment As Usual (TAU) i.e. medication with routine psychiatric consultations. This is a new and valuable area of research that is still in its infancy and it requires additional work to address some of the methodological issues and weaknesses involved. For instance, just as with Naeem et al.'s (2010) study, there was very limited information provided as to how the CBT was modified. Moreover, there was no control group of 'standard CBT' against which to compare the results from the modified CBT group. There was therefore no way of knowing whether it was the cultural adaptation that had had the positive effect. Perhaps the brief nature of the intervention itself could have contributed to the effectiveness of the therapy rather than the cultural modification of the CBT. A three-way comparison between TAU, standard CBT and culturally adapted CBT may have yielded the information as to what was providing the benefit for the participants.

Another important aspect of the study was that carers were involved in the therapy sessions in the modified CBT, and the treatment included an additional session with the participant's family, and these factors could also have contributed to the effectiveness of the treatment. In addition, the participants in the treatment group were seeking help from various other sources such as faith healers, and all these factors could have contributed to the positive outcome of the culturally adapted CBT treatment. There therefore needs to be a fair amount of caution exercised when using this study to make claims for a culturally modified form of CBT. Further studies are needed to provide more evidence in support of culturally modified CBT. Moreover, all the above studies seem to investigate these issues from the researchers' or the therapists' perspective – and thus the voices of the clients are missing and have yet to be heard.

In the light of the above studies, it can be argued that CBT can be beneficial for PM clients; but, since the studies took place in Pakistan, it can be argued that due to the acculturation processes discussed earlier in this review, the experience of this group may differ from the experiences of second-generation PMs residing in the UK.

2.4.2 Individual CBT for PMs in the UK

Rathod, Kingdon, Phiri and Gobbi (2010) undertook one of the first qualitative, thematic analysis studies in the UK to research the suitability of culturally sensitive CBT for ethnic minority patients with psychosis. The study investigated the views of patients, lay people selected from ethnic communities, and mental health practitioners. The participants in the client group were African-Caribbean, Black African, Black British and South Asian Muslims some of whom had experienced CBT. The study found that CBT can be an acceptable treatment if it is culturally modified. A number of interviews and focus groups were conducted, but only three out of the 15 patients were South Asian Muslims (two females and one male). The voices and experiences of South Asian Muslims, and in particular those of male voices were thus not prominent.

More recently Rathod, Phiri, Harris, Underwood and Kingdon (2013) conducted an important quantitative study in the UK with 35 participants (African-Caribbean, Black African, Mixed race, Pakistani, Bangladeshi and Iranian) to assess the effectiveness of

culturally adapted CBT for ethnic minority groups with schizophrenia. All the participants were randomly allocated to either a culturally adapted CBT study group or to a control group (receiving standard CBT). Participants in the study group received 16 sessions of individual culturally modified CBT whilst the control group participants received 16 sessions of standard CBT. The study found that in comparison to the control group, the participants in the culturally adapted CBT group achieved significantly improved post-treatment outcomes. The use of the patient experience questionnaire (PEQ; Steine, Finset & Laerum 2001) revealed that the participants in the modified CBT group also reported a high level of satisfaction with treatment. This finding is consistent with the results of other studies, namely that CBT modified for minority populations can be helpful and is an appropriate form of treatment (Patel et al., 2007; Rojas et al., 2007).

However, despite the generally positive outcome, Rathod et al. (2010; 2013) paid little attention to gender differences and did not differentiate between the views of first and second-generation participants. More importantly, they grouped together all the participants of different ethnicities and did not attempt to differentiate between the different cultures in a culturally heterogeneous group of participants (Bhui, Christie, & Bhugra, 1995; Lloyd, 2006). The above studies have thus not provided detailed information regarding CBT for any specific Muslim group such as PM men in the UK.

2.4.3 Individual CBT for PM Men in the UK

Mahr, McLachlan, Friedberg, Mahr and Pearl (2015) carried out a UK based case study of modified CBT for an 11-year-old second-generation PM male suffering from post-traumatic stress disorder. They employed CBT interventions that involved cognitive restructuring, parenting work, and sleep hygiene. The treatment consisted of 12 sessions of individual therapy and seven sessions of family work in line with Stallard's (2002) cognitive model. The Mahr et al. (2015) study provided encouraging results, and it was one of the first studies to explore the effectiveness of CBT that had been culturally adapted specifically for a Pakistani Muslim male client. The findings of the study are timely given the on-going attempts to reduce the disparity in the psychological therapies provided across diverse populations (DoH, 2014). The study showed that culturally adapted CBT was appropriate in treating a second-generation Pakistani male suffering from Post Traumatic Stress Disorder (PTSD). In the UK, other research (such as Grant, Huh, Perivoliotis &

Stolar, 2012; Jiménez-Chafey, Duarté-Vélez & Bernal, 2011) has also reported that CBT is suitable for treating ethnic minority youths. For example, Huey and Polo (2008), and Hays (1995; 2009) pointed out that individualised intervention and client empowerment make CBT especially responsive to multicultural applications.

Even though positive findings were reported, there are a number of limitations to Mahr et al.'s (2015) study. The authors highlighted the importance of providing a culturally informed CBT intervention tailored to the client's needs, but they did not provide any information on how the interventions were employed. Moreover, the client received individual therapy and family sessions, and the client's parents were encouraged to perform one-to-one interventions at home with the client. Modifications were also made at school to address some of the client's problems as in getting him to join after-school clubs, and to sit in the front of classes to aid his hearing difficulties. Therefore, because there were many different factors contributing to the client's mental well-being, this raises questions about the effectiveness of the CBT alone.

It is noteworthy, that the majority of studies mentioned above employed psychological measures (e.g. HADS, PANSS and PEQ) based on American and European ways of assessing psychological difficulties in clients and/or their treatment satisfaction (Bhui, 1999; 2013). Such psychological measures have been conceptualised and designed within societies considered as the 'Western World' (Small, 2006), and arguably, as discussed in the introduction section, they differ in many socio-cultural ways from the societies from which the participants came. It could thus be argued that any findings should be treated with caution because it is uncertain whether the tools were used and understood by the participants in the manner intended by the researchers. This therefore raises an important question regarding the validity and reliability of the findings from these studies.

Furthermore, the above studies primarily employed quantitative methods (Naeem et al., 2010; Naeem et al., 2015; Rathod et al., 2013) and did not provide any detailed information on how beneficial CBT was, how the CBT was modified, how these modifications were experienced by the PM clients, and how the clients made sense of their experience of therapy. There is therefore an important gap in the knowledge that needs to be addressed in order to modify CBT interventions appropriately to address the needs of this particular group of clients more effectively.

2.5 Summary of the Review and Identified Gap in the Literature

As mentioned earlier, previous research has highlighted the fact that PMs underutilise mental health services, including those of counselling and psychotherapy (Greenwood, Hussain, Burns, & Raphael, 2000; Netto et al., 2006). The few studies that there are have not considered the gender and generational differences that exist within South Asian immigrant groups (Bowl, 2007). Moreover, almost one half of all the Muslims in the UK are second and subsequent generation British Muslims (ONS, 2011) who might have different perspectives from those of their parents and their grandparents. Much of the research conducted has focussed on first-generation immigrants (Weatherhead & Daiches, 2010), and the experiences of second-generation Muslim men in the UK have hardly been explored. Second-generation PM men's views and experiences have thus been completely neglected. There is therefore an important deficit in the literature that needs to be addressed to provide new insights into this neglected group. In addition, the majority of the studies have not taken into consideration the heterogeneity of Muslim communities, and have assumed commonality across the various communities (Netto, 2006; Weatherhead & Daiches, 2010).

Moreover, Hodge and Nadir (2008) suggest that group therapy, and psychodynamic (Shah, 2005) and humanistic (Dhiman, 2007) approaches are not particularly suitable for the majority of Muslim clients, but Chaudhry and Li (2011) state that CBT as a short-term, solution-focussed, goal-directed therapy is consistent with Muslim clients' characteristics, needs and expectations. In contrast, Beshai et al. (2012; 2016) state that there are some key philosophical conflicts between Islam and CBT, and argue that CBT may not be suitable for the majority of Muslims. However, some studies such as Naeem et al. (2015) have revealed that religiously modified CBT can be more suitable for PMs.

There is therefore the need for a qualitative study which explores specific issues which PMs have with CBT in relation to their faith. In addition, several studies have shown that CBT can be suitable for PM clients in the UK (Mahr et al., 2015; Rathod et al., 2013), and Weatherhead and Daiches (2010) found that Muslims in the UK already use cognitive strategies such as positive thinking, inner strength, and the search for solutions to overcome their problems. Nonetheless, whilst research into the domain of CBT for PMs is on the increase (Mahr et al., 2015), to date there has been no investigation to explore UK PM men's experiences of CBT.

In the light of this, the following research question is proposed: ***How do Second-Generation British Pakistani Muslim male clients in the UK experience individual Cognitive Behavioural Therapy?*** The proposed research hopes to provide a meaningful contribution to meeting the psychological needs of this under-researched client group and to give them a voice to express their treatment needs and experiences of CBT. The ultimate aim is to help practitioners to tailor interventions to meet the group's needs more effectively.

2.6 Relevance of This Research Topic to Counselling Psychology

Haque and Kamil (2012) have argued that as the Muslim population in the UK continues to grow, the challenge of providing them with culturally appropriate psychological therapies needs to be addressed. Counselling Psychology research has thus far made very little contribution in the area of psychological therapies for Muslims in general, and for PMs in particular. However, Counselling Psychologists can make a significant contribution by exploring the subjective experiences of second-generation PM men who have utilised CBT. This is consistent with the theoretical, philosophical and epistemological underpinnings of Counselling Psychology which is primarily concerned with clients' subjective experiences, feelings and meanings (BPS, 2010; Strawbridge, 2016). The research proposed in this review would therefore be aligned with the practice guidelines of Counselling Psychologists "to know empathically and respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world views" (BPS, DCP, 2005, p.1-2; Hill & Cooper, 2016).

The NICE guidelines (2004; 2011) recommend individual CBT for all ethnic minority groups, and a large number of practitioners employ CBT interventions whilst working with ethnic minority groups such as PM men. There is however, very little research to inform therapists as to how interventions should be applied to this particular group. In their role as scientist-practitioners (Blair, 2010; Hanley et al., 2013) Counselling Psychologists have the potential to contribute to the literature by bridging the apparent gap between research and clinical practice. The relationship between research and clinical practice is under pressure as, increasingly, "professional accountability and regulation demand a research evidence-base to underpin safe and effective practice" (Moran, 2011, p.171). This is clearly manifested in the IAPT programme (NIMHE, 2008) by the inclusion of psychological

therapies that are classified by NICE (DoH, 2010) as evidence-based. Similarly, Kasket (2011, p2) has highlighted the importance of "producing knowledge that practitioners can readily use". The proposed study endeavours to contribute to an evidence-based understanding that Counselling Psychologists can use in order to provide more flexible, creative and tailored interventions for second-generation PM male clients. Douglas (2016) and Orlans (2011) state that tailoring interventions to address clients' needs is one of the central practices of Counselling Psychology, and it could also enhance the therapeutic alliance between therapists and clients, and thus improve the well-being of clients.

PM men are currently under-represented in the literature of psychological therapies (Rathod, Naeem, & Kingdon, 2013) and the discipline of Counselling Psychology aims to give a voice to under-represented groups (Douglas, Woolfe, Strawbridge, Kasket & Galbraith, 2016; Werth, 1993). Equally, CBT and the appreciation of differences and diversity are key parts of Counselling Psychology training to help practitioners to engage better with different client groups (Sanders, 2016; Parritt, 2016). The proposed study thus endeavours to contribute to the discussion about how differences and diversity can be addressed meaningfully within Counselling Psychology training.

3 Method

This section will discuss the rationale for employing a qualitative research methodology and an Interpretative Phenomenological Analysis (IPA) method for the current study. In addition, ethical considerations and the analytical process will be discussed herein.

3.1 Rationale for a Qualitative Study

According to Willig (2013), the use of qualitative research is well-suited for an in-depth exploration, description, and interpretation of the personal and social experiences of small well-defined groups of individuals. Qualitative methods emphasise the understanding of an individuals' subjective experiences and provide an exploration of the meanings that individuals attach to those experiences and events. Qualitative research thus aims to capture the complexities, idiosyncrasies and richness of subjective experiences. Quantitative approaches in contrast adopt a positivist-empiricist epistemological position where the goal of research is to produce objective and unbiased knowledge by employing scientific measures without personal involvement on the part of the researcher (Lyons & Coyle, 2007). As Marks and Yardley (2004) point out, qualitative methods are based on the assumption that subjective experiences of individuals are mediated and shaped by cultural, historical, and linguistic factors. Qualitative findings are thus assumed to be influenced by context rather than by a single "objective truth" (Willig, 2013, p.7). Qualitative research methods therefore take a holistic approach and explore data in all its richness and are suited to the wider contextual milieu of experiences.

Since this study explores the complex and multifaceted phenomenon of SGPMM's experience of CBT, the use of a qualitative method thus seems an appropriate choice. As pointed out by Nelson and Quintana (2005), the emphasis in qualitative research is upon 'discovery', while in quantitative research the emphasis is on 'confirmation'. Qualitative research can thus be argued to correspond better with the core principles of Counselling Psychology which are concerned more with individuals' subjective experiences, feelings and meanings (BPS, 2005; 2010) rather than with any 'universal truth' (Strawbridge & Woolfe, 2010). Given the exploratory nature of the present study, a qualitative method was considered more suitable than a quantitative one because the former allows for 'participant-generated' meaning to be uncovered, which according to Willig (2013) enables the possibility of new unanticipated meanings and findings to surface.

3.2 Ontological and Epistemological Position

The current study adopts a critical realist stance. Critical realism proposes that there are stable realities such as experiences and events that exist independent of human conceptualisation and beyond our social constructions of them (Bhaskar, 1975; Finlay, 2006). Nonetheless, this reality can be accessed only partially and not factually or absolutely. Similarly, Smith et al. (2009) propose that researchers must listen to and read participants' accounts carefully to get as close as possible to participants in order to understand how they experience their worlds. Researchers must acknowledge that they will never fully know how it feels to be in participants' shoes. However, Smith (2008) argues that researchers can still develop a good understanding of what it might have been like or how it felt for the participants to experience certain events, and that this could enhance the researcher's understanding of the phenomena.

Critical realism states that different perspectives on the world are possible because of the differences in meanings that individuals attach to their own events and experiences, and different people experience different aspects of the same reality (Fade, 2004). This corresponds with the core principles of Counselling Psychology philosophy and practice which emphasise the importance of individuals' subjective experiences and the recognition of individuals' social context and meaning-making (Strawbridge 2016). Critical realists thus admit to an inherent subjectivity in their generation of knowledge and that other alternative viewpoints are valid. They accept that knowledge is context-specific and that it is influenced by the viewpoint of the perceiver (Lyons & Coyle, 2007). In the context of the present study, a critical realist theoretical position favours the view that for Pakistani Muslim men the experience of CBT does exist, and it hopes to gain a good understanding of what that CBT experience might be like for them.

In adopting a critical realist perspective, the researcher believes that it is impossible to access directly individuals' worlds, and he acknowledges that the findings produced are indeed dependent upon his own perspective. This is consistent with the tenets of IPA which is also grounded in Hermeneutics (the study of interpretation) and which is critical of the idea that knowledge can be obtained outside of an interpretative stance (Heidegger, 1927). Hermeneutics acknowledges that only a partial access to reality is possible due to the limited links between cognition, body and language (Smith & Osborn, 2004). Critical realism and IPA are thus compatible.

In the current study the researcher adopted a relativist ontological position whereby a variety of interpretations can be associated with reality thus throwing the focus on subjectivity. This aligns with the aims of IPA which are concerned with *how* individuals experience particular phenomena (Willig, 2008). Counselling Psychology also aims to explore in a sensitive, empathic way an understanding of how clients perceive particular events and experiences (Milton, 2016). Counselling Psychology and IPA therefore share theoretical underpinnings in which clients (in clinical practice) and participants (in research) are experts on their own experiences.

3.3 Rationale for employing IPA

The range of qualitative research methodologies including grounded theory (Oliver, 2012), and discourse analysis (Sims-Schouten, Riley & Willig, 2007) may also take a critical realist perspective, but the researcher has chosen to employ IPA (Smith, 2011). IPA aims to develop an understanding of individuals' lived experiences of particular phenomena or events, and through "the process of interpretative engagement with the text and transcript" (Smith, 1998, p.189) seeks to understand how they make sense of these experiences. According to Conrad (1987) the researchers must enter the life-world of the participants and try to gain an "insider's perspective" (ibid, p.9). IPA was developed primarily by Jonathan Smith and draws on three philosophical theories: phenomenology, hermeneutics and idiography, and it is also influenced by symbolic interactionism (Eatough & Smith, 2008). According to Howitt and Cramer (2014) symbolic interactionism is the process whereby individuals' understandings of the world are developed through social interaction with others by utilising significant communication.

Giorgi and Giorgi (2008) argue that there are two main approaches within phenomenological psychology: Husserl's descriptive pre-transcendental phenomenology, and Heidegger's interpretive phenomenology. According to Eatough and Smith (2008), Husserl's phenomenological approach focuses primarily on the description of a particular experience or phenomenon, whilst Heidegger's interpretative phenomenology emphasises the interpretative aspects of analysis. The latter offers a flexible approach and focuses on the variation in people's experiences and supports a more interpretative methodology, and it is within this approach that IPA is positioned. The phenomenological component of IPA thus focuses on the thoughts and perceptions of participants' experiences. IPA seeks to

explore participants' unique subjective meanings from their own viewpoints and it does not try to formulate objective explanations and descriptions (Smith, 1996; Smith & Osborn, 2008).

IPA is influenced by Hermeneutics which is concerned with people as interpreting and sense-making individuals. Smith et al. (2009) suggest that the process of analysis necessitates interpretation by the researcher in order to give participants a voice and to gain an insider's perspective on the phenomenon of interest. Smith (2008) goes on to state that there is a double stage hermeneutic process in progress where participants try to make sense of their experiences, whilst researchers try to interpret that sense-making. As a crucial point of reflexivity, it is noteworthy that the researcher of the current study will not only be looking at the participants' experiences from his role as a trainee Counselling Psychologist, but also as a man and as a member of the Muslim community and as an ex-recipient of CBT. The researcher is therefore contributing additional agendas and frameworks, and there will be a multi-stage hermeneutic operation occurring within the different aspects of the researcher's identity. Throughout the data collection viz. interviewing, transcribing and analysis, the researcher thus needed to take into account his own biases and assumptions, and this corresponds with the reflective-practitioner identity of Counselling Psychology (Hanley et al., 2013).

IPA was also considered most suitable for the current study because of its idiographic practices. IPA is committed to in-depth analysis of lived experiences by focussing on how certain phenomena are understood in a particular context by a particular individual, and it therefore concentrates on purposively selected small sample sizes (Smith et al., 2009). This serves the purpose of the current study which is to provide a deep nuanced understanding of SGPMM's experiences of individual CBT by engaging with each participant's transcript to capture a textured understanding of each individual's perceptions (Willig, 2008).

3.4 Other Qualitative Methods Considered For the Current Study

Grounded Theory (GT) is one of the main alternative approaches to the study of lived experiences (Willig, 2013). GT was developed by Glaser and Strauss (1967) and there are various forms of GT. Constructivist GT (Charmaz, 2006; 2008) is the most widely used because it provides great flexibility (Smith et al., 2009). Corbin and Strauss (2015) state

that GT requires data to reach saturation, and thus a large sample is usually required of typically 8 to 12 participants. However, IPA's idiographic philosophy is concerned with the particulars of individuals' experiences and is suitable for small sample size studies enabling a 'micro analysis' rather than a 'macro analysis' of data (Smith et al., 2009). Moreover, Holloway and Todres (2003) state that, in contrast to IPA, GT adopts an explanatory model and aims to develop a theoretical analysis to explain particular phenomena. It is thus concerned with the formulation of a theory or a model as opposed to capturing personal experiences. This study does not seek to formulate a theoretical explanation of these experiences. Instead it endeavours to explore Pakistani Muslim men's personal lived experiences of CBT in order to gain new understandings into those personal experiences. The aim and objective of this study is thus in line with the philosophical and epistemological underpinnings of IPA methodology (Smith et al., 2009), and IPA was therefore deemed more suitable than GT.

Discourse Analysis (DA) was also considered but was not chosen for this study because DA investigates how participants use language to construct versions of their world. DA acknowledges that participants' subjectivity is largely structured through language, and it explores how meaning is made through language and linguistic nuances (Willig, 2008), rather than through understanding personal experiences (Willig, 2003). In contrast, IPA is concerned primarily with in-depth subjectivity, and with understanding how an individual makes sense of what is happening to him/her, and it attempts to gain an insider's perspective of participants' personal experiences. IPA takes the language used into account. It argues that individuals not only act as discursive agents, but it also gives meaning to their lived experiences (Willig, 2013). Rather than being primarily concerned with the language that is used by the individuals to construct their experiences, the current research was interested in the individuals' subjective experiences, how they made sense of their experiences, and the meanings that they attached to those experiences. IPA was thus deemed to be a more suitable methodology than DA for this study.

3.5 Personal and Methodological Reflexivity

In line with Willig's (2008) suggestion, as a researcher I have developed a theoretical and methodological viewpoint that fitted well with the aims and objectives of my study and which reflects my personal outlook on reality (Etherington, 2004). In conducting this research I reflected upon why a qualitative method and why IPA methodology was most suitable for my research and also how this approach fits me as an individual.

Whilst growing up I have been interested in the meaning of concepts and the circumstances that surround events. I wanted to make sense of situations and to understand the personal meanings of these events and experiences rather than the causes of certain phenomena. In my early experiences I witnessed close family relatives who had severe psychological issues, and I wanted to understand the issues involved and the difficulties being experienced by the people close to me. I became interested in the meaning of those experiences for my relatives, my family, and myself, and I wanted to develop a richer understanding of those events and experiences in order to help my relatives. They felt that nobody understood them and I wanted to be able to empathise with them and to help them to feel understood.

Willig (2008) states that it is important for qualitative researchers to understand how they make sense of their worlds. My long-held interest in understanding individuals' subjective lived-experiences underpins my theoretical position and it grounds me in a qualitative method aligned with IPA methodology. Indeed, Etherington (2004) argues that researchers' roles are enriched by their personal backgrounds which allow them to connect emotionally and empathically with the participants in their research. However, this could have had a potential impact of favouring IPA and disregarding other non-phenomenological methodologies. As a result, during the research process I was aware of this personal preference, and I endeavoured to choose a method and methodology that was best suited to address my research question and which filled the gaps in the existing literature rather than one that suited my own desired method and methodology.

3.6 Participants

The participants were six SGPMM who had received 10-16 sessions of individual CBT. This is in line with one of the characteristics of IPA which uses relatively small homogenous purposive-samples (Smith & Eatough, 2006). The ages of the participants ranged from 22 to 45 years with a mean age of 30 years, and the mean number of CBT sessions attended was 13 (see Table 4). CBT treatment had been provided to the participants by senior CBT therapists, or counselling/clinical psychologists. All the therapists were supervised by internal psychologists specialised in CBT who were registered with the Health and Care Professions Council to ensure that a high standard of CBT had been provided. This information was collected from the organisations concerned.

The age range and the number of CBT sessions completed were in line with the NICE guidelines (2004; 2011) for adult participants and for standard CBT treatments for general psychological problems. In this study a minimum of 6 sessions was required in order for the participants to have had sufficient experience of CBT therapy (Haman & Hollon, 2009; Goldthorpe, Peters, Lovell, McGowan & Aggarwal, 2016). Additionally, in order to provide participants with sufficient time to reflect on their experiences of CBT and to preserve the accuracy of participants' memories of their experiences of therapy, only those men who had completed therapy in the last 18 months were included in this study.

The sample was also in line with the recommendation of Smith et al. (2009) that "for professional doctoral projects, between four and eight cases seems about right" (p. 52), but because of IPA's purposive sampling nature, this study focussed on the experiences of six participants. This number was considered sufficient to provide information for this study whilst enabling the researcher to focus on in-depth accounts of the participants' experiences. It also allowed for the analysis of convergence and divergence, and similarities and differences between the participants (Brocki & Wearden, 2006).

Table 4. Summary of the participants' demographics

Pseudonym	Age	Sessions attended	Occupation	Marital status	Therapy completed	Therapist	Presenting difficulty
Abdul	22	10	Employed	Married	5 months	Male Muslim Therapist	Relationship Problems
Imran	28	16	Employed	Married	14 months	Female Muslim Therapist	OCD & Depression
Khashif	20	16	Unemployed	Engaged	8 months	Female Muslim Therapist	Anxiety
Omar	24	12	Employed	Married	12 months	Female Muslim Therapist	Depression
Salman	43	16	Unemployed	Divorced	3 months	Male non-Muslim Therapist	Drug & Alcohol Abuse
Sunny	45	11	Unemployed	Married	7 months	Male non-Muslim Therapist	Panic & depression

3.7 Procedure

3.7.1 Recruitment

The participants were recruited from charitable organisations that cater for Asian populations. The study was advertised on the organisations' websites and in their newsletters, and potential participants were provided with the researcher's contact details. On contact, the researcher explained the purpose and requirements of the research, and set out the inclusion and exclusion criteria (Appendix A). This was followed up by supplying the relevant information to potential participants either by e-mail or by post. When they had agreed to take part in the research, the interviews were arranged by telephone or by e-mail. The interviews then took place in secure locations that offered privacy and safety for both the participants and the researcher e.g. rooms within the premises of London Metropolitan University (LMU) or rooms within the organisation in which they had had their therapy.

3.7.2 Data collection

The researcher utilised face-to-face semi-structured interviews with the participants, and each interview lasted approximately 75 minutes. Guterman (1994) argues that semi-structured interviews can enable researchers and participants to facilitate a good rapport with each other and that this enhances the research experience of the participants. Semi-structured interviews are the recommended data collection methodology for IPA because this gives the researcher and the participants more flexibility to follow up any particular avenues that emerge during the interview (Willig, 2013; Smith & Osborn, 2015). Moreover, researchers enable participants to take the lead in where "the conversation goes" (Smith & Osborn, 2008. p 57). Smith et al. (2009) suggest that the use of open-ended and non-directive questions in semi-structured interviews can provide participants with the opportunity to present their narrative in their own words. The interviews thus included open-ended questions with prompts to help participants understand the questions and to encourage them to expand their responses.

3.7.3 Pilot Study

A pilot study with two South Asian Muslim men who had completed their CBT treatment was conducted in accordance with Knox and Burkard's (2009) recommendations. This was to allow revisions to data collection procedures to be made as necessary (Leon, Davis & Kraemer, 2011). The participants were briefed on how their data would be used and the pilot data were not included in this study because they were not representative of the study sample. The outcomes of the pilot interviews were discussed with the researcher's supervisor and it was agreed that some changes were needed. Accordingly, the questions were modified to avoid the asking of leading questions and to give the participants a chance to provide their own personal view of their experiences of CBT. Additionally, the order of the questions was changed to improve the flow of the interview. The interview questions were designed in the following order:

"Can you tell me about why you decided to have therapy?
What were your thoughts and feelings before entering therapy?
How did you feel as a Muslim man receiving therapy?
What did you like about your therapy? How has the process helped you?
What, if anything did you find unhelpful about your therapy?
What role does religion play in your life?

Did religion come up at all in therapy?
How well do you think therapy and religion fit together?
What do you think would prevent Muslims from having therapy?
What would help them use therapy better?"

3.7.4 Materials

The materials required for this study were recruitment posters (Appendix B) that were displayed by a number of different organisations (Appendix C), and a demographic form (Appendix D) was used to contextualise the sample. Moreover, prior to the interview, the information sheet (Appendix E) and informed consent form (Appendix F) were discussed with the participants. An audio-recorder was used for recording the interviews and an interview schedule (Appendix G) was employed to elicit the data. After the interview a debriefing form (Appendix H) was given to the participants, and a sensitive verbal debriefing took place (Appendix I). To manage any distress, the Distress Protocol (Appendix J) was adhered to.

3.8 Data analysis

In line with Howitt and Cramer's (2014) suggestion, all the interviews were transcribed verbatim by the researcher employing the 'orthographic transcription method' to record what was said by the participants (including all the hesitations, pauses, repetitions and background noises). All the interviews were transcribed using Hutchby and Wooffitt's (2008) and Jefferson's (2004) transcription conventions (Appendix K). The analytical process for IPA was guided by Smith et al.'s (2009) recommendations. Large margins on each side of the text were left for comments. Each transcript was read and re-read three times to make sure that the participants' voices were the main focus of the analysis. In the left hand margin of the transcript, initial thoughts, feelings, similarities or contradictions, and anything that appeared important to the researcher was recorded using the participants' own words. This was done whilst simultaneously listening to the participants' audio-recordings to ensure that the analysis was grounded in the participants' data (Smith, 2011).

The researcher again read the transcript and the initial notes in the left hand-margin, and noted down all the emergent themes in the right hand margin of the transcript. These

emergent themes were then developed through the interpretation of the initial notes in the left hand margin (Smith & Osborn, 2008). This phase involved a hermeneutic process because it required the interpretation of what the participant had said, and it also involved the researcher's attempt to understand how each participant was making sense of his experiences (Rizq & Target, 2008). Thereafter, whilst staying very close to the text to make sure that the connections between the participant's responses and the researcher's interpretations were apparent, initial notes from the left hand margin were transformed into higher level interpretation and abstraction in the right hand margin (Smith & Eatough, 2006).

Emerging themes in the right hand margins were listed and any connections between them were examined. The themes were then grouped together to form clusters of themes, and as clusters of themes started to emerge, the researcher moved back and forth in the transcript to ensure that the integrity of what the participants had said was preserved as far as possible (Smith, 2004). The identified clusters were labelled with a title and the researcher then produced a summary table of the themes that had emerged together with the relevant quotations. Mcleod (2011) emphasises the importance of idiography in IPA, and the above process was therefore carried out for each individual transcript. In line with the idiographic principle of IPA, the researcher tried to 'bracket' (Smith et al., 2009) any themes that had been identified in the previous transcript. The researcher however acknowledges that to some extent it was inevitable that the analysis of a prior transcript would exert some influence on the analysis of the next transcript in the analysis.

The next stage of the process was to look for patterns across all the individual tables of emergent themes and to construct one main table of master themes for all the participants in the study. During this process some of the themes were relabelled in order to capture the complexities and richness of the participants' experiences of CBT. Smith et al. (2009) suggest that the selection of themes should be based on the richness of the themes, whether or not these themes contributed something new and insightful to the existing literature.

Finally, the researcher looked for connections, similarities and differences between all the participants' accounts. Sub-themes were produced, and these were then grouped into superordinate themes. These were supported by quotations from the transcripts to keep the interpretation grounded in the participants' words (Smith & Eatough, 2016). The researcher's interpretations play an important role in IPA, and throughout the research

process the researcher as suggested by Kasket (2013) kept a 'reflective journal' in order to be transparent in the process of interpreting the data. This also helped to structure the analysis and the discussion. In addition, in order to increase the rigour of the research, the researcher's reflections were discussed with the researcher's supervisor and with the researcher's peers (please see Appendix L for extracts from the Reflexive Diary).

3.9 Ethical considerations

The study was carried out in accordance with both the London Metropolitan University's Code of Good Research Practice (2005) and the BPS's ethical guidelines (2006; 2009) and, prior to embarking on the research, ethical approval was obtained from the Research Ethics Committee at LMU (Appendix M). This study did not involve the intentional deception of the participants nor the withholding of any information about the nature of the study. Prior to conducting the interviews, all the participants were thoroughly briefed on all aspects of the interviews before signing the consent forms. Participants were informed that they could say as much or as little as they wished to reveal, and at the end of each interview session there was space for discussion about any concerns that had arisen regarding the study.

Signed consent forms were obtained from every participant prior to commencing the interviews. One copy was given to the participant and a second copy was kept by the researcher. Participants were informed that they had the right to withdraw from the study at any time during a four week period after the interview, but not thereafter because withdrawal after this period would make it difficult to separate the responses of individual participants from the overall analysis. Additionally, the participants were given an opportunity to discuss with the researcher any concerns they may have had regarding the audio-recording (none of the participants objected to being recorded), or confidentiality, or any other aspects of the study.

Participants were informed that the audio-recordings would be utilised only for the purpose of this study, and that summarised and anonymised data would be used in the published thesis and also in any articles for wider publication. Anonymity was ensured throughout the study by the use of pseudonyms for all the participants, and all other identifiable information was removed or changed to protect confidentiality (Bond, 2010; 2015). The participants' audio-recordings and interview transcripts and all other electronic data were

kept in a password protected computer in the researcher's house. All other sensitive information was kept in a locked filing cabinet in a secure location in the researcher's house. The interview material will be retained for five years after the completion of the study, and all the data was processed in accordance with the Data Protection Act (1998).

It was not expected that the participants would experience undue distress during the interviews. However, the researcher was responsive to, and continually monitored the participants' psychological and emotional state throughout the interviews. In the preceding three years, as a trainee Counselling Psychologist, the researcher had developed a set of skills for working with people with psychological difficulties, and this allowed the researcher to unpack the depth of the participants' experiences whilst ensuring their safety. The researcher was not offering therapy, but even so, by asking appropriate questions and by encouraging participants to talk about their experiences in-depth, and perhaps more importantly by allowing their voices to be heard, the interviews could have had a therapeutic effect on the participants (Guterman, 1994).

At the end of the interview, the participants were debriefed. Throughout the interviews none of the participants exhibited any distress and the LMU distress protocol was not needed. All the participants were provided with the details of useful organisations (Appendix N) that could support them should they experience any distress after the interviews. In case any of the participants had any concerns or complaints about the study, both the researcher's and the research supervisor's contact details were provided to each participant.

3.10 Research Quality

According to Barker, Pistrang and Elliott (2002) qualitative and quantitative research have different epistemological underpinnings, therefore qualitative research employs different criteria to assess validity and reliability. Smith et al. (2009) argue that Yardley's (2000; 2009) guidelines should be utilised in qualitative studies to assess the quality of the research.

To ensure this, sensitivity to context was demonstrated by the researcher by being sensitive and by being aware of the existing literature in the research topic (cf. Section 2.0). The researcher was also sensitive to any of his own characteristics (his culture, gender, and age) that could have influenced data collection, the interview process, and the findings (and this is discussed further in the reflexivity throughout the study). Sensitivity to data was specifically illustrated through the analysis of extracts from the participants' interviews, as described above. According to Smith and Eatough (2012) this process gives a voice to the participants in the research and enables the reader to see how the interpretations and the analysis have been made.

Commitment and rigour were demonstrated by paying careful attention to the needs, words, and body language of the participants during the interview. Great care was taken in the process of in-depth analysis of each transcript and, in line with Yin's (1989) recommendation, an audit trail was conducted to ensure the validity of the research. Yin states that all data should be carefully filed so that anyone can follow the chain of evidence from the initial stages to the final report. This is shown by the inclusion of Imran's annotated transcript (Appendix O) together with an example of his emergent themes (Appendix P). His table of subthemes and superordinate themes is also included (Appendix Q). A table of superordinate themes and sub-themes together with relevant quotes across all the participants is also shown (Appendix R). The photographs provided demonstrate the development of the sub-themes and superordinate themes for Imran (Appendix S), and for all the participants (Appendix T).

Yin points out that this 'paper trail' helps the researcher to examine the rigour of his/her claims and findings. Furthermore, to improve the validity of the research, 'participant validation' was considered. Langdridge (2007) and Giorgi (2008) state that participants may not be in a position to validate the researcher's findings because they may not be aware of some of the meanings/connections in their own narrative, or because they do not recognise the researcher's interpretations or consider them relevant. In contrast, Kvale (2003) suggests that the participants' involvement in the process of analysis could improve the validity and objectivity of the findings. Similarly, Willig (2013) argues that in phenomenological research, participants' feedback on their experiences is valuable, and Finlay (2008) states that participants' validation can strengthen and improve the interpretation made by the researcher. The summary of the findings was sent to all the participants to review and comment on. Three participants did not respond, but three

participants stated that they were happy with the overall summary of the findings, and no additional comment or interpretation was provided.

In order to provide feedback and to ensure that the superordinate themes, sub-themes and emergent themes were grounded in the participants' interviews, a peer review was conducted by two fellow trainees who were familiar with the process of IPA. Angen (2000) argues that even though peers do not have the same involvement with the data as the researcher, nevertheless they can still help in the process of making sure that the themes are coherent and make sense. The peers' feedback revealed that at times the researcher's analysis was too descriptive and the researcher looked at the transcripts more closely to see whether he could improve his interpretative skills whilst remaining grounded in the participants' data. Nonetheless, the overall analysis was seen as coherent and it corresponded with the participants' account.

Lastly, the impact and the importance of this study is measured by whether or not it makes a contribution to the existing theory, research, and literature in this field, and whether or not the application of its findings can make a contribution to the practice of Counselling Psychology. It is hoped that the findings of this study will be found to be of interest, be original, fill a gap in the literature, and be useful, and that they will make a contribution to the treatment of Pakistani Muslim men in CBT in the future (please see Appendix U for a list of recommendations for clinical practice and research).

4 Analysis[1]

Three superordinate themes emerged from the IPA analysis of the six semi-structured interviews. Firstly, 'pre-CBT difficulties' describes the participants' desperate need for help, and the stresses, challenges, cultural, family and community difficulties encountered by Second Generation Pakistani Muslim Men (SGPMM) who seek therapy. Secondly, 'the process of CBT' discusses what CBT means to the participants and what they learned from therapy. It illustrates some of the issues that they encountered regarding the process of CBT and the therapist. Finally 'the interaction between CBT and Islam' explores the significance of religion and how Islam and CBT complement, fit and conflict with each other. The summary of these superordinate themes and their sub-themes and appropriate extracts can be seen in Table 2.

[1] In the analysis section, the theme of shame for SGPMM is hinted at but is not explicitly mentioned, and this was because two of the participants in their feedback were reluctant for the theme of 'shame' to be included in the review. Perhaps this illustrates the enormity of the negative connotations regarding the shame surrounding mental illness and therapy that exist within the Pakistani community. Tabassum et al. (2000) and Naeem et al. (2015) state that the word "shame" carries "enormous" negative connotations for Pakistanis, and clinicians and researchers should use the word shame sensitively with this population group.

Table 2: *Summary of superordinate and sub-themes with relevant quotes*

Superordinate theme	Sub-theme	Relevant quotes/extracts
Pre-CBT Difficulties	The need for help	*"I was in serious need of help because my whole life was just falling apart". Salman, Line 9-10.*
	Pakistani community stigma and hiding	*"I stayed away because I was so scared of what people would say, especially my family and our Pakistani community". Omar, Line 317-318.*
	Pakistani men without feelings	*"It's more like you have to be a man, there's no such thing as feelings for Pakistani men basically". Abdul, Line 457-458.*
	Being stuck in the middle ground and living in two worlds	*"We get caught up in the middle, that tug of war going on within yourself." Khashif, Line 2112-2113.*
The Process of CBT for Pakistani men	Mirror, guide or conversation	*"I was being steered in a way where you know I would find the right solution for myself". Khashif, Line 701-702.*
	The Muslim therapist: tailor or taboo	*"It was tailored to me because my therapist understood what background I came from". Omar, Line 630-631.*
	Being in a learning environment	*"Therapy helped me to question my religion, my beliefs and my values...If anything, it's brought me closer to my religion". Abdul, Line 970-972.*
	Lack of space and too difficult	*"I wasn't allowed able to do that so that was frustrating". Imran, Line 556-557.*
Interaction between CBT and Islam	Personal significance of Religion	*"Islam is really important not only for me, for 99% of Pakistanis". Sunny, Line, 1226.*
	The need for two knowledges	*"I need some counselling session of both knowledges". Sunny, Line 847.*
	Clash, conflict or complement	*"CBT teachings are saying it's not God, you are the one in control…but I believe everything in my life is controlled by the will of Allah". Salman, Line 685-688.*

4.1 Superordinate Theme One: Pre-CBT Difficulties

This first superordinate theme reflects the participants' thoughts, feelings and expectations of CBT, and also some of the difficulties encountered prior to CBT. It contains four subthemes, 'the need for help', 'Pakistani community, stigma and hiding', 'Pakistani men without feelings', and 'being stuck in the middle ground, and living in two worlds'.

4.1.1 Subtheme One: The need for help. This sub-theme explores the participants' issues of being beyond their ability to cope with their difficulties by themselves, and this led to a deterioration in their mental wellbeing. All the participants express their desperate need for help in very strong terms, and this is demonstrated by the following quotation from Sunny.

> *"It was a living nightmare, at times I really wanted to die but you know Islam forbids suicide, it was just horrible time of my life".* ***Sunny****, 1143-1144.*

Sunny's reference to a "living nightmare" implies a life associated with constant fear, anxiety, terror and an inability to control the situation. This use of imagery also seems to imply the process of a dream-like state that is unreal and unwanted. Perhaps he saw death as the only way of dealing with his problems, which illustrates his state of desperation.

Salman also gives the impression of despair.

> *"I was in serious need of help because my whole life was just falling apart, tearing apart into pieces, one of the darkest times of my life".* ***Salman****, 9-11.*

Salman consciously acknowledges his need for help in order to manage his situation. Perhaps his whole life is being fragmented and he needs help to put his life back together as a whole again. Moreover, Salman creates an image of brooding "darkness", which conveys the impression that he does not know which way to go to seek help; perhaps he sees therapy as an escape or as a guiding light.

> *"I would maintain that strong face, but inside I knew how crumbled I was, how much I was crumbling, and how little support I felt I had so needed therapy desperately really desperately".* ***Khashif****, 46-48.*

Khashif's image of being "crumbled" is in many ways similar to Salman's metaphor of being torn "into pieces". Khashif's need for help is highlighted by his repetition of the word "desperately" to emphasise his distress, his need for help, and the lack of support in his life. This seems to create a sense of isolation and desperation, and perhaps he expects to get this help from therapy instead. It can be said that all the participants seem to have reached a very difficult, stressful and desperate time in their lives before considering therapy.

4.1.2 Subtheme Two: Pakistani Community stigma and hiding. The participants argue that the Pakistani community views mental health problems as something that should not be talked about, and certainly not outside of the family unit. They all agreed that the Pakistani community believes that Pakistanis should deal with their issues without outside help and should not seek help for mental health problems. These perceptions are therefore a barrier to the seeking of help from therapy. Moreover, for the participants, their community's perceptions of therapy seem to include issues of fear, stigma, judgment, and shame, and this is demonstrated in the following extracts.

> *"I wanted CBT therapy really badly, but it ended up becoming a last resort, because I stayed away, I stayed away, I stayed away because I was so scared of what people would say, especially my family and our Pakistani community[…]I really didn't want to bring shame to them".* ***Omar,*** *315-318.*

Omar may have been judging his desire to break the taboo about seeking help for mental health problems as something 'bad'. Omar's repeated use of the phrase "stayed away" suggests that he tried hard to distance himself from external help, but that he was drawn repeatedly to the help that CBT might offer. It appears that Omar is more concerned about not bringing shame to others than about his own needs.

Likewise, Khashif associates the possibility of attending therapy with feelings of fear and shame.

> *"Stigma attached to therapy, I was so scared to coming to therapy if people found out I was going to therapy people will look down on you…talk behind your back. What is wrong with him…is he mad, crazy, things like that…Pakistani Community is really bad like that, we judge".* ***Khashif****, 1110-1116.*

For Khashif attending therapy is related to feelings of being uncovered, being looked down on, being inferior and perhaps all this played an important role in delaying him from seeking therapy. Khashif makes a direct reference to the Pakistani community as being "really bad" in judging people who go to therapy. He uses the phrase "we judge", perhaps implying that he had been part of the Pakistani community that had judged someone who had attended therapy or perhaps Khashif might also be judging his own community.

Imran indicates the strength of his identification with the Pakistani community prior to CBT, implying that he had once shared the community's perceptions of the stigma associated with therapy.

> *"You're a failure automatically in their eyes. They look at you as if you are diseased and weak. I suppose I had the same stigma about therapy (laugh), before my CBT".* ***Imran****, 425-427.*

The word "disease" may imply something contagious with which people do not want to be associated. Interestingly, here Imran laughs and perhaps this is an indication of his embarrassment at his previous prejudices regarding therapy. There may, however, have been a shift in Imran's view regarding therapy because he describes it in the past tense, and this might indicate that he no longer holds such views. Imran's use of the word 'they' in comparison to Khashif's 'we' indicates a change in his identification with the Pakistani community following his experience of therapy.

Emotions are described as things not to be talked about to people outside of the family, and yet it seems that even within the family there is "no one to talk to". Abdul appears to suggest that Pakistani families expect emotional difficulties not to be responded to and to be things that must be overcome independently.

> *"This sort of big stigma attached to you know, going out and speaking about your emotions, and there is no one, no one to talk to, if I ever did try to speak to someone older in my family, they'd tell me, say, "Oh, it's just the time of life. Don't worry about it. It happens, just get over it".* ***Abdul,*** *27-31.*

When Abdul tries to access help from his family there is a lack of validation of his feelings, and his emotions are blocked and suppressed. It seems that in the Pakistani community it is discomforting to listen to and shameful to talk about one's problems.

Like the other participants, Sunny goes on to suggest that his community discourages the discussion of emotions and instead encourages the masking of emotions.

> *"We hide them so well especially in our community. People probably look at me and think Oh yeah he's fine there's nothing wrong with him because you've learnt to hide it so well but there's a lot going on".* ***Sunny,*** *1341-1344.*

Sunny has learnt to conceal his issues but perhaps there is a tension in managing these two parts of his 'self'. One wonders how effective this was in dealing with his problems because, as mentioned earlier, he said his life was "a living nightmare".

Salman reflects on the perceived differences between the English and the Pakistani perspectives of therapy.

> *"If someone English finds out you're in therapy they're very supportive of you but Pakistani would be the opposite, not want to speak to you anymore. They'll not want to associate with you not everyone, of course, but majority they probably won't want to associate with you, coming to therapy is risky because you might lose people".* ***Salman,*** *1135-1141.*

For Salman going to therapy is therefore perhaps seen as dangerous because it represents a real risk of isolation, loss and alienation from the Pakistani community. Going to therapy may present a risky dilemma: namely, is the cost of "losing people" worth the benefit to be gained from therapy?

4.1.3 Subtheme Three: Pakistani men without feelings. This sub-theme discusses the gender stresses, challenges, and cultural difficulties for Pakistani Muslim Men (PMM) who seek therapy. The following narrative captures this.

> *"It's more like you have to be a man, there's no such thing as feelings for Pakistani men basically. What's going on inside it don't really matter".* ***Abdul,*** *457-458.*

Abdul describes what he sees as a custom of the Pakistani community where people avoid discussions about 'feelings', and this is especially the case for Pakistani men. It seems that this view of talking about emotional difficulties is more deep-rooted in Pakistani men than in Pakistani women. Abdul emphasises the belief that PMM are particularly discouraged from talking about their emotions and "what's going on inside". Abdul seems to suggest

that the outside is more important than the inside. This may be because the outside can be seen by others and cannot be hidden away, whereas nobody can see what is going on inside. This seems to link back to what Sunny said earlier (Line 1341) about hiding what is going on internally.

This theme is elaborated by Khashif when he discusses how Pakistani men deal with their emotions.

> *"The man is supposed to be strong, breadwinner and things like that. They don't get bothered by petty things like emotions and feelings and things like that and having been brought up in home like that and you know it's almost, it's almost automatically passed on to myself".* ***Khashif,*** *1870-1875.*

The word "petty" is used in such a way as to suggest that emotional problems are not viewed as serious, and therefore PMM should not be concerned with or require help in managing them. This indicates that any admission of problems regarding one's emotional state would impact upon one's perceived masculinity: negatively affecting the identity of a "strong" man. The "almost" automatic expectations imposed on men also appear to Khashif as passed on from generation to generation, and he has little choice but to accept them. His mention of being "brought up in a home like that" suggests that his father was an unstated but implied example of what a PMM should be by not discussing his emotions.

Like Abdul and Khashif, Omar articulates a similar view regarding masculinity, and the expressing of emotions is seen as "taboo".

> *"Pakistani men, especially, are very egotistic, have large egos, huge egos, so they would never want to do something like therapy. Because they always have the fear that What if someone found out I was doing therapy? You know it's taboo. In Asian culture, men are really meant to be the strong, dominant men and if you're going to therapy, then you're not".* ***Omar,*** *1228-1234.*

Omar repeatedly uses the word "ego", and he seems to perceive that having a big "ego" conflicts with the concept of going to therapy. The seeking of therapy for help by PMM is not only an admission of weakness and involves the breaking of a taboo, but the discussion of emotions in therapy might also threaten their male "ego" and their masculine identity. Therefore, for Pakistani men, going to therapy is seen as a feminine thing to do. This may thus act as a barrier to seeking therapy, and perhaps why they would "never" consider therapy. It is of interest that Omar uses the phrase "something like therapy". This could be

interpreted as not just therapy, but as anything that perhaps involves exposing weakness such as expressing and discussing emotions.

As with Salman in the previous sub-theme, Sunny makes an interesting comparison between English and Pakistani people's approaches to gender in therapy.

> *"I mean a lot of English people men and women get into therapy but for Pakistani men is a no-go area because they believe men should cope better with problems, therapy is for women. This issue then prevent people to seek therapy early, rather than leaving it to the death point (laugh)".* ***Sunny,*** *1972-1974.*

For Sunny, accessing therapy seems to imply that he is no longer self-reliant and that he is unable to cope. Sunny indicates that in his community, accessing therapy would expose his weaknesses to others, and perhaps there is a sense of his failure as a man, and this leads to feelings of emasculation. It is interesting that Sunny uses the phrase a "no-go area" which portrays the image of entry being prohibited and an area forbidden to him. However it is seen as acceptable for women to seek therapy perhaps because of the perception that women cannot cope with their problems as well as men can. It may also be that women do not need to be strong like men, or perhaps women have emotions, whereas men do not. Like Omar, Sunny seems to imply that attending therapy is associated with femininity.

Sunny states that therapy is considered only as a last resort. It seems that the final choice is between therapy and death. It seems that for Sunny the choice is either to go to therapy and be like a woman, or to stay away and be a man and maybe die.

In addition to all the above difficulties and challenges, the participants spoke of a further barrier to therapy, one that was associated with their identity as PMM, and this is illustrated by a quotation from Imran.

> *"What's the impression that this person is having of me as a Pakistani Muslim man because nowadays people think Muslim men they automatically think Muslim men are fanatics, terrorists even though you hope that the therapist is an open mind to it and not judge all Muslims like that."* ***Imran,*** *1551-1555.*

Imran seems to be concerned with how he might be perceived by the therapist. He hopes that the therapist will be open-minded and non-judgmental, and like Khashif, he uses the word "automatically" to suggest that Muslim men are immediately perceived negatively.

Perhaps he has been worried about judging and being judged throughout his life and he wants to be not judged by the therapist. Possibly he believes that there is no way of escaping serious, catastrophic judgment in therapy.

4.1.4 Subtheme Four: Being stuck in the middle ground and living in two worlds.

This sub-theme explores how the participants struggled with being SGPMM in trying to identify with two different cultures, have two different personalities, and balance two different sets of expectations. The participants also seem to have had concerns about whether their therapists would understand these difficulties. The following quotation captures some of the difficulties experienced by the participants.

> *"Like at home you're a different person and when you go outside with your friends you're a completely different person. Like your parents probably don't even know the person you are outside. So, in reality you become two different people because the culture and family expects you to be like this but you wanna be like that. And that's where it gets a bit difficult, but you'd be stuck in the middle ground".* ***Abdul,*** *373-379.*

Perhaps Abdul is trying to keep the peace between the two sides to avoid the complication of a clash of cultures. One wonders what the ramifications would be for Abdul if his parents were to find out about his outside identity. The use of the word 'we' suggests that this is something that he sees as being a common feature of SGPMM.

To reject parental traditions and norms may result in feelings of guilt, anxiety and loneliness, but equally, rejecting the host society could also result in loneliness and alienation. This could have resulted in him being "stuck" in the "middle ground", and it implies that he cannot move from the middle ground and it is thus a permanent position. The word "stuck" seems to give the impression of being trapped outside both his old and his new communities, unsure of which way to go or of being unable to move, and thus not having a single strong identity.

A similar view is expressed by Khashif.

> *"Growing up here as second generation, where society is going one way and then you know our beliefs and practices, family are pulling us another way and we get caught up caught up in the middle, that tug of war going on within yourself...You're*

totally lost which one to follow because both have good and bad points." ***Khashif,*** *2112-2116.*

Khashif's account seems to reflect the constant tension that second-generation individuals experience. It sounds as though Khashif is having to hold on to two sets of cultural values without fully identifying with either one. Khashif uses words such as "us" and "we" indicating that he does not feel alone in experiencing this tension. He may be generalising this difficulty to all second-generation individuals who are "caught up in the middle". Perhaps he is creating a sense of belonging to a group of 'in-betweeners'. This relates to Hutchison et al.'s (2015) and Shibli's (2010) suggestion that British Muslims feel tension and pressure to choose between their Muslim and British identities. Khashif refers to this tension as a "tug of war" which creates a vivid image of a battle being fought between two sides. When he says "You're totally lost (as to) which one to follow" it suggests that perhaps it is unclear as to which is the stronger, more powerful force and which will be the winner. Maybe he does not have a choice, nor does he have the capacity to choose sides in this "tug of war" within himself.

The importance of managing two cultural realities is illustrated by Salman's narrative.

"One of the big reason for coming to therapy was to find a way to cope being in the middle". ***Salman,*** *280-281.*

Salman like Abdul uses the word "middle" perhaps to indicate a state of uncertainty and of not knowing which way to go. Perhaps being in the "middle" seems good to these men because it might be a place of safety for them, and they can experience a sense of relief where the expectations of each side can be accommodated.

Similarly, Omar goes on to explain that despite the difficulties of being in the "middle of two cultures" he still has concerns about seeking therapy, and that those concerns perhaps act as a barrier in accessing therapy.

"Being Pakistani second-generation we're in the middle of two cultures, Pakistani upbringing at home and learning the western values outside home which can be really really stressful at times because these two cultures are in conflict big time, it was difficult for me to balance (laugh). I didn't want therapy you know I had a big concern cos I didn't know that my CBT therapist would understand this specific difficulty of being in the middle of two cultures." ***Omar,*** *392-398.*

Despite his difficulties, Omar seems to be reluctant to seek therapeutic help because his "big concern" was that his cultural conflicts might not be understood by his therapist. Perhaps he assumes that he will be misunderstood by the therapist just as he was misunderstood by his two different cultures. It is worth noting that Omar calls the problem of being in the middle of two cultures a "specific difficulty". This seems to be an indication that he sees the issue as being very specific to second-generation individuals and thus not everyone, not even CBT therapists, would be able to understand the difficulty. Perhaps he is suggesting that ideal therapists are those who are second-generation themselves, or those who are sufficiently experienced at working with second-generation immigrants and who can therefore understand him.

4.2 Superordinate Theme Two: The Process of CBT for Pakistani men.

This superordinate theme discusses the participants' thoughts and feelings regarding CBT therapists and the process of CBT itself. It contains four subthemes, 'mirror, guide or conversation', 'the match or mismatch of the therapist-client religious backgrounds', 'being in a learning environment', and 'limitations of CBT', and these will be explored in detail below.

4.2.1 Subtheme One: 'Mirror, guide or conversation'. This sub-theme refers to the participants' mixed experiences of CBT and what it means to them.

> *"In my other therapy I don't know I just kind of felt like I felt like I was talking to a mirror sometimes, whereas with CBT or the structure you know you have a therapist going right this is Step A, what's the situation? This is Step B, what goes through your mind? This is Step C, how do you feel?".* ***Imran,*** *323-327.*

Unlike other forms of therapy, Imran sees CBT as having a clear step-by-step helpful guiding structure. Imran views CBT as being more directive and expert-led, with the therapist being in control of the direction of the therapy, and there is a sense of satisfaction when Imran talks about CBT. He appears to indicate that the framework of CBT is less frustrating than 'mirror gazing', and with CBT there are observable results. However, Imran seems to imply that CBT therapy does not provide enough space for client-led exploration and self-reflection.

Interestingly, Salman does see CBT as standing in front of a mirror, but he sees CBT in a positive light.

> *"It was more like making you see your own inner self, it was like, the therapy was more like me standing in front of the mirror[...]I'd like to use this two words all the time "self-assessments" of oneself really and that was like kind of beaten into me in the therapy…not in a forceful way though".* ***Salman,*** *278-281.*

In Salman's account, the concept of the mirror is used to describe the guided self-reflection that he experiences in his CBT sessions. In Salman's account the word "self" is repeated perhaps to illustrate the focus that CBT has on the 'self' as it explores, assesses and evaluates the 'self'. For Salman the concept of "self-assessment" was "beaten into" him (albeit not literally) and this process may imply force and suffering. Perhaps he has to suffer before he understands who he is.

Salman and Imran both use the word "mirror" in their narrative. Salman uses it to describe CBT, whereas Imran uses the image of a mirror to describe other forms of therapy.

In contrast, Khashif sees CBT as more to do with guidance from the therapist.

> *"It was sort of like guidance and it was almost as though I was being steered in a way where you know I would find the right solution for myself[…]went back and forth. Initially thought therapy will show me the right way to happiness but I found that therapy guided me to find happiness for myself".* ***Khashif,*** *701-705.*

The word "steered" may be associated with a vehicle being propelled in a safe direction, and this creates an image of Khashif being helped to get where he wants to go. He conveys the image of a journey of guided self-discovery. Perhaps he has a driver with him and so is not alone in therapy. Someone with a better understanding of how to drive a car is assisting him, not to his goal but in how to find his goal. Khashif therefore appears to have some autonomy, and he is not controlled but helped. He uses the phrase "went back and forth" suggesting that therapy was not travelling on a fixed course but rather that it is a journey where one is constantly striving to find the right direction to take.

Khashif goes on to describe the difference between his expectations and the realities of CBT. He repeats the word "guide" possibly to suggest that therapists offer companionship as fellow-travellers. He seems to view therapists as people who to some extent know the

rough direction in which to go, and the therapist has to let him find his own way and not take away his autonomy, independence, and responsibility for his own actions. Khashif therefore uses his guide to find his own happiness and to find his own destination.

Abdul however, unlike the other participants, sees CBT as a "conversation" and portrays his experience as one where the balance of power is equal.

> *"It's just more of a conversation in general. It's just unloading and being able to talk to someone about your problems without there being a negative consequence".* ***Abdul,*** *447-449.*

He describes therapy as an interchange between two people and this indicates that he is assured that control is not being wrested from him. Abdul's use of the verb 'unload' could imply that he has been carrying something that has become a burden which he would like to let go, and therapy gives him the opportunity to cast off or perhaps share his burden. He does not fear reprimand for expressing his thoughts, and this creates a picture of an equal partnership. Abdul indicates that, for him, going to therapy is sufficiently safe for him to take the risk of revealing his vulnerabilities because there are no "negative" outcomes. This seems to imply that the therapy outcome could be neutral or positive, and therefore there is no need to hide from or to fear therapy.

4.2.2 Subtheme two: The Muslim therapist: tailor or taboo. This sub-theme describes the importance of the therapist's religion and background in the process of therapy. Some participants draw attention to the fact that working with a Muslim therapist can be advantageous for them, whilst others mention the possible negative consequences of seeing a non-Muslim therapist.

> *"If the therapist was probably not a Muslim I probably wouldn't have related to him as well...I don't think it would have been as effective as the results I've got what which are fairly good. I mean if the person wasn't a Muslim I don't think I would have been able to say a few things in the sessions that come out of it because I would have felt uncomfortable with them understanding...our culture, religion".* ***Abdul,*** *247-254.*

Abdul attributes the effectiveness of his therapy to the sharing of a religion and mutual understanding with his therapist. By presenting non-Muslim therapists as "them" and by using the word "our", Abdul perhaps shows his in-group and out-group identifications in this narrative.

Like Abdul, Omar also talks about the advantages of seeing a Muslim therapist with regards to the individualisation of CBT.

> *"The advice was very much tailored to me, and it was tailored to me because my therapist understood what background I came from because my therapist was from a similar sort of background...It was advice, you know, tailored to me and my needs at the time. So that's what, you know, I appreciated the most".* ***Omar,*** *630-635.*

Omar repeats the word "tailored" frequently in this extract, using the image of the therapist as a tailor who measures and customises a product to fit him perfectly. He seems to value the concept of individual focus and being at the centre of attention and being understood by his therapist, and all of this is attributed to the sharing of common religious foundations with the therapist and not to the model of CBT itself.

It is noteworthy that Omar says that the therapist gave him "advice". This creates an image of a teacher-student relationship in which the teacher gives an instruction for the student to follow, and the student follows it. This may have left Omar feeling dependent on the therapist. One wonders whether this dependence led to feelings of disempowerment or of enjoyment.

Both Omar and Imran saw female Muslim therapists, but in contrast to what Omar says above, Imran reveals that he has experienced the negative aspects of having a Muslim therapist.

> *"I was talking about sex and...she said you know, professionally what you're saying to me is fine. Personally you know she's like my heart kind of bleeds for you with everything you're doing and I just thought how can you say that?[...]I was quite shocked when she said that so I think the shock the initial shock kind of turned into frustration."* ***Imran,*** *112-116.*

Imran was unable to talk about some taboo-related subjects such as sex to his Muslim therapist. Imran repeats the word "shock" perhaps to emphasise his disbelief at the therapist's response. Moreover, Imran notes that his therapist holds two positions, a professional one and a personal one, and it is the provision of personal disclosure that

compromises the professional boundary and provokes "frustration" and possibly anger in Imran. Perhaps Imran felt that he was being judged by his therapist. It seems that there is a drawback and a tension in seeing Muslim therapists because on the one hand it is acceptable to talk to them and to benefit from the shared religious and cultural understanding, but it is still unacceptable to talk about taboo subjects which are in conflict with religious and cultural beliefs. This therefore portrays the tension of being a PMM stuck between two cultures that is played out in a therapy room.

4.2.3 Subtheme Three: Being in a learning environment. The participants discussed how they had found CBT beneficial. In particular they talked about the learning environment within the therapy and how it had helped them to deal with their difficulties such as the learning of tools and skills to manage and overcome their problems. Moreover, some participants also suggested that CBT helped them to get close to their religion and they found the process of therapy "enlightening".

Salman demonstrates how CBT "tools" and techniques helped him.

> *"Helped me to analyse my problems and deal with my problems effectively using mindfulness and using awareness charts, thought challenging sheet...those were my very important tools. I couldn't believe something so simple could have a big impact".* ***Salman,*** *1194-1197.*

Salman, like Khashif, shows that CBT has taught and helped him to identify his difficulties and then to work out how to solve them on his own. He reveals a sense of surprise and relief that CBT interventions have made such a "big" impact on him. Salman uses phrases such as "my problems", "my tools" which seem to imply that the tools were appropriate to his problems. This seems to signify the importance of these for him and perhaps this highlights his sense of ownership. It may also demonstrate his wish to protect these newly gained tools. There is also a sense of feeling empowered by CBT in that it has given him personalised tools that he can use to continue the process on his own.

Similarly, Omar states that he utilises CBT tools for self-improvement.

> *"Use CBT tools to better yourself all the time, even after completing therapy".* ***Omar****, 499-500.*

This indicates that the education that he has received has not only helped him to manage his problems better but that CBT has enabled him to become a better version of himself. Moreover, the learning and improving processes do not end after therapy concludes, and the outcomes of therapy are potentially on-going and long-term ones.

Abdul points out an unexpected benefit of CBT. He describes an element of learning which allows him to question things to gain a deeper understanding of the concepts involved. It appears that this is the first opportunity that he has had to question his religion.

> *"As a culture we're too scared to question something, but if you question your religion there's a stigma attached to it...therapy helped me to question my religion, my beliefs and my values...If anything, it's brought me closer to my religion".* ***Abdul,*** *970-974.*

Abdul uses the phrase "we're too scared" to imply that he is not alone in his fear. Perhaps he does this to portray a cultural attitude, or possibly he does not want to admit to his own anxiety with regards to the questioning of things. However, Abdul expresses a sense of surprise and relief that therapy and the questioning of his religious beliefs have actually brought him "closer" to Islam. Perhaps he thought that the process of therapy would distance him from his religious beliefs. The fear of questioning seems to be inherent in his culture, but he appears to have overcome the fear and the stigma associated with the questioning of Islam. Perhaps CBT has helped him to face, challenge and overcome the stigma. However, for Abdul it seems that the process of questioning has liberated him.

Khashif also shows how CBT has enhanced his understanding of his religion and the impact that this has had on his life.

> *"CBT therapy for me has been a quite enlightening process because I discover so much about my emotions and my behaviours...how my religion affect all these things".* ***Khashif,*** *2244-2246.*

Khashif describes CBT as an "enlightening process" in terms of the new understandings that enable him to learn more about himself. Of interest is that when Khashif says that CBT has been "enlightening", he may imply that things were previously quite dark and that CBT has lightened up his life. His life is now brighter, perhaps suggesting a lighter feeling and not a heavy gloomy feeling.

4.2.4 Subtheme Four: Lack of space and too difficult. The participants spoke about a number of aspects within CBT that they found distressing, challenging and too difficult. The participants talked about issues regarding the challenging of negative thoughts, the difficulty in understanding the terminology used in CBT, and some found that even the very name "CBT" was daunting and intimidating.

Imran's description is that of the therapist being in control of the session, and of how little space Imran was "allowed" for deeper exploration.

> *"You want to go a bit more deeper about something, and I wasn't allowed able to do that so that was frustrating as in therapist would actively pull me back and say we are losing focus...I found that quite frustrating and sometimes it felt a bit incomplete. The therapist really let me look at is what happens when you have negative thoughts…not really going into the kind of like causes just the symptoms on the surface so I think yeah I think it would be helpful a bit more depth".* ***Imran,*** *556-563.*

This perhaps indicates that Imran may not have had a strong enough relationship with his therapist to give constructive feedback on how he experienced the process. It also echoes the experience of a PM man, feeling that he has to fulfil an expected role and not challenge this expectation but just conform to and comply with it.

Imran repeats the word "frustrating" possibly to emphasise how angry he felt when he was prevented from exploring other areas of his life. The phrase "pulled back" seems to create an image of Imran moving in a specific direction and being restrained from going in any other direction. Also the phrase "pull back" suggests some force being exerted by the therapist on Imran which he does not want imposed on him.

Salman goes on to describe the difficulties that he experiences regarding the language of CBT.

> *"Words like core beliefs...critical incidents...assumptions, activation, negative automatic thoughts, it was very difficult to understand them".* ***Salman,*** *550-551.*

Salman seems to be expressing a sense of distress in understanding the terminology of CBT: and by listing the technical terms that were used in his therapy, Salman may be amplifying his dissatisfaction with the terminology of CBT. Salman reveals something important here. If he found it difficult to understand the terminology and the technical terms, then how did he make sense of the therapy itself, and what impact did this have, not

only on the process of therapy but also on the client/therapist relationship? Perhaps there is also an implied disjunction with Islamic explanations of being and behaviour because these CBT phrases are not just new but are a paradigm shift in his personal understanding.

Sunny shares some of Salman's feelings with regards to CBT assignments and homework.

> *"I was the patient, and I was thinking that really the therapist should treat me as a patient, not give me like something to do like a homework, like a student. I was not his student, I was his patient. So, I was unable to complete my assignment".* ***Sunny,*** *441-445.*

Sunny's use of the word "patient" indicates the role that he expected to take in the therapy relationship, namely a person receiving a medical treatment where no "homework" is involved. He is possibly hoping/expecting that the therapist will be active like a doctor and that he can then take a passive role. Sunny's dislike of "homework" suggests that he was there to have something done to him and he did not expect to have to be an active agent in his treatment. When Sunny says "I was not his student" it may be that he thinks that he was being patronised with homework, or that he found the student role unsatisfactory and that he preferred the patient role. Moreover, if Sunny feels like a student, then this seems to imply that the therapist was behaving like a teacher in a position of authority. This also creates a sense of Sunny not being in control or having any say in what was expected of him, possibly like a student. When he reflects on homework assignments, his use of the word 'unable' suggests that his resistance to the student role perhaps prevented him from completing the homework assignments.

Omar points to another difficulty regarding challenging negative thoughts.

> *"Although things like challenging and changing negative thoughts and beliefs seemed really easy in the session but it was frustrating and really difficult to do outside the session".* ***Omar,*** *719-722.*

Omar draws a contrast between the techniques that he is learning being easy to do in sessions, but being "really difficult" to do when he is by himself. The struggle in reconciling theory and practice seems to create feelings of frustration in him. It is noteworthy, that Omar and Imran both use the same word "frustration" to express their feelings with regards to different aspects of CBT.

The participants also describe issues with regard to the name 'therapy' and in particular to the label "CBT". Salman goes on to demonstrate deep concerns about the name "CBT".

> *"Word, cognitive behavioural therapy, is enough to scare any person's living daylights out of the person…just the word 'CBT' is quite intimidating, it's intimidating term you're just labelled straight away, even before anything goes on, you have a mental problem and that's quite, quite intimidating, quite scary, quite daunting". **Salman,** 1625-1630.*

Being in CBT evokes in Salman the stigma that is attached to being "mental". For him, by being allocated to this particular type of therapy, he has in effect been diagnosed even before he has been assessed. Perhaps this has further increased his feelings of anxiety and even created a sense of dread in him. For Salman, it appears that CBT conveys the impression that a judgement has already been made and that something is wrong with him. Salman not only has to face the Pakistani cultural stigmas regarding mental health, but he also has to confront the stigmas that are attached to the "CBT" label.

4.3 Superordinate Theme Three: Interaction between CBT and Islam

This superordinate theme discusses three sub-themes: the important role that Islam plays in the participants' lives, their wish to integrate Islam into CBT, and the good fit or the conflict between religion and CBT.

4.3.1 Subtheme One: Personal significance of Religion. In this sub-theme the participants reflect on the significance of Islam in their lives and the influential role that it has on their social, physical and psychological wellbeing. The significance of religion is demonstrated by the following quotations.

> *"Religion is a massive part of my life. It's not just something you do on a Sunday morning going to a church. It's something that you do every day, every second, every hour. I think that's why it's different, we have to consider it in everything we do". **Oma**r, 930-934.*

Omar is perhaps comparing Islam and Christianity by suggesting that for him religion is not something that is limited to a particular context or a particular time. When describing the omnipresence of his religion, it seems that there is not a single moment, not even in therapy, when religion does not govern Omar's life. For him, Islam is more than just a

regularised formality: it encompasses every aspect of his life and he practices his religion constantly.

Salman uses the concept of the 'self' to portray the same experience.

> *"It's not addressing just one thing, it takes the whole person, religion for me is the most imperative and important thing, from the time I wake up to my daily activities and everything from my work to livelihood, my earnings, my bread, my butter, I am totally dependent on Allah [God] for everything physically, religiously, morally, everything Tawakal-to-Al-Allah (dependence, trust, and reliance on Allah's plan)".* ***Salman,*** *633-639.*

The imagery that Salman uses is one of dependency, and he is never independent of God. Salman's statement of dependence implies that he recognises that Allah has given him everything that he has in his life, and that makes him the person that he is. This conjures up the idea that without Allah he would have nothing and be nothing.

An alternative interpretation could be that if Omar believes that everything happens because it is supposed to happen, because Allah is in charge, then there may be a sense of certainty that everything in his life will be fine. In addition, when Salman says that religion is the "most imperative" thing in his life, perhaps he is indicating that he is bound by the concept of obedience. He has to obey Allah's every command and therefore, depending on the therapist, may have created a sense of tension and conflict.

The participants talked about how their religion has a positive impact on their lives. Abdul for example describes participating in the religious practice of "Zikr" (a form of prayer) and how this has a positive impact on his mental wellbeing by providing emotional release.

> *"I do Zikr [praying to God/Allah], it's something different, it's a different form of therapy, I mean like meditation, you know a complete stress-reliever. It feels uplifting, uplifting, it's emotional release, releasing emotions, you feel good emotionally."* ***Abdul,*** *1216-1219*

Perhaps Abdul's claim that praying is something different is an attempt to create a sense of uniqueness about prayer. He likens the religious practice to therapy and to meditation in that all three relieve stress, but only Zikr is "uplifting". He says "uplifting" twice, perhaps to emphasise the spiritual dimension of prayer. Perhaps Zikr lifts one 'up' to God. Abdul also uses the word "release" which creates an image of being free. Perhaps in prayer his

emotions flow freely. As previously stated by the participants, the release of emotions is, in normal circumstances, frowned upon. Perhaps prayer grants him permission to acknowledge and engage with his emotional state and to set free his emotions, and he escapes from being confined.

Sunny like Abdul appears to suggest that religion has positive effects on his life.

> *"Islam is really important not only for me, for 99% of Pakistanis religion is really important regardless how religious they are. I am not religious but Islam is my way of life and not just a belief. Whereas in this country people are not religious therapists shouldn't assume that religion is not important for us."* ***Sunny,*** *1226-1230.*

Sunny's use of the word "just" appears to emphasise the enormity of Islam. It is more than a belief system, it is an integrated or core cultural practice. This indicates a deeper cultural identification where religion is the unifying factor even for those who are not completely committed doctrinally. Religion appears to be a core aspect of Pakistani identity, ethnicity and cultural make-up – but this is not the case in CBT and perhaps not in non-Muslim British people.

4.3.2 Subtheme Two: The need for two 'knowledges'. This sub-theme discusses the impact of the inclusion and exclusion of Islamic considerations in CBT. Salman here talks about the importance of paying attention to "religious belief" in therapy.

> *"People who do come with religious belief like me and other Pakistanis, if a little bit of emphasis, a little bit of care and little bit of consideration is given to religious beliefs would be great."* ***Salman,*** *700-702.*

The participants seem to make an assumption that "other Pakistanis" are also religious, implying a strong sense of shared community. Yet Salman uses the phrase "a little", to suggest that there is very little or no consideration of religion contained in therapy, and that even "a little" would create an impact. Salman also expresses a wish that "care" and "consideration" be given to religion, and this might show that for him religion is something precious that needs to be given due care and attention. Given the central role that religion has in his life, then therapy must not ignore religion.

Imran however conveys the impression of external forces, including religion moulding something into shape.

> *"You know culture, family, religion kind of shape who you are they shape your value they shape your beliefs they shape how you think unless you really understand why or how it's quite difficult to make serious changes."* ***Imran****, 405-408.*

Imran describes the external factors that continuously shape and influence him but he does not talk about the internal factors, or he may be unable to talk about these, or he may perceive them as not as powerful as the external factors.

Just as Imran and Salman did, Sunny also explains why religion should be included in CBT.

> *"I am very westernised Muslim and I'm not 100% religious person, and I'm not 100% Westernized person, so I'm a mixture of both. So I need a knowledge from a mixture of both things (laughs). I need some counselling session of both knowledges. With any one of them we will still struggle we need the combination of them".* ***Sunny,*** *847-852.*

Sunny highlights the core parts of his identity: his religion and his Westernised version of Pakistani culture, and his use of the word "mixture" portrays an image of a mix of religious and Western identities, values and ideas being combined together in a way that cannot be separated. Sunny requires a mix of Western and Islamic "knowledge" in therapy.

In the next passage Khashif talks about the implications of not including religion in CBT.

> *"So if therapist recommend a solution to me and not taking into consideration my religious belief system. Then that to me is no solution at all really because I can't personally relate to that."* ***Khashif,*** *260-263.*

Perhaps Khashif wishes to be appreciated as a whole person i.e. including his religious beliefs. He repeats the word "personally" perhaps to highlight the need for the personalisation of treatment. Moreover, he expresses himself in 'black and white' – either include religious beliefs or there will be "no solution". Therapy therefore needs to be personalised to his needs, wishes and beliefs for it to be effective.

4.3.3 Subtheme Three: Clash, conflict or complement. This sub-theme reveals the participants' experience of the good fit and conflict between Islam and CBT.

The following account from Khashif demonstrates the good fit.

> *"Therapy is something that is not going against the religion and that it goes hand-in-hand with religion[...]In my faith there is passages you know constant reminders that question things, reflect on your action, reflect on your behaviour, reflect on yourself. And CBT therapy for me was another platform to reflect on a lot of things and question a lot of things as well".* ***Khashif****, 2404-2409*

Going "hand-in-hand" suggests an image of a level of intimacy between two individuals who are close to one another. Khashif goes on to illustrate this close relationship by drawing a vivid likeness between CBT and Islam, where self-reflection is an essential feature of both of them and perhaps self-reflection acted as the binding ingredient that brought them closer to each other and possibly strengthened their relationship. Of interest, Khashif uses words such as "passage" and "platform" with regard to self-reflection. Both words are associated with a journey, and one interpretation could be that reading the Qur'an began a journey of self-reflection, and therapy has provided a platform from which he can move further in this journey. New perspectives may thereby have opened up for him.

Another compatibility between Islam and CBT is that the combination of the two has helped the participants with their difficulties.

> *"There was a period I was getting angry[…]I suppose if a different therapist, who didn't have Muslim belief understanding, and I told him I was getting angry, they'd probably tell me to okay…if you're angry, just take a deep breath and count from ten backwards. But, my therapist said, if you're angry, read a prayer and take deep breath. It's the same principle, incorporated religion into it and it's made me feel a lot more accepting of all of it".* ***Omar,*** *975-982.*

Because religion plays an important role in Omar's life, whatever is approved by religion or is expressed through a religious lens is perhaps 'acceptable' to him. Therefore, "the same principle" coupled with some personalising feature of Islam would make therapy more understandable and 'acceptable' to him.

Omar goes on to state what might happen if there were a conflict or a disagreement between CBT and religion.

> *"I think if it didn't fit nicely or there was disagreement between therapy and my religious values, beliefs, practices anything like that I wouldn't have been going to CBT because no one likes having their religious belief system being attacked or something said against their belief system[…]Even if it is a small thing, no one likes it. I think Muslims have very strong feelings about religion and they perhaps would have walked away and said no to therapy."* ***Omar****, 1070-1077.*

Omar's use of the word "wouldn't" seems to highlight his resistance to therapy were this to represent any danger to his religious beliefs. For Omar, religion is precious and so he would want to protect and defend it in case of an 'attack'. Omar appears to interpret disagreement between therapy and religion as a form of attack on religion, which would not be tolerable to him and to other Muslims.

In contrast, Abdul says that he would "try it for a bit" even if therapy contradicts his religion.

> *"I wouldn't do it but if it's something like OK it contradicts my religion to a certain extent but it could be beneficial if you tried it I might try it for a bit. It just depends on the circumstances as to that".* ***Abdul****, 1256-1258.*

It would be interesting to know what sort of "circumstances" Abdul is referring to here: perhaps where he could manage the conflict between the two, or where the therapy was really beneficial to him.

So far the participants have talked about how CBT and Islam can fit together and the possible impact that a conflict between the two might have. However, the participants also identified some differences and the lack of fit between CBT and Islam.

Sunny talks about the differences between CBT and Islam with regard to the causes of psychological difficulties.

> *"According to the CBT Cognitive Behaviour Therapy mental problems are caused by problems in the mind, thinking wrongly, but whereas from Islamic point of view this problem is a test from Allah, to test our patience, test our ability to deal with problems".* ***Sunny,*** *777-782.*

Sunny's repetition of word "test", perhaps indicates the significance of the concept of being tested, and this test seems to have a multi-functional purpose because it tests different things such as "ability" and "patience".

The participants talked about some of the conflicts that they had experienced in CBT, and Salman's account demonstrates this.

> *"CBT teachings are saying it's not God, you are the one in control…but I believe everything in my life is controlled by the will of Allah, In-Sha-Allah (God Willing) and you know I am reliance upon Allah for everything I do. So I find that quite conflicting, I don't have complete control of everything I do, Allah does. That's how I found that quite conflicting at times".* ***Salman,*** *685-691.*

Salman talks about the clash of the two conflicting belief systems that he experienced during his CBT: one where he is "in control" versus one where he does not have "complete control". In one sentence he repeats the word "everything" twice, perhaps to emphasise the role of religion – that there is no area of his life, not even CBT, that is not affected by the influence and control of Allah, and this was further emphasised by the phrase "In-Sha-Allah". If Salman perceives that he does not have much control in his life, then it may be difficult for him to engage in changing things in his life, and this potentially creates a conflict between his perception of control and what CBT suggests.

Salman goes on to talk about other conflicts that he has encountered in CBT.

> *"The way that I've been brought up all my life with Islamic belief that I put everybody forward first, I keep myself on the back kind of thing. So, those were the things I really didn't feel very comfortable at all with the CBT side of things…and I just don't like this idea of self, self, I, I, I, me, me, Oneself fuck self (laughs). Everything is about the individual and no <u>real</u> consideration about religion, parents, family, it's all about oneness[…]totally confusing, I like to look after my family, my wife and children but whereas in CBT it's all about, no, no, no, no look after yourself first. You do all yourself, you rely upon yourself. CBT is reflection of Western society that everything is about the individual…And that's not the case for Pakistani Muslims…CBT is not for me. I am not you know completely knocking it down but for me CBT is never scenario again".* ***Salman,*** *531-538, 1095-1100.*

As Salman sees it, CBT is a reflection of Western society which focuses primarily on individualism and not on collectivism as is the case with Muslim culture. Salman's swearing could suggest strong dissatisfaction with the individualistic focus, and he thus expresses his sense of frustration and dissatisfaction with this viewpoint. Moreover,

Salman uses the word "oneness" perhaps to illustrate that CBT is concerned with the "self" and does not take into consideration the variety of personal interactions such as religion within which he has to operate. It seems that focussing on the concept of 'self' was difficult and that it totally negated the possibility of any future experience of CBT, because it conflicted with his culture and religion and it did not sufficiently meet his requirements.

However, if Salman sees himself as a mix of two cultures, then he may be struggling with the idea of therapy for the 'self' because this takes care of only one part of him and does not take care of other important parts of his life. In a way, perhaps this excerpt demonstrates not only the deep conflict that second generation Pakistani Muslim men like Salman experience between following the precepts of their Islamic faith and those of Western therapy, but it also shows the stresses that they may endure in trying to reconcile the conflicting pressures of their collectivist culture and the Western individualistic values in which they are embedded. This extract therefore seems to illustrate the multi-layered conflict that second generation Pakistanis like Salman can experience.

In contrast, Imran suggests that there is no clash or conflict between religion and CBT.

> *"I don't personally see any clash ok. I don't because ultimately all CBT does is it helps you understand how you think and what your thought processes are so yeah I don't I don't particularly see any clash between them if anything I think CBT can help you understand how religion affects your way of life or how it influences your way of life but I don't see any I don't personally see any fundamental clash [...] I think they complement each other very well".* ***Imran,*** *604-610.*

Imran repeats that there is no "clash" perhaps in order to highlight the fact that he perceives no conflict between CBT and Islam. However there seems to be a contradiction between Imran's initial use of the word "any" when saying that that there is no conflict, and later when he says that there is no "fundamental" clash. This could be interpreted to mean that there is no important clash. Of interest would be to consider what would constitute a "fundamental" clash for him. Imran, just as with Khashif and Omar and to a certain extent Abdul, thought that there is good fit and a positive interaction between CBT and religion, whereas for Salman and Sunny there is a clash between the two, and the impact of the conflict caused Salman not to consider CBT "ever again".

5 Discussion

This section discusses the findings with regards to the existing literature, and the implication of these findings for theory, research and clinical practice. The findings of this study are then evaluated, and some suggestions are made for future research. This will be followed by a reflexive statement on the process of the research.

5.1 Research findings in relation to the existing literature and the implications of these findings

5.1.1 First Superordinate Theme: Pre-CBT difficulties. The current study confirmed the existing research as follows. Despite a desperate need for therapy, the participants expressed an initial reluctance to seek help. This was due to their belief that not only would this be an admission of weakness but that it would also threaten their masculine identity. These findings are consistent with the existing literature which suggests that men in general are less likely to seek psychological help than women (Good & Wood, 1995; Hammer, Vogel & Heimerdinger-Edwards, 2013). It would appear that how Pakistani men view their masculine identity prevents them from seeking therapy. This is consistent with research that suggests that South Asian men are less likely to seek help than are other groups of men in the UK (Ahmed & Amer, 2012). The participants in this study stated that their Pakistani culture places specific responsibilities and expectations on them. Such responsibilities include being the dominant breadwinner, not worrying about emotions, and upholding the family name and honour, and this is consistent with the research by Chadda and Deb (2013) and Mahalik et al. (2003). Similarly, Bhui et al. (2002) and Lalwani et al. (2004) state that there is an even greater tendency for South Asian men not to report psychological issues because that would threaten their perceived gender obligations to be self-reliant, strong and controlled. The seeking of help could also bring shame and loss of respect to their families and within their communities (Mahmood, 2012).

The current study provides some important new insights regarding SGPMM. It was found that the participants' views on masculinity and cultural responsibility were passed on to them almost hereditarily, and they seemed to have little or no choice but to accept these traditional cultural expectations. This finding is important for clinical practice because it may require practitioners to consider and to address the psychological impact that these traditional expectations and values may have on their clients' wellbeing. They may want to

employ more targeted interventions to help these individuals to manage such emotions better. If therapists could understand the issues that Pakistani men face, and talk to them about how therapy can help with these issues, then it might encourage Pakistani men to consider therapy more favourably and thus engage in it more readily.

The participants' accounts illustrate the need to appear strong and to show others that they are in control and coping. This corresponds with the Western idea of "individualism" which emphasises the importance of self-control, self-reliance, and self-fulfilment (Fernando, 2002; Laungani, 2004). For instance, the participants appeared not to turn to their families for help with their emotional problems perhaps because emotional issues were beyond what families could help with. This in part supports the traditional cultural view that it is the responsibility of male individuals to deal with problems by themselves. It can be argued that for these participants to seek help, even from their family or from their community, could be seen as an admission of failure to cope independently and to uphold the family's image. PM gender role stereotypes expect men to be independent and self-sufficient, and the seeking of help from outside of the family or the community could itself be considered as an inability to manage things independently (Addis & Mahalik, 2003).

However, this finding appears to be inconsistent with previous qualitative research which emphasises the significance of family emotional support for South Asians and for Pakistanis (Bowl, 2007; Netto et al., 2003; Tabassum et al., 2000). It could be argued that SGPMM feel pressurised into managing by themselves because their families do not understand the nature of second generation problems such as managing two sets of cultural values simultaneously (Dhillon & Ubhi, 2003; Furnham & Sheikh, 1993). Therapists therefore need to be aware of the generational and isolation issues and the dual identities of SGPMM, and that the lack of available support may cause them to 'suffer in silence'.

All the participants experienced a sense of shame associated with the stigma related to mental and psychological concerns, and with the fear of losing face and of bringing shame to their family and community. This finding is in line with Bowl's (2007) and Tabassum et al.'s (2000) research that suggests that family and community stigma regarding mental illness affects South Asians significantly. This includes those SGPMM who engage in psychological therapies. Likewise, for the participants in the present study, seeking help and speaking about their feelings and intimate issues to an outsider is a cultural taboo, and it could be seen as letting both oneself and the community down. This highlights the

anxiety within the Pakistani culture with regard to what others in the community think (Seegobin, 1999). Such stigmas should therefore be considered when working therapeutically with this particular client group.

The current research thus throws some light on why SGPMM may engage less in the therapeutic process and underutilise mental health services and seek therapy as a "last resort", and the findings of this study have a number of implications for clinical practice. It follows that best practice would normalise these psychological issues for this particular group of clients and allow them to see their decision to seek therapy not as weakness or defeat, but rather as an act of courage and of strength. This could go a long way towards reducing the feelings of embarrassment and shame for SGPMM seeking therapy.

The participants' interviews also revealed that they feel that they are 'stuck in a middle ground with two different personalities'. They struggle to identify with two different cultures and to balance two different sets of expectations and values simultaneously. The first identity comes into play at home to accommodate the expectations of the family and of Pakistani culture, and the other manifests itself outside of the house to fulfil the mainstream norms and values of Western culture, and of UK culture in particular. This finding is consistent with previous research (Goodwin & Cramer, 2000; Lalonde & Giguère, 2008) which explored the struggles and concerns of second generation individuals regarding the cultural clashes that arise from the incompatibility of the norms and expectations associated with each culture.

In this study the participants talk about the pressure from each side to behave in a certain way, and the tension and difficulty that this creates for them, such as the feelings of being torn apart by the two opposing cultures. Likewise, Lalonde and Giguère (2008) discuss some of the conflicts that second generation individuals might face because Western culture emphasises the importance of individual autonomy and independence. This encourages individuals to pursue their own passions, whereas Eastern cultures place a strong emphasis on community interdependence and family connectedness, and this encourages individuals to pursue values recognised by the community. Clément and Noels (1992) further argue that this conflict requires individuals to follow just one of the two sets of values and norms, but the participants in the current study seemed to struggle with choosing which one to follow.

This tension creates a sense of isolation, hopelessness, lack of belonging, and it undermines and even destroys the sense of 'self' and identity of SGPMMs. This is important for clinical practice because therapists therefore need to be mindful of how compatible their therapeutic approach is with the multiple identities of SGPMM. Therapists thus need to evaluate carefully the relationship or the interaction between the clients' individualist norms and collectivist values in therapy, and to help SGPMM in the process of establishing their identity, autonomy, and intimate relationships.

5.1.2 Second Superordinate Theme: The process of CBT for Pakistani men. The participants expressed a sense of satisfaction that CBT has a step-by-step guiding structure and is directive and expert-led with the therapist being in control of the therapy. This is consistent with Amer and Jalal's (2012) and Naeem et al.'s (2011) suggestion that South Asian Muslims in the UK will find a brief, expert-led and structured model of therapy more suitable to their needs because they typically expect therapists to provide clear, practical and guiding advice. Dwairy (2006) and Haque (2009) found that many Muslim clients, and especially Muslim men, are more likely to terminate therapy prematurely if they do not receive immediate advice or concrete feedback from the therapist.

In addition, the participants in the current study also regarded CBT as a learning environment because it helps them to learn tools, techniques, and skills to manage and overcome their difficulties. The participants revealed a sense of surprise and relief that CBT tools and techniques had had such a positive impact on their lives. This seems to be in line with the findings of other studies (Naeem et al., 2015; Weatherhead & Daiches, 2010) where South Asian Muslims reported that they regarded CBT as a learning process. It provided them with helpful tools to manage their lives more effectively.

Nevertheless, the findings of this study do not entirely support the research by Amer and Jalal (2012), and Chaudhry and Li (2011) which suggest that therapy that is exploratory in nature and non-directive, is most likely to be met with scepticism from South Asian Muslim client groups who would then view the therapist as passive and ineffective. In this study some of the participants described the experience of CBT as a "conversation", possibly implying an equal partnership between client and therapist. An important implication for practitioners when working with SGPMM is that they should not assume that Muslim client groups such as SGPMM would always find structured and expert-led

therapy a useful and appropriate treatment. It would be useful to explore SGPMM's expectations of therapy in detail in the assessment or during the initial therapy sessions. This would strengthen the therapeutic rapport between the client and the therapist. This suggestion is in line with the core principles of Counselling Psychology which emphasise the importance of exploring clients' expectations in clinical practice (Douglas 2016; Hanley, 2010). More specific research about a less directive or structured form of therapy is therefore needed to map out this issue better.

Another key theme that was revealed by the participants was that there are both advantages and limitations to SGPMM seeing either a Muslim or a non-Muslim therapist. The participants stated that seeing a Muslim therapist allowed them to relate better to the therapist and to feel more comfortable. It enabled them to open up about matters close to their hearts. As a result therapy was seen as beneficial and effective. This supports Watter's (1996) and Meer and Mir's (2014) research that found that South Asian Muslims in the UK expressed a preference for a Muslim therapist because the clients thought that a Muslim therapist was likely to understand their cultural metaphors, religious beliefs, and values better than a non-Muslim therapist would. The participants in the current study also talked about seeing a Muslim therapist as leading to a tailored CBT, and suggested that working with a Muslim therapist helps the process of therapy through a shared religious understanding. This finding is supported by Arshad's (2014) study which reported that shared Islamic beliefs and values between Muslim clients and Muslim therapists helps the process of tailoring and personalising therapy to a clients' individual needs.

Participants in the present study also seem to suggest that seeing a non-Muslim therapist is accompanied by feelings of discomfort, an inability to be open, and the possibility of being misunderstood. According to Smith (1998) this could be the result of feelings of anxiety, fear and threat that exist when there are differences in religious beliefs and cultural values between differing people. Similarly, participants in the present study also seemed anxious about seeing a non-Muslim therapist and they showed in-group and out-group identifications in their accounts by referring to Muslim therapists as "we" and "us" and non-Muslim therapists as "they" and "them". This could be seen as an example of the participants attributing positive qualities to the in-group and less favourable ones to the out-group (Tajfel, 1978). This could be explained using Social Identity Theory (Tajfel & Turner, 1981) which proposes that individuals tend to relate more positively towards individuals who share their culture and religion than to those who do not. A similar finding

was also reported in other religions. Similarly, Greenidge and Baker (2012) found that Christian clients prefer to see therapists who were from a Christian background. As a result, it could be speculated that the participants in the current study identified strongly with their religion, and this then could have an impact on how the participants perceived their Muslim or non-Muslim therapist and this could have an impact on the therapeutic relationship and on the CBT treatment as a whole.

However, the participants in the present study also stated that seeing a Muslim therapist prevented them from discussing certain topics such as sex before marriage, alcohol, and gambling which are all seen as sinful acts in Islam (Amer & Jalal, 2012). For instance, when the participants talked about sexually related matters with their Muslim therapists, they felt that they were being judged by their therapists. This is consistent with Netto et al.'s (2006) findings, who reported that some participants did not want to see counsellors from the same background because they feared that they would be judged on the grounds of cultural and/or religious values, and they were also concerned about breaches in confidentiality. Meer and Mir (2014) found that the majority of South Asian Muslim clients had concerns regarding confidentiality, and they expressed a preference for a therapist from a different cultural and religious background. Similarly, Virdee (2004) reported that UK based South Asian men preferred to see 'white' therapists and trusted them more because they felt that a South Asian therapist might take the information disclosed in therapy and share it with the community.

Another key potential issue for Muslim clients seeing Muslim therapists could be that Muslim clients might feel ambivalent about religion or embarrassed about disclosing a low level of religious observance and knowledge, and thus fear being judged by their therapist on religious grounds (Mir & Sheikh, 2010). As a result, this could have a negative impact on the therapeutic relationship such as Muslim clients not opening up and not discussing issues that could be associated with religion. It could be speculated that not opening up about one's religion could have a negative effect on the therapeutic relationship because religion could influence their lives by providing coping strategies to deal with difficulties, and by shaping their beliefs and behaviour (Inayat, 2005; Netto et al., 2006).

In contrast, Muslim clients who see non-Muslim therapists could enter therapy feeling neither ambivalent nor embarrassed about their knowledge regarding their religion and their religious practices. They would thus be able to explore these issues more freely

without the fear of being judged by the therapist. This could potentially develop a stronger therapeutic alliance between client and therapist. It is also stated that the difference in background between Muslim clients and non-Muslim therapists can produce curiosity and insight which can help to abandon preconceived ideas and aid good therapeutic relationships (Mir & Meer, 2014). In several studies (Hodge, 2011; Ahmed & Amer, 2012) prior to therapy, Muslim religious clients indicated a fear that non-Muslim therapists would be insensitive to their religious needs, but in reality therapy with the non-Muslim therapist proved positive.

The findings of the current study thus produce an interesting paradox in that the cultural and/or religious matching of clients and therapists is clearly preferred because it facilitates a better understanding of nuanced community, cultural and religious beliefs. However, against this, Muslim clients may fear that a therapist from a similar background could judge them critically thus making it harder for them to express their intimate anxieties freely. However, although there could be the issue of misunderstandings regarding religion and culture when seeing non-Muslim therapists, such therapists could provide a therapeutic space for topics (such as sex and alcohol) that Muslim clients may find difficult and embarrassing to discuss with Muslim therapists. Muslim therapists who are working with SGPMM clients are advised to keep in mind that their clients may not feel able to discuss their difficulties openly due to the fear of being judged adversely. Therapists are therefore advised to discuss these concerns openly, and to provide clients with a safe therapeutic space to explore their concerns/issues.

The match and mismatch of client and therapist to religion and culture does have an impact on the therapeutic relationship, and it is a complicated and important factor in the whole process of therapy. Nonetheless, there is limited published research regarding the investigation of clinical outcomes when client and therapist are either matched or unmatched according to their religion and culture. The published literature generally shows little significant difference between matched and unmatched outcomes. Betteridge (2012) found that Muslim clients who are religiously committed wanted to be seen by Muslim therapists. Similarly, Greenidge and Baker (2012) found that individuals who are highly committed religiously wanted to be matched with a therapist from the same religious background, but that clients who are not so committed religiously preferred to seek help from outside their faith. Perhaps, this is reflected in the current study, because some SGPMM sought therapy from Muslim therapists and some from non-Muslim therapists,

and this perhaps illustrates the diversity of and the level of religious commitment amongst SGPMM.

Moreover, Mir and Meer (2014) suggest that compassion, empathy, openness, trust, acceptance, and respect in the understanding of Muslim clients' religious beliefs were found to be the most important qualities for therapists to have regardless of the therapist's background. Similarly, Betteridge (2012) reported that opinion was mixed about whether Muslim clients should be matched to Muslim therapists. However, the therapeutic alliance was strongest when the therapist simply accepted and respected a client's views whatever they might be. In addition, the published literature (Netto et al., 2006; Bowl, 2007) shows that the therapist's competence and skill are more significant than the matching of client and therapist with regard to religion. It could be suggested that a basic level of knowledge about religion and cultural issues in general would facilitate a meaningful therapeutic relationship and engagement in therapy. Practitioners should therefore be prepared to acquire some knowledge about the religious beliefs and cultural issues that may arise for clients (such as SGPMM) from the communities within which they work. However, more studies are needed to look at the effect and impact of 'matching' and 'mismatching' client and therapist's beliefs, and also whether the explicit examination of religious beliefs influences the therapeutic process and outcome.

Interestingly, during the interviews, the participants (except for Imran) did not reveal much about the effect that the therapist's gender had on the therapeutic relationship and/or the process of CBT as whole, and there could have been several reasons for this. For example, the focus of the study did not specifically explore the impact of the therapist's gender in CBT and therefore the participants perhaps did not talk about it for this reason. Another possibility might have been that the participants felt that there were other issues which were more pertinent than the gender of the therapist viz. stigma, CBT tools, issues regarding second generation identity, and the interaction between CBT and Islam. It could also have been the case that the researcher was male and the participants thus did not feel very comfortable talking about gender-related issues with a male researcher (Werrbach & Gilbert 1987). Perhaps, they felt an increased need to project and protect their sense of 'maleness' or 'masculinity'. This could be despite the fact that the researcher tried to make them feel comfortable enough to talk about issues and concerns regarding their experiences of CBT. Naeem et al. (2013; 2015) point out that for Pakistani Muslims, and particularly for Pakistani men, it is common to avoid talking about difficulties regarding therapy and

CBT, because in front of other men they may not want to come across as individuals who cannot cope with uncomfortable issues. However, this may not be the case for this particular group of SGPMM because they were able to voice their difficulties regarding CBT viz. not understanding the terminology of CBT, not liking the CBT label, and they did want to discuss the conflict between CBT and Islam.

Moreover, differences in the cultural expectations of men and women tend to vary by generation and by degree of acculturation. As Naeem et al. (2010) argue, first generation South Asian Muslim clients often prefer to be seen by a therapist of the same gender, but second generation Muslims are more flexible and do not mind being seen by either a male or a female therapist (so as long as the therapist is aware of and respects their cultural and religious background). However, not everyone is the same, and it is therefore important to be flexible wherever possible.

The influence of the therapist's gender on Muslim women in therapy and in CBT is well documented. For instance, Muslim women do not feel comfortable discussing intimate issues with therapists regardless of the therapist's gender, and in particular are reluctant to discuss issues relating to sex (Hussain & Cochrane, 2004). Muslim women are even less comfortable discussing such matters with male therapists (especially Muslim male therapists) because of the traditional religious and cultural injunctions involved (Hodge, 2005; Hussain, 2009). However, the impact of the therapist's gender in men's therapy (Millar, 2003) and in particular for South Asian and PMM is less clear (Mahmood, 2012). There could be a number of ways in which the therapist's gender could have an impact on the therapeutic relationship and the process of therapy. For instance, Mahalik (2001) found that Muslim male clients in CBT try to avoid anything that appears to be even remotely feminine, whether it be in terms of cognitions, affects, or behaviours. Muslim men place a very low value on the expression of their feelings because it is seen as evidence of vulnerability, weakness, and femininity. In contrast, expressions of anger, hostility and aggression are seen as more acceptable (Dwairy, 2006), and indeed can be viewed as exhibitions of 'manliness'. As a result of this blocking or suppression of emotions, Muslim men appear not to allow themselves to experience the interpersonal aspects of therapy, and thus tend not to develop an intimate close and emotional relationship with either male or female therapists (Haque & Kamal, 2012). This could then perhaps explain the absence of the impact of gender of the therapist in the study.

However, this issue of sharing emotions becomes complicated by the therapist's gender. Many Muslim men (including PMM) who see male therapists, instead of working out their feelings and emotions in therapy, tend to become cognitively oriented and want to engage in problem-solving strategies. This is so even when the recognition of and the working through of their emotions would deal effectively with the manifestation of those difficulties (Khan & Waheed, 2009; Bhui, 2013). There could be a range of reasons for this such as PMM not wanting to come across as vulnerable and weak in front of another man (Mahmood, 2012). Another issue could be that when a male therapist displays care, compassion and kindness towards a SGPMM, then this could be mistaken for covertly sexual behaviour. The same mistake could occur with regard to a PMM client and a female therapist. When feelings of empathy, warmth and intimacy are evinced as part of the therapeutic work, a PMM client may feel that the therapist is acting 'seductively', and PMM might find it difficult to cope with such feelings in therapy (Lalwani et al., 2004; Khan & Waheed, 2009).

Moreover, the process of therapy is further complicated when there is physical contact such as the client's hand or knee being accidentally touched by the therapist. Such contact could be misinterpreted as a 'sexual' gesture, or indeed as 'forbidden' sexual contact, and therapy might thus be ended prematurely (Siraj, 2010). Furthermore, there could be serious consequences for the therapeutic relationship and the process of therapy. According to their cultural and religious beliefs engaging in any form of forbidden sexual behaviour can be seen as a breach of family honour (Ali et al., 2004; Goodwin, 2003). Therapists might therefore want to avoid any form of physical contact with PMM such as touching, hugging etc, because such behaviour could be misinterpreted and it could have a negative impact on therapy.

Another gender-based factor that could influence the therapeutic relationship between male therapists and PMM clients is that the clients are unwilling to share their underlying difficulties due to the fear of becoming dependent on the therapist and of losing control and they thus do not enter into therapy fully (Netto et al., 2006; Bowl, 2007). By the same token, Mahmood (2012) found that there is a particular issue for PMM because they often fear that if they open up about their emotional difficulties, then their male therapist will become critical of them and will evaluate them negatively. In Pakistani culture, for PMM to be open could indicate that they are weak and 'un-masculine' (Bhui et al., 2002). As a result, South Asian Muslims (including SGPMM) often prefer to see female therapists

rather than male therapists. This is perhaps because they find it easier to be more open emotionally with female therapists than with male therapists and because they might feel competitive with other men. It might also be because their traditional social and cultural pressures keep PMM from opening up to male therapists (Mahmood, 2012). This could have been the case in the current study for the SGPMM who saw male therapists (as Salman & Sunny did). They seemed to have had a less satisfactory experience of CBT than those who saw female therapists.

However, there could also be issues for SGPMM who see female therapists because Muslim families are largely patriarchal (Al-Hashimi, 2005). Men are seen as being the head of the family, being in charge, and being the authority figure, whereas women are responsible for child-bearing and rearing. In therapy however, the roles could be reversed, and a female therapist (and in particular in CBT) could be seen as the person who is in power and in authority, and it is the client who is in the position of dependency. For SGPMM such a power dynamic could be difficult to cope with, and this may cause them to end therapy prematurely (Ali, 2013). Moreover, the therapist-client gender issue could be further influenced by the therapeutic relationship, because in Pakistani communities men are not allowed to associate with women outside of the family without supervision, and the therapeutic room is not excluded from this restriction (Carter & Rashidi, 2004).

In addition, issues concerning eye contact may impede the therapeutic relationship because it would be inappropriate for a female therapist to look directly at a Muslim male client. Eye contact for female clients could also be an issue when they see male therapists. Moreover, a therapist who lacks an understanding of Muslim traditions may perceive the lack of eye contact as revealing a client with low self-image, low self-worth, or one who is lying (Carter & Rashidi, 2004). Interestingly, in Western forms of therapy such as CBT, good eye contact is encouraged and this is seen as a sign of confidence (Beck 2011; Sanders, 2016). In Islam, how men engage with women is governed by a strict cultural and religious code of conduct. Thus how SGPMM engage in therapy is profoundly affected by the gender roles in Muslim communities (Ahmed & Amer, 2012).

It appears then that for PMM the therapist's gender has a considerable impact in therapy and it seems to have impacted on the participants in the study. When PMM clients see male therapists, they try to portray an image of being strong, self-contained, in control of their emotions, and they tend to stay on an intellectual plane and be cognitive and problem-

solving (Mahmood, 2012). SGPMM clients do not want to appear weak or vulnerable to another man and thus tend not to explore their experiences nor their relevant underlying emotions. This could have clinical implications, such as helping SGPMM to understand that the therapeutic space is created for them to feel comfortable, and that therapists are there not to judge them nor to criticise them for experiencing and expressing emotions and feelings. Therapists could help SGPMM by showing them that they can feel relief once they feel that they are free to express their feelings in the therapeutic situation.

A significant finding from this study that is not identified in the existing research, is that some participants in the current study suggest that CBT had helped to bring them closer to their religion by allowing them to explore and question their religion and to gain a deeper understanding of their beliefs. Given how significant Islam is in the life of Muslims, this may be important in overcoming some of the religious and cultural barriers to CBT that exist in Pakistani and other Muslim communities. If Muslims become aware that CBT could actually help them to get closer to their religion rather than it being in conflict with their religion, then this could remove some of their concerns and could possibly encourage them to see CBT in a more positive light. For instance, clients who have had a positive experience of religion being part of their therapy could attend seminars and workshops to share their experiences of CBT with others thus encouraging them to access therapy more readily.

However, some of the participants expressed difficulties in understanding CBT terminology such as “core beliefs” or “negative automatic thoughts”. This supports Naeem et al.’s (2015) and Rathod et al.’s (2010; 2013) findings that CBT terminology and techniques need to be modified for South Asian Muslim clients because they have a different cultural and religious background which may find these concepts difficult to comprehend. Participants in the current study also expressed a strong sense of being overwhelmed by the nature of CBT such as homework assignments, and as a result some participants did not engage with them. This echoes the findings of Ahmed and Amer (2012) who found that that Muslim clients may not find homework helpful and could find the word “homework” patronising, and they could therefore be less inclined to do it. This has an implication for practice whereby therapists should be advised to spend some time explaining and discussing the benefits of doing homework. They might also consider changing the term “homework” to something more acceptable such as “between-session-activity”.

The idea that "CBT" provokes anxiety and is intimidating has also not been reported in the existing research. For the participants it seemed that the label "CBT" evokes negative connotations and conveys the impression that a judgement has already been made that something is wrong with the client. This increases feelings of anxiety about attending therapy. The participants felt that by attending CBT they were immediately being labelled as abnormal, and such negative connotations may not be immediately obvious to health care professionals. The above findings have several implications for the practice of CBT. For instance, it would be beneficial for professionals to explain the terminology of CBT more clearly to SGPMM clients. The therapist could also explain the collaborative nature of the therapeutic relationship, namely that it is more of a partnership than a teacher-student relationship. Lastly, the issues of stigma and shame around therapy and the label of "CBT" could be explored and discussed in therapy thus normalising the mental distress experienced by clients.

5.1.3 Third Superordinate Theme: The interaction between CBT and Islam. The participants spoke of the significance of religion in all the aspects of their lives. This is consistent with previous research which found that religion is the most important aspect of most Muslim people's lives, and it influences the whole of their wellbeing (Basit & Hamid, 2010; Haque & Kamil 2012; Utz, 2012; Naeem, 2011; 2015). The participants expressed dependence on Allah for everything, and said that without religion they would have nothing, and they would thus not be able to function at all. This is evident in the interviews, where some participants used phrases such as "Tawakal-to-Al-Allah" (dependence, trust, reliance on Allah) and "Inshallah" (God willing) to emphasise their dependency and reliance on Allah. Furthermore, the participants also talked about the positive impact that religion has on their wellbeing with regards to stress and emotional release. This is congruent with Amjad and Bokharey's (2014) suggestion that Islam is a form of coping for Muslims. However, the current study has added new insights to the existing literature by revealing that specific religious practices such as "zikr" and "Du'a" are viewed as "uplifting" and seem to provide the participants with psychological resources to deal with their difficulties.

Another new finding from this study is that, if religion were not a part of their therapy then the participants indicated that they may not engage well with therapy, or that the therapist's

recommendations may not be taken on board, or that they may even choose to terminate the therapy. Moreover, some participants in the present study have argued that if there were a conflict or a disagreement between CBT and religion, then they would terminate their therapy because they would never tolerate any 'attack' on their religion. It is important therefore for practitioners to bear in mind that they are not only searching for a good fit between CBT and Islam, but that they should also try to avoid any conflict between Islam and CBT. It is reasonable to expect there to be some level of disagreement between the two sets of values, and it is important for practitioners in their assessments to explore the role that Islam plays in Muslim clients' lives. This could reduce or avoid any misunderstandings and misconceptions about the importance that Islam has for Muslim clients and the benefit that it confers on their psychological wellbeing. This could be an area for future research. The therapist could explore how religion has an impact on the daily lives of their clients, and in what religious practices they participate, and how clients' religious orientation could have an effect on therapeutic work.

This study supports previous research that suggests that South Asian Muslims (Bowl, 2007; Rathod et al., 2010), and Pakistani clients in the UK (Naeem et al., 2015; Tabassum et al., 2000) want elements of Islam to be integrated into their therapy. Recent studies have argued that religiously-adapted therapy, compared to therapy that places no emphasis on the clients' religious identity, produces either the same (Paukert, Phillips, Cullly & Stanley, 2011) or improved outcomes (Ripley, Leon, Worthington, & Sierra, 2014). The existing literature also suggests that tailored CBT can result in more positive therapeutic outcomes when treatments are adapted to clients' needs (Anderson, Heywood-Everett, Siddiqui & McMillan, 2015; Carlson & González-Prendes, 2016). In the current study the participants suggested that taking religious beliefs into account would help them to relate to treatments personally. The resulting therapy would be more efficient and meaningful. This echoes Haque's (2004) and Hodge's (2005) suggestion that incorporating Islamic beliefs into therapy would show that the therapist accepted and respected the client's religion, and this would result in an increase in trust and strengthen the therapeutic alliance. This is a particularly important factor for the SGPMM in this study because prior to attending CBT, they thought that therapists might not want to help them with their difficulties. This stems from the general public's negative attitudes to Islam and to Muslims (Hussain, 2009; Inayat, 2005, 2007). The importance of integrating Islam into CBT is well documented in the literature (Hamdan, 2008; Hodge & Nadir, 2008), but there is a lack of information and empirical support as to what specific aspects of religion should be included for Muslim

clients such as SGPMM. The current study thus provides new information as to how CBT and Islam could fit or clash with each other.

The participants emphasised that for them self-reflection and accountability are essential features of both CBT and Islam. They therefore complement each other. A number of authors have argued that CBT and Islam fit together (Hodge & Nadir, 2008; Haque & Kamil 2012), and they believe that CBT can be tailored to suit Muslim clients (Abudabbeh & Hays, 2006; Carter and Rashidi, 2004; Hamdan, 2008). In all the above studies the suitability of CBT for Muslims appears to be based solely on the researcher's experience of working with Muslim clients, but the clients' views are not made known. In the present study it is the participants themselves who have talked about how and when aspects of religion (such as saying special prayers in times of anger) could be included in CBT. It appears that when standard CBT interventions are coupled with some feature of Islam they become more understandable and thereby become more accessible and more acceptable to SGPMM. This is particularly important because the literature review revealed that the research on tailored CBT lacks information about how it was tailored, whereas the current study has revealed specific suggestions on personalisation of CBT based on their experiences of therapy.

The participants in this study also identified some dissonance between CBT and Islam with regard to the causes of psychological difficulties. According to the participants, in CBT psychological problems are viewed as being caused by faulty thinking, but from the Islamic point of view mental health problems can represent a test from Allah. As discussed in Section 2.3, this is congruent with Al-Krenawi and Graham's (2000) and Utz's (2012) findings that many Muslims believe that Allah tests the love and patience of individuals by sending them various trials including physical and psychological difficulties. Thus it appears that CBT emphasises internal influences and focuses on the individual's internal locus of control, whereas Islam focuses on external/supernatural forces and thus encourages an external locus of control.

Health-care professionals need to be aware of how these explanations for mental illnesses may impact on a Muslim client's attitudes, beliefs and approach to therapy. Another conflict that was reported by the participants was with regards to the concept of control, and it is important for practitioners to be aware of how much control Muslim clients think that they have over their own lives. The participants felt that in CBT the individual is in

control, whereas in Islam Allah is in control of everything. An important conflict then seems to arise, and a way that practitioners might deal with this issue is that they could make it a part of their on-going work throughout the treatment to check to see how CBT interventions fit or conflict with their clients' religious beliefs.

For instance, participants in the current study expressed a strong dissatisfaction with the individualistic viewpoint. This was illustrated by the use of the expletive phrase "oneself, fuck self". For practitioners it is therefore not only important to consider whether and how to integrate Islam into CBT, but it is also important to ensure that what is discussed in therapy is not in conflict with Islamic cultural and value systems. Training programmes could perhaps therefore encourage clinicians to become aware of how to deal with Muslim clients such as SGPMM. Training programmes could encompass lectures or seminars on specific ways of integrating aspects of Islam into CBT treatments. Therapists would then be better equipped to deal with Muslim clients such as SGPMM who may prefer features of their religion to be included in therapy.

However, it should be noted that this finding is inconsistent with Ali and Aboul-Fotouh's (2012) conclusion that second-generation Muslims who are born and bred in Western societies tend to embrace Western individualistic values, and are less concerned with their Eastern collectivist heritage. This is not the case with the SGPMM in the present study, because for them the needs of the family and the community are more important than the concept of 'self'. This could be influenced by the teaching of Islam that suggests that all Muslims are part of one worldwide community, namely the "ummah wahida" (Daneshpour, 1998; 2003). As discussed in Section 2.1, in this belief system the needs of any one individual are subservient to the good of the whole community (Al-Krenawi & Graham, 2000; Al-Mateen & Afzal, 2004). This viewpoint is in direct conflict with the traditional Western individualistic values on which CBT is founded (Beshai et al., 2012). Perhaps this particular group of SGPMM was indirectly or unconsciously trying to preserve or protect some of their collectivist values, and maybe the SGPMM felt that Western culture was eliminating or threatening their Asian values.

Since SGPMM possess two conflicting value systems, i.e. individualist and collectivist, they need a therapy that takes both of these into consideration. However, CBT in its current form tends to favour the former. This illustrates the multi-layered conflict that SGPMM could experience in therapy. South Asian clients in the UK are known to end

therapy prematurely and to underutilise mental health services (Bowl, 2007; Netto et al., 2006; Tabassum et al., 2000) and this conflict could contribute to the understanding of the reasons for this. Clinicians therefore need to be aware of the potential conflict between individualistic and collectivist cultural norms and expectations. The exploration of this issue with Muslim clients early in therapy might not only avoid any conflict between these issues but it might also improve both the therapeutic relationship and the client's experience of therapy. This echoes Nezu's (2005; 2010) finding that addressing issues of differences and diversity such as religion in therapy could positively contribute to the outcome of therapy.

5.2 Applications for research and clinical practice

The current study provided some useful insights as to how this group of SGPMM experience CBT. These insights can be helpful for Counselling Psychologists when they work therapeutically with SGPMM. For instance, as mentioned earlier, SGPMM inherit their views on masculinity and cultural responsibilities from their parents and their community. They report being pulled apart by two cultures, and they often present themselves in therapy as two conflicted 'selves' (one meeting family expectations and emphasising collective values, while the other fulfils Western cultural norms emphasising the values of the individual). Counselling Psychologists should therefore be mindful and aware of these individualist and collectivist values and explore them with their clients. This would enable clinicians to employ more tailored treatments to help these clients to manage their norms and values better. Clinicians can do this by evaluating how compatible clinical interventions are with the multiple identities of SGPMM which are influenced by their religion, culture, collectivist values, etc. Some of the SGPMM described the experience of CBT as a "conversation", and others liked the structured form of therapy and found it useful and appropriate. For Counselling Psychologists, it would thus be useful to discuss SGPMM clients' expectations of therapy as part of the initial assessment process.

This study also confirms existing research in relation to Muslim and South Asian men as discussed in Section 5.1, and extends it to Pakistani men living in the UK and specifically to SGPMM. This study thus provides a stronger basis for research in these areas, but further research is needed to explore these insights. For instance, in contrast to the research by Amer and Jalal (2012), some participants found the questioning and exploratory

experiences offered by CBT as being very helpful, and this indicates that Muslim expectations of therapy need further investigation. Furthermore, the participants also discussed 'locus of control' as a potential conflict between CBT (the individual being in control) and Islam (Allah being in control of everything), and this conflict needs further research.

Another important area of investigation could be the idea that the term 'CBT' provokes anxiety and is intimidating. It was reported that CBT helped to bring some of the participants in the study closer to their religion and if religion is not a part of their therapy, or there were a conflict between the fundamental tenets of CBT and Islam, then the participants may not engage well with therapy, or they may even terminate the therapy. This notion of a good fit versus conflict between CBT and Islam thus needs further exploration, and a condensed list of the implications for research and practice has been included in Appendix U.

5.3 Evaluation and suggestions for future research

This section will evaluate the methodological issues, limitations and strengths of this research study. IPA could be considered to be a methodological strength of this study. It provides a detailed and coherent account of the participants' experiences of individual CBT which contribute to the understanding of therapeutic interactions and processes in CBT for this particular group of clients. In line with the idiographic commitment of IPA (Smith et al., 2009), the conclusions from this study provide an insight into the group of SGPMM's experiences of therapy but are not necessarily representative of the experiences of all SGPMM. Moreover, due to the subjective nature of qualitative studies, all the conclusions are a result of the researcher's interpretations. The current study thus needs to be viewed in this particular context.

One of the strengths of the current study lies in the contribution that it makes to the evidence-based practice of CBT for SGPMM. It has provided a nuanced understanding of processes, considerations, and experiences that are involved in therapy (such as being caught between two cultures, community stigma, and how CBT could fit or clash with the religious beliefs of SGPMM). This integration of research and practice is congruent with Counselling Psychology's scientist-practitioner role (Vossler & Moller, 2015) which

emphasises the importance of evidence-based practice and developing knowledge that practitioners can utilise readily (Hanley et al., 2016; Kasket, 2016; Moran, 2011). Another finding contributed by this study is that the majority of the participants revealed both satisfaction and dissatisfaction about the process of CBT. Previous research with South Asians (Bowl, 2007; Netto et al., 2006; Virdee, 2014) and with Pakistanis in particular (Tabassum et al., 2000) have reported very high levels of satisfaction with their treatment. Individuals who are dissatisfied with their treatment are reluctant to engage in research and their voices thus remain unheard. This could leave practitioners unaware of what changes need to be implemented to address the needs of this group of clients better. The current study therefore provides a more balanced view and interpretation of the participants' experiences of CBT. Both good fit and conflict, and the helpful and unhelpful aspects of CBT practice for this group of individuals were identified. As a result, practitioners can be mindful of all of these issues when working with this client group.

Another strength of this study was that the homogeneity of the sample was achieved by recruiting only SGPMM who had received CBT. Previous research studies (Durvasula & Mylvaganam, 1994; Virdee, 2014) have found it difficult to recruit a homogenous sample of participants and the majority of the studies in the field of South Asians have had to broaden their inclusion criteria. Perhaps this thereby neglected the salient features in the experiences of a narrow population group such as SGPMM (Bowl, 2007; Greenwood et al., 2000; Netto et al., 2003). This difficulty in recruitment could be the result of the very stigma, anxiety, and shame whose existence has been confirmed by this study as being related to this particular group of SGPMM attending therapy. Because of the prevalence of these factors, it is important to aim to overcome the concerns of SGPMM and to engage them in future research. This can be achieved by clinicians normalising clients' anxiety about research, by providing more information about research confidentiality, and by emphasising the importance of and the benefits of research (Meer & Mir, 2014). For instance, research findings can be used to help mental health organisations to improve and develop services for ethnic minority groups such as Pakistani men. The current study's success in recruiting a homogeneous group was achieved by contacting major organisations that provide CBT for South Asians, especially for those of Pakistani origin. Distinct features and key aspects of their experiences of CBT were thus captured and analysed. To increase the breath of research in this area and to ensure that more participants such as SGPMM engage in research, it would be beneficial to try to widen the scope of recruitment to include the NHS, and private therapists.

The current study also has a number of limitations. Firstly, the individual profiles of SGPMM can vary enormously because of factors such as masculinity, religiosity, community, family, and generation. This means that the findings from the current study need to be considered carefully before any generalisations are made. IPA based studies of other groups might reveal different insights. Moreover, the findings of this study may be applicable only to SGPMM who have received individual CBT. It might be helpful to build on the current study's findings and to provide a better understanding of how factors such as generation, age, and the model of therapy can influence the seeking of therapy and the experience of therapy in general. It might therefore be appropriate to replicate this study with a group of SGPMM of different ages and also with different forms of CBT because these factors may have an impact on the overall experience of CBT. This may provide new useful insights for future clinical practice and research. Moreover, in the present study the participants were self-selected. The results may thus not be reflective of SGPMM's experiences of therapy in general, but only of the experience of those who attended a reasonable number of sessions and completed their treatment. The problem of attrition is an ever-present one, and SGPMM who did not attend many CBT sessions, or did not complete their therapy, or dropped out of therapy prematurely may have a very different experience of CBT, and might possibly have responded differently from the participants in this study. They might well have had different experiences of therapy altogether. One suggestion for future research could thus be to explore the experiences of SGPMM who did not complete therapy or who dropped out of therapy early. Such research may thereby generate new findings.

The participants in this study were aged between 20 and 45. It could be argued that this is quite a broad age range and it is possible that younger men in such a study could encounter different kinds of personal difficulties from those experienced by older men. For instance, according to the National Institute for Mental Health in England (2012), younger men are more likely to experience stresses associated with unemployment, financial difficulties, violence and poor housing conditions, whilst older men may have issues relating to physical health, mobility, retirement, bereavement, loneliness and social isolation (Mental Health Foundation, 2010). Specific age-related issues could thus be addressed in future research by recruiting under 20's or those aged 45 and over. Health care professionals could then target the difficulties of these different age groups more specifically.

It is also important to consider the fact that the SGPMM belong to a culture in which they are discouraged from talking about their emotional difficulties. It is possible that this factor could have prevented the participants from being even more open about their experiences than they were. Indeed, this could possibly have been compounded by the fact that the researcher was a male belonging to the same religion and similar culture as the participants. The participants may also have felt under pressure to present a strong image of themselves (and this will be elaborated on in the Reflexivity section). These issues could therefore have impacted on the ability of the participants to communicate the richness of their experiences. Perhaps, if a second generation Pakistani female researcher had conducted the interviews, the participants may have been less concerned about their masculine image and might have provided a richer account of their experiences (Virdee, 2014). Smith and Osborn (2008) suggest that participants in any piece of research often struggle to talk about how they feel and think. They argue therefore, that the researcher should not only analyse what the participants have said, but also give consideration to what they did not say.

A further limitation of the current study was associated with the lack of information regarding therapist variables. As is evident in this study, therapist factors such as religious beliefs, attitudes towards SGPMM, levels of training, and competency to deliver CBT to individuals from a different cultural and religious background have influenced the participants' experiences of CBT. The BPS (2010) however, argues that the NICE guidelines (2009; 2011; 2015) promote specific types of therapy, such as time-limited CBT for general psychological difficulties, but they do not stipulate who should provide the therapy. This omission occurs despite the suggestion from Roth and Fonagy (2004) that the therapeutic alliance is relevant to the therapeutic experience and its outcomes. It may therefore be helpful to focus on therapist factors in future qualitative studies. In addition, clients' experiences of therapy are likely to be influenced by the duration and types of CBT being delivered (Pick, 1992; Norcross, 2005). In the current study all the participants had roughly the same number of sessions of CBT. However, this study did not assess the therapists' adherence to a particular approach of CBT, nor were the participants' specific presenting difficulties taken into consideration.

6 Reflexive Statement Part Two

The reflexive statement at the start of this thesis examined the Critical Literature Review and discussed my pre-results reflections and considerations. In contrast, this statement will concern itself with reflections about the methodology, analysis and findings of this thesis. Throughout the research process, in my reflective journal, supervision, and personal therapy I have reflected on my assumptions and beliefs about the world, people, therapy, religion, masculinity, and on the impact that my preconceptions may have on the study. I have tried to 'bracket' (Smith et al., 2009) my own personal views, feelings and understandings as much as I could in order to minimise their influence on the data. For example, I did this during the selection and interpretation of passages from the transcript (Ashworth, 2003). I subsequently submitted a random selection of my interpretations of the data to peer researchers (of different genders, and religious and cultural backgrounds), and I also discussed these with my female non-Muslim supervisor so that I could explore and monitor my interpretations. The feedback suggested that I had stayed close to the participants' transcripts in general, and this ensured that my interpretations were grounded in the participants' accounts (for further reflexivity regarding the process of research such as the pilot study and analysis please see Appendix X).

During both the interviews and the analysis, I had some concerns about how the participants regarded me: being a Muslim man may have been both beneficial and/or disadvantageous to the study. All the participants were male and belonged to the same religion as I belong to, and I therefore regarded myself as an 'insider'. Nevertheless, as I am not a Pakistani and as I do not speak Urdu, the participants may have regarded me as a partial 'outsider' rather than as an 'insider'. This may have influenced their responses about their experiences. Consequently, I addressed this issue by employing Rogers' (1957) core principle of adopting a non-judgmental and empathic attitude throughout the interviews.

Conducting this research has encouraged me to question and examine my own identity as a first and/or a second-generation immigrant, and to see how this identification might have impacted on the process of my research. Interestingly, on reflection, I see that I identified very strongly with my participants in their feeling of "being stuck in the middle". This is because I also find myself feeling somewhat caught in the middle of two sets of generational values, norms and expectations. This is because I lived my early life in

Afghanistan where I absorbed most of the traditional Eastern values. However, when I came to England at the age of 13, I was then transported into a completely different world with an entirely different culture and with totally different values (e.g. regarding the importance of independence and individual autonomy), and during my teenage years and adulthood I was then totally immersed in Western/British culture. I therefore do not have either a purely first or a purely second-generation identity. It could be said that I am partially a first and partially a second generation immigrant, in that I was not born here, yet came here in my early teens and attended schooling here. I tend to identify more with second generation immigrants, and with Western cultural values than with first generation values and Eastern norms, maybe because I experienced adolescence and becoming an adult immersed in UK culture.

This identification might be having an influence and an impact on all my work. For instance, during the design of the interview questions I included a number of questions that were related to second generation issues and concerns rather than to the experiences of the participants in CBT such as processes, techniques and difficulties. After discussion with my supervisor, I realised that my identity was interfering with the process of my research and that I was including questions in which I myself was specifically interested. Perhaps, rather than formulating questions that explored the participants' experiences of therapy, I wanted to understand and discover my own experiences of therapy. I therefore examined my interview questions carefully and modified them in order to capture not my interests but the phenomena under investigation (i.e. the participants' experiences of CBT).

Furthermore, in the analysis stage I noticed that I was being drawn towards themes that were related to second generation identity. It is possible that because I myself felt 'stuck in the middle' and because I was unsure of my own identity I was being driven towards themes that confirmed my own experiences. It could therefore be argued that my findings may have started to reflect my own experiences rather than those purely of the participants. However, discussions with my peer researchers helped me to adopt a more neutral reflective position and to explore transcripts more objectively in such a way that it enabled me to identify themes that were important to the participants rather than themes that made sense to me. Throughout the research, by using my 'reflective-journal' to increase my awareness and to remain as open-minded as possible, I continued with my personal and epistemological reflexivity.

Moreover, during the interview process when the participants (e.g. Salman and Sunny) were talking about "being caught between two opposing cultures", and about how their religious and collectivist values were not considered nor acknowledged in CBT, I did find myself being drawn towards them. I then started to say things such as "that must have been difficult for you" or "I know what that is like" – and this could have prevented them from telling me their own unique stories. My interruption of their narratives may thus have prevented them from exploring their own issues in depth, and prevented them from conveying to me their own experiences of CBT. My beliefs and assumptions would thus have influenced the way in which I engaged with and made sense of their narratives. However, even though this was a limitation in the narrative process, in a sense it may have been useful in the interpretative process where IPA recognises 'interpretation' as being both inevitable and legitimate in the process of analysis. In addition, my position (of being caught in the middle of two generations, and identifying more with second generation immigrants) could have been beneficial. For instance, my identification of being stuck in the middle possibly enabled me to explore some of the participants' difficulties in depth and to capture the complexity and multi-layered issues that they were experiencing. Willig (2008) and Etherington (2004) argue that researchers' roles are enriched by their own personal backgrounds and this allows them to connect emotionally and empathically with the participants in their research.

Moreover, as a Muslim man, I was aware that there could have been an additional layer of interpretation added to the two-stage hermeneutic process that Smith (2008) suggests takes place in IPA where participants try to make sense of their experiences and the researcher tries to interpret the participants' experiences. Furthermore, a third layer of interpretation was added to this study because I was trying to make sense of the participants' experiences not only in my role as a researcher but also as a Muslim man. I assumed that I understood what the participants said with regards to religion, culture, collectivist communities, and had I not been a Muslim I might not have made such an assumption. Moreover, this was despite me 'bracketing' my own experiences and receiving CBT. It was inevitable that I would identify with the wider cultural milieu of these Muslim men, and this influenced my interpretation of their experiences. Nonetheless, one cannot simply block out one's own cultural understanding and experiences completely. This was an important constituent of the dynamics of the process and I was mindful of it, particularly during the interviews and then during the analysis of my data.

For instance, whilst analysing the data, I found that I was occasionally over-interpreting the participants' responses by making interpretations that were not always supported by the transcript. Reflection in supervision helped me to improve my objectivity and reflexivity by increasing my awareness of the impact that my identity as a Muslim therapist was having on my analysis. The over-interpretations may have resulted from a combination of factors such as CBT having been the cornerstone of my therapeutic training, and from my preference for using CBT over other therapeutic approaches, and the fact that I enjoy practising CBT. These assumptions may have let me mis-interpret what the participants meant when they talked about which CBT interventions they found helpful and which unhelpful. I became increasingly aware that I made assumptions about how easy it would be for the participants to express their emotions. However, on the contrary, I realised that expressing emotions was actually an important concern for my participants even though it was not one for me. Consequently, throughout the interviews and during the data analysis process, I was mindful of this difference and of my own assumptions. I thus carefully documented my thoughts and feelings in my reflective journal.

During this research I was continuously surprised and fascinated by what the data revealed. I was astonished particularly by the strong conflict experienced by the participants being stuck in a 'middle ground' and being pulled in opposing directions. The findings of this study have helped and encouraged me to evaluate the assumptions and perceptions that I have about the suitability of CBT for SGPMM and have increased my awareness about how difficult it can be to be objective when there are cultural or religious similarities between a therapist/researcher and clients/participants. Prior to the interviews, I thought that the participants would disclose positive experiences about CBT techniques and interventions, and how therapy had changed their lives for the better. On reflection, I realised that this was influenced by my own clinical experiences, because in general Pakistani men had reported certain CBT techniques such as guided discovery and Socratic questioning as being beneficial (Greenberger & Padesky, 2016; Tarrier & Johnson, 2016). The findings of this study went against my own preconceptions because although the participants did report positive aspects of CBT, they also revealed negative factors that had never occurred to me, such as that the name "CBT" was intimidating.

The participants also talked about the significance of Islam in their lives, and how Islam and CBT could fit or conflict with each other and for me these findings were unexpected. Religion is important to me and it provides me with hope, comfort and purpose. I was

somewhat surprised to share this similarity with my participants because I had assumed that religion would not play an important role in the lives of SGPMM who were born and raised in Western society where it appears that religion does not play a dominant role in everyday lives. In addition, the subject of religion had not come up in therapy with the SGPMM with whom I had worked previously. I therefore possibly incorrectly assumed that religion was not particularly important to them. However, perhaps religion was not discussed because I did not know which aspects of religion to include in CBT and, since I am not particularly knowledgeable about the teachings of Islam, I was worried that I might be judged adversely by my clients for being ignorant about religious matters. I may not have included religion in therapy because when my own therapist had tried to include religion, it was quite unhelpful. This clearly highlighted to me the fact that when working cross-culturally or even within a similar culture, one can automatically make assumptions about the cultural and religious background of clients, and these beliefs and inaccurate assumptions can go unchallenged (as did mine) until they are confronted by the findings of research.

The whole process of research, such as the interpreting and analysing of data and interacting with participants, may have been influenced by self-disclosure about being a Muslim. The reason for this disclosure was because my participants had asked about my religion. I may have been sub-consciously concerned about participants' rejection of me or reduced participant openness had I not self-disclosed my religious identity. Perhaps, I had a sub-conscious need for the participants to identify and accept me as 'one of them' in order for us to form a more helpful connection that would benefit the research findings. The disclosure of this aspect of my identity may have influenced what the participants shared with me about their experiences because they may have assumed that I had experienced similar experiences to theirs and may not have felt that it was necessary to mention these experiences. This was evident in some of the interviews when the participants made statements such as "you know how difficult it is in UK for PM men to seek therapy".

It could also be the case that the participants may not have shared some of their experiences with me because they may have feared that I would judge them negatively on religious grounds. Issues such as sex, drugs and alcohol, which are difficult subjects to discuss in a religious context, may have been deliberately avoided in the interviews by the participants. Consequently, it is possible that self-disclosure of my religious background to

the participants may have inhibited some participants from sharing their experiences whereas others may have felt at ease with it, and it may have encouraged them to talk more openly to me. However, I tried to manage my religious beliefs by being aware of all of these factors, and I made a conscious effort to avoid imposing my personal religious beliefs on the participants. Instead, I was open and curious about the participants' own unique experiences.

To conclude, the process of data collection, interviewing and data analysis was stressful because of the on-going uncertainty of interpreting and mis-interpreting the data. However, it was also exciting and interesting to discover and immerse myself in the rich experiences of the participants. Perhaps more importantly, it was an 'honour' to be able to give these participants a voice in the literature. This study has challenged and changed the way that I process and deliver CBT to clients in general, particularly with clients who hold religious beliefs such as Pakistani men. I am increasingly more open to discussing religious beliefs with my clients, and I have an increased awareness of the effect that my religious and cultural beliefs can have on my clinical practice. I have also started to explore my religious and cultural beliefs in personal therapy in depth. I believe that this will help to improve my clinical practice by providing me with insights into religion and into how it could consciously or unconsciously influence my therapeutic work (Hill & Cooper, 2016).

7 Concluding Words

This study has revealed that the views that SGPMM hold with regard to masculinity and cultural responsibilities are passed to them almost hereditarily, and that the participants seemed to have little or no choice but to accept these traditional cultural expectations. This study has thus provided a nuanced understanding of how a group of SGPMM experienced individual CBT. Moreover, the SGPMM find themselves stuck in a middle ground with two different personalities, and they struggle in trying to identify with two different cultural expectations and values simultaneously. For the participants, the seeking of external help to cope with their difficulties would involve the breaking of a cultural taboo, and to do so would be seen as letting themselves and their communities down.

For SGPMM seeing a Muslim therapist allows them to relate to the therapist better, whereas seeing a non-Muslim therapist is associated with feelings of discomfort and the possibility of being misunderstood. In addition, some SGPMM suggested that CBT had helped to bring them closer to their religion because it had allowed them to gain a deeper understanding of their beliefs. In addition, some participants revealed that CBT and Islam do complement each other in that self-reflection and accountability are essential features of both CBT and Islam; but, even so, the participants identified dissonance between CBT and Islam with regard to the causes of psychological difficulties and to the concept of control.

The findings of this study have offered practitioners a new understanding of the therapeutic needs of SGPMM. This should help practitioners and training programmes to develop CBT interventions that are tailored to suit this particular client group. There is a lack of research into SGPMM's experience of psychological therapies in general, and it is hoped that this study has contributed something useful to the evidence-based practice of CBT for SGPMM by providing information about the CBT processes, techniques, and interventions that could be helpful and/or unhelpful for SGPMM.

8 References

Abudabbeh, N., & Hays, P. A. (2006). Cognitive behavioural therapy with people of Arab heritage. In P. A. Hays & G. Y. Iwamasa (Eds.), *Culturally responsive cognitive-behavioural therapy: Assessment, practice and supervision* (pp. 141-160). Washington: APA.

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5-14.

Ahmed, S. & Amer, M. M. (2012). *Counselling Muslims handbook of mental health issues and interventions*. London, England: Routledge.

Al-Hashimi, M. A. (2005). *The ideal Muslim: The true Islamic personality of the Muslim as defined by the Qu'ran and the Sunnah.* Riyadh, Kingdom of Saudi Arabia: International Islamic Publishing House.

Al-Krenawi, A., & Graham J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health & Social Work, 25*(1)*,* 9-22.

Al-Krenawi, A., & Graham, J. R. (2000). Islamic theology and prayer: Relevance for social work practice. *International Social Work, 43*(3), 289-304.

Al-Mateen, C. S., & Afzal, A. (2004). The Muslim child, adolescent, and family. *Child and Adolescent Psychiatric Clinics of North America, 13,* 183-200.

Ali, I. (2013). Religion , spirituality and mental health. In Bhui, K. S. (Ed.), *Elements of culture and mental health*. *Critical questions for clinicians* (pp 87-90). London, England: Royal College of Psychiatrists.

Ali, O. M., & Aboul-Fotouh, F. (2012). Traditional mental health coping and help-seeking. In S. Ahmed & M. M. Amer (Eds.), *Counselling Muslims: Handbook of mental health issues and interventions* (pp. 33-51). Hove, England: Routledge.

Ali, S. R., Liu, W. M., & Humeidan, M. (2004). Islam 101: Understanding the religion and therapy implications. *Professional Psychology: Research and Practice, 35*(6), 635-642.

Amer, M. M., & Jalal, B. (2012). Individual psychotherapy/counselling: psychodynamic, cognitive-behavioural, and humanistic-experiential models. In S. Ahmed & M. M. Amer (Eds.), *Counselling Muslims: Handbook of mental health issues and interventions* (pp. 87-118). Hove, England: Routledge.

Amjad, F., & Bokharey, I. Z. (2014). The impact of spiritual well-being and coping strategies on patients with generalized anxiety disorder. *Journal of Muslim Mental Health, 8*(1)*, 21-38*.

Anand, A. S., & Cochrane, R. (2005). The mental health status of South Asian women in Britain: A review of the UK literature. P*sychology & Developing Societies, 17*(2), 195-214.

Anderson, N., Heywood-Everett, S., Siddiqui, N., Wright, J., Meredith, J., & McMillan, D. (2015). Faith-adapted psychological therapies for depression and anxiety: Systematic review and meta-analysis. *Journal of Affective Disorders, 176*, 183-196.

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research, 10*(3), 378-395.

Anwar, M. (1976). *Between two cultures*: *A study of the relationship between the generations in the Asian community in Britain.* London, England: Commission for Racial Equality.

Arshad, Z. (2015). *The experiences of non-muslim caucasian licensed marriage and family therapists working with South Asian and Middle Eastern Muslim clients* (Unpublished Thesis). Falls Church, Virginia: Virginia Polytechnic Institute and State University.

Ashworth, P. (2003). The origins of qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp 4-25). London, England: Sage.

Barker, C., Pistrang, N., & Elliott, R. (2002). *Research methods in clinical psychology: An introduction for students and practitioners* (2nd ed.). Chichester, England: Wiley.

Basit, A., & Hamid, M. (2010). Mental health issues of Muslim Americans. *The Journal of the Islamic Medical Association of North America, 42*(3), 106-110.

Beck, A. T. (1976). Cognitive therapy and the emotional disorders. New York: Meridian.

Beck, A. T., Epstein, N., Brown, G., & Steer, R.A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology, 56,* 893-897.

Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intention: The scale for suicide ideation. *Journal of Consulting and Clinical Psychology, 47*, 343-352.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: The Guilford Press.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond*. New York: The Guilford Press.

Berger, R. (2010). Increasing clinical and contextual awareness when working with new fathers. In Oren, C. Z., & Oren, D. C., *Counselling fathers* (pp. 187-206). New York: Routledge.

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29*, 697-712.

Berry, J. W. (2008). Globalization and acculturation. *International Journal of Intercultural Relations, 32(4)*, 328-336.

Beshai, S., Clark, C. M., & Dobson, K. S. (2012). Conceptual and pragmatic considerations in the use of cognitive behavioural therapy with Muslim clients. *Cognitive Therapy and Research, 37*(1), 197-206.

Beshai, S., Dobson, K. S., Adel, A., & Hanna, N. (2016). A cross-cultural study of the cognitive model of depression: Cognitive experiences converge between Egypt and Canada. *PLoS ONE, 11*(3). e0150699. doi:10.1371/journal.pone.0150699

Betteridge, S. (2012). Exploring the clinical experiences of Muslim psychologists in the UK when working with Religion in Therapy. Unpublished thesis.

Bhaskar, R. (1975). *A realist theory of science*. (1st ed. Leeds Books, 2nd edition with new Postscript 1978, Reprinted as Verso Classic 1997.) Hassocks, England: Harvester Press.

Bhugra, D., & Becker, M. A. (2005). Migration, cultural bereavement and cultural identity. *World Psychiatry, 4*(1), 18-24.

Bhui, K. S. (1999). Common mental disorders among people with origins in or immigrant from India and Pakistan. *International Review of Psychiatry, 11*, 136-144.

Bhui, K. S. (2013). Public mental health and inequalities. In Bhui, K. S. (Ed.), *Elements of culture and mental health*. *Critical questions for clinicians* (pp 73-75). London, England: Royal College of Psychiatrists.

Bhui, K. S. (2013). Cultural competence models, measures and movements. In Bhui, K. S. (Ed.), *Elements of culture and mental health*. *Critical questions for clinicians* (pp 83-86). London, England: Royal College of Psychiatrists.

Bhui, K. S., & Bhugra, D. (2002). Mental illness in Black and Asian ethnic minorities: Pathways to care and outcomes. *Advances in Psychiatric Treatment, 8*(1), 26-33.

Bhui, K. S., Chandran, M., & Sathyamoorthy, G. (2002). Mental health assessment and South Asian men. *International Review of Psychiatry, 14*(1), 52-59.

Bhui, K. S., Christie, Y., & Bhugra, D. (1995). The essential elements of culturally sensitive psychiatric services. *International Journal of Social Psychiatry, 41*(4), 242-256.

Blair, L. (2010). A critical review of the scientist-practitioner model for counselling psychology. *Counselling Psychology Review, 25*(4), 19-30.

Bond, T. N. (2010). *Standards and ethics for counselling in action.* London, England: Sage.

Bond, T. N. (2015). *Standards and ethics for counselling in action*. (4^{th} ed.). London, England: Sage.

Bowl, R. (2007). The need for change in UK mental health services: South Asian service users' views. *Ethnicity and Health, 12*(1), 1-19.

British Psychological Society (2005). *The division of counselling psychology professional practice guidelines*. Leicester: Author.

British Psychological Society (2005). *Code of ethics, ethical principles and guideline.* Leicester: Author.

British Psychological Society (2006). Ethical principles for conducting research with human participants. In Code of ethics and conduct. Leicester: British Psychological-Society.-Retrieved-from http://www.bps.org.uk/system/files/code_of_ethics_and_conduct.pdf.

British Psychological Society (2007). *Division of counselling psychology: Professional practice guidelines*. Leicester, England: British Psychological Society.

British Psychological Society (2009). *Code of Ethics and Conduct: Guidance published by the Ethics Committee of the British Psychological Society*. Leicester, England: The British Psychological Society.

British Psychological Society (2010). *Code of Human Research Ethics*. The British Psychological Society. Leicester. England.

British Psychological Society (2010). *What is Counselling Psychology?* Retrieved December 18, 2013, from www.bps.org.uk, careers, society qual, counselling.cfm

British Psychological Society (2010). *Code of Human Research Ethics*. Leicester, England: The British Psychological Society.

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

Carlson, K. M., & González-Prendes, A. A. (2016). Cognitive Behavioural Therapy with religious and spiritual clients. *Journal of Spirituality in Mental Health, 00(00)*, 1-30. Published online. http://dx.doi.org/10.1080/19349637.2016.1159940

Carter, D. J., & Rashidi, A. (2003). Theoretical model of psychotherapy: Eastern Asian-Islamic women with mental illness. *Health Care for Women International, 24*(5), 399-413.

Carter, D. J., & Rashidi, A. (2004). East meets West: integrating psychotherapy approaches for Muslim women. *Holistic Nursing Practice, 18*(3), 152-159.

Chadda, R. K., & Deb, K. S. (2013). Indian family systems, collectivist society and psychotherapy. *Indian Journal of Psychiatry, 55*(6), 299-309.

Charmaz, K. (2006) Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis. London: Sage.

Charmaz, K. (2008). *"What is Grounded Theory?"* Presented at: the 3rd National Centre for Research Methods Festival. Oxford, England: St Catherine's College. Retrieved from http://eprints.ncrm.ac.uk/208/

Charmaz, K. (2008) The Legacy of Anselm Strauss for Constructivist Grounded Theory, in N. K. Denzin (ed.), Studies in Symbolic Interaction 32, Bingley, UK: Emerald Publishing Group, Ltd.

Chaudhry, S., & Li, C. (2011). Is solution-focused brief therapy culturally appropriate for Muslim American counselees? *Journal of Contemporary Psychotherapy, 41*(2), 109-113.

Ciftci, A., Jones, N., & Corrigan, P. W. (2013). Mental Health Stigma in the Muslim Community. *Journal of Muslim Mental Health, 7*(1), 17-32.

Clément, R., & Noels, K. A. (1992). Towards a situated approach to ethnolinguistic identity: The effects of status on individuals and groups. *Journal of Language and Social Psychology, 11*(4), 203-232.

Commander, M. J., Odell, S. M., Surtees, P. G., & Sashidharan, S. P. (2004). Care pathways for South Asian and white people with depressive and anxiety disorders in the community. *Social Psychiatry and Psychiatric Epidemiology, 39*(4), 259-264.

Conrad, P. (1987). The experience of illness: Recent and new directions. *Research in the Sociology of Health Care, 6,* 1-31.

Cooper, M. & McLeod, J. (2007). *A* pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling and Psychotherapy Research*: *Linking research with practice*, *7*(3), 135-143.

Cooper, M. & Mcleod, J. (2011). *Pluralistic counselling and psychotherapy.* London, England: Sage.

Corbin, J., & Strauss, A. L. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Newbury Park, CA: Sage.

Daneshpour, M. (1998). Muslim families and family therapy. *Journal of Marital and Family Therapy, 24*(3), 355-390.

Daneshpour, M. (2003). Lives together, worlds apart? The lives of multicultural Muslim couples. *Journal of Couple & Relationship Therapy, 2*(2/3), 57-71.

Data Protection Act (1998). *Chapter 29: Part I, Preliminary document including subsequent amendments generated by Parliament 7th December 2016*. London, England: The Parliamentary Bookshop.

Department of Health (2005). Delivering race equality in mental health care. London, England: Department of Health.

Department of Health (2010). Equity and Excellence: Liberating the NHS. London: Department of Health, Command 7881, ISBN: 9780101788120.

Department of Health (2014). *Closing the Gap: Priorities for essential change in mental health [V2].* London, England: Department of Health.

Dhillon, K., & Ubhi, M. (2003). Acculturation and ethnic identity in marginal immigrant South Asian men in Britain: A psychotherapeutic perspective. *Counselling and Psychotherapy Research, 3*(1), 42-48. doi:10.1080/14733140312331384618

Dhiman, S. (2007). Personal mastery: Our quest for self-actualization, meaning, and highest purpose. *Interbeing, 1*(1), 25-35.

Donati, M. (2016). Becoming a reflective practitioner. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.). *The Handbook of Counselling Psychology* (4th ed., pp 55-73). London, England: Sage.

Douglas, B. (2016). Conceptualising in client work. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.), *The Handbook of Counselling Psychology* (4th ed.,
pp 151-168). London, England: Sage.

Dryden, W., & Branch, R. (2011). *The CBT handbook.* London, England: Sage.

Durvasula, R. S., & Mylvaganam, G. A. (1994). Mental health of Asian Indians: Relevant issues and community implications. *Journal of Community Psychology: Special Issue: Asian-American Mental Health, 22*(2), 97-108.

Dwairy, M. (2006). *Counseling and Psychotherapy with Arabs and Muslims: A Culturally sensitive approach*. New York: Teachers College Press, Columbia University.

Eatough, V. & Smith, J. A. (2006). I was like a wild wild person: Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology, 97,* 483-498.

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

Eatough, V., & Smith, J. A. (2008). Interpretative Phenomenological Analysis. In Willig C., Stainton-Rogers W. (Eds.). *The Sage handbook of qualitative research in psychology* pp 179-194. Los Angeles, Sage.

Eatough, V., Smith, J. A., & Shaw, R. (2008). Women, anger, and aggression: An interpretative phenomenological analysis. *Journal of Interpersonal Violence, 23*(12), 1767-1799. ISSN 0886-2605.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology (1999), 38*, 215-229.

Elliott, R., Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: The process-experiential approach to change*. Washington: American Psychological Association.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York: Lyle Stuart.

Ellis, A. (2003). Similarities and differences between rational emotive behavior therapy and cognitive therapy. *Journal of Cognitive Psychotherapy, 17*(3)*,* 225-240.

Etherington, K. (2004). *Becoming a Reflexive Researcher: Using Our Selves in Research.* London, England: Jessica Kingsley Publishers.

Evans, K. (2007). Relational-centred research: A work in progress. *European Journal for Qualitative Research in Psychotherapy 2,* 42-44.

Everall, R. D., & Paulson, B. L. (2002). The therapeutic alliance: Adolescent perspectives. *Counselling and Psychotherapy Research, 2*(2), 78-87.

Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: a practical guide. *Proceedings of the Nutrition Society, 63*(4), 647-653.

Fernando, S. (2002). *Mental Health, Race and Culture* (2nd ed.). Basingstoke, England: Palgrave.

Finlay, L. (2006). Going exploring: The nature of qualitative research. In L. Finlay & C. Ballinger (Eds.), *Qualitative research for health professionals: challenging choices* (pp 3-9). Chichester, England: Wiley.

Finlay, L. (2006). Mapping methodology. In L. Finlay & C. Ballinger (Eds.), *Qualitative research for health professionals: Challenging choices* (pp 9-29). Chichester, England: Wiley.

Finlay, L. (2006). 'Rigour', 'Ethical integrity' or 'Artistry': Reflexively reviewing criteria for evaluating qualitative research. *British Journal of Occupational Therapy, 69*(7), 319-326.

Finlay, L. (2008). *Reflecting on reflective practice: Discussion paper prepared for PBPL CETL.* Milton Keynes, England: The Open University.

Funke, T. (2002). *Muslims in the USA after 9/11*. Unpublished manuscript. Berlin: On behalf of the American Council on Germany.

Furnham, A., & Sheikh, S. (1993). Gender, generational and social support correlates of mental health in Asian immigrants. *The International Journal of Social Psychiatry, 39*(1), 22-33.

Garraway, H. (2016). 'Free to be me': Introducing an holistic approach to cognitive behaviour therapy. *Clinical Psychology Forum, 280, 27-33.*

Geels, A. (1997). The function of the Koran and the psychology of religion. *The International Journal for the Psychology of Religion*, *7*(4), 237-240.

Giorgi, A. (2008). Concerning a serious misunderstanding of the essence of the phenomenological method in psychology. *Journal of Phenomenological Psychology, 39*(1), 33-58.

Giorgi, A., & Giorgi, B. (2008) Phenomenological psychology. In C. Willig & W. Stainton-Rogers, *The Sage Handbook of Qualitative Research in Psychology* (pp 165-178). London, England: Sage.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research (2006 ed.).* New Brunswick, USA: Transaction Publishers.

Goldthorpe, J., Peters, S., Lovell, K., McGowan, L., & Aggarwal, V. (2016). 'I just wanted someone to tell me it wasn't all in my mind and do something for me': Qualitative exploration of acceptability of a CBT based intervention to manage chronic orofacial pain. *British Dental Journal, 220,* 459-463.

Good, G. E., Thomson, D. A., & Brathwaite A. D. (2005). Men and therapy: critical concepts, theoretical frameworks, and research recommendations. *Journal of clinical psychology. 61*(6), 699-711.

Good, G. E., & Wood, P. K. (1995). Male gender role conflict, depression, and help seeking: Do college men face double jeopardy? *Journal of Counselling Development, 74*(1), 70-76.

Goodwin, J. (2003). *Price of honor: Muslim women lift the veil of silence on the Islamic world*. London, England: Penguin.

Goodwin, R., & Cramer, D. (2000). Marriage and social support in a British-Asian community. *Journal of Community and Applied Social Psychology, 10*(1), 49-62.

Grant, P. M., Huh, G, A., Perivoliotis, D., Stolar, N. M., & Beck, A. T. (2012). Randomized trial to evaluate the efficacy of cognitive therapy for low-functioning patients with schizophrenia. *Archives of General Psychiatry/JAMA Psychiatry, 69*(2), 121-127.

Greenberger, D., & Padesky, C.A. (2016). *Mind Over Mood: Change How You Feel by Changing the Way You Think (2nd ed.).* New York: The Guilford Press.

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

Greenwood, N., Hussain, F., Burns, T., & Raphael, F. (2000). Asian in-patient and carer views of mental health care: Asian views of mental health care. *Journal of Mental Health. 9*(4), 397-408.

Guterman, J. T. (1994). A social constructionist position for mental health counseling. *Journal of Mental Health Counseling, 16*(2)*,* 226-244.

Haman, K. L., & Hollon, S. D. (2009). Ethical considerations for cognitive-behavioural therapists in psychotherapy research trials. *Cognitive and Behavioural Practice, 16*(2), 153-163. 10.1016/j.cbpra.2008.08.005

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

Hammer, J. H., Vogel, D. L., & Heimerdinger-Edwards, S. R. (2013). Men's help seeking: Examination of differences across community size, education, and income. *Psychology of Men & Masculinity, 14*(1), 65-75.

Hanley, T. (2010). Counselling Psychology Review. Information about the review process. *Counselling Psychology Review*, *25*(4), 74-77.

Hanley, T., Cutts, L., Gordon, R., Scott, A., & Davey, G. (2013). A research informed approach to counselling psychology. In G. Davey (Ed.). *Applied psychology*. London, England: BPS Wiley-Blackwell.

Hanley, T., Steffen, E., & O'Hara, D. (2016). Research: from consumer to producer. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith, (2016). *The Handbook of Counselling Psychology* (4th ed., pp. 530-546). London, England: Sage.

Haque, A. (2004). Islamophobia in North America: Confronting the menace. In P. Batelaan & B. Van Driel (Eds.), *Islamophobia in educational settings* (pp. 1-8). London, England: Trentham House.

Haque, A. (2004). Psychology from an Islamic perspective: Contributions of early Muslim scholars and challenges to contemporary Muslim psychologists. *Journal of Religion and Health*. *43*(4), 357-377.

Haque, A. (2009). Review of Healing of the Soul: Shamanism and Psyche. *Psychology, Health, and Medicine, Journal of Muslim Mental Health*, *14*(1), 127-128.

Haque, A. (2009). Review of Spirituality and Mental Health. *Journal of Muslim Mental Health*, *4*(2), 194-197.

Haque, A., & Kamil, N. (2012). Islam, Muslims and Mental Health. In S. Ahmed & M. M. Amer (Eds.), *Counselling Muslims: Handbook of Mental Health Issues and Interventions* (pp 3-14). Hove, England: Routledge.

Hays, P. A. (1995). Multicultural applications of cognitive-behaviour therapy. *Professional Psychology: Research and Practice, 26*(3), 309-315.

Hays, P. A. (2009). Integrating evidence-based practice, cognitive-behaviour therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice*, *40*(4), 354-360.

Heidegger, M. (1927). *Being and Time.* Translated by J. Macquarrie, & E. Robinson (1962 ed.). New York: Harper & Row.

Hill, A., & Cooper, M. (2016). Person centred therapy in the twenty-first century: growth and development. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith, (Eds.). *The Handbook of Counselling Psychology* (4th ed., 279-296). London, England: Sage.

Hodge, D. R. (2005). Social work and the house of Islam: Orienting practitioners to the beliefs and values of Muslims in the United States. *Social Work*, *50*(2), 162-173.

Hodge, D. R. (2011). Alcohol treatment and cognitive-behavioral therapy: enhancing effectiveness by incorporating spirituality and religion. *Social Work, 56*(1), 21-31.

Hodge, D. R., & Nadir, A. (2008). Moving toward culturally competent practice with Muslims: Modifying cognitive therapy with Islamic tenets. *Social work*, *53*(1), 31-41.

Holloway, I., & Todres, L. (2003). The status of method: flexibility, consistency and coherence. *Qualitative Research, 3*(3), 345-357.

Howitt, D., & Cramer, D. (2014). *Introduction to research methods in psychology* (4th ed.). Harlow, England: Pearson.

Huey, S. J. Jr., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child Adolescent Psychology*, *37*(1), 262-301.

Hussain, F. (2009). The Mental Health of Muslims in Britain: Relevant Therapeutic Concepts. *International Journal of Mental Health*, *38*(2), 21-36.

Hussain, F., & Cochrane, R. (2004). Depression in South Asian women living in the UK: A review of the literature with implications for Service Provision. *Transcultural Psychiatry, 41*(2), 253-270.

Hutchby, I., & Wooffitt, R. (2008). *Conversation analysis: Principles, practices and applications* (2nd ed.). Oxford: Polity Press.

Hutchison, P., Lubna, S. A., Goncalves-Portelinha, I., Kamali, P., & Khan, N. (2015). Group-based discrimination, national identification, and British Muslims' attitudes toward non-Muslims: the mediating role of perceived identity incompatibility. *Journal of Applied Social Psychology, 45*(6), 330-344.

Inayat, Q. (2005). *Psychotherapy in a multi-ethnic society*. Retrieved 27th July 2016 from http://www.baatn.org.uk/resources/Documents/20087292136300.Psychotherapy%20in%20a%20Multicultural%20society.pdf

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

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. H. Lerner (Ed.) *Conversation analysis: Studies from the first generation* (pp. 13-23). Philadelphia: John Benjamins Publishing.

Jiménez-Chafey, M. I., Duarté-Vélez, Y. M., & Bernal, G. (2011). Mother-daughter interactions among depressed Puerto Rican adolescents: Two case studies in CBT. *Revista Puertorriqueña de Psicología, 22,* 46-71.

Kasket, E. (2011). *Counselling psychology research training and beyond.* London, England: British Psychological Society Division of Counselling Psychology Trainee Talk.

Kasket, E. (2013). The counselling psychologist researcher. In G. C. Davey (Ed.). *Applied Psychology*. London, England: BPS Wiley-Blackwell.

Kasket, E. (2016). Carrying out research. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.), *The Handbook of Counselling Psychology* (4th ed., pp. 228-243). London, England: Sage.

Kasket, E. & Gil-Rodriguez, E. (2011). The identity crisis in trainee Counselling Psychology Research, and what to do about it. *Counselling Psychology Review, 26*(4), 20-30.

Khan, F., & Waheed, W. (2009). Suicide and self-harm in South Asian Immigrants. *Psychiatry, 8*(7), 261-264.

Knox, S., Burkard, A. W, (2009) Qualitative research interviews. *Psychotherapy Research, 19*(4-5), 566-575.

Kvale, S. (2003). The psychoanalytic interview as inspiration for qualitative research. In P. Camic, J. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 275-297). Washington, DC: American Psychological Association.

Lalonde, R. N., & Giguère, B. (2008). When might the two cultural worlds of second generation biculturals collide? *Canadian Diversity - Diversité Canadienne, 58-62.* Retrieved from https://www.researchgate.net/profile/Richard_Lalonde/publication/281032465_Lalonde_RN_Giguere_B_Spring_2008_When_might_the_two_cultural_worlds_of_second_generation_biculturals_collide_Canadian_Diversity_-_Diversite_canadienne_58-62/links/55d1e48908ae95c3504d610d.pdf?origin=publication_detail

Lalwani, S., Sharma, G. A. S. K., Rautji, R., & Millo, T. (2004). Study of suicide among young and middle aged adults in South Delhi. *Indian Journal of Preventive and Social Medicine, 35*(3/4), *173-178.*

Langdridge, D. (2007). *Phenomenological Psychology: Theory, Research and Method.* Harlow, England: Pearson Prentice Hall.

Laungani, P. (1997). Replacing client-centred counselling with culture-centred counselling. *Counselling Psychology Quarterly*, *10*(4), 343-351.

Laungani, P. (1998). The changing patterns of Hindu funerals in Britain. *Pharos International*, *64*(4), 4-10.

Laungani, P. (2004). *Asian perspectives in counselling and psychotherapy*. Hove, England: Brunner-Routledge.

Laungani, P. (2004). Counselling and therapy in a multi-cultural setting. *Counselling Psychology Quarterly*. *17*(2), 195-207.

Laungani, P. (2005). Building multicultural counselling bridges: The Holy Grail or a poisoned chalice? *Counselling Psychology Quarterly, 18*(4), 247-259.

Leon, A. C., Davis, L. L., & Kraemer, H. C. (2011). The role and interpretation of pilot studies in clinical research. *Journal of Psychiatric Research*, *45*(5): 626-629.

Lloyd, K. (2006). Common mental disorders among black and minority ethnic groups in the UK. *Psychiatry, 5*(11), 388-391.

London Metropolitan University. (2005). Code of Good Research Practice. London, England: LMU.

Lyons. E., & Coyle, A. (2007), *Analysing qualitative data in psychology.* London, England: Sage.

Mahalik, J. R. (2001). Cognitive therapy for men. In G. E. Good, & G. R. Brooks (Eds.), *The new handbook of psychotherapy and counselling with men: A comprehensive guide to settings, problems, and treatment approaches* (Vol. 2, pp. 544-564). San Francisco: Jossey-Bass.

Mahalik, J. R., Good, G. E., Englar-Carlson, M. (2003). Masculinity scripts, presenting concerns, and help seeking: Implications for practice and training. *Professional Psychology: Research and Practice, 34*(2), 123-131.

Mahmood, Z. J. (2012). *A qualitative exploration into how UK Pakistani male immigrants deal with personal problems and stresses in everyday life. Unpublished thesis.* London, England: London Metropolitan University.

Mahr, F., McLachlan, N., Friedberg, R. D., Mahr, S., & Pearl, A. M. (2015). Cognitive-behavioral treatment of a second-generation child of Pakistani descent: Ethnocultural and clinical considerations. *Clinical Child Psychology and Psychiatry*, *20*(1):134-47.

Marks. D. F., & Yardley, L (2004.), *Research Methods for Clinical and Health Psychology.* Sage Publications Ltd.

McGoldrick, M., Giordano, J., & Garcia-Preto, N. (2005). *Ethnicity and family therapy* (3rd ed.), New York: Guildford Press.

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. London, England: Sage.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy* (2nd ed.). London, England: Sage.

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

Mental Health Foundation (2010). *Grouchy old men? A brief guide to help develop services that engage isolated older men and promote good mental health and well being.* London, England: Mental Health Foundation.

Millar, A. (2003). Men's experience of considering counselling: Entering the unknown. *Counselling and Psychotherapy Research*, *3*(1), 16-24.

Milton, M. M. (2010). *Therapy and Beyond*: *Counselling psychology contributions to therapeutic and social issues.* Chichester, England: Wiley-Blackwell.

Milton, M. (2016). Forming a relationship: A phenomenological encounter. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith, (Eds.). *The Handbook of Counselling Psychology* (4th ed., pp. 184-197). London, England: Sage.

Mir, G. & Sheikh, A. (2010). 'Fasting and prayer don't concern the doctors … they don't even knmow what it is': communications, decision-making and perceived social relations of Pakistani Muslim patients with long-term illnesses. *Ethnicity & Health, 15*(4), 327-342.

Moodley, R. (2007). (Re)placing multiculturalism in counselling and psychotherapy. *British Journal of Guidance & Counselling, 35*(1), 1-22.

Moran, P. (2011). Bridging the gap between research and practice in counselling and psychotherapy training: Learning from trainees. *Counselling and Psychotherapy Research: Linking research with practice, 11*(3), 171-178.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling psychology, 52* (2), 250-260.

Naeem, F., Gobbi, M., Ayub, M., & Kingdon, D. (2010). Psychologists experience of cognitive behaviour therapy in a developing country: a qualitative study from Pakistan. *International Journal of Mental Health Systems, 4(2).* DOI:10.1186/1752-4458-4-2

Naeem, F., Gul, M., Irfan, M., Munshi, T., Asif, A., Rashid S., Khan, M. N., Ghani, S., Malik, A., Aslam, M., Farooq, S., Husain, N., & Ayub, M. (2015). Brief Culturally adapted CBT (CaCBT) for depression: A randomized controlled trial from Pakistan. *Journal of Affective Disorders, 177,* 101-107.

Naeem, F., Phiri, P., Munshi, T., Rathod, S, Ayub, M., Gobbi, M., & Kingdon, D. (2015). Using cognitive behaviour therapy with south Asian Muslims: Findings from the culturally sensitive CBT project. *International Review of Psychiatry, 27*(3), 233-246.

Naeem, F., Saeed, S., Irfan, M., Kiran, T., Mehmood, N., Gul, M., Munshi, T., Ahmad, S., Kazmi, A., Husain, N., Farooq, S., Ayub, M., & Kingdon, D. (2015). Brief culturally adapted CBT for psychosis (CaCBTp): A randomized control trial from a low income country. *Schizophrenia Research, 164*(1-3), 143-148.

Naeem, F., Sarhandi, I., Gul, M., Khalid, M., Aslam, M., Anbrin, A., Saeed, S., Noor, M., Fatima, G., Minhas, F., Husain, N., & Ayub, M. (2014). A multicentre randomised controlled trial of a carer supervised Culturally adapted CBT (CaCBT) based self-help for depression in Pakistan. *Journal of Affective Disorders, 156*, 224-227.

Naeem, F., Waheed, W., Gobbi, M., Ayub, M., & Kingdon, D. (2011). Preliminary evaluation of culturally sensitive CBT for depression in Pakistan: findings from developing culturally-sensitive CBT project (DCCP). *Behavioural and Cognitive Psychotherapy 39(2), 165-173.*

National Institute for Health and Care Excellence, NICE (2004). *Depression: management of depression in primary and secondary care. NICE guideline 23*. London: NICE.

National Institute for Health and Care Excellence (2009). *Clinical Guideline 90: Depression in adults: recognition and management.* Issued October 2009 and updated April 2016 (to replace Clinical Guideline 23, Issued 2003 and Amended 2007). London, England: NICE.

National Institute for Health and Care Excellence (2011). *National Clinical Practice Guideline (CG) 115: Alcohol-use disorders, Diagnosis, assessment and management of harmful drinking and alcohol dependence.* London, England: NICE and the National Collaborating Centre for Mental Health.

National Institute for Health and Care Excellence, (2015). *First-choice antidepressant use in adults with depression or generalised anxiety disorder.* Key therapeutic topic [KTT8]. London, England: NICE.

National Institute for Mental Health in England (2008). *Improving access to psychological therapies implementation plan: Implementational plan, national guidelines for regional delivery.* London, England: Care Services Improvement Partnership (Department of Health).

National Institute for Mental Health in England. (2012). *Reaching Out - Evaluation of three mental health promotion pilots to reduce suicide amongst young men.* Retrieved from http://www.tasc-uk.org/reaching-out-evaluation-three-mental-health-promotion-pilots-reduce-suicide-amongst-young-men.

Nelson, M. L., & Quintana, S. M. (2005). Qualitative clinical research with children and adolescents. *Journal of Clinical Child and Adolescent Psychology, 34*(2):344-56.

Netto, G. (2006). Creating a suitable space: A qualitative study of the cultural sensitivity of counselling provision in the voluntary sector in the UK. *Journal of Mental Health, 15*(5), 593-604.

Netto, G., Fancy, C., Lomax, D., Satsangi, M., & Smith, H. (2003). *Improving understanding of the housing circumstances of minority ethnic communities in Aberdeen City.* Aberdeen, Scotland: Communities Scotland.

Netto, G., Gaag, S., & Thanki, M. (2006). *Increasing access to appropriate counselling services for Asian people: The role of Primary Care services*. Retrieved 6, February, 2014, from http://www.priory.com/psych/counselling.htm

Nezu, A. M. (2005). Beyond cultural competence: Human diversity and the appositeness of asseverative goals. *Clinical Psychology: Science and Practice, 12*(1),19-24.

Nezu, A. M. (2010). Cultural influences on the process of conducting psychotherapy: personal reflections of an ethnic minority psychologist. *Psychotherapy Theory, Research, Practice, Training, 47*(2), 169-176.

Norcross, J. C. (2005). A primer on psychotherapy integration. In J. C. Norcross, & M. R. Goldfield (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 3-24). New York: Oxford University Press.

Office for National Statistics (2011) *Census: Ethnic group, local authorities in the United Kingdom.* UK by countries and, within England, regions, counties, London boroughs, metropolitan districts. (ONS, 2011 for England and Wales / National Records 2011 for Scotland / and Northern Ireland Statistics and Research Agency for Northern Ireland.) Newport, Wales: ONS.

Ogrodniczuk, J. S. (2006). Men, women, and their outcome in psychotherapy. *Psychotherapy Research, 16*(4), 453-462.

Oliver, C. (2012). Critical realist grounded theory: A new approach for social work Research. *British Journal of Social Work, 42*(2), 371-387.

Oliver C, Storey P. (2006). *Reaching out: Evaluation of three mental health promotion pilots to reduce suicide amongst young men*. Leeds, England: National Institute for Mental Health in England. Leeds. Retrieved from http://www.teespublichealth.nhs.uk/Download/Public/1012/DOCUMENT/4088/Reaching%20Out%20Exec%20Summary.pdf

Orlans, V. (2011). The nature and scope of counselling psychology. In G. Davey (Ed.). *Applied psychology (1-6)*. Chichester, England: Wiley-Blackwell.

Overall, J. E., & Gorham, D. R. (1962). The brief psychiatric rating scale. *Psychological Reports, 10,* 799-812.

Osborn, M., & Smith, J. A. (2015). The personal experience of chronic benign lower back pain: An interpretative phenomenological analysis. British Journal of Pain, 9. Reprint of original paper published as *British Journal of Health Psychology, 1998, 3,* 65-83.

Padesky, C. A. & Beck, A. T. (2005). Response to Ellis' Discussion of "Science and Philosophy: Comparison of Cognitive Therapy and Rational Emotive Behavior Therapy". *Journal of Cognitive Psychotherapy, 19*(2) 187-189.

Parritt, S. (2016). Working with difference and diversity. In B. Douglas., R. Woolfe., S. Strawbridge., E. Kasket., & V. Galbraith, (2016). *The Handbook of counselling Psychology* (2nd eds., pp. 198-212). London: Sage.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., Hosman, C., McGuire, H., Rojas, G. & van Ommeren, M. (2007). *Treatment and prevention of mental disorders in low-income and middle-income countries. Lancet, 370*(9591), 991-1005.

Paukert, A. L., Phillips, L. L., Cully, J. A., Romero, C., & Stanley, M. A. (2011). Systematic review of the effects of religion-accommodative psychotherapy for depression and anxiety. *Journal Of Contemporary Psychotherapy*, *41*(2), 99-108.

Pecheur, D. R., & Edwards, K. J. (1984). A comparison of secular and religious versions of cognitive therapy with depressed Christian college students. *Journal of Psychology and Theology, 12*(1), 45-54.

Pick, I, R. (1992). The Emergence of Early Object Relations in Psychoanalytic Setting. In R. Anderson & H. Segal. (1992). *Clinical Lectures on Klein and Bion,* pp. 24-33. London: Routledge.

Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behavioural and Cognitive Psychotherapy*, *38*(5), 511-533.

Rathod, S., Naeem, F. (2013). Can you do meaningful cognitive-behavioural therapy through an interpreter. In K. Bhui. *Elements of culture and mental health: critical questions for clinicians* (pp.17-20). London, England: Royal College of Psychiatrists Publications.

Rathod, S., Naeem, F., & Kingdon, D. (2013). Does cognitive-behavioural therapy work for people with very different cultural orientations and backgrounds? In K. Bhui. *Elements of culture and mental health: critical questions for clinicians* (pp.12-16). London, England: Royal College of Psychiatrists Publications.

Rathod, S., Phiri, P., Harris, S., Underwood, C., Thagadur, M., Padmanabi, U., & Kingdon, D. (2013). Cognitive behaviour therapy for psychosis can be adapted for minority ethnic groups: A randomised controlled trail. *Schizophrenia Research,143*(2-3), 319-326.

Razali, S. M., Aminah, K., & Khan, U. A. (2002). Religious-cultural psychotherapy in the management of anxiety patients. *Transcultural Psychiatry*, *39*(1), 130-136.

Razali, S. M., Hasanah, C. I., Aminah, K., & Subramaniam, M. (1998). Religious-sociocultural psychotherapy in patients with anxiety and depression. *Australian and New Zealand Journal of Psychiatry, 32*(6), 867-872.

Ripley, J. S., Leon, C., Worthington, E. L. Jr., Berry, J. W., Davis, E. B., Smith, A., Atkinson, A., & Sierra, T. (2014). Efficacy of religion-accommodative strategic hope-focused theory applied to couples therapy. *Couple & Family Psychology: Research and Practice, 3*(2), 83-98.

Rizq, R. & Target, M. (2008). "Not a little Mickey Mouse thing": how experienced counselling psychologists describe the significance of personal therapy in clinical practice and training. Some results from an interpretative phenomenological analysis. *Counselling Psychology Quarterly, 21*(1), 29-48.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. J*ournal of Consulting Psychology, 21,* 95-103.

Rojas, G., Fritsch, R., Solis J., Jadresic, E., Castillo, C., González, M., Guajardo, V., Lewis, G., Peters, T. J., & Araya, R. (2007). Treatment of postnatal depression in low-income mothers in primary-care clinics in Santiago, Chile: a randomised controlled trial. *Lancet, 370*(9599), 1629-1637.

Roth, A. D., & Fonagy, P. (2004). *What works for whom? A critical review of psychotherapy research* (2nd ed.). New York: Guilford Press.

Sabry, W. M., & Vohra, A. (2013). Role of Islam in the management of Psychiatric disorders. *Indian Journal Psychiatry, 55*(2), S205-S214.

Sanders, D. (2016). The evolving world of cognitive and mindfulness-based interventions. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith, (Eds.). *The Handbook of Counselling Psychology* (4th ed., pp. 297-316). London, England: Sage.

Seegobin, W. (1999). Important Considerations in Counseling Asian Indians (Paper 126). Newburg, Oregon: Graduate School of Clinical Psychology, George Fox University.

Shah, A. A. (2005). Psychotherapy in vacuum or reality: Secular or Islamic psychotherapy with Muslim clients. *Pakistan Journal of Social and Clinical Psychology, 3*(1-2), 3-20.

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

Shibli, M. (2010). *7/7 Muslim perspectives.* Northolt, England: Rabita.

Sims-Schouten, W., Riley, S. C. E., & Willig, C. (2007). Critical realism in discourse analysis: A presentation of a systematic method of analysis using women's talk of motherhood, childcare and female employment as an example. *Theory & Psychology*, *17*(1), 101-124.

Siraj, A. (2010). "Because I'm the man! I'm the head": British married Muslims and the patriarchal family structure. *Contemporary Islam, 4*(2), 195-214.

Small, M, F. (2006). *The culture of our discontent: beyond the medical model of mental illness.* Washington: National Academies Press.

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

Smith, J. A. (1996). Qualitative methodology: analysing participants' perspectives. *Current Opinion in Psychiatry, 9,* 417-421.

Smith, J. A. (1998). Developing theory from case studies: self-reconstruction and the transition to motherhood. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp 187-189). Hove, England: Psychology Press.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*(1), 39-54.

Smith, J. A. (2008). Introduction in J. A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods* (2nd ed., pp 1-8). London, England: Sage.

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

Smith, J. A. (2015). *Qualitative Psychology: A Practical Guide to Research Methods* (3rd ed., pp 1-10). London, England: Sage.

Smith J. A., & Eatough, V. (2006). Interpretative phenomenological analysis. In G. Breakwell, C. Fife-Schaw, S. Hammond & J. A. Smith (Eds.), *Research Methods in Psychology* (3rd ed., pp.11-20). London, England: Sage.

Smith, J. A., & Eatough, V. (2007) Interpretative phenomenological analysis. In E. Lyons and A. Coyle (Eds.), *Analysing Qualitative Data in Psychology*. London, England: Sage.

Smith, J. A. & Eatough, V. (2012). Interpretative phenomenological analysis. In G. M. Breakwell, J. A. Smith, & D. B. Wright (Eds.), *Research Methods in Psychology* (4th ed., pp. 439-461). London: Sage.

Smith, J. A. & Eatough, V. (2016) Interpretative phenomenological analysis. In E. Lyons & A. Coyle (Eds.), *Analysing Qualitative Data in Psychology* (2nd ed.). London, England: Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, England: Sage.

Smith, J. A., & Osborn, M. (2004) Interpretative phenomenological analysis. In: G. Breakwell (Ed.) *Doing Social Psychology*, pp. 229-254. Oxford, England: Blackwell.

Smith, J. A. & Osborn, M. (2008). Interpretive phenomenological analysis. In J. A. Smith (Ed.) *Qualitative psychology: A practical guide to research methods* (pp. 53-80). London, England: Sage.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain, 9,* 41-42.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Methods* (3rd ed.). London, England: Sage.

Social Exclusion Unit (2004). *Action on mental health: A guide to promoting social inclusion. Office of the Deputy Prime Minister*. London, England: Social Exclusion Unit.

Springer, P. R., Abbott, D. A., & Reisbig, A. M. J. (2009). Therapy with Muslim couples and families: basic guidelines for effective practice. *The Family Journal: Counselling and therapy for couples and familie*s, *17*(3), 229-235.

Stallard, P. (2002). Cognitive behaviour therapy with children and young people: A selective review of key issues. *Behavioural and Cognitive Psychotherapy*, *30*(3), 297-309.

Steine, S., Finset, A., & Laerum, E. (2001). A new, brief questionnaire (PEQ) developed in primary care for measuring patients' experience of interaction, emotion and consultation outcome. *Family Practice: 18*(4)**,** 410-418.

Strawbridge, S., & Woolfe. R. (2010). Counselling psychology: Origins, developments, and challenges. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of counselling psychology* (3rd ed. pp. 3-22). London, England: Sage.

Strawbridge, S. (2016). *Science, craft and professional values.* In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.). *The Handbook of Counselling Psychology* (4th ed., pp. 20-38). London, England: Sage.

Tabassum, R., Macaskill, A., & Ahmad, I. (2000). Attitudes towards mental health in an urban Pakistani community in the United Kingdom. *International Journal of Social Psychiatry*, *46*(3), 170-181.

Tajfel, H. (1978). *Differentiation between social groups: Studies in the social psychology of inter-group relations.* London, England: Published in cooperation with the European Association of Experimental Social Psychology by Academic Press.

Tajfel, H., & Turner, J.C. (1986). The social identity theory of intergroup behaviour. In S. Worchel, & L. W. Austin (Eds.), *Psychology of inter-group relations* (pp 7-24). Chicago: Nelson-Hall.

Tarrier, N., & Johnson, J. (Eds.) (2016). *Case Formulation in Cognitive Behaviour Therapy: The Treatment of Challenging and Complex Cases*. Hove, England: Routledge Taylor & Francis.

Trubisky, P., Ting-Toomey, S., & Lin, S-L. (1991). The influence of individualism-collectivism and self-monitoring on conflict styles. *International Journal of Intercultural Relations*, *15*(1), 65-84.

Utz, A. (2012). Conceptualizations of Mental Health, Illness, and Healing. In S. Ahmed, & M. M. Amer (Eds.), *Counselling Muslims: Handbook of mental health issues and interventions* (pp 15-32). London, England: Routledge.

Virdee, H. (2004). Confidentiality in counselling Asian clients. *Counselling and Psychotherapy Journal, 15(4), 36-37.*

Virdee, S. (2014). *"It was quite helpful": an interpretative phenomenological analysis of Indian fathers' experience of family therapy,* Unpublished Thesis. London, England: London Metropolitan University.

Vossler, A., & Moller, N. P. (2015). Attitudes to and perceptions of research. In Vossler, A., & Moller, N. P. (Eds.), *The counselling and psychotherapy research handbook* (pp 17-30). London, England: Sage.

Warr, D. J. (2005). 'It was fun... but we don't usually talk about these things': Analyzing sociable interaction in focus groups. *Qualitative Inquiry, 11*(2), 200-225.

Watters, C. (1996). Inequalities in mental health: The inner city mental health project. *Journal of Community and Applied Social Psychology, 6*, 383-3.

Watters, C. (1996). Representations of Asians' Mental Health in British Psychiatry. In C. Samson, & N. South, *The social construction of social policy: Methodologies, racism, citizen-ship and the environment*. London, England: MacMillan.

Weatherhead, S., & Daiches, A. (2010). Muslim views on mental health and psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *83*(1), 75-89.

Werth, J. L., Jr. (1993). Recommendations for the inclusion of training about persons with HIV disease in counselling psychology graduate programs. *The Counselling Psychologist*, *21*(4), 668-686.

Werrbach, J. & Gilbert, L. A. (1987). Men, gender stereotyping, and psychotherapy: therapists' perceptions of male clients. *Professional Psychology: Research & Practice, 18*(6), 562-566.

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

Willig, C. (2003). Discourse Analysis. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp 160-185). London, England: Sage.

Willig, C. (2008). A phenomenological investigation of the experience of taking part in 'extreme sports'. *Journal of Health Psychology, 13*(5), 690-702.

Willig, C. (2008). *Introducing qualitative research in psychology***.** Maidenhead, England: Open University Press.

Willig, C. (2013). *Introducing qualitative research in psychology.* Maidenhead, England: Open University Press.

Woolfe, R. (2016). Mapping the world of helping: the place of counselling psychology. In B. Douglas., R. Woolfe., S. Strawbridge., E. Kasket., & V. Galbraith, (Eds.). *The Handbook of counselling Psychology* (4th ed., pp. 5-19). London, England: Sage.

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

Yardley, L. (2009). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed. pp. 235-251). London, England: Sage.

Yin, R. K. (1989). *Case study research: design and methods.* California: Sage.

Zigmond, A. S., & Snaith, R. P. (1983). The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica 67*(6)*, 361-370.*

9 Appendices

Appendix A: Inclusion and Exclusion criteria

Appendix B: Recruitment Posters

Appendix C: Organisations that displayed the study poster

Appendix D: Demographic Details Form

Appendix E: Participant Information Sheet

Appendix F: Participant Informed Consent Form

Appendix G: Interview Schedule

Appendix H: Debriefing Form

Appendix I: Sensitive Verbal Debriefing

Appendix J: London Metropolitan University Distress Protocol

Appendix K: Transcription Conventions

Appendix L: Extracts from my reflexive diary

Appendix M: Ethical Consent Certificate

Appendix N: List of useful resources and organisations

Appendix O: An example of a participant's annotated transcript (Imran's)

Appendix P: An example of the participant's (Imran's) emergent themes with line numbers

Appendix Q: A participant's (Imran's) table of subthemes and superordinate themes and corresponding page and line numbers

Appendix R: Table of Superordinate themes, sub-themes and relevant quotes of all the participants

Appendix S: The process of developing subthemes and superordinate themes for the participant Imran (Photographic record)

Appendix T: The process of developing subthemes and superordinate themes developed for *all* the participants (Photographic record)

Appendix U: List of recommendations for clinical practice

Appendix V: Brief Psychiatric Rating Scale (Overall & Gorham, 1962)

Appendix W: Beck's Scale for Suicidal Ideation (SSI)

Appendix X: Reflexivity

Appendix Y: Template of e-mail to relevant organisations

Appendix A

Inclusion and Exclusion Criteria

Inclusion Criteria

- Second Generation British Pakistanis: Pakistanis constitute the largest Muslim group in the UK (Hussain, 2009) and are currently under-represented in the literature. The term 'second-generation immigrant' refers to children born in the UK to first-generation immigrant parents. Much of the research conducted so far on the treatment needs of Muslims in the UK has focussed on first-generation immigrants (Tabassum et al., 2000; Weatherhead & Daiches, 2010), and in particular the experiences of second-generation Pakistani Muslim men in the UK have been completely overlooked.
- Muslims: The second largest religious grouping after Christianity in the UK (ONS, 2011).
- Males: Currently under-represented in the literature and Pakistani Muslim men are the focus of this study.
- Age: 18-65: Considered to be adults by the National Institute of Health and Clinical Excellence (NICE; 2004; 2009; 2011).
- CBT: One of the most widely used approaches by practitioners.
- Those who have utilised 6-16 sessions of individual CBT: this being in line with the NICE (2011) guidelines for standard CBT treatments for general psychological problems.
- A minimum of one month and a maximum of 18 months after completing therapy. This provides clients with sufficient time to reflect on their experiences of therapy.

Exclusion Criteria

- Some of the topics that will be discussed could evoke distress, therefore in order to safeguard all the participants, psychotic and suicidal participants will not be included in the study.
- Prior to the interview, participants will be asked questions about their previous psychiatric diagnoses, suicidal thoughts/intention and psychoses (see below). This means that vulnerable participants, will not be included in the study.

Previous Psychiatric Diagnosis, Suicide and Psychoses Questions

There are just a few things that I need to check with you before we start the interview.

- Have you been diagnosed with any psychiatric disorder? (Yes or No.)
- If yes, what was the diagnosis or what is the diagnosis?
- Are you currently being treated for a psychological or a psychiatric condition?
- Have you ever had any thoughts about killing yourself? (If yes, how severe are they?)
- Do you hear any voices?
- Clients who have or have had symptoms of psychosis in the past will not be included in this research study.
- Moreover, prior to the interview, if the participant indicates that he has suicidal or psychotic symptoms such as hearing voices, then I will re-assess his suitability for this study, and ask the participant to fill in the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham,1962; see Appendix V) and Beck's Suicidal Scale (BSS; Beck et al., 1979; 1988; see Appendix W). These two scales will assess the risk of suicide, psychosis and self-harm in participants, and any participant who scores above *19* (15-19 indicating Low Suicide Ideation) on the BSS and above *3* (1-3 indicating Mild) on any items in the BPRS will not be included in the study. Such participants will be strongly advised to contact their GP and will be given a list of useful organisations (see Appendix N) to contact if they need support in order to ensure that their wellbeing is protected.
- It is worth noting that if a participant scores above 19 on the BSS or above 4 on any items in the BPRS and would still like to take part in this study, then I would thank the participant and inform him very sensitively and empathically that unfortunately it is not possible for him to participate in this study.

Appendix B

Recruitment Posters

Second Generation Pakistani Muslim male participants needed

What is your experience of individual Cognitive Behavioural Therapy (CBT)

My name is Said Aris Tarabi. I am a Trainee Counselling Psychologist at London Metropolitan University, and for my research I have chosen to investigate how Pakistani Muslim men in the UK use psychological therapies, and in particular how they use individual Cognitive Behavioural Therapy (CBT).

Your participation involves attending an interview at a mutually convenient place in a secure and private location, and the interview will last approximately one hour where you will be asked to share your experiences of therapy. This research project has been reviewed by and gained ethical approval from the London Metropolitan University Ethics Committee.

Are you a Pakistani Muslim man who was born in the UK?
Are you aged between 18 and 65?
Have you had minimum of 6 and maximum of 16 sessions of individual CBT therapy?

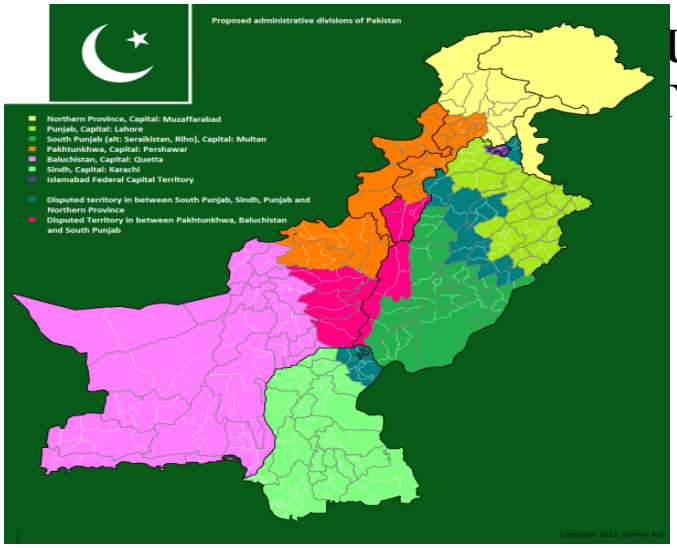
If yes and you would like to participate in this study or you would like to know more about the study please do not hesitate to contact me on ……. or at ……...

Thank you

ARE YOU A PAKISTANI MUSLIM MALE WHO WAS BORN IN THE UK?

PAKISTANI MUSLIM MALE PARTICIPANTS

ARE YOU AGED 18-65?



U HAD CBT IN
18 MONTHS?

WOULD YOU BE INTERESTED IN PARTICIPATING IN A DOCTORAL RESEARCH STUDY?

IF YES THEN PLEASE READ ON .....

My name is Said Aris Tarabi and I am a Trainee Counselling Psychologist at London Metropolitan University. For my doctoral research I am conducting a study into how **Second Generation Pakistani Muslim Men** in the UK experience Cognitive Behavioural Therapy (CBT) in order to give them a voice to express their treatment needs. I am therefore seeking to recruit **Second Generation Pakistani Muslim Men** who have had **a minimum of 6 and a maximum of 16 sessions of one-to-one CBT in the last 18 months.**

Your participation in this study will involve a **one-hour** conversation with me at a time and location convenient to you where you would be asked to share your experiences of therapy.

If you are interested in participating or would like more information about this study please contact me on ……

THANK YOU

Appendix C

Organisations that displayed the study poster

1: Asian Family Counselling Service (London Office)

Suite 51 Windmill Place

2-4 Windmill Lane

Southall

Middlesex

UB2 4NJ

Tel : 020 8571 3933/ 020 8813 9714

Fax: 020 8571 3933

Email:admin@asianfamilycounselling.org

2: Asian Counselling Service

1 Hampton Court

George Road

Edgbaston

Birmingham

West Midlands

B15 1PU

Phone/ Fax: 0121 454 1130

Email: birmingham@asianfamilycounselling.org

3: Nafsiyat Intercultural Therapy Centre

Unit 4, Clifton House

Clifton Terrace

London N4 3JP

Tel: 020 7263 6947

Fax: 020 7561 1884

Email: **admin@nafsiyat.org.uk**

Appendix D

Demographic Details Form

Age: …….

Gender: …….

Religion: …….

Place of birth: …….

Nationality: …….

Model of Therapy: …….

Presenting difficulty: …….

Length of Therapy: …….

Dates between which therapy was completed …….

Therapist's gender …….

Appendix E

Participant Information Sheet

Title of the Study: The experience of Second Generation Pakistani Muslim men receiving individual Cognitive Behavioural Therapy.

You are being invited to take part in a research study. Before you make a decision, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish to do so.

What are the aims and objectives of this study?

This research study aims

- To explore the experiences of second-generation Pakistani Muslim men who have utilised CBT for their psychological problems.

The objectives of this research study are

- To contribute to the knowledge base of psychological therapies and in particular to that of CBT and also to identify which features of CBT Pakistani Muslim men find helpful and/or unhelpful.

- To give a voice to Pakistani Muslim men in order for their experiences and their needs to be heard and to be taken into account.

- To provide practitioners such as Counselling Psychologists with a nuanced understanding of this particular cohort in order for them to develop effective interventions for this group.

Do you have to take part?

There is no obligation to take part in this study because it is entirely voluntary. If you do wish to participate in this research you will be required to sign a consent form.

Will my participation be kept confidential?

Yes, the information that you provide will be confidential unless there appears to be a risk of harm to yourself or to others, and if there is a risk of harm to yourself or to others the appropriate services and organisations will be notified of the situation. Moreover, all the information that you give for this study will be securely stored, and all identifiable information will be removed or altered. For instance, pseudonyms will be given to all the participants in order to protect their anonymity. The results of all the interviews will form the basis of my Counselling Doctorate thesis, and this will then become a public document. However, none of your identifiable information will be included in the document.

What does taking part involve?

You will be required to sign a written consent form prior to participation in the study. Your participation involves attending a face-to-face interview at a mutually convenient place in a secure and private location, and the interview will last for approximately one hour. The interview will be audio-recorded.

What are the possible disadvantages and risks of taking part in this study?

This study covers topics that may evoke discomfort and might even cause you some distress, and in order to manage any distress that may arise, I will adhere very closely to the guidelines of the London Metropolitan University Distress Protocol. In order to help you to feel calmer and to be more relaxed about exploring your experiences of therapy, you will be able to take short breaks during the interview should you wish to do so, and you will certainly be free to refuse to answer any questions that you do not feel like answering. Should you experience any discomfort as a result of taking part in this study, you will be offered post-interview support if any such support were to be required. For example, if at the end of the interview you have any concerns, you will be given time to discuss with me any concerns that you may have. After the interview, you will be provided with a list of useful counselling and support services which you may find helpful should you experience any distress. Furthermore, due to its sensitive content, the interview may not be suitable for people who are feeling suicidal or are hearing voices. If that applies to you, please discuss

this either with the researcher, and the researcher will then assess your suitability with the appropriate scales, or you may choose not to participate in this study.

Costs

You will be reimbursed for your travel expenses.

What if there is a problem?

If you wish to report or complain about something, or if you have any concerns about any aspect of the way that you have been treated during the course of this study, then please get in touch with the research supervisor, Dr Angela Ioanna Loulopoulou (see contact details below).

Who has reviewed the study?

This research project has been reviewed and approved by the London Metropolitan University Ethics Committee.

Your contribution to this study

Your contribution to this study will be immensely valuable in that it will provide practitioners with a nuanced understanding of how Pakistani Muslim male clients make sense of their experiences of CBT, and this will allow practitioners to develop tailored interventions to address their needs more effectively. Practitioners will thus be better informed about the requirements of and will be better able to provide effective therapy for the Pakistani Muslim community. Perhaps more importantly, your input will thus give second-generation Pakistani Muslim men a voice to express their therapeutic needs and to make sense of their experiences of CBT therapy, and it will help in the endeavour to gain a better understanding of how second-generation Pakistani Muslim men experience Cognitive Behavioural Therapy (CBT).

How do I get involved?

If you would like more information about this study or you would like to participate in this study please contact me on the details below.

Researcher: Said Aris Tarabi, Trainee Counselling Psychologist

E-mail: …….

Mobile Number: …….

Research Supervisor: *Dr Angela Ioanna Loulopoulou*

……..

E-mail: ……

Tel: ……..

Appendix F

Participant Informed Consent Form

Title of the Study: The experience of Second-Generation Pakistani Muslim men receiving individual Cognitive Behavioural Therapy.

This consent form is to ensure that you are happy with the information that you have received about the study, and that you are aware of your rights as a participant, and that you are happy to participate in this study.

Please Initial Box

1. I confirm that I have read and that I understand the information sheet for this study. ☐

2. I have had the opportunity to consider the information about the study, and to ask questions about it. ☐

3. I have received enough information about the study to enable me to decide whether or not I want to take part in it. ☐

4. I understand that all the information that I reveal will be kept confidential. ☐

5. I understand that the principle of confidentiality cannot be maintained if the information disclosed is to cause harm to myself or to others. ☐

6. I understand that this study has received ethical approval from the Research Ethics Committee at London Metropolitan University. ☐

7. I understand that the study will be carried out in accordance with both the London Metropolitan University's Code of Good Research Practice, and the British Psychological Society's ethical guidelines. ☐

8. I also understand that both I and the researcher have the right to bring the interview to an end if undue distress is being experienced . ☐

10. I understand that I am free to decline to answer any questions that I do not wish to answer. ☐

11. I understand that participation in this study is entirely voluntary. ☐

12. I am aware that I have the right to withdraw myself and all the details of my interview from the study for a period of up to four weeks following the interview. ☐

13. I understand that I will participate in a face-to-face interview that will last for about one hour. The interview will be audio-recorded and will later on be transcribed by the researcher. ☐

14. I understand that the researcher will use quotations from my interview in the writing-up and the publication of the study. ☐

15. I understand that my identity will be completely anonymous and that my name will not be revealed at any point in time. ☐

17. I understand that for publication purposes both the recording of the interview and the transcript will be kept for a period of five years. ☐

18. Please initial the box if you would like to receive by e-mail a summary of the results of the study. ☐

19. I hereby agree to take part in this study. ☐

Name of participant: _____

Date: _____

Signature: _____

Name of Researcher: _____

Date: _____

Signature: _____

When the consent form has been completed, one copy of it will be given to the participant, and one copy will be kept by me in a securely locked filing cabinet.

Appendix G

Interview Schedule

Before conducting the interview.

First introduce the study and myself to the participant. Second, go through the participant information sheet and get the participant consent form signed. Then provide the participants with an opportunity to voice their concerns or ask any questions that they may have regarding the study and/or interview process.

General Questions/CBT

Can you tell me about why you decided to have therapy?

What were your thoughts and feelings before entering therapy?

How did you feel as a Muslim man receiving therapy?

- Can you tell me what therapy means to you?
- How did it feel to talk about your problems?

(Advantages) What did you like about your therapy? How has the process helped you?

- Did you find any particular or specific thing helpful in your therapy?
- Why do you think it helped?

(Disadvantages) What, if anything did you find *unhelpful* about your therapy?

- Did you find any particular aspect/approach of your therapy unhelpful? What was it?
- How could it have been better?

Religion

What role does religion play in your life?

- How important is your religion to you?
- What is your view about religion and personal wellbeing?

Did religion come up at all in therapy?

- Why? Why not?

How well do you think therapy and religion fit together?

- Did your religious and cultural beliefs help or prevent you from participating in your therapy?
- Did the therapy improve or get in the way of your religious practice?

What do you think would prevent Muslims from having therapy?

- If you knew then what you know now about therapy, how would you have done things differently?
- Would you consider therapy in the future? Could you tell me more about it?

What would help them use therapy better?

- If a friend of yours were going to have the same therapy as you had, what advice would you give him?

Ending

Is there anything that you thought was important that I did not ask you about, and if so would you like to tell me about it now?

How do you feel about what we have discussed today?

What has your experience been of taking part in this interview?

Is there anything you would like to ask me about our discussion today?

Prompts:

Can you say a bit more? What do you mean when you say that? What makes you say that? What was it about therapy that made you...?

Appendix H

Debriefing form

Title of the Study: The experience of Second-Generation Pakistani Muslim men receiving individual Cognitive Behavioural Therapy.

Thank you very much for participating in this study. This debriefing form is designed to provide you with more information about the study, and to make you aware of how important your participation in the study has been and how this research will now be used.

According to the 2011 census statistics, Islam now constitutes the second largest religious community after Christianity in the UK, and the majority of UK Muslims come from South Asia (and predominantly from Pakistan and Bangladesh). Currently South Asian Muslim men and in particular second-generation Pakistani Muslim men, under-utilise mental health services and they are under-represented in the literature of psychological therapies. Studies that have been conducted have shown that CBT in particular can be suitable for Pakistani Muslim men, but some authors argue that there are fundamental conflicts between Islamic belief systems and Western psychological therapies. However, there has been no research to date on how CBT is experienced by Pakistani Muslim men, and the needs of this under-represented group remain unexplored.

The aim of this study has been to explore the experiences of second-generation Pakistani Muslim men living in the UK who have utilised individual Cognitive-Behavioural Therapy (CBT) for their psychological problems. This involved exploring how beneficial CBT was for you, what impact the therapeutic process had on you, whether you experienced an interaction between CBT and your religious beliefs, and how you made sense of your experience of therapy.

This study aims to give a voice to second-generation Pakistani Muslim men in order for their experiences and their needs to be heard and to be taken into account. Moreover, the

research hopes to provide practitioners with a nuanced understanding of the relationship of second-generation Pakistani Muslim men with CBT in order to develop tailored interventions to suit this particular client group. Your contribution is thus immensely valuable and will help in the endeavour to gain a better understanding of how second-generation Pakistani Muslim men experience Cognitive-Behavioural Therapy (CBT).

I understand that it may have been difficult for you to answer some of the questions that were put to you during the interview and if any of the questions have caused you anxiety, distress or concern, then please do not hesitate to speak to someone about your concerns. I am enclosing a list of organisations which you may find helpful. As mentioned before, your anonymity will be ensured throughout the whole of the study (by the use of pseudonyms), and all identifiable information will be changed (or removed) in order to protect your confidentiality.

If you would like to receive a copy of your interview transcript and/or a summary of the findings of this study, then I will be more than happy to send these documents to you. Please do let me know if there is anything that you would like to receive, and if you have any questions or concerns about the study then please do not hesitate to contact me or my supervisor.

Researcher: Said Aris Tarabi
Trainee Counselling Psychologist
E-mail: …….
Mobile Number: ……..

Research Supervisor: *Dr Angela Ioanna Loulopoulou*
…….
E-mail: ……...
Tel: ……..

Appendix I

Sensitive Verbal Debriefing

Dear Participant,

Thank you very much for participating in this study, and your participation in the study will contribute to a better understanding of CBT – and ultimately it will help practitioners to develop CBT interventions to suit second-generation Pakistani Muslim men. This verbal debriefing is off-the-record and is designed to provide you with the time and the space to ask any questions or raise any concerns that you may have regarding the study, the interview process, and the data analysis, etc.

Has taking part in the interview caused you any distress or concern, and if so would you like to talk about it? Was this your first time of taking part in research, and if so what was it like for you? Was there anything you found helpful today?

The aim of these questions is to provide you with the opportunity to reflect on the experiences of the interview.

THANK YOU

Appendix J

London Metropolitan University Distress Protocol

This protocol will be followed if participants become distressed during the interview process.

This Distress Protocol is designed to deal with the possibility that some participants may become distressed during the interviews while discussing their experiences of therapy. As a Trainee Counselling Psychologist, the researcher has developed a set of skills for working with people with psychological difficulties, and this allows the researcher to ensure the safety of the participants and to manage situations where distress occurs. It is not expected that severe or extreme distress will occur during this research study because every attempt will be made to ensure that potential participants such as psychotic, unstable and suicidal participants will be excluded from the study. In the situation where participants do become unduly distressed, the following action will be taken to ensure the wellbeing of the participants.

Mild distress:

When mild distress occurs, it tends to be evidenced by signs such as tearfulness (watering and redness of the eyes), crying, difficulty in speaking, and the voice tends to become choked with emotion and the participant becomes distracted/restless.

In such cases appropriate action will be taken. The researcher will ask participants whether they are experiencing distress, and if they are, then the researcher will offer them time to pause and compose themselves and ask whether they would like to continue with the interview.

Severe distress:

Severe distress can be identified by signs such as uncontrolled crying, uncontrollable tremors, inability to talk coherently, panic attacks, and hyperventilation.

In such cases appropriate action will be taken. The researcher will stop the interview, debrief the participant immediately and employ relaxation techniques to regulate breathing and reduce agitation. The researcher will recognise the participants' distress, and will reassure the participants that their experiences are normal reactions to abnormal events and that most people recover gradually from such experiences. If any unresolved issues arise during the interview, the researcher will accept and validate the participants' distress, and suggest that they might want to discuss the experience with a mental health professional. Participants will be reminded that this research study is not designed as a therapeutic interaction and details of counselling/therapeutic services will be offered to the participants.

Extreme distress:

Extreme distress is manifested by signs such as severe agitation and possibly verbal or physical aggression. In extreme cases psychotic breakdown can take place where the participant relives traumatic incidents and begins to lose touch with reality.

In such cases appropriate action will be taken to maintain the safety of the participants and of the researcher, and if the researcher has concerns about the safety of the participants or of others, then he will inform the participants that he has a duty to notify mental health services such as a Community Psychiatric Nurse or the participant's General Practitioner. However, if the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask to be seen by the on-call Psychiatric liaison team. If the participant is unwilling to seek immediate help and becomes violent, then the Police may have to be called and be asked to use their powers under the Mental Health Act to detain the person and take him to a place of safety pending psychiatric assessment. (This last option would be used only in an extreme emergency.)

© Chris Cocking, London Metropolitan University Nov 2008

Appendix K

Transcription Conventions

Originally developed by Gail Jefferson (2002; cited in Hutchby & Wooffitt, 2008) the transcriptions of data utilise the following conventions:

Transcript notation key

Symbol	Explanation
( )	Unclear talk
(( ))	Non-verbal behaviour
...	Significant pause
-	Unfinished word
[ ]	Explanatory material added by the researcher
[...]	Material omitted
Underline	Speaker emphasis
CAPITAL	Section of speech noticeably louder
(Inaudible)	Difficult to understand.

Appendix L

Extracts from my Reflexive diary

The current study is about the experience of therapy and the feelings and reactions that were evoked in the participants during therapy. Equally, my own reactions and feelings during the interview process with the participants were of note because my relationship with them could have had an impact on their narratives and affected my analysis.

Reflections on the process of literature research

10/12/2013

I found the experience of the Literature Review challenging, absorbing and exciting, and during it I learnt a great deal about the research process and also about myself. For instance, I experienced uncertainty and worry as to whether or not I would find a gap in the literature, and whether or not that gap in the knowledge would be worth addressing. I fell prey to uncertainty and started to ask myself questions such as "am I approaching this correctly" and "what if I fail to produce something original or material that does not contribute to the existing literature", and the anxiety and the stress regarding the research led me to be almost overwhelmed by it all. Never having done something like this before, it was anxiety-provoking to have to deal with the demands of the research and, on reflection, initially I did not feel very confident about doing my doctoral research. This fear may also have been associated with the fear of not knowing what kind of research would be expected from me as a Counselling Psychologist when eventually I receive my Doctorate. My research supervisor's support was therefore invaluable in helping me to manage my anxieties because she normalised the process for me.

Reflections on the process of the interviews

20.02.2015 (Imran)

I have just arrived at the location of the interview 45 minutes early, and I am feeling a bit nervous because this is my first interview. I am very much hoping that the interview will go well. I feel under the constraint of an additional pressure in that I 'must' now do a good interview because recruiting Second Generation Pakistani Muslim men (SGPMM) who have received individual CBT has been so difficult. Now that I have at last recruited my participants, I cannot let them down. These feelings of nervousness, worry and pressure might impact negatively on the interview process because when I am under pressure I tend to speak very fast and then my English suffers because I start to find it difficult to construct good grammatical sentences that people can understand. The added pressure increases my anxiety levels and makes me feel uncomfortable and ill at ease. While I am feeling nervous and anxious and waiting for the participants to arrive I try to relax by doing some mindfulness-breathing and slowly repeating some of the interview questions to myself to make sure that they are easy to understand and that I do not use any technical CBT terms that the participant might find it hard to comprehend.

18.04.15 (Omar)

I interviewed my second participant at lunchtime and when I arrived for the interview he was having a sandwich, and he offered to share his sandwich with me. I therefore immediately regarded him as a very welcoming, approachable, and friendly person, and I found myself feeling comfortable and at ease with him. I had already had a conversation with him over the phone when we talked about the inclusion and exclusion criteria of the study, and from my conversation with him I had formed the impression that he had a good sense of humour, and I was very much looking forward to our interview. As a result, I was not as nervous nor as worried as I was before my first interview. The interview went well and I learned a lot from the participant. In particular I learnt how difficult it had been for him to seek therapy, and I at last gained an awareness of the huge stigma that is still attached to mental illness and therapy in the Pakistani community. This stigma evokes a reaction of anger and frustration in me because it could prevent or make it considerably difficult and stressful for clients to seek therapy or emotional help in general. I was thus inspired by the courage that he had displayed in seeking therapy and in completing his CBT treatment. He had done this despite family, cultural, and community pressures and challenges such as family members not talking to him and being ignored by community leaders and members.

17/07/16 (Khashif)

This was one of the longest interviews that I have conducted thus far, and this may well be a reflection of how helpful the participant had found the process of research to be. The participant said that he was very glad/happy that he participated in my study and that he had been able to talk about and share his experiences of therapy with me. I found him to be friendly, warm and engaging and I soon felt at ease. I felt drawn to him and enjoyed his company, and I felt no concern about probing his experiences of therapy deeply. On reflection, the fact he was from Pakistan could have had an impact on the data that was generated in the interview. It seems that within his culture, hospitality is a significant aspect of social life and it is often extended to outsiders, and perhaps my experience of the interview was a reflection of that very hospitality. On further reflection, I felt honoured that I was able to provide an opportunity for an unheard voice to be heard, and I was also pleased that he found the experience of taking part in the research a positive, useful and rewarding experience.

General Reflections

02/05/2016

We all see life through the lenses of our own emotions, experiences, beliefs and values, and throughout the research process my reflections have enabled me to monitor, recognise and work with my internal processes such as my feelings and attitudes. Within the reflective space I have been able to examine critically issues that would inevitably influence and shape my research (such as the beliefs that I hold about CBT, Islam and PM men). I have also used supervision, personal therapy and peer discussions to explore my reflections, and they have been a source of insight that has deepened my understanding of the research process.

Appendix M

Ethical Consent Certificate

London Metropolitan University,
School of Psychology,
Research Ethics Review Panel

I can confirm that the following project has received ethical approval by one anonymous Reviewer, the Head of School of Psychology and the Dean of the FLSC to proceed with the following research study (Professional doctorate):

Title: The experience of Pakistani Muslim men receiving individual Cognitive Behavioural Therapy: an Interpretative Phenomenological Analysis.

Student: **Mr Said Aris Tarabi**

Supervisor: *Dr. Angela Loulopoulou*

Ethical clearance to proceed has been granted providing that the study follows the most recent Ethical guidelines to dated used by the School of Psychology and British Psychological Society, and follows the above proposal in detail.

The researcher and her supervisor are responsible for conducting the research and should inform the Ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: Date: 27 October 2014

Prof Dr Chris Lange-Küttner
(Chair - School of Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

Ethical Approval E-mail

27 Oct 2014

Dear Mr. Tarabi/Dear Dr. Loulopoulou,

I have the pleasure to inform you that your Ethics proposal was approved by the Departmental Reviewer, the Head of School and the Dean of the faculty. I wish you good luck with your data collection.

Student name & code	**Supervisor**	**Comments** **If none write 'clear without amendment'**
Said Aris Tarabi	Dr Angela Louolopoulou	Clear without amendment

Yours sincerely, CLK

Prof. Dr. Chris(tiane) Lange-Kuettner CPsychol AFBPsS
Associate Professor (Adjunct Faculty University of Nicosia)

London Metropolitan University
…….

Appendix N

List of useful resources and organisations

If you need counselling or mental health support please do not hesitate to contact the following organisations.

MENTAL HEALTH SUPPORT/GUIDANCE

Men's Health Forum
The Men's Health Forum
32-36 Loman Street
London
SEI OEH
United Kingdom.
Tel: 020 7922 7908
www. menshealthforum.org.uk
Offers information, guidance and support to men regarding a number of health-related issues including mental health.

Mind
15 - 19 Broadway
London E15 4BQ
Tel: 020 8519 2122
Email: contact@mind.org.uk
Website: www. mind. org. uk
Has a confidential help line. Local Mind Associations provide services such as counselling, advocacy, befriending and support on a wide range of mental health issues.

Multikulti
Lasa, Universal House,
88/94 Wentworth Street,
London, E 17SA
www. multikulti.org.uk

Muslim Council of Britain
PO Box 57330
London E1 2WJ
Tel: +44(0) 845 2626 786
Email: admin@mcb.org.uk

Muslim Youth Helpline (MYH)
18 Rosemont Road
London, NW3 6NE
www.myh.org.uk
Helpline: 0808 808 2008 Lines open: Mon to Fri 6pm-12 midnight /Sat & Sun 12pm-12am
General enquiries: 020 7435 8171 Lines open: 10am-6pm
Provides a free and confidential service run by young Muslims trained in Islamic counselling skills.

Sakinah
72 -74 Selwyn Road
Plaistow
London E 13 OAP.
Tel: 0870 005 3084
Email : info@sakinah.org.uk
supportnasakinah.org.uk
Works largely with a Muslim population in London.

Samaritans
Offers a 24 hour help-line service.
Tel: 08457 90 90 90

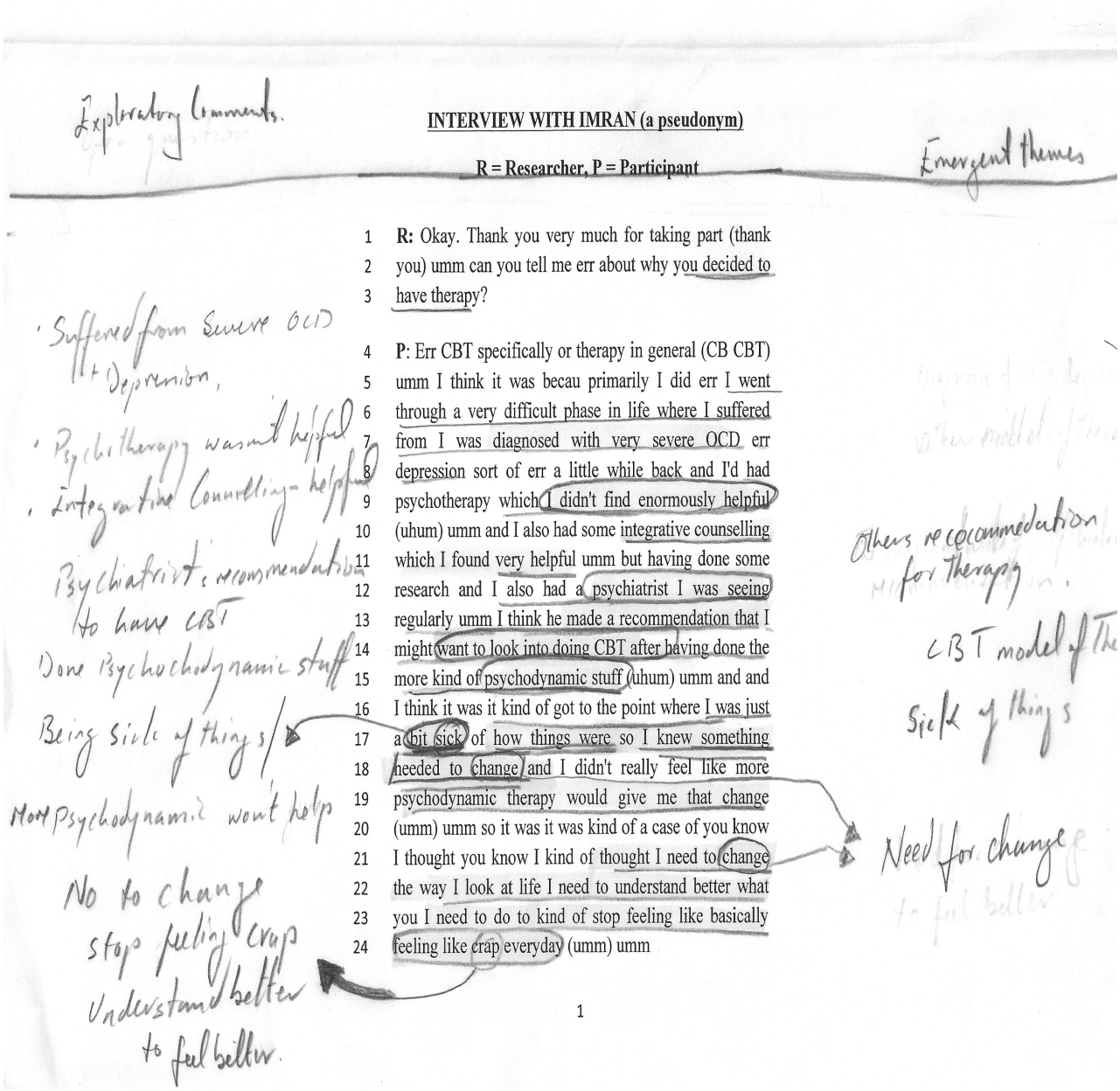
British Psychological Society
St Andrews House, 48 Princess Road East
Leicester LE 1 7DR
Tel: +44 (0)1 16 254 9568
Fax: +44 (0)1 16 227 1314
Provides details regarding qualified psychologists trained in a variety of approaches in the UK.

LONDON metropolitan university

Appendix O

An Example of a participant's annotated transcript (Imran's)

On left hand side of the transcript the exploratory comments were noted, and the emergent themes were noted on the right hand side of the transcript. Then a list of emergent themes was created for each of the participants.



Exploratory Comments.

INTERVIEW WITH IMRAN (a pseudonym)

R = Researcher, P = Participant

Emergent themes

R: Okay. Thank you very much for taking part (thank you) umm can you tell me err about why you decided to have therapy?

P: Err CBT specifically or therapy in general (CB CBT) umm I think it was becau primarily I did err I went through a very difficult phase in life where I suffered from I was diagnosed with very severe OCD err depression sort of err a little while back and I'd had psychotherapy which I didn't find enormously helpful (uhum) umm and I also had some integrative counselling which I found very helpful umm but having done some research and I also had a psychiatrist I was seeing regularly umm I think he made a recommendation that I might want to look into doing CBT after having done the more kind of psychodynamic stuff (uhum) umm and and I think it was it kind of got to the point where I was just a bit sick of how things were so I knew something needed to change and I didn't really feel like more psychodynamic therapy would give me that change (umm) umm so it was it was kind of a case of you know I thought you know I kind of thought I need to change the way I look at life I need to understand better what you I need to do to kind of stop feeling like basically feeling like crap everyday (umm) umm

1

· Suffered from Severe OCD + Depression,

· Psychotherapy was not helpful

· Integrative Counselling - helpful

Psychiatrist's recommendation to have CBT

Done Psychodynamic stuff

Being sick of things

Mom Psychodynamic won't help

No to change

stops feeling crap

Understand better

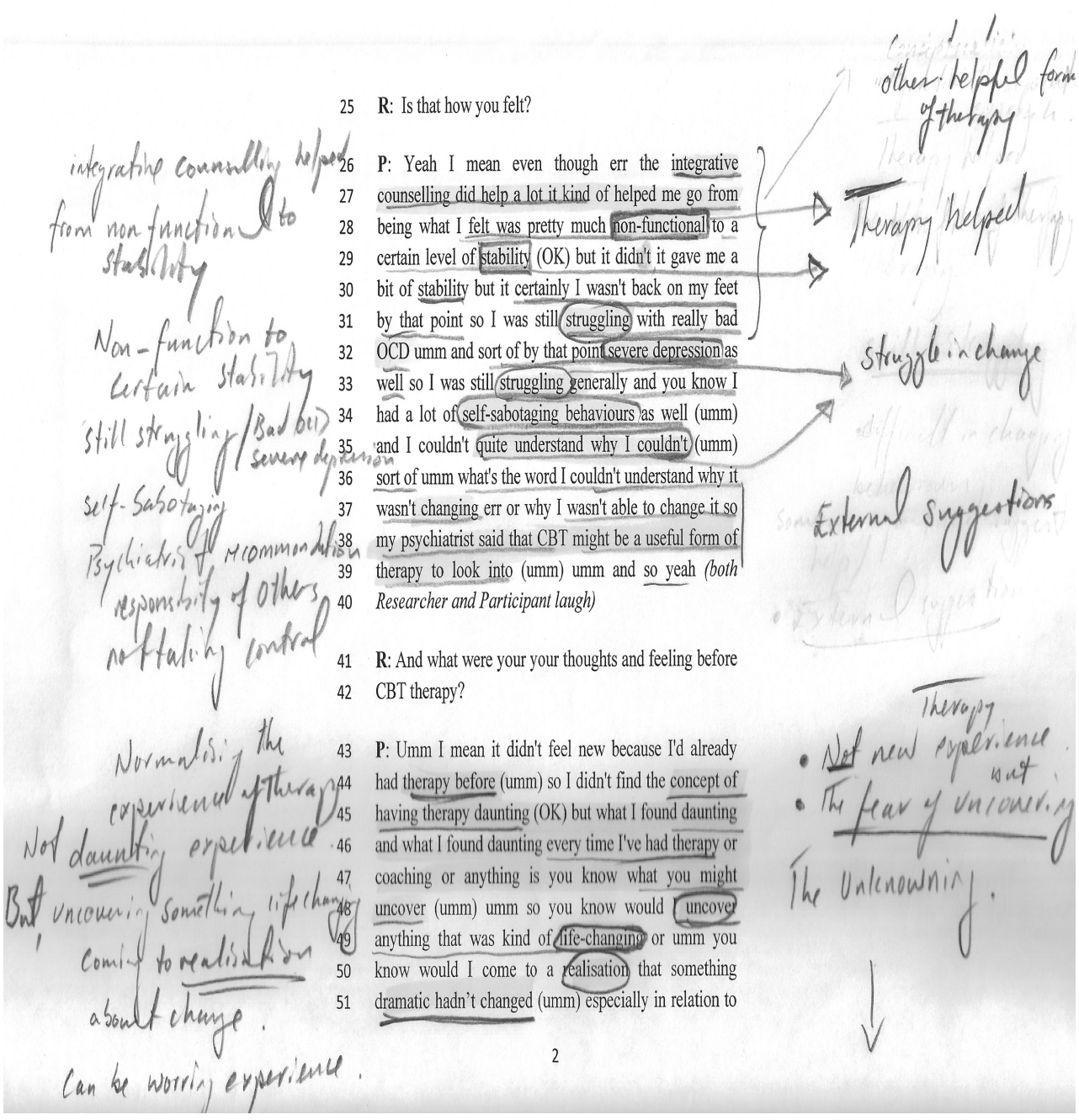
to feel better.

Others recommendation for therapy.

CBT model of the

Sick of things

Need for change



R: Is that how you felt?

P: Yeah I mean even though err the integrative counselling did help a lot it kind of helped me go from being what I felt was pretty much non-functional to a certain level of stability (OK) but it didn't it gave me a bit of stability but it certainly I wasn't back on my feet by that point so I was still struggling with really bad OCD umm and sort of by that point severe depression as well so I was still struggling generally and you know I had a lot of self-sabotaging behaviours as well (umm) and I couldn't quite understand why I couldn't (umm) sort of umm what's the word I couldn't understand why it wasn't changing err or why I wasn't able to change it so my psychiatrist said that CBT might be a useful form of therapy to look into (umm) umm and so yeah *(both Researcher and Participant laugh)*

R: And what were your your thoughts and feeling before CBT therapy?

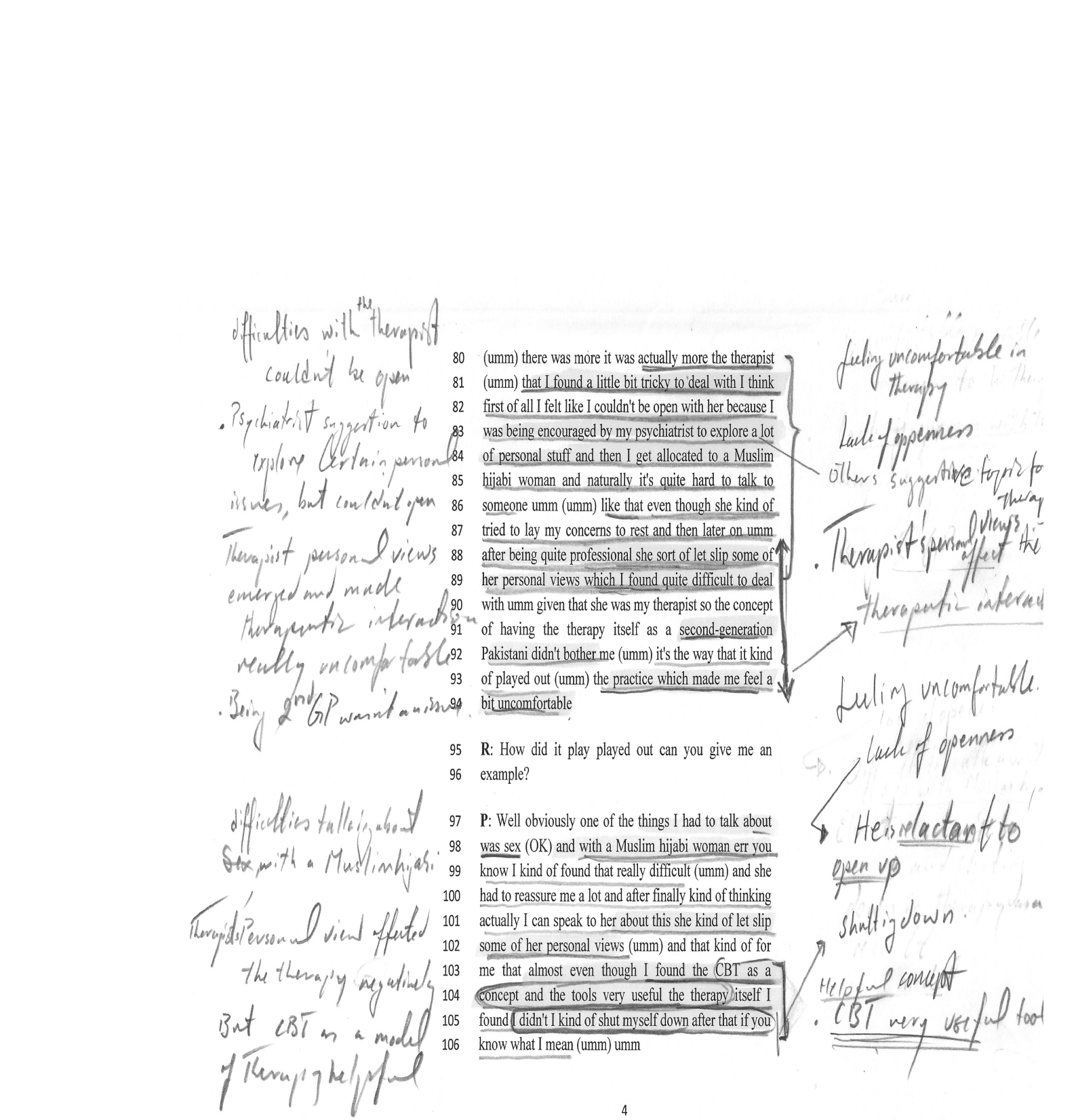
P: Umm I mean it didn't feel new because I'd already had therapy before (umm) so I didn't find the concept of having therapy daunting (OK) but what I found daunting and what I found daunting every time I've had therapy or coaching or anything is you know what you might uncover (umm) umm so you know would I uncover anything that was kind of life-changing or umm you know would I come to a realisation that something dramatic hadn't changed (umm) especially in relation to

2

my family and (umm) whatnot err and my relationship with my now wife umm so I think it was a case of what's gonna come out of it sorry am I not speaking loudly enough umm it was kind of there's a lot of fear about what was going to come out of it (umm) rather than fear of therapy itself yeah

R: And and how did you feel as a second-generation Pakistani Muslim man receiving CBT therapy?

P: Umm ... like I think well my my therapist was actually a Muslim woman so in that respect it was good because she obviously had a bit more of an understanding of my background religion culture at the same time umm she was a lot more I almost felt like whereas you might have some therapists that don't understand that she was too far the other way (umm) umm so I didn't feel like she understood that you know there's there's even though I am Muslim Pakistani background you know I've been brought up in a very Western society my parents are quite laid back in that respect umm so, I kind of the the concept of having therapy itself as a second-generation Pakistani didn't bother me (uhum) it was the fact that there was an element sometimes of feeling judged by the therapist (umm) and that coming through as well (umm) umm I think that bothered me umm but there was no there was no I didn't hesitate in the sense that yeah yeah well I don't know what I'm trying to say here (umm) I didn't feel strange because I was a second-generation Pakistani



(umm) there was more it was actually more the therapist (umm) that I found a little bit tricky to deal with I think first of all I felt like I couldn't be open with her because I was being encouraged by my psychiatrist to explore a lot of personal stuff and then I get allocated to a Muslim hijabi woman and naturally it's quite hard to talk to someone umm (umm) like that even though she kind of tried to lay my concerns to rest and then later on umm after being quite professional she sort of let slip some of her personal views which I found quite difficult to deal with umm given that she was my therapist so the concept of having the therapy itself as a second-generation Pakistani didn't bother me (umm) it's the way that it kind of played out (umm) the practice which made me feel a bit uncomfortable

R: How did it play played out can you give me an example?

P: Well obviously one of the things I had to talk about was sex (OK) and with a Muslim hijabi woman err you know I kind of found that really difficult (umm) and she had to reassure me a lot and after finally kind of thinking actually I can speak to her about this she kind of let slip some of her personal views (umm) and that kind of for me that almost even though I found the CBT as a concept and the tools very useful the therapy itself I found I didn't I kind of shut myself down after that if you know what I mean (umm) umm

Direct Question.

107 **R**: In what way were you shutting yourself ?

Stopped being open with his therapist judgmental therapist

108 **P**: Well I just stopped being completely open with her
109 cos I didn't want to feel like umm you know everyone
110 judges right there's no

111 **R**: How did she judge you?

Personal views affected his openess, Difficulty talking about Sex

112 **P**: Well I think it was more a case of she let slip her
113 views (umm) so she said umm I was talking about sex
114 and then I asked her randomly just as a kind of
115 throwaway remark as I said something like "Oh, you
116 must think I'm gonna go to hell" just as a bit of a joke
117 well not a joke well yeah kind of a joke (umm) umm and
118 she said "You know, professionally what you're saying
119 to me is fine. Personally" you know she's like "My heart
120 kind of bleeds for you with everything you're doing" and
121 I just thought I just thought "That's incr.. do you how can
122 you say that?" umm

Shocked by therapist's response.

123 **R**: How did it make you feel?

Trust was gone and created frustration in him. Waiting/long waiting list difficulties accessing and changing therapist Shocked, frustrated.

124 **P**: Oh I just just lost my trust in an instant umm I I think
125 I was frustrated more than anything else because I
126 invested a lot of time into this umm and waited you
127 know the waiting list is ridiculous so I had a really long
128 wait and I knew that I wouldn't be able to have more
129 sessions or get another therapist so I was just really
130 frustrated umm I was trying and I was quite shocked
131 when she said that umm so I think the shock the initial

5

Lack of openness with the therapist

Therapists personal views affecting therapeutic relationship

Lack of trust in the relationships

feeling frustrated

shocked.

Appendix P

An example of the participant's (Imran's) emergent themes with Line Numbers

Other people had recommended CBT [12-14],
CBT model of therapy [12-14]
Sick of things [16-18]
The need for change [17-18]
Other helpful forms of therapy [26-27]
Therapy helped [26-29]
Struggle in change [31-32]
External suggestions [38-39]
Therapy was not a new experience [43-44]
The fear of uncovering something life-changing [45-48]
The unknown [53-54]
Therapeutic expectations [55-57]
Ambivalence about therapy [53-54]
The therapist's understanding [60-63]
Lack of understanding [67-70]
Being judged/judgemental therapist [73-74]
SG Pakistanis in therapy not an issue? [71-73]
Feeling uncomfortable in therapy [81]
Lack of openness [82-85]
Suggestions by others with regard to therapy [82-84]
A therapist's personal views affect the therapeutic interaction [88-90]
Feeling uncomfortable [91-94]
Lack of openness [97-99]
Reluctance to open up [98-100]
Shutting down [104-106]
Helpful concepts [103-104]
CBT very useful tool [103-104]
Shocked [111-112]
Lack of openness with the therapist [105-106], [108]
The therapist's personal views affecting the therapeutic relationship [121-122]
Lack of trust in the relationship [124]
Feeling frustrated [129-130]
Lack of openness [133-134]
Helped him to become more independent [135-136]
Lack of trust between client and therapist [137-138]
Expectations of/in therapy [140-143]
Difficulties in being non-judgemental [145-146]
Feeling judged prevented openness in therapy [149-151]
CBT model of therapy [153-154]
Thinking differently [153-155]
Understanding thought processes [156-159]

Apply CBT [162-163]
Understanding changing thought processes [162-164]
Thinking differently [162-164]
Difficulties in applying CBT model [168-169]
Developing self-awareness/insight [175-176]
Make it easier to put into practice [176-177]
Thinking differently [179-181]
Previous struggle [185-189]
Curiosity [193-195]
Thinking differently [197]
Competency in applying CBT [198-200]
Become aware of the thoughts [203-204]
Feelings of anxiety [200-202]
Accepting things rather than reacting to things [202-204]
Snapping out of negative thoughts [204-206]
Importance of self-awareness in CBT [20-208]
Reflecting [209-211]
Not over-reacting [210]
Catastrophising [210]
Difficulties in discussing certain topics with a Muslim therapist [217-220]
Lack of openness with a Muslim therapist [219-220]
Being matched or unmatched with the therapist [225-227]
Religion [225]
Helpful [225-227]
Struggles [228-233]
Barriers to therapy [231-234]
Lack of openness with the therapist [231-234]
CBT step by step [239-241]
Structure [240-241]
Framework [242-243]
Improved self-awareness [243-246]
Insight [243-246]
Advantage of CBT framework [251-252]
Difficulties of applying CBT [255-257]
Importance of practice in CBT [257-260]
Usefulness of CBT framework [257-259]
Helpful [260-261]
Solution-focussed approach [264-265]
Sense of direction [266-268]
Open-ended [268-269]
Completely lost [269-271]
Management of specific problems [271-273]
The importance of structure [273-275], [284]
Timing in therapy [285-286]
Solution focussed [286]
Limitations of CBT [287-288] [289-292]
Good to talk to somebody objective [299-300]
Therapist completely objective [299-300]
Sense of direction [302-303]
Structure [303-305]
Identify progress and lack of progress [303-306]
Therapist in control [309-310]

Sense of annoyance with unstructured therapy [311-314]
Expectations of therapy [318-319]
The process involved in CBT [317-318]
Self-discovery [320-321]
Self-awareness [320-321]
Talking to a mirror [323-324]
CBT structure [325-326]
The importance of structure [329-330]
The therapist more in control [329-330]
The therapist is an expert [329-330]
Trust the CBT structure [331-332]
Helped [332-333]
Liked solution-focussed [343]
Therapist taking an active role [346-347]
Directive stance [346-347]
Therapist being too directive/forceful [346-347]
Unhelpful aspects of CBT [348-349]
Feeling incomplete [349-350]
Lack of deep exploration [355-356]
Lack of space to explore concepts in depth [357-358]
Treating symptoms rather than causes [358-360]
Modification of CBT concepts [367-370]
More depth [367-370]
Deep exploration [367-370]
More fundamental change [367-370]
Dealing with symptoms [371-372]
No fundamental change [374-376]
Lack of space [376-377]
Suggestions for future therapy [377-379]
Expectations [377-379]
Space for exploration [382-384]
Change at deeper level [386-388]
Religion/Culture requires fundamental understanding [388-389]
Lack of exploration [390-392]
Barriers to therapy [390-392]
Suggestions for future therapy [392-395]
Usefulness of in-depth exploration [395-397], [400-402]
Importance of religion for second-generation Pakistani Muslim men [400-402]
In-depth discussion about religion/culture [405-409]
Importance of religion and culture [397-400], [405]
Usefulness of in-depth exploration for religious people [409-413]
Therapy Stigma [425-427]
Therapy Shame [426-428]
Symptom management [409-414]
Useful suggestions for therapy [421-425]
Role of religion in shaping beliefs [430-431]
Importance of religion in shaping beliefs [435-439]
Western influences [441-443]
Culture vs. religion [443-446]
Exploring the principles [446-447]
Importance of religion [449-451], [453-455]
Religious importance diminished [457-459]

Rituals [458-460]
Importance of religious beliefs [461-462]
Different meanings of being religious [470-473]
Interaction between religion and wellbeing [479-482]
Integrated part of religion and personal wellbeing [479-482]
Helpful religious principles [484-485]
Relationship between religion and wellbeing [489-491]
Important [487-489]
The input of religion on mental wellbeing [489-491]
Important role of religion [490-493]
Important role of religion [502-507]
Taboo subjects [512-514]
Lack of openness [512-514]
Feeling judged [515]
Symptom management [518-519]
Religion overlooked in therapy [520-523]
Importance of religion in therapy [525-526]
Suggestions for the future [525-526]
Importance of religion / culture for Pakistani men [528-533]
Importance of in-depth exploration [533-534]
Helpful suggestions [533-534]
Lack of space in CBT [536-538]
Understanding mind [539-540]
Retraining thoughts/processes [539-540]
Lack of depth in therapy [543]
Thinking differently [550-553]
Helpful suggestions [550-553]
Exploration of religion and culture in therapy [550-553]
CBT and religious interaction [550-556]
The impact of fundamental change [558-560]
Lack of depth/space [558-562]
Feelings of incomplete [556-560]
Here and now [560-564]
Limited exploration [558-560]
Unhelpful [561-564]
Symptoms but not causes [561-565]
Focussed treatment [561-564]
Symptom-based approach [568]
CBT model of therapy[569-573]
Lack of space [573-574]
Compare/contrast [568-574]
Wishes for deeper exploration [568-574]
CBT framework [577-582]
CBT process [577-582]
Therapist active expert [583-585]
Therapist taking control [584-587]
Symptoms [587-599]
Meaningful change through in-depth exploration [589-593]
Lack of therapeutic space for in-depth exploration [596-601]
Wishes for more exploration [596-601]
Future improvements [596-601]
No clash between CBT and religion [604]

CBT model [605-607]
CBT enhanced religious impact [608-610]
No clash [610-611]
Family loyalty [615-617]
CBT enhanced thought processes [617-622]
Self-awareness [619-621]
Solution-focussed [619-621]
Insight [621-622]
Thinking differently [610-621]
Religion [623-625]
No clash between religion and CBT [623-625] , [640-642]
Effectiveness of CBT [630-634]
CBT suitable for religious people [630-634]
Suitability of CBT [630-634]
No clash [636]
People's perceptions of CBT [638-640]
Complement each other (religion and CBT) [640-642]
Fit well together [640-642]
Good fit [640-642]
CBT in practice [645-647]
CBT can help understand religious values/beliefs [647-648]
Usefulness of CBT [651]
Applying CBT in challenge [662-655]
Fear of change [654-657]
Good fit with CBT and religion / fit well together [658-659]
Continuing exploration of how CBT and religion can complement each other [667-671]
Suggestions regarding therapy [669-671]
Important inputs lack of education about therapy [671-673]
Fear [671-673]
Good fit of religion and therapy [673-674]
Lack of education/information about therapy [671-673]
Suggestions for improvements [695-698]
No conflict [695-698]
No clash [695-698]
CBT strengths [698-702]
Religious understanding [700-702]
Usefulness of CBT [702-708]
Fit well together [697-699]
Good fit between religion and CBT [700-702]
Suggestion for engagement [705-717]
No clash [702-705]
Usefulness of therapy [715-717]
Uncomfortable with Muslim therapist [729-730]
Lack of trust [732-734]
Judgement of therapist [732-734]
Cultural barriers [736-740]
Lack of openness [738-740]
Resistance to change [740-743]
Taboo subject [738-740]
Lack of openness in the family [741-743]
Barriers to therapy [744-747]
Difficulties in talking/opening up [738-743]

Lack of openness [738-743]
Development of therapeutic connections/relationship [748-750]
Usefulness of therapy [758-759]
Uncovering the unknown [760-762]
Culture vs Religion [762-764]
Realisation [762-764]
Feeling guilty about change [762-765]
Ambivalent about change [767-768], [766-769]
Self-awareness [766-769]
Uncovering the unknown [767-769]
Change way of life [773-776]
Difficulty in accepting change [773-776]
Very resistant to change [775-776], [780]
Accept changes [780-783]
Enhanced therapy progress [780-783]
Accepting changes [781-783] , [784-787]
Accepting changes [784-787]
Positive impact of therapy [788-789]
Changing unhelpful behaviour [793-795]
Better understanding of self-care [795-796]
Difficulty in changing behaviour [798-799]
Fear of discovery [802-803]
Fear of the unknown [803-805]
Ignorance [803-805]
Muslim men [805-806]
Muslim Fanatics [804-809]
Judging all Muslims [807-809]
The therapist's understanding of culture / religion [809-810]
Barriers [810-812]
Preconceptions about the therapist's understanding [813-816]
Barriers [812-816], [820-823]
Fear [812-816]
Personal reservations [823-826]
Core beliefs [826-828]
Analysing the problem [823-828]
Realisation [826-828]
Better therapist [831-833]
Trust in the process [831-833]
Open to future therapy [836-837]
Therapy learning process [843-845]
Open to more therapy [844-845]
Willingness to learn more [844-845]
Trust in the process [849-852]
CBT model [850-852]
CBT framework [850-852]
Future suggestions [852-856]
CBT is not anti-religion [856-857]
Shame in therapy [857]
Suggestions for future improvement [860-863]
Stigma around CBT [860-863]
Lack of understanding about therapy [862-863]
Education [864-868]

Muslim medical community [860-862], [864-868]
Ignorance [864-868]
Therapy promotion [864-868]
Useful suggestions [867-869]
Importance of engagement [874-877]
Open-mindedness about therapy [881-883]
Unhelpful therapist [883-887]
Helpful model [883-887]
CBT model [885-887]
Knowledge of religion / culture [892-895]
Training needs [895-897]
Openness [896-899]
Given time and space [899-902]
Willingness to explore [901-902]
The importance of in-depth exploration [901-905]
Unhelpful aspects of CBT [901-905]
Helpful aspects of CBT [912-918]
Homework [917-918]
Technique [912-915]
Theory into practice [913-916]
Work outside therapy [915-916]
Homework [917-918]
Summarising his experience [922-923]
CBT model [922-923]
Helpful [923-925]
Changes in life [928-929]
Therapist less helpful [923-925]
CBT treatment beneficial / helped [922-923], [929-933]
Helpful process [928-931]
Therapy enhanced self-understanding /self-awareness [9227-931]
Unhelpful therapist [932-933]
Suitability of CBT for second-generation Pakistani Muslim men [939]
Impact of therapy [942-944]
Helpful [942-944]
Enhanced understanding [939-944]
Importance of CBT [947-950]
Managing symptoms [948-949]
Thinking differently [950-955]
New way of thinking [951-952]
Profound change [955-956]
Increased awareness [950-952]
CBT model encouraged [952-958]
Fundamental changes [952-958]
Appropriateness of timing [962-967]
Feeling comfortable talking about experience of therapy [962-967]
Give time to reflect [962-967]
Important in IPA that the participant felt that his experience was captured [976]

Appendix Q

A participant's (Imran's) list of subthemes, superordinate themes and corresponding page and line numbers

Pre-therapy
Recommendations for therapy by other people [1: 11-13, 2: 38-39, 4: 82-84]
Recognised the need for a change [1: 18, 1: 21-24, 2: 50-51]
Fear of uncovering something life-changing [2: 44-47, 2: 49, 2: 50-51, 3: 52-54, 3: 55-56, 31: 803-805]
Fear of the unknown [2: 46-49, 2: 50-51, 3: 55-56, 29: 759-766, 31: 803-805]
Therapy stigma/shame/being diseased [16: 425-427]
Realisation of what was involved in therapy [13: 317-322, 29: 758-766, 30: 822-828, 32: 822-828]
Ambivalent about change [25: 653-654, 29: 760-766]

CBT Techniques
Useful tools [4: 103-104, 35: 911-918]
Thinking differently [6:153-155, 7:162-165, 7:179-181, 8:193-196, 21:538-542, 24:621-622, 36: 947-959]
Understanding and changing thought processes [6: 156-157, 7: 164 -165, 21: 538-542, 24: 621-622]
Improving/developing self-awareness and insight [7: 174-175, 13: 320-322, 24: 621-622, 36: 942-944]
Solution-focussed approach [11: 264-266, 11: 285-288, 14: 343, 24: 621-622]

The Therapist
Religious/Cultural expectations [3: 62-68, 4: 88-89, 4: 101-102, 20: 514, 28: 730-740, 29: 747-748]
Being Judged/Judgmental therapist [3: 74, 4: 88-89, 5: 110, 5: 112-122, 6: 143, 6: 145-147, 28: 732-735]
Feeling uncomfortable with a Muslim therapist [3: 66, 3: 76, 4: 80-90, 4: 91-94, 28: 728-735]
Lack of openness with the therapist/therapy [4: 80-87, 4: 97-102, 5: 108-110, 9: 220-223, 9: 225-229,
9: 233-236, 20: 511-514, 28: 738-743, 29: 748-750]
Muslim men [31: 805-806]; Muslim are fanatics [31: 804-809]
Therapist taking active role/directive stance/An expert [13: 320-334, 13: 329-330, 14: 346-354, 23: 582-587]
Therapist judging Muslims [31: 807-809]

The benefits of therapy
Effectiveness of CBT [24: 629-632, 25: 645-649]
Usefulness/helpfulness/suitability of therapy [27: 698-702, 28: 716-717, 29: 758-769, 30: 783-795
35/36: 925-933, 36: 939-944, 36/37: 947-959]
Changing unhelpful behaviour [30: 780-787, 30: 783-795]
Managing difficulties [36: 947-959, 36: 948-950]

The limitations of therapy
Difficulties in applying/implementing CBT [7: 168-173, 7: 175-178, 7: 178-181, 10: 256-257, 35: 913-918]
Lack of in-depth exploration [14: 343-350, 14: 355-359, 14/15: 367-370, 15: 382-395, 21: 533- 534, 21: 543-544, 22: 558-562, 22: 561-566]
Feeling incomplete [14: 348-351] [22: 556-560]
The benefits of deep exploration [15: 371-376, 15: 385-388, 15/16: 395-400, 16: 405-410, 22: 568-574, 23: 586-594, 23: 597-601, 34/35: 898-905, 36 /37: 951-959]
Lack of space [15: 382-388, 15: 376-379, 21: 537-538, 22: 568-569]

The interaction between CBT and religion
Religion overlooked in therapy [20: 520-524]
No clash/conflict (complementarity) between CBT & Religion [23/24: 604-611, 24: 624-626, 25: 636-642, 25: 650-651, 26: 673-677, 27: 697-708, 29/30: 766-769]
CBT enhanced religious impact [23/24: 608-611]
CBT suitable for religious people/suitability of CBT [24: 629-636, 36: 939-944]
Complement each other/fit well together/good fit [25: 640-642, 26: 673-680, 27: 703-708]
Therapy can strengthen the understanding of religion [25: 645-649, 26: 675-678]

CBT process
Applying CBT to challenge [25: 653-655]
Trust in the process [32: 831-833, 33: 850-852, 34: 882-887]
Therapy is a learning process [32: 843-845]
Willingness to learn [32: 843-845]

Considerations for the future
Suggestions for the future [15: 378-388, 15/16: 395-399, 16/17: 421-425, 20: 525-526, 21: 533-543, 21: 550-553, 22: 568-574, 23: 597-601, 26: 667-673, 33: 852-858, 33: 860-869, 33/34: 871-877, 33/34: 852-877]
Lack of education about therapy [26: 667-671, 26: 679-680]
Suggestions for engagement [27: 694-702, 27: 709-714]
Training needs [34/35: 895-905]
Open to future therapy [32: 836-845]

Being Pakistani
Being a 2nd generation Pakistani [3: 68-70, 3: 72, 3: 78-79, 4: 91-92]

Religious understanding
The importance of religion and culture [16: 405-412, 17: 437-439, 21: 530-535]
The importance of Religion for second-generation Pakistani Muslim men [16: 400-402, 19: 490-496, 20: 504-507]
Different meanings of being religious [18: 471-474]
Helpful religious principles [19: 484-489]
The positive impacts of religion on wellbeing [19 : 484-489]

Post therapy
Shame in therapy [33: 854-858]
Stigma around therapy [33: 860-869]

Appendix R

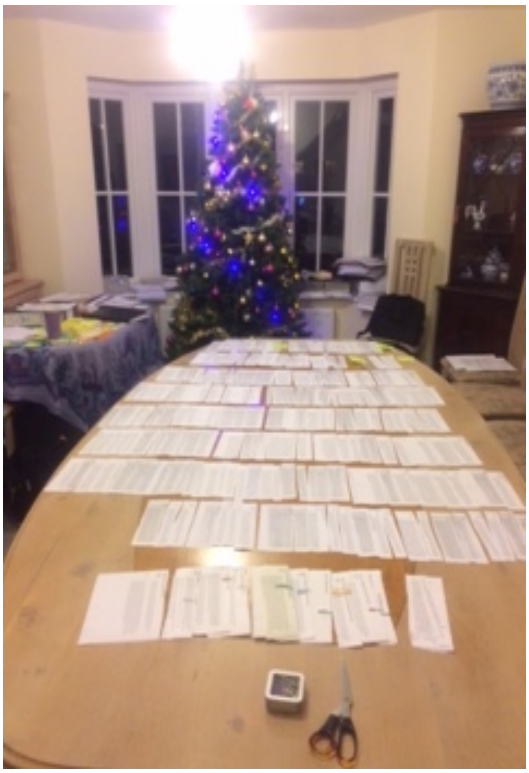
Summary of superordinate and sub-themes with the relevant quotes for all the participants

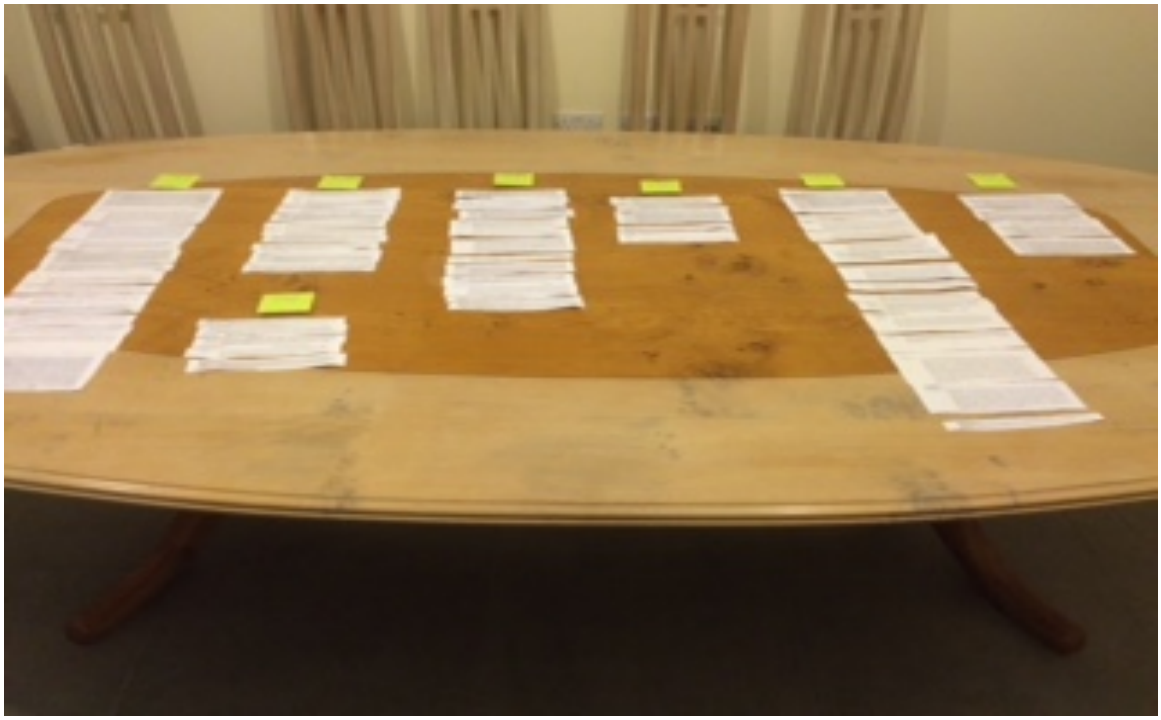
Superordinate theme	Sub-theme	Relevant quote/extracts
Pre-CBT consideration/difficulties	The need for help	*"I was in serious need of help because my whole life was just falling apart". Salman, Line 9-25.*
	Pakistani Community stigma and hiding	*" I stayed away because I was so scared of what people would say, especially my family and our Pakistani community[…]I really didn't want to bring shame to them". Omar, Line 317-321.*
	"There's no such a thing as feelings for Pakistani men"	*"It's more like you have to be a man, there's no such thing as feelings for Pakistani men basically. What's going on inside it don't really matter". Abdul, Line 457-458.*
	Being stuck in the middle ground and living in two worlds	*"Growing up here as second generation, where society is going one way and then you know our beliefs and practices, family are pulling us another way and we get caught up caught up in the middle, that tug of war going on within yourself." Khashif, Line 2112-2116.*
The Process of CBT for Pakistani Muslim men	Mirror, guide or conversation	*"It was sort of like guidance and it was almost as though I was being steered in a way where you know I would find the right solution for myself". Khashif, 701-711.* *"It was more like making you see your own inner self, it was like, the therapy was more like me standing in front of the mirror[...]I'd like to use this two words all the time "self-assessments" of oneself really and that was like kind of beaten into me in the therapy". Salman, Line, 278-281.*

	The Muslim therapist, tailor or taboo	*"The advice was very much tailored to me, and it was tailored to me because my therapist understood what background I came from". Omar, Line 630-635.*
	Learning Environment	*"Therapy helped me to question my religion, my beliefs and my values...If anything, it's brought me closer to my religion". Abdul, Line 970-977.* *"Use CBT tools to better yourself all the time, even after completing therapy". Omar, 499-500.*
	Lack of space and too difficult	*"You want to go a bit more deeper about something, and I wasn't allowed able to do that so that was frustrating". Imran, Line 556-566*
Interaction between CBT and Islam	Personal significance of Religion	*"Islam is really important not only for me, for 99% of Pakistanis religion is really important regardless how religious they are." Sunny, Line, 1226-1232.*
	"Need a knowledge from a mixture of both"	*"I'm a mixture of both. So I need a knowledge from a mixture of both things I need some counselling session of both knowledges". Sunny, Line 847-857.*
	Clash, conflict or complement	*"CBT teachings are saying it's not God, you are the one in control…but I believe everything in my life is controlled by the will of Allah. That's how I found that quite conflicting at times". Salman, Line 685-699.* *"According to the CBT Cognitive Behaviour Therapy mental problems are caused by problems in the mind, thinking wrongly, but whereas from Islamic point of view this problem is a test from Allah". Sunny, 777*

Appendix S

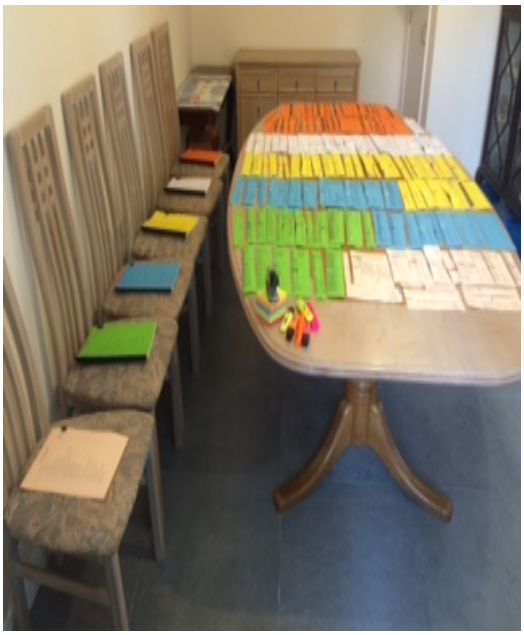
The process of creating the subthemes and superordinate themes for the participant (Imran)

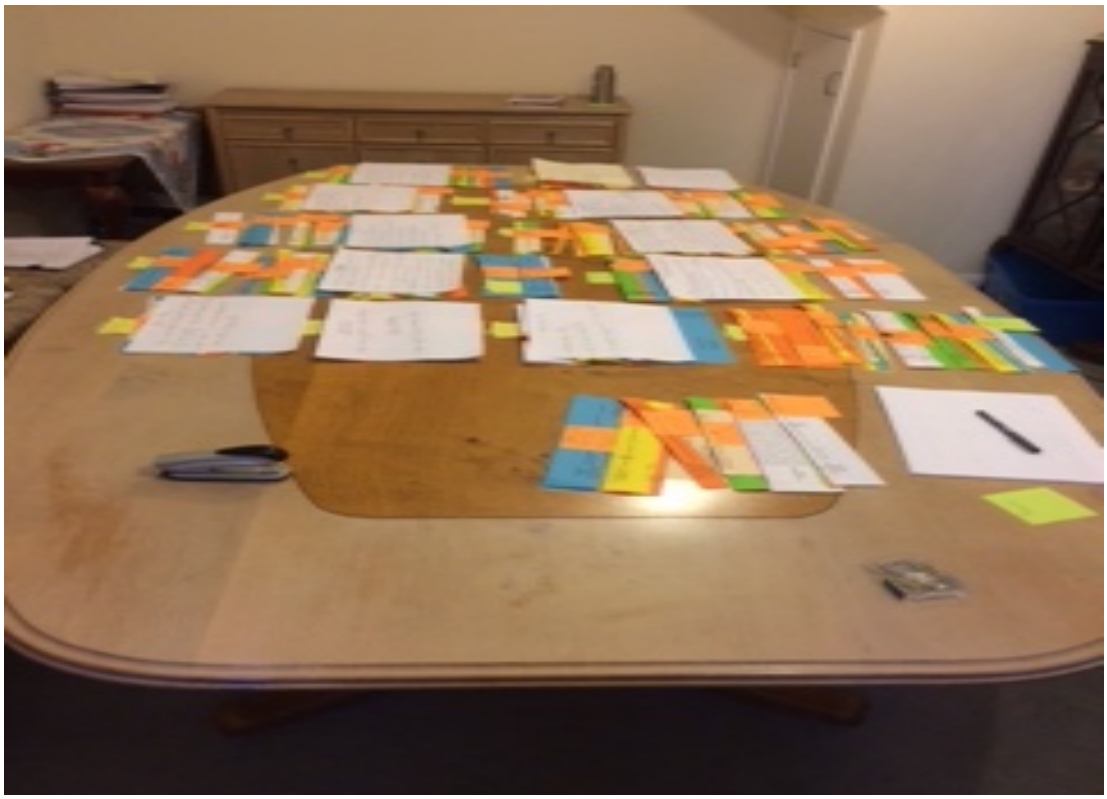




Appendix T

The process of creating the subthemes and superordinate themes for *all* the participants





Appendix U

List of Recommendations for Clinical Practice

The current study provided some useful insights with regards to SGPMM and CBT. When working with this particular client group therapeutically, practitioners might take the following into account.

- SGPMM inherit their views on masculinity and cultural responsibilities. Clinicians should therefore be mindful to address these cultural norms and values by asking Muslim clients what their thoughts on the matter are – and this would allow clinicians to employ more targeted interventions to help the individuals to manage the norms/ values.

- SGPMM are under pressure to comply with two different cultural values simultaneously. Therapists therefore need to be aware of the generational issues and dual identities of SGPMM. When working with SGPMM, therapists need to be aware of how compatible their therapeutic approach is with the multiple identities of SGPMM. They can do this in therapy by evaluating carefully the relationship or the interaction between the clients' individualist norms and collectivist values.

- For SGPMM seeking help and speaking about their feelings and intimate issues to an outsider is a cultural taboo, and there could be a sense of failure and weakness involved if these men have to seek help. Practitioners could therefore go a long way towards reducing the feelings of embarrassment and shame that SGPMM feel by normalising these psychological issues for this particular group of clients.

- Some SGPMM described the experience of CBT as a "conversation". Therapists thus need to be aware that it is not appropriate for them to make the assumption that Muslim client groups such as SGPMM would always find structured and expert-led therapy a useful and appropriate treatment. It would be useful to explore SGPMM's expectations of therapy in detail in the assessment or during the initial therapy sessions.

- SGPMM state that seeing a Muslim therapist can prevent them from discussing topics such as sex before marriage, alcohol and gambling. Therapists are therefore advised to

discuss these concerns openly and to provide clients with a safe therapeutic space to explore their concerns/issues.

- Some SGPMM suggested that CBT had helped to bring them closer to their religion because it allowed them to explore and question their religion and to gain a deeper understanding of their beliefs. If therapists help Muslim clients to become aware that CBT could actually help them to get closer to their religion rather than it being in conflict with their religion, then this could remove some of the concerns that SGPMM might have, and it could possibly encourage them to see CBT in a more positive light, and thus possibly encourage others to access therapy more readily.

- SGPMM revealed that the label "CBT" evokes negative connotations and assumptions. It would be beneficial for therapists to spend some time in discussing the issues of stigma and shame around therapy, and the label of "CBT" could be explored in therapy thus normalising the mental distress experienced by clients.

- SGPMM talked about the difficulty in understanding the terminology of CBT, and being overwhelmed by the homework and assignments in CBT. Therapists would be advised to spend some time explaining CBT terminology more clearly and discussing the benefits of doing homework. They could also consider changing the name of "homework" to something more acceptable such as "between-session-activity".

- The SGPMM in this study revealed that if religion were not a part of their therapy then they may not engage well with therapy, and if there were a conflict or a disagreement between CBT and Islam then they would terminate their therapy. In their work, practitioners should therefore bear in mind that they are not only searching for a good fit between CBT and Islam, but that they should also try to avoid any conflict between Islam and CBT.

- Practitioners might deal with the issue of the integration of religion into therapy by making it a part of their on-going work throughout the treatment to check and see how CBT interventions fit or conflict with their clients' religious beliefs. Training programmes could encompass lectures or seminars on specific ways of integrating aspects of Islam into CBT treatments so that therapists are better equipped to deal with

Muslim clients such as SGPMM who may prefer features of their religion to be included in therapy.

- SGPMM believe that Allah tests the love and patience of individuals by sending them various trials including physical and psychological difficulties. Health-care professionals need to be aware of how these explanations of mental illnesses may impact on a Muslim client's attitudes, beliefs and approach to therapy.

List of Recommendations for Research

- SGPMM spoke about the significance of the role that religion plays in all aspects of their lives. This could be an area for future research – for instance exploring the impact of religion on the daily lives of their clients, and how client's religion can have an effect on therapeutic work.

- Some SGPMM expressed a sense of satisfaction that CBT has a step-by-step guiding structure and is directive and expert-led, whilst others liked the exploratory and non-directive nature of therapy. More specific research about a less directive or structured form of therapy is therefore needed to map out this issue better.

- It is important in the future to overcome the concerns of SGPMM and to engage them in research. This can be achieved by clinicians normalising clients' anxiety about research, by providing more information about research confidentiality, and by talking about the importance and benefits of research. For instance, research findings can be used to help mental health organisations to improve and develop services for ethnic minority groups such as Pakistani men.

- The findings herein may reflect the experience merely of those who attended a reasonable number of sessions of therapy and completed their treatment. One suggestion for future research could thus be to explore the experiences of SGPMM men who did not complete therapy or who dropped out of therapy early, and such research may thereby generate different findings.

- Specific age-related issues could be addressed in future research by recruiting participants under 20 or those aged 45 and over, and this could provide new and valuable insights into the issues that could impact on the mental wellbeing of different

age groups. Health care professionals could then target the difficulties of these different age groups more specifically.

- The researcher was a male belonging to the same religion and roughly the same culture as the participants, and thus the participants may have felt under pressure to present a strong image of themselves. Perhaps, a second generation Pakistani female researcher could conduct the interviews, and that might help participants to be less concerned about their masculine image.

- The current study was associated with the lack of information regarding therapist variables (such as religious beliefs/attitudes towards SGPMM/levels of training/and competency to deliver CBT to individuals from a different cultural and religious background) – and these factors could have an influence on the participants' experience of CBT. It may therefore be helpful in future qualitative studies to focus on therapist factors. This will offer a rich and in-depth understanding of the factors that create better therapy experiences for clients.

- This study did not assess the therapists' adherence to a particular approach of CBT, nor were the participants' specific presenting difficulties taken into consideration. A more exploratory study would be helpful by considering variables such as the type of interventions employed in terms of different approaches within CBT (e.g. 'third wave' CBT or traditional CBT), or by exploring SGPMM's experiences of CBT interventions for specific difficulties such as anxiety or depression.

- Future research could examine the effectiveness of CBT by exploring the efficacy of CBT treatment against other therapeutic orientations such as psychodynamic or humanistic approaches. This type of research could help to determine whether or not CBT interventions are most suitable and appropriate for SGPMM individuals.

- In order to increase the breath of research in the area of psychological therapies for ethnic minority groups, and to ensure that more participants such as SGPMM engage in research, it would be beneficial to try to widen the scope of recruitment to include areas such as the NHS, and private therapists.

Appendix V

Brief Psychiatric Rating Scale (Overall & Gorham,1962)

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Patient Name _____ Today's Date _____

Please enter the score for the term that best describes the patient's condition.

0 = Not assessed, 1 = Not present, 2 = Very mild, 3 = Mild, 4 = Moderate, 5 = Moderately severe, 6 = Severe, 7 = Extremely severe

Score		
☐	1.	SOMATIC CONCERN Preoccupation with physical health, fear of physical illness, hypochondriasis.
☐	2.	ANXIETY Worry, fear, over-concern for present or future, uneasiness.
☐	3.	EMOTIONAL WITHDRAWAL Lack of spontaneous interaction, isolation deficiency in relating to others.
☐	4.	CONCEPTUAL DISORGANIZATION Thought processes confused, disconnected, disorganized, disrupted.
☐	5.	GUILT FEELINGS Self-blame, shame, remorse for past behavior.
☐	6.	TENSION Physical and motor manifestations of nervousness, over-activation.
☐	7.	MANNERISMS AND POSTURING Peculiar, bizarre, unnatural motor behavior (not including tic).
☐	8.	GRANDIOSITY Exaggerated self-opinion, arrogance, conviction of unusual power or abilities.
☐	9.	DEPRESSIVE MOOD Sorrow, sadness, despondency, pessimism.
☐	10.	HOSTILITY Animosity, contempt, belligerence, disdain for others.
☐	11.	SUSPICIOUSNESS Mistrust, belief others harbor malicious or discriminatory intent.
☐	12.	HALLUCINATORY BEHAVIOR Perceptions without normal external stimulus correspondence.
☐	13.	MOTOR RETARDATION Slowed, weakened movements or speech, reduced body tone.
☐	14.	UNCOOPERATIVENESS Resistance, guardedness, rejection of authority.
☐	15.	UNUSUAL THOUGHT CONTENT Unusual, odd, strange, bizarre thought content.
☐	16.	BLUNTED AFFECT Reduced emotional tone, reduction in formal intensity of feelings, flatness.
☐	17.	EXCITEMENT Heightened emotional tone, agitation, increased reactivity.
☐	18.	DISORIENTATION Confusion or lack of proper association for person, place or time.

Appendix W

Beck's Scale for Suicide Ideation (SSI)

The SSI measures characteristics of an individual's plans and wishes to commit suicide. The scale of suicidal ideation consists of 19 items which can be used to evaluate a patient's suicidal intentions (Beck et al., 1979; 1988).

Item	Response	Points
1. Wish to live	Moderate to strong	0
	Weak	1
	None	2
2. Wish to die	None	0
	Weak	1
	Moderate to strong	2
3. Reasons for living/dying	For living outweigh for dying	0
	About equal	1
	For dying outweigh for living	2
4. Desire to make active suicide attempt	None	0
	Weak	1
	Moderate to strong	2
5. Passive suicidal desire	Would take precautions to save life	0
	Would leave life/death to	1

	chance	
	Would avoid steps necessary to save or maintain life	2
6. Duration of suicide ideation/ wish	Brief fleeting periods	0
	Longer periods	1
	Continuous (chronic) or almost continuous	2
7. Frequency of suicide ideation	Rare occasional	0
	Intermittent	1
	Persistent or continuous	2
8. Attitude toward ideation/wish	Rejecting	0
	Ambivalent indifferent	1
	Accepting	2
9. Control over suicidal action/ acting-out wish	Has sense of control	0
	Unsure of control	1
	Has no sense of control	2
10. Deterrents to active attempt	Would not attempt because of a deterrent	0
	Some concern about deterrents	1
	Minimal or no concern about deterrents	2

11. Reason for contemplated attempt	To manipulate the environment; get attention or revenge	0
	Combination of desire to manipulate and to escape	1
	To escape or solve problems	2
12. Method: specificity or planning of contemplated attempt	Not considered	0
	Considered but details not worked out	1
	Details worked out and well-formulated	2
13. Method: availability or opportunity for contemplated attempt	Method not available or no opportunity	0
	Method would take time or effort; opportunity not readily available	1
	Method and opportunity available	2
	Future opportunity or availability of method anticipated	2
14. Sense of "capability" to carry out attempt	No courage too weak afraid incompetent	0
	Unsure of courage or competence	1

	Sure of competence courage	2
15. Expectancy/anticipation of actual attempt	No	0
	Uncertain not sure	1
	Yes	2
16. Actual preparation for contemplated attempt	None	0
	Partial	1
	Complete	2
17. Suicide note	None	0
	Started but not completed; only thought about	1
	Completed	2
18. Final acts in anticipation of death	None	0
	Thought about or made some arrangements	1
	Made definite plans or completed arrangements	2
19. Deception or concealment of contemplated suicide	Revealed ideas openly	0
	Held back on revealing	1
	Attempted to deceive conceal	2

or lie

Scoring:

The total score for the 19 items is calculated.

Minimum score = 0

Maximum score = 38

Higher scores indicate greater suicidal ideation

Assessment of the Scores:

15-19 Low Suicide Ideation

20-28 Medium Suicide Ideation

29+ High Suicide Ideation

Appendix X

Reflexivity

Reflexivity on my personal interest in the topic

I feel that my passion, interest and close personal relationship with this topic has been of major benefit in that it has motivated me to try to make a meaningful contribution to the field of CBT for PM men. I believe that the results of my research have given a voice to the participants to express their treatment needs and to enable practitioners to thereby develop effective therapeutic interventions. More importantly, it enables Counselling Psychology research to enter novel areas to demonstrate the extent of its horizons and the relevance of the discipline (Woolfe, 2016).

I found the experience of the Literature Review challenging, absorbing and exciting, and looking at some of my reflective accounts, I have learnt a great deal about the research process and also about myself. For instance, I noticed a real sense of uncertainty and worry as to whether I would find a gap in the literature, and whether that gap in the knowledge would be worth addressing. I fell prey to uncertainty and started to ask questions such as "am I approaching it correctly" and "what if I fail to produce something original that does not contribute to the existing literature", and the anxiety and stress regarding the research led me to feel almost overwhelmed by it all. Never having done something like this before, it was anxiety-provoking to have to deal with the demands of the research, and on reflection, initially, I did not feel very confident about doing my doctoral research. This fear may have been associated with the fear of not knowing what kind of research would be expected from me as a Counselling Psychologist at the end of my Doctorate. My research supervisor's support was invaluable in helping me to manage my anxieties by normalising the process of uncertainty in research. Evans (2007) highlights the important role of supervisors in supporting researchers while they explore their personal conscious and unconscious intentions.

We all see life through the lenses of our own emotions, experiences, beliefs and values, and throughout the research process my reflective commentary has enabled me to monitor, recognise and work with my internal processes such as feelings and attitudes. Within the reflective space I have been able to examine critically issues that would inevitably influence and shape my research (such as the beliefs that I hold about CBT, Islam and PM

men). I have also used supervision, personal therapy and peer discussions to explore my reflections, and they have been a source of insight that have deepened my understanding of the research process (Kasket & Gil-Rodriguez, 2011).

Reflexivity on the pilot study

The process of data collection in the pilot study helped me to develop my interview skills because when I interviewed the two participants in the pilot I was concerned that I might influence the participants' narratives. I therefore stuck rigidly to my prepared interview questions and avoided asking the participants to elaborate on their responses as I feared influencing their responses with my own ideas, assumptions and beliefs. However, prior to conducting the interviews for the actual study, my supervisor encouraged me not to focus so much on the prepared interview questions and instead to follow the participants' stories more closely, and she pointed out that this would allow the participants to provide detailed personal accounts of their experiences of CBT. This is what I therefore tried to do in the actual interviews, and as the interviews with each successive participant progressed I noticed that my confidence started to grow and that I relied less on my prepared interview questions. By asking the participants to elaborate, clarify and expand on their responses I was becoming more immersed in the lived experiences of the participants, and the change in my approach enabled the participants to talk more openly/freely about their experiences. This allowed me to obtain a rich account of their experiences of therapy. The change in approach was quite possibly reflected in the duration of the interviews, because the durations became longer as the study progressed, and in particular the last two interviews were considerably longer than the earlier ones. It could be the case however, that the change in duration may have reflected nothing more than the difference in personalities of the different participants. The approach that I adopted for my interviews was in line with IPA (Smith, 2008; Osborn & Smith, 2015) and Counselling Psychology theory and practice, which is to be client-led and relationally focussed (Strawbridge, 2016).

Reflexivity on the data analysis

My primary professional therapeutic approach is that of CBT integrated with humanistic values, and this may have influenced the way that I viewed and interpreted my participants' experiences of CBT. In my professional practice I am aware that I work relationally with my clients within the CBT framework, and perhaps I was thus driven to search for relational themes within the research data and to make interpretations that were

from a relational perspective. Perhaps I was looking for evidence for working relationally, and I needed confirmation of the approach that I had adopted. It could therefore be argued that my findings may reflect my own professional viewpoint. Discussions with my peer researchers helped me to adopt a more neutral reflective position and to look more objectively for themes that were important to the participants rather than themes that made sense to me. I therefore continued with my personal and epistemological reflexivity throughout the research process by bracketing my assumptions and using a 'reflective-journal' to enhance my awareness and to remain as open-minded as possible (Hanley, Cutts, Gordon & Scott, 2013).

Appendix Y

Template of e-mail to relevant organisations

Subject: Research study into How Pakistani Muslim Men experience CBT

Recruitment for the study

Dear ….. ,

My name is Said Aris Tarabi. I am a Trainee Counselling Psychologist at London Metropolitan University, and for my Doctorate I have chosen to investigate how Pakistani Muslim men in the UK use psychological therapies, and in particular how they use Cognitive Behavioural Therapy (CBT). According to the 2011 census statistics, Islam now constitutes the second largest religious community after Christianity in the UK, and the majority of UK Muslims come from South Asia (and predominantly from Pakistan and Bangladesh). Currently Pakistani Muslim men under-utilise mental health services, and they are under-represented in the literature of psychological therapies. Studies that have been conducted show that CBT can be suitable for second-generation Pakistani Muslim men, but some authors argue that there are fundamental conflicts between the Islamic belief system and CBT. However, there has been no research to date on how CBT is experienced by second-generation Pakistani Muslim men, and the needs of this under-represented group remain unexplored.

The objective of my study is to explore the *experiences of second-generation Pakistani Muslim men who have utilised individual CBT.* This study will aim to give a voice to Pakistani Muslim men in order for their experiences and their needs to be heard and to be taken into account. Moreover, the research hopes to provide practitioners with a nuanced understanding of the psychological needs of Pakistani Muslim men in order to develop tailored interventions to suit this client group.

I am therefore seeking to recruit second-generation Pakistani Muslim men who have used a minimum of 6 and a maximum of 16 sessions of individual CBT who are willing to participate in face-to-face interviews that will last for approximately one hour. I am contacting you to enquire whether you would be so kind as to help me in my recruitment process, and whether you know of any other organisations that would also help me.

I am intending to publish the findings of my study, but even before publication I would be very happy indeed to share my findings with you once the study has been completed, and I do hope that you will be able to help me in this endeavour. If you have any questions or concerns about the study then please do not hesitate to contact me or my supervisor, Dr Angela Ioanna Loulopoulou.

Thank you very much indeed for your kindness, and I very much appreciate any help that you can afford me.

Yours most sincerely,

Said Aris Tarabi

……

Research Supervisor: *Dr Angela Ioanna Loulopoulou*

……

E-mail: ….…..…..…..…...

Tel: ……..