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Biographical notes

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Abstract

This paper draws upon qualitative research with three Kuwaiti counselling clients to explore how they negotiated accessing counselling in the context of their communities, culture and faith. Contrary to the prevailing view in the established literature which portrays Islamic faith as a barrier to help-seeking in relation to mental health, these counselling clients formulated perspectives which constructed their faith as an important facilitator for accessing formal help. In particular, participants distinguished faith from culture and appealed to sacred scripture to demonstrate the convergence of Muslim values and virtues with help-seeking in relation to psychological distress. With the expansion of counselling and other mental health services in Muslim-majority countries, and concerns relating to equal access to mental health care for Muslim communities in other nations, this paper offers an original and timely discussion of one aspect of the potential interface of Islamic faith and counselling, while acknowledging the limitations of the small self-selected sample from which the findings are drawn.

Key Words: Counselling, Islam, facilitator, barrier, help-seeking, Kuwait

Introduction

The majority of the research literature addressing the interface of Islamic faith and mental health reports that faith beliefs among Muslims lead to negative attitudes towards formal help-seeking (See, for example, Al-Adawi *et al.*, 2002; Al-Darmaki *et al.*, 2016; Al-Issa, 2000; Al-Krenawi, 2005; Aloud & Rathur, 2009; Bener & Ghuloum, 2011; Ciftci *et al.*, 2013; Dardas & Simmons, 2015; Eltaiba, 2007; Williams, 2005; Youssef & Deane, 2006). While not seeking to refute this important body of work, this paper highlights an alternative narrative which has received much less attention: that Muslim people suffering from mental health problems may also interpret their faith as conducive to reaching out and accessing formal help. This was indeed a surprising theme that emerged from a small-scale qualitative research study focusing on three Kuwaiti clients' experience of counselling. This paper begins with an overview of the existing literature addressing Islam and help-seeking in relation to mental health and then offers a brief outline of the research project. It goes on to explore those findings which addressed the interface of faith and help-seeking, using interview excerpts, then discusses these in relation to the existing literature and concludes with implications for further research and practice. The first author is the principal researcher who undertook the Kuwaiti research. The second author supervised the research and assisted with the analysis. This paper is co-authored.

Islamic faith, mental health and help-seeking

Originating in the Arabian Peninsula in the seventh century of the Christian era, Islam is an Abrahamic and monotheistic religion based on the revelations and oracles of the Prophet Muhammad collected in the *Hadith* and the direct word of God, Allah, contained in the *Quran* (Sabry & Vohra, 2013). Islam means *surrender* or *submission* in Arabic, reflecting the essence of Islam as submission to the will of God (Rassool, 2016). Islam provides Muslims

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with a framework and direct guidance for living, addressing areas as diverse as family, relationships, sexuality, health, education and financial exchange (Scull *et al.*, 2014). Islam also sets ethical codes, social values and adaptation strategies to help Muslims cope with life transitions and adversity (Sabry & Vohra, 2013). It is beyond the scope of this paper to describe the Islamic faith system in detail and interested readers are directed to Rassool's (2016) recent comprehensive text on Islamic Counselling.

Research conducted in Islamic countries and with Muslim communities in other countries highlights a complex web of factors that contribute to strong negative attitudes towards formal help-seeking in relation to mental health problems or psychological distress. These include mental health stigma and the protection of family honour and reputation, explanatory models concerning the origins of mental health problems, and preferences for family support and for faith-based remedies in the alleviation of distress.

Stigma and honour

The extended family is the principal social unit in Muslim communities and the main source of personal identity and belonging. Family honour is a highly salient organising principle around which the actions and behaviours of family members are facilitated and regulated, both internally and externally (Moller *et al.,* 2016). While mental health stigma exists in all societies and cultures, its interaction with the concept of family honour and public shame creates particularly powerful disincentives to the identification and disclosure of psychological distress, which are the necessary first steps in help-seeking (Aloud & Rathur, 2009). This results in reluctance on the part of individuals to admit to themselves that they are suffering from a problem and, when it comes to the attention of others, on the part of family members to acknolwedge the true extent of an emerging difficulty or to consider

seeking support outside the family. These problems can be exacerbated by gendered power relations where younger unmarried women must guard against the threat to their marraiage prospects that any hint of psychological problems would constitute and where married women may keep their experience secret for fear of divorce or inviting the disapproval of their husband's family (Ciftci *et al.*, 2012; Hamdan, 2009; Shoaib & Peel, 2003).

Explanatory models

Research studies with Muslim communities across the globe highlight common explanatory models of mental illness which rely upon recourse to supernatural explanations, both demonic and divine, and may therefore disrupt or divert help-seeking within a mental health care framework. Possession by *Jinn*, which may be translated as demons or evil spirits, being cursed by the evil eye or temptation by the devil are widespread causal explanations which Muslims espouse, whether resident in Islamic countries or Western nations, especially in relation to more severe mental illness symptoms (Alansari *et al.*, 1989; Al-Adawi *et al.*, 2002; Fakhr El-Islam, 2008). There is some evidence, however, that younger and more educated people are less likely to retain these beliefs (Al-Krenawi *et al.*, 2000).

Other faith-based explanatory models instead construct mental health distress as an act of God, regarded either as divine punsihment for sinfulness or weakness in faith or as a divine testing of the personal fortitude or strength of faith of the person suffering (Aloud & Rathur, 2009; Heath *et al.*, 2016; Padela *et al.*, 2011; Scull *et al.*, 2014). Such beliefs are likely to bolster coping strategies focused on self-reliance and non-disclosure and in turn, according to Fakhr El-Islam (2008) may augment fears of stigma and public shame.

While not regarding God as the direct instigator of psychological distress, the Islamic concept of predestination, that everything happens because of God's will, is also an important belief that influences how Muslim people may interptret and respond to psychological distress. Fakhr El-Islam (2008) argues that this belief might lead some Muslims to consider that somatic and psychological symptoms appear and disappear entirely as a result of God's will, therefore inhibiting potential pro-active, problem-solving responses. Similarly, belief in the afterlife, a core tenet of Islamic faith, might contribute to the view that people should tolerate pain and suffering in this life in order to gain reward in the life to come.

Family help and faith-based remedies

People of all faiths and none will take action to avoid what Goffman (1963) terms 'a spoiled identity' and there can be few identities as stigmatised in any culture as that of the mentally unstable or, for Muslims, *manjoon*. Rassool (2016) explains that when self-reliance and coping alone break down, Muslims' first port of call will usually be their families. Qualifying this, some recent research has found a preference for peer support among some younger Muslims, especially when the issues may relate to sexuality and relationships (Scull & Mousa, 2017), and there is some evidence that families may not always be perceived as safe havens in the disclosure of personal problems (Almajed, 2017; Shoaib & Peel, 2003). Within families, wise counsel will be sought from elders of both genders and extended family resources will be mobilised to provide support, both practical and emotional.

When a situation emerges such that help from outside the home is required, Rassool (2016) asserts that Muslim families will often turn to family doctors or imams, religious leaders and teachers, with practising Muslims more likely to access the latter. Whether presenting to a GP or imam, the distressed family member is often accompanied by one or

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more relatives. Research shows that religious community contexts are routinely preferred over formal mental health services for reasons of reputation management (Al-Issa, 2000; Al-Adawi *et al*., 2002; Al-Krenawi, 2005; Fakhr El-Islam, 2008; Okasha *et al*., 2012). Attendance at a mental health service immediately risks identifying the patient and their family as tainted with the label mentally ill. In contrast, people consult imams for a wide variety of reasons and, so long as confidentiality can be assured, reputational damage is much less likely.

Religious remedies may also be preferred as a result of the faith-based explanatory model for the presenting issues and due to the familiarity of the remedies offered. When distress is interpreted as associated with weakness or problems in faith or religious observance, or as a test or punishment from God, recourse to religious remedies offers more cultural salience than other remedies. Furthermore, religious instruction, prayer and Quranic verse recitation are well-established and trusted practices within Muslim communities and will likely be more familiar than either psychological therapies or pharmacological treatment, which may be regarded with suspicion as a foreign import.

Alternative perspectives

While these are commonly held beliefs among Muslims, it is important to distinguish between lay theories and cultural practices related to mental illness and the actual teachings of Islamic faith, many of which offer alternative interpretations of both the causes of, and treatments for, psychological distress.

Islam, as a faith system that establishes guidelines and religious practices for its adherents, and culture, as an amalgam of rituals and beliefs inherited inter-generationally and

embedded in local customs and practices, are often seen as one in many Muslim countries. According to Philips (2007), the cultural practices of Muslims are often an entangled mix of Islamic teachings, local traditions and customs such that it is difficult to distinguish faith from culture. He argues that much of the contemporary Muslim world practises what may be termed *Cultural Islam* or *Folk Islam*, characterised by adherence to historically transmitted, institutionalised local customs and traditions, usually assumed to be founded in Islam. However, cultural practices may not only interfere at times with Islamic belief, they may even undermine it. For example, some traditional practices, often assumed to be religious rituals, have no justification in Islam, or may even be strictly prohibited, such as female genital mutilation (Rizvi *et al.*, 1999). The potential clash of culture and faith is explicitly addressed in Islamic scripture, where in the Surah Al-Maidah Allah states: "And when it is said to them, 'Come to what Allah has revealed and to the Messenger,' they say, 'Sufficient for us is that upon which we found our fathers,' even though their fathers knew nothing, nor were they guided" (Quran, 5:104).

Given the global reach of contemporary Islam, Mulsim countries and their cultures are highly heterogeneous, yet also appear to share significant similarities. Philips (2007) believes that the way to distinguish between local traditions and a shared Islamic culture that may reflect the true essence of Islam is through examining and comparing different cultures. The commonalities that are then revealed will represent the core of the Islamic culture, while the differences and variations will more likely reflect the local customs of each country. However, shared Islamic culture does not necessarily equate to congruence with Islamic faith *per se*, and Rassool (2000) argues that a cultural practice can only be deemed to be religious when it is directly derived from the Quran or the Sunnah.

Despite widespread beliefs, the notion of illness resulting from sin does not exist in Islam, with the Quran (48:17) explicitly stating, 'The blind are not to be blamed, the crippled are not to be blamed, and the sick are not to be blamed'. As Al-Issa (2000) argues, Qur'anic and prophetic teachings do not consider sickness as a punishment from God, nor are the afflicted to be considered blameworthy. On the contrary, Islam teaches that people who suffer will be rewarded for their patience with many verses in the Quran addressing the importance of patience and prayer for bearing trials, for example, 'O you who believed, seek assistance through forbearance and prayer. Indeed, Allah is with the steadfast' (Quran 2: 135). Another example is also found in the Prophet's *Hadith*, detailing that any kind of suffering is seen as an opportunity for expiation of sins and purification. The Prophet said, "No fatigue, nor disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick he receives from a thorn, but that Allah expiates some of his sins for that" (Bukhārī, 1280).

While God's will is an overarching tenet of Islamic faith, Muslims are obliged and encouraged to take action to address need, seek help and apply problem-solving methods to maintain their wellbeing (Ypinazar & Margolis, 2006). Rassool (2016) offers a cogent argument regarding the significant overlap of Islamic faith principles in relation to human health and well-being and contemporary Western health care principles, originally articulated by Beauchamp and Childress in the 1970s (Beauchamp, 2007). While it is beyond the scope of this paper to offer a comprehensive overview of this argument, the following points are worth noting. The Islamic principle that all human persons are to be honoured and respected chimes closely with respect for autonomy. The principle of the right to life and the duty to maintain life for all human beings coincides closely with beneficence, while the principle of causing no harm encompassing all harmful acts to self and others, as well as acts that could

bring harm to others in society despite personal benefit, aligns closely with non-maleficence. The principle of equity and justice is also present in Islamic teaching, implying the equal distribution of health care resources to all individuals regardless of their race, ethnicity, religion or gender. Where Islamic principles extend beyond health care ethics principles is in the principle of striving for excellence in all facets of life, called *Ihsan,* which encourages Muslims to push themselves to their limits in personal, spiritual and professional life.

While counselling, psychotherapy and non-faith based mental health treatments are often regarded as a Western import into Islamic countries and communities, Al-Issa (2000) provides a richly detailed account of the long tradition of medical approaches to mental health care in Islamic societies across the globe. The world's first medical hospital for the treatment of mental illness was established in Baghdad in the year 809 of the Christian era, nearly a whole millenium before the establishment of similar institutions in the West (Dols, 1992). Contrast this, for example, with the re-organisation of London's Bethlem Hospital as an explicitly psychiatric care facility in 1634. Building on the work of ancient Greek physicians, mental illness was recognised, and a range of holistic treatment approaches advocated, by Muslim medical scholars from the ninth century onwards. For example, Al-Razi (d.932) dedicated a whole chapter in his medical textbook to the understanding and treatment of depression, dismissing supernatural causes and recommending talking treatments and physical exercise, alongside the use of herbs and other potions. This work was followed in the eleventh century by Ibn Sina (d.1073) who encouraged an holistic treatment approach to depression, combining environmental factors, such as living in well-ventilated housing, with nutrition, physical exercise, talking and socialising.

Summary

In summary, mental health stigma and negative attitudes towards formal help-seeking are particularly strong and have distinctive characteristics within Muslim communities. However, beliefs and proscriptions attributed to Islamic faith are often more accurately reflections of cultural practices and discourses than of faith teaching *per se*. In fact, a close reading of sacred scripture can provide resources to combat stigma and to promote help-seeking, both formal and informal. Furthermore, in Islamic history, there is a long and distinguished tradition of secular mental health care, founded on medical conceptualisations of mental illness and containing a range of holistic treatments, complementary to faith-based beliefs and remedies. Despite stigmatisation fears and negative attitudes to help-seeking, some Muslims do access mental health care, including counselling, and it is to this group that we now turn to outline our Kuwait-based research study.

The research study

While the Gulf States have enjoyed rapid economic growth since the 1970s, with a concomitant expansion in state-funded health and education services, mental health provision remains significantly under-developed in comparison with physical health care (Hamdan, 2009; Okasha *et al.,* 2012). Associated research in mental health and counselling is sparse, with the perspectives of service users almost entirely absent (Almoshawah, 2010; Scull *et al.,* 2014). Building on the work of the second author (ANONYMISED), who developed theoretical understandings of how British young people overcome stigmatisation fears to access school counselling, the first author devised a masters dissertation research project to investigate the experience of Kuwaiti citizens who had accessed counselling. As a Kuwaiti-based counselling psychologist, the first author was aware of the widespread stigma surrounding mental health in her country and she was particularly interested in how clients negotiated accessing and maintaining therapeutic relationships in this context.

Devising a small scale qualitative study, she undertook in-depth semi-structured individual interviews with three self-selecting counselling clients, addressing four main question topics: understanding of counselling and decisions to seek help, experiences of seeking help-seeking, cultural facilitators and barriers to help-seeking, and the role of faith in help-seeking. Recruitment was via a snowballing sampling technique using WhatsApp groups and emails. Three Kuwaiti women, aged between 28 and 39 and not previously known to the researcher, agreed to participate and were interviewed. Although the researcher had not intended to recruit only women participants, due to the time constraints of the Masters project, she was unable to undertake further recruitment and proceeded with these three women participants. The interviews lasted between 30 to 50 minutes and participants chose their preferred language, whether Arabic or English, which are both widely spoken in Kuwait. Two interviews were conducted in Arabic, while the other was in English. All participants had attended counselling for more than a year. To ensure anonymity, participants chose a pseudonym, an occupation, and an age close, but not identical, to their actual age. Ethical considerations included confidentiality and anonymity, ensuring research integrity through establishing a safe interview context where personal experience could be shared, responding to potential distress during and after the interview, and ensuring participant rights to amend research data or withdraw from the study. Ethical review was conducted via the university where the authors are located.

The interviews were audio-recorded and transcribed in full, with the Arabic interviews translated into English. Braun and Clarke's (2006) thematic analysis approach was adopted to identify themes, with the first author developing the thematic frame and the second author consulting the transcripts to review and amend the frame. Three main themes

emerged: 1. experiencing and negotiating stigma and shame; 2. the power of the media and public education; 3. faith as a facilitator and support in accessing help. This paper focuses on the third theme.

Faith and help-seeking research findings

The theme of faith as a facilitator and support in formal help-seeking consisted of four sub-themes, which are now addressed in turn. These four sub-themes have been termed: *refuting illness as sinfulness or lack of devotion; prayer vs. counselling – both/and rather than either/or; religious obligation to seek help;* and *understanding the self strengthens faith*. The participants have chosen the pseudonyms Razan, Badrah and Sarah.

Refuting illness as sinfulness or lack of devotion

The participants acknowledged that within their communities experiencing psychological distress and help-seeking were often associated with failure in faith or religious practice. In their own ways, each participant refuted this association. In interview, Razan was openly annoyed with such ideas which she saw as stemming from a lack of understanding of mental health, religion, and what counselling offers.

Razan: Lots of people would question your faith, if you seek help, which is total nonsense! They don't understand that the cause could be due to hormones, not faith. There's absolutely no connection between faith and having problems in life!

Like Razan, Badrah and Sarah both drew on common lay beliefs of health and illness that link psychological well-being and faith: having a strong faith is seen as a source of happiness

and comfort, and conversely psychological distress is interpreted as evidence that the sufferer is detached from God and Islamic teachings or even as evidence of sinfulness.

> *Badrah: People link accessing counselling to the strength of your faith. They would say 'Yeah, of course, she doesn't pray, and she's sinful. That's why she goes to counselling.'*

Sarah turned this aetiological theory on its head, arguing that suffering psychological distress is often the *cause* of people losing their interest and enthusiasm for activities and interests including religious observance. However, cause and symptom are then commonly misattributed.

> *Sarah: In our society, people attack those who might stray away from their religion, but it could be due to their psychological health. So, everything will eventually be affected in their life including their spirituality, so people started to link the weakening in the psychological health to lack of faith.*

Badrah distinguished between faith and culture, explaining how people often conflate the two, mixing up what is religiously forbidden *(Haram)* and what is socially unacceptable *(Aibb).* In her view, the opinions people hold are often quite different from the actual teachings of Islam, yet they remain unaware that their views are more influenced by cultural norms than by scripture.

> *Badrah: There has been a huge misconception between what teachings are of religion and what are the cultural. So, the real essence of Islam is extremely different from the way people are behaving and believing regarding help-seeking attitudes.*

Prayer vs. counselling – both/and rather than either/or

Participants recognised that it was more socially acceptable in Kuwait for people suffering psychological distress to consult religious leaders and employ religious practices, such as reciting verses from the Quran or praying more assiduously, than to consult a mental health practitioner. However, each participant developed a theme of both/and rather than either/or. They did not dismiss or criticise those who sought solace through religious practice or spiritual direction. Instead they defended formal help-seeking as either an alternative or an adjunct to faith-based help-seeking. In the following excerpt Badrah insisted that religious practice is 'not the only treatment' and provides an example of distress that may persist even in the face of religious devotion.

Badrah: Many devoted Muslims, if they hear about someone seeking help for depression or problems in life, they will automatically say 'You should read the Quran and pray more.' Ok, I am not saying that it's not beneficial or could help us feel better, but it's not the only treatment! What about the cases of a person very close to God and who practises everything, but still feels depressed or does not feel well about life?

Sarah argued that religious practice and counselling should not stand in conflict or opposition; rather they should work together for more holistic wellbeing and stronger faith.

Sarah: Faith and counselling are two parallel lines that work together not against each other. You need to build yourself physically, religiously and psychologically all together, in order to feel good and settled. Just like when you have an illness like cancer, you can't be

strong enough to pray and fast and worship God, as strong as when you're fully healthy. So,

the same applies for your psychological state!

Here Sarah references cancer, a physical illness, to align psychological distress with illness experience rather than moral failure. The sufferer needs to care for themselves and pursue healing in order to enhance their religious observance and strengthen their faith, themes that are explored further below.

Religious obligation to seek help

In contrast to lay beliefs that associate psychological distress with failures in faith or sinfulness, all three participants claimed positive linkages between formal help-seeking and Islamic teachings. Badrah drew upon the Hadith to assert a religious obligation to seek help in order to alleviate suffering.

Badrah: You know the Hadith has interpreted that Allah has not made a disease without

appointing a remedy for it. You can't just sit on your prayer mat and ask God to change your

situation! Take action! Islam calls us to make use of all available means, to do whatever is

possible to be better in all aspects of life, including psychologically.

Similarly, Razan quoted from the Quran to demonstrate how Islamic teaching warned against self-destructive practices such as not seeking help when help is needed, imposing an obligation of self-care and virtuous help-seeking.

Razan: Not accessing help is against faith. If you are genuinely practising the teachings of

Islam, then it says, "Do not throw yourselves with your own hands into destruction." You

need to take all possible means to be better. Our religion encourages us to ask for help.

Understanding the self strengthens the faith

Participants went on to strengthen the argument about the harmonious inter-relationship of faith and counselling, arguing that counselling is consistent with core Islamic teachings in relation to the importance of self-understanding in the support of faith. Sarah stated how accessing a counsellor with the same faith belief enabled her to work on enhancing both aspects of her life simultaneously.

Sarah: Nothing in my counselling experience has contradicted Islamic teaching. There's a very positive relationship between counselling and Islam. There are teachings in Islam that have a relation to counselling, like a person has to understand himself, and counselling helps us on that. It is good to take counselling with religion, like going to a counsellor with the same faith, because he will give you tips on both ways. They are very interlocked and make sense together.

Badrah also developed this theme, emphasising the role of counselling in alleviating distress and promoting inner peace in order to open up a clearer space for her faith.

Badrah: God ordered us to learn, think about his words (Quran), his creation and ourselves. How can I understand myself and be closer to God when I'm busy with my diseases and continuous internal conflicts? My mind needs to be clear to work for God and practise religion.

Sarah regarded her counselling experience as a 'blessing' and regarded the professional skill of counsellors as a God-given talent that should be appreciated and respected.

Sarah: Having counselling is one of the blessings in my life. Islam calls for being professional and encourages each person to have a specialty in life, like counsellors and other helping professions are essential to help us understand ourselves and consequently strengthen our faith rather than relying on unprofessional support.

Sarah then drew on the Prophet's life to demonstrate that psychological distress was an ineradicable aspect of the human condition and that everyone, even the most devout, will suffer from personal problems or difficulties at times. She drew parallels between verses in the Quran which offer guidance and reassurance and the therapeutic goals of counselling.

Sarah: Devoted Muslims are no less human. Even the prophet Muhammad (peace be upon him) who was very devout was sad and depressed at certain times in his life. God specifically revealed for him verses as a guidance and reassurance, which is what we need from counselling.

Discussion

The narratives offered by these three counselling clients join the growing corpus of accounts of mental health and help-seeking experience from service users themselves. Particular and unique to these are their culture and context: they are Kuwaiti citizens and residents, women of faith, integrated into their families and communities, yet enabled by this research to break the formidable taboos that surround disclosure of psychological distress and accessing counselling. While the participants were well aware of the negative attitudes towards

psychological distress and formal help-seeking in their communities, they developed

effective counter-narratives which supported them in seeking help, including narratives

which drew upon sacred scripture and core faith beliefs. This can be seen as a particular

example of the resourceful ways in which people learn to 'dodge stigma', to use Link and

Phelan's (2001) evocative phrase.

Participants offered no critique of faith-based practices, instead developing a

'both/and' discourse which emphasised the complementary benefits of combined treatments

and acknowledged the interrelationship of spirituality and health. Their holistic

conceptualisations of health, integrating physical, mental and spiritual well-being, resonate

with Al-Issa's (2000) treatise on the long tradition of holistic health care practice in Islam.

Echoing Chantler's (2005) work with Muslim women in Northern England, these women

drew on Islamic scripture, teaching and stories of the Prophet's life, to define help-seeking as

a virtuous action befitting a devout Muslim. Contrary to prevailing beliefs which characterise

psychological theory and practice as Western imports, inimical to the traditions and practices

of Islam, these narratives complement the call issued by a growing number of Muslim

scholars and practitioners to integrate Islam into psychology and its associated practices,

including counselling (Haque, Khan, Keshavarzi, & Rothman, 2016; Keshavarzi & Haque,

2012; Rothman & Coyle, 2018; Skinner, 2018). In her recent research about establishing a

conceptual framework for the practice of Islamic psychology, York Al-Karam (2018, p. 101)

offers the following broad definition for Islamic psychology: "An interdisciplinary science

where psychology sub-disciplines and/or related disciplines engage scientifically about a

particular topic and at a particular level with various Islamic sects, sources, sciences, and/or

schools of thought using a variety of methodological tools." As counselling and other mental

health care services expand within Muslim majority nations, rich opportunities open up to

explore the potential integration of Islam and psychological theory and practice. The current research demonstrates how service users themselves may be engaging in such integration attempts, as they employ scriptural sources and iterations of their faith to overcome cultural taboos on help-seeking and the disclosure of personal or familial problems. Their use of scripture and faith to strategically position themselves as virtuous health care service users highlights the creative disjunctions that may emerge when faith and culture are differentiated in Islam, as both Rassool (2000) and York Al-Karam (2018) contend.

Conducted within the frame of a Masters project, this research was necessarily small scale and the study design meant that participants were self-selecting; the results therefore cannot be deemed generalizable, representative or transferable. It was also the case that all three participants were female and the study's timeframe did not allow the researcher to undertake further recruitment in order to include the experiences of male counselling clients. However, one of the study's strengths was that the participants were mature adults who had accessed and maintained long term counselling for help with psychological problems. This provides a useful contrast to the majority of research on Muslim help-seeking which is conducted with university students and based on the *hypothetical* experience of distress and help-seeking (see, for example, Al-Adawi *et al.,* 2002; Al-Krenawi *et al.,* 2000, 2009; Alajlan, 2016; Heath *et al.,* 2016).

It is also important to note that while Islamic faith is monotheistic and all Muslim cultures and societies share significant characteristics, Islam itself is not monolithic. It contains a huge diversity of faith communities, ethnicities, influences and cultural practices, and the experiences of people in Kuwait and other Gulf States may not reflect the experiences of people in other Muslim-majority nations nor of Muslim communities in other countries.

Furthermore, Muslim societies, like all societies, are changing and evolving, transforming and renewing, and attempts to categorically define a culture, especially in the context of rapidly evolving technologies, will necessarily be flawed.

The current study focuses on a small sample of self-selecting participants and, as such, its transferability is extremely limited. Nonetheless, the researchers were surprised to uncover the resourceful ways in which all three participants, unknown to each other, drew upon their reading of Islamic scripture and their faith beliefs to support themselves in accessing help for mental health concerns. This shared narrative strikes a new note in the existing research into mental health help-seeking in Muslim communities and, despite the study's limitations, we argue that these stories are worth disseminating to add to ongoing dialogue and exploration in this area. Empirical research on the interface of Islamic faith and culture, mental health and counselling is extremely limited, while research with Muslim counselling service users, with rare exceptions such as Eltaiba (2007), is virtually non-existent. In this context, this paper makes a timely, if small, foray into this uncharted territory and, we hope, will serve as an encouragement to other researchers and practitioners to undertake similar research with Muslim counselling service users.

Bridges need to be built between mental health concepts and practices, founded on Judaeo-Christian beliefs, Western scientific knowledge and a predominantly secular health care culture, on the one hand, and the faith, practices and beliefs of Islamic communities and societies, on the other. Counsellors and other mental health practitioners need to find ways to harness Islamic faith beliefs and cultural practices to promote help-seeking rather than regarding Muslim faith and culture as inevitable barriers to help-seeking. The themes developed in this paper, albeit from a small sample of self-selecting research participants in

one Islamic country at one point in time, serve such a project, providing resources, grounded in Islamic faith discourses, which support self-care, disclosure and help-seeking as the virtuous actions of believing Muslims. The narratives of these counselling clients resonate with Rassool's (2016) account of the convergence of Islamic principles and the four principles of contemporary Western bio-ethics. The aims of human health, well-being and flourishing are as fundamental to Islamic faith and culture as they are to health care and counselling, wherever and however they are practised.

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