Mindfulness and Black, Asian and Minority Ethnic (BAME) Muslims: Exploring the Intersection of Culture, Religion and Mental Health

Sadjia Nesrine Nasseur

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School of Health and Social Care

University of Essex

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Research Summary

Aims: To explore the religio-cultural experiences of Black, Asian and Minority Ethnic (BAME) Muslims who have participated in Mindfulness-based interventions (MBIs). The study also sought to explore the acceptability of MBIs based on participants' religio-cultural experiences.

Background: Despite the increasing popularity of MBIs, previous research has shown that participants rarely come from BAME backgrounds (Bignall et al., 2019). Moreover, research has primarily focused on quantitative outcome-based studies neglecting qualitative experiences (DeLuca et al., 2018). Although some qualitative research is emerging, there remains a need to explore the experiences of BAME Muslims (Thomas et al., 2017).

Methodology: A critical realist research paradigm was used to explore participants' religio-cultural experiences qualitatively. Semi-structured interviews were utilised with a purposive sample of 10 self-identified BAME Muslim adults. All participants had completed an MBI in the UK.

Results: A reflexive thematic analysis was used to develop five themes and 16 sub-themes: "Mindfulness Has Been Colonised."; "It's [Mindfulness] Ingrained In our Religion."; "Islam is not [Always] Practiced Mindfully"; "You Can't Separate Culture and Religion"; Transformative Mindfulness When "Life Was Upside Down". These themes shed light on the unique religio-cultural experiences of BAME Muslims and highlight the importance of considering the religio-cultural context in the design and delivery of MBIs.

Conclusion: The findings suggest mindfulness can be a valuable and acceptable intervention for BAME Muslims. The findings also highlight the need for culturally sensitive MBIs that consider the specific religio-cultural experiences of BAME Muslims. The findings are discussed in the context of the strengths and limitations of the study and have important implications for practice, policy, and further research.

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Notes on style

Due to the reflexive nature of this thesis, the writing after the introduction (chapter one) switches freely between the first and third person. This flexible narrative convention acknowledges and hopefully blurs the author's dual position as both a researcher and a thinking, feeling human being and is appropriate for truly reflexive research practice (Terry et al., 2017). Moreover, this has been used in previous reflexive thematic analyses (Braun & Clarke, 2019, 2020b) as it allows for a "transparent report" of researcher decisions and rationale (Berger, 2015, p.4).

Chapter One: Introduction

Chapter Overview

This study examines the religio-cultural experiences and acceptability of mindfulness-based interventions (MBIs) for Muslims from Black, Asian, and Minority Ethnic (BAME) backgrounds. Previous authors (Blignault et al., 2021b; Thomas et al., 2016) outside of the United Kingdom (UK) have explored mindfulness experiences for BAME Muslims. The term *acceptability* has been used in conjunction with religio-cultural appropriateness (Thomas et al., 2016) or feasibility (Burnett-Zeigler et al., 2019a; Dutton et al., 2013; Hunter-Jones et al., 2019) to capture the cultural resonance and sensitivity of MBIs. In this study, acceptability refers specifically to the religio-cultural resonance and alignment of mindfulness for BAME Muslims.

The introduction chapter explores the study's social, psychological, and historical context. It offers an overview of mindfulness's historical and contemporary conceptualisation and discusses reported benefits associated with MBIs and the challenges and criticisms in this field. These discussions set the context for the literature review in chapter two, which concludes with a problem statement and research aims. The underlying philosophical framework will be presented in chapter three, where the methodology is explored. Finally, chapter four presents the study's findings and a discussion, relating them to the research outlined in the first two chapters.

Mindfulness

This study focuses on *secular* mindfulness interventions not grounded in religion (Kabat-Zinn et al., 1985). In understanding the context of MBIs in their current form, it is essential to acknowledge the historical and religious context of the practice that has been taken and adapted for secular audiences (Monteiro et al., 2017).

Historical Context of Mindfulness

Mindfulness resides at the core of the teachings of the Buddha (Dwivedi, 1994), who asserts that pain and hardship are universal aspects of the human experience (Anālayo, 2020). Within a Buddhist framework, meditation is a mental cultivation method that promotes self-reflection and awareness of the body and mind (Fujisaki, 2020). From a Buddhist perspective, mindfulness's goal is enlightenment and liberation from delusion and inner turmoil, a gradual and ongoing process (Dwivedi, 1994).

Mindfulness is embedded in the four noble truths (Yetunde & Giles., 2020), which explain that suffering is shared throughout humanity, with discernible causes that can be "transformed" through the eightfold path (Yetunde & Giles., 2020). The eightfold path comprises three categories; mental cultivation, wisdom and ethics. Mindfulness is a part of the mental cultivation category, and it must align with correct wisdom and ethics to be considered "right" mindfulness (Fujisaki, 2020). Thus, in Buddhist scriptures, mindfulness is not value-neutral; it encompasses attention guided by purposeful actions to achieve freedom from suffering (Fujisaki, 2020; Monteiro et al., 2017). Secular practices that depict mindfulness as neutral bare attention lack support in authoritative Buddhist texts (Frank et al., 2019) and are far removed from the Buddhist ethos of mindfulness, which is concerned with values and ethics (Tsui et al., 2020).

Key Buddhist doctrines and practices have been adapted and re-presented within psychological and biomedical frameworks in the late 1970s and early 1980s (Kabat-Zinn, 2003; Kabat-Zinn et al., 1985; Segal et al., 2002). The context of this will be discussed further throughout this chapter. The secularisation of mindfulness has been criticised for its attempt to detach from its religious origins and align with Western values and objectives (Lindahl et al., 2017). Consequently, it is crucial to adopt a critical perspective when

examining culturally appropriated interventions like MBIs (Anālayo, 2020; Van Dam et al., 2018).

The Development of Contemporary "Secular" Mindfulness

To understand the context of secularised mindfulness, this research will briefly consider the roots of secular practices (Monteiro et al., 2017). During the modern era in Europe, which in this context refers to the late 1700s to mid-1940s (Kaufmann, 1997), religion was defined as a separate entity from other aspects of life. Conversely, in premodern communities, religion was deeply embedded into everyday life and culture (Anālayo, 2020; Monteiro et al., 2017). The establishment of 'science' as a distinct field and the division of science and religion occurred during this era (Hyman, 2020).

The separation of religion and science is multifaceted, including promoting individual freedom and addressing perceived conflicts and abuses associated with the Christian church at the time (Hyman, 2020; Kaufmann, 1997). Concurrently, psychology emerged as a discipline focusing on rational and observable phenomena, aligned with the prevailing emphasis on rational inquiry during the modern era (Kaufmann, 1997). This emphasis on rational inquiry resulted in a reluctance to incorporate religious and spiritual aspects (Loewenthal & Cinnirella, 1999). Influential figures critical of religion, such as Freud, Skinner, and Watson, significantly shaped the field, prioritising "correct" scientific methodologies (Kaufmann, 1997), often overlooking spiritual or religious dimensions (Loewenthal & Cinnirella, 1999; Patel & Shikongo, 2006).

As biases against religion intensified, healthcare organisations became increasingly hesitant to include religious values in psychological interventions (Monteiro et al., 2017). Western thinkers perceived Buddhism as universally appealing, while the relationship between science and Christianity grew strained (Monteiro et al., 2017). Consequently, the

popularity of secular mindfulness and the presentation of Buddhism in the West can be traced back to the modernist movement (Monteiro et al., 2017).

Jon Kabat-Zinn (1985) developed Mindfulness-Based Stress Reduction (MBSR) to offer a novel and cost-effective method to encourage individuals to take responsibility for managing chronic pain (Kabat-Zinn et al., 1985). The hope was to avoid the "cultural, religious and ideological factors associated with the Buddhist origins" (Kabat-Zinn, 2003, p. 149) to make MBSR more attractive to Western audiences (Monteiro et al., 2017). Conversely, Kabat-Zinn (2003) describes seeking to retain the essence of Buddha-dharma[1] "without being restricted by cultural bounds that would make it impenetrable to the vast majority of people" (Kabat-Zinn, 2003, p.227). Thus it could be argued that MBIs were designed with a White, secular audience in mind (Rogge et al., 2022), which may have contributed to the challenges faced in applying mindfulness across multicultural societies (Bignall et al., 2019).

Definitions of Mindfulness in "Secular" Traditions

The development of contemporary MBIs led to various definitions and conceptualisations removed from the Buddhist roots (Van Dam et al., 2018). Kabat-Zinn was one of the first to define mindfulness in secular traditions (Kabat-Zinn, 1994) and described it as "paying attention in a particular way, on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn, 1994, p4). Another definition proposed by Brown and Ryan (2003) considers mindfulness an attribute of consciousness that encompasses awareness and attention. However, these definitions have been criticised by Bishop and colleagues (2004) for their "abstract and poetic" nature. Bishop et al. (2004) posit that mindfulness is "The awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment." (p. 232). The

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[1] Dharma is a term often used to describe the Buddha's teachings or "Path" (Kabat-Zinn, 1994)

variability of mindfulness definitions within secular traditions has complicated the research (Keng et al., 2011; Shapiro et al., 2006). Secular mindfulness definitions have been described as convenient because they prioritise easily comprehensible constructs to Western audiences (Monteiro et al., 2017; Van Dam et al., 2018). To address this, Van Dam et al. (2018) proposed that the primary feature of mindfulness is "the clear and stable awareness of what is happening in the present moment", and the secondary features of mindfulness are "intention, attention regulation, attitude, and nonjudgment." (p. 39).

Mindfulness research also distinguishes between "trait" mindfulness, which refers to an individual natural tendency to be aware and attentive to their thoughts, emotions and sensations in the present moment (Amutio et al., 2014; Arch & Craske, 2010). High-trait mindfulness has been found to have a stress and anxiety-reducing effect across populations, including various BAME groups (Shallcross & Spruill, 2018). Trait mindfulness does not require a person to be engaged in a state of meditation as it refers to their inherent capacity for mindfulness (Arch & Craske, 2010). To explore mindfulness experiences, *mindfulness* in this study refers to the meditative state cultivated through practice rather than trait mindfulness (Amutio et al., 2014; Shallcross & Spruill, 2018).

Mindfulness-Based Interventions (MBIs)

MBIs are widely utilised in healthcare, education, and workplaces to enhance participants' mindful awareness (Goldberg et al.,2021). These interventions include psycho-educational components, daily meditation, and mindfulness practices (Baer et al., 2019; Crane, 2017). In the UK, the most prevalent forms of mindfulness interventions are MBSR and Mindfulness-Based Cognitive Therapy (MBCT) (Mindfulness All Party Parliamentary Group [MAPPG], 2015).

MBSR was initially developed at the University of Massachusetts Medical Centre in the United States of America (USA) for chronic pain patients unresponsive to other

treatments (Kabat-Zinn et al., 1985). The ten-week program incorporated Hatha yoga and meditation to cultivate present-moment awareness and improve pain management (Kabat-Zinn, 2003).

MBCT, designed by Segal et al. (2002), integrates Cognitive Behavioural Therapy (CBT) and information processing theories. It aims to modify participants' relationship with their thoughts, feelings, and bodily sensations, reducing the risk of depressive relapse (Ottaviani & Beck, 1987; Segal et al., 2002, 2018; Teasdale et al., 1995). MBCT was introduced in the UK by the National Institute for Health and Care Excellence (NICE) as part of the NHS Talking Therapies agenda, previously known as Increasing Access to Psychological Therapy (IAPT). The aim of introducing this agenda, was to facilitate the return to work for individuals with depression and contributing to the goals of Modern Britain (Bignall et al., 2019; MAPPG, 2015). MBCT and MBSR have been described as the 'gold-standard model' of MBIs within Western discourses (Valley & Stallones, 2018). However, ‘Third-wave’ interventions rooted in CBT have also emerged (e.g. Acceptance and Commitment Therapy (ACT): Hayes et al., 1999; Compassion Focused Therapy (CFT), Gilbert, 2014). These interventions teach clients to practice mindfulness skills in the presence of discomfort (Eifert et al., 2009) and include elements of mindfulness meditation as part of a broader syllabus (Valley & Stallones, 2018).

Reported Benefits of MBIs

MBSR and MBCT have been reported to reduce anxiety and depression while increasing mindfulness skills (Brown & Ryan, 2003; Chiesa & Serretti, 2011; Fjorback et al., 2011; Keng et al., 2011). Early reviews caution readers to interpret the findings cautiously due to the lack of randomisation, small sample sizes, and varied definitions of mindfulness used in the literature (Chiesa & Serretti, 2011). In the most extensive systematic review of randomised controlled trials (RCTs), Goldberg and colleagues (2021) found that MBIs can be effective for anxiety and depression compared to active controls. However, the authors note a

lack of research and systematic reviews on the efficacy of MBIs for underrepresented groups, such as BAME groups (Goldberg et al., 2021). This exclusion from the literature makes it difficult to assess its value for the general population (Chin et al., 2019; Goldberg et al., 2021). The "blanket recommendation" of MBCT for depression across ethnic and cultural backgrounds (NICE, 2021) underscores the importance of studying mindfulness's acceptability and religio-cultural alignment (Bignall et al., 2019; NICE, 2009, 2021). Thus, despite some promising results for MBIs and their potential utility for BAME groups (Deluca et al., 2018), findings must be interpreted with caution due to the challenges and criticisms in the field (McPherson et al., 2020; Van Dam et al., 2018).

Challenges and Criticism of MBIs

The present study seeks to explore BAME Muslim experiences' of MBIs, so an understanding of mindfulness's broader challenges and criticisms are considered to ensure a comprehensive analysis (Farias & Wikholm, 2016).

Adverse Effects

Researchers and clinicians must prioritise the ethical considerations of "no harm" when providing evidence-based interventions (Baer et al., 2019; BPS, 2014), and so there is a necessity to examine potential adverse effects (AEs) in existing evidence-based MBIs (Lindahl et al., 2017). A recent systematic review of AEs (Farias et al., 2020) identified a range of potential difficulties with mindfulness practice, such as anxiety, depression and reliving of traumatic experiences. The authors' (Farias et al., 2020) highlight the importance of active monitoring of these potential AEs, but there remains no routine method of monitoring relying instead on spontaneous reporting, which may "underestimate AE frequency" (Farias et al., 2020; Van Gordon et al., 2017). This historical lack of research on AE's can also create unrealistic expectations of mindfulness that are not always supported by subsequent participation in interventions (McPherson et al., 2020; Van Dam et al., 2018).

Methodological Challenges

MBIs are also limited by the lack of clear and consistent definitions of mindfulness, leading to research design challenges (Van Dam et al., 2018). These varying definitions make replicating or comparing findings challenging (Goldberg et al., 2021; Jandaghi et al., 2020). Moreover, prioritising cost-effective MBIs has contributed to focusing on outcome research rather than personal accounts (Baer et al., 2019; McPherson et al., 2020; Waldron et al., 2018). While outcome research is essential, MBIs can only address disparities in BAME communities if they can successfully recruit and retain participants (Watson et al., 2016). The literature often excludes BAME participants and prioritises the outcomes and experiences of White participants (Chin et al., 2019).

Systematic reviews are starting to address the inclusion of BAME participants in the MBIs (DeLuca et al., 2018; Eichel et al., 2021; Waldron et al., 2018). A recent systematic review (Eichel et al., 2021) reported that 79% of participants in mindfulness studies are White and emphasised the lack of BAME participants as a significant criticism of the field. Moreover, MBIs are most commonly led by White, middle-class women (Chin et al., 2019; Eichel et al., 2021), which limits the generalisability of findings and leads to MBIs that neglect the needs of BAME populations (Proulx et al., 2018; Purser, 2018).

Lack of Research on BAME Experiences

Evidence on the experiences of BAME participants is also underdeveloped (Proulx et al., 2018; Thomas et al., 2017), potentially leading to missed cultural adaptations that might be needed to increase the appropriateness and acceptability of MBIs (Proulx et al.,2020). Understanding BAME experiences is crucial, as these communities currently have the least access to MBIs in the UK (Bignall et al., 2019). BAME communities often follow a theistic religion (Bignall et al., 2019), and one source of disparity with MBIS may be tensions between different perspectives on their religious nature (Deluca et al., 2018). Some studies in

the USA (Proulx et al., 2018; Woods-giscombé & Gaylord, 2014), the Middle East (Thomas et al., 2016) and Australia (Blignault et al., 2021b) have attempted to address the lack of cultural inclusivity in the literature by exploring experiences of BAME participants. These studies will be explored further in chapter two. Nonetheless, these studies have primarily focused on USA-based Christian populations, overlooking major religious groups like Islam (Patel & Shikongo, 2006; Thomas et al., 2017). For many Muslims, Islam is the reference point and framework to understand the world and offers support in times of difficulty (Meer & Mir, 2014; Tarabi, Loulopoulou, Henton, et al., 2020). Thus, understanding the context of mindfulness within Islam is essential in MBI research (Isgandarova, 2019).

The Intersection Between Culture and Religion

BAME communities in the UK predominantly come from religious countries and practise a religion, most commonly Christianity and Islam (Office for National Statistics, 2019). In exploring the religio-cultural experiences of mindfulness for Muslims, the intersectionality of these experiences must be considered to avoid overlooking essential facets of their experience and perpetuating the disparities faced by this group (Meer & Mir, 2014; Mir et al., 2019). Intersectionality is an essential consideration within BAME research on mindfulness (Al-Adawi et al., 2002; Eichel et al., 2021; Loewenthal et al., 2014).

Intersectionality is a “key contribution of Black feminist scholarship" that recognises how individuals or groups experience discrimination based on multiple aspects of their identity (Ahmed, 2012, p.195). Despite being ethnically diverse and well-represented in the UK census, the Muslim community often experiences discrimination and prejudice based on race, ethnicity, national origin, social class, and immigration status (Allen, 2014; Younis & Jadhav, 2020). At the same time, they may also experience Islamophobia[2], which can coexist with and sometimes supersede these other differences (Laird et al., 2007). Islamaphobia leads

[2] Islamaphobia here refers to the fear of or prejudice against, the religion of Islam and Muslim people

to the exclusion of Muslims from healthcare, education and workplace settings (ONS, 2019; Stevenson et al., 2017).

Ahmed and Matthes (2017) conducted a meta-analysis which found that post-9/11 media portrayed Islam and Muslims negatively, linking the religion to extremism and portraying it as incompatible with Western culture. This portrayal has created a narrow and negative understanding of Islam and contributed to Muslims' marginalisation based on their racial and religious identity (Younis & Jadhav, 2020). Some studies have started to address this marginalisation by conducting studies that account for Muslims' religious and cultural experiences (Al-Ghalib & Salim, 2018; Hammad et al., 2020). For example, Hammad and colleagues (2020) adopted an intervention for Arabic-speaking Middle Eastern and North African (MENA) Muslims affected by the Grenfell Tower fire in London. They used religio-cultural practices such as storytelling, Nasheed (religious) singing, and drumming to promote social connectedness and psychological well-being in the aftermath of the Grenfell Tower fire in London. Participants valued engaging in a culturally appropriate, faith-informed therapy delivered in their native language (Hammad et al., 2020). The authors highlight the need for such studies to develop further, to counteract the marginalisation that Muslim communities have faced in research (Allen, 2014; Stevenson et al., 2017; Walpole et al., 2013).

Relevant to this study, there are also several differences between various Muslim communities (Allen, 2014; O'Toole, 2021; Walpole et al., 2013). For example, Pakistani and Bangladeshi Muslims often have the most significant stigma and shame associated with accessing mental health services (Tarabi et al., 2020), whereas issues around confidentiality have been emphasised in Muslim participants with MENA origins (Al-Adawi et al., 2002; Hammad et al., 2020). These subtle nuances serve as a reminder that religio-cultural

acceptability is an essential factor to consider that is likely to influence experiences of interventions such as mindfulness (Magee., 2016).

Islam and Mindfulness

Islam is a monotheistic religion, with the second largest following in the UK after Christianity, and is the fastest-growing religion World-Wide (Lipka &Hacket, 2017; Office for National Statistics(ONS), 2019; ONS,2013). In line with other theistic religions (Christianity and Judaism), Muslims believe in a single all-knowing and all-powerful deity and an afterlife based on one's life actions (Pilkington et al., 2012; Poole et al., 2021; Younis & Jadhav, 2020). The Prophet Muhammad (Peace Be Upon Him [PBUH])[3] is considered the final messenger of Allah (God), and the Five Pillars of Islam mentioned in the Quran offer a framework for behaviour and etiquette (Pilkington et al., 2012; Skinner, 2010). Moreover, adhering to the principles outlined in the Quran and sunnah (life of the Prophet) is believed to prepare Muslims for life's challenges mentally and is discussed in relation to developing psychological and spiritual well-being (Pilkington et al., 2012; Thomas et al., 2017).

The development of Islamic psychology ideas framed within the language of *Psychology* has grown in recent years (Hammad et al., 2020). However, Islamic scholars have discussed Islamic psychology principles that include elements similar to mindfulness for hundreds of years (Haque, 2000). These texts have been written in Arabic, excluding them from Western discourses (Kaplick & Skinner, 2017; Rothman & Coyle, 2018). When discussing Islamic psychology, researchers typically refer to classical Islamic philosophers of the self, such as Abu Hamid al-Ghazali (d. 1111). Al-Ghazali discussed the concept of the self and the causes of its misery and happiness. An Islamic model of the inner self is composed of the intellect ('aql), spirit (Ruh), spiritual heart (Qalb) and soul (Nafs) (Rothman

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[3] Peace Be Upon Him [PBUH] is a common honorific phrase used by Muslims after any mention in speech or print of holy persons including the Prophet Muhammed as a mark of respect.

& Coyle, 2018). In the Islamic tradition, the ‘Nafs' is also interpreted as the human potential for self-awareness through Islamic meditation (Kaplick & Skinner, 2017).

In recent years, increasing explorations of Islamic theological and psychological sources show that many aspects of MBIs exist in the Islamic tradition (Isgandarova, 2019; Rothman & Coyle, 2018). Isgandarova (2019) explains that the concept of self-awareness is captured by the term *Muraqaba* (Isgandarova, 2019), which derives from the Arabic word 'raqeeb', meaning 'to watch over' or 'to keep an eye'. Muraqaba has been translated as 'meditation' or contemplation. In the Qur'an (4:1), Muraqaba is described as caring for one's nafs (soul) and strengthening the relationship with God. This is thought to happen by being mindful of one's inner feelings and outer surroundings (Rothman & Coyle, 2018).

In a similar way to descriptions in Buddhist traditions (Anālayo, 2020; Weick & Putnam, 2006), during Muraqaba, an object for contemplation can be used and may take the form of a physical object (e.g. the Quran) or an image in the mind's eye (e.g. of God) that reduces mind wondering (Kaplick & Skinner, 2017). These similarities with mindfulness have led to questions about how the practice of muraqaba might align with MBIs and increase the acceptability of mindfulness for Muslims (Isgandarova, 2019).

Mindfulness research with Muslims is in its infancy, and Muslims remain primarily excluded from the literature (Al-Ghalib & Salim, 2018; Blignault et al., 2019; Thomas et al., 2017). Al-Ghalib and Salim (2018) tried to address this in Saudi Arabia by creating The Mindful Jeddah Training Programme, an adapted MBCT intervention delivered online. The programme focused on physical, psychological and spiritual awareness to make mindfulness more relatable. The spiritual awareness elements included practices of Dhikr and awareness of God, which helped participants connect to the MBCT principles and report a sense of religio-cultural alignment with the programme (Al-Ghalib & Salim, 2018).

Despite the potential value of MBIs when understood through Islamic practices such as Muraqaba, these practices vary between and within communities (Poole & Williamson, 2021). Thus, there is a need to consider the social and cultural experiences that may intersect with the understanding and experiences of Islam and mindfulness (Tarabi, Loulopoulou, Henton, et al., 2020).

The Theoretical Context of BAME Disparities

'BAME' or 'BME' are terms used to refer to minority populations in the UK with non-European heritage (Office for National Statistics, 2019). However, these terms have been criticised for their lack of nuance and exclusion of certain minorities (Ahmed, 2012; Arday, 2018). Moreover, the term can erase different groups' unique experiences and needs and perpetuate harmful stereotypes (Arday, 2018). *BAME* is used in this thesis for clarity and consistency, since despite its evident limitations it has been used within relevant scholarship. Some of these limitations will be explored further in chapter three when discussing this study's sample. BAME groups continue to face health disparities (Public Health England [PHE] 2018), including higher risks of stress- related chronic illnesses and mental health difficulties (Eichel et al., 2021; Shallcross & Spruill, 2018). The disproportionate impact of COVID-19 on BAME communities has recently highlighted this issue (PHE, 2020).

Various systemic and psychodynamic theories can help highlight the roots of some of the disparities BAME groups face (Sue & Sue, 2012; Sue et al., 2009)**.** These roots are complex and multifaceted, including factors such as racism, discrimination, and social and cultural barriers to BAME individuals accessing mental health services (Ahmed, 2012; Byrne et al., 2017).

Systemic Theories

Systemic theories focus on the broader social, economic, and political contexts in which BAME disparities occur (PHE, 2020) rather than on individual-level factors that contribute to these disparities (Biener & Zuvekas, 2020; Shallcross & Spruill, 2018).

Critical race theory emphasises that structural inequalities such as poverty, limited access to healthcare and inadequate social support in Western societies are embedded in institutions (Lyons & Brewer, 2021). Consequently, BAME communities often face unequal access to resources like education, employment and healthcare and report feeling stigmatised by mental health services (Hammad et al., 2020). As a result, they are less likely to access mental health services and experience more barriers to accessing appropriate care (PHE, 2018). These disparities have led to the exclusion of BAME individuals from MBI considerations, which reflects "institutional racism" that persists across healthcare (Al-Adawi et al., 2002; Wood & Patel, 2017).

Institutional racism emphasises that racial disparities are not solely the result of individual prejudice and discrimination, but perpetuated by institutions' policies, practises and procedures (Sue & Sue, 2012; Sue et al., 2009). The factors outlined above have led to " the collective failure of organisation [s] to provide an appropriate and professional service to people because of their colour, culture or ethnic origin" (Ahmed., 2012, p.44). This can manifest in several ways, such as favouring White candidates over equally qualified BAME candidates to train in MBIs or carry out MBI research (Moore et al., 2008).

Wood and Patel (2017, p. 281) argue that research in the UK reflects systemic 'Whiteness'. MBIs have been adapted to and promoted within the dominant White culture, often at the expense of considering BAME needs (Chin et al., 2019). Monteiro et al. (2017) and Purser (2018) suggest that this involves the appropriation of mindfulness from Ancient Asian traditions (Monteiro et al., 2017; Purser, 2018) and its repackaging as a marketable self-help tool (Bautista et al., 2022). This cultural appropriation serves capitalist objectives

rather than the needs of marginalised communities (Abbasi et al., 2018; Purser, 2018). Moreover, the marketing of MBIs in this way has resulted in the inequitable distribution of mindfulness as a solution to individual stress rather than addressing broader societal issues that may contribute to their experiences (Bautista et al., 2022). This also perpetuates the idea that BAME communities are responsible for their well-being rather than recognising the structural inequalities contributing to their experiences (Ahmed, 2012).

Moreover, the dominance of White perspectives in the development of MBIs has created barriers, including the cost of training teachers and delivery catered to White audiences (Proulx et al.,2018). Thus, MBIs may not be compatible with the needs of BAME groups due to the Eurocentric values, norms and beliefs that underpin them (Proulx et al., 2018; Sue et al., 2009; Wood & Patel, 2017). Further research is crucial to understand whether MBIs are culturally sensitive and whether they can address the religio-cultural needs of BAME groups

(Bercean et al., 2020; Hamid & Furnham, 2013; Kulwicki et al., 2010; Woods-Giscombe et al., 2019).

Psychodynamic Theories

Psychodynamic theories can provide valuable insights into understanding the pervasive exclusionary experiences of minoritised groups by delving into the complexities of human psychology, particularly in the context of social dynamics, identity, and trauma.A leading mental health charity survey revealed that only 10% of mental health service users felt their religious needs were met (Mind, 2013), and this could be due to factors such as therapists neglecting religio-cultural practices in treatment and services fearing talking about race and culture (Mind, 2013). Psychodynamic theories of disparities emphasise individuals' and organisations' unconscious biases and attitudes in discussing race and culture (Lowe, 2014).

Güveli and Platt (2011) describe a cultural transference process whereby mental health practitioners' beliefs and biases about other cultures lead to misunderstandings or

pathologising views of BAME clients (Walpole et al., 2013). This may contribute to

excluding BAME participants from MBIs, and concurrently they may feel stigmatised by services (Chin et al., 2019).

Additionally, the impact of historical and intergenerational trauma from colonialism, racism and oppression may lead to a sense of powerlessness, hopelessness and mistrust of services (Byrne et al., 2017; King et al., 2017). Fanon's (1963) critique of colonialism and racism emphasises how dominant groups can impose their values, beliefs and practises on the colonised. He argued that this process led to internalised feelings of worthlessness and a loss of identity (Fanon, 1963;2008). He also described how this led to various psychological symptoms, including anxiety, depression, and a sense of identity fragmentation (2008). These factors may also influence the underutilisation of mental health services by BAME communities in the UK (Femi-Ajao, 2018; Department of Health[DOH], 2017; Mind, 2013) and poorer mental health outcomes in mainstream services (Byrne et al., 2017).

BAME communities may have different cultural beliefs and practices to make sense of emotional and mental distress that may differ from Western-oriented beliefs (Byrne et al., 2017; Rothman & Coyle, 2018). One example is that BAME communities may be more likely to view distress as a socio-political issue (Younis & Jadhav, 2020) or emphasise social support and community to address their well-being (King et al., 2017; Walpole et al., 2013). Eurocentric models, such as those underpinning MBIs, tend to focus more on individual psychological factors that may not address these needs (Walpole et al., 2013).

Moreover, mental health practitioners socialised within a secular or non-religious context may also have unconscious biases in discussing religio-cultural experiences with clients (Coyle,2008). They may also experience anxieties that lead to a fear of "offending" BAME clients, leading to hesitations in discussing religion (Byrne et al., 2017). Because of the abovementioned considerations, a "circle of fear" is thought to have developed,

characterised by mistrust and anxiety between BAME clients and mental health services (Byrne et al., 2017; Coyle, 2008).

These factors suggest that BAME communities may have different views regarding the perception, acceptance and acknowledgement of mindfulness (DeLuca et al., 2018; Rawlings & Bains, 2020). Shame-focused attitudes, concerns about confidentiality and sensitive information being shared with others, such as GPs, have been identified as barriers to accessing MBIs (Bignall et al., 2019). Moreover, when MBIs are accessed, they have been described as culturally insensitive (Dutton et al.,2013). This cultural insensitivity is often related to the lack of consideration towards religion which is valued amongst many BAME communities (Loewenthal & Cinnirella, 1999; Mir et al., 2019; Tarabi et al., 2020). Researchers (Bernal et al., 1995; Isgandarova, 2019; Purser, 2018) and guidelines (NICE, 2018) advocate for understanding individual experiences, acceptability, and perceived religio-cultural appropriateness for BAME religious groups. Nevertheless, limited research on religion and mental health focuses on Christian populations in the USA, overlooking major religious groups like Islam and missing valuable insights (Patel & Shikongo, 2006; Thomas et al., 2017).

Recognition of Faith Needs in Research and Policy

The recognition of faith needs in research, and policy is crucial in addressing the mental health disparities experienced by BAME communities (Bignall et al., 2019; DOH, n.d.). Religious practices can shape Muslims' understanding and experience of mental health and health-seeking behaviours (Meer & Mir, 2014; Skinner, 2010; Walpole et al., 2013). The Department of Health's "No Health Without Mental Health" strategy (2011) recognises the significance of culture and religion for BAME groups, emphasising that ignoring religion in mental health services has a disproportionate impact on BAME populations (DOH, 2011). Moreover, The British Psychological Society (BPS) emphasises healthcare providers'

collaboration with patients' religio-cultural beliefs to provide adequate mental health treatment (BPS, 2017).

A central policy on MBIs from Mindfulness All Party Parliamentary Group (MAPPG, 2015) highlights the need to explore the potential benefits of MBIs for BAME and religious groups. However, despite these policies and guidelines, there remains uncertainty about healthcare professionals engaging with religious and ethnic 'diversity' (Meer & Mir, 2014; Poole et al., 2021). NICE (2018) recommends that healthcare professionals carefully consider clients' needs and preferences on MBCT programmes, yet this is often not adhered to (Bignall et al., 2019). Moreover, a recent National Health Service (NHS) report (Bignall et al., 2019) has criticised the failure of MBIs to address religio- cultural needs and highlights that BAME groups have the least access to MBIs (Bignall et al.,2019). One possibility is that MBIs were developed within secular frameworks; thus, they were not created to fit into "the world" of BAME individuals (Ahmed., 2012, p.81). Thus, their design and implementation have addressed individual, secular rather than cultural or religious goals (Poulin et al., 2021).

Religion is thought to have a more significant influence than ethnicity on attitudes towards seeking psychological help during a crisis, and religious coping varies within and between religious groups (Hamid & Furnham, 2013; Loewenthal et al., 2014; Loewenthal & Cinnirella, 1999). Studies by Koeing (2012; 2015) show that religious coping can benefit mental well-being, promote resilience, and improve psychological adjustment to stressors. Recent research with Muslims (Hammad et al., 2020) has also emphasised the benefits of religion on mental health and daily stressors. However, negative religious coping, where an individual feels punished by God when struggling with mental health difficulties, can increase shame and guilt and negatively affect mental well-being (Koenig, 2012)**.** Until the

intersection between religious considerations and evidence-based interventions is prioritised, the needs of BAME communities may not be adequately addressed (Witkiewitz et al., 2013).

This chapter sought to set the historical, social and political context for the literature review in chapter two. Due to the dearth of literature focusing exclusively on Muslims, the next chapter will explore the experiences of MBIs for participants across BAME and religious groups.

Chapter Two: Systematic Review

Overview

The chapter addresses criticism about a lack of MBI research on BAME experiences and the subsequent lack of reviews exploring mindfulness experiences in this population (Chin et al., 2019; DeLuca et al., 2018). This chapter includes a systematic review of the literature to date, which provides the context for the present study. This chapter concludes by including the rationale and aims of this study.

Introduction

NICE (2018;2020) guidelines often highlight the importance of exploring patient experiences of treatment but omit qualitative reviews of patient experiences of treatment in their guidelines (Mcpherson et al., 2020). Gathering feedback and using it to inform the development of psychological interventions aligns with the NHS's ongoing commitment to a patient-centred health service (Morgan et al., 2015). Qualitative reviews have reported that MBIs can benefit mental health in clinical (Malpass et al., 2012; Wyatt et al., 2014) and community settings (Dussault et al., 2020). However, no qualitative reviews have focused on the experiences of BAME individuals (DeLuca et al., 2018; Eichel et al., 2021). Such reviews may help clinicians and services better understand this group's needs and assist patients in making informed decisions about undergoing MBIs (DeLuca et al., 2018; Malpass et al., 2012).

This systematic review aims to address the existing gap in knowledge by examining the experiences of BAME participants on MBIs. This review focuses on the experiences of BAME communities more generally than solely on Muslims due to the lack of available literature specifically on Muslim mindfulness experiences (Thomas et al., 2017). BAME communities often incorporate religio-cultural values when addressing their mental and

physical well-being (Kulwicki et al., 2010; Pilkington et al., 2012); thus, their experiences with MBIs offer valuable insights into the potential benefits and challenges of the practice**.** Nonetheless, it is essential to acknowledge that this approach may not fully capture the unique experiences of Muslim participants.

Design

The present review aims to provide a structured and thematic summary of qualitative research that examines mindfulness experiences in adults from BAME communities. A qualitative methodology was chosen, as these provide additional insight into a phenomenon, particularly when there is a limited evidence base (Dixon-Woods et al., 2006). The review adhered to PRISMA guidelines (Page et al., 2020) to ensure methodological rigour (Moher et al., 2009).

Methods

Search Terms

Search terms were developed by identifying the Sample, Phenomenon of Interest, Design, Evaluation and Research type according to the SPIDER framework (Cooke et al., 2012). Earlier searches suggested a need to remove the Evaluation and Research type, to avoid limiting the results. The final search categories were clustered and combined with the other searches using the 'OR' and '*" Boolean operators. Terms were searched for within either the abstract or title and each cluster of terms was entered individually and then combined using the 'AND' Boolean operator. The E and R were not used as there was sufficient coverage based on the aims of the study using the other search categories. (Appendix A).

Search Strategy

During October-November 2022, the EBESCO host search service was used to access the CINAHL Complete, MEDLINE, PsycARTICLES, and PsycINFO databases. These were

deemed appropriate due to their widespread use in meta-syntheses (Colman., 2019). The separate groups of terms were searched individually and combined using the 'AND' Boolean operator (Appendix B).

Screening and Selection

The screening and selection were done in stages and using a systematic approach in line with PRISMA guidelines (Page et al., 2022, see Appendix C). Six studies were accessed via the inter-library loans system at the University of Essex. All country settings were included but limited to those published in English. Search settings were limited to peer-reviewed academic journal studies published between 1980-2022. The dates chosen aimed to capture all relevant studies from the development of MBIs (Kabat-Zinn et al., 1985) to when the search was conducted. The remaining results were screened sequentially by title and abstract and were reviewed in full to check whether they met the inclusion criteria. Once the screening was complete, the reference lists of the studies were hand-searched for any additional references, and I included two additional studies (Abercrombie et al., 2007; Bermudez et al., 2013).

Inclusion and Exclusion

This review included peer-reviewed English papers reporting qualitative methodologies and focused on adults (18+) who have participated in MBIs. Grey literature was not included as sufficient studies were identified using the search terms. Studies were included if over 75% of the sample were BAME and if participants were non-White but not formally identified as 'BAME' in line with the methods of a previous metanalysis (DeLuca et al., 2018). 'BAME' terminology is not commonly used in non-European countries (Arday, 2018), which was addressed through the search terms outlined above (see Appendix A). Studies were not excluded based on the length of the intervention, as this is recommended for reviews to capture all relevant data in unresearched populations (Morgan et al., 2015); mixed-methods studies were included if the qualitative findings held equal weight or more to the

outcome measures. All relevant literature published between 1980 and 2022 was included to capture relevant data.

Studies were excluded if they explored trait mindfulness, as this measures an individual's inherent mindfulness ability rather than an exploration of their experience with mindfulness practice (Arch & Craske, 2010). Studies were also excluded if they involved participants under 18 and did not explore qualitative experiences in BAME participants. Other factors I considered when excluding articles can be found in the PRISMA diagram (Appendix C).

Reflexivity

I, a trainee clinical psychologist who identifies as a BAME Muslim, conducted this review. Thus, the quality of studies and synthesis of findings are based on my subjective interpretations. The findings should therefore be considered critically in respect of this. Moreover, different raters may assign other quality scores based on their interpretation or using different qualitative tools. Nonetheless, by being aware of my potential biases and adhering to the criteria outlines above, I hope to have mitigated against my own position impacting the synthesis and conclusions drawn.

Quality of Studies

Methods for systematically reviewing qualitative research are still emerging (Heron & Eisma, 2021) ; thus, the quality appraisal was not used to exclude articles but to supplement their evaluation (Dixon-Woods et al., 2006). The CASP (Critical Appraisal Skills Programme) tool (Long et al., 2020) has been used in previous meta-syntheses exploring mindfulness experiences (Morgan et al., 2015; Wyatt et al., 2014), and I deemed it appropriate for this review. A summary of quality scores using the CASP tool for each study can be found in Appendix D. The Mixed methods assessment tool ([MMAT] Hong et al., 2018) has been used in previous mixed-methods studies on mindfulness. I chose it it to guide the appraisal of studies in this review (Hong et al., 2022). A summary of scores based on this tool can be found in the appendices (Appendix E). I assigned studies ++ for quality if all

criteria were met, + if the majority of criteria were met, and - if few criteria were met (Appendix F) following the methods of a recent meta-synthesis on mindfulness (Rawlings & Bains, 2020). The authors' emphasised the difficulty of using number ratings grounded in positivist ideas for qualitative reviews (Rawlings & Bains, 2020).

Synthesis

Thematic synthesis (Thomas & Harden, 2008), an adapted version of thematic analysis (Braun & Clarke, 2017, 2020a), was chosen for the review. The data included all text under the paper 'results' or 'findings' headings. Key participant and method features from the studies were extracted and put into a table in Microsoft Excel. Articles were then manually coded to enable complete immersion into the data (Terry et al., 2017). The first step involved line-by-line text coding, translating concepts between studies (Britten et al., 2002), adding new codes as necessary, and checking for interpretation consistency. Next, the descriptive themes were combined into a list. Finally, 'third order' interpretations were created by grouping similarities and differences between the themes, going beyond the content of the original studies (Britten et al., 2002).

Results

Search Results

The search identified a total of 198 studies. Once duplicates were removed, studies were assessed against the inclusion and exclusion criteria, and papers were hand-searched for additional references identifying two further studies (Bermudez et al., 2013; Szanton et al., 2011). Seventeen studies were included in the synthesis, exploring the experiences of 323 participants . Analysis of the data led to seven analytical themes. Table 1 below presents the summary characteristics of the studies included in the analysis.

Table 1

Summary characteristics for included studies

Authors and date	Population, setting	Sample		Type and length of intervention	Design	Methodology	Main Findings
		Participants	Religion				
Abercrombie et al. (2007).	Multi-ethnic woman with abnormal pap smears, community	5 (F=5)	-	MBSR, 6 weeks	Mixed-Methods	FG[1], interviews, Constant comparison analysis	Reduction in stress and anxiety, participants discussed importance of social support of the group.
Bermudez et al. (2013)	Low-income minority women with a history of IPV, community	10 (F=10)	-	MBSR –telephone weekly half-hour sessions for 4 weeks	Qualitative	Interviews and FG, IPA[2]	Tool for stress/emotional regulation, barriers to practice and interpersonal benefits.
Blignault et al.(2021b)	Arabic-speaking, Australian community	20 (F=20)	Muslim	ACT/MCBCT adapted CD, 5 weeks	Mixed-Methods	Diary logs, qualitative feedback, TA[3], inductive approach	Notion of self-compassion and self-care consistent with Islam, awareness of thoughts and feelings. Personal challenges of practise.
Burnett-Ziegler et al. (2019)	Predominantly African American with depression,	27 (F=27)	Predominantly Christian	MBODY intervention 8 weeks	Mixed-Methods	FG, Inductive Content Analysis	Benefits for anger , social connection and stress, barriers to attendance, all but one

[1] Focus Group
[2] Interpretive Phenomenological Analysis
[3] Thematic Analysis

Authors and date	Population, setting	Sample		Type and length of intervention	Design	Methodology	Main Findings
		Participants	Religion				
	treatment-seeking community						report religious alignment.
Dutton et al. (2013)	Multi-ethnic Women with PTSD, community	53 (F=53)	-	MBSR (adapted) 10 sessions	Mixed-Methods	Interviews, observation,	Helped cope with daily stressors, barriers to practice and social benefits of mindfulness.
Hartwell et al. (2018)	Black and Latina women with a family history of homicide, community	9 (F=9)	Predominantly Christian	MBSR 8 weeks	Mixed-Methods	Questionnaires, FG, GT[4]	Tool for emotion regulation, spiritual and religious alignment, social support, barriers to practice.
Hong et al. 2022	African American with Depression	24 (F=24)	-	MBODY (MBSR), 8 weeks	Mixed-Methods	Focus groups, TA	Increased awareness of depression stigma, , adaptations to mindfulness needed, barriers to attending sessions.
Hunter-Jones et al. (2019)	African American cis and transgender women living with HIV, community	18 (12 = cisgender, 6 = transgender)	Predominantly Christian	MBCT/MBSR group 8 weeks	Qualitative	FG, Describe initial codes based on a priori coding	Increased emotion regulation, culturally relevant with modifications, adverse effects.

[4] Grounded Theory

Authors and date	Population, setting	Sample		Type and length of intervention	Design	Methodology	Main Findings
		Participants	Religion				
Proulx et al. (2020)	African American Older Adults, Community	10 (F=10)	Christian	MBSR- 4 weeks	Qualitative	FG, GT	Similarities with Christianity, social benefits of MBSR, modifications needed, mindfulness as self-care.
Spears et al. (2017)	Predominantly African American with Depression, community	32 (F=16)	69% Christian	MBSR (2 practices in a group)	Qualitative	FG, TA	All discussed religious alignment, benefits for stress, emotion regulation and pain management, barriers to practice.
Szanton et al. (2011)	African American Older Adults, housing residence	13 (F=13)	Protestant	MBSR based group (8 weeks)	Qualitative	3 FG, Inductive Content Analysis	Social support and connection, coping with depression and stress.
Thomas et al. (2016)	Emirati students, University	12 (F=12)	Muslim	MBSR 8 weeks	Qualitative	FG, TA	All discussed religious alignment, benefits for stress management and emotion regulation, modifications needed and barriers to practice.
Vroegindewey & Sabri. (2022)	Black immigrant women's experience of IPV	18 (F=18)	-	MBSR –telephone, 4 weeks	Qualitative	Facilitator fidelity forms, qualitative surveys, qualitative descriptive approach	Stronger sense of self-compassion and loving-kindness, stress-reduction and similarities with religion

Authors and date	Population, setting	Sample		Type and length of intervention	Design	Methodology	Main Findings
		Participants	Religion				
Watson et al. (2016)	African American females, community	12 (F=12)	-	MBSR 4 workshops	Qualitative	FG, TA	Religio-cultural barriers to practice, accessibility of MBSR, greater awareness skills and stress reduction
Watson-Singleton, et al. (2019)	African American females, community	7 (F=7)	Predominantly Christian	MBSR 4 weeks	Qualitative	FG, TA	Cultural similarities barriers to engagement, modifications needed, concerns about connection to Buddhism
Woods-Giscombe et al. (2019)	African American, prediabetes community health setting	38 (F= 18)	80% 'Religious affiliation'	MBSR + psychoéducation, 8 weeks	Mixed-Methods	Questionnaires, BMI, interviews, TA	Culturally relevant practice, benefits for stress management and awareness, barriers related to caregiving responsibilities.
Woods-Giscombe & Gaylord (2014)	African American mindfulness meditators, community	15 (F=12)	6 Christian, 3 Buddhist, 1 Nondenominal	MBSR and Buddhist (Zen/Tibetan)	Qualitative	Interviews, Applied TA	Religious congruence and incongruence, benefits for emotion regulation and stress management, cultural similarities and barriers to practice,

Quality Appraisal

The 17 studies included in the final synthesis varied regarding the type and length of intervention, mindfulness definitions, locations used to deliver the study, mindfulness definitions and the inclusion of BAME facilitators. These were considered in the appraisal of studies and are summarised in Table 2 below.

Table 2

Quality considerations for included studies

Author(s)	Length of Intervention	Mindfulness Definition	Reporting of Dropouts	BAME Facilitators
Abercrombie et al. (2007)	6 weeks	Kabat-Zinn (2003)	3	Not reported
Bermudez et al. (2013)	4 weeks	Kabat-Zinn (2003)	No dropouts	Not reported
Blignault et al. (2021b)	5 weeks	Kabat-Zinn (2003)	7 (from waitlist to intervention)	Yes
Burnett-Zeigler et al. (2019)	8 weeks	None Specified	1 (Religious conflict)	Not reported
Dutton et al. (2013)	10 weeks	Kabat-Zinn (1994)	report 70% completion rate and 1 dropout (Religious conflict), 2 dropouts (not in need of mindfulness skills)	Not reported
Hartwell et al. (2018)	8 weeks	Turning towards difficult experiences / staying present	1 (Family obligations)	Yes

Author(s)	Length of Intervention	Mindfulness Definition	Reporting of Dropouts	BAME Facilitators
Hong et al. (2022)	8 weeks	Bishop et al. (2004)	No dropouts	Yes
Hunter-Jones et al. (2019)	8 weeks	None Specified	No transport	Not reported
Proulx et al. (2020)	4 weeks	Kabat-Zinn (2003)	Not reported	Not reported
Spears et al. (2017)	< 4 weeks	Kabat-Zinn (2003)	Not reported	Not reported
Szanton et al. (2011)	8 weeks	Awareness / Acceptance Skill	Not reported	Yes
Thomas et al. (2016)	8 weeks	Kabat-Zinn (2003)	Not reported	Not reported
Vroegindewey & Sabri (2022)	4 weeks remote	Kabat-Zinn (2003)	Not reported	Not reported
Watson et al. (2016)	4 weeks	Bishop et al. (2004)	Not reported	Yes
Watson-Singleton et al. (2019)	4 weeks	Bishop et al. (2004)	Not reported	Not reported
Woods-Giscombe et al. (2019)	8 weeks	None Specified	3 (during intervention), 1 (post-intervention but before follow-up)	Not reported
Woods-Giscombe et al. (2014)	Not an intervention	Participant perspective	Not applicable	Yes

The lack of consistency in definitions of mindfulness is a common criticism of secular MBI research (Farias & Wikholm, 2016; Goldberg et al., 2021) and contributed to difficulties in comparing and synthesising findings in this review. The variations in lengths and approaches to mindfulness are also essential to acknowledge, as studies could be exploring fundamentally different states, experiences, skills, and practices (Van Dam et al., 2018). Moreover, the variability in the available qualitative data presented some challenges in the analysis. These challenges were due to differences in the level of depth and detail in the studies (Goldberg et al., 2021), which made it challenging to synthesise common themes and patterns across studies (Chin et al., 2019). Three studies (Burnett-Zeigler et al., 2019; Hong et al., 2022; Spears et al., 2017) focussed on depression yet used an MBSR rather than an MBCT approach which may have impacted the quality of the intervention for their needs (Crane, 2017; Keng et al., 2011).

Another significant criticism of MBI research is the lack of reporting on dropouts (DeLuca et al., 2018; Van Dam et al., 2018; Waldron et al., 2018). Several studies omitted this information (see Table 2), which is a concern when addressing the inclusion of BAME participants in mindfulness research (Van Gordon et al., 2017). The lack of reporting of dropouts may also make it difficult to understand the religio-cultural acceptability and appropriateness of mindfulness for BAME communities (Blignall et al., 2019).

Other considerations during the appraisal not included in Table 2 included issues of ethics, reflexivity and the consideration of BAME needs. Reflexivity is considered a core method of reducing bias in qualitative research (Braun & Clarke, 2019; Finlay, 2002; Shaw, 2010), and only two studies with BAME facilitators (Blignault et al., 2021b; Hong et al., 2022) reflected on how this may have impacted on findings.

Ethical and risk protocols were only sometimes reported and often limited to discussions on informed consent. Two studies explicitly mentioned risk protocols (Blignault

et al., 2021b; Hunter-Jones et al., 2019), such as excluding participants with high self-reported scores for suicidality. To reduce barriers regarding accessibility, two studies provided free childcare to participants to increase the accessibility and retention of participants (Blignault et al., 2021b; Dutton et al., 2013), and one study provided free bus travel (Hong et al., 2022). Such considerations can help address the economic barriers preventing BAME participants from participating and remaining in an MBI (MAPPG.,2015; Bignall et al.,2019).

A quality appraisal must consider both the practical and conceptual challenges of researching marginalised populations with less data available (Deluca et al., 2018). Thus, despite limitations in reflexivity and transparency, these articles were deemed suitable for analysis with some restrictions on validity and reliability. The authors' inclusion of direct quotations from participants provides greater insight into personal experiences. Thus despite limitations, the included articles offered valuable insights into an under-researched field (Chin et al., 2019).

Analysis and Synthesis

The final analysis included the experiences of 323 participants across 17 articles. A summary of the themes based on author summaries of participant accounts is presented in Table 3 below. The number of papers contributing to each sub-theme is included besides each subtheme for reference.

Table 3

Generated themes and subthemes from synthesis

Theme	Subthemes
Mindfulness Needs to be Culturally Sensitive (16 papers)	Cultural Relevance (10 papers) The Importance of Collectivism (seven papers) Cultural Adaptations (12 papers)
The Importance of Considering Religion (13 papers)	Congruence with religion (nine papers) Incongruence with religion (four papers)
Overcoming Barriers (14 papers)	Adverse Effects (three papers)

Theme	Subthemes
	Practical Barriers (10 papers)
	Socio-Cultural Barriers (seven papers)
Looking After the Self (17 papers)	Managing Stress (17 papers)
	Recognising the Need For Self-Care (11 papers)
Becoming More Mindful (15 papers)	Developing Attention and Awareness Skills (11 papers) Non-Reactivity is Important (nine papers)

Theme One: Mindfulness Needs to be Culturally Sensitive

The review found that authors stressed the importance of culturally sensitive MBIs that can address BAME communities' unique stressors and socio-political issues. Thus, culturally sensitive MBIs could increase the credibility and acceptability of MBIs.

Cultural Relevance

Authors across nine studies reported on some cultural practices that helped participants "connect" to mindfulness. Participants described having alternative forms of mindfulness that still required the same core skills, such as mindful attention and awareness of the present moment. These were often “community activities” that participants did with others. For example, the authors of a study on cultural relevance describe similar activities “included quilting, knitting or shelling peas” (Woods-Giscombe et al., 2014, p.156). Notably, these participants were familiar with mindfulness and may have been better equipped to draw comparisons.

Most authors reported on some "recommendations" and "adaptations" to increase cultural relevance across their community. These recommendations were necessary, as participants felt that some people in their community might miss the ability to resonate mindfulness with their cultural practices due to beliefs that mindfulness was for “White folk” (Watson-Singleton et al., 2019; Watson et al., 2016; Woods-Giscombé & Gaylord, 2014).

The Importance of Collectivism

Several authors reported on the desire to "share" mindfulness skills with others, and in seven studies authors report on the participants sharing these skills with other members of their community. Participants wanted to share the "stress management and health benefits that they gained" (Woods-Giscombe.,2015, p.10) and their experience of mindfulness was discussed on a group level rather than an individual level. This collectivism was emphasised in studies that recruited older adults (Burnett-Ziegler et al., 2019; Szanton et al., 2011). The authors report that group membership provided a "social connection to others from a similar background" (Burnett-Ziegler et al., 2019, p.12). In addition, the participants expressed the importance of "being connected to and respected by fellow members of the group" (Szanton et al., 2011, p.5). However, the authors of one study noted that these features were not necessarily linked directly to mindfulness but rather to the group setting that aligned with collectivist cultures (Burnett-Ziegler et al., 2019).

Cultural Adaptations

For mindfulness to be more accessible, authors across studies reported participants' preference for facilitators of the same "race" or "culture". Interestingly participants from studies that had BAME facilitators (Blignault et al., 2021b; Hartwell et al., 2018; Hong et al., 2022; Szanton et al., 2011; Watson et al., 2016; Woods-Giscombé & Gaylord, 2014) did not suggest any modifications relating to the facilitator, which suggests this is of importance to participants.

There was a general desire for the interventions to include stories from the same cultural background or religion to support community members to relate to mindfulness (Blignault et al., 2021b; Thomas et al., 2016; Watson-Singleton et al., 2019). Authors' also reported on preferences for more "culturally relevant" music or images (Watson-Singleton et al., 2019; Woods-giscombé & Gaylord, 2014). Watson-Singleton and colleagues (2019) suggest incorporating three cultural values in a mindfulness program: "self-empowerment,

interdependence, and storytelling". These cultural considerations encouraged participation and an increased ability to relate to mindfulness for participants across studies.

Across the studies, there was also the belief that facilitators must show an "understanding of stressors and historical trajectories that contributed to them..' (Proulx et al., p6). Understanding these stressors was essential to increase the cultural sensitivity of the intervention, but differences between communities were also noted. In one study (Abercrombie et al., 2007, p.32), the authors note the different needs of each community and as such, "distrust of the medical community" is present in the African American population, whereas “[a] lack of information about healthcare or research” exists in the Latino population.

Several authors reported that participants preferred more information about mindfulness or "clarification of key concepts" (Hartwell et al., 2018, p.20) before starting the programme to increase trust. Moreover, The authors report on language changes recommended by participants and "other terms be used in place of meditation, such as awareness relaxation or mindful" (Watson-Singleton et al., 2019, p.137). Finally, articles reported that MBIs should be delivered in the context of health, for example, diabetes (Woods-Giscombe et al., 2014;2019), to increase the acceptability of mindfulness.

Theme Two: The Importance of Considering Religion

Religion and faith played a significant role in the lives of many participants across the studies. While some individuals may find conflicts between their religious beliefs and MBIs, many authors report that participants saw mindfulness as “enhancing” their religious practices.

Congruence With Religion

Authors in one study (Vroegindewey & Sabri., 2022, p. 8) reported the importance of religion as it “helped them [participants] reduce stress and cope with daily challenges”. In

several studies with participants who ascribed to religion, mindfulness was described as compatible with their beliefs (Blignault et al., 2021b; Thomas et al., 2016; Proulx et al., 2020; Vroegindewey & Sabri, 2022; Woods-giscombé & Gaylord, 2014). Christian and Muslim participants across these studies reported similarities between mindfulness and faith-based practices such as praying, journaling, or meditation. As Proulx and colleagues (2020, p.5) note, "Eastern traditions emphasis on benevolence and loving kindness resonated with familiar Christian principles of love thy neighbour". Christian participants also drew connections between "religious hymns and text that promote meditation, quietness and being still" (Woods-Giscombe et al., 2014, p. 157). Similarly, Muslim participants found similarities between mindfulness and "well-known Qur'anic passages and stories illustrating concepts of acceptance and compassion (Thomas et al., 2016, p. 302). Although participants in this study were fluent in English, scriptures were translated from Arabic to English, which may have impacted the interpretation of the findings. The authors note that the notion of self-compassion and self-care promoted in mindfulness is consistent with the self-care practices promoted in Islam (Thomas et al.,2016).

Muslim participants who connected mindfulness with their religion described it as "enhancing" their religious practices (Blignault et al., 2021b; Thomas et al., 2016). The authors of one of these studies (Blignault et al., 2021b, p. 9) note the importance of mindfulness for participants as it "assisted them in prayer and recitations".

Incongruence with Religion

Despite an overall congruence with religion, it is essential to note that the nuances between participants' relationship to mindfulness and religion were reported in four studies. Some participants expressed concerns about recommending mindfulness to other religious group members, which may be interpreted as choosing the practice over their reliance on God (Woods-giscombé & Gaylord, 2014). Christian participants in two studies found that the

mention of Buddha and the intervention were incongruent with their religious views and dropped out due to religious conflict (Burnett-Zeigler et al., 2019; Dutton et al., 2013). To address these concerns in future, a pre-intervention information session to clarify any religious concerns (Dutton et al., 2013). Participants in a later study that included a session of this nature reported that participants were better able to relate to the practice and its intentions, reporting no conflicts between mindfulness and their religion (Blignault et al., 2021b). However, these participants were Muslim, so a direct comparison of these conflicts across the studies is impossible.

Theme Three: Overcoming Barriers

Some barriers to implementing mindfulness were reported across studies. These were often related to adverse effects of the practice, personal barriers and broader socio-cultural barriers.

Adverse effects

Some authors reported that participants valued mindfulness as it allowed them to "revisit their traumas without feeling judged" (Bermudez et al., 2013, p. 107). Through increased practice, participants' found it "easier to focus without being redirected to past traumas" (Blignault et al., 2021b, p. 8). Nonetheless, adverse effects were reported in three studies (Hunter-Jones et al., 2019; Spears et al., 2017; Watson-singleton et al., 2016). All authors described "frustration with mind wandering or perceptions of not doing it right" (Spears et al., 2017, p.6).

Difficulties with the body scan were emphasised in a study with HIV-positive cis and transgender women "as it [bodyscan] relates to body transitioning and trauma related to being identified as male at birth and journeying towards womanhood" (Hunter-Jones et al., 2019, p.8). The authors of one study (Dutton et al., 2013) highlight providing a choice regarding

body positions and keeping eyes open during practice to account for possible individual trauma experiences.

Practical Barriers

Many authors' highlighted practical barriers that impacted programme engagement or retention. Most of these barriers were related to "transportation, employment, family responsibilities, and childcare" (Burnett-Ziegler et al., 2019, p.4). Participants across studies valued mindfulness because "they inherently possessed the resources necessary to practice mindfulness", which helped overcome some of the financial barriers they experienced (Burnett-Zieger et al., 2019, p.5).

Authors across studies reported that participants' competing obligations and life demands made finding time to practice mindfulness outside the group complex (Woods-Giscombe et al., 2014). To address this, participants preferred shorter practices and sessions and no requirement for "homework". Nonetheless, studies that did not include homework (Hartwell et al., 2018) or assigned shorter homework practices (Watson-Singleton et al., 2019) still identified time as a significant barrier. One study described additional barriers not mentioned in other studies, such as insecure housing and access to food (Hong et al., 2022).

Socio-Cultural Barriers

Several authors' identified sociocultural barriers that impact the implementation of mindfulness in participants' communities. These barriers were contextualised within the concepts of stigma and shame towards identifying as "depressed" or in need of help, and "participants reported feeling embarrassed" discussing experiences of depression (Burnett-Zielger et al., 2019, p.4). The authors also reported on stigmatised views of caregiving responsibilities, and some participants expressed concerns about being judged for not taking care of children while meditating (Watson et al., 2016).

This stigma led to uncertainty about recommending the practice to friends and family. For instance, some participants believed that mindfulness was only practised by "atheists, hippies, and new age spiritualists "(Watson et al., 2016, p. 8). Moreover, the authors of one study (Watson-Singleton et al., 2019, p.135) reported that Christian participants discussed religio-cultural views that mindfulness could be seen as "being controlled by sources outside of themselves". The authors note the preference for "other terms be used in place of meditation, such as awareness relaxation or mindful" (Watson-Singleton et al., 2019, p. 137) to minimise cultural incongruence or negative connotations.

Authors across studies also reported that the difference in race or ethnicity between participants and facilitators or meditation audios was a barrier. As Watson and colleagues (2016) note, using a White voice in recordings can implicitly bring up past and present experiences of "racial trauma". In order to overcome these barriers, there was a shared recommendation across authors that facilitators should acknowledge barriers and work collaboratively with communities to overcome them. All authors' emphasised the importance of culturally responsive facilitation to promote the value of mindfulness as a self-care strategy.

Theme Four: Looking After the Self

The authors report that participants valued mindfulness as it improved their ability to recognise and respond to stressful situations, motivating them to prioritise their needs and engage in self-care practices.

Managing Stress

All authors reported that participants valued mindfulness in reducing stress and enhancing their ability to manage it (Blignault et al., 2021b; Burnett-Zeigler et al., 2019; Dutton et al., 2013; Vroegindewey & Sabri, 2022; Watson et al., 2016; Woods-Giscombé & Gaylord, 2014). Some participants in studies of depression valued non-pharmacological

interventions for managing stress in the context of depression (Burnett-Zeigler et al., 2019b; Proulx et al., 2020; Szanton et al., 2011).

Various authors' reported on participants' beliefs that mindfulness was empowering and enabled participants to “effectively handle stressful situations” (Burnett-Zeigler et al., 2019, p. 21). In a study of gender and race-related stress (Watson et al., 2016), the authors reported that mindfulness allowed them to overcome feelings of “powerlessness” and equipped them with the right “tools” to manage it. Some authors also reported that mindfulness prevented participants from feeling “overwhelmed” (Burnett-Zeigler et al., 2019; Woods-Giscombé & Gaylord, 2014) and allowed them to implement self-care strategies.

Recognising the Need for Self-Care

Participants generally found mindfulness a helpful form of self-care that promoted relaxation and well-being in their daily lives (Hartwell et al., 2018; Proulx et al., 2020; Vroegindewey & Sabri, 2022). Several authors noted that self-care strategies were absent in participants' lives before mindfulness(Burnett-Zeigler et al., 2019; Woods-Giscombé & Gaylord, 2014; Bermudez et al., 2013). Participants described mindfulness as helping them to "prioritise" their own needs (Bermudez et al., 2013; Watson et al., 2016) rather than the caregiving responsibilities they faced outside of the intervention (Watson et al., 2016).

By employing greater self-care strategies and "taking time out to reconnect" with oneself (Proulx et al.,2020, p.4), participants described an overall improvement in daily mood and self-compassion (Abercrombie et al., 2007; Vroegindewey & Sabri, 2022; Woods-Giscombé & Gaylord, 2014). The authors in a study of experienced meditators (Woods-Giscombe and Gaylord (2014, p. 10) describe a "higher quality of life through quiet contemplation" for participants, who felt "more affirmed" in their self-worth. Several authors’ noted a send of self-awareness and self-purpose brought about by mindfulness (Thomas et al., 2016; Vroegindewey & Sabri, 2022; Woods-Giscombe et al., 2019).

Theme Five: Becoming More Mindful

Authors across studies report on the value of mindfulness in promoting and increasing present-moment awareness, a non-judgmental approach to experiences, and enhancing awareness of one's surroundings.

Developing Attention and Awareness Skills

Across studies, authors' described how participants "acquire[d] transferable skills" that helped participants to "concentrate [and] pay more attention" (Spears et al., 2017; p4). They reported increased attention towards daily tasks "such as showering, getting ready for bed, and walking" (Watson et al., 2016, p.5).

Some authors reported behavioural changes related to mindfulness in eating habits (Bermudez et al., 2013; Blignault et al., 2021b; Woods-Giscombe et al., 2019). For example, "increased consciousness of eating mindfully" (Woods-Giscombe et al., 2019, p. 11), which was considered a "core feature" of mindfulness (Blignault et al., 2021b, p.9).

Non-Reactivity is Important

By "reflecting inwards" and developing skills such as attention, awareness, and non-reactivity, participants could "quiet" their minds. These skills helped participants modify their emotional reactivity under challenging situations (Woods-Giscombe & Gaylord, 2014; Proulx et al., 2020; Bermudez et al., 2013). Some authors report that this led to greater insight and the ability to mindfully respond rather than react (Burnett-Ziegler et al.,2019); to situations, particularly in expressions of anger (Vroegindewey & Sabri, 2022; Woods-Giscombe et al.,2014). Moreover, non-reactivity was described as "a necessary precursor for greater emotion regulation" (Bermudez et al., 2013, pp. 22-23).

Discussion

Overview

This synthesis reviewed experiences of MBIs for participants from a BAME background, resulting in five analytic themes. These themes reflect diverse experiences across cultures, countries and religious groups. Therefore, it is not possible to draw unified or universal conclusions from these experiences, which should inform any discussion or interpretation of the findings. The findings in this review do, however, provide new insights into mindfulness experiences for BAME participants. Moreover, they have highlighted the importance of considering socio-cultural and religious factors that intersect with mindfulness experiences for BAME participants. The studies will be used to support findings from this thesis, but a summary of the evidence is included below to set the context for the present study.

Summary of the Evidence

The range of experiences reported reflects indications from previous guidelines and reports that factors mediating engagement with MBIs are located in multiple contexts (Bignall et al., 2019; MAPPG, 2015). This review highlighted the need to consider racism and disadvantage in experiences of mental health interventions (Sue & Sue, 2012; Sue et al., 2009; Wood & Patel, 2017; Younis & Jadhav, 2020). Moreover, the authors' reported findings support the notion that facilitators of the same race or ethnic background could encourage participation in MBIs (Biggers et al., 2020; Hartwell et al., 2018; Mir et al., 2019).

Firstly, the articles reviewed here support previous findings that access to mindfulness is mediated and grounded in historical and current experiences of institutional racism (Baer et al., 2006; DeLuca et al., 2018; Dixon-Woods et al., 2006). The review alone would not be able to support assertions about whether MBIs are, therefore, institutionally racist or not.

Nevertheless, participants reported a lack of provision for culturally sensitive MBIs (Proulx et al., 2020; Watson et al., 2016).

Secondly, the findings acknowledge gaps in reporting adverse effects in mindfulness research (Baer et al., 2019; Farias et al., 2020; Van Dam et al.,2018). The Bodyscan[8] practice has been reported to trigger flashbacks or severe anxiety for individuals with experiences of trauma (Cloitre et al., 2018; Farias et al., 2020; McPherson et al., 2020). Findings in this review also speak to other time-related barriers, such as the difficulties in implementing home practice (Wyatt et al., 2014). Despite concerns about completing homework, there seems to be no correlation between homework practice and mindfulness outcomes (Wyatt et al., 2014). The findings raise a question about whether mindfulness skills or formal practice time has a greater impact on skill development, as suggested by Crane (2017).

Thirdly, the findings suggest that people from BAME groups often use religio-cultural experiences to conceptualise and relate to secular interventions (Byrne et al., 2017; Loewenthal et al., 2014; Loewenthal & Cinnirella, 1999; Meer & Mir, 2014). Prior reviews *(*Malpass et al., 2012; Morgan et al., 2015) have emphasised the similarity between mindfulness exercises and participants' religious practices. Morgan et al. (2015) found overall congruence and familiarity between mindfulness and the religious beliefs of healthcare workers. Although, they also report that some participants expressed concerns about potential misalignment with religion due to stigma around including non-religious activities to address well-being (Morgan et al., 2015). These findings speak to the importance of considering religion in mindfulness research and the nuances between how religion is practised and integrated into participants' lives across cultures (Mir et al., 2019; Monteiro et al., 2017; White et al., 2019).

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8 During the body scan, participants are guided to focus systematically on various parts of the body, redirecting their back to the practice when they notice that their mind has wondered

Muslim participants in this review perceived MBIs as beneficial to their overall well-being and consistent with their religious beliefs (Blignault et al., 2021b; Thomas et el., 2016). Participants across the studies noted the similarities between religious prayer and Islamic teachings of compassion (Blignault et al., 2019; Blignault et al., 2021b; Isgandarova, 2019; Thomas et al., 2017). One study included in this review (Blignault et al., 2021b) was part of a series of culturally adapted interventions in Australia reporting on Muslim Arabic speaking (Blignault et al., 2019) and Muslim Arab and Bangla speaking (Blignault et al., 2021a) women. These studies found that culturally adapted MbIs were sensitive to participants' needs and resonated with their experiences (Blignault et al., 2021a;2021b). The findings here also support that of Al-Ghalib and Salim (2018), where participants in their study felt more connected to Islam by understanding practices such as dhikr through a mindfulness lens. This study had minimal qualitative feedback, so it was not included in this review. However, the authors highlight the need for more qualitative research with Muslim participants to understand the religio-cultural acceptability of mindfulness (Al-Ghalib & Salim.,2018).

Finally, the authors across studies' descriptions of participants' greater mindful awareness skills, self-care practises, and perceived stress reduction are consistent with findings in BAME (Charlot et al., 2019) and non-minoritised populations (Amutio et al., 2014). These findings also reflect previous metanalysis on the benefits of mindful awareness skills (Chiesa & Serretti, 2011; Gu et al., 2015; Kuyken et al., 2016). Participants in this review also discussed increases in dispositional mindfulness, including observing, describing, non-reactivity, non-judgement, and acting with awareness (Baer et al., 2006). These findings are important to consider within this population due to the buffering effect on stress for BAME communities (Li et al., 2017; Shallcross & Spruill, 2018). Thus, mindfulness may be a meaningful intervention for these communities.

This review's findings reflect a recent meta-synthesis regarding compassion (Dussault et al., 2020). The authors note that mindfulness can increase social connectedness and self-compassion (Dussault et al., 2020). These findings about compassion have been suggested to be increased when mindfulness is practised within collectivist communities (Poulin et al., 2021). These findings suggest a potential social benefit of mindfulness of BAME groups, who often hold more collectivist values (Salter, 2017; Sue & Sue, 2012).

The findings in this review can be contextualised through theories on BAME disparities. Firstly, the identified themes and sub-themes suggest that access to MBIs is influenced by systemic racism (Biggers et al., 2020; Chin et al., 2019; Eichel et al., 2021). Namely, the lack of cultural sensitivity and relevance can be understood through institutionalised racism that ignores minoritised communities' cultural practices and beliefs (Sue & Sue, 2012; Sue et al., 2009; Wood & Patel, 2017; Younis & Jadhav, 2020). The emphasis on religious and collectivist practices for participants included in the review highlights how religio-cultural factors shape the experiences of BAME groups (Kulwicki et al., 2010; Pilkington et al., 2012; Walpole et al., 2013). Moreover, the findings highlight the need to consider religio-cultural practices in developing and implementing MBIs (Bautista et al., 2022).

The findings also emphasise the need to overcome personal and socio-cultural barriers for BAME participants to engage fully in MBIs (Bautista et al., 2022; Ortiz et al., 2019; Taylor et al., 2021). This points to the impact of systemic racism on the well-being and mental health of BAME communities (Sue & Sue, 2012; Sue et al., 2009). Finally, the emphasis on self-care and managing stress highlights that BAME communities' experiences are shaped by broader social and economic structures perpetuating systemic racism, such as access to physical and mental healthcare (Biener & Zuvekas, 2020; Proulx et al., 2018; Wood & Patel, 2017).

Whilst the range of participants allowed the review to gain insight into the experiences of BAME participants on MBIs, findings also highlighted variation between participants and their contexts. Gaining further insight into these experiences may address the issues of accessibility on MBIs (Bignall et al.,2019; MAPPG,2015).

Strengths and Limitations

This review included contemporary research that focussed exclusively on the BAME experiences of MBIs. As a result, some themes were developed that highlighted some gaps in research, such as the need for more research on Muslim experiences (Thomas et al., 2017).

Nonetheless, this synthesis has some limitations that should be considered. Firstly, non-English papers were excluded, and databases were limited to Western databases such as Medline. A previous meta-analysis (Walpole et al., 2013) has recommended using databases like ArabPsychinfo, PakMediNet, and Index Islamicus so that potentially relevant publications are not excluded.

There was also no uniform definition of mindfulness, which may have impacted participants' experiences and the authors' findings (Bishop et al., 2004). Moreover, the lack of authors' reflexivity can result in biased findings that are not transparently stated (Braun & Clarke, 2020b; Frank et al., 2019; Shaw, 2010). This may have limited the richness of information interpreted by the synthesis (Berger, 2015).

More time, resources and collaboration with reviewers from different cultural backgrounds can facilitate a deeper understanding of cultural experiences, such as those of Black participants(Mir et al., 2019; White et al., 2019).

Problem Statement

BAME individuals experience more significant physical and mental health disparities but have limited access to interventions like mindfulness (Bignall et al., 2019; MAPPG, 2015). Partly because evidence-based interventions like MBIs often overlook or ignore the

religious beliefs commonly held within BAME communities (Proulx et al., 2018; Thomas et al., 2017)**.** Despite calls for therapists to treat spirituality and religion as an integral part of interventions, this remains on the periphery of secular interventions (Bignall et al., 2019; Health, n.d.; BPS, 2017; Toleikyte & Salway, 2008). This is problematic given the importance of religion in BAME communities (Mir et al., 2019; White et al., 2019). The literature review above highlights this need to consider the social, cultural and religious context when working with BAME communities, as they can all impact mindfulness experiences (Tarabi et al., 2020). Therefore, what follows seeks to explore the intersection of these experiences with mindfulness interventions. There remains limited research explicitly exploring the experiences of BAME Muslims, with some emerging research situated outside of the UK (Blignault et al., 2021a; Thomas et al., 2016).

Aims and Objectives

This study aimed to inform future interventions and improve access to MBIs for BAME Muslims. The specific research aims of this study are:

- To explore the religio-cultural experiences of BAME Muslims who have participated in MBIs.

- To explore the acceptability of mindfulness for this group based on their religio-cultural experiences.

Chapter Three: Method

Overview

The current research used an exploratory qualitative design as part of a critical realist approach to explore mindfulness experiences for Muslims from BAME backgrounds. This chapter provides a summary of the philosophical and theoretical frameworks that underpin the methodology chosen. The research aims are discussed in relation to the methodology chosen. This chapter also includes a self-reflexive statement representing the beliefs, experiences and potential biases underpinning the analysis. The chapter concludes by describing the procedure of the study and quality considerations.

Philosophical Framework

Qualitative research requires the researcher to consider how their own 'experiences, views, ethical and political position' has influenced their philosophical beliefs and interest in the research topic (Crosswell & Poth, 2018, p.18) to conduct robust and ethical research. (Zhang et al., 1985). These are discussed in terms of ontology; *what* the researcher views as reality (Stutchbury, 2022), epistemology; or *how* we learn about this reality (Denzin & Lincoln, 2018). More recently, there has been greater emphasis on discussions of axiology; the value and ethical stance taken by the researcher, and how this influences the research process (Crosswell & Poth, 2018).

Ontology

The question of ontology concerns both the nature of reality (Al-Saadi, 2014) and what exists (Maxwell, 2012). Two opposing ontological positions exist realism and relativism. Realism believes that an observable and measurable objective reality exists and that we can discover through observations or research (Cresswell & Poth, 2018; Ormston et al., 2014). In contrast, relativism views reality as a relative concept that exists solely through human interpretation and responses to their environment (Dixon-Woods et al., 2006). My

position sits between these two within a critical realist ontology, which asserts that the social world comprises both observable and unobservable phenomena (Braun & Clarke, 2017; Stutchbury, 2022). Critical realism aligns with an Interpretivist ontology, which challenges the positivist view that social reality can be objectively measured and understood through empirical observation. Instead, interpretivism highlights the importance of understanding social phenomena from the perspective of the individuals who experience them (Al-Saadi, 2014). I believe there is a reality of "mindfulness" and "Islam", and these constructs exist independent of my observations. However, I acknowledge that the reality of these experiences has been moulded by social, political and cultural factors (Denzin & Lincoln, 2018). This research is also relevant to the longstanding philosophical debate about the existence or otherwise of God or a 'higher being' (Crosswell & Poth, 2018). It is something beyond the boundaries of my study to investigate but important to acknowledge in the study of religious and spiritual experiences.

Epistemology

Critical realism also has implications for epistemology, or *how* reality is learned. Critical realism aligns with interpretivism as both approaches emphasise understanding subjective interpretation and meanings (Creswell & Poth, 2018). Critical realism asserts that our knowledge of reality is partial and fallible but that we can better understand participants' reality through scientific enquiry (Creswell & Poth, 2018; Denzin & Lincoln, 2018). Conversely, positivism asserts that reality can be known precisely through objective and measurable approaches to research and that research can be conducted in a "value-free" way, unaffected by the researcher (Al-Saadi, 2014, p.2). Whilst constructionism rejects the idea of objective reality altogether and focuses solely on the construction of reality through language and discourse (Ormston et al., 2014). Researchers taking a critical realist position start with assumptions about the phenomenon they are studying and collect data to test whether these

assumptions hold up in reality (Stutchbury, 2022). Critical realism emphasises the importance of recognising the limitations of our knowledge (Thyer et al., 2019) and being open to revising our understanding of reality based on new evidence (Creswell & Poth,2018). Thus, critical realism allows for nuanced and more holistic approaches to knowledge generation through research (Bazzano et al., 2015).

Reflexivity

Axiology

Axiology, the branch of philosophy concerned with value, is essential in critical realism because it acknowledges that research is not value-neutral (Stutchbury, 2022). Instead, the values and beliefs of the researcher can shape the research questions, the data collected, and the conclusions drawn (Guba & Lincoln, 1985). Critical realism encourages researchers to be transparent about their values and beliefs and to critically reflect on how these may influence their research (Croswell and Poth.,2018). By being aware of their positionality, values and beliefs, researchers can strive for transparency (Denzin & Lincoln, 2018) and increase reflexivity (Braun & Clark., 2020). In the context of this study, my axiology may influence my assumptions about mindfulness practises, how I relate to Islam and how my religio-cultural beliefs have shaped my interest in the research topic.

Self-Reflexive Statement

Self-reflexivity refers to critically reflecting on one's positionality and biases and considering how these may influence research (Denzin & Lincoln, 2018). In critical realism, reflexivity is crucial because it acknowledges that the researcher is not a neutral observer (Sirkeci et al., 2019) but an active participant in the research process (Stutchbury, 2022). By being reflexive, researchers can ensure they are aware of their biases and how they may impact their research (Creswell & Poth, 2018). Moreover, reflexivity allows researchers to mitigate potential biases and ensure their research is as rigorous and valid as possible (Braun

& Clarke,2022). Reflexivity is critical when working with BAME individuals who often have their voices marginalised in research (Creswell & Poth, 2018).

During my research, I maintained a reflexive diary and had discussions with my supervisor to facilitate self-reflexivity. These helped me to evaluate myself and recognise how my beliefs and values influenced the research process. (Berger, 2015).

I am a 29-year-old 'BAME' Muslim female from a working-class, first-generation immigrant family. My experiences and culture have shaped my ontological and epistemological position, influencing my belief in life after biological death and the presence of God. Coming from a similar cultural background can help researchers to connect with participants but guard themselves against assuming that they "share the same experiences or language to describe these experiences" (Finlay, 2002, p.537). I acknowledge that my and the participants' worlds are shaped by "social, historical and relational" experiences (Creswell & Poth, 2018, p.24). Positivist methods rely on empirical observation and quantification, which only partially captures the complexity and subjectivity of human behaviour and experience (Al-Saadi, 2014; Braun & Clarke, 2006; Cohen et al., 2017). Thus, I do not believe they are suitable for studying social phenomena.

My practical and academic experience with MBIs has influenced my views and interest in this research topic. During my MSc in Mindfulness, I critically examined the role of religion and spirituality, which often appeared peripheral in mindfulness studies, despite mindfulness originating from a religious practice. As I progressed through this thesis and conducted a systematic review, my interest intensified. I observed how culture frequently shapes religious practice, fueling my curiosity in this area. This thesis has been moulded by my growing fascination with religious and cultural aspects of mindfulness. Initially, my intention was to explore experiences across religious groups, but the nuances between African American Christians and Middle Eastern Muslims highlighted the uniqueness of these experiences. Consequently, I chose to focus exclusively on Muslims. Reflecting on my own experiences, I anticipated finding parallels between Islam and mindfulness, given my

evolving connection with both. I also expected to identify systemic barriers that can overshadow engagement in individual practices like MBIs. However, I acknowledge that I cannot claim to fully comprehend participants' experiences. I hope this work allows their stories to take centre stage and reflect their unique journeys." My personal and professional experiences have also made me aware of inequalities in mental health services, fuelling my desire to research this topic. As a trainee clinical psychologist, I acknowledge that my position has allowed me to conduct this research. There may be an investigator more suited to this topic that does not have the same power or resources. By being transparent about these reflections, I hope to contribute to new knowledge and be open to critique (Cohen et al., 2017).

Methodology Concerning Research Aims

I chose a qualitative approach for this research as it allows researchers to understand better complex social phenomena such as religio-cultural experiences (Creswell & Poth, 2018). A qualitative methodology uses the "voice of participants", as well as the reflexivity of the researcher, to develop descriptive and interpretive studies that contribute to the body of research (Tarabi et al., 2020, p.5). Religious and cultural experiences are subjective phenomena influenced by various personal and social factors (Cohen et al.,2017), so I sought to understand participants' experiences from their accounts and interpretations (Sundler et al., 2019). Moreover, by understanding participants' religio-cultural experiences, researchers can gain insight into the acceptability of mindfulness for BAME Muslims (Thomas et al., 2016).

An interpretivist approach emphasises the importance of understanding social phenomena through the lenses of individuals who experience them (Frank et al., 2019). I considered it appropriate to understand how participants make sense of their world (Creswell & Poth, 2018). Moreover, interpretivism is relevant in exploring religio-cultural experiences as these are personal and shaped by cultural and social factors (Denzin & Lincoln, 2018). A critical realist approach allowed me to explore these religio-cultural experiences and the underlying structures that may have shaped the experiences shared by participants (Stutchbury, 2022). Moreover, a critical realist approach allowed me to consider some of the participants' experiences of religion and MBIs and acknowledge their existence as external realities independent of my interpretations (Stutchbury, 2022). Thus, combining a critical realist and interpretivist framework allowed me to answer my research question and work within a qualitative framework (Denzin & Lincoln, 2018).

Five main approaches to qualitative research exist; Ethnography, Phenomenology, Grounded Theory, Case Study and Narrative Research (Creswell & Poth, 2018). Before deciding to conduct a reflexive thematic analysis (Croswell & Poth.,2018; Denzin &

Lincoln.,2018), I considered some, including Narrative and Phenomenological Research (RTA).

There are recommendations for less experienced researchers to ground their research within one of the abovementioned approaches, as these methods provide a "structured framework for rigorous and systematic" data analysis (Crosswell & Poth, 2018, p.65).

Mindfulness is a multifaceted construct that can be defined and operationalised in different ways and encompass a range of experiences (Van Dam et al., 2018). This complexity can make it challenging to fit into a single qualitative approach that often requires a focused research question (Creswell & Poth, 2018). Moreover, MBI experience varies based on religio-cultural and environmental contexts (Proulx, 2018), making it challenging to use approaches with a fixed and standardised methodology (Denzin & Lincoln, 2018).

This study on the religio-cultural experiences of participants and their acceptability of mindfulness was exploratory and did not necessarily fit within the frameworks mentioned above (Denzin & Lincoln.,2018). Moreover, the aim was to gain a broader understanding of participants' experiences without imposing a pre-determined theoretical lens (Cresswell & Poth, 2018). Therefore, I conducted a more general qualitative inquiry to understand their subjective experiences and used Reflexive thematic analysis (RTA) to analyse data (Creswell & Poth,2018).

RTA is not grounded in traditional approaches (Braun & Clarke, 2022). Nonetheless, RTA offers a rigorous qualitative data analysis method that can provide rich insights into a research topic (Braun & Clarke, 2022; Terry et al., 2017). This approach requires the researcher to be explicit about their ontological, epistemological and axiological positions (Braun & Clarke, 2020a), and once these positions are stated and considered, it can be a valuable approach to research with BAME groups (Biggers et al., 2020; Femi-Ajao et al., 2020; Wyatt et al., 2014) Moreover, RTA encourages researchers to be reflexive and critically reflect on their assumptions throughout the data analysis process (Braun & Clarke, 2022).

Moreover, reflexive TA also aims to identify patterns and themes that reflect reality for participants independent of my perceptions (Braun & Clarke, 2020b). This approach fits with the study's critical realist framework, which acknowledges the importance of

subjectivity and some underlying patterns or structures that reflect an objective reality (Al-Saadi, 2014; Braun & Clarke, 2019; Stutchbury, 2022). To account for the lack of alignment with a specific qualitative approach, I hope to be clear about the methodology used to collect and analyse data and to ensure that my approach to the research is systematic, rigorous, and ethical (Creswell & Poth, 2018; Denzin & Lincoln, 2018). Additionally, I aim to address some critiques regarding the lack of researcher positioning in research that claims to take a reflexive approach (Braun & Clarke, 2020b; Terry et al., 2017).

Narrative research explores participants' personal stories and experiences (Crosswell & Poth, 2018). It offers a holistic way to holistically understand participants' stories and experiences, using their own words (Denzin & Lincoln, 2018). However, the focus is on individual experiences rather than broader religio-cultural trends (Denzin & Lincoln, 2018). This approach could be helpful if the study were not exploratory and aimed to gain a deeper understanding of individual perceptions and experiences of MBIs (Creswell & Poth, 2018). Using a narrative approach, I would have collected the personal stories from participants, which would have allowed for a detailed exploration of subjective experiences and can uncover the meaning behind their experiences (Cresswell & Poth, 2018). A narrative approach could have helped explore how participants' religio-cultural identities have influenced their perceptions of MBIs and shaped their overall life stories (Denzin & Lincoln, 2018). Thus, a narrative approach may have been more suited to exploring individual experiences rather than broader religio-cultural experiences (Chin et al., 2019).

Phenomenological research explores the essence of a phenomenon or experience as it is lived by participants (Denzin & Lincoln.,2018). This method could have been helpful if the study aimed to explore and report on the subjective experiences of a particular ethnic 'group' of BAME Muslims and their individual experiences (Denzin & Lincoln, 2018). This approach would have involved in-depth interviews or observations with a homogenous

sample to uncover nuances and subtilties in their perspectives (Pietkiewicz & Smith, 2014)**.** This approach may not be suitable for generalising findings to larger contexts and may be limited by participants' ability to articulate their experiences (Pietkiewicz & Smith, 2014). Moreover, IPA analysis is highly subjective and dependent on researchers' interpretation. As IPA does not require researchers to be explicit about their positioning in the same way as reflexive TA, it may not have been suitable to address issues of bias which is essential in religio-cultural research (Braune & Clarke, 2019).

Both narrative and IPA approaches may be better aligned with a constructionist epistemology that emphasises how reality is constructed through individuals' perceptions and understandings rather than acknowledging a 'reality' of MBIs and Islam (Creswell & Poth, 2018). Thus, while IPA and narrative approaches may have been valuable, they were considered more suitable to questions focussed on identity or life stories (Creswell & Poth, 2018) rather than the exploratory aims of this study.

Sampling and Recruitment Strategy

I used purposive sampling to ensure the research question had relevance and personal significance to participants (Bercean et al., 2020). Smaller sample sizes are well suited to qualitative research (Crosswell & Poth., 2018), and different sample sizes have been suggested for RTA (Braun & Clarke, 2013; Terry et al., 2017). Between 10 and 12 participants have been recommended for a UK professional doctorate study using this approach (Braun & Clarke, 2013).

Inclusion and Exclusion Criteria

The study recruited participants who:

- Were adults (aged 18+) who identified as Muslim and had a 'BAME' background
- had previously taken part in an MBI in the UK
- had a sufficient understanding of English due to the nature of the methodology (Croswell &Poth., 2018)
- had taken part in a recognised mindfulness programme, such as MBCT, MBSR, or

third-wave approaches (e.g., CFT), to ensure consistency due to variations in mindfulness-based interventions (Golberg et al., 2021)

The following exclusion criteria were applied:

- Individuals who do not identify as BAME Muslims
- Individuals who have not previously participated in an MBI in the UK
- Individuals who do not have a sufficient understanding of English. Although, this can restrict access to research participation for socially disadvantaged groups (Walpole et al., 2013)
- Individuals who have participated in a mindfulness programme that is not a recognised MBI, such as a relaxation or stress reduction program that does not explicitly focus on mindfulness.

This research considers the use of the terms 'BAME' or 'BME', which are used interchangeably when referring to minority populations who have a non-European heritage (Agyemang et al., 2005; Cotter & Jones, 2020). However, these terms have limitations due to their lack of cultural and racial nuances within these groups and because they exclude individuals who do not fit into these categories, such as those from "other" White minorities (Agyemang et al., 2005; Arday 2018). Individuals determine their ethnicity subjectively, but the synonymous use of ethnicity with race complicates it due to historical and prejudicial connotations based on imagined genetic differences. (Agyemang et al., 2005). The lack of identification for individuals exemplifies the difficulty of categorising people based on race; for example, introducing the 'Arab' category was not included until the 2011 census (ONS, 2013). One recommendation to address these challenges is to provide specific descriptions of ethnic backgrounds when discussing research results. (ONS, 2013). I will include the country of origin in this study if participants share it. I will use the BAME category while recognising that shared ethnicity or language does not necessarily indicate similarity in cultural beliefs and practices. (Arday, 2018). These limitations are essential to keep in mind when interpreting this thesis to avoid making inaccurate assumptions about different cultures.

Recruitment Method

I created a poster advertisement for the study (Appendix G), which I shared via social media, namely WhatsApp, Linkedin, Facebook and Twitter. I contacted organisations such as the Mindfulness for Social Change group, which has a BAME mindfulness facilitators and practitioners' network, and an Islamic psychology special-interest group. Additionally, I contacted researchers and university lecturers interested in this area and asked them to share the study with their contacts.

Due to the COVID-19 pandemic restrictions, I conducted online advertisements, recruitment, and data collection. I did not offer any face-to-face interviews. Conducting the study online allowed me to reach participants from across the UK, increasing the likelihood of variance in ethnicity, education, and socioeconomic status (Johnson et al., 2022a; Vroegindewey & Sabri, 2022).

Ethics

I gained ethical approval from the University of Essex ethics committee (Appendix H) through the Ethics Review Application and Management System (ERAMS), and I conducted the study in line with The British Psychological Society (BPS) Code of Ethics and Conduct (2018). I paid particular attention to the issues of trust, power, and confidentiality, which are crucial when working with participants from BAME backgrounds (Crosswell & Poth, 2018). I disclosed my position as a BAME Muslim before interviews to increase trust and safety in the research process (Cresswell & Poth, 2018). Disclosing my position is recommended (Proulx et al., 2018) to address potential power imbalances in research with marginalised communities.

Informed Consent

I emphasised the importance of obtaining informed consent and conducting culturally sensitive research that accounts for differences in language and literacy levels, as highlighted

by the BPS (2018). Due to their historical exclusion from services, BAME participants may require more detailed information to decide about participating in research (Rawlings & Bains, 2020). I asked them to read a participant information sheet (Appendix I) before deciding whether they wished to participate. To ensure compliance with ethical standards, I designed a consent form (Appendix J) that was provided to all participants for their signature before formal recruitment into the study.

Right to Withdraw

I informed participants of their right to withdraw from the study without any negative consequences until the write-up of the results. I also reminded participants to take breaks or reschedule the interview at any point. Four individuals decided to withdraw their participation after agreeing to participate but before signing the consent form.

Confidentiality

Confidentiality may be a significant concern for minority groups (Iob et al., 2020; Woods-giscombé & Gaylord, 2014) based on their historical and political treatments in mental health services (Liamputtong, 2010). Due to the online nature of interviews, and the potential ethical implications, I asked participants if they were in a confidential location and felt free and able to speak when participating in the interview.

In order to retain anonymity, participants' names were redacted from the coding process, initially given participant numbers and later pseudonyms, which helps bring participants "to life" (Pietkiewicz & Smith, 2014). A key was created and stored on a password-protected file identifying which pseudonyms correspond with which participant (Crosswell & Poth., 2018).

Data Management

Only my supervisors and I had access to the transcripts to maintain confidentiality. Interviews were audio recorded using a high-quality device to ensure accurate transcription

and prevent losing important information (Lindahl et al., 2017). I performed the transcription solely and erased the original files from the recording device upon completion. I stored the collected data on the University of Essex's Box Drive, which will be kept for five years. I kept hard copies of the transcripts in a password-protected folder on my NHS computer. Backup copies of the transcripts were saved on the University of Essex's Box Drive to prevent potential data loss.

Protection from Harm

I determined that the potential benefits outweighed any potential harm, and I did not anticipate any significant risks for participants in the study (BPS, 2018). I closely monitored participants' responses during interviews and would have ended the interview if I had observed any distress. As a research method, interviews involve "more subtle forms of power than quantitative approaches" (Denzin & Lincoln, 2017, p.589). To balance this power dynamic, I sought to "learn from" rather than "speak for" participants (Denzin & Lincoln, 2017, p.86) to avoid imposing my cultural assumptions on them (Pillow, 2003). Reflexivity was employed throughout the process to decolonise the discourse of the 'other', and I monitored my cultural standards through this approach (Pillow, 2003). While involving participants in data analysis could have been "empowering" for participants (Cresswell & Poth, 2018), this was not feasible due to time and resource constraints.

Debriefing

I debriefed participants at the end of the interview, in line with recommendations (BPS, 2014). Debriefing was facilitated through a verbal discussion and a debrief sheet (APPENDIX K). No participants shared any distressing experiences, and all indicated they understood the implications of using their interview data.

Risk

Discussions around mindfulness practice could be experienced as therapeutic, although some studies suggest possible difficulties could arise (Hunter-Jones et al., 2019; Spears et al., 2017). I monitored this by making observations and debriefing the participants. If any adverse effects had occurred, I would have reported them immediately to the Ethics committee.

Data Collection

Qualitative research methods involve approaches such as interviews and conversations to gain an understanding of participants' lived experiences (Crosswell & Poth.,2018). The most common approaches are focus groups and interviews, and the final appropriate approach was selected based on the research aims and objectives (Creswell & Poth, 2018).

Interviews

Interviews are a standard data collection method done face-to-face, by phone or online to elicit information or expressions of opinion or belief from participants (Crosswell & Poth., 2018). This approach allowed for a full exploration of lived experiences but limited the sample size compared to focus groups (Cervantes & Sherman, 2021). Researchers commonly discuss three types of an interview; structured, unstructured or semi-structured (Patel & Shikongo, 2006).

Semi-structured interviews are a flexible and popular approach that promotes opportunities to tailor questions to individual participants and the context of their experiences (Crosswell &Poth., 2018). Moreover, they allowed participants to share their experiences in their own words rather than being limited by pre-determined responses, options or 'scales' (Braun & Clarke, 2022). This approach can also be valuable when studying phenomena that are difficult to quantify, such as religio-cultural experiences and the acceptability of mindfulness (Woods-Giscombe et al., 2014). The flexibility of semi-structured interviews is

particularly beneficial when working with BAME communities who are often excluded from opportunities to 'have their voice heard' (Liamputtong, 2012). They also allowed for pre-determined questions and prompts and the opportunity to follow up on responses with additional questions or probes (Cresswell & Poth., 2018). This flexibility is essential when exploring religio-cultural experiences, as they allowed me to explore the nuances and complex ways mindfulness is experienced and understood in different religio-cultural contexts (Loewenthal & Cinnirella, 1999). Semi-structured interviews can provide rich and detailed data that can help researchers gain a deeper understanding of the experiences and attitudes of BAME Muslims towards mindfulness (Thomas et al., 2016) and can help inform the development of culturally appropriate mindfulness interventions (Woods-Giscombe et al., 2014).

Semi-structured interviews have been used to explore the acceptability of mindfulness in BAME communities (Dutton et al., 2013; Gaylord et al., 2022) and mindfulness experiences for BAME participants who identify as Muslim (Thomas et al., 2016). Based on the considerations outlined above, they were deemed the most appropriate for this study. The semi-structured nature of the interviews also allowed me to change the pace and wording of questions for participants to suit their level of English or understanding. An interview transcript **(**Appendix L) guided the interviews.

Research Procedure

As the primary researcher, I asked interested individuals to contact me directly and gave them 24 hours to consider participation. During the initial contact, I asked participants about their ability to use the Zoom video conference platform for video interviews. Those who could not use Zoom were offered telephone interviews, which two participants chose to do. Prior to the interview, I obtained informed consent from the participants, which they

signed and returned by email. Following this, depending on their circumstances, they were invited to participate in a telephone or online interview via the Zoom platform.

During the interviews, I asked participants to confirm whether they had privacy in their rooms. Three participants mentioned having children but were willing to proceed with the interview. To establish rapport and maintain transparency, I disclosed my insider perspective (as a BAME Muslim with lived experience of mindfulness) and outsider perspective (as a trainee clinical psychologist conducting research)

I collected anonymous demographic information from the participants at the start of the interview, which included their age, ethnicity, gender, religion, job title, education, mindfulness training, and length of experience practising mindfulness (Appendix M). I informed participants that they did not have to share any demographic information they felt uncomfortable sharing. I then used a semi-structured interview guide (Appendix L) to encourage participants to discuss their experiences. Following the interviews, I provided verbal debriefing and gave participants the debrief sheet (Appendix K) containing contact details for the primary investigator, supervisor, and the national Talking Therapies service.

Throughout the interviews, I used my mindfulness skills to notice any assumptions or associations I made in response to participants' accounts. When I noticed my mind wandering, I attempted to bring my awareness back to their descriptions in a non-judgemental manner.

Data Analysis

Data Transcription

I ensured that the transcription was as accurate as possible and that no critical information was missed by transcribing the interviews verbatim and typing them onto the computer shortly after each interview, following the recommendation by Braun and Clarke

(2020b). After transcribing, I imported the data into Nvivo 12 software to organise, manage and analyse qualitative data (Braun & Clarke, 2022).

Data Analysis

To support the data analysis from the interviews, I used a reflexive journal, an anonymous demographic sheet (Appendix M), and answers from discussions in the interview guide (Appendix L). The data analysis took place between August 2022 and January 2023.

I chose reflexive thematic analysis (TA) to analyse the data collected from participant interviews. RTA is a flexible method that does not have to be linked to a particular theory(Terry et al., 2017). However, Braun and Clarke (2019) have highlighted how this does

not mean opposing theoretical underpinnings can be used by researchers within one study. RTA Allowed me to examine my own biases and experiences that may influence the research process and outcomes in line with a critical realist approach (Braun & Clarke, 2022).

RTA is an iterative process that allows for developing themes as the analysis progresses (Terry et al., 2017). TA allows researchers to explore latent themes and develop findings based on underlying meanings and nuances not apparent in semantic themes (Braune & Clarke, 2022). Using latent themes allowed me to have a deeper emersion in the data. It enabled me to conduct a rigorous data analysis to identify key emerging themes and patterns (Terry et al., 2017). Moreover, latent themes allowed me to gain a grounded understanding of participants' religio-cultural experiences, as discussed by Braun and Clarke (2019; 2022). In addition, RTA is a transparent approach that can be easily communicated to a range of stakeholders (Terry et al., 2017). Thus, RTA can be communicated to those within and outside academic settings, increasing the possibilities for disseminating findings (Braun & Clarke, 2022).

TA has also been used in mindfulness studies to explore the cultural relevance and experiences of MBIs (Thomas et al., 2016; Watson et al., 2016; Woods-giscombé & Gaylord, 2014). Broadly, TA involves six phases: familiarisation; coding; generating initial themes; reviewing and developing themes; refining, defining and naming themes; and writing up (Braun & Clarke, 2006, p. 87). Braun and Clark (2019) highlight the importance of immersion and repeated data engagement to build depth in the codes developed (Braun & Clarke.,2022).

The first familiarisation stage involved re-reading transcripts and keeping reflective notes on "different ways to make sense of the data" (Braun & Clark., 2022, p.38). The "critical distancing and questioning" of my assumptions (Braun & Clark.,2022, p.49) felt particularly important when reading participants' transcripts from my cultural background.

Coding was not done at this stage to avoid cherry-picking initial statements that fit my preconceptions or ideas (Braun & Clarke, 2020b; Terry et al., 2017).

Then, in the coding stage, I explored diversity in the patterns of meaning with the research question in mind (Terry et al., 2017). This open and inclusive process identified all relevant topics without coding every line of text(Braun & Clark, 2017). I used semantic codes to capture surface-level descriptions of mindfulness and Islam. At the same time, I employed latent codes to explore their words' possible underlying meanings and unconscious aspects, aiming to uncover hidden patterns or dynamics. Additionally, I utilised Nvivo 12 for coding. (Braun & Clarke, n.d.). I have included a sample codebook in the appendices(Appendix N). The initial coding process led to the generation of 1040 codes. Initial coding was done twice and in different orders in line with recommendations for reflexive TA (Braun & Clarke, 2022).

Braun and Clarke (2022, p.65) recommend moving between electronic and hand-coding to "immerse in the data". Thus all subsequent coding and theme production was done by hand, increasingly moving from semantic towards more latent coding.

As the primary researcher, I followed the research question to determine the relevance of the data. I printed and highlighted the initial codes (Appendix O)to update, rearrange, and adjust them according to the central organising concept underlying each developing theme, as Braun and Clarke recommend (2022, p. 102).

The fourth and fifth phases involved reviewing and defining the themes (Appendix PO to ensure they "matched the story" of the experiences shared by participants. These phases were iterative, generating new themes and dissolving pre-existing themes. I created some visual maps to determine the final themes and subthemes (Braun & Clarke, 2022), which resulted in the collapse of several themes into subthemes and the generation of several overarching themes. The final step was the development of this report, and at this stage, I

started to shift from an analytic phase towards a broader view of the project and its wider clinical and research implications.

Reflexive Statement

During the analysis, I spent some time noticing the quotes and statements I most readily picked out and included and went back and re-read transcripts to which I was ascribing less 'weight'. I also noticed the pull towards more codes from participants who spoke in my 'mother tongue' of Arabic and French. I chose to spend more time immersing myself in transcripts where participants did not speak French or Arabic. This also highlighted the notion of 'loss of meaning' in translating text from the Algerian dialect to English. I wondered how participants from other backgrounds, most of whom English was not their first language, may have struggled to articulate their perspectives and how this impacted the quality of my themes.

Quality Considerations

There are no strict guidelines for assessing quality research, although some tools have been discussed in the literature (Braun and Clark.,2015; CASP.,2018). I considered Braun and Clarke's (2019) reflexive TA an appropriate tool to ensure clarity in the research aims analysis process and my role within the research (appendix Q) as I followed their approach. Self-appraisal is crucial for improving researcher credibility in qualitative research (Liamputtong, 2012), and I achieved this through reflexivity, as previously mentioned in this chapter.

Chapter Four: Findings

Overview

This chapter discusses the results of the present study in relation to the research aims. This chapter begins by reporting participants' demographic information and mindfulness experiences to position the results within the sample from which they were generated. Then, I discuss the themes and subthemes generated from the reflexive thematic analysis. I present verbatim extracts from participants to illustrate the analysis and describe the experiences of participants as they have perceived it. I referred all participants to pseudonyms and removed identifiable information from their extracts to protect their anonymity.

Participant Demographic Information

Study Sample

A total of 14 people expressed an interest in participating in the study. Two males and two females withdrew after initially agreeing to participate but before signing a consent form. Two stated time constraints, one expressed fears about confidentiality, and one did not respond to follow-up contact. A total of 10 people took part in the study. The sample consisted of all females aged between 25 and 60 (mean age 39.5 years). Of 10 participants, eight different descriptors of ethnicity were disclosed. Table 4 below summarises the participant characteristics. Notably, the participants were all female and highly educated which may not be reflective of the wider BAME Muslim population.

Table 4

Research sample demographics

Demographic		N=10
Age	20-29 years	1
	30-39 years	4
	40-49 years	4
	50-60	1
Gender	Female	10

Demographic		N=10
Ethnicity	Algerian	1
	Bangladeshi	1
	British Pakistani	2
	Middle Eastern/ Egyptian	1
	North African	1
	Indian	1
	Pakistani	2
	Turkish/ White other	1
Level of Education	A-level equivalent	1
	Undergraduate degree	2
	Master's degree	5
	Doctoral Degree	2

Mindfulness Experiences

The average experience of mindfulness ranged from two to 20 years (mean six years). Two participants participated in an MBSR programme, two in an MBCT programme, four in both MBCT and MBSR programmes, and two in MBCT and CFT programmes. Table two below summarises the type of mindfulness training and length of practice.

Table 5

Participant experience of mindfulness and self-reported practice levels

Participant Pseudonym	Mindfulness-Based Stress Reduction Programme	Mindfulness-Based Cognitive Therapy programme	Compassion Focussed Therapy programme	Continued daily practice	Length of practice experience (in years)
Duaa	x			x	5 +
Fatima		x		x	2
Zainab		x		-	
Mariam	x	x		x	10+
Aisha	x	x		x	20+

Participant Pseudonym	Mindfulness-Based Stress Reduction Programme	Mindfulness-Based Cognitive Therapy programme	Compassion Focussed Therapy programme	Continued daily practice	Length of practice experience (in years)
Sara	x	x		x	3
Aaliyah	x	x		x	10+
Maria		x (online)	x	x	5
Nora		x (online	x	x	3
Aya	x			-	2

Generated Themes and Subthemes

The interviews lasted between 29 and 65 minutes (the mean time was 48 minutes). The total data collected was 484 minutes. From my 10 interviews, I developed five themes, including 16 sub-themes. I present these themes and sub-themes in Table 6 below, which also includes the number of participants who contributed to each of the sub-themes.

Table 6

Generated themes and subthemes for this study

Theme	Subtheme
"Mindfulness has been Colonised." (10 participants)	Eurocentric Discourse in MBI's (1o participants) The Rise of Mindfulness in Popular Western Culture (six participants) Mindfulness is not A Priority (eight participants) Eastern Ideals within "Whitewashed" Mindfulness (six participants)
"It's [Mindfulness] Ingrained in our Religion." (10 participants)	Islam is a Mindful Religion. (10 participants) Mindfulness through Daily Islamic Practices (10 participants) Islamic Meditation (10 participants)
"Islam is not [Always] Practiced Mindfully" (four participants)	Living in a Secular World (four participants) A Lack of Understanding (four participants)

“You Can't Separate Culture and Religion” (1o participants)	Everyone Has their Way (10participants)
	Resistance to the Unknown (six participants)
	Mindfulness Needs Validation (five participants)

Theme	Subtheme
“Transformative Mindfulness when Life Was Upside Down” (10 participants)	A Tool you can Rely on (10 participants) Slowing Down the Internal Pendulum (10 participants) Regaining Control (five participants) Developing Connections (10 participants)

The themes developed from the interviews demonstrate the nuanced ways mindfulness was perceived, experienced and implemented within participants' lives. All participants shared an overall acceptance of mindfulness practice and experienced the courses they attended as relevant to their lived experiences. Participants shared that cultural sensitivity to their beliefs would encourage communities who may be more hesitant to accept secular interventions to participate in MBIs. Participants’ religio-cultural experiences appeared to mediate their perceptions and understanding of mindfulness and how they integrated it into their daily lives.

Theme One: "Mindfulness Has Been Colonised."

The "Western" discourse of mindfulness was seen as something that has shaped and shifted mindfulness from its Buddhist roots. The first sub-theme, "Eurocentric discourse in MBIs", explores how "Whiteness" has prevailed in the design and implementation of MBIs. This theme was developed from participants' ideas that Western ideology, language and "voices" had been at the forefront of the courses they attended, which presented some challenges. The second theme, "The rise of mindfulness in popular Western culture", captures how mindfulness in the West has led to some misunderstandings about the "essence" of mindfulness but has also increased acceptability for Muslims. The third sub-theme, "mindfulness is not a priority", explores the socio-political context of BAME lives, which may be a barrier to committed mindfulness practice. Participants felt pressure to "make

mindfulness work" (Aaliyah) regardless of their personal or family obligations. This sense of pressure manifested differently across participants, and participants increasingly shared information related to this sub-theme as the conversation developed and rapport was built. Finally, the last theme, "The pervasiveness of Eastern ideals in Whitewashed mindfulness", explores the ways mindfulness has the potential to be relevant and acceptable if culturally sensitive programmes were available.

Eurocentric Discourse in MBI's

All participants had taken part in MBIs led by White facilitators. For those for whom English was not their first language, this meant sometimes struggling to reconcile with the metaphors and analogies. For example, Sara shares:

> The teachers are usually White teachers, or you know, they use examples in their narrative about [pause], you know. For example, Norway or Scandinavia or, umm, just different European countries… I think it's a diversity issue

There were also fewer opportunities for participants who had attended group MBCT or MBSR programmes to share their narratives and stories, which contrasted with storytelling preferences they shared within their country of origin. Additionally, the lack of visibility of BAME or Muslim facilitators in mindfulness programmes was experienced as "isolating" and led to uncertainty about whether the programme was sensitive to their needs:

> It [MBCT] was led by two [White] males … I like the voice of one of them, but I didn't concentrate as well with the second one, so maybe I was less … engaged in it (Aaliyah)

The sense of safety and trust determined participants' engagement with their respective programmes and how they experienced the facilitator. Some participants highlighted differences in cultural norms within NHS mindfulness programmes, such as male facilitators leading practices for both genders. Some discomfort was reported regarding "the tone of voice and instructiveness" (Aya) of male facilitators, which conflicted with their preferences. Duaa discussed informing facilitators that lying down in a shared mixed-gender room was not in line with her religio-cultural beliefs:

> Like lying down, for example [during the body scan], as a woman…I don't want to do with a man...they recognise this, and they respected this is what I wanted so, so I would be in the section with the ladies and men will be on the other side

When these preferences were respected, she described feeling better able to trust facilitators, which increased her acceptability of the programme. No other participants felt able to share these preferences, and some explicitly mentioned avoiding this due to fears that facilitators "might think I'm weird or extreme" (Aaliyah).

There was a particular focus on the Eurocentric discourses used in MBIs, as alienating and one that made it more challenging to relate to the teachings and examples within the session. Sara spoke about experiences of teaching mindfulness within a Black community in the USA after attending MBIs in the UK. She described the Eurocentric language as less accessible for group members:

> I think with people who are not White or not European American. The language was definitely a Ch Like challenge… I'm not sure like I'm not sure what it is about the language, but I mean, some of the feedback I get is like the language is like too White

Other participants contextualised the language as “intellectual", which alienated members of their community who had initially shown an interest in mindfulness. For example, Nora shared, "I know when I've shared a book or something on Mindfulness with them, they say the language is um er little confusing or not something they understand well or too complicated".

This Eurocentric discourse and language got in the way of some participants' engagement with the programme. Zainab, who described English as her third language, listed this as a reason for mind wandering during sessions. She dropped out of her MBCT programme after four weeks, but she positioned this in the context of her pregnancy:

> To be honest, they didn't er they didn't explain it properly to me. It was like, am I doing yoga? Am I doing meditation? They didn't explain, really … this because I didn't understand it…I didn't really understand what it was… I didn't know that I was pregnant, and I was the three first ... so I was just, I mean, I slept in the mindfulness session. I was sleeping

Even in some cases where facilitators were not White, and there were no barriers related to the voice or gender of the facilitator, Sara highlighted that BAME communities are more drawn to facilitators from their ethnocultural background:

> People who become trained in mindfulness but they will sort of stick to like their own communities. So Um! A lot of like Black or African Americans, they'll try to just target mindfulness for like their communities since, you know, these industries are not really doing a good job of it, you know, doing more community outreach

Several participants also experienced tensions between the structured approach of MBCT and MBSR and the experiential essence of mindfulness. They found that the structured approach needed to connect more to their experiential practices and religio-cultural understandings. Mariam shared:

> I would say that they compress the course into eight parts, and then you focus on those eight parts. Sometimes you get bored because you're spending too much time on one specific thing—for example, mindful eating. You're just dragging, dragging, dragging certain things for an hour rather than letting the person *experience* the present moment of mindful eating

This Rise of Mindfulness in Popular Western Culture

All participants discussed the "popularity" of mindfulness and its promotion in workplaces, social media and broader media outlets. This popularity was seen as containing enabling and hindering elements, specifically to the participant's understanding of mindfulness and mindfulness within their community. All participants experienced a shift in how they and others around them understood and engaged with mindfulness over recent years. They attributed this to the fact that mindfulness is now "quite popular". For example, Maria shared:

> There's probably a shift…because people are practising it at work and that kind of thing. Um, and so it's a bit more kind of like, normalised, I would say. I think like for myself

Participants also acknowledged the increasing popularity of technological advancements, such as mindfulness apps, led to more "uptake" from the Muslim community. Sara shared:

> I think also hearing about it more, and like the media, also health, or just hearing about it more [pause] like the news, or in bookstores or in Tv programmes like, I think, just the way it's sort of propagated itself through pop culture has developed [mindfulness in the Muslim community] ironically

Participants identified the COVID-19 pandemic as a critical factor in the recent spread of mindfulness practises within their community. Some participants valued this opportunity to make time for their well-being. Maria, who describes herself as a regular user of the mindfulness app "Headspace", shared, "It's just like really become so popular with the pandemic it just Boom: [Researcher: Yes, yeah] it's brilliant [laughs].

Three participants noted that the popularity of mindfulness apps was due to their “design for modern life” (Aya), which allowed for greater control over how and when they practised mindfulness exercises. Additionally, the choice of exercises and the ability to select the voice of a facilitator made participants feel "safe" and "comfortable", which was not an option on MBCT or MBSR programmes:

> I guess that the good thing about the app is you have that power and control over how much you want to engage in it. So it sounds like, Yeah, that's a good decision not to Ah push yourself beyond what's comfortable (Nora)

Conversely, some participants saw this popularisation as causing a loss of meaning and confusion about what "[mindfulness] really is" (Mariam). As a result, there was an increase in hesitancy within participants' communities to engage with mindfulness. Aya explained, "Sometimes you use a term so much that you lose its essence. When you hear it so often, you become desensitised to it. It's like, oh, mindfulness, all that kind of thing!".

All participants highlighted the importance of MBIs being sensitive to the needs of Muslims, especially given the rise in popularity. Some participants gave examples of commercial products they had used that included mindfulness elements or exercises that were sensitive to the needs of Muslims:

> We were bought…Mindful Muslim cards…and journals… really interesting because it just shows that there's definitely take up amongst the Muslim community of mindfulness (Maria)

Participants also described MBIs as 'expensive' and 'inaccessible' to members of their community if they were not delivered within an NHS context. Mariam shared:

> I paid four five hundred pounds, almost four hundred something pounds [Researcher: mmhmm] for that course um eight-week programmes, even though the lady was extremely good and very kind, but I believe majority of people are not able to afford [mindfulness]

These financial implications of participating in MBIs created an accessibility barrier for participants, and many reflected that they could only engage in mindfulness due to the offer of a free NHS programme. Several participants credited free mindfulness resources for

making the concepts of mindfulness and exercise more accessible to their community. Nevertheless, these participants expressed a need to develop mindfulness resources in their native language. Aaliyah shared, "A lot of the like free materials or resources they're all in English, or they're very Western [in their reference]". To enhance the acceptability of mindfulness practices in their community, participants recognised the importance of providing resources in languages other than English.

Mindfulness is not a Priority

Alongside the challenges posed by the Eurocentric nature of mindfulness courses, participants discussed how their immediate and wider family and community did not prioritise courses such as MBIs in their lives. Some participants felt that mindfulness was being oversold as a resource that could be used at any moment, which was perceived as culturally insensitive, "Especially with kids and other commitments" (Duaa).

Participants explored how they were encouraged to engage in extended mindfulness practices outside of the programmes, regardless of their other commitments. Two participants who engaged in MBIs while completing doctoral degrees adapted mindfulness practices to fit their schedules and daily routines—for example, mindful cooking or mindful movement. Adapting mindfulness practices made maintaining their practice easier whilst honouring their other commitments. Nora shared, "I can make time for a 5 min practice...that's not the issue. But I think I just have so many other things to prioritise…cooking is something I can do that fits."

Participants discussed barriers related to time at a community level. They explored ideas about the potential value of mindfulness if there were fewer caretaking responsibilities

, for women in their culture such as looking after children or elders in their community. Sara captured this when she shared that these gendered responsibilities prevented female family members from committing to the required lengths of practice, even if they valued being introduced to mindfulness:

> I think I think one dropback for them [family members] is the time commitment... They [family members] think that they have to do it for a long period of time, multiple days a week. So they see the value in it ... It's a time commitment, and that's like the mental block, I suppose

Some participants shared strategies with family members for overcoming these community barriers to make mindfulness more feasible. For example, Aya shared, "The body scan was very useful at three minutes err because sometimes people want to do short and quick". Additionally, participants described encouraging "busy" friends and family members to take "time for themselves". As Zainab expressed, "They can do it once-twice a day of five times a day for five-ten minutes if they really give themselves this um er this privilege [R: mm]... it would really like help".

Five participants discussed broader social narratives surrounding household roles and internal conflict around how much time they committed to practising mindfulness. These participants emphasised their efforts to balance competing priorities, enabling them to carve out time for self-care and still fulfil their caregiving and "family duties".

> As you can imagine, and especially in our culture, obviously, these roles are very important. So when you are juggling so many things, you one head is at the same time different things. So this is the work assignment. This is the project I'm doing. Oh, I need to er [pause] So the you know dinner what we you know. I'm making tonight's kids' homework this, so…sometime for that short period of time. Just focus on your breathing. …bring your, you know, mind back to the present moment (Aya)

During the discussions on the various roles and priorities, participants expanded on the context of being from a BAME community that faces heightened health and social disparities. They noted that such disparities are not adequately considered in how MBIs are "pitched" in society.

Participants conceptualised that BAME communities in Western societies prioritise survival over self-development and often juggle multiple responsibilities simultaneously. Participants were of the view that this may impede community engagement in MBIs. For example, Fatima stated that BAME individuals "must do 100 things at once", while Aya commented that this could "get in the way" of mindfulness practice. Mariam, who teaches mindfulness within her Pakistani community, shared:

> There are other infrastructural issues, poverty. You know. Health disparities, kind of thing on these kind of things…where these kind of mindfulness kind of things seem like a nice to have not an essential kind of thing…I get that kind of impression from people…No, my problems are real in life. How can I just? You know, closing my eyes and ignoring that doesn't take my problems away

Overall, Muslims from BAME communities were perceived as facing distinct barriers and living different lifestyles, necessitating a mindfulness practice tailored to their needs. This tailoring involved adapting the programme's language, duration and cost to enhance its accessibility for community members.

Eastern Ideals within 'Whitewashed' Mindfulness

Participants showed a unified preference to teach mindfulness in a way that considered the context of their religio-cultural experiences. They described a need for these

intersecting factors to be considered by facilitators or healthcare organisations when designing and developing MBIs.

Several participants explored issues around the lack of acknowledgement of the Eastern influences of secular MBIs. Participants often discussed these Eastern influences concerning the works of Rumi, an Islamic scholar whose poem "The Guest House" is incorporated into the MBCT programme. They noted that the programme did not contextualise his position as a Muslim scholar. Including his poems in the programme helped participants engage with the sessions' content and deepen their religio-cultural understanding of mindfulness. As Mariam expressed:

> You know the Rumi Shams? They were teaching about them, and all those people who are from this branch [Researcher: mmhmm] of Sufism. They are doing practical practices, which is resonating in mindfulness

These participants described a lack of attunement between the teachings in MBIs and some of the resources used, such as Rumi's poetry. These participants noticed that they emphasised the importance of Rumi's poetry to their community to help community members connect to mindfulness teachings. This re-contextualisation of his poetry became more embedded in their conversations with family members over time when describing mindfulness. Participants believed mindfulness should not be portrayed as foreign to other Muslims in their community to increase cultural congruence and acceptability. They explored how mindfulness could be linked to their religious beliefs to achieve this. Participants suggested that this could help promote greater mindfulness acceptance in their community. Participants also described how this would encourage future BAME Muslims participating in MBIs to recognise their value. Zainab emphasised:

> We need to show [mindfulness] to the Muslim community…so try to, I mean try to find all the Sura's (chapters) in the Quran…trying to explain to our Muslim community that it's not just you know a new trendy er er thingies of psychology it really something… we just need to be aware of it and er doing it

Another way to overcome the lack of cultural sensitivity in secular MBIs was to include language more attuned to their religio-cultural experiences. Fatima shared a need for a "Kind of word change, yes, words change and that could be err be much acceptable like that, but the words could be changed to include more relevant examples like using dhikr".

Participants also recognised the lack of representation of people who "look" like them as an alienating feature of the programmes they attended, and participants emphasised that promoting the visibility of Muslims would encourage more acceptance and engagement. Maria, who regularly engages in mindfulness practice, shared:

> Imagery is so important in terms of, um, making any activity inclusive... people can't be what they can't see if mindfulness-based programmes had Muslims in their literature, you know, or in their social media, or flyers, or whatever they had visible Muslims showing them participating in it, making sure that it's clear that everyone is accepted and included

Participants also referred to the guided imagery content used in mindfulness as a tool for bridging secular interventions' concepts with BAME individuals' lived experiences. They emphasised "things that could be done around imagery" (Nora), such as ensuring that the Imagery used was ethnically diverse and reflected the multicultural makeup of the UK population. This representation was considered to be of great significance by participants.

All the participants from MENA communities mentioned the Sahara desert as a feature of their own imagery or visualisation practices, which could help bridge the gap between their experiences and the content of the mindfulness programme:

> There's a lot of beauty in the Middle East, like we have the Sahara that's a That's the that I mean. We liked it so much. So we have so many beautiful landscapes that we [could] use for like guided Imagery (Sara)

Participants expressed the desire to be "seen" (Nora) and "heard" (Aya) within the mindfulness community, which they felt had been obscured by the inaccessible English language. This was most common for those participants whose first language was not English. Participants also highlighted the difficulty in translating words from their first language that captured mental health challenges, such as anxiety, as these words were not directly translatable to English. Duaa shared that "in Bangladeshi... Ashanti would be like anxiety, but it[the meaning] has other things too". This loss of meaning through a translation made discussing personal experiences in group MBCT settings challenging.

Some participants explored the idea of increasing accessibility to mindfulness through changes in terminology that would account for these differences in language. Aya said, "Maybe we need to think about more fitting in terminology for our culture, for our thing what shall [we] ? Yeah, maybe. Yeah, we need to explore something along those lines."

Four participants also felt it was essential to consider the socio-political experiences BAME participants have so that MBIs can go beyond personal development and move towards targeting community stressors:

> If there were mindfulness practices that targeted dealing with political crises or, um, you know, just the just, the Middle-Eastern related stressors, or even identity. I think that would be like meditations that target these specific stressors of um Middle Easterners. I think that would be so helpful (Sara)

The suggestions made by the participants were viewed as a means to enhance their mindfulness practice, facilitate sharing with their loved ones, and potentially generate social benefits and outcomes for the NHS. Fatima emphasised that mindfulness could be "for everyone...For everyone actually" if courses were more culturally sensitive. Zainab, who lives with a long-term health condition, pointed out that MBIs more culturally sensitive and accessible to BAME community members would have broader social benefits for the NHS:

> I think it will really change things. It will really benefit even for the NHS; they will have less people with diabetes or with or er pressure thingies…I think they [the NHS] really need to put *more* [emphasis added] er er effort on this

Theme Two: "It's [Mindfulness] Ingrained in our Religion."

Overall, participants felt that the Islamic practises they took part in aligned with mindfulness qualities such as paying attention, mindful awareness of the body and mind and present moment awareness. The first sub-theme, "Islam is a mindful religion", captures the diverse ways participants made sense of mindfulness within the programme they attended through Islamic teachings. The second sub-theme, "Mindfulness through daily Islamic practices", considers the Islamic practises they felt aligned with mindfulness. Finally,

"Islamic meditation" explores Islamic prayer and dhikr (supplications) and focuses on the mind-body connections described by participants during fasting and religious festivals.

Islam is a Mindful Religion.

The mindfulness concepts of awareness, connection to present experiences, and focused attention resonated with all participants and gained significance through their religious understanding. Participants believed mindfulness is already a part of Islamic teachings in the Quran, the five pillars, and the Sunnah (way of life) promoted by the Prophet Mohammed [PBUH]. Six participants reported that their perceived relationship with Islam aided their identification with the mindfulness interventions they participated in. Before attending an MBI, these participants sometimes struggled to articulate the connection between the two, but the programme enabled them to express these links more clearly. For example, Aya described, "I think our in our religion we do have mindfulness…You might not name it it's ingrained in our religious practices, anyway, but we might just not think it that way". This connection to Islamic principles was valued as it allowed for greater understanding of their faith without adopting secular thoughts or ideas misaligned with their beliefs.

Participants shared that the teachings in the Quran encourage individuals to be mindful of how they approach daily tasks, their interactions with others, and their present-moment experiences. As Zainab shared:

> With our religion…the feet, our foot, the ground to really feel the impression that we are here to feel all the connection with the ground and with the space here … We don't put a name on mindfulness, but what we are doing is similar … it's [mindfulness] really fitting I mean we have it already in Islam

Mindfulness principles were also perceived to be compatible with Islam due to the structured daily routines recommended in Islam. Participants viewed these religious practices as encouraging opportunities for mindfulness throughout the day. Fatima shared:

> Actually, umm, our religion is erm er mindfulness based eh em on the structure of daily routines. Five times we need to um go to pray, this is err the way that we are doing the umm mindfulness… it's going the base of the mindfulness via religion like … In my opinion

Mindfulness through Daily Islamic Practises.

All participants spoke more specifically about Islam encouraging mindful awareness of the here and now throughout the day, beyond the general sense of Islam being experienced as a mindful religion. These examples demonstrated the integration in participants' minds between Islamic teachings and mindfulness. Duaa, who described integrating mindfulness skills with Islamic practises throughout the day, shared:

> You're going out, and then when you go outside, you're mindful, you're doing your Dua [prayer in Arabic]…before you go out, you stop, then you make your Dua, then you start you're walking…everything that in Islam is - everything is about mindfulness

Several participants noted that mindfulness could be practised in daily life, particularly when eating and drinking, by intentionally using words such as Bismillah (In the Name of God) and Hamdullah (Thank God). Participants understood these phrases as ways to increase their awareness of what they were consuming:

> It's not like just eating or drinking; even when we drink, you have to be aware of what you are drinking and what you are eating. That's why for example, we have to say, Bismillah, Hamdullah. I mean, it is to come back to the reality to the here (Zainab)

Six participants who described themselves as "religious" related mindfulness practices in daily life to the Prophet Mohammed's (PBUH) way of life. They referenced his periods of meditation in the cave of Mount Hira (located in Saudi Arabia) before he was thought to have received prophecy. "He used to go in. You know the cave in [Mount] Hira...that was purely meditation…" (Aya)

Participants also discussed the times they would listen to the Quran in times of distress to help regulate their emotions and shift from rumination towards focussed attention on the present moment. Duaa shared, "Because prophet, Peace Be Upon Him said just listen sometimes sit down and listen to the Quran, you know lie down and listen to the Quran without you know distraction". Moreover, these six participants discussed how the etiquette promoted by the Prophet encouraged mindful communication with others. They tried to implement this etiquette into their lives, further enhanced by regularly practising mindfulness. Nora said:

> Within Hadith, you know the Prophet, peace be upon him, talks about like, you know, when you're speaking to someone, for example, turn your body to them, give your full attention to them like you know it's show them that you're listening. Be present…it [mindfulness] really made me think about this

Beyond general teachings in Islam and the way of life of the Prophet, participants explored how Islam encourages a focus on faith and religious practices during specific times of the year. Participants saw the month of Ramadan and the lead-up to the Hajj pilgrimage as opportunities to relate to mindfulness principles. Participants considered the increased focus on prayer during the last ten days of Ramadan significant. Maria shared that during this period: "It's even more important to cut [oneself] off mentally from the world, and focus...not know what's going on elsewhere". Participants described these periods as facilitators to Muslims across cultures relating to mindfulness principles. All participants, regardless of self-disclosed religiosity, shared feeling more connected to their faith during these times and using mindfulness to increase this. Aya captured this when she shared:

> But during the whole month of Ramadan, there is a you know you. You are extra mindful of what you're doing and what you're not doing. There's more of a focus on the kind of living in the present…There's a different focus during that month

In addition to the overall state of mindfulness associated with Ramadan, participants observed that fasting demanded mindful attention towards their bodies and the practice of re-focusing their attention on the present moment. They viewed fasting as an act of worship that aided them in recognising where their mind had wandered. As Nora expressed:

> Even the fasting as well you are aware of. Obviously, your mind could wander. You will, you know, maybe hungry, whatever. But you bring it back ... You know this is the cause that I'm doing and come back to You know I'm fasting

The alignment of Islamic and mindfulness practices enabled participants to derive lasting benefits from MBIs beyond completing the intervention.

Islamic Meditation

All participants discussed using the breath and body as an "instrument" for greater connection during prayer. Participants referenced the three-minute breathing space and body-scan practice they took part in during their interventions. Participants explained that prayer involved "physical movement and breathwork" (Aisha), which required them to focus on their bodies and the prayer itself. Maria captured this when she shared:

> In the Salat, the player. We're um encouraged to just really focus on the prayer and not focus on anything else, and not in our distractions to come to our mind, and [pause] and part of that is around some of the physical movements

In addition to explicitly mentioning prayer, participants spoke about using supplications as a form of Islamic meditation using an object of focus. Participants discussed several ways in which they practised 'Dhikr'(remembrance of God), including using beads, counting whilst repeating supplications on their fingers and verbally repeating Islamic phrases. Fatima said:

> Especially you know the Dhikr, Dhikr we are doing? [Researcher: Yes yeah] And it is very helpful. At that time, you're counting and err repeating the things and err, you are focussed erm on the on that action

Dhikr was considered a religious practice as part of Muraqaba that aims to increase mindfulness and awareness of one's relationship with God. Zainab shared, "What we have in Islam, the Muraqaba that we know, God is watching [over] us that he is here". Participants shared that Dhikr could be incorporated into daily activities outside of prayer. Three participants shared how they integrated Dhikr into mindful walks and "visualisation" activities. The integration of Dhikr helped them consolidate their mindfulness learning, and participants' often used Dhikr practices instead of lengthier homework tasks from the programme they attended. Participants felt that their understanding of Dhikr evolved alongside their mindfulness practice through the programme they attended. Consequently, participants wanted to develop their faith practices in a "mindful way", and many reported including elements of mindfulness with their usual practices of Dhikr. For example, Mariam described:

> [Using] The names of Allah for chanting, and Al-hak Mean is truthful Al- Rahman means the most merciful and most forgiving one… I'm thinking that I'm saying Allah when I'm inhaling, and er when I'm exhaling, hu is coming automatically through my breath

These dhikr practices were seen as an integral part of achieving muraqaba and developing their “one to one relationship” (Aaliyah) with God.

Theme Three: "Islam is not [Always] Practiced Mindfully."

This theme conveys four participants' “frustration” with Islamic practices they believe are “not being correctly observed” (Nora) by their friends, family, and community. This theme reflects some of the reasons they attributed to this observation, such as living within a

secular society and a lack of understanding of Islamic principles and the “mindful roots” (Aisha) of Islam.

Living in a Secular World

Some participants felt that Muslims living within Western societies are more likely to be engaged in secular rather than traditional practices, and they reflected on how this has led to a secular "lens" in daily life. As Aya notes, "I think my [mindfulness] it's such a fundamental, and I think ingrained part of all our daily practices, if we follow it through religious lens [pause] [researcher: yes] But do we?".

Some participants attributed this to the fact that prayer was being performed without the mindfulness element intended to be a part of it. "There are very few people who connect with Salah [prayer] and understand its meaning. They keep doing it without truly knowing it," said Mariam. Other participants shared that this was due to the "disconnected" nature of life in the West, which meant people were often functioning on autopilot mode and were not prioritising their spiritual needs and growth. These priorities were seen by participants' as leading to "rushed" practices. As Zainab acknowledges:

> When you pray, you're not doing er er sports exercise; you're not doing gym …you have to really do it and be complete erm aware of what we are doing, how we are talking to God… trying to really focus

Participants also attributed “praying on autopilot” (Nora) to individualistic lifestyles within secular societies. Individualistic lifestyles were seen as taking priority over practising Islam in "the right way" (Zainab). Aya captured this idea when she shared, "There are more (pause) dire issues in the West...lack of family connections or lack of human connection and then the pandemic has made its part into it”.

A Lack of Understanding

As participants gained a greater understanding of the principles of mindfulness, they began to question whether they were practising their faith as intended. A few participants expressed curiosity about whether they were genuinely practising Islam if they were not practising in a "mindful" way. As Nora explained, “There's different levels there, and I could say that I'm mindfully reciting Quran but still not understand what I'm reciting. And then, is that, I don't know, is that being mindful?”.

This increased reflective capacity on how aligned their practice of Islam was with mindfulness and also developed their questioning of observing others' practice within their wider community. An example was observing Dhikr practices and how they could be done without mindfulness when the intention does not align with the actual practice. Duaa shared this when describing a group gathering of Dhikr.

> You know they do 'Subhannallah Hamdullah Allahu Akbar[Glory be to God, praise be to God, God is the greatest]…they even use the finger [to guide], you know…they are touching they are feeling it. But one thing they're not doing is not focusing on it. Then we're doing the beads. So what they do, they do it,un-mindful un mindfully…which is unmindfulness is ‘Ghaafla' because your mind your mind you're thinking of other things you need to bring yourself here now

Some participants attributed the lack of understanding to language barriers within their community. Nora, who comes from a South Asian community where Arabic was not the first language spoken, shared, “You know you're reciting it off by heart, and you don't

know what you're saying, and for me. That makes it very difficult to to be mindful, because you don't know what you're connecting to".

While Arabic being a second language may be a contributing factor, others are at play, as the three participants from Arabic-speaking countries also shared similar experiences regarding the lack of understanding within their communities. As participants explored other factors, they began to consider the impact of culture and how it can influence the practice of Islam, as well as their understanding of mindfulness:

> I mean in our religion they are not really aware it is just like bla-bla-bla like practising, and I mean not aware they are just er you know they just er repeat like a parroquet [parrot] blah…[mindfulness] is not only bringing the Islamic texts because many people they just read without understanding what is the real meaning (Zainab)

This theme highlights the diversity within the Muslim community and emphasises the significance of avoiding assumptions that all Muslims practice Islam uniformly. It acknowledges the nuanced experiences expressed by participants, highlighting the need to recognise that Muslims come from different cultural, ethnic, and linguistic backgrounds, and their practice of Islam can vary accordingly.

Theme Four: 'You Can't Separate Culture and Religion.'

All participants discussed the intersection between cultural and religious practices and how these shape individuals' understanding of mindfulness and Islam. The first subtheme, "everyone has their way," highlights participants' views that Islam is practised differently based on their culture and community of origin. "Resistance to the unknown" captures how cultural beliefs regarding mental health and MBIs can hinder community members from

engaging in mindfulness. Finally, "Mindfulness needs validation" captures participants' various steps to comfortably implement mindfulness into their lives.

Everyone has Their Way

Throughout the interviews, all participants explored how Islam was practised within their community and in others. They highlighted the challenge of categorising BAME individuals into "groups" and emphasised the importance of understandings that Muslims have diverse perceptions regarding the acceptability of mindfulness. Participants described separating culture from mindfulness as "so hard" (Sara) and "challenging" (Nora). This separation was challenging because participants expressed variation in how their community might view mindfulness. For instance, Mariam discussed the challenges of teaching mindfulness in her community, as it was impossible to separate the constructs of culture and religion:

> If you say Islam, or if you say Muslim, you will find a billion of colours of Muslims…the religion and culture everyone has got his own…It's not that everyone is thinking in the same way, and not everyone is practising in the same way

Other participants discussed how all teachings and practices within their country of origin included religio-cultural elements, making it hard to separate these constructs. As Sara highlights:

> I think in Egypt because it's, um, mostly majority Muslim country… it's really, really, really hard to separate the two over there. I mean, even on my ID, It says like Muslim[…] I consider myself culturally Muslim. I follow some practices, but not all of them

Each participant shared examples of how their community had activities they would consider "mindful", such as bread-making, sewing, group games, and stargazing. Participants did not feel a need to label these experiences as mindfulness activities or to put them into a specific category; they were "happy memories" (Aya). Participants had only adopted the mindfulness terminology to describe their experiences after attending an MBI. Zainab described spending time with family making clothes for weddings and cultural events:

> He [family member] sent us two weeks in like [names village], and I think this is kind of, you know ... Five ten times you are doing the thingie and you know maybe sometimes it works, or it doesn't work, but you are completely in it, you are there

This integration of "mindful" practice was mediated by personal family traditions and cultures, with some participants describing mindfulness as a part of "[my] family they are all we are all [laughs] really in[to] this" (Aaliyah). Participants also discussed how community practises that included religio-cultural practises they experienced as mindful. Three participants from Pakistani and Bangladeshi backgrounds described using prayer beads to accompany chanting, which was considered a mindful practice; for example, Aya discussed the social gatherings within her Pakistani community that tended to include a religious element: "We have gatherings of Dhikr...people do chanting together and that kind of thing...that has a religious connotation".

Other participants reflected on an individual meditation practice that was encouraged within their community. For example, Aisha, who comes from a community that includes mindfulness exercises in their tradition, shared:

> That [culture] that I'm it that I was born into has a four o'clock meditation. That's an hour long. So umm … it's from basically it's the Dawn hour…it's like three, thirty to four, thirty, and they I think they set it because that's just time now in modern day. But it used to be the dawn hour. So where the night and morning are shifting, and there's an hour of it. It's basically just a meditation period…like a time for reflection

Resistance to the Unknown

Several participants viewed culture as a barrier to acceptability for some community members. Participants shared their experiences of introducing mindfulness to friends, family, and wider community members, which was sometimes met with more resistance than expected. This resistance led to internal conflicts about with whom they could share their mindfulness practice. Several participants described a fear of judgement in sharing what they had learned during the MBIs. For example, Mariam said, " [If] you share these mindfulness-based practices, people might say she's gone into this psychic state". Participants from these communities felt compelled to overexplain or justify mindfulness to counteract this resistance to "new" ideas that were unfamiliar to their community. Participants attributed this resistance to cultural backgrounds that emphasised adherence to religious teachings and scepticism towards "deviating" from religious practices. Nora captured this notion when she shared:

> I generally think, at least in the community, that I'm. Kind of familiar with, say, like the British Pakistani community, there is some [pause] something about kind of adhering to religious practices that are supposed to be healing in and of themselves. And so the idea of practising something else that that isn't, you know, isn't explicitly based in kind of religious practice…Um, it's something I think people stay away from

Some participants explored cultural ideas that religion should be "enough" to heal people from mental health difficulties. They described a sense of community fear that practices outside of Islamic teachings would lead people astray from their faith. This viewpoint was particularly evident among participants from South Asian communities, who contextualised the resistance as a practice that could lead people to stray from their faith. Mariam shared:

> They [community members] don't agree with me like they think oh this is wrong, this is going to take us astray[…]like we call it astray but like leaving your deen [religion] all that[…]So I have met with quite a few conflict because…They think it is an innovation. Is Dangerous

Two participants, who emphasised their acceptability of mindfulness, shared community beliefs around resistance to "mystical" practises, which caused resistance towards mindfulness. Duaa, who has been practising secular mindfulness for over five years, shared:

> I was [the] first one who's doing it so, and I felt like I, this is something no no Bangladesh you know that's why you find less Muslim people doing especially very oldest generation they might think is some kind of magic you're doing it, we have to be careful of magical…Yes yeah [laughs] cultural!

These viewpoints led to resistance towards sharing mindfulness exercises with friends and family who might accuse them of having their faith "washed out" in favour of more secular practices. All participants who discussed resistance to mindfulness practices noted a

shift towards greater acceptance of MBIs in their community over time. Facilitators of this change included living in a multicultural age, changes in the practice of Islam within their community, from what they described as more “conservative” to centred understandings, and increased awareness of mindfulness through popular culture. Maria who has been practicing mindfulness for several years, shared:

> I remember 20 years ago, um, there was this kind of um viewpoint amongst [pause] a minority, but some, you know enough to say that it was a shared view that meditation idea is quite Buddhist in its origin. And therefore is it okay for us to do as Muslims?... I think now in 2022 will be much easier. People are a bit more aware of engaging in these different tools

Many participants shared that it was important to limit the Buddhist "ideas" that were not "Islamic" due to the absence of a belief in God. To overcome these tensions, some described the 'removal' of Buddhist teachings when describing mindfulness to friends and family. Duaa shared, "I know there's Buddhism in it, but you have to sift that Buddhism out. and use whatever breathing exercises and if it helps [you]...the Buddhist Buddhism concept is not your concept".

Even though many participants described the Buddhist elements of mindfulness as “incompatible”, few were aware of *what* the Buddhist origins of the practice included. Fatima captured this when she shared, "I don't know what it is offering [Buddhism]...I think [mindfulness] is mainly related to err people's suffering err trying to solve these problems".

This unfamiliarity with the Buddhist origins reflects how removing the Buddhist ethics and values base has fed into participants' understandings of mindfulness, including those from religious backgrounds.

Four participants also explored resistance to seeking support for mental health difficulties "You don't talk about anti-stress of looking after your mind or this or that..they [community] will just tell me we don't believe in that [psychological therapy] or this is not our way" (Aaliyah).

Mindfulness needs Validation

Some participants saw mindfulness as needing to be validated in order to be accepted within their community. The beliefs and opinions of their community were seen as important, so participants made efforts to support community members in this validation process. Some participants discussed this regarding community discussions around mindfulness to make it more relevant. As Nora said:

> I think there's something about getting buy-in because I don't think there's a religious kind of element to it in that sense. I think there's something about it. You know. It's just breathing like [pause], getting people to understand the rationale

Some participants sought external validation from religious scholars and considered it a necessary step in pursuing a greater understanding of mindfulness as a tool. This validation was considered a requisite step by some participants. As Duaa shared:

> I went to the scholars before I did it [mindfulness] because I didn't want to cross the boundaries of Islam because that's very important to me .. it's my value and belief, so I asked, can I do mindfulness? And the scholar was really, really good … scholar said, yes

Other participants shared this need for validation from a scientific rather than an Islamic lens and validated mindfulness through “the neuroscience behind it.” (Aisha). Aya captured this idea when discussing her experiences:

> [I am] believer of the mind-body connection and how physiological changes and an impact it can, has. : So I think, sometimes, knowing the neuroscience behind it, that I think sometimes is the lack of education as well, because what actually it does what happens in your mind..you know

All three participants from the MENA community described their family and wider culture as more concerned with the scientific than religious validity of mindfulness. For these participants, the uncertainty their community expressed related to ideas around mindfulness being "fluffy", an "unvalidated tool", and "not science". Sara shared, "So back then, there was less acceptance about mindfulness, a lot of hesitation. Um, not because of its Buddhist roots, but because it wasn't in science, I think”.

Theme Five: “Transformative Mindfulness when Life was Upside Down."

Overall, the skills gained through MBIs took many forms and were mediated by their personal or religio-cultural experiences. Participants saw these mindfulness skills as transformative in helping them to access their inner resources following a life difficulty. The first sub-theme, "a tool you can rely on," explores how participants conceptualised mindfulness as a "tool" or "skill" following a crisis or difficulty that developed into a daily mindfulness routine. "Slowing down the internal pendulum" reflects the value of MBIs to counteract the autopilot mode participants often found themselves in. Then, "Regaining control" reflects how participants drew on mindfulness skills to address personal difficulties. The final theme, "developing connections," explored how mindfulness helped participants to

develop deeper connections within themselves, their faith practices, and their wider community.

A Tool you can Rely On

All participants expressed that mindfulness was a "tool to compose and ground yourself" (Aisha) or a "life skill" they had discovered during challenging life periods, which helped them cope with adversity and difficult circumstances. Mindfulness skills introduced participants to managing their emotions, reducing rumination, and increasing cognitive flexibility towards their difficulties. Five participants described mindfulness as a novel tool that helped them when they lacked "coping strategies" outside religion. They noted that mindfulness took them away from feeling overwhelmed and towards "life-changing" (Fatima) shifts in their mood and state of mind. Fatima credited mindfulness skills for transforming some of the crises she had ensured into something meaningful. She said, “This is the thing err [coughs] which I need to be known because err my life err upside down four years ago, and everything was changed um totally".

Many participants who had attended MBCT courses did so on the recommendation of others. For example, Zainab shared accessing mindfulness through “[my] psychologist; he proposed to me to try to or to try mindfulness". Although it was not explicitly mentioned as a limitation, the previous sub-theme discussion on the pressure to make mindfulness work despite other priorities implies that there may have been subtle experiences that were not addressed.

Participants viewed mindfulness as equipping them with coping skills they had not previously learned during their upbringing or earlier. Duaa reflected on her realisation that they needed to engage in mindfulness: "I didn't recognise my mental health was going down. "I wasn't completely [un]aware. Then I realised, you know what, I didn't know how to deal with this anxiety because it was something new to me”.

All participants reported implementing what they had learned through formal mindfulness practices or those that were part of their religious practice. They described how everyday activities such as driving and cooking were “transformed” once they began engaging in mindfulness more formally. Participants observed that they could draw upon mindfulness throughout the day and that mindfulness was not restricted to those specific moments, which they referred to as "mindfulness throughout the day" (Maria).

When discussing her experiences with bereavement, Maria went on to share using mindfulness throughout the day; "even at work, making the time to just connect with my body for a few minutes can be a way to bring mindfulness into the day without a formal practice". Maria attributed this ability to engage in mindfulness to the availability of the practice, which could be done independently; Aya echoed, "It's really simplistic, and I can., And that is a mindset which I can take it into anything."

Slowing Down the Internal Pendulum

All participants described the context of living on "autopilot" and using mindfulness as a skill to counteract the effects of this. Some participants discussed this in relation to rumination during periods of depression or heightened anxiety. For example, Aya shared, "[Noticing] "whatever your mind is, you know, picturing for you, but taking a deep breath and coming back to. Oh, my mind is really creating a horrible story here for me". Others utilised mindfulness skills to enhance their focus on daily tasks or to become aware when engaging in activities without intention. As Mariam explains:

> Sometimes, when you are scrolling through social media..and all of the sudden, that switch goes off, and you say, oh, my goodness, I've been here for 15 min. What am I doing? Where am I mentally? And I do tend to take [takes a deep breath] deep breath and come back into my body

Participants expressed that mindfulness enabled them to recognise the importance of paying attention and shifting from autopilot mode to a more present mode. Aisha described this shift as moving from feeling like a "hamster in a cage running in a ball" to the ability to slow down and connect to the present moment. Other participants felt that mindfulness helped them to recognise unhelpful thinking patterns that caused them to ruminate and contributed to functioning on autopilot. Participants felt that this was one of the essential mindfulness skills that they developed. Aya shared:

> It's kind of, you know, when the pendulum is swinging that way and that way, and suddenly you as oh, my goodness, this is my! What about what my mind is doing? And it's [swings hands from left to right] kind of, you know. Back into that zen straight wave, it kind of slows down the pendulum… helps me to kind of unpack and bring back to reality, I think. Oh, my God! How much am I contributing to this noise…So yeah, it visibly made it. You know I felt a difference in how I was feeling within my body?

This ability to redirect their attention back to the present gave participants the sense that they could gain 'control' over their minds, which they explored concerning broader mental and physical health difficulties.

Regaining Control

Participants experienced mindfulness as a helpful practice for gaining “greater autonomy" (Aisha) in challenging moments when they perceived a lack of control. This lack of control was often related to personal factors such as their mental and physical well-being and broader issues such as managing caregiving responsibilities and work commitments that could be difficult to balance with their self-care needs.

Regaining control made participants feel like "being the CEO of my life" (Aisha). Participants described being able to return to work, engage in more social activities, and cope with conditions they were living with as a direct result of developing their mindfulness skills. Some participants valued drawing upon mindfulness skills after periods of sickness that led to time off work and increased social isolation. Duaa shared:

> I'm getting social anxiety as well…if I stayed home, I don't think I would be back to work because I wouldn't have known how to deal with it…. mindfulness which helped me…I was scared, and I did the breathing and then…move forward, and then I did the breathing and…I do it… I'm more in tuned

Six participants discussed experiences of recurrent depression and how mindfulness helped them to "accept" their experience and change the relationship with their thoughts and feelings. Fatima shared:

> "I was in a depression. Stress and depression. I was thinking, how am I going to adapt.. a new lifestyle…So there was that kind of a step [to recovery]..important. Mindfulness was [important]…so it was the main reason [I recovered]...I was suffering… With my err …With my myself

Although many participants recognised the advantages of mindfulness in alleviating depression, they found it challenging to consistently practice it when their mood was low due to motivational difficulties. As Sara expressed:

> I think before; I had really bad depression…before, it was more of a mood stabiliser, and now it's more shifted. Ok, I think now that I have my depression under control or that I'm managing it better now, it's more like an anchor…it definitely can help you. But it's quite hard to be strict about doing it. But it's quite hard to be strict about doing it up when you're not feeling motivated

Others discussed how mindfulness could bring up feelings they had pushed aside due to a desire to appear "strong" to friends and family. Participants were explicitly asked about any adverse effects during the programme or their practice; however, they did not report any. Nevertheless, participants acknowledged that some practices could come with some difficulties. Aisha spoke about specific practices from the past that led to some complex feelings:

> I've had [practises] that are a bit sad and others that are a bit angry. But that's because of what I'm going through in life as well…they don't necessarily make me feel worse. It's just like bringing to the forefront how I'm feeling and, like, there's a level of like accepting that and being okay with that

Three participants spoke about mindfulness as a way to regain control over long-term physical health conditions. Participants considered this sense of control necessary to reclaim part of their life and identity lost through injury or illness. Zainab described introducing carers and friends to mindfulness so that they could assist her during a crisis:

> I got…er neurological problem [R: mm] er head issue and a movement…when I have some attack, how to try to breathe and because of my um breathing and try to for

example, if someone is next to me they can give a tap in my hand so I can divert my brain and [R: mm] come back to that moment…either from the attack and you know

Zainab and others expressed a greater interest in mindfulness from friends and family members when mindfulness was linked to physical health benefits that they deemed essential for their community.

Developing Connections

All participants spoke about mindfulness practice leading to some form of deeper 'connection'. These connections included; the connection with themselves, their "connection to God" (Zainab) and their "friends and family" (Maria). Mindfulness helped participants to "slow things… and connect to er my mind my body" *(*Fatima). This perceived sense of connection resulted from practising mindfulness more regularly and developing their practice outside the intervention or course they attended. They described a process of mindfulness, making it "much easier to understand" (Fatima) themselves and find their "new roots" (Aaliyah). This process was described as “a contemplation within me rather than around me.” (Mariam).

Participants also discussed the increased sense of connection as enhancing their prayers. Some discussed specific prayers they made for themselves or others, which mindfulness helped them connect with. In their view, this increased the acceptability of the prayer due to a more focused intention and attention when reciting it. Zainab stated: "Prayers such as shifaa [prayers for good health] must be done mindfully to count...you really have to connect to the words you are saying."

Five participants spoke specifically about mindfulness as a practice related to a sense of social connection. Participants described practising mindfulness with others, including friends, family, and wider networks, to strengthen and develop more significant connections

with them. Participants valued these perceived benefits and felt that practising mindfulness aligned with their collectivist outlook on life. Three participants voluntarily led mindfulness practises within their communities, and they captured this sense of connection through the experiences shared between group members participating in a mindfulness programme. Duaa, who facilitates a walking group, shared:

> I have about three women who walk with me as well, and we sometimes will quietly.. we do mindful walk… and it's therapeutic as well that they talk sometimes….and they even if I don't go some days…they still go

Mindfulness was also discussed as a practice to counteract loneliness, particularly by those who worked with older adults and those who described feeling "disconnected" from others since the COVID-19 pandemic and the social changes this brought. Mariam explained, "They might have depression and anxiety, stress levels, and loneliness... mindfulness helps to reduce loneliness because people feel connected to themselves and to others as well."

Several participants with children described a desire to be a good "example" to them by sharing the skills they had learned. Participants with children discussed how their children started using mindfulness skills once they had been introduced to them by participants. Nora said, "I think they've used it in different ways. I don't know if they've noticed differences in me. But yeah... they've definitely used it in their own lives". This implementation of mindfulness skills, in turn, helped participants to feel more connected to their families and wider networks who adopted the practice. For those who attended CFT groups, They described an increase in compassion for self and others, which developed alongside their mindfulness experiences. The loving-kindness exercises, which include a visualisation

element, were valued by Duaa, who shared, " [These exercises]really touched my heart and everything [in life]is the compassion one you know, and you see the people you love visualises".

The nuanced experiences of mindfulness outlined above highlight some of the challenges in adapting an intervention rooted in collectivist cultures within an individualistic and capitalistic society. As Mariam put it, “Mindfulness is about connecting …should be seen as an act of charity and therefore offered for free and not commercialised”.

Summary of the Findings

Based on participants accounts, MBIs could be an acceptable and appropriate intervention for Muslims, but they needs to be delivered culturally sensitively. Participants also emphasized the importance of appropriate religious considerations. The themes developed from participants' accounts suggest:

- Mindfulness has been secularised and popularised in Western discourse, bringing benefits and challenges.
- Participants experienced mindfulness as a familiar intervention when grounded in the context of Islam and shared similarities between MBIs and Islamic practices.
- They acknowledged that religio-cultural practices are shaped by various factors, such as their community, language and religious identity.
- Participants described skills gained from MBIs, and that mindfulness gave them access to greater resources for coping with mental health difficulties

Chapter Five: Discussion

Overview

In this chapter, I will discuss the findings of this study and how they may apply in broader contexts. Firstly, I provide a summary of the findings in relation to the research aims. Secondly, I will discuss the findings in relation to past theories and research. Then I will discuss the study's strengths and limitations to contextualise the developed themes. I will then suggest clinical, policy and research implications to reflect on the potential applicability of the findings in broader contexts. Finally, I will conclude with my final reflections through a reflexive account, followed by a concluding statement.

Summary of Main Findings

To my knowledge, this is the first study in the UK to explore the religio-cultural experiences and acceptability of MBIs for BAME Muslims. Ten participants were interviewed and openly shared their experiences of MBIs and mindfulness practice. I used reflexive thematic analysis to develop five themes with 16 sub-themes, which relate to the socio-cultural and religious experiences of the participants. In the UK, academic research into mental health has generally lacked perspectives from BAME communities (Iob et al., 2020; McPherson et al., 2020), particularly regarding psychological interventions (Wood & Patel, 2017). While there is some emerging research on BAME experiences of MBIs, studies have primarily focused on a single ethnic or religious group and have often been situated within an American context (Proulx et al., 2018).

The current study aligns with the literature review in Chapter Two, reinforcing the assertion that cultural sensitivity serves as a crucial prerequisite for the successful implementation of MBIs within BAME communities Participants in both the current study and the literature review underscored the importance of tailoring mindfulness practices to their cultural values to enhance engagement (Hunter-Jones et al., 2019; Proulx et al., 2020; Thomas et al., 2016; Woods-Giscombe et al., 2014). They emphasised cultural practices pivotal for deriving meaning during their participation in MBIs (Watson et al., 2019), noting

that although these practices did not fall under the label of 'Mindfulness,' they shared principles of awareness and attention (Watson et al., 2016; Watson-Singleton et al., 2019).

Participants in this study and the aforementioned literature review also acknowledged the presence of unique practical (Bermudez et al., 2013; Hong et al., 2022) and socio-cultural barriers encountered by themselves and their communities (Woods-Giscombe & Gaylord., 2014;2019). To address these barriers, participants advocate for systemic interventions aimed at facilitating MBI participation among other BAME communities. Several implementation suggestions are outlined in the clinical implications of this thesis.

Another significant finding pertains to the intersection of mindfulness with religion. As stated in the introduction, mindfulness originated from Buddhism, with MBIs originally designed to maintain the essence of Buddha Dharma while adapting the practice for secular contexts (Kabat-Zinn, 2003). Participants in this study and the literature review discussed the intricate interplay between mindfulness, religious beliefs, and cultural norms (Proulx et al., 2020; Spears et al., 2017; Szanton et al., 2011) They also emphasised the challenge of divorcing their religious identity from a purely secular perspective on mindfulness (Burnett-Zielger et al., 2019; Hartwell et al., 2018). Consequently, complete removal of religious elements from mindfulness may not be suitable for BAME communities subscribing to theistic religions (References), and it has been deemed unethical to decontextualize mindfulness in this manner (Monteiro et al., 2017).

Notably, the study's sample included BAME women from diverse backgrounds, contrasting with the predominantly African American sample discussed in the literature review. This difference may explain variations in reported gender-race-related stressors (Watson et al., 2016) and how participants linked religio-cultural practices to MBIs. The subtheme concerning religious incongruence among some African American Christians and MBIs (Burnett-Ziegler et al., 2019; Dutton et al., 2013; Watson et al., 2016; Watson-Singleton et al., 2019) highlights the need for further research into specific religious groups.

Consistently, all authors in the literature emphasised that participants experienced significant stress that impacted their well-being and underscored the value of integrating

mindfulness skills into their daily lives to manage stressors effectively.

The present study's scope provides a nuanced examination of mindfulness integration within both secular and Islamic contexts, deviating from the broader focus of the literature review. Additionally, participants in this study discussed elements absent in the literature review, such as the popularisation of mindfulness through technology, the intertwined nature of culture and religion, and discussions on Eastern ideals within ostensibly secular interventions. Moreover, participants in this study highlighted the phenomenon of "whitewashing" of MBIs from Eastern traditions, a perspective not reported in the literature review. This divergence may reflect the highly educated and experienced mindfulness practitioners in the current study. Thus, study provides a much-needed novel contribution to the literature base (Bignall et al., 2019).

The study provides preliminary evidence that MBIs can be an acceptable and valuable intervention for BAME Muslims. Moreover, participants described a sense of cultural alignment between MBIs and their religio-cultural experiences. These findings regarding MBIs' resonance with Islam are consistent with previous research with Muslim participants

(Blignault et al.,2021b; Thomas et al.,2016). This indicates some commonality among the experiences of BAME Muslims regarding MBIs. However, participants also emphasised the importance of religio-cultural considerations to increase the acceptability of MBIs within their community, reflecting findings with Christian participants (Proulx et al., 2020; Watson et al., 2016; Woods-giscombé & Gaylord, 2014). Nevertheless, some differences in the experiences of Christian and Muslim participants have been shared, highlighting the importance of recognising the nuanced experiences of each faith group (Thomas et al., 2017). Participants reflected on the socio-cultural context of their lives and how this influenced their capacity to engage with MBIs (Proulx et al., 2018). Finally, participants eluded to some of the core features of mindfulness (Kabat-Zinn, 2003; Segal et al.,2018; Van Dam et al., 2018). These include interrupting unhelpful behavioural patterns, developing greater awareness and attention, and engaging in compassion-focused practices (Goldberg et al.,2021). Notably, these study's themes represent various experiences in various contexts, making it difficult to form a universal concept. Therefore, when interpreting and discussing the results, this should be considered.

Addressing 'Diversity' in Mindfulness Research

Systemic theory suggests that racism, discrimination, and unequal access to healthcare services have contributed to the marginalisation of BAME communities within MBIs (Garven & White, 2009; Sue & Sue, 2012). This propagation can be traced back to the secular White context in which MBIs were developed (Baer et al., 2019). Consequently, White voices have been privileged in designing and delivering MBIs, discriminating against BAME communities by excluding them from this process (Monteiro et al., 2017). Participants in this study discussed the predominantly White, middle-class facilitators of the MBIs they attended and in popular mindfulness apps and resources (Deluca et al., 2018). This 'Whiteness' in the MBI field reflects a broader systemic problem within UK healthcare:

there remains a visible dearth of culturally diverse clinicians to deliver interventions such as MBIs (Wood & Patel, 2017). The persistence of White cultural norms can create a hurdle for non-dominant groups with different religio-cultural frameworks to engage in mainstream psychological therapies (Loewenthal et al., 2014; Loewenthal & Cinnirella, 1999; Thomas et al., 2016). Moreover, the White cultural references and experiences emphasised in MBIs can limit engagement and acceptability (Proulx et al., 2018). Participants in this study emphasised the Eurocentric references and unfamiliar metaphors and analogies in MBIs, which were a potential barrier (Watson-Singleton et al., 2019).

The participants also expressed their uncertainty about sharing mindfulness with their loved ones because they found it challenging to explain the unfamiliar terms to them (Watson-Singleton et al., 2019; Woods-Giscombé & Gaylord, 2014). Muslim participants here and elsewhere (Blignault et al., 2021b; Thomas et al.,2016) have recommended using culturally relevant metaphors, poems and imagery to address this. Adding this element can enhance the engagement, relevance, and acceptability of MBIs. Participants will have more opportunities to interact with the teachings' content and context.(Bercean et al., 2020; Blignault et al., 2021b; Hartwell et al., 2018; Proulx et al., 2018). Without the inclusion of culturally relevant content, BAME communities may continue to feel disconnected from the people delivering the interventions (Blignault et al., 2021a;2021b).

Participants in this study also reflected previous findings regarding a preference for facilitators from the same ethnic or cultural background (Burnett-Zeigler et al., 2019a; Szanton et al., 2011; Watson et al., 2016; Woods-giscombé & Gaylord, 2014). Participants also shared that a facilitator of the same religio-cultural background would facilitate others in their community to engage in MBIs (Chin et al., 2019; DeLuca et al., 2018; Waldron et al., 2018). One possibility is that a sense of ethnic or cultural matching can reduce mistrust in services and increase therapeutic trust between participants and facilitators (Woods-giscombé

& Gaylord, 2014). The sense of mistrust can be understood through the historical and intergenerational trauma related to systemic oppression, colonialism and discrimination that has disadvantaged BAME communities and left them with a sense of fear of services (Ahmed, 2012; Wood & Patel.,2017). For example, a 'White voice' has been conceptualised as bringing up past experiences of racial trauma for Black participants (Watson et al., 2016). Although participants here did not explicitly state racial trauma, many discussed a sense of safety brought on by a facilitator of a similar ethnic or cultural background (Watson et al., 2016). A previous meta-analysis on ethnic matching between clients and clinicians (Cabral & Smith, 2011) has suggested that despite preferences for ethnic matching, treatment outcomes are primarily independent of this. Perhaps the cultural sensitivity of the facilitator, rather than their ethnic background, is most important in addressing trust and safety (Proulx et al., 2018; Sue & Sue, 2012). Interestingly, Cabral and Smith (2011) did not reflect on their ethnic-racial identification and how this may have impacted the findings of their metanalysis.

Fanon (2008) emphasised that dominant groups can impose their beliefs, values, and practices on BAME communities. This is thought to result in a sense of inferiority or self-doubt about one's cultural practices (Fanon,1963). To date, BAME communities report feeling misunderstood and stigmatised by NHS providers leading to self-doubt about the value of engaging in services (Bignall et al.,2019). Participants in this study highlighted how they were initially uncertain about attending an MBI due to uncertainty that services could meet their needs. Their accounts also demonstrate how BAME communities may continue to be excluded from mainstream services if they feel they cannot meet their religio-cultural needs (Sue & Sue, 2012; Sue et al., 2009).

A Lack of Cultural Understanding

The lack of diversity in secular MBIs may also be influenced by the lack of understanding towards cultural goals and values in the design and implementation of MBIs

(Biggers et al., 2020; White et al., 2019). Psychodynamic theory suggests that unconscious biases, stereotypes, and defence mechanisms from secular healthcare organisations may lead to excluding religio-cultural practices (Fanon, 2008). These unconscious biases may inadvertently exclude BAME individuals from MBIs by neglecting their personal beliefs and religio-cultural understandings (Proulx et al., 2018).

Participants emphasised misrepresentations of mindfulness as only a skill and a lack of Buddhist grounding (Belli et al., 2015; Monteiro et al., 2017). MBIs have been accused of lacking integrity by sharing concepts derived from religious practice that is not explicitly stated (Baer et al., 2019; Monteiro et al., 2017). Monteiro and colleagues (2017) found that mindfulness practice lacks transparency and relies heavily on the 'evidence base' for credibility (Brown, 2017), which could be a significant barrier for BAME groups who identify with a theistic religion (Monteiro et al., 2017).

When discussing the Eurocentric nature of MBIs, participants' accounts also reflect the paradigm clash between the contemplative roots of mindfulness and the neoliberal culture promoted in Western societies (Crane, 2017). Rather than add something to the practice or make it neutral, Eurocentric secularised ideas have removed the 'heart' of mindfulness and alienated the cultures that developed it (Bautista et al., 2022). This secularisation could explain why participants here and elsewhere describe conflicts between the practice's structured manualised and experiential elements (Blignault et al., 2021b; Eichel et al., 2021).

Moreover, the manualised structure decontextualises and dismisses the philosophical and ethics-bound context in which mindfulness originated (Tsui et al., 2020). In Buddhism, Right mindfulness is a component of the Eightfold Path, which provides moral guidance and can help alleviate suffering (Baer et al., 2019). However, reducing mindfulness to a mere technique for relieving symptoms could lead to passivity and self-indulgence rather than growth through "right" mindfulness (Anālayo, 2020; Monteiro et al., 2017). These factors

could explain contradicting findings that MBIs can lead to more selfishness (Poulin et al., 2021), as they meet the needs for more individualistic lifestyles and modes of being.

Individualism vs Collectivism

The findings in this study suggest that secular mindfulness, framed in individualistic ways, conflicts with the needs of BAME Muslims, and this should be considered in the design and development of MBIs (Thomas et al., 2017). BAME Muslim communities often hold more collectivist thinking styles (Sue & Sue.,2003), and participants often discussed the barriers and benefits of MBIs in relation to their wider community (Blignault et al., 2021b; Proulx et al., 2018; Woods-giscombé & Gaylord, 2014). Poulin and colleagues (2021) report that mindfulness can enhance prosocial behaviour, such as compassion, making it valuable for BAME communities. However, Poulin and colleagues (2021) emphasise that this effect may depend on individual social goals, with collectivist thinking leading to more prosocial outcomes. Moreover, they ascertain that more individualistic goals lead to increases in selfishness and MBIs delivered in this way may not benefit participants from collectivist communities (Poulin et al., 2021). Participants described some ambivalence in sharing the skills gained on MBIs, due to the individualistic goals of the practice that dismiss the broader social context or potential of MBIs (Burnett-Zeigler et al., 2019; Kulwicki et al., 2010; Spears et al., 2017). Psychodynamic theories could explain participants' internal conflicts concerning the individual introspection and self-reflection encouraged in MBIs (Fanon, 2008). This focus on individualism may have conflicted with participants' collectivist thinking styles, leading to ambivalence in sharing the practice with community members (Monteiro et al.,2017; Poulin et al., 2021).

Some participants also reported how their colleagues rejected mindfulness training as it would not address workload or burnout (Badham & King, 2021). Badham and King's (2021) review of mindfulness in the workplace highlights that the simplistic view of

mindfulness as a set of individualistic programmes to prevent burnout is problematic. They emphasise that delivering mindfulness this way overlooks the broader systemic factors that impact BAME workers' well-being (Badham & King, 2021). Thus, the delivery of MBIs as individualistic means to prevent work-related burnout further marginalises BAME communities, who have to "work harder" to achieve the same benefits as their White peers (Loewenthal et al., 2014; McTiernan et al., 2021; Sue et al., 2009; Thomas et al., 2016).

Rather than deliver MBIs in an individualistic way, MBIs aligned with more collectivist goals could be valued in BAME Muslim communities (Lowenthal et al., 2011). Participants in this study valued the potential social benefits of MBIs when practising mindfulness with others in their community (Proulx et al., 2020; Szanton et al., 2011). These findings speak to the importance of considering the potential social benefits of mindfulness. For example, participants described more frequent social interactions and a deeper connection with their families (Woods-Giscombé & Black, 2010). Moreover, a social connection may have particular value when working with older adults, who often emphasise the benefits of social support (Szanton et al.,2011). The relational benefits have been reported in a recent meta-synthesis on mindfulness, which emphasised that increases in self-acceptance and compassion can be a benefit of MBIs (Dussault et al., 2020). However, to derive such benefits, MBIs must first address the systemic barriers to accessibility that BAME communities face (Chin et al., 2019; DeLuca et al.,2018; Proulx et al., 2018).

Addressing Accessibility Issues

The findings in this study support the notion that MBIs can be culturally valuable if accessibility issues are acknowledged and addressed (Watson-Singleton et al., 2019). Participants described financial, language and broader systemic barriers that influence the accessibility of MBIs. Vroegindewey and Sabri (2022) note that poverty and immigration limit BAME groups' opportunities to participate in MBIs. Thus, the accessibility issues

should be considered in the context of wider BAME disparities (Vroegindewey & Sabri, 2022).

The drive for MBIs to meet capitalist needs has been accused of making mindfulness inequitable (Bautista et al., 2022) and increasing financial barriers (Johnson et al., 2022; Watson et al., 2016). This inequity could explain participants' views that MBIs are too expensive and neglect wider financial barriers BAME communities face (Akbary et al., 2020; Gaylord et al., 2022; Sue & Sue, 2012). Participants in this study noted that they would not have been able to afford a private MBI, relying instead on an MBI funded by mental health services (Blignault et al., 2019; Proulx et al., 2020; Vroegindewey & Sabri, 2022).

When MBIs are accessed, participants here and elsewhere have noted that mindfulness resources remain primarily in English (Blignault et al., 2019). The lack of resources outside of English is a significant barrier to BAME access to health services (Loewenthal et al., 2014). According to systemic theory, language and communication are essential to understand the experiences and values of each community (Sue & Sue, 2012). BAME communities in the UK often speak languages other than English, limiting their opportunities to express the values and preferences of MBIs (Walpole et al., 2013). Moreover, participants acknowledged that the English description of anxiety and depression differs from their country of origin. BAME Muslims have previously emphasised different descriptors for 'anxiety' and 'depression', making it more challenging for them to express themselves through psychological interventions (Loewenthal et al., 2014). Moreover, in Thomas et al. (2016), the main accessibility barrier was related to the use of the English language. The sole use of English MBSR materials and audio CDs reduces the accessibility and subsequent acceptability of MBIs as the content cannot be fully immersed (Thomas et al.,2016).

Participants in this study also described competing demands, such as family or work obligations, that got in the way of mindfulness practice (Vroegindewey & Sabri, 2022). BAME communities have consistently reported these competing demands on MBIs (Abercrombie et al., 2007). Moreover, competing demands primarily contribute to drop-outs (Watson et al., 2016). Watson and colleagues (2016) report that competing demands, especially related to caretaking responsibilities, are essential to address to improve the retention of BAME clients on MBIs. Participants here also described mindfulness as a luxury rather than essential activity. The socio-historical context of BAME participants means they have often come from cultures that have had to 'survive' rather than have time for self-development practices (Muuo et al., 2020). These contexts can lead BAME individuals to access services later and limit their ability to engage fully in services (Chin et al., 2019; Sue & Sue, 2012; Taylor et al., 2021).

Participants in this study differed concerning some barriers, such as access to food or housing, as reported by BAME participants in the USA (Hartwell et al., 2017; Hong et al., 2022). Research conducted by Beer et al. (2020) and Charlot et al. (2019) suggests that African Americans experience significant inequality in various aspects of life, including work, housing, education, and healthcare. This is partly due to the historical and continued systemic and institutional racism against them in the USA (Eichel et al., 2021). However, these variances in findings may also reflect differences in how BAME communities in the UK and USA experience and engage with services (Dutton et al., 2013; Waldron et al., 2018). In this context, participants did not report feeling uncomfortable or reminded of racial trauma when referred to MBIs by White clinicians, unlike some studies conducted in the USA. (Watson et al., 2016; Watson et al., 2019). Nonetheless, the findings in this study suggest that access to fundamental rights and resources such as healthcare and education are

crucial to address to increase the acceptability and accessibility of MBIs (Burnett-Zeigler et al., 2019a; Hong et al., 2022; Li et al., 2017).

The sample in this study was all female and it has been documented that women hold greater caretaking roles amongst BAME adults (Watson et al., 2016). Participants discussed the competing demands that often take priority in their lives and the lives of other women in their community. The women in this study also emphasised a fear of judgement regarding taking time for their own self-care and wellbeing that has been discussed in previous studies (Watson et all., 2019; Hartwell et al., 2018) and is reflective of the gendered roles present in society that shape the everyday experiences of BAME women (Deluca et al., 2018).

The competing demands faced by BAME communities can contribute to difficulties in accessing the MBIs (Wyatt et al., 2014), and female participants here and elsewhere prefer homework adaptations to address this (Hartwell et al., 2018; Szanton et al., 2011; Watson et al., 2016). Moreover, the focus on homework in MBCT has been described as a culturally insensitive feature for BAME women (Dutton et al., 2013; Watson et al., 2016). Watson and colleagues (2016) note that small changes to MBIs can increase the accessibility and feasibility of MBIs for women within communities with higher caretaking responsibilities.

Most recently (Johnson et al., 2022; Vroegindewey & Sabri, 2022), MBI researchers have tried to address accessibility by incorporating technology into their programmes. In an exploratory study (Johnson et al., 2022) with primarily BAME participants (70%), the use of a popular mindfulness app (headspace) was facilitated. Authors reported that participants from Black, African American, Asian, or Hispanic groups valued the sense of empowerment from being able to choose the instructor on the app (Johnson et al., 2022). This sense of empowerment aligns with the findings here and demonstrates how technology can improve accessibility for BAME participants on MBIs (Johnson et al., 2022; Vroegindewey & Sabri, 2022). Notably, the present study was comprised of highly educated women who are more likely to utilise technology to address mental health needs (Johnson et al., 2022) and these findings may not have been present with a less formally educated sample. It is of note that

the one participant in this study with solely a undergraduate education, did not discuss the use of mindfulness apps or technology throughout her interview which highlights this factor.

Interestingly, participants in Johnson et al. (2022) who had the least (<50%) adherence to the mindfulness app reported that an increase in scientific evidence would have helped retain participants.

Participants here experienced the choice of an app facilitator and the empowerment it gave in choosing the gender of the facilitators. Some participants in this study noted a sense of discomfort towards male facilitators and preferred using apps to address this. Using audio files on MBIs is common practice (Burnett-Zeigler et al., 2019), but incorporating or

promoting app use may be helpful to reinforce mindfulness practice in a culturally sensitive and private home environment (Blignault et al., 2019). Culturally sensitive MBIs may, in turn, help to improve access and engagement with mental health interventions (Chin et al., 2019) and with MBIs (Bignall et al., 2019).

Psychodynamic ideas around the anxiety-driven defences of individuals and organisations could also explain accessibility issues (Lowe, 2014 Parth et al., 2017). Rather than acknowledge accessibility issues, facilitators may experience participants as uninterested or resistant to MBI's, overlooking their preferences (Thomas et al., 2017). These organisational defences may also lead to overlooked central aspects of people's identities, such as religion (Ahmed & Mathes.,2017). Overlooking these aspects can exacerbate the impact of institutional racism against Muslims from BAME backgrounds by neglecting their religio-cultural needs (Rothman & Coyle, 2018). These institutional defences against the inclusion of religion have increased fear and mistrust between Muslim communities and healthcare providers (Victor & Treschuk, 2020; Younis & Jadhav, 2020). Moreover, BAME participants may seek to outwardly show acceptance of the intervention, overlooking their cultural or religious preferences to gain social acceptance or avoid judgement (Sue & Sue, 2012; Sue et al., 2009). This drive for socio-cultural acceptance could explain why some participants here centralised their acceptance of MBIs throughout their interviews despite listing some potential barriers for members of their community.

Addressing Stigma and Shame

Participants in this study eluded to cultural ideas that mainstream healthcare services may not meet their needs. Tarabi et al. (2020) discuss a culture of distrust in mental health services for Muslims, grounded in fear of stigma and mistreatment by services (Tarabi et al.,

2020). The impact of Islamophobia post 9/11 has increased judgement and bias towards Muslims, reducing engagement between Muslims and healthcare services (Allen, 2014). Thus, the participants in this study who discussed seeking religio-cultural advice before engaging in an MBI may reflect the heightened fear of services being able to meet their needs as Muslims (Byrne et al., 2017). This distrust of services may reflect a 'circle of fear' (Coyle, 2008) created through the social, political and economic exclusion of Muslims (Byrne et al., 2017). Studies with Black participants (Proulx et al., 2020; Watson et al., 2016) have emphasised how circles of fear can be addressed by including communities in designing and developing interventions sensitive to their needs. Moreover, Watson et al. (2016) highlight that the stigma associated with MBIs can not be addressed without community involvement and may hinder participation in BAME communities.

Stigma and Shame

Stigma and shame about mental health difficulties may also arise from community views towards discussing mental health difficulties (Rawlings & Bains, 2020; Rizkalla et al., 2020). This study's participants reflected that the shame of discussing mental health could lead some community members to avoid mainstream services (Hamid & Furnham, 2013; Rizkalla et al., 2020). Moreover, some participants described an initial reluctance or uncertainty to address their mental health difficulties due to the fear of judgement from other family or community members (Poole et al., 2021; Stevenson et al., 2017; Younis & Jadhav, 2020). However, participants emphasised psychoeducation to reduce stigma and increase the acceptability of seeking mental health support (Muuo et al., 2020; Rizkalla et al., 2020).

This study's participants' experiences align with previous research; for instance, Pakistani and Bangladeshi Muslims tend to encounter the highest levels of stigma and shame in seeking mental health services (Tarabi et al., 2020), while issues related to confidentiality have been highlighted in Muslim participants of Middle Eastern and North African (MENA)

origin (Al-Adawi et al., 2002; Hammad et al., 2020). Although the factors influencing this are multifaceted, some include cultural, gender or generational differences relating to the post-colonial differences in these communities in the UK (Tarabi et al., 2020) . Moreover, these nuanced differences serve as a reminder that religio-cultural acceptability is an essential consideration in the development, evaluation, and facilitation of interventions such as MBIs (Biggers et al., 2020; Blignault et al., 2019; Woods-Giscombe et al., 2019).

Participants in this study also noted the shift in generations on discussing mental health within their communities, with first-generation migrants or older generations holding more stigmatised views on mental health (Proulx et al.,2020). Participants discussed the growing diversity in opinions due to higher education and acculturation levels. The highly educated sample may not represent all of the BAME Muslim population, but supports previous findings that higher education levels lead to more acceptance of mindfulness (Pilkington et al., 2012). Thus, the acceptability of MBIs may be increasing as shifts in speaking openly about mental health in BAME communities and the wider population increases (Arday, 2018; Younis & Jadhav, 2020). Nonetheless, some researchers have suggested that mindfulness may be less stigmatising than traditional mental health services because non-judgement and present-moment awareness align with existing cultural and religious practices (Dutton et al., 2013). Thus, mindfulness may be an acceptable alternative or complementary to traditional treatments with the right religio-cultural considerations (Burnett-Zeigler et al., 2019).

Religio-Cultural Understandings of Mental Health

A Western healthcare model extols the healthcare professional's expertise, whereas an Islamic framework often draws upon prayer, religious leaders, and family for support (Weatherhead & Daiches, 2010). Muslims across BAME communities emphasise the importance of both religious and cultural acceptance of the practices they are taking part in (Meer & Mir, 2014; Pilkington et al., 2012; Walpole et al., 2013). Moreover, Muslims often

go to an Imam or faith leader rather than seek medical advice (Rothman & Coyle, 2018; White et al., 2019), which was reflected in the accounts of some participants in this study.

Blignault et al.'s (2019; 2021a, 2021b) series of adapted MBIs for Muslims in Australia included explanations of mindfulness's cultural and spiritual significance in Muslim cultures (Blignault et al., 2019). The programme also included exercises from MBCT and MBSR protocols, such as mindfulness of the breath, emotions and thought Blignault et al., 2021a, 2021b). Participants in this study reflected previous findings (Blignault et al., 2021a, 2021b) that both secular and religious understandings of MBIs were valuable. Moreover, participants in this study contextualised the skills gained in mindfulness through a religio-cultural lens, such as linking similar cultural practices to the content (Blignault et al., 2019; Blignault et al., 2021b). The examples of cultural practices shared by participants in this study, and the material in MBIs demonstrate the importance of contextualising mindfulness practices to the experiences of BAME cultures and communities (Woods-Giscombe et al., 2014, 2019). These practices included community gatherings, cooking and embroidery, which can familiarise the content on MBIs to BAME clients (Eifert et al., 2009; Hartwell et al., 2018; Proulx et al., 2020; Woods-Giscombe et al., 2019). Moreover, highlighting or including such practices may increase the relevance and cultural alignment of MBIs (Eifert et al., 2009; Hartwell et al., 2018; Proulx et al., 2020; Woods-Giscombe et al., 2019).

Participants in this study from Bangladeshi and Pakistani backgrounds shared that religio-cultural practices such as group prayer and recitation helped them to consolidate what they learned on the MBI (Blignault et al., 2021a). The inclusion of such religio-cultural practices may be meaningful to encourage engagement in MBIs (Blignault et al., 2021b), but may also be relevant to encourage participation in other psychological interventions (Pilkington et al., 2012).

Nonetheless, some participants did not mention validation through religio-cultural practices and viewed mindfulness as a secular practice. One possibility is that alignment with secular practice may reflect internalised ideas about the credibility of religio-cultural interventions (DeLuca et al., 2018; Koenig, 2012) at the expense of one's religio-cultural identity (Fanon, 1963). However, it may be that the secular alignment over the Buddhist traditions is important to avoid conflicts with cultural and Islamic practices (Blignault et al., 2019; Blignault et al., 2021b; Mannan et al., 2021; Thomas et al., 2016).

A few participants expressed potential concerns within their community that the connection between MBIs and Buddhism might impede Muslim engagement. Christian participants have previously expressed similar concerns (Woods-Giscombe et al., 2019). One possibility for this is community beliefs that faith should be enough to "heal" mental health challenges (Woods-Giscombe et al., 2019; Woods-giscombé & Gaylord, 2014). Moreover, guilt can arise around choosing to address mental health concerns with secular rather than religious traditions (Woods-Giscombe & Gaylord., 2014). Although guilt was not named explicitly by participants in this study, some participants were reluctant to rely on other means of dealing with distress rather than God (Koenig, 2012).

Some religio-cultural perspectives might attribute mental health difficulties to supernatural forces or influence (Al-Adawi et al., 2002). One participant in this study shared statements that reflected African American Christian participants (Watson et al., 2016). The authors noted that cultural stereotypes may lead to the belief that meditation is a 'magical' practice (Watson et al., 2016). Although it is beyond the scope of this research to explore supernatural ideas about mindfulness, these findings speak to the importance of clarifying misconceptions about mindfulness before MBIs (Proulx et al., 2020).

Considering Faith and Spirituality

All participants in this study discussed MBIs in relation to Islam, highlighting the influence of religion on the cultural alignment and acceptability of MBIs (Blignault et al., 2019; Blignault et al., 2021b; Thomas et al., 2016). Participants in this study often cited their religion as a primary way through which they understood mindfulness, which reflects the experiences of BAME Christians (Proulx et al.,2020; Spears et al., 2017; Woods-Giscombe et al.,2014) and Muslims (Blignault et al., 2021b; Thomas et al., 2016). Moreover, the findings reported here suggest that religion is a fundamental factor to consider during intervention planning (Walpole et al.,2013). One study (King et al., 2017) has involved liaising with imams to deliver mental health workshops with BAME Muslim communities. This study was the first to explore the potential of mosques and associated fora, such as women's circles, Qur'an classes and Islamic schools in the UK, as settings for health promotion programmes (King et al., 2017). The authors report that this is an appropriate and acceptable way to encourage health promotion within the Muslim community. However, they emphasise the importance of considering different communities' nuanced interpretations and practices (King et al., 2017). Conversely, the lack of consideration of faith and spirituality in MBIs can hinder Muslims from seeking secular psychological treatments (Hamid & Furnham, 2013).

Participants believed Islam shares similar goals with MBIs as both teach awareness, patience, and non-reactivity (Isgandarova, 2019; Thomas et al., 2017). These connections can increase the potential value and acceptability of MBIs for Muslims (Al-Ghalib & Salim, 2018). Muslim participants also spontaneously draw upon teachings in the Quran and Sunnah (life of the Prophet) to make sense of mindfulness skills (Blignault et al.,2021b; Thomas et al.,2016). Moreover, participants shared an enhanced connection with their faith and spiritual growth when they connected mindfulness to Quranic teachings and practices (Isgandarova, 2019; Thomas et al., 2017).

In Vroegindewey and Sabri's (2022) study with Muslim and Christian participants, they highlighted the importance of praying, journaling, and meditating on Scripture to cope with trauma. These faith-based practices are thought to strengthen coping mechanisms and may be particularly valuable to BAME individuals coping with trauma (Vroegindewey & Sabri, 2022). Of note is that the authors did not capture demographic data on religion, which did not allow for a distinction between Christian and Muslim participants' experiences (Vroegindewey & Sabri, 2022). Nevertheless, the findings demonstrate the value of using faith-based and secular coping mechanisms concurrently for followers of theistic religions (Thomas et al., 2017). Integrating the two may also help to increase trust in secular mental health practices and their cultural sensitivity (Hammad et al., 2020; Muuo et al., 2020; O'Toole, 2021).

Muraqaba and Prayer

The findings in this study contribute to the new and dynamic discourse about mindfulness in contemporary Islamic psychotherapy and how mindfulness might align with Muraqaba (Isgandarova, 2019). Participants described muraqaba practices such as incorporating Islamic prayers, dhikr and the Quran as objects of contemplation in meditation (Isgandarova, 2019). Participants here also spoke about using an image in the mind's eye, such as contemplation of Allah's names and guided imagery of the Kaaba[9] to enhance their mindfulness practice. And sense of muraqaba (Kaplick & Skinner., 2017).

Islamic practices, such as daily prayers, are considered integral to the religion (Walpole et al.,2013). Recognising the similarities between mindfulness and Islamic practices can be beneficial for both teachers and participants to increase the religio-cultural alignment of MBIs (Thomas et al.,2017). Participants here and elsewhere (Blignault et al.,2021; Thomas et al., 2016) spontaneously drew connections between prayer and

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[9] The Kaaba is a building at the centre of the central mosque in Mecca, an Islamic pilgrimage site

mindfulness. Prayer may also enhance the understanding of MBIs for Christian participants (Hartwell et al., 2018; Proulx et al., 2020; Woods-Giscombé & Gaylord, 2014), thus explaining the concept of meditation through religious prayer may increase the religio-cultural relevance of MBIs for followers of theistic religions (Proulx et al., 2020).

During prayer, Muslims are encouraged to focus on the present moment by letting go of rumination and increasing awareness of God (Isgandarova, 2019; Rothman & Coyle, 2018). While praying, Muslims also focus on bodily movements, just as the breathing space exercise promotes mindfulness of bodily sensations (Blignault et al., 2019). Thus, prayer and breathing exercises may aid in redirecting attention away from thoughts and overthinking (Segal et al., 2013). Moreover, they both facilitate the cultivation of mindfulness regarding the direction of one's attention to the present moment (Blignault et al., 2019; Blignault et al., 2021a; 2021b).

Islamic prayer also includes physical movements that engage muscles and joints (Skinner, 2010). The Sajdah position, in which the head is lower than the heart, increases blood flow to the brain and is thought to "relax" the mind and body (Nazish & Kalra, 2018; Sayeed & Prakash, 2013). In this sense, it is comparable to the yoga movements in MBSR that promote blood flow and are reported to have similar benefits (McDonnell et al., 2020).

The participants in this study also noted Islamic practices that promote bodily awareness, such as fasting during Ramadan (Thomas et al.,2017). Similarly, they linked the concept of mindful eating to the practice of beginning each meal with a specific remembrance (Bismillah - in the name of God), as described by Thomas et al. (2016).

No participants interviewed in this study reported dropping out of a mindfulness intervention due to perceived incongruence with their religious beliefs, which suggests some acceptability (Blignault et al., 2021b; Dutton et al., 2013; Vallejo & Amaro, 2009). Conversely, two studies described in the literature review of this thesis (Burnett-Zeigler et al.,

2019; Dutton et al., 2013) reported drop-outs due to incongruence with participants' Christian beliefs, although there was no additional information given to elaborate on the religious incongruence.

Negotiating Religious Identity

Overall, participants here did not see any personal religious issues or discrepancies between being Muslim (Islamic practice) and participating in MBIs (Blignault et al., 2019; Thomas et al., 2016). However, participants described different ways of practising Islam, often related to culture (Haque, 2000). A recent study (Pew research centre,2021) identified Islam as the second most ethnically diverse group after Christianity, which results in various understandings and interpretations of Islam. Participants also reflected on how their own religious identity was explored during the MBI and how Muslim community members negotiate their religious and cultural identities within Western secular societies (Abbasi et al., 2018; Stevenson et al., 2017). One participant here shared that, ultimately, life is seen through the lens of a higher power, for example, not being in complete control of the breath (Isgandarova, 2019). Conversely, secular mindfulness teachings posit a person's complete control of their breath (Kabat-Zinn, 2003). Moreover, MBIs emphasise non-judgmental awareness of the present moment, which contrasts with the Islamic framework of simultaneously holding present and future goals in mind (Isgandarova, 2019; Rothman & Coyle, 2018).

The aforementioned findings demonstrate the importance of MBIs, including Muslim advisors, in their design and facilitation (Haque., 2000; Skinner & Kaplick., 2017). Including Muslims could increase engagement, retention and acceptability by considering the religious congruence and potential incongruence within and between Muslim communities (Thomas et al., 2016).

Using Mindfulness to Address Depression

Findings in this study suggest that BAME Muslims can benefit from MBI skills when they experience mindfulness as an acceptable practice. Research suggests that MBIs can be effective in reducing symptoms of depression and preventing relapse in other ethnic and religious groups (Goldberg et al., 2021; Keng et al., 2011b; Shallcross & Spruill, 2018). Moreover, there is some preliminary evidence that MBIs can reduce symptoms of depression in Muslim clients (Mir et al., 2019; Walpole et al., 2013). Many participants here described arriving at MBIs following experiences of depression and valuing the impact of mindfulness on these experiences (O'Toole, 2021; Poole et al., 2021; Younis & Jadhav, 2020).

Participants in the study reported experiencing various benefits, such as improved control over their thoughts, emotions, and behaviours and a sense of calm and relaxation. These findings have been reported in studies with other BAME groups, indicating a commonality regarding the benefits of MBIs (Burnett-Ziegler et al., 2019; Watson et al., 2016; Woods-Giscombé & Black, 2010).

Participants here also shared that mindfulness helped them to change their relationship with thoughts and feelings related to depression (Goldberg et al., 2021). They described decentring from complex thoughts to promote more acceptance of their difficulties (Vroegindewey & Sabri., 2022). Participants discussed the benefits of MBIs long after they had, which suggests the long-term benefits of MBCT for depressive relapse (Kuyken et al., 2016). Moreover, participants shared that they were better able to recognise potential signs of relapse, which can reduce the likelihood of future depression (Burnett-Ziegler et al., 2019; Szanton et al., 2011).

Mindfulness and Autonomy

A benefit of MBIs is that they can be personalised to suit participants' needs and preferences (Abbasi et al., 2018; Bercean et al., 2020). This personalisation can lead to increased engagement and adherence to mindfulness practice (Wyatt et al., 2014). A meta-

synthesis conducted by Wyatt and colleagues (2014) found that MBIs are most effective when the frequency, duration and type of practices are adapted to suit clients' needs. Participants in this study emphasised the importance of personalising mindfulness to fit their daily lives and other commitments. Such personalisation is important for BAME groups who may experience a lack of power in culturally insensitive interventions (Bermudez et al., 2013; Szanton et al., 2011; Woods-Giscombé & Gaylord, 2014).

All participants agreed that mindfulness skills could be applied throughout the day, such as noticing physical sensations during walks and personal care activities (Szanton et al., 2011; Watson et al., 2016). Such mindfulness skills may be valuable for BAME communities to increase the empowerment and acceptability of MBIs (Hartwell et al., 2018; Stern et al., 2020).

Participants reported becoming increasingly aware of their bodies, sensations and emotions in busy times. Notably, the majority of the study's sample were highly educated women, who may have had greater opportunities to liniguistically categorise these experiences and connect them to the psychoeducation elements of MBCT. Participants described a shift from autopilot to a more present mode of being, in line with previous findings (Bermudez et al., 2013). By focusing on the present moment, participants described the skill of quieting a 'busy' mind which they had not been able to do prior to mindfulness practice (Thomas et al., 2016; Watson et al., 2016). These autopilot shifts can be achieved by personalising mindfulness skills to fit into clients' working days (Bermudez et al., 2013; DeLuca et al., 2018), and all but two women in this sample were in employment which may have made this benefit more meaningful for them.

Participants in this study discussed the benefits of MBIs with regard to mental and physical health, regardless of the frequency and duration of their mindfulness practice. These findings suggest that acquiring core mindfulness skills is more critical than the length of practice (Baer et al., 2019). Regardless of regular' formal' meditations, participants' ability to adopt mindfulness skills into their life challenges the notion of 'gold-standard' eight-week

interventions to derive the most benefits from the practice (Valley & Stallones, 2018). Thus,

MBIs can potentially benefit BAME Muslims whilst being sensitive to the needs and priorities that prevent them from engaging in longer daily practices (Blignault et al., 2019).

While MBIs are generally well-tolerated, some individuals may experience adverse effects (AEs), such as increased anxiety or negative affect (Farias et al., 2020). These AEs were reflected in the nuances of experiences shared by participants (Hunter-Jones et al., 2019). Participants were asked explicitly about AEs in the interviews, in line with previous recommendations (Farias et al., 2020; Van Dam et al., 2018). Despite sharing an acceptance and the value of MBIs, two participants in this study shared difficult experiences with anxiety and awareness of their symptoms of depression (Farias et al., 2020). These experiences may be because mindfulness can bring difficult emotions to the surface (Farias et al.,2020; Van Dam et al.,2018). However, it is essential to note that participants in this study did not frame these difficulties as AE's.

In contrast, previous studies with African American participants reported several adverse effects pertaining to the content of the course or personal challenges in implementing mindfulness (Hunter-Jones et al., 2019; Spears et al., 2017). One possibility is that the Black community has historically faced the most significant number of disparities (Spears et al., 2017) and levels of racial and gender-related stress (Watson et al., 2016). Thus, when faced with an intervention that may not be culturally sensitive, they may be more likely to face AE's (Farias et al., 2020). No participants in this study identified as Black, which may have contributed to a greater diversity of experiences and possibly different reports regarding adverse effects (Watson et al., 2016). Moreover, all participants were practising mindfulness in some way and chose to participate in the study to discuss their experiences, which could have led to a bias towards more favourable experiences of the practice (Woods-giscombé & Gaylord, 2014).

Developing Mindfulness Skills

The original MBCT programme, as described by Segal and colleagues (2002), teaches individuals how to disengage from automatic unhelpful cognitive patterns, which can reduce the likelihood of depression relapses and recurrences. Participants in this study described fostering a deeper understanding of mindfulness over time, which interrupted unhelpful behavioural patterns concerning depression (Bishop et al., 2004; Segal et al., 2002). Moreover, participants described how mindfulness helped anchor them back to the present during times of distress, reflecting findings in previous research (Gu et al., 2015). Thus, the findings presented here support the theoretical underpinnings of MBIs regarding the benefits of disengaging from autopilot, towards more present modes of being (Kabat-Zinn, 2003; Segal et al., 2002).

MBSR was developed to help individuals cope with chronic pain and stress-related illness (Kabat-Zinn et al., 1985), and participants in this study valued MBIs in helping them to cope with physical and chronic illness (Cotter & Jones, 2020; McDonnell et al., 2020). Moreover, participants utilised mindfulness to cope with illness-related stress (Beer et al., 2020). In a study with African American participants, Zhang and colleagues (2018) emphasised the physical health benefits of mindfulness to promote MBIs in BAME communities. The findings here suggest this could apply to BAME Muslims.

Participants emphasised that mindfulness was a novice skill that allowed them and members of their community to cope with stressful events beyond their control (Burnett-Zeigler et al., 2019; Woods-Giscombé & Gaylord, 2014; Bermudez et al., 2013). Thus, MBIs could provide mental and physical health benefits, making them valuable for BAME Muslims who value these factors (Thomas et al., 2016).

Nevertheless, further research on the skills and mechanisms of mindfulness is needed (Van Dam et al., 2018). To address the "Mindfulness Hype," (Van Dam et al., 2018, p.21), developing more specific and accurate language for the mental and physical states related to

mindfulness and its associated behaviours (Van Dam et al., 2018) could help researchers and practitioners ensure they deliver ethnically and culturally sensitive interventions that will not further marginalise BAME communities (Goldberg et al., 2021; Van Dam et al., 2018).

The findings from this thesis suggest that MBIs may be valuable for BAME Muslims. Nevertheless, to contextualise the findings mentioned above, one must acknowledge its strengths and limitations. Future research should also consider the practice, policy and research implications identified by this study.

Strengths and Limitations

MBI Research with BAME participants

The current research is unique in exploring the religio-cultural experiences of BAME Muslims and the acceptability of MBIs. There have been some publications that explore BAME Muslim experiences of mindfulness. However, these have been primarily conducted outside UK academia (Bignall et al.,2019; Thomas et al., 2016). This exclusion of BAME perspectives from mental health literature reflects broader criticisms that UK academia lacks BAME perspectives in clinical psychology research (Wood & Patel, 2017). Despite this strength, this research does not claim to provide an all-encompassing portrayal of BAME Muslim experiences of MBIs. Instead, it serves as an initial investigation aimed at comprehending and drawing attention to additional opportunities for research in this field.

It is also important to note that *mindfulness* is a multifaceted construct, making it difficult to 'capture' mindfulness skills in research (Van Dam et al., 2018). Participants also varied in the courses they attended and delivery mode, which may have affected their understanding of mindfulness and integrating mindfulness skills into their lives (Abbasi et al., 2018). Moreover, this variation made conducting research using a single qualitative approach challenging. I tried to address this by conducting a general qualitative enquiry that aligned with the exploratory aims of this study. Nevertheless, I may not have captured the

same depth of information had I closely aligned with a specific and standardised methodology such as phenomenology (Cresswell & Poth, 2018).

Addressing BAME Needs

This study sought to address the lack of cultural and religious diversity in mindfulness research (DeLuca et al., 2018; Eichel et al., 2021). However, Ahmed (2012) asserts that rather than directing a particular action to increase equity for minoritised individuals, the drive to generate ‘diversity’ in policy and research has led to a "bureaucratisation of diversity" (Ahmed., 2012, p. 97). This bureaucratisation makes the concepts of equality and diversity auditable, resulting in surface-level changes such as demographic characteristics in MBIs rather than addressing the root causes of inequality and access to MBIs (Baer et al., 2019; Monteiro et al., 2017). Moreover, by reducing diversity to checkboxes, bureaucratic approaches can overlook the intersectionality of people's identities and experiences (Anālayo, 2020).

The current study was limited by the BAME descriptors used to describe individuals, most commonly from countries outside Western Europe (Adray, 2018). Pooling participants across different ethnicities may not reflect the individual needs of each community (Agyemang et al., 2005; DeLuca et al., 2018), and the BAME label has been described as othering (Arday, 2018; Wood & Patel, 2017). To address these criticisms, I chose not to use recommended 'categories' to capture data on ethnicity and race (ONS, 2019). Instead, participants were encouraged to use their own descriptors to identify their ethnic identities, which I considered a strength of this study. However, one participant’s description of herself as "not sure" and "White-other” before choosing to name her country of origin reflects the challenges in categorising people this way. Despite this, using BAME terminology follows the context of previous national reports and research (Bignall et al., 2019; Iob et al., 2020; NICE, 2020) and reflects a lack of current alternative language in research (Arday, 2018).

Due to colourism and entrenched systemic racism across societies, individuals from Black communities are most likely to avoid mainstream services (Femi-Ajao, 2018; DOH, 2017; Shankley & Laurence, 2022). Their heightened experience of systematic racism and related fears (Chin et al., 2019) could explain why no one from the Black Muslim community participated in the study. However, this may also reflect limitations in my recruitment approach as only one organisation for Black meditators was approached. With more time and resources, I could have contacted more organisations to address this limitation.

Sample and Recruitment

All participants were recruited directly from the community, and using social media allowed participants to come from a broader range of geographical locations (Johnson et al., 2022; Vroegindewey & Sabri, 2022). The use of technology allowed for greater variation in the participants' demographics, which aimed to increase the variation in the experiences of the sample. Nevertheless, concerns about confidentiality led to drop-outs, which I tried to address by offering as much information about the study as possible. BAME groups may be wary of outsider research due to the potential of being racially traumatised or stereotyped (Younis & Jadhav, 2020) or data being misused by researchers (Shaheen et al., 2020). With more time and resources, I could have made further efforts to contact drop-out participants to address their concerns or gather their perspectives for the betterment of future research.

Time constraints for participants were also an issue, and I tried to mitigate this by offering as large a timeframe as possible to conduct the interviews, including evenings and weekends.

Four social media platforms were used (WhatsApp, Facebook, Twitter, and LinkedIn), but nearly half of the participants were recruited via LinkedIn. Thus, the participants represented a more educated sample of professional working age. The

mindfulness experiences reported may have differed for participants with low socio-economic demographics (Hong et al., 2022).

Research Paradigm

I considered using a critical realist approach a strength, which allowed me to explore the complex interplay between socio-cultural structures, individual agency and subjective realities (Creswell & Poth, 2018). Critical realism facilitated the exploration of how BAME Muslims actively engage in MBIs and negotiate their experiences within the context of their religio-cultural identities (Cresswell & Poth, 2018; Stutchbury, 2022). Moreover, critical realism allowed for an interpretivist epistemology, which provided further subjective understandings of the religio-cultural experiences of participants (Stutchbury, 2022). However, to further explore religio-cultural constructs, I could have developed interview questions that explored the power dynamics that influenced participants' experiences (Denzin & Lincoln, 2018)—for example, asking explicitly about the impact of colonialism and institutional racism and how MBIs may reproduce or challenge existing power structures and inequalities (Belli et al., 2015). Critical realism can be thought of as a 'Western' framework (Stutchbury, 2022), and there are other approaches, such as critical race theory, which emphasise the context of race and power in research that I could have utilised (Waller et al., 2021). Critical race theory may have been particularly valuable for a BAME Muslim sample to explore how institutional practices, policies and cultural norms perpetuate Islamophobia and inequalities in the context of MBIs (Poole & Williamson, 2021; Tarabi et al., 2020).

Interviews

The study used semi-structured interviews, which helped explore participants' lived experiences flexibly to elicit more nuanced and open dialogue (Creswell & Poth, 2018). I attempted to adjust the language and level of detail to suit the participants' understanding. I

left time for reflection at the end of each interview to allow participants to modify or share additional information (BPS, 2019).

Despite some of the strengths outlined above, the interviews were shorter than planned, which may indicate limitations in the interview guide and my interview skills. It also reflects the competing demands on participants' time, as many noted they were "juggling" other tasks around the interviews. Nevertheless, the shorter length may reflect that participants felt their perspectives were sufficiently captured in the time frame.

The videoconference format of interviews may have also negatively impacted the richness of data, given the internet connection interviews that occurred in some interviews. Although research has found face-to-face interviews to be marginally superior to videoconference interviews (Crosswell & Poth, 2018), further research adopting face-to-face may have allowed for more rapport to be built, resulting in richer data (Creswell & Poth, 2018).

Reflexivity

Clinicians with similar demographics should be involved in researching and developing MBIs to promote culturally sensitive interventions (Proulx et al.,2018). My dual position as an insider, who identifies as a BAME Muslim who has participated in MBIs and an outsider as someone outside of the participant's culture or community, and the disclosure of both helped build rapport and understanding of religio-cultural practices and rituals (Proulx et al., 2020). Moreover, this position allowed me to draw upon my knowledge of Arabic and French for participants from Arabic or French-speaking communities who felt restricted by using English.

Some entries reflecting some of the key challenges of my dual position can be found in the appendices (Appendix R). Regular entries into a reflective log helped ground this thesis within a reflexive approach (Braun & Clark.,2019). It has also allowed for greater

awareness of my biases, misunderstandings and personal views that may have impacted the research process (Braun & Clark,2022). I hope this process allowed me to reduce unconscious and conscious biases regarding culturally practised Islam, for which I only hold one perspective.

Despite some strengths of this study, the study does not claim to provide a complete narrative of BAME Muslims' mindfulness experiences, given these communities' nuanced and diverse experiences. Instead, it aims to use the common ground as an essential starting point for future clinical and research considerations in this area.

Clinical Implications of The Findings

The current research reflects information that could be valuable for MBI facilitators and within a therapeutic context to illustrate the potential for culturally sensitive MBIs. Additionally, the lived experiences shared by participants have given insight into the possible needs of Muslim clients that have not been considered in UK literature (Bignall et al., 2019).

Addressing Wider Systemic Issues

The dominance of White facilitators shared participants reflects a broader discourse of White professionals receiving training over BAME professionals (Wood & Patel,2017). This study recommends addressing systemic racism in all its forms and increasing mindfulness training for BAME clinicians. Moreover, including Muslim facilitators can improve the cultural resonance and acceptability of MBIs (Thomas et al., 2016). Participants in this study emphasised the cost of interventions mediates that accessibility to MBIs, and it is well-documented that MBIs are often inaccessible to BAME communities due to the cost (Beer et al., 2020; Bignall et al., 2019; Ortiz et al., 2019). Moreover, the tuition fees for training as a mindfulness teacher are costly (Bautista et al., 2022; Johnson et al., 2022), limiting opportunities for low-income individuals to obtain certification (Biggers et al., 2020). This research, therefore, recommends that the number of facilitators from such backgrounds be

increased. One possibility may be to train healthcare workers from BAME backgrounds to deliver MBIs (Biggers et al., 2020).

Nonetheless, BAME healthcare workers should not be trained *solely* to deliver MBIs to their community, as BAME facilitators may experience this as segregating (Cabral & Smith, 2011). Thus, the importance of individual preferences should be considered. Conversely, MBI training should not be exclusively for BAME practitioners (Wood & Patel, 2017). Culturally sensitive training for White practitioners may encourage cultural competency skills and ensure that the responsibility to address disparities created by dominant groups does not fall on BAME communities (Cabral & Smith, 2011; Wood & Patel, 2017).

Equitable Mindfulness

The concept of mindfulness is inherently equitable (Bautista et al., 2022). However, the application of mindfulness is characterised by inequity due to the contexts and secular lens it is often taught (DeLuca et al., 2018). Reframing mindfulness as equitable mindfulness may help disassociate it from an "exclusively White" connotation and make it more accessible.

The equitable mindfulness framework, recently developed by Bautista and colleagues (2022), can help understand the clinical implications of this research. Bautista et al. (2022) suggest ways to make mindfulness training more accessible to BAME groups, highlighting that mindfulness needs to be; accessible and inclusive, value the knowledge of multiple perspectives and draw on our inherent capacity for mindfulness.[10] to reduce disparities faced by BAME groups (Bautista et al., 2022).

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[10] Mindfulness here refers to trait mindfulness, as discussed in the introduction, rather than state mindfulness which has been used to describe the practice of mindfulness in this research

Based on the personalisation of mindfulness skills shared by participants, power and agency in how BAME Muslims engage with interventions may help to promote mindfulness as an equitable practice (Proulx et al., 2020). This study, therefore, supports the notion that clinicians should highlight the power of choice in how and when participants engage in MBIs (Bautista et al., 2022). Such considerations may encourage self-compassion, promoting self-worth in minoritised communities (Hammad et al., 2020). Moreover, this research recommends that MBIs draw on the community's strengths, using them as a resource to develop greater power and agency. More power and choice could also be provided to future participants in MBIs by explicitly providing options to participants during the body scan exercise (Hunter-Jones et al., 2019). Such considerations for the body-scan practice can help to address cultural concerns shared by participants regarding the potential discomfort of the body-scan practice in a mixed-gender room.

Implementing non-pharmacological treatment options is valued amongst BAME communities, which engage in more holistic approaches to address mental health needs (Burnett-Ziegler et al.,2019; Szanton et al.,2011). Therefore, this study recommends increasing non-pharmacological treatment options for BAME Muslims, considering their unique religio-cultural experiences.

Facilitators working with BAME communities should consider the diverse social, economic and political factors that can impact accessibility on MBIs (Hong et al., 2022; Watson et al., 2016). Thus, this research recommends transparency regarding the broader socio-cultural factors that may be preventing participants accessing and engaging in MBIs.

Facilitators should strive to address BAME disparities by considering more equitable modes of mindfulness intervention delivery (Johnson et al., 2022; Vroegindewey & Sabri, 2022). Based on participants' accounts regarding the value of apps, this study recommends using technology to adapt mindfulness by utilising apps and remote delivery options

(Blignault et al., 2019;2021a;2021b). The use of technology and apps can make it easier to include more information about mindfulness that is accessible outside of the intervention (Johnson et al., 2022; Proulx et al.,2020).

The study also recommends psychoeducation, which can reduce stigma in MBIs (Hong et al.,2022) and may increase accessibility and retention rates for future participants from BAME backgrounds (Hunter-Jones et al., 2019).

Adaptations To Address Accessibility

According to a recent narrative review (Chin et al.,2019), minor adaptations to MBIs, such as contextualising teachings using a religious lens and modifying programmes to consider time restraints, can increase engagement in MBIs. This research recommends modifying MBIs to suit the needs of BAME populations to address accessibility issues. This research also recommends considering time demands, which are influenced by caregiving responsibilities in BAME communities (Szanton et al., 2011). The reduction of homework or session length is recommended here, based on participants' accounts of how much time they could dedicate to mindfulness in the context of their competing demands.

Mindfulness can be done alone regardless of external resources, which may be particularly important for participants with lower socio-economic resources (Spears et al., 2017). This research recommends addressing attrition rates by addressing practical barriers impacting accessibility. Attrition rates can be ameliorated when researchers provide meals, childcare, transportation or reimbursement of participant costs (Dutton et al., 2013; Hong et al., 2022). Therefore this research recommends the inclusion of these incentives to encourage accessibility to MBIs for BAME participants across socio-demographic backgrounds.

Cultural Considerations

Equitable mindfulness transcends accessibility; it necessitates creating an environment that instils a sense of safety and inclusivity for BAME participants while actively discouraging exclusionary practices (Bautista et al.,2022). Thus, the present research recommends utilising iterative feedback to culturally adapt MBIs, whilst acknowledging multiple perspectives and diversity of thoughts and experiences across BAME communities (Bautista et al., 2022; Hartwell et al., 2018).

The MAPPG (2015) recommend "translating mindfulness teaching materials and methods to fit different languages, contexts and cultures." p.32; however, this has not developed in line with recommendations (Bignall et al., 2019). Participants in this study highlighted the language barriers within MBIs and the interviews. Thus, this research recommends translating materials and providing resources in a language other than English.

This research also recommends considering religio-cultural perspectives to develop culturally sensitive MBIs. Mir et al. (2019) investigated using religious coping mechanisms and reliance on faith as coping resources for depression. Their culturally-adapted intervention facilitated therapists' engagement and self-reflection with a group often subjected to the negative social portrayal and widespread Islamophobia (Mir et al.,2019; Poole et al., 2021). Several participants in this study revealed that they received MBCT through the NHS. Thus, religio-cultural adaptations and considerations may benefit Muslims engaging in NHS interventions.

This research also recommends addressing the professional and institutional defences regarding religion's inclusion in secular mental health care (Byrne et al., 2017; Poole et al., 2021). These defences may stem from therapists' spirituality, which may differ from their clients' (Eubanks et al., 2018). Thus, this research recommends further training and supervision for clinicians working with religious or spiritual groups to address their religio-cultural needs.

Drawing on Community Resources

Working with community members can enhance the acceptability of mindfulness practices and interventions (Proulx et al.,2020). Therefore, this study recommends working in partnership with communities to encourage participation and enhance the acceptability of MBIs. For example, incorporating storytelling to promote community connectedness and highlighting the importance of interdependence can benefit BAME communities (Watson et al., 2016; Watson-Singleton et al., 2019).

This research recommends using community-based MBIs to move towards equitable mindfulness that addresses the needs of BAME Muslims. Community members can uniquely cultivate cultural connections between healthcare systems and marginalised communities (Hartwell et al., 2018) and deliver low-cost health services that are culturally sensitive (Watson-Singleton et al., 2019). Thus, offering mindfulness training to community members can facilitate engagement in MBIs for those who may not otherwise have access to such interventions (Bautista et al., 2022).

The value of community involvement was emphasised in Hammad and colleagues' (2020) 'Hand of Hope' intervention, described in the introduction. The study demonstrates how healing practices such as religious chants to encourage more participation from the community. Moreover, participants valued the sense of greater community engagement, and the chance to include religio-cultural factors (Hammad et al., 2020). In an earlier study using grounded in a narrative approach (Ncube, 2006), participants were supported to create desired stories and narratives from a stance of power, hope, and recuperation. According to the participants, the most crucial aspect of the approach was exploring the meaning of difficulties, as discussed in specific chapters in the Qur'an.

Participants in this study emphasised teachings related to the Prophet Muhammad's [PBUH] life and mindfulness concepts, reflecting findings from previous research with

Muslims (Thomas et al., 2016). This study, therefore, recommends incorporating these religious concepts or drawing upon them as examples to enhance understanding and increase acceptability for BAME Muslims. Moreover, based on participants accounts regarding discomfort laying in mixed-gender rooms, this study recommends providing participants choice in how they engage in in-session mindfulness practices. This has previously been described as a crucial element of culturally sensitive MBIs (Dutton et al., 2013).

This research also recommends altering the language used to describe meditation and focusing on stress reduction rather than “clinical-sounding” terminology, which can carry negative connotations (Proulx et al., 2020). In a study by Proulx et al. (2018), these language changes were recommended to counteract words that may sound too "White" or exclusive to White populations. In another study by Watson-Singleton et al. (2019), participants highlighted the need to clarify the difference between "mindfulness" and "meditation" terminology. They suggested that the word "meditation" may carry foreign or negative connotations and recommended the more accessible term "mindfulness". These recommendations align with the preferences shared by participants in this study. Participants emphasised the importance of carefully selecting the language used to describe mindfulness to community members. Thus this study recommends adopting more culturally sensitive language to increase the acceptability of MBIs for BAME Muslims.

Policy Implication of the Findings

Several policies seek to address the mental health needs of BAME populations in the UK (Department of Health, n.d.). Nonetheless, policies concerning MBIs remain sparse, yet they are crucial to ensure MBIs are as valuable as the "hype" (VanDam, 2017). A notable omission in MBI documents and recommendations that do exist (MAPPG, 2015) is that they overlook the crucial aspect of implementing specific regulatory policies to address BAME participants' needs (Bignall et al.,2019). However, some of the clinical recommendations in

this study are not novel, which suggests some incongruence between policies that address BAME mental health needs and their implementation in practice (Bignall et al., 2019; MAPPG, 2015; Proulx et al., 2018).

This research recommends committed action to clinical, research and policy changes that address the needs of BAME communities. As Ahmed (2012) describes, a meaningful change to addressing BAME needs is "an interface between policy and action" (p.140), which this research supports. Coverley, a 'tick box' approach to policy implementation may involve recruiting more participants and facilitators from BAME backgrounds whilst overlooking an institutional commitment to change (Ahmed, 2012).

Religio-Cultural Sensitivity in Policy

The "Delivering Race Equality: A Framework for Action" (DOH, 2005) was developed to ensure the cultural appropriateness, inclusivity, and responsiveness of mental health services to meet the needs of BAME communities. The policy outlined by DOH (2005) acknowledged the underutilisation of psychological therapies among BAME communities and aimed to address this issue with assurance and attentiveness. Nevertheless, the desired result has yet to be achieved, primarily due to a lack of attention given to religio-cultural aspects concerning BAME communities(DOH, 2014).

Policies and ethical guidelines mandate that healthcare providers respect patients' cultural and personal values, beliefs, and preferences, including their religious or spiritual beliefs (Health, n.d.; NICE, 2020; Society, 2017). Additionally, "Faith-blind" health policies block religious groups, including Muslims, from accessing culturally appropriate care (Laird et al., 2007). Based on participants' accounts regarding their religio-cultural experiences of MBIs, this research recommends incorporating religious considerations into mental health policy, as emphasised by the BPS (2017, p.34) guidelines on religion. The guidelines also emphasise that mental health professionals should not allow their own beliefs to hinder their

ability to engage with the religious beliefs of their clients and should incorporate religion into interventions (BPS, 2017). Loewenthal et al. (2014) suggest that religious considerations extend to individual and community interventions, particularly for training GPs, interpreters, and therapists who work with BAME communities. This research also recommends using existing policies to address BAME needs to establish a foundation of evidence that values qualitative research on par with conventional quantitative research (McPherson et al., 2020). Moreover, additional policies are needed to improve the design of training programmes for BAME Muslims (Thomas et al., 2017). Such policies may help to promote a culture of more personalised treatments for BAME Muslims and facilitate trust between these communities and healthcare providers (Vroegindewey & Sabri., 2022).

Ethical Considerations

The concerns expressed by participants regarding the absence of contextualising MBIs within a Buddhist framework have been previously documented (Monteiro et al., 2017). Early guidelines for developing MBIs emphasised the importance of instructors having a deep understanding of the underlying principles of *dharma*, which form the core of mindfulness practice (Kabat-Zinn, 2003). Conversely, these principles have been diluted as neoliberal and capitalist approaches to healthcare have gained prominence (Anālayo, 2020). To ensure ethical conduct among mindfulness facilitators, Brown (2017) proposes that they take personal responsibility and clearly articulate the nature of their interventions (Brown, 2017, p. 25). The lack of transparency reported by participants in this study underscores the need for further efforts to ensure that NICE-recommended interventions such as MBCT (NICE, 2016) adhere to ethical standards and do not unintentionally harm vulnerable clients (Baer et al., 2019).

Utilising Technology in MBIs

As society progresses technologically, these advancements can potentially empower individuals, aid healthcare professionals, improve clinical efficiency and safety, and enhance mental health policy (Vroegindewey & Sabri, 2022). The "No health without mental health" strategy (DOH, 2011, p. 37) also recommends the utilisation of technology to promote innovation, expand choice, and increase the accessibility of services. These technology benefits align with this study's findings, indicating the potential for technology development to benefit BAME groups while being mindful of their specific needs (DOH, 2011). Thus, this research recommends incorporating technology in MBI policies to address BAME needs specifically.

Participants' experiences regarding the empowerment and flexibility offered by mobile applications align with the NHS's long-term plan to incorporate technology in client care (NICE, 2016; NHS, 2020) and may be particularly valuable for BAME communities who are disempowered by the impact of structural and systemic racism within UK society (Ghafournia, 2017; Poole & Williamson, 2021). However, it is crucial to conduct further research to explore the cultural sensitivity required when implementing apps (Johnson et al., 2022). This study recommends this to avoid inadvertently causing harm to marginalised and minoritised communities.

Research Implications of the Findings

The present study supports recommendations from the MAPPG (2015) to conduct further research to assess the long-term effects of mindfulness that have not yet been adequately explored (Bignall et al., 2019). In order to address accessibility issues, this research supports the notion that MBIs need to explicitly acknowledge the influence of race and oppression on MBI engagement (Magee, 2016). Recognising oppression will enable the identification of systemic barriers and facilitate the development of solutions to improve access to mindfulness resources.

The current study's participants acknowledged the limited understanding of mindfulness, aligning with broader criticisms found in the mindfulness literature (Van Dam et al., 2018). The perspectives shared by participants also support Spears et al.'s (2017) assertion that ineffective communication regarding MBIs hampers participation among marginalised and underrepresented communities. Thus, future research should emphasise explicit and comprehensive communication of mindfulness concepts to foster better comprehension.

Facilitating access to comprehensive information about therapy can mitigate potential long-term adverse effects by enhancing knowledge and understanding of the practice (Crawford et al., 2016). Therefore, this research also recommends addressing the dearth of systematic reporting or investigation into adverse events (AEs) associated with MBIs (Farias et al., 2020; Farias & Wikholm, 2016; Van Gordon et al., 2017). Neglecting to address this issue may prematurely lead to the conclusion that MBIs are devoid of adverse effects (Baer et al., 2019; Farias & Wikholm, 2016; Van Gordon et al., 2017).

While emerging research suggests the possibility of delivering MBIs remotely with BAME groups (Johnson et al., 2022; Vroegindewey & Sabri, 2022), this study recommends caution with applying this universally without appropriate research. Delivering MBIs solely remotely may inadvertently push mindfulness further into individualistic realms, potentially disadvantaging BAME communities that value collectivism (Poulin et al., 2021). Nonetheless, this study aligns with Vroegindewey and Sabri's (2022) recommendations for future studies to explore mindfulness apps specifically with BAME participants. Research on the value of these apps may contribute to the advancement of BAME mindfulness research and provide much-needed improvements in BAME mental health care (Biggers et al., 2020; Gaylord et al., 2022; Johnson et al., 2022; Rogge et al., 2022).

This research also recommends conducting holistic research that considers diverse stakeholder perspectives on the experiences of MBIs for BAME Muslims. The Medical Research Council's Complex Interventions Framework (Skivington et al., 2021) emphasises phased research with underserved groups, considering the intervention's contextual factors and the refinement of the intervention to meet the population's needs. Skivington et al. (2021) recommend this approach to build on research and establish theories for possible religio-cultural variances in treatment experiences. The development of such theories would also help to justify cultural adaptations and modifications for BAME communities (Deluca et al., 2018), while some studies have explored cultural congruence and incongruence among African American adults (Watson, 2016; Woods-Giscombe & Gaylord,2014) and older adults (Proulx et al., 2020; Szanton et al., 2011). This study recommends more research to understand BAME Muslim experiences of mindfulness, which have been largely excluded from the literature (Thomas et al., 2017). This research recommends using cultural sensitivity, community involvement, and incorporating technology to ensure that MBIs are appropriate and meaningful for underserved populations (Blignault et al., 2019; Bautista et al., 2022; Waldron et al., 2018).

Religio-Cultural Research

This study emphasises the significance of understanding the experiences of BAME Muslims through further qualitative research to identify potential challenges and adaptations required to enhance mindfulness acceptance within this community (Walpole et al., 2013). However, in line with a critical realist approach (Stutchbury, 2022), employing mixed-method research could facilitate the establishment of both clinical utility and qualitative insights. Additional research aimed at formulating theories that consider potential religio-cultural differences in the experience of mindfulness for BAME Muslims could justify modifying treatments (Thomas et al., 2017).

Moreover, this research recommends investigating the application of mindfulness within an Islamic psychology framework whilst acknowledging its Buddhist origins, which would enable ethical modifications aligned with Islamic practices (Isgandarova, 2019; Rothman & Coyle, 2018). The demographic data collected in this study did not include measures of religiosity, although participants indicated varying levels of religiosity. Future studies should account for this factor to gather more comprehensive data (DeLuca et al., 2018; Koenig, 2012). Blignault and colleagues (2021a) reported high retention rates among Arabic (78% retention) and Bangla-speaking (84% retention) groups due to the cultural sensitivity of programmes delivered in participants' native languages. Subsequent studies should therefore explore the religio-cultural acceptability of MBIs conducted in participants' mother tongues. This would avoid further exclusion of BAME participants from mainstream research (Al-Ghalib & Salim, 2018; Thomas et al., 2017). In cases where delivering interventions in participants' native languages is not feasible, this study recommends utilising interpreters to meet the community's needs and address accessibility issues (BPS, 2014; Loewenthal et al., 2011).

Although this study uncovered some shared experiences, researchers should acknowledge the nuances within and between different cultures. Recruiting Muslims from diverse ethnic and cultural backgrounds would provide a more comprehensive understanding of their interpretation and practice of Islam (Pilkington et al., 2012). The significance of considering the needs of various groups is underscored by the variations in experiences reported by Black (Charlot et al., 2019; Proulx et al., 2020), Latinos (Hartwell et al., 2018), and Arabs (Blignault et al., 2021b; Thomas et al., 2016) participants. Thus, this study recommends considering the needs of each community in future research.

This study included all female participants, so this research recommends further studies exploring the experiences of male participants. Spears and colleagues (2017)

discovered that time was a more significant obstacle for women than men in their study. These gender-related findings emphasise the need to consider gender and other factors when exploring future MBIs experiences. Additionally, conducting research encompassing both genders is needed to understand male experiences, often excluded in mindfulness research (Deluca et al., 2018).

Researchers working within BAME community settings recommend involving the community in utilising local knowledge to research interventions that are culturally sensitive and appropriate (Hartwell et al., 2018; Proulx et al., 2020). Previous research employing participatory action research techniques has shown increased participation and acceptance in African American Christian communities (Hartwell et al., 2018; Proulx et al., 2020). This research, therefore, uses this approach with the Muslim community, as it may encourage greater engagement. Moreover, using a focus group for participants from similar cultural backgrounds may have provided a sense of safety and different insights (Nyumba et al., 2018), which should also be considered in future studies with BAME Muslims.

Dissemination

Disseminating research findings with stakeholders is a crucial ethical aspect of the research process (Crosswell & Poth, 2018). Firstly, upon completion of the Doctorate in Clinical Psychology, the thesis for this study will be accessible to students, academic staff, and the general public through the University of Essex's open-access research repository. Additionally, participants will have the opportunity to receive a copy of the final written report. Finally, I aim to submit the study for publication in a suitable peer-reviewed journal, such as "Mindfulness" or the "Journal of Muslim Mental Health."

Reflective Account

Recognising and reflecting upon one's positionality through a reflexive journal is vital in managing ethical considerations, power dynamics, and data collection within research

(Braun & Clark, 2022). I made a conscious effort to record my activities throughout the research regularly, but also moments that prompted self-reflection and, at times, challenged my ideas and beliefs. In doing so, I hoped to address criticisms regarding the absence of positionality and reflexivity in mindfulness research, which has been noted as an area requiring further development (Goldberg et al., 2021).

In contemplation of my findings, I found myself unsurprised by participants' ready association of Islamic practices, such as prayer and fasting during Ramadan, with the fundamental qualities of awareness and attentiveness that are fervently encouraged within the context of MBIs. Given the manifold caregiving responsibilities incumbent upon women, both as prescribed by individual cultures and imposed by broader societal constructs, I had anticipated that these obligations might serve as formidable impediments to the allocation of time for self-nurturance. It was, however, a revelation, and perhaps an illustration of my own naivety, to discover the rich diversity in the practice of Islam across distinct cultural contexts. My initial suppositions, rooted in my Algerian heritage, had erroneously inclined me towards an expectation of uniformity in Islamic observance. This revelation, while enlightening, also imbued me with a profound sense of inspiration and humility. It served as a poignant reminder that each individual's experience of culture and religion is, indeed, subjective and idiosyncratic.

Additionally, I have experienced a palpable sense of validation, knowing that my instinctual discernment regarding the parallels between my own research findings and the extant literature review bears semblance in certain facets. Particularly, this convergence pertains to the multifaceted challenges encountered in the practice and engagement of mindfulness, within the unique context of being a BAME Muslim burdened with a distinctive set of challenges and stressors.

As the researcher, I acknowledge that my experiences of mindfulness come from working in the context of the NHS and using mindfulness as part of my clinical work as a trainee clinical psychologist. I have also worked in clinical roles in community psychology,

including with the refugee and asylum-seeking population and non-English-speaking groups. This work has prompted me to consider the language barriers and the potential to conduct more robust research had I considered this more in my research. My approach to clinical practice is integrative, curious, and collaborative. In undertaking this thesis, I became invested personally and professionally, with my interest in the topic influenced by my awareness that Muslim voices remain primarily unheard in research.

This study is the first time I have conducted doctoral work and the third time I have had the privilege of conducting research of my choosing. The process has allowed me to explore Islam from an academic perspective, and I discovered journals, authors, and publications that I would not have encountered otherwise. During the research, I was very conscious of two key moments. Firstly, the realisation that I am more of an outsider than an insider. Having grown up in an Algerian home, my religio-cultural experiences of Islam significantly differ from most participants I conversed with. I have learned a lot about myself and other cultures through the research. I have also valued the version of myself that has grown and evolved through this research. The experiences shared by participants have inspired me to continue research in Muslim mental health, and I have thoroughly enjoyed all interviews. They have helped me see the importance of giving a voice to Muslims, who are

often marginalised in Western discourse. I am also left wondering how the research would have been shaped had I co-produced the research with Muslim community members and organisations such as local mosques or community centres.

Overcoming Personal Challenges

It is also important to acknowledge that the research posed challenges, including capturing the essence of 'acceptability'. I had internal conflicts that the multifaceted and nuanced experiences shared were reduced to a simple term. I could not find a word to capture the essence of religio-cultural alignment, resonance and acceptability. Another challenge was the timeframe for completing the thesis, which did not allow for the co-production of questions. I noticed an overarching theme in my journal regarding the authenticity of my research without this element. I continually considered how much my beliefs influenced my interpretation of the participants' lived experiences. To align with a critical realist framework, the themes identified in the analysis should be consistent with the data and not force-fit the data to fit preconceived assumptions (Braun & Clarke, 2017; Stutchbury, 2022). I reminded myself of this throughout the analysis and write-up to ensure my research reflected the community's needs rather than my biases and beliefs based on my subjective experiences of Islam, culture and mindfulness.

Final Reflections

I am left with a sense of pride in contributing to the literature on this topic and hoping that the final report reflects an accurate account of the participants' stories. There are no original or controversial findings regarding Buddhism and the root of mindfulness, and the credit should not be taken away from those who have previously conducted research in this area.

Conclusion

This research has attempted to make a novel contribution to the evidence base on mindfulness experiences. The themes developed in this research suggest that mindfulness can be an acceptable intervention for BAME Muslims based on their religio-cultural experiences. Nonetheless, this research underscores the need for continued efforts to ensure that MBIs are accessible, culturally sensitive, and inclusive. Further research involving BAME communities as co-researchers is recommended to explore their experiences and address the specific needs of different BAME communities. Moreover, the research suggests more nuanced explorations of the distinct needs within different BAME communities, instead of categorising them under a single umbrella term. Further studies should consider conducting comprehensive research, theory development and policies to address the barriers to accessing and engaging in MBIs for minoritised communities.

References

Abbasi, F., Shariati, K., & Tajikzadeh, F. (2018). Comparison of the Cognitive Behavioral Therapy (CBT) and Mindfulness-Based Stress Reduction (MBSR): Reducing Anxiety Symptoms. *Women's Health Bulletin*, *5*(4), 0–4. https://doi.org/10.5812/whb.60585

Agyemang, C., Bhopal, R., & Bruijnzeels, M. (2005). Negro, Black, Black African, African Caribbean, African American or what? Labelling African origin populations in the health arena in the 21st century. *Journal of Epidemiology and Community Health*, *59*(12), 1014–1018. https://doi.org/10.1136/jech.2005.035964

Ahmed, S. (2012). *On being included: Racism and diversity in institutional life*. Duke University Press.

Akbary, M. F., Ariyo, T., & Jiang, Q. (2020). Sociocultural Determinants of Attitudes Toward Domestic Violence Among Women and Men in Afghanistan: Evidence from Afghanistan Demographic and Health Survey 2015. *Journal of Interpersonal Violence*. https://doi.org/10.1177/0886260520980400

Al-Adawi, S., Dorvlo, A. S. S., Al-Ismaily, S. S., Alghafry, D. A., Al-Noobi, B. Z., Al-Salmi, A., Burke, D. T., Shah, M. K., Ghassany, H., & Chand, S. P. (2002). Perception of and attitude towards mental illness in Oman. *International Journal of Social Psychiatry*, *48*(4), 305–317. https://doi.org/10.1177/002076402128783334

Al-Ghalib, S. J., & Salim, A. Y. (2018). A mindfulness based intervention to enhance university student wellbeing in Saudi Arabia. *Middle East Journal of Positive Psychology*, *4*(1), 142–157.

Al-Saadi, H. (2014). Demystifying Ontology and Epistemology in Research Methods. *ResearchGate*, 1–11.

Allen, F. (2014). Islamophobia in the UK: The Role of British Newspapers in Shaping

Attitudes towards Islam and Muslims. *PQDT - Global*, 138. https://search.proquest.com/docview/2314597087?accountid=9645%0Ahttp://repository.uwtsd.ac.uk/413/

Amutio, A., Franco, C., Pérez-Fuentes, M. de C., Gázquez, J. J., & Mercader, I. (2014). Mindfulness training for reducing anger, anxiety, and depression in fibromyalgia patients. *Frontiers in Psychology*, *5*(OCT). https://doi.org/10.3389/fpsyg.2014.01572

Anālayo, B. (2020). The Myth of McMindfulness. *Mindfulness*, *11*(2), 472–479. https://doi.org/10.1007/s12671-019-01264-x

Arch, J. J., & Craske, M. G. (2010). Laboratory stressors in clinically anxious and non-anxious individuals: The moderating role of mindfulness. *Behaviour Research and Therapy*, *48*(6). https://doi.org/10.1016/j.brat.2010.02.005

Arday, J. (2018). Understanding mental health: What are the issues for Black and ethnic minority students at University? *Social Sciences*, *7*(10). https://doi.org/10.3390/socsci7100196

Badham, R., & King, E. (2021). Mindfulness at work: A critical re-view. *Organization*, *28*(4), 531–554. https://doi.org/10.1177/1350508419888897

Baer, R. A., Smith, G. T., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment*, *13*(1), 27–45. https://doi.org/10.1177/1073191105283504

Baer, R., Crane, C., Miller, E., & Kuyken, W. (2019). Doing no harm in mindfulness-based programs: Conceptual issues and empirical findings. *Clinical Psychology Review*, *71*(March 2018), 101–114. https://doi.org/10.1016/j.cpr.2019.01.001

Bautista, T., A. Cash, T., Meyerhoefer, T., & Pipe, T. (2022). Equitable Mindfulness: The practice of mindfulness for all. *Journal of Community Psychology*, *January*, 1–15.

https://doi.org/10.1002/jcop.22821

Bazzano, A., Wolfe, C., Zylowska, L., Wang, S., Schuster, E., Barrett, C., & Lehrer, D. (2015). Mindfulness Based Stress Reduction (MBSR) for Parents and Caregivers of Individuals with Developmental Disabilities: A Community-Based Approach. *Journal of Child and Family Studies*, *24*(2), 298–308. https://doi.org/10.1007/s10826-013-9836-9

Beer, J. M., Smith, K. N., Kennedy, T., Mois, G., Acena, D., Gallerani, D. G., McDonnell, K. K., & Owens, O. L. (2020). A Focus Group Evaluation of Breathe Easier: A Mindfulness-Based mHealth App for Survivors of Lung Cancer and Their Family Members. *American Journal of Health Promotion*, *34*(7), 770–778. https://doi.org/10.1177/0890117120924176

Belli, S., Aceros, J. C., & Harré, R. (2015). "It's all discursive!" crossing boundaries and crossing words with Rom Harré. *Universitas Psychologica*, *14*(2), 755–768. https://doi.org/10.11144/Javeriana.upsy14-2.iadc

Benuto, L. T., Casas, J., & O'Donohue, W. T. (2018). Training culturally competent psychologists: A systematic review of the training outcome literature. *Training and Education in Professional Psychology*, *12*(3), 125–134. https://doi.org/10.1037/tep0000190

Bercean, A. V., Breen, L. J., McEvoy, P. M., Yeak, S., & Rooney, R. (2020). Improving the Cultural Sensitivity of Cognitive-Behavioral Therapy for Chinese Migrants With Depression: Community Members' and Clinicians' Perspectives. *Professional Psychology: Research and Practice*. https://doi.org/10.1037/pro0000326

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Bermudez, D., Benjamin, M. T., Porter, S. E., Saunders, P. A., Myers, N. A. L., & Dutton, M. A. (2013). A qualitative analysis of beginning mindfulness experiences for women with post-traumatic stress disorder and a history of intimate partner violence. *Complementary Therapies in Clinical Practice*, *19*(2), 104–108. https://doi.org/10.1016/j.ctcp.2013.02.004

Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology*, *23*(1), 67–82. https://doi.org/10.1007/BF01447045

Biener, A. I., & Zuvekas, S. H. (2020). Do Racial and Ethnic Disparities in Mental Health Treatment Vary With Underlying Mental Health? *Medical Care Research and Review*. https://doi.org/10.1177/1077558720903589

Biggers, A., Spears, C. A., Sanders, K., Ong, J., Sharp, L. K., & Gerber, B. S. (2020). Promoting Mindfulness in African American Communities. *Mindfulness*, *11*(10), 2274–2282. https://doi.org/10.1007/s12671-020-01480-w

Bignall, T., Jeraj, S., Helsby, E., & Butt, J. (2019). Racial disparities in mental health: Literature and evidence review. In *Race Equality Foundation and Health and Well-being Alliance*. https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf

Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., Segal, Z. V., Abbey, S., Speca, M., Velting, D., & Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice*, *11*(3). https://doi.org/10.1093/clipsy/bph077

Blignault, I., Saab, H., Woodland, L., & Comino, E. (2019). Evaluation of the acceptability

and clinical utility of an Arabic-language mindfulness CD in an Australian community setting. *Transcultural Psychiatry*, *56*(3), 552–568. https://doi.org/10.1177/1363461519825880

Blignault, I., Saab, H., Woodland, L., Mannan, H., & Kaur, A. (2021a). Effectiveness of a Community-based Group Mindfulness Program tailored for Arabic and Bangla-speaking Migrants. *International Journal of Mental Health Systems*, *15*(1), 1–13. https://doi.org/10.1186/s13033-021-00456-0

Blignault, I., Saab, H., Woodland, L., & O'Callaghan, C. (2021b). Cultivating mindfulness: evaluation of a community-based mindfulness program for Arabic-speaking women in Australia. *Current Psychology*, *Cd*. https://doi.org/10.1007/s12144-021-02146-z

Braun, V., & Clarke, V. (n.d.). *Answers to frequently asked questions about thematic analysis*. Retrieved February 3, 2021, from https://cdn.auckland.ac.nz/assets/psych/about/our-research/documents/Answers to frequently asked questions about thematic analysis April 2019.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *(PDF) Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning*. The Psychologist. https://www.researchgate.net/publication/269928387_Teaching_thematic_analysis_Overcoming_challenges_and_developing_strategies_for_effective_learning

Braun, V., & Clarke, V. (2017). *Evaluating and reviewing TA research: A checklist for editors and reviewers*. https://cdn.auckland.ac.nz/assets/psych/about/our-research/documents/TA website update 10.8.17 review checklist.pdf

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative*

Research in Sport, Exercise and Health, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2020a). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *August*, 1–11. https://doi.org/10.1002/capr.12360

Braun, V., & Clarke, V. (2020b). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *00*(00), 1–25. https://doi.org/10.1080/14780887.2020.1769238

Braun, V., & Clarke, V. (2022). *Thematic Analysis: a practical guide to understanding and doing.* Sage Publications.

Bridges, N. A. (1999). Psychodynamic perspective on therapeutic boundaries: Creative clinical possibilities. *Journal of Psychotherapy Practice and Research*, *8*(4), 292–300.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: a worked example. In *Journal of Health Services Research & Policy* (Vol. 7, Issue 4). SAGE PublicationsSage UK: London, England. https://doi.org/10.1258/135581902320432732

British Psychological Society (2014). Code of Human Research Ethics. In *The British Psychological Society*. British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy - Files/BPS Code of Human Research Ethics.pdf

British Psychological Society (2017). Practice Guidelines - Third Edition. *Bps*, *August*, 1–89. https://www.bps.org.uk/sites/bps.org.uk/files/Policy - Files/BPS Practice Guidelines (Third Edition).pdf

British Psychological Society. (2018). Code of ethics and conduct: Guidance published by the Ethics Committee of the British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20%26%20Conduct%20%282018%29.pdf

Brown, K. W., & Ryan, R. M. (2003). The Benefits of Being Present: Mindfulness and Its Role in Psychological Well-Being. In *Journal of Personality and Social Psychology* (Vol. 84, Issue 4). https://doi.org/10.1037/0022-3514.84.4.822

Burnett-Zeigler, I., Satyshur, M. D., Hong, S., Wisner, K. L., & Moskowitz, J. (2019a). Acceptability of a mindfulness intervention for depressive symptoms among African-American women in a community health center: A qualitative study. *Complementary Therapies in Medicine*, *45*, 19–24. https://doi.org/10.1016/j.ctim.2019.05.012

Burnett-Zeigler, I., Satyshur, M. D., Hong, S., Wisner, K. L., & Moskowitz, J. (2019b). Acceptability of a mindfulness intervention for depressive symptoms among African-American women in a community health center: A qualitative study. *Complementary Therapies in Medicine*, *45*(May), 19–24. https://doi.org/10.1016/j.ctim.2019.05.012

Byrne, A., Mustafa, S., & Miah, I. Q. (2017). Working together to break the ‘ circles of fear ’ between Muslim communities and mental health services. *Psychoanalytic Psychotherapy*, *8734*, 1–8. https://doi.org/10.1080/02668734.2017.1322131

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*(4). https://doi.org/10.1037/a0025266

Cervantes, M. V., & Sherman, J. (2021). Falling for the Ones That Were Abusive: Cycles of Violence in Low-Income Women’s Intimate Relationships. *Journal of Interpersonal Violence*, *36*(13–14), NP7567–NP7595. https://doi.org/10.1177/0886260519829771

Charlot, M., D'amico, S., Luo, M., Gemei, A., Kathuria, H., & Gardiner, P. (2019). Feasibility and Acceptability of Mindfulness-Based Group Visits for Smoking Cessation in Low-Socioeconomic Status and Minority Smokers with Cancer. *Journal of Alternative and Complementary Medicine*, *25*(7), 762–769. https://doi.org/10.1089/acm.2019.0016

Chiesa, A., & Serretti, A. (2011). Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis. In *Psychiatry Research* (Vol. 187, Issue 3, pp. 441–453). https://doi.org/10.1016/j.psychres.2010.08.011

Chin, G., Anyanso, V., & Greeson, J. (2019). Addressing Diversity in Mindfulness Research on Health: A Narrative Review using the ADDRESSING Framework. *The Cooper Rowan Medical Journal*, *1*(1), 1–13. https://doi.org/10.31986/issn.2578-3343_vol1iss1.1.2

Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., Karatzias, T., & Hyland, P. (2018). The International Trauma Questionnaire: development of a self-report measure of ICD-11 PTSD and complex PTSD. In *Acta Psychiatrica Scandinavica* (Vol. 138, Issue 6). https://doi.org/10.1111/acps.12956

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research*, *22*(10). https://doi.org/10.1177/1049732312452938

Cooper, A., & Lees, A. (n.d.). *Spotlit: defences against anxiety in contemporary human service organizations*.

Cotter, E. W., & Jones, N. (2020). A Review of Latino/Latinx Participants in Mindfulness-Based Intervention Research. *Mindfulness*, *11*(3), 529–553. https://doi.org/10.1007/s12671-019-01266-9

Crane, R. S. (2017). Implementing Mindfulness in the Mainstream: Making the Path by Walking It. *Mindfulness*, *8*(3), 585–594. https://doi.org/10.1007/s12671-016-0632-7

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches*. SAGE Publications.

DeLuca, S. M., Kelman, A. R., & Waelde, L. C. (2018). A Systematic Review of Ethnoracial Representation and Cultural Adaptation of Mindfulness- and Meditation-Based Interventions. *Psychological Studies*, *63*(2), 117–129. https://doi.org/10.1007/s12646-018-0452-z

Denzin, N. K., & Lincoln, Y. S. (2018). *The SAGE handbook of qualitative research*. SAGE Publications.

Department of Health (n.d.). *Delivering race equality in mental health care An action plan for reform inside and outside services The Government ' s response to the independent inquiry into the death of David Bennett Immediate*.

Department of Health (2017). Responding to domestic abuse: *Domestic Abuse: A Resource for Health Professionals*, 221–246. https://doi.org/10.2307/j.ctt1ggjk7c.16

Dixon-Woods, M., Bonas, S., Booth, A., Jones, D. R., Miller, T., Sutton, A. J., Shaw, R. L., Smith, J. A., & Young, B. (2006). How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research*, *6*(1), 27–44. https://doi.org/10.1177/1468794106058867

Dussault, É., Fernet, M., & Godbout, N. (2020). A Metasynthesis of Qualitative Studies on Mindfulness, Sexuality, and Relationality. *Mindfulness*, *11*(12), 2682–2694. https://doi.org/10.1007/s12671-020-01463-x

Dutton, M. A., Bermudez, D., Matás, A., Majid, H., & Myers, N. L. (2013). Mindfulness-Based Stress Reduction for Low-Income, Predominantly African American Women

With PTSD and a History of Intimate Partner Violence. *Cognitive and Behavioral Practice*, *20*(1), 23–32. https://doi.org/10.1016/j.cbpra.2011.08.003

Dwivedi, K. N. (1994). Mental cultivation (meditation) in Buddhism. *Psychiatric Bulletin*, *18*(8), 503–504. https://doi.org/10.1192/pb.18.8.503

Eichel, K., Gawande, R., Acabchuk, R. L., Palitsky, R., Chau, S., Pham, A., Cheaito, A., Yam, D., Lipsky, J., Dumais, T., Zhu, Z., King, J., Fulwiler, C., Schuman-Olivier, Z., Moitra, E., Proulx, J., Alejandre-Lara, A., & Britton, W. (2021). A Retrospective Systematic Review of Diversity Variables in Mindfulness Research, 2000–2016. *Mindfulness*, *12*(11), 2573–2592. https://doi.org/10.1007/s12671-021-01715-4

Eifert, G. H., Forsyth, J. P., Arch, J., Espejo, E., Keller, M., & Langer, D. (2009). Acceptance and Commitment Therapy for Anxiety Disorders: Three Case Studies Exemplifying a Unified Treatment Protocol. *Cognitive and Behavioral Practice*, *16*(4), 368–385. https://doi.org/10.1016/j.cbpra.2009.06.001

Fanon, F. (1963). *The wretched of the earth*. Grove Press.

Fanon, F. (2008). *Black skin, White masks* (R. Philcox, Trans.). Grove Press. (Original work published 1952).

Farias, M., Maraldi, E., Wallenkampf, K. C., & Lucchetti, G. (2020). Adverse events in meditation practices and meditation-based therapies: a systematic review. *Acta Psychiatrica Scandinavica*, *142*(5), 374–393. https://doi.org/10.1111/acps.13225

Farias, Miguel, & Wikholm, C. (2016). Has the science of mindfulness lost its mind? *BJPsych Bulletin*, *40*(6), 329–332. https://doi.org/10.1192/pb.bp.116.053686

Femi-Ajao, O. (2018). Intimate partner violence and abuse against Nigerian women resident in England, UK: A cross- sectional qualitative study. *BMC Women's Health*, *18*(1), 1–14. https://doi.org/10.1186/s12905-018-0610-4

Femi-Ajao, O., Kendal, S., & Lovell, K. (2020). A qualitative systematic review of published work on disclosure and help-seeking for domestic violence and abuse among women from ethnic minority populations in the UK. *Ethnicity and Health, 25*(5), 732–746. https://doi.org/10.1080/13557858.2018.1447652

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research, 12*(4), 531–545. https://doi.org/10.1177/104973202129120052

Fjorback, L. O., Arendt, M., Ornbol, E., Fink, P., & Walach, H. (2011). Mindfulness-based stress reduction and mindfulness-based cognitive therapy - a systematic review of randomized controlled trials. *Acta Psychiatrica Scandinavica, 124*(2), 102–119. https://doi.org/10.1111/j.1600-0447.2011.01704.x

Frank, P., Stanszus, L., Fischer, D., Kehnel, K., & Grossman, P. (2019). Cross-Fertilizing Qualitative Perspectives on Effects of a Mindfulness-Based Intervention: An Empirical Comparison of Four Methodical Approaches. *Mindfulness*, *10*(11), 2452–2467. https://doi.org/10.1007/s12671-019-01227-2

Fujisaki, C. (2020). A Study Evaluating Mindfulness and Naikan-Based Therapy: AEON-HO for Attachment Style, Self-Actualization, and Depression. *Psychological Reports*, *123*(2), 239–251. https://doi.org/10.1177/0033294118811106

Bautista, T., A. Cash, T., Meyerhoefer, T., & Pipe, T. (2022). Equitable Mindfulness: The practice of mindfulness for all. *Journal of Community Psychology*, *January*, 1–15. https://doi.org/10.1002/jcop.22821

Gaylord, S., Faurot, K. R., Shafer, J., Harr, E., Lathren, C., Roth, I., Giscombe, K., Sheffield-Abdullah, K., & Williams, S. (2022). Easing the burden of dementia caregiving: Protocol development for a telephone-delivered mindfulness intervention for rural,

African American families. *Contemporary Clinical Trials Communications*, *30*(October), 101031. https://doi.org/10.1016/j.conctc.2022.101031

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6–41. https://doi.org/10.1111/bjc.12043

Goldberg, S. B., Riordan, K. M., Sun, S., & Davidson, R. J. (2021). The Empirical Status of Mindfulness-Based Interventions: A Systematic Review of 44 Meta-Analyses of Randomized Controlled Trials. *Perspectives on Psychological Science*. https://doi.org/10.1177/1745691620968771

Gu, J., Strauss, C., Bond, R., & Cavanagh, K. (2015). How do mindfulness-based cognitive therapy and mindfulness-based stress reduction improve mental health and wellbeing? A systematic review and meta-analysis of mediation studies. *Clinical Psychology Review*, *37*, 1–12. https://doi.org/10.1016/j.cpr.2015.01.006

Güveli, A., & Platt, L. (2011). D*iversity, ethnicity and religion: A qualitative study of the intersections between diversity, ethnicity and religion in contemporary England.* Ethnic and Racial Studies, 34(3), 399-418. https://doi.org/10.1080/01419870.2010.496538

Hamid, A., & Furnham, A. (2013). Factors affecting attitude towards seeking professional help for mental illness: A UK Arab perspective. *Mental Health, Religion and Culture*, *16*(7), 741–758. https://doi.org/10.1080/13674676.2012.718753

Hammad, J., El-Guenuni, A., Bouzir, I., & El-Guenuni, F. (2020). The hand of hope: A coproduced culturally appropriate therapeutic intervention for muslim communities affected by the grenfell tower fire. *Journal of Muslim Mental Health*, *14*(2). https://doi.org/10.3998/JMMH.10381607.0014.202

Haque, A. (2000). Psychology and Religion: Two Approaches to Positive Mental Health. *Intellectual Discourse*, *8*(1), 81–94.

Hartwell, S., Allison, J., Jones, B., Rodrigues, R., Chery, C., Andrews, J., & Fulwiler, C. (2018). Feasibility and Acceptability of Mindfulness for Survivors of Homicide and Their Providers. *Explore*, *14*(1), 66–75. https://doi.org/10.1016/j.explore.2017.04.021

Hong, Q., Pluye, P., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M.-P., Griffiths, F., Nicolau, B., Rousseau, M.-C., & Vedel, I. (2018). Mixed Methods Appraisal Tool (MMAT), Version 2018. User guide. *McGill*, 1–11. http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf%0Ahttp://mixedmethodsappraisaltoolpublic.pbworks.com/

Hong, S., Satyshur, M. D., & Burnett-Zeigler, I. (2022). The association of mindfulness and depression stigma among African American women participants in a mindfulness-based intervention: A pilot study. *Transcultural Psychiatry*. https://doi.org/10.1177/13634615221076709

Hunter-Jones, J. J., Gilliam, S. M., Carswell, A. L., & Hansen, N. B. (2019). Assessing the Acceptability of a Mindfulness-Based Cognitive Therapy Intervention for African-American Women Living with HIV/AIDS. *Journal of Racial and Ethnic Health Disparities*, *6*(6). https://doi.org/10.1007/s40615-019-00617-5

Hyman, G. (2020). Atheism and the Rise of Science. *A Short History of Atheism*, *January 2013*, 101–124. https://doi.org/10.5040/9780755625352.ch-006

Iob, E., Steptoe, A., & Fancourt, D. (2020). Abuse, self-harm and suicidal ideation in the UK during the COVID-19 pandemic. *British Journal of Psychiatry*, *217*(4), 543–546. https://doi.org/10.1192/bjp.2020.130

Isgandarova, N. (2019). Muraqaba as a Mindfulness-Based Therapy in Islamic Psychotherapy. *Journal of Religion and Health*, *58*(4), 1146–1160.

https://doi.org/10.1007/s10943-018-0695-y

Jandaghi, G., Firoozi, M., & Zia-Tohidi, A. (2020). Psychological interventions for depression and anxiety: A systematic review and meta-analysis of Iranian chronic pain trials. In *Health Promotion Perspectives* (Vol. 10, Issue 3). https://doi.org/10.34172/hpp.2020.31

Jenks, D. B., & Oka, M. (2020). Breaking Hearts: Ethically Handling Transference and Countertransference in Therapy. *American Journal of Family Therapy*, *0*(0), 1–18. https://doi.org/10.1080/01926187.2020.1830732

Johnson, L. C. M., Aiello, J. J., Jagtiani, A., Moore, K. N., Barber, L., Gujral, U. P., & Johnson, D. A. (2022). Feasibility, appropriateness, and acceptability of a mobile mindfulness meditation intervention to improve sleep quality among a racially/ethnically diverse population. *Sleep Health*, *000*, 10–12. https://doi.org/10.1016/j.sleh.2022.09.014

Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life.* Hyperion.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. In *Clinical Psychology: Science and Practice* (Vol. 10, Issue 2). https://doi.org/10.1093/clipsy/bpg016

Kabat-Zinn, J. (2009). *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness*. Delta.

Kabat-Zinn, J. (2013). M*indfulness for Beginners: Reclaiming the Present Moment-and Your Life*. Sounds True.

Kabat-Zinn, J., Lipworth, L., & Burney, R. (1985). The clinical use of mindfulness meditation for the self-regulation of chronic pain. *Journal of Behavioral Medicine*, *8*(2). https://doi.org/10.1007/BF00845519

Kaplick, P. M., & Skinner, R. (2017). The evolving islam and psychology movement. *European Psychologist*, *22*(3), 198–204. https://doi.org/10.1027/1016-9040/a000297

Kaufmann, F.-X. (1997). Religion and Modernization in Europe. *Journal of Institutional and Theoretical Economics (JITE) / Zeitschrift Für Die Gesamte Staatswissenschaft*, *153*(1), 80–96. http://www.jstor.org/stable/40752988

Keng, S. L., Smoski, M. J., & Robins, C. J. (2011). Effects of mindfulness on psychological health: A review of empirical studies. In *Clinical Psychology Review* (Vol. 31, Issue 6). https://doi.org/10.1016/j.cpr.2011.04.006

King, R., Warsi, S., Amos, A., Shah, S., Mir, G., Sheikh, A., & Siddiqi, K. (2017). Involving mosques in health promotion programmes: A qualitative exploration of the MCLASS intervention on smoking in the home. *Health Education Research*, *32*(4), 293–305. https://doi.org/10.1093/her/cyx051

Koenig, H. G. (2012). Religion , Spirituality , and Health : The Research and Clinical Implications. *Nternational Scholarly Research Network, 2012*, 33. https://doi.org/10.5402/2012/278730

Kulwicki, A., Aswad, B., Carmona, T., & Ballout, S. (2010). Barriers in the Utilization of Domestic Violence Services Among Arab Immigrant Women: Perceptions of Professionals, Service Providers & Community Leaders. *Journal of Family Violence*, *25*(8), 727–735. https://doi.org/10.1007/s10896-010-9330-8

Kuyken, W., Warren, F. C., Taylor, R. S., Whalley, B., Crane, C., Bondolfi, G., Hayes, R., Huijbers, M., Ma, H., Schweizer, S., Segal, Z., Speckens, A., Teasdale, J. D., Van Heeringen, K., Williams, M., Byford, S., Byng, R., & Dalgleish, T. (2016). Efficacy of mindfulness-based cognitive therapy in prevention of depressive relapse an individual patient data meta-analysis from randomized trials. *JAMA Psychiatry*, *73*(6), 565–574.

https://doi.org/10.1001/jamapsychiatry.2016.0076

Laird, L. D., Amer, M. M., Barnett, E. D., & Barnes, L. L. (2007). *Muslim patients and health disparities in the UK and the US*. 922–926. https://doi.org/10.1136/adc.2006.104364

Li, M. J., Distefano, A. S., Thing, J. P., Black, D. S., Simpson, K., Unger, J. B., Milam, J., Bluthenthal, R. N., Erves, J. C., Mayo-Gamble, T. L., Malin-Fair, A., Boyer, A., Joosten, Y., Vaughn, Y. C., Sherden, L., Luther, P., Miller, S., & Wilkins, C. H. (2017). Needs, Priorities, and Recommendations for Engaging Underrepresented Populations in Clinical Research: A Community Perspective. *Journal of Community Health*, *6*(3), 408–419. https://doi.org/10.1007/s10900-016-0279-2

Liamputtong, P. (2012). Writing a Qualitative Research Proposal. *Qualitative Research Methods*, *4th*.

Lindahl, J. R., Fisher, N. E., Cooper, D. J., Rosen, R. K., & Britton, W. B. (2017). The varieties of contemplative experience: A mixed-methods study of meditation-related challenges in Western Buddhists. In *PLoS ONE* (Vol. 12, Issue 5). https://doi.org/10.1371/journal.pone.0176239

Loewenthal, D., Mohamed, A. D., District, M., Board, H., Mukhopadhyay, S., & Thomas, R. (2014). *British Journal of Guidance & Reducing the barriers to accessing psychological therapies for Bengali , Urdu , Tamil and Somali communities in the UK : some implications for training , policy and practice*. *January 2011*. https://doi.org/10.1080/03069885.2011.621519

Loewenthal, K. M., & Cinnirella, M. (1999). Beliefs about the Efficacy of Religious, Medical and Psychotherapeutic Interventions for Depression and Schizophrenia among Women from Different Cultural–Religious Groups in Great Britain. *Transcultural Psychiatry*,

36(4), 491–504. https://doi.org/10.1177/136346159903600408

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31–42. https://doi.org/10.1177/2632084320947559

Lowe, Frank (2014) Thinking space: The model. In: *Thinking space: Promoting thinking about race, culture, and diversity in psychotherapy and beyond.* (pp. 11-34)The Tavistock Clinic Series. Karnac, https://repository.tavistockandportman.ac.uk/758/

Lyons, M., & Brewer, G. (2021). Experiences of Intimate Partner Violence during Lockdown and the COVID-19 Pandemic. *Journal of Family Violence*. https://doi.org/10.1007/s10896-021-00260-x

Malpass, A., Carel, H., Ridd, M., Shaw, A., Kessler, D., Sharp, D., Bowden, M., & Wallond, J. (2012). Transforming the perceptual situation: A meta-ethnography of qualitative work reporting patients' experiences of mindfulness-based approaches. *Mindfulness*, *3*(1), 60–75. https://doi.org/10.1007/s12671-011-0081-2

McDonnell, K. K., Gallerani, D. G., Newsome, B. R., Owens, O. L., Beer, J., Myren-Bennett, A. R., Regan, E., Hardin, J. W., & Webb, L. A. (2020). A Prospective Pilot Study Evaluating Feasibility and Preliminary Effects of Breathe Easier: A Mindfulness-based Intervention for Survivors of Lung Cancer and Their Family Members (Dyads). *Integrative Cancer Therapies, 19*. https://doi.org/10.1177/1534735420969829

McPherson, S., Wicks, C., & Tercelli, I. (2020). Patient experiences of psychological therapy for depression: A qualitative metasynthesis. *BMC Psychiatry*, *20*(1), 1–18. https://doi.org/10.1186/s12888-020-02682-1

McTiernan, K., Jackman, L., Robinson, L., & Thomas, M. (2021). A Thematic Analysis of the Multidisciplinary Team Understanding of the 5P Team Formulation Model and Its

Evaluation on a Psychosis Rehabilitation Unit. *Community Mental Health Journal*, *57*(3), 579–588. https://doi.org/10.1007/s10597-020-00684-7

Meer, S., & Mir, G. (2014). Muslims and depression: the role of religious beliefs in therapy. *Journal of Integrative Psychology and Therapeutics*, *2*(1), 2. https://doi.org/10.7243/2054-4723-2-2

Mind. (2013). We still need to talk. *Mind*, 40. https://www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf

Mind. (2019). *Muslim communities and mental health.* Retrieved from https://www.mind.org.uk/media-a/5828/muslim-communities-and-mental-health-2019.pdf

Mindfulness All Party Parlimetary Group. (2015). *Mindfulness-APPG-Report_2.0. October*.

Mir, G., Ghani, R., Meer, S., & Hussain, G. (2019). Delivering a culturally adapted therapy for Muslim clients with depression. *Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X19000059

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. In *BMJ (Online)* (Vol. 339, Issue 7716, pp. 332–336). British Medical Journal Publishing Group. https://doi.org/10.1136/bmj.b2535

Monteiro, L. M., Compson, J. F., & Musten, F. (2017). *The Moral Arc of Mindfulness: Cultivating Concentration, Wisdom, and Compassion*. https://doi.org/10.1007/978-3-319-64924-5_6

Moore, K., Mason, P., & Lewis, J. M. W. (2008). *Images of Islam in the UK - The Representation of British Muslims in the National Print News Media 2000-2008. July*, 40. http://orca.cf.ac.uk/18396/

Morgan, P., Simpson, J., & Smith, A. (2015). Health Care Workers' Experiences of Mindfulness Training: a Qualitative Review. In *Mindfulness* (Vol. 6, Issue 4, pp. 744–

758). Springer New York LLC. https://doi.org/10.1007/s12671-014-0313-3

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research. *International Journal of Qualitative Methods*, *1*(2). https://doi.org/10.1177/160940690200100202

Muuo, S., Muthuri, S. K., Mutua, M. K., McAlpine, A., Bacchus, L. J., Ogego, H., Bangha, M., Hossain, M., & Izugbara, C. (2020). Barriers and facilitators to care-seeking among survivors of gender-based violence in the Dadaab refugee complex. *Sexual and Reproductive Health Matters*, *28*(1). https://doi.org/10.1080/26410397.2020.1722404

National Institute for Health and Care Excellence. (2018). *Depression in adults: recognition and management. Clinical guideline* [CG90]. https://www.nice.org.uk/guidance/cg90/chapter/Recommendations#psychological-interventions-for-maintenance-treatment

NICE. (2020). Obsessive-compulsive disorder and body dysmorphic disorder: treatment. *Nice (National Institute for Health and Care Excellence), November 2005*, 15–46. https://www.nice.org.uk/guidance/cg31/resources/obsessivecompulsive-disorder-and-body-dysmorphic-disorder-treatment-975381519301

NICE, N. I. for C. E. (2009). *Depression in adults: recognition and management* (Issue October 2009). https://doi.org/10.1211/pj.2017.20202439

O'Toole, T. (2021). Governing and contesting marginality: Muslims and urban governance in the UK. *Journal of Ethnic and Migration Studies*, *47*(11), 2497–2515. https://doi.org/10.1080/1369183X.2019.1696670

Office for National Statistics (2013). *Summary: What does the Census tell us about religion in 2011? May*, 1–18.

Office for National Statistics. (2019). *Research report on population estimates by ethnic*

group and religion. *December*, 1–19.

Ortiz, J. A., Smith, B. W., Shelley, B. M., & Erickson, K. S. (2019). Adapting Mindfulness to Engage Latinos and Improve Mental Health in Primary Care: a Pilot Study. *Mindfulness*, *10*(12), 2522–2531. https://doi.org/10.1007/s12671-019-01229-0

Ottaviani, R., & Beck, A. T. (1987). Cognitive aspects of panic disorders. *Journal of Anxiety Disorders*, *1*(1), 15–28. https://doi.org/10.1016/0887-6185(87)90019-3

Page M J, McKenzie J E, Bossuyt P M, Boutron I, Hoffmann T C, Mulrow C D et al. (2022) The PRISMA 2020 statement: an updated guideline for reporting systematic reviews *BMJ* 2021; 372 :n71 doi:10.1136/bmj.n71

Parth, K., Datz, F., Seidman, C., & Löffler-Stastka, H. (2017). Transference and countertransference: A review. *Bulletin of the Menninger Clinic*, *81*(2), 167–211. https://doi.org/10.1521/bumc.2017.81.2.167

Patel, C. J., & Shikongo, A. E. E. (2006). Handling spirituality/religion in professional training: Experiences of a sample of muslim psychology students. *Journal of Religion and Health*, *45*(1), 93–112. https://doi.org/10.1007/s10943-005-9009-2

Paul Victor, C. G., & Treschuk, J. V. (2020). Critical Literature Review on the Definition Clarity of the Concept of Faith, Religion, and Spirituality. *Journal of Holistic Nursing*, *38*(1), 107–113. https://doi.org/10.1177/0898010119895368

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Czasopismo Psychologiczne Psychological Journal*, *20*(1). https://doi.org/10.14691/cppj.20.1.7

Pilkington, A., Msetfi, R. M., & Watson, R. (2012). Factors affecting intention to access psychological services amongst British Muslims of South Asian origin. *Mental Health,*

Religion and Culture, *15*(1), 1–22. https://doi.org/10.1080/13674676.2010.545947

Poole, E., & Williamson, M. (2021). Disrupting or reconfiguring racist narratives about Muslims? The representation of British Muslims during the Covid crisis. *Journalism*. https://doi.org/10.1177/14648849211030129

Poole, E., Williamson, M., Meer, S., Mir, G., O'Toole, T., Tuckett, D., Hayley, T., Güveli, A., Platt, L., Stevenson, J., Demack, S., Stiell, B., Abdi, M., Clarkson, L., Ghaffar, F., Hassan, S., Kaplick, P. M., Skinner, R., Sara, B., & Allen, F. (2021). Islamophobia in the UK: The Role of British Newspapers in Shaping Attitudes towards Islam and Muslims. *Journal of Ethnic and Migration Studies*, *22*(1), 138. https://doi.org/10.1080/1369183X.2019.1696670

Poulin, M. J., Ministero, L. M., Gabriel, S., Morrison, C. D., & Naidu, E. (2021). Minding Your Own Business? Mindfulness Decreases Prosocial Behavior for People With Independent Self-Construals. *Psychological Science*, *32*(11), 1699–1708. https://doi.org/10.1177/09567976211015184

Proulx, J., Croff, R., Hebert, M., & Oken, B. (2020). Results of a mindfulness intervention feasibility study among elder African American women: A qualitative analysis. *Complementary Therapies in Medicine*, *52*(April). https://doi.org/10.1016/j.ctim.2020.102455

Proulx, J., Croff, R., Oken, B., Aldwin, C. M., Fleming, C., Bergen-Cico, D., Le, T., & Noorani, M. (2018). Considerations for Research and Development of Culturally Relevant Mindfulness Interventions in American Minority Communities. *Mindfulness*, *9*(2), 361–370. https://doi.org/10.1007/s12671-017-0785-z

Public Health England. (2018). *NHS health check and inequalities in uptake: Evaluation of the first four years in England*, 2009/10–2012/13. Retrieved from

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/708152/Health_check_inequalities_evaluation_report.pdf

Public Health England. (2020). *COVID-19: Review of Disparities in Risks and Outcomes.* Retrieved from https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes

Purser, R. E. (2018). Critical perspectives on corporate mindfulness. *Journal of Management, Spirituality and Religion*, *15*(2), 105–108. https://doi.org/10.1080/14766086.2018.1438038

Rawlings, G. H., & Bains, M. (2020). Experiences of depression in older adults from non-White and ethnic minority groups: A thematic synthesis of qualitative studies. *Journal of Affective Disorders*, *266*(January), 341–348. https://doi.org/10.1016/j.jad.2020.01.165

Rizkalla, K., Maar, M., Pilon, R., McGregor, L., & Reade, M. (2020). Improving the response of primary care providers to rural First Nation women who experience intimate partner violence: A qualitative study. *BMC Women's Health*, *20*(1), 1–14. https://doi.org/10.1186/s12905-020-01053-y

Rogge, R. D., Lin, Y. Y., Swanson, D. P., & Amaro, A. (2022). Tracing the Path Toward Mindfulness Back to Its Origins: Linking Tenets of Buddhism to Mindfulness Within the Buddhism-Informed Unified Flexibility and Mindfulness (BI-UFM) Model. *Mindfulness*, *0123456789*. https://doi.org/10.1007/s12671-022-01886-8

Rothman, A., & Coyle, A. (2018). Toward a Framework for Islamic Psychology and Psychotherapy: An Islamic Model of the Soul. *Journal of Religion and Health*, *57*(5), 1731–1744. https://doi.org/10.1007/s10943-018-0651-x

Salter, L. (2017). Research as resistance and solidarity: 'spinning transformative yarns'- a narrative inquiry with women going on from abuse and oppression. *Journal of Family*

Therapy, *39*(3), 366–385. https://doi.org/10.1111/1467-6427.12172

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. Guilford Press.

Shallcross, A. J., & Spruill, T. M. (2018). The Protective Role of Mindfulness in the Relationship Between Perceived Discrimination and Depression. *Mindfulness*, *9*(4), 1100–1109. https://doi.org/10.1007/s12671-017-0845-4

Shapiro, S. L., Carlson, L. E., Astin, J. A., & Freedman, B. (2006). Mechanisms of mindfulness. In *Journal of Clinical Psychology* (Vol. 62, Issue 3, pp. 373–386). https://doi.org/10.1002/jclp.20237

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology*, *7*(3), 233–243. https://doi.org/10.1080/14780880802699092

Sirkeci, I., Iosifides, T., DeTona, C., & Frisina, A. (2019). *Reader in Qualitative Methods in Migration Research* (Issue February). Transnational Press London.

Skinner, R. (2010). An islamic approach to psychology and mental health. *Mental Health, Religion and Culture*, *13*(6), 547–551. https://doi.org/10.1080/13674676.2010.488441

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K. A., Craig, N., French, D. P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M., & Moore, L. (2021). A new framework for developing and evaluating complex interventions: Update of Medical Research Council guidance. *The BMJ*, *374*(2018), 1–11. https://doi.org/10.1136/bmj.n2061

Spears, C. A., Houchins, S. C., Bamatter, W. P., Barrueco, S., Hoover, D. S., & Perskaudas, R. (2017). Perceptions of Mindfulness in a Low-Income, Primarily African American Treatment-Seeking Sample. *Mindfulness*, *8*(6), 1532–1543.

https://doi.org/10.1007/s12671-017-0720-3

Stern, E., van der Heijden, I., & Dunkle, K. (2020). How people with disabilities experience programs to prevent intimate partner violence across four countries. *Evaluation and Program Planning*, *79*(July 2019), 101770. https://doi.org/10.1016/j.evalprogplan.2019.101770

Stevenson, J., Demack, S., Stiell, B., Abdi, M., Clarkson, L., Ghaffar, F., & Hassan, S. (2017). The Social Mobility Challenges Faced by Young Muslims. *Social Mobility Commission*, *September*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/642220/Young_Muslims_SMC.pdf

Stutchbury, K. (2022). Critical realism: an explanatory framework for small-scale qualitative studies or an 'unhelpful edifice'? *International Journal of Research and Method in Education*, *45*(2), 113–128. https://doi.org/10.1080/1743727X.2021.1966623

Sue, D. W., & Sue, D. (2012). Counseling the culturally diverse: Theory and practice. In *Adolescence* (Vol. 5th).

Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology*, *60*, 525–548. https://doi.org/10.1146/annurev.psych.60.110707.163651

Sundler, A. J., Lindberg, E., Nilsson, C., & Palmér, L. (2019). Qualitative thematic analysis based on descriptive phenomenology. *Nursing Open*, *6*(3), 733–739. https://doi.org/10.1002/nop2.275

Szanton, S. L., Wenzel, J., Connolly, A. B., & Piferi, R. L. (2011). Examining mindfulness-based stress reduction: Perceptions from minority older adults residing in a low-income housing facility. *BMC Complementary and Alternative Medicine*, *11*.

https://doi.org/10.1186/1472-6882-11-44

Tarabi, S. A., Loulopoulou, A. I., Henton, I., Shankley, W., & Laurence, J. (2020). "Guide or conversation?" The experience of Second-Generation Pakistani Muslim men receiving CBT in the UK*. *Counselling Psychology Quarterly*, *33*(1), 0–2. https://doi.org/10.1080/09515070.2018.1471587

Taylor, S., Qiao, S., Weissman, S., & Li, X. (2021). Attitudes toward a mindfulness-based intervention from African American women living with HIV: A qualitative study. *SAGE Open Medicine*, *9*, 205031212110251. https://doi.org/10.1177/20503121211025144

Teasdale, J. D., Segal, Z., & Williams, J. M. G. (1995). How does cognitive therapy prevent depressive relapse and why should attentional control (mindfulness) training help? *Behaviour Research and Therapy*, *33*(1), 25–39. https://doi.org/10.1016/0005-7967(94)E0011-7

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). *Thematic Analysis In: The SAGE Handbook of Qualitative Research in Psychology Thematic Analysis*. https://doi.org/10.4135/9781526405555

Thomas, James, & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*(1), 45. https://doi.org/10.1186/1471-2288-8-45

Thomas, Justin, Furber, S. W., & Grey, I. (2017). The rise of mindfulness and its resonance with the Islamic tradition. *Mental Health, Religion and Culture*, *20*(10), 973–985. https://doi.org/10.1080/13674676.2017.1412410

Thomas, Justin, Raynor, M., & Bakker, M. C. (2016). Mindfulness-based stress reduction among Emirati Muslim women. *Mental Health, Religion and Culture*, *19*(3), 295–304. https://doi.org/10.1080/13674676.2016.1168389

Thyer, B. A., Miles, B. W., & Jozefowicz-Simbeni, D. M. H. (2019). Naturalistic Inquiry. In *The Handbook of Social Work Research Methods*. https://doi.org/10.4135/9781544364902.n22

Toleikyte, L., & Salway, S. (2008). *Local action on health inequalities: Understanding and reducing ethnic inequalities in health About Public Health England*. 1–81.

Tsui, M. C. F., To, J. C. N., & Lee, A. T. C. (2020). Mindfulness Meditation, Mental Health, and Health-Related Quality of Life in Chinese Buddhist Monastics. *East Asian Archives of Psychiatry : Official Journal of the Hong Kong College of Psychiatrists = Dong Ya Jing Shen Ke Xue Zhi : Xianggang Jing Shen Ke Yi Xue Yuan Qi Kan*, *30*(3), 67–72. https://doi.org/10.12809/eaap1949

Tungjitcharoen, W., & Berntsen, D. (2022). Cultural Life Scripts Across Religions: The Influences of Religion on Expectations of Life Events. *Psychology of Religion and Spirituality*, *14*(1), 59–69. https://doi.org/10.1037/rel0000392

Vallejo, Z., & Amaro, H. (2009). Adaptation of mindfulness-based stress reduction program for addiction relapse prevention. *Humanistic Psychologist*, *37*(2), 192–206. https://doi.org/10.1080/08873260902892287

Valley, M., & Stallones, L. (2018). A Thematic Analysis of Health Care Workers' Adoption of Mindfulness Practices. *Workplace Health and Safety*, *66*(11), 538–544. https://doi.org/10.1177/2165079918771991

Van Dam, N. T., van Vugt, M. K., Vago, D. R., Schmalzl, L., Saron, C. D., Olendzki, A., ... Meyer, D. E. (2018). Mind the hype: A critical evaluation and prescriptive agenda for research on mindfulness and meditation. *Perspectives on Psychological Science*, 13(1), 36-61. https://doi.org/10.1177/1745691617709589

Van Gordon, W., Shonin, E., & Garcia-Campayo, J. (2017). Are there adverse effects

associated with mindfulness? In *Australian and New Zealand Journal of Psychiatry* (Vol. 51, Issue 10, pp. 977–979). SAGE Publications Inc. https://doi.org/10.1177/0004867417716309

Vroegindewey, A., & Sabri, B. (2022). Using Mindfulness to Improve Mental Health Outcomes of Immigrant Women with Experiences of Intimate Partner Violence. *International Journal of Environmental Research and Public Health*, *19*(19). https://doi.org/10.3390/ijerph191912714

Waldron, E. M., Hong, S., Moskowitz, J. T., & Burnett-Zeigler, I. (2018). A Systematic Review of the Demographic Characteristics of Participants in US-Based Randomized Controlled Trials of Mindfulness-Based Interventions. *Mindfulness*, *9*(6), 1671–1692. https://doi.org/10.1007/s12671-018-0920-5

Waller, B. Y., Harris, J., & Quinn, C. R. (2021). Caught in the Crossroad: An Intersectional Examination of African American Women Intimate Partner Violence Survivors' Help Seeking. *Trauma, Violence, and Abuse*. https://doi.org/10.1177/1524838021991303

Walpole, S. C., McMillan, D., House, A., Cottrell, D., & Mir, G. (2013). Interventions for treating depression in Muslim Patients: A systematic review. *Journal of Affective Disorders*, *145*(1), 11–20. https://doi.org/10.1016/j.jad.2012.06.035

Watson-Singleton, N. N., Black, A. R., & Spivey, B. N. (2019). Recommendations for a culturally-responsive mindfulness-based intervention for African Americans. *Complementary Therapies in Clinical Practice*, *34*. https://doi.org/10.1016/j.ctcp.2018.11.013

Watson, N. N., Black, A. R., & Hunter, C. D. (2016). African American Women's Perceptions of Mindfulness Meditation Training and Gendered Race-Related Stress. *Mindfulness*, *7*(5), 1034–1043. https://doi.org/10.1007/s12671-016-0539-3

Weatherhead, S., & Daiches, A. (2010). *Copyright © The British Psychological Society Muslim views on mental health and psychotherapy Copyright © The British Psychological Society*. 75–89. https://doi.org/10.1348/147608309X467807

Weick, K. E., & Putnam, T. (2006). Organizing for mindfulness: Eastern wisdom and Western knowledge. *Journal of Management Inquiry*, *15*(3), 275–287. https://doi.org/10.1177/1056492606291202

White, J. H., Peirce, A. G., & Jacobowitz, W. (2019). The relationship amongst ethical position, religiosity and self-identified culture in student nurses. *Nursing Ethics*, *26*(7–8), 2398–2412. https://doi.org/10.1177/0969733018792738

Witkiewitz, K., Greenfield, B. L., & Bowen, S. (2013). Mindfulness-based relapse prevention with racial and ethnic minority women. *Addictive Behaviors*, *38*(12). https://doi.org/10.1016/j.addbeh.2013.08.018

Wood, N., & Patel, N. (2017). *On addressing ' Whiteness ' during clinical psychology training*. *47*(3), 280–291. https://doi.org/10.1177/0081246317722099

Woods-Giscombé, C. L., & Black, A. R. (2010). Mind-body interventions to reduce risk for health disparities related to stress and strength among African American women: The potential of mindfulness-based stress reduction, loving-kindness, and the NTU therapeutic framework. *Complementary Health Practice Review*, *15*(3). https://doi.org/10.1177/1533210110386776

Woods-giscombé, C. L., & Gaylord, S. A. (2014). The cultural relevance of Mindfulness Meditation as a Health Intervention for African Americans. *Journal of Ho*, *32*(3), 147–160.

Woods-Giscombé, C. L., & Gaylord, S. A. (2014). The Cultural Relevance of Mindfulness Meditation as a Health Intervention for African Americans: Implications for Reducing

Stress-Related Health Disparities. *Journal of Holistic Nursing*, *32*(3). https://doi.org/10.1177/0898010113519010

Woods-Giscombe, C. L., Gaylord, S. A., Li, Y., Brintz, C. E., Bangdiwala, S. I., Buse, J. B., Mann, J. D., Lynch, C., Phillips, P., Smith, S., Leniek, K., Young, L., Al-Barwani, S., Yoo, J., & Faurot, K. (2019). A Mixed-Methods, Randomized Clinical Trial to Examine Feasibility of a Mindfulness-Based Stress Management and Diabetes Risk Reduction Intervention for African Americans with Prediabetes. *Evidence-Based Complementary and Alternative Medicine, 2019*. https://doi.org/10.1155/2019/3962623

Wyatt, C., Harper, B., & Weatherhead, S. (2014). The experience of group mindfulness-based interventions for individuals with mental health difficulties: A meta-synthesis. *Psychotherapy Research*, *24*(2). https://doi.org/10.1080/10503307.2013.864788

Yetunde, P. A., & Giles, C. A. (2020). *Black and Buddhist: What Buddhism Can Teach Us about Race, Resilience, Transformation, and Freedom*. Shambhala Publications.

Younis, T., & Jadhav, S. (2020). *Islamophobia in the National Health Service : an ethnography of institutional racism in PREVENT ' s counter-radicalisation policy*. *42*(3), 610–626. https://doi.org/10.1111/1467-9566.13047

Zhang, H., Emory, E. K., Program, R., Al-Saadi, H., Smith, T. B., Cabral, R. R., Racial, ", Keng, S. L., Smoski, M. J., Robins, C. J., & Kabat-Zinn, J. (1985). Demystifying Ontology and Epistemology in Research Methods. *ResearchGate*, *8*(2), 663–674. https://doi.org/10.1007/s12671-014-0304-4

Appendices

Appendix A

Grouped Search Terms Using The SPIDER Framework

SPIDER anagram	Search terms
1. **S**ample	"BAME" or "Black" or "African*" or "people of col#r" or "ethnic minority" or "Asian" or "minority" or "Arab*" or "Middle Eastern" or "North African" or "Latin*" or "South americ*" or "Hispanic" or "South Asia*" or "racial minority" or "BME" or "ethnic*" (In abstract)
2. **P**henomenon OF Interest	"mindfulness" or "mindfulness based stress reduction" or "mbsr" or "mindfulness based cognitive therapy" or "mbct" or "mindfulness based" or "mindfulness informed" (In title)
3. **D**esign	"Focus group*" or "interview*" or "observ*" or "narrative" or "phenomenolog*" or "ethnograph*" OR "qualitative" (In abstract)

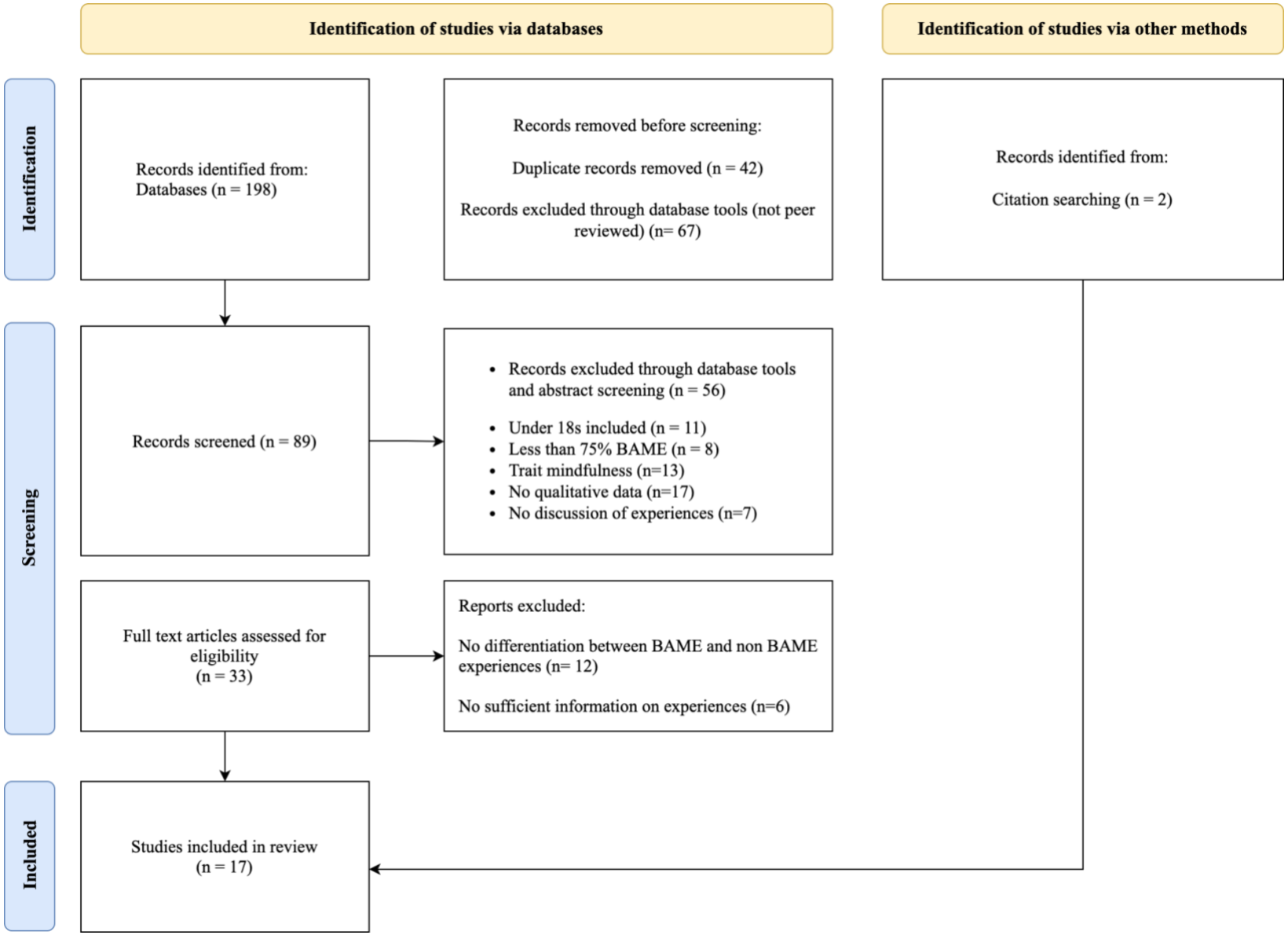
Appendix B

Search Term Groups and Results

Search term groups	Results
1	(1,187,373)
2	(22,414)
3	(6,226,154)
AND (2) AND (3)	198

Appendix C

Prisma Flow Diagram


Identification of studies via databases
Identification of studies via other methods
Identification
Records identified from:
Databases (n = 198)
Records removed before screening:
Duplicate records removed (n = 42)
Records excluded through database tools (not peer reviewed) (n= 67)
Records identified from:
Citation searching (n = 2)
Screening
Records screened (n = 89)
Records excluded through database tools and abstract screening (n = 56)
Under 18s included (n = 11)
Less than 75% BAME (n = 8)
Trait mindfulness (n=13)
No qualitative data (n=17)
No discussion of experiences (n=7)
Full text articles assessed for eligibility
(n = 33)
Reports excluded:
No differentiation between BAME and non BAME experiences (n= 12)
No sufficient information on experiences (n=6)
Included
Studies included in review
(n = 17)

Appendix D

Quality Scores Based On CASP

CASP guiding questions	Study and question response											
	Bermudez et al. (2013)	Burnett-Ziegler et al. (2019)	Dutton et al. (2013)	Hunter-Jones et al. (2019)	Proulx et al. (2020)	Spears et al. (2017)	Szanton et al. (2011)	Thomas et al. (2016)	Vroegindewey & Sabri. (2022)	Watson et al. (2016)	Watson-Singleton, et al. (2019)	Woods-Giscombe & Gaylord (2014)
1.Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

3. Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes overall but not enough information in methods	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

CASP guiding questions	Study and question response											
	Bermudez et al. (2013)	Burnett-Ziegler et al. (2019)	Dutton et al. (2013)	Hunter-Jones et al. (2019)	Proulx et al. (2020)	Spears et al. (2017)	Szanton et al. (2011)	Thomas et al. (2016)	Vroegindewey & Sabri. (2022)	Watson et al. (2016)	Watson-Singleton, et al. (2019)	Woods-Giscombe & Gaylord (2014)
4. Was the recruitment strategy appropriate to the aims of the research?		Yes	Yes	Yes	Yes	Yes	Yes, but no discussions of why people didn't take part	Yes	Yes	Yes	Yes	Yes
5. Was the data collected in a way that addressed the research issue?	Yes	Yes	Can't tell due to lack of analysis sharing etc	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes but didn't say how interviews conducted/ steps for data analysis	Yes

6. Has the relationship between researcher and participants been adequately considered?	Can't tell, no mention of their own role, limitations etc	Can't tell	Yes but not their own positioning	Yes, bias but no reflexivity	Can't tell, but mention AA want Black facilitators in their own community spaces (church)	Can't tell, mentions two coders to address bias	Yes, member checks, bias, participa nt review no reflexivit y	Can't tell	Can't tell reflexivity, but reflect on limits of COVID and only recruiting English speakers	Can't tell – Mention Black research team but no reflexivity	Can't tell	Yes, some acknowledge ment of potential bias

CASP guiding questions	Study and question response											
	Bermudez et al. (2013)	Burnett-Ziegler et al. (2019)	Dutton et al. (2013)	Hunter-Jones et al. (2019)	Proulx et al. (2020)	Spears et al. (2017)	Szanton et al. (2011)	Thomas et al. (2016)	Vroegindeweyy & Sabri. (2022)	Watson et al. (2016)	Watson-Singleton, et al. (2019)	Woods-Giscombe & Gaylord (2014)
7. Have ethical issues been taken into consideration?	Yes	Yes but no mention of risk	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes but no issues aroura informed Consent and confidentiality explored		Yes
8. Was the data Analysis sufficiently rigorous?	Can't tell, some description of analysis, contradict ory data not really considered	Yes	Can't tell, weakest area and not enough information from responses to themes shared	Yes, and gave examples of contradicti ng findings	Yes	Yes	Yes	Yes	Can't tell the analysis methods	Yes, considers gender, race and some incongruence with culture not reported elsewhere		Yes

9. Is there a clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10. . How valuable is the research ?	Yes, early research in a new area valuable	Yes, valuable for accepta bil ity in	Yes, Good outline of interventi o n for future researche r	Valuable , consider s the experien ce s of cis	Valuable, use stress and coping theories to support work,	Yes, Feasibili ty in low SES BAME	Yes, used membe r checki ng and early	Yes, Early study exploring experiences of Muslims and	Yes, uses culturally tailored and trauma informed	Yes, Builds on work of Szanton et al. and offers knowledge on

CASP guiding questions	Study and question response										
	Bermudez et al. (2013)	Burnett-Ziegler et al. (2019)	Dutton et al. (2013)	Hunter-Jones et al. (2019)	Proulx et al. (2020)	Spears et al. (2017)	Szanton et al. (2011)	Thomas et al. (2016)	Vroeginde we y & Sabri. (2022)	Watson et al. (2016)	Watso n-Singlet o n, et al. (2019)	Woods-Giscombe & Gaylord (2014)
		depress io n and wide range of ages reporte d on	and consider ati ons e.g. food, shelter, time adjustme nt	and transgen de r woman and addition al needs/ adverse effects	advice future studies with Muslims and culturally sensitive recommend ati ons	commu nit ies	eviden ce on MBSR for BAM E older adult s	offered some recommend ati ons for more future studies	approach and focussed on experiences of immigrant women experiencin g IPV with good recommend ati ons (clinical/pol ic y)			cultural relevan ce

Appendix E

Quality Scores for Mixed-Methods Studies

Authors	Methodological quality criteria	Responses
Abercrombie et al. (2007)	Yes No due to high dropout rates 51 pre intervention to 8 at start of intervention then 5 in focus group Yes Yes Yes	Good reflexivity. Acknowledge should have involved multi-ethnic researchers and seeking advice from community
Blignault et al. (2021b)	Yes Yes Yes Yes and used measure which is validated for Arabic speakers Yes	No 'formal' interview or focus group but provided childcare and Arabic/English speaking Psychologist , detailed methods ,mention building trust and that they checked in on those who dropped out
Hartwell et al. (2018)	Yes Yes Yes and one drop out discussed Yes (Anger/PTSD checklists) Yes	First study to look at homicide family survivors , included community developers
Hong et al. (2022)	Yes Yes Yes Yes (16 week follow up) Yes	One of the first for depression stigma and mindfulness, bus cards to get to intervention, Good reflection that researcher who isn't Black has 'extensive awareness' of values important in AA culture
Woods-Giscombe et al. (2019)	Yes Yes Yes Yes Yes	Rationale for mindfulness as a physical health intervention, reflected on scores and position/bias

Appendix F

Quality Appraisal Scores

Study Authors	Quality Appraisal Scores
Abercrombe et al. (2007)	++
Bermudez et al. (2013)	++
Blignault et al. (2021b)	+
Burnett-Ziegler et al. (2019)	++
Dutton et al. (2013)	-
Hartwell et al. (2018)	++
Hong et al. (2022)	++
Hunter-Jones et al. (2019)	++
Proulx et al. (2020)	++
Spears et al. (2017)	++
Szanton et al. (2011)	++
Thomas et al. (2016)	++
Vroegindewey & Sabri. (2022)	++
Watson et al. (2016)	++
Watson-Singleton, et al. (2019)	++
Woods-Giscombe et al. (2019)	++
Woods-Giscombe & Gaylord (2014)	++

Appendix G

Poster Advertisement For Study

Appendix H

Ethics Approval Email

From: [REDACTED]
Subject:
Date:
To:

H

University of Essex ERAMS

18/03/2022

[REDACTED]

Ethics Committee Decision

Application: ETH2122-0663

I am writing to advise you that your research proposal entitled "Exploring the religio-cultural experiences of mindfulness amongst BAME individuals' committed to an Islamic religious tradition " has been reviewed by the Ethics Sub Committee 2.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Aaron Wyllie

Ethics ETH2122-0663: [REDACTED]

This email was sent by the University of Essex Ethics Review Application and Management System (ERAMS).

Appendix I

Participant Information Sheet

University of Essex

Participant Information Sheet: "Exploring the religio-cultural experiences of mindfulness amongst BAME individuals' committed to an Islamic religious tradition"

Dear participant,

First and foremost, thank you for taking the time to read this information sheet. My name is **[REDACTED]** and I am conducting this research as part of my Doctorate course in Clinical Psychology. Before you decide whether to take part it is important that you understand what the research is about and what it will involve. Please take your time to read the following information carefully before you decide whether you want to take part.

What is the purpose of this study?

This study aims to explore experiences of Mindfulness, for people from Black, Asian and Minority Ethnic (BAME) backgrounds, who identify as Muslim. The study will focus on your religious and/ or cultural experiences, and how well you feel the practise fits (or doesn't) with these. It is hoped that this research will help to identify the needs of BAME Muslims who practise or take part in a Mindfulness course. There is currently little research on how Mindfulness is experienced by this community, and previous studies have highlighted the need for research with this population to be carried out.

Who can take part?

You can take part in this study if you identify as a BAME Muslim adult who has completed a mindfulness programme in the UK. You must have taken part in a Mindfulness course lasting four weeks or more such as Mindfulness Based Cognitive Therapy, Mindfulness Based Stress Reduction, Breathworks. Or a recognised Mindfulness-Based intervention. Please get in touch if you are unsure whether the course you took part in would qualify. We are very interested in hearing about your experiences, although there is no obligation to take part in the study. It is entirely up to you.

What will happen next if I chose to take part?

If you do decide to take part, you can contact me on the email address provided at the end of this information sheet. You will then be asked to sign a written consent form confirming that you have read this information sheet and are participating willingly. You will then be given the choice to attend a one-off interview via video-link using the Zoom video-conferencing platform or through a telephone call. This will be at a time and date that suits you. The interview will be conducted by me and is anticipated to last up to 90 minutes. In the interview, you will be asked questions about your experiences of mindfulness, and how it fits/ or doesn't fit with your religious and cultural views. You do not have to answer any questions that you do not want to and can stop the interview at any time.

You will also be asked to provide anonymous demographic details at the start of the interview. At the end of the interview, you will have some time to ask any questions and a chance to discuss the research in detail.

What will happen to the information I provide?
The information you provide will be kept confidential, and pseudonymised. The interview data you provide will be typed into a transcript by me. It will then be analysed and created into a final written report.

All information collected will be kept securely on a password encrypted folder and will only be accessible by me and my supervisors. You do not have to provide your name if you do not wish, but you may be asked to provide some anonymous demographic information for analysis purposes. If you are mentioned individually in any publications or reports then a participant number or pseudonym will be used and identifying details will be removed. A list may be kept linking participant numbers or pseudonyms to names, but this will be kept securely and will only be accessible by myself and my supervisor. A copy of the information which we record about you, but not other participants, will be provided, free of charge, on request.
If you decide to participate in the study and then change your mind in future, you can withdraw at any point from when the data is collected until the data analysis stage.

What is the legal basis for using the data and who is the Data Controller?

In line with GDPR participants, we (The University of Essex) must manage your data in specific and confidential ways, which means we are unable to let you see or change data held as part of the study. Universities are funded from taxes and required to do research in the public interest. The legal basis for processing your data is through public interest, and the data controller is the University of Essex. Your data will be kept for three years, after which is it will be destroyed and removed from the network. Should you have any concerns or questions regarding the data collected from yourself, you can use the contact details here: **[REDACTED]**

What are the possible benefits of participating?

I hope that you will find having the space to share your experiences helpful. It is also hoped that the information you share can help to identify the ways in which mindfulness is experienced by BAME Muslims, an area of research which is significantly underdeveloped. Although no direct benefits are guaranteed, it is hoped that the interview process will be experienced as a positive one that gives you the opportunity to discuss your experience of mindfulness which you may not have had the chance to do before.

What are the possible disadvantages of participating?

There are no expected dangers of taking part. However, it is possible that you may become upset if you are discussing something that you have found difficult or upsetting. The details

Appendix J

Consent Form

University of Essex

Participant Consent form for Research Project: "Exploring the religio-cultural appropriateness of mindfulness amongst BAME individuals' committed to an Islamic religious tradition"

Dear participant,

We would be very grateful for your participation in this study. If you need to contact us in future, please contact me at **[REDACTED]** or **[REDACTED]** You can also contact us in writing at: School of Health and Social Care, Essex University Colchester CO4 3SQ

I agree with the below statements (please write your initials in the adjacent boxes to the right of each statement if you agree:

Statement of Consent	**Please initial each box**
• ***Example***	**Type inititals here**
• I confirm that I have carefully read and understood the information sheet for the above research study	
• I confirm that I have had the opportunity to ask questions about the research and my participation in it	
• I understand that my participation in the above research study is entirely voluntary, and I am free to withdraw at any time up until the analysis of my data without giving a reason	
• I understand that this research will involve partaking in an interview with the researcher which will be audio recorded	
• I understand that I do not have to answer any questions I do not want to during the interview	
• I understand that I will not be identifiable in any written report of this research study or any publications arising from it	
• I understand that any information I provide in the above research study will be kept confidential, unless I disclose information that puts myself off others at risk of harm	
• I give permission for my anonymised quote(s) to be used in any written report or publication	

_____ _____

Participant's name and signature Date

_____

Name and signature of researcher

_____ Date

Appendix K

Participant Debrief Form

Participant debrief sheet

Research title: Exploring the religio-cultural experiences of mindfulness amongst BAME individuals' committed to an Islamic religious tradition

What happens next?

Thank you for taking your time to take part in this research. I hope our conversation at the end of the interview covered the questions you had in mind regarding this research. The recording of the interview will be typed up, and your transcript will be anonymised and not contain any identifying information such as your name. Your data will be kept safely (please see information sheet for more details, and once the analysis is complete you will be offered the chance to see a copy of the final report).

Wellbeing support

We hope that taking part in this interview, has been experienced in a positive way. However, if you feel you need any wellbeing support we would encourage you to seek support from your GP or 111 should you wish to do so. Moreover, if you would like professional psychological support to manage any distress or difficulties you may be facing, please visit the NHS improving Access to Psychological Therapies website (NHS England » Adult

Improving Access to Psychological Therapies programme), where you can make a self-referral.

Further information and contact details

If you would like to ask any further questions, please contact me using the details below and I would be happy to answer your queries.

Primary researcher: [REDACTED] Trainee Clinical Psychologist, University of Essex

Email: **[REDACTED]** Tel: **[REDACTED]**

Research Supervisor: [REDACTED] Senior Lecturer, School of Health and Social Care, University of Essex Email: **[REDACTED]**

Research Supervisor: [REDACTED], School of Health and Social Care, University of Essex, Email: **[REDACTED]**

Appendix L

Interview Guide

Interview schedule

1. **How did you first come across mindfulness?**
    - Prompt: What led you to decide to take part in a mindfulness program?
2. **What led you to choose that particular course?**
    - Prompt: What were your expectations of the program?
    - Prompt: How do you feel looking back about choosing to take part in a program?
3. **What does mindfulness mean to you?**
    - Prompt: Is there anything that has influenced how you developed your view of mindfulness?
    - Prompt: does your view of mindfulness differ from when you were first introduced to it?
    - Prompt: Have you noticed any changes in your understanding of mindfulness as a result of the course you attended (wordy)
4. **Do you still practise mindfulness?**
    - Prompt: Why/Why not?
    - If yes: what does the practise involve? E.g., mindfulness of the breath, body scan, mindful movement, or something else
    - Prompt: What things impact on whether or not you practise?
    - Prompt: Do you practise mindfulness in any other ways?

5. **What do you think influences whether people from your religious or cultural background engage in mindfulness?**
    - Prompt: Is there anything you feel makes it easier or harder for them to engage?

6. **Are there any practises from your cultural or religious background that are similar to mindfulness?**
    - Prompt: What feels familiar/unfamiliar?
    - Prompt: Can you give any examples?

7. **Do you think Mindfulness fits with your religious beliefs?**
    - Prompt: Is there any way in which mindfulness fits with Islam?
    - Prompt: Is there any way in which mindfulness conflicts with Islam?
    - Prompt: What practises in Islam feel familiar/unfamiliar with mindfulness?
    - Prompt: Do your friends/family/religious community know you practice mindfulness? What has their response been?
8. **Would you recommend mindfulness to family or friends?**
    - Prompt: what would prevent/ encourage you to recommend it
    - Prompt: What do you think they might not enjoy or find difficult?

9. **Do you think there are ways mindfulness programmes can be made more meaningful to Muslims?**
    - Prompt: Are there any modifications you would make if you could change the program you attended?
    - Prompt: Why would you/ would you not want to make these modifications?

- Prompt: Do you have any views on what would make mindfulness more accessible to Muslims?

Appendix M

Participant Demographics Form

Demographic form

Please answer these anonymous questions below if this feels comfortable for you. You do not have to answer any question that you do not wish to.

1. How old are you? (e.g., 21 years)
2. How would you describe your gender? (e.g., female)
3. How would you describe your ethnicity (e.g., Black African, Arab etc)
4. What is your level of education? Please circle all relevant options
    - Secondary school education or equivalent
    - A-level/ College diploma or equivalent
    - Undergraduate Degree
    - Master's Degree
    - Doctoral Degree
    - Other (please specify)
5. How long have you been practising mindfulness (e.g., 1 year 3 months)
6. What formal mindfulness training have you received?

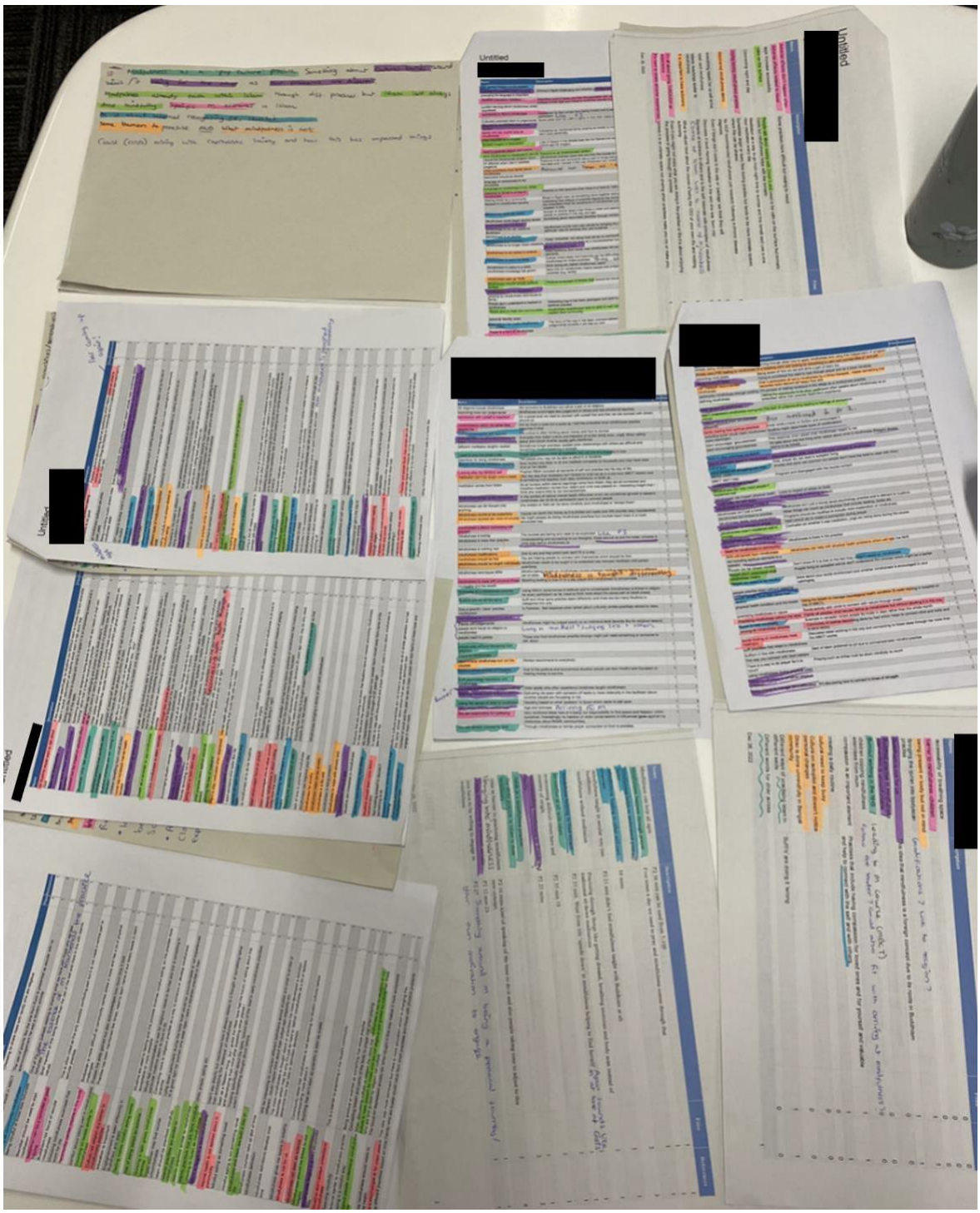
Appendix N

Sample From Codebook

Name	Description	Files	References
Mindfulness is your head to be where your feet are	We are often mindless in day to day life so learning to be where we are is her definition of mindfulness	1	1
mindfulness is 'new'	Mindfulness might be seen as treading new ground and therefore not accepted in the community	1	1
mindfulness provides calm in the storm	Sometimes tasks feel overwhelming with too many demands but you can make a choice to just drop them for a moment and do something mindful or mindfully	1	3
mindfulness skills can be passed onto children	Even though it might not always be labelled as mindfulness these skills can be passed onto children to get them to focus, get off their tablets etc..	1	1
mindfulness works for 'the other'	There is a narrative about mindfulness being for other people but 'not me' when you talk about it as seen as a bit hippy dippy or woo-ha	1	1
Muslims have a 'way' of living that makes mindfulness challenging	This paragraph is getting at the cultural expectations or way of living that can bring challenges to mindfulness (Doesn't state what in this paragraph)	1	1
Our culture means meeting multiple demands	Interesting she also said 'our culture' despite knowing I am from a different 'culture' if we go by tick boxes, does she mean non-European in general or Muslim culture	1	1
Mindfulness is simple	You can take mindfulness into everything not just in a meditative state (First example given is prayer showing how central it is)	1	1
People are tired of hearing about mindfulness	Mindfulness has become such a popular term that people are tired of hearing about it and 'desensitised'	1	2
People don't talk about mental health in Pakistan	Depression and mental health are not spoken about culturally.	1	1
People have different reasons to reject mindfulness	Hearing colleagues talk about things like being too busy , or not wanting to take part from a religious perspective	1	1
People need more education on mindfulness	Education leads to acceptance	1	4
Popularity of mindfulness is a good thing	The western and secular popularity of mindfulness is good as it has made it more accessible for people	1	3
The five pillars of Islam involve mindfulness	Hajj, fasting, prayer etc. help to embody mindfulness	1	3

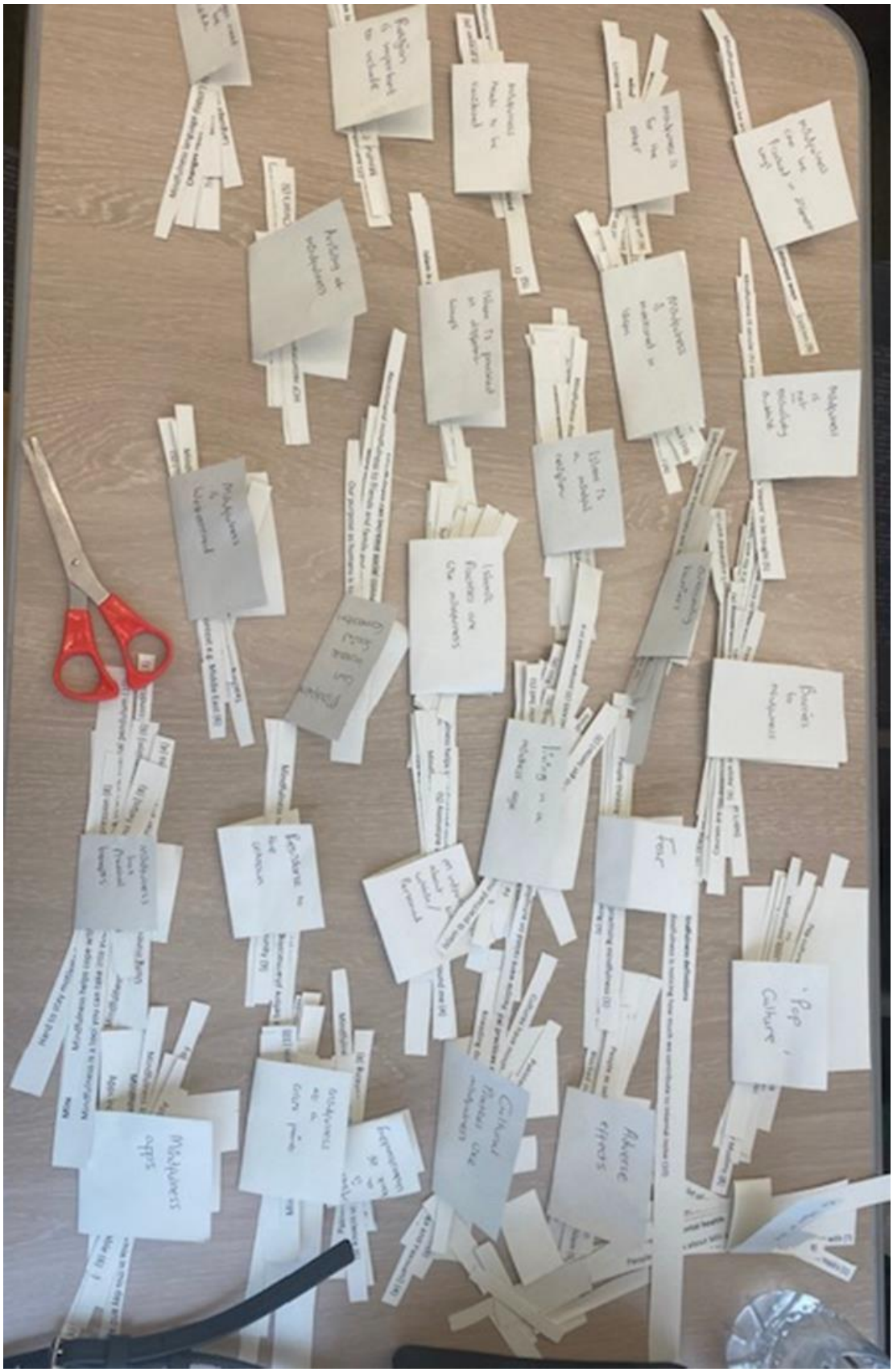
Appendix O

Highlighted and Printed Notes from Codebook



Appendix P

Review of Themes



Appendix Q

15-Point Checklist By Braun and Clarke (2006, P.37) of Criteria For Good Thematic Analysis

Transcription	1.	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2.	Each data item has been given equal attention in the coding process.
	3.	Themes have not been generated from a few vivid examples (an anecdotal approach) but, instead, the coding process has been thorough, inclusive and comprehensive.
	4.	All relevant extracts for all each theme have been collated.
	5.	Themes have been checked against each other and back to the original data set.
	6.	Themes are internally coherent, consistent, and distinctive.
Analysis	7.	Data have been analysed rather than just paraphrased or described.
	8.	Analysis and data match each other – the extracts illustrate the analytic claims.
	9.	Analysis tells a convincing and well-organised story about the data and topic.
	10.	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11.	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12.	The assumptions about ThA are clearly explicated.
	13.	There is a good fit between what you claim you do, and what you show you have done – ie, described method and reported analysis are consistent.
	14.	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15.	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

Appendix R

Extracts on Challenges: Reflective Lo

8th May 2022
Interview with [REDACTED] immediately noticed how it is difficult to categorise people with race as she considered herself to be White other and [REDACTED] as she said “ethnicity is based on the colour of your skin isn’t it?” Rather than taking in any cultural considerations. So interesting how two participants in and this is already coming up as a confusing and difficult question. Interestingly there was no mention of mindfulness conflicting with her culture in the same way it did for [REDACTED] which I kind of expected [REDCATED] more conservative understandings of Islam and the way in which they practise. Even writing that I am realising that is a huge stereotype and I’m noticing just how many biases I hold that I hadn’t really thought about before. I feel a bit ashamed that I have taken on so many media narratives about [REDACTED]’s community given I thought I was more mindful of how media discourses can play out and impact Muslims. Maybe need to spend some time checking my biases before interviews!
12th July 2022
I am finding the following problems most common when it comes to recruitment: I am noticing how many people haven’t done a ‘formal’ mindfulness course which fits with this research. People have not done a formal mindfulness course as this is expensive or the community doesn’t talk about their mental health difficulties and I just want to say in interviews I KNOW how you feel my community is exactly like that.. I am just finding my feet and balance between being genuine and sticking to the interview transcript so I feel a bit conflicted. … the trickle down from people who have actually done a mindfulness intervention is small…I feel like this project would have made more sense for me if I was still living in [REDACTED] and not here in [REDACTED] Also, I’m noticing that many people don’t live in the UK (a lot of people from Malaysia, Pakistan). It would have been nice to explore experiences in more than one country as I feel like this makes everything harder given there’s such a small Muslim population here! I notice my Algerian self saying why can’t we just do it? It can’t be that risky and my British self entering the conversation with an overally cautious ethics cap!
15th November 2022
[REDACTED] even think about mentioning that [Quotes from religious text rather than academia] feels scary. I can feel my stomach tighten, my jaw clench and my anxiety that any mention of Islam or mindful principles in Islam will be seen as a person “pushing” their views as we are so often portrayed. It is hard when the evidence you hold in your mind is within a religious text and not a Western academic journal and I wonder if I should have used more Quran quotes I just don’t know if that “counts”.

December 28th 2022

So many codes feel like they fit with each other but actually don't or so many codes feel important. I have hundreds of codes as I am struggling to identify which are the most important and perhaps need to always take it back to the research question more…maybe my problem is things being too broad and feeling like I can't fit everything I want to say into my story or word count. Everyone is sharing such unique experiences but there is a united undertone when it comes to Islam being a mindful religion and including the elements of mindfulness that are only recently being discussed in Western discourse. This is a lot harder and longer than I expected! My ideas keep shifting and have changed so much from my initial codes and everything feels so important! I had a completely different theme structure last week and I can see why Braun and Clark describe this as the 'building blocks' part…

I can't help but think that if I had someone from the community helping me to develop this I could get some richer data and just delve a little deeper into the themes of compassion, connection and the underlying islamophobia they are eluding to through facial expressions, understandings nods etc but not actual 'data' I can use

Sunday 15th January 2023

Remember to reflect on the fact if I had a translator then some voices could be heard better for example participant 2 who I could barely use any quotes for may have been better able to express herself had I been given the opportunity to work with an interpreter.. I could get what she was trying to say but not enough actual words or quote I can weave in.

There ended up being more of a bias in whose quotes I included at first.. basically based on who had stronger English even though some others might have been saying meaningful things I needed to stop and clarify so couldn't include as much of what they were saying.