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Views of British South Asian Muslim leaders on mental health: a focus group study

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Abstract

Background: The purpose of this research was to explore how British South Asian Muslim community members including religious leaders living in the UK perceive mental health disorders, particularly schizophrenia. It also aims to examine religious leaders' perceptions of mental health and their influence on members of the South Asian Muslim community.

Methods: The focused group discussion was conducted among religious leaders and some members of South Asian community and it was facilitated by researchers. The process included a description of a hypothetical scenario of a member of a South Asian family undergoing a change in attitude, behaviour and speech that was significantly affecting his psychological and emotional health. The group members were encouraged to share their views, opinions and understandings of what they thought might be responsible for various aspects of the presentation. That group discussion was recorded and transcribed. Interpretation and thematic analysis of the transcribed data were carried out.

Results: The understanding and perceptions of the British South Asian Muslim community members significantly depend upon their world views and on the cultural explanatory model of illness causation. It reinforced the initial impression that culture, faith and religiosity are the major factors that contribute to the understanding and perceptions of this ethnic-cultural group towards mental illness and mental health problems.

Conclusions: Members of the British South Asian Muslim community have a unique explanatory model of the causation of mental illness where mental illness is often attributed to supernatural phenomena like possession by spirits (jinn), the evil eye (nazar), or harmful amulets (tawiz). This all directly affects treatment options and interactions with the National Health Service (NHS).

Keywords

British South Asian Muslim religious leaders, British South Asian community, explanatory model of illness, culture-specific mental health care, culture-specific treatment

INTRODUCTION

Mental health and the South Asian community

Culture shapes how communities perceive and address mental health issues (Gaw, 1993). A Cochrane review emphasises that understanding cultural variations and needs in ethnic minorities aids in delivering effective care (Cochrane and Sashidharan, 1996). Studies on South Asian communities in Western countries highlight their unique, culture-driven perspectives on mental health (McCabe and Priebe, 2004). Research indicates higher-than-expected psychosis rates in Britain's South Asian community, particularly among the growing young population in areas like Lancashire (Coid et al., 2008; Kirkbride et al., 2012).

Ethnic variations in the use of services

Studies confirm that ethnic variations in pathways to UK mental health services are influenced by cultural interpretations of mental phenomena and symptoms (Carpenter-Song et al., 2010; McCabe and Priebe, 2004). Faith, spirituality and religion shape these interpretations (Bhikha et al., 2015). British ethnic minorities, including South Asians, who form nearly half of this group, often receive poorer services

and outcomes than White British populations (Halvorsrud et al., 2018; Parkman et al., 1997). So therefore engaging with South Asian communities is vital for improving healthcare.

Explanatory models for psychosis

Explanatory models (including those that explain mental illness) describe a phenomenon without claiming complete accuracy (Clement, 1989). Bhikha et al (2015) found that over half of South Asian patients attributed psychosis to supernatural causes like black magic, evil spirits (*jinn*), or the evil eye (*nazar*), often consulting faith healers. This aligns with findings on ethnic variations in psychosis models among African-Caribbean, West African, Bangladeshi and White participants (McCabe and Priebe, 2004). Rathod et al. (2010) identified diverse beliefs in UK ethnic minorities, attributing psychosis to punishment, supernatural forces, social factors and biological

causes. Recognising South Asians' belief models is crucial as they influence patient and family responses towards understanding, tackling and treating mental illness.

Religious leaders and faith healers

Religious leaders and faith healers significantly influence beliefs in South Asian communities. Penny et al (2009) found that British Pakistani families supported by early intervention services often viewed psychosis as a supernatural or social issue, leading them to seek help from faith healers. This can delay access to mental health services and create confusion as families reconcile symptoms with culturally rooted spiritual models, posing a key barrier to effective healthcare.

Aims of the study

Understanding how religious leaders and faith healers approach mental health symptoms is key to addressing barriers in the South Asian community. This study aims to expand their perspective by integrating psychological and psychiatric models, potentially improving mental health care for this hard-to-reach group. As a first step, it explores South Asian religious leaders' understanding of mental health issues. Findings will inform the cultural adaptation of the Relative Education and Coping Toolkit (REACT), widely used in the UK to support families managing psychosis, and ensure its relevance for British South Asian clients (Lobban et al., 2011).

METHODS

Study design

A team of clinical researchers organised a focus group discussion with members of the British Muslim South Asian community in Lancashire, UK. This included members of the public and religious leaders.

The paradigm that was used in this qualitative research was phenomenology (Carel, 2011). Phenomenology is a qualitative research paradigm that seeks to explore and understand individuals' lived experiences of a phenomenon (Ribau, 2005). It acknowledges that every individual has a unique perspective, shaped by personal history, culture and emotions, which can inform better healthcare practices and policies (Neubauer et al., 2019).

According to Braun and Clark (2006), Thematic Analysis is a method used to interpret qualitative data by identifying, analysing and reporting patterns (themes and subthemes) within the data in a transparent manner. Therefore, Thematic Analysis is used to interpret this qualitative data to provide an account of the multiple aspects of the topic being studied.

Ethical approval: a formal ethical approval was received from University of Manchester for conducting the focused group.

Recruitment: the team planned to recruit South Asian Muslim religious leaders, spiritual healers and faith healers. Local religious and community centres in Lancashire were contacted to invite suitable participants. Posters explaining the Cultural Adaptation of Relative Education and Coping

Toolkit (CA-REACT) were displayed in local health services to recruit interested participants. Those who expressed interest were sent an invitation and a participant information sheet, then contacted by researchers to explain the research process. The group was selected from central Blackburn's community centres, mosques and Islamic schools, as they were considered as representative of the areas South Asian Muslim community.

Preparation using REACT

Participants voluntarily consented to take part in the study. Once written consent was received, participants were provided with the CA-REACT toolkit to review one week before the focus group.

Participants were informed that the focus group would be held at a convenient time and location, and that they would sign two copies of a consent form—one for the participant and one for the researcher. The focus group was expected to last 45 to 60 minutes with a break, and refreshments were provided.

Lancaster University (n.d.) developed the Relatives Education And Coping Toolkit (REACT), which is an online resource developed in the UK to support relatives of individuals experiencing psychosis or bipolar disorder. It provides evidence-based information, practical coping strategies and peer support to help families manage stress and navigate mental health challenges. REACT aims to reduce carer distress and improve wellbeing by offering accessible guidance and interactive support (Lobban et al, 2011).

REACT is used by mental health professionals to engage and educate the relatives of patients with mental illnesses through structured sessions or workshops. Professionals provide tailored information about the patient's condition, teach coping strategies and offer guidance on effective communication and emotional support. This collaborative approach helps families manage challenges, reduces caregiver stress and improves overall patient outcomes by fostering a supportive home environment (Lobban et al., 2020).

Participants

Eleven Muslim participants from diverse ethno-national and ethno-lingual backgrounds joined the discussion. They identified as having a good knowledge of Islam. Not all of them identified as religious leaders or faith healers and some joined justbeing part of the South Asian Muslim community living in Lancashire. See Table 1.

Table 1. Demographic details of participants in focus group.

Demographics of participants	Number
Gender:	
Male	9
Female	2
Background:	
Community worker	4
Primary school worker	1
Maulana	3
Imam	2
Identified as mosque local community representative	1
Faith:	
Islam	11

The term 'Maulana' is of Arabic origin. In South Asia, particularly in countries like India and Pakistan it is commonly used as a title to address or refer to a learned scholar of Islam or someone with deep knowledge of Islamic sources including the Quran and Hadith. These are commonly used by the person

who leads prayers in a mosque – often the Imam (religious leader).

Participants completed personal information sheets upon arrival, identifying themselves as having a good knowledge of Islam. The focus group was led by the lead researcher with the help of four assistants (two males, two females) who were research associates.

Focus group meeting

The focus group was conducted in a community centre in the centre of Blackburn, Lancashire. Participants sat on chairs in a circle and were asked to use a microphone when speaking so that no data would be lost – and to avoid later difficulty in understanding the contents of the recording.

A research assistant recorded field notes, focusing on emerging themes and key points.

The focus group discussion was carried out in steps: welcoming all participants, offering refreshments, signing the consent forms, an introduction to the group and its ground rules, and presenting a vignette of the focus group discussion.

Time was kept for final comments and questions at the end.

Focus group discussion

In this study, a topic guide on a South Asian psychosis case helped gather participants' opinions on the stages of illness. Compared to individual interviews, focus groups are scenario-specific, limiting deeper insights. Discussions may be dominated by assertive participants, while others may withhold views due to shyness or conformity (Roller and Lavarkas, 2015).

Non-attendance risks wasting resources, though all participants attended as planned in this project.

When required, discussions were conducted in languages other than English, including Urdu and Hindi, which were mutually understood by the participants and research assistants. The data generated during the discussions was audio recorded and transcribed verbatim by the author. To ensure transparency, Urdu and Hindi expressions were transcribed using Roman English script where necessary.

DATA INTERPRETATION

Data triangulation

Themes derived from field notes taken by research assistants during the focus groups contributed to the triangulation process.

Use of data-interpretation tools

Qualitative data analysis was conducted using NVivo software (QSR International, 2012). The author transferred data to NVIVO-10 for coding, summarising excerpts with descriptions or titles based on personal understanding.

Using NVIVO's tools, the author highlighted, colour-coded, and categorised data without focusing initially on research questions. Alpha-numeric symbols were used to differentiate participants' and researchers' inputs.

After summarisation, the author separated researchers' and participants' excerpts, revisited participants' responses, and identified themes from the codes. Data was then transferred to Excel, where similar codes were grouped under common headings so forming themes which were further organised into four meta-themes, plus an additional miscellaneous category.

Themes were guided by the primary research question about South Asian communities' views on changes in appearance, actions, speech and mental illness. The author reviewed and refined the Excel file several times.

RESULTS

The themes identified are presented in Table 2. Comparing field notes with the themes from the transcription's thematic analysis revealed no additional themes.

Meta-theme	Subtheme
1: Spirituality and its relationship with health is a complex and complicated area that is beyond ordinary comprehension.	1. Complex issues that require further clarification, learning and understanding and have doubts attached. 2. Scepticism about what this could be and possibly that it might be another diagnosis or untreated medical illness. 3. Attempts to understand what psychosis is and if it responds to psychotherapeutic options.
2: Supernatural reasons can cause illness; faith and religion are the answer.	1. Supernatural reasons can affect a person by various means. 2. Religion and faith are strengths in many ways. 3. Weakness in faith can cause spiritual problems. 4. Faith healers may be deceptive and fraudulent but the true ones have some unique characteristics. No one knows how to differentiate between a true and fake healer.
3: The NHS is deficient and needs to learn the cultural needs and demands of the South Asian community.	1. NHS improvements are required to tackle problems. 2. NHS staff must make some improvements to support the Asian community. The South Asian community must also play a role in helping the NHS understand the needs of the community. 3. Ignorance and lack of awareness towards the overall system occurs on both sides.
4: By engaging in debate religion can face some threats.	Apprehensions and concerns of participants that they are talking on behalf of an entire community or religion.
5: Miscellaneous.	1. Importance of language in therapeutic consultations. 2. Cross-cultural comparisons.

Narrative accounts supported what we believe emerged in the form of four meta-themes, based on the views of the study participants.

The first meta-theme: spirituality and health

Complex issues that require further clarification

The participants accepted that making a final opinion or impression about a change in the psychological and emotional presentation of an individual is a very complex and complicated area to understand. It can be beyond ordinary comprehension for psychological, medical and especially, spiritual reasons. For example, if a condition remains undiagnosed then it is difficult for a doctor to prescribe medication. One participant described how it is complicated when trying to understand how spiritual and supernatural reasons might lead to a change in the presentation of health in individuals and cannot be fully understood by science as it has limitations. Therefore, spirituality and the supernatural cannot be understood from a scientific frame of reference alone.

Scepticism about the supernatural

One participant who didn't identify as a religious leader but a community member having a good knowledge of Islam, differed from the others by questioning the possibility of supernatural factors causing the health problems, stating that it may not be a popular view, and asked whether the rest of the participants really believed that supernatural reasons and practices could cause a change in a person's presentation. The rest of the group immediately responded that they did not have the slightest doubt that this happens as these were authentic ideas from religious sources and they believed in these factors as an integral part of their faith and worldview.

Attempts to understand what psychosis is

The lack of understanding of 'psychosis' resulted in participants questioning each other on whether such a condition responded to psychological approaches or counselling and how it differs from depression.

The second meta-theme: supernatural reasons can cause illness; faith and religion are the answer.

There was a strong belief that supernatural reasons are responsible for causing mental illnesses. Most

participants said that they believe in the existence of such things because they are mentioned in the holy scriptures and incidents happened in the life of holy individuals. Participants felt that there is no doubt in the existence of the supernatural and their interactions with human life, including the possibility that they were involved in the causation of illness. For example, participants used phrases such as, 'genuine religious concept' and 'authentic religious concept' to emphasise the importance of the supernatural. Although there existed at least one difference of opinion, namely, how such things could interfere with human life, the majority of differences that emerged during the discussion focused on the degree and frequency of such phenomena. For example, one participant emphasised that such phenomena are mentioned in the holy scriptures and that such events happened to holy individuals but were rare occurrences. As there was a consensus on the 'genuineness' and 'authenticity' of the concept, most of the discussion revolved around sharing personal experiences and observations. Participants concluded that practical manifestations, real-life observations and personal experiences were happening due to supernatural causes. These manifestations included infestation by the spirits/*jinns*, being attacked by black magic, being attacked by amulets (*taweez*); and being a victim of the evil eye. During the discussion, it was clear that everyone knew what these terms meant.

From participants' perspectives, once it was accepted that patient's presentation was due to supernatural reasons, it brings into view another complexity in finding the 'correct' sources to address the spiritual and supernatural issues that are responsible.

Religion and faith are strengths in many ways

Participants felt that the answer came from the religious leaders, religious institutions and faith healers in society. Some participants felt that places of worship could play an important role in teaching people within a spiritual framework. If the religious leaders felt that a person needed more than faith-based help, they could refer the person to medical services. Some participants felt that their spiritual efforts brought them strength and courage to avoid or cease medications. For example, one participant recounted how the doctor prescribed medication, but it was his recitation of religious scripture that enabled him to develop the strength to stop using this at a later point and carry on in life. Another participant described how his late-night prayers and recitation of holy scripture helped develop an inner strength that enabled him to stop his negative thinking and continue in life.

Weakness in faith can cause spiritual problems

Some participants agreed that what they initially perceived and understood as supernatural later turned out to be a mental illness, while others emphasised that what someone perceived as 'a spiritual problem' must be appreciated and understood by everyone as 'a spiritual problem'. Relevant actions have to be taken as soon as possible as delaying action would not be in the best interest of the patient. This led discussion to the next question of why would someone develop such problems. Most participants felt that it is because of a weakness in faith, in other words, if you are not a strong believer in God and other aspects of religion then you are prey to supernatural creatures. One participant said, "If your faith is weak then even a third-class *jinn* can attack you." In other words, closeness to religion, engagement in religious practices and keeping a strong faith in God were advocated as protective factors, while deficiency in these led to vulnerability.

Faith healers may be deceptive/fraudulent

The participants expressed views that not all faith healers were genuine or authentic. Some of them were fraudulent or fake. Based on this premise, participants discussed how one would decide if a faith healer was authentic. No consensus was reached on how to establish the authenticity of a true faith healer. Participants, however, expressed personal opinions about what they believed were the characteristics and traits of a true faith healer and what one should look for in such a person. Additionally, they shared what

they thought were the characteristics of fake and fraudulent faith healers, providing a few examples of how, in their observations and experience, troubled people were negatively affected by such encounters. Participants also suggested that just like doctors who deal with medical conditions, faith healers may differ in their opinions about a troubled person's presentation. The participants emphasised that spirituality and the supernatural are areas beyond scientific comprehension.

The third meta-theme: the NHS needs to understand the cultural needs and demands of the South Asian community

Overall, participants expressed dissatisfaction with how the cultural needs and demands of the South Asian community are neither fully appreciated nor met by the NHS or NHS professionals at present. Participants identified a few deficiencies in the NHS system that, in their opinion, required improvement. Participants said that people may not have 100% faith in doctors. For example, as all faith healers are not trustworthy, likewise, not all doctors may be trustworthy. The doctors may prescribe antidepressants when they might not be required. The doctors may expect patients to continue treatment for long durations without review or paying only superficial attention to regular review of medication. One participant expressed the feeling that doctors only prescribe medications that are aimed at bringing symptomatic relief and differentiated the concept of treatment from the concept of healing, further elaborating that religion brings healing. According to several participants, the doctors prescribed antidepressant medications and expected the participant to continue medications for a long time, but it was the person's religion that enabled them to stop medication and achieve recovery. One participant described how his recitation of religious scripts and engagement in religious practices enabled him to get rid of medication and achieve complete recovery. There was agreement among the group that complete recovery is achieved when one does not need medication anymore.

NHS staff must make improvements to support the South Asian Muslim community

Participants felt that the NHS is unaware of the spiritual belief systems that patients have. A participant shared that the lack of awareness caused a funeral delay. In this example the participant described that how one word expressed in Arabic caused confusion between family members and professionals who didn't understand, leading to delay in completion of paperwork required for a death certificate. A doctor's lack of awareness of concepts like 'spirit-infestation' and 'black magic' causes difficulty in communication as the patient undergoes a feeling of being misunderstood and possibly Shamed because the doctor has no understanding of what members of the community are talking about when expressing such ideas. Various concepts and understandings are automatically understood as a part of the Muslim faith system if a doctor belongs to the same cultural background. One participant felt that the NHS must incorporate the expertise of spiritual and religious practitioners in their service framework, and such a step would support the unfulfilled needs of the community.

Participants also felt that the South Asian community is not utilising its strengths fully as the community does a lot of fundraising for charitable causes and engages in welfare activities for the wider community, but issues around mental health are largely ignored.

Ignorance and lack of awareness on both sides

There was at least one opinion expressed that was different from the majority: that the ignorance and lack of awareness towards the overall system is shared because, while the service providers may not be appreciative of some cultural aspects and needs of participants, at the same time members of the community had an ignorance towards how the NHS system works. This participant suggested a solution similar to the workshops and awareness programmes conducted by the NHS to improve public understanding about certain illnesses and conditions (for example cancer awareness programmes).

Therefore, similar awareness promoting work needs to be done to equip both parties (the NHS and the South Asian community) with regards to broadening the understandings of each party around mental health and mental illness.

The fourth meta-theme: concerns over religious engagement

Participants expressed worries that they were having to talk on behalf of the wider community, especially in religious matters.

Some participants expressed the opinion that Islam has the potential to accept new ideas. And one participant suggested that attributing mental illnesses to causes such as spirit infestation or the evil eye might be an incorrect perspective. They emphasised the importance of the community maintaining an open mind towards understanding alternative reasons for mental illness.

However, this was debated by what the participant meant by 'openness' – openness to what? This meant that expressing doubt at any level, that such supernatural reasons may not be responsible for causing mental illnesses, would be disagreeing with the religious sources and indirectly considered a disagreement with the religion and wider community. In other words, if someone is dismissing something suggested by the religion, then it could be considered blasphemous. This concern has been making participants apprehensive of receiving such a label and encouraged them to avoid directly confronting others (except for one occasion where one participant chose a direct confrontation). Some of the group had been trying to indirectly put their point across by carefully choosing their words. Participants expressed their fear in expressions like 'We are opening Islam to something new and, in the context of this small discussion, let's be careful that it may not cost us our faith because, as a part of faith, one must believe in the existence of such supernatural phenomena without any doubt. Being doubtful means that one's faith is weak or incomplete'. Some participants took a mid-way approach and talked about a 'marriage' between the NHS and Islam: 'let's not attempt to challenge the understanding of the community' or 'let's not attempt to challenge the primary sources from where such understandings are derived but instead let's try to attempt to find some common ground where service providers are made aware of the needs of the community without challenging the community in any way'.

Other considerations, the last meta-theme.

Importance of language in therapeutic consultations

Language plays an important role in the therapeutic interactions between service providers and patients. Some participants felt that they would prefer consultations with practitioners with similar language and cultural backgrounds and identified that a language barrier can generate serious misunderstandings between two parties.

Cross-cultural comparisons

The second significant theme is related to cross-cultural comparisons. For example, one participant reflected that being a teacher and managing discipline in a class of children was difficult in a local culture that is different from the culture of origin because teachers were not allowed to punish children. In the context of the present discussion, the participant was attempting to express how approaches towards addressing various practical issues may differ across cultures.

DISCUSSION

Social, religious and cultural reasons of illness causation

This study explored how members of British Muslim South Asian community especially Muslim religious leaders in Northwest England perceive mental illness, particularly psychosis. Participants attributed illness causation to a mix of social, religious and cultural factors, emphasising supernatural elements like the evil eye (*nazar*), evil amulets (*tawiz*), and spirits (*jinns*). While the exact mechanisms were

unclear, these beliefs were rooted in their faith and considered authentic. Diagnosis and treatment of what they considered spiritual illnesses or weakness of faith, were deemed the domain of religious leaders and faith healers, whose expertise in religious texts and metaphysical matters made them essential. However, challenges arise due to the prevalence of fraudulent healers, with no standardised criteria or qualifications to distinguish authentic practitioners.

Seeking help when things go wrong

It is perfectly natural for people to ask the opinions of friends and family, once they encounter or experience any difficulty or problem. A family member might start displaying unusual behavioural patterns, for example talking to themselves or smiling incongruently and inappropriately. For some people, such presentations may raise the suspicion that something spiritual or supernatural might be responsible. Religious leaders are contacted by community members if spiritual or supernatural reasons are considered or attributed to anything happening to them or to someone that they know. Some religious leaders also play the roles of spiritual and faith healers in society. Sometimes people approach them not only to seek explanations for their experiences but to receive treatment as well. Bhika et al (2012) carried out a systematic review of 14 studies that were conducted in developing countries, including some South Asian countries, and found that "most studies reported predominantly supernatural and psychosocial explanatory models of psychosis. Having a supernatural and psychosocial explanatory model impacts help-seeking behaviour, treatment modalities used and duration of untreated psychosis". In a separate study Bhika et al (2015) found that South Asian Muslim communities living in the UK tend to contact religious leaders and faith healers to seek spiritual treatment. It delays the patient access to the relevant health services. The current study confirms findings by Bhika: that religious leaders advocate in favour of people accessing opinions of experts in spirituality, to ensure that they may not be experiencing any spiritual or supernatural problem that might need attention from such experts and not from the NHS.

Seeking help from spiritual healers and religious leaders

A few questions emerge if someone seeks help from religious leaders and faith healers. For example, how will the religious leaders approach such matters? What do they think might be the reasons behind the change in a person's presentation? If someone has started engaging in self-talk, smiling incongruently, responding to unseen stimuli and displaying social withdrawal and change in interpersonal interactions, what do religious leaders think are the reasons for this? Another question is if religious leaders have opinions about the causation of such problems then do they offer solutions?

Answers involving supernatural reasons causing illness

It was found that some South Asian Muslim religious leaders ascribe supernatural causation to some mental health presentations. These leaders believed that several types of supernatural causes may lead to such unusual presentations; for example, one may be possessed by a spirit or ghost (*jin*), it can be the result of an evil eye (*nazar*) or from an evil amulet (*tawiz*). There can be a variety of causative reasons, which may lead to a changed presentation. However, it would require an expert to establish which specific cause led to the development of abnormal symptoms in each patient. This confirms the findings from the study done by Khalifa et al (2011) who studied the role of supernatural causation of illness in British Muslim ethnic minorities, exploring concepts like jin, black magic and the evil eye, and confirming this community believes in these causative reasons.

Final decision about causality of illness lays with respective expert

In view of the group participants, the final decision about the causality lies with the expert, in other words, with the religious leader who is identifying and treating the illness. If we compare it with the medical model of causality, we think of the concept of differential diagnosis. For instance, the symptom of a headache can indicate several potential differential

diagnoses that may be causing it. A trained doctor keeps in mind all possibilities based on medical knowledge while coming up with a conclusion for the patient. Likewise, religious leaders said that only an expert in spirituality can decide what kind of spiritual or supernatural reason could be responsible for causing an illness.

Involvement of an expert in religiosity and spirituality is essential

This implies that, in the opinion of participants, the involvement of an expert in spirituality is essential for finding out what is happening to a patient. These experts are convinced that if the spiritual treatment is delayed then the delay can have far-reaching negative implications for the patient. But medical professionals have no idea about spirituality or spiritual illnesses, and it is only the religious and faith healers that can identify and treat such conditions. According to participants, without the involvement of experts in the supernatural and spirituality the treatment and management of South Asian patients will remain incomplete. Al Padela et al (2010) found in the US that Imams can play an important role in directing community members to the correct services.

Who is a genuine healer

Participants could not agree or elaborate on who would qualify and be accepted as a true healer, because there are many fake and fraudulent healers in society. Again, if we keep the medical model in mind, we can reflect that a doctor can practice medicine once they pass the required examinations regulated by a central body nationally or internationally. Most participants had personal opinions that they believed were the criteria for judging a person to be a genuine healer, however, these choices were seen by the majority as no more than personal opinions. The overall outcome of the discussion was that there is no agreement on the criteria or standards for the authenticity of a practitioner but instead personally identified criteria by individual participants. There were no standardised criteria offered by national or international bodies. The discussion about what a good Imam and bad Imam is has been carried out by Jonathan Birt (2006) in a completely different context in the aftermath of 9/11 in the article "Good Imam, Bad Imam: Civic Religion and National Integration in Britain post-9/11".

Religious leaders in this study were aware that some leaders are unreliable and can cause damage to people instead of bringing benefit.

UK NHS must take steps to understand aspects of South Asian culture

Participants remained convinced that the NHS must take steps to understand the cultural aspects of the South Asian community and if such aspects are not considered then the service provision remains deficient. Participants had several ideas about how they can incorporate the culturally specific needs into mainstream services. Some participants said that members of the South Asian community and NHS professionals must get together on certain platforms, for example conducting workshops or teaching sessions through which the South Asian community can help NHS professionals understand their model of illness: a model that comprises spiritual and supernatural causation of illnesses. Participants felt that by doing this affected people (considered patients to some) will not feel as culturally alienated as they usually feel. For example, a participant thought that as soon as supernatural or spiritual causation is felt to be playing a role in a patient's illness, both doctor and spiritual expert can start treating the patient so that they receive both treatments to their satisfaction, and perhaps the best results can be achieved by adopting such methods. This deficiency and expectation have been identified in the past in some studies including a focus group with South Asian service users by Bowl et al (2007) in the UK.

Doubting religion and faith is weakness

Lastly, there are some culturally unique patterns identified within the discussion. Participants felt, for example, that once they claim to have acquired and expressed an idea based on the religion and religious

sources then, in their opinion, there remains no possibility of doubting its authenticity. For example, if religious scripts have talked about spirits and jins then doubting or questioning these concepts will be like challenging their authenticity and genuineness, which indirectly symbolises a weakness in belief and faith. One of the participants feared that they would experience community shame if they expressed something or accepted something that was against their mutually accepted religious beliefs. Secondly, they feared that their faith would become weaker if they disagreed with some mutually agreed beliefs. Participants cautiously described that they didn't find much evidence of supernatural causation responsible for illnesses in the past times and lives of holy personalities. However, despite the anecdotal evidence, most participants continued to believe that they would not doubt their model of understanding illness causation by supernatural and spiritual means because it is a part of their faith. Any differences were dismissed immediately without much consideration.

Other. Communities that believe in similar model of illness causation

Similar patterns are also shown by other communities. For example, Chatters et al (2011) found that in African American communities, spirituality and religion are deeply influential in addressing mental health challenges. Many people seek solace and guidance through churches and pastoral counselling, often perceiving their struggles as a test of faith or a spiritual journey. This perspective can sometimes result in hesitation to pursue formal mental health services, as there is a belief that such issues should be resolved within the faith community. Furthermore, the stigma surrounding mental illness may discourage individuals from seeking help beyond their family or religious networks (Chatters et al, 2015). Aguirre-Molina et al (2002) noted that in Latino communities, mental health is frequently viewed through the framework of family, spirituality and a collective mindset. Religion, particularly Catholicism, holds significant importance, and many individuals attribute mental health challenges to spiritual imbalance or view them as a trial of faith. As a result, prayer and spiritual healing are often prioritised over pursuing professional mental health services (Aguirre-Molina et al, 2007 Chapter 7). Tayeb (2018) examined the beliefs of healthcare professionals regarding the causes of neurological and psychiatric disorders. The study found a high frequency of belief in supernatural factors, such as the evil eye, divine testing and punishment, and sorcery, among healthcare professionals, including attending physicians and physicians in training.

Communities that differ in understanding of illness causation

With advancement in scientific technology, medical professionals like psychiatrists, psychologists and biomedical scientists worldwide (regardless of cultural background) typically reject supernatural explanations for mental illness and general health conditions, focusing instead on neurobiology, genetics, trauma, and environmental factors (Howick, 2019). For example, members of behavioural and cognitive sciences communities emphasise empirical research, evidence-based medicine and psychological theories to explain behaviours and illnesses (Salkovskis, 2002). Secular and scientifically oriented societies like Scandinavian countries and Japan are among the least religious in the world and tend to rely heavily on scientific and medical explanations for illnesses (Zukerman, 2017 and Nakane, 2005). They emphasise public health, genetics and environmental factors over supernatural causes. Many individuals living in Western atheist and secular-humanist societies such as parts of Western Europe, Canada, and Australia, attribute diseases to biological, psychological and social factors rather than supernatural influences (Baker et al., 2018).

Epistemic differences

Overall, it appears that differences in understanding of illness causation relate to epistemic underpinnings and worldviews of individuals and communities. The social theory of epistemology is a perspective that emphasises the social context in which knowledge

is produced, shared and validated. It suggests that knowledge is not just an individual endeavour, but is influenced by social interactions, institutions, and cultural factors (Goldman, 2002, chapter 9, p182). According to this theory, the production of knowledge involves collaboration, negotiation and the involvement of various social agents (such as experts, communities and institutions), which shape how knowledge is constructed and understood. Social epistemology highlights that knowledge is often shaped by groups of people who share a common understanding or expertise in a particular field. These groups contribute to knowledge production by setting standards, establishing frameworks and evaluating what counts as valid knowledge (Goldman, 2002 chapter 9, p183) It also describes that knowledge is often distributed across a community or society and no one individual holds all the knowledge required to understand complex issues. This perspective emphasises collective rather than individual knowledge. Social theory of epistemology also examines how power dynamics influence which knowledge is accepted and who is considered a legitimate authority in the production of knowledge. It investigates how cultural, political and institutional factors shape the recognition of knowledge (Goldman, 2002, chapter 9, pp182–183).

The epistemic understandings however keep changing and evolving in groups and communities (Hong and Henrich, 2021). For example, those societies that were (in the course of their social evolution) previously religious and later took a rather secular outlook still have individuals/groups living in them that have a religious and spiritual understanding of illness causation. Tomkins (2023) discussed the presence of spiritual beliefs and practices in secular Denmark. The study revealed that a significant portion of the population still holds spiritual beliefs and practices, indicating that even in secular societies, spirituality can play a role in individuals' lives and potentially influence their perceptions of health and illness. Japan is widely regarded as a secular society, with low levels of religious adherence in daily life and a strong emphasis on science and modern medicine. However, many Japanese people still hold spiritual and supernatural beliefs related to health and illness (Kirmayer and Young, 1998). Likewise, Rivadossi (2021) reported about Shamanism and the role of the supernatural in contemporary Japanese healing practices.

CONCLUSION

Based on personal and the group's epistemic underpinnings and their worldview, participants stressed the need for spiritual experts to identify and address the causes of mental illnesses, emphasising that medical professionals lack the requisite spiritual knowledge. However, the group recognized differing opinions and the challenge posed by fraudulent healers and the lack of standard criteria to identify genuine faith healers for reliable spiritual care. This contrasts with the medical model, where practitioners are certified by standardised regulations.

The participants suggested that the NHS should address cultural gaps by conducting workshops to educate healthcare professionals on South Asian spiritual beliefs and integrating spiritual and medical treatments. They believed such collaboration could reduce cultural alienation among patients and enhance outcomes. However, concerns were expressed about community resistance to questioning religious explanations, as this could be seen as weakening faith.

From a service provision point of view, the findings of this paper will add up to the pool of existing social/culture/religion driven understanding of South Asian community members.

Limitations: The study utilised focus groups, providing valuable insights but acknowledging limitations, such as the dominance of majority opinions and the inability to generalise findings.

Implications: These findings aim to improve cultural sensitivity and collaborative care in healthcare settings.

The findings of this research might enable members of the South Asian community, especially South

Asian Muslim religious leaders to reflect on their current understanding of the causality of mental illness.

This study also provides useful insights for clinicians and researchers. From a clinical point of view, the clinicians would become more sensitive to the specific-cultural needs of this community. In addition, clinicians may consider involving a religious leader, as they might do by involving a Chaplaincy for some other patients. The clinicians can use this knowledge to remain sensitive towards the culture, faith and religious-driven ideas of this community.

The researcher may explore these beliefs and thoughts in more depth by using more robust methods or a combination of methods. Some observational studies can also be designed to record the presentations that a community member may attribute to spiritual or supernatural events. More in-depth research might also be carried out into the unique patterns identified in this project. For example, how do participants feel, and what are their fears, when they say that doubting or disagreeing with something that is emanating from religious sources results in a loss of faith or is a sign of weak belief? By considering the possibility that supernatural reasons may not be causing certain problems, some participants felt and expressed the fear, that they might be opening Islam up to something new.

As a future direction, it would be worth exploring what they fear they are opening Islam to. Another research possibility is planning more focus groups with members of the same community elsewhere in the UK or across the world.

It might be worth exploring with the community members how they can come up with standardised or mutually agreeable criteria for deciding who is a genuine and true faith healer and who is fake. If an agreement is reached, further exploration is required to determine how these practices could be standardised nationwide or globally if possible.

Finally, it would be useful to explore how South Asian Muslim religious leaders and community members distinguish between treatment/care and healing.

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