Exploring the Feasibility of Behavioural Activation Therapy Delivered by Faith Leaders for Depression in Pakistan

Mujeeb Masud Bhatti

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Abstract

Background: Statutory healthcare services are overstretched, impeding access to mental healthcare in Pakistan. Many people with mental disorders, including depression, turn to faith leaders for support. Simple but effective psychotherapeutic treatments for depression can be delivered by trained lay workers, potentially including faith leaders.

Research Questions: My research questions were: 1) Is it feasible for faith leaders to deliver behavioural activation for depression in Pakistan? and 2) What adaptations need to be made to behavioural activation so faith leaders can deliver it in Pakistan?

Methods: I used a mixed methods approach and conducted four interrelated studies: 1. A systematic review to understand pathways to accessing mental healthcare in Pakistan; 2. A systematic review on the effectiveness of interventions by faith leaders for common mental disorders, including barriers and facilitators to their delivery; 3. Qualitative interviews with faith leaders; and 4. with individuals with depression attending them.

Findings: The first systematic review (12 studies) found that one-third of people with mental illness first contact faith leaders in Pakistan. The second review (33 studies) highlighted that "spiritual passe" interventions are effective for common mental disorders. In spiritual passe, faith leaders move their hands over an individual without touching to heal illness. In qualitative study with faith leaders (N = 12), they expressed interest in receiving training to manage depression with subtle resistance to becoming trainees of healthcare professionals. The qualitative study involving people with depression who attended faith leaders (N = 13) highlighted the beneficial effects of faith leaders' interventions while showing dissatisfaction with faith leaders' understanding of mental illnesses.

Conclusion: There are two barriers to behavioural activation delivered by faith leaders, including the limited autonomy of attendees in their interactions with faith leaders and power tension between faith leaders and healthcare professionals. There is a need for dialogue between faith leaders, healthcare professionals, and attendees on integrating faith-based practices in behavioural activation without compromising the autonomy of attendees and core elements of behavioural activation.

Keywords: Faith Leaders; Behavioural Activation; Depression; Pakistan

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Declarations

I declare that this thesis is a presentation of original work, and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as references. I acknowledge that I received assistance from Grammarly to proofread this thesis in line with the Policy on Transparency in Authorship in PGR Programmes.

1 Chapter One: Background

1.1 Structure of Thesis

In this thesis, I present nine chapters covering four research studies. Chapters one to three address background, overarching methods, and reflexivity. Chapters four and five provide detailed descriptions of systematic reviews, while chapters six and seven present studies based on primary data, including qualitative interviews. Chapter eight synthesises qualitative data from my evidence syntheses and interview studies. Finally, chapter nine provides an overall discussion of my findings and the methodological strengths and limitations and implications of this research. All chapters follow the monographic thesis style, except for chapter five, which is presented in journal style, and has been published in "Transcultural Psychiatry."

1.2 Clinical Depression

The term "*Depression*" originated from the term "*Melancholia*" (Kendler, 2020). Until the late 19th century, melancholia was considered a disorder of intellect, judgment, and reasoning (Kendler, 2020). The writings of Krafft-Ebing and Emil Kraepelin played an integral role in developing the modern concept of depression (von Krafft-Ebing, 1874; Kraepelin, 1893). According to their conceptualisation, depression (melancholia) was primarily considered a disorder of mood, including the symptoms of sadness, hopelessness, and debilitating low mood (von Krafft-Ebing, 1874). Disorientation of intellect may co-exist but cannot be considered a core symptom; instead, it may emerge from affective disturbance (Kraepelin, 1893). Currently, depression is formally known as Major Depressive Disorder (MDD) and is a medical concept. The current conceptualisation of depression has been captured by two widely used classification systems: the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition Text Revision (DSM-5TR) (American Psychiatric Association, 2013) and the International Classification of Diseases (ICD-11) (World Health Organization, 2022).

As per DSM-5 TR criteria, depression can be diagnosed if an individual is experiencing five (or more) symptoms over two weeks. These symptoms include 1) depressed mood; 2) loss of interest; 3) significant weight loss or gain; 4) psycho-motor retardation; 5) fatigue; 6) guilt feelings/ feelings of worthlessness; 7) inability to think or concentrate; 8) suicidal ideation or attempt. Out of those five (or more) symptoms, at least one of the symptoms should be either 1) depressed mood or 2) loss of interest. To receive a diagnosis of depression, symptoms must cause clinically significant distress and significantly impair daily life routine. Depression is generally diagnosed through a clinical interview operationalising the diagnostic criteria along with physical examinations to exclude other causes, such as medical conditions or effects of psychoactive drugs. Self-report measures are also used but are not considered as a gold standard to diagnose depression.

1.2.1 Depression in a Cultural Context

Cultural differences in depression have been observed mainly across three domains: 1) conceptualisation of depression, 2) help-seeking behaviour, and 3) presentation of depression (Kleinman, 2004). The contemporary understanding of depression has been primarily influenced by the medical model, where a chemical imbalance in the brain is considered the principal cause of depression. While psychosocial factors are often acknowledged in its aetiology, depression is viewed primarily in medical terms. In low-middle-income countries (LMICs), it is more likely that a non-medical understanding of depression may be held more widely (Karasz, 2005). Social, cultural, and religious embeddedness of depression are often core elements of non-medical explanations of depression. In this regard, relational, social (e.g., divorce, death of loved ones, loss, conflict), and religious aspects (e.g., non-conformity with religious obligations and irregularity in religious rituals) are often used as explanations for depression (Johnson et al., 2017). Spirituality, cultural relevance, and faith have increasingly been recognised as crucial elements in mental healthcare and person-centred care in high-income countries (HICs) (Forrester-Jones et al., 2018). Mental health practitioners are increasingly interested in mindfulness and faith-based psychosocial treatment programmes. Such models incorporate familiar spiritual or faith-related language, challenge irrational thoughts using religious texts, incorporate religious teachings, and utilise spiritual and faith-based activities to enhance engagement for those with depression (Anderson et al., 2015). Also, depression in non-medical contexts is often managed in informal settings through traditional and faith-based healing and bringing the individual back to familiar (cultural and traditional) rhythms (Tekola et al., 2021; Haroz et al., 2017). Compared with people living in HICs, people living in LMICs are more likely to consult faith leaders for their mental illnesses (Burns and Tomita, 2015).

1.2.2 Epidemiology of Depression

In 2019, 279 million cases of depressive disorders were noted globally (affecting about 3 to 4% of the total world population), with high prevalence in females (170 million; approximately 61% of combined prevalence) compared to males (109 million; 39% of combined prevalence) (GBD 2019 Mental Disorders Collaborators, 2022). The rates of depression have increased, with about a 12% increase in rates recorded between 2001 and 2020 (Shorey, Debby and Wong, 2022; James et al., 2018). Quality and variation in study designs cannot fully explain the increase (Moreno-Agostino et al., 2021). However, improved awareness and accessibility of mental health services are potential factors. Rates of depression vary considerably across regions with a higher prevalence in low-resource areas such as South Asia and Africa (Whiteford et al., 2013; Assariparambil et al., 2021; Bedaso, Mekonnen and Duko, 2022).

Depression is also a leading cause of disability worldwide. It accounts for approximately 32 million years of life lost (YLL) (James et al., 2018) and 34 million disability-adjusted life years (DALYs) globally (Hay et al., 2017). The estimates of DALYs have been increasing by about 11% between 2006 and 2016 (Hay et al., 2017). Depression accounts for approximately 2.5% of global DALYs across all diseases and 40.5% of the total DALYs attributed to mental illnesses. (Whiteford et al., 2013; Ferrari et al., 2013). Vigo and colleagues argue that the burden associated with mental illness is underestimated by more than 30% due to several reasons, including 1) the overlap between mental and neurological disorders; 2) separate categories exist for self-harm and suicide, not covered within the classification of depression, despite depression being the primary factor in most of such cases, and 3) the exclusion of personality disorders from estimations (Vigo, Thornicroft and Atun, 2016; Atun, Vigo and Thornicroft, 2016).

Also, while considering the prevalence and disease burden of depression, the challenge lies in developing standardised and valid tools to identify depression at a global scale accurately. Such challenge arises due to differences in culture, language, and traditions. Data related to depression have been predominantly gathered from Western populations. Therefore, current tools used to measure depression are based primarily on the Western understanding (Haroz et al., 2017). In a recent systematic review of qualitative evidence (Haroz et al., 2017), depressed mood/sadness, fatigue/loss of energy and problems with sleep were found to be shared among western populations and non-western populations. Despite such commonalities, other features such as social isolation, crying, anger and general pain were commonly reported in many non-western populations but are not present in DSM-5 to inform diagnosis. Similarly, problems with concentration, psychomotor agitation, or slowing, which are present in DSM-5, were reported infrequently in non-western populations (Haroz et al., 2017). Such evidence suggests that depression is expressed differently across different regions of the world. Failure to use culturally adapted tools may result in overlooking genuine cases of depression, subsequently resulting in underestimating the prevalence and disease burden associated with depression.

Depression is also associated with various social and economic factors and physical conditions (Pilevarzadeh et al., 2019; Rezaei et al., 2019; Lotfaliany et al., 2019). In LMICs, depression is comparatively higher in females, the underweight, those with lower education levels, and in lower wealth cohorts (Lotfaliany et al., 2019). Depression prevalence is comparatively higher in people with a range of physical conditions such as diabetes, cancer, and cardiovascular disease (Ghaemmohamadi et al., 2018; Pilevarzadeh et al., 2019; Rezaei et al., 2019). For example, recent systematic reviews noted a 19% prevalence of depression in type 2 diabetes (compared to 11% in people without type 2 diabetes) (Farooqi et al., 2022),

31.3% in cardiovascular disease (Karami et al., 2023) and 27% in cancer (Mejareh et al., 2021). A review of almost 100 systematic reviews has suggested that people with mental illness have a 1.4-to-2-fold increased risk of physical conditions such as diabetes and cardiovascular diseases compared to people without any mental illness (Firth et al., 2019). Further, people with both physical and mental illnesses have several adverse implications, including worse outcomes for both illnesses, reduced treatment adherence, higher mortality rates, and higher expenditure on healthcare (Berk et al., 2023).

1.2.3 Treatments for Depression

Recommended treatment options for depression include psychological therapies, medication (antidepressants), and their combination. Psychological therapies are first-line treatment options for depression. Such therapies are combined with antidepressants depending upon the severity of depression. Evidence suggests antidepressants improve the symptoms of depression (Bollini et al., 1999). However, low adherence and high dropout rates have been observed in using antidepressants alone (Demyttenaere, 1997; Anderson and Tomenson, 1995). Antidepressant medications combined with psychological therapies are not only more effective compared with antidepressants alone but also increase treatment engagement and adherence (Pampallona et al., 2004). Cognitive and behavioural therapy (CBT) is a widely used psychological treatment for depression. CBT is recommended as the "gold standard" psychological therapy for depression and other mental disorders (Pampallona et al., 2004; David, Cristea and Hofmann, 2018).

1.3 Treatment Gap for Depression

Globally, only one-third of individuals with depression receive treatment, revealing a substantial treatment gap, particularly in LMICs. In HICs, the percentage of individuals with depression who receive treatment ranges from 33% to 48%. However, in LMICs, the corresponding figures are 8% to 21% (Mekonen et al., 2021; Moitra et al., 2022). Several factors contribute to such a large treatment gap in LMICs, including 1) low budgets allocated to mental health care, 2) limited human resources, 3) lack of appropriate healthcare infrastructure, 4) lack of integration of mental health care in primary health services and 5) lack of availability of mental health services in public hospitals (Saraceno et al., 2007; Sarikhani et al., 2021).

In LMICs, budgets allocated to mental health care range from less than 1% to 3%, with some countries not having a specified budget (Saxena, Sharan and Saraceno, 2003; Raja et al., 2010). Mental health per capita expenditure ranges from 0.02 to 0.76 US dollars (Raja et al., 2010), which is 70 times lower than upper-middle-income countries (UMICs) and lower than the recommended mental health expenditure per capita, i.e. 4 US dollars (World Health Organization, 2010). Median rates for each health professional category per 100,000

population in LMICs are as follows: 0.1 psychiatrists, 0.1 psychologists, social workers, and occupational therapists, and 0.2 other mental health workers. The number of outpatient facilities varies considerably within different LMIC regions, with one patient facility covering about 0.2 to 2 million population. In community-based psychiatric inpatient units, less than one bed is available to cover a population of 100,000, with some countries having no community inpatient facilities. Primary health care services are available in the majority of LMICs. Only 14% of countries have assessment or treatment protocols available for mental health in primary care. The median rate of beds in specialised mental health care facilities is 5.90 per 1000,000 population, with most facilities available only in urban areas (World Health Organization, 2010).

The accessibility of evidence-based treatment in LMICs has remained a severe challenge in the last three decades with little advancement. Mental health experts and organisations have proposed that an innovative solution to tackle this challenge is expanding low-intensity and non-specialised treatments for mental illnesses (Purgato et al., 2020). This involves developing and evaluating relatively simple, non-specialised, and cost-effective interventions for common mental disorders (CMDs), such as depression, that non-specialist healthcare workers or lay workers can deliver in the community, primary care, and healthcare settings (Zavala et al., 2023).

1.4 Behavioural Activation for Depression

Behavioural activation (BA) is an evidence-based psychotherapeutic treatment used to treat mental illness. BA's effectiveness has been evaluated for various mental illnesses such as post-traumatic stress disorder (PTSD), anxiety, and substance misuse. However, BA has been most extensively evaluated for its effectiveness for depression (section 1.2.3).

Dimidjian and colleagues describe BA as:

> *"BA* is *a structured, brief psychotherapeutic approach that aims to (a) increase engagement in adaptive activities (which often are those associated with the experience of pleasure or mastery), (b) decrease engagement in activities that sustain depression or increase risk for depression, and (c) solve problems that limit access to reward or that maintain or increase aversive control"* (Dimidjian et al., 2011).

BA is a simple, brief psychotherapeutic treatment. The approach can be described as "outside-in", meaning by changing or engaging in behaviour or activities ('outside'), the 'inside' (mood) will change (Jacobson and Gortner, 2000). Individuals are encouraged to engage in goal-directed (adaptive) activities with beneficial outcomes for health and overall functioning. A typical course of BA comprises a collaborative therapeutic relationship between a BA facilitator (or therapist) and a recipient. Both facilitator and recipient collaboratively work on

four key aspects: 1) identify triggers for maladaptive behavioural patterns, 2) develop treatment goals emphasising behavioural engagement, 3) relaxation exercises, and 4) relapse prevention strategies (Kanter et al., 2010; Lejuez, Hopko and Hopko, 2001; Martell, Addis and Jacobson, 2001). Problem-solving and skills training to facilitate an individual's exposure to adaptive activities (such as educational, physical exercise, social and day-to-day activities) are additional aspects of BA (Veale, 2008).

1.4.1 Historical Context

B.F. Skinner, the founder of behaviourism, used the concepts of "reinforcement" and "punishment" to understand depression (Skinner, 1957). Ferster suggested that decreased exposure to positive reinforcements and increased exposure to punishing behaviours lead to the development and maintenance of depression (Ferster, 1973). Lewinsohn developed and tested behavioural treatment for depression, which encouraged individuals with depression to increase their exposure to adaptive activities (Lewinsohn, 1975). Despite the availability of theories and evidence related to the behavioural explanation of depression, cognitive therapy was the gold-standard treatment for depression from the 1970s to the early 1990s (Beck, 1979). Therefore, during this period, behavioural therapies to treat depression were not able to identify themselves as a separate treatment for depression due to the popularity of cognitive therapy (Lewinsohn and Graf, 1973). However, cognitive therapy was later combined with behavioural strategies, resulting in the emergence of CBT. CBT consists of interventions that target observable behaviour, negative automatic thoughts, and the cognitive structures that underlie them (Beck, 2005). Cognitive therapy and CBT are often used interchangeably in literature. In the late 1990s, a clinical trial separated the behavioural component, i.e., BA from CBT, to determine the effectiveness of BA compared to a complete package of CBT (Jacobson et al., 1996). The findings suggested that BA alone was equally effective compared to CBT at the sixth-month follow-up (Jacobson et al., 1996). These findings challenged cognitive theory (Beck, 1979), which asserts that modifying maladaptive cognitions is necessary for better treatment outcomes and relapse prevention.

1.4.2 Effectiveness of BA for Depression

Early studies examining BA's effectiveness were primarily based in the United States of America (USA). Such studies compared BA against standard treatment, antidepressant medications, and cognitive therapy. The findings demonstrated that BA is more effective for depression compared to standard treatment and equally effective compared to antidepressants and cognitive therapy (Hopko et al., 2003; Dimidjian et al., 2006; MacPherson et al., 2010; Jacobson et al., 1996). Furthermore, a meta-analysis confirmed that BA is more effective than waitlist control groups, supportive therapy, and standard and usual care. It also indicated that BA is equally effective compared to CBT (Ekers, Richards and Gilbody, 2008).

Given the relative simplicity of BA compared to CBT, expert groups suggested that BA can be delivered by non-specialist health workers (without a prior mental health background) with less associated cost. However, most studies between 1995 and 2010 used trained mental health professionals (trained clinical psychologists) to deliver BA (Ekers, Richards and Gilbody, 2008).

Later, this evidence was extended to other high-income regions, and involved investigating the effectiveness of BA delivered by non-specialist health workers. In a phase II randomised control trial (RCT) in the United Kingdom, individuals with depression in primary health care centres were randomly assigned either to receive the 12 sessions of BA delivered by mental health nurses or routine care by general physicians (Ekers et al., 2011). BA improved depression compared to usual care at treatment end and follow-up. The study was well designed, with adequate consideration given to sample size estimation, standard randomisation procedures for clinical trials and records of treatment fidelity (Ekers et al., 2011).

Further, a non-inferiority RCT was conducted to examine the clinical and cost-effectiveness of the BA compared to CBT (Richards et al., 2016). A junior mental health worker delivered BA, while psychotherapists delivered CBT. This trial reported that BA was non-inferior to CBT, indicating the non-significant mean difference between BA and CBT groups on depression. Having junior workers deliver BA means it can be inexpensive. Growing evidence suggests that activation and environmental rewards are potential mechanisms for BA, indicating that it increases activity and exposure to environmental rewards, reducing depression (Fernández-Rodríguez et al., 2023). Further, BA's cost-effectiveness (in addition to clinical effectiveness) has been demonstrated in various clinical trials across different settings (Egede et al., 2018; Raue et al., 2019). Recent systematic reviews indicate that BA is an effective psychological treatment potentially highly scalable across many settings, populations, and cultures (Zabihi, Lemmel and Orgeta, 2020; Uphoff et al., 2020).

Two main factors limit the certainty of available evidence favouring BA: performance bias and conflict of interest. It has been noted in a recent systematic review (Uphoff et al., 2020) that individuals assigned to the BA group always knew that they were receiving treatment for depression as opposed to those in control or treatment as usual. In addition, in most clinical trials, BA developers were part of the clinical trials, leaving doubts regarding the certainty of the evidence. Reviewers, therefore, assessed this evidence as providing a moderate level of certainty (Uphoff et al., 2020).

1.4.3 Effectiveness of BA in Different Populations

As mentioned previously, BA is an "outside-in" approach that focuses on behaviour rather than exploring cognitions. Therefore, BA has been described as potentially more "culturally portable" compared to CBT (Uphoff et al., 2020). Until now, clinical trials assessing the effectiveness of BA have been carried out in 14 HICs (Uphoff et al., 2020) and a few LMICs, including India (Ali et al., 2020). BA has been evaluated across different age groups, including early adulthood (18 to 40 years), middle age (40 to 60 years) and late adulthood (60 and above years). Meta-analysis of the studies suggests BA is effective for both young (early adulthood) and older (late adulthood) individuals; however, given the small sample size, particularly for studies in older adults, findings should be interpreted with caution (Orgeta, Brede and Livingston, 2017; Tindall et al., 2017). BA manuals have been developed in different languages and adapted successfully for other cultures and settings, including Pakistan, implying the flexibility of the intervention (Collado et al., 2016; Zavala et al., 2023). BA may also be effective in treating depression in physical conditions such as cancer, smoking, and postnatal issues (MacPherson et al., 2010; O'Mahen et al., 2013; Hopko et al., 2011). Furthermore, ongoing trials are currently in progress in LMICs to assess the effectiveness of BA in addressing mental-physical multimorbidity, such as depression, in individuals with diabetes (Siddiqui et al., 2023).

1.5 Faith Leaders and Mental Health Care in Low and Middle-Income Countries

'Traditional healing' is one of the common pathways used by people seeking mental health care in LMICs, offering a range of treatment methods. 'Traditional healing' is defined as the "knowledge, skills and practices based on theories indigenous to different cultures to manage physical and mental illnesses" (World Health Organization, 2019). It is a broad term covering different indigenous practices and theories; some of them include 1) faith healing, 2) homoeopathy, 3) *unani* medicine, and 4) *ayurvedic* medicine. Different traditional treatments originate from other regions of the world; for example, homoeopathy originated in Europe (Fisher, 2012), *Unani* medicine originated in Greece (Islam, 2018), and *ayurvedic* medicine originated in India (Narayanaswamy, 1981).

1.5.1 Terminology: Traditional Healers, Faith Healers, and Faith Leaders

Several terms are used in the mental health literature for people who practise traditional healing, including "traditional healers", "faith healers", "faith leaders", and "religious healers" (Meran and Mason, 2019; van der Watt et al., 2018). Given the cultural, regional, and religious variations within traditional healing, such terms have often been used interchangeably without a clear definition and differentiation of roles. I am using the term "faith leaders" throughout this thesis. I have defined faith leaders as "*individuals providing informal care and support to those with mental illnesses using practices grounded in faith, spirituality, magic, and religion. They*

also offer additional roles like helping community members, involving in volunteer work, and leading religious and faith-based matters in the community".

This definition of faith leader is similar to definitions of traditional healer used previously in reviews (van der Watt et al., 2018; Nortje et al., 2016). However, I have changed from using the term "traditional healer" to "faith leader" based on findings from the systematic review I conducted (See Chapter 5). By doing so, I can acknowledge the broader role of faith leaders other than their role as a healer (See Details: Chapter 6: Healers vs. Leaders: Which Term).

1.5.2 Faith Leaders and Pathways to Mental Healthcare

Seeking care for mental illness is linked with various cultural, indigenous, and religious beliefs, which further shape the treatment choices of people (Chilale et al., 2017). Furthermore, in many LMICs, a lack of formal healthcare infrastructure, facilities, and healthcare staff limits treatment choices for people with mental illness (World Health Organization, 2010). Growing evidence suggests that people with mental illness frequently seek faith leaders' support for their illness, particularly in LMICs. For instance, a review of 14 studies based in African countries found that nearly half of people with mental illnesses (48%) have first contact with faith leaders before engaging with formal healthcare workers. There is no such review for South Asia. However, several studies based on primary data indicate that 25% to 49% of people with mental illness initially contact faith leaders for help with their illness before contacting formal healthcare services (Khan et al., 2023; Jain et al., 2012; Jalal et al., 2020). Evidence also suggests that such engagement with faith leaders often results in delays in getting evidence-based formal care and poor outcomes and relapse, particularly in psychosis (Lilford, Wickramaseckara Rajapakshe and Singh, 2020). Faith healing practices used by faith leaders are driven mainly by the popular religion within a particular geographical region; for example, in Pakistan, where Islam is a popular religion, people often attend shrines of saints and get involved in different rituals to relieve their distress (Charan et al., 2020). I will present a comprehensive discussion about faith healing practices in Pakistan in upcoming chapters.

1.6 Task Shifting, Task Sharing and Collaboration with Faith Leaders

Task shifting refers to the redistribution of healthcare tasks by either 1) shifting specific tasks from specialised healthcare workers to other specialised healthcare workers with different backgrounds or 2) shifting tasks from specialised healthcare workers to non-specialist health workers such as community health workers or to lay workers (World Health Organization, 2008). "Task shifting" is frequently interchanged with "task sharing" in the literature; however, recent expert discussions recommend the preference for using the term "task sharing," as the "sharing" part of this term recognises teamwork and collaborative engagement (Robertson et al., 2020). Task sharing has been recommended and widely used

to tackle the limited accessibility of evidence-based mental health care in LMICs (Hoeft et al., 2018). Task sharing has shown promising results in addressing non-communicable diseases and mental health (Coales et al., 2023). Given the complexity of task sharing, however, personal commitment, motivation, and availability of training resources for those involved in task sharing are essential for its successful implementation in LMIC settings (Coales et al., 2023).

Recent examples of task-sharing approaches include innovative solutions for tackling treatment gaps in LMICs. For example, a large-scale clinical trial demonstrated the beneficial effects of care provided by both faith leaders and community health workers to people with psychosis in Ghana, Africa. In this clinical trial, faith leaders were trained to i) identify psychosis, ii) refer to health professionals, and iii) refrain from potentially harmful practices (Gureje et al., 2020). The trial results showed a significant reduction in psychosis in people receiving care from faith leaders and health workers compared to people assigned to treatment as usual at the sixth-month follow-up (Gureje et al., 2020). Similar research is being conducted in Pakistan, where researchers are evaluating the effectiveness of training faith leaders to identify and provide initial non-specialised support to people with psychosis in a cluster RCT (Farooq et al., 2023). The feasibility of training faith leaders on the identification and provision of first-line non-specialised support to people with depression has also been successfully implemented and tested in Kenya (Musyimi et al., 2017a).

1.7 Depression and Mental Health Care Pathways in Pakistan

Pakistan is an LMIC with a population of 210 million people and is the fifth most populated country in the world. Islam is the primary religion, with 97% of the population being Muslim. The WHO reported 7 million cases of depression in 2015, constituting approximately 4.2% of the population (World Health Organization, 2017). WHO figures for depression, however, are underestimated mainly due to the stigma associated with mental illness, lack of access to mental health care (where it might be recognised) and limited high-quality research. Studies based on primary data have found considerably heterogeneous rates of depression in Pakistan, ranging between 23 and 53% in community household surveys (Muhammad Gadit and Mumford, 2007; Mubeen, Henry and Nazimuddin Qureshi, 2012). A recent synthesis of systematic reviews and primary studies noted that the pooled prevalence of depression in the general population is 16% in South Asia and 6% in Pakistan (Vidyasagaran et al., 2023). This review also highlighted that the prevalence of depression is comparatively higher for specific populations, such as people with co-morbidities and older people (Vidyasagaran et al., 2023).

The mental health care system in Pakistan is in a rudimentary stage with limited financial, human and infrastructure resources. Only 0.04% of the total healthcare budget is spent on mental health. The number of trained mental health facilities and workforce is minimal

compared to the size of the general population (Karim et al., 2004). For example, there are 3729 outpatient mental health facilities attached to hospitals and 624 community-based nonhospital outpatients' mental health facilities. There are 11 mental health hospitals (with inpatient units) and 800 psychiatric departments nationwide. The total mental health workforce is 1200, including 300 psychiatrists, 200 mental health nurses, 100 psychologists and 600 social workers. Overall, 0.55 mental health workers are available per 100,000 people (World Health Organisation, 2020). This is considerably lower than the 201 and 205 mental health workers for 100,000 people in the UK and Australia (World Health Organisation, 2020).

Cultural and religious beliefs and the limited availability of mental health services play a pivotal role when it comes to decisions regarding treatment options in Pakistan (Choudhry, Khan and Munawar, 2023). A substantial percentage of individuals with mental illnesses, ranging from 20% to 49%, opt to seek care from Muslim faith leaders (Anwar, Green and Norris, 2012; Khan et al., 2023; Chaudhry et al., 2017). There is a broad spectrum of Muslim faith leaders in Pakistan, including 1) prayer leaders (*Imam Masjid* in Urdu); 2) Islamic religious scholars (*Ulma* or *Mufti*); 3) spiritual leaders (*Peer* in Urdu); 4) reciters of *Quran* (Holy and revealed book of Muslims) (*Qari*) and 5) preachers (*Mubaligh*). One of the studies noted that spiritual leaders are most approached for treatment of mental illnesses, and depression is the most common mental illness reported (about 24%) to such faith leaders (Saeed et al., 2000).

1.8 Rationale and Research Gaps

In summary, depression is common in Pakistan, and there is a large treatment gap. BA delivered by trained non-specialists could address the treatment gap. A lot of people with mental illness seem to be already going to faith leaders for help, and there is some evidence that they could have a role in supporting them (Chaudhry et al., 2017; Farooqi, 2006). Training faith leaders in BA could be a promising approach, given so many people with depression seem to be already going to them. However, transposing and implementing evidence-based interventions developed in a particular setting into a different context requires careful consideration of what adaptations may be needed. There are likely to be some challenges, including cultural, logistic, and paradigmatic differences in training faith leaders in BA and further delivering BA to people with depression.

Evidence suggests that many faith leaders' practices focus on prayers, recitations, and supplications, which may potentially align with BA's rationale. For example, Mir and colleagues (2019) conducted a study to determine the feasibility of integrating Islamic practices into BA therapy among Muslims in the UK (Mir et al., 2019). They found that incorporating religious activities such as reading the Quran and supplications into a self-help book used in conjunction with BA therapy was acceptable to clients with depression. However, the BA therapists faced

challenges in relating the adapted self-help book to the therapeutic sessions and lacked sufficient knowledge about religious aspects. It is likely that faith leaders who have a better understanding of Islamic culture and religion could better align themselves with such aspects. This BA treatment for Muslims with a client self-help book has been recently tested in a RCT in Pakistan. Findings highlighted an improvement in depression in people receiving BA compared to CBT, both delivered by less experienced psychologists (Dawood, Mir and West, 2023).

To explore the feasibility of faith leaders delivering BA, an understanding of the context of faith leaders and their current role in depression care pathways must be developed. There is a need to understand faith leaders' perspectives towards BA and the perspectives of those attending them. Only two recent studies have explored in-depth the perspectives of faith leaders and those attending them regarding the support provided by faith leaders in Pakistan (Charan et al., 2020). Khan et al. (2023) focused on psychosis, while Charan et al. (2020) studied a non-clinical population. Quantitative studies have focused on exploring the percentage of people attending faith leaders, associated demographic or clinical factors with those who attend faith leaders and described common faith leaders' practices, such as religious advice, recitations, and chants, to manage mental illness (Saeed et al., 2000; Farooqi, 2006). None of the studies focused comprehensively on the perspectives of both faith leaders and their attendees regarding depression, the support provided by faith leaders, the possibility of training faith leaders in evidence-based practices and to take on task-shifted roles to treat mental illness. This information led me to investigate whether BA delivered by faith leaders could be feasible and what adaptations are needed to implement it successfully in Pakistan's cultural context.

2 Chapter Two: Aims and Objectives, Methodological Framework and Philosophical Underpinnings of this Thesis

This chapter explains the research methods I have used and the reasoning behind them. I have provided a comprehensive overview of the aims, philosophical perspectives, frameworks, and methods employed in the studies and synthesis (described in Chapters 4 to 8). The chapter starts with overarching aims and objectives, and I have specified how they are addressed by each of the studies in my thesis. It also highlights how different studies in later chapters complement each other. A broader intervention adaptation framework has informed all studies and is also discussed in detail. Further, a description of worldview and philosophical positions, which have informed my research methods, is given. The latter part of the chapter provides an outline of methods, including systematic reviews, qualitative interviews, and ethical considerations. While referring to those methods, I have also explained how and why I have used them and how they match the overall rationale.

2.1 Aims, Research Questions and Objectives

As described in Chapter 1, people with mental illnesses often consult faith leaders, and faith leaders could potentially be trained to deliver BA in a 'task sharing' approach. My overall aim was to explore the feasibility of training faith leaders in evidence-based practices and BA delivered by faith leaders from the perspective of faith leaders and those who consult them. Given this, my overarching research questions were:

I. Is it feasible for faith leaders in Pakistan to deliver BA?
   a) What are the potential benefits and harms of faith leaders' practices?
   b) What are the barriers and facilitators to the delivery of faith leaders' practices?
   c) What are the common practices used by faith leaders for the identification and management of depression?
   d) What are the attitudes of key stakeholders regarding training faith leaders in BA and the provision of BA by faith leaders?

II. What adaptations need to be made to BA so that it can be delivered by faith leaders in Pakistan?
   a) What are the possible barriers and facilitators if BA is to be delivered by faith leaders?
   b) What are the power and gender dynamics, and how do they affect interactions between faith leaders and their attendees?

To answer those overarching research questions, I conducted four studies and a synthesis of qualitative data with different but interlinked objectives - see table 2.1

Table 2.1: Summary of Settings, Population and Methods

Objectives	Settings and (Geography)	Population	Data Collection	Data Analysis/ Synthesis
To review the evidence on the proportion of people with mental illnesses attending faith leaders before their contact with any statutory mental health services in Pakistan (Chapter 4)	Healthcare (Pakistan)	Individuals with mental illnesses attending formal healthcare	Data extraction sheets for secondary data.	Narrative synthesis and meta-analysis
To review the evidence on the effectiveness, barriers, facilitators, and safety issues related to interventions for CMDs delivered by faith leaders (Chapter 5)	Healthcare, healing centres, religious institutions (Global)	Faith leaders and individuals with CMDs	Data extraction sheets for secondary data	Narrative synthesis, meta-analysis, and thematic synthesis
To explore the perspectives of faith leaders in Pakistan on their practices to support people with depression and their willingness to receive training for delivering talking treatments, including BA (Chapter 6)	Mosques and shrines (Pakistan)	Faith leaders who are supporting individuals with mental illnesses	Semi-structured interviews	Thematic analysis
To explore the perspectives and experiences of individuals with depression attending faith leaders in Pakistan on the support received and their willingness to receive BA delivered by faith leaders (Chapter 7)	Tertiary care psychiatric facilities (Pakistan)	Individuals with depression who are currently attending psychiatric facilities and attended faith leaders previously	Semi-structured interviews	Thematic analysis
To develop a more in-depth understanding of contextual factors related to the delivery of BA by faith leaders by comparing the perspectives of faith leaders and their attendees with depression (Chapter 8)	Healthcare, community, and religious sites (Pakistan)	Faith leaders and individuals with CMDs	The ecological model used for data extraction and organisation	Integrative synthesis

2.2 Criteria of Feasibility

The feasibility of an intervention refers to the extent to which the proposed intervention can be successfully implemented, evaluated, and sustained under real-world conditions (Craig et al., 2008). My criteria for the feasibility of faith leaders delivering BA for depression were: i) the acceptability of faith leaders and their attendees to the idea of faith leaders delivering a BA for depression, ii) the practicality of faith leaders delivering a BA considering their current practices, awareness of mental illnesses, training, capacity, time and relevant resources, iii) potential barriers and facilitators to integrating BA into their routine practice, iv) possibility of faith leaders delivering BA without compromising on its core elements, considering the safety of their attendees.

2.3 ADAPT Process Framework

My aims mainly involve adapting BA to fit a context with different norms, resources, and delivery structures. Various healthcare interventions have been successfully transferred to new contexts (Gardner, Montgomery and Knerr, 2016). At the same time, research has also shown that sometimes interventions transferred to new contexts are ineffective or even harmful (Althabe et al., 2015). Potential reasons for failure in transferability include contextual mismatch, lack of local adaptations, or different evaluation methods used in the original and new contexts (Evans et al., 2019). Whenever an intervention is transferred to a new context, understanding the match between the intervention and the new context, local adaptations, and re-evaluation are crucial (Evans et al., 2019). Defining standard and robust methods to adapt and re-evaluate existing interventions in the new context is essential to replicate findings and ensure interventions have the same benefits as the original context. In recent years, several academic papers have been published to provide recommendations, guidance, and frameworks for researchers who are planning to adapt existing evidence-informed healthcare interventions to new contexts (Day et al., 2023; Movsisyan et al., 2019).

Several frameworks have been developed to guide the adaptation of psychotherapies specifically. Some notable frameworks specific to psychotherapies include the ecological validity framework (Bernal, Bonilla and Bellido, 1995), cultural accommodation model (Leong and Lee, 2006), and the 4-domain cultural adaptation model (Sorenson and Harrell, 2021). Such frameworks provide comprehensive guidance on adapting key aspects of psychotherapies, including i) content, ii) context, iii) engagement, and iv) cultural competence (Day et al., 2023). Such elements are helpful to guide the adaptation process in the later stages when the rationale of transferring the intervention to the new context has been fully understood. However, these frameworks place less emphasis on clearly delineating the steps involved in adaptation, the methods to be employed for adaptation, and the process of re-evaluation. While some frameworks may not be exclusively tailored to psychotherapy, they provide a broader approach by outlining logical steps (Movsisyan et al., 2019). Those steps includes i) evaluating the effectiveness of existing interventions, ii) considering the rationale and connection between the intervention and the new context, iii) involving a range of stakeholders in the adaptation process, and iv) assessing the intervention through mixed methods research (Movsisyan et al., 2019). Until recently, however, no overarching and consensus-based guidance was available to adapt healthcare interventions. To develop a comprehensive framework encompassing all existing recommendations on adaptation, a research team led by UK investigators synthesised available relevant frameworks. Further, they conducted a Delphi-based survey to formulate the ‘Adapt Process Model’ to cover all essential elements found in existing frameworks (Moore et al., 2021). This approach ensures

that all key components are included in the model, giving it an advantage over other frameworks.

The Adapt framework provides step-by-step, systematic, and comprehensive guidance on adapting complex healthcare interventions for a new context while promoting “compatibility” between the existing intervention and the new context. It was developed through numerous methods, including reviews of existing intervention adaptation guidance, expert consultations, and consensus development exercises (Munthe-Kaas et al., 2020). This framework offers four steps in adapting an intervention to a new context: (i) assessing the rationale for intervention adaptation while considering intervention-context fit, (ii) undertaking adaptations, (iii) undertaking pilots and evaluation and (iv) implementation. It is a flexible framework and allows researchers to move between steps depending on the available evidence and compatibility of the existing intervention with the new context by collecting new data (Moore et al., 2021).

Conducting a complete adaptation and evaluation of faith leader-facilitated BA was not feasible within the resources and timelines of the PhD. My main objective, therefore, was to gain insights into faith leaders' context and practice relevant to delivery of BA, and to explore the feasibility of faith leaders being trained on and delivering BA. Therefore, this PhD work corresponds only to the ADAPT process model's first step, assessing the intervention's rationale and considering intervention-context fit.

Several sub-steps are to be considered within this first step of the ADAPT process model. These include the involvement of stakeholders early and throughout the adaptation process and understanding the prevalence of the health problem. Further, there is a need to review existing effectiveness evidence for the chosen intervention or conduct new reviews if necessary; and to gather additional data to build a comprehensive and in-depth understanding of the new context. Such information helps to establish the similarities and differences between the old context/s (in which the chosen intervention has already been tested) and the new context. This step is likely to guide in understanding whether a chosen intervention is closely aligned with the new context.

Diverse stakeholders were involved in this dissertation, including NS, HJ, and SA (who led or co-led a programme of research aiming to adapt BA for people with depression and diabetes in Pakistan), service users (people attending faith leaders) and faith leaders (potential delivery agents). Given the growing evidence documenting BA's feasibility, effectiveness, flexibility, and transferability, I did not undertake a new systematic review. Instead, I referred to the findings of a recently conducted systematic review on BA (Uphoff et al., 2020). The focus of this dissertation was to understand the context and explore the feasibility of faith healers delivering BA while retaining the core elements of BA. For this, I performed systematic

reviews focusing on (i) the proportion of people with mental illness who attend faith leaders prior to accessing statutory healthcare services in Pakistan, and (ii) the effectiveness, barriers, and facilitators associated with faith leaders' interventions. Subsequently, I conducted in-depth qualitative interviews with faith leaders and their attendees. This evidence enabled me to answer whether delivering BA can align with faith leaders' context and practice in Pakistan and whether it can be adapted, delivered and evaluated in such settings.

2.4 Mixed Methods Research and Pragmatic Position

I have used a mixed methods approach in my dissertation; the primary research has been qualitative. I have also conducted systematic reviews and meta-analyses, reviewing quantitative and qualitative data. In my PhD, I built upon the findings from each study to formulate and carry out the subsequent studies. The understanding, conclusions and recommendations are based on qualitative and quantitative data. However, I acknowledge the primacy of qualitative data when I refer to this study as a mixed methods study.

Creswell and Poth noted that qualitative research methods are often led by “interpretative frameworks” (Creswell and Poth, 2016). Interpretative frameworks are the researcher’s “set of beliefs” brought into the research process. Such frameworks are primarily shaped by differing views on philosophical assumptions such as single versus multiples realities (ontology), subjectivity versus objectivity (epistemology) and recognition of researchers’ values versus controlling researchers’ values (axiology).

The dissertation focuses on objectivity, specifically in quantitative data analysis. However, since most of the work is based on qualitative data, a perspectives-based pragmatic approach to reality is adopted. The perspective-based approach combined with pragmatism emphasises what is workable and beneficial according to those involved in research. This approach is based on the works of Cherryholmes (1992) and Phillips and Burbules (2000) (Cherryholmes, 1992; Phillips and Burbules, 2000). It offers workable solutions as perceived by research participants and, to some extent, by the researcher. Therefore, reality in this dissertation is co-constructed by researchers, participants, and other stakeholders who take part in the research (Burr, 2015). If this co-constructed reality provides "beneficial" solutions to stakeholders as seen by them, it aligns with the position on reality in this dissertation.

I am critical of power imbalances in research, specifically the researcher’s dominance and authority in creating knowledge (Kemmis and Wilkinson, 1998). Researcher dominance in the research process creates challenges in developing practical solutions which consider different perspectives. At the same time, the co-constructive approach emphasises the active roles of both researchers and participants in generating knowledge. Researchers' dominance is also a possible barrier to effectively using up-to-date research frameworks and methods in

healthcare research, as some methods have predominantly evolved under co-constructive philosophies. For example, co-design methodology values end-user (service users) involvement in designing healthcare innovations, interventions and systems – eventually mitigating the power imbalance between researchers and service users (O'Brien, Fossey and Palmer, 2021).

However, passing ownership of knowledge generation to only research participants appear impractical. Also, it is exceedingly difficult to eliminate the researcher's role or subjectivity. However, it is crucial for researchers to actively identify their role in the research process to mitigate (as far as is possible) any power imbalances. I acknowledge that the researcher (myself) owned the interpretation of the data. Usually, it is recommended as good practice to ask study participants to check on findings or ideas the researcher gains from the data, but in my case, it was not possible due to time limitations, and this is one of the limitations of studies presented here. However, I gave importance to research participants' perspectives by actively engaging in reflexivity, prioritising and relating myself to the perspectives of research participants. I have documented my active role in research to provide a clearer perspective on how I may have influenced the research process (See Chapter 3).

It is essential to consider whether researchers are distancing themselves (positioning out) or identifying themselves (positioning in) with the research participants. As a researcher, I have noticed similarities and differences between myself and the research participants. Therefore, embracing a transparent, one-sided, and unambiguous position is difficult. Instead, I view this as a dynamic process, and I shifted between these two positions during research.

Constructivism is a philosophical concept that says that individuals actively construct knowledge through their interactions with their environment and experiences rather than being passively received (Burr, 2015). Interpretivism is also a philosophy that acknowledges that the meanings or understanding attributed to experiences and conscious elements by individuals are subjective and unique to each individual (Alharahsheh and Pius, 2020). It appears in my writing that there are interpretivism and constructivism elements (Burr, 2015). However, I identify my core philosophical position in this dissertation as most closely aligned with a "pragmatic" framework. Pragmatism is not committed to being just one philosophical position. The researcher has the freedom to select methods and techniques which are required, and it focuses on "outcome" and "consequences" (Cherryholmes, 1992; Murphy and Murphy, 1990).

Mixed methods research is embedded within a "pragmatic" worldview and is commonly practised in applied healthcare research (Tariq and Woodman, 2013). Qualitative and quantitative research can be combined at different points in a single mixed methods study, including data collection, analysis, and interpretation (Creswell and Plano Clark, 2017). It can

also be done at the interpretation level only by collecting data from different studies. A mixed methods approach is often used when multi-faceted research questions require qualitative and quantitative research methods to address questions effectively. Similarly, mixed methods are also used when one method is insufficient to answer the question; for example, my research questions focused on quantitative elements (proportions of people attending faith leaders) and qualitative elements (in-depth perspectives of faith leaders and their attendees). Both inductive and deductive approaches were used; quantitative systematic reviews were primarily grounded in an inductive approach, while qualitative data analyses (primary and secondary) were based on both inductive and deductive.

2.5 Mixed Methods Designs

Creswell and Clarke (2018) have identified five major mixed methods designs, including i) convergent parallel design, ii) explanatory sequential design, iii) exploratory sequential design, iv) embedded design and v) multi-phase design (Creswell and Plano Clark, 2017). Brief descriptions of those designs are given below:

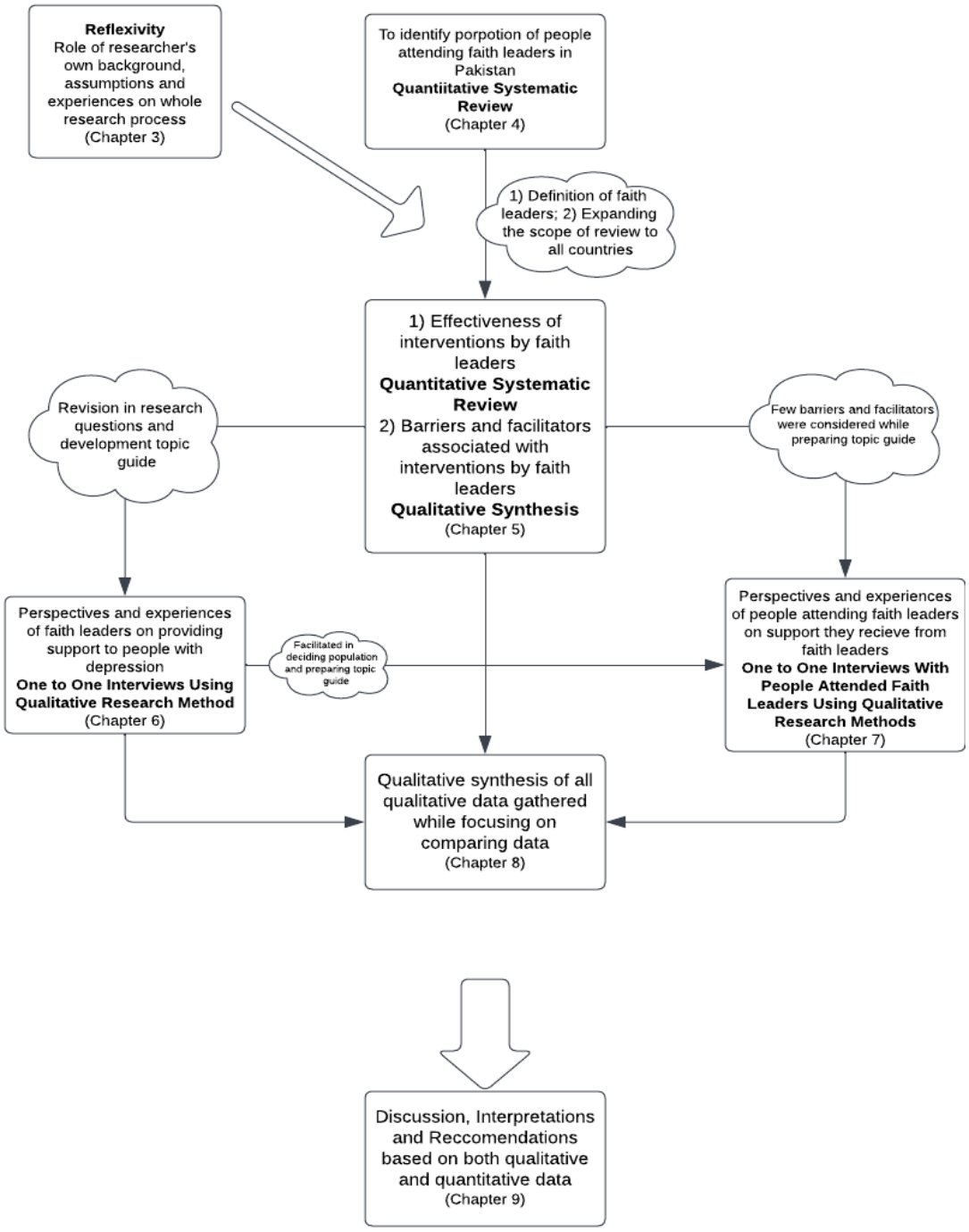
I. The convergent parallel design includes concurrently collecting quantitative and qualitative data. However, separate quantitative and qualitative data analyses are performed, compared and combined to draw interpretations.
II. The explanatory sequential design contains collecting and analysing quantitative data first. Further, qualitative data is collected and informed by findings collected in quantitative data. Qualitative data is collected and analysed to gain a deeper understanding, and explanations related to quantitative findings.
III. The exploratory sequential design starts by collecting and analysing qualitative data. These data inform the quantitative study, which generalises, validates, and tests all (or some parts) of the qualitative findings.
IV. In embedded design, data collection or analysis sequence is not of primary importance. Instead, its primary element is to embed one type of data (e.g. qualitative) within the larger research design/ method that primarily uses another type of data (e.g. qualitative data).
V. In a multiphase design, a series of qualitative and quantitative data collections is conducted over time. All these studies are linked by common research questions, and each build on the results of the previous study.

Creswell and Clarke (2018) propose considering various factors while choosing a particular design, including the interaction between qualitative and quantitative data, the potential influence of data collection timings, and when (or how) to integrate both data. My research questions were based entirely on iterative logic, where I was looking to understand different aspects driven by some common or linked objectives; this included

I. Looking at different data at different stages.
II. Iteratively looking back and planning the next course of action.
III. Making sense or synthesising of data by having the liberty to prioritise specific findings (related to research questions) that may emerge from the data regardless of the data collection method.

It was clear from the initial stages of this dissertation that formulating further data collection is to be based on findings and needs identified by previous studies. Therefore, I opted for a multiphase mixed methods design. I have developed a visual representation illustrating how quantitative and qualitative data are interlinked in my study and highlighting the specific research methods used for each objective (See Figure 2.1). I used quantitative synthesis methods in systematic reviews and qualitative methods to explore the in-depth perspectives of faith leaders and their attendees (See Figure 2.1).

Figure 2.1: Flow and Inter-relationships between Studies



2.6 Settings and Population

The research studies were conducted in various settings. In my systematic review, global data were used to examine the effectiveness of interventions delivered by faith leaders in different settings such as religious institutions, communities, and healthcare. However, all other studies relied on healthcare, community, and religious (institutional) settings within

Pakistan. A review focusing on the proportion of people attending faith leaders covered data from healthcare settings in major urban cities in Pakistan. Qualitative interviews with Muslim faith leaders were mainly conducted in religious institutions, while interviews with individuals who had attended faith leaders were conducted in tertiary care psychiatric facilities in Pakistan (See Table 2.1).

Overall, faith leaders supporting people with mental illnesses and their attendees were the subjects of interest in this dissertation. The eligibility criteria for participants were adjusted as required to address the specific research question. Pragmatic decisions were made while carefully considering the aims of each study, either to narrow down the criteria (such as including only those who have a history of attending faith leaders and are currently diagnosed with depression) or to widen it (such as including faith leaders providing support to people with any mental disorder). More specific details about eligibility criteria and participant characteristics are provided in each study chapter (See Table 2.1).

2.7 Systematic Reviews

Two systematic reviews were conducted, including 1) a review of the proportion of people with mental illnesses attending faith leaders in Pakistan and 2) a review of the effectiveness of interventions delivered by faith leaders and associated barriers and facilitators to deliver such interventions for CMDs (See Table 2.1). These reviews were guided by the Adapt framework, which suggests carrying out reviews to understand the characteristics of intervention and context (Moore et al., 2021). After conducting an informal literature review, I found that sufficient research has been conducted on both topics, which could be synthesised. This includes the availability of randomised controlled trials assessing the effectiveness of interventions delivered by faith leaders globally and the percentages of people attending faith leaders in Pakistan. A specific review focusing on these areas was unavailable, however. Systematic reviews are a comprehensive method to identify research gaps and relevant factors associated with intervention or context of delivery (Siddaway, Wood and Hedges, 2019). Therefore, for such research questions, I relied on systematic reviews rather than relying on conducting studies using primary data. More specific details about methods, including eligibility criteria, search strategy, selection of studies and data synthesis, are provided in chapters 4 and 5.

2.8 Semi-Structured Interviews

Primary data collected in the study was based on semi-structured interviews with i) faith leaders - those who reported providing support to people with mental illness - and ii) their attendees - those who received diagnosis by consultant psychiatrists (See Table 2.1). My philosophical position and the nature of the research questions led to the selection of semi-structured individual interviews as being most appropriate. My philosophical position focused

on valuing and understanding research participants. Individual interviews provide a better opportunity to interact more with research participants than focus groups. Also, the research questions were about their perspectives and experiences. Braun and Clarke proposed that individual interviews are well-suited for addressing research questions focused on perspectives and experiences (Clarke and Braun, 2017; Braun and Clarke, 2013). Also, the Adapt framework recommends early engagement of stakeholders during the assessment of the rationale for the suitability of intervention in the new context. Semi-structured interviews have the flexibility for interviewees to raise additional topics for discussion, which may have yet to be considered or anticipated by researchers. More specific details about interview methods, including participant characteristics, interview guide, and data analysis, are provided in chapters 6 and 7.

2.9 Qualitative Synthesis

Further, a synthesis of all qualitative data using an integrative synthesis was conducted. This synthesis was undertaken to get an in-depth understanding of the perspectives of faith leaders and their attendees. Integrative reviews bring together diverse perspectives rooted in different or similar paradigms, providing new insights (Cronin and George, 2023). Such reviews are particularly relevant to identify new insights and to gain a more in-depth understanding of the phenomenon under investigation. For more details about methods used in synthesis, see chapter 8.

2.10 Ethical Considerations

The research involves collecting data from human participants, including vulnerable groups—particularly those with depression and attending faith leaders. Thus, the research raises several ethical issues around informed consent, assessing capacity and obtaining consent, safeguarding, confidentiality, data processing and storage, minimising the research burden, and potential distress. Some of the notable ethical issues that emerged during research are summarised briefly.

Informed consent was taken from all study participants, and they were informed about study details in writing and, where applicable, orally. Participants were informed that they were free to withdraw their participation during the interview or to withdraw data before it was analysed. Participants, especially people with depression, were excluded if they were unable to respond to interview questions or were experiencing active suicidal ideation, as informed by their consultants. Any incident reported by those with depression which may have the potential to cause harm was instantly reported to a consulting psychiatrist for further course of action. Participants' confidentiality was maintained throughout the study by restricting access to identified data only to those involved in interviewing, transcription or analysis. However, before analysis, all identifying details were removed. Where required, identifiable data was

shared using secure York drop-off services in encrypted form. All identified data, such as recordings or consent forms, were stored on my personal computer in encrypted form and password protection. After transcription, these recordings were deleted. All other non-sensitive or unidentifiable data were stored in Google Drive. As participants with depression may experience distress during interviews, they were informed about routine care pathways to get support in case they felt distressed; this information was provided on the participant information sheet.

Ethical approval was obtained from the Health Sciences Research and Governance Committee (HSRGC) (Approval no. HSRGC/2022/498/D) (See Appendix 2.1) and the local ethics board at Khyber Medical University (KMU) (Approval no. DIR/KMU-EB/ET/000112/DR) (See Appendix 2.2). Ethical approval was obtained twice: before interviews with faith leaders and after amendments to data collection for interviews with faith leaders' attendees.

3 Chapter Three: Reflexivity and Positionality

Reflexivity refers to questioning and acknowledging personal assumptions, experiences, and beliefs, which can potentially introduce biases into the research process (Berger, 2015). It involves developing strategies to mitigate the influence of such factors while acknowledging our limitations. Aspects to consider include professional background, education, beliefs about gender, philosophical positioning, and emotional reactions towards research participants. Reflexivity is about mitigating bias and acknowledging one's role (or position) in the research process. During reflexive engagement, it is also essential for researchers to position themselves while simultaneously relating to research participants (Dodgson, 2019). While I had shared experiences with the study participants, including faith leaders and their attendees, it was difficult for me to position myself solely as an insider or solely as an outsider to the community I was researching. My shared experiences with this faith-based community have a temporal relation, and I have moved from "inside to outside" (Berger, 2015). Before starting my higher education, I was proactively engaged with a faith-based community and faith-based activities; however, as I entered higher education, my involvement in this community gradually decreased due to educational commitments. In this chapter, I discuss my views of being in a hybrid position, placing myself at the intersection of insider and outsider perspectives and frequently switching between them (Paechter, 2013). This chapter also discusses how my assumptions and beliefs have been transformed during this transition.

3.1 Educational Background and Work Experience

I have a master's degree in clinical psychology from the International Islamic University, Islamabad. I have attended numerous modules related to clinical psychology, including psychodiagnostics and psychotherapeutic interventions (covering cognitive and behavioural interventions). Also, I have completed modules related to applied research in clinical psychology, including advanced research methods and statistical analysis. My work experience, however, is focused more on research than clinical practice. I started my professional career as a research assistant on projects funded by the Higher Education Commission of Pakistan (i. RCT for evaluating the effectiveness of adapted CBT for problematic screen time, depression, and anxiety in adolescents and ii. mixed methods study for understanding stakeholders' perspectives on existing mental health laws in Pakistan). I have experience in collecting both quantitative and qualitative data. I am very interested in conducting quantitative data analysis, and I am trained in performing simple and complex statistical analyses. As a requirement for my master's degree, I translated, adapted, and validated an instrument to measure pathological narcissism and performed complex statistical analysis, including exploratory and confirmatory factor analysis for validation. I also have

experience performing quantitative data analysis as part of locally funded projects and scientific publications. However, my experience of research is not limited to quantitative research. In one of the previous research projects, I conducted face-to-face interviews with different stakeholders in mental health care, including people with mental illnesses, their caregivers, mental health specialists and policymakers. I also assisted with a thematic data analysis of those interviews. However, I am more of a quantitative-minded researcher as I value measurements and precision in the research process while also recognising that achieving absolute objectivity is impossible. I have less clinical experience than research; my clinical experience has been limited to internships as a part of my master's degree. During my clinical experience, I preferred focusing on behaviour over thoughts in understanding mental illness. My brief clinical experience showed me that engagement through activities is easier and more effective than discussing maladaptive thoughts, especially with people with low literacy, insight, and analytical abilities. My work as a researcher in mental health led me to this PhD, where I have been able to pursue these interests further.

3.2 Beliefs about Gender

I believe that some gender roles are socially constructed. I prefer to challenge those roles undermining access to social justice, transparency, and fairness. However, I think that some roles are biologically determined and are, therefore, difficult to transform. Recognition of the diversity of roles, mainly when these roles result in beneficial outcomes and do not impede justice and fairness, is essential for attaining gender equity, in my view. Furthermore, the rights and responsibilities of both genders should be observed together with a holistic approach, where one complements the other.

I grew up in a family where my parents valued daughters highly, particularly their education. I have noted some positive outcomes of educated women in my family, such as equal recognition and power, leadership and caregiving skills development, and better mutual understanding and respect. I am convinced that women's education will likely promote gender equality and personal and societal growth. Therefore, education may be even more important for women than for men. As most of my education after 10^{th} grade has taken place in a segregated gender education system, I occasionally find it difficult to interact with women in workplace settings. At the beginning of my career, when I took reflective feedback from female colleagues, they responded and described me as "reserved" and "introverted". However, I have similar interactions with male colleagues, except for a few closer to me. However, I must say that my interaction with women working in professional settings has improved and evolved. As part of my PhD, I needed to work with women, especially since all my supervisors were female and female participants were part of my sample. I have observed women with strong leadership and excellent human interaction skills, particularly during my PhD.

3.3 Religious Background

As an individual who identifies as a Muslim belonging to the *Sunni* sect, I have been influenced by my family's cultural identity in matters of religion. Sunni Muslims primarily follow the practices and traditions guided by Prophet Muhammad; may peace be upon him (PBUH). At the same time, the other sect of Muslims, known as *Shia*, emphasises the significance of the prophet's family in matters of leadership and succession. It is worth noting that both sects share common Islamic worship and practices. The majority of Muslims in Pakistan identify as *Sunni*, while a minority identifies as *Shia*. As someone associated with the *Tableeghi* Jamat, a missionary movement that emerged in the colonial Subcontinent, I believe in the fundamental value of preaching the Islamic faith to Muslims to help them become better and more practising Muslims.

3.4 Experience of Attending Faith Leaders and Practising Faith

I also consider faith as an essential element for mental well-being. In recent years, when I felt distressed, I found it helpful to practise my religion, including prayers, fasting and recitation of the Quran (The holy book of Muslims). This could reflect my belief that challenges, including illness, come with the will of Allah (God), and if I get closer to Allah, I can solve such issues. I attended one of my faith leaders (an Islamic scholar) when I was having obsessions and continuous thoughts while praying, which caused me significant distress. During my encounter with the Islamic scholar, I noticed that he used informal discussion to challenge my maladaptive assumptions. At the time, I believed the repetitive thoughts kept coming because I was a sinful person. However, the Islamic scholar explained with great confidence that this was a clear indication that I had faith and that satan was trying to demotivate and divert me. This encounter led me to contemplate how good some faith leaders are at using words to comfort people. Also, the religious authority provides an extraordinary position to make people believe in themselves.

I acknowledge that I do value faith for mental well-being. However, I believe in practising those components of faith which have some scientific evidence (such as prayers) in improving mental health issues. However, I also acknowledge that such evidence is contested. Also, magical explanations about mental illness, such as it is due to evil possession or a curse, are not aligned with my worldview. My personal religious experiences influenced my enthusiasm for the topic of my PhD. However, while informing my work, my religious beliefs do not contradict my scientific beliefs and reasoning.

3.5 Beliefs about 'Faith Leaders'

A wide range of terms are used for faith leaders in Pakistan, and they use many practices to help people with various issues, including faith, health, and relationships. One of the most well-known categories of faith leaders is called *Peer* in Urdu, and they are often known as spiritual leaders or saints in English (See Chapter 6: Table 6.1). Spiritual leaders

identify them as the successors of pious people and saints whose virtues and kindness are popular among the local community. Some people respect the successors of such saints because they believe that those saints were gifted with enlightenment that aids in healing people. Other types of faith leaders mainly include Islamic scholars (*Ulma e Karam* in Urdu) and prayer leaders (*Imam Masjid* in Urdu).

I may have a more positive attitude and liking towards faith leaders having strong connections within diverse communities, including the more educated. In day-to-day interactions with such faith leaders, they appear willing to embrace innovation. Also, in my interactions with young prayer leaders and Islamic scholars, I have informally observed that they are well-informed and have comparatively more flexibility towards considering new ideas. Some spiritual leaders focus on mysticism, which does not align with my worldview.

During the recent political crises in Pakistan, I have developed a more sceptical perspective on the role of faith leaders, particularly those involved in politics. While I do not oppose the application of fair religious principles in politics, my concern lies in balancing personal and political gains. My opinion of faith leaders is nuanced, and I approach engaging and interacting with them in research with respect but with a sceptical approach. Although I am interested in learning their views, I also take care to examine their motives and question their opinions.

3.6 Opinions and Expectations about Behavioural Activation

BA is a simple talk therapy focusing on overt behaviours and activities. BA also closely aligns with the Pakistani cultural context and Islamic context. For example, in the Quran, the word *Aamal* has been repeatedly used, and the meaning can be equated to "behaviours" or "deeds" (actions performed consciously). The emphasis in the Quran and Hadith (sayings and actions of prophet PBUH) is to change the activities and behaviour of individuals. The difference, however, between BA and suggestions in the Quran and Hadith is primarily around autonomy and morality. Islamic teachings tend to change behaviours by expediting moral authority and limiting one's autonomy, while the current understanding of BA values autonomy in choosing activities. The degree of autonomy is not absolute but rather culturally dependent. Therefore, if BA can be practised within Pakistani society, where culture shapes "autonomy," it may be a restricted worldview compared to the Western understanding of autonomy. However, if such limited autonomy is acceptable to end users (individuals who attend faith leaders), it goes within the philosophical principles of BA.

3.7 How My Beliefs and Background Could Potentially Affect My Research

Drawing from my experience with faith-based communities, a limited clinical background, and a strong inclination towards community-based approaches to research and practice, I am firmly committed to establishing non-institutionalised, accessible, and community-based service delivery pathways for tackling mental health problems at scale.

Multiple aspects of my background discussed above have potentially influenced my choice of research topic and questions, approach to study data collection and analysis and interpretation.

My identification as a S*unni* Muslim and connections with *Sunni* faith leaders facilitated approaching faith leaders with a *Sunni* background. At the same time, it has also created a few challenges in accessing faith leaders with a *Shia* background. Two of the 12 faith leaders I interviewed had a *Shia* background. As interview participants were selected conveniently, I had limited access to *Shia* faith leaders, given my background. However, as the *Shia* are a minority in Pakistan, there are fewer *Shia* faith leaders. I felt at ease discussing things in interviews with faith leaders, given that I knew most of the terms they use. However, during the interview with the *Shia* faith leaders, I could not help but wonder if he could recognise my beliefs/ sect simply by observing my appearance. I was cautious about uttering anything that might contradict his beliefs. Also, as I identified, I may feel hesitant in interacting with females; I was reluctant to interview female faith leaders directly, especially given that such female faith leaders were hesitant to speak to a man.

My belief in the moderate religious authority of some faith leaders (not all) and potentially unfavourable attitudes towards politically active and spiritual faith leaders might have influenced me during interviews, analysis, and interpretation of the data. Mainly, I was internally disagreeing (not verbally) whilst a few faith leaders were providing magical explanations for mental illness or were designating (in my view) too much respect and honour for their elder faith leaders or saints. This does not mean I do not respect elderly saints. Still, some stories associated with saints that were based on supernatural abilities perhaps go against my worldview of Islamic teachings.

Due to my identity as a healthcare researcher, I did not find any significant challenges in accessing and engaging with people with a history of contact with faith leaders while currently seeking care for depression in tertiary care. It was observed in the interviews that people who were seeking care at tertiary care openly expressed their experiences with faith leaders. In statutory mental health services in Pakistan, it is common to hold faith-based beliefs related to mental illnesses; therefore, it is less stigmatised than it might be in the West. My exposure to attending faith leaders during distress was similar to some faith leaders' attendees, who interpreted it positively. However, some of the participants expressed concerns related to autonomy and potential verbal abuse and showed antagonism towards faith leaders. Overall, I found it comparatively easier to interview faith leaders' attendees, perhaps because they were happy to answer questions and did so straightforwardly. The minor challenge I encountered was engaging people seeking care at tertiary facilities in interviews and using simple language to ensure their comprehension of the interview questions.

Lastly, my enthusiastic attitude while I link BA more closely to cultural and Islamic traditions might have influenced data analysis and recommendations. When coding, it is plausible that I focused on data fitting with the rationale of BA. However, to help mitigate this, I discussed the data and codes with fellow researchers (HJ), who also independently reviewed the codes. I took notes during interviews and discussed them with HJ, NS and SA to reflect on potential bias. I have provided study-specific details on reflexivity and how I tackled issues related to reflexivity in upcoming chapters focusing on primary data (See Chapters 6 and 7).

4 Chapter Four: Faith Leaders in Mental Health Pathways of Care in Pakistan: A Systematic Review and Meta-Analysis

4.1 Introduction

Mental illnesses are non-communicable chronic health conditions. Empirical evidence suggests an increasing burden of mental illnesses in the last two decades (James et al., 2018). Such illnesses are one of the leading causes of disability worldwide, accounting for about 418 million DALYs in 2019, representing approximately 16% of the global DALYs (Arias, Saxena and Verguet, 2022). The economic burden is estimated to be $5 trillion (Arias, Saxena and Verguet, 2022). Despite such a burden, only 36.8% of those with known mental illnesses seek help from professional healthcare workers in developed countries (Evans-Lacko et al., 2018). Access to formal mental health services in LMICs is even more challenging, where only 12% of those with mental illnesses seek professional care (Evans-Lacko et al., 2018). The most prominent factors which hinder accessibility include lack of awareness, social stigma, financial constraints, and the influence of sociocultural and religious factors (Muhorakeye and Biracyaza, 2021). Cultural and religious attributions for mental illnesses impact individuals' help-seeking behaviour, further complicating access to mental health services and treatment outcomes (Shafiq, 2020). In many cases, individuals initially turn to complementary practitioners such as faith leaders (Khoso et al., 2018).

Recent studies have highlighted that individuals with mental illnesses often have a first encounter with faith leaders to get support, which is associated with a delay in getting formal treatment (Jain et al., 2012; Jilani et al., 2018). A systematic review reported that about 48% of people with some mental illness initially attend informal health services such as faith leaders (Burns and Tomita, 2015). Similarly, another systematic review indicated that a substantial percentage of individuals with psychosis (60–81%) attended faith leaders as the first point of contact for seeking care, leading to a longer duration of untreated psychosis in LMICs (Lilford, Wickramaseckara Rajapakshe and Singh, 2020). These reviews, though, were specific to particular regions and disorders. For instance, Burns and Tomita (2015) exclusively included studies from African countries, and Lifford and colleagues (2020) focused solely on psychosis, restricting their review to LMICs.

Faith healing practices vary a lot from region to region depending upon cultural, social, legal, and religious traditions in the context of mental health. For example, African practices involve ancestral spirits and rituals (Kpobi and Swartz, 2019), while in South Asia, practices emphasise ayurveda (Narayanaswamy, 1981), and Islamic *Sufi* traditions (spiritual and saints tradition) (Charan et al., 2020). In Africa, governments have formally recognised and legalised faith healing in some countries, while faith healing is unregulated in other low-resource

jurisdictions such as South Asia (Street, 2016). In Pakistan, faith leaders often rely on religious, spiritual, and faith-based worldviews to conceptualise and manage mental illnesses (Khan et al., 2023). Mental illnesses are often attributed to the influence of *jinn* or *saya* (invisible creatures or shadows), magic and curse (Shafiq, 2020). People with different mental illnesses contact faith leaders, and faith leaders use a diverse range of practices such as prayers, exorcism for possession and recitations of holy verses (Saeed et al., 2000).

Research in Pakistan has focused on the percentage of people with mental illnesses attending faith leaders. To date, there are several studies conducted suggesting a significant percentage of people with mental illnesses attend faith leaders in Pakistan (Khoso et al., 2018). However, estimates are heterogeneous. For example, two studies conducted in urban hospital settings revealed varying proportions of people with mental illnesses having lifetime or first contact with faith leaders, ranging from 32% to 42% (Khoso et al., 2018; Chaudhry et al., 2017). Notably, most such studies have generally focused on mental illnesses as a whole rather than examining specific mental illnesses (Abidi et al., 2011). However, a few studies have looked at either psychosis or depression and found that a higher percentage of people with psychosis seek help from faith leaders (Ahmad, Khalily and Hallahan, 2017) compared to those with depression (Afridi, Siddiqui and Ansari, 2009). Without a comprehensive review, it is unclear from these studies how many people with mental illnesses, or some specific mental illness have any contact with faith leaders. No comprehensive review has been conducted of studies from Pakistan to explore the mental health care pathways involving faith healing.

In the context of this dissertation, a comprehensive understanding of how people with mental illness currently access mental health care, including consulting faith leaders, is required. This will help inform considerations of the feasibility of BA delivered by faith leaders and adjustment of care pathways. Further, examining how common is it for people with mental illnesses who attend healthcare facilities to have previous contact with faith leaders in Pakistan.. Moreover, it is important to understand the specific characteristics of the population presenting to faith leaders, such as the types of mental illnesses (including depression), as well as the socio-demographic characteristics of this population. This will allow us to understand the training needs for example training for identifying and managing different mental illnesses including depression and considering which age group or gender to target if any.

Considering the gaps in the literature, I conducted a systematic review focusing on pathways of care for mental illnesses and specifically depression, focusing on consultations with faith leaders. I have also considered the various contexts in which research has been

conducted, the population's demographic and clinical characteristics, and whether the contact with faith leaders investigated was the ‘first contact’ or ‘any contact during a lifetime’.

4.2 Aims and Objectives

My main objective in this systematic review was to explore the pathways to accessing mental healthcare in Pakistan to understand how common it is for people attending statutory health services to have also consulted faith leaders for their mental illness. Specifically, in people with mental illnesses attending formal healthcare services, what proportion have previously attended:

I. Faith leaders, for the first time for their mental illness.
II. Faith leaders ever during their lives.
III. Formal healthcare service providers (without encountering faith leaders), including general practitioners and mental health specialists, to seek support for their mental illness.

I also aimed to explore the associated demographic characteristics (such as gender and age) of the population that had consulted with faith leaders.

4.3 Methods

The preferred reporting items for systematic reviews and meta-analyses 2020 (PRISMA) were used for reporting this paper. The protocol for this systematic review was registered at the International Prospective Register for Systematic Review - PROSPERO (Reg. No. CRD42023448550). The details of the methods are given below:

4.3.1 Search Strategy

Four databases were searched from inception until July 2023: MEDLINE (Ovid interface: 1946 to July 21, 2023), APA PsycINFO (Ovid interface: 1806 to July Week 3, 2023), Embase (Ovid interface: 1974 to July 20, 2023), and PakMediNet (Inception to July 23, 2023). Search strategies used for MEDLINE, PsychINFO and Embase, comprised of a combination of free text words and subject headings, encompassing synonyms, alternatives, and database-specific subject heading(s) for "faith healers," such as "faith heal*" or "traditional heal*". I restricted records only to Pakistan by including the free text term in the search, i.e., "Pakistan*" (See Appendix 4.9: Search History).

Some local journals in Pakistan are not indexed on major medical databases such as MEDLINE. PakMediNet is a local database containing data from medical journals in Pakistan. PakMediNet database lacks support for complex search queries, truncation, wildcards, and subject headings features. While it does offer Boolean operators, using them resulted in a few records. Subsequently, I searched for terms related to "faith healing" individually. To be comprehensive, I also examined the reference lists of previous reviews (Lilford,

Wickramaseckara Rajapakshe and Singh, 2020; Burns and Tomita, 2015; Nortje et al., 2016; van der Watt et al., 2018) that focused on faith healing and Pakistani journals related to psychology that PakMediNet did not cover.

4.3.2 Inclusion and Exclusion Criteria

4.3.2.1 Study Design

Any published or unpublished study reporting quantitative data, including but not limited to randomised control trials, cohort, case-control, cross-sectional, and mixed methods. Studies reporting data only from the Pakistani context were eligible. Also, studies in English and Urdu (the local language in Pakistan) were considered for inclusion.

4.3.2.2 Settings and Population

Studies were eligible if conducted in any healthcare settings, including community, primary, secondary, and specialist healthcare and included participants:

I. Who were receiving care from formal healthcare workers, including only those with mental illnesses who gave retrospective reports regarding their previous visit(s) to faith leaders (or the range of other terms used for them) or formal healthcare workers.

II. Diagnosed or identified with any mental illnesses categorised by the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5 TR) or equivalent through standardised diagnostic interviews, screening tools, or clinical judgement conducted by healthcare workers.

III. Having any co-comorbid mental or physical illnesses belonging to any age group or socio, economic and demographic factors.

Studies were excluded if researchers directly reached out to faith leaders and identified the prevalence of people with mental illnesses in faith leaders' settings. The decision to exclude such studies was because recruiting people from healthcare settings ensured that there was an accurate diagnosis or identification of mental illness as opposed to self-reported in the general population or faith leaders' settings.

4.3.2.3 Outcome

Faith healing was explicitly defined as practices rooted in religious, spiritual, and magical traditions intended to support individuals dealing with mental illnesses (Nortje et al., 2016). The outcome of this review was the proportion of people with any mental illnesses who attended faith leaders to get support for their illness. All studies, irrespective of the timing of the visit to seek the faith leaders' support for mental illnesses, were eligible.

4.3.3 Study Selection

I initially screened all the identified records, and excluded records were cross-checked by an independent reviewer at the title screening stage. Subsequently, two reviewers

independently screened full texts for eligibility and resolved any discrepancies through discussion. In case of any unresolved disagreement after discussion, a senior reviewer was invited to make the final decision.

One important part of the study selection was to ascertain who qualifies as a faith leader. I (and other reviewers) used a systematic approach to identify studies relevant to faith leaders. Firstly, I examined whether the authors explicitly used the term "faith healer or leader" in their studies. If this term was present, it served as an indication of the involvement of faith leaders in the study. However, recognising the potential variability in terminologies for faith leaders, I also examined studies to identify any local terms that could be synonymous with the concept of faith leaders. For example, I looked for terms such as *Imam* (Prayer leader) or *Peer* (Spiritual leader). In the review, I then compared the definition of such terms provided in the studies with the definition of faith leaders I am following in this thesis. This comprehensive approach aimed to capture the diverse range of terminologies associated with faith healing practices and ensure no relevant information was overlooked.

4.3.4 Data Extraction and Quality Assessment

I developed a data extraction form, which was tested with the first two studies and further adjusted. The data extraction form covered comprehensive details, including the authors, publication year, and study design (such as cross-sectional). Participant-related data, such as sample size, demographic characteristics (age, gender, etc.), settings, and clinical characteristics (diagnosis etc.), were also extracted. Detailed information about the study data collection methods was also recorded, including the standardised diagnostic interviews, screening tools, or clinical assessments used to diagnose or screen for mental illness. I extracted the proportion of people who reported that they previously sought support for their mental illness and depression (where available) by attending: i) faith leaders for the first time, ii) faith leaders ever in their life before accessing formal healthcare services and iii) healthcare professionals without encountering faith leaders.

The Systematic Assessment of Quality in Observational Research (SAQOR) tool was used to assess the quality of the included studies (Ross et al., 2011). This tool has been used successfully in previous reviews focused on traditional and faith leaders' roles in pathways to care for individuals with mental illnesses in African countries (Burns and Tomita, 2015). The SAQOR tool comprises six dimensions: sample, control, exposure or intervention, follow-up, distorting influence, and reporting. All studies were based on a cross-sectional design – in which data were collected at a one-time point without any comparison group. The control dimension in SAQOR checks on the potential bias emerging due to the presence of unmatched groups based on the characteristics of the participants, while the follow-up dimension focuses on potential biases due to drop-outs and premature timings of the

outcomes. I did not present those two dimensions in the results, as the identified studies had no control groups or follow-up assessments. Two reviewers independently assigned each dimension a rating from four categories, namely 1) adequate, 2) unclear, 3) inadequate, and 4) not applicable. Subsequently, by evaluating all dimensions, each study was categorised into one of the following overall quality levels: 1) very low, 2) low, 3) moderate, or 4) high, reflecting the study's overall methodological rigour and quality. Criteria for the overall quality of studies are as follows:

I. Very low quality: At least one dimension is inadequate.
II. Low: Either all are rated as unclear, or at least two are adequate, and the remaining are unclear.
III. Moderate: At least three dimensions are rated as adequate, with no dimension rated as inadequate.
IV. High quality: All dimensions are rated as adequate.

Two independent reviewers (MMB and AK) performed the data extraction and quality assessment. Any discrepancies in extraction or ratings between the two reviewers were resolved through discussion. The senior researcher was invited to make the final decision if consensus was not achieved through discussion.

4.3.5 Data Synthesis

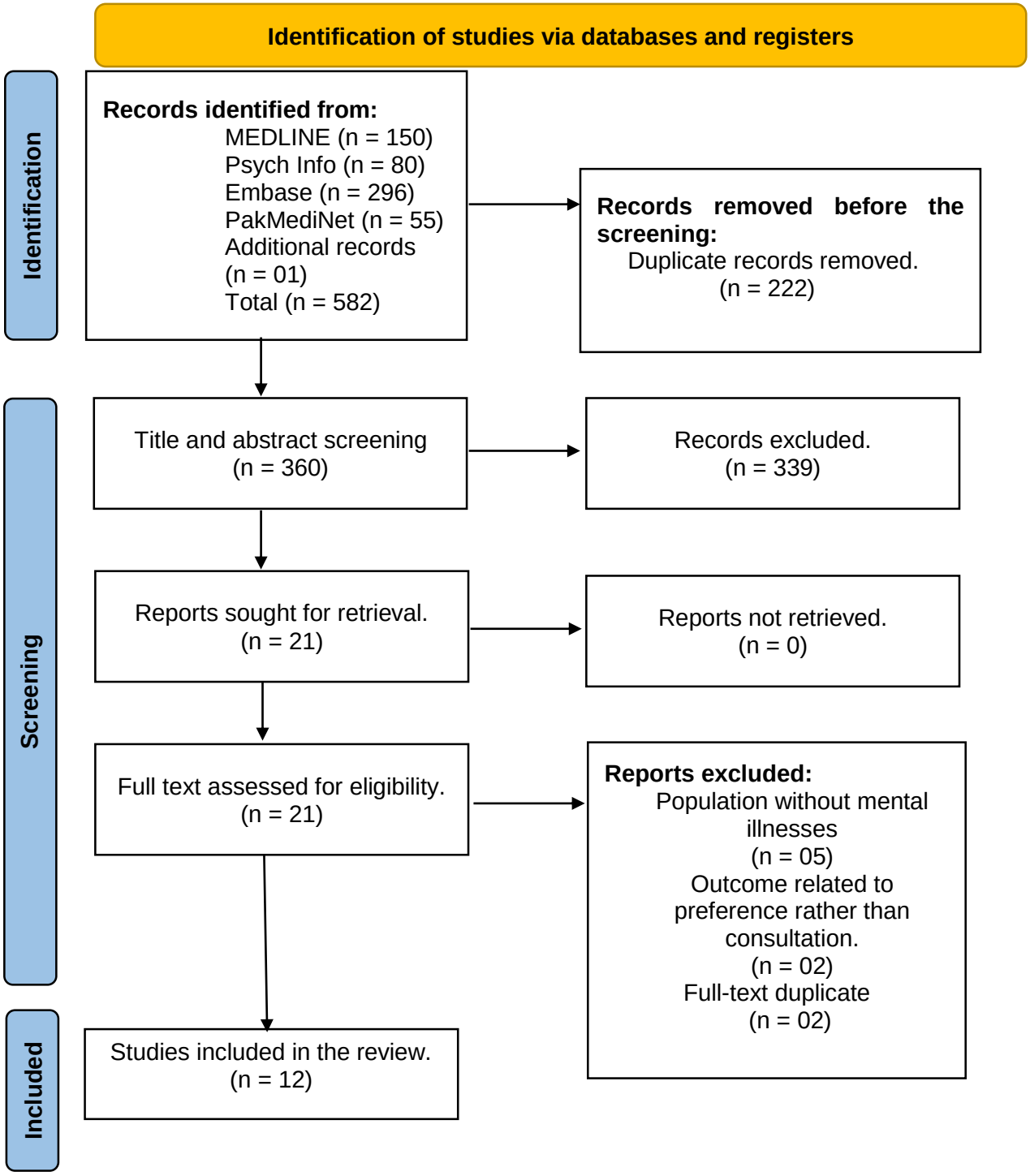
A narrative synthesis was presented by summarising participants, assessment measures and study-specific proportions using narration and tabulation. Meta-analysis was performed by using the "metaprop" command (Nyaga, Arbyn and Aerts, 2014) in STATA (Version 17). To address potential issues related to extreme study-specific proportions (falling closer to 0% or 100%) and to keep the confidence interval limit associated with pooled estimates within the 0 to 1 limit, I applied the Tukey and Freeman double arcsine transformation method by using the “ftt” command (Chen et al., 2023). For the estimation of the pooled prevalence, I used the random-effects model. Heterogeneity among the studies was quantified using the I^2 statistics, which is used to assess the degree of variability between the study results. I performed a sensitivity analysis to examine the robustness of pooled estimates by excluding studies with “very low” and “low” quality. Subgroup analysis was based on “first contact” with or “ever attended” faith leaders reported by authors in studies. Meta-regression was performed by taking gender, age and study years as covariates and pooling contact estimates with faith leaders. Publication bias was assessed using a funnel plot and the Egger test.

4.4 Results

4.4.1 Selection and Characteristics of Studies

I identified 582 records from the databases and hand searches. After deduplication, 222 records were excluded, and 360 titles and abstracts were screened. Subsequently, 339 records were excluded from the title and abstract screening, and I sought 21 full-text reports. I examined 21 full texts for eligibility. Nine records at the full-text stage were excluded for multiple reasons, such as studies involving participants with only physical/ medical conditions (N = 5), studies focusing on preference for formal or informal help for mental illness rather than previous consultation (N = 2) and full-text duplicates (N = 2) (See Figure 4.1). Twelve records met the eligibility criteria and were included in the review.

Figure 4.1: PRISMA Flow Chart



I extracted data from 12 studies, including 3267 participants with approximately equal representation of males (n=1505; 46.06%) and females (n=1671; 51.14%). All studies were cross-sectional; 11 studies were conducted in urban cities, including Lahore (N = 4), Karachi (N = 4), Islamabad (N = 2) and Peshawar (N = 1), while one was in a rural town. Most studies were conducted in secondary or tertiary care (N = 10), mainly including psychiatric departments in private and public hospitals; the remaining two were based in primary care and community settings. Studies mainly involved cohorts with mixed diagnoses of mental illnesses (N = 7), including two studies which provided separate results for depression. Few studies focused on specific disorders such as depression (N = 2), schizophrenia (N = 2) and dissociative disorder (N = 1). The studies commonly used informal assessment of mental illnesses using case histories, hospital records, and clinical judgement to inform diagnosis (N = 6). Standardised tools to assess mental illnesses, including retrospective assessment of the onset of schizophrenia (IRAOS) (N = 1), positive and negative syndrome scale (PANSS) (N = 1) and mini-international neuropsychiatric interview (MINI) (N = 1) were noted in three studies only. Three studies provided no information on how participants were assessed for the presence of any mental illness.

All studies indicated that participants had contact with faith leaders. Of the studies reporting attendance, eight did not differentiate whether it was the first contact or not. Four studies clearly mentioned that participants had first contact with faith leaders. Seven studies reported contact with general practitioners and mental health specialists during individuals' lifetime. Studies (N = 9) widely used past psychiatric history, demographic or semi-structured questionnaires to assess treatment history, while three used pathways to care questionnaires.

4.4.2 Quality Assessment

Two studies were categorised as “very low” in quality, as such studies provided little or no information relating to two or more dimensions, including i) how participants were approached, recruited, and identified, ii) any formal or informal assessment to inform diagnosis, iii) inclusion/ exclusion criteria and iv) inadequate reporting (result section lacks sufficient details regarding specific measures outlined in the method section). Three studies were of “low quality”, given that they lacked clarity in participant assessment and were susceptible to distorting influences. Four studies were “moderate”, though they provided information regarding informal assessment but did not use any standardised tool to corroborate positive cases or diagnoses. The remaining three studies were of high quality (See Table 4.2).

4.4.3 Narrative Summary

Overall, individuals more commonly approached faith leaders and general practitioners for support compared to mental health specialists. Considerable heterogeneity in help-seeking behaviour, however, was evident for all three categories, including contact with faith leaders (15% to 96%), general practitioners (5% to 89%) and mental health specialists (0 to 43%). The highest percentage of people who had previously attended faith leaders (96%) was noted for the study including participants diagnosed with schizophrenia. Similarly, the lowest percentage identified for people attending faith leaders (15%) previously was also noted for people with schizophrenia; however, unlike the study presenting the highest percentage, study with lowest highlighted that those people had their first contact with faith leaders in seeking help for their mental illness. Both of the studies which included participants with depression exhibited comparatively higher percentages of those who previously contacted general practitioners (i.e. 89% and 66%). Few studies (N = 6) reported those people with mental illnesses who previously attended mental health specialists. Notably, one study reported no such people who had contacted specialists previously. Again, the highest proportion of those who attended specialists previously was for participants diagnosed with schizophrenia (i.e. 43%) (See Table 4.1)

Table 4.1: Characteristics of Included Studies (N = 12)

Authors and Year	Settings, City	Participants	n (%Female)	Age M (SD)	Assessment	Contact History with FL	Pathways of Care		
							FL (%)	GP (%)	MHS (%)
(Farooqi, 2006) *	Psychiatry departments, Public hospitals, Lahore	Individuals with mental illnesses	87 (40)	-	Case history interview schedule and hospital records	Ever attended	21	-	-
(Mirza et al., 2006)	Community mental health team, Choti	Depression	107 (75)	38.14	Diagnosed by a psychiatrist based on clinical judgment. Semi-structured questionnaire on previous treatment	Ever attended	46	89	-
(Afridi, Siddiqui and Ansari, 2009)	Private hospital, Karachi	Depression	1165 (43)	35 (5.6)	Physical and mental examination and detailed treatment history	Ever attended	16	66	-
(Naqvi et al., 2009)	Psychiatry department, Private hospital, Karachi	Schizophrenia	93 (41)	35 (10.4)	Interview for the retrospective assessment of the onset of schizophrenia (IRAOS), detailed psychiatric history and pathway to care questionnaire	First	15	5	43
(Abidi et al., 2011)	Psychiatric OPD, Private hospital, Karachi	Individuals with mental illnesses	531 (58)	32.1 (12.1)	-	First	19	34	37
(Ahmad, Khalily and Hallahan, 2017)	Psychiatry departments, Public and private hospitals, Peshawar	Schizophrenia	55 (20)	31.78 (8)	The positive and negative syndrome scale (PANSS) and treatment history	Ever attended	96	-	-
(Chaudhry et al., 2017)	Psychiatric OPD,	Individuals with mental illnesses	191 (28)	31 (15.02)	It does not mention how patients were diagnosed, but health-seeking practices	Ever attended	20	42	3

	Public Hospital, Lahore				were measured through a structured questionnaire.				
(Aslam et al., 2018)	Primary Care, Lahore	Individuals with mental illnesses	282 (68)	41.2 (15.1)	The mini-international neuropsychiatric interview (MINI) and treatment history	Ever attended	33	-	0
(Khoso et al., 2018) *	Psychiatric OPD, Public Hospital, Karachi	Individuals with mental illnesses	219 (47)	36.5 (13.8)	Semi-structured interviews by residents in psychiatry	Ever attended	32	-	-
(Mansoor and Mansoor, 2018)	Psychiatry department, Private hospital, Islamabad	Individuals with mental illnesses	246 (61)	-	It is unclear how patients were diagnosed, but past psychiatric history and demographic details were recorded using a questionnaire.	First	38	23	10
(Khan et al., 2019)	Psychiatry department, Private hospital, Islamabad	Individuals with mental illnesses	231 (72)	-	Demographics and care pathways were recorded using a questionnaire, with no information regarding the diagnosis.	Ever attended	45	5	-
(Farooq et al., 2022)	Psychiatry departments, Public hospitals, Lahore	Dissociative disorder	60	25.75 (11.19)	Diagnosed by consultant psychiatrists and past psychiatric history	First	63	-	25

Note. Fem = Females; FL = Faith leaders; GP = General practitioners; M = Mean; MHS = Mental health specialists; N = Sample size; OPD = Outpatient Day; SD = Standard deviation; Studies with * provided focused on overall mental illnesses but also provided separate results for depression.

Table 4.2: Quality Assessment of Included Studies Using Systematic Appraisal of Quality in Observational Research (SAQOR) tool (N = 12)

Authors and Year	**Sample** (Adequate, Unclear, Inadequate)	**Exposure/ Outcome** (Adequate, Unclear, Inadequate)	**Distorting Influences** (Adequate, Unclear, Inadequate)	**Reporting of data** (Adequate, Unclear, Inadequate)	**Overall Rating** (High, Moderate, Low, Very Low)
(Farooqi, 2006)	Adequate	Unclear	Adequate	Unclear	**Low**
(Mirza et al., 2006)	Adequate	Adequate	Unclear	Adequate	**Moderate**
(Afridi, Siddiqui and Ansari, 2009)	Adequate	Adequate	Unclear	Adequate	**Moderate**
(Naqvi et al., 2009)	Adequate	Adequate	Adequate	Adequate	**High**
(Abidi et al., 2011)	Adequate	Unclear	Unclear	Unclear	**Low**
(Ahmad, Khalily and Hallahan, 2017)	Adequate	Adequate	Adequate	Adequate	**High**
(Chaudhry et al., 2017)	Unclear	Unclear	Inadequate	Inadequate	**Very low**
(Aslam et al., 2018)	Adequate	Adequate	Adequate	Adequate	**High**
(Khoso et al., 2018)	Adequate	Adequate	Unclear	Adequate	**Moderate**
(Mansoor and Mansoor, 2018)	Adequate	Adequate	Unclear	Adequate	**Moderate**
(Khan et al., 2019)	Adequate	Inadequate	Inadequate	Unclear	**Very low**
(Farooq et al., 2022)	Unclear	Unclear	Unclear	Adequate	**Low**

4.4.4 Pooled Proportion of Individuals with Mental Illnesses Attending Faith Leaders

I performed a meta-analysis to examine the pooled prevalence of individuals with mental illnesses who attended faith leaders. Overall, this meta-analysis included 12 studies (n = 3267), including two groups:

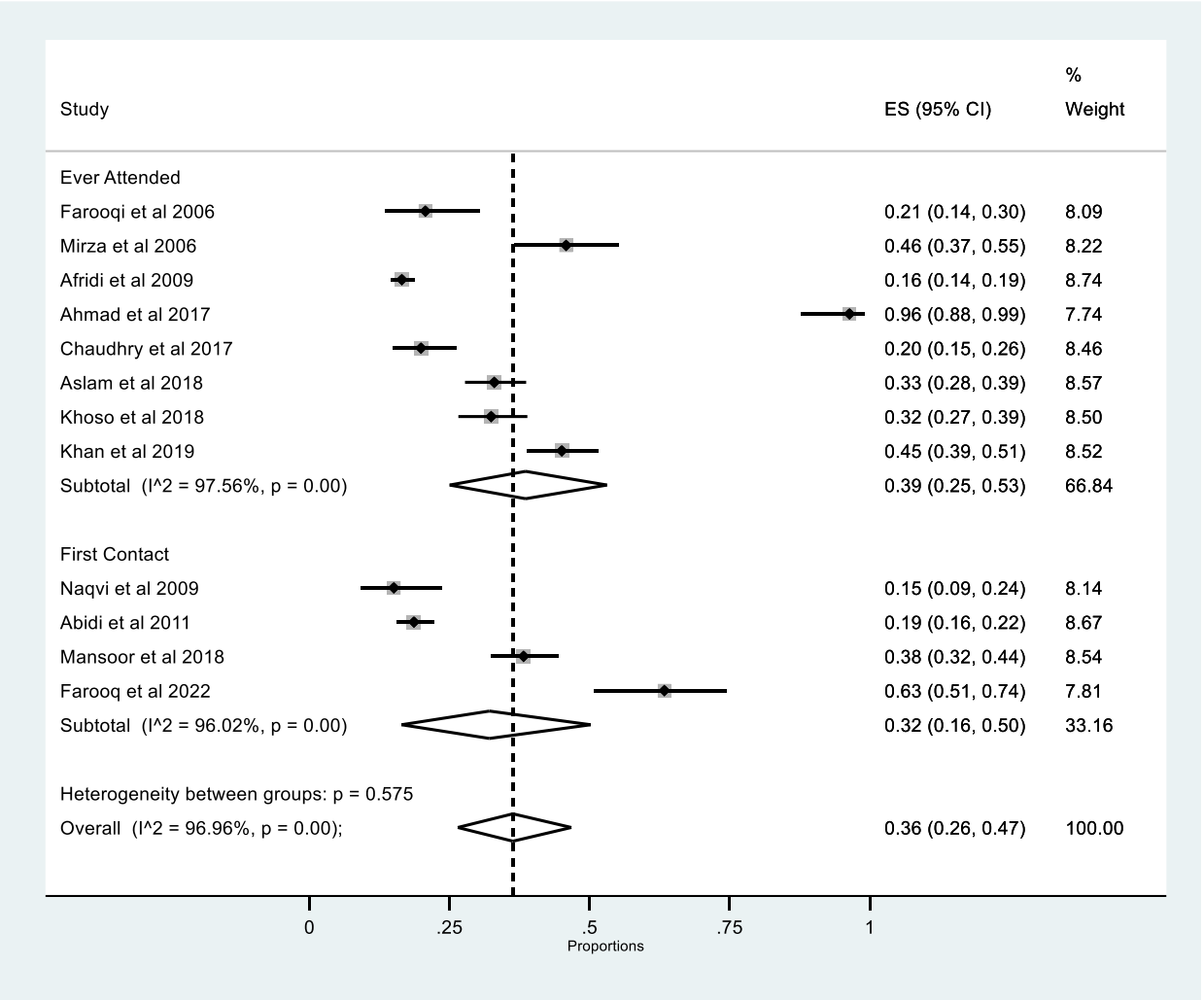
I. Four studies reported on people with mental illnesses (n = 930) who had their first contact with faith leaders.
II. Eight studies reported on people with mental illnesses (n = 2337) without distinguishing whether it was a first contact or not.

Figure 4.2 represents the overall pooled estimate of contact with faith leaders regardless of considering the aforementioned subgroups – see the overall estimate. This figure also presents the separate pooled estimates for both subgroups – see the subtotals.

The overall pooled proportion of people with mental illnesses who previously attended (including both first-contact and ever-attended) faith leaders was 36% (95% C.I. = 26-47), with substantial heterogeneity between studies (I2 = 96.96%; p = .00) (See Figure 4.2 – Overall Estimate). After removing five studies identified as either “very low” or “low” quality, only a +4% change in the overall pooled proportion of people attending faith leaders was observed (See Appendix Figure 4.1). A funnel plot based on study estimates for contact with faith leaders indicated apparent asymmetry. Subsequently, the Egger test formally showed the presence of publication bias (beta1 = 4.21; p = 0.005) (See Appendix Figure 4.5). This finding suggests a statistically significant positive association between the estimates of proportions and standard errors in the studies. It indicates that studies reporting comparatively higher proportions also tended to have higher standard errors. In other words, studies with greater heterogeneity are likely to exhibit high proportion estimates.

Further, I found that 32% (95% C.I. = 16-50) of individuals with mental illness had their first contact with faith leaders. On the other hand, 39% (95% C.I. = 25-53) of individuals with mental illness had ever attended faith leaders. I noted substantial heterogeneity for both subgroups, including first contact (I2 = 96.02%; p = .00) and ever attended (I2 = 97.56%; p = .00) (See Figure 4.2 – Subtotals). All four studies in the first contact group were based in psychiatry departments in hospital settings. In comparison, eight in the ever-attended group included six studies in hospitals, one in primary care and one in community settings (See Table 4.1).

Figure 4.2: Pooled Proportion of Individuals with Mental Illnesses Attending Faith Leaders



4.4.5 Contact with Faith Leaders by Sex, Age and Publication Year

I conducted a meta-regression analysis, incorporating three covariates or moderators: sex (coded as the number of females for each study), age (coded as the mean age in years reported in each study), and publication year (e.g., 2004, 2005, etc.). I aimed to examine the influence of these covariates on the pooled proportion of individuals with mental illnesses who sought support from faith leaders (including both first and ever contacted). All studies reported the number of females and publication year, while the mean age for the three studies was not reported (See Table 4.1). Three regression models were run for those three covariates separately. I found no evidence of an association between sex (Coefficient for female = -0.0006; p = 0.10), age (Coefficient = -0.0166; p = 0.413) and year (Coefficient = 0.0183; p = 0.079) with the proportions of people attending faith leaders (See Table 4.3).

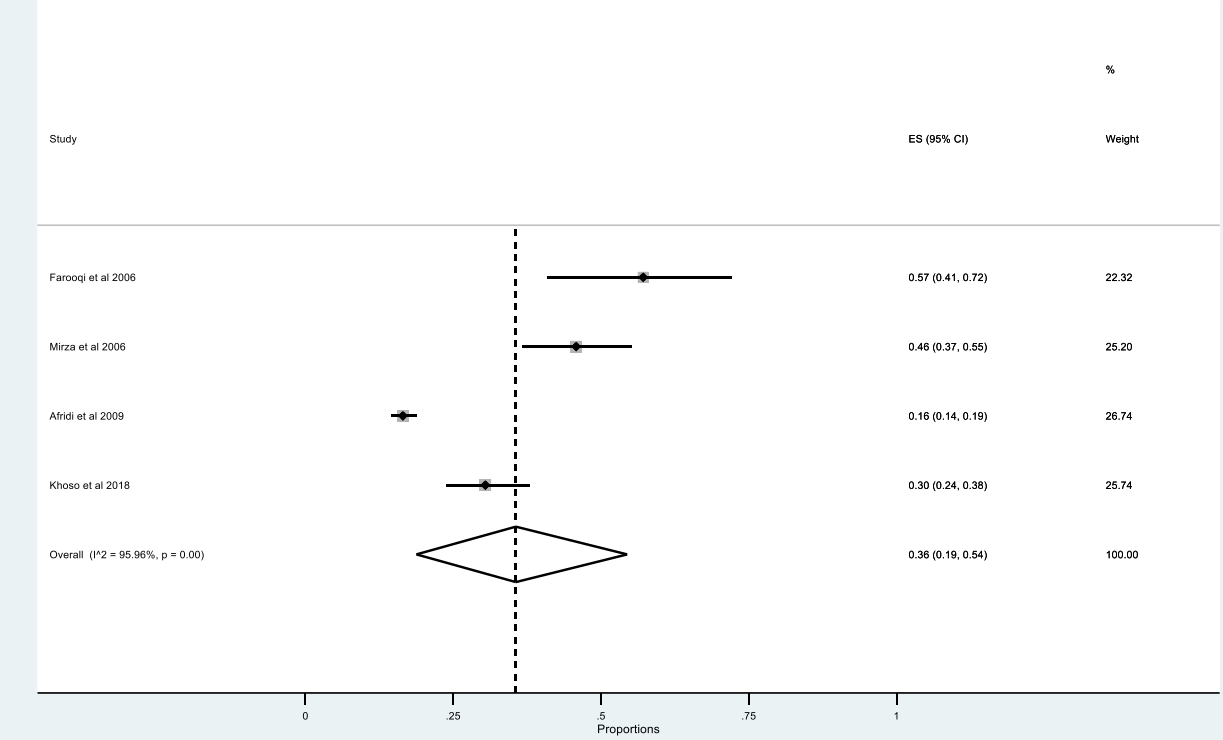
Table 4.3: Meta-regression: Association between Sex, Age and Study Year with Pooled Estimate of Contact with Faith Leaders

Covariates	Coefficient	Z	P	95% conf. interval	
				LL	UL
Sex (number of studies = 12)					
Female	-0.0006	-1.60	0.10	-0.0013	0.0001
Constant	0.4477	5.46	0.000	0.2870	0.6085
Age (number of studies = 09)					
Age	-0.0166	-0.82	0.413	-0.0566	0.0232
Constant	0.9323	1.33	0.185	-0.4458	2.3105
Year (number of studies = 12)					
Year	0.0183	1.76	0.079	-0.0021	0.0388
Constant	-36.6833	-1.74	0.082	-77.9912	4.6246

4.4.6 Pooled Proportion of Individuals with Depression Attending Faith Leaders

Four studies (n = 1468) reported the proportion of people with depression who previously attended faith leaders; all of them did not specify whether this contact was first or not. All four studies were conducted in psychiatric departments in hospitals, except for one in community settings. After combining those studies, the pooled prevalence of individuals with depression who ever attended faith leaders was 36% (95% C.I. = 19-54) with substantial heterogeneity (I2 = 95.96%; p = 0.00) (See Figure 4.3). I found -6% change after removing the study with low quality (See Appendix Figure 4.2). The funnel plot indicated asymmetry; however, the Egger test was significant, showing potential publication bias (Beta1 = 3.34; p = 0.002) (See Appendix Figure 4.6).

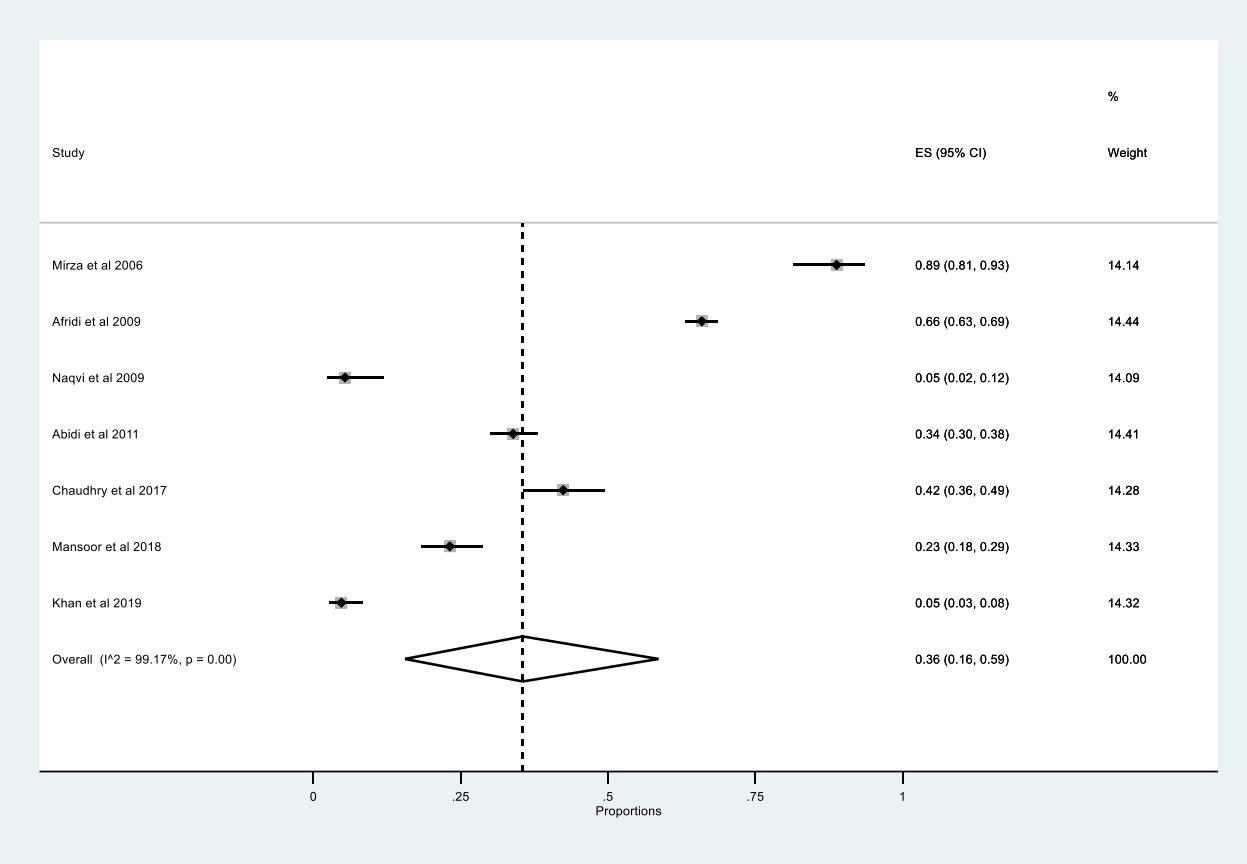
Figure 4.3: Pooled Proportion of Individuals with Depression Attending Faith Leaders



4.4.7 Pooled Proportion of Individuals with Mental Illnesses Attending General Practitioners

Further, I combined estimates from 7 studies (n = 1014); those studies reported on the proportion of people attending general practitioners and the proportion of those attending faith leaders. All those studies were conducted in hospitals except for one in community settings. I noted 36% (95% C.I. = 16-59) of people with mental illness who ever consulted general practitioners during their lifetimes without any encounter with faith leaders. Substantial heterogeneity was associated with this pooled estimate (I2 = 99.17%; p = .00) (See Figure 4.4). After removing studies of “low” or “very low” quality, a +8% increase in pooled estimates was observed (See Appendix Figure 4.3). The funnel plot showed asymmetry (See Appendix Figure 4.7), but no publication bias was observed (Beta1 = -1.36; p = 0.790).

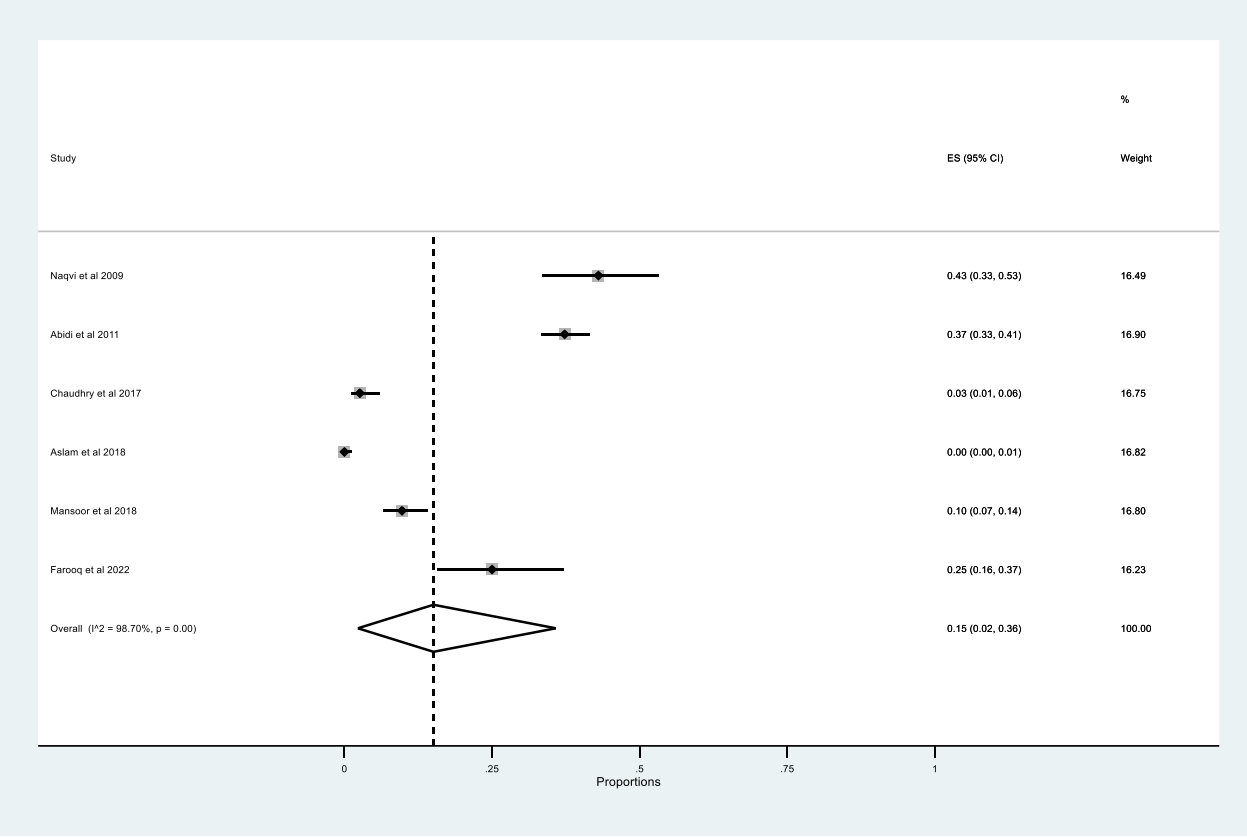
Figure 4.4: Pooled Proportion of Individuals with Mental Illnesses Attending General Practitioners



4.4.8 Pooled Proportion of Individuals with Mental Illnesses Attending Mental Health Specialists

Only six studies (n = 282) reported contact with mental health specialists besides contact with faith leaders and general practitioners, all conducted in psychiatry departments in hospitals, except for one conducted in primary care settings. The pooled proportion of people with mental illness who ever consulted mental health specialists previously without encountering faith leaders was 15% (95% C.I. = 2-36), with substantial heterogeneity between study estimates (I2 = 98.70%; p = .00) (See Figure 4.5). After removing low-quality studies, I found a -3 % change in pooled proportion (See Appendix Figure 4.4). No evidence for publication bias was found (Beta1 = 1.53; p = 0.608) (See Appendix Figure 4.8).

Figure 4.5: Pooled Proportion of Individuals with Mental Illnesses Attending Mental Health Specialists



4.5 Discussion

This is the first review focusing on the role of faith leaders in pathways to mental health care in an Asian Pakistani context. Previous reviews focused predominantly on East and West African countries or LMICs, with a specific focus on psychosis only (Burns and Tomita, 2015; Lilford, Wickramaseckara Rajapakshe and Singh, 2020). In summary, my findings indicated that a considerable proportion of individuals (i.e., 36%) presenting to mental health services had also attended faith leaders for a range of mental illnesses (schizophrenia, depression, dissociative, etc.) in Pakistan. Notably, this percentage is similar to the proportion of individuals who had previously attended general practitioners (36%). Further, findings also indicated that estimates for the proportion of individuals attending faith leaders were not associated with gender, age, or year of publication.

This review also indicated that individuals with mental illnesses having first contact with faith leaders (i.e. 32%) to get support for their illness is also substantial. However, it is lower compared to that reported (48.1%) for first contact with religious healers in African countries (Burns and

Tomita, 2015) and suggests regional variations between estimates of people having first contact with faith leaders. Notably, research interest in faith healing among African healthcare professionals shows potentially higher acceptance of faith leaders and their efforts to bring faith healing into the formal domain. Numerous efforts have been made to formalise faith healing practices in the Western African regions, for example, forming associations of traditional and faith leaders and establishing conventional and alternative medicine divisions under the Ministry of Health in Ghana (Kpobi and Swartz, 2019). However, little or no efforts have been explicitly made in Pakistan to formalise or collaborate with faith leaders in mental health care until recently (Farooq et al., 2023). Such practices have remained under-researched and unregulated (Mushtaq, 2019). Further evidence is required to understand what potential barriers have inhibited researchers, policymakers, and practitioners from developing working relations with faith leaders. Studies documenting faith leaders' and healthcare professionals' attitudes and views, focusing on developing possible collaboration, have been largely overlooked in Pakistan in contrast to the African region (Green and Colucci, 2020).

Since all the studies were based in healthcare settings, including i) psychiatry departments in hospitals, ii) primary care, and iii) community mental health services, estimates for people whom ever or first time attended faith leaders in this review might be underestimated. Therefore, such findings might not reflect population-based estimates and cannot be generalised to non-healthcare settings. All of the studies, except for one, were based in major cities and urban settings; only one was found in rural communities. People living in rural settings have more difficulties accessing specialised mental healthcare services. In contrast, most government and public sector mental health facilities are based in major cities in Pakistan. Some additional barriers to accessing healthcare in rural settings may include a lack of priority to spend on healthcare, travel expenses and disapproval of unassisted travel, especially for women and children (Habib et al., 2021; Choudhry, Khan and Munawar, 2023). People, especially women living in rural areas, may have to travel long distances to consult healthcare workers equipped with mental health skills. Also, mental health facilities in private healthcare facilities in urban settings may be costly, which further complicates access to formal healthcare services while facilitating reliance on informal service providers like faith leaders, as reflected in this review.

In this review, I found that only 15% of people with mental illnesses reported that they had previously consulted mental health specialists. Most of the studies reporting such contact were based in the urban context. Such findings reflect that there are potential barriers for people with mental illnesses to access specialist care in urban areas as well. Research evidence in Pakistan

has identified several barriers that prevent people with mental illness from accessing specialist care. One of these barriers is the attribution of mental illness to black magic, possession, evil shadow, curse, faith, and spirituality by people with mental illness. This belief system often leads individuals to seek out faith leaders instead of medical professionals, hindering their access to proper care (Khan et al., 2023). Family dynamics and the influence of family members, including elders, parents, and husband (considered head of family in Pakistan), also shape healthcare preferences. In addition to such cultural dynamics, lack of specialised mental health facilities, unavailability of adequate mental health services in primary and community settings and lack of clear pathways to mental health care are some notable barriers in this context.

Only four studies provided sufficient data to quantitatively synthesise the proportion of individuals with depression who ever attended faith leaders. By combining those studies, I found that 36% of individuals with depression who ever attended faith leaders seek support for their mental illness. It was difficult to clarify whether such contact with faith leaders was first or not, as all studies included did not clarify it. However, this proportion was similar to the proportion of people who attended general practitioners (36%) and the overall presentation of mental illnesses to faith leaders (36%) found in this review. It, therefore, likely suggests that depression is commonly presented to faith leaders with no major difference compared to severe mental illnesses. This is also supported by a study conducted in Pakistan with a different approach. The study found that 24% of individuals attending faith leaders in Pakistan were positive for depression (Saeed et al., 2000).

4.6 Strengths and Limitations

This review has expanded evidence relating to mental health pathways of care in Pakistan. It did not only focus on the overall presentation of mental illnesses to faith leaders, general practitioners and mental health specialists but also highlighted the percentage of individuals who attended faith leaders before consulting any formal healthcare services. Notably, it also indicated that individuals with depression commonly attend faith leaders in Pakistan. Recent efforts to collaborate with faith leaders in Africa and Pakistan have focused on severe mental illnesses like psychosis. My findings has highlighted a potential rationale for working with faith leaders to identify and manage depression in faith leaders' settings as well. Throughout the review, I followed standard protocols, such as protocol registration, reporting guidelines, and standards for conducting high quality meta-analysis.

This review has several methodological limitations. For instance, I only looked at the studies which included participants attending formal healthcare workers and settings. Any findings based

on such criteria may come up with different estimates compared to those studies which directly identified people with depression in faith leaders' settings. Also, though I planned to search for unpublished data and theses, the search strategy I used might not be comprehensive enough to cover unpublished theses conducted within the local universities of Pakistan as there are no online databases available in Pakistan to access such records. Therefore, I may have missed some unpublished studies. A meta-analysis conducted for individuals with depression included only four studies.

Findings from this review cannot be generalised to other regions and countries in the world. Also, most of the studies in this review were based in urban/ major cities in Pakistan within healthcare settings; therefore, findings cannot be generalised to rural or non-healthcare settings. Only three studies were classified as having high quality. Thus, the evidence synthesised may be designated as low to moderate. I conducted the sensitivity analysis by separating studies at low or very low levels. Sensitivity analysis results inflated the overall proportion of people attending faith leaders with a +4% change, indicating a minor influence on findings.

4.7 Conclusion and Implications

A substantial percentage of people with a range of mental illnesses who seek care at private and public hospitals in urban areas in Pakistan have a lifetime history of attending either faith leaders (including those having first contact with faith leaders) or general practitioners. Such estimates are similar for depression as well. Recent efforts have been made to engage primary and community healthcare workers in mental healthcare by establishing referral channels, identifying mental illnesses, and offering non-specialised psychosocial interventions. Our findings, however, are important for establishing a collaborative engagement that includes faith leaders and general practitioners alongside mental health specialists to expand the access to and provision of comprehensive and effective mental health care for the population.

This review has several implications for practice and research. It suggested that individuals with mental illnesses, specifically depression, commonly attend faith leaders. Therefore, gathering information about psychiatric history, including informal care such as attending faith leaders, can inform diagnostic and treatment-related decisions. Such information can help healthcare workers identify any i) cultural, religious or spiritual beliefs of individuals relevant to their mental illnesses, ii) faith-based beliefs acting as barriers or facilitators to formal treatment and iii) aligning treatment (specifically psychotherapeutic) with religious beliefs. Future research focusing on the experiences of individuals attending faith leaders and their attendees can potentially facilitate the development of a better understanding of faith leaders' context.

In the context of this dissertation, findings suggested that it is common for people with depression attending healthcare facilities to have previous contacts with faith leaders, strengthening the rationale of training needs for faith leaders targeting the identification and management of depression. Also, presenting that age or gender is not associated with attending faith leaders implies focusing training on dealing with different age and gender groups. Given this reality, it is worth knowing in further studies how depression is presented in faith leaders' settings and how current practices in faith leaders' settings are consistent or inconsistent with BA theory, philosophy and practice.

5 Effectiveness, Barriers, and Facilitators of Interventions Delivered by Faith leaders for Treatment of Common Mental Disorders: A Systematic Review

Authors: Mujeeb Masud Bhatti; Prof. Najma Siddiqi; Dr. Hannah Jennings; Dr. Saima Afaq; Aatik Arsh[1] and Bilal Khan[2]

This chapter is tied with the overarching research questions aiming to understand faith leaders' practices, its potential benefits or harms and barriers and facilitators to their practice. My previous review (See Chapter 4) suggested that a significant proportion of people attended faith leaders, including those with depression. A high proportion attended them before contacting formal healthcare services. Therefore, faith leaders could play a role in providing mental health care. I further undertook a systematic review to explore the evidence on effectiveness, barriers, and facilitators potentially associated with engaging with faith leaders' intervention or practices targeting common mental disorders including depression. This review was planned to get deeper insights into the practices of faith leaders and to draw parallels (if any) between faith leaders' approaches and BA. At the end of this chapter in conclusion section, I have summarised how this review has advanced my understanding relevant to research questions and how it has informed ideas about the latter part of the dissertation.

This review has been published in Transcultural Psychiatry (Scientific journal). Journal allows authors of the paper to use the final published paper in a dissertation or thesis, including where the dissertation or thesis will be posted in any electronic institutional repository or database. In line with journal policy on using final published paper, the reference to the published paper according to the recommended format has been provided below:

Bhatti, M.M., Siddiqi, N., Jennings, H., Afaq, S., Arsh, A. and Khan, B.A., 2024. Effectiveness, barriers, and facilitators of interventions delivered by traditional healers for the treatment of common mental disorders: A systematic review. *Transcultural Psychiatry*, 61(6), 885-904. Available at: doi: 10.1177/13634615241273001

I am the primary author who planned, initiated, synthesised, and wrote the draft submitted to the journal. NS, HJ, and SA provided supervision and reviewed the written draft. BK and AA independently checked screening and extraction, apart from my own. For presenting it here, I revised the submitted draft to ensure consistency in terminology (such as using faith leaders

[1] PhD Student, Department of Health Sciences, University of York
[2] Research Assistant, Pakistan Institute of Living and Learning

rather than traditional healers), writing style (consistent with the heading structure of other chapters presented) and context within the dissertation.

5.1 Introduction

Common mental disorders (CMDs), including depressive and anxiety disorders, are highly prevalent. Approximately 600 million people worldwide suffer from depression and a range of anxiety-related disorders (World Health Organization, 2017). Depression is the leading cause of disability, and anxiety disorders are the sixth leading cause of disability worldwide (World Health Organization, 2017). Despite the high burden of mental illness, many affected people do not have access to evidence-based treatment in LMICs (Moitra et al., 2022). Financial, infrastructural, and human resources required to reduce the disease burden associated with mental illness are considerably limited (World Health Organization, 2009). Given the lack of mental health services, people may prefer faith-based treatments embedded in a cultural milieu (Cohen et al., 2021). Growing evidence suggests that many people in LMICs attend faith leaders before they contact formal healthcare professionals (See Chapter 4) (Burns and Tomita, 2015; Khan et al., 2019; Nuri et al., 2018). Collaboration between formal healthcare professionals and faith leaders may have the potential to improve access to mental health care (Musyimi et al., 2017a, 2017b). A recent study found that collaborative psychosocial interventions provided by faith leaders and formal healthcare professionals are feasible and beneficial for improving psychosis symptoms (Gureje et al., 2020). Another study found training and delivery of non-specialised psychotherapy for depression by faith leaders to be feasible (Musyimi et al., 2017a).

With the increasing availability of primary data and research on faith leaders in mental healthcare, recent efforts have been made to synthesise these data, aiming to draw more robust conclusions. A systematic review focusing on the initial contact with faith leaders in Africa revealed that approximately 48% of individuals with mental illnesses first contact with informal care providers, exceeding the 13% who first seek formal mental health services (Burns and Tomita, 2015). Given this reality, there have been efforts to understand the perspectives of faith leaders and healthcare professionals regarding potential collaboration. A qualitative review including data from seven (primarily African) countries suggests that faith leaders and healthcare professionals are willing to cooperate despite differing approaches to addressing mental illnesses (Green and Colucci, 2020). However, healthcare professionals have consistently expressed concerns about the safety and autonomy of individuals who seek faith healing. In contrast, faith leaders often hesitate about acknowledging the benefits of formal healthcare practices. The effectiveness of interventions delivered by faith leaders has been a long-standing question. Two

systematic reviews have been conducted aiming to explore the effects of faith healing on mental health. Both suggested potential benefits for CMDs while indicating that people value faith healing, particularly regarding mental health (Nortje et al., 2016; van der Watt et al., 2018).

One of these reviews, based on 32 studies (primarily non-randomised and observational) from 20 countries, reported that interventions delivered by faith leaders comprise a wide range of practices, including sacred rituals, divination, and prayers (Nortje et al., 2016). This review found that faith leaders' interventions are beneficial for CMDs but not for severe mental illnesses such as bipolar disorder or psychosis (Nortje et al., 2016). However, the review included observational studies, and there were some difficulties with using standardised and uniform methods to extract, synthesise, and critically appraise included studies, precluding concluding effectiveness. The second review had qualitative studies exploring the perceived effectiveness of interventions delivered by faith leaders; it reported that individuals with mental illness value such interventions and perceive them to be helpful in the alleviation of mental health problems regardless of the availability of alternative formal healthcare services (van der Watt et al., 2018). Faith leaders' practices, however, were also considered ineffective in rare cases where a curse was too strong compared to the power of the healing method (van der Watt et al., 2018). There was limited information on barriers and facilitators people may face in accessing and engaging in interventions by faith leaders (Green and Colucci, 2020). A recent scoping review, including studies in Nepal, reported religious-magical explanations and practices, informal cognitive restructuring methods and catharsis were common interventions used by faith leaders. Still, this review did not address effectiveness (Pham et al., 2021).

5.2 Rationale

Randomised controlled trials (RCTs) are the gold standard for evaluating the effectiveness of interventions and rigorously conducted systematic reviews of RCTs provide the most robust evidence for establishing or revising treatment policies (Evans et al., 2019). Barriers and facilitators are likely influence the effectiveness and uptake of any intervention to improve health outcomes in a particular service delivery context (Oliver et al., 2014). Understanding barriers and facilitators associated with interventions provided by faith leaders is important when current evidence suggests that potential collaboration between faith leaders and healthcare professionals could be beneficial (Gureje et al., 2020). Understanding such determinants can facilitate the efficient implementation of such programmes (Le et al., 2022). I, therefore, aimed to explore the effectiveness of interventions for CMDs delivered by faith leaders by synthesising data from RCTs and using standardised methods for synthesis (i.e., meta-analysis) and critical appraisal

(Cumpston et al., 2019). I prioritised CMDs due to their high prevalence and the consideration that treatment of severe mental illnesses typically requires specialist mental health care. My focus on CMDs is supported by previous reviews indicating the beneficial effects of faith healing on CMDs only (Nortje et al., 2016; van der Watt et al., 2018).

Barriers to accessing and engaging with interventions provided by faith leaders are critical to understanding yet have received limited attention. One review focused on barriers to collaboration between faith leaders and healthcare professionals but did not encompass the perspectives of individuals seeking faith healing (Green and Colucci, 2020). Therefore, I sought to examine the barriers and facilitators to access and engage with interventions delivered by faith leaders by reviewing qualitative studies based on faith leaders and their attendees' perspectives and experiences. This approach enabled me to consider data from a unique perspective, i.e., a barrier to formal healthcare intervention could facilitate interventions delivered by faith leaders and vice versa. To ensure comprehensiveness, I aimed to include interventions provided independently by faith leaders and interventions offered by faith leaders in collaboration with formal healthcare providers. I have used Preferred Reporting Items for Reviews and Meta-Analyses (PRISMA) statements to present and report this review.

5.3 Review Questions

This review seeks to answer the following questions:

1. Are interventions delivered by faith leaders for the management of CMDs effective?
2. What are the perspectives of faith leaders and individuals with CMDs regarding the barriers and facilitators to engaging with and accessing faith healing to manage CMD?

5.4 Methods

5.4.1 Eligibility Criteria

Studies fulfilling the following criteria were included in the review:

I. RCTs investigating the effectiveness of treatment provided by faith leaders, qualitative studies, and mixed methods studies.

II. Individuals with CMD symptoms (self-reported or clinically diagnosed) seeking care from faith leaders and faith leaders expressing their perspectives on their treatment for CMDs. I have used the definition of faith leaders, which has been consistently used by previous reviews (Nortje et al., 2016; van der Watt et al., 2018). Faith leaders were "healers who explicitly appeal to spiritual, magical, or religious explanations for disease and distress" (Nortje et al., 2016). I adopted the definition of CMDs as outlined in a commissioned report

by the National Centre for Mental Health in the United Kingdom (UK) when formulating clinical guidelines for the National Health Service (NHS) in the UK. CMDs encompass the symptoms associated with Major Depressive Disorder (MDD), Anxiety Disorders, Panic Disorder, Obsessive Compulsive Disorder (OCD), and Post Traumatic Stress Disorder (PTSD) as defined by the Diagnostic and Statistical Manual (DSM), the International Classification of Diseases (ICD), or as assessed through a standardised evaluation tool (National Collaborating Centre for Mental Health, 2011).

III. The intervention includes any faith-based intervention provided by faith leaders independently, any evidence-based treatment where faith leaders were trained by healthcare professionals, or any care provided by faith leaders and healthcare professionals in collaboration. Studies were excluded if the intervention was limited to faith leaders only providing oral, topical, or inhaled herbal or chemical substances.

IV. Three types of comparators were considered: 1) Usual/routine care: psychological care provided in primary, secondary, or tertiary care routinely; 2) Placebo/mock/sham healing 3) Control group: no intervention.

V. Primary outcomes included any standardised instrument to quantitatively measure depression, anxiety disorders, panic disorder, OCD and PTSD. No restrictions on the timings of the outcome were placed. The barriers and facilitators relating to the accessibility and engagement with treatment for CMDs by faith leaders were based on reflections and experiences of individuals with CMDs treated by faith leaders, faith leaders' understandings of treating people with CMDs and faith leaders' perspectives and views regarding CMDs.

5.4.2 Information Sources

To ensure comprehensiveness, searching more than one bibliographic database is recommended (Lefebvre et al., 2019). I searched seven databases. Databases searched were MEDLINE (Epub Ahead of Print, MEDLINE In-Process & Other Non-Indexed Citations; Ovid interface; 1946 onwards); APA PsychInfo (Ovid interface; 1987 onwards); Allied and Complementary Medicine (AMED Ovid interface; 1985 onwards); Embase (Ovid interface; 1974 onwards); CINAHL (EBSCO Host); Social Science Citation Index (Web of Science, 1956 onwards) and Scopus (1946 onwards). I searched all databases from their inception to October 2021. The reference lists of articles included in recent relevant systematic reviews (Nortje et al., 2016) were also searched. A hand search was done to find pertinent studies of journals, conference proceedings, and unpublished theses.

5.4.3 Search Strategy and Study Selection

The search strategy was developed with the help of an information specialist, and I ran all searches by myself in October 2021 (Lefebvre et al., 2019). The search terms include synonyms (singulars, plurals, and alternative spellings) for two concepts (Faith leaders and Common mental disorders). A mixed method search filter was used. A search filter is a ready-made strategy that efficiently retrieves relevant records and has been tested previously (Lefebvre et al., 2019). Given the study's scope, I used a mixed methods search filter to retrieve qualitative and quantitative records. Search terms included: 1) “Traditional” or “Faith”, for example, 2) “Depression” or “Anxiety”, for example. 3) Mixed method filter (See Appendix Table 5.1) (Sherif et al., 2016).

5.4.4 Study Selection

I examined all titles and abstracts using pre-specified screening criteria to identify eligible papers (See Appendix Table 5.2). At least two reviewers (MMB, AA and BAK) independently read the full-text articles of all potentially eligible studies to decide which should be included. Queries were discussed between reviewers at each stage, and disagreements were resolved through consensus or third-reviewer arbitration.

5.5 Data Items

The Cochrane Collaboration data extraction form for RCTs was used for RCT studies. The form included bibliographic information, study design, population, intervention, comparator, and outcomes (Li, Higgins and Deeks, 2019). For the qualitative and mixed methods studies, details including study characteristics, methodology, data collection method, participants, data analysis and results were extracted. I also carefully noted verbatim statements of faith leaders, and their attendees reported in the included records, which were further used for the synthesis. I used a data extraction form for qualitative studies developed by the first author (MMB), and this was piloted with the first three studies.

5.5.1 Risk of Bias

The Cochrane Collaboration tool for assessing the Risk of Bias, version 1 (RoB-1), was used for critical appraisal of RCTs (Higgins et al., 2011), and the quality of qualitative studies and mixed method studies was assessed using the Critical Appraisal Skills Program (CASP) checklist (Long, French and Brooks, 2020). The CASP was chosen due to its extensive usage and endorsement by the Cochrane Qualitative and Implementation Methods Group (Long, French and Brooks, 2020). It is a convenient and user-friendly tool, offering adaptability to accommodate various philosophical foundations that underlie different qualitative studies included in the review (Long, French and Brooks, 2020). It also emphasises the researchers-participants relationship, allowing the evaluation of potential reflexivity issues in included studies. Each domain or item for

risk of bias was rated for each study, and further global ratings collating all domains for each survey were reported (Higgins et al., 2019).

5.5.2 Data Collection

The data extraction tools were piloted with the first three studies and were adapted accordingly. Study characteristics (sample and intervention characteristics) were extracted by myself. Data related to the outcomes, verbatim statements, and risk of bias assessment were noted or rated independently by at least two reviewers (MMB, AA, and BAK), and disagreements were discussed between the two reviewers. If an agreement was not reached between the two reviewers, a third senior reviewer made the final decision.

5.5.3 Data Synthesis

I narratively summarised the characteristics of participants, interventions, comparisons and outcomes or phenomena of interest for all studies included in tables and texts (McKenzie et al., 2019). Quantitative synthesis was performed using RevMan 5.4.1. A meta-analysis using the Random effect model (mantel-Haenszel method) was conducted to account for heterogeneity (Field and Gillett, 2010). All studies were based on continuous data, the mean and standard deviation were extracted, and the pooled effect was estimated in standardised mean difference (95% confidence interval). Statistical heterogeneity was assessed through the chi-square test (χ^2) and I^2 statistics.

Meta-analysis was performed on an “all-time outcome” basis ranging from 3 days outcome to a six-month outcome. Given the high level of heterogeneity, subgroup analysis based on intervention and participants' characteristics was carried out, and publication bias was assessed through a funnel plot. Studies reporting median and interquartile ranges were included in the meta-analysis. Therefore, sensitivity analysis was performed by removing those studies to observe their effects on the pooled estimates (Deeks et al., 2019).

Thematic synthesis of qualitative findings was used to explore the barriers and facilitators to accessing and engaging with interventions for CMDs by faith leaders (Thomas and Harden, 2008). NVivo was used to organise and manage the qualitative data. All the qualitative or mixed methods studies were uploaded onto NVivo. Synthesis was performed on the verbatim statements by faith leaders and their attendees reported in studies. I followed the process of reading, familiarising, and coding verbatim statements line by line. The emergent coding approach was observed; I immersed myself in the data, and coding emerged from the data rather than pre-determined codes. Similar codes were collated to form subordinate themes. Themes were subsequently categorised under barriers and facilitators. The identified themes and quotes were

described in narration in the results section. Any discrepancies relating to coding and themes were resolved through discussion between two reviewers (MMB and HJ).

5.6 Results

5.6.1 Study Selection

Thirty-three studies were included in the review; sixteen were clinical trials, and seventeen were qualitative or mixed methods (See Appendix Figure 5.3). Studies that were excluded were either: 1) wrong study design (N=19), 2) wrong outcome (N=10) or 3) wrong intervention (n=7) (See Appendix Figure 5.3).

5.7 Effectiveness of Interventions Provided by Faith Leaders

5.7.1 Characteristics of the Included Studies

A total of sixteen studies were selected. Eight were based in High-Income Countries (HIC) (4 in the USA, 3 in the UK, 1 in Finland), seven in Higher Middle-Income Countries (HMIC) (6 in Brazil, 1 in Iran) and one in an LMIC (India). All but three studies (church=1, healing centre=1 and community setting =1) were conducted in healthcare settings (Table 5.1). Depression and anxiety were the only reported outcomes. Nine out of the sixteen studies primarily focused on physical conditions along with symptoms of depression and anxiety, whilst seven studies primarily addressed depression and anxiety (Table 5.2). Eight studies used a “spiritual passe” intervention, in which faith leaders move their hands above an individual body without touching. Two studies included Reiki and energy healing techniques, focusing on curing through the universal energy systems. The remaining five studies used various healing techniques, including prayers, building a relationship with God, psychosocial support from lay pastors, energy healing and prana healing. All the trials evaluated interventions provided independently by faith leaders, and I did not find any trial focusing on jointly or collaboratively delivered interventions. Ten studies included a mock/ sham healing comparison group with an actor (a non-healer volunteer) copying faith leader actions as a control. The remaining studies did not provide intervention to the control group (Table 5.2).

Table 5.1: Included Studies

Study ID	Document	Country	Study	Study Settings	Quality
(Abbot et al., 2001)	Journal Article	England	RCT	Healthcare Settings	Low
(Boelens et al., 2009)	Journal Article	USA	RCT	Healthcare Settings	Low
(Carneiro et al., 2020a)	Journal Article	Brazil	RCT	Healthcare Settings	Low
(Carneiro et al., 2020b)	Journal Article	Brazil	RCT	Healthcare Settings	Moderate
(Carneiro et al., 2017)	Journal Article	Brazil	RCT	Healthcare Settings	Low
(Cleland et al., 2006)	Journal Article	Scotland	RCT	Healthcare Settings	Low
(de Souza Cavalcante et al., 2016)	Journal Article	Brazil	RCT	Healthcare Settings	Moderate
(Gerard, Smith and Simpson, 2003)	Journal Article	Scotland	RCT	Healthcare Settings	Very Low
(Jain, 2009)	Dissertation	USA	RCT	Healthcare Settings	Low
(Miranda et al., 2020)	Journal Article	Brazil	RCT	Healthcare Settings	Low
(Nikfarjam et al., 2018)	Journal Article	Iran	RCT	Healthcare Settings	Very Low
(Palmer, 1997)	Dissertation	USA	RCT	Church	Very Low
(Rajagopal et al., 2018)	Journal Article	India	RCT	Healthcare Settings	Low
(Shore, 2004)	Journal Article	USA	RCT	Healing Center	Low
(Sundblom et al., 1994)	Journal Article	Finland	RCT	Healthcare Settings	Low
(Zacaron et al., 2021)	Journal Article	Brazil	RCT	Community Settings	Moderate
(Stansbury, Brown-Hughes and Harley, 2009)	Journal Article	USA	Qualitative	Community Settings	Poor
(Bryant et al., 2014)	Journal Article	USA	Qualitative	Community Settings	Poor
(Hankerson, Crayton and Duenas, 2021)	Journal Article	USA	Qualitative	Healthcare Settings	Poor
(Jang et al., 2017)	Journal Article	USA	Qualitative	Church Settings	Moderate
(Kitchen Andren and McKibbin, 2018)	Journal Article	USA	Mixed Method	Community Settings	Poor

(Kpobi and Swartz, 2018)	Journal Article	Ghana	Qualitative	NA	Moderate
(Lucchetti et al., 2015)	Journal Article	Brazil	Mixed Method	Spiritist/ Healing Center	Poor
(Moodley, Joosub and Khotu, 2018)	Journal Article	South Africa	Qualitative	Community Settings	Good
(Payne and Hays, 2016)	Journal Article	USA	Qualitative	Social Media	Moderate
(Pullen et al., 2021)	Journal Article	Liberia	Qualitative	NA	Good
(Pyne et al., 2021)	Journal Article	USA	Mixed Method	Healthcare Settings	Moderate
(Pyne, Rabalais and Sullivan, 2019)	Journal Article	USA	Qualitative	Healthcare Settings	Moderate
(Stansbury, 2011)	Journal Article	USA	Qualitative	NA	Good
(Storck, Csordas and Strauss, 2000)	Journal Article	USA	Qualitative	Community Settings	Poor
(Tobah, 2017)	Journal Article	Canada	Qualitative	Community Settings	Moderate
(Wahbeh et al., 2017)	Journal Article	USA	Mixed Method	Healthcare Settings	Poor
(Zoellner et al., 2021)	Journal Article	Somalia	Mixed Method	Mosques	Moderate

Note. NA = Not Available or not reported in source; RCT = Randomised Control Trial; USA = United States of America

Table 5.2: Participants, Intervention, Comparison(s) and Outcome(s) in Included RCTs

Study	Participants	N	Age M(SD)	Female N (%)	Intervention	Comparison(s)	Outcome	CMD Measures	Findings
(Abbot et al., 2001)	Chronic Pain	132	52.85 (NA)	59 (56.1)	Face to Face Spiritual Healing	Placebo Healing Distant Healing Control	Week 8	HADS	Depression: ND (For all comparisons) Anxiety: ND (For all comparisons)
(Boelens et al., 2009)	Major Depressive Disorder with Anxiety	74	43.85 (13.25)	60 (95.3)	Prayer Intervention	Control	Week 6	HAMS D HAMS A	Depression: + Anxiety: +
(Carneiro et al., 2020a)	Surgical risk and systemic alterations with anxiety	59	57 (13.24)	20 (45.5)	Spiritual Passe	Placebo/ Mock Healing Standard Medical Care	Day 3	HADS	Anxiety: + (Compared to Placebo and Standard Medical Care)
(Carneiro et al., 2020b)	Anxiety and stress among hospital employees	84	38.39 (10.04)	73 (87)	Spiritual Passe	Control	Day 1	DASS	Depression: ND Anxiety: ND
(Carneiro et al., 2017)	Cardiovascular inpatients	48	58.33 (17.1)	18 (43.9)	Spiritual Passe	Placebo/ Mock Healing Control	Day 3	HADS	Depression: + (Compared to both Placebo and Control) Anxiety: + (Compared to both Placebo and Control)
(Cleland et al., 2006)	Asthma patients	92	46.26 (14.04)	62 (70.4)	Spiritual Healing	Placebo/ Mock Healing Control	Week 4, 8, 12 & 24	HADS	Anxiety on week 12: + (Compared to both Placebo and Control)
(de Souza Cavalcante et al., 2016)	Anxiety	65	45.5 (15.5)	28 (76)	Spiritual Passe	Placebo/ Mock Healing	Week 8	TAI BDI	Depression: ND Anxiety: +

(Gerard, Smith and Simpson, 2003)	Volunteers with restricted neck movement	68	53.2 (NA)	46 (67.65)	Prayer, meditation and the laying on of hands	Control	Week 3	HADS	Depression: ND Anxiety: ND
(Jain, 2009)	Breast cancer	31	52.5 (NA)	31 (100)	Energy Healing	Placebo/ Mock Healing	Week 4	CESD-R	Depression: +
(Miranda et al., 2020)	Breast cancer with depression and anxiety	31	50.95 (8.55)	31 (100)	Intercessory Prayer	Control	Week 4	HADS	Depression: ND Anxiety: ND
(Nikfarjam et al., 2018)	Anxiety	72	31.8 (10.22)	42 (58.34)	Repentance, prayers, recitations, meditation and drug therapy	Drug Therapy with no religious teaching	Week 3	STAI	Anxiety: +
(Palmer, 1997)	Individuals attending church	127	37.89 (9.84)	78 (61.52)	Lay Pastoral Telecare	Control	Week 24	CSA	Depression: +
(Rajagopal et al., 2018)	Mild to moderate depression	60	34.4 (NA)	31 (59.61)	Pranic Healing with Medicine	Placebo/ Mock Pranic Healing with Medication	Week 4	HAMS-D	Depression: +
(Shore, 2004)	Depression	45	NA	NA	Hands-On Reiki	Distance Non-Touch Reiki Placebo/ Mock Reiki	Week 6	BDI	Depression: + (Compared to Placebo)
(Sundblom et al., 1994)	Idiopathic pain syndrome with depression	24	51.35 (NA)	12 (50)	Spiritual Healing	Control	Week 2	BDI	Depression: ND
(Zacaron et al., 2021)	Knee osteoarthritis	120	69.26 (5.29)	120 (100)	Spiritual Passe	Placebo/ Mock Healing Control	Week 8	HADS	Depression: + Anxiety: + (Compared to Control Group)

Note. BDS = Beck Depression Scale; CESD-R = Center for Epidemiological Studies Depression Scale-revised; CMD = Common Mental Disorders; Conversion Symptoms Assessment = CSA; DASS = Depression Anxiety Stress Scale; HADS= Hospital Anxiety Depression Scale; HAMS-D = Hamilton Depression Scale; HAMS-A= Hamilton Anxiety Scale; M = Mean; N = Numbers of participants; NA = Not Available or not reported in source; ND = No Difference; SD = Standard Deviation STAI = State-Trait Anxiety Inventory; Trait Anxiety Inventory = TAI; + = Improvement of symptoms in intervention group

5.7.2 Results of Individual Studies Focusing on Depression

Fifteen studies measured depression. Ten of these studies found that symptoms of depression improved among individuals attending interventions provided by faith leaders when compared to control or placebo groups; four studies indicated no difference. Cleland and colleagues (2006) neither provided descriptive statistics nor results in narratives. Miranda and colleagues (2020), though they did not offer statistics, reported that no significant differences were observed in depression between individuals attending faith leaders and the control group on the post-test. Two studies provided the difference in mean change scores (from baseline to outcome); Abbot and colleagues (2001) reported non-significant findings with no difference between the intervention and control group. However, Zacaron and colleagues (2021) reported significant improvement in the intervention group compared to the control group by week eight.

5.7.3 Meta-Analysis for Depression Outcome

The overall quantitative synthesis of eleven studies included 570 participants, with 274 randomised to interventions provided by faith leaders and 296 randomised to control or placebo group. Findings demonstrated significant improvement in depression symptoms for individuals in the intervention group (Standardised Mean Difference = -0.93; 95 % Confidence Interval = -1.48 to -0.37) compared to control/placebo groups. A significant amount of variability was found (I^2 = 89%) (Figure 5.1).

5.7.4 Subgroup Analysis Based on Co-Existing Physical Conditions

Five of the studies looked at depression in people who had co-morbid physical conditions, and six studies on depression did not identify people with co-morbid physical conditions. Five studies on depression with physical conditions, spiritual passe or a form of energy or spiritual healing were used. However, the studies on depression without physical conditions included a range of interventions, including spiritual passe, energy healing, informal counselling, prayer, repentance, and meditation. Individuals randomised to the intervention group had significantly lower depression symptoms compared to control for both subgroups. However, the difference was greater for depression without any physical conditions subgroup. However, heterogeneity in the estimates of the studies within depression with physical conditions subgroup was less (Figure 5.1).

5.7.5 Subgroup Analysis Based on Types of Intervention

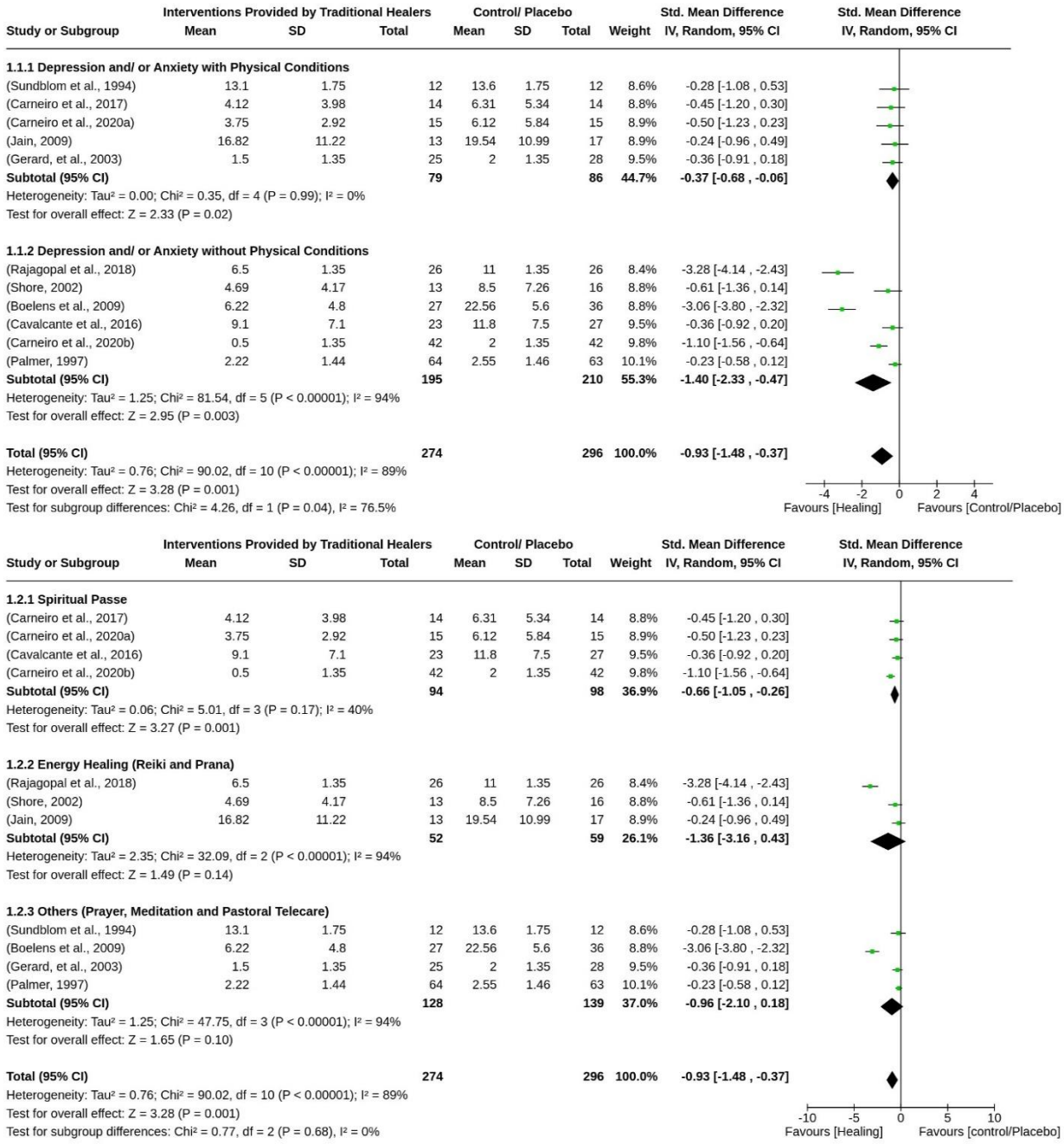
Four studies were included in the spiritual passe subgroup, three in energy healing and four in other interventions (such as prayer, meditation, etc.). Intervention groups were significantly lower on depression symptoms compared to control only for the spiritual passe intervention. No

statistically significant differences were observed between interventions and control for energy healing and other types of healing (Figure 5.1).

5.7.6 Sensitivity Analysis

Three studies (Carneiro et al., 2020b; Gerard, Smith and Simpson, 2003; Rajagopal et al., 2018) providing only medians and interquartile ranges were included in the meta-analysis. These three studies were removed to rule out any possibility of bias. The overall effect favouring interventions by faith leaders compared to control remained significant. However, no significant improvements in individuals attending faith leaders for subgroups of depression with physical conditions and depression without physical conditions were observed. For subgroups based on intervention type, there was no effect of removing these three trials; the difference favouring interventions compared to control for the spiritual passe subgroup remained significant, while no difference was observed for other subgroups.

Figure 5.1: Effectiveness of Interventions by Faith Leaders Compared to Control or Placebo for Depression on All-Time Outcome



5.7.7 Results of Individual Studies Focusing on Anxiety

Anxiety was measured either as a primary or secondary outcome in twelve studies. Six studies reported low levels of anxiety symptoms among individuals attending faith leaders compared to control, whilst five studies reported non-significant findings. Two studies (Jain, 2009; Miranda et al., 2020) did not provide descriptive statistics. Cleland and colleagues (2006) reported fewer participants positive on anxiety in week twelve in the intervention group compared to control, whilst Miranda and colleagues (2020) reported non-significant differences. Two studies found changes in mean scores; Abbot and colleagues (2001) reported non-significant findings, whilst Zacron and colleagues (2021) reported significantly lower anxiety levels among intervention compared to control in week eight.

5.7.8 Meta-Analysis for Anxiety Outcome

The quantitative synthesis of eight studies included 493 participants, with 246 randomised to interventions and 247 randomised to control/placebo groups. Findings demonstrated improved anxiety symptoms among individuals attending faith leaders (Standardised Mean Difference = -0.82; 95 % Confidence Interval = -1.36 to -0.27) compared to control/placebo groups. A significant amount of variability was found (I^2 = 87%) (Figure 5.2).

5.7.9 Subgroup Analysis Based on Co-Existing Physical Conditions

Three studies were included in the anxiety with physical conditions subgroup, and five were included in the anxiety without physical conditions subgroup. All studies in the anxiety with physical conditions subgroup used spiritual passe intervention; interventions in the anxiety without physical conditions subgroup were heterogenous, including spiritual passe, prayer and meditation. This subgroup analysis indicated significantly lower scores in anxiety among individuals who received interventions compared to control for both subgroups. The estimates of the studies within the anxiety with physical conditions subgroup were more homogenous than the estimates of the studies included in the without physical conditions subgroup (Figure 5.2).

5.7.10 Subgroup Analysis Based on Types of Interventions

There were three studies in the spiritual passe subgroup and four in the other interventions subgroup. There were lower levels of anxiety symptoms among the intervention compared to the control group in the spiritual passe subgroup. No significant differences were observed for other intervention subgroups. The estimates of studies within the spiritual passe subgroup were more homogenous than different intervention subgroups (such as prayers and meditation, etc.) (Figure 5.2).

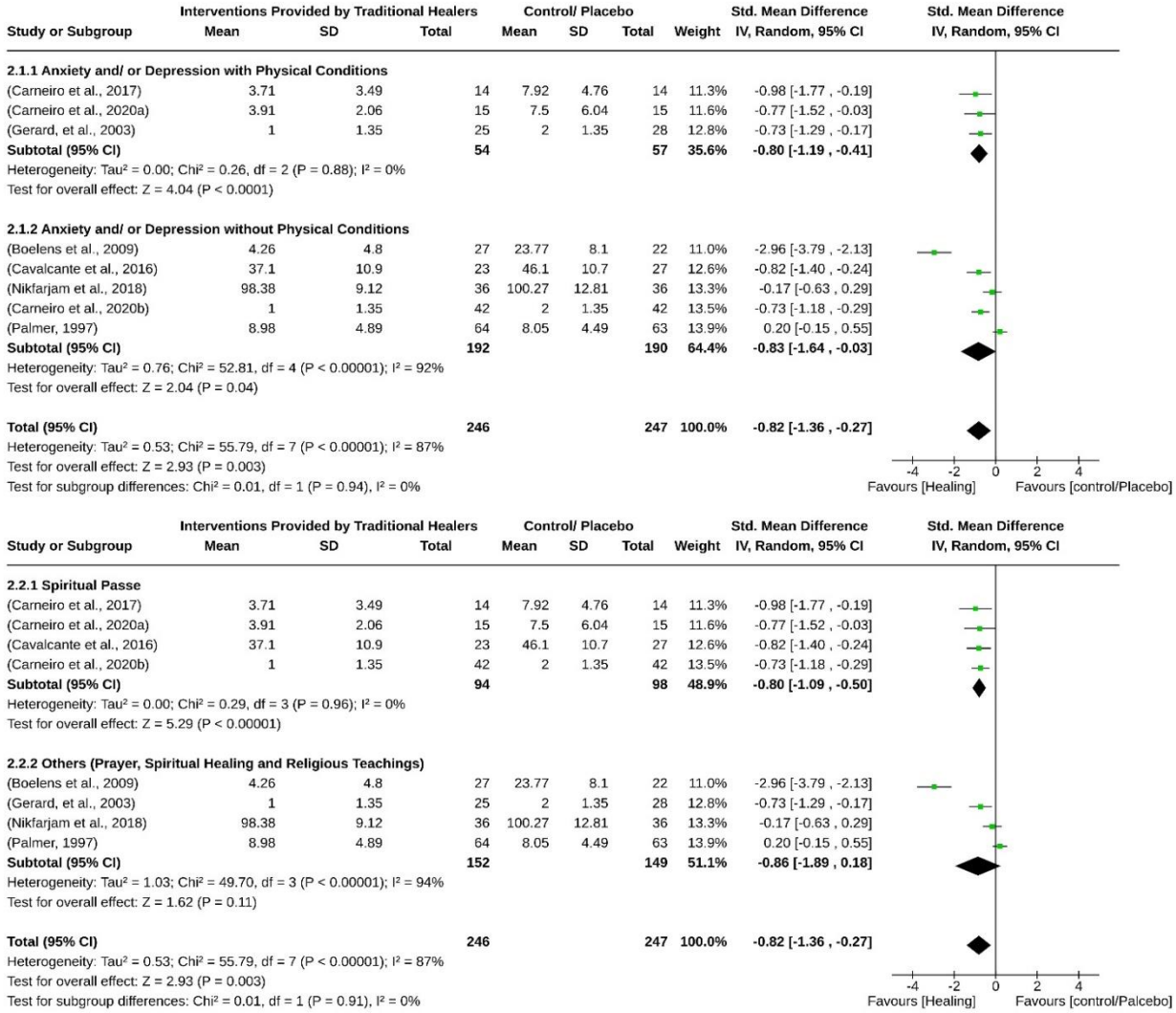
5.7.11 Sensitivity Analysis

The meta-analysis included two studies providing median and interquartile ranges for anxiety outcomes (Carneiro et al., 2020b; Gerard, Smith and Simpson, 2003). By excluding the two studies, the difference between intervention and control remained significant for the anxiety with physical conditions subgroup. However, the difference in favour of intervention vs control for anxiety without physical conditions subgroup was no longer critical. Removal of the two studies did not affect estimates for spiritual passe and other intervention subgroups.

5.7.12 Risk of Bias

The overall quality of the studies was generally low, with thirteen studies rated either “low” or “very low”. The reviewers rated three studies as having “moderate” quality (See Table 5.1). Seven studies (43%) were at high risk of bias due to incomplete data or attrition bias, and five (30%) were at increased risk for performance bias. Fourteen studies (90%) were unclear about allocation concealment, twelve studies (75%) were unclear about the blinding of participants and personals and blinding of outcome assessors, and nine studies were unclear about selective reporting (about 55%) (See Appendix Figure 5.4). The figure in the appendix indicates potential publication bias with uneven distribution of studies (See Appendix Figure 5.5).

Figure 5.2: Effectiveness of Interventions by Faith Leaders Compared to Control or placebo for Anxiety on All Time Outcome



5.8 Barriers and Facilitators to Interventions Delivered by Faith Leaders

5.8.1 Characteristics of the Included Studies

The synthesis incorporated qualitative findings from twelve qualitative studies and five mixed methods studies. Twelve studies were conducted in non-healthcare settings (including in the community, mosques, and faith-based institutions) and four in healthcare settings. About eleven studies focused on the views and perspectives of faith leaders towards CMDs, and six studies explored participants' experiences with CMDs who received interventions from faith leaders (Table 5.1 and 5.3). The studies were based in the following countries: eleven studies were found in the USA, and the other six were conducted in Ghana, Brazil, South Africa, Liberia, Canada, and Somalia.

Table 5.3: Participants' Characteristics, Focus, Key Findings and Quality of the Studies Included in Synthesis

Study ID	Characteristics of Participants	Number of Participants	Females n (%)	Age Range/ Age M (SD)	Topic of interest
(Stansbury, Brown-Hughes and Harley, 2009)	Baptist Clergy/ Pastors (	9	0 (0%)	36 to 58	Views on experience in dealing with depression in elder congregants
(Bryant et al., 2014)	Pastors	9	0 (0%)	Not Given	Knowledge, attitude, and perspective about depression
(Hankerson, Crayton and Duenas, 2021)	Clergy Members	2	1 (50%)	27 to 42	Perspectives on training clergy members in an evidence-based intervention for depression
(Jang et al., 2017)	Clergy Members	17	1 (5.9%)	35 to 87/ 52.4 (14.3)	Awareness and literacy related to depression
(Kitchen Andren and McKibbin, 2018)	Clergy Members	126	Not Given	19 to 80/ 58.24 (9.28)	Referral choice for depression
(Kpobi and Swartz, 2018)	Traditional and Faith Leaders	36	Not Given	Not given	Views and perspectives on depression
(Lucchetti et al., 2015)	Patients with depression	2	1 (50%)	26 to 34	Questions related to the experience of treatment provided by faith leaders
(Moodley, Joosub and Khotu, 2018)	Muslim Faith Leaders/ Islamic Scholars	5	0 (0%)	30 to 69	Understanding of mental illness, depression, treatment, and collaboration with medical professionals
(Payne and Hays, 2016)	Christian Clergy and Pastors	35	Not Given	Not given	Management strategies for individuals with depression, suicidal ideation, PTSD, and anxiety
(Pullen et al., 2021)	Traditional and faith leaders and their attendees	35	9 (37.5)	Not given	Common healthcare and psychosocial problems, attitude towards Western medicine, treatment provided by faith leaders
(Pyne et al., 2021)	Veterans with Post Traumatic Stress Disorder; Community Clergy Members	13	4 (31%)	56.8 (8.8)	Barriers and facilitators related to PTSD intervention facilitated by clergy members
(Pyne, Rabalais and Sullivan, 2019)	Veterans with Post Traumatic Stress Disorder, Community Clergy Members, and Mental Health Clinicians	39	6 (5.4)	49.06 (10.9)	Veterans experience talking with clergy; clergy clinicians experience talking with veterans about spiritual issues and related barriers and facilitators.
(Stansbury, 2011)	Baptist Pastors	9	0 (0%)	47 to 68	Awareness, causes and treatment for depression
(Storck, Csordas and Strauss, 2000)	Individuals with Depression	3	2 (66.6)	47 to 64	Understanding of illness, traditional and religious interventions
(Tobah, 2017)	Muslim Faith Leaders (Who lead prayer in Mosque)	8	Not Given	Not Given	Difference between professional mental health organisations' illustrations and

					opinions of religious leaders regarding mental health, mental illness, and depression
(Wahbeh et al., 2017)	Post-Traumatic Stress Disorder	6	0 (0%)	27 to 67/ 49.3 (13.1)	Views regarding intervention related to PTSD
(Zoellner et al., 2021)	Post-Traumatic Stress Disorder and Muslim Leaders	26	14 (53.9)	18 to 47/ 27.64 (7.35)	Views regarding Islamic Trauma Healing in intervention, barriers, and facilitators

5.8.2 Facilitators Identified by Faith Leaders

Religious and faith-based worldview: The overall attitude of both Christian and Muslim faith leaders was inclined towards a spiritual explanation of mental illness. The explanation of the mental illness concerning why it happens was based on religious scriptures such as the Bible and the Quran. The focus was on the spiritual nature of humans, emphasising the importance of the spiritual self and God in the healing of mental illness. While the care provided by faith leaders included talking with individuals and listening to their concerns, the discussion between faith leaders and individuals is grounded in religious, spiritual, and faith-based worldviews.

> *I provide care from a spiritual perspective, meeting with them, hearing their concerns, letting them talk through them, and offering alternatives that may be more of a spiritual nature or biblical nature than what a secular counsellor might offer.* (Stansbury, Brown-Hughes and Harley, 2009)

It was noted that such approaches are distinct from secular counselling provided by professional health care providers. In one instance, faith leaders indicated that religious people are less prone to mental illness without differentiating between the religions.

> *I don't know much about depression, but I do know that religious people do not get depressed. You know that a famous Korean actress committed suicide a few years ago because of her depression. I heard she was Christian. But I don't believe so. People deeply rooted in religion would never get depressed* (Jang et al., 2017)

For faith leaders and their attendees, it was seen as imperative to incorporate religious values and beliefs into mental health interventions, as they are critical to their belief systems. Their faith and spiritual values shape the choice and preference for choosing faith leaders for religious communities.

Knowledge of mental illness and risk factors: Some faith leaders were aware of the signs and symptoms of depression; they used terminologies such as "hopelessness", "disinterest", "sadness", and "detachment" to portray depression.

> *I feel like there are indicators of a bad state for me, and I tend to see that they don't have much hope. They're not . . . they've become disinterested in certain things in life. They . .*

> *. you know, the way that they're talking is almost monotone . . . you know, detached. It's not so much about solutions anymore. Those are things that I find very concerning* (Tobah, 2017)

A psychosocial explanation was apparent in the data, and faith leaders reported that lack of interest and detachment from life activities are significant indicators of depression. Risk factors for depression, such as the loss of a spouse, were also identified by the faith leaders.

> *I worry about my elders who lose their spouse of forty, fifty, or sometimes sixty years. In my line of work, I find that when an older person loses their spouse, they become depressed and despondent* (Stansbury, 2011)

The difference between depression and severe mental illness (referred to as madness) was acknowledged by the faith leaders.

> *Yes, that is also a mental problem, but it is not like the madness… I think you people call it depression… it often happens with ladies. I'm sure the lady has many problems in her life, and she can't cope. So, she will be thinking about it all the time…and then it makes her sad* (Kpobi and Swartz, 2018)

While it was apparent that faith leaders were aware of indicators and associated factors of depression, it is evident that this is due to exposure rather than formalised training. As indicated above, the language of depression is somewhat different to a more medicalised language, and differentiations between various forms of CMDs were not acknowledged.

Distrust in statutory mental health approaches: Distrust in services was considered a facilitator to CMD care accessed through faith leaders. It meant people with CMD were more likely to see the faith leaders and trust them for advice than formal services. Distrust in the effectiveness of professional mental health services has been apparent in faith leaders' responses in two studies (Stansbury, Brown-Hughes and Harley, 2009; Stansbury, 2011).

> *It may not be all the time that they may need that professional help because sometimes the professional help doesn't help, so most of the time, I try not to send them to professional help* (Stansbury, Brown-Hughes and Harley, 2009)

Both studies involved Baptist pastors in the USA. They explicitly reported that they prefer not to advise individuals to consult professional healthcare providers. The explanation provided for not notifying individuals to consult healthcare providers was that medical practices rely on prescribing medicine for mental illness, which is often ineffective.

> *There are some good psychiatrists, therapists, social workers, doctors. I just do not know of them. It seems that all these mental health practitioners want to do is give pills to everyone with mental health problems. Just take a pill, and everything will be okay. Sometimes, good old talk therapy is all an elder needs to snap back into reality. I do not believe in medication because the medicine turns them into zombies to a point where they do not know if they are coming or going* (Stansbury, 2011)

Distrust may relate to not having a medical explanation of illness. Additionally, there is a potential lack of contact between faith leaders and health professionals and perceptions of professional healthcare providers over-prescribing medicines for mental problems.

Use of informal counselling and guidance: As 'sadness' or depression was recognised, so informal care provided through talking was reported by faith leaders. Informal psychosocial care, such as the use of guidance through talking and teaching activation strategies, was used by faith leaders, such as advice to become involved in activities.

> *I got her to take part in activities and that is one thing to get her not to look down or become depressed and not have the will to live. I think I always encouraged her to be more active, but don't just stay home because that brings on more depression but getting out and going and getting members to encourage her also* (Stansbury, Brown-Hughes and Harley, 2009)

The psychosocial explanation for depression was also apparent, and it was explicitly mentioned that "staying at home" exacerbates the symptoms of depression. Religion was seen as part of life that encouraged participation in daily activities, especially religious activities such as praying at churches and mosques. Such explanations for alleviating one's low mood are common grounds between faith leaders and health professionals.

Community engagement in religious institutions: Involvement of religious institutions with community members was encouraged, and members were invited to various church activities

– such as prayers, community gatherings and volunteer support groups for immigrants. This indicates that faith leaders have utilised a proactive approach to approach individuals.

> *Mainly through personal home visits, encouraging church members to do likewise, always including her and keeping her informed about church activities* (Stansbury, Brown-Hughes and Harley, 2009)

It should be noted that most faith leaders in the study are not only healers but also religious and community leaders who have a broader role in society. People approach them not only for their mental illness but also for their other personal problems and for religious and spiritual guidance (even if they have no mental illness). For instance, one faith leader discussed providing practical support to immigrants.

> *We are not only clergy members but also social service providers. From their arrival to settlement, we provide all kinds of help and information to newcomers. When immigrant families arrive, we are there at the airport and help them settle* (Jang et al., 2017)

A proactive and community-based approach utilised by faith leaders has increased the accessibility and availability of such services to the community. Making connections by visiting home and helping people is one of the essential elements that shape the preference of individuals with mental illness to see faith leaders. Based on this theme, which emerged in this review, I used the term faith leader throughout the dissertation.

5.8.3 Barriers Identified by Faith Leaders

Stigma and silence regarding mental illness: Stigma associated with mental illnesses for minorities (including Korean immigrants settled in the USA and Black community members in the USA) was reported by faith leaders in two studies (Jang et al., 2017; Bryant et al., 2014). For instance, it was highlighted that among a Korean community in the USA, admitting having mental health issues is often seen as shameful by family and community members.

> *Mental health problems are perceived as a shame and something that should not be disclosed to other than family members* (Jang et al., 2017)

In another study, a faith leader explained that in the Black community in the USA, depression is often considered a sign of weakness, which may make people reluctant to seek help from professional mental health services and attend faith leaders.

Admitting depression for a man, especially a Black man, is admitting weakness……. I'm going to find a way to get it [depression] fixed. That's admitting I'm weak, and I can control it [depression]. As black men, we don't do it [admit depression] (Bryant et al., 2014)

In both these studies, rather than sharing or discussing mental illness, individuals with mental illness tend to try to manage it by themselves; this includes not seeking help from faith leaders. Furthermore, in these studies, it was reported to be common practice to hide emotions in general and teach children not to cry when upset. Family values and norms also play a significant role in recognising and pursuing help for mental illness. Again, it reflects that such family beliefs hinder accessing professional and informal help (such as from faith leaders). It especially applies to vulnerable communities with collectivistic family norms.

Lack of training and capacity building: Despite distrust towards services in two of the studies and some knowledge of depression in most of the studies, faith leaders explicitly stated that they needed extra training as they were not confident in detecting cases of depression. Any knowledge of depression was a result of their exposure and experience with cases of depression rather than confidence in being able to identify depression categorically.

I don't think there is one easy and simple way to say what depression is. I am personally not quite sure if I can correctly detect someone who has depression (Jang et al., 2017)

Furthermore, most faith leaders reported that they do not feel prepared to manage people's mental illness properly, and in some studies, the presence of professional counsellors in the church was identified as a helpful way to build capacity (Hankerson, Crayton and Duenas, 2021; Jang et al., 2017).

I [clergy member] don't necessarily feel the most prepared to do [depression counselling]. I do it, but yeah, I don't necessarily feel as prepared as I should be (Hankerson, Crayton and Duenas, 2021)

Openness towards medical and statutory mental health care: It has been observed across multiple studies that faith leaders were open towards statutory mental health services for their followers and congregants, except in two studies discussed above under distrust in the medical approach. In these studies, faith leaders acknowledge the role of medical factors such as chemical imbalance in mental illness and accordingly believe that they cannot be fixed through

healing strategies such as prayer. It was apparent in the data that faith leaders reporting openness towards medical approaches were aware of basic medical terminologies, indicating exposure to health professionals.

> *How would you fix a hormonal problem with prayer? It is impossible. You need to see a mental health specialist and get medical treatment* (Jang et al., 2017)

The limitations on practices of faith leaders were also acknowledged by faith leaders, who explicitly pointed out that medical problems are not their area, and they don't have sufficient training for this.

> *I feel that I am equipped to address spiritual needs; however, if there is a need for medical treatment or a medication, those are areas in which I have not been trained* (Kitchen Andren and McKibbin, 2018)

Additionally, in one of the studies, Muslim faith leaders reported advising people to seek medical treatment when necessary.

> *We advise them to go for medical treatment to psychiatrist or psychologist because we are not qualified in that area* (Moodley, Joosub and Khotu, 2018)

This theme is identified as a barrier, as it may mean individuals are less likely to attend faith leaders. This may highlight that faith leaders are open to medical healthcare, that individuals may use both services and that there is scope for collaboration.

5.8.4 Facilitators Identified by Faith Leaders' Attendees

Inclination towards faith and religion: Faith-related activities and focus on spirituality were apparent in responses of the individuals with CMD attending faith leaders. Faith leaders' attendees reported leaving problems to God and reported that faith helps alleviate mental illness. They reported that they must rely on religious rituals such as prayers with pure intention and devotion. For building trust in God, prayer was identified as a beneficial activity.

> *When I got saved, I had to say my prayer from my heart, from my inner self just to give everything, all my problems back to the Lord and let Him take care of it* (Storck, Csordas and Strauss, 2000)

I noted that historical accounts preserved in religious texts serve as an enduring source of inspiration for people attending faith leaders. These narratives provided a sense of relation, where people can draw parallels between their difficulties and the adversities overcome by their

elders. As pointed out by faith leaders, their practices are guided by texts like the Quran and the Bible. The holy books contain accounts of Prophets (messengers of God), such as their difficulties and how they coped with them. Such coping behaviours utilised by Prophets were considered as guidance for followers.

> *What I most liked about this program was the stories of the Prophets" and expressing appreciation for "making healing from the Islamic religion* (Zoellner et al., 2021)

This theme converges with the theme and responses reported by faith leaders; it indicates that faith leaders and individuals who attend those faith leaders have shared values and beliefs that shape the preferences of individuals seeking help for mental illnesses (Zoellner et al., 2021).

Helpfulness of religious interventions: I noted people attending religious ceremonies, prayers, and other faith-related activities; such activities offer an opportunity for emotional catharsis and healing through communal gatherings and shared spirituality. Experiences while attending such ceremonies and going through the healing process reflect the transformative process as well as adverse experiences felt during mental illness. People attending faith leaders reported that healing remedies help improve well-being and relationships with family members (Storck, Csordas and Strauss, 2000).

> *Attended the meeting and cried my heart out for my late father. I felt like something was crushing my chest and that it was wrapped all around my chest as hard as you could tighten it, but at this meeting, the tightness softened up, and then I settled down, and that is how I am today* (Storck, Csordas and Strauss, 2000)

They tend to relate their experience of mental illnesses and their transformation phase to the heart rather than the mind. Among individuals who attended faith leaders, there was a reference to one's 'heart' or 'chest', which would relax due to religious interventions.

> *My heart continues to soften. It is much easier to see people as individuals. While I have fleeting moments and flashes on negative circumstances, I care and feel better about myself* (Wahbeh et al., 2017)

In many religious scriptures, the "heart" is considered a controlling unit of the body. Thus, faith leaders using culturally relevant terminologies allow individuals with mental illness to express their beliefs in an appropriate and meaningful way.

5.8.5 Barriers Identified by Faith Leaders' Attendees

Contextual and logistic barriers: I observed that accessibility to faith leaders remained a challenge due to constraints on their time and resource limitations. Contextual and logistic barriers to accessing faith leaders included time constraints.

> *Three months just wasn't enough for me.* (Pyne et al., 2021)

In one of the studies, an individual attending faith leader exhibited concern about confidentiality and privacy, especially in informal settings; faith leaders lack a proper space to ensure privacy and confidentiality (Pyne et al., 2021).

> *I do not want my business on the street.* (Pyne, Rabalais and Sullivan, 2019).

Training and awareness barriers: As with faith leaders, their attendees also identified a lack of formal training in mental health among faith leaders.

> *Not be too quick to think you understand. You have not been there. Every veteran's story is different* (Pyne, Rabalais and Sullivan, 2019)

They reported that faith leaders need to understand the problems in greater depth and address them on a case-by-case basis.

5.8.6 High-Income vs. Low-Income Regions

Most of the studies in the qualitative synthesis were based on HICs (N=11), with only three based in low-resource settings. Most barriers and facilitators identified were limited to HIC. Faith leaders identified facilitators, including knowledge of mental illnesses and use of informal guidance, were observed in studies based on LMICs (Kpobi and Swartz, 2018; Pullen et al., 2021), as well as HICs. Further, attendees identified facilitators were observed in both HICs and LMICs.

5.8.7 Risk of Bias

The quality of the qualitative or mixed methods studies was mostly moderate to low; seven were rated as moderate, seven as poor, and three as good (See Table 5.1). Generally, the studies used an appropriate method for data collection and provided a clear rationale for their methodology and recruitment. However, there was little evidence of reflexivity being addressed

in most of the studies. Additionally, several studies did not provide comprehensive details about data analysis.

5.9 Discussion

This is the first review, based on a synthesis of RCTs and a review of barriers and facilitators regarding implementing interventions delivered by faith leaders for CMD. Overall, I found that high-quality evidence was limited. Most of the studies on the effectiveness of interventions by faith leaders were carried out in HICs. Given the considerable proportion of people attending faith leaders for mental health (Burns and Tomita, 2015; Khan et al., 2019) coupled with the lack of trained human resources and facilities for mental health care in these countries (World Health Organization, 2009) it is worth considering why this area has been overlooked in LMICs (Rathod et al., 2017). This is particularly important, considering the significant mental health treatment gap and that previous evidence suggests interventions offered by faith leaders may be effective for treating depression and anxiety (Nortje et al., 2016). There is also some evidence demonstrating the willingness of both faith leaders and healthcare professionals to collaborate (Green and Colucci, 2020).

Overall, the present review suggests that interventions provided by faith leaders improved the symptoms of depression and anxiety compared to control groups. However, subgroup analysis, together with sensitivity analysis, further suggested that interventions provided by faith leaders improved symptoms of anxiety only in individuals with co-existing physical conditions. Additionally, spiritual passe interventions also improved symptoms of depression and anxiety, whereas other interventions (meditation, prayer, etc.) demonstrated non-conclusive findings. The effectiveness of spiritual passe interventions with more precise estimates for each study reflects that it is a well-explored intervention in medical care with consistent methodological approaches, geographical location, and homogeneous participant characteristics. Intervention characteristics of spiritual passe may be another characteristic where procedures and ways of performing spiritual passe are well defined. However, it should be noted that outcomes of anxiety in the co-existing physical conditions and spiritual passe subgroups were mainly measured up to only three days after delivering interventions. Therefore, findings about improvements in depression and anxiety for spiritual passe interventions and improvements in anxiety for participants with physical conditions are primarily limited by premature timing of outcome measurement.

Studies evaluating other interventions (prayer, repentance, religious teaching, etc.) were inconclusive, largely heterogeneous, and were fewer (five studies) in this review. Interventions such as prayers, repentance, meditation, and religious teachings may vary due to religious and

cultural values. Therefore, inconclusive findings identified by this review may warrant more clarity around defining faith healing approaches other than spiritual passe. Additionally, compared to the outcome timings for the spiritual passe intervention, studies evaluating other interventions measured outcomes at considerably different timings, ranging from 4 weeks to 12 weeks. Further, the studies in effectiveness review were at higher risk for attrition bias, which concurs with the previous systematic review (Nortje et al., 2016).

There were differences in interventions that addressed CMD with co-existing physical conditions and CMD without any physical conditions. Almost all the studies, including participants having CMD with co-existing physical conditions, used either spiritual passe or another energy healing intervention except for one study (which utilised prayer). In comparison, various interventions were used for participants with CMD without physical conditions, including spiritual passe, energy healing and worship traditions (such as prayers, repentance, and religious teaching). Spiritual passe and other forms of healing, such as reiki or prana, are based on the belief that universal energy flows through the human body, and the goal of healing is to bring balance to the energy flow in an individual body (Schmidt, 2021). Energy healing interventions have different names in different parts of the world and depend on other spiritual practices and traditions. For example, spiritual passe is widely practised in Western countries (Schmidt, 2021), whereas prana healing originated and is practised in India (Sui, 2015). Such interventions may be referred to as spiritual; however, these energy healings are not well supported by religious traditions in religions such as Christianity as positioned by the Committee of Catholic Bishops.

While there are differences in performing prayer, repentance, and meditation, the most practised Abrahamic religions (Islam, Christianity, and Judaism) generally consider prayers, repentance, and meditation integral to their worship traditions. For instance, Quranic and Biblical interpretations show that the soul and closeness to God are essential parts of human psychology and believe the soul can be purified through following worship traditions. Thereby, through the purification of the soul, human beings become more connected to God and hence are less prone to psychological or mental illness (Jeppsen et al., 2022; Rothman and Coyle, 2018).

This review has strengthened the existing evidence provided by previous reviews, further supporting the potential effectiveness of interventions delivered by faith leaders for anxiety (Nortje et al., 2016; van der Watt et al., 2018). However, findings were also different in the case of depression, where I found no substantiated evidence for their effectiveness. An additional unique feature of our review was evidence indicating the beneficial effects of interventions by faith leaders on anxiety, even when co-existing physical conditions accompany it. This highlights the potential

versatility and broader applicability of such interventions in addressing mental health concerns within the context of comorbid physical health issues. However, it might only be accurate for some kinds of faith healing and warrants further investigation, considering heterogeneity related to interventions and long-term outcomes. Furthermore, qualitative and mixed methods studies incorporated in the review give more insight into the findings.

The findings from the qualitative synthesis were in line with the quantitative findings. People who had engaged in faith healing reported feeling better after attending religious ceremonies and faith healing sessions. It was also apparent in the data from faith leaders that faith-based activities, including believing in God, having a relationship with God, and attending church activities, may act as a protective factor against common mental health issues such as depression. Data from intervention-based (Gonçalves et al., 2015) and correlational studies (Anderson et al., 2015) have suggested similar findings whereby integrated faith-based approaches have been found more effective compared to non-faith-based psychosocial interventions (Anderson et al., 2015). Community engagement of faith leaders and religious institutions was well documented in the studies as faith leaders engaged in community-based activities. This is especially important in facilitating and increasing access to treatment care. Stigma, especially related to minority groups, is a noteworthy barrier which may result in the suppression of mental health issues and access to both formal and informal care.

My findings were similar to previous reviews, which identified barriers to collaboration between faith leaders and healthcare professionals (Green and Colucci, 2020). Some facilitators I identified were consistent with these previous reviews, such as a shared understanding of faith-related mental illnesses, enabling people to access faith leaders. However, my findings and samples were also different in certain aspects; my review included perspectives from both faith leaders and their attendees. I identified relationship dynamics between faith leaders and their attendees, for example, concerns related to privacy issues reported by attendees. In contrast, a previous review only focused on collaborative aspects, writing about institutional dynamics and professional reputation, prioritising the perspectives of faith leaders and healthcare providers (Green and Colucci, 2020). Primary data catering to the perspectives of people attending faith leaders is limited. In future studies, it would be essential to address barriers to collaboration between faith leaders and healthcare providers based on the perspectives of people attending faith leaders. Although faith leaders were open to learning and getting formal mental health services such as psychosocial training, they showed distrust in medicine-related treatments. Previous reviews also identified this perspective, which reported that faith leaders often feel that

health professionals consider their practices inferior (Green and Colucci, 2020). Their openness towards psychosocial strategies was not only identified in their perspective. Instead, they reported that they informally used psychosocial guidance through activation strategies (by encouraging individuals to engage in adaptive behaviours). It was also found that informal care providers with a religious background, which are often referred to as “faith leaders” (as in this review) or “faith healers” in the medical literature, have a wider role in society. Developing a broader understanding and terminologies for faith leaders could potentially facilitate mental health professionals to acknowledge (and tap into) the more comprehensive social network, following and approachability of such leaders.

5.10 Strengths and Limitations

I conducted a systematic review and meta-analysis, along with a narrative synthesis, which comprehensively reviewed the evidence on treating CMD by faith leaders and included perspectives of faith leaders, those attending them, and mental health providers. I followed established and recommended methods for such evidence syntheses. Some limitations of the evidence, which limit definitive conclusions, such as the timing of outcome measurements, have been described above. In addition, participants in the included studies did not receive diagnoses of depressive or anxiety disorders. Instead, the presence of symptoms related to depression and anxiety was assessed using standardised measurement tools. As a result, the findings from our review may not be directly applicable to individuals formally diagnosed with these disorders.

5.11 Conclusion and Implications

This review provides evidence that interventions delivered by faith leaders improve symptoms of anxiety in individuals with co-existing physical conditions. Also, spiritual passe interventions improve symptoms of both depression and anxiety. However, these findings are limited mainly by premature timings of outcome measurement in these studies. The qualitative data indicated that faith leaders and their users generally found faith healing helpful for mental health. Such findings indicated that interventions provided by faith leader have a potential to offer some benefits implying robust evaluation of such interventions particularly those targeting depression and anxiety. While stigma, lack of training of faith leaders and infrastructure or logistics were identified as significant barriers to faith leaders’ treatment for CMDs, facilitators included a faith-based worldview, some knowledge of CMDs and an acknowledgement of a need for further training by faith leaders. Also, it highlighted some forms of activation approaches aiming to increase the activities in an individual life to overcome depression. This warrants further investigation into the perspectives of faith leaders and their attendees regarding training faith

leaders in managing depression, as training need has been explicitly noted. In addition, developing a more nuanced understanding of depression from faith leaders and their attendee's perspectives and how it aligns or conflicts with BA, especially given the faith-based interpretations of depression found in this review. Additionally, to get more insight into how faith leaders and their attendees respond to the idea of faith leaders delivering BA.

6 Chapter Six: Faith Leaders' Attitudes to Using Behavioural Activation (BA) for Depression: A Qualitative Interview Study

This chapter describes a qualitative study in which I collected primary data. I conducted in-depth, semi-structured, one-to-one interviews with faith leaders about their practices and their attitudes to practising BA in their day-to-day engagement with their attendees. The chapter begins with a discussion about the terminology used to describe faith leaders or healers, and what is known from the existing research literature about the role of Muslim faith leaders in mental healthcare. It sets out the knowledge gaps relevant to their potential role in delivering BA for people with depression, before describing the methods of the qualitative study and my findings. Finally, I discuss the study's strengths and limitations and how it informed subsequent studies in this thesis.

6.1 Background

6.1.1 Healers vs. Leaders: Which Term?

There are a multitude of terms used to describe people who have a role providing 'traditional' or 'faith based' services to 'heal' people with health, personal or societal problems. Based on my systematic review, I decided to use the term 'faith leaders' in order to recognise the broader societal roles of faith leaders.

In the literature, the terms "traditional healers" and "faith healers" are often used interchangeably. However, there are conceptual differences between traditional and faith healing. Traditional healing refers to knowledge, skills and practices based on theories, beliefs, and experiences indigenous to different cultures, used in identifying, treating, and preventing physical or mental illness (World Health Organization, 2019). Faith healing involves explicitly using religious, spiritual, and magical knowledge and practices to heal physical and mental illnesses (Nortje et al., 2016; van der Watt et al., 2018) . Nortje and colleagues (2016) used the term "traditional healer" but offered a somewhat restricted interpretation of traditional healers as individuals who use "spiritual, religious, or magical explanations" for dealing with mental health issues. This description closely aligns with definitions of the other commonly used term, "faith healers". Other authors, acknowledging their wider role in society, have used the terms "religious leader" or "faith leader" rather than traditional or faith healers (Meran and Mason, 2019).

In my systematic review, I found that faith leaders play a broader role in community settings in addition to focusing solely on the healing of mental illnesses (See Chapter 5: Faith Leaders Identified Facilitators: Community Engagement in Religious Institutions). Beyond providing

informal care to individuals with mental illness, faith leaders were identified as supporting immigrants and newcomers, arranging church-based activities, and providing guidance to those who do not have an illness. There are examples in the literature where the term ‘leaders’ has been used to refer to faith healers or traditional healers, often referring to their more expansive role. For instance, in the context of informal mental health services provided to Muslims in the UK, many studies have identified that Muslims frequently approach “Muslim faith leaders” rather than health practitioners to get support for mental illness (Singh et al., 2015; Dein, 2013).

Typically, people who rely on religious, spiritual, or magical explanations to heal mental illness do not have a role only as a "healer". This is especially true of Muslim faith leaders. The duties of most Muslim faith leaders who provide support to individuals with mental illness are heterogeneous and include leading prayer, managing religious rituals, giving sermons, preaching Islamic values and principles, and offering spiritual guidance. Generally, many Muslims invest a great degree of confidence and respect in faith leaders, and they play a significant role in their religious, spiritual, and communal life. Members of the Muslim community experiencing psychological issues may seek any of the many types of faith leaders, including prayer leaders, spiritual mentors, and scholars based in mosques, community centres, and educational institutions. Given their broader role in society, the terminology used in the available literature and findings from my systematic review, I have used the term "faith leaders"' from the beginning of this dissertation. Based on these considerations, I have used the following definition:

“Individuals providing informal care and support to those with mental illnesses using practices grounded in faith, spirituality, magic, and religion. They also offer additional roles like helping community members, involving in volunteer work, and leading religious and faith-based matters in the community”.

The categorisation of Muslim faith leaders has been comprehensively documented by Padela and colleagues (2011). I have presented the types and descriptions of faith leaders below:

Figure 6.1: Taxonomy of Muslim Faith Leaders (Padela et al., 2011)

Type	Urdu Terminology	Description
Prayer leader	*Imam Masjid*	The general definition of an *Imam Masjid* is a congregational prayer leader. Most Imams are either *Hafiz-e-Quran* (one who remembers the whole *Quran)* or Islamic scholars (described below).
Islamic scholar or Islamic law expert	*Aalim or Mufti*	Studies Islamic laws through traditional Islamic educational colleges/ schools. *Aalim* and *Mufti* both have Islamic education, but usually, *Mufti* is authorised to issue religious edicts. *Aalim* requires one to two years of additional education to become a *Mufti*.
Spiritual leader or spiritual guide or spiritual mentor	*Peer or Shaykh*	Muslims usually approach them for spiritual guidance around life events. They are often descendants of saints or *Sufis*, well-known and famous for their pious deeds.

When considering a suitable term that conveys respect and engagement, the term “leader” is far more conducive to translation from English to Urdu than “healer”. The term “leader” (*Rehnuma* in Urdu) helped to engage and interact with faith leaders. Furthermore, if the study had been restricted only to “healers”, there was a possibility that many faith leaders who provide informal guidance and care to individuals with mental illness may have fallen short of the inclusion criteria for the study - even though their roles would be highly relevant to include.

6.1.2 The Role of Muslim Faith Leaders in Mental Health

The role of Muslim faith leaders is not limited to Muslim majority jurisdictions; some studies from HICs, including the UK and USA, have documented that they provide informal mental health care to Muslim minorities. Muslims residing in HICs tend to be less inclined to seek assistance from mental health professionals. Instead, they often turn to faith leaders for support with their mental health concerns. A study including 54 Bangladeshi Muslim women living in East London reported that they primarily use Islamic scholars, prayer leaders and spiritual leaders for mental health issues (Barn and Sidhu, 2004). A similar trend is reported in the USA; a study conducted in 22 mosques in New York City indicated that prayer leaders (imam) in mosques play a vital role in providing mental health care to Muslims, especially in times of crisis (such as in the days post 9/11) (Abu-Ras, Gheith and Cournos, 2008).

This trend is also apparent in LMICs. For example, a systematic review, including studies from LMICs in Africa, found that faith leaders are commonly approached as a gateway for mental health issues (approximately 26% of people with mental health issues) (Burns and Tomita, 2015).

The percentage of people approaching faith leaders with mental illness was higher compared to general health services (24%) and mental health services (13%). Although there are no similar systematic reviews available for South Asia, the findings of my review suggested that approximately 32% of people with mental illness seek care from faith leaders before their contact with healthcare workers (See Chapter 4).

6.1.3 Collaboration between Faith Leaders and Healthcare Professionals

Most studies involving faith leaders have used qualitative methods to understand the perspectives of faith leaders regarding the nature of mental illness, the causes of mental illness, their practice, and their views on collaborating with bio-medical professionals. They report that faith leaders' understanding of mental illnesses is considerably different from the biomedical profession, with more emphasis on social context, cultural beliefs, and religious rituals (Soori, Regmi and Pappas, 2024). A study conducted in a rural locality in Kenya used focus groups to understand the practices of faith leaders and identified that they attribute mental illness both to "traditional beliefs", such as witchcraft, and psychosocial elements, such as distressing life events (Musyimi et al., 2018). In another study, qualitative interviews with Muslim faith leaders found that the conceptualisation of mental illness among Muslim faith leaders is primarily grounded in a religious conceptualisation (Rashid, Copello and Birchwood, 2012). Other recent studies have indicated that faith leaders are willing to collaborate with mental health professionals (Akol et al., 2018). However, concerns among faith leaders about biomedical professionals are present, and many faith leaders believe that biomedical professionals tend to disregard faith healing practices and are unwilling to work with faith leaders (Akol et al., 2018). A study carried out in Tanzania used a focus group to understand the perspectives of faith leaders regarding collaboration with bio-medical professionals. The findings reported that although faith leaders view collaboration as a doorway to learning bio-medical practices (in addition to traditional practice) to treat mental illness, bio-medical professionals disagree with developing an office in hospitals for faith leaders (Solera-Deuchar et al., 2020). The disagreement by bio-medical professionals to work closely with faith leaders in the hospital may be because bio-medical professionals value evidence of effectiveness in what they practice, and such evidence for faith healing practices is limited (See Chapter 5).

6.1.4 Behavioural Activation for Depression

Depression has been described as the "common cold" of psychiatry, given its high prevalence (approximately 3 to 4% of the world population) (GBD 2019 Mental Disorders Collaborators, 2022). It is one of the leading causes of disability worldwide. In LMICs, people with depression are often left undiagnosed and untreated due to a lack of mental health workforce,

infrastructure, and financial resources (Vigo et al., 2020). Effective evidence-based brief and non-specialist psychological treatment are suitable for low-resource settings. BA is a brief psychological treatment developed specifically for depression, facilitated by non-specialist healthcare workers. Several clinical trials have suggested that BA is not only equally effective for depression compared to cognitive behavioural therapy but also is simple, relies less on specialists and is cost-effective (Jacobson et al., 1996; Ekers et al., 2011). The evidence about the effectiveness of BA has been extended to various regions and countries, including LMICs (Ekers et al., 2014) (For more details on BA, See Chapter 1). Recent studies have suggested that it is feasible to train faith leaders in non-specialised psychosocial interventions to manage depression (Musyimi et al., 2017a). However, data about the views and perspectives of faith leaders on being trained and the delivery of psychological therapies such as BA is not available.

6.1.5 Problem Statement and Aims

Several recent studies have highlighted that faith leaders are willing to work with healthcare professionals and are flexible in embracing change (Green and Colucci, 2020). However, these studies are mainly from African countries and have not been extended to other LMICs like Pakistan (Green and Colucci, 2020). Pakistan is the fifth most populous country in the world, where most of the population identifies as Muslims (approximately 97%). Recent studies have documented that a considerable proportion of people attend Muslim faith leaders to get support for mental illness (See Chapter 4). However, there is a lack of evidence regarding faith leaders' views and practices regarding the treatment of mental illnesses (and depression precisely) and how their practices may align or contradict with therapeutic interventions, specifically talking therapies such as BA. The present study, therefore, aims to develop a better understanding by exploring their current practices to identify and manage depression and their willingness to use BA for treating depression in Pakistan.

6.2 Research Questions

The research questions explored in this study are:

1 What common practices are used by faith leaders to identify depression in their routine practice?
2 What are the common practices of faith leaders to manage or treat depression?
3 What are faith leaders' perspectives on working collaboratively with healthcare workers to manage depression?
4 Are faith leaders open to acquiring training and delivering BA to individuals with depression?
5 What barriers and facilitators are there to integrating BA in faith leaders' routine practice?

6.3 Methods

6.3.1 Qualitative Approach and Research Paradigm

This study took a qualitative interpretative approach with a pragmatic position. The study aimed to explore the perspectives of faith leaders relating to depression, its identification, treatment, and willingness to learn and deliver BA in a Pakistani setting. It is essential to highlight that while it was anticipated that faith leaders might hold varying perspectives on explaining depression, the primary objective was to explore the potential for establishing workable partnerships of biomedical professionals with faith leaders. Such partnership aims to enhance and facilitate the accessibility of evidence-based treatments (such as BA) for individuals with depression. Therefore, the present study is rooted in a pragmatic position searching for the potential for faith leaders to deliver BA as a part of their routine practice.

5.1.1 Setting

The study was conducted in the cities of Rawalpindi and Islamabad. Islamabad is the capital city of Pakistan, and Rawalpindi is a neighbouring city located in the Punjab (Province in Pakistan). The overall population of Pakistan is about 216 million, with Rawalpindi and Islamabad having populations of 1 million and 2 million, respectively. There were three types of institutional settings where faith leaders were approached conveniently for this study, including i) shrines, ii) mosques and iii) Islamic educational institutions. According to the *Auqaf* (assets that are donated for charitable purposes)[3] and Religious Affairs Department in Pakistan, there are over 70 shrines in and around Rawalpindi (Auqaf and Religious Affairs Department, 2023). Most shrines have tombs of saints from past ages, and some have mosques associated with those shrines, but not all of them. The number of mosques in both cities is undetermined because most mosques are not registered with provincial religious ministries. There are about 50 registered Islamic educational institutions (*Madaris* in Urdu) in Islamabad and more than 2000 in Punjab (Directorate General of Religious Education, 2021). People living in communities near such institutions relate to them depending on their faith; for example, some prefer to educate themselves or their children in Islamic educational institutions. Also, people, especially in Punjab, have respect for saints. Similarly, many people attend Friday prayer in nearby mosques, and a minority attend mosques for daily prayers. Both cities have higher literacy and education levels than other regions of the country. Rawalpindi has a specialised mental health facility (the Institute of Psychiatry) serving neighbouring cities (in Punjab). In comparison, Islamabad also has a government mental health

[3] People in Pakistan usually donate their land or money to build mosques and shrines for charitable purposes. These properties are managed by local committees or religious trusts and serve as community assets rather than personal property.

facility; however, due to comparatively higher levels of household income, Islamabad has many private rehabilitation and outpatient mental health facilities.

6.3.2 Sampling Strategy and Sample Size

There is no legislation or registration process related specifically to faith leaders who practise religious ways of treating mental illness in Pakistan. However, faith leaders are usually associated with religious institutions (mosques, shrines, and Islamic educational institutions). The relevant people at these institutions were approached conveniently, either physically or through phone calls. The sampling method was based on a purposive convenience sample (criteria provided below). To achieve a diverse representation among faith leaders, I aimed to recruit faith leaders with different characteristics. This included differences in their i) roles and responsibilities (Islamic scholar, prayer leader and spiritual leader), ii) gender, iii) age, and iv) sect (*Sunni* and *Shia*) affiliation (See Chapter 3). I visited some well-known mosques and shrines in Rawalpindi and Islamabad, such as *Faisal Mosque*, *Eid Gah Shareef* (Shrine in Rawalpindi) and *Golra Shareef* (Shrine in Islamabad). After approaching potential participants (i.e. faith leaders) either by visiting or through a third-person reference, I verbally informed (and provided participant information leaflet) them about the study's purpose. If those faith leaders fulfilled the inclusion criteria, their consent was taken; otherwise, they were requested to refer to a person in their institution (or neighbouring locality) who might fulfil the criteria.

Muslim faith leaders were included if they:

I. Practised any traditional treatment grounded in religious conceptualisation of mental health (through their verbal reports).
II. Did not have any background in formal mental health training/ education.
III. Had at least secondary level education or equivalent (usually called matriculation in Pakistan and equivalent to 10th grade).
IV. Were willing to participate.

Faith leaders providing only herbal or chemical substances for healing were excluded. I considered the breadth of the topic, the nature of the questions and the characteristics of the participants to inform the sample size (Malterud, Siersma and Guassora, 2016; Morse, 2000). The aim of the study was specific and comparatively narrow, as it focused on the perspectives of faith leaders on current practices of managing depression and the delivery of BA for depression in their routine practice rather than their views on mental health (or views to collaborate with healthcare professionals) in general. Also, my sample criteria were based on faith leaders who had experience of providing treatment or advice to people with mental illness. Saturation in

qualitative data analysis is usually a point at which no new ideas or insights are found in the data as the researcher proceeds to analyse additional data. In a previous qualitative study including Muslim faith leaders, saturation at the category level was reached at the sixth interview (Rashid, Copello and Birchwood, 2012). A systematic review of qualitative studies indicated that most of the studies with a narrowly defined objective (as in my dissertation) usually achieve saturation in codes by conducting 9 to 17 interviews (Hennink and Kaiser, 2022). However, given the uniqueness and richness of qualitative data, it may be impractical to identify an absolute saturation point – indicating the emergence of no new information or codes (O'Reilly and Parker, 2013). Based on these considerations, I planned to analyse the transcripts after completing 12 interviews. If consistent code repetition was observed and no new, distinct codes emerged that may require a separate category or theme, I planned to stop data collection at 12 interviews. If this level of repetition and saturation was not achieved, I planned to continue with three additional interviews before re-analysing.

6.3.3 Ethical Considerations

Prior to the commencement of the study, ethical approval was obtained from the ethics committee at Khyber Medical University, Pakistan, and the Health Sciences Research Governance Committee (HSRGC) at the University of York, United Kingdom. All the approached participants (faith leaders) were initially provided with the participant information sheet providing comprehensive details (objectives, benefits, anticipated harms, and contact details for queries) in Urdu (See Appendix 6.1: Participant Information Sheet). All faith leaders were usually well-read in Urdu. Therefore, they were able to understand the information sheet. Any subsequent queries were discussed at the start of the interview. After ensuring that participants were well informed about the study's overall purpose and role, informed consent was obtained via a hard paper copy or WhatsApp (verbal or text-based) (See Appendix 6.2: Consent Form). Participants were explicitly informed that their participation was voluntary, and they could leave study participation at any time without any reason or justification. Faith leaders were told that they were free to share their thoughts and could withdraw any information until 15 days after the interviews. I provided my contact number in case they changed their mind within the period.

6.3.4 Data Collection Methods

Studies have utilised an approach where researchers interviewed faith leaders at home or at faith leaders' places of practice (Rashid, Copello and Birchwood, 2012). This strategy can effectively reduce social desirability and pressure to elicit false positive views regarding the bio-medical profession within a hospital or clinic setting. Therefore, interviews were conducted at i) faith leaders' homes, ii) through an online platform (Zoom), iii) mosques and shrines in Rawalpindi

and Islamabad (neighbouring cities in Pakistan). Also, given the social status and time constraints of faith leaders, it was impractical to call them to a research facility at a university or hospital for interviews.

Interviews are generally suitable for exploring research questions about peoples' experiences. Similarly, when exploring research questions about understanding and perceptions of people, interviews are an appropriate method for data collection (Braun and Clarke, 2013). The research questions in this study explored faith leaders' experiences in dealing with depression and their attitudes to using BA, including engaging in training in BA. Both online and face-to-face in-depth semi-structured interviews were used for data collection.

One female researcher with a master's degree in clinical psychology and two years of experience in doing qualitative interviews and I conducted the interviews. I interviewed all male participants (n = 10), while the female researcher interviewed the female faith leaders (n = 2). The female researcher interviewed them as it was more culturally appropriate and to ensure the female faith leaders felt more comfortable and open in sharing. After approaching eligible participants and obtaining informed consent, participants were asked about their preference for interview mode (face-to-face or online). Out of 12 interviews, four were face-to-face, whilst the remaining eight were conducted online (Zoom). Interviews were conducted in Urdu and were between 45 minutes and 1 hour and 20 minutes duration. The interviews used questions and prompts developed as part of the topic guides.

To be more culturally sensitive I and other interviewers were not explicit about disclosing my sect, nor did I ask them to share theirs. Their sect was noted either by a third person who referred them or through the institutions I visited. The sect affiliation of any institution is common knowledge in Pakistan. Explicitly stating one's sect is rare among people, especially in the first interaction. Not disclosing my sect to faith leaders helped me in engaging with faith leaders in interviews.

I have written a chapter on reflexivity (See Chapter 3) to identify the characteristics and experiences that can influence the selection of a topic, method, and interpretation of findings in research. I have explicitly highlighted my own beliefs and experiences. These characteristics were discussed with my supervisors (NS, HJ, and SA), and appropriate measures were taken to ensure reflective engagement. A heterogeneous sample of faith leaders representing *Sunni* and *Shia* sects in Islam was included in my research to get a diversity of views. I found it challenging to recruit older faith leaders and engage with them. My hesitance to interact with older faith leaders

was likely due to the age difference. I expect older faith leaders to receive proper respect from those interacting with them, especially those younger than faith leaders. I was constantly mindful of not saying anything they may perceive as disrespectful. Three faith leaders in the sample were above 40 years old. The inclusion of female faith leaders was also ensured in the sample. Hence, faith leaders within the sample may or may not concur with my beliefs and perspectives.

During the interviews, I maintained a reflective diary and wrote down my thoughts related to my responses. Power dynamics favoured faith leaders, potentially due to their elevated status as leaders in the faith; in some interviews, they dominated the discussion. This is unusual in research that research participant dominates, usually the researcher often occupies a higher hierarchical position than the research participant. I found it difficult to ask questions about their willingness to learn about BA, especially of spiritual leaders whose followers strongly believe in the respect and dignity of their spiritual mentors, which usually precludes questioning them. Instead, their followers are expected to wait until they are spoken to.

6.3.5 Topic Guide

The topic guide was based on the research objectives, informed by information from effectiveness, barriers, and facilitators review (See Chapter 5), and developed in discussion with my PhD supervisors (NS, HJ, SA). Given the wide range of settings and culturally aligned practices and terms identified in Chapter 5, probes addressed faith leaders' roles at both the community and institutional levels (mosques and shrines). Cultural and religious-based approaches and terms used for depression/ mental illnesses were included in the topic guide. While my earlier effectiveness review found some healing remedies used by faith leaders (e.g., spiritual passe) were effective for common mental disorders, it was ambiguous about other strategies, such as prayers and recitations. The topic guide included questions about faith leaders' practices related to mental illnesses (and specifically depression) and their thoughts about their effectiveness (religious practices). There were also questions about their broader role in society.

The main topics covered by the guide were: 1) recognition and current support for depression; 2) views about talk therapy and BA; 3) openness to training by faith leaders on BA; 4) potential barriers and facilitators associated with integrating BA in faith leaders practice (See Appendix 6.3: Topic guide). The guide incorporated a brief description of depression and BA in lay language. Initially, I developed a topic guide, which was shared and discussed with my supervisors before being finalised. The guide was piloted in the first three interviews. No major revisions were needed. The only minor thing was that I noted that questions were overlapping.

To prevent repetition of questions during interviews, I avoided asking questions that were already extensively covered previously in the conversation.

6.3.6 Data Management

All interviews were recorded and transcribed verbatim. These interviews were subsequently translated from Urdu into English for analysis. Translation into English facilitated collaboration with supervisors. By doing so, I could discuss transcripts and codes with my supervisor (HJ, an expert in qualitative research), who cannot read and understand Urdu. Further, data management software for qualitative data does not facilitate uploading and working in the Urdu language. Also, the final write-up was required to be done in English for this dissertation. However, I acknowledge that coding and analysing translated transcripts can lead to a loss of nuanced meaning, potentially affecting the accuracy of data interpretation.

To check for the accuracy of the translation, the first two interviews were back-translated into Urdu. Any information through which participants could be identified was removed from the transcription. The identifying information of the participants was separated from transcriptions, and any discussion about the interviews in supervision meetings was done through anonymous transcripts. The identifying data were only available to people involved in interviews, i.e., myself and the female researcher. A unique identification code was assigned to each participant. The soft copies of the English transcripts with other details (date, location, name of the researcher, anonymised IDs of participants, etc.) were stored in password-protected electronic folders and were imported into NVIVO (version 12) for data analysis.

6.3.7 Data Analysis

I used thematic analysis to analyse data. It is a qualitative data analysis approach used to identify common patterns in experiences, behaviours, and thoughts across qualitative data (Kiger and Varpio, 2020). My approach toward the overall research questions was pragmatic, implying a lack of any clear linkage to any single theoretical commitment - this does not imply that the analysis was descriptive or atheoretical; just that it was not primarily led by any single theory framework or philosophical position (Braun and Clarke, 2006). Thematic analysis is flexible and can bridge different philosophical positions. It balances descriptive and transformative data, seeking to understand context and processes. My goal was not to remain descriptive nor move to an analytical position to develop a theory or model. Therefore, thematic analysis was suitable for balancing descriptive and analytical positions. Recently, Braun and Clarke highlighted the active role of subjectivity and researcher interpretations in thematic analysis (Braun and Clarke,

2019). Therefore, I reflected upon my experiences and related myself to participants throughout the study.

The thematic analysis (Braun and Clarke, 2006) was conducted through NVivo (qualitative data management software; version 12). This approach comprised six steps. First, I immersed myself in the data; this involved reading all the interview transcripts in English. Where required, I looked back into Urdu transcripts, both first and back translations. From the first step, I started taking notes of different aspects of the data, questions, and preliminary ideas. The notetaking was continued till the end of the data analysis. In the second step, I started coding data, and the codes were based on the ideas I identified in the data. In addition to the coding, I developed descriptions of codes to differentiate each code. Initially, a coding framework was developed from the first six interviews and was discussed with the supervisor (HJ). This approach facilitated the development of a framework of codes derived from the data and its description while also considering trustworthiness. It implies that codes are defined as concepts and ideas I identified from the data rather than applying pre-existing ideas. However, my approach was not based only on induction; a priori, agreed research questions and semi-structured interviews guided my research process. For coding and themes, however, my approach was rooted in induction. In the third step, I looked for potential themes mainly by looking at different concepts that emerged in codes and how they related to each other.

Further, in the fourth step, I reviewed all the themes identified; this step covered relating identified themes to codes and original data where required. Adjustments were made, such as merging codes or separating a single code into different codes to develop themes representing the data. In the fifth step, titles of themes were developed; while doing so, two main things were considered: i) to develop brief descriptive titles and ii) to ensure that the content of themes should be reflected in the title. In the sixth step, however, I tried to go beyond descriptive elements to develop higher-order interpretative themes; I presented results in both narrative descriptions and participants' quotes. I reflected on my writing and discussed it with my supervisor (HJ) to capture all essential information related to the research questions.

Throughout this process, I was cognizant of my active role in interpretation. I noted my responses related to data and a few elements that might have affected the data analysis. During the data analysis, one of my PhD supervisors with qualitative expertise (HJ) independently read through two transcripts and drew up initial codes. We subsequently discussed our findings and codes before I finalised the initial coding set. I discussed themes and codes with HJ. As well as

this being good practice, it helped highlight areas I may have missed and added a different perspective to the analysis (See Chapter 3).

6.4 Results

I collated all interview transcripts, memos and reflective notes and analysed them after completing the twelfth interview. It appeared that after completing the coding of six interviews, new ideas or codes became less evident in the data. Some new ideas emerged from female faith leaders or *Shia* scholars e.g. showing empathy to people, however, such ideas or codes fitted well with the broader understanding of what has been said in earlier transcripts. This reflected some success in achieving diversity in responses, which is also evident in the table representing the characteristics of the participants (See Table 6.1). Faith leaders with different roles, including prayer leader (*Imam*), spiritual leader (*Shaykh or Peer*) and Islamic scholar (*Aalim or Mufti*) were included along with representation of both major sects of Islam (*Sunni* and *Shia*). Similarly, two female faith leaders were interviewed; most of the faith leaders were young, but three of them were over 40 years old (See Table 6.1). Overall, this criterion was based on the findings of a systematic review to acknowledge the broader role of faith leaders.

Table 6.1: Participants Socio-demographic Characteristics (N = 12)

Faith Leaders' Role	Gender	Age (M= 40.08; SD = 8.84)	Ethnicity	Sects
Islamic Scholar (*Mufti/ Aalim*)	Male	30	Punjabi	Sunni
Islamic Scholar (*Aalima*)	Female	27	Punjabi	Sunni
Islamic Scholar (*Mufti/ Aalim*)	Male	35	Punjabi	Sunni
Prayer Leader (*Imam*)	Male	35	Punjabi	Sunni
Spiritual Leader (*Peer/ Shaikh*)	Male	36	Sindhi	Shia
Spiritual Leader (*Peer/ Shaikh*)	Male	50	Punjabi	Not Known
Spiritual Leader (Peer, Shaikh)	Male	44	Punjabi	Sunni
Prayer Leader (*Imam*)	Male	60	Punjabi	Sunni
Spiritual Leader (*Peer/ Shaikh*)	Male	40	Sindhi	Shia
Islamic Scholar (*Aalima*)	Female	43	Punjabi	Sunni
Islamic Scholar (*Mufti/ Aalim*)	Male	41	Punjabi	Sunni
Islamic Scholar (*Mufti/ Aalim*)	Male	40	Punjabi	Sunni

Note. Sects were noted based on their institutional affiliation or the person who referred them.

Seven themes were identified; they were: 1) faith leaders recognise depression through experience and intuition, 2) faith leaders may use psychosocial approaches aligned with Islamic history and cultural values, 3) faith leaders may also use approaches grounded in metaphysical explanations, 4) faith leaders and faith institutions frequently play an active role in the community, 5) faith leaders' conceptualisation of mental illnesses and practice can conflict with those of formal healthcare services 6) there are areas of compatibility and potential collaboration with formal healthcare services and 7) there are also potential barriers associated with collaboration.

6.4.1 Theme 1: Faith Leaders Recognise Depression Through Experience and Intuition

Faith leaders reported that they rely on questioning, history-taking, and intuitive judgment to identify mental health issues or problems. Through exposure and interaction with a large number and diversity of people and followers, they have gained experience to build an

understanding and identification of problems. Based on this judgement, they offer solutions.

> *These gentlemen [faith leaders] are so intelligent, because of their interaction with the people, they also get a better idea... even by looking at the man in front of them, and their questions suggest that they can give them a much better solution.* (Islamic Scholar; Male; Age 30)

The data also revealed that faith leaders attributed some extraordinary abilities to themselves, reporting that they can even have an idea of people's problems by "just looking at them". However, it was also reported that occasionally, they do not only rely on the individual but may also take a history through family members.

> *So, my first thing for judgment, I call the man, after calling him, I see him, call his family, and discuss with the family.* (Spiritual Leader; Male; Age 35)

During interactions with people potentially presenting with mental illnesses, faith leaders reported that, in most cases, individuals do not report any symptoms directly. This implies that individuals with mental illness do not approach faith leaders specifically for mental health issues. However, faith leaders explicitly mentioned that people without any awareness share their mental illnesses indirectly under problems related to *Islamic Shariah* (Islamic laws), relationship issues (such as divorce) and other issues related to social and religious life — indicating that people may think that issues related to religion are more appropriate to share with faith leaders. Underlying traditions in faith-based communities and faith leaders' practices, which rely less on diagnosis and labelling, were evident and are discussed in greater detail in upcoming themes (Faith leaders' conceptualisation of mental illnesses and practice conflict with the formal healthcare services).

> *See I think this is with every mufti* [Islamic scholar]*, with almost everyone who interacts with people, people don't talk about their mental illnesses directly, but they share their mental illnesses under their personal problems.* (Islamic Scholar; Male; Age 30)

In Islamic traditions and practices, most scholars, *Sunni,* and *Shia,* have a consensus on following the traditions and practices of the prophet Muhammad (PBUH; peace be upon him). Similarly, there is consensus on following the ways of the prophet PBUH while performing worship and social life. However, the difference lies in the interpretations of such traditions. Traditions of

the prophet PBUH to provide solutions to problems without diagnosing mental illnesses were noted; however, traditions to overcome such problems may vary (these will be discussed further under faith leaders' use of psychosocial approaches aligned with Islamic history and cultural values).

> *So, without mentioning any mental illness, the prophet (peace and blessings of Allah (God) be upon him) has guided us about the cure for this issue.* (Islamic Scholar; Male; Age 30)

Mostly, faith leaders were aware of the term depression. They generally reported that people with depression are often hopeless, indecisive, anxious about the future and isolated. One female religious scholar identified depression and reported that negative thinking is a significant sign of depression and that individuals with depression tend to interpret positive things negatively. Negative thinking (*Manfi Sauch*) is commonly used to portray depression and mental illnesses in Pakistan.

> *Nothing will happen for us - negativity comes in a lot, negativity comes in everything, someone is trying to do well with them, someone is positive with them, so if you take it negatively, then negativity is all. I see the biggest sign that this person is depressed.* (Islamic Scholar; Female; Age 27)

One Islamic scholar also differentiated between normal feelings of distress and clinical depression in the light of Quranic verses. The differentiation was based on situation-specific scenarios where it was acknowledged that feelings of sadness under a pressured situation are expected, and depression is considered clinically significant when it is prolonged and is generalised across different situations. He also pointed out that such situations are attributed as a test for Muslims, and in Islamic theology, trials and struggles for Muslims hold a central position.

> *In the Quran Allah* [God] *says in "Surah Ahzab"* [Chapter 33 of Quran] *that there was a tough test of Muslims, where many forces were against Muslims, Muslims were locked inside Medina (a* City in Saudi Arabia*) and Jews started a revolt against Muslims, Allah said that Muslims in this time were depressed as the hearts of Muslims were in distress and they were worried about what will happen. The initial phase of distress is not depression, it happens and it's natural and normal. But when it prolongs then it's depression.* (Islamic Scholar, Male; Age 40)

It was also pointed out that being anxious and worrying about one's future is a part of depression.

> *What I understand in depression is that the person who is not sitting gets lost in thoughts, and keeps thinking about the future, how it will be, and how it will be if this happens.* (Islamic Scholar, Male; Age 35)

Several other factors associated with depression were also identified, including divorce, unnecessary strictness by parents, disrupted family relations, financial issues, unemployment, lack of communication and excessive use of mobile phones. Research participants also reported the risk of suicide among people with depression. One male spiritual leader explicitly advocated for the provision of early treatment to people with depression for suicide prevention.

> *This is where it needs to be paid attention to. If you don't address it, then it will continue to decline. There is no limit to it, it can also happen that the person commits suicide.* (Spiritual Leader; Male; Age 40)

Symptoms of obsessive-compulsive disorders (OCD) with religious content were also reported in those who attend faith leaders. People often complain about repetitively performing ablutions (*Wudu* in Arabic) and prayer because they think their ablution and prayer have not been performed appropriately (For Additional Quotes See Appendix Table 6.4).

6.4.2 Theme 2: Faith Leaders May Use Psychosocial Approaches Aligned with Islamic History and Cultural Values

All faith leaders reported that involvement in personal, social, domestic, and religious activities is core to Islam. The majority reported Islam is a complete guide to living. It instructs people to perform worship and rituals and guides them regarding matters other than worship. One participant referenced a saying of the prophet PBUH, explaining that earning a livelihood while staying away from prohibited acts is a good deed. In this context, the struggle for livelihood and sustenance is equivalent to worship (like prayer).

> *Companions [of the prophet PBUH] saw a person struggling for his livelihood and running after his livelihood all day. They asked the prophet PBUH, "If he does this struggle for the religion of Allah (God), how much reward will he get? Should he do it for the sake of preaching, should he do it for the sake of Allah Almighty (God), should he do it for the sake*

of Islam?" The Holy Prophet PBUH replied: "This is also the worship of Allah Almighty. It is not just a matter of preaching and sitting in the mosque, God willing. He is running for the lawful sustenance of his children. Allah will also write good deeds in his book of deeds". (Prayer Leader; Male; Age 35)

Activities related to the domestic life of the prophet PBUH with his wife were also reported, where they pointed out that the prophet PBUH had a habit of spending time with his wives.

From the life of the prophet PBUH we find these things in which he ran with Hazrat (Arabic word used to give respect and honour to a person) Ayesha (Allah be pleased with her), who is the mother of all Muslims… so it is present in the Islamic literature. (Islamic Scholar, Male; Age 35)

Notably, one female scholar advises young women to keep themselves engaged in social and communal activities, such as meeting people (or implying meeting friends). She encourages them to both identify and implement activities. She emphasised that it was necessary, particularly for women who stay at home.

First of all, I suggest you keep them busy as much as possible, involve themselves in some other activity because I have all those ladies who stay at home or torture while staying at home… This is what we advise them to do like everything that I told you before, we advise them to engage with people and to do more activities or sometimes we suggest people do activities (Islamic Scholar; Female; Age: 27)

The significance of praying five times a day was highlighted. While prayers are one of the significant ways of worshipping, the concept of prayer was highlighted with a broad understanding. Prayer with the congregation in the mosque five times a day was attributed to social life and presented as a gateway to social interaction[4].

[4] According to most Islamic scholars, every male Muslim must attend mosque five times a day. Moreover, there are some other ways of communal gatherings or interaction in mosques, including sermons (*Khutba* in Urdu) and lectures (*Bayan* in Urdu) given by faith leaders from the stage (*Mimber* in Urdu) and one-to-one interaction of congregants with faith leaders (or other congregants). Females do have a tradition of attending sermons, lectures, or other religious activities.

Like the concept of prayer, when people leave the house and pray, that's why the reward is more. But this is that when you leave home, you will meet people, whatever problems you have in the world, whatever things you have in your mind, you will share them, and somewhere you will get good advice. (Spiritual Leader, Male; Age 40)

When faith leaders were asked about the role of talking in treating mental illnesses, I found that at some instances during the interview they (especially male faith leaders) were not able to relate the concept of talking or communication to the treatment of mental illnesses. Rather, like the previous statements they related it to Islamic history and traditions in a broader context i.e. how communication and talking helped the prophet PBUH in spreading Islam or how it can help in educating women about marital life. Open communication with the community was reported to have originated during the prophet PBUH's life; it was pointed out that it was the tradition of the prophet PBUH to talk with people, and without interacting with people, it was not possible to spread Islamic values and culture. This tradition has been reported to be followed since then by his PBUH followers. One of the spiritual leaders considered such communication to be a part of talk therapy.

So, what I have understood in talk therapy and what I have learned from my religion is that Islam did not spread until the prophet PBUH, and the Imams [successors of the prophet PBUH family] did that therapy. It was the main channel in the propagation of our religion and even today. (Spiritual Leader, Male; Age 40)

In contrast, one female scholar was able to relate the benefits offered by talking with people having mental illnesses and exhibited an understanding closely aligned with talking treatment. She reported that in her practice with female students engaging in communication helps her to build rapport and to identify the problem.

See, as far as I understand, it is through talking to someone, knowing the problems, and then engaging them in the conversation by talking to them more and getting some clues out of which one can find out what their problem is or what is the cause of the problem with them (Islamic Scholar; Female; Age: 27)

This was further reflected in another quote where that female scholar emphasised listening to peoples' problems – potentially hinting at the role of empathy. However, this time, that female

scholar mentioned that relating those problems of people with the Quran and Hadith (Sayings of prophet PBUH) is common practice.

> *Okay fine. So, for them, we should listen to their problem and relate it to the Quranic verse or sayings of the prophet PBUH.* (Islamic Scholar, Female; Age 27)

It was also apparent in the data that the prophet PBUH talked openly to his followers. One scholar during the interview pointed out that usually talking openly with people regarding controversial or taboo topics is discouraged in Islamic society; however, the prophet PBUH openly guided a woman about her marital life. Notably, the prophet PBUH guided a woman; however, another scholar during the interview pointed out that male faith leaders cannot engage in communication with females (this will be discussed in upcoming themes; faith leaders' conceptualisation of mental illnesses and practice conflict with the formal healthcare services).

> *Don't talk here. Don't talk to them on the internet. This is a taboo. But people were coming and talking openly to the prophet PBUH. As a woman, she got divorced from one place and then she went to another husband. She was not sexually satisfied. So, she came to the prophet PBUH and took a piece of cloth and indicated that the genitalia of her husband was like a piece of cloth. So, I want to go back to my old husband*. (Islamic Scholar, Male; Age 30)

In another quote, an Islamic scholar highlights an understanding of how a person can get distressed and what factors can prolong that distress. It was highlighted that difficult life events such as the death of relatives or close family members usually can cause an onset of distress, however, according to him if that person does not try to move away by realising that such difficulties are inevitable in life then such distress can take a form of depression or can prolong it. Again, like previous quotes, this statement was linked to the prophet's (PBUH) own life.

> *If we see that the prophet Muhammad (PBUH) had faced a lot of distress in life for example on the death of the prophet's (PBUH) mother, his grandfather, his uncle, his wife or when the first divine revelation was brought to him (PBUH), he (PBUH) was worried so worried…. Difficulties are bound to happen in everyone's life, but we should not cling ourselves to this distress as it prolongs the depression.* (Islamic Scholar; Male; Age: 40)

A spiritual leader, who further clarified how a person can distract or move away from such distress resulting from the death of close family members, that spiritual leader emphasised teaching patience. According to him, patience (*Sabr* in Urdu) is essential in communicating with people in distress. It is commonly practised and reported. An example was given by a spiritual leader who guided a person who had lost his father recently. In addition, concepts such as embracing the *will of Allah* (God) and putting faith in *Allah* (God) were also observed.

> *Someone's father passed away and he was worried that I have become an orphan, so what solution will you tell him except to be patient. It was Allah's property; Allah has taken it back from you. So, Allah has blessed you that your father was in your life if he had time. You must teach him a lesson trust in Allah (God), be patient, and there is no other way.* (Spiritual Leader, Male; Age 40)

All the statements or quotes provided by the faith leaders discussed above showed that faith leaders are hinting at i) psychosocial explanations, ii) encouraging dialogue and communication, and iii) highlighting potential activities that can distract people from distress. While one can argue that such activities are consistently linked with Islamic history, which is true, however, explanations provided by faith leaders are not purely driven by metaphysical assumptions – which is the case in the next theme.

6.4.3 Theme 3: Faith Leaders May also Use Approaches Grounded in Metaphysical Explanations

Some of the interventions used by faith leaders held metaphysical explanations for mental illnesses. For example, in this theme faith leaders talked about acts and rituals such as proximity to saints or spiritual leaders, recitation of scripture and prayer – which are grounded in spiritual and faith-based explanations rather than psychosocial explanations. It is different from the previous theme despite commonalities in some acts, for example, religious rituals like prayers are present here and in the previous theme but previously it was discussed by faith leaders in the context of benefits it offers in the communal life. In contrast, here such rituals are presented but faith leaders are implying towards innate healing power of such rituals or of those who offer them i.e. spiritual leaders – which implies metaphysical explanations associated with such rituals. I noted that different rituals or acts were preferred by Islamic scholars and spiritual leaders, for example, spiritual leaders emphasised more that people who attend them should build a close relationship with spiritual leaders or saints. Followers of spiritual leaders generally give their leaders more importance, respect, and honour. One spiritual leader pointed out that “friends of

Allah" or saints (*Wali Allah*) have a particular essence in their words that an ordinary person cannot achieve. Such opinions were not apparent in the responses of Islamic scholars.

> *Those words that I wrote, will not quench the thirst, I am thirsty, and water will not fill my stomach. For this, I need to be near the well, near the tube well, or near the cooler. Will have to go there. Isn't it? So that's why I am saying the words whatever you use…don't just use words. In the words, he (spiritual leader; friend of Allah; saint) is the right one. Then words will be effective, words will be useful and will satisfy what is inside the other person.* (Spiritual Leader, Male; Age 50)

When explaining the power of the words of saints, participants reasoned that Islamic literature (exceedingly oriented towards the spiritual domain in Islam), events and accounts of saints demonstrate that saints became closer to Allah (God) after facing hardships, struggles and series of trials/ tests.

> *All the saints you see have lived in a small hut. They ate dry bread and dipped it in water. Why didn't they get sick? Why didn't you sleep at night? They are sleeping peacefully. They did not even sleep.* (Prayer Leader, Male, Age 35)

Recitation of the *Quran* was also reported to be recommended by faith leaders to individuals with mental illnesses (including depression). Some faith leaders highlighted during the interview that they ask individuals to recite "*Surah Al Fatiha*" (Chapter 1 of the Quran), which consists of seven verses, and to blow them on themselves (known as *Dum* in Urdu). It is a common practice used by Muslims.

> *There are seven verses of "Surah Al Fatiha" (*Chapter 1 of the Quran*). These are the verses of "Surah Al Fatiha" (*Chapter 1 of the Quran*). If he recites it once after every prayer and breathes on himself, peace of mind will come to him.* (Prayer Leader, Male; Age 35)

In addition to the recitation of the *Quran*, remembrance of *Allah* (*Zikr in* Urdu) during the morning and evening was also considered a traditional remedy for mental illnesses. Morning evening supplications (*Subah shaam key azkar in* Urdu) are a formal way of remembering *Allah*, and such supplications are strongly recommended by the *Quran* and *Hadith* (Sayings of prophet PBUH).

In the light of the Quran and Sunnah, the morning and evening azkar (morning and evening supplications) have been especially described as a means of avoiding many such diseases. (Prayer Leader, Male; Age 60)

Numerous other traditions were reported, including helping others and asking *Allah* (God) for forgiveness. The ability to control desires and sacrifice wishes were also reported as the key factors in overcoming depression (For Additional Quotes See Appendix Table 6.4).

6.4.4 Theme 4: Faith Leaders and Faith Institutions Frequently Play an Active Role in the Community

Faith leaders engage in a range of activities which connect themselves to the community, including leading a prayer, leading, and addressing funeral prayers, guiding people about questions relating to Islamic laws and principles and, in some instances, visiting their followers' houses to attend or lead religious ceremonies. Among them, Friday prayer holds an essential position in worship. It was reported that after prayers, and especially after Friday prayer, faith leaders engage with their followers and listen to their problems and queries.

Mosque as mosque is a public platform so it happens that during Friday prayer when lecture (Bayan in Urdu) is given people listen and after that share issues with us. Usually, it happens that in all 5 prayers there are people who share issues and ask for advice. So, we provide them advice. (Islamic Scholar, Male; Age 40)

Various problems and queries were reported, including domestic issues, property issues and confusion regarding religious matters. This may highlight the broader role and connections of faith leaders in society.

So, when people come to him, whether they're there are domestic problems, whether it is a dispute between husband and wife, whether two brothers have a property problem, whether they have religious confusion, according to sects, according to religions, or whether there is a worldly problem, a political problem, a problem of the times, then when individuals share it and we tell them the solution to their problem. (Spiritual Leader, Male; Age 40)

It was evident from the data that shrines and tombs of spiritual figures/saints (*Dargah* or *darbar* in Urdu) were important gathering places for many people. Shrines usually hold

different kinds of religious ceremonies on an annual basis, such as *Urs* (the death anniversary of a saint) or every month *gayarvi shareef* (refers to the 11th date of the Islamic calendar for each month). Such ceremonies allow the followers of spiritual leaders to meet them and share their matters related to religious life. In addition, most shrines are open 24 hours a day, and people can meet spiritual leaders during specified times. Though some Islamic scholars consider it a forbidden act to build a shrine on the graves however, in the subcontinent, including Pakistan, a significant proportion of people follow the concept of shrines because they attribute the spread of Islam (in the subcontinent) to such saints and spiritual figures.

> *People do come because of my spiritual leader, the door is open, all the time, and many people come. Okay. And people will keep on coming, every time 24 hours Darbar Sharif (Shrine) is open to everyone, it is for his creatures.* (Spiritual Leader, Male; Age 50)

Notably, it was evident from the data that faith leaders play a vital role in their communities, as people tend to approach them with respect and trust to discuss personal issues. (For Additional Quotes See Appendix Table 6.1).

6.4.5 Theme 5: Faith Leaders' Conceptualisation of Mental Illnesses and Practice Can Conflict with those of Formal Healthcare Services

Though, it was directly highlighted by only one scholar about how formal healthcare, or psychiatric approaches are different. However, the point is important in the context of this dissertation as it might have implications relating to the autonomy of people attending faith leaders. One scholar pointed out that usually when a person contacts any faith leader with or without a mental illness, the main goal of the faith leader is to correct him/ her morally (moral standards defined by Islam)[5]. This might be one of the reasons that faith leaders reported that their assessment of a person is generally not based upon a symptomatology framework – as their ultimate goal is not reduction in symptoms. According to them, in the Quran, strong emphasis has been given to building the moral character of human beings, with the assumption that human beings are born for a noble cause. Human beings have been rated above and beyond angels if they follow the path of the Quran and *Sunnah* (Practices and traditions of prophet *PBUH*).

[5] Moral standards here imply those standards or laws based on the commandments of *Allah* (God) and sayings of the prophet (PBUH), which Muslims are obliged to comply with.

Now if a person goes to the doctor, or the psychiatrist and reviews the diagnosis related to routine, then at least he is going to take it towards a healthy activity, towards a healthy mind though he is not morally correcting him/her. (Islamic Scholar, Male; Age 30)

Differences in the framework of various spiritual chains[6] in mysticism (*tassawuf*) were highlighted by one of the spiritual leaders. He provided a detailed account of the differences between various chains or schools of thought of spiritual leaders in Islam and highlighted differences in their frameworks; for instance, some focus on love while others focus on the honour and dignity of spiritual leaders. However, in most chains, diagnosing and labelling someone is discouraged because it undermines the respect and dignity of the person. This statement contrasts with the previous statement (given above), as restricting people's autonomy by teaching or leading them to the right path (correcting them morally) as seen by faith leaders does not imply that attendees are to be dealt with disregard. As in a quote given below spiritual leader highlighted how the self-respect of attendees is important to them and this is why they do not want to label them by diagnosing.

> *If you study it, you will find that each [spiritual] chain has its framework, that is, sometimes it is azkar (supplications), somewhere love is dominant, somewhere fear is dominant, somewhere the concept of the shaykh (spiritual leader) is dominant, somewhere spending time with nature is dominant. Basically, what is the style of modern psychology today? They identify the problem, and they (spiritual leaders) do not follow this model. Its benefits were also that the self-respect of a person shouldn't be undermined, and he used to get out of this disease without considering himself as a patient.*
> (Islamic Scholar, Male; Age 41)

There was also a tendency to attribute mental illnesses to the heart, given the strong emphasis of the Quran on the heart.

> *Whatever mental diseases there are, they are diseases in the same way, so by correction of the heart, these diseases can also be cured. The negative effects of all of them, come*

[6] *Tassawuf*, or *Sufism*, in Islam, is a spiritual practice aiming for a deep personal connection with *Allah* (God) through mystical experiences and connecting oneself with saints. It involves teachings passed down through a chain of spiritual leaders or saints, those saints evolved in different schools of thought and every one of them claims that they are descendants (or followers) of prophet PBUH.

from the heart, that's why whenever the Holy Quran talks or whenever there is a talk in Shariat (Islamic Laws), it starts from the heart. (Prayer Leader, Male; Age 60)

The heart (*Qalb* in Arabic) and soul (*Rooh* in Arabic) have been repetitively mentioned by most Islamic scholars who view the soul as a connection with *Allah* and the heart as a piece of body that will impact evil or good deeds. If a person is living his/ her life per Islamic guidance, it will positively impact the heart and connect the person with Allah through the soul. Therefore, the purification of heart and soul was evident in the responses of faith leaders.

So, I have done this to make you understand that you should purify your soul from all, that is sinless, lighten it from sins. In your soul, there is the weight of sins. When this soul becomes light and is free from sins, it will go to the throne.
(Prayer Leader, Male; Age 35)

Some differences were also apparent in cultural terms used for depression or other common mental illnesses, such as *waham* (doubts) and *waswasa* (whisper of satan). There were a few other terms identified, those terms are commonly used by people to possibly present depression in a wider setting (like at homes, in media or formal healthcare settings), such as *zehani dabao* (mental pressure) and *pareshani* (stress). Also, one of the spiritual leaders attributed such problems to black magic and demons (usually referred to as *asarat* in Urdu). Some of the participant's statements and themes discussed here, such as the role of *qalb* (heart) and *asarat* (magical influence), can be part of the theme provided above (See faith leaders may also use approaches grounded in metaphysical explanations). However, the primary aspect of those statements reflects the conflict between the worldview and practice of healthcare professionals (For Additional Quotes See Appendix Table 6.4).

6.4.6 Theme 6: There are Areas of Compatibility and Potential Collaboration with Formal Mental Healthcare Services

Most faith leaders reported being willing to engage in mutual learning; a few reported having a burden of ongoing responsibilities and, therefore, would not have time to collaborate, and one did not explicitly answer this question. Rather, the spiritual leader who did not opt to answer this question directly, actually diverted the answer and said that not everyone qualifies to heal people. He further pointed out that only the words of saints and the desire of the person attending that saint will determine the authenticity and effectiveness of spoken words. This has been discussed previously (See theme: faith leaders use approaches grounded in metaphysical

explanations). In contrast, those who were expressive were also willing to learn treatments based on scientific methods.

> *Exactly so there is no issue. Learning is important as we also learn our management techniques. So, it's important to learn about symptoms, causes and treatment considering scientific methods. So, this is very good, no issues in this.* (Islamic Scholar, Male; Age 40)

It was also reported that given their responsibilities, they have connections with healthcare professionals, including general physicians. During interaction with people, there are specific terminologies based on medical literature that are unknown to them, so they contact healthcare professionals to learn about those terminologies in such scenarios. Contacts were reported to be made through social networking Apps (WhatsApp), and it was evident that faith leaders could understand and learn by communicating. In addition, using the Google search engine to learn about medical terms and, importantly, read some scientific articles mentioned by one Islamic scholar.

> *As far as I am concerned, I have connections with some doctors, every time I have a problem, I send him a voice note, asking why this term is used. First, I Google things and the professional places like NCBI, which is a place where articles are published which are precise and which is an international publication. If there is something I don't understand or if I have some doubts. So, I have something in my mind by asking them (doctors), for example, whether it is true or not, I can understand it by asking them (doctors).* (Islamic Scholar, Male; Age 30)

A working relationship with healthcare professionals was also evident in the data, where it was explicitly mentioned that if they think that person needs help, they send them to doctors. A recognition of psychotherapeutic intervention was also identified; however, it was not mentioned how their treatment methods and practices differ from psychotherapeutic interventions in the context of this discussion.

> *If they feel the need to go to a psychiatrist again, she sends people there because they have links with doctors there, so they send them there for any type of therapy they need. If it happens, she guides people.* (Islamic Scholar, Female; Age 27)

Though faith healers acknowledged that they have established social connections with healthcare professionals and are willing to have an environment based on mutual learning, some key factors to improve the process of mutual learning were also identified. Faith leaders reported that, generally, they are bound by their activities and responsibilities. Therefore, given the time limitation, in-depth training or learning is not feasible. Instead, basic training in mental health might be more practical.

> *It should not be too much, that is, it should not include technical terms that a person (Islamic scholar) remains totally bound to such activities. Then at least for him to know some of the basic methods, he thinks it necessary to know a little bit.* (Islamic Scholar, Male; Age 30)

Faith leaders, after receiving a lay description of BA , reported that it is compatible with cultural and religious values. BA was related to the practice of spiritual leaders, where the follower of a spiritual leader tells him about his/ her routine activities and communicates with them through letters.

> *Look at this, after listening to all of your talk, first of all, the impression about the field is that in Sufism (Spirituality in Islam), it is usually decided that when a person swears allegiance to a shaykh (Spiritual leader), give him [faith/ spiritual leader] the right to correct that person, one thing is to keep in mind that he must write a letter to his shaykh (Spiritual leader) every week, two weeks, after three weeks and after a month. Come to him and tell him about your daily routine and the shaykh (Spiritual leader) will review it* (Islamic Scholar; Male; Age 30)

Faith leaders provided some other recommendations to increase or build the compatibility with Islamic culture, including the use of same gender (male therapist for male followers) for therapeutic sessions, using in-group members of faith leaders to convince other faith leaders for training and mutual learning and using non-famous faith leaders for this purpose (For Additional Quotes See Appendix Table 6.4).

6.4.7 Theme 7: There are also Potential Barriers Associated with Collaboration

After listening to the description of the BA, it was mentioned by one faith leader that anything that is against the laws and principles of Islam should not be communicated or prescribed. This may highlight the limited autonomy of those who attend faith leaders.

Apparently, there is nothing wrong with this treatment, or there is nothing against "Shairah" (Islamic Law) in this treatment. (Islamic Scholar, Male; Age 35)

As reported previously, due to the pressures of work and daily activities, it might not be possible for faith leaders to get involved in other activities.

The point is that the scholars already have their responsibilities and there is so much pressure on them that they do not have the patience to do more and more. (Islamic Scholar; Male; Age 30)

However, it was also acknowledged that the decision to get involved depends on the priority of faith leaders. It was reported that faith leaders have different roles; some are oriented towards spiritual guidance, while others are involved in preaching. Faith leaders with preaching roles are more suitable for such activities as they have more exposure to the community and are involved with the community through a proactive approach.

And can he give his time for it or not. That is, to what extent he can prioritise this work along with the work in which he is engaged. (Prayer Leader, Male; Age 60)

Although some faith leaders reported that they have well-established connections with healthcare professionals, they also acknowledged that some faith leaders may not agree to learn from healthcare professionals. Power dynamics may likely arise, as faith leaders may hesitate to undergo training, which may result in them occupying lower positions in the hierarchy and accepting the dominance of healthcare professionals.

If there is something I don't understand or if I have some doubts. So, I have something in my mind by asking them (doctors), for example, whether it is true or not, I can understand it by asking them (doctors). What happens now is that sometimes many muftis do not feel the need for it. (Islamic Scholar, Male; Age 30)

It was further highlighted that some faith leaders have many followers and receive respect, honour, and dignity from their followers. Their readiness to become students or trainees can undermine their image and integrity.

It is obvious that they will not be ready to come as a student or as a trainee or as a learner. (Islamic Scholar; Male; Age 41)

Another barrier was the tendency of faith leaders to take their jobs as a business. Therefore, according to one spiritual leader, faith leaders would not be interested in anything they are not paid for. However, on the contrary, many other faith leaders reported that they are willing to work on a volunteer basis to serve humanity (For Additional Quotes See Appendix Table 6.4).

6.5 Discussion

This study highlighted that faith leaders who provide support to people with mental illnesses have an understanding of the signs and symptoms of depression. Their understanding is likely to be developed due to their day-to-day experiences with their attendees. In usual practice, people present themselves to faith leaders with domestic and social issues without highlighting any mental health issues. Faith leaders usually asses people by asking questions and sometimes rely on information from family members. However, any diagnostic framework for mental illnesses is not part of their routine practice, as is in fact not favoured as it is perceived to promote labelling and stigma. Faith leaders use moral, religious, traditional, and social authority, or practices to support people who attend them. Institutional platforms like mosques and shrines serve as gateways for people to connect with faith leaders. Most faith leaders reported that BA is consistent with Islamic culture, and some faith leaders provided examples from Islamic history to share their understanding of BA. Faith leaders expressed interest in learning BA from healthcare professionals. Some notable barriers were also identified including i) time constraints, ii) reluctance to become students of healthcare professionals, iii) the power dynamic between faith leaders and healthcare professionals and iv) the authority faith leaders exert over those who attend them, which limit attendees' autonomy.

Overall, these findings concur with studies conducted in African regions, indicating that practices to identify and manage mental illness were primarily grounded in religious and faith-based worldviews (Meran and Mason, 2019; Tobah, 2017). A range of approaches or activities to support individuals with or without mental illnesses were identified in this study. Some of those traditions were activities based on a metaphysical, spiritual, and faith-based worldview (such as recitation of the Quran, day, and night supplications, etc.). However, a few of them were based on the faith-based world view but faith leaders associated social and psychological benefits offered by those activities (such as involvement in work life, domestic activities, and physical activities). I also found that there was a tendency to link such activities to Islamic scriptures and history, including the Quran and the practices of the prophet Muhammad PBUH. This is evident

in recent literature, where faith leaders attributed mental illness to religious factors, including supernatural events, fate, and religiosity (Youssef and Deane, 2013). In this study, most faith leaders were willing to collaborate, were open to a mutual learning platform, and were interested in delivering a BA. However, some were concerned that any immoral (immoral activities defined by Islam and as seen by faith leaders) practices or activities which are prohibited under Islamic laws should not be used. While faith leaders emphasise religious and communal activities such as prayers, meeting people, and attending religious ceremonies, further research, mainly focusing on adapting BA, may be required to explore what activities can and cannot be part of BA delivered by faith leaders in Pakistan. In contrast, recent evidence noted that faith leaders are commonly apprehensive about how healthcare professionals perceive them. For example, they may contemplate that healthcare professionals do not respect their norms, assumptions, and worldviews (Green and Colucci, 2020; Akol et al., 2018). This was not the case here, as faith leaders did not specify that their certain assumptions and practices are overlooked by healthcare professionals. However, their resistance to going beyond their traditions and valuing the autonomy of their attendees may potentially indicate their anticipation that healthcare professionals are likely to disregard their practices. This contrast highlights some consistency with previous research and findings noted in diverse settings i.e. African countries.

This study found differences between the approaches of faith leaders and modern psychiatry in identifying individuals with mental illnesses. Faith leaders reported that diagnosing and labelling individuals with mental illness would disregard their respect and, hence, may promote stigma and undermine the person's dignity. Also, they differentiated their practice based on moral principles defined by Islam, believing it is more oriented towards a "spiritual-based paradigm" rather than disease-based. They believed their practice targets people to comply with moral standards defined by Islam rather than treating symptoms. The data suggest that clinical and symptomatology-based assessment may be inconsistent with faith leaders' practices. It is, however, expected that the roles of faith leaders and healthcare professionals will differ. Faith leaders want people to practice their faith which according to them can automatically heal the illness, while healthcare professionals' practice is based on treating symptoms of illnesses, without exploring faith. The other difference can be that faith leaders conceptualise mental illnesses resulting from spiritual and faith-based conflicts and non-compliance with religious practice while healthcare professionals attribute such illnesses to psychosocial and medical factors supported by scientific evidence. Some other challenges were also found related to engaging faith leaders with healthcare professionals. Such challenges include the burden of their routine tasks, resistance to learning as a student or trainee and their priorities. The burden of

routine tasks seems to be a notable challenge for collaboration with faith leaders using a task shifting approach (Galvin and Byansi, 2020).

I also explored the perspectives of faith leaders regarding delivering BA to individuals with depression. During depressive episodes, individuals often resort to avoidance behaviour, such as staying at home or staying in bed, to reduce negative thoughts and feelings. However, such a short-term reduction of symptoms is not practical in the long run. BA proposes that engaging in "value-driven behaviour", such as going to work, socialising with friends, etc., can lead to enduring and long-term happiness. BA emphasises the importance of autonomy in choosing an activity based on their values and preferences. However, some faith leaders believe that activities that contradict Islamic laws and principles are not consistent with their values. Such activities may include but are not limited to involvement in unlawful couple relationships and drinking alcohol in social gatherings. Also, as evident in the data, faith leaders have authority because of different factors depending on the type of leader. For example, a spiritual leader, who is a descendant of some well-known saint may have a large following and is respected by the community due to their bloodline (that is connected to saints in past and in some cases, they are identified as descendants of the prophet PBUH). In contrast, scholars traditionally gain respect from the community due to their knowledge of Islam. This also has implications for the autonomy of those who attend these faith leaders. By showing such respect, these faith leaders gain the privilege to direct and lead their attendees. This leadership often encourages people to act according to the leaders' suggestions without acknowledging the attendees' choices. This raises concerns about the compatibility of the faith leader's worldview with the philosophical positions of BA. However, at the same time, it warrants cultural adaptation of BA, which values norms and practices within Pakistani culture and Muslim traditions.

According to Mir et al. (2019), when delivering BA therapy to Muslim clients, it is important to respect an individual's autonomy. Therapists should avoid imposing religious or faith-based values unless the clients prefer them. A non-judgmental environment should be provided to ensure the comfort of the clients. In this study, faith leaders preferred recommending healthy activities that comply with Islamic laws. Most of these activities have a religious component and include acts of worship such as praying, going to the mosque or shrines, and daily activities of the Prophet (PBUH), such as spending time with his wives, performing household chores, and meeting people.

Concerns about the inconsistency of BA with Islamic values may stem from faith leaders' lack of trust or maybe knowledge of/ about scientific practices rather than an inherent conflict; not all faith leaders share these concerns. It might be early to say whether the successful adaptation

of BA delivered by faith leaders is feasible at this stage. However, there is a potential knowledge and communication gap between faith leaders and healthcare professionals. For example, healthcare professionals in current days are keen to learn cultural norms and further adapt psychotherapeutic treatments such as BA consistent with cultural traditions. Therefore, a dialogue in an interactive setting and knowledge exchange might be crucial in developing a better understanding and building consensus-based BA delivery. Finally, exploring the perspectives of those attending faith leaders can improve this understanding, especially about understanding of autonomy while attending faith leaders.

6.5.1 Strengths and Limitations

This is the first study to my knowledge that used in-depth qualitative interviews to understand the common practices of faith leaders in providing support to people with depression, specifically in Pakistan. Also, this study has targeted faith leaders' perspectives on evidence-based practices such as BA. I used robust methods such as one-to-one interviews and piloted topic guides informed by systematic reviews and thematic analysis. I gave special consideration to the role heterogeneity of faith leaders while selecting and defining faith leaders and considering their broad role in society.

Based on my systematic review, I have used the term 'faith leaders' to acknowledge the broader role of people - with leadership influence relevant to Islamic faith - providing informal support to people with mental illnesses. Some limitations of using 'faith leaders' include a lack of recognition of i) the considerably different roles of different groups of faith leaders, ii) hierarchies among faith leaders, and iii) the acceptability of this term to stakeholders. I limited the sample to Muslim faith leaders only. Although there is a tradition of faith healing in other religions practised in Pakistan, Islam is the major region in Pakistan (followed by approximately 98% of the population), and data show Muslims in Pakistan are likely to seek Muslim faith leaders (Farooqi, 2006). The sample included in this study primarily represented perspectives of male faith leaders who identified themselves as *Sunni* and were comparatively younger. Also, faith leaders who have at least ten grades or equivalent education have been included in the study. However, I did ensure that *Shia* (N=2) and women (N=2) faith leaders were represented in the sample. I collected data from two neighbouring cities in Pakistan: i) Rawalpindi and ii) Islamabad. These cities are notably different from other areas in Pakistan, especially rural areas, in terms of education and economic factors. Both of those cities have in general higher levels of literacy and potentially more job opportunities. This is why many residents of Rawalpindi, and particularly Islamabad, are typically immigrants from remote rural areas rather than native inhabitants of these cities.

The sample was taken from areas with potentially higher literacy rates, those who are exposed and habituated to urban settings and especially younger faith leaders. I acknowledge these are some potential factors which may partly explain why some faith leaders gave some psychosocial explanations of depression. Also, they showed an understanding of depression including signs and symptoms where such understanding was communicated using terms often used in psychiatric practice. Meta-physical explanations like spiritual and faith-based worldviews were also common but unexpectedly magical explanations (e.g. being cursed or possessed) were offered by only two faith leaders. In case data were to be collected from rural settings or from those faith leaders with no or minimum education, my results could have been different. Therefore, my findings can only apply to those faith leaders practising in urban areas and having 10 grades (secondary education) of formal education or equivalent. A few faith leaders above 50 years of age were part of the sample, I acknowledge caution is required when discussing findings related to the age of faith leaders. Some of the themes discussed may not accurately represent the perspectives of older faith leaders.

6.5.2 Conclusion

The findings suggest that faith leaders commonly advise faith-based activities for those who attend them. Faith leaders can link those activities to the psychosocial benefits such activities offer, and they also link those activities to spiritual and faith-based assumptions simultaneously. Such activities are partially consistent with BA practice, which faith leaders highlighted by linking them to Islamic history and culture. However, given the divergence around the assessment procedures and values-based autonomy for individuals with depression, the perspectives of those attending faith leaders are likely to provide a broader picture. I have considered the wider role of faith leaders in Pakistan, which has enabled me to obtain more inclusive and diverse perspectives. However, my findings are limited to those leaders working in urban areas and having at least a secondary education level.

7 Chapter Seven: Perspective and Experiences of Individuals Diagnosed with Depression of Attending Faith Leaders

In this chapter, I start by providing the background about why and how it is essential to consider the perspectives of those attending faith leaders. I also explain how this is linked with my previous work in the dissertation. Further, I have presented methods, findings, and discussions for a qualitative study including one-to-one semi-structured interviews with people with depression who attended faith leaders.

7.1 Background

7.1.1 Evidence Synthesis Findings (Qualitative): Highlights

In the qualitative synthesis of the systematic review, I conducted (See Chapter 5, Barrier and Facilitators), 11/17 studies explored faith leaders' perspectives and experiences, while only 6/17 focused on individuals attending faith leaders. Information on the experiences of individuals attending faith leaders was limited; however, those attending faith leaders generally expressed favourable views towards interventions provided by faith leaders and reflected on their positive experience of healing. A few concerns, such as lack of privacy while attending faith leaders, were also highlighted. Research on people seeking faith leaders is scarce compared to research on faith leaders. This scarcity may limit the multi-perspective approach considering unique perspectives of both faith leaders and their attendees and hinder the formation of inclusive interpretations. The criteria for including studies in my systematic review were limited to CMDs; therefore, studies reporting perspectives of individuals attending faith leaders for other mental illnesses were excluded. The subsequent sections describe research focusing on those attending faith leaders, not limited to people with CMDs.

7.1.2 Experiences and Perspectives of Individuals Attending Faith Leaders

Quantitative studies on the role of faith leaders in mental health have focused primarily upon i) the proportion of individuals attending faith leaders for mental illnesses, ii) types of mental illnesses reported to faith leaders and iii) factors influencing going to faith leaders (such as gender, education etc.) (Burns and Tomita, 2015). A recent study found that advice given by family or friends is a common reason for attending faith leaders while being a woman, and lower educational levels are associated with attending faith leaders (Adel et al., 2023). Regarding types of mental illnesses, a significant proportion of individuals with psychosis – around half – (48%) of those who seek treatment at formal healthcare facilities have a history of also consulting with a faith leader (Khoso et al., 2018). One study reported that depression is the most common mental illness presented to faith leaders, and 24% of those who attend have this condition (Saeed et al.,

2000). Qualitative studies rarely address the experiences and perspectives of individuals with mental illnesses who attended faith leaders (van der Watt et al., 2018; Green and Colucci, 2020). The literature tends to focus on other features such as i) collaboration between health professionals and faith leaders, ii) faith leaders' willingness and practice to refer individuals to health professionals, iii) understanding of mental illness, cultural and religious explanations, and stigma (van der Watt et al., 2018; Green and Colucci, 2020). Only a few studies have explored the perspectives of individuals with mental illnesses attending faith leaders regarding aspects such as the conceptualisation of mental illnesses and support received from faith leaders. Some of those studies are discussed below.

Generally, CMDs are not considered medical illnesses by individuals who attend faith leaders; the explanations for CMDs are grounded in psychosocial, spiritual, and cultural explanations. For example, a study conducted within a faith-based community in Ethiopia revealed that depression was perceived as a common reaction to challenging community circumstances, and the community members did not categorise it as a mental illness. The research also documented instances of spiritual interpretations of depression and a willingness to embrace faith-based treatments within the same community (Tekola et al., 2021). Another study looking at American African faith-based community members reported that depression is caused by a loss of hope or initiative and physical or psychological abuse (Bryant et al., 2014). People living in LMICs sometimes associate traditional beliefs such as "being bewitched" and "demon possession" with depression. For example, a study looking at individuals with mental illness and their caregivers in Zambia reported that such perceived states are common features of depression (Sichimba, Janlöv and Khalaf, 2022).

According to a qualitative review by van der Watt et al. (2018), people with mental illnesses find receiving treatment from faith leaders helpful, especially when combined with biomedical treatment. The review also suggests that individuals continue to seek support from faith leaders even if alternative biomedical treatments are available. This finding is consistent with the qualitative review in Chapter 5, which highlights the barriers and facilitators identified by faith leaders and their attendees regarding receiving treatment from faith leaders. Notably, the quality of the studies in both reviews was generally low.

7.1.3 Perspectives and Experiences of Individuals Attending Muslim Faith Leaders

Mental health and Muslim culture have recently gained the attention of researchers, particularly in places where Muslims are minorities, including the UK and USA. Research in Muslim mental health covers a range of topics, including Muslims' reflections on mental illnesses

(Musbahi et al., 2022), faith-based treatments grounded in Islamic teachings (Mir et al., 2015) and their treatment preferences for getting support (Meran and Mason, 2019). A study looking at Muslims in the USA highlighted healing experiences and support for mental health received from faith leaders (Padela et al., 2011). This study reported the prominent role of faith leaders in promoting mental health through means such as delivering healthcare messages and providing spiritual support, healing, and counselling. Participants also reflected on faith leaders' role in mental health hospitals, such as establishing Friday prayer services (Padela et al., 2012). However, the study also pointed out some issues with how faith leaders work, such as not having proper training in managing mental illnesses and individuals who attend faith leaders may face pressure from family and friends to seek their guidance (Padela et al., 2012).

In Muslim-majority countries, there has been less emphasis on the role of faith leaders in addressing mental health concerns. This may be due to a shortage of research infrastructure and resources, especially in low-income regions where research primarily focuses on identifying pathways to access mental healthcare (Chaudhry et al., 2017; Giasuddin et al., 2012). Most Muslim-majority countries, however, have alternative informal mental health pathways of care, where the proportion of people, whose first point of contact for getting mental health support is a non-statutory service, is substantial: United Arab Emirates (60%) (Sherra, Shahda and Khalil, 2017), Bangladesh (22%) (Giasuddin et al., 2012) and Pakistan (32%) (See Chapter 4).

In Muslim cultures, there are various sources of healing which can be practised by individuals who have a mental illness, including self-healing using supplications and recitations or through faith leaders (Prayer leaders, Islamic scholars, spiritual leaders/ mentors) (Saeed et al., 2000). A study conducted in Malaysia found Muslim participants' descriptions of their healing experience to be predominantly based on religious experiences. They reported that religion helped them understand their condition, and they used their faith to aid in their recovery (Eltaiba and Harries, 2015). Individuals in the study discussed their recovery experiences within the framework of their faith and religious values. Family support was identified as an integral factor in the healing process – likely due to the importance of collectivist family values (Eltaiba and Harries, 2015).

In Pakistan, studies aiming to explore the perspectives of those attending faith leaders are limited. An ethnography study in Pakistan observing 70 individuals who attended a shrine reported that the attendee’s primary objective was to perform rituals and worship. According to this study, the prominence of shrine ritual healing is not solely due to the exorcist rituals but instead practising sacred and religious rituals such as *Dhamal* (dancing ritual) and *Dum* (recitation of Quranic

verses). The study, however, included any participants who were attending the shrine and did not attempt to identify any mental illness (Charan et al., 2020). There is one study that explored the perspectives of people diagnosed with depression about their understanding of depression (Naeem et al., 2012). Still, the authors did not attempt to identify people having previous contact with faith leaders. One participant highlighted using some form of faith-based self-healing practices like saying prayers but acknowledged that she did not visit or attend any faith leader. Almost all the participants in this study reflected on depression by saying it was due to environmental stressors or overthinking (Naeem et al., 2012). There have been no studies from Pakistan exploring people's views about the support they received for depression from faith leaders.

7.1.4 Problem Statement and Aims

This study builds on and helps to fill in the gaps from the other studies reported in the dissertation (Chapters 5 and 6). The evidence synthesis (Chapter 5) found that practices employed by faith leaders can be beneficial, and many are willing to receive basic mental health training; the findings were broad and not context-specific to Pakistan or BA. The qualitative study (Chapter 6) in Rawalpindi and Islamabad revealed that faith leaders related their understanding of BA with religious texts like the *Quran*. Such faith leaders were open towards promoting activities in individuals' lives to overcome depression; however, they argued that activities prohibited by Islamic values could not be suggested to individuals, limiting the choice of activities.

I also identified that qualitative evidence about the perspectives of individuals with depression and attending faith leaders is limited, particularly in Muslim-majority countries, and this is particularly true for Pakistan. Studies focus more on faith leaders' perspectives and less on those attending them. This creates a knowledge gap that can be filled by gathering attendees' insights. The research presented in this chapter aims to get an insight into the experiences and perspectives of individuals with mental illness attending faith leaders, particularly regarding the support received from faith leaders for depression and willingness to receive BA from faith leaders. It would be helpful to have a greater understanding of the opinions and experiences of those who attend faith leaders within a similar context; this will provide a more holistic understanding. This understanding allows me to contrast the perspective of those attending to faith leaders to the data presented earlier in the dissertation. Some of the factors identified (e.g., limit over autonomy, authority exerted by faith leaders, and role of family members) are especially relevant to those who attend faith leaders. So, attendees' perspectives may be more informative

and distinct. Such an understanding can facilitate making informed and inclusive recommendations regarding the feasibility of faith leaders' delivering BA.

7.2 Research Questions

The research questions for this study are:

I. What are the expectations of individuals with depression regarding support from faith leaders?
II. Do faith leaders identify depression (or mental illness) in individuals, and how?
III. What types of support do faith leaders provide to individuals with depression?
IV. What are the perspectives and experiences of individuals with depression related to interventions provided by faith leaders?
V. What are the attitudes of individuals with depression to receiving brief psychotherapeutic interventions such as BA by faith leaders?

7.3 Method

7.3.1 Qualitative Approach and Research Paradigm

This study addressed practical issues, such as support provided by faith leaders and people's preference for receiving BA from faith leaders. The overarching goal was to explore if evidence-based practices can be integrated into faith leaders' routines as seen by their attendees. The study primarily follows a pragmatic approach. A pragmatic approach integrates techniques to address specific problems, valuing practical solutions and real-world applications (Creswell and Plano Clark, 2017). This flexible paradigm prioritises useful, applicable findings, allowing researchers to employ diverse qualitative and quantitative methods to better understand research questions (See Chapter 2 for more details on philosophical positions).

7.3.2 Setting

Data were collected from the Institute of Psychiatry (IoP) in Rawalpindi. Rawalpindi is one of the major cities in Punjab (the most populated province in Pakistan). IoP is a public sector facility and provides specialised mental health services. It provides coverage not only to Rawalpindi but also to neighbouring cities and rural areas in the Punjab. About 12 consultant psychiatrists and 20 postgraduate trainees work in this institute. It is affiliated with Rawalpindi Medical University, also located in Rawalpindi. It provides clinical services, including outpatient, inpatient, emergency, liaison, forensic psychiatry, and community mental health services. Outpatient clinics are operated four days a week, and more than 100 people are seen daily. Inpatient services include 50 beds with separate wards for males and females.

Rawalpindi (and its associated urban and rural areas) has many religious and faith-based institutions, including mosques, Islamic education centres and shrines. The exact number of such religious institutions is unknown because most are unregistered or such data are unavailable. For details of the number of registered shrines and Islamic education centres in Rawalpindi (See Chapter 6, settings).

7.3.3 Sampling Strategy and Sample Size

Participants were included in the study if they were: i) diagnosed with depression within the last six months of recruitment and ii) had attended Muslim faith leaders for their depression. Consenting participants with capacity (i.e., those who could understand the information given about the study, retain it, and communicate their decisions), were interviewed. Participants who attended faith leaders whose practice was based on herbal, chemical or other substance-based interventions were excluded. Participants who were classified as having severe depression and an imminent risk of suicide, as determined by their psychiatrists or psychologists, were not interviewed. The sampling strategy was a purposive convenience sampling strategy, ensuring a diversity of socio-demographic (age, gender, locality) and clinical characteristics (mild to moderate depression). Also, given the different roles of faith leaders identified in my systematic review and interviews with faith leaders, I considered diversity in the type of faith leader consulted by the participants.

There are lack of formal channels to access faith-based organisations. Also, given my informal encounters with faith leaders (Chapter 3), I was expecting possible resistance arising from someone with a mental health background approaching people in faith leaders' settings. Therefore, potential participants were approached at a tertiary care psychiatric facility i.e. IoP. The researcher obtained permission to recruit participants and collect data from the relevant authorities at IoP (head of the institution). Before recruitment, mental health staff (consultant and trainee psychiatrists and psychologists) were informed about the study and its relevance to mental health. They had an opportunity to ask questions—those who agreed referred participants meeting the eligibility criteria to the researcher. The researcher subsequently contacted eligible participants and had the opportunity to discuss the study with them (See Appendix 7.1 Participant Information Sheet); the informed consent process was followed, and those who agreed were recruited for the study (See Appendix 7.2 Consent Form).

The ‘power of information’ criterion informed the sample size estimation, which refers to basing decisions on sample size based on how much information can be gathered from participants. This criterion considers the richness and diversity of the data that can be expected

from each participant, and it helps ensure that the sample size is sufficient to reach a comprehensive understanding of the research topic (Malterud, Siersma and Guassora, 2016). If more information is expected from each participant, a small sample size can be sufficient; however, a comparatively large sample size may be required if less information is expected. I anticipated receiving substantial and diverse information from each participant, considering the diverse participant characteristics and direct exposure to faith leaders. Based on these assumptions and recommendations, I estimated 8 to 17 participants may be required to reach saturation point (Hennink and Kaiser, 2022; Braun and Clarke, 2013). I aimed initially to perform an interim analysis after completing interviews with 11 participants. As it could be argued that my participants were diagnosed with depression and may have been less likely to engage in interviews, I opted for 11 participants rather than 8, which is the minimal threshold reported to achieve saturation in interview data (Hennink and Kaiser, 2022). This sample was consistent with a previous study, which recruited 10 participants who attended faith leaders to reflect on their experiences (Khan et al., 2023). My stopping criterion was to reach the point where newly identified codes in the later transcripts fitted well with existing categories (identified at an earlier stage of the analysis) and were not distinct enough to form a new theme (the final sample size was therefore 13 participants; see results).

7.3.4 Ethical Consideration

Ethical approval was obtained from the Khyber Medical University, Ethics Board, Pakistan and Health Sciences Research Governance Committee (HSRGC) at the University of York, United Kingdom. Informed consent was taken from each participant before they were interviewed. I found it challenging to explain the purpose of the research using information sheets provided in the local language. This challenge emerged because some participants were not able to read. To manage this, I hired research assistants working at IoP with experience in conducting research and clinical interviews with people with mental health problems. Participants were also verbally informed about the purpose of the study and other aspects mentioned in the information sheet. Participants were informed that their confidentiality would be maintained, their participation was voluntary, and they could leave the interview at any time. Data provided by the participants was only accessible to me and those researchers involved in transcribing the interviews. Also, they were told that the information they provided would be published only after removing personal details through which they could be identified. It was anticipated before the start of research while attaining ethical review that those interviewed might feel distressed during the interview. To manage this, all those involved in conducting interviews were trained in, and had at least one year of experience in mental health research. Any participants at imminent risk of suicide or those with

severe depression were not interviewed. Information about how to access support for mental health was provided in the information sheet. However, the other interviewers and I did not observe any participant who reported experiencing distress during the interviews. Finally, one female participant reported that she was hit by the faith leader with a knife, though she did not sustain any injury. I reported this event to the consultant psychiatrist providing treatment to that participants for any further action as per their institutional policies.

7.3.5 Data Collection Methods

In this study, the perspectives, experiences, and expectations of individuals attending faith leaders were central elements; therefore, one-to-one interviews were carried out (Braun and Clarke, 2013). Interviews were conducted either face-to-face (n = 3), online (n = 2) or by phone (n = 8). I interviewed 8 participants, while three trained researchers (Working on the DiaDeM project at the IoP) with at least one year of experience in mental health research, interviewed 5 participants. Interviews were arranged at a time convenient to the participant. Face-to-face interviews took place in a private room in a health facility. For remote interviews, participants were asked to find a private space where the interviewee could call them. Interviews took approximately 20 to 45 minutes to complete. Interviews were conducted in Urdu and were audio recorded.

The chapter on reflexivity explores my personal characteristics and cultural background and their possible influence on study methods and findings (See Chapter 3). During the interviews, I and other researchers maintained a reflective diary and noted our beliefs and thoughts related to responses, which were regularly discussed in supervision meetings with PhD supervisors. During the data collection, it was evident that I had a preexisting positive and enthusiastic attitude towards faith healers and believed faith leaders could be influential in providing accessible, evidence-based services. I actively engaged with NS, HJ, and SA to discuss my progress in data collection to ensure that my personal beliefs did not hinder participants from speaking openly during interviews and to reflect the data in the analysis accurately. Notably, people with healthcare backgrounds (including myself) interviewed participants, and those participants were likely to express positive attitudes towards formal healthcare services. There were some additional minor challenges, such as difficulty in engaging participants in interviews (e.g. faced difficulties to get more in-depth responses in some interviews) and using lay terms to explain depression and BA.

7.3.6 Topic Guide

The interview guide was based on the research questions and informed by the findings from my earlier systematic reviews and interviews with faith leaders. For example, to understand

the broader role of faith leaders from attendees' perspectives, probes regarding the role of faith leaders were added. Similarly, the type of faith leaders, the preference of certain faith leaders, and probes on how faith leaders identify depression were added to the topic guide to link it with findings obtained from interviews with faith leaders. The topic guide was piloted with the first three interviewees before being finalised. The final topic guide included non-directive questions and themes, subsequently reviewed by HJ for impartiality and precision.

The topic guide included identifying mental illness, treatment strategies, preferences for certain types of faith leaders, views, and experiences on interventions/ support from faith leaders, expectations of support or treatment from faith leaders, and willingness and attitudes towards receiving BA from faith leaders. Some terms were simplified for participants, such as replacing "treatment" with "guidance" or "support." The term ‘BA’ remained the same, explained in lay language (See Appendix 7.3 Topic Guide).

7.3.7 Data Management

I used the same data processing methods as outlined in the previous chapter (See Chapter 6: Data Processing). Audio-recorded interviews were checked for audibility and transcribed verbatim into Urdu, then translated into English. I transcribed and translated eight interviews and other researchers transcribed the remaining five. The same people transcribed/translated interviews they had conducted themselves to bring efficiency to transcriptions. Translating a transcript into English and then performing analysis offered me an opportunity to collaborate with and take feedback from supervisors, but it may pose a risk of losing the original meaning. Therefore, I back-translated the first two transcripts to check the accuracy of the translation. All transcripts were stored in password-protected electronic folders in secure drives provided by University of York, and access was limited only to me.

7.3.8 Data Analysis

Thematic analysis employing an inductive coding approach was conducted utilising NVivo software (version 12). However, deductive elements were also present, as research questions and semi-structured interviews guided the analysis. Thematic analysis is flexible enough to accommodate inductive and deductive elements and different philosophical positions and is closely aligned with pragmatic positions (Kiger and Varpio, 2020). Chapter six provides further details, including an overview of the pragmatic approach and how it is aligned with thematic analysis (See Chapter 6 Data Analysis).

Coding was done on transcripts in English, ensuring accessibility (not being able to transfer Urdu into NVivo), broader comprehension, and facilitating collaboration. With the latter, HJ, who

supported the analysis, does not understand Urdu. This approach supports a more rigorous and transparent analysis, as it allows for the cross-verification of the coding process, enhancing the overall trustworthiness and credibility of the findings.

For the analysis, the process followed the steps suggested by Braun and Clarke (Braun and Clarke, 2013). Initially, I thoroughly read and re-read the data in Urdu and English to familiarise myself with its content. Subsequently, I highlighted statements relevant to research questions throughout the transcripts pertinent to the research questions. After reviewing the statements, emerging codes were assigned to these selected statements, and similar codes were subsequently grouped to create broader themes. A framework of sub-themes and themes was created, with assigned quotes. The codes and themes were compared across transcripts, and discrepancies and relationships between the themes were examined and checked. The findings were written up. Two coded transcripts were reviewed and discussed in detail with HJ to ensure reliability. HJ and I discussed the analysis at different stages.

There were some factors which have possibly influenced how I associated meaning with data fragments while analysing. I assumed most people preferred to get support for their mental illnesses from faith leaders. As my systematic reviews (Chapter 4 and 5) demonstrated, these assumptions are not always supported by the literature. However, the evidence observed also contradicted my assumptions, particularly in the data gathered in this study. For example, some participants (though not all) reported that they went to faith leaders because of their families and they would not want to revisit them. In this context, combining the conflicting statements in data analysis was akin to weaving a complex tapestry, where each thread represented a unique perspective, sometimes clashing, sometimes harmonising, but ultimately contributing to a richer understanding of how those attending faith leaders make sense of their relationship with faith leaders. Having a background in clinical psychology, I also closely identify myself with bio-medical professionals, which may have also influenced the data analysis.

7.4 Results

My study initially interviewed 11 individuals for this study, after which an interim analysis was performed to explore emerging themes and topics. Notably, as conflicting statements were identified, especially relating to the attendees' trust in faith leaders, I went on to conduct two more interviews with a total sample of 13 (N = 13), and no major themes or topics were further identified. I recruited participants with diverse characteristics (See Table 7.1).

Table 7.1: Socio-Demographic Characteristics of Participants (N = 13)

Participant	Gender	Age (years)	Residence Locality	Type of Faith Leader Attended
P001	Female	50	Rural	Spiritual Leader (*Dum Wala**)
P002	Male	32	Rural	Spiritual Leader (*Peer**)
P003	Female	40	Urban	Prayer Leader (*Hafiz e Quran**)
P004	Female	58	Urban	Islamic Scholar
P005	Female	50	Urban	Spiritual Leader (*Peer**)
P006	Female	33	Urban	Spiritual Leader (*Peer**)
P007	Male	25	Rural	Spiritual Leader (*Peer**)
P008	Female	53	Urban	Spiritual Leader (*Peer**)
P009	Female	36	Urban	Prayer Leader
P010	Male	NA	City	Islamic Scholar
P011	Male	NA	City	Spiritual Leader (Peer*)
P012	Male	30	City	Islamic Preacher
P013	Male	43	Rural	Spiritual Leader (Peer*)

Note. Missing values are represented by NA (Not Available)
**Dum Wala*: Usually a spiritual leader, who recites verses of Quran and blow on body (or affected areas of body) of the person with some illness for healing; *Hafiz-e-Quran*: S/he is the person who memorises the Quran and lead the prayer at mosques. Mostly, this person is male; *Peer*: Usually one type of faith leaders whose worldview is grounded in mysticism and spiritual understanding of religion.

Six overarching themes were identified, they were: 1) the dynamics of talking in faith leaders' settings; 2) diverse and conflicting understanding of depression; 3) traditional and faith-based orientations and practices; 4) divergent views on faith leaders' practices; 5) contesting

positions on treatment preferences and 6) engagement of family members in treatment-related decision making. Appendix 7.4 shows additional quotes, themes, sub-themes, and illustrative quotes.

7.4.1 Theme 1: The Dynamics of Talking in Faith Leaders' Settings

During the interviews, participants rarely discussed talk therapies or behavioural activation in depth compared to other topics. Hesitation to engage in talk with faith leaders and limited instances of verbal guidance suggests that either talk-based traditions are uncommon in faith leaders' practices or participants do not view discussions as a type of intervention but rather as everyday aspects of life, including within faith leaders' settings. A notable minority of participants (N=4) reported receiving verbal advice or guidance from faith healers. This guidance was often limited and primarily focused on religion, and it generally did not consider people's psychological and social situation. While listening is part of this interaction, some form of instruction/feedback also occurs in these types of interactions. One male participant emphasised listening as a crucial part of the faith leader's role.

> *Yes, yes, he (*the faith leader*) listens like you do. I told him that I had a stomach issue, feels like a burden on my head, and I had thoughts, so then he wrote my name and told me what issue I had* (P012; age 30, male)

This communication was not limited to face-to-face discussions; one female participant reported that she regularly connects with her faith leader via phone. This demonstrates the strong ties between attendees and faith leaders, and the participant reported that these telephonic conversations are often helpful during stressful situations. These conversations are typically grounded in religious advice, with faith leaders directing or advising individuals to perform certain rituals, such as reciting holy verses.

> *When I am too tense, I call them (referring to faith leaders) and tell them my problems. All they say is things will get fine, so recite this and that.* (P004; age 58, female)

Another female participant highlighted significant cultural dynamics, including not wanting to share her thoughts with others (including the faith leader from whom she sought help). The finding that most participants did not report sharing their problems, and sharing does not appear to be part of normal practice, reinforces the plausibility of people being reluctant to share openly as part of the culture.

> *No, I wouldn't like this if I go and share my thoughts with someone else or ask them about it……. Whether it is happiness or hurt, I keep it to myself, and I just stay with myself. My*

daughter says sometimes you stare at the roof, sometimes you stare at the fan, sometimes you stare at the bulb, so I say it's okay. I just talk to myself (P001; age 50, Female)

Notable gender dynamics were identified by a few participants, potentially making both men and women less inclined to share personal issues with faith healers of the opposite gender. However, many female participants reported visiting male faith leaders without explicit concerns. One male participant said he preferred speaking with male faith leaders. However, due to fewer female faith leaders, females traditionally visit male faith leaders, with segregated seating arrangements and treatment provided. This involves separate waiting rooms or areas and faith leaders meeting them individually. However, this practice may not be applied to all faith leaders' settings.

They provide treatment to women and men in segregation. (P008; age 53, female)

Segregation in faith leader settings varies depending on cultural and religious interpretations. Some enforce strict segregation between males and females, while others use a more flexible approach, with no strict segregation between males and females (For Additional Quotes: See Appendix Table 7.4).

7.4.2 Theme 2: Diverse and Conflicting Understandings of Depression

Regarding the symptoms and reasons associated with depression, participants tended to report them in line with biomedical understandings. For instance, they reported core symptoms of depression, including sadness, disturbing/intrusive thoughts, hopelessness, and sleep problems. Similarly, participants identified a few reasons for their depression, including failures in life and marital issues. Knowledge about depression in line with biomedical understandings may partly be explained by the fact that study participants were recruited from psychiatric facilities. When providing explanations for the causes of depression, participants also referred to *taweez* (Amulets), *jinnat* (Demons) and *asarat* (Possession). However, with a few exceptions, most participants reported that these explanations were given by faith leaders rather than expressing their positions. Despite knowledge about depression, one participant explained how recognising and understanding depression may be difficult in the first instance.

People do get depression without their awareness……. Initially, you don't understand what's happening, as it affects the brain more. It affects the brain in a way that the person is unable to understand what's the problem (P013; age 43, male).

By reflecting on their experience, participants were able to identify and discuss their experiences and symptoms of depression. For instance, one of the participants discussed the sadness she experienced and her loss of interest in performing routine activities.

> *Yes, a lot of sadness. Sadness is still there. Yes, a lot of sadness and hopelessness. Nothing would feel good like life has completely become purposeless. Neither any interest in wearing nor any interest in eating. No interest in going outside the house. Nor do I like people. Even now, I don't go anywhere.* (P001; age 50, female)

When reflecting on their symptoms of depression, many were also consistent with cultural norms and world views. Participants reflected on their mood by describing losing interest and behavioural disengagement with everyday activities. Other core symptoms like sadness and hopelessness were explicitly communicated. One participant did not only reflect on her symptoms but reported that was how she identified her depression.

> *I identified depression from my symptoms, which were sadness, hopelessness, and disturbing thoughts. I have this one thought about the future that I don't know if things are going to be better ever. That's what kind of things I face* (P004; age 58, female).

Another female participant described her experiences of depression through emotional and physical responses, including anger, frustration, sweating and burning. She also described feeling anxious and the impact on her body. The quote illustrates that she was experiencing somatic symptoms and related her somatic symptoms to depression,

> *I used to get very angry, and I used to shout and scold my children. And the biggest issue was that I used to get excessive sweating suddenly on my face and body which would make my whole body wet, I used to get a burning sensation in my feet, I used to get the feeling of chest tightness as well...* (P005; age 50, female)

Participants often relate their depression to life events which may have triggered its onset. During one interview a participant, rather than pointing towards a specific life event, provided a generic overview by describing a personal failure as a reason for his depression.

> *If the person experiences failure and then the person breaks from inside, I tried my best but still I failed - this makes a person tense and in psychological distress*. (P010; male)

Although psychosocial explanations were present in the data, faith-based, spiritual, magical, and supernatural explanations were more prevalent, necessitating a broader examination of these explanations within the context of Muslim traditions. Not all participants

agreed with some of these explanations, and their perspectives were shaped by their relationship with Islam [7]. The quote below highlights differing belief systems and practices when visiting faith leaders for mental health problems.

> *I mean mostly it is that someone (referring to faith leader) says that you should do namaz (prayer) so I say this is better but when someone (faith leader) says that no she has "saya" (Evil shadow) ….. Some people don't ask whether you pray or not, they simply ask tell mother's name and then say someone did magic on you.... I believe whoever we visit the first question should be of prayer when someone have psychological issues, they should talk about praying, suggest some supplications, some "wazeefa" (Recitations)* (P009; age 36, female)

Some participants talked about magical beliefs and explanations but referred to faith leaders' explanations rather than their own interpretations. Faith leaders widely communicate their understanding of depression in two interrelated contexts: i) interpersonal and ii) magic or curse. Participants reported that faith leaders explained that someone had cursed them (participants) with magic, and this is the root cause of depression or their issues.

> *No he (Faith leader) didn't say anything about this he just said someone had done some "taweez" (Magic using amulets) and "jinnat" (Demon possession) on you. And these "jinnat" (Demon possession) are bad with negative effects and your condition is because of this. It's not a disease.* (P005; age 50, female)

Participants across the data consistently reported contexts where faith leaders used interpersonal and magical beliefs; 7 out of the 13 participants reported that faith leaders told them that their problems were due to a curse put on them by another person. A few participants explicitly reported that they had experienced such magic,

> *They've sent demons and they're still in the house. There is some influence. This is how it feels sometimes……. I was sleeping and it was early morning. On my face, it felt as if someone had slapped it and the entire day I felt as if that hand was still on my face, like someone slapped me. Yeah, this happened to me once or twice. And like while sleeping,*

[7] Generally, there are two broad categories among Muslims: those who practise "*Shariat*" (obligatory duties and responsibilities in the Quran and sayings of the prophet PBUH) and those inclined towards *tariqat* (mysticism or spirituality). *Shariat* proponents emphasise obligations like offering prayers, fasting, and pilgrimage. In contrast, *tariqat* proponents aim to connect with God and purify the soul, moving beyond obligatory duties. There are various views, tensions, and interplay on and between these categories. This complex interplay of perspectives highlights the intricate relationship between religious beliefs and understanding of mental health issues.

someone moves my foot and I feel it. That grandchild of mine, he also felt this once and he kept saying look at that look at that he's standing there. I have a son, he also feels all this and says there is some influence (P001; age 50, female)

In summary, magical and supernatural explanations were common in faith leaders' discussions with participants; however, the responses from participants were more nuanced. While a few (as described) concurred with these explanations, others disagreed (For Additional Quotes: See Appendix Table 7.4).

7.4.3 Theme 3: Traditional and Faith-based Orientation and Practices

Despite no clear-cut answers, the data reveal differences and potential similarities between faith and health professionals' practices. The participants reported a range of faith-based practices, including blowing recitations, amulets, blessed water, prayers, and recitation of holy verses (See Table 7.2). Some practices, such as blowing recitations (by reading holy verses and blowing them onto people) and amulets (written holy verses inside an object or rolled in a piece of rubber/ cloth which a person can wear), were identified as common across the data. Such strategies also reflected expectations held by attendees about faith leaders - for example, participants often used the term *dum wala* (a person who blows recitations) rather than terms like religious leader, Muslim scholar or spiritual mentor.

They (Spiritual leader) don't tell as there are lots of people who visit there they just give "dum" (Blowing recitations). (P008; age 53, female)

Participants also shared their experiences, and the process involved in blowing recitations. Blowing recitations (Dum) typically involve reciting holy verses, blowing into water, and splashing the water onto the body. Alternatively, the verses can be blown directly on the body or affected areas, such as the head, in cases of mental illnesses. It is believed that these verses possess healing power.

He (Faith leader) says to recite those verses and perform "dum" (Blowing recitations) on water to drink, so he does this according to the Islamic method. (P013; age 43, male)

Blowing recitations can be done in multiple ways, such as reading the verses of the *Quran* and blowing onto a person's body. In some instances, blowing may not be utilised at all, and such practice is limited to reading or saying holy verses by placing a hand over a person's head (or any other part of the body that is thought to be affected). A few participants reported that faith leaders just suggested they only read/ recite holy verses by themselves (without blowing).

Yes. I went to some place where someone suggested a scholar. I thought I should consult him, maybe he might solve my issues, problems, and depression. He told me some recitations from "Holy Qur'an" which thanks to the Almighty that we already pray. (P004; age 58, female)

This difference in approaches is based on differing underlying beliefs; for example, those faith leaders who perform recitations and blow by themselves or their attendees (who insist faith leaders perform this) may believe that such faith leaders are close to God and that there is a spiritual power and blessing which can heal. However, some disagree with this proposition and agree that spiritual power and blessings lie within holy recitations, which anyone can get by reciting the Quran. However, most participants in this study believed in the spiritual power of faith leaders by assuming they are closer to God than an ordinary person, sometimes referring to them as 'friends of *Allah'*.

Allah also provides shifa (cure) for that I also visit "Auliya Allah" (Friends of God, Saints) as well for "dum" (Blowing recitations). Sometimes they give something to recite as well, sometimes they give water for drinking after doing "dum" (blowing recitations on water; blessed water) on it. So, like this, my spiritual treatment also goes side by side. (P010; male)

These traditions and practices are not only thought to heal mental illness but also to counteract curses, as mental illness was often attributed to magic or curses. Wearing amulets, which typically consist of holy verses written on paper, was another widespread practice identified by participants. People wore amulets to receive spiritual blessings and protection from curses, evil, and Satan. One participant reported receiving an amulet to wear and another to drink, suggesting that amulets can be consumed by mixing them with water. While reciting holy verses and blowing is common, drinking amulets may be less prevalent.

Initially he (Spiritual leader) gave me a "taweez" (Amulet), one for wearing and another for drinking. He hoped that it would make you feel better …like these ones you can write yourself and keep using them. Then I did this. I copied those and kept using them, then I stopped using them. Then he told me to recite "Surah Muzammil" (Verses in Quran). He told me not to stop this and I used to read this 11 times a day. (P006; age 33, female)

Other practices reported in the data included daily prayers and day and night supplications practised by the holy prophet PBUH. A widely held belief reported was that daily prayers (praying

5 times a day is obligatory for Muslims) and the recitation of the Quran kept Muslims away from satan and evil.

> *He basically provides treatment according to "sunnah" (Practice of Prophet Peace Be Upon Him) and gives patients something to read, he also suggests praying five times a day religiously and after every "namaz" (prayers) there are some "azkaar" (Supplications and recitations) that the patient has to recite themselves. So, this is how he treats patients, basically he helps patients to follow the path of Allah. The morning and evening supplications that are "masnoon azkaar" (Morning evening supplications) that the Prophet Muhammad (PBUH) used to do that help keep away the "shayateen" (satan) he also suggested to recite those.* (P010; male)

Some believed visiting faith leaders for blessings or remedies might be less effective than personally praying and reciting holy verses. These participants expressed dissatisfaction with the costs of seeking faith leaders' guidance. They argued that directly praying to God was more advantageous, as God understood their intentions and needs better than anyone else.

> *I have seen that there is no purpose, they (faith leaders) also write "Allah's kalam" (Quranic verses) and we should pray and recite ourselves that is better. We spend so much money visiting these people but there is no gain, rather it's better to pray to "Allah" (God) yourself… Allah is watching, he knows what my intentions are while talking to someone.* (P009; age 36, female)

The data indicated the importance of personal autonomy and self-care. One participant explained that it is crucial for an individual to take personal responsibility for their well-being, as relying solely on others may not yield the desired results. While external support can be beneficial, self-care is essential for improving and progressing one's life.

> *But it's also important that a person takes care of himself otherwise others can't do anything. It's beneficial but one who doesn't care about himself won't get better.* (P013; age 43, male)

It was explained by some respondents that in Islam, a range of misfortunes (social, economic, relational, etc.) are believed to be manifestations of a lack of relationship with *Allah* (God). Also, one is more exposed to evil spirits or spells when one is distant from *Allah* (God). To avoid these issues, people need to put their belief in *Allah* (God), and with the will of *Allah* (God), problems are more likely to subside.

Honestly speaking I don't believe in these things. I believe Allah is the one who gives "shifa" (cure). I think that if someone with pure intentions uses "Allah's kalam" (words of Qur'an) it may give us "shifa" (cure)... .so this is what I believe in. (P005; age 50, female) (For Additional Quotes: See Appendix Table 7.4)

Based on the participants' statements discussed in themes and some of them given in appendix table 7.4, I have provided below a table containing the list of those practices suggested by the participants along with their description (See Table 7.2).

Table 7.2: Faith-based and Traditional Practices Used by Faith Leaders

Practices	Description
Dum (Blowing recitation)	Faith leaders read/ recite holy verses (e.g., verses in the Quran) and blow on the person (or any affected areas)
Dum wala pani (Blessed Water)	Faith leaders read/ recite holly verses on water, and subsequently, people splash this water at their residence or onto themselves
Namaz (Prayers)	Daily five times prayers in Islam
Discussion and advice	Faith leaders engage participants in discussions usually grounded in religious and faith-based content.
Zikar (Supplications)	Day and night supplications are as per tradition of the holy Prophet, peace be upon him.
Taweez (Amulets)	Writing verses of the Quran on a piece of paper and wearing it
Tilawat (Reading and/ or reciting Quran)	Faith leaders suggested participants recite the Quran (e.g. different chapters, including the *Fateha* chapter and Muzammil chapter)
Sadqa and/ or zakat (Charity)	A form of charity in Islam where people usually give a certain amount of money, food, or livelihoods to people in need.
Tauba (Repentance)	Repenting on sins
Darood (Sending blessings on the Prophet, peace be upon him)	Sending blessings and prayers on the Prophet, peace be upon him
Chilla (40 days worship)	Forty days of worship are usually performed in isolation
Attending "*Urs*" (Annual death anniversary of saint)	The death anniversary of a saint is organised on an annual basis by successors of the saint in shrines.
Attending "*Gyarvi shareef*"	Free food distribution in mosques and/ or shrines monthly to commemorate one of the saints (known as Abdul Qadir Jillani)

7.4.4 Theme 4: Divergent Views on Faith Leaders' Practices

Participants provided divergent and contesting views on faith leaders' practices, with some participants reporting that they felt better after visiting faith leaders while others reported perceived ineffectiveness of such practices. There were also different views in the data relating to trust in faith leaders, and some participants were primarily concerned about the authenticity of faith leaders and their practices. Participants also reflected on how their perceptions have been transformed after visiting faith leaders, with a couple of participants reporting a few safety concerns and privacy issues.

Participants reflected on receiving healing remedies such as attending *urs* (death anniversaries in shrines), prayers, amulets, recitations, day and night supplications and events such as commemorating saints. Events such as *gyarvi shareef* (*Gyarvi* means 11th in Urdu) were reported by participants. This event commemorates a Sufi saint (Abdul Qadir Jilani). It includes mosques/shrines to distribute *niyaz* (free food with sacred and spiritual significance) on the 11th lunar Islamic month. It is believed that the master saint and their successors can mediate between people and Allah, and therefore, attendees of the events request that the successors of saints pray for their wellbeing. One of the participants who attended this event reported that she felt better after attending, which she believed was a result of the prayers said there,

> *I got back from a peer's (Spiritual leader) house, so my condition got better due to his "dua" (Prayers). A lot of people from my village and even from far away areas… the "urs" (Religious event) happens once a year and even on "gyarvi shareef" people visit from far away areas.* (P008; age 53, female)

Notably, the practice of such events is limited only to one sect (*Barelvi* sect), and others may not follow it, demonstrating considerable heterogeneity in practising faith. A few other participants reported that they felt improvement after taking a session of *dum* (blowing recitations); this contrasted with medicines they had taken that they were not satisfied with. However, a few participants reported on the ineffectiveness of such practices and reported on the financial burden of going to faith leaders. The ineffectiveness of practices coincided with distrust and confusion regarding the authenticity of faith leaders.

> *I tried a lot of "dum" but haven't felt any change. Initially, it used to happen that I would get sick for 5 to 6 months but then Allah used to provide help from different ways. But recently I have tried a lot of "dum" but couldn't feel any better.* (P012; age 30, male)

One female participant reflected on her experience of visiting a faith leader who mocked her about her marriage. The experience caused her to lose trust in faith healers for a while; however, regardless of her negative experience, she later visited another faith leader for *dum* and found it helpful. It also illustrates how people may "shop around" for faith leaders and that the relationship between a faith leader and the person they are attending to is important.

> *I completely stopped visiting spiritual healers as I lost faith in them. I thought that they were such big names, the successors of saints but when they abused me so much, they abused me in their gathering then I stopped visiting peer fakeers (spiritual mentors/ leaders). Now the one I visit for "dum" (Blowing recitations) that man…. he is far away I don't know who he is but it's just I go to him for "dum" (Blowing recitations) which makes me feel better.* (P006; age 33, female)

Participants' perspectives were heterogeneous and ambivalent when discussing their trust in faith leaders. Data suggested that participants were "in between trust and distrust", which partially refers to the uncertainty and indecisiveness on the part of participants. It is clear that a few people showed distrust, and a few showed their confidence in faith leaders. Albeit those who reflected their explicit trust (or distrust) in faith leaders at one instance did not adhere to their view on some other occasions during the interviews. Participants' perspectives were situational and context-dependent. Some extreme positions were also apparent in the data, with one female participant expressing her trust by using the term "saviour" whilst some other participants labelled a few (not all) faith leaders as "manipulators".

> *But thanks to Allah, I don't know who he (faith leader) is but I pray for him from my heart that, I don't know how he is with others but for me he is my saviour.* (P006; age 33, female)

There have been growing concerns in the community that faith leaders running religious institutions have earned money for their own personal matters[8]. This public perception was apparent in a couple of responses.

> *Their role is something like that… out of 100 more than 80% are in this profession to earn money. Their appearance… As women do makeup they make their appearance according*

[8] In the Pakistani context, the public spends a lot of charity money on religious institutions - in the majority of cases, mosques/shrines/*madrassas* (Islamic educational institutions) are built up by local people by raising charity – and *zakat* (Muslim requirement of giving a proportion of income to charity) is considered as an obligatory act.

to “sunnah” (Appearance and traditions of Prophet Peace be upon him) to trap weak people like us and start treating us to earn. (P011; male)

Usually, Muslim faith leaders are associated with a certain appearance, including a beard and turban (or traditional Muslim cap); one male participant viewed that such appearance can be used by non-authentic faith leaders to earn money. While this participant did not believe that all faith leaders are only working for money, he was very distrustful and believed there were very few authentic faith leaders,

There are few like I would say people who are "Allah’s wali" (saints), they pray and keep fasts they are few and I would like to say that this world is still standing due to them who try to keep the sunnah (traditions) of Prophet Muhammad (Peace Be Upon Him) alive. (P011; male)

Interestingly, the confusion regarding fake versus authentic is so prevalent that another female participant reported that it is so hard to differentiate that it may be better to seek help from a psychologist.

But now I don’t know who is real and who is fake. So it’s better to seek a psychologist rather than faith leaders. (P003; age 40, female)

This significant statement shows how contextual forces and public perception about faith leaders can transform people's treatment choices. Despite concerns regarding the charity earnings of faith leaders, conversely, it was also identified that they do not explicitly ask for fees for their guidance and often do this work on a volunteer basis. In most of the mosques and shrines, people do not pay for their visits. Instead, charity boxes are placed inside, and any person who visits has an option either to pay or not.

I mean he is “Qari sahab” (Prayer leader), his work is to do "dum" (Blowing recitations) without taking any money if anyone wants to give money, they can but “Qari Sahab” (Prayer leader) doesn’t ask himself. (P012; age 30, male)

Free food is also provided to people on different religious occasions, such as annual gatherings on shrines. One of the female participants reported major safety concerns, including a faith leader hitting her with a knife, though she reported it had not caused her any injury.

When he came, he said that I was possessed so he hit me with a knife and gave me medicines, this is the story. (P003; age 40, female)

The knife was held by a faith leader with a blade facing away from the body and was used to evict evil spirits from the body. Another female participant reported a negative emotional experience when she went to a faith leader. When she told the faith leader about her sleep-related problems – in front of others, he responded that this was because she had not gotten married, resulting in laughter from the people gathered. She reported that this caused her distress, and she never visited there again. Such experiences highlight privacy concerns present in faith leaders' settings. In some cases, faith leaders did not use a separate space to engage with their attendees, and this is potentially a significant barrier to maintaining privacy during talks and discussions with attendees (For additional quotes: See Appendix Table 7.4). Additionally, this incident of mocking, the hitting with a knife and another report of a faith leader mocking a participant all happened to women participants. The gendered dynamic highlights safety concerns and how women are often treated and humiliated by male faith leaders (For Additional Quotes: See Appendix Table 7.4).

7.4.5 Theme 5: Contesting Positions on Treatment Preferences

Participants reflected mixed opinions about their preference towards professional help-seeking and medicines and highlighted potential undesirable effects of the medicine. Whilst a considerable proportion of people preferred a psychologist or doctor for receiving any psychosocial and/ or medical treatment, a few reported that both medical professionals and faith leaders are important to them.

Several reasons for getting professional support were apparent in the data, including the lack of training of faith leaders to deal with people with mental illnesses and some other reasons, including negative experiences with faith leaders, disagreement with magical explanations and the limited role of faith-based practices only. One of the male participants also reflected upon his positive experience and treatment during inpatient admission in support of preferring professional services.

> *The one that you provide is better (referring to medical treatment and hospital admission). If I spend 20 to 25 days in a single room where I get to rest with a good diet and peaceful environment in a facility, I can get more than 90% better*. (P011; male)

Magical and traditional explanations of depression were reflected mainly in faith leaders' practices and were endorsed by a few participants (and were disagreed by others). Depression is usually linked with interpersonal and psychosocial contexts and is subsequently related to magical explanations by faith leaders. For this reason, those participants who believed in such explanations identified the limitations associated with professional services. For instance, one

male participant reflected that both services (informal and formal) have their understanding, explanation, and practices and, therefore, are important.

> *But as in medical science there is no concept of "jaddu" (Magic) and "jinnat" (Demons), so these are the things that Islam tells us. So, the religious people treat in their own way, but doctors treat patients according to their knowledge of medical science. So, I believe both things are necessary*. (P010; male)

Nevertheless, participants did not oppose professional help but agreed that both pathways can complement each other. One potential reason for getting support from faith leaders was negative experiences with medicines – such as becoming dependent on medicine. One female participant reported that she did feel better after taking medicine, but once she stopped, symptoms re-emerged.

> *I take medicine for depression, and I feel better. I mean… body aches and body trembling, headache, lack of appetite…. These types of complaints get better when I take medicine but if I don't take medicine my condition becomes as it used to be before.* (P006; age 33, female)

Though this is not the case with all participants, another participant highlighted that doctors only prescribe medicine and do not offer other interventions (i.e., psychotherapeutic). She reported the negative effect of the medicine was that it made her sleep a lot,

About the doctor, it's just that they give me medicines and I keep sleeping. (P001; age 50, female)

Some undesirable effects of the medicine were also reported in cultural terms. For instance, one female participant reported that medicine has a warming effect on her. It is a common and traditional perception in the local context that different foods have been classified as having warming or cooling effects after consuming them. Generally, foods with heating effects are discouraged, especially during summer.

> *So, I feel dizzy and then I fall, as the effect of medicines is warming as the doctor was asking why I left taking medicine this was the reason … I forgot to inform her. As this happens with me, I feel dizzy while walking and then I fall.* (P008; age 53, female).

Such traditional beliefs associated with medicines have significant implications for adherence to medicine routines and attitudes towards professional help-seeking (For Additional Quotes: See Appendix Table 7.4).

7.4.6 Theme 6: Family and Tradition Influence Help-Seeking Behaviour

Participants reported that they relate to faith leaders for many reasons, including supervision in practising religion, scholarly guidance, and arrangement of religious ceremonies at homes (like marriage and funeral occasions) and sometimes for health-related matters. These connections sometimes are a legacy of their forefathers; for example, if someone's grandfather had sworn allegiance to any spiritual mentor, this is followed by the subsequent generation. The data suggests that such ties have a considerable impact on visiting faith leaders for mental illness.

> *I went to a faith leader who was "Hafiz e Quran" (One who has memorised the whole Quran) and died four to five months ago…. also advised my family to keep me happy and that's all. He was a great teacher and was even my father's teacher.* (P013; age 43, male)

Such ties are so strong that faith leaders are occasionally involved in almost all-important family decisions, such as marriage, jobs, study, and divorce. The data found a strong involvement of family members in treatment-related decisions—and in some instances, individual decisions were overruled by older members (or those with a higher power hierarchy in the family). Women in the study reported they needed to comply with family directives, and not doing so would result in negative consequences.

> *So other than that, wherever my family takes me I don't like going but I can't say no, as if I won't go they will blame me for everything and they will say we are taking her (to faith leader) for the sake of her children (referring to bearing children) and she doesn't want to. That's why I am obliged to go but I don't want to go.* (P009; age 36, female)

Family members' influence to direct their relatives to visit faith leaders was comparatively common, with several participants reporting such events. Also, the data indicated that participants had less autonomy in making their own decisions (For Additional Quotes: See Appendix Table 7.4).

7.5 Discussion

This study aimed to investigate faith leaders' routine practices for supporting people with depression, from the perspective of their attendees, their views about the support they received and their willingness to receive BA from faith leaders. The data highlighted individuals with depression who attended faith leaders had knowledge of the typical symptoms of depression, and their understanding of depression was based mainly on medical and psychosocial explanations. However, they also reported alternative explanations for depression, such as magic, curses, and possession. At times, faith leaders may have conveyed alternative explanations to their attendees

that do not necessarily reflect the attendees' perspectives. While there was almost a consensus that faith leaders hold faith-based and magical explanations for depression, some participants disagreed with these explanations. This highlights that individuals' attitudes towards formal or alternative mental healthcare systems are complex and likely determined by their context, worldviews and experiences (including family and tradition influences), indicating substantial pluralism (Kyei et al., 2014).

The participants described several faith-based practices offered by faith leaders, including recitations, prayers, amulets, and advice; such findings are consistent with previous studies conducted in Pakistan (Saeed et al., 2000; Farooqi, 2006). This study enhances our understanding of faith-based practices employed by faith leaders in diverse settings, indicating that these practices primarily involve using *Quranic* verses in different ways, such as reading, blowing on affected areas, or using amulets. This tradition, sometimes called *ruqyah shariah* (*Quranic* and prophetic incantations), employs holy verses to heal individuals with various physical and mental conditions (Eneborg, 2013). Extensive verbal discussion is uncommon in consultations with faith leaders, although a few participants reported it. Data suggested that faith leaders are mostly known for faith-based practices (such as blowing recitations) rather than talking or discussions. This may be partly due to participants' not viewing talking as something that may relieve symptoms or faith leaders tend not to view depression as an “illness”, which is consistent with the findings obtained in systematic reviews in the Pakistani context (Choudhry, Khan and Munawar, 2023; Munawar et al., 2020). The cultural construction of talking seems more solution-focused (to solve daily life challenges or religious matters) rather than illness-focused or treatment. People generally take scholarly or spiritual guidance from faith leaders when facing any issues with Islamic legal significance, like divorce, marriage, and rules for worship. Discussion is mainly grounded in Islamic literature, the *Quran*, and *Hadith* (Sayings of prophet PBUH). This highlights and supports some of the psychotherapeutic interventions developed for Muslims, in which discussion is mainly guided by Islamic faith-based values and literature (Anderson et al., 2015). However, data suggested this might not be true for all participants, especially those who expect faith leaders to draw on recitations and incantations.

Participants found understanding and reflecting on talk therapy and BA concepts challenging. Nevertheless, they identified several aspects of their experiences that could align with the principles of BA. For example, they recognised that depression often arises from life failures or stressors and that a loss of interest in daily activities can exacerbate mental illness. In most cases, faith leaders recommended religious-based practices, which, for some participants,

improved their mood. By engaging in these practices, which may have some elements in common with BA, contributing to their overall well-being. Participants also noted that introducing various religious activities mitigated the symptoms of depression. Such findings were also reported in a recent study aiming to develop culturally relevant BA in Pakistan (Zavala et al., 2023). Possible barriers to using BA in faith leaders' settings, including limited reliance on psychosocial practices, hesitancy to speak to faith leaders, and safety and privacy issues while engaging with them, were also present. Also, very few participants agreed with magical or supernatural causes of depression, like possession or curse. This has some implications for BA delivery in a faith leaders' context. It might be challenging to present the rationale of BA to those people who identify strongly with magical causes of depression, and they might be less likely to internalise it. It has been noted in earlier research that people with mental illnesses having such beliefs are less likely to adhere to standard medical treatment (Ahmad, Khalily and Hallahan, 2017).

Participants also expressed concerns regarding privacy issues, emphasising the need to address these concerns, especially when engaging in talk therapy within faith leaders' settings. Ensuring a confidential and secure environment for open communication is crucial for individuals to feel comfortable discussing their challenges and experiences, which can significantly impact the effectiveness of the therapeutic process in such settings. Repeated reports of safety and privacy concerns, predominantly expressed by female participants, indicate a heightened vulnerability in faith leader settings. These findings suggest that women may be particularly susceptible to such issues during interactions with faith leaders. The consistency of these reports underscores a critical need to address safety and privacy provisions in these contexts. Ensuring these provisions could enhance trust and confidentiality, improving the safety of engagements between women and faith leaders. Further, this could contribute to a more inclusive and gender-sensitive approach to faith-based mental health interventions.

Previously, studies have reported that attendees have a sense of relation, trust and faith in practices used by faith leaders (Charan et al., 2020; Usman Shah et al., 2018). However, inconsistencies about explanations, healing remedies, and trust in faith-based practices were evident in the data. Some participants endorsed such practices. However, some disagreed. There were significant discrepancies in preference towards specific treatments, with some showing their preference mainly for biomedical treatment, a few favouring faith healing, and a sizeable number preferring both. Much of this depended on their context, worldview and experiences with faith leaders and biomedical treatment. Those with an adverse experience with faith leaders were more likely to exhibit a critical attitude towards faith leaders. In contrast, those who i) swore allegiance

to faith leaders, ii) experienced some side effects of medicines, and iii) were influenced by their healing powers were likely to show compliance and satisfaction with faith leaders' practices. This was even more complicated by attendees' worldview; for example, believing in healing through practising faith alone was also linked with challenging faith leaders' authority. Some other notable factors were family dynamics, religious orientation, and exposure to statutory mental health services. Family culture, for instance, was integral, where some participants reported that it is the family who makes decisions on their part about seeking care for mental illness. Public and community discourse relating to the authenticity of faith leaders and what they offer was another critical factor. Attendees' views were likely transformed after contacting mental health professionals, implying that quality care in psychiatric facilities can also reshape preferences.

7.6 Strengths and Limitations

The unique aspect of this study was its specific focus on the views and experiences of people with depression attending faith leaders. Another notable aspect was discussing participants' attitudes towards faith leaders providing evidence-based treatment. This study used rigorous methods, including one-to-one interviews. All other methods, including forming a topic guide, sampling strategy and data analysis, were informed by this dissertation's literature or previous studies/reviews. This study was driven by clear research questions and problem statement. I used SRQR guidelines for reporting the study according to standards. Further, the methodology, data collection and analysis were justified and I demonstrated how they fit with the overall rationale of the problem statement. Data collection in practice followed the apriori written protocol. Notably, relationship dynamics between research participants and myself (or other researchers involved in data collection) were considered and I explicitly expressed my views, expectations and reactions to study participants.

This study also has numerous limitations. First, participants were recruited from a psychiatric hospital and were concurrently taking (or had taken) treatment for depression. Therefore, findings cannot be generalised to all people who have first-hand encounters with faith leaders (but have not attended formal mental health services). Participants were recruited from tertiary care in Rawalpindi, but as mentioned, tertiary care provides coverage to many neighbouring cities, including rural and urban areas. Still, those findings are potentially relevant only to faith leaders in Punjab (Province in Pakistan). Further, only Muslim participants attending Muslim faith leaders were in the sample. The majority of people in Pakistan are Muslim and attend Muslim faith leaders- however there are minority populations following other faiths, whose views

have not been captured in this study. Lastly, it was difficult for participants to reflect on the idea of talk therapy and psychotherapy in greater detail.

7.7 Conclusion

Participants noted significant differences between faith leaders' practices and standard mental health services. However, they acknowledged the impact of life events on depression onset and observed a connection between faith-based activities and mood improvement, hinting potentially at the feasibility of elements of BA being used within faith leaders' settings. However, using BA in faith leaders' settings may be challenging due to participants' lack of connection to faith leaders' settings through engaging in discussion, a stronger emphasis on faith-based practices, privacy and safety issues, mixed public perceptions, and a lesser reliance on psychosocial understanding. Therefore, integrating task-shifted BA may not be straight forward and requires considering social, religious, and public perceptions and familial context. Careful consideration is required to select the right people and context for delivering BA while ensuring attendees' safety and privacy. These findings are limited only to people who have attended faith leaders before they contacted formal healthcare services and to those attending faith leaders in Punjab.

8 Chapter Eight: Qualitative Data Synthesis

I presented a systematic review earlier in this dissertation, which included a qualitative synthesis of the literature on the barriers and facilitators to accessing support provided by faith leaders to individuals with CMDs (Chapter 5). Further, I have described two qualitative studies, including one-on-one interviews with faith leaders (Chapter 6) and their attendees (Chapter 7). This chapter presents a synthesis of the conclusions from those three studies, in which I collected qualitative data. It aims to draw a thread that connects all the qualitative data to get more in-depth insights about the research questions presented in the beginning (Chapter 2).

8.1 Background

Most research (quantitative and qualitative) on training faith leaders (such as training on identifying mental illnesses and making referrals to formal healthcare services) and how such training has influenced faith leaders, and their attendees has been conducted in Africa. Recently, a cluster trial evaluating the effectiveness of training faith leaders on the identification of psychosis, making referrals to primary healthcare facilities and refraining from harmful practices has been carried out in two African countries, Ghana and Nigeria (Gureje et al., 2020). It reported a significant reduction in psychosis in the collaborative care arm (the intervention delivered by faith leaders and primary healthcare workers working together) compared to the enhanced treatment (control) arm at the six-month follow-up. A significant reduction in the overall costs associated with psychosis management was also observed (Gureje et al., 2020). Further, a qualitative study reported that training faith leaders on basic mental health skills improves the psychosocial understanding of faith leaders, and they avoid using harmful restraining strategies like chaining (Yaro et al. 2020). Furthermore, both faith leaders and their attendees reported the benefits of such training (Yaro et al., 2020). The research suggests that faith leaders may be open to changing their practices and can reconsider beliefs about etiological factors underlying mental illnesses when exposed to training workshops (Baheretibeb et al., 2022).

A few qualitative studies have explored the views of faith leaders and their attendees in the context of mental illnesses in Pakistan (Khan et al., 2023; Charan et al., 2020). One of the studies examined the perceptions of i) service users who attended both healthcare providers and faith leaders, ii) healthcare providers and iii) faith leaders about the support provided by informal (faith leaders) and formal healthcare providers for psychosis (Khan et al., 2023). This study found that faith-based understandings of psychosis (such as psychosis happening due to the will of God) were present among a few participants who attended faith leaders, but this was not true for all participants (Khan et al., 2023). Magical and supernatural explanations were less common

compared to medical explanations among those seeking support from formal healthcare service providers and those who attended faith leaders. Service users reported that formal healthcare providers were often overburdened and that faith leaders commonly gave misleading information about the treatment of mental illnesses. Those service users also expressed mixed perceptions towards formal healthcare support – some reported it as beneficial while others were unsatisfied, especially with the delayed effects of medicines.

The same study also found that faith leaders relied heavily on magical, spiritual, and faith-based explanations of psychosis, while formal healthcare considered medical and psychosocial determinants contributing to such conditions (Khan et al., 2023). Other qualitative studies have reported different results; Rathod et al reported that people with psychosis (or their carers) i) attribute their illness to sins (wrongdoings), and ii) prefer to seek care from faith leaders in the first instance (Rathod et al., 2023). Kattak et al reported that both spiritual and medical treatment are important to faith leaders (Khattak et al., 2022). Building on this evidence, a cluster control trial has been initiated in Pakistan, aiming to involve faith leaders to work together with primary healthcare providers and psychiatrists on identification, referrals and treatment of psychosis (Farooq et al., 2023).

All these studies focused only on psychosis rather than including other mental illnesses like depression. Moreover, these studies have not explored the feasibility of training faith leaders and have not considered how diversity in interpretations of religion may influence faith leaders and their attendees in Pakistan (Khan et al., 2023). There is an overall paucity of data on the perspectives of faith leaders and their attendees on depression and on the potential to train faith leaders to use evidence-based approaches' to manage the condition (Khan et al., 2023; Khattak et al., 2022; Rathod et al., 2023).

In my two qualitative interview studies I explored the perspectives of both faith leaders and their attendees on depression – its conceptualisation, attribution of its causes and approaches to its management (See Chapters 6 and 7). I found some commonalities, such as that both were driven by faith, religious beliefs and values. Notably, there were some apparent contrasts within the data, indicating that both hold different perspectives, at least on some matters. My findings, particularly in the interviews with those who attended faith leaders, were more nuanced and diverse than the data collected in the studies included in my barriers and facilitators review. By looking at the data separately, it was not entirely clear whether it is feasible to train faith leaders in the identification of depression and the provision of BA. Comparing and contrasting qualitative data from multiple studies (including reviews) can enable triangulation of findings, which may

facilitate a more comprehensive understanding of the phenomenon. Additionally, this approach is likely to reveal more clearly, if present, contradictory or contrasting findings, further enriching my understanding. There were also areas in the studies that, after reflection, we (myself in discussion with my supervisors and TAP members) did not feel were fully explored in the analyses from these studies, such as the influence of gender, authority, and power dynamics. I, therefore, determined to carry out an integrative synthesis, with the aim of getting a better, more in-depth understanding by synthesising the evidence from the studies in my systematic review (Chapter 5: Barriers and Facilitators) and my qualitative interviews with faith leaders (Chapter 6) and their attendees (Chapter 7).

8.2 Research Questions

The synthesis broadly aimed to gain a deeper understanding of how depression is recognised and managed by faith leaders, as seen by faith leaders and their attendees. It collated the findings from the three studies to develop integrated explanatory concepts by comparing and contrasting the data.

In this synthesis, I explored in greater detail about the research questions I introduced in the beginning (See Chapter 2):

I. What are the common practices used by faith leaders (identification and management of depression) reported?
II. What are perceptions and experiences related to the benefits and harms of these practices?
III. What are the attitudes to training faith leaders in evidence-based psychotherapies and the provision of such psychotherapies by faith leaders?
IV. What are the power and gender dynamics, and how do they affect interactions and the feasibility of training faith leaders in evidence-based psychotherapies?

8.3 Synthesis Methods

8.3.1 Integrative Synthesis

An integrative synthesis approach was used to collate data from two qualitative studies involving primary data collection and one qualitative evidence synthesis study. An integrative qualitative synthesis involves integrating data from multiple studies to develop new ideas, insights and interconnection between the emerging concepts while also acknowledging the deductive process whereby the generation of ideas and concepts are aligned with well-established and predefined research questions (Saini and Shlonsky, 2012).

"Integrative synthesis" is a broad term that encompasses various approaches to synthesising qualitative research, including meta-synthesis (Endacott, Eliott and Chaboyer, 2009) and thematic synthesis (Chambers et al., 2019). A "meta-synthesis" is a formal qualitative evidence synthesis approach to synthesise secondary data to generate theoretical insights (Sandelowski and Barroso, 2003). A thematic synthesis is also a formal qualitative evidence synthesis approach that aims for new interpretative themes that go beyond what is found in the studies individually (Thomas and Harden, 2008). The key difference is that meta-synthesis involves a higher level of interpretation to develop a theory, whereas thematic synthesis does not necessarily aim for a new theory but rather to identify higher-order analytical patterns and themes. I used different elements and features of integrative synthesis including i) conceptual model to guide the synthesis, ii) establishing pre-defined synthesis questions, iii) comparing, and contrasting the data, iv) in-depth interpretations, v) generating new ideas and concepts, and vi) developing thematic maps and links between themes.

8.3.2 Ecological Model

To guide the process of synthesis, an adapted ecological framework was applied. The model covers four levels embedded within the ecological system that shape our perspectives, experiences, and behaviours. They are i) individual, ii) relationship, iii) community and iv) societal levels (Garbarino, 1985). These levels are conceptually different, but often, they overlap and interplay with each other. It is a flexible framework and has been widely used across diverse disciplines (Cushing et al., 2014; Stanford et al., 2024). It provides an opportunity to develop a broader understanding of the relationship between faith leaders and their followers, focusing on potential power and gender dynamics. It also facilitates the exploration of the dynamics between differing worldviews and institutions, i.e., religious and statutory healthcare worldviews, including how they relate to each other. Recently, an interview-based study including spiritual and faith leaders focusing on training such healers used an adapted ecological model by considering factors at each level, for example, the benefits of training (at the individual level) and relationship with spiritual healers' attendees after getting training (relationship level) (Yaro et al., 2020). The model helped researchers organise and focus on each level and identify the interplay between them.

I framed my synthesis according to the four different levels of the ecological model: i) individual, ii) relationship, iii) institutional, and iv) societal. The individual level in the context of this synthesis refers to the personal level factors such as personal preferences of faith leaders and attendees and the individual's understanding of faith and related worldviews. The

relationship, which is the second level, examines the interpersonal context between faith leaders and their attendees, such as gender dynamics, communication and related trust or distrust. The third level, the community or institutional level, explores the attitude towards collaboration between faith leaders and healthcare professionals as seen by faith leaders and their attendees, such as willingness for mutual learning and potential convergences and agreements on worldviews relating to mental illness. The societal level includes data relevant to society, such as the broader roles of faith leaders and the public's perception of such leaders.

8.3.3 Methods: Data Organisation and Synthesis

I included two types of coded data in this synthesis. The first type is secondary data, which consist of coded quotes or statements from faith leaders and their attendees found in papers identified in the barriers and facilitators' review (Chapter 5). The second type is primary data, which includes coded quotes or statements collected in interviews with faith leaders (Chapter 6) and their attendees (Chapter 7). I did not recode these data but instead used the existing codes from previous studies, making adjustments or refinements (by merging or splitting codes as they relate to each other across different sources) as needed. I organised all the data for synthesis by creating a Word document that included the codes, their corresponding quotes, and an identification index. This index indicates the source of each quote, specifying whether it was from a faith leader or an attendee, and identifies the study in which the quote was collected.

Data were synthesised using NVivo (Version 20) in five steps. In step 1, all data (including documents containing quotes and their respective codes) were uploaded into NVivo. Subsequently, in step 2, four nodes/ categories aligned with the ecological model were developed in NVivo, including individual level, relationship level, community, and society level. In step 3, I examined all coding and source data (where required) to organise data within these established nodes or categories, which I had developed in the second step. Further, in step 4, overarching and subthemes were identified. This step involved a higher-level analytical process, allowing for a more interpretative data synthesis. In step 5, I investigated the interrelationship between emerging themes by comparing the data across interviews, studies, and participants (i.e. faith leaders and their attendees). New ideas, codes (especially those not identified in individual studies or in my systematic review), and themes I identified during the synthesis were discussed with my supervisor (HJ). Her input was incorporated to ensure that diverse perspectives were considered.

Finally, data were organised through tabulation and thematic maps. I developed a table containing identified themes and embedded them within ecological levels, placed in a higher

order. Also, I planned to add quotes or statements by faith leaders and their attendees under themes to present a comparison. Developing tables and creating thematic maps were iteratively completed, allowing the development and accommodation of new ideas and insights about the themes. I also colour-coded the quotes to highlight which quotes belong to my interview-based studies and which belong to the review. Thematic maps aim to present themes identified and how those themes are linked to each other.

I did not perform the quality appraisal of the studies to avoid repetition, particularly for those studies presented in the systematic review in Chapter 5. Based on what was found about the quality of studies in the systematic review and the strengths and limitations identified for the interview-based studies (including interviews with faith leaders and their attendees), the discussion and conclusion in this synthesis have taken account of the quality of evidence.

8.4 Results

Secondary data were based on 17 studies (380 participants) included in my systematic review, while primary data were based on the two qualitative studies (25 participants) I conducted. Overall, the number of faith leader participants (n = 317) was substantially higher than that of attendee participants (n = 88). Six themes were identified, which are reported below. At an *individual level*, two themes were identified: 1) recognising but not naming depression and 2) seeking immediate and direct connection with Allah (God). Two themes were identified at the *relationship level:* 3) complex dynamics in interactions with faith leaders and 4) contested authority exercised by faith leaders. One theme was identified at the *institutional level:* 5) negotiating collaborative learning and compatibility. One theme was identified at the *societal level:* 6) community outreach by faith leaders using established institutional platforms (See Table 8.1 and Figure 8.1).

8.4.1 Theme 1: Recognising But Not Naming Depression

Different patterns emerged within this theme, including the presentation of mental illnesses to faith leaders and the understanding of depression. Both faith leaders and individuals attending faith leaders were aware of emotional, behavioural, and physical indicators of depression. However, faith leaders highlighted that in Islamic tradition, the approach to addressing mental illness is undertaken without explicitly referring to mental illness (Islamic Scholar; Male; Age: 30). On the one hand, it may imply that Islamic tradition does not follow the statutory mental health practices and discourages labelling people by diagnosing. At the same time, it was also evident that during the presentation of any mental illnesses, people often describe their problems rather than symptoms or terms used for mental illnesses. This implies a broader

role of faith leaders, which is not limited only to providing support to people with mental health issues; rather, people may come up with problems without awareness regarding the presence of mental illness. Shared characteristics between faith leaders and their followers, such as sharing an Islamic worldview regarding the causes of daily life problems, having common religious beliefs, and having a shared community, encourage people to seek support and guidance from their faith leaders (See Figure 8.1: Relationships between themes).

Further, faith leaders exhibited a good understanding of depression and were able to link depression to social and economic reasons such as financial issues, divorce and death of relatives (Prayer Leader; Male; Age: 35). A good understanding of faith leaders regarding depression was also evident in one of the study (Tobah & Ali, 2017). In contrast, individuals attending faith leaders directly described their emotional experiences - for example, sadness and behaviours, withdrawal from daily activities and a lack of interest. Gender differences were apparent in the data, with females attending faith leaders more likely to highlight emotional distress (P001; age 50, female), while males would discuss experiencing personal failures in life not limited to the religious domain only (P012; age 30, male) (See table 8.1: Recognising but not naming depression).

Table 8.1: Themes and Subthemes Nested within Ecological Framework

Themes	Subthemes	Quotes (Faith leaders)	Quotes (Individuals attending faith leaders)
Individual Level			
Recognising but not naming depression	Mental illness is not discussed directly	**1)** People do not talk about their mental illnesses directly, but they share their mental illnesses under their personal problems (Islamic Scholar; Male; Age: 30) **2)** So, without mentioning any mental illness for it, the Prophet (peace and blessings be upon him) has guided about the cure for this issue. (Islamic Scholar; Male; Age: 30)	-
	Problems presented to faith leaders	**3)** So, we see different cases such as divorce or any other, so we deliver something, so I hope some benefit is delivered (Islamic Scholar; Male; Age: 30) **4)** Divorces and separations depress families just about more than anything else (Bryant et al. 2013) **5)** Obviously, sometimes a person gets frustrated with his life, someone's education is left, he gets upset, there is some damage in the house, there is a death in someone's house, or he loses his business. He is drowning in debts; these are the issues that cause him to go into depression. (Prayer Leader; Male; Age: 35) **6)** Let me tell you what makes folk depressed. You ain't got no money. We ain't got any money (Bryant et al. 2013).	-
	Awareness of signs and	**7)** Someone is trying to do well with them, someone is positive with them, so if they take it in a negative	**1)** A lot of sadness and hopelessness; nothing would feel good like life has completely become purposeless.

	symptoms of depression	way, then negativity is all I see the biggest sign that this person is depressed (Islamic Scholar; Female; Age: 27) **8)** They've become disinterested in certain things in life. They . . . you know, the way that they're talking is almost monotone . . . you know, detached. It's not so much about solutions anymore. Those are things that I find very concerning (Tobah & Ali, 2017) **9)** Depression is that the person who is not sitting, gets lost in thoughts, keeps thinking about the future, how will it be, how will it be if this happens (Islamic Scholar; Male; Age: 35)	Neither any interest in wearing nor any interest in eating. No interest in going outside the house. Nor do I like people. Even now, I do not go anywhere. (P001; age 50, female) **2)** Maybe apparently there's no guidance, you know, like a comforter, sometimes when you are lonely, you have no advisor (Pullen et al. 2021) **3)** I feel like when someone gives their best for something but still if the person experiences failure and then the person breaks from the inside (P010, male) **4)** I feel pain in my muscles as well, the thoughts I want to end; I feel like that thought is causing worry for me, and then that thought comes again and again, and I cannot control it. (P012; age 30, male)
Seeking immediate and direct connection with *Allah* (or God)	People tend to practise faith on their own to get a cure	-	**5)** Umm… I mean, I read *Surah Rehman* (verses in the *Quran*), and I feel a lot better (P006; age 33, female) **6)** So, I have seen that there is no purpose. They [faith leaders] also write *kalam Allah* (*Quranic* verses), and we should pray and recite ourselves; that is better. So, I believe *Allah* (God) is watching. He knows what my intentions are while talking to someone. (P009; age 36, female) **7)** The best thing is to pray for yourself by cleaning yourself and doing self-care. Take proteins and eat healthy, but these things become expensive, and financial support is important (P011; male)

	Faith and belief in *Allah* (God)	**10)** When the love of *Allah* (God) comes to the heart, then *Allah* (God) will give a reward in paradise (Prayer Leader; Male; Age: 35) **11)** That Lord you know everything, it's your creature, and have mercy, bless him… So, he says that I love as much as seventy mothers. He never leaves; mercy must be done, doesn't it? (Spiritual Leader; Male; Age: 50) **12)** Many things are beyond our control; we have to make an effort, but then we must leave everything in the hands of *Allah*, in his trust (Moodley et al. 2018) **13)** The house owner said, you can keep my visiting card. If you call me or come to my office, just tell me, and do not tell anyone, I will help you. The person did not take his card, so he returned it and said, I do not need your card. No. I will go to the house of *Allah* (God), just as *Allah* (God) has sent you to me today, and *Allah* will send any other to me. (Prayer Leader; Male; Age: 35)	**8)** Honestly speaking, I do not believe in these things I believe *Allah* (God) is the one who gives *shifa* (Cure), but I think that if someone with pure intentions uses *kalam Allah* (*Quranic* verses), it may give us *shifa* (Cure) that *Allah* brought me here and will give me *shifa* (Cure) so this is what I believe in. (P005; age 50, female) **9)** Yes, before, I used to feel better, but it was from *Allah*; he used to open doors for help, but not this time. But *Allah* (God) had helped before, and still, he is the one who will help. (P012; age 30, male) **10)** Otherwise, I thank *Allah* (God) that whatever is in my life I have is due to the will of *Allah* (God's will). (P013; age 43, male)
Relationship Level			
Complex dynamics in interactions with faith leaders	Reluctance to speak and share problems	**14)** But it's taboo for us to be depressed 'cause we men of God and we preachers, and we don't have problems. We sit on the left hand of God and Jesus on the right hand, and we just…it does not happen (Bryant et al. 2013) **15)** Most of our religious people say that we have only asked and said to *Allah*, and He will solve our problems. They do not want to tell their story openly they do not want to disclose it to anyone else (Islamic Scholar; Female; Age: 27)	11) I'm going to suppress it [depression]. I'm going to find a way to get it [depression] fixed. That's admitting I'm weak, and I can control it [depression]. As black men, we don't do it [admit depression] (Bryant et al. 2013) **12)** No, I would not like this if I go and share my thoughts with someone else or ask them about it. Whether it is happiness or hurt, I just keep it to myself, and I just stay with myself. My daughter says sometimes you stare at the roof, sometimes you stare at the fan, sometimes you

		16) Mental health problems are perceived as a shame and something that should not be disclosed to other than family members (Jang et al., 2017)	stare at the bulb, so I say it's okay I just talk to myself (P001; age 50, Female)
	Role of gender in interacting with faith leaders	**17)** It is obvious that when the patient is male, there is no problem, but in the case of a female, we may face a little problem while treating them. We keep ourselves a little bit on the back step; for those who are patients, it is obvious that they say, we are patients, but we can have a little trouble in this matter. Neither the screen nor the curtain can be too much. (Islamic Scholar; Male; Age: 35)	**11)** They provide treatment to women and men in segregation. (P008; age 53, female) **12)** Also, the things that I can easily share with a male I can't with a female. (P011; male) **13)** There are few *peers (Spiritual leaders) who are good;* they respect women, but I have seen many who are ignorant…. They are greedy for money. (P006; age 33, female)
	Safety and privacy issues reported by people attending faith leaders	-	**14)** When he [referring to the faith leader] came, he said that I was possessed, so he hit me with a knife and gave me medicines; this is the story. (P003; age 40, female) **15)** She [referring to a faith leader] asked what was wrong with me, I said that I could not sleep and…. she said that if you are unable to sleep, then get married, you will get such peaceful sleep that you will say that I am unable to get time to sleep. So, there were so many women sitting there, and they all started laughing and I… I felt so embarrassed (P006; age 33, female) **16)** I do not want my business on the street (Pyne et al., 2019).
	Differing perceptions on the effectiveness of faith leaders' practices	**18)** Sometimes, we recite a small *hadith* (Saying of the prophet Muhammad, peace and blessings upon him) based on patience or reward, which is of great benefit. Sometimes, if you make a hadith referring towards patience, that person immediately becomes very calm. In the same way, if you recite a *hadith* of	**17)** I have just told you all this. I go for the *dum* (Blowing recitations) when my condition worsens. It gets a little peaceful, so maybe it's better when I go for the *dum* (Blowing recitations). (P001; age 50, female)

		reward or recite a verse, that person becomes calm immediately. In the same way, by imagining the mercy of *Allah* (God), that person immediately comes to a very cool and very calm state (Islamic Scholar; Male; Age: 30)	**18)** What I most liked about this program was the stories of the prophets and expressing appreciation for making healing from the Islamic religion (Zoellner et al., 2021) **19)** I tried a lot of *dum* (Blowing recitations) but have not felt any change. I have tried a lot of *dum* (Blowing recitations) but could not feel any better. (P012; age 30, male) **20)** I think this program is the best to heal the hurt people (Zoellner al., 2021)
	In between trust and distrust on faith leaders	**19)** I am sad to say that, in my opinion, unless you tell the religious leaders what they are getting in return, they will not be ready. Because they are doing business, they will take money for the time they invest (Spiritual Leader; Male; Age: 40)	**21)** Real faith leaders do not talk to you. They do not encourage discussion; they blow recitations on you and tell you to go. But now, I do not know who is real or fake. (P003; age 40, female) **22)** Umm…. no, I do not know. There are different types of *peers* (Spiritual leaders), and I have seen weird scenarios, so in a way, I have no faith left in these *peers* (Spiritual leaders). (P006; age 33, female) **23)** No, everyone from my village goes there; he is a very powerful peer (spiritual leader). Whatever he says, it happens. (P008; age 53, female)
	Pluralism in treatment preferences	**20)** Muslim people do tend to shy away from going to a psychologist or psychiatrist because of the stigma attached to it. However, I have come to realise in many ways, through family, when people become very depressed, together with giving advice that we would normally give, perhaps medical advice would also be needed (Moodley et al., 2018)	**24)** So, doctors are better if the problem is depression. Whatever they tell me gives peace to my heart that this will make me better whatever they suggest. (P005; age 50, female) **25)** I believe if medical treatment and *dum darood* (Blowing recitations) both go side by side, it's better. (P012; age 30, male)
	Familial ties and pressure	-	**26)** He is our *peer* (Spiritual leader) from the times of our ancestors. My maternal family used to go there, so my

	for visiting faith leaders		mother knew about him. My father also went there so we went. (P013; age 43, male) **27)** So other than that, wherever my family takes me I do not like going but I cannot say no, as if I won't go they will blame me for everything that see we take her for the sake of children (referring to bearing children) and she does not want to. That's why I am obliged to go but I do not want to go. (P009; age 36, female)
Contested authority exercised by faith leaders	Competing explanations of problems and mental illnesses	**21)** People come and say to us, but we say the same thing; we call it by the name of *asarat* (effects of demon or magic); brother, there are effects on you, meaning they are affected by demons or some magic etc. (Islamic Scholar; Male; Age: 35) **22)** So, by correcting the heart, these diseases can also be cured. The negative effects of all of them come from the heart, so whenever the Holy *Quran* talks, it starts from the heart. (Prayer Leader; Male; Age: 60) **23)** You should purify your soul from sins. In your soul is the weight of sins. If this soul becomes light, free from sins, it will go to the throne. (Prayer Leader; Male; Age: 35)	**28)** I have spoken to various faith leaders, and many have guided me in this. I have visited villages and many places to take their suggestions. All of them said I have been possessed, someone has done magic on me, or amulets have been put in graveyards, etc. Everyone has their own story… (P003; age 40, female) **29)** No, as I told you, I went to [Name of faith leader], but he did not tell me about depression or any other psychiatric issue. He only told me it's *asraat* (effects of possession) and *jaddu* (Magic). And he said that whenever something happens to you, you should recite *azkaar* (Supplications). (P010; male)
	Islamic faith-based and traditional practices suggested by faith leaders	**24)** There are seven verses of *Surah fateha* (*Quranic* Verses). If he recites it once after every prayer and breathes on himself, peace of mind will come to him. (Prayer Leader; Male; Age: 35) **25)** Concept of *dua* (prayer), due to which you get forgiveness for your sins. And getting out reduces negative thinking. (Spiritual Leader; Male; Age: 40)	**30)** Yes, he [referring to the faith leader] says to offer *namaz* (Prayer). He does offer prayers and says a lot of other things, too (P001; age 50, female) **31)** He (referring to the faith leader) told me some recitations from the *Quran*, which, thanks to the Almighty, we already pray. (P004; age 58, female) **32)** Sometimes, they (referring to faith leaders) give something to recite as well; sometimes, they give water

		26) If you see depression occur in isolation and when, according to Islam, you engage yourself in 5 times daily congregational prayer…. When you meet each other, you will know each other's problems. (Spiritual Leader; Male; Age: 36)	for drinking after doing *dum* (blowing recitations on water; blessed water) on it. (P010; male)
	Faith leaders' discussion with followers is guided by Islamic (or religious) text or history	**27)** Sometimes, we read a small *hadith* (saying of prophet Muhammad, peace and blessings upon him) based on patience or reward, which is of great benefit. Sometimes, if you make a *hadith* about patience, that person immediately becomes very calm. (Islamic Scholar; Male; Age: 30) **28)** So, he said, what are you doing? They said that you did the same yesterday by reading *qul sharif* (recitations from the Quran) and blowing on mud, and it would turn into a sweet dessert. So, he said that this is the same *qul sharif* (recitations from the *Quran*), but the tongue should be of Farid's (spiritual mentor). (Spiritual Leader; Male; Age: 50) **29)** I provide care from a spiritual perspective, meeting with them, hearing their concerns, letting talk through that, offering alternatives that my be more of a spiritual nature or biblical nature than what a secular counsellor might offer (Stansbury et al. 2009).	**33)** When I am too tense, I call them [referring to faith leaders] and tell them my problems. All they say is things will get fine and recite this and that, etc. I do not talk to them much. I contacted them twice (P004; age 58, female) **34)** No, nothing else. He [referring to the faith leader] did not even do any *dum* (Blowing recitations) on me to ask about my condition. He asked me how much better I was feeling. I told him *Shukar Alhamdulillah* (Thankful to God) it is 50% to 60% better (P005; age 50, female) **35)** Yes, he [referring to the faith leader] listens as you do. I said that I had a stomach issue, feels like a burden on my head, and I had thoughts, so then he wrote my name and told me what issue I had (P012; age 30, male)
	Faith leaders encourage their followers to engage in activities	**30)** One thing is to keep in mind that he must write a letter to his *shaykh* (Spiritual leader) every week, two weeks, after three weeks and after a month. Tell him about your daily routine, and the *shaykh* (Spiritual leader) will review it. (Islamic Scholar; Male; Age: 30)	**36)** Yes. I went to some place where someone suggested a scholar. I thought I should consult him; maybe he might solve my issues, problems and depression. He told me some recitations from the *Quran*, which, thanks to the almighty, we already pray. (P004; age 58, female)

		31) Absolutely, it has a very close connection with Islamic culture [referring to engaging in activities]. However, one should be careful not to be guided by things that conflict with the *shariat* (Islamic principles). This means that, while guiding him, no vulgar activities should be told to him. (Prayer Leader; Male; Age: 60) **32)** I think I always encouraged her to be more active, but don't just stay home because that brings on more depression but getting out and going and getting members to encourage her also" (Stansbury et al., 2009)	**37)** He [faith leader] strictly told me that people who are *bay namazi* (people who do not pray) should not try to come towards us, so he suggested to everyone first that they should pray five times a day and then do recitation, otherwise, they should not come. (P010; male)
Community/ Institutional Level			
Negotiating collaborative learning and compatibility	Resistance to learn from healthcare professionals	**33)** So, I have something in my mind [talking about health issues] by asking them (doctors); for example, whether it is true or not, I can understand it by asking them (doctors). What happens now is that many muftis do not feel the need for it (Islamic Scholar; Male; Age: 30) **34)** It is obvious that they will not be ready to come as a student or as a trainee or as a learner. (Islamic Scholar; Male; Age: 41)	-
	Differences in approach and practice	**35)** Now, if a person goes to the doctor or to the psychiatrist and reviews the diagnosis related to routine, then at least he is going to take it towards a healthy activity, towards a healthy mind, though he is not morally correcting him/her. (Islamic Scholar; Male; Age: 30)	-

		36) Diagnosing and informing him about his condition and finding its causes is unimportant. (Islamic Scholar; Male; Age: 41) **37)** There are some good psychiatrists, therapists, social workers, doctors. I do not know of them. It seems to me that all these mental health practitioners want to do is give pills to everyone with mental health problems. Just take a pill and everything will be okay. Sometimes good old talk therapy is all an elder need to snap back into reality. I do not believe in medication because the medicine turns them into zombies to a point where they do not know if they are coming or going (Kim Stansbury & Blasi, 2011)	
	The burden of responsibilities on faith leaders	**37)** I think *peer* (Spiritual leader), but the problem is that no one will take up the job properly. The reason is that he has a routine life of his own. His glorification, his recitations, and his daily routines (Islamic Scholar; Male; Age: 30) **38)** And can he give his time for it or not. That is, to what extent he can prioritise this work along with the work in which he is engaged. (Prayer Leader; Male; Age: 60)	-
	Convincing faith leaders through in-group interaction	**39)** The problem is that with us, no one will agree on what is happening outside until the people inside tell them. It won't happen. Yes, if people like scholars tell them, they should be agreed first, which can be much more effective. (Islamic Scholar, Male; Age: 41)	-

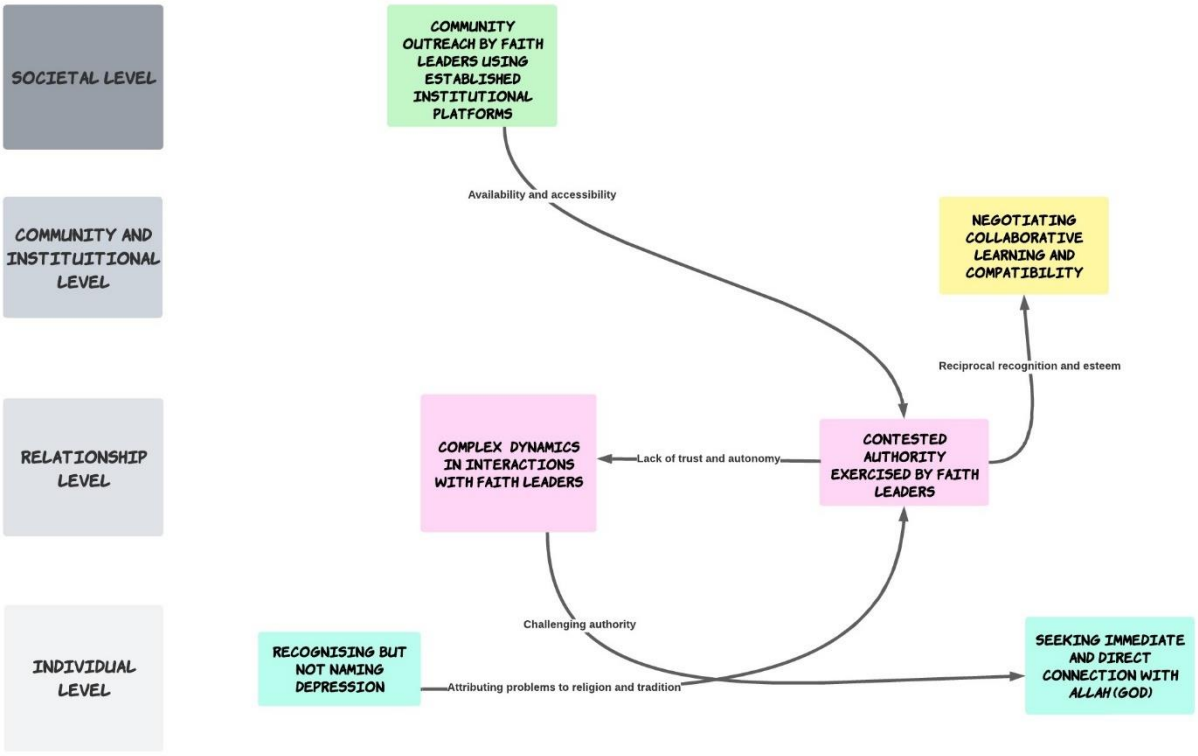
	Role compatibility of non-famous spiritual leaders	**40)** Not with famous *peers* (famous spiritual leaders) but with non-famous people. Let them sit with a psychologist. (Islamic Scholar; Male; Age: 30)	**-**
	Basic training and learning	**41)** It should not be too much; that is, it should not include technical terms that a person (Islamic scholar) remains bound to such activities (Islamic Scholar; Male; Age: 30)	**-**
	Openness for mutual learning	**42)** We have never understood such a meaning, and that's why we also go to our friends. What it means is that some are doctors, and some are psychologists. They are good people, and we continue to hang out and learn with them. (Spiritual Leader; Male; Age: 44) **43)** Yes, God willing, I do not have the temperament for debates, etc., but if there is something like that, if we can have such a meeting together, then it can be done. (Prayer Leader; Male; Age: 60)	**-**
Societal Level			
Community outreach by faith leaders using established institutional platforms	Faith leaders' engagement in volunteer and charity work	**44)** Absolutely can and should be. And they do. And I think they are. And they are doing it free of cost. In fact, we do not charge fees. (Islamic Scholar; Male; Age: 30) **45)** Those who are *imam* of the mosque (Prayer leaders) are working free of cost; they listen to the sufferings of people only for the sake of *Allah* (God), they try to solve their problems, there is no fee (Islamic Scholar; Female; Age: 43)	**38)** I mean, he is *Qari Sahab* (Prayer leader), it's his work he does *dum* (Blowing recitations) without taking any money; if anyone wants to give money, they can, but *Qari Sahab* (Prayer leader) does not ask himself. (P012; age 30, male) **39)** He sits three days a week and distributes *langar* (Free food for all who come) to 100 or 500 people. No one does this as much as he does. (P013; age 43, male)

		46) We are not only clergy members but also social service providers. From their arrival to settlement, we provide all kinds of help and information to newcomers. When immigrant families arrive, we are there at the airport and help them settle (Jang et al., 2017)	
	Role of religious institutions	**47)** The door is open all the time, and many people come. Okay. And people will keep on coming... every time a 24-hour shrine is open to everyone, it is for his creatures. (Spiritual Leader; Male; Age: 50) **48)**The church is fortunate to have an active social service ministry. I have some really good and experienced members who make up the ministry. Some are retired social workers, nurses, and other professionals in the social and medical fields; however, there are some who are currently working in their respective disciplines. They do a nice job of educating the congregation on medical and mental health issues. More importantly, they are there when a congregant, particularly older congregants, and their family members, need additional assistance for something like depression (Stansbury et al. 2011). **49)** The mosque is a public platform, so it happens that during Friday prayer, when the lecture is given, people listen and, after that, share issues with us. Usually, it happens that in all 5 prayers, there are people who share issues and ask for advice. So, we provide them with advice. (Islamic Scholar; Male; Age: 40) **50)** Mainly through personal home visits, encouraging church members to do likewise, always	-

		including her and keeping her informed about church activities" (Stansbury et al., 2009)	

** ***Note*****.** Text in brown colour represents quotes taken from a systematic review (Chapter 5); text in black represents quotes taken from interviews with faith leader (Chapter 6) and their attendees (Chapter 7). **

Figure 8.1: Relationships between Themes



8.4.2 Theme 2: Seeking Immediate and Direct Connection with Allah (God)

People attending faith leaders also referred to practising faith independently rather than using faith leaders as mediators. Individuals attending faith leaders reported that they prefer to recite verses from the *Quran* on their own, and some were against going to faith leaders, though they had previous contact with faith leaders. For example, a woman who had previously visited faith leaders expressed attending faith leaders showed a lack of control, autonomy and making a direct connection with *Allah* (God) when she pointed out she had no purpose for going to faith leaders (P009; age 36, female). Such a perspective was driven by previous aversive encounters with faith leaders for some participants, while for some, it was due to their faith in *Allah*. Such interpretations, experiences and lack of control over one's practice may challenge the authority of faith leaders while preserving belief and faith in overall religious values (See Figure 8.1: Relationship between themes). The upcoming theme discusses previous aversive experiences with faith leaders in more detail.

One participant who previously attended a faith leader also linked faith with self-hygiene and reported that practising self-care and faith-based practices is important for well-being (P011;

male). No direct reference for practising faith on oneself was exhibited by faith leaders, although they guided participants to practise faith. Still, it was not clarified by faith leaders whether such practice can be performed without taking guidance and supervision from faith leaders. Also, there was no reference to practising faith alone in data from the qualitative synthesis. One female participant who attended faith leaders showed more inclination towards self-practice of faith while referring to faith leaders' practises having "no purpose" (P009; age 36, female), whilst a male participant referred to self-practice without linking it to faith leaders (P011; male).

The concept of faith in *Allah* and the attribution of illnesses - that they come and go with *Allah's* will - was reflected in responses from both faith leaders and their attendees. However, different interpretations of faith were observed between different faith leaders. For example, a spiritual leader discussed the mercy and love *Allah* has for its creation (Spiritual Leader; Male; Age: 50), whilst prayer leaders were more oriented towards trust and belief in *Allah's* (God) help (Prayer Leader; Male; Age: 35) (See Table 8.1: Seeking immediate and direct connection with God).

8.4.3 Theme 3: Complex Dynamics in Interactions with Faith Leaders

Both faith leaders and their attendees expressed that people are generally reluctant to engage in open conversations, discuss their issues, and share their thoughts, even with family members and close acquaintances. From the faith leaders' perspectives, such reluctance stems from two factors. The first is reliance and faith in *Allah* — seeking and asking for help from the creator rather than creation (Islamic Scholar; Female; Age: 27). The second is the experience of shame attached to acknowledging mental illness; therefore, it may act as a barrier in reporting and seeking care (Jang et al., 2017). This concept is further illustrated in a statement from a female participant who had visited a faith leader. She reported her unwillingness to talk to her daughter; however, she did not express any reason for not engaging in discussion (P001; age 50, Female). However, communication gaps may arise due to people's reluctance to talk. Such reluctance to share issues was never linked to faith leaders' context by any of the participants; rather, it was more generic and seemed related to a culture of not sharing. Even individuals with collectivistic values, who might discuss their issues and challenges within their social circles, tend to avoid discussing topics perceived as showing vulnerability.

Data also revealed gender dynamics within faith leaders' settings. This was illustrated through male faith leaders' discomfort when treating females (Islamic Scholar; Male; Age: 35), gender-segregated settings to provide treatment (P008; age 53, female), and male participants' difficulty in talking with female faith leaders (P011; male). Two women also spoke about troubling

experiences related to safety and privacy issues while attending faith leaders. One female participant narrated an encounter where a faith leader possibly considered that she was possessed and hit her with a knife to heal her. The knife was held with the blade facing away from the body, and it did not result in any serious injury. The knife was purportedly used as a healing tool by the faith leader. Since this action was initiated by the faith leader, the attendee could not explain the reason behind its use. However, it may have been intended for exorcism to remove evil spirits from the body. This has been discussed in ethical considerations previously (Chapter 7: Ethical Considerations) (P003; age 40, female). Another female participant shared her sleep issues and depressive feelings with the faith leader; the faith leader made fun of her, making a culturally insensitive suggestion of the woman getting married to solve her sleep issues (P006; age 33, female). Such situations highlight that sometimes the faith leaders' advice lacks empathy and may be detrimental to one's emotional well-being. The aforementioned participant (P006) reported that the remark invoked an intense experience of shame (marital discussions are very confidential matters, especially for females in Pakistan), and she never visited the same faith leader again. The issues related to privacy were also present in the qualitative synthesis data, where participants reported that they "do not want business on the street", reflecting apprehensions about personal matters becoming public, potentially leading to feelings of stigma or shame (Pyne et al., 2019). Faith leaders said nothing about potentially harmful practices used in the healing context.

Regarding the perceptions about the effectiveness of faith leaders' healing methods, female faith leaders pointed out that using verbal communication and making the link of such communication with the sayings of the prophet (peace be upon him) results in improvement (Islamic Scholar; Male; Age: 30). However, there was a clear inconsistency between responses of individuals who attended faith leaders - with two participants highlighting those stories of the prophet (peace be upon him) (Zoellner et al., 2021) and *dum* (recitation of holy verses and blowing on body) being helpful (P001; age 50, female), while another participant reported no benefits of such healing practices (P012; age 30, male). Such differing perceptions about effectiveness were accompanied by contradicting statements relating to trust in faith leaders. Two participants reported that they are either confused about who is a real faith leader (P003; age 40, female) or do not trust them (P006; age 33, female). One spiritual leader agreed with such interpretations and reported that faith and religious leaders often treat their services as a business, reflecting this distrust (Spiritual Leader; Male; Age: 40). This was further reflected in pluralism in treatment preference with one female participant preferring health professionals to faith leaders (P005; age

50, female) whilst another male participant preferred both health professionals and faith leaders (P012; age 30, male).

Many interview participants who attended faith leaders reflected significant distrust. In contrast, faith leaders did not mention attendees' lack of trust. Such distrust may reflect a mix of adverse experiences (such as using the knife), differing beliefs about the cause of their problems, including differing faith, and the fact that they were not consulting faith leaders by their own choice. In some instances, however, despite such distrust, some of those who attended faith leaders preferred visiting faith leaders again. The data in the synthesis covered distinct but related aspects like i) faith, ii) dynamics between faith leaders and healthcare professionals and iii) a few logistic issues faced by attendees in faith leaders' settings. (See Table 8.1: Relationship between themes).

8.4.4 Theme 4: Contested Authority Exercised by Faith Leaders

The dominance and authority of the explanation and practices employed to address mental health issues were noted. This authority was largely driven by faith leaders' perspectives. One Islamic scholar attributed mental illness to possession by evil spirits and the effects of magic (Islamic Scholar; Male; Age: 35). Prayer leaders emphasised the role of the heart and soul and linked them to mental illness. Prayer, *Quranic* recitation, and supplications are commonly regarded as means to purify oneself from sins, guiding individuals toward a life that avoids sins. Interview participants who visited faith leaders primarily linked mental illness to possession and magic. However, in most cases, they referred to faith leaders when presenting such explanations without indicating whether they held those beliefs (P003; age 40, female). In certain instances, interview participants expressed their disagreement with such explanations. A top-down hierarchical influence was noted where such explanations were disseminated from individuals higher up in the power hierarchy, specifically faith leaders. Both faith leaders and their attendees narrated that *dum* (blowing recitations on body), prayer, recitation of the *Quran* and supplications were mostly offered by faith leaders.

A male Islamic scholar referred to communication by linking it to the religious context, where he preferred to link personal context with *hadith* (Saying of the prophet, peace be upon him), which can bring patience, tolerance and acceptance in people (Islamic Scholar; Male; Age: 30). Some of the interview participants, including two females, also acknowledged that faith leaders listen to people and build rapport for communication with respect. The spiritual leader held a unique perspective, emphasising that spiritual mentors and elder saints own a unique authority in their words, superior to the ordinary individuals (Spiritual Leader; Male; Age: 50). This

approach revolves around the “honour” they command, as spiritual mentors might anticipate devotion and recognition from their followers.

Scheduling and changing activities to overcome depression and how this approach relates to Islam were discussed with faith leaders. Islamic scholars and prayer leaders agreed that using behavioural activation by changing activities to overcome low mood is consistent with Islamic values until and unless such activities are prohibited under *Islamic shariah* (Islamic laws) (Prayer Leader; Male; Age: 60). They took an approach that emphasised permissible outward behaviours. This differed from the perspective of spiritual leaders, who focused more on the authority of spiritual leaders to decide what was permissible rather than relying solely on established Islamic laws. One Islamic scholar mentioned that when a person accepts allegiance to a spiritual mentor, there is a tradition within the *Sufi* context (saints/ spiritual tradition) to review the activities of a person (Islamic Scholar; Male; Age: 30) (See Table 8.1: Relationship between themes).

There are some potential positive signs, such as the value of communication and the consistency of beliefs with changing and scheduling activities amongst some faith leaders. However, faith leaders also exhibit the authority, which can bring complex challenges when engaging them in training (See Figure 8.1: Relationship between themes).

8.4.5 Theme 5: Negotiating Collaborative Learning and Compatibility

In this theme, faith leaders identified some notable barriers to engaging them in the delivery of BA, suggesting that there may be areas where engagement is necessary to achieve consensus or, if consensus is not possible, to recognise limitations. Further, it highlights some notable strategies or facilitators that can be mobilised to develop a collaboration between faith leaders and healthcare professionals. Firstly, it was noted that the identification of specific mental health issues such as depression in people is not aligned with faith leaders' approach as narrated by one of the Islamic scholars (Islamic Scholar; Male; Age: 41). Additionally, one of the Islamic scholars identified that faith leaders' approach is based primarily on moral and ethical standards (standards consistent with their religious values) with their main objective being the moral betterment of individuals (Islamic Scholar; Male; Age: 30). This position is different from healthcare professionals, who do not seek to exert moral authority over the individuals they are assisting. In qualitative data synthesis, one of the faith leaders also pointed out how they are critical towards using medicines and do not believe that medicine can help (Kim Stansbury & Blasi, 2011). These differences underscore the varying roles and responsibilities between these two support domains. Additionally, resistance to learning from healthcare professionals who may

consider them to be at a lower hierarchy of power, i.e. student (Islamic Scholar; Male; Age: 41) and also their existing responsibilities and busy schedule may hinder their involvement in the training process (Islamic Scholar; Male; Age: 30) (See Table 8.1: Negotiating collaborative learning and compatibility)

A few faith leaders highlighted how a workable negotiation for building a conducive environment could be developed. Understanding the context of faith leaders and reciprocating the esteem were key considerations identified by faith leaders, which may facilitate the development of working collaboration (See Figure 8.1: Relationship between themes). First, faith leaders, including prayer leaders and spiritual leaders, narrated that they have connections with health professionals and occasionally take their advice on health-related matters. They are willing to engage in discussion not only for debate but also to take actionable steps (Prayer Leader; Male; Age: 60). One of the Islamic scholars reflected on the feasibility of persuading and engaging faith leaders in training and collaborative learning. Islamic scholars reported that persuasion and engagement exercises would be useful if being carried out by individuals within their group i.e., faith leaders themselves, as opposed to healthcare professionals (Islamic Scholar, Male; Age: 41). Further basic training with less focus on a specialised approach which may require more time and resources on faith leaders' part was suggested (Islamic Scholar; Male; Age: 30). Also, faith leaders who are well known and famous in their locality should not be approached due to their strict schedule and high regard (in society) which may not let them engage in training (Islamic Scholar; Male; Age: 30) (See Table 8.1: Negotiating collaborative learning and compatibility). Of note, no response on how collaboration can be developed was found in spiritual leaders' data, regardless of including such topics in interviews. It can be related to a few quotes presented in previous themes where spiritual leaders tend to relate special power to their forefather saints and believe that only the words of saints hold the essence of changing people.

8.4.6 Theme 6: Community Outreach by Faith Leaders Using Established Institutional Platforms

Religious institutions such as mosques and shrines are core platforms linking people to faith leaders[9]. Faith leaders highlighted accessibility to such institutions by referring to Friday prayers (Islamic Scholar; Male; Age: 40) and shrines which remain open 24 hours (Spiritual Leader; Male; Age: 50). This was also supported one of the study qualitative synthesis, though

[9] There are a few domestic or faith-based activities in which faith-based institutions play a role. For example, daily (five-time) prayers in mosques, Friday prayers, funeral prayers and arrangements, *Nikkah* (contract of marriage in Islam), and other religious matters inevitably link people to such institutions. This is accompanied by the availability of religious institutions in all residences and localities, even in remote and rural areas where basic health facilities are unavailable.

here it was through observations by Christian faith leaders who reflected on a more proactive community approach — for example through visiting people in their home to inform them about church activities (Stansbury et al., 2009). In contrast to this, this theme also reflects that formal healthcare facilities are limited and overstretched, making it difficult for people with mental illnesses to approach.

Also, Islamic scholars highlighted the altruistic approach of faith leaders who provided support without fees. One participant who attended faith leader mentioned that prayer leaders performed *dum* (reciting holy verses and blowing on body) without asking for fees (P012; age 30, male). Another attendee further complemented this by highlighting how faith leaders distribute free food in their community (P013; age 43, male). Overall, this overlaps with the data from Pakistan and the other parts of world (reported in studies included qualitative synthesis), demonstrating how some faith leaders may go beyond their financial interests to serve people. Faith leaders' responses and actions exhibited shared characteristics across cultures and religious contexts, developing a sense of communal support and service. However, this was not a viewpoint shared across all the data. A strong perception of distrust of faith leaders relating to monetary benefits[10] they may get as a part of their practice is discussed in an earlier theme (Complex dynamics in interactions with faith leaders) (See Table 8.1: Community outreach by faith leaders using established institutional platforms).

8.5 Discussion

Faith leaders and their attendees were able to identify core symptoms of depression. However, faith leaders had a better understanding than attendees, and they were able to link depression to psychosocial stressors such as domestic issues. Faith leader's exposure to people within their community was important in this context, allowing them to learn about symptoms and associated features by referring to their experiences over many years. However, faith leaders were unable to discern a normal expression of sadness from clinical depression, as faith leaders pointed out that Islamic tradition does not rely on labelling people with mental illness. This is partially consistent with one of the studies that explored the understanding of depression among African faith leaders who described depression as an intense form of sadness whilst they rely on their intuition for assessment (Starkowitz, 2013). There are several advantages of avoiding labels

[10] There is a tradition that faith leaders may not directly ask people to spend money; however, due to strong relations and religious beliefs, people in the community provide a large amount of their earnings every year to such institutions, considering it a religious obligation.

and avoiding using medicalised language. Avoiding labels in mental health may be beneficial and potentially allow for a broad understanding of individual experiences. It reduces stigma and promotes a collaborative therapeutic relationship. Also, focusing on etiological factors rather than diagnosis promotes personalised care and adapts interventions to individual needs. However, the mechanism of identification of mental illnesses currently largely relies on symptoms-based assessment, encouraging clinicians to diagnose mental illnesses. To achieve a balance, more culturally sensitive and appropriate terminologies while focusing on non-medicalised language can be considered while working with faith leaders.

Also, how depression is presented in faith leaders' settings is relevant, as people report their problems, such as financial loss, divorce, etc., rather than reporting the symptoms of depression. Such presentations offer a non-medical understanding where mental illness is viewed as disrupting psychosocial functioning, mainly affecting relationships (Naeem et al., 2012). Similarly, understanding of mental illness, including depression, was also linked with religious worldviews among both faith leaders and their attendees. However, it was also noted that even depression, which is a common mental illness, was often attributed to magical explanations. Recent literature from Pakistan suggests that people commonly attribute mental illnesses to magic, although this literature is limited to severe mental illnesses like psychosis (Khan et al., 2023). This view is not universal, as a recent study documented that some individuals who attended faith leaders did not attribute psychosis directly to religious or magical explanations (Khan et al., 2023). Pluralism in perspectives was also commonly apparent in this synthesis. It is noted that such magical explanations are embedded within the power hierarchy, where they are disseminated to people seeking care from faith leaders. This can partly explain pluralism and diversity in views. Traditional magical views about depression might not genuinely be owned by people but rather transmitted by powerful hierarchical segments and are further amenable to disagreement, especially in the case of aversive experiences with faith leaders.

There were several potential reasons likely to contribute to the observed power imbalance; it is apparent that faith leaders have a position of prominence and status within society. As observed in the data, in some instances, this authority may lead them to use explicitly risky and abusive practices (like in the case of two women: one reported being hit by a knife, and the other reported emotionally abusive remarks by faith leaders). In comparison, some participants exhibited honour and allegiance to faith leaders. People's views of faith leaders are largely shaped within this context and often depend on their relationship and how they were treated (particularly

whether they used their position for money and were not trustworthy or used their position for good- interpreted as genuine).

The novel findings obtained in this synthesis include the identification of complex dynamics representing different perceptions regarding satisfaction with healing methods and pluralism in preferences for treatment. Such perceptions and opinions were largely observed in data provided by individuals attending faith leaders. Lack of autonomy, lack of trust and previous aversive encounters with faith leaders led people to become critical of faith healing remedies and further challenge the authority of faith leaders. Challenging authority did not make people critical of religious beliefs. Rather, being critical of the authority of faith leaders further leads them to practise faith on their own. This is not a universal opinion among people attending faith leaders, and few people have preserved their faith in faith leaders.

As reported by faith leaders, communication and discussion were identified as an integral part of faith leaders' methods; however, only a few people attending faith leaders corroborated this perspective. This was partly due to two factors: hesitation to acknowledge the presence of mental illness and/ or inability to relate mental illness with taking treatment (Munawar et al., 2020). Previous studies in Pakistan do suggest that people are unable to relate their mental illness to verbal communication and are unable to view communication or talk therapy as treatment for alleviating mental illness (Shafiq, 2020). Therefore, the lack of in-depth data from people attending faith leaders on their engagement in discussions with faith leaders may imply a more generic and context-free nature of such a concept.

Faith leaders, including prayer leaders and Islamic scholars, explicitly agreed that behavioural activation and introducing pleasant activities are consistent with Islamic thought and worldview until and unless any activity is against Islamic law. However, in practice, people attending faith leaders reported only religious activities were prescribed by faith leaders. Faith leaders were open to psychosocial and behavioural remedies, indicating their lack of practical understanding of such strategies. It presented a moral-dominated worldview of faith leaders with a focus on developing morality defined by Islam as opposed to symptoms-based management practised by statutory mental health practitioners (Elzamzamy and Keshavarzi, 2019).

Negotiating with faith leaders by showing respect and building trust through clear communication can help create a positive relationship between faith leaders and healthcare professionals. It is important to communicate that healthcare professionals have no hidden agendas in challenging moral standards and the beliefs of Islam. Searching for common ground

is another avenue where healthcare professionals can embrace a more pragmatic approach by relying minimally on diagnostic methods, using very brief measures of depression, and using transdiagnostic interventions (Cuijpers et al., 2023). Some useful recommendations were offered by faith leaders to build mutual trust and a learning environment, such as involving in-group members to engage faith leaders in building collaboration and focusing on basic learning of faith leaders. Community outreach and engagement of faith leaders were identified as core factors facilitating their availability at the societal level.

This synthesis has offered some notable insights that contrast with previous literature. For example, findings such as i) contested authority exhibited by faith leaders, ii) attendees' dissatisfaction with some interventions and explanations about depression provided by faith leaders, and iii) challenging the faith leaders' authority by encouraging oneself to practise faith on their own are those that have been rarely reported in previous studies (Malmi, Chreim and Aden, 2024; van der Watt et al., 2018). Some previous studies have reported that faith leaders use physical restraining strategies like chaining (Nyame et al., 2021). However, this synthesis identified more intangible factors, such as the authority of faith leaders driven by their religious worldview and how this relates to the relationship dynamics between faith leaders and their attendees. Some differences were apparent when I compared ideas from my systematic review with interview-based primary data. Issues such as lack of trust in faith leaders and pluralism in treatment preferences while acknowledging that faith leaders' practices might not be beneficial, as seen by their attendees, were less common in data in the systematic review. However, when I looked at the primary data from interview-based studies, issues like lack of trust in faith leaders, safety and privacy problems faced by attendees (especially females) and acknowledging the contested authority of faith leaders were commonly reported. This may be due to two main reasons, as it was evident in my review that in-depth data relating to views of those attending faith leaders is lacking - which may limit such findings from being observed because of the lack of evidence (See Chapter 5). The other reason might be that pluralism in interpreting religion (or Islam) and cultural and social diversity is much more prominent in Pakistan (or South Asia) than other regions. Therefore, religious and cultural diversity needs to be considered, which can present the uniqueness of different faith leaders' settings.

8.6 Strengths and Limitations

This qualitative synthesis used an integrative approach while using the ecological framework to guide the organisation and synthesis of qualitative data. All steps and methods used in this synthesis are laid out and justified. Findings are presented in both tabulation and narrative

forms. In addition to themes, I provided a thematic map by giving special consideration to how identified themes are interlinked, which provided an analytical and broader understanding. The quality appraisal of the secondary data was done previously and reported in Chapter 5 (See Table 5.1). My primary studies did follow quality and reporting guidelines (Chapters 6 and 7).

The overall limitation of this synthesis is that I did not opt for a formal meta-synthesis or thematic synthesis approach in this synthesis. Such formal methods require reviewers to develop a protocol, search databases, synthesise data, and report findings. So, some components, such as searching for additional external literature and quality appraisal, are not part of my synthesis. I did not conduct a formal and complete integrative synthesis because the purpose of this final chapter was to collate and synthesise my research contributions and data collected as part of this dissertation. As mentioned in the background and rationale of this chapter, my approach here was to bring more clarity to my research question set out at the beginning to compare perspectives of faith leaders and their attendees, which were initially presented separately. Therefore, following all steps (such as search strategy and study selection) was beyond the scope of this synthesis. Hence, this synthesis does not qualify as a separate study, where I re-analysed the data from different lens rather it is a synthesis of coded data and findings from qualitative studies presented previously. However, this still integrates findings from multiple studies I conducted (either based on primary or secondary data) and it attempted to identify links between them and to generate analytical ideas.

Some other limitations were that the faith leader study only included 2 women; there were some differences in opinions between them and their male counterparts; it would have been helpful to examine whether the views expressed were common across a larger sample of women faith leaders. Also, samples of people attending faith leaders were taken from tertiary mental health care facilities and, therefore, cannot be generalised to those who contacted faith leaders without any contact with statutory mental health facilities. Finally, the findings presented in this chapter do not apply to those who have not attended faith leaders for depression or any other mental illness.

8.7 Conclusion

I found both barriers and facilitators to possibility of faith leaders delivering BA to their attendees with depression. Facilitators may indicate the potential for adoption of BA in the faith leader's context after careful consideration. Some facilitators common among faith leaders and their attendees were: an understanding of depression and its risk factors, the ability to link depression to faith-based activities, some perceived benefits of practices offered by faith leaders,

shared values, and a problem-focused approach. Part of the data suggested that faith leaders have some practices aligned with the rationale of BA; however, only religious-based activities were suggested by faith leaders, which was also reflected in responses by people attending faith leaders. Moreover, established religious institutions are widely available and can be instrumental in increasing access to evidence-based mental health care if collaboration between faith leaders and health professionals is navigated carefully.

However, certain barriers may undermine the possibility of transferring BA to a faith leader's context. For example, different understanding of depression among faith leaders and attendees, unique needs/ choices of attendees, limited autonomy of attendees to make their own choices relevant to treatment, lack of tradition to diagnose illnesses by faith leaders and some reluctance exhibited by attendees to engage in discussions with faith leaders. Now most of these aspects are relevant to the core elements of the BA, particularly allowing an autonomous environment for BA recipients to set goals, engage in functional analysis of behaviour, schedule activities, monitor activities and adjust to those activities by focusing on shared decision-making. Therefore, rather than directly engaging stakeholders in co-designing to adapt BA a consultative dialogue is required with faith leaders to discuss how this autonomy can be promoted in interactions between faith leaders and their attendees. Further, we may need to adapt BA by giving more prominence to a problem/solution-focused approach and integration of faith-based activities. Faith leaders can potentially deliver BA, but further work is required to address the aspects mentioned earlier while ensuring that core elements of BA are retained.

Most of the studies in my systematic review were rated as potentially low in quality, as many did not consider how researcher characteristics may influence the findings. Primary data were limited due to a small number of females and *Shia* (a minority sect in Pakistan) in the faith leader's sample. While faith leaders' attendees were not directly approached in faith leaders' settings, they were recruited through tertiary care facilities, which may represent a subset of those who attend faith leaders. Such limitations may have reduced the diversity in responses. Further discussion and implications of findings reported in this dissertation are provided in the next chapter (Chapter 9).

9 Chapter Nine: Discussion

This dissertation explored the feasibility of engaging faith leaders in delivering non-specialised, cost-effective, evidence-based treatment for depression, BA. I mainly relied on qualitative data, while secondary quantitative data were collated to complement the qualitative data. Studies focusing on the role of faith healing in mental health care in Pakistan are largely based on quantitative data; in-depth qualitative studies considering the perspectives of key stakeholders, including individuals with depression and faith leaders, were largely overlooked (Khan et al., 2023). This study aims to address this gap through a qualitative, in-depth inquiry into Muslim faith leaders' context in Pakistan by interviewing faith leaders and their attendees. In this chapter, I summarise my findings concerning my research objectives and questions (Chapter 2) and discuss them in the context of relevant literature. Also, I draw out the implications based on the data and describe how the ADAPT (Moore et al., 2021) and ecological frameworks led me to propose some implications and establish further actions (Garbarino, 1985). Finally, I describe the strengths and limitations of this PhD dissertation.

9.1 Proportion of People Attending Faith Leaders in Pakistan

Linking mental illness to faith is common in Muslims in Pakistan – as has been highlighted consistently – resulting in people commonly turning towards faith leaders whilst often concealing any mental health issues, since one's suffering may be believed to be an indication of one's weak faith and lack of adherence to Islamic values and practices (Chaudhry et al., 2017; Khan et al., 2023). My review found approximately 36% of people with mental illnesses reported lifetime contact (including all studies that clearly reported that such contacts were first-hand encounters with faith leaders and also those that did not clarified this) with faith leaders, while 32% reported first-hand encounters (only those studies that clearly indicated first encounters with faith leaders) with faith leaders (See Chapter 4). Seeking help from faith leaders for mental illness is partially due to the scarcity of statutory mental health services, inadequate healthcare infrastructure, a lack of integration of mental health into primary care and a lack of political commitment at the governmental level to tackle the burden associated with mental illnesses (World Health Organization, 2009). Of note, public attitudes and understandings of mental illnesses are often deeply rooted in social stigma, which also acts as a significant barrier to accessing statutory healthcare facilities. Such barriers impede access to healthcare – potentially paving the way for people with mental illness to seek support from faith leaders; this was apparent in the barriers identified in the barriers and facilitators review (See Chapter 5: Faith Leaders' Identified Barriers). For example, the expression of mental illness is seen as shameful and admitting oneself as weak. I found that such interpretations can also deter individuals from discussing their mental health

concerns with faith leaders. This dissertation also broadened our understanding by emphasising that faith leaders typically do not engage in diagnosing mental health conditions (See Chapter 6: Faith Leaders Recognise Depression Through Experience and Intuition). People attending faith leaders typically present their social, familial, and domestic issues to faith leaders without explicitly naming depression. Faith leaders acknowledged that such people do have symptoms of distress, sadness, and lack of interest – indicating the potential presence of depression. Further, faith leaders support them using faith-based rituals without using the term depression. As a result, mental health issues often remain concealed beneath broader domestic concerns when people seek guidance from faith leaders.

Faith-based institutions in remote, rural, and urban localities also ease people's access to faith leaders. My research found that they operate 24 hours a day. On the other hand, the healthcare system in Pakistan is under-resourced. For example, tertiary care facilities are only available in major cities (Choudhry, Khan and Munawar, 2023). While basic health units are available in Pakistan, they lack trained doctors, medical staff, and medicines; furthermore, they are often located far away from residences, and people are often unsatisfied with the facilities (Aziz and Hanif, 2016; Ali, Panezai et al., 2021). I found some evidence that faith leaders attendees reported some discomfort with medicines, and a few others highlighted the importance of both faith-based and medical treatment. Also, long-existing familial and ancestral ties of faith leaders with community members who have shared characteristics, beliefs, and traditions play a vital role in accessing faith leaders for mental illnesses (See Chapter 7: Family and Tradition Influence Help-Seeking Behaviour).

There are some ethical and rights-related issues involved while people with mental illnesses attend faith leaders; I have discussed them later in the discussion. However, the reach, influence, and engagement (informal) of faith leaders in the context of mental illness in Pakistan is an undisputable reality evident from this research. People attending both faith leaders and formal mental health services seem to recognise the importance of formal healthcare and value it, but faith leaders serve as a gateway for a significant number of people with mental illnesses. Such role and influence of faith leaders in mental health care was evident from the previous literature presented in systematic reviews (Chapters 4 and 5). However, unfortunately, few on-ground, practical and pragmatic steps have been taken by the scientific and formal healthcare community to work with faith leaders in Pakistan. This is potentially due to unequal power dynamics between religious and healthcare institutions, which have been documented in African countries (Akol et al., 2018). However, how those power dynamics are similar to or different from the Pakistani context has yet to be explored.

9.2 Effectiveness of Interventions Provided by Faith Leaders

Despite evidence suggesting that a significant proportion of people in Africa and Pakistan attend faith leaders as the first point of contact for getting support for mental illnesses (Burns and Tomita, 2015), I did not find any clinical trial aiming to explore the effectiveness of faith healing for mental illnesses in LMICs except one trial in India (Rajagopal et al., 2018). My effectiveness review (See Chapter 5: Effectiveness of Interventions Provided by Faith Leaders) suggested that interventions delivered by faith leaders reduce anxiety in people with physical conditions, such findings were limited mainly by i) pre-mature timings of outcome measurement, ii) studies primarily focusing on physical conditions rather than mental conditions, iii) lack of high-quality and fully powered trials. Also, such trials evaluated energy healing practices like reiki and spiritual passe, which are common in Western faith healing traditions but are not aligned with faith healing practices used in Pakistan (Usman Shah et al., 2018); therefore, they cannot be generalised to the Pakistani context. Subsequently, I found inconclusive results (non-significant differences) between interventions provided by faith leaders and the control/ placebo/ sham group for depression after performing a sensitivity analysis (excluding those studies that reported median and interquartile range rather than mean and standard deviation). At the same time, it was apparent that none of the studies were fully powered and were considerably heterogeneous concerning faith healing practices. Also, the lack of comprehensive and high-quality clinical trials warrants a more robust and evidence-based approach to understanding actual effectiveness of faith leaders' practices in tackling mental illnesses.

The qualitative evidence from my PhD research was also inconsistent in this regard; my review (See Chapter 5) focusing on barriers and facilitators to interventions used by faith leaders highlighted broadly positive perspectives of people towards attending faith leaders, where people attending faith leaders reported they felt satisfaction after attending faith-based ceremonies. The primary data I collected from attendees of faith leaders (See Chapter 7) was contradictory, however. Some reported concerns regarding the genuineness of faith leaders, ethical insensitivity, and potentially harmful practices, while at the same time also reporting the benefits of attending faith leaders (See Chapter 8: Complex in Interactions with Faith Leaders). Such contradictions were observed in the same people at different instances during the interviews and between different people. One of the noticeable reasons for such contradictions within interview data compared to barriers and facilitators review is that for interviews I relied on people who attended faith leaders previously, and while I interviewed them, they were attending tertiary care services for depression. At certain stages, it appeared that their views and perspectives had been transformed and evolved over time and as they encountered statutory mental health practices.

Subsequently, concerns about the practices of faith leaders, as seen by those who attended them were not straightforward. I noted that concerns shown about the practices of faith leaders were mainly due to previous aversive experiences or faith leaders' magical and supernatural explanations of mental illnesses. Participants who attended faith leaders also highlighted that both faith-based and medical treatments are essential and helpful for improving mental health. Amongst those who expressed concerns about faith leaders, participants were likely to exhibit a strong inclination to practice faith while preferring not to visit faith leaders, in order to maintain their autonomy. How to safeguard the autonomy and safety of individuals who seek help for their mental health issues from faith leaders, especially when healthcare professionals collaborate with faith leaders, is one of the least understood areas. This is a challenging aspect to consider, mainly when health professionals aim to develop a working relationship with faith leaders to support people with mental illness. A better understanding is needed of how faith leaders can best support individuals with mental illnesses, whether such practices are effective, and how to create a safe environment where people's choices are upheld.

9.3 Practices of Faith Leaders and Support Offered by Them

People attending faith leaders and faith leaders themselves were aware of the indicators, signs, and symptoms of depression, but it was noted that both faith leaders and their attendees usually do not expect faith leaders to manage symptoms of depression. People visit faith leaders to seek support when they encounter challenges in their daily lives, including domestic, financial, and religious matters. I noticed that their approach to tackling such issues is primarily shaped by traditional and Islamic beliefs rather than an explicit focus on identifying and treating mental illnesses. Faith leaders commonly rely on their intuition and the teachings of their faith to identify the problems presented to them (Farooqi, 2006). Their worldview is mainly driven by traditional and Islamic explanations based on their cultural traditions and religious texts. Subsequently, it led them to interpret mental health problems because of factors such as a if person is not praying regularly and the effects of magic or curses (Farooqi, 2006; Saeed et al., 2000).

Faith leaders hinted at top-down power hierarchies, mainly when discussing their common practices used to support their attendees (See Chapter 8: Contested Authority Exercised by Faith Leaders). Such power hierarchies exhibited variations between different types of faith leaders. For example, Islamic scholars prioritised the understanding and adherence to Islamic laws and principles, placing less emphasis on seeking personal esteem and respect. In contrast, spiritual leaders expected higher esteem and respect from their attendees. Such expectations among spiritual leaders are rooted in their belief system, which was based on the idea of a special power lineage descending through the bloodline of saints; subsequently, such spiritual leaders

(descendants of famous saints) are considered different and extraordinary compared to ordinary people. Therefore, common practices identified by faith leaders and their attendees were largely based on Islamic practices, including different cultural interpretations of Islam or demonstrating allegiance to spiritual leaders.

I found that faith leaders offered several healing remedies, including blowing the *Quranic* recitations on individuals, using blessed water (making attendees drink water after blowing recitations), faith-based discussions and advice, prayers, supplications, amulets, charity, and repentance. There were some key differences between faith leaders and their attendee's responses. Most of the attendees highlighted that they attended faith leaders so faith leaders can recite *Quranic* verses and blow it on themselves. On the other hand, faith leaders highlighted more about their engagement in faith-based discussions with their attendees and motivating attendees to perform worship.

While faith leaders engaged in discussion with their followers, such discussions were based mainly on religious topics, often including references to Islamic history, quoted in the *Quran* and *Hadith* (Sayings of the prophet PBUH) (See Chapter 8: Contested Authority Exercised by Faith Leaders). Faith leaders, especially female Islamic scholars, were able to link discussions and talks with improvement in mood, especially when such discussions are linked with Islamic history.

Islamic scholars and prayer leaders agreed and were enthusiastic about learning about BA and delivering BA if it is aligned with the principles of Islamic laws. After listening to the lay description of BA, faith leaders did not show any concerns about its compatibility with Islamic principles and laws. Instead, Islamic scholars and prayer leaders identified how daily life activities are important for preserving well-being and an important part of religious obligations. Spiritual leaders, however, showed subtle hesitancy in engaging with healthcare professionals, especially concerning the extraordinary abilities they attribute to themselves; however, such hesitancy was not shown by all spiritual leaders.

9.4 Compatibility Or Incompatibility Between BA and Faith Leaders' Context

Islamic scholars and prayer leaders were willing to learn about BA; however, they firmly opposed endorsing 'activation' of activities that contradict Islamic laws. Consequently, a significant challenge emerged concerning the autonomy and choices available to individuals' seeking guidance from faith leaders if BA interventions were to be provided. Challenges to the autonomy of people receiving BA were also identified. A team led by a UK investigator developed an adapted BA approach for Muslims living in the UK where they integrated Islamic teachings and practices into the BA manual (Mir et al., 2015). In this BA manual/ intervention, recipients of BA were given a choice to rate their religious orientation so their personal values and preferences

could be prioritised (Mir et al., 2015, 2016). The findings of the feasibility study on this BA intervention reported that some therapists (trained in non-faith based interventions), but none of the patients reported difficulties related to the imposition of religious views on people attending BA sessions – where there were difficulties it was when introducing the client self-help book (Mir et al., 2016). This highlights that inconsistency in values and beliefs among BA providers and recipients can undermine the engagement of BA recipients with some components of intervention such as client self-help book.

However, this differs from our case, as faith leaders and their attendees hold similar characteristics and shared beliefs compared to BA providers in the UK study, who might have training grounded in a medical or psychological understanding of mental illness. Also, in my interview-based study with those attending faith leaders, I did not observe that individuals attending faith leaders preferred activities that were incompatible with those faith leaders' views on Islamic laws. Instead, in some instances where they showed reluctance to visit faith leaders, it was primarily driven by their communal authority over people and their (faith leaders') attribution of illness to magical beliefs. Attendees were inclined to maintain their faith in Islamic practices on their own. BA's philosophical position values autonomy; however, the understanding of autonomy is often shaped by cultural perspectives. In other words, a person with a broader and more secular understanding of autonomy beyond limitations imposed by Islamic laws might not choose to visit faith leaders in the first instance, except those who are compelled to visit under familial pressure.

As discussed above, the BA manual for Muslims originally developed for Muslims in UK, along with the client self-help book, was recently tested in RCT in Pakistan and was found to be more effective in reducing depression compared to CBT, 3 months after delivery of therapies (Dawood, Mir and West, 2023). However, in this trial, authors did not explore issues regarding BA providers imposing or patronising religious beliefs in the Pakistani context, as there was no mixed-methods embedded process evaluation part of this trial (Dawood, Mir and West, 2023). Additionally, in the trial conducted by Dawood and colleagues (2023), several issues related to the quality of the trial were not reported or clarified, such as how i) outcome assessors were blinded, ii) allocation concealment was achieved for outcome assessors and iii) whether randomisation was done independently of the research team. Also, that trial was underpowered, and sample size calculations were based on a standardised mean difference higher than 0.50 (with 80% statistical power), potentially overestimating the actual effect size. Further, statistical analysis was not based on the intention to treat principle.

I also found that people who visited faith leaders, however, had a different understanding of BA and talk therapies. They demonstrated less understanding of a link between communication

and mental illnesses compared to link between faith-based rituals and mental health problems (See Chapter 7: Talking Dynamic in Faith Leaders' Settings). My interpretation of these data is based on two assumptions; the first one is that people were unable to view talk therapy or behavioural activities as a "treatment" for depression, mainly when such talk or activities are unrelated to religious topics. In Pakistan, people with depression attending health services tend to relate medicine-based treatment with depression and consider it primarily the job of the doctor to prescribe medicine for the treatment of depression or any other mental illness (Choudhry, Khan and Munawar, 2023). I also observed that there were culturally based barriers impeding people from engaging in psychotherapy; for instance, one older female pointed out that she did not like to discuss her problems with her close acquaintances, like family members and also faith leaders. Secondly, some participants in the qualitative study highlighted that faith leaders do not provide talking treatments or psychotherapy to their attendees. They believe this is not the intended role of faith leaders, and from their perspective, faith leaders' roles are not seen aligning with those who provide psychotherapy or BA.

On the contrary, a few participants attending faith leaders pointed out that they would prefer to engage in BA and discuss their illness with faith leaders, although most preferred to engage with healthcare professionals for this purpose. However, people attending faith leaders were able to link performing religious activities with improvement in depression, and such activities included prayers, reading religious texts, and attending religious ceremonies.

9.5 The Way Forward

In Pakistan, healthcare professionals have rarely attempted to approach faith leaders to develop working relations despite identifying a considerable role for faith leaders in informal service provision for mental health. Recent attempts have been made to train faith leaders to engage in the identification and management of psychosis (Farooq et al., 2023). However, my findings indicated that there may be some pitfalls in such engagement. For instance, faith leaders value morality (according to Islamic principles) and are not potentially open to identifying people with mental illness. Therefore, implementing such plans may be challenging. For instance, asking faith leaders to screen people with mental illness regularly may be a big ask and potentially impractical, especially in the case of common mental illnesses. For healthcare professionals seeking to establish working relations with faith leaders, it is crucial to understand the indigenous faith practices of these leaders.

Instead of solely focusing on training faith leaders to identify specific mental illnesses, which is often influenced by a medical and healthcare perspective, there is an opportunity to introduce transdiagnostic psychotherapeutic interventions (Fernández-Rodríguez et al., 2023). This

approach may involve incorporating behavioural strategies to streamline the process. This further involves co-adaption and co-production of the plan for identification and treatment while providing equal recognition to Indigenous faith-based practices to mitigate potential power imbalance between faith leaders, healthcare professionals and service users (those who attend faith leaders or healthcare professionals). Subsequently, it is necessary to recognise the importance of co-learning, knowledge exchange and sharing rather than relying on one-way traditional training and learning methods where power and supervisory roles are attributed only to mental health professionals. Mainly, as my philosophical position was oriented towards co-production, co-creation and valuing all relevant stakeholders in expanding knowledge (See Chapter 2: Mixed Methods Research), I could relate to faith leaders' concerns at different stages. Further, I contemplate the power hierarchical lines need to be challenged. This initiative must be taken by healthcare professionals, especially when they consider that they possibly are well educated and trained to support people with depression, which subsequently can facilitate co-involvement.

Seeking innovative solutions is not only critical but also holds immense potential for building sustainable and practical partnerships with faith leaders in mental health care. The strong ancestral ties of faith leaders within communities, their broader role in society, and the preference of service users for faith-based practices, particularly those attending faith leaders, are all crucial factors in addressing the current treatment gap in mental health care in low-resource jurisdictions like Pakistan. While concerns about the autonomy and safety of people attending faith leaders were apparent in the data, these issues are addressable given the openness of some faith leaders to engage with healthcare professionals. This presents a promising opportunity for change.

Also, my recommendations based on data suggest that BA may require substantial adaptation in case BA needs to be delivered by faith leaders. I have identified some green flags and red flags to the delivery of BA in the faith leader’s context in the next section. But at the same time, considering alternative psychotherapeutic treatments is also worth mentioning given faith leaders' approach was problem focused. For example, transdiagnostic, simple and widely tested approaches focusing on problem-solving techniques may be more suitable for this purpose. Problem Management Plus (PM Plus) is one of the possible options, which, though distinct from BA, also holds some similarities with BA (Schäfer et al., 2023). PM Plus is a brief transdiagnostic therapy having comparatively a broader approach to tackle different mental illnesses such as depression, anxiety and PTSD. It integrates components from other approaches, including CBT, problem-solving and stress management. It has proven effective in a range of settings globally (Hamdani et al., 2020; Schäfer et al., 2023).

9.6 Green and Red Flags Relevant to Feasibility of Faith Leaders Delivering BA

There are some green flags indicating what faith leaders offer and what attendees receive are aligned with some aspects relevant to the core components of BA and its practice. For example, recognition of training needs, the know-how of depression and its associated factors, shared values and beliefs, problem/ solution-based approach, family involvement in depression care and faith-based understanding of depression were commonly found in the perspectives of faith leaders and their attendees. Also, few faith leaders have connections in the community particularly with healthcare professionals, faith leaders like Islamic scholars were more receptive to receive training, they ask attendees to involve in daily life activities or faith-based activities and have an intention to work on a volunteer basis and they have ability to engage people in discussions. Those aspects of data indicate that faith leaders can develop rapport with people having depression, understand their culture and faith, can engage people to monitor and change their daily activities and can involve family/ carers in treatment.

At the same time, I identified red flags that suggest potential risks of faith leaders delivering BA. One of the main red flags is reluctance to address unique choices and needs of recipients on case-by-case basis, which potentially turn those attendees away from faith leaders. Data highlighted some risks to safety of attendees and those were more intangible in contrast to what we already know for example, lack of sensitivity to address emotional aspects of life potentially indicating lack of empathy. This can result in amplifying the symptoms of depression rather than reduction. Societal, communal or religious authority of faith leaders may restrict attendees to share their problems and choices openly, which can undermine the therapeutic relationship. BA theory and philosophy suggests that sustaining healthy activities within an individual is achievable if such activities are consistent with an individual goal and values. Similarly, some other barriers are: magical attribution to mental illnesses among faith leaders, differing perspectives of attendees on authenticity of faith leaders and attendees not viewing faith leaders as psychotherapist.

My findings indicate that BA may be feasible for faith leaders to deliver, but before we can reach a definitive conclusion, a number of further questions need to be addressed in future research.

I. How can some balance in power be achieved and mobilised within interactions between faith leaders and their attendees?
II. Can training of or consultative engagement with faith leaders enhance the autonomy of their attendees with depression during interactions with faith leaders?

III. Can faith-based activities commonly suggested by faith leaders to their attendees be incorporated into BA while retaining its core components?

9.7 Implications for Research, Policy and Practice

The available data indicates significant challenges when adapting BA for faith leaders in their context. This may require further substantial adaptations, mainly due to the potential overemphasis on religious practices by faith leaders and the possible lack of autonomy for those seeking assistance. There is also a need to identify other suitable options for this purpose. Moreover, faith leaders tend to rely on intuitive judgments to identify problems, and there may be potential complexities arising from differences between faith leaders and healthcare professionals, as well as the power dynamics involved, further complicating the training and supervisory process. However, ADAPT guidance (Moore et al., 2021), which I followed, argues that overemphasis on dissimilarities and ignoring similarities between an intervention and the new context might lead to failing to establish a congruency between the intervention and the new context (Moore et al., 2021). For example, I identified that a substantial percentage of people with mental illness attend faith leaders, faith leaders' interventions for common mental illnesses are potentially effective; activities-based support was the core of faith leaders' settings, such activities or rituals were congruent with Islamic history and values, and specific type of faith leaders were enthusiastic to engage in knowledge sharing and exchange. These constraints and facilitators must be seen together. While the ecological model helped me focus on certain crucial levels, it appears for further action, two key levels should be considered when adapting. They are: 1. Relationship level - to strike a balance between faith leaders and the autonomy of their attendees by ensuring attendees' choices are upheld; and 2. Institutional level - to mitigate power dynamics and to value knowledge exchange between faith leaders and healthcare workers. This balance is crucial and ethical, considering the individual's autonomy.

My findings have the following implications for policy, practice and research.

I. *Further research is needed to understand faith leaders' context and culturally specific practices, particularly in LMICs.*

   Notably, high-quality, and fully powered RCTs evaluating the efficacy of practices used by faith leaders are lacking overall, especially in LMICs. Similarly, none of the trials attempted to understand the process of change associated with faith leaders' practices by using embedded process evaluation including both qualitative and quantitative data. RCTs combined with nested qualitative data are required to develop a deeper understanding of culturally specific practices within faith leader settings, further shedding light on attendees'

autonomy and rights. Incorporating nested qualitative data within such trials will enrich the research process by capturing the nuanced experiences and perspectives of the individuals involved. It will allow investigators to quantify the effect of indigenous practices used by faith leaders and explore the underlying mechanisms, reasons, contextual factors, and potential variations that may exist among different cultural and religious groups or faith leader settings. Ultimately, such a comprehensive and inclusive approach can enable us to develop more informed policies and interventions that respect attendees' autonomy and safeguard their rights.

II. *Training is required for healthcare professionals to understand the broader role of faith leaders in society.*

Healthcare professionals need to understand the broader role of faith leaders, which is not limited to providing support to people with mental illness. Faith leaders have different roles, particularly in Pakistan, including Islamic scholars, spiritual mentors, and prayer leaders. Many such faith leaders act as a gateway to informal support for people with mental illness. However, there is a role heterogeneity. Some faith leaders, including Islamic scholars and prayer leaders, have existing public platforms and community outreach programmes. A broader understanding of faith leaders' role provides an opportunity for mental health professionals to focus on building the clinical capacity of faith leaders and explore more about the potential role of faith leaders in co-leading and advocating mental health at their public forums and community outreach programmes. This necessitates faith leaders' involvement in public mental health campaigns led by mental healthcare professionals.

III. *There is a need to work closely with both faith leaders and healthcare professionals in exploring and developing interventions/care pathways involving faith leaders in addressing mental health conditions such as depression.*

My data supports the notion that faith leaders generally exhibited an openness to receive basic mental health education, albeit with some reservations about becoming the student of healthcare workers. Not all categories of faith leaders were equally receptive to training. Particularly those with a traditional Islamic educational background and pre-existing informal ties to communities and healthcare professionals are better suited for such training initiatives. Identifying individuals with a common identity, such as healthcare professionals with religious beliefs, can be a facilitator. Including them in adaptation meetings and consultations can provide valuable reinforcement. The crucial aspect is the early and gradual engagement with faith leaders to foster trust and harmony where both learn to value each other perspectives. Establishing and nurturing strong relationships

between health professionals and these faith leaders, particularly during the initial stages of any intervention development, is paramount.

IV. *Dialogue, co-designing and developing roles and rules for engagement between faith leaders and healthcare professionals.*

Furthermore, achieving sustainability in these efforts necessitates a role shift, wherein faith leaders take on partial trainer and advocacy responsibilities. This sense of ownership can empower faith leaders to play a more active role in the long-term success of mental health education initiatives. Consequently, a co-leading approach to training and learning can emerge as a promising strategy. Mental health professionals can lead training sessions on basic mental health education while providing faith leaders the opportunity to lead sessions on understanding mental illnesses in Islam. The latter is perceived as a crucial element for healthcare service providers engaging with religiously oriented patients, fostering cultural competency, particularly within the field of psychotherapy. Such training consultations and engagement can take the shape of co-designing and co-adaptation workshops where attendees of faith leaders could also be included. Such workshops, if required, may not focus specifically on intervention development but rather can focus initially on establishing rules for engagement. Considering factors such as how to i) share knowledge, ii) safeguard the rights of people with mental illnesses, and iii) maintain the power balance. Further, based on the success of those workshops, co-design workshops targeted to identify depression and deliver BA.

V. *Introducing tailored training programmes compatible with faith leaders' values and traditions.*

Training faith leaders on identifying specific mental illnesses to incorporate such screening into their routine practice seems challenging. When engaging with faith leaders, the emphasis should be on a minimal level of recognition of mental illness, further introducing a transdiagnostic approach to treatment rather than disorder-specific treatment. A minimal level of engagement of faith leaders may involve broadly categorising people with mental illness into common and severe categories, which is supported by the data in this study. I found that faith leaders could identify cases on a severity basis. Further, such assessment procedures need to be simple, precise and evidence-based.

The role of faith leaders as providers of BA to their attendees is a complex matter that warrants further examination. It necessitates considering factors such as determining which faith leaders should be trained and be chosen for BA delivery (maybe setting some criteria), establishing procedures to ensure that BA is provided to individuals while

respecting their choices, and implementing a supervisory mechanism to ensure the quality of care provided by BA providers. Given the data, Islamic scholars and prayer leaders are more suitable and hold BA-compatible practices, at least partially. Ensuring the autonomy and choices of faith leaders' attendees when selecting activities aligned with attendees' values during the delivery of BA within faith leader settings presents a complex challenge. This issue can be more effectively addressed through tailored training programs and consultations, especially considering recent evidence indicating their willingness to give up potentially harmful practices when adequately trained.

VI. *Valuing attendees' preferences by providing choices and establishing a referral system.* Further, given that most people in my study prefer to receive BA sessions from healthcare professionals. In contrast, a few prefer faith leaders; it necessitates an informed decision-making process whereby faith leaders, if they agree, can provide the option to their attendees to either receive BA from faith leaders or refer to the community or lay health workers. It is, however, essential to mention that interviews of individuals who attended faith leaders were mainly carried out by those receiving treatment from healthcare professionals, and interviews were conducted by myself (I have a healthcare background). The perspectives of people having first encounters with faith leaders without contact with healthcare professionals might differ from what I found in this study.

VII. *Valuing the attendees' preferences while they visit statutory healthcare practices*
People attending faith leaders have different perceptions about the support offered by faith leaders and how trustworthy faith leaders are. However, most who attended faith leaders preferred faith-based activities and rituals. This implies that though attendees may need autonomy at the same time, they value their faith while dealing with depression. Current treatments (especially psychotherapeutic) may need to consider including a discussion of faith if interest is exhibited by those attending healthcare professionals.

9.8 Strengths

Research has rarely considered the perspectives and experiences of faith leaders and their attendees using a mixed methods approach. Choosing a pragmatic position while taking some elements of constructivism, too, allowed me to value the perspectives of research participants and recognise my role regarding how data is constructed. Usually, in research practice in Pakistan, research on faith leaders has been done with a more formal healthcare perspective, which tends to separate researchers from research participants. However, I had shared experiences with the research participants. I was able to link both my faith-based and healthcare perspectives with data while also acknowledging my potential active role in the research process.

Research with faith leaders and their attendees has previously documented overly optimistic views of attendees towards faith healing while, at the same time, healthcare professionals viewed it as a barrier. My data and interpretations led me to different positions; perspectives of people attending faith leaders were not unidirectional, i.e., they were positive and somewhat contradictory. As a result, I could recognise and consider both barriers and facilitators in this process instead of the dominant healthcare perspective.

Also, I have used existing guidance, the ADAPT framework, to guide the research process and make further recommendations. Subsequently, adding an ecological framework has powered and sensitised ADAPT by enhancing its sensitivity to focus on multiple segments of the ecological system and prioritising those segments, which can effectively contribute to the further successful adaptation of BA. I considered the role and characteristic heterogeneity of the research participants, especially gender. Very rarely have female faith leaders' perspectives been explored in Pakistan, but I was able to do this. Recent studies in the faith leader's context have long remained descriptive, focusing less on action and pragmatism. However, my approach was specific, with a clear and exclusive focus on BA and depression. This will allow further research to develop practical solutions and bring change in research, policy, and practice rather than remaining limited to a description of faith leaders' settings.

9.9 Limitations

I have used the term 'faith leaders' throughout the dissertation, informed by my systematic review, to acknowledge the broader role of people providing informal support to people with mental illnesses using religious and faith-based practices. This term is also closer to the role of the sample interviewed as it highlights the leadership roles of such people. However, I acknowledge that no universal term can fully capture the roles and duties of such people. The term 'faith leaders' has few limitations; for example, it does not capture the heterogeneity or hierarchy in roles or duties performed by groups of such people. For example, a prayer leader may not have the same communal respect and authority as a spiritual leader. Similarly, some additional limitations are whether it is reasonable to use a universal term to identify different groups of people having considerably different roles and whether such a term is acceptable to stakeholders.

Two different but critical arguments can be considered depending on how those who critically evaluate position themselves. For example, those who may have more openness towards diversity, uniqueness and inclusion might say that the idea of training faith leaders in BA may be led by the dominancy of the healthcare perspective, which may undermine the native practices

offered by faith leaders. In contrast, those who closely identify themselves with healthcare perspectives and skills might argue that faith leaders may lack background knowledge, practice and worldview to practice evidence-based healthcare interventions effectively. The former argument appeals more to me, aligning with my position. However, studies exploring the native practices of faith leaders have been done previously but often failed to produce actionable results. This is likely because current healthcare researchers value scientific evidence for practice – exploring and evaluating native practices by faith leaders may require much scientific work and may not be directly relevant to healthcare providers' practice. Therefore, I aimed to produce an actionable output, which would only be possible if I narrowed down the scope of research rather than exploring generic practices offered by faith leaders. However, I was able to value the perspectives of faith leaders (as mentioned above in the strengths). The second argument increases my dissertation's scientific integrity: scientific research should be falsifiable. The second argument highlights that there might be good reasons to believe that faith leaders are not suitable for delivering such interventions, and my research question was about exploring it. In other words, a good research question can be one in which researchers or related people may have different opinions or perspectives, and it pushes the researcher who is researching to consider all perspectives.

There were a few methodological limitations. Firstly, this study does not comprehensively adapt and evaluate BA led by faith leaders; I only investigated whether faith leaders' context can take up BA practice while considering the fitness between faith leaders' context and BA practice. Further studies are required to substantially adapt BA by conducting consultative engagements/ meetings and co-design workshops. Secondly, primary data, including interviews with faith leaders and their attendees diagnosed with depression, were limited to Muslim faith leaders and attendees. Such limitations must be addressed further; however, they were mainly driven by pragmatic reasons and a literature review. Islam is the major religion in Pakistan, with over ninety percentage of people identifying as Muslims. At the same time, all studies exploring the role of faith leaders in Pakistan focused on Muslim faith leaders. The limited literature on the role of faith healing in Pakistan, apart from Islam, presents challenges when formulating research inquiries and elucidating the roles of faith leaders across different religions practised in Pakistan, especially when there are considerable variations in religious customs and traditions. It was also challenging to define and further approach non-Muslim faith leaders within the given resources. To partially address it, I deliberately used the broad criteria in the effectiveness, barriers, and facilitators review (Chapter 5) to avoid religious-based limitations and to ensure some inclusivity. On the other hand, studies focusing on religious minorities in HICs have highlighted the role of religious

and cultural customs in shaping people's preferences to seek support for mental illnesses. Therefore, future studies need to expand this evidence to religious minorities in Pakistan (Meran and Mason, 2019; Sherra, Shahda and Khalil, 2017). Thirdly, due to the scarcity of evidence on the effectiveness of faith healing, most of the studies included in the effectiveness review did not take diagnosed cases of CMD, and healing was primarily focused on physical conditions rather than CMDs. Fourth in interviews with faith leaders, though I included female and male faith leaders while considering heterogeneity concerning sects in Islam, my sample of faith leaders essentially represented male *Sunni* faith leaders. Fifth, in interviews with people with depression who visited faith leaders involved interviewees having contact statutory mental health services and were selected from psychiatric facilities. Perspectives of people with depression attending faith leaders without any exposure to formal healthcare services can be substantially different.

Last, dyadic interviews (pairs of faith leaders and those who attended them) would have offered a more extensive and in-depth comparison; however, there were many practical issues. Two options were present: either to approach dyads through the faith leaders' context or from a tertiary care context. In the first scenario, asking faith leaders to refer to some of the people consulting them would have been challenging. One of the challenges is that faith leaders may not have been allowed to access their attendees. Most faith leaders and attendees live in the same area and have strong connections. They might not want to risk their reputation by disclosing personal issues about their attendees to others. The other way was to approach dyads by identifying attendees coming to tertiary care and asking them to share information about the faith leaders they attended. It might be difficult to approach those faith leaders identified by those who attended them. Most of those who attend tertiary care (IoP), where data was collected, come from remote rural areas. Travelling to those remote areas without prior knowledge would have posed some safety concerns for the researcher. Therefore, a more practical approach was used to take nondyadic data, which provided useful insights, but a direct comparison could not be made.

9.10 Conclusion

The mixed-methods evidence collected in this thesis offers several key implications and useful information regarding the role of faith leaders in the provision of care to people with common mental illnesses and depression in particular. My findings show that a significant proportion of people attend faith leaders to get support for their mental illnesses. In contrast, some, not all, of the faith leaders' interventions could offer some benefits for common mental illnesses. Faith leaders' understanding of depression may have some elements similar to medical or psychological perspectives, but it also tends to differ as well. Faith leaders provide a range of

religious rituals and activities. However, faith leaders' verbal engagement with their attendees is limited, and those attending faith leaders are unable to consider faith leaders as psychotherapists. Those attending faith leaders experienced a lack of autonomy, and a few were treated unethically. Therefore, BA may not be well suited to be delivered by faith leaders, and it may require further substantial revisions. There is a need for healthcare professionals to have dialogues with faith leaders (also taking on board those attending faith leaders) in a respectful manner, focusing on identifying measures to safeguard the autonomy and rights of the people attending them.

9.11 Dissemination of Findings

The key beneficiaries of my research include healthcare professionals, mental health specialists, faith representatives and leaders, those who attend faith leaders, applied healthcare researchers, policymakers and people with mental illnesses, particularly depression. Findings from this study have offered valuable insight for healthcare professionals to understand the influence of faith leaders in healthcare, which can be instrumental in improving care delivery for people with depression. Further, pluralism in treatment preferences and unique perspectives of people with depression, particularly among those attending faith leaders can facilitate mental health specialists in tailoring psychological treatments accordingly considering current or any past contact history with faith leaders.

This study also offers an opportunity for faith leaders to understand the nuance/ differing experiences of those attending them and possibly reach out to healthcare professionals for engagement to enhance their perceived authenticity – which varies among attendees based on past experiences, as shown in this study. The conclusions and future directions derived are highly relevant to applied healthcare researchers, especially those interested in reducing the treatment gap for depression. This research has highlighted potential barriers, facilitators and targeted areas of adaptation if BA is to be delivered by faith leaders in Pakistan. Having a dialogue with faith leaders in consultative workshops or focus group discussions to conclude whether faith leaders can provide an autonomous environment to their attendees and further adapting BA to faith leaders' context and performing an evaluation of adapted BA delivered by faith leaders are potential future directions in research. Some aspects of the findings were relevant to policymakers such as understanding the role of faith leaders in the provision of care for depression and faith leaders' enthusiastic attitude to engage with healthcare professionals while focusing on their concerns related to their identity and native practice.

To ensure the findings reach those beneficiaries, I will disseminate those findings tailored according to the audience. I plan to disseminate findings through peer-reviewed publications. I

have already published a paper (See Chapter 5) in a journal which is highly relevant to this area. I plan to publish a paper combining data from interviews with faith leaders and their attendees. Further, I plan to disseminate those findings through presentations at relevant conferences, particularly, local conferences targeting healthcare professionals and applied healthcare researchers working in Pakistan. I am part of a local mosque social media group and was once invited as a speaker to talk about my research. I plan to continue to disseminate those findings to faith communities and leaders through public forums and social media including X and WhatsApp. My dissemination strategy until now and in future will be tailored according to the audience where I plan to communicate key relevant messages in the simple and local language where applicable.

10 Abbreviations

List of Abbreviations

Abbreviations	Complete Terms
BA	Behavioural activation
DALYs	Disability-adjusted life years
CASP	Critical appraisal skills programme
CBT	Cognitive behavioural therapy
CMDs	Common mental disorders
DSM 5TR	Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition Text Revision
HIC	High Income countries
ICD-11	International classification of diseases
LMICs	Lower middle-income countries
MDD	Major depressive disorder
PBUH	Peace be upon him
PM Plus	Problem Management Plus
PTSD	Post-traumatic stress disorder
RCTs	Randomised control trials
RoB-1	Cochrane Risk of Bias Assessment Tool-Version 1
SAQOR	Systematic Assessment of Quality in Observational Research
UMICs	Upper middle-income countries
USA or US	United States of America
WHO	World Health Organisation
YLL	Years of life lost

11 List of Glossary

Terms	Explanation of Terms
Allah kalam	Referring to Quran
Assarat	Influence of demon or magic
Asr	Afternoon prayer in Islam
Barelvi	A sub-sect within the Sunni Sect among Muslims
Bayan	Lecture
Bay namazi	A person who does not pray
Chilla	40 days worship
Data darbar	A famous shrine in Lahore (City in Pakistan)
Dargah or darbar	Shrine
Darood	Sending blessings on prophet Muhammad peace be upon him
Dhamal	A traditional dancing ritual, usually practised in South Asian region.
Dhur	Noon prayer in Islam
Dua	Praying or supplication
Dum or dum darood	Reciting holy verses and blowing on head or body or water
Dum wala pani	Blessed water; recitations of Quran verses and blowing onto water for drinking and splinting
Eidgah shareef	Famous shrine in Rawalpindi (City in Pakistan)
Faith leader	Individuals offering informal support and care to those with mental illnesses through practices grounded in spirituality, faith, magic, and religion. They also perform additional roles like helping community members, involving in volunteer work, and leading religious and faith-related matters within the community.

Fajr	Sunrise prayer in Islam
Gumrahi	Wrong path
Gyarvi shareef	Commemorating well-known saint “Shaykh Abdul Qadir Jilani” on every 11th date of the Islamic calendar for each month
Hafiz e Quran	One who has memorised the whole Quran
Hadith	Sayings of prophet Muhammad PBUH
Haram	Acts forbidden in Islam
Hakim	Traditional physician generally uses herbs and plants for treatment
Hazrat	The Arabic word used to give respect and honour to a person
Hijab	The scarf that Muslim women wear to cover the body and hairs
Hisab kitab	Faith healers perform some traditional and religious calculations to identify problems. In simple Urdu, this refers to calculations.
Imam masjid or Imam	Prayer Leader
Isha	Night prayer in Islam
Islamic scholar/ Islamic law expert	Studies Islamic education and law through formal Islamic seminaries and educational institutions. Specialised in Islam laws and authorised to issue religious edicts
Islamic shariah	Islamic laws and principles
Istikhara	A prayer in which individuals pray to Allah (God) to show or to make him choose the right path or to take the right decision for the future.
Jaddu	Magic
Jinn (Singular)/ Jinnat (Plural)	An invisible creature made of fire
Kalonji	Black cumin

Khula	A legal way for women getting a divorce in Islam
Khutba	Sermons
Langar	Free food on religious occasions such as Urs
Madrasah	Islamic education institutions
Maghrib	Sunset prayer
Manfi sauch	Negative thinking
Maulvi Sahab	Typically, a common word used to address Islamic scholar
Mimber	The stage is usually inside a mosque from where Islamic scholars deliver a speech
Mubaligh	Preachers of Islams
Mufti	Islamic Scholar
Namaz	Prayer in Islam
Nikah	A contract of marriage in Islam
Niyaz	Free food with sacred and spiritual significance
Pareshani	Stress
Peer or pir	Spiritual mentors associated with mysticism and spirituality or saints
Prayer leader	Lead the congregational prayer at mosques
Qari sahab or Qari	People who remember and recite the Quran usually are prayer leaders
Qalb	Heart
Qul sharif	Four chapters at the end of the Quran, are referred to as Qul because they start with the Arabic word Qul (Meaning say)

Quran	Holly book of Muslims and Muslims believe this book contains the words of Allah (God) and this book has been revealed to the prophet PBUH
Rooh	Soul
Sabr	Patience
Sadqa and/ or zakat	Obligatory charity in Islam
Shaykh	Spiritual leader or spiritual mentor
Shaitan (Singular) *Shayateen (Plural)*	Satan or Devil
Sayya or saya	The evil shadow which can possess an individual
Spiritual passe	In spiritual passe practice, faith leaders without touching move their hands over an individual to heal illness.
Subah shaam key azkar	Day and night supplications or morning and evening supplications
Sufism	Mysticism and spirituality in Islam
Sufi	Typically referred to as one who practices spirituality and mysticism in Islam
Sunnah	Set of practices and traditions guided by Prophet Muhammad PBUH
Sunni	A sect within Muslims who claim to follow the traditions and practices of Prophet Muhammad PBUH
Surah e fateha	The first chapter in the Quran
Surah e rehman	55th chapter in Quran
Shariat	Obligatory duties and responsibilities in Islam
Shifa	Cure

Shia	A sect within Muslims, who place emphasis on the significance of the prophet's family in matters of leadership and succession after Prophet Muhammad, PBUH
Spiritual leader	Sought out by Muslims for spiritual guidance around life events for purification of one's character and belief and "spiritual cures"
Shukar alhamdulillah	Thanks to Allah (God)
Tauba	Repentance
Tablighi jamaat	A missionary movement that included *Sunni* scholars and Muslims from Southeast Asia before reaching a global scale
Tareeqat	Spirituality and mysticism
Taweez	Amulets
Tilawat	Reciting Quran
Ulma e Karam	Islamic Scholars (Plural)
Urs	The death anniversary of a saint
Waham	Doubt
Waswasa	Whispers of satan
Wali Allah	Friend of Allah (God), usually term used for saints
Wazeefa	Supplications and recitations
Wudu	Ablutions
Zehani dabao	Mental pressure
Zikr (Singular); *Azkar* (Plural)	Remembering Allah by heart or words using supplication(s) or recitations

12 Appendices

12.1 Appendix 2.1 Ethical Approval

(Health Sciences Research and Governance Committee, University of York)

DEPARTMENT OF HEALTH SCIENCES

c/o Department of Philosophy
Heslington
York YO10 5DD

Telephone (01904) 323253/1
E-mail stephen.holland@york.ac.uk

13 Prof Stephen Holland
Chair, Health Sciences Research Governance Committee

www.york.ac.uk/healthsciences

9 November 2022

Mr Mujeeb Bhatti

University of York

Department of Health Sciences

Heslington

York

YO10 5DD

Dear Mujeeb

HSRGC/2022/498/D: **IMPROVE**

Thank you for your email of 4 November informing me of substantial amendments to your study. You clarified the amendments in yesterday's zoom call; thank you for today's email confirming that the changes are as follows:

(A) You have HSRGC approval to undertake interviews with Faith Leaders (FL) and these are now completed. In addition, you now intend to interview individuals with depression who have recently approached FLs (i.e., in the last six months). These participants were in your original submission to the HSRGC, but as participants in focus groups (FG) not as interviewees, and

without having to meet the new criterion of attending an FL within the last six months. The method for identifying and approaching these participants - i.e., through hospitals where they are patients - has already been approved. Also, the interview schedule will be similar to the topics covered in interviews with the FLs that have been completed. You have adapted the participant information sheet and consent form so they are relevant to these interviews (as opposed to the original FGs). Thank you for sending me the redrafted information sheet, consent form, and interview schedule, in today's email.

(B) Originally, you intended to hold FGs with patients and family members; this was approved by HSRGC, but you have decided not to go ahead with this. Instead, you will hold FGs including FLs and practitioners; the HSRGC has already approved this, but you will change the focus of the FGs to consensus development. As we discussed, please send me the new FG topic guide when it has been developed.

I am writing to approve these substantial amendments by Chair's Action. Please note that this approval is conditional on in-country ethics approval from Ethical Review Committee Khyber Medical University (KMU), Pakistan, so please send us their approval letter when you have it. In the meantime, if you have any queries regarding the decision or make any further substantial amendments to the study, please contact me.

Yours sincerely

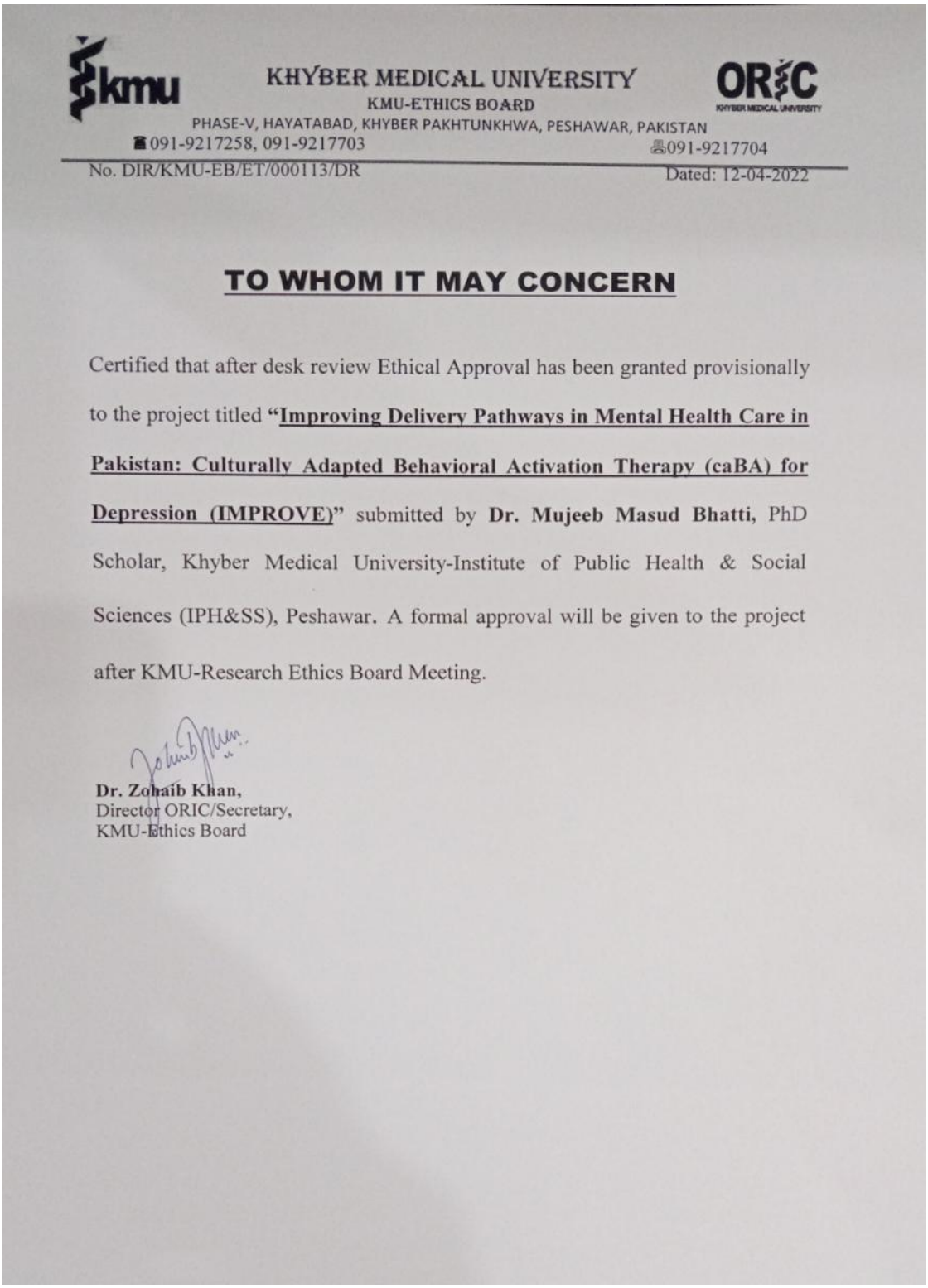
Stephen Holland

Chair: HSRGC

cc: Prof Najma Siddiqi, Dr Hannah Jennings, Dr Saima Afaq

13.1 Appendix 2.2 Local Ethical Approval

(Khyber Medical University)



KHYBER MEDICAL UNIVERSITY
KMU-ETHICS BOARD
PHASE-V, HAYATABAD, KHYBER PAKHTUNKHWA, PESHAWAR, PAKISTAN
091-9217258, 091-9217703 091-9217704

No. DIR/KMU-EB/ET/000113/DR Dated: 12-04-2022

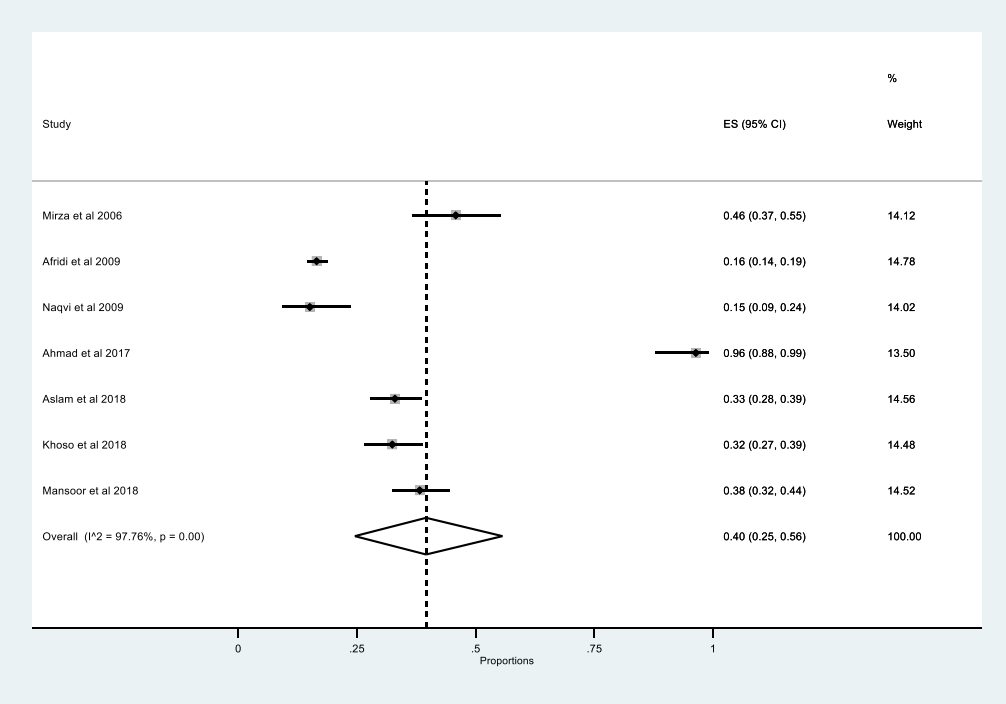
TO WHOM IT MAY CONCERN

Certified that after desk review Ethical Approval has been granted provisionally to the project titled **"Improving Delivery Pathways in Mental Health Care in Pakistan: Culturally Adapted Behavioral Activation Therapy (caBA) for Depression (IMPROVE)"** submitted by **Dr. Mujeeb Masud Bhatti,** PhD Scholar, Khyber Medical University-Institute of Public Health & Social Sciences (IPH&SS), Peshawar. A formal approval will be given to the project after KMU-Research Ethics Board Meeting.

Dr. Zohaib Khan,
Director ORIC/Secretary,
KMU-Ethics Board

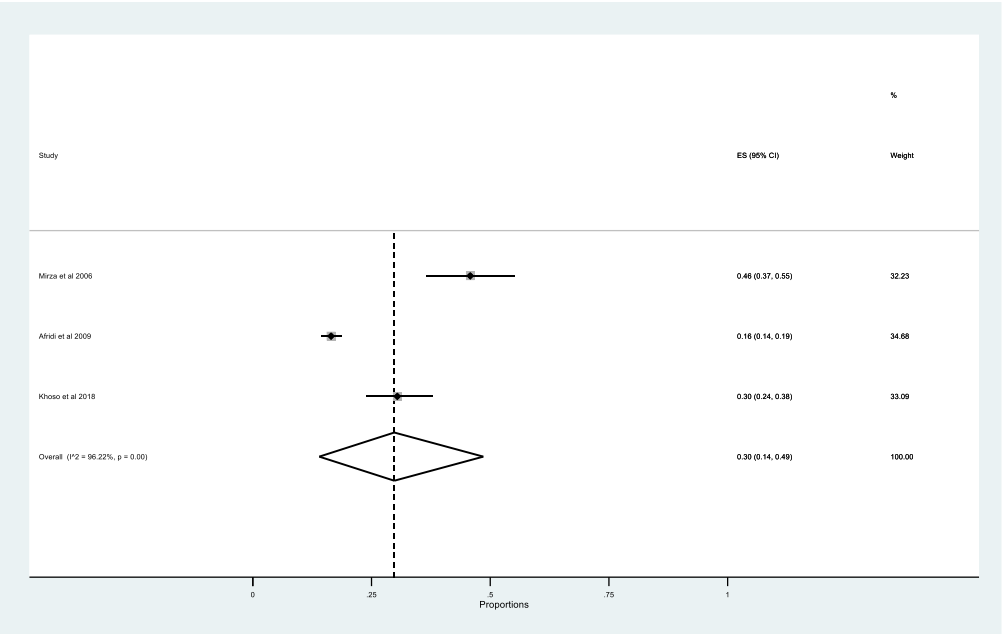
13.2 Appendix 4.1 Figure: Sensitivity Analysis for Pooled Proportion of Individuals with Mental Illnesses Attending Faith Leaders

(After removing studies at low and very low quality)



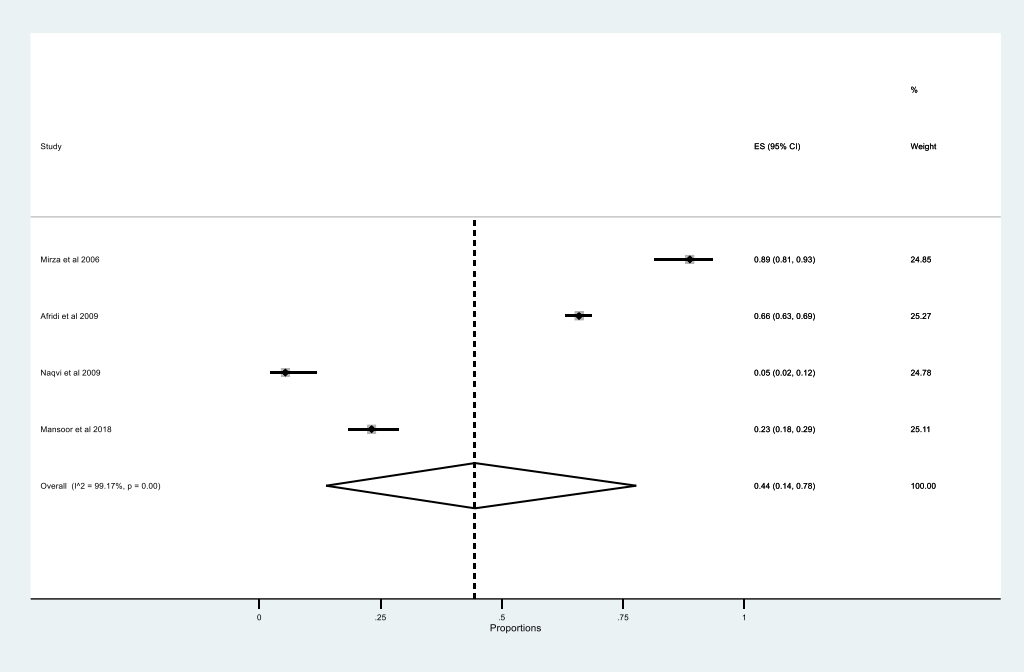
13.3 Appendix 4.2 Figure: Sensitivity Analysis for Pooled Proportion of Individuals with Depression Attending Faith Leaders

(After removing studies at low and very low quality)



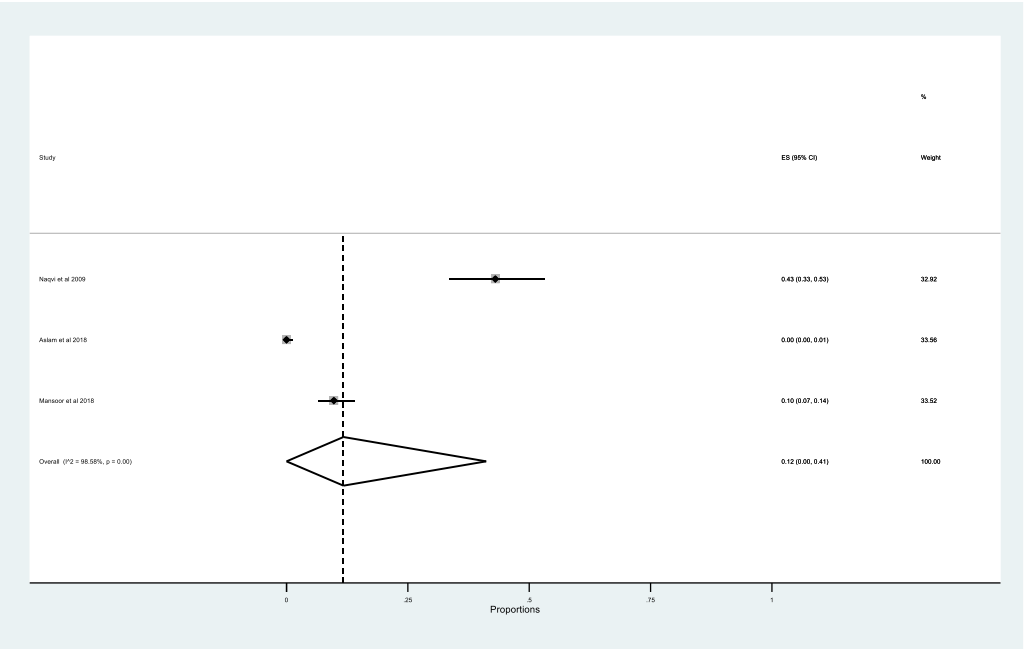
13.4 Appendix 4.3 Figure: Sensitivity Analysis for Pooled Proportion of Individuals with Mental Illnesses Attending General Practitioners

(After removing studies at low and very low quality)

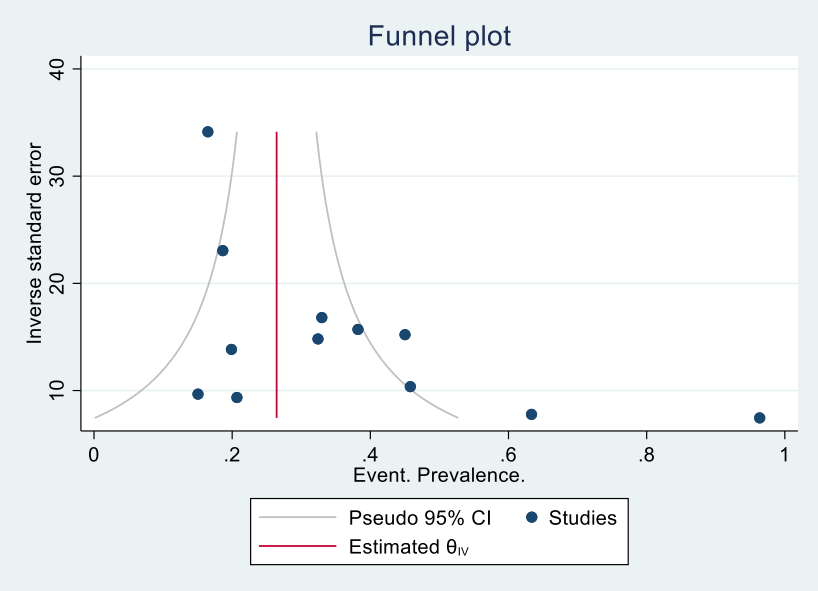


13.5 Appendix 4.4 Figure: Sensitivity Analysis for Pooled Proportion of Individuals with Mental Illnesses Attending Mental Health Specialists

(After removing studies at low and very low quality)

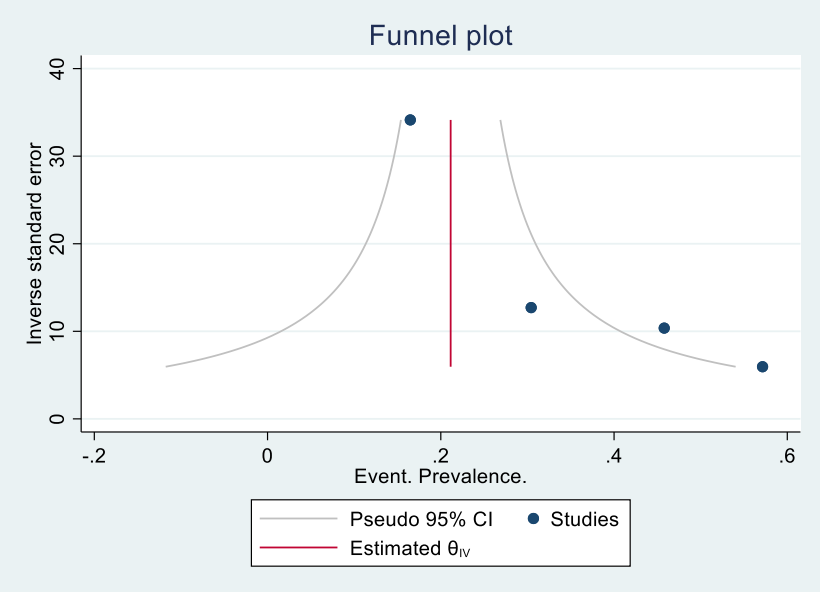


13.6 Appendix 4.5 Figure: Publication Bias for Pooled Proportion of Individuals with Mental Illnesses Attending Faith Leaders



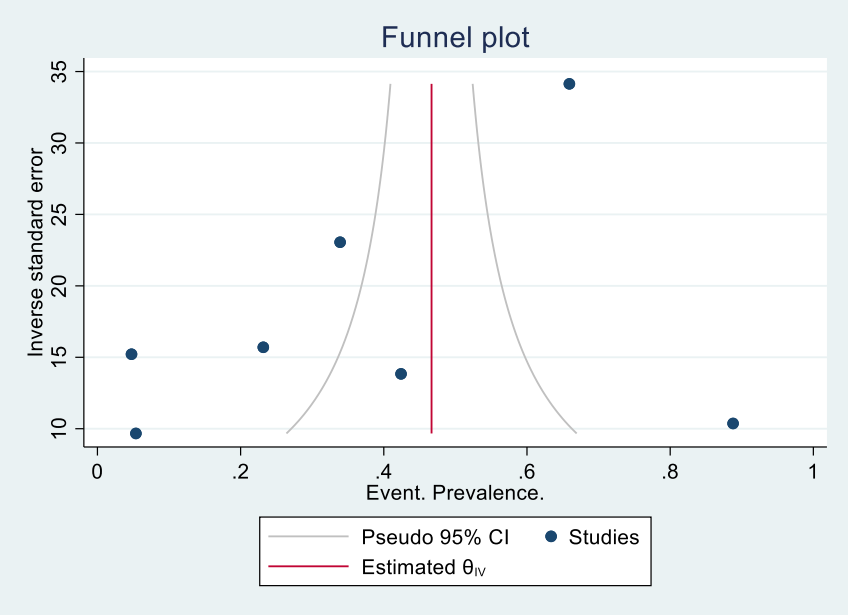
Note. Egger Test: Beta1 = 4.21; z = 2.79; p = 0.005

13.7 Appendix 4.6 Figure: Publication Bias for Pooled Proportion of Individuals with Depression Attending Faith Leaders



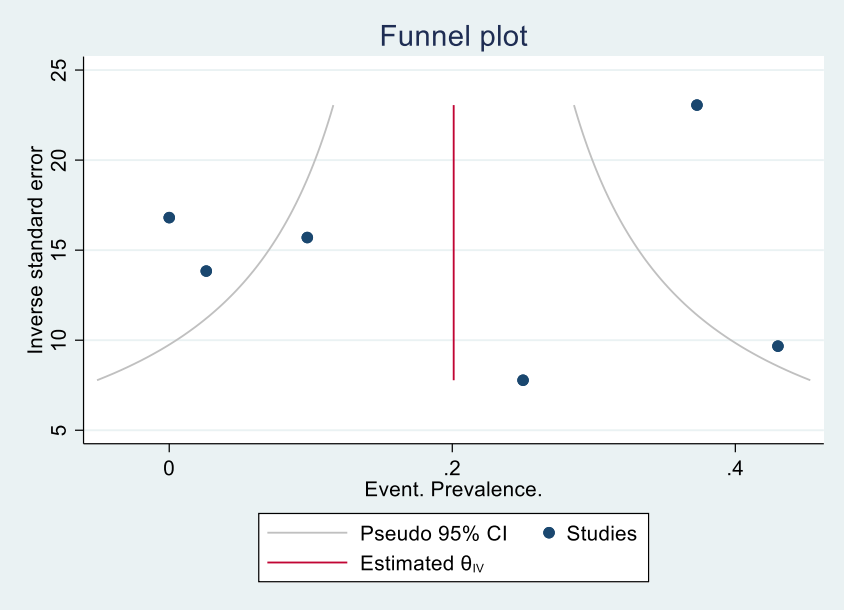
Note. Egger Test: Beta1 = 3.34; z = 3.79; p = 0.002

13.8 Appendix 4.7 Figure: Publication Bias for Pooled Proportion of Individuals with Mental Illnesses Attending General Practitioners



Note: Egger Test: Beta1 = -1.36; z = -0.27; p = 0.790

13.9 Appendix 4.8 Figure: Publication Bias for Pooled Proportion of Individuals with Mental Illnesses Attending Mental Health Specialists



Note: Egger Test: Beta1 = 1.53; z = 0.51; p = 0.608

13.10 Appendix 4.9 Full Search History for Review on Faith Leaders in Mental Healthcare Pathways in Pakistan

Database: Ovid MEDLINE(R) <1946 to July 21, 2023>
Search Strategy:
1 Faith Healing/ (606)
2 Indigenous Heal*.mp. (1792)
3 Traditional Heal*.mp. (4183)
4 Native Heal*.mp. (246)
5 Faith heal*.mp. (892)
6 Religious Heal*.mp. (186)
7 Spiritual Heal*.mp. (783)
8 Faith leader*.mp. (145)
9 Religious leader*.mp. (902)
10 Religious cleric*.mp. (5)
11 Spiritual leader*.mp. (102)
12 Shaykh.mp. (3)
13 Sufi.mp. (78)
14 Imam.mp. (782)
15 Saint*.mp. (7867)
16 Fakir.mp. (28)
17 Malang.mp. (70)
18 or/1-17 (17646)
19 Pakistan*.mp. (29598)
20 18 and 19 (150)

Database: APA PsycInfo <1806 to July Week 3 2023>
Search Strategy:
1 Faith Healing/ (1643)
2 Indigenous Heal*.mp. (666)
3 Traditional Heal*.mp. (1856)
4 Native Heal*.mp. (118)
5 Faith heal*.mp. (1933)
6 Religious Heal*.mp. (234)
7 Spiritual Heal*.mp. (1011)
8 Faith leader*.mp. (157)
9 Religious leader*.mp. (1163)
10 Religious cleric*.mp. (7)
11 Spiritual leader*.mp. (512)
12 Shaykh.mp. (9)
13 Sufi.mp. (231)
14 Imam.mp. (167)
15 Saint*.mp. (2572)
16 Fakir.mp. (14)
17 Malang.mp. (17)
18 or/1-17 (9817)
19 Pakistan*.mp. (5036)
20 18 and 19 (80)

Database: Embase <1974 to 2023 July 20>
Search Strategy:
1 Faith Healing/ (102)
2 Indigenous Heal*.mp. (3362)
3 Traditional Heal*.mp. (7293)
4 Native Heal*.mp. (334)
5 Faith heal*.mp. (652)
6 Religious Heal*.mp. (263)
7 Spiritual Heal*.mp. (2728)
8 Faith leader*.mp. (199)
9 Religious leader*.mp (1228)
10 Religious cleric*.mp (8)
11 Spiritual leader*.mp. (164)
12 Shaykh.mp. (8)
13 Sufi.mp. (124)
14 Imam.mp. (3478)
15 Saint*.mp. (14324)
16 Fakir.mp. (47)
17 Malang.mp. (472)
18 or/1-17 (33849)
19 Pakistan*.mp. (51366)
20 18 and 19 (296)

PakMEdiNet (Inception till 23 July 2023)

This database doesn't provide advanced search tools including truncation and wildcards and subject headings. Therefore, following terms were search separately:

1 Traditional healing (21)
2 Traditional healer (3)
3 Faith healing (6)
4 Faith healer (5)
5 Spiritual healing (11)
6 Spiritual healer (7)
7 Religious healer (1)
8 Native healer (1)
Total records identified (55)

*Other terms provided no results

13.11 Appendix 5.1 Table: Search Terms for Effectiveness, Barriers, and Facilitator Review

		Search Terms
1.	Participants	Sangoma OR Curander* OR Spiritis* OR Spiritualis* OR Voodoo OR Voudou OR Santeria OR Divination OR Diviner OR Shaman* OR Clergy OR Witchdoctor OR "Witch-Doctor" OR "Faith Heal*" OR Faith Leader* OR Faith healing/ OR "Indigenous Heal*" OR "Traditional Heal*" OR "Native Heal*" OR "Religious Heal*" OR "Religious leader" OR "Ritual Heal*" OR "Spiritual Heal*" OR Marabout OR Dervish OR Sheikh OR Sufi OR Imam
2.	Intervention	------
3.	Comparison	-----
4.	Outcome	Mental disorder/ OR Mental OR Psychiatr* OR "Common Mental Disorders" OR Depress* OR Anxi* OR Panic OR "Obsessive Compulsive" OR "Obsessive-Compulsive" OR OCD OR "Post Traumatic Stress" OR "Post-Traumatic-Stress" Or PTSD
5.	Study Method (Mixed Method Filter)	Case Reports/ OR Organizational Case Studies/ OR Qualitative Research/ OR qualitative research* OR qualitative stud* OR action research OR Community-Based Participatory Research/ OR participatory research OR case stud* OR ethno* OR grounded theory OR phenomeno* OR Narration/ OR narrative* OR biograph* OR Autobiography/ OR Autobiograph* OR documentar* OR qualitative synthes* OR active feedback OR conversation* OR discourse* OR thematic OR qualitative data OR key informant* OR Focus Groups/ OR focus group* OR case report* OR Interview/ OR interview* OR Observation/ OR observer* OR visual data OR (audio adj record*) OR Anthropology, Cultural/ OR experience* OR exp clinical trial/ OR exp Research Design/ OR random allocation/ OR double-blind method/ OR Single-Blind Method/ OR Placebos/ OR Cross-Over Studies/ OR (clinic* adj25 trial*) OR random* OR control* OR (latin adj square) OR placebo* OR Comparative Study/ OR comparative stud* OR Validation Studies/ OR validation stud* OR evaluation studies/ OR evaluation stud* OR Follow-Up Studies/ OR followup OR follow-up OR Prospective Studies/ OR Cross-Over Studies/ OR cross over OR crossover OR

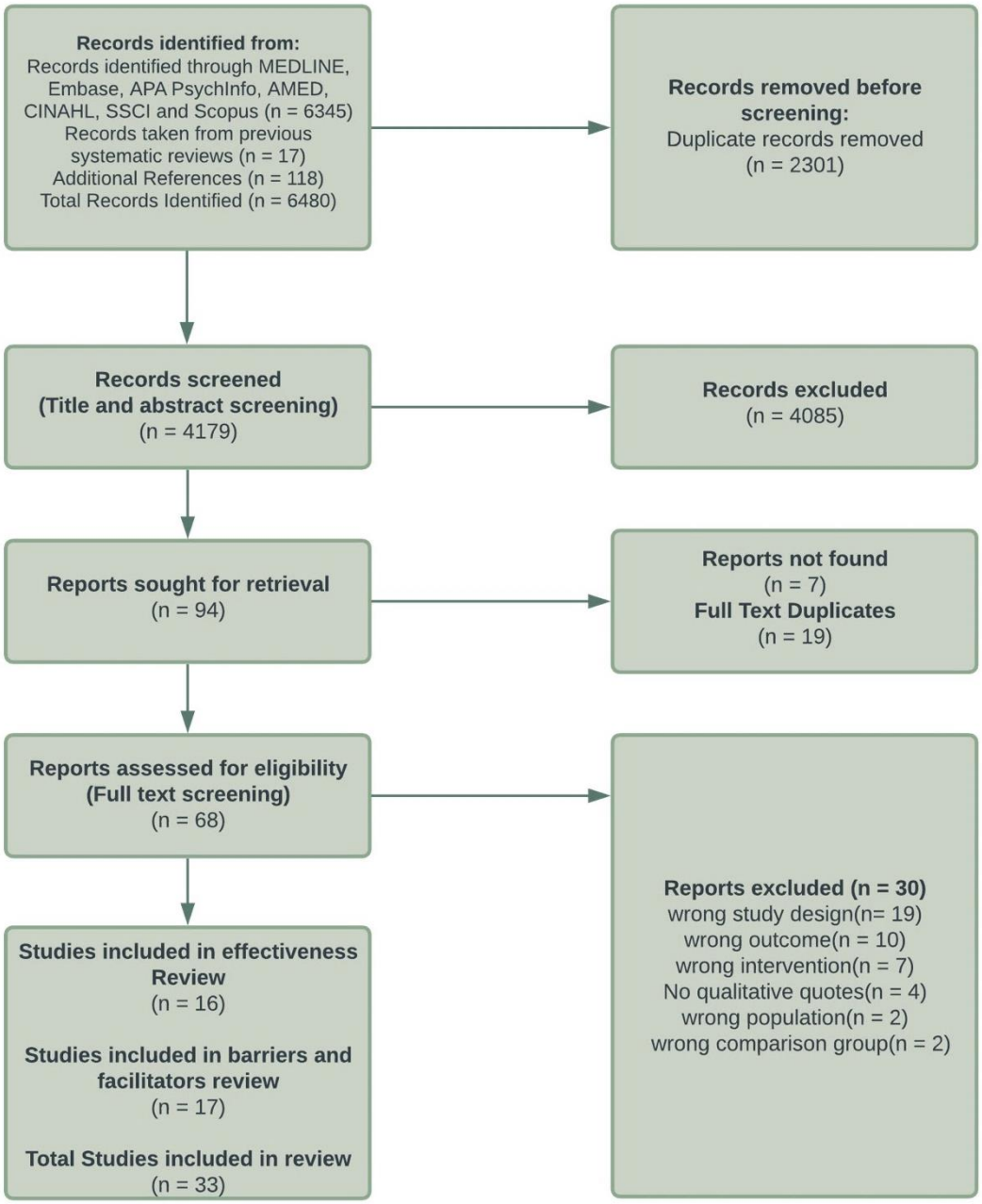
		prospective* OR volunteer* OR ((singl* OR doubl* OR trebl* OR tripl*) AND (mask* OR blind*)) OR Cohort Studies/ OR Case-Control Studies/ OR Cross-Sectional Studies/ OR Health Surveys/ OR Health Care Surveys/ OR Risk/ OR Incidence/ OR Prevalence/ OR Mortality/ OR cohort* OR case-control OR cross sectional OR (health* adj2 survey*) OR risk OR incidence OR prevalence OR mortality.tw OR "case series" OR "time series" OR "before and after" OR prognos* OR predict* OR course* OR (mixed adj5 method*) OR multimethod* OR (multiple adj5 method*) OR ((qualitative) AND (Qualitative Research/ OR quantitative))

13.12 Appendix 5.2 Table: Screening Checklist for Effectiveness, Barriers, and Facilitator Review

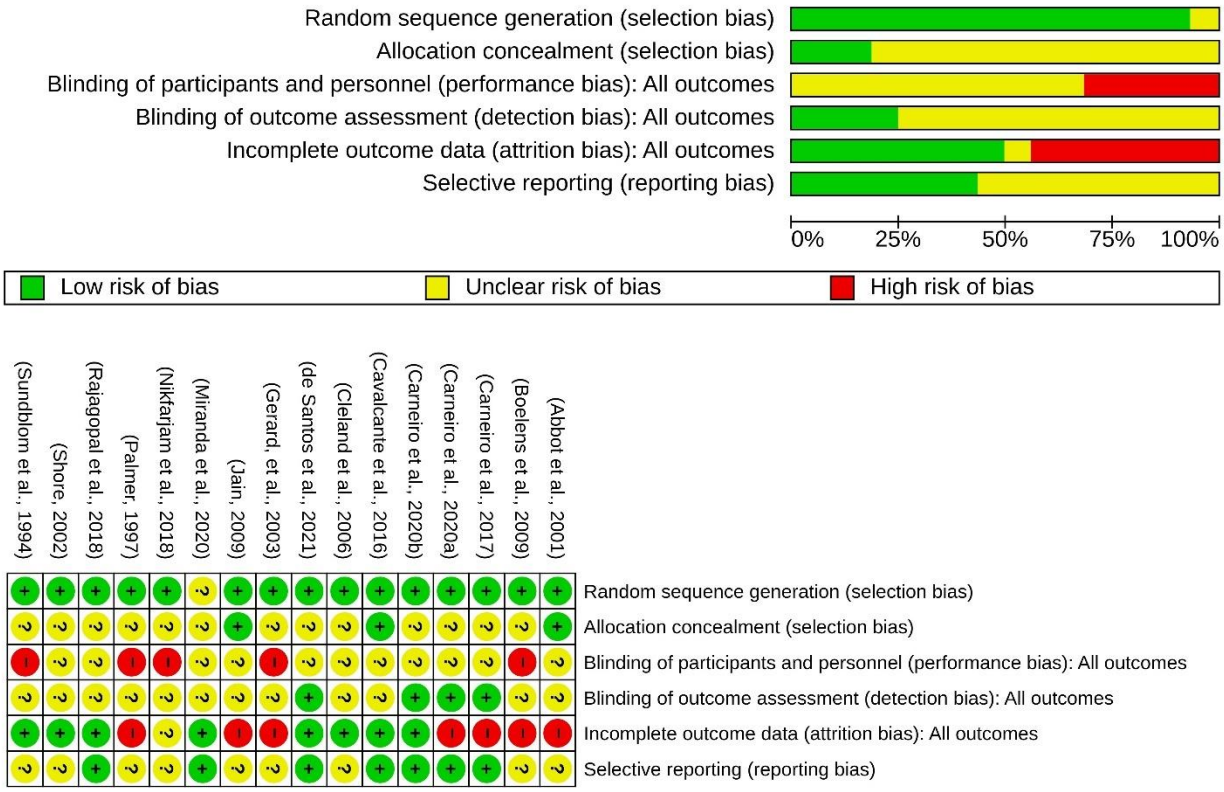
Inclusion Criteria	
1	Participants who have experienced or concurrently experiencing any intervention from faith leaders[11] (in collaboration with bio medical or trained by bio medical professionals or independently) for symptoms of Common Mental Disorders (CMD) [including Anxiety Disorder, Panic Disorder, Depression, Obsessive Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD)] with or without any physical or other mental conditions
2	Faith leaders talking about any intervention (in collaboration with bio medical or trained by bio medical professionals or independently), they provide to people with CMD
3	Study is based:
a)	Either on Randomised Controlled Trial (RCT) design with or without qualitative elements
b)	Or any qualitative & quantitative study with qualitative elements/ quotes
4	Studies with qualitative elements reporting the experiences, perspective or opinions of patients, faith leaders relating to the any intervention provided by faith leaders
Exclusion Criteria	
1	Faith leaders prescribing some oral or topical or nasal or inhaling herbal/ chemical/ substances
2	Studies including multiple interventions from faith leaders, and it is not possible to differentiate psychosocial interventions (including prayer, recitation, etc.) from herbal/ chemical/ substance-based intervention
3	Studies in which either participants with both CMD and severe mental disorders or participants with dual diagnosis were included, and it is not possible to differentiate quantitative outcomes or qualitative responses (quotes) of participants with common mental disorders from participants with severe mental disorders

[11] Faith leaders are defined as "healers who explicitly appeal to spiritual, magical, or religious explanations for disease and distress"

13.13 Appendix 5.3 Figure: PRISMA Flow Diagram for Effectiveness, Barriers, and Facilitators Review

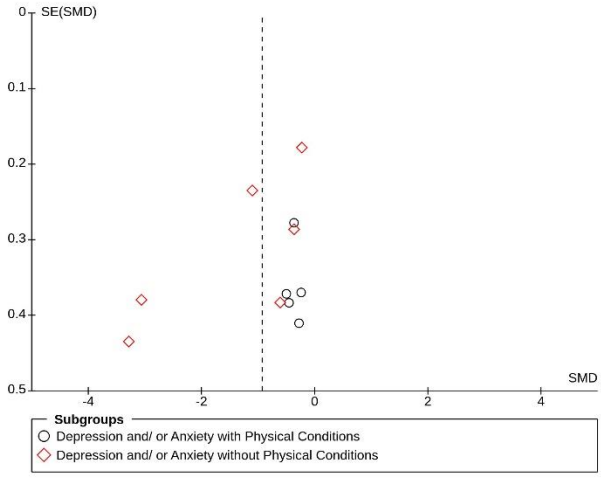


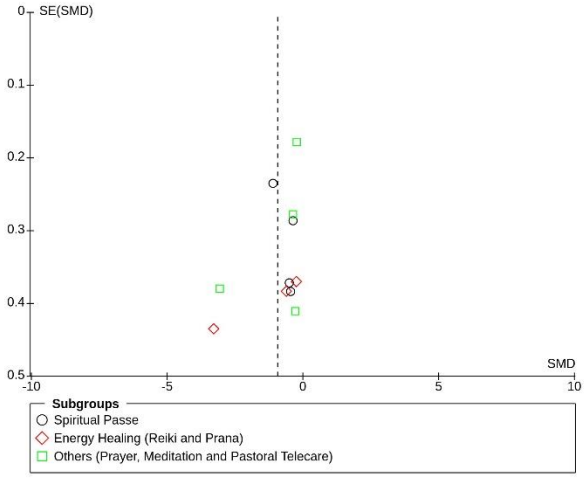
13.14 Appendix 5.4 Figure: Risk of Bias for Studies Included in Effectiveness Based Review



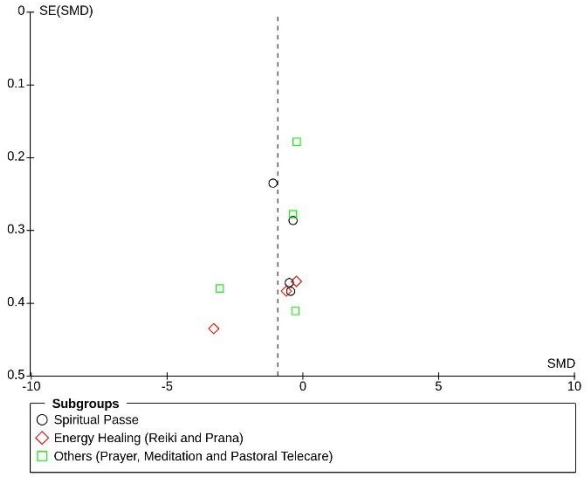
13.15 Appendix 5.5 Figure: Publication Bias for Pooled Effectiveness Estimates for Interventions Provided by Faith Leaders

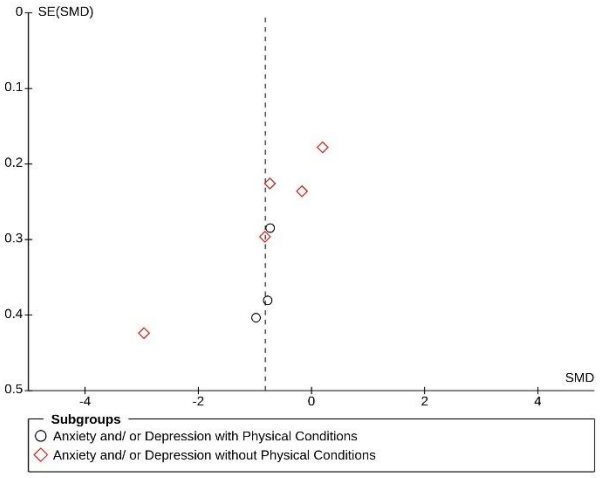
Depression





Anxiety





13.16 Appendix 6.1 Participant Information Sheet for Faith Leaders

We are inviting you to take part in the research. This is an information letter which contains the necessary information you may need to make your decision about participation. It covers the information about the purpose of the research; what someone needs to know or do if he/ she is willing to participate and any possible benefits and disadvantages. You can discuss it with your friends, relatives, and doctor. You can also contact us if you have any further queries (Contact details are given at the end).

What is depression?

Depression is a common mental illness in which a person experiences different symptoms mainly including loss of interest in daily life activities, hopelessness, and sadness. Depression can be treated by medicines and talking treatments in which a healthcare provider talks with person suffering from depression.

What is Behavioural Activation?

Behavioural activation is a brief talking treatment for depression. In behavioural activation, a health care provider without any specialised experience in mental health (such as nurse, lay health workers) talks with an individual seeking help for depression and together they identify the activities which are meaningful and important to that individual. They discuss the possibilities about how that person can participate in such activities and how to keep track of progress. They prepare the plan to engage that individual in such activities, implement this plan, and evaluate the progress.

What is the purpose of this study?

Due to religious and cultural values along with lack of mental health services in Pakistan, people with mental illnesses (such as depression) usually consult religious and community leaders (such as *Imam Masjid, Peer, Sheikh, Mufti* etc.) for treatment. Mental health experts have now recognised that a collaborative approach where both mental health practitioners and faith leaders engage with each other and provide treatment where both are involved in delivery of care are important steps to increase the availability of mental health services. This study therefore aims to take views and perspectives from faith leaders regarding their current practices to identify and manage mental illness (including depression) and regarding talk therapy for depression known as “Behavioural Activation”. The data gathered from this study will be utilised to understand the perspective of faith leaders about their interest to engage with mental health practitioners for delivering behavioural activation to people with depression.

Who is doing the study?

This study is carried out by a PhD student (Mujeeb Masud Bhatti) at department of health sciences, university of York and is currently based in Khyber Medical University, Peshawar, Pakistan. This study will be a PhD dissertation work of the student. This research is supervised

by Professor Najma Siddiqi, who is a psychiatrist and Professor in Psychiatry at department of health sciences university of York. Student is not getting any direct funds for data collection.

Why have I been asked to participate?

We are looking for religious, faith and community leaders *(*such as *Imam Masjid, Peer, Sheikh, Mufti etc.)* who provide informal care to people with mental illness. Religious and community leaders who utilise religious or faith-based strategies (such as prayer, recitation, religious teachings etc.) to manage mental illnesses are eligible for this study. Those faith leaders who utilise some herbal or chemical remedies to manage mental illness are not eligible for this study.

Do I have to take part?

The decision to take part or not in this study is based upon you. We recommend reading this information letter, understand the anticipated advantages, and disadvantages for participating in the study. Discuss it with your friends, relatives or doctors and take decision on your own.

What will be involved if I take part in this study?

If you are willing to participate in this study after reading this information letter, researcher will contact you to arrange a meeting for signing a written consent form and interview. You will have to attend this meeting at Khyber Medical University (if you are living in Peshawar) or Institute of Psychiatry (if you are living in Rawalpindi or Islamabad). Meeting date and timings will be decided as per your convenience and availability. The meeting will start by signing a written consent form, which is a written agreement between researcher and participant. By signing the consent form, you and the researcher are agreeing to terms and conditions relating to your participation. These terms and condition include that you have received enough information about the study, you have given the chance to ask questions, your participation is on voluntarily basis, you are willing to provide access to information you give during interview only to researcher who is conducting the study, interviews will be audio recorded, your information will be kept confidential and will only be published anonymously. During the interview an interviewer will ask questions to gather your perspective and views about your understanding of mental illnesses and depression (a mental disorder including symptoms of sadness, hopelessness, and loss of interest in daily life activities), your methods of managing mental illnesses including depression, your interest to deliver talk therapy and engaging with mental health practitioners. Interviews will take about one hour in the presence of an interviewer who will conduct the interview. Due to Covid 19 restrictions or for some other reasons if we are unable to meet physically, we can arrange a telephonic interview for a meeting if it is possible for you. For telephonic interviews, a soft copy of the written consent form will be emailed to you for your electronic signatures and verbal confirmation (through social networking apps such as WhatsApp). Interview date and timing will be decided on your availability after the researcher receives back the electronically signed or verbally recorded consent. The researcher will call you on the decided date and time and interview will be conducted. Researcher will bear the expenses of the call and the interview will last for about one hour.

What are the advantages or benefits of taking part?

Your participation in the study will help us in developing an understanding of your perspectives towards talk therapy for depression and possible engagement between faith leaders and mental

health professionals. You will have an opportunity to know more about talk therapy and the traditions of identifying and managing depression in formal mental health care.

What are the disadvantages or risks of taking part?

Taking part in the study will require you to visit a research unit or to attend telephonic meetings or meetings at any other place (mosque, faith-based organisation etc.) for interviews which takes time. It may be possible that talking about medical or psychological ways of treatment may be a barrier to express your views openly and potentially be distressing. However, a PhD researcher is trained and has got experience in conducting interviews and will ensure that you will be provided a non-judgemental environment and will ask non-directive questions or topics so you can openly express your thoughts about mental illness grounded in your religious or spiritual views.

Any incentive or stipend for your participation will not be provided, however, we will provide travel costs to you. Travel cost (i.e., 1000/- Pakistani rupees) will be reimbursed in cash on the interview date.

Can I withdraw from the study at any time?

Your participation will be voluntary, and you can quit the study at any time during the interview without giving any explanation. In case after giving the interview, you decide to withdraw your given information, then you can withdraw it within 15 days after the interview date. After 15 days it will not be possible for us to withdraw your given information or data.

How will the information and personal data I give be handled?

The information or data gathered from you during the interview will be audio recorded. The audio recording will be removed from the recorder after checking its audibility and transferring it to the computer. Further the audio recording will be converted into written documents by copying your responses to the questions. Researcher will assign a unique identifying number to your audio recording and your responses in written. The access of your data including identifying information will be only available to PhD researcher and if supervisors need to check or access data then data provided by you will be presented without your identifying information. All your electronic data including recordings and written responses will be stored in an electronic folder. The computer and electronic folders will be password protected. Also, any discussion related to the data in meetings with supervisors will be discussed through identification numbers to ensure confidentiality. The hard copy documents including your consent forms will be placed in a locked cabinet at the research office at Khyber Medical University. The cabinet will be locked if it is not in use by PhD researcher and only PhD researcher will have access to the cabinet. Participants' data will be utilised for study purposes only and confidentiality will be ensured all the time. The information or data provided by you will be kept for 10 years after the study is completed.

What will happen to the results of the study?

The results of the study will be reported in the PhD dissertation, scientific publication, and conferences; however, no personal information of participants will be shared. Results will be reported anonymously with maintaining the confidentiality of the participants. The description of these reports in lay language will be shared with you if you are willing to do so (through emails).

Who has reviewed and approved this study?

This study is approved by University of York's Health Sciences Research Governance Committee and Khyber Medical University Ethical Board.

Who do I contact for more information about the study?

For more information about the study, you can PhD research Mujeeb Masud and can send you queries to email: mmb546@york.ac.uk; Cell no: 00923321947321

Who do I contact in the event of a complaint?

For complaints you can contact following:

1) Professor Najma Siddiqi, Professor, Department of Health Sciences, and University of York (Email: najma.siddiqi@york.ac.uk)

2) Dr. Saima Afaq, Associate Professor, Institute of Public Health, and Social Sciences Khyber Medical University (Email: saima.iph@kmu.edu.pk)

3) Dr. Hannah Jennings, Lecturer, Department of Health Sciences, and University of York (Email: hannah.jennings@york.ac.uk)

Prof Stephan Holland, Chair Health Sciences and Research Governance Committee, Department of Health Sciences University of York, UK (Email: stephen.holland@york.ac.uk)

Thank you for taking the time to read this information sheet.

13.17 Appendix 6.2 Participant Consent Form For Faith Leaders

	Please confirm agreement to each statement by putting your initials in the boxes below
I have read and understood the participant information sheet [Version 1; Date: 11-04-2022]	
I have had the opportunity to ask questions and discuss this study	
I have received satisfactory answers to all my questions	
I have received enough information about the study	
I understand my participation in the study is voluntary and that I am free to withdraw from the study: 1 At any stage during the interview 2 Without having to give a reason for withdrawing 3 However, if I decided to withdraw after the completing interview, I can withdraw my information (provided during interview) within 15 days after the interview date	
I understand that my interview will be audio-recorded	
I understand that relevant sections of the data collected during the study may be looked at by researchers. I give permission for these individuals to have access to my records	

I understand that any information I provide, including personal data, will be kept confidential, stored securely and only accessed by those carrying out the study	
I understand that any information I give may be included in published documents, but all information will be anonymised.	
I agree to take part in this study	
Participant Signature …… Date	
Name of Participant	
Researcher Signature …… Date	
Name of Researcher	

13.18 Appendix 6.3 Topic Guide for Faith Leaders

INTRODUCTION

I am Mujeeb Masud Bhatti, a PhD student at the department of health sciences university of York. I have about four to five years of experience in teaching and research in mental health. I appreciate your willingness to take part in this study. During this interview, I will ask you about your views and thoughts on your current practices for dealing with depression among your attendees. I will also ask you about your views on receiving training on talking treatment (such as behavioural activation) from mental health professionals and to offer talking treatment to those who are attending you to receive care for depression or distress. Stay assured that you will be able to freely express your thoughts based upon your own experiences. These questions are not intended to assess your knowledge or experience in giving support to those who are depressed. The opinions you will provide during the interview will be kept confidential, and only the PhD researcher (or those involved in this research) will have access to them. Your participation in this interview is voluntary, and you can leave at any time during the interview without any explanation. The interview will take about 45 minutes to one hour.

A brief introduction of depression

Depression

Depression is a mental illness in which an individual experiences sadness, hopelessness, and tearfulness. Individual usually loses his/ her interest in normal activities such as job, family matters, studies, and sports. Sleep disturbances, weight loss and loss of appetite are also common symptoms of depression.

Questions related to the training of identification and treatment of depression

a) Have you received the training to recognise depression? Yes/ No
b) Have you received training to manage or treat depression? Yes/ No

(A) Recognition of Depression

(A1) How often have you come across individuals with mental health issues?

(Probes: at your residence, workplace, at mosque, pathways, any informal referral system)

(A2) Tell us about your personal experience while you engage with individuals suffering from mental health issues?

(Probes: Types of mental illness, religious/ cultural terms for mental illness, treatments used for mental illness; ask for example)

(A3) In your opinion, what are the major symptoms/ indicators of depression/ distress?

(Probes: Religious or cultural terms used for depression, reasons of depression, consequences of depression; ask for example)

(A4) How important is it for religious and community leaders to be able to identify potential cases of depression/ distress?

(A5) In your opinion, how can religious and community leaders identify the potential case of depression/ distress?

(A6) Have you identified any potential cases of depression while you are working with patients in your routine practice? Yes/ No

(A7) What procedures do you follow to identify and report potential cases of depression? [*If the answer to the A6 is yes*]

(B) Treatment and Support for Depression

(B1) In your opinion, how important is it to treat depression/ distress?

(B2) In your opinion, how can a faith leader provide support to individuals with depression?

(B3) Are there any treatment/ support available for depression at your place? Yes/ No

(B4) What kind of treatment and support is available? Answer the questions with considering following things:

1. Who delivers the treatment/ support?
2. What do these individuals (with diagnosed depression) are being told to do?
3. Any other support?

Brief Description of Behavioural Activation

A Behavioural Activation (BA) is a psychotherapy/ talk therapy, in which a health care provider talks with an individual suffering from depression about his/ her distress/ depression. In BA, health care providers support an individual with depression to change his/ her unhealthy habits (e.g., sleeping in the daytime, not going to work, not meeting with friends etc.) with healthy habits/ activities (going to work/ university, engaging with family, meeting with friends). It is believed that whenever person becomes active and starts engaging in healthy activities (just like he/ she was involved before depression) can automatically cure depression. Health care workers and patients collaboratively plan activities and an individual with depression tries to perform those activities.

(A) Attitude towards Talk therapy

(A1) What do you think might be the effects of talking with an individual with distress/ depression on their health?

(A2) Are you aware of talk therapy or Psychotherapy?

(A3) In your opinion, what is talk therapy or psychotherapy?

[If respondent has chosen "Yes" for A4]

(B) Attitude towards Behavioural Activation

(B1) What would you suggest to a person if he/ she is suffering from depression/ distress?

(B2) Do you think lack of engagement in daily activities influences depression/ distress?

(How? Why? Any example)

(B3) In which ways, becoming active and involved in activities which make one happy can influence depression/ distress?

(How? Why? Any example)

(B4) Do you think that BA is compatible with the cultural and religious values of Pakistan?

(Probes: Cultural compatibility, Islamic values, Quran, and Hadith)

(C)Potential Barriers and Facilitators in engagement with BA

(C1) Do you think participating in daily life activities becomes difficult for an individual with depression/ distress or not? (Probes: How? Why? Any examples)

(C2) What could individuals with depression be encouraged to do to participate in daily activities?

(C3) Do you anticipate any difficulties associated with delivering BA in the Pakistani context? (Probes: What kind of difficulties, ways to address those difficulties)

(A) Integrating BA into Faith Leaders Practice

(A1) Do you think that religious or community leaders could provide BA to individuals with depression? (Probes: How? Why?)

(A3) What are your opinions if you were given an opportunity to engage with health care professionals for learning BA?

(Prompts: would you be open to learning how to facilitate BA? Why or why not?)

(A4) What are your opinions and thoughts, if you were asked to provide BA to individuals with depression? (Probes: Any support required, infrastructure, training)

(B) Barriers and Facilitators

(B1) What difficulties do you anticipate in providing BA to individuals with depression?

(B2) What can be done to overcome those difficulties while you provide BA during your routine practice?

13.19 Appendix 6.4 Table: Additional Quotes from Interviews with Faith Leaders

Subthemes	Examples of Quotes
Faith Leaders Recognise Depression Through Experience and Intuition	
Subtheme 1a: Assessment based on intuitive judgement	1) These gentlemen are so intelligent, and because of their interaction with the people, they also get a better idea... even by looking at the man in front of them, and their questions suggest that they can give them a much better solution. (Islamic Scholar; Male; Age 30)
Subtheme 1b: Problems presented to faith leaders	2) For example, there is a problem with worship, and affairs, such as divorce, *nikah* (marriage), and *khula* (divorce taken by females). (Islamic Scholar; Male; Age: 30)
Subtheme 1c: Discussing Problems Without Specifying Mental Illness	3) As I speak, it is no longer necessary to mention a mental illness regularly. Rather, they talk about their problems in a way that suggests that person is suffering from a mental illness. (Islamic Scholar; Male; Age: 30)
Subtheme 1d: Signs and Symptoms of Depression	4) See. I think I told you that depression increases with isolation. The more you stay alone, the more you will have it. (Spiritual Leader; Male; Age: 36)
Faith Leaders May Use Psychosocial Approaches Aligned with Islamic History and Cultural Values	
Subtheme 2a: Life is About Facing Struggles	1) Companions [of the prophet PBUH] saw a person struggling for his livelihood and running after his livelihood all day. They asked the prophet PBUH, if he does this struggle for the religion of *Allah* (God), how much reward will he get? Should he do it for the sake of preaching, should he do it for the sake of *Allah* Almighty (God), should he do it for the sake of Islam? The holy Prophet PBUH replied: This is also the worship of *Allah Almighty*. It is not just a matter of preaching and sitting in the mosque, God willing. He is running for the lawful sustenance of his children. *Allah* will also write good deeds in his book of deeds. (Prayer Leader; Male; Age 35)
Subtheme 2b: Activities to Distract People from Distress	2) Like the concept of prayer, when people leave the house and pray, that's why the reward is more. But this is that when you leave home, you will meet people, whatever problems you have in the world, whatever things you have in your mind, you will share them, and somewhere you will get good advice. (Spiritual Leader, Male; Age 40)
Subtheme 2c: Encouraging Dialogue and Communication	3) See, as far as I understand, it is through talking to someone, knowing the problems, and then engaging them in the conversation by talking to them more and getting some clues out of which one can find out what their problem

	is or what is the cause of the problem with them (Islamic Scholar; Female; Age: 27)
Faith Leaders May also Use Approaches Grounded in Metaphysical Explanations	
Subtheme 3a: Company of *Wali Allah* (Friends of Allah)	1) Those words that I wrote, that will not quench the thirst, I am thirsty, water will not fill my stomach. For this, I need to be near the well, near the tube well, near the faucet, and near the cooler. Will have to go. Isn't it? So that's why I am saying the words whatever you use…do not just use words. With the words, he is the right one. Take it and talk then your words will be effective, your words will be useful and will satisfy what is inside the other person. (Spiritual Leader: Male; Age: 50)
Subtheme 3b: Words can be beneficial if they come from *Wali Allah* (Friends of Allah)	2) Those words that I wrote, that will not quench the thirst, I am thirsty, water will not fill my stomach. For this, I need to be near the well, near the tube well, near the faucet, and near the cooler. Will have to go. Isn't it? So that's why I am saying the words whatever you use…don't just use words. With the words, he is the right one. Take it and talk then your words will be effective, your words will be useful and will satisfy what is inside the other person. (Spiritual Leader; Male; Age: 50)
Subtheme 3c: Listening to Spiritual Leader	3) When someone comes, we sit, patiently listen… say okay *Allah* (God) will have mercy, *Allah* (God) will bless you…so let's do this. Or let's do that now… So, it's his mind…from different ways we must end the chaos of his mind…. to be taken out. (Spiritual Leader; Male; Age: 50)
Subtheme 3d: Remembrance of *Allah*	4) They did not even sleep. They spent the whole night in the remembrance of *Allah* Almighty (God). He fasted during the day and lived in the love of *Allah* Almighty (God). (Prayer Leader; Male; Age: 35)
Subtheme 3e: Asking for Allah's Help and Forgiveness	5) Most of the people who contact us, say to us, ask us to tell them about *Dua* (asking for help from Allah) because they have a problem. (Islamic Scholar; Female; Age: 27) 6) So, on top of that I say, and the other thing is to ask for forgiveness throughout the day. That asks for forgiveness. Keep doing it often. So, God willing, a person can get out of these things. (Islamic Scholar; Male; Age: 35)
Subtheme 3f: Recitation of the Quran and Holy Verses	7) At the same time, I talked to them and sometimes I raised them by reciting *surah al fatiha* (Chapter 1 in the *Quran*) or some such *ayat* (Verses in the *Quran*) and then I explained what they had to do to come to worship. (Islamic Scholar; Male; Age: 35)
Subtheme 3g: Controlling Desires to Overcome Depression	8) The treatment in this is to control your desires before going to a *hakim* (traditional physician) or a doctor, to bring our daily routine by *Islamic shariah* (Islamic law). One should limit the things/needs according to his means and the time he has. (Prayer Leader; Male; Age: 60)

Subtheme 3h: Cure Given by Prophet (PBUH)	6) The Messenger of *Allah* (peace and blessings of Allah be upon him) himself told medicines. The prophet PBUH mentioned some components of dates as a treatment for diseases. In the same way, the prophet PBUH has mentioned *kalonji* (Black cumin) as a remedy. (Prayer Leader; Male; Age: 60)
Subtheme 3i: Helping Others	7) When he finished his prayer. So, he sat down next to him. What is your problem, brother? He says, yes, tomorrow is my last day. So, I cannot make any arrangements. I am very poor. He took his hand and took it to his house and gave him the money he needed. The person who was stressed and worried said, as soon as I give him money, my heart was at peace (Prayer Leader; Male; Age: 35) 8) First of all, you should help them. Yes, if they are financially weak, then you should help them, and if they have any family problems, then you should help them and solve them. (Spiritual Leader; Male; Age: 44)
Subtheme 3j: Ignoring the Whispers	9) We suggest that you pay attention to it, if you pay attention to it, do it, it does not matter, but it's satan. He is telling you to do this. So, do not worry about it, do not worry. No problem, tell the satan, well, my prayer is lost, no problem. (Islamic Scholar; Male; Age: 30)
Subtheme 3k: Recognising Mercy and Love *Allah* (God) Has for its Creation	10) That Lord you know everything, it's your creature, and have mercy, bless him… So, he says that I love as much as seventy mothers, He never leaves, mercy must be done, isn't it? (Spiritual Leader; Male; Age: 50)
Faith Leaders and Faith Institutions Frequently Play an Active Role in the Community	
Subtheme 4a: Faith Leaders Role and Connections in Community	1) So, not just for their psychological issues but for their social issues often. (Spiritual Leader; Male; Age: 40) 2) Whether he is a scholar or a preacher, he has a circle of friends within the area in which he is working, if he is related to the people. So, in my opinion, if there is such a relationship, then the problems will come to him automatically, and whatever such problem the man will have, he will be close to him, and he has also taken recognition. (Islamic Scholar; Male; Age: 35)
Subtheme 4b: Role of Darbar (Shrine)	3) People do come because of my *murshid pak* (referring to spiritual leader), the door is open all the time, and many people come. Okay. And people will keep on coming... every 24 hours *darbar* (Shrine) is open to everyone, it is for his creatures. (Spiritual Leader; Male; Age: 50)
Subtheme 4c: Role of Mosques	4) Yes, they approached me in the mosque, one person took his brother to me, and he felt improvement (Prayer Leader; Male; Age: 35) 5) Well, as far as I understand, almost if not 100%, maybe 80-90%, they can help because what is the role of our mosques, not just for the five times prayer and to lock them but mosques have to open whole day. If faith leaders

	understand the problems of the new generation, then people will automatically come towards the mosque. And the third thing is that people trust religious people to solve their problems. (Islamic Scholar; Female; Age: 27)
Faith Leaders' Conceptualisation of Mental Illnesses and Practice can Conflict with those of Formal Healthcare Services	
Subtheme 5a: Cultural and Native Terms for Mental Illnesses	1) Look *Pareshani* (Stress) is used. I think *Zahani Dabao* (mental pressure) and *Pareshani* (Stress) are two words. (Islamic Scholar; Male; Age: 30) 2) They seem to be suffering from whispers. That we have whispers. Whether we are at home, or we are in worship or we are performing ablution, at that time we have whispers, we have this problem, whispering thoughts come to me and I am in these thoughts. (Islamic Scholar; Male; Age: 35)
Subtheme 5b: Perception of the Difference Between Psychiatry and Islamic Values	3) So even on that basis they call it healthy and because of the mental stress it creates they call it... So sometimes from a *shariah* (Islamic law) point of view, somewhere, somewhere, somewhere, it can happen where psychology clashes with Islamic teaching (Islamic Scholar; Male; Age: 30)
Subtheme 5c: Attribution of Mental Illnesses to Heart Rather Than Mind	4) As there is arrogance, there is malice, there is malice and various diseases, there is information, there are different kinds of it, people are engaged in it. So, these are the diseases that are called heart diseases. (Islamic Scholar; Male; Age: 30) 5) Whether it is called a heart disease or a mental disease, as in medicine and spirituality, the heart and the mind have separate diseases, but basically what the *Quran* or Islamic *shariah* (Islamic law) draws attention to is the heart. (Prayer Leader; Male; Age: 60)
Subtheme 5e: Illness and Healing comes with Allah's Will	6) That's it. Where does healing come from, where does illness come from? From where healing comes, there also comes sickness. Okay, fine, *Allah* (referring to God) openly said in the *Quran*, that the leaf does not move without His command. Now after this, if there is anything left, everything is according to His will. (Spiritual Leader; Male; Age: 50) 7) But if there is no order and decision from *Allah* Almighty (God) to heal him, then no medicine in the world can benefit him. (Prayer Leader; Male; Age: 60)
Subtheme 5f: Purification and Satisfaction of the Soul	8) Now this is our body, it is uncomfortable, we will be in a good house, the carpet will be spread, the air conditioner will be on, and we will be relaxed. But there is a soul in it. That soul is not satisfied with these things because this soul does not belong to this earth. This soul belongs to heaven. It is the command of *Allah* (God). It has come from *Allah* (God), so it will find peace

	by getting higher. (Prayer Leader; Male; Age: 35) 9) We worry that if we look in the mirror ten times a day my face should be fine. I would like a haircut. Let me shave my beard. Dude, look beautiful. We do not care if the soul stays inside or not. Because it is invisible to us, and the real thing is the soul. When the soul becomes strong while the body remains injured, broken, destroyed, arms cut off, and legs paralysed the person remains strong. If the soul becomes ill and the body may seem strong, the person will not find peace. (Prayer Leader; Male; Age: 35)
There are Areas of Compatibility and Potential Collaboration with Formal Mental Healthcare Services	
Subtheme 6a: Basic Training and Learning	1) But two things have come to my mind. One thing is that the training of an Islamic scholar can also be put under an innovative field, in which he has three to four months of training. (Islamic Scholar; Male; Age: 30)
Subtheme 6b: Partial Compatibility of Behavioural Activation with Islamic Values	2) Absolutely, it has a very close connection with Islamic culture. However, one should be careful not to be guided by things that conflict with the *shariat* (Islamic law). Meaning that, while guiding him, no vulgar type of things should be told to him. (Prayer Leader; Male; Age: 60)
Subtheme 6c: Convincing Faith Leaders Through In-group Interaction	3) The problem is that with us, no one will agree on what is happening outside until the people inside tell them. It will not happen. Yes, if those people bring them from this category, they should be agreed first, then that can be so much more effective. (Islamic Scholar, Male; Age: 41)
Subtheme 6d: Difficult to Interact with Opposite Gender	4) It is obvious that when there is a male attending us, there is no problem, but in the case of a female, we may face a little problem while treating them. We keep ourselves a little bit on the backup, those who are patients, it is obvious that they say, we are patients, but we can have a little trouble in this matter… Neither the screen nor the curtain can be too much. (Islamic Scholar; Male; Age: 35)
Subtheme 6e: Openness Towards Medical-Based Treatment	5) But these mentions never become an obstacle in the way of medicine, they do not mean that medicine should not be used. Whatever is the medicine for the disease, one should take and whatever is the treatment, one should go for that. (Prayer Leader; Male; Age: 60)
Subtheme 6f: Faith Leaders Connections with Healthcare Professionals	7) We have many psychologists, so we keep in touch with them and discuss with each other (Spiritual Leader; Male; Age: 44) 8) I have doctor friends who sometimes tell us that when people come to us with strange diseases, we think that this person will not be able to recover from this disease (Islamic Scholar; Male; Age: 41)

Subtheme 6g: Role Compatibility of Non-Famous Spiritual Leaders	9) Not with famous *peer* (famous spiritual leaders) but with non-famous people. Let them sit with a psychologist. (Islamic Scholar; Male; Age: 30)
Subtheme 6h: Serving Humanity on a Volunteer Basis	11) I am ready to do anything for humanity, for the sake of *Allah* (God). If anyone's illness, any problem, any suffering is removed because of me, then I am present 24 hours a day. And for the sake of Allah. I have been doing it till today. (Spiritual Leader; Male; Age: 36) 12) See that the disciples who come to their *peer* (Spiritual leader) learn quickly, they come quickly to their routines. Or in general. The reason for this is that they do not have a financial aspect here (Islamic Scholar; Male; Age: 30)
Subtheme 6i: Willingness for mutual learning	13) Its course training (three to four months, year-round training) should be developed so that if they are seated with a psychologist or psychiatrist, they will also be trained at the same time. So, a combination can be made. (Islamic Scholar; Male; Age: 30) 14) God willing, I will do it for him, and I will do it with great enthusiasm (Islamic Scholar; Male; Age: 35)
There are also Potential Barriers Associated with Collaboration	
Subtheme 7a: Burden of Responsibilities	1) Because the point is that the scholars already have their responsibilities and there is so much art and so much pressure on them that they do not have the patience to teach more and more. (Islamic Scholar; Male; Age: 30)
Subtheme 7b: Faith Leaders Take Religion as Business	2) Man, I am sad to say that in my opinion, unless you tell the religious leaders what they are getting in return, they will not be ready. Because they are doing business, they will take money for the time they invest. (Spiritual Leader; Male; Age: 40)
Subtheme 7c: Lack of Awareness of Medical Terms	3) The term (referring to medical terms or conditions) is sometimes completely ignored, and his symptoms are put in front of him. For example, he says that this is happening to me, it happens to me no matter how frequent it is or how intense it is, if the terms are not familiar to them. (Islamic Scholar; Male; Age: 30)
Subtheme 7d: Silence about problems in religious people	4) Good. I think my work is good. Is it among the religious people or is it in the religious circle, the biggest problem for me is that most of our religious people say that we have only asked and said to *Alla*h (God), and *Allah* (God) will solve our problems. They did not want to tell their story openly; they did not want to disclose to anyone else that there was a death of a child in our neighbourhood, but his family was also crying they did not say that their brother told us loudly. (Islamic Scholar; Female; Age: 27)
Subtheme 7e:	5) If there is something I do not understand or if I have some doubts. So, I have something in my mind by asking them (doctors), for example, whether

Resistance to Learn from Healthcare Professionals	it is true or not, I can understand it by asking them (doctors). What happens now is that sometimes many scholars do not feel the need for it (Islamic Scholar; Male; Age: 30) 6) It is obvious that they will not be ready to come as a student or as a trainee or as a learner. (Islamic Scholar; Male; Age: 41)

13.20 Appendix 7.1 Participant Information Sheet for Attendees of Faith Leaders

We are inviting you to take part in the research. This is an information letter which contains the necessary information you may need to make your decision about participation. It covers the information about the purpose of the research; what someone needs to know about participation in this study and any possible benefits and disadvantages. You can discuss it with your friends, relatives, and doctor. You can also contact us if you have any further queries (Contact details are given at the end).

What is depression?

Depression is a common mental illness in which a person experiences different symptoms mainly including loss of interest in daily life activities, hopelessness, change in appetite (eating less or too much) and sadness. Depression can be treated by medicines and talking treatments. In talking treatment, a healthcare provider talks with a person suffering from depression.

What if I am already taking services for depression or any other mental or physical problems?

If you are taking any treatment for a mental or physical problem, we advise you to keep taking that treatment as advised by a physician or doctor. Also, if you want you can discuss your participation in this study with your physician or doctor.

What is Behavioural Activation?

Behavioural activation (BA) is a brief talking treatment for depression. In behavioural activation, a health care provider without any specialised experience in mental health (such as nurse, lay health workers) talks with an individual seeking help for depression and together they identify the activities which are meaningful and important to that individual. They discuss the possibilities about how that person can participate in such activities and how to keep track of progress. They prepare the plan to engage that individual in such activities, implement this plan, and evaluate the progress.

What is the purpose of this study?

People with mental illness, such as depression, sometimes seek the help and support of faith leaders (such as the Mufti, Peer, Sheikh, Imam Masjid, etc.) to manage their mental illness. Research suggests that support provided by faith leaders is meaningful and helpful for some people however, the evidence of such support in reducing mental illness is still unclear.

Low-income countries (such as Pakistan) have less numbers of trained mental health care providers. In this context, mental health experts have developed talking treatments that can be provided by someone without any specialised training in mental health (Such as nurses, lady health workers, community volunteers). BA is one of the talking treatments for depression which can be provided by someone without any specialised mental health training. Research from different parts of the world have suggested that BA reduces the symptoms of depression.

This research aims to explore how people who seek the help of faith leaders for depression think and feel about getting talking treatments like BA from faith leaders. This study will also explore the recent experiences of such people while visiting faith leaders for depression. The findings from the study will help us to understand the possibility of collaborating with and training faith leaders on BA for depression.

Who is doing the study?

This study is carried out by a PhD student (Mujeeb Masud Bhatti) at the Department of Health Sciences, University of York, who is currently based at Khyber Medical University, Peshawar, Pakistan. This study will be a PhD dissertation work of the student. This research is supervised by Professor Najma Siddiqi (Psychiatrist and Professor in Psychiatry at department of health sciences university of York), Dr. Hannah Jennings (Lecturer at department of health sciences university of York) and Dr. Saima Afaq (Assistant Professor at Public health and Social Sciences department, Khyber Medical University, Peshawar). PhD student is not getting any direct funds for data collection.

Why have I been asked to participate?

We are looking for the participants who are appropriate for the purpose of the study including individuals diagnosed with depression and have attended any faith leader in recent six months.

Do I have to take part?

The decision to take part or not in this study is based upon you. We recommend reading this information letter, understanding the anticipated advantages, and disadvantages for participating in the study. Discuss it with your friends, relatives or doctors and make decisions on your own. If you have any further questions regarding your participation after reading this letter you can contact us. Contact details are given at the end.

What will be involved if I take part in this study?

If you are willing to participate in this study after reading this information letter, researchers will contact you for signing a written consent form and for an interview. You will be invited to take part in an interview at a place and time that is convenient to you. In case, if an appropriate place where the researcher can approach you for an interview is unavailable, you can visit Institute of Psychiatry (if you live in Rawalpindi or Islamabad) on Monday to Friday between 9AM to 5PM depending upon your convenience. Travel reimbursement will be provided to those who will visit research sites. We advise you to keep receipt of your travel record (including amount of travelling) or use online Apps (such as Careem or In-driver) for travelling. In case you don't use such Apps, you can contact a researcher who can arrange your travelling at timings convenient for you (Contact details are given at the end).

Due to Covid 19 restrictions or for some other reasons if we are unable to meet physically, we can arrange telephonic interviews or video conferencing if it is possible for you. For telephonic interviews or video conferencing, a soft copy of the written consent form will be emailed to you for your electronic signatures or verbal confirmation (through social networking apps such as WhatsApp). Interview date and timing will be decided on your availability after the researcher receives back the electronically signed or verbally recorded consent. The researcher will call you

on the decided date and time and interview will be conducted. Researcher will bear the expenses of the call and the interview will last for about one hour.

The interview will start by signing a written consent form, which is a written agreement between researcher and participants. By signing the consent form, you and the researcher are agreeing to terms and conditions relating to your participation. These terms and condition include that you have received enough information about the study, you have given the chance to ask questions, your participation is on voluntarily basis, you are willing to provide access to information you give during interview to researcher who is conducting the study, interview will be audio recorded, your information will be kept confidential and will only be published anonymously. During the interview meeting, an interviewer will ask questions to gather your recent experiences while attending faith leaders and your preferences on receiving talking treatment from faith leaders. Interviews will take about one hour in the presence of an interviewer who will conduct the interview.

What are the advantages or benefits of taking part?

Your participation in the study will help us in developing an understanding of perspectives and experiences of attending faith leaders for depression and possible collaboration between faith leaders and mental health professionals. This information can possibly be used to develop talking treatment for depression that can be delivered by someone who is not a mental health specialist such as faith leaders. It will further help to increase the availability and accessibility of quality care to people with depression. Please note that this study does not guarantee that we will be able to develop such talking treatment and that it will be beneficial for people with depression. It will be largely dependent upon findings obtained from this study and some other studies. It will only be possible if people with different cultural backgrounds think that it is aligned with their cultural, social, and religious preferences.

What are the disadvantages or risks of taking part?

Taking part in the study will require you to attend a face to face meeting or to attend a phone call or video conferencing for an interview which takes time. Also, it is sometimes distressing and difficult to respond to questions during an interview.

In case, if you feel that you are feeling distress during the interview, we can suggest you avail free specialised mental health facilities in Rawalpindi/ Islamabad if you want to seek professional help.

If you are living in Rawalpindi or Islamabad, you can visit Institute of Psychiatry (IoP) at Benazir Bhutto Hospital (BBH) located near Chandni Chowk, Murree Road Rawalpindi. Outpatient facilities facilitated by trainee and consultant psychiatrists and psychologists are available from Monday to Thursday (9 AM to 2 PM).

Any incentive to the participant will not be provided, however, only travel expenses for participants to visit research sites will be reimbursed to the participants on interview day.

Can I withdraw from the study at any time?

Your participation will be voluntary, and you can quit the study at any time during the interview without giving any explanation. In case after giving the interview, you decide to withdraw your

given information, then you can withdraw it before your given information is analysed. The analysis is expected to start 15 days after interview date therefore, you can withdraw your data within 15 days after interview date.

How will the information and personal data I give be handled?

The information or data gathered from you during the interview will be audio recorded. The audio recording will be removed from the recorder after checking its audibility and transferring it to the computer. Further the audio recording will be converted into written documents. Personal information will be removed before information/ data storage. The access of your data including identifying information will be only available to PhD researcher and if supervisors need to check or access data then data provided by you will be presented anonymously. All your electronic data including recordings and written responses will be stored in an electronic folder in the personal computer (PC) of the PhD student. The PC will be password protected. The hard copy documents including your consent forms will be placed in a locked cabinet at the research office at Khyber Medical University. The cabinet will be locked if it is not in use by PhD researcher and only PhD researcher will have access to the cabinet. Participants' data will be utilised for study purposes only and confidentiality will be ensured all the time. The information or data provided by you will be kept for 10 years after the study is completed.

What will happen to the results of the study?

The results of the study will be reported in the PhD dissertation, scientific publication, and conferences; however, no personal information of participants will be shared. Results will be reported anonymously with maintaining the confidentiality of the participants. The description of these reports in lay language will be shared with you if you are willing to do so (through emails).

Who has reviewed and approved this study?

This study is approved by University of York's Health Sciences Research Governance Committee and Khyber Medical University Ethical Board.

Who do I contact for more information about the study?

For more information about the study, you can contact PhD research Mujeeb Masud and can send you queries to email: mmb546@york.ac.uk

Who do I contact in the event of a complaint?

For complaints you can contact following:

1) Professor Najma Siddiqi, Professor, Department of Health Sciences, and University of York (Email: najma.siddiqi@york.ac.uk)

2) Dr. Saima Afaq, Associate Professor, Institute of Public Health, and Social Sciences Khyber Medical University (Email: saima.iph@kmu.edu.pk)

3) Dr. Hannah Jennings, Lecturer, Department of Health Sciences, and University of York (Email: hannah.jennings@york.ac.uk)

4) Prof Stephan Holland, Chair Health Sciences and Research Governance Committee, Department of Health Sciences University of York, UK (Email: stephen.holland@york.ac.uk)

Thank you for taking the time to read this information sheet.

13.21 Appendix 7.2 Participant Consent Form for Attendees of Faith Leaders

	Please confirm agreement to each statement by putting your initials in the boxes below
I have read and understood the participant information sheet [Version 1; Date: 20-10-2022]	
I have had the opportunity to ask questions and discuss this study	
I have received satisfactory answers to all my questions	
I have received enough information about the study	
I understand that if I am currently taking treatment for depression, I am advised by researcher to continue this treatment	
I understand that participating in interviews may be upsetting	
I am informed about the freely available mental health services in my locality	
I understand my participation in the study is voluntary and that I am free to withdraw from the study: a) At any stage during the interview	

b) Without having to give a reason for withdrawing c) However, if I decided to withdraw after the completing interview, I can withdraw my information (provided during interview) within 15 days after the interview date	
I understand that my interview will be audio-recorded	
I understand that data collected during the study will be mainly handled by PhD researcher or may be looked at by supervisors and examiners. I give permission for these individuals to have access to my records	
I understand that any information I provide, including personal data, will be kept confidential, stored securely and only accessed by those carrying out the study	
I understand that any information I give may be included in published documents, but all information will be anonymised	
I agree to take part in this study	
Participant Signature …… Date	
Name of Participant	
Researcher Signature …… Date	
Name of Researcher	

13.22 Appendix 7.3 Topic Guide for Attendees of Faith Leaders

Introduction

I am Mujeeb Masud Bhatti, a PhD student at the University of York's Department of Health Sciences. I have about four to five years of experience in research and teaching in the field of mental health. Thank you for your interest and time to join this study. During this interview, we will explore your thoughts and experiences regarding your previous interactions with faith leaders for mental health support, as you told earlier. We will also discuss your views on receiving support from both faith leaders and medical/ healthcare professionals, including doctors and psychologists. Our discussion remains confidential and will be accessible only to me (or those involved in this research). Your participation is voluntary, and you can withdraw at any point without the need for an explanation. If you find the interview distressing, please pause or stop it. The duration of this interview will be approximately 45 minutes to one hour.

Section A

A brief introduction to depression

Depression is a mental illness in which an individual experiences sadness, hopelessness, and tearfulness. The individual usually loses his/ her interest in normal activities such as jobs, family matters, studies, and sports. Sleep disturbances, weight loss and loss of appetite are also common symptoms of depression.

1. I am interested to hear about your experiences and your perspectives. Please tell me about how you came to know you had depression.
2. Can you tell me about your understanding of depression and what depression is for you?
3. Tell me about your experiences and from where you took help. (Probes: duration, trigger event, treatment, family support, any other support)
4. Tell about your experience with your visit to a faith leader during depression. (Probes: Why attended faith leaders; who referred; place; type of faith leader)
5. In your opinion, what is the role of faith leaders? (Probes: their role, meaning, importance)
6. Do you prefer certain types of faith leaders? If yes, why? (Probes: Islamic scholar, spiritual leader, imam; famous vs. non-famous)
7. What were your expectations from faith leaders? (Probes: treatment, advice, discussion, religious matters, activities in life)
8. Did the faith leader you attended identify that you had depression? If yes, how?
9. How did the faith leader you attended support you? What were you told to do? (Probes: communication/ discussion; prayer; day night supplications; recitation of holy verses)
10. What are your opinions about the readiness, preparedness, and training of faith leaders to support people with depression?
11. How do you differentiate between the support you received from faith leaders and the support you received from doctors/ psychologists/ psychiatrists at the hospital?
12. How helpful was the support you received from faith leaders in managing depression?

Section B

A Brief Introduction to Behavioural Activation

Behavioural activation is a brief talking treatment for depression. In behavioural activation, a healthcare provider without any specialised experience in mental health (such as a nurse or lay health worker) talks with an individual seeking help for depression. Together, they identify the activities that are meaningful and important to that individual. They discuss the possibilities of how that person can participate in such activities and how to keep track of progress. They prepare the plan to engage that individual in such activities, implement this plan, and evaluate the progress.

1. What are your opinions and thoughts about talk therapy? (Probes: personal experience, examples, behavioural activation)
2. How do the things you do impact how you feel? (Probes: daily activities, job, study, household activities, religious activities)
3. Do you think that behavioural activation can be a good option to treat people with depression? If yes, how? (Probes: cultural values, religious values)
4. If we give you the opportunity to select a person from the following list who will provide you with behavioural activation, what will be your choice, and why?
   a) Healthcare professionals; b) Faith leaders
5. What are your opinions if you are asked to receive behavioural activation from faith leaders? (Probes: Any difficulties, challenges, facilitators)
6. Any other thoughts?

13.23 Appendix 7.4 Table: Additional Quotes from Attendees of Faith Leaders

Theme 1: The dynamics of talking in faith leaders' settings	
Subtheme 1a: Faith leaders listening to people's problems and giving advice	1) No nothing else he (referring to the faith leader) did not even do any *dum* (Blowing recitations) on me just ask me about my condition. He asked me how much better I was feeling I told him *shukar alhamdulillah* (Thankful to God) its 50% to 60% better (P005; age 50, female)
	2) No, I never took *wazeefa* (supplications) from him. He just gives good advice (P013; age 43, male)
Subtheme 1b: Reluctance to speak to/ share problems with faith leaders	3) Even when I am at home I do not feel good if someone talks to me without my approval (P001; age 50, Female)
Subtheme 1c: Role of gender in interacting with faith leaders	4) Also, the things that I can easily share with a male I can't with a female. (P011; male)
Theme 2: Diverse and conflicting understanding of depression	
Subtheme 2a: Adequate awareness with symptoms and reasons of depression	1) I cannot sleep properly. There are thoughts that come around so I cannot get good sleep. These thoughts do not come but still they are present. (P002; age 32, male)
	2) Depression as I understand, the symptoms and causes of depression that I had I feel like when someone gives their best for something but still if the person experiences failure and then the person breaks from inside that I tried my best but still I failed this makes a person tensed and in psychological distress. (P010; male)
	3) It's like that a lot of thoughts come to my mind… I mean my body is not well. I feel pain in my bones, my stomach is also upset a lot, I feel pain in my muscles as well, the thoughts I want to end I feel like that thought is causing worry for me that thought comes again and again itself and I can't control it. So now as you are living in this life like this, I also used to work but now the situation is that…. it's a disease. (P012; age 30, male)
Subtheme 2b: Competing and complementary explanations of problems and mental illnesses	4) It happens because of the forest as there are paranormal entities present there these things get along with a person it attaches to them. (P002; age 32, male)
	5) All of them said I have been possessed, someone has done magic on me or have put amulets in a graveyard etc. Everyone had their own story. (P003; age 40, female)

	6) All I was told about was that I have an evil spirit, magic, possession etc. recite *surah jin* (Chapter no. 72 in Quran) forty-one times so that the evils can be repent. Went to another one who also told me something to recite. I did everything but nothing really helped. (P003; age 40, female)
	7) Some *peer* (Spiritual leaders) used to say someone had done magic on me, some said its *jinn* (Demon/ creature made of fire according to Islamic beliefs), some said its *saya* (Evil shadow) and all. I remained in the same condition… no matter which *peer* (Spiritual leader) I visit they say that she has *taweez* (Effects of amulet) or *jaddu* (Magic) on her, its *jinnat* (Demon), its *saya* (Evil shadow) this is what they say. (P006; age 33, female)
	8) No, as I told you I went to [Name of faith leader] but he did not tell me about depression or any other psychiatric issue. He only told me that it's *asraat* (Effects of possession) and *jaddu* (Magic). And he said that whenever something happens to you, you should recite *azkaa*r (Supplications). (P010; male)
	9) So, he told me that someone had tried to make things difficult for me and I will briefly say that may Allah and prophet PBUH be kind to you (help you). (P011; male)
	10) Yes, people suggest that maybe it can be magic, so they take you. (P013; age 43, male)
Theme 3: Traditional and faith-based orientation and practices	
Subtheme 3a: Faith based practices by faith leaders suggested to people	1) Yes, he (referring to the faith leader) says to offer *namaz* (Prayer). He does offer prayers and says a lot of other things too, he has very nice stuff to say nothing bad. He just says that I get well. (P001; age 50, female)
	2) The *peer* (Spiritual leader) I went to tells me to pray, do decent work, help other people, and do not make anyone worried from your acts. (P002; age 32, male)
	3) So, he did his *hisab kitab* (calculations that usually faith leaders do, using their knowledge) and told us that this is the problem. So, when I took his amulets in six seven days, I got a lot better, I used to get up and work as well but then my condition was like it used to be. Then he said that my issue is severe and for this I need his 5 to 6 months course of *dum darood* (Blowing recitations) and *chilla* (a committed worship for 40 days) then I will get completely healthy……. he just gave me *taweez* (Amulets) to drink by mixing in water and some amulets are for burning after revolving around body there are some of black colour that I use at night and remove during daytime, like this he told me to keep pulses or sugar or amulets under my pillow he used to say its *sadqa* (Charity or sacrifice in Islam). And then *sadqa* (Charity in Islam) of 3 hens after revolving around my head and then sacrificing them and throwing them in graveyard every

	night, and then these amulets he also told to throw in graveyard or water. (P005; age 50, female)
	4) These days…. I got a *taweez* (Amulet) from my village. I am wearing that and *dum* (Blowing recitations) my father and asked a person in the mosque to do *dum (*Blowing recitations). (P007; age 25, male)
	5) Advice… when we swear our allegiance, they (Faith leaders) do give advice to pray on time regularly. (P008; age 53, female)
	7) Yes, mostly they have said to do *zikar* (recitations and supplications), mostly they did treatment for children (referring to bearing children) suggested to drink some water to both of us (Husband and wife). Even they did not suggest *azkaar* (recitations and supplications) or *namaz* (Prayers) that much mostly it was *taweez* (Amulets). I mean they should have suggested to pray with *azka*r (recitations and supplications) but no. Just gave *taweez* (Amulets) for drinking to drink for certain number of days. (P009; age 36, female)
	6) So, there he gave me water to drink, *taweez* (Amulet), oil that I had to apply on my forehead. And *dum water* (Blessed water) that he told me not to drink too much. I had to drink it in small quantities in the morning and evening and apply it on my face. He told me that he will do *Istikhara* (A type of prayer where an individual prays to God to show him the right path in future) that is the *sunnah* (tradition of prophet PBUH) and then in the morning will prepare things for me if needed. (P011; male)
	7) They (Spiritual leader) see that, they write your name, your mother's name and do some calculations if there is a problem, they tell you that there are *asraa*t (Effects of possession) or *jinnat* (Demons/ creatures made of fire according to Islamic beliefs) whatever it is. They give *dum* water (Blowing recitations on water) to drink so this is their method. (P012; age 30, male)
	8) Yes, they gave *wazaif* (Recitation of Quranic verses) like *astaghfar* (Repentance) and *darood shareef* (Sending prayers and peace on prophet PBUH). Yes mostly *azkaar* (Supplications). (P012; age 30, male)
	9) No nothing if someone asks then he gives *Qurani ayat* (Quranic verses) otherwise not. (P013; age 43, male)
Subtheme 3b People tend to practise faith on their own to get cure	13) Umm… I mean I read *Surah Rehman* (Chapter no. 55 in Quran) and I feel a lot better with this, but the medicines given by doctors for depression help in elevating my mood. (P006; age 33, female)
	14) The best thing is to pray for yourself by cleaning yourself and doing self-care. Take proteins, eat healthy but these things become expensive, financial support is important. I am saying these things but it's difficult to practise. (P011; male)

Subtheme 3c Faith in Allah (God)	15) Yes, before I used to feel better, but it was from Allah, He used to open doors for help but not this time. But Allah had helped before and still he is the one who will help. (P012; age 30, male)
Theme 4: Divergent views on faith leaders' practices	
Subtheme 4a Differing perceptions on effectiveness of faith healers' practices	1) No no I did not have any of this preference. I never had this thought. I told my son to take me to a hospital as I did not have this belief that anyone can do this type of thing on me. So, I used to say son take me to hospital. I do not have any spiritual issues, it's because of depression. But the medicines I got from the complex did not have any effect on me but then the *dum darood* (Blowing recitations) influenced me and I got better. (P005; age 50, female)
	2) It's just all this I have told you. I go for the *dum* (Blowing recitations) when my condition worsens, it gets a little peaceful, so I feel maybe it's better when I go for the *dum* (Blowing recitations). (P001; age 50, female)
	3) *Dum maulvi sahab* (Prayer leader) did helped me a lot s*hukar alhamdulillah* (Thankful to God) but the feeling of uneasiness in crowd and sweating this does not get better with *dum* it only gets better with medicine of depression. (P005; age 50, female)
	4) I mean they should have suggested praying and *azkar* (Recitations and supplications) but no. Just give *taweez* (Amulets) for drinking for a certain number of days. So, I have seen that there is no purpose, they also write *Allah's kalam* (Quranic verses) and we should pray and recite ourselves that is better. We spend so much money visiting these people but there is no gain, rather it's better to pray to *Allah* (God) yourself. So, I believe it's better if *Allah* (God) is watching. He knows what my intentions are while talking to someone. (P009; age 36, female)
	5) I felt more better better due to *peer sahab.* (Faith/ Spiritual leader) (P013; age 43, male)
Subtheme 4b In between trust and distrust on faith leaders	6) It's in our belief, they do, and that person gets better and that's why we tell them what they say about any desire to fulfil, the charities that we are advised to give we fulfil that charity we keep them happy by fulfilling their commands. (P002; age 32, male)
	7) Umm…. no, I do not know… there are different types of *peer* (Spiritual leaders) and I have seen weird scenarios so in a way I have no faith left on these *peer* (Spiritual leaders). Now I have started taking medicines till now my family says to stop using medicines, but I say that when I am getting better with medicines so at least it's working somehow. (P006; age 33, female)

	8) There are few *peer* (Spiritual leaders) who are good, they respect women, but I have seen many who are ignorant…. They are greedy for money. (P006; age 33, female)
	9) No all people from my village go there, he is a very powerful *peer* (spiritual leader) whatever he says. When my sister visited him, my condition was severe, so she cried she said… even we sister swear our allegiance there. (P008; age 53, female)
	10) I do not trust any other *peer* (Spiritual Leader) …. I say that Allah is the highest, no one is beyond him……. I do not say that they are not very knowledgeable (referring to faith leaders) now a days where ever you see there are many famous like *data darbar* (Famous shrine in Lahore) in Lahore and as in Rawalpindi there is *eidgah shareef* (Famous shrine in Rawalpindi) I mean other than this when people say that go to a village I do not believe this, I believe in them because its *data darbar* (Shrine) or *eidgah shareef* (Shrine) and other higher status *darbars* (Shrine) but other than these I do not believe in these…… These *peer* (Spiritual leaders) cannot do anything unless a person is not in the right state of mind, otherwise the whole world should leave doctors and visit these people. I mean everyone must spend their lives with those diseases that are written in their fate, I do hear that people get cured by visiting these people, but that cure is from Allah only. (P009; age 36, female)
	11) My expectations are that they (Referring to faith leaders) should give us guidelines from religious point of views and that they lead us to the path of prophet Muhammad PBUH, and the path of other prophets and *sahabas* (Companions of Prophet Peace Be Upon Him). They help us by keeping us away from the path of *gumrahi* (Wrong path) and will lead us to the right path. (P010; male)
	12) I believe that prayer and Quran is a good thing but following them (referring to faith leaders) the person gets trapped. (P011; male)
Theme 4c Faith leaders' engagement in volunteer and charity work	13) He sits for three days a week, and he distributes *langa*r (Free food for all who come) to 100 or 500 people. No one does this as much as he does. (P013; age 43, male)
	14) They (Faith leaders) also do not take money if anyone gives, they can otherwise they do not take. They also give *langar* (Free food). So, I think he is better. According to my understanding, doctors are also good. (P013; age 43, male)
Theme 4d: Safety and privacy issues reported by people attending faith leaders	15) Then he (referring to the faith leader) wrapped a bandage on my head and started treating me, but I did not feel any better. Now coming to second number, it was a treatment there was an old man (referring to faith leader), he said that I must take bath and have to wrap a white shawl around body other than that there was water on which he did dum (Blowing of recitations) (P008; age 53, female)

	16) I went there and there were a lot of women sitting there that day and I went there and sat. She (referring to a woman faith leader) asked what's wrong with you. I said that I cannot sleep and…. depression like state and she said that if you are unable to sleep then get married you will get such peaceful sleep that you will say that I am unable to get time to sleep. So there were so many women sitting there and they all started laughing and I… I felt so embarrassed that I wanted the earth to open so that I could hide in it. I felt too much… I was hurt, too much hurt that I cannot tell. So, and my tears started to feel like I started crying. When I came back my condition was too bad…. Too bad everyone asked what happened to you, but I did not share with anyone what happened to me, only my sister-in-law… only she knew that this had happened as she was with me. From that day till now I cannot get this incident out of my heart that how in front everyone they have insulted me so much (P006; age 33, female)
Theme 5: Contesting positions on treatment preferences	
Subtheme 5a Preference for bio-medical professionals and care	1) I do not have much experience, but I would say psychologists are much better than faith leaders. If we want therapy, it should be from psychologists not from them. (P004; age 58, female)
	2) Doctor because …the things *mufti* (Islamic scholars) tells me make me angrier. Because these things (patient is referring to the demon) become irritated if *mufti* (Islamic scholars) says anything. So, doctors are better if the problem is depression. Whatever they tell it gives peace to my heart that this will make me better whatever they are suggesting. (P005; age 50, female)
	3) Back then I used to depend on these *peer*s (Spiritual leaders) but now I do not, now I say that doctors give good advice whatever they say. (P006; age 33, female)
	4) Patient: I visit *maulvi sahab* (Prayer leader) for *dum* (Blowing recitation) …. I do not understand this, I prefer to take medicine. Interviewer: So according to you which is better? Patient: Doctor is better.
	5) Psychologically… doctors can do this well. As I told them *peers* (spiritual leader) do not have this, they can only do *dum* (Blowing recitations) and give *dua* (Prayers). (P008; age 53, female)
	6) Religious leaders do not use talk therapy; they just suggest recitation. And talk therapy is provided by a psychiatrist so I will choose doctors in this regard. (P010; male)
Subtheme 5b	7) If someone is good, a *peer* (Spiritual leader) so I will say ok he can guide me well, and doctors I also do not say that they are not good as they are well educated. (P009; age 36, female)

Importance of both spiritual and medical	8) I believe if medical treatment and *dum darood* (Blowing recitations) both go side by side, it's better. (P012; age 30, male)
	9) Spiritual and doctor's treatment both are important. (P013; age 43, male)
Subtheme 5c Perceived effects of medicine	10) About the doctor, it's just that they give me medicines and I keep sleeping. (P001; age 50, female)
	11) No, no one told me my daughter herself checked from a few places that my mother has this condition. We took her to doctors to give her medicine as well but it's not getting better, like day by day my condition was getting worse. Problem was too much. I was also getting weak. (P005; age 50, female)
	12) At that time no medication was benefiting me, anyway, I went for *dum* (Blowing of recitations) and I felt a bit better. Then I got better for a while then I got sick again. (P012; age 30, male)
Theme 6: Family and Tradition Influence on Help-Seeking Behaviour	
Theme 6a Ancestral ties with faith leaders	1) My peer (Spiritual leader), he is our *peer* (Spiritual leader) from the times of our ancestors. My maternal family used to go there, so my mother knew about him. My father also went there so we went. (P013; age 43, male)
Theme 6b Family pressure for visiting faith leaders	2) Interviewer: so, who took you to the *peer* (Spiritual leader) Participant: My father used to take me (P012; age 30, male)
	3) Interviewer: Ok tell me what was the reason that you got these *taweez* (Amulet) made for yourself? Patient: Father made me wear these. (P007; age 25, male)
	4) Sometimes, I used to say, sometimes family insisted, sometimes they used to get fed up, sometimes I used to get fed up I could not understand. (P011; male)

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