Does one-size-fit-all?
Exploring the cross-cultural validity of evidence-based psychological interventions offered by Improving Access to Psychological Therapies (IAPT) services.

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Declaration

This thesis is submitted in partial fulfilment for the degree of Doctor of Philosophy (PhD) at Birmingham City University within the School of Psychology, Faculty of Business, Law & Social Sciences (BLSS). I declare that no material contained in this thesis has been used for any other submission for an academic award. I confirm that this thesis is entirely my own work and based on my own research. Where the words or material of others are used, these are clearly placed in quotation marks and referenced.

Signed:

Date: 18 April 2022

بسم الله الرحمن الرحيم

"In the name of God, the Merciful, the Compassionate"

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فَإِنَّ مَعَ ٱلْعُسْرِ يُسْرًا ٥

"After hardship comes ease"

Abstract

Purpose. This thesis explored the effectiveness of evidence-based psychological interventions for Black, Asian and Minority Ethnic (BAME) communities accessing Improving Access to Psychological Therapies (IAPT) services in England, UK.

Methods. Multiple-methodologies were guided by the Transdisciplinary model of evidence-based practice. This included 1) a systematic literature review; 2) examination of predictors of recovery and therapeutic effectiveness; 3) exploration of whether therapies were suitable to BAME service users' needs; and 4) exploration of IAPT practitioners' cultural competency.

Findings. Findings from the systematic review highlighted scarce inclusion of BAME participants in clinical trials. Only two studies met the inclusion criteria which found that psychoeducation at an early stage of referral was more effective in reducing depression when compared to delayed access (N = total 217 participants). Examination of routine clinical data revealed that ethnicity, religion, age, and initial baseline severity were predictors of recovery (N =13,710 patients). For therapeutic effectiveness, there were significant main effects for treatment modality and ethnicity after controlling for baseline severity and age, however, there was no significant interaction (N = 9,925 patients). Poor recovery outcomes (< 35%) were observed across the entire clinical sample. Findings from BAME service users recovery narrative (N = 9) revealed the importance of recognising cultural dissonance within therapy; the need for therapists to develop cultural competency; and evaluations of their road to recovery. Service users felt therapy was not a cure, but generally found it helpful. Interviews with therapists (N = 16) revealed that only nine therapists received one day of formal cultural competence training and seven received none at all. Therapists discussed the cultural dissonance encountered during therapy; the challenges in making cultural adaptations to therapy; and their cultural competency needs.

Conclusion. Overall, evidence suggests that the *'one-size-fits-all'* approach adopted by Western evidence-based psychological interventions fails to consider the cultural complexities that may present in ethnically diverse communities. Implications and considerations for decision-making processes are discussed in the context of clinical psychology practice, education, leadership, policy and research.

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List of Abbreviations

ADSM	Anxiety Disorder Specific Measures
BAME	Black, Asian and Minority Ethnic
BA	Behavioural Activation
BDI	Becks Depression Inventory
CA	Culturally Adapted
CMHDs	Common Mental Health Disorders
CBT	Cognitive Behavioural Therapy
DoH	Department of Health
EMPIRIC	Ethnic Minority Psychiatric Rates in the Community
GAD	Generalised Anxiety Disorder
GP	General Practitioner
HADS	Hospital Anxiety and Depression Scale
HI	High-Intensity (therapies)
IAPT	Improving Access to Psychological Therapies
ICD -10	International Classification of Diseases
IPT	Interpersonal Psychotherapy
LI	Low-Intensity (therapies)
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OCD	Obsessive-Compulsive Disorder
ONS	Office for National Statistics
PCTs	Primary Care Trusts
PTSD	Post-Traumatic Stress Disorder
PWPs	Psychological Wellbeing Practitioners
RCTs	Randomised-Controlled Trials
SAD	Social Anxiety Disorder
TAU	Treatment as Usual
WSAS	Work and Social Adjustment Scale

Preface

Introduction

Introduction

Research problem

The growth of common mental health disorders (CMHDs) has meant that one in six people in the United Kingdom (UK) are now diagnosed with a depressive or anxiety related disorder, which can have debilitating effects on the individual, economy and society (e.g., Grey, Salkovskis, Quigley, Clark, & Ehlers, 2008; McManus, Bebbington, Jenkins, & Brugha, 2016; Pilling, Whittington, Taylor, & Kendrick, 2011). Long term trends indicate an increase in figures from 6.9% in the adult population in 1993 (Spiers, et al., 2011) to 9.3% in 2014 (McManus et al., 2016). Poor mental health resulting in sickness absence, loss of productivity, and job losses can costs employers up to £42 billion a year, with an annual cost to the UK economy of up to £99 billion (Parsonage & Saini, 2017; Stevenson & Farmer, 2017). Recent figures show that around 1 in 5 adults in Britain (21%) now experience some form of depression in early 2021 which is more than double that observed before the Covid-19 pandemic (10%) (Williams, Davis, Figueira, & Vizard, 2021). England is a multi-cultural society, with over 7.9 million people identifying from Black, Asian, and Minority Ethnic (BAME) backgrounds (ONS, 2012). Mental health statistics report that BAME communities experience equivalent, if not greater levels of CMHDs when compared to the White British population (e.g., Rehman & Owen, 2013; Stansfeld et al., 2016). Yet, there are disproportionate inequalities in mental health treatment and care for ethnic minority groups, who in turn are less likely to access mental health services or engage with psychological therapies (e.g., Fernando, 2012; Gill, Husain, Vowden, Aznar, & Blake, 2014; Good & Hannah, 2015; Harwood et al., 2021; HSCIC, 2015).

In England, the Improving Access to Psychological Therapies (IAPT) service has received substantial government investment to help improve mental health outcomes for those diagnosed with CMHDs (Clark, 2018a). By implementing a stepped-care approach, IAPT services deliver evidence-based psychological interventions recommended by the National Institute of Care and Excellence (NICE) to provide cost-effective and clinically-effective treatments (e.g., Ekers & Webster, 2013; Pilling et al., 2011). Whilst there is sufficient evidence to suggest that evidence-based interventions are effective in treating CMHDs in the general population (e.g., Hedman, Ljotsson, & Lindefors, 2012; Kaltenthaler et al., 2006; Cuijpers, van Straten, & Warmerdam, 2007; Ekers et al., 2014; Kishita & Laidlaw, 2017), little is known about their effectiveness for ethnically diverse communities (Carter, Mitchell, Sbrocco, 2012; Ridgway & Williams, 2011). In instances where BAME populations are included in clinical trials, specific group findings tend not to be reported (Bernal & Saez-Santiago, 2006; Weersing & Weisz, 2002) or include minoritised groups from the United States (US) which makes it difficult to generalise findings to the UK population distribution (e.g., Antoniades et al., 2014; Griner & Smith, 2006; Tang, Li, Rodgers & Ballou, 2016).

Evidence-based practices are rooted in universal rhetoric and individualistic value systems which seldom consider cultural particularism (Frese III, Stanley, Kress, & Vogel-Scibilia, 2001; Fenn & Byrne, 2013; Good & Hannah, 2015; Rogers, 2009). Psychotherapy is a product of the West, thus individuals from non-Western communities may not know what it is, how it can help, or what to expect from therapy (Sue, 2006). By adopting the values, beliefs and principles of the dominant individualistic culture, person-centered care is deemed important for recovery whereby self-sufficiency, independence, and autonomy are promoted without consideration of non-Western cultural value systems (Al-Krenawi & Graham, 2000; Christopher, 2001; Fernando, 2012; Laungani, 2007). Ethnic minority communities tend to originate from collectivist societies, which work hard to instil and preserve cultural norms, values, and traditions of their country of origin (Hofstede, 2011; Tse & Ng, 2014). Here, greater precedence is given to others (e.g., family members, clans, tribes) whereby the interdependent nature of the self is expected to adjust, restrain and maintain harmony over self-serving desires and expectations (Markus & Kitayama, 1991). Thus, greater regard for mental health decision-making is placed on close-knit families and the wider community (Al-Krenawi & Graham, 2000; Hofstede, 2011; Wan & Chew, 2013). The individualism-collectivism paradigm (Hofstede, 1980; 2011; Triandis, 1995) and self-construal theory (Markus & Kitayama, 1991) offer a guiding framework to help understand how and why cultural dissonance may occur (Hwang, Myers, Abe-Kim, & Ting, 2008). Previous work utilising these theoretical concepts have largely been conducted in the US and found comparative differences between minority groups and the majority population, whilst also identifying the cultural clash between bi-cultural identities (e.g., Allen & Bagozzi, 2001; Gushue & Constantine, 2003; Phinney & Devich-Navarro, 1997). However, it is unclear how well these models transpose to the ethnic minority populations living in England. Cultural influences can play an integral role in the perception, uptake and engagement of Western interventions (Bhugra, 2005). Given the growth of ethnic minority communities, both settled and emergent, it is relatively unknown to what extent cultural identity interacts with these facets.

Typically, clinical trials examining the efficacy of evidence-based interventions tend to use a homogenous set of participants (e.g., White / Caucasian, middle-class), thus when interventions are applied to ‘real-world’ clinical settings seldom do the produce consistent findings (Gordis, 2014; Pawson & Tilley, 2004). Whilst the general service target for IAPT services is to achieve 50% recovery rates for those it serves, rarely do these outcomes transpire when data are reviewed in independent studies (between 9 – 22% recovery) (Griffiths & Steen, 2013a, Marks, 2018; Scott, 2018a), nor between BAME groups and the White British population (up to 10% difference in recovery outcomes) (Baker, 2018; Harwood et al., 2021; Moller, Ryans, Rollings, & Barkham, 2019). Despite these disparities, it is relatively unclear whether certain patient characteristics, such as ethnicity, are salient in predicting recovery (Green et al., 2015). In addition, recovery outcomes based on therapeutic modality have seldom assessed or reported what works well for ethnic minority communities (Woodall, Morgan, Sloan, & Howard, 2010). Previous studies examining therapeutic success in the general population have found inconsistent findings for low-intensity (e.g., guided self-help, non-guided self-help) and high-intensity (e.g., CBT, counselling) treatments (Delgadillo & Gonzalez Salas Duhne, 2020; Gyani, Pumphrey, Parker, Shafran, & Rose, 2011; Moller et al., 2019; Pybis, Saxon, Hill, & Barkham, 2017). Given high treatment attrition rates in BAME communities, exploring therapeutic effectiveness is cruicial in order to offer clinically effective treatments (Baker, 2018; Harwood et al., 2021).

Whilst evidence-based assessment of therapeutic programmes offer legitimate ways to review, plan, and monitor therapeutic outcomes, they are limited in understanding broader and complex dynamics that patients from diverse communities bring to therapy (Good & Hannah, 2015). Here, the recovery narratives are often ignored which is integral to understanding what works well, for who, and when (Williams, 2015). Previous literature has highlighted a number of fundamental issues that hinder therapeutic success in BAME communities accessing IAPT services (e.g., Beck & Naz, 2019). This includes unmet needs due to services not being able to facilitate or recognise distress across cultures; service users failing to attend appointments in fear of therapeutic expectations; and poorer therapeutic outcomes due to inadequately adapted cultural requirements. Echoing these concerns, findings from a qualitative meta-analysis reported that UK based ‘hard-to-reach’ communities held different world-views and expressions of mental illness, which included increased barriers to accessing mental health services and poorer engagement with psychological interventions due to cultural needs not being met (Lamb, Bower, Rogers, Dowrick, & Gask, 2011). Given the limited qualitative research within this area, patient lived experiences and culturally sensitive issues need to be considered to maximise recovery goals (Christodoulou, Fortune, Arslan, & Canan, 2018; Dausch et al., 2012; Roy-Chowdhury, 2013; Tse & Ng, 2014).

Moreover, research shows that training programmes and psychotherapy manuals are developed to the needs of the dominant Western cultural group, therefore the needs of clients from diverse communities tend to be absent from traditional theory, processes, and practice (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Clegg et al., 2016; Kirmayer, 2012; Sue, Zane, Hall, & Berger, 2009). Mental health professionals now work in an increasingly multicultural society which necessitates the need for cultural competency to be incorporated within clinical training programmes to equip them to offer culturally informed and empirically supported therapy (Good & Hannah, 2015; Keith, 2011; Leong & Lee, 2006; Sue, 1998; Yan, 2018). However, research shows that mental health practitioners seldom receive adequate training that equips them to work with diversity (Clegg et al., 2016; Edge & Lemetyine, 2019). Given the inherent overrepresentation of White therapists within UK clinical settings (Lang, 2020), concerns are raised about Eurocentric practitioners lacking an understanding of cultural expressions of mental health and diversity which can have detrimental effects on the therapeutic care for ethnic minority communities (Turpin et al., 2008; Good & Hannah, 2015). Thus, more research is needed to explore whether therapists are adequately trained to meet the needs of BAME communities.

Purpose of thesis

The purpose of this thesis is to explore to what extent evidence-based psychological interventions are effective in improving mental health outcomes for BAME communities accessing IAPT services. By adopting a critical realist epistemology, it is acknowledged that regularities are rare, thus exploration of underlying mechanisms can help explain empirical clinical outcomes (Bergin, Wells, & Owen, 2008; Ron, 2002). The methodological pragmatism of critical realism offers a holistic understanding of the phenomenon under investigation (Clark, MacIntyre, & Cruickshank, 2007; McEvoy & Richards, 2003; Palinkas et al., 2011). By using the Transdisciplinary model of evidence-based practice as a guiding methodological framework, a multi-layered approach will be adopted (Satterfield et al., 2009; Schreiber, 2013). First, a systematic literature review of clinical trials will be carried out to scope the efficacy of evidence-based psychological interventions for BAME communities in England. Next, the effectiveness of routine clinical data will be examined to explore whether certain patient characteristics are more salient in predicting recovery. Moreover, evidence-based interventions will be comparatively assessed by treatment modality and ethnicity to establish what therapies are most effective in improving mental health outcomes. Adding to this, interviews will be carried out with BAME service users who have accessed IAPT services to understand whether evidence-based interventions are suitable to their needs. Finally, interviews with IAPT practitioners will be conducted to explore whether they are culturally competent to meet the needs of BAME communities. It is envisaged that the findings from this research will help understand whether evidence-based interventions rooted in Western rhetoric are effective in improving recovery outcomes for diverse clinical populations in real-world clinical settings (Guy, Loewenthal, Thomas, & Stephenson, 2012; McPherson, Evans, & Richardson, 2009). Findings from across the studies will be integrated to help inform decision-making processes for clinical psychology practice, education, leadership, policy, and research. The thesis overview is outlined below:

Chapter	**Chapter Title**
1.	Systematic Literature Review
2.	Literature Review
3.	Methodology
4.	Study One: Exploring Predictors of Recovery and Therapeutic Effectiveness
5.	Study Two: *"Not a cure, but helpful"* – Exploring the Suitability of Evidence-Based Psychological Interventions to the Needs of BAME Communities
6.	Study Three: *"It's been quite a poor show"* – Exploring Whether IAPT Mental Health Practitioners are Culturally Competent to deal with the needs of BAME Communities
7.	Integrated Discussion

Chapter 1

Systematic Literature Review

1. Systematic Literature Review

“Are evidence-based psychological interventions for depression and/or anxiety related disorders effective in improving mental health outcomes for BAME groups in England, UK?”

1.1 Chapter overview

Although the English government has invested a substantial amount to tackle common mental health disorders (CMHDs), it is unclear how well evidence-based psychological interventions recommended by the National Institute of Care and Excellence (NICE) and adopted by Improving Access to Psychological Therapies (IAPT) services are catered to the needs of Black, Asian, and Minority Ethnic (BAME) communities living in England. To my knowledge, no previous systematic literature review has specifically researched the effectiveness of evidence-based psychological therapies for BAME communities in England, UK. This review seeks to cover a breadth of CMHDs and evidence-based psychological interventions adopted by IAPT to understand which treatments are most effective in improving mental health outcomes for BAME communities.

1.2 Introduction

The rapid growth of CMHDs has meant that one in six people in the UK are now diagnosed with a depressive or anxiety related disorder, which can have debilitating effects on the individual, the economy and society (e.g., Grey et al., 2008; McManus et al., 2016; Pilling et al., 2012). More recently, figures have soared, following the toll of the global pandemic – Covid-19 (Williams et al, 2021). Mental health disparities based on ethnicity are prominent, with those from BAME communities experiencing greater severity of CMHDs when compared to the White British population (e.g., Rehman & Owen, 2013; Stansfeld et al., 2016), yet BAME groups are less likely to utilise mental health services or engage in psychological therapies (e.g., Gill et al., 2014; HSCIC, 2015). Cultural influences can play an integral role in the perception and uptake of Western interventions (Bhugra, 2005). Ethnic minority communities tend to belong to collectivist cultures, which place greater regard on the decision-making processes for mental health concerns with close-knit families and the wider community (Al-Krenawi & Graham, 2000; Hofstede, 2011; Wan & Chew, 2013). Western notions of therapy adopted in the UK value independence, autonomy, and self-reliance to empower individuals to take control of their own lives (Christopher, 2001; Loewenthal, 2018; Williams, 2015). However, given the interdependence nature of collectivist communities, western therapies are often reported unsuitable to the needs of diverse groups (Benish, Quintana, & Wampold; 2011; Buffin, Ahmed, & Singh, 2009; Zane, & Blozis, 2012). This includes increased mental health stigma (Bristow, et al., 2011; Givens et al., 2007; Hatch et al., 2011), discrimination (Ryan & Pritchard, 2004), and language and literacy difficulties which can impede therapeutic success (Aggarwal et al., 2016; Turpin et al., 2008).

Given such concerns, culturally adapted (CA) psychological interventions have been developed to incorporate cultural sensitivity, values, beliefs, idioms of distress, and cultural-specific notions in response to missing concepts in mainstream psychotherapies (Barrera Jr, Castro, Strycker, & Toobert, 2013). Previous systematic reviews have shown that culturally adapted therapies such as CA-Cognitive Behavioural Therapy (CA-CBT) and CA-Interpersonal Psychotherapy (CA-IPT) (Benish et al., 2011; Chowdhary et al., 2014; van Loon, Schaik, Dekker, & Beekman, 2013) are shown to increase patient satisfaction and adherence to therapy (Antoniades et al., 2014; Ward & Brown, 2015). However, despite promise, research shows that CA psychological interventions often lack methodological rigour (Mirza & Jenkins, 2004) and tend to be piloted to specific populations (Horrell, 2008), this limits generalisability and fails to provide convincing evidence to be recommended or adopted as part of primary treatments of choice within the UK mental health settings (NICE: CG123, 2011). Moreover, time-limited services and inadequate cultural competence training mean that CA therapies are seldom offered within clinical practice (Cabassa & Baumann, 2013; Hinton et al., 2012; Lovell et al., 2014).

In England, IAPT services has received substantial government investment to help improve mental health outcomes for those diagnosed with CMHDs (Clark, 2018a). IAPT services is predominately delivered under the National Health Service (NHS) banner which aims to deliver evidence-based psychological interventions recommended by NICE in order to provide cost-effective and clinically-effective treatments (e.g., Ekers & Webster, 2012; Pilling et al., 2011). Evidence-based practice (EBP) of psychotherapy is viewed as a collaborative decision making process which includes the best evidence-research, practitioner expertise, and patient preferences (American Psychological Association, 2006; Mullen, 2015; Schreiber, 2013). Despite sufficient evidence to suggest that evidence-based psychological interventions recommended by NICE are effective in treating CMHDs in the general population (e.g., Hedman et al., 2012; Kaltenthaler et al., 2006; Cuijpers et al., 2007; Ekers et al., 2014; Kishita & Laidlaw, 2017), little is known about their effectiveness for ethnic minority groups (Carter, Mitchell, Sbrocco, 2012; Ridgway & Williams, 2011). This is largely due to ethnic group outcomes not being reported in clinical trials (Bernal & Saez-Santiago, 2006; Weersing & Weisz, 2002). In instances where BAME populations are included, therapies tend to be culturally adapted which are seldom practiced in mainstream clinical settings (Barrera et al., 2013), or are conducted with minoritised groups from the US which makes it difficult to generalise findings to the UK population distribution (e.g., Antoniades et al., 2014; Griner & Smith, 2006; Tang et al., 2016).

Despite the rapid growth of ethnic minority populations in England and the increased prevalence of CMHDs, the evidence-base for psychological interventions offered as part of routine care is limited (Horrell, 2008). Gold-standard therapies adopted by IAPT services are often implemented given their success in randomized-controlled trials (RCTs) (Pilling et al., 2011), however, it is unclear whether such trials include or consider the needs of ethnic minority populations in England (Bhugra, 2005; Buffin et al., 2009; Kirmayer 2012; Waheed et al., 2015). A recent systematic review and meta-analysis exploring the 10 years of practice-based evidence of IAPT services identified large pre-post treatment effect sizes for depression and anxiety outcomes, and moderate effect size on functional impairment, however, ethnic minority specific treatment outcomes were not reported, nor was it clear what therapy was most effective (Wakefield et al., 2021). Identifying literature that is context specific (i.e., clinical populations served by IAPT services) is useful for a number of reasons. Firstly, it helps understand whether evidence-based interventions implemented by national mental health services such as IAPT are effective in improving recovery outcomes for diverse clinical populations (Bernal & Saez-Santiago, 2006), and secondly, it helps identify ways in which therapists, services, and commissioning bodies in the UK can cater to the needs of minority groups (Horrell, 2008; Givens et al., 2007; Rathod, Phiri, & Naeem, 2019).

Objective of the current review

To my knowledge, no previous systematic review has specifically researched the effectiveness of evidence-based psychological therapies for BAME communities in England, UK. This review seeks to cover the most common evidence-based psychological interventions adopted by IAPT, whilst offering context specificity in terms of ethnic minority groups in England. By considering a range of therapeutic modalities offered by IAPT (e.g., low-intensity and high-intensity therapies), treatment effectiveness in minority populations can be evaluated. Given the bid for the English government to continue to fund and expand IAPT services for the future (Clark, 2018a), it is important to establish whether therapies recommended by NICE meet the needs of BAME communities who are often reported to have poorer mental health outcomes than their White British counterparts. It is envisaged that findings from this review will not only add to the sparse literature within this area, but may also help mental health services consider which therapies are most effective in improving mental health outcomes for BAME communities in England. Thus, the objective of this review is to explore;

Research Question: Are evidence-based psychological interventions for depression and/or anxiety related disorders effective in improving mental health outcomes for BAME groups in England, UK?

1.3 Method

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist was used as the standard reporting method for this systematic review (Moher et al., 2009).

1.3.1 Protocol

The systematic review protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO) on 26th May 2017 (registration number CRD42017067551). The protocol can be accessed here: https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=67551.

1.3.2 Eligibility criteria

***Study Designs*:** Randomised-controlled trials (RCTs) or non-RCTs that evaluated the efficacy of an evidence-based psychological intervention were included. Although non-RCTs are not considered as the 'gold standard' method by NICE (NICE: CG90, 2009), they too provide valuable information about the efficacy of interventions.

Population: BAME is classified as non-White communities in the UK (ONS, 2012; Gov.UK, 2022), therefore ethnic groups who fell within this remit were included (*see* Table 1.1). Studies that examined the adult aged (aged 18 >) population living in England were included. This is because IAPT services is only currently offered nationally within England. Studies focusing on specific ethnic group categories were considered (e.g., Pakistani, Black Caribbean etc.).

Interventions: Standard evidence-based psychological interventions recommended by NICE and adopted by IAPT (stepped-care model) for mild to severe depression and/or anxiety related disorders such as Cognitive Behavioural Therapy (Step 2 and 3) were included (*see* Appendix A.1.1). For anxiety related disorders, only generalised anxiety disorder (GAD), mixed anxiety and depressive disorder (MADD), panic disorder, social anxiety disorder (SAD), obsessive compulsive disorder (OCD), and post-traumatic stress disorder (PTSD) were included as they are the most common anxiety disorders treated within IAPT (Clark, 2018b).

Comparison: Evidence-based psychological interventions that made comparisons with *a)* another evidence-based psychological intervention, or *b)* any other psychological intervention (e.g., culturally-adapted psychological interventions), or *c)* treatment as usual (TAU), or *d)* control group, or *e)* wait list, or *f)* between different ethnic groups, or *g)* psychotropic medication were included. Studies that did not have a comparator group were excluded from the review.

Outcomes: The efficacy of the psychological interventions were assessed by comparing the mean differences and/or pre and post-treatment scores in studies that had used outcome measures such as the Generalised Anxiety Disorder-7 (GAD-7), Patient Health Questionnaire-9 (PHQ-9), Becks Depression Inventory (BDI), or Hospital Anxiety and Depression Scale (HADS). Follow-up outcomes (if reported) and any other relevant outcome measures that supported the study were also considered (e.g., self-esteem, levels of distress).

Language and Setting: Articles reported in English language and carried out in England, UK were only considered for the review.

Table 1. 1 *BAME Ethnic Group Categories Included in the Review (ONS, 2012)*

Ethnic Group Category	**Ethnic Groups**
Asian/Asian British	Indian Pakistani Bangladeshi Chinese Other Asian
Black/Black British	African Caribbean Other Black
Mixed/Multiple Ethnic Groups	White and Black Caribbean White and Asian White and Black African Other Mixed
Other Ethnic Groups	Arab Other Ethnic Groups

1.3.3 Exclusion criteria

- Only studies that assessed common mental health disorders were considered for the review. Any studies that evaluated the efficacy of psychological interventions for chronic or treatment resistant conditions, comorbid disorders with other severe mental health disorders (e.g., schizophrenia, bipolar disorder), and physiological conditions (e.g., diabetes, cancer) were excluded from the review as they are not typically treated within primary mental healthcare.
- Studies that did not report specific outcomes for the psychological interventions were excluded because the effectiveness of the intervention could not be determined. For example, if a care package was offered but the efficacy of the specific psychological intervention was not reported (e.g., psychoeducation).

- Studies that included BAME participants but did not report specific outcomes (e.g., combined results for all participants) were excluded if data could not be obtained from authors.

1.3.4 Information sources

Databases Searched: Web of Science (Clarivate Analytics interface), Cochrane Central Register of Controlled Trials – CENTRAL (Wiley Online Library interface), PsycARTICLES, PsycINFO and CINAHL Complete (EBSCOhost interface) and PubMed (NCBI interface) were searched. All databases searched were given a start date of January 1999 onwards to represent the implementation of NICE during this year. The database search was carried out between April and June 2021. Filters included English language, adults (> 18 years) and humans.

Websites: NHS England (IAPT) and NICE were searched to identify any studies that had been reported elsewhere or in reports.

Cross-referencing: Studies reported in systematic reviews and meta-analyses reviewing evidence-based psychological therapies were hand-searched to identify any additional articles that may have been missed during the database search.

Bibliographies and Grey Literature: Reference lists of included studies and relevant reviews were hand-searched to identify any studies that met the inclusion criteria.

Experts: Known experts and authors within the field of mental health research were contacted to identify additional studies that could be included in the review.

Authors of Published Studies: Authors of studies identified in the database search were contacted to obtain more information about the ethnicity of participants and/or to provide outcome data for BAME participants and/or to recommend further studies that may have been missed during the search.

1.3.5 Search strategy

A literature search strategy was developed by creating 19 search categories (e.g., ethnicity/culture, disorders, location) and medical subject headings (MeSH terms) such as '*depression*', '*psychotherapies*' and '*ethnic groups'* (*see* Appendix A.1.2). The first four combination terms (ethnicity, disorder, location, and study type) remained consistent throughout the search, with each therapy type added per combination (14 combinations in total) (*see* Appendix A.1.3). The excluded terms (e.g., cancer, pain, and veterans) were added to 'NOT' include any articles that were identified with such terms at the title [TI] stage. Any duplicate studies found at the end of the database search were removed. To note, the location of the studies was not available as a filter across the databases used for this review. As such, the location was first filtered at the title [TI] stage, however, this yielded a large number of missing articles due to the locality not being mentioned in the title of the article (e.g., United Kingdom or England). The search was repeated by including articles stating the location at the abstract [AB] stage, however, again, a number of known articles / authors were missing from the search. On closer inspection, it was identified that the majority of returned articles had failed to mention the location of the study in the title or abstract. As such, to ensure rigour of the search, the location was added to the full text search despite producing a large number of returned articles. Whilst the researcher understands that this was a disruptive aspect to the review, it is important to acknowledge the concern with studies failing to state the location of the study, as well as database restrictions in filtering articles by location for future reviews.

1.3.6 Study selection

Due to resource constraints, the initial database search and screening at title, abstract and preliminary full-text stage was carried out by the lead reviewer (AF) and cross-checked by assistant researchers (GZ and CH). Studies that appeared to meet the eligibility criteria were discussed and reviewed with the supervisor (PR). In instances where studies appeared to meet the eligibility criteria, but had missing information (e.g., specific outcomes for ethnic groups, or for specific psychotherapies), AF contacted the lead authors of the articles for further information. After three unsuccessful attempts to obtain further information, the study was excluded from the review. Once the final full-text studies had been identified, they were reviewed by the research team independently. Any disagreements were discussed until consensus was reached.

1.3.7 Data collection process

A customized data extraction form was created in Microsoft Excel 2016, piloted and refined to collect data such as participant demographics, type of disorder, intervention, methodology and outcomes from each study (*see* Appendix A.1.4). A traffic light system was used to mark studies that potentially met the eligibility criteria (green), required more information (amber), or did not meet the eligibility criteria (red). Due to the large volume of studies that had missing information, particularly in relation to participant ethnicity, this method was a valuable way to manage data.

1.3.8 Data items

The following data items were extracted for each respective study: psychological disorder (e.g., depression), the specific type of disorder (e.g., Major depression), psychological intervention offered (e.g., CBT), sample size, ethnicity, patient characteristics (e.g., age, gender, number of patients allocated to each condition), setting (e.g., England), language intervention was delivered, service provider (e.g., IAPT), design of study (e.g., RCT), comparator (e.g., TAU), outcome measure (e.g., PHQ-9), programme length (e.g., how long the intervention was offered), frequency (e.g., how often the intervention was offered), duration (e.g., how long the intervention session lasted), follow-up (e.g., 3 months), results (e.g., pre-post treatment scores), limitations (e.g., those reported by the author), conclusion, and funding organisation. Comments and potential studies identified in the bibliographies were also noted in separate columns (*see* Appendix A.1.4).

1.3.9 Risk of bias of individual studies

The revised Cochrane risk-of-bias tool for randomised controlled trials (RoB 2) was used to assess included studies (Higgins, Savovic, Page, & Sterne, 2019). The RoB tool covers five domains, which include RoB arising from the randomization process, the RoB due to deviations from the intended interventions, the RoB due to missing outcome data, the RoB in measurement of the outcome, and the RoB in selection of the reported result. Each domain was rated as either '*low risk*', '*some concerns'* or '*high risk*'. The RoB was independently checked by three reviewers (AF, GZ, and CH) and any disagreements were discussed until a consensus was reached.

1.3.10 Summary measures

Dichotomous outcomes were analysed using a pooled risk ratio, 95% confidence intervals (CIs), significance levels (*p* values) and effect size for each comparison group. Continuous outcomes were measured by analysing the mean differences, CIs, significance levels (*p* values) and effect size.

1.3.11 Synthesis of results

A systematic narrative synthesis was used both in text and in tables to summarise and explain the study characteristics and findings of the included studies (*see* Table 1.2). There were an insufficient number of studies in the final results to carry out a meta-analysis for this review.

1.4 Results

1.4.1 Study selection

The database searches were carried out between April and June 2021 using a number of combinatory search terms discussed in section 1.3.5. The initial database search yielded 38,342 articles, of which 4,071 were duplicates (*see* Figure 1.1). As previously discussed, the reason for the large number of returned articles was due to challenges in isolating studies by location, thus making it difficult to refine the returned number of responses. After screening at the title stage, 433 articles were reviewed at abstract, of which 425 were excluded. The reasons for exclusion were due to the type of disorder examined (e.g., depression and diabetes) (32), the location of the study (e.g., non-UK) (32), the population group being examined (e.g., did not include BAME outcomes) (153), the study design (e.g., not a clinical trial) (159), treatment type (e.g., not a psychological treatment) (6), and missing information (e.g., unclear information about population sample) (43). The lead author of studies that had missing information were contacted for further information. Upon three unsuccessful attempts, the studies were excluded from the review. A total of 8 studies were screened at full-text against the eligibility criteria, of which 6 were excluded. The main reason for removal of these studies was due to the study design (e.g., care-package), no specific therapeutic outcome being reported (e.g., pre-post treatment results), and no comparator group to assess against. The final 2 studies that met the inclusion criteria were included in the final review (*see* Table 1.2).

Figure 1. 1 *Study Flow Diagram*

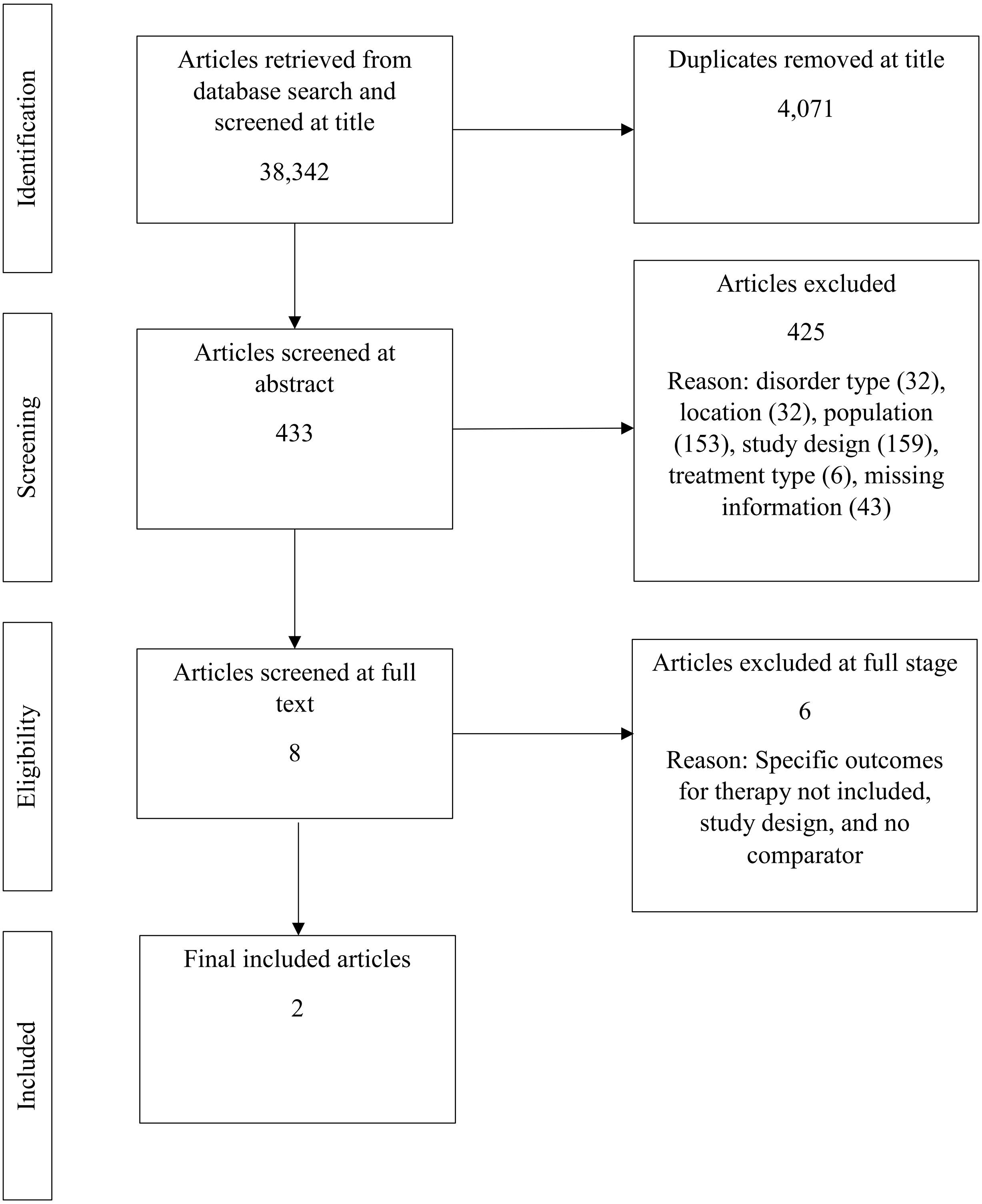

Table 1. 2 *Study Characteristics of the Included Studies in the Systematic Literature Review*

Disorder	Population (Ethnicity, Sample Size, Mean Age)	Intervention	Comparison Group	Language Therapy Delivered & Setting	Study Design	Therapy Duration, Frequency of Therapy & Programme Length	Follow-Up	Outcome Measures	Results*
Horrell et al., (2014)									
Depression	*Ethnicity:* 68% White & 32% BAME 32% *Sample Size:* 459 (Exp: 228 & WL: 231) *Mean Age:* 44.1 (Exp: 42.3 WL: 45.9)	Psychoeducational CBT self-confidence workshops (Exp)	Wait-list (WL)	*Language:* English *Setting:* 8 London Boroughs	RCT (multi-centre open trial)	*Duration:* One full day *Frequency:* not specified, however, 2-hour booster session after one month *Programme Length:* 4 sessions	12 weeks	*Primary:* BDI-II *Secondary:* GAD-7 RSES *[a]Other Measures:* EQ-5D CSRI CSQ	*BDI-II* Exp: Baseline (*M* = 28.9, *SD* = 10.1); 3 months (*M* = 19.0, *SD* = 13.3) | WL: Baseline (*M* = 29.7, *SD* = 10.8); 3 months (*M* = 25.4, *SD* = 11.8) | *Adj mean diff* -5.3 (95% CI -7.26 to -2.9), *p* = 0.001. *GAD-7* Exp: Baseline (*M* = 11.7, *SD* = 5.0); 3 months (*M* = 8.6, *SD* = 6.0) | WL: Baseline (*M* = 11.8, *SD* = 5.2); 3 months (*M* = 10.5, *SD* = 5.3) | *Adj mean diff* -1.6 (95% CI -2.8 to -0.4), *p* = 0.015. *RSES*

									Exp: Baseline ($M = 11.9$, $SD = 4.3$); 3 months ($M = 14.6$, $SD = 5.0$) | WL: Baseline ($M = 12.0$, $SD = 4.7$); 3 months ($M = 12.9$, $SD = 4.8$) | *Adj mean diff* -1.8 (95% CI 0.9 to 2.7), $p = 0.003$.
Jacob et al., (2002)									
Depression	*Ethnicity:* Indian women *Sample Size:* 70 (Exp: 35 & UC: 35) *Mean Age:* 47.9 (Exp: 47.4 UC: 48.3)	Psychoeducation - Educational leaflet (Exp)	Usual Care (UC)	*Language:* English or Hindi *Setting:* GP practice in London Borough of Ealing	RCT	*Duration:* Not specified *Frequency:* Educational leaflet at initial referral *Programme Length:* Not specified	2 months	*Primary:* GHQ-12 *Secondary:* SEMI	*GHQ-12* Exp: (15/35 recovered); UC: (7/35 recovered); $p < 0.05$ *SEMI* No significant differences between groups in considering depression as mental illness and conversion to non-medical beliefs.

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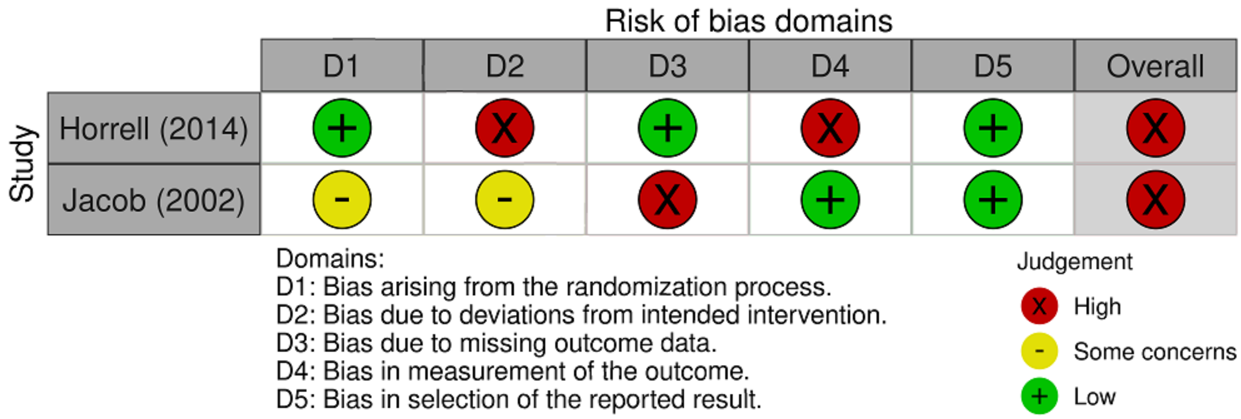
*Results for the main outcomes of interest are reported. [a]Other measures assessed in original article but not included in scope of this review. *Exp:* Experimental Condition. *RCT:* Randomized-Controlled Trial. Outcome Measures: *BDI-II:* Beck Depression Inventory-II; *GAD-7:* Generalized Anxiety Disorder-7; *RSES:* Rosenberg Self-Esteem Scale; EQ-5D: Health-Related Quality of Life Measure; *CSRI:* Client Service Receipt Inventory; CSQ: Client Satisfaction Questionnaire; *GHQ-12:* General Health Questionnaire-12; *SEMI:* Short Explanatory Model Interview.

1.4.2 Risk of bias assessment

The risk of bias for each study was assessed in accordance to the revised Cochrane RoB-2 (Higgins et al., 2019). Both studies (Horrell et al., 2014 and Jacob et al., 2002) were rated as having high risk of bias due to some concerns and high risk of bias in two or more categories (*see* Figure 1.2). In the study by Horrell and colleagues (2014), high risk was recorded for bias due to deviations from the intended intervention, and bias in measurement of the outcome. For Jacob and colleagues (2002) there were some concerns for bias arising from the randomisation process and deviations from the intended intervention. High risk of bias was observed for missing outcome data. Lead authors of the studies were contacted to obtain further information, however, without success.

Figure 1. 2 *Risk of Bias Assessment of Included Studies*



1.4.3 Findings

Two studies were identified for the final review which examined the efficacy of psychoeducation, in different forms, for depression (Horrell et al., 2014; Jacob et al., 2002). Psychoeducation is considered a low-intensity therapy within IAPT services, however, NICE has not specified its recommendation for the treatment of depression (NICE: CG90, 2009). In the first study, Horrell and colleagues (2014) examined the efficacy of one-day psychoeducational based CBT self-confidence workshop across eight London Boroughs. The ethnic minority population in this region was diverse, which meant that the study attracted 32% BAME participants. A total of 459 participants were recruited in the RCT. In the experimental condition, 228 service users were offered a one-day group workshop 3 weeks after referral. The workshop was based on the development and cognitive components of low self-confidence and behavioural methods and action plans on how to improve this. One month later, service users were offered 2-hour nontherapeutic booster sessions. At follow-up (12 weeks), a further 2-hour session was provided where outcome data was collected and participants were signposted. In the control condition, 231 participants were advised to visit their GP as usual before they were offered the workshop after 12 weeks waiting period. Findings revealed that those in the experimental condition showed significantly greater improvement in levels of depression, anxiety and self-esteem than those in the wait-list condition. At baseline, depression scores for the experimental (*M* = 28.9, *SD* = 10.1) and wait-list (*M* = 29.7, *SD* = 10.8) conditions were similar, however, those in the experimental condition (*M* = 19.0, *SD* = 13.3) showed significantly greater reductions in depression when compared to the wait-list condition at post-treatment (*M* = 25.4, *SD* = 11.8), *p* = 0.001. Similarly, little difference was observed in baseline anxiety scores for the experimental (*M* = 11.7, *SD* = 5.0) and wait-list (*M* = 11.8, *SD* = 5.2) conditions, however, significantly greater reductions in anxiety were observed in the experimental condition at post-treatment (*M* = 8.6, *SD* = 6.0) when compared to the wait-list condition (*M* = 10.5, *SD* = 5.3), *p* = 0.015. In terms of self-esteem, outcomes of the Rosenberg Self-Esteem Scale (RSES) indicated that those in experimental (*M* = 11.9, *SD* = 4.3) and wait-list (*M* = 12.0, *SD* = 4.7) had similar low self-esteem scores at the start of treatment. However, those in the experimental condition (*M* = 14.6, *SD* = 5.0) showed significantly greater improvement in self-esteem when compared to the wait-list condition at post-treatment (*M* = 12.9, *SD* = 4.8), *p* = 0.003.

In the second study, Jacob et al., (2002) offered psychoeducation in the form of an educational leaflet to Indian women who accessed their local GP service in the London Borough of Ealing. A total of 70 participants were recruited in this RCT. In the experimental condition, 35 women were provided with an educational leaflet that contained cultural relevant information about depression, such as symptoms of depression and anxiety, and treatment options. Leaflets were available in both English and Hindi. The control condition (35 women) received treatment as usual without the leaflet. At baseline, those in the experimental (*M* = 5.17, *SD* = 2.0) and usual care (*M* = 5.31, *SD* = 2.2) were reported to have a common mental health disorder. Post-treatment results indicated that those in the experimental condition (15 out of 35 women) had recovered and shown significantly greater improvement in GHQ-12 scores than the usual care condition (7 out of 35 women), $p < 0.05$. However, findings for the explanatory model did not find any significant differences between the way in which mental illness was recognised nor did it change patients non-medical beliefs.

No studies were identified for mixed depressive and anxiety disorders (MADD) or any other anxiety related disorder.

1.5 Discussion

This review aimed to explore the effectiveness of evidence-based psychological interventions for depression and/or anxiety related disorders in BAME groups living in England, UK. Following the literature search, only two studies met the inclusion criteria and were included in the final review. Both studies offered psychoeducation; one in the form of an educational leaflets (Jacob et al., 2002) and the other in the form of psychoeducational self-confidence workshops (Horrell et al., 2014) for the treatment of depression. A total of 217 BAME participants were included in both studies. Results showed that the efficacy of psychoeducation at an early stage of referral was significantly more effective in reducing depression when compared with delayed access. However, given the risk of bias assessment, these findings are to be taken with caution.

In Horrell et al., (2014) study, a one-day psychoeducational based CBT self-confidence workshop significantly improved levels of depression, anxiety and self-esteem when compared with a 12 week wait-list condition. This study attracted 32% of participants from BAME backgrounds from London boroughs with higher levels of deprivation. This was a particular strength of the study, since recruitment of BAME populations can be challenging in RCTs (Adams, 2008; Woodall et al., 2010). Authors suggested that the large recruitment of BAME participants may have been due to how the study participation was promoted. Due to inherent mental health stigma within BAME communities, authors named the workshops as *'How to improve your self-confidence'* which deflected any shame and stigma attached to depression. One of the limitations of the trial was that it did not report specific outcomes for BAME participants, despite being a significant proportion of the sample. This trend is not uncommon in RCTs (Bernal & Saez-Santiago, 2006; Weersing & Weisz, 2002). However, following contact with the author of the paper, it was confirmed that there were comparable findings between both the White and BAME groups. However, the initial attrition rate was high (32%) which required subsequent recruitment. Despite some of these limitations, authors reported that the cost-effectiveness of such workshops would enhance engagement of hard-to-reach groups and improve mental wellbeing of diverse communities.

In the second study by Jacob et al., (2002), the effectiveness of psychoeducation leaflets in a GP surgery that was targeted towards Indian women was examined. Findings showed that those who received the leaflets were significantly more likely to recover than those who received standard usual care alone. However, this outcome was more pronounced for those with milder conditions at referral. Authors did not report specific post-treatment scores, so it was not possible to review the exact change difference between patient outcome scores. Subsequent measures found that there was little change in how mental health was perceived or how medical help was sought between groups. Authors reported that educational leaflets did not aid in changing patient ways of perceiving mental health; nor did it improve GP treatment rates; or increase help-seeking from other sources. A possible reasons for this may be due to the psychoeducation material being provided without therapists support (Anderson et al., 2005). Research shows that some individuals from BAME communities may have poor literacy proficiency, regardless of whether leaflets were offered in English or Hindi (Anderson et al., 2005; Beck, 2019). As such, intervention effectiveness may have been reduced considerably. Both studies were categorised as poor methodological quality, largely due to concerns with some high risk of bias. These findings are consistent with previous reviews which have reported the lack of methodological robustness in clinical trials carried out with BAME populations (Mirza & Jenkins, 2004; NICE: CG123, 2011; Walpole et al., 2013).

Despite national statistics, policies and research reporting the inequalities in mental health access and care in the UK (e.g., Rehman & Owen, 2013; Stansfeld et al., 2016), the findings from this review highlight the paucity of research that has explicitly explored the effectiveness of evidence-based psychological interventions for ethnic minority populations. Even though NICE and IAPT recommend and adopt gold standard evidence-based psychological therapies such as CBT for the treatment of CMHDs, it is argued that the efficacy of these interventions may only be suitable to the population recruited in clinical trials (e.g., the White population) (Bassey & Melluish, 2012; Hall, 2001; Williams, 2015). Yet this study was neither able to confirm nor refute the latter point. Research shows that when psychotherapies are delivered in ‘real-world’ clinical settings, they seldom produce the same outcomes as clinical trials, particularly in ethnic minority populations (Hall, 2001; Keith, 2019; Sue et al., 2009). Notably, what is of most concern is the lack of research examining the effectiveness of psychological therapies for anxiety related disorders, thus future research needs to examine this further, especially since national statistics show comparable rates of anxiety related disorders in the BAME population to the majority White group (Stansfeld et al., 2016).

Despite English government initiatives to include marginalised groups in the delivery and design of therapeutic services, there appears to still be a disproportionate gap within this area of research (Bee et al., 2008). The homogeneity of the population sample included in clinical trials minimises generalizability and fails to consider the needs of diverse communities (Woodall et al., 2010). Whilst Wakefield and colleagues (2021) identified ethnicity reporting in three studies, treatment outcomes were not reported, nor was it clear what therapies were most effective in improving mental health outcomes for these populations. Authors did however encourage future research to include such detail in order to offer meaningful findings. If evidence-based psychological interventions truly want to be inclusive, clinical trials and studies need to incorporate ethnic minority populations as they can hold varying socio-cultural and language needs to the majority White group (Bernal & Saez-Santiago, 2006). Whilst it is acknowledged that recruitment of ethnic minority populations can be challenging, often due to mistrust in researchers, stigma, language proficiency and logistical reasons (Brown, Boardman, Whittinger, & Ashworth, 2010; Gask, Rogers, Oliver, May, & Roland, 2003), future research may consider including caregivers and labelling research in a way that helps minimise stigma associated with mental health (Ehlers et al., 2013; Gater et al., 2009; Horrell et al., 2014; Woodall et al., 2010).

The studies included in this review show promise, however, given the high risk of bias in methodological rigour, more high quality studies are needed. Whilst clinical trials are seen to provide the most rigorous methods to investigate therapeutic success, patient narrative tends to be missing, therefore it is difficult to understand what works well for ethnic minority populations (Williams, 2015). By considering socio-cultural perspectives and experiences of minority ethnic groups, services can begin to better understand the needs and expectations of diverse communities (Bristow et al., 2011; NIHME, 2003). Positive steps can be seen in incorporating culturally specific therapies and services for minority groups such as the Asian family counselling service set up by IAPT Ealing (Southall) (IAPT, 2009) and adapted behavioural activation for Muslims trialled in Bradford (Mir et al., 2015). However, initiatives such as these are too little and sparse to make significant changes to healthcare policies. Therefore, such interventions need to be researched on a larger scale to explore the effectiveness for the wider population.

1.5.1 Strengths and limitations

The strengths of this study is that, to my knowledge, it is the first systematic review that has investigated whether evidence-based psychological interventions offered within routine clinical care (e.g., IAPT services) in England are effective to the needs of BAME populations. This brings to light the lack of inclusion of ethnic minority communities in clinical trials which has implications for clinical practice and service user needs (Carter et al., 2012; Ridgway & Williams, 2011). Whilst the number of returned articles at title stage appears cumbersome, there were a number of reasons why it was difficult to mitigate the specificity of results. Despite several attempts to confine the search strategy and to maintain methodological rigour, we were unable to reduce the returned number of articles without the expense of losing sight of potential studies that may have been applicable for the review. The reasons for this were due to the poor reporting of study settings and locations; researchers not specifying if ethnic minority populations were included in the study sample; and unclear study aims. Thus, future research should consider the transparency of how studies are reported in order to make research accessible so that therapeutic efficacy for hard-to-reach communities can be better understood (Woodall et al., 2010). Moreover, due to the lack of sample specificity (i.e., ethnicity of participants), 43 studies were not included in the review as it was not possible to obtain further information from the authors. This presents as a limitation as there may have been additional studies that could have met the inclusion criteria for this review. Finally, qualitative studies were not considered as part of the initial review which may have enriched the findings by providing participant perspectives and experiences of receiving psychological interventions.

1.5.2 Conclusion

This review brings to light the scarcity of research carried out in a much-needed area of mental health research. Despite substantial investment and efforts by the English government to tackle CMHDs, there appears to be lack of good quality research investigating whether evidence-based psychological interventions recommended by NICE, and adopted by IAPT service, improve mental health outcomes for BAME communities. Whilst clinical trials tend to provide sound evidence-base for the efficacy of psychological interventions, it is unclear how well this translates to real-world clinical settings. Given that mental health services such as IAPT rely on evidence-based psychological interventions as part of routine clinical practice, there is limited understanding of the suitability of therapies to the needs of ethnic minority populations (Guy et al., 2012). Thus, future research should consider patients recovery narrative to explore how well individuals from ethnic minority backgrounds engage with treatment, what kind of psychological interventions they find acceptable, and whether interventions are effective in improving mental health outcomes (Cardemil, Nelson, & Keefe, 2015; Williams, 2015).

1.6 Chapter summary

This chapter was set as a scoping review to explore whether evidence-based psychological interventions for CMHDs are effective in improving mental health outcomes for BAME communities in England, UK. Only two studies were found, which examined the efficacy of psychoeducation for depression. The studies reported that psychoeducation at an early stage of referral was more effective in reducing depression when compared to delayed access. No studies were found for any anxiety-related disorder. The poor of inclusion of BAME participants in clinical trials is of concern, especially given the inherent challenges faced by ethnic minority communities. This can have profound implications for clinical practice, thus will be unpacked further in the extant literature review.

Chapter 2

Literature Review

2. Literature Review

2.1 Prevalence of common mental health disorders

England is a multi-cultural society, with over 7.9 million people identifying as Black, Asian, or Minority Ethnic (BAME) backgrounds (ONS, 2012). With the growth of new migrants joining the already established ethnic minority communities within the UK, the Office for National Statistics (ONS) reported that since the last census in 2011, England has become more ethnically diverse than ever before (ONS, 2018). However, despite efforts to settle into the host culture, individuals from BAME communities continue to experience social-exclusion, discrimination, racism, and poorer socio-economic living standards that perpetuates mental distress (e.g., Bhui et al., 2006; Hinton & Lewis-Fernandez, 2011; Abu-Ras & Suarez, 2009). Mental health inequalities have a deep-rooted history in the UK which has led to increased stigma, poorer help-seeking attitudes and under-utilisation of mental health services (Butler, 1993; Ryan & Pritchard, 2004). Common mental health disorders (CMHDs) such as depression and anxiety dominate the mental health provision and are debilitating for some individuals (Mathers & Loncar, 2005; McManus et al., 2016). With the rapid growth of depressive and anxiety related disorders, it is predicted that CMHDs will be the leading cause of disability by the year 2030 (Mathers & Loncar, 2005). CMHDs tend to interfere with daily functioning by causing emotional distress, considerable impairment and disability (Pilling et al., 2011).

In England, one in six adults now meet the criteria for CMHDs with one in three adults accessing some form of mental health treatment (McManus et al., 2016). Long term trends indicate an increase in figures from 6.9% in the adult population in 1993 (Spiers, et al., 2011) to 9.3% in 2014 (McManus et al., 2016). Poor mental health resulting in sickness absence, loss of productivity, and job losses can costs employers up to £42 billion a year, with an annual cost to the UK economy of up to £99 billion (Parsonage & Saini, 2017; Stevenson & Farmer, 2017). Increased absence from work and low productivity has meant that more people are now dependent on state benefits (i.e., incapacity benefits) leaving damaging effects for both the individual and society (Clark et al., 2012; Hunot, Churchill, Teixeira, & Silva de Lima, 2007; Husain, Chaudhry, Rehman, & Ahmed, 2014; Grey et al., 2008; Pilling et al., 2012; Subramaniam et al., 2012). It is estimated that over 17.6 million days of sick leave are taken due to mental health related reasons alone (Mental Health Foundation, 2016). Recent figures show that around 1 in 5 adults in Britain (21%) now experience some form of depression in early 2021 which is more than double that observed before the Covid-19 pandemic (10%) (Williams, Davis, Figueira, & Vizard, 2021). Over recent years, several national reports, including the Adult Psychiatric Morbidity Survey (Fear, Bridges, Hatch, Hawkins & Wessely, 2016; Stansfeld et al., 2016), Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) study (Weich & McManus, 2002; Weich et al., 2004), and the Mental Health Survey of Ethnic Minorities (Rehman & Owen, 2013) have been conducted to assess the prevalence of CMHDs in the UK population. Findings have consistently reported greater, if not similar rates of CMHDs in BAME communities when compared to the White British population. In spite of such findings, individuals from BAME communities are less likely to seek professional help, access appropriate mental health services or engage in therapy (e.g., Gill et al., 2014; Mallinson & Popay, 2007; HSCIC, 2015; Sashidharan, 2003). A possible explanation for this may the inherent cultural disparities between Western practices and non-Western cultural value systems, norms, behaviours, and beliefs (e.g., Hofstede, 1980; 2011; Hofmann, Asnaani, & Hinton, 2010; Markus & Kitayama, 1991; Snowden, 2007). This assertion will be unpacked henceforth.

2.2 Introduction to culture

2.2.1 Defining culture

People from ethnic minority communities tend to share common cultural practices and attitudes which can include language, rituals, ancestry, and religion (Fernando, 2012; Smaje, 1996). Culture is a complex construct with over a hundred varied definitions (Baldwin & Lindsley, 1994). Culture tends to refer to a group of people who share similar world-views, values, beliefs, norms and traditions as part of a collective system (Betancourt & Lopez, 1993). Cultural heritage is often transmitted by elders through to younger generations and can offer a blue-print for living (Fernando, 2010). Hofstede (2011) describes culture as "*…the collective programming of the mind that distinguishes the members of one group or category of people from others*" (*p*. 3). The term culture is often used to describe tribes or ethnic groups who share similar experiences and live (or have lived) in the same social environment (Hofstede, Hodstede & Minkov, 2010). Whilst it is generally understood that shared universal characteristics define culture, this does not denounce subcultural and individual differences that may apply to specific groups of people (Fernando, 2010; Munoz & Mendelson, 2005). Instead, it is recognised that culture forms as part of a flexible system which combines cognitions and behaviours that are embedded in shared beliefs, learned experiences and day-to-day patterns for living (Damen, 1987). Whilst it is acknowledged that culture and ethnicity are not synonymous (Betancourt & Lopez 1993), ethnic classifications can play an integral role in understanding inequalities in mental healthcare and are useful for monitoring and planning service provision and care (Ahmed & Bradby, 2008; Fernando, 2012; Smaje, 1996). Thus, for the purpose of this thesis, those who identify from BAME backgrounds will be considered as non-Western cultural groups and those who identify as White British will be considered Western.

2.2.2 Theoretical understanding of cultural differences

Cross-cultural theorists have dabbled into cultural differences for many years. Cultural (dis)similarities have been a point of interest to gain better understanding of human cognitions, behaviours, and how individuals define themselves and their relationship with others (Brewer & Chen, 2007; Papadopoulos, Foster & Caldwell, 2013). Theories that have received popularity within the cross-cultural arena, and are of interest to this thesis, are individualism-collectivism (Hofstede, 1980; 2011; Triandis, 1995) and the self-construal theory (Markus & Kitayama, 1991). The development of such theories have challenged researcher assumptions of the self being viewed as independent, autonomous and unique which is synonymous to Western mental healthcare (Cross, Hardin, & Gercek-Swing, 2011).

In the early 80s, Hofstede (1980) began to explore cultural differences by assessing the values and sentiments of International Business Machines (IBM) employees from over 50 countries around the world. Extracting the data and reviewing findings from over 115,000 questionnaires, Hofstede proposed four dimensions of cultural attributional differences which included power distance; uncertainty avoidance; masculinity versus femininity; and individualism versus collectivism. Focusing on the individualism-collectivism dimension, Hofstede defined individualism as *"...cultures in which the ties between individuals are loose: everyone is expected to look after him/herself and his/her immediate family"* and collectivism as *"...cultures in which people from birth onwards are integrated into strong, cohesive in-groups, often extended families (with uncles, aunts and grandparents) that continue protecting them in exchange for unquestioning loyalty, and oppose other in-groups"* (Hofstede, 2011, *p*. 11). As expected, countries from the Western world such as the United States (US), United Kingdom (UK) and many European nations scored higher on levels of individualism whilst those typically from the non-Western world such as China, Bangladesh and Pakistan held greater collectivist attributes (Hofstede, 2015). Hofstede found a number of cultural differences between nations (*see* Table 2.1), primarily that being the way in which people from individualistic societies adopt an *'I'* consciousness that focuses on the individual person, whilst those from collectivist societies adopt a *'We'* consciousness that considers the role of others (Hofstede et al., 2010). The way society perceives its social environment is often embedded in past successes that are transmitted to future generations, including aspects such as language, religious beliefs, and political positioning (Triandis, 1972). Similar to Hofstede, Triandis (1995) defines individualism as *"... a social pattern that consists of loosely linked individuals who view themselves as independent of collectives"*, and collectivism *"...a social pattern consisting of closely linked individuals who see themselves as parts of one or more collectives (family, co-workers, tribe, nation)"* (*p*. 2). Essentially, those from individualistic societies hold *independent* self-construals, whilst those from collectivist societies embody *interdependent* self-construals (Cross et al., 2011).

Table 2.1 *Cultural Differences Between Individualistic and Collectivist Societies*

Individualism	**Collectivism**
Everyone is supposed to take care of him or herself and his or her immediate family only	People are born into extended families or clans which protect them in exchange for loyalty
"I" consciousness	"We" consciousness
Right of privacy	Stress on belonging
Speaking one's mind is healthy	Harmony should always be maintained
Others classified as individuals	Others classified as in-group or out-group
Personal opinion expected: one person one vote	Opinions and votes predetermined by in-group
Transgression of norms leads to guilt feelings	Transgression of norms leads to shame feelings
Languages in which the word "I" is indispensable	Languages in which the word "I" is avoided
Purpose of education is learning how to learn	Purpose of education is learning how to do
Task prevails over relationship	Relationship prevails over task

Note. Adapted from Hofstede (2011)

Self-construal refers to the way in which an individual makes meaning of the self (e.g., thoughts, feelings, actions) and how this self-definition influences their relationships with others (Cross et al., 2011; Singelis, 1994). Markus and Kitayama (1991) developed the self-construal theory to challenge the Western, monocultural approach to psychology which inherently views the self as independent, thus failing to consider those from non-Western societies. Embedded within the *self-system* are a host of self-relevant schemata's' which are influenced by past experiences and used to evaluate, organise and regulate one's current and future behaviours (Markus & Kitayama, 1991) (*see* Table 2.2). Unlike those from the Western world, who tend to view themselves separate from their social context, non-Western cultures tend to embody interdependent self-construals that connects them to their social context by placing greater regard on relevant others (e.g., family members, partners, extended families). Cultural identities tends to be formed from both a macro perspective, that is, identity that belongs to the nation in which an individual belongs (individualism-collectivism) and a micro perspective that entails psychological processes that are pertinent to specific cultural groups (self-construal) (Cross et al., 2011; Yan, 2018). Cultural identity is often referred to as the shared experiences and psychological connection between an individual's self and a culture (Wan & Chew, 2013). Cultural identities can be dynamic and flexible, incorporating multifaceted intersections between constructs such as ethnicity, race, religion and social class (Wan & Chew, 2013).

Research shows that people from BAME communities are more likely to retain their ethnic identity to preserve their cultural values and ideals (Phinney, 2005), whilst this is less common for their White counterparts (DeVos & Banaii, 2005; Sagiv & Schwarts, 2007). People from minority ethnic communities, tend to originate from non-Western populations, thus are more likely to hold onto collectivist values and inherit interdependent self-consturals that tie them with close family networks, clans, and communities (Hofstede, 2011; Markus & Kitayama, 1991). People from collectivist societies tend to share commonalties which bind them together, which include their heritage, cultural practices, values and experiences that have been passed on through generations (Collier, 1998; Zagefka, 2009). Even though behavioural changes are likely to occur as part of the acculturation process, the degree to which people adapt to the new society seldom see dramatic shifts to internal beliefs and cultural value systems (Hovey et al., 2006). Ethnic minority parents that migrate from non-Western countries often work hard to instil collectivist values in younger generations in order to preserve cultural norms and traditions, thus the individualistic nature of the host country is not entirely adopted (Tse & Ng, 2014).

Table 2.2 *Key Differences between Independent and Interdependent Self-Construal*

Feature Compared	**Independent**	**Interdependent**
Definition	Separate from social context	Connected with social context
Structure	Bounded, unitary, stable	Flexible, variable
Important Features	Internal, private (abilities, thoughts, feelings)	External, public (statuses, roles, relationships)
Tasks	Be unique	Belong, fit-in
	Express self	Occupy one’s proper place
	Realize internal attributes	Engage in appropriate action
	Promote own goals	Promote others’ goals
	Be direct; “say what’s on your mind”	Be indirect; “read other’s mind”
Roles of Others	*Self-evaluation:* others important for social comparison, reflected appraisal	*Self-definition:* relationships with others in specific contexts define the self
Basis of Self-Esteem	Ability to express self, validate internal attributes	Ability to adjust, restrain self, maintain harmony with social context

Note. Adapted from Markus & Kitayama (1991, *p*.230)

According to Hofstede (2011), people from collectivist cultures stress on the need for belonging, where harmony should always be maintained and self-centred words such as *'I'* are avoided. The interdependent nature of such individuals tends to be guided by external roles and relationships that encourage them to promote the goals of others and avoid confrontation (Markus & Kitayama, 1991). Thus, *other-focused* emotional consequences ('*Us'*) consider the needs of others since cognitions are embedded in specific social contexts (Markus & Kitayama, 1991). In contrast, those from individualistic societies promote the right to privacy and value speaking one's mind (Hofstede, 2011). Having an independent view of the self allows individuals to express themselves readily and promote their own goals over others (Markus & Kitayama, 1991). Here, *ego-focused* emotional consequences (*'I'*) foster personal psychological traits, attributes and self-knowledge which enables individuals to express their own needs over others (Markus & Kitayama, 1991) (*see* Table 2.3).

The role and relationship of others tends to guide individuals from individualistic and collectivist societies. Those from individualistic cultures classify others as independent from themselves, where personal opinions are valued and expectations of tasks prevail over relationships (Hofstede, 2011). Thus transgression from the norm leads to feelings of guilt. The independent self considers others important for social comparison, where ability to express oneself is important to validate internal attributes and desire for uniqueness is important for self-esteem (Markus & Kitayama, 1991). In the Western world, open emotional expression and attainment of personal goals over group goals are viewed as important for wellbeing and life satisfaction (Markus & Kitayama, 1991; Scott, Ciarrochi, & Deane., 2004), however, the pursuit for self-actualisation may in fact lead to alienation, psychological distress and social isolation (Mohamed & Lowenthal, 2009; Triandis, 2001). In contrast, in collectivist cultures, the role and opinions of the in-group (e.g., family, clans, tribes) take precedence over out-groups, thus maintaining one's relationship prevails task (Hofstede, 2011). Here, transgression from the norm leads to feelings of shame. The interdependent nature of the self is expected to maintain harmony, adjust, and restrain (Markus & Kitayama, 1991). The regulation of emotions are guided by others, thus motivation to fit in and change one's behaviour is deemed important for self-esteem (Markus & Kitayama, 1991; Oyserman et al., 2002). Meeting such cultural standards, rules and expectations are regarded as signs of self-integrity and maturity (Cross, Gore & Morris, 2003). However, obeying authoritarian older adults (e.g., parents, grandparents) and meeting cultural obligations can supress the pursuit for autonomy, thus having consequences for mental wellbeing during a life crisis (Caldwell-Harris & Aycicegi, 2006; Holmes-Eber, 1997; Triandis, 1995). Moreover, gender roles in collectivist societies tend to be more profound, with males expected to adopt dominant, patriarchal roles, whilst females are expected to take on matriarchal roles, which necessitates a submissive character that is considerate of family reputation, values, and expectations (Al-Krenawi & Graham, 2000). Deflection from such gender norms can be seen as a sign of weakness, shame and dishonour (Gilbert, Gilbert & Sanghera, 2004; Memon et al., 2016; Mohammed & Loewenthal, 2009).

Despite research showing comparable differences between individualistic and collectivist cultures (e.g., Hofmann, Asnaani, & Hinton, 2010; Snowden, 2007), critics argue that cultural dimensions may be a product of their time and too simplistic given the diversity of modern societies (Yoo & Donthu, 1998). With increasing globalisation, it is suggested that pure individualists or collectivists may no longer exist since cultures are ever-evolving, therefore the concept of individualism-collectivism may need to be seen on a continuum rather than far polarising categories (Cohen, Wu, & Miller, 2016; Laungani 2007; Matsumoto, 1999; Triandis, 1995). A meta-analysis assessing individualism-collectivism orientation in the US reported that although European American participants held greater individualistic orientation, the differences between cultures were not large enough to support the once polarizing view of the individualism-collectivism paradigm. Here, European Americans were reported as no more individualistic than African Americans or Latinos, who were no less collectivist than Japanese or Koreans (Oyserman, Coon, & Kemmelmeier, 2002). However, Oyserman and colleagues identified that the vast majority of cross-cultural studies reported in the meta-analysis were not representative of the general population since research participants were recruited from student populations who tend to hold more individualistic values, higher levels of education and socioeconomic background, irrespective of culture. To my knowledge, such findings have not been explored in the UK population.

Table 2.3 *Consequences for Cognition, Emotion and Motivation Based on Self-Construal Theory*

Consequences	**Independent**	**Interdependent**
Cognition	Knowledge about self is more distinctive than knowledge about others	Representation of self and other embedded in specific social context
	Personal psychological traits or attributes more prominent than interpersonal relationships	Consideration and reaction to others shaped by non-social cognitive activities (e.g., categorization)
		More attentive and sensitive to others
Emotion	*Ego-focused* emotions (related to *'I'*)	*Other-focused* emotions (related to *'Us'*)
	Regulation of emotions guided by internal attributes (e.g., anger, sadness)	Regulation of emotions guided by others (e.g., shame, guilt)
	Need to maintain and affirm sense of autonomy	Consideration of others emotions take precedence
Motivation	Effort to express one's own needs	Consider needs of others
	Desire to demonstrate uniqueness important for self-esteem	Ability to fit in deemed important for self-esteem
	Ability to express and validate internal traits (e.g., ambitious, intelligent) and use others as a source of social comparison	Changing behaviour to correspond to the needs and harmony of the group important

Note. Adapted from Markus & Kitayama (1991, pp. 231 - 345)

Similarly, critics argue that notions of the independent-interdependent self may co-exist rather than being viewed as far polar dimensions (Cross and Markus, 1991; Kolstad & Horpestad, 2009; Tse & Ng, 2014). Studies examining cultural identity in the African American populations reported that despite Africans being inherently viewed as collectivist, those living in the West may hold bi-cultural identities, termed *'double consciousness'*, which enables them to interchange between individualistic–collectivist patterns depending on their cultural context (Allen & Bagozzi, 2001; Gushue & Constantine, 2003; Phinney & Devich-Navarro, 1997). In other words, even though African American participants value uniqueness, synonymous to individualistic cultures, they still preserve collectivist values shared by those similar to themselves. These cultural values remain embedded within an individual's identity regardless of the place of birth or upbringing (Zagefka, 2009). The consequences of adapting to the host culture can increase marginalisation from one's own culture by giving up on some aspects of their own identity. On the other hand, staying loyal to one's culture of origin can increase cultural incongruity and cause alienation from the host culture (Bhugra, 2005; Maas, Van Assen, van Balkom, Rutten & Bekker, 2019). Thus, the cultural clash for those living in Western societies can have implicit impact on their mental wellbeing (Bhullar, Schutte & Malouff, 2012; Hong & Woody, 2007; Marsella & White, 1982) and lead to greater levels of social anxiety, depression, and self-criticism than European counterparts (Hong & Woody, 2007; Hovey et al., 2006).

2.2.3 Culture and mental health

Mental health research exploring cross-cultural differences have used concepts of individualism-collectivism and self-construal to understand cultural norms and behaviours to identify how cultural identity impacts the lives of those from non-Western societies (Caldwell-Harris & Aycicegi, 2006; Hui & Triandis, 1986; Tse & Ng, 2014). This challenges traditional psychological theories to reconsider human behaviour and notions of individuality, community, and society for ethnically diverse communities (Cooper, 2009; Markus & Kitayama, 1991; McCarthy, 2005; Oh, 2014). Historically, psychology and psychiatry have been developed on a Western medical model, where monocultural application of psychotherapy fails to recognise the importance of cultural meaning and understanding of mental illness, thus, limiting its applicability to diverse communities (Hall, 2001; Ryan & Pritchard, 2004). It is now more widely accepted that concepts of mental illness are complex as societies become multicultural (Ryan & Pritchard, 2004). Culture plays an important role in the presentation of illness, which can impact the diagnosis, treatment and mental health outcomes for patients from ethnically minoritised communities (Bhugra, 2005; Christopher, 2001; Leighton, 2003; Morrall, 1998). Leighton (2003) argues that the individualistic view of mental healthcare...

> *"...has been a disastrously 'narrow' view of individual's needs, which condemns almost every service user to a particular cultural model of behaviour, and then fails to understand the alienation produced. It is a cultural straitjacket no less humiliating than its physical counterpart."* (*p*. 487).

According to Castillo (1997), culture can affect mental wellbeing in at least five ways - that is, an individual's subjective experience; their idioms of distress; how diagnosis is sought; acceptability of treatment; and evaluation of treatment outcomes. Culture-based *subjective experiences* and knowledge about a disorder can differ from Western understanding of mental health (Castillo, 1997). Mental health stigma tends to be rife in ethnic minority communities due to shame associated with mental illness (Bristow, et al, 2011; Buffin, Ahmed, & Singh, 2009; Clement et al., 2015). As a result, family members with mental health problems are more likely to be hidden from the community (Papadopoulos et al., 2013) which can inevitably slow the recovery process and lead to feelings of entrapment (Tse & Ng, 2014). Often, a ‘circle of fear’ prevents and delays individuals accessing mental health services, thus when services are sought, mental health conditions may have become more critical (Sainsbury Centre for Mental Health, 2007). Moreover, mental health disorders synonymous to the Western world are often unrecognised in non-Western societies. In some cultures there are no words for depression or anxiety related disorders therefore mental health conditions can go unnoticed for prolonged periods (Aggarwal et al., 2016; Kirmayer, 2001; Mallinson & Popay, 2007; Mohamed & Lowenthal, 2009).

Instead, symptoms are explained based on cultural *idioms of distress* (Castillo, 1997). People from ethnic minority groups often have distressing stories to tell, which include incidents from the past that shape their current experiences (Costa & Briggs, 2014; Bristow et al., 2011). Due to language barriers and lack of knowledge about mental health disorders, some individuals are unable to express their feelings openly which can result in a loss of translation and misdiagnosis (Buffin et al., 2009). It is common for terms such as *‘thinking too much’*, *‘tension’* (Karasz, 2005; Mallinson & Popay, 2007) and *‘my heart fell down’* being used to describe idioms of distress (Al-Krenawi & Graham, 2000). Other common somatic symptoms such as heavy headedness, numbness and emptiness are used (Kirmayer, 2001; Mallinson & Popay, 2007; Mohamed & Lowenthal, 2009). Individuals from BAME communities often reject the biomedical model to explain mental health problems and instead adopt a mixture of naturalistic model of disease with supernatural or spiritual models (Bristow et al., 2011; Ryan & Pritchard, 2004). Religious and spiritual concepts relating to divine punishment, sorcery, spirits and the devil tend to be prominent in some cultures, therefore help-seeking attitudes and understanding of mental illness differ from Western perspectives. For many, low mood, bad fortune and mental distress can be seen as inflictions from God, moral failings, or part of innate life’s trials and tribulations (Al-Krenwai & Graham, 2000; Mantovani et al., 2017). Thus, Western therapists may not always understand idioms of distress or behaviours that are perceived as cultural norms, and instead mistake cultural beliefs as signs of mental illness (e.g., belief in possession and witchcraft as schizophrenia) (Dein, 1997). In ethnic minority communities, idioms of distress tend to remain constant which can consequently influence mental help-seeking attitudes and expressions of symptomology (Bhugra, 2005; Zagefka, 2009).

Given the subjective experiences, knowledge about mental health and idioms of distress, evaluations of whether *diagnosis* is sought via professional or non-professional (e.g., spiritual healer) personnel are made (Castillo, 1997). Often, high degrees of mistrust and suspicion in professional services results in individuals from collectivist cultures turning to family, religious or spiritual leaders for mental health support rather than seeking help from mental health services (Brown et al., 2010; Cook & Powell, 2013; McCarthy, 2005; McCrone, 2013). Given high surveillance in ethnic minority communities, individuals are less likely to seek professional help in fear of breach of confidentiality and lack of cultural understanding by European clinicians (Gilbert, Gilbert & Sanghera, 2004; Gilbert et al, 2007). For some individuals, religious and spiritual coping mechanism such as praying, reciting scriptures, and beliefs in supernatural causes are used to explain deviant behaviours and undesirable life events (Abouhendy & Jawad, 2013; Bhui et al., 2008; Lakeman, 2013; Loewenthal et al., 2012; Singh et al., 2015).

In instances where professional services are sought, *treatments* tend to be judged according to an individual's cultural needs (Castillo, 1997). With psychotherapy being a product of the West, some individuals from non-Western communities may not know what it is, how it can help, or what to expect from therapy (Sue, 2006). Given the desire for expressive individualism, the process of expressing inner thoughts and feeling are viewed as an essential objective of Western psychotherapy (Christopher, 2001). However, channelling such characteristics tends to be inconsiderate to those from non-Western societies who value outer world relationships and the stability, balance, and group harmony that this brings to their lives (Fernando, 2012). Western psychological models of mental healthcare tend to be developed for White, middle-class, educated individuals who adopt an individualistic value system, thus, understanding of therapeutic challenges for non-Western cultures are limited (Keith, 2019; Leighton, 2003; Leong & Lee, 2006). By adopting the values, beliefs and principles of the dominant individualistic culture, person-centered care is deemed important for recovery (Laungani, 2007). The recovery model emphasises that patients are largely responsible for their own recovery process, by empowering them to take control of the decisions in their life (Frese III et al., 2001). Here, gold standard therapies such as Cognitive Behavioural Therapy (CBT) focuses on the *self* and the ‘here and now’ by considering the relationship between negative thoughts, feelings and behaviours (Fenn & Byrne, 2013; Williams, 2015). Such therapies tend to prescribe what the self is, or ought to be, by insisting on self-sufficiency, independence, and autonomy at the expense of risking eternalising factors such as cultural value systems (Al-Krenawi & Graham, 2000; Christopher, 2001; Fernando, 2012). Patients are taught to be their *own* therapist in order to deal with their *own* problems (Fenn & Byrne, 2013; Rogers, 2009). However, the interconnectedness and ‘we consciousness’ of ethnic minority communities which tend to rely on family can present challenges during therapy. Often this is due to Eurocentric practitioners not understanding cultural boundaries which leads to greater levels of dissatisfaction with mental health services and poorer treatment outcomes (Benish, Quintana, & Wampold, 2011). Therapeutic success is culturally assessed, whereby treatment *outcomes* determine future uptake and recommendation of therapy (Castillo, 1997). With religion and spirituality playing an integral role of the lives of many, the desire for certainty and miracles can lead to a premise of viewing therapies as a ‘cure’ to alleviate mental distress (Lakeman, 2013). When this does not happen, therapeutic uptake and engagement is jeopardised (Ibrahim & Heuer, 2016). Even though mental health services aim to cater for ethnic minority groups by providing culturally sensitive material, conflicts between Western practices and interventions result in individuals feeling misunderstood or even mistreated by mental health service providers (Bristow et al., 2011; Mclean et al., 2003; Mofrad & Webster, 2012).

2.3 Introduction to evidence-based practice

2.3.1 Emergence of evidence-based practice (EBP)

The economic burden of mental distress on society led to evidence-based practice (EBP) becoming an integral part of UK mental health provisions. EBP of psychotherapy is viewed as a collaborative decision making process which includes the best evidence-research, practitioner expertise, and patient preferences (American Psychological Association, 2006; Mullen, 2014; Schreiber, 2013). Akin to medicine, disciplines such as psychology and psychiatry began to recognise the importance of EBP and the use of scientific evidence to gauge the efficacy of treatment programmes (Leong & Lee, 2006; Schreiber, 2013). Despite domination of drug treatments in mental healthcare, developments of evidence-based interventions homogenised and improved quality of care, broadened the choice of therapies available to patients, improved recovery outcomes in the general population, and saw a reduction in healthcare costs (Melnyk et al., 2010; Turner et al., 2015; Spring et al., 2019). In the UK, the National Institute for Health and Care Excellence (NICE) make clinical recommendations and assess the cost-effectiveness of evidence-based psychological interventions by gathering data from systematic reviews (Pilling et al., 2011). NICE was formed in the late nineties to help minimise disparities within health care and to maximise the availability of good quality psychological interventions for mental health concerns (NICE, 2018). Using high quality evidence-based research, often from randomised-controlled trials (RCTs), NICE assembled a range of guidelines making recommendations for a range of disorders, including CMHDs. The stepped-care model was developed with least intrusive treatments (low-intensity interventions) being offered as a first step, which if unsuccessful, are followed-up by adjusted treatment (e.g., high-intensity interventions) after close monitoring of outcome measures (*see* Appendix A.1.1). The economic rationalism of the stepped-care model was imperative since it was no longer viable to offer extended number of therapeutic sessions without any measurable outcomes of their success (Pilgrim, 2017). As such, the stepped-care approach was integrated into UK mental health services to optimise level of care and to offer efficient and cost-effective ways to manage resource limited services (Ekers & Webster, 2013; Glover et al., 2010; Gyani, Pumphrey, Parker, Shafran & Rose, 2011).

Low-intensity interventions such as guided self-help, non-guided self-help, and psychoeducation are recommended for mild to moderate conditions (Step 2) and are the least resource intensive as they are quicker to administer, require the least therapist support, and most cost-effective (NICE: CG113, 2011; NICE: CG123, 2011). The primary purpose of low-intensity therapies is to enhance access to psychological interventions to enable patients with more severe conditions to be seen by experienced trained therapists. By using trained low-intensity therapists (e.g., Psychological Wellbeing Practitioners), services such as Improving Access to Psychological Therapies (IAPT) are able to offer a ‘rapid’ response to patients by reducing wait-times and offering cost-effective self-help materials with therapist support where needed (Bower & Gilbody, 2005; Bennet-Levy et al., 2010). Although low-intensity treatments have shown promise, patients who do not respond to such therapies, or who are diagnosed with moderate to severe symptoms from the outset, are ‘stepped-up’ (Step 3) and offered high-intensity therapies such as CBT or counselling (NICE: CG123, 2011). Despite its benefits, critics argue that the hierarchical nature of the stepped-care model may prolong the recovery period if ‘weaker’ therapy options are ineffective (Turpin et al., 2008) and may mislead patients and therapists to perceive certain therapies as more superior than others (Williams & Martinez, 2008). Moreover, given limited research, it is unclear whether the stepped-care model is suitable and accepted by those who deliver or receive therapy (Bower & Gilbody, 2005; Richards et al., 2012).

2.3.2 Fidelity of evidence-based psychological interventions

It is argued that the over-reliance on evidence from controlled clinical trials mislead patients to think evidence-based therapies are the most clinically effective, when in fact they seldom include participants from diverse populations (Adams, 2008). In the hierarchy of research, evidence from RCTs and systematic reviews are regarded as top-level research whilst personal experience is placed at the bottom of the pyramid (Pilgrim, 2017). This is problematic for services catering to diverse communities when reliance on clinical trials outrank the lived experiences of patients (Pilgrim, 2017). Typically, outcomes of a treatment programme are assessed according to their *efficiency*, *efficacy*, or *effectiveness* (Gordis, 2014). *Efficiency* studies tend to focus on the cost-effectiveness of the intervention being offered and its benefits to patients, healthcare service and wider social and political providers (Gordis, 2014). *Efficacy* studies traditionally offer objective assessment and evaluation of how well an intervention programme has achieved its goals (McEvoy & Richards, 2003). This tends to be examined in controlled conditions to determine how well the phenomenon under investigation compares to other conditions (e.g., treatment as usual or control group) (Gordis, 2014). In contrast, research that seeks to explore the *effectiveness* of an intervention programme tend to explore the impact of interventions programs when applied to ‘real-world’ clinical settings (Gordis, 2014). The efficacy versus effectiveness debate is based on the belief that research carried out in RCTs place importance on internal validity, that is, to ensure that factors such as sampling, random assignment, and external influences are minimised (Miranda et al., 2005; Mullen, 2014). Contrastingly, studies that focus on therapeutic effectiveness seek to maximise external validity so that outcomes can be generalised to real-world clinical populations (Mullen, 2014). Patient values and judgement of treatment options can affect the success and engagement with therapy, thus producing heterogeneous outcomes when compared to efficacy trials (Frese III et al., 2001). Pawson and Tilley (2004) argue that “*interventions never work indefinitely, in the same way and in all circumstances, or for all people*” (*p*. 3). Thus, findings from controlled trials are likely to overestimate treatment effects with little consideration of diverse populations (Ormel, Kessler, & Schoevers, 2019). Given the limitations of the populations recruited in efficacy trials, it is unclear how beneficial or acceptable Western psychotherapy is for diverse communities (Hall, 2001; Keith, 2011; Sue, 2009). Critics argue that the legitimacy of EBP movement may be compromised for services who only consider the treatment outcomes and recommendations based on experimental designs and controlled conditions (Mullen, 2014).

2.3.3 Implementation of Improving Access to Psychological Therapies (IAPT) services

Given the escalation of non-psychiatric disorders in modern Britain, seminal work from social economist Layard (2005) to government representatives titled *‘Mental Health: Britain’s Biggest Social Problem’* expressed concern about the impact CMHDs were having on the economy, workforce, society, and wellbeing of individuals and their families. It was predicted that the impact of CMHDs costs English healthcare expenditure £70 – 100 billion pounds a year due to loss of productivity alone (McManus et al., 2009). Due to over-reliance of prescribed medication and limited availability of evidence-based psychological therapies, Layard argued that the direct benefit of increasing access to psychological therapies would improve mental health recovery, whilst reducing the financial impact sick days and poor productivity had on the economy (Ekers & Webster, 2013; Holland, 2009). In subsequent years, Layard's *'The Depression Report'* (Layard & The CEP Mental Health Policy Group, 2006) and reports such as *'We need to Talk' (*Mind, 2010) urged government representatives to increase access to psychological therapies to curb the repercussions on public healthcare costs and to help more people return to work. As such, on World Mental Health Day in 2007, the English government announced the launch of Improving Access to Psychological Therapies (IAPT) services to raise standards of mental healthcare and to broaden access to evidence-based psychological treatments (Clark, 2011; CSIP Choice and Access Team, 2007). IAPT services adopted an 'intermediate' position between primary and secondary mental health services and was primarily set-up to tackle CMHDs classified as 'mild to moderate' by mental health professionals (Holland, 2009). Following initial success, the government announced a further £400 million pounds investment to increase access to psychological therapies (IAPT, 2011). By 2012, the IAPT programme was available in 151 of its Primary Care Trusts (PCTs) (Sreeharan, Madden, Lee, Millett, & Majeed, 2013) and reported as the largest sustained investment in mental health services since the NHS (BPS, 2012). Since its initial launch, multi-millions of pounds have been invested into the IAPT program to help combat CMHDs in England, with over 7,000 newly trained psychological therapists (NHS England, 2015). Latest figures show that over 900,000 people access the service every year, of which around 550,000 people receive some form of evidence-based psychological therapy (Clark, 2018a). With further investment of £1.3 billion, the English government announced that as part of *'The Five Year Forward View for Mental Health'* plan a further 1.5 million people could be seen by the end of 2021 (NHS England, 2016a).

2.3.4 IAPT services critiqued

Despite its benefits, the IAPT programme has received copious criticism about its effectiveness and plans to combat CMHDs in England. Critics have named IAPT services a '*silver bullet*' to the mental health crisis, without real consideration of its acceptability for mental health professionals and patients who access the service (Cotton, 2018). Marks (2018) argues that a *'new service that delivers happiness on an industrial scale and costs nothing is not easily refused'*, however, there is an *'urgent need for an independent review of IAPT by impartial experts'* (*p.* 1131 - 4). Whilst there is general consensus in the world of IAPT that recovery targets are being achieved, others have contended that IAPT over-estimates its recovery outcomes and effectiveness for those it serves (Marks, 2018; Scott; 2018a/b). The economic rationale that the cost of evidence-based psychological therapies would pay for themselves is based on the notion that 50% of patients accessing IAPT services are able to recover from their disorder and inevitably return to work (Marks, 2018). Earlier independent studies, such as that by Griffiths and Steen (2013b) found that only 22% of patients moved to recovery. These findings were supported by the Centre for Social Justice (Callan & Fry, 2012) who reported that 86% of patients referred to IAPT were not being helped, despite IAPT claims of over 40% recovery rates. These findings were further echoed by Scott (2018a) who reported that only 24% of patients recovered from their disorder, falling to 9.2% when assessing across all disorders. Based on these findings, Scott (2018a) suggested that reasons for such divergent results may be due to inaccuracies in outcome measures used by IAPT which do not fully account for the variability amongst disorders. Waltman (2018) supported these concerns and argues that IAPT's national recovery rates are misleading the public to think 50% of patients recover from their disorder, when in reality, this is only based on those who enter treatment. Recovery outcomes for those who do not attend sessions or who drop-out of therapy are seldom reported in national figures. Moreover, patient characteristics are rarely considered, thus, making it difficult to ascertain the effectiveness of therapy for diverse populations.

In a recent editorial, Loewenthal (2018) questioned whether IAPT was promoting individualism at the expense of the common good. In this critique article, Loewenthal considered IAPT as;

> *"…not as well-intentioned, though sometimes misguided, attempt to improve the mental health of a nation but an ideological attempt at social control which is more part of the problem than the solution.''* (*p*. 249).

Loewenthal (2018) expressed concerns that therapies such as CBT promote individualistic values that place responsibility on patients to manage their own wellbeing. As a result, the individual or collective struggles that people encounter are often ignored. It is argued that ill-informed, media-led marketing often directs patient choice (Rogers, 2009) with the domination of CBT as the primary treatment option for many CMHDs (Williams, 2015). Attributing individualised pathology as the source of social problems lends itself to self-reliance rather than reliance on state expenditure (i.e., benefits) (Leighton, 2003). Thus, the nature of therapy is often seen as an individual problem which can inflict blame on those who are hopeless and powerless in challenging times (Knight & Thomas, 2019). Timimi (2018) echoes concerns that IAPT promotes notions of individualism whereby distress is seen as a personal problem, thus deflecting from social inequalities and disempowerment of populations it serves. Timimi argues that focus on NICE compliance may in fact be the problem, rather than the solution. The nature of RCTs, which NICE relies upon, often fails to consider long-term benefits of therapy, attrition, remission, or those who refuse therapy. Moreover, reliance on the NICE guidelines assumes that evidence-based therapies are most effective in improving outcomes, when in reality, this is not always the case. Instead, the use of flexible treatment options should be implemented which incorporate service user feedback and the needs of diverse populations. Given such concerns, critics such as Scott (2018a) worry that the IAPT programme has become an '*article of faith*' whereby on face validity it shows promise, yet evidence of therapeutic effectiveness and remission following the course of treatment remain unclear. Scott questions IAPTs effectiveness since outcomes tend to be self-produced and the post-treatment scores may not be indicative of *actual* recovery. Stressing the '*need for robust evaluation*' and *'radical reform',* Scott encourages more independent assessment of the IAPT program since it's been '*allowed to mark its own homework using psychometric test*' which merely achieves the *'tip of the iceberg'* in recovery outcomes (Scott, 2018a; Scott, 2019, *p*. 893).

2.4 Cultural needs and evidence-based psychological interventions

2.4.1 Inclusion of ethnic minority populations in evidence-based research

Despite policies such as Delivering Race Equality in Mental Health (DRE) (Wilson, 2009) being set up to reduce inequalities, discrimination and disadvantage in UK mental healthcare, the suitability of evidence-based psychological therapies have been vague, sparse, and conducted with poor methodological rigour (Chambless et al., 1996; Sue, 1998). Throughout the NICE guidelines, it is recognised that there may be challenges in delivering psychological interventions to disadvantaged groups, including BAME communities (NICE: CG123, 2011). Recommendations are made to offer culturally appropriate treatments and care, which promote access for marginalised groups, provide information in a range of languages, and consider culturally competent care to the needs of diverse groups. However, variations in assessment and delivery of interventions are not favoured due to the lack of convincing evidence to support these adaptations (NICE: CG123, 2011). Even though previous studies have considered the role of cultural-adaptations and culturally-sensitive therapies, the evidence-base for such studies are sparse and are seldom offered as part of mainstream clinical practice (Hall, 2001; Sue, 1998). As discussed in Chapter 1, systematic investigation of the effectiveness of evidence-based psychological therapies for BAME communities in England are profoundly limited. This is problematic. Despite increased demands for clinical research to include ethnic minority populations, there is still inadequate empirically supported evidence to determine therapeutic efficacy *and* effectiveness for these populations (Hall, 2001). Those from ethnic minority communities, in most parts, have been excluded from initiatives that validate empirically supported treatments (Hwang et al., 2008). This is largely due to poor recruitment of ethnic minority groups in RCTs, which means that it is less clear whether therapies are accepted, suitable or effective for such groups (Woodall et al., 2010). In instances where minority groups have been recruited, caution is advised since those who participate in research tend to be students, or are more likely to hold similar characteristics to the middle-class, European-American participants that psychotherapy has been developed upon (Hall, 2001). That is, they may be more acculturated, fluent in English, educated, and westernised. As such, it is unclear how successful therapies are to those who do not hold these characteristics or are from ‘real-world’ clinical populations.

2.4.2 Therapeutic effectiveness of evidence-based psychological interventions for ethnic minority populations accessing IAPT services

Given that evidence-based treatments adopted by IAPT services are fundamentally based on efficacy research, the implications of this in real-world clinical settings warrants investigation. IAPT uses the recovery model to assess baseline outcome measures for service success (Pilgrim, 2017). Here, patients are expected to complete a course of treatment (at least two treatment sessions) and show a reduction in the severity of their disorder below the clinical threshold for each respective depression and anxiety outcome measure (NHS Digital, 2019). It is expected that patients who successfully complete a course of treatment are able to gain control over their lives, in which hope, achievement and social connectedness are some of the direct benefits (Frese III et al., 2001; Ryan & Pritchard, 2004). Earlier studies assessing the effectiveness of the IAPT programme in the general clinical population have found recovery outcomes ranging from 40.3% to 55.4% (Delgadillo et al., 2012; Gyani et al., 2013; Richards & Borglin, 2011). Later, IAPT reports saw recovery outcomes rise from 46.3% (NHS Digital, 2016b) to 52.1% (NHS Digital, 2019). However, ethnic group differences were absent. In instances where ethnic group differences have been reported, findings revealed that those from White British group showed comparatively greater recovery rates (47.8%) when compared to BAME patients (39.9%) (NHS Digital, 2016b). Asians, on average, had the poorest recovery outcomes (37.5%), followed by those from the Black (40.5%), Mixed (40.5%) and Other (41%) ethnic groups. More recently, Baker (2018) and Moller and colleagues (2018) echoed these findings which reaffirmed the White British group as more likely to achieve recovery (50 – 51.2%) in comparison to BAME patients (42 – 45%). Given these disparities, studies have sought to establish what factors are salient in predicting recovery outcomes. This can be useful in understanding both negative and positive outcomes of psychotherapy, as well as allowing clinicians to consider how treatment programmes can be personalised to patients from diverse communities (Amati et al., 2017; Caterinio et al., 2018).

Real-world clinical application of psychotherapy produces heterogeneous outcomes to clinical trials, and this has been no different in studies examining predictive factors for therapeutic success. In a systematic review by Amati and colleagues (2017), researchers reported varying findings when examining predictors for patients receiving psychological therapies for CMHDs.

Initial severity and comorbidity of depression was the most significant predictor for negatively impacting outcomes across a range of studies, whilst other socio-demographic factors such as ethnicity, gender, and age produced inconsistent results. Studies assessing the predictive value of variables for IAPT services have also found differing outcomes. An earlier study by Gyani et al., (2012) reported that the number of therapy sessions and clinician expertise were associated with higher recovery rates, whilst initial disorder severity had negative impact on recovery outcomes. Although a battery of variables were used in the model, this did not include patient characteristics such as ethnicity, age, and gender. Thus, the predictive value of these factors is unclear. In a later study, Green et al., (2015) identified initial disorder severity, ethnicity, gender, and indices of deprivation as pre-treatment predictors of recovery. However, the variability between such characteristics was less clear. Other studies using IAPT samples identified older age, lower symptom severity, long-term conditions (Caterino et al., 2018), and lower scores of functional impairment (Haug et al., 2015) as positive predictors to treatment outcomes. However, most of the studies failed to consider ethnicity. Given the disparities in therapeutic outcomes for BAME communities, it is unclear whether being from a certain ethnicity is a precursor to therapeutic success (Green et al., 2015).

Furthermore, recovery outcomes based on therapeutic modality have highlighted disparities in therapeutic effectiveness, however, ethnic group differences are seldom assessed or reported. In the general clinical population, Gyani and colleagues (2011) reported that, for depression, patients receiving guided self-help (38.4%) were more likely to reliably recover than those receiving non-guided self-help (27.6%). These findings are reflective of NICE (CG90: 2009) recommendations for guided self-help as the preferred low-intensity treatment option for depression. For anxiety related disorders, little difference was observed between guided (54.2%) and non-guided self-help (52.3%). Here, authors reported that initial disorder severity did not influence these findings, however, significantly more patients allocated to non-guided self-help failed to turn up for further sessions. Reasons as to why this trend was observed were not reported, however previous research indicates patient preference for guided therapeutic support over non-guided treatment modalities. For high-intensity therapies, Gyani and colleagues (2011) found CBT (40%) to be similarly effective to counselling (38.3%) for depressed patients. These findings have been echoed in other studies who have reported no significant differences between CBT and counselling in the IAPT clinical populations (Delgadillo & Gonzalez Salas Duhne, 2020; Moller et al., 2019; Pybis et al., 2017). In contrast, CBT (54.2%) was more effective than counselling (39.7%) for patients diagnosed with anxiety. Again, these findings are reflective of NICE recommendations for CBT as the preferred treatment option for anxiety (NICE: CG159, 2013). Thus, deviation from NICE guidance is not recommended as this can have implications for therapeutic success (Gyani et al., 2011). However, given the inconsistencies of recovery outcomes reaching beyond 50%, concerns are raised about the therapeutic effectiveness of treatments for patients who do not recover (Pybis et al., 2017).

2.4.3 Service user experiences of receiving evidence-based psychological interventions

Given data limitations of routinely collected data within IAPT services, individual characteristics relating to cultural identity factors such as religiosity (Chen et al., 2007), race (Aubuchon-Endsley et al., 2014) and socio-cultural factors are seldom examined in empirical research. Such factors can present disproportionately in people from ethnic minority groups, thus, conflicting with universal aspects of mental health care, treatment and outcomes (Good & Hannah, 2015). When clients enter therapy, they do not only bring their presenting concerns, but also their cultural identities which in turn interact with that of the therapist (Crawford, 2012). Sometimes, clients from ethnic minority communities are reluctant to speak to White therapist in fear that "*they just don't get it*" (Jones, 1997). A qualitative meta-analysis exploring service user experiences from 'hard-to-reach' communities in the UK reported that expression of mental illness, differing world-views, barriers to accessing mental health services, and psychological interventions not accounting for patient cultural needs disrupted therapeutic uptake and engagement (Lamb et al., 2012). Studies exploring BAME service user experiences of mental health services have reported a number of barriers to accessing mental health services and therapeutic engagement. For example, focus groups with service users from BAME communities found that the relationship between service users and service providers was one of the main barriers to therapeutic engagement (Memon et al., 2016). Service users felt that practitioners did not listen to them, provided second-class treatment due to their ethnic status, and lacked understanding of their cultural needs. In addition, language difficulties, stigma associated with mental health, and feelings of isolation due to not being able to speak to family and friends about mental health concerns further perpetuated mental health concerns. Given the heightened stigma and shame associated with mental health, research shows that mental health services inadequately cater for 'men of colour' who often find psychotherapy 'feminising' and unsuitable to their needs (Memon et al., 2016; Mohammed & Loewenthal, 2009). Growing scepticism about psychotherapy lacking credibility in alleviating distress increases reluctance in accessing mental health services and perpetuates resistance to therapy (Sue, 2006).

Over a decade since the first IAPT BAME Positive Practice Guide was published, it appears that many of the issues remain the same. This includes poorer access to IAPT services by BAME communities, language barriers, cultural and social differences, community isolation, and lack of understanding of psychological therapies (IAPT, 2009). IAPT recognises that service users from BAME groups may be more disadvantaged than the majority White population and face a number of additional barriers which incorporate their ethnicity, culture and religion (IAPT, 2009). In the renewed IAPT BAME Positive Practice Guide, it is made clear from the outset that whilst IAPT has helped improve access to psychological therapies, more needs to be done to improve outcomes for BAME communities (Beck, Naz, Brooks, & Jankowska, 2019; Brooks, 2019). A recent study by Harwood and colleagues (2021) reported that individuals from BAME community were less likely to self-refer to IAPT than the White British population. Possible reasons for this were attributed to cultural dissonance between ethnic minority service users and understanding of Western mental health services and treatment options. Moreover, findings revealed that BAME service users were less likely to receive psychological treatment and had greater drop-out rates when compared to the White British group. Beck and Naz (2019) highlighted a number of fundamental issues that hinder therapeutic success in BAME communities accessing IAPT services. This includes unmet needs due to services not being able to facilitate or recognise distress across cultures; service users failing to attend appointments in fear of therapeutic expectations; disengagement from services due to clinicians not being adequately equipped to deal with culturally specific needs; and poorer therapeutic outcomes due to inadequately adapted cultural requirements. Whilst IAPT services aim to provide culturally sensitive therapies that incorporate issues around ethnicity and culture, rarely do these types of adaptations consider culturally specific factors such as patient idioms of distress and values (Beck, 2016).

Qualitative studies exploring IAPT service user experiences have been few and far but have highlighted some critical concerns. For example, Omylinska-Thurston and colleagues (2019) reported that patients accessing IAPT services found CBT unhelpful to their needs. This included difficulties with grasping CBT concepts, negative perceptions of therapists, patient unhelpful internal patterns, and unhelpful IAPT processes. All participants (*N* = 9) stated that the consequences of unhelpful CBT meant that their core underlying issues and feelings were not addressed by therapy. Instead, patients reported feeling worse and aggravated at post-treatment and did not find CBT effective in helping them recover from their disorder. However, the population sample was majority White British, thus the need for exploration in ethnic minority populations was recommended given high attrition rates. In another study, Christodoulou, Fortune, Arslan, and Koc (2019) explored the experiences of 34 Turkish-speaking service users who had received guided self-help from a London based IAPT service. Findings revealed six broad themes, which included service users' experiences of distress, ambivalent help-seeking, limited self-efficacy, and problems with continuity. Researchers found that guided self-help did not appear to meet the clients' needs due to confusion and anxiety surrounding the service and therapeutic expectations. Often the sessions were too short for clients to make real progress which impacted on client recovery process. Although this study was limited to the Turkish-speaking population, exploration to other cultural groups was recommended. Given such concerns, a recent review titled *'Frontline, yet back of the queue'* stressed on the importance of tackling inequalities within IAPT services by enhancing service provisions for minority communities, increased funding, culturally sensitive training, and inclusion of workforce that represent and reflect the ethnic minority population being served (Lawton, McRae, & Gordon, 2021).

2.5 Therapists cultural competency

Cultural competency has received considerable attention in mental healthcare, particularly in relation to its usefulness when working with people from ethnic minority backgrounds (Sue, 2006). Terms such as *'cultural sensitivity'*, *'cultural responsiveness'*, and '*multicultural competence'* have been assigned to open up discussions about cultural competency (Sue, 2009). Whilst there is no agreed consensus of the definition of cultural competence, the most cited definition describes the term as "*A set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations*" (Cross et al., 1989, *p.* 7). Others have described cultural competency as *"the ability to establish interpersonal relationships with persons from different cultures by developing understanding through effective exchange of both verbal and nonverbal levels of behaviour"* (Chan, 1992, *p.* 183 in Leong & Lee, 2006). Given the lack of clear definition of cultural competency, this can lead to confusion, and even resistance by mental health professionals to adopt culturally competent care in clinical practice (Engebretson, Hougaard, & Rosenberg, 2008). Cultural competency is not only the belief that practitioners should be able to appreciate and recognize other cultural groups, but to also work with them effectively (Sue, 1998). Culturally competent care acknowledges and integrates culture when making considerations about assessment, treatment, and outcomes (Castillo & Guo, 2011; Good & Hannah, 2015). Often, Eurocentric practitioners lack understanding of cultural diversity and expression of mental health in diverse communities which can have detrimental effects on the individual and the therapeutic effectiveness (Turpin et al., 2008). The power imbalance between the therapist and patient can be unsettling, with concepts of psychotherapy seen as irrelevant to patient's own coping mechanism or understanding of mental illness (Aggarwal et al., 2016). Thus, mental health practitioners and services are encouraged to consider patient lived experiences, culturally sensitive issues and complexities in order to offer person-centred care that maximises recovery goals (Dausch et al., 2012; Good & Hannah, 2015; Tse & Ng, 2014).

There are a number of ways in which therapists can become more culturally competent. This begins with establishing basic knowledge about clients' culture, which may include their values, norms, and practices (La Roche & Maxie, 2003; Wan & Chew, 2013). It is important to note that acquiring complete knowledge about every culture is impossible, however, therapists should develop appropriate skills to recognise which aspects of the client's culture are important to know (Sue, 2006). A key component of developing cultural competency skills is knowing when to generalise and when to individualise care (Sue, 1998). By reflecting on encounters with patients from different cultural backgrounds, therapists should consider what works well, and what could be done to improve future treatment sessions (La Roche & Maxie, 2003; Sue, 2006). Moreover, by reflecting on their own 'isms', therapists should consider how their own biases interact and intercede with patients which may include ways to lighten feelings of White guilt (Crawford, 2012). Therapists who are culturally competent are attuned to cultural cues that present in their clinical encounters with clients from diverse communities. This includes the way in which patients discuss their beliefs about illness, treatment expectations, and how family structures influence mental wellbeing (Engebretson et al., 2008). Given high mistrust in ethnic minority communities, cultural curiosity should be proceeded with care, gradually, to avoid feelings of interrogation and suspicion (La Roche & Maxie, 2003). Mental health professionals now work in an increasingly multicultural society which necessitates urgent need for cultural competency training so that therapists are able to provide culturally informed and empirically supported therapy to patients who present differing cultural issues and needs to the majority group (Good & Hannah, 2015; Keith, 2011; Leong & Lee, 2006; Sue, 1998; Yan, 2018).

2.5.1 Cultural competency training

Cultural competency training can help improve the quality of care for people of diverse communities (Bhui et al., 2007) and therapeutic outcomes can be enhanced when therapist are equipped to incorporate culturally specific needs of the client (Keith, 2011). In recognition of the importance of culturally competent practice, many UK professional bodies such as British

Association for Behavioural and Cognitive Psychotherapies (BABCP, 2010) and The Royal College of Psychiatry (2015) have incorporated cultural competence units as part of training programmes (Ibrahim & Heuer, 2016). However, there is limited evidence of their success (Bhui et al., 2007; Clegg et al., 2016). Even though inclusion of cultural competency training has been encouraged, evidence-based practices are rooted in universal rhetoric which seldom considers cultural particularism (Good & Hannah, 2015). Typically, training programmes and manuals of psychotherapy are developed to the needs of the dominant Western cultural group (Sue, 2009), therefore the needs of clients from diverse communities tend to be absent from traditional theory, processes, and manuals (Kirmayer, 2012). Mental health practitioners in Western society seldom receive adequate training that equips them to work with diversity (Edge & Lemetyine, 2019). Often training programmes and psychological theories dealing with cultural competency fail to consider the role of the therapist, and how their own identity interacts with that of the client, which includes stereotypes, biases, and positions of power and privilege (Bhui et al., 2007; Crawford, 2012; Ibrahim & Heuer, 2016; Sue, Ivey, Pederson, 1996).

There are many barriers that prevent mental health services in providing appropriate culturally competent care, which includes poor communication with service users and the lack of diversity in leadership roles and workforce (Castillo & Guo, 2011). Services that are more successful in integrating cultural competency tend to employ multicultural teams, offer diversity training, understand the importance of religion and spirituality, and consider ways to appropriately adapt therapy (Castillo & Guo, 2011; Fernando, 2010). Given that cultural values and meanings may change over time, the process of learning should be continual and life-long (La Roche &Maxie, 2003; Papadopoulos, 2006). Therapists should actively consider self-education as part of their continual professional development, and aim to learn about client's history and systemic barriers to mental healthcare and treatment (Bhui et al., 2007; Eshun & Gurung, 2009; Graham, Sorenson & Hayes-Skelton, 2013). By increasing education through supervision and consultation with diverse peers and colleagues (La Roche & Maxie, 2003), mental health services should regularly reflect and assess the competencies of their workforce in order to provide appropriate services to disadvantaged communities (Clegg et al., 2016).

2.5.2 Challenges in delivering culturally competent care to ethnic minority populations accessing IAPT services

Whilst the important of cultural competency is recognised in Western mental healthcare, there are a number of challenges which this presents in clinical practice. In attempt to increase cultural sensitivity within IAPT, practitioners are encouraged to consider the world-views and beliefs of service users from diverse backgrounds, which can often differ from the models and treatment options developed for Western populations (Roy-Chowdhury, 2013). However, it is recognised that this is not standard practice, but rather hinged on the *'passion and commitment'* of the workforce who deliver services to minority populations (Roy-Chowdhury, 2013). In addition to core training programmes, IAPT developed the BAME positive practice guidance to enhance the cultural competency of its workforce (IAPT, 2009; Beck et al., 2019). A key theme throughout the guidance is for therapists to offer culturally adapted and culturally responsive services that meet the needs of the local community which incorporates support from others in instances where the workforce does not reflect the cultural diversity of the communities being served (Beck et al., 2019). Despite IAPT therapists using their own initiatives to deliver culturally sensitive therapy, often, time limitations, lack of training, and evaluation of therapeutic adaptations to the client needs make it difficult to assess therapeutic effectiveness (Bassey & Malluish, 2012).

With IAPT being one of the most closely monitored workforces within the NHS sector (Rizq, 2011), increased demands and pressure to meet service targets leave practitioners experiencing burnout, resulting in greater staff turnover and poorer quality of care for patients (Westwood, Morison, Allt, & Holmes, 2017). Having worked within IAPT services, Binnie (2015) characterised the IAPT programme as an example of 'McDonaldization' on a national scale where patients are put through a system, therapies are delivered and outcomes are measured. Witnessing PWPs conducting telephone assessments in the form of a 'therapy factory' raised concerns that therapists failed to view patients as individuals with individual problems and inexperienced staff were quick to put clients on waiting lists as opposed to seeking training or guidance for complex issues. Moreover, the reduction in NICE recommended sessions meant that patients were left dissatisfied with therapy. Such pressures have meant that therapists working for IAPT struggle to cope with patient numbers and find workload challenging and draining (Rizq et al., 2010). Therapists also worried that Western concepts integrated within therapeutic models such as building assertiveness were not culturally appropriate and could have repercussions for BAME clients in their social context (Bassey & Malluish, 2012). Whilst ethnic matching is encouraged to minimise drop-out rates and improve mental health outcomes (Sue, 1991), therapists from BAME backgrounds are often allocated complex caseloads, without adequate support or resources (Naz et al., 2019). This can be problematic for BAME therapists, who unlike their White colleagues, are left feeling responsible for the quality of care of ethnic minority patients who tend to be more difficult to engage in therapy. Given such challenges and concerns, it is unclear whether IAPT practitioners are culturally competent to deal with the needs of ethnic minority communities.

2.6 Thesis overview, aims, and research questions

Given what is known insofar, it is important to recognise the advantages and disadvantages of evidence-based psychological therapies to the needs of ethnic minority communities. Whilst evidence-based assessment of therapeutic programmes can offer legitimate ways to assess therapeutic outcomes, they are limited in understanding broader, more complex dynamics that patients from diverse communities bring to therapy. Whilst cultural differences have been historically considered as part of mental health inclusion agendas, research has demonstrated considerable disparities in access to care, treatment quality, and therapeutic outcomes for minority communities (Good & Hannah, 2015). With increased diversity in clinical populations, it is unclear whether mental health services are appropriately set up to address historic and emergent dynamics of patient identity and cultural characteristics, whilst also considering group dynamics, challenges, barriers, and expectations of care (Good & Hannah, 2015). The individualism-collectivism paradigm (Hofstede, 1980; 2011; Triandis, 1995) and self-construal theory (Markus & Kitayama, 1991) offer a guiding framework to help mental health services to understand how and why cultural differences may occur (Hwang et al., 2008). Previous work utilising these theoretical concepts have been largely conducted in the US and found comparative differences between minority groups and the majority population, whilst also unpacking cultural complexities such as bi-cultural identities (e.g., Allen & Bagozzi, 2001; Gushue & Constantine, 2003; Phinney & Devich-Navarro, 1997). However, it is unclear how well these models transpose to the ethnic minority populations living in England which adopts a Westernised and individualistic landscape. Given the growth of ethnic minority communities, both settled and emergent, it is relatively unknown to what extent cultural identity interacts with mental wellbeing, therapeutic encounters and therapeutic success. Previous mental health research has identified key barriers that are synonymous to non-Western cultural groups such as religion, ethnic status, and socio-cultural factors (e.g., Mohamed & Lowenthal, 2009; Tse &

Ng, 2014), however, literature assessing the effectiveness of evidence-based psychological interventions have been sparse. Western models of psychotherapy delivered in the UK adopt notions of individualism, that is, for patients to be their own therapists and to develop a sense of autonomy to deal with their own life problems (Frese III et al., 2001; Fenn & Byrne, 2013; Rogers, 2009). However, given the cultural influences inherent in ethnic minority populations, it is unclear how well therapies are accepted and suited to the needs of BAME communities.

Moreover, previous empirical research and clinical trials assessing the efficacy of evidence-based psychological therapies in ethnic minority populations have been scarce (*see* Chapter 1). With the national roll-out of the IAPT programme across England, it is unclear how well evidence-based interventions meet the needs of BAME communities. This may be particularly important to understand given the individualistic nature of Western interventions serving characteristically collectivist communities living in England. Whilst empirically supported outcomes are useful for planning and monitoring, they often ignore the recovery narrative which is integral to understanding what works well, for who, and when (Williams, 2015). Given the limited qualitative research exploring service user therapeutic needs (Christodoulou et al., 2019), it is unclear how well Western interventions adopted by IAPT services suit the needs of ethnic minority communities. Moreover, the inadequacy of cultural competency training programmes have highlighted potential concerns within clinical practice and care (Bhui et al., 2007; Clegg et al., 2016). Concerns around Eurocentric practitioners lacking understanding of cultural nuances and differences (Turpin et al., 2008) warrants further investigation since IAPT practitioners are increasingly serving more diverse communities. It is envisaged that the ‘holistic’ investigation within this thesis of empirical data coupled with the narrative experiences of service users and clinicians will enrich our understanding of the English mental health provision and care. Such investigation is valued within evidence-based practice as a collaborative decision making process including the best evidence-research, practitioner expertise, and patient preferences can help mental health services to plan and improve mental healthcare (Mullen, 2014; Schreiber, 2013). Learning from these findings may be useful for commissioning bodies, mental health provisions, and practitioners to understand and enhance quality of care for the ethnic minority populations being served within the English IAPT services and beyond. Thus, the overall aim of this thesis is to explore to what extent evidence-based psychological interventions are effective in improving mental health outcomes for BAME communities accessing IAPT services. This includes comparative empirical investigation of therapeutic clinical outcomes, service users' narrative therapeutic experience, and the practitioner cultural competency in dealing with diverse communities. To this end, the specific research questions are as follows;

Study 1: Predictors of Recovery and Therapeutic Effectiveness

Research Question 1: What factors are most salient in predicting recovery outcomes?

Research Question 2: Which evidence-based psychological therapies are most effective in improving mental health outcomes between White British and BAME groups?

Study 2: Service User Therapeutic Experiences

Research Question 3: Are evidence-based psychological therapies suitable to the needs of BAME communities?

Study 3: Therapists Cultural Competence

Research Question 4: Are IAPT practitioners culturally competent to deal with the needs of BAME communities?

Chapter 3

Methodology

3. Methodology

3.1 Chapter overview

This chapter offers a methodological overview for this thesis. Here, the philosophical position is reviewed with the rationale for selecting critical realism as the epistemological position of choice. The ontological position of methodological pluralism is discussed with the Transdisciplinary Model of Evidence-Based Practice used as a methodological framework (Satterfield et al., 2009). The methodological approach for the quantitative (study one) and qualitative studies (two and three) are discussed in light of the research rationale, ethical considerations, and data handling. Specific procedural process for each respective study are discussed later in more detail (e.g., participant demographics, procedure) (Chapters 4 – 6).

3.2 Philosophical Approach

3.2.1 Research Philosophy

3.2.1.1 Classic philosophical debates in mental health research

The primary philosophical debate within mental healthcare has oriented around the opposing positions of positivism and interpretivist / constructivist approaches (McEvoy & Richards, 2003). Positivism, as a philosophy, proposes that knowledge gained through observations, using measurable techniques, can be deemed as trustworthy (Bryman, 2016). Typically, researchers seek law-like facts by using empirical observations and quantifiable data collection methods that can be statistically analysed. By using a deductive approach, researchers develop hypotheses based on existing theory that are tested and interpreted through an objective lens (Jones, 2010). Whilst researchers acknowledge that this is not the only *'truth'* to understanding the human condition, the general preference to *'acquire knowledge'* in mental health research is geared towards a positivist approach where reliance on empirical evidence supersedes any form of unobservable phenomenon (Clark et al., 2007). Within this realm, studies such as randomised-controlled trials (RCTs), meta-analyses and systematic reviews are considered gold standard research paradigms in reporting the efficacy of therapeutic treatment programs (NICE: CG123, 2011). Whilst this has its benefits in homogenising treatment programmes and is arguably successful at measuring impact, the positivist approach often fails to consider the wider socio-cultural or environmental context, thus, limiting the meaning behind the findings (Clark et al., 2007). Increasing debate about the fidelity of evidence-based treatment programmes have been under scrutiny for many years (*see* Chapter 2). Whilst there is increasing acknowledgment of the shortcomings of clinical trials, evidence-based interventions tested in controlled conditions tend to provide the most methodological rigour when tested in the general population. However, critics argue that traditional positivist oriented studies tend to apply *'facts'* across populations without paying genuine consideration to contributing intersectional factors such as age, culture, and social economic differences (Pilgrim, 2017). Even though studies such as RCTs are useful in explaining therapeutic success in test conditions, seldom do these findings transpire to real-world clinical settings (Clark et al., 2007; Woodall et al., 2010). Thus, when interventions are presented in diverse clinical settings with diverse clients, practitioners have little information on how to make appropriate evidence-based adjustments (McEvoy & Richards, 2003; Pilgrim, 2017).

Alternatively, philosophical approaches such as interpretivism/constructivism tend to oppose the positivist view of the world and how to acquire knowledge by considering reality as socially constructed (Creswell, 2009). Here, researchers embark on understanding reality through social constructions such as language and shared meaning using qualitative methodology such as qualitative interviews and observations to gather rich data from which meanings can emerge

(Braun & Clarke, 2013; Bryman, 2016). By adopting an inductive approach, researchers seek to develop theory based on the experiences and knowledge gathered from subjective data (Braun & Clarke, 2013). In mental health research, a focus placed on the lived experiences of individuals (e.g., social, political, and cultural influences) has seen a shift away from the objective view of the human condition and acquirement of knowledge (e.g., Bhugra, 2005; Bryman, 2016; Gilbert et al, 2007; Loewenthal et al., 2012). This has enabled researchers to consider health inequalities and the way in which people discuss their wellbeing and experiences of healthcare services (Wainwright & Forbes, 2000). However, critics argue that by reducing human knowledge to individualistic subjective discourse fails to recognise structural and institutional inequalities and may be subject to linguistic fallacy and interpretive error (Bhaskar, 1975; Pawson & Tilley, 1997). Moreover, findings from small samples may not be easily generalized to larger populations (Bryman, 2016; Smith, Denzin & Lincoln, 1994). As such, critics question the soundness of these philosophical positions and continue to embrace conventional objective methods on reporting treatment efficacy (Pilling et al., 2011). Given the ongoing debate between these polar philosophical positions, an intermediate stream of philosophy has popularised over recent years – critical realism.

3.2.1.2 Critical realism

The epistemological debate between positivist and interpretivist / constructivist related approaches saw the emergence of post-positivist philosophies such as critical realism to help resolve philosophical shortfalls of such approaches and to negate the ontological dispute between quantitative and qualitative research methodologies (Bhaskar, 1998; Bryman, 2016). Critical realism is often considered an intermediate philosophical position (Wainwright & Forbes, 2000) which considers itself as a moral philosophy that gives importance to an ontological position that considers human wellbeing first, rather than competing methodologies (Collier, 1999). Although it resides in the post-positivist realm, critical realism often combines a realist ontology with a relativist epistemology to understand the complexities of the world (Issac 1990). Bhaskar (1998) suggests that reality is differentiated and stratified which encompasses multiple domains of reality – the empirical, the actual and the real. Walsh and Evens (2014) depict Bhaskar's work as that of a tree-like structure; at a superficial level the empirical is observed or experienced (the tree branches) that tends to be underpinned by the actual (tree trunk) which regulates the empirical findings. However, the actual may not necessarily be observed within the data, therefore, at a deeper level, the real (tree roots) go beyond the actual by considering underlying mechanisms, tendencies and causal explanations that may explain the phenomenon under investigation (Walsh & Evens, 2014).

Unlike the positivist approach, the primary focus of critical realism is to go beyond the observable in an attempt to obtain knowledge about the underlying mechanisms, structures or powers that may explain why things occur the way in which they do (Bhaskar, 1975, 1989; Danermark, 2019). For critical realists, it is acceptable that generative mechanisms do not necessarily have to be directly observable nor predict outcomes, but rather used to understand or form a theoretical account of the effects (Bryman, 2016; Lawson, 2003). Critical realists accept that scientific observations are fallible and can be influenced by wider conceptual frameworks (McEvoy & Richards, 2003). The central goal of the realist approach is to explain outcomes using a generative ontology which brings to surface mechanisms and contextual factors that may influence outcomes, albeit subject to fallacy. The explanation of social events, processes and structures should be considered within social sciences, regardless of the way in which the information is sought (Bhaskar, 1998). As such, critical realists do not concern themselves with the method of enquiry, but rather use varied techniques such as ethnography, interviews, descriptive statistics, quasi-experimental designs and observations to acquire knowledge (McEvoy & Richards, 2003). Critical realism is regarded as a reflective philosophical approach which draws upon social sciences to enhance the understanding of empirical data (Archer et al., 2016). Critical realists argue that intervention outcomes are seldom stable or fixed given the wider contextual factors (e.g., social, cultural and environmental) that may affect outcomes (Sayer, 2000).

Thus, critical realists tend to provide broad philosophical questions, which consider historical, social and culturally situated realities that inform empirical investigations (Archer et al., 2016). Whilst developing theory can have its advantages, often this can be a lengthy process which requires extensive research to draw firm conclusions to understand which mechanisms best explain how well interventions work in particular contexts (McEvoy & Richards, 2003). As such, in the presence of a strong initial theory, exploratory data analysis can help offer explanations by making comparison with diverse groups or services (McEvoy & Richards, 2003). Adopting a critical realist approach, with the use of both mixed methodologies can be useful in providing empirical findings whilst also accepting that there are influencing factors and complexities that need to be considered (Clark et al., 2007). Although the critical realist approach has often been neglected in research (Bhaskar, 1975; Clark et al., 2007), the application of the approach has begun to flourish in a number of disciplines, including psychology, sociology, and economics (Nash, 2005).

3.3 Methodological pluralism

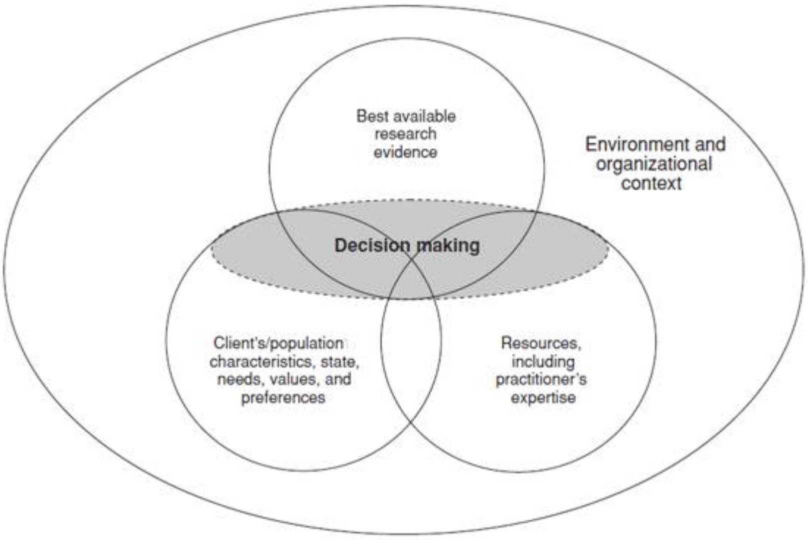
The divide that separates quantitative and qualitative methods has existed for decades (Tashakkori & Teddlie, 2003) until recently where mixed approaches have merged to bring together both formats (Haverkamp, Morrow, & Ponterotto, 2005). Critical realists welcome *'whatever it takes'* to acquire knowledge, which includes both quantitative and qualitative schools of thought (Clark et al., 2007; McEvoy & Richards, 2003). These methods of enquiry can be prospective, concurrent or retrospective depending on the available data (Pawson & Tilley, 2004). Critical realists recognise that regularities are rare and therefore seek to explore underlying mechanisms that may explain what is observed in empirical outcomes (Bergin et al., 2008; Ron, 2002). Realist evaluation is *"sensitive to diversity and change in programme delivery and development. It provides a principled steer from failed one-size-fits-all ways of responding to problems''* (Pawson & Tilley, 2004, *p.* 22). Realist evaluations are diverse in incorporating perspectives which question how and why services operate the way they do (Redfern, 1998).

As such, a pragmatic methodological approach fits well with critical realism as an ontological position as the focus on meaning and truth is concerned with *'what works'* for the phenomenon under investigation (Tashakkori & Teddlie, 2010). Here, both quantitative and qualitative methods are valued. Quantitative methods offer facts and objective statistical data which can be useful in assessing the impact of treatment outcomes (Robson, 2011), whilst qualitative methods offer deeper meaning and understanding using interviews which include rich and detailed accounts of the individual experience (Savin-Baden & Major, 2013). The ongoing debate between the efficacy and effectiveness of treatment outcomes questions how well evidence-based therapies transpire to real-world clinical settings given that the characteristics of participants in clinical trials do not reflect heterogeneous clinical populations (Guy et al., 2012; McPherson et al., 2009). IAPT services tends to adopt the biomedical model, which shows preference for a positivist method of inquiry based on clinical outcomes produced through patient data (Guy et al., 2012; Williams, 2015). Whilst this offers detailed outcomes of therapeutic success in clinical settings (Clark, 2018a) when compared to controlled conditions found in RCTs (Ron, 2002), the primary reliance on quantitative methods fails to consider the individual experiences and implications for diverse communities (Viruell-Fuentes, 2007). The methodological pragmatism of critical realism offers a holistic understanding of the phenomenon under investigation, which can be particularly useful when considering the perspectives of service users and clinicians working in IAPT services (McEvoy, 2002; Palinkas et al., 2019). Qualitative methods of inquiry offer in-depth accounts of human complexities, which include cultural experiences, family systems, socio-political-environmental facets that cannot always be captured by quantitative methods (Plano Clark, Huddleston-Casas, Churchill, Green, & Garrett, 2008). By adopting an exploratory data analysis approach, researchers can begin to recognise that the data seldom produces *'facts'* that positivist may depend upon, but rather offers sources of information (or clues) that enable us to speculate and explain outcomes (Jones, 2010).

3.3.1 Methodological framework

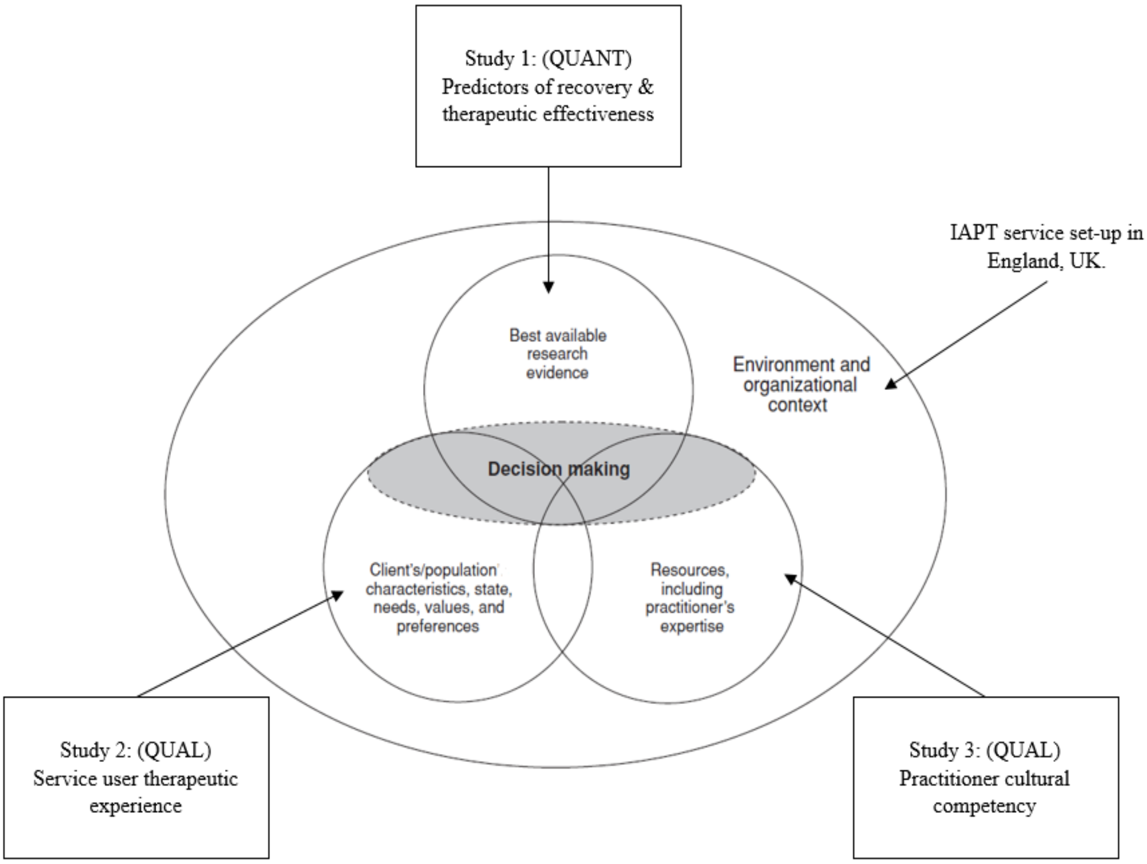
Whilst evidence-based assessment of therapeutic programmes can offer legitimate ways to assess therapeutic outcomes, they are limited in understanding broader, more complex dynamics that patients from diverse communities bring to therapy. Evidence-based practice (EBP) is viewed as a collaborative decision making process which includes the best evidence-research, practitioner expertise, and patient preferences (Mullen, 2014; Schreiber, 2013). Frameworks such as the Transdisciplinary model of EBP encourage healthcare disciplines such as psychology, social work, and medicine to consider multifaceted sources of information during the assessment, formulation and decision making processes (Mullen, 2014; Satterfield et al., 2009; Spring et al., 2019). Haynes and colleagues (1996) endorsed the EBP conceptual model, which stipulated the inclusion of evidence from empirical research, coupled with clinician's expertise and client's preferences by healthcare services. Satterfield et al., (2009) further extended this by incorporating environmental and organisational factors that consider the cultural context where treatment fidelity, acceptability, and need for adaptation can be considered (*see* Figure 3.1). When considering the best scientific research evidence, findings from systematic reviews through to experimental empirical research can be included (Satterfield et al., 2009). Expertise in diagnostic judgment, case formulation, and treatment planning are some of the considerations made by clinicians, whilst patient characteristics, values, and identity are vital considerations for patient preferences (Satterfield et al., 2009). The added value of incorporating both quantitative and qualitative data can help healthcare services to design and tailor evidence-based interventions more effectively.

Figure 3. 1. *Transdisciplinary Model of Evidence-Based Practice taken from Satterfield et al., (2009).*



The methodological framework aforementioned aligns well to a concurrent mixed-methods design, where equal status is given to both quantitative and qualitative components, thus allowing researchers to gather insights that both methodological outcomes produce (Schoonenboom & Johnson, 2017). Here, both methods are conducted simultaneously and independently to offer a holistic account of the phenomenon under investigation, thus adding a broader perspective to the research inquiry (Tashakkori & Teddlie, 2009). This approach befits pluralistic (Schoonenboom & Johnson, 2017) and pragmatic (Johnson & Onwuegbuzie, 2004) ontological positions. As such, the present thesis will utilise the Transdisciplinary Model of Evidence-Based Practice by adopting a concurrent mixed-methods design which will inhibit three simultaneous studies in the environmental and organizational context of IAPT services delivered in England, UK (*see* Figure 3.2). Study one will use empirical research evidence obtained through IAPT clinical data to explore predictors of recovery and therapeutic effectiveness for ethnic minority population when compared to the White British population. The second study will qualitatively explore whether evidence-based psychological interventions meet the needs of ethnic minority service users by exploring their values, preferences and experiences of therapy. The third study will similarly explore the experiences of practitioners employed by IAPT to understand if they are culturally competent to deal with the needs of ethnic minority populations. It is envisaged that the findings from these studies will help better understand the effectiveness of evidence-based psychological interventions to the needs of ethnic minority communities, which in turn will aid the decision making processes for mental health services, practitioners, and funding bodies.

Figure 3. 2. *Adapted Transdisciplinary Model of Evidence-Based Practice (Satterfield et al., 2009) in the context of the current thesis.*



3.4 Study One: Quantitative methodological approach

3.4.1 Rationale for using cross-sectional retrospective design

Given the limitations of ethnic minority populations in clinical trials and the fidelity of evidence-based psychological interventions (Adams, 2008; Pawson & Tilley, 2004), cross-sectional retrospective study designs offer researchers the opportunity to collect naturally occurring data collected as part of routine clinical practice to assess therapeutic outcomes and success (Talari & Goyal, 2020). Whilst it is acknowledged that there are some challenges with cross-sectional retrospective designs such as potential unfamiliarity with all aspects of the dataset, absence of key variables, and missing information that can cause obstacles in processing and handling the data, there are several advantages (Bryman, 2016; Gordis, 2014). Firstly, using high-quality secondary data enables researchers to harvest data that has already been collected which saves time, and is thereby cost-resource effective (Bryman, 2016). Secondly, the data are often more representative of the population it is intended for, with greater ecological validity than data which may have been collected by someone who is an outside agent relative to the population. This also has added external validity, thus allowing for inclusion of a wider pool of sample which allows researchers to infer '*representativeness and generalizability*' across the population (Bryman, 2016; Gordis, 2014). Given the challenges in recruiting BAME individuals in clinical trials and research, the use of clinical data obtained from IAPT services generates access to largescale datasets which can be used to answer the research questions more clearly. Thirdly, large datasets are often checked by experienced analysts to ensure that the minimum dataset (MDS) quality required is maintained (Bryman, 2016). All data collected by IAPT services are required to meet the MDS standards stipulated by NHS Digital and the Health and Social Care Information Centre (HSCIC) (NHS Digital, 2014) which includes standardised measures for depression (Patient Health Questionnaire - 9), anxiety (Generalised Anxiety Disorder -7) and functional impairment (Work & Social Adjustment Scale) which are recorded as part of routine clinical practice at each session (*see* Chapter 4). Fourth, by using existing data, more time is available for data analysis as this saves time needed for data collection and preparation (Bryman, 2016).

3.4.2 IAPT context and settings

IAPT services is a national mental health service operating across England. For the present study, IAPT services that operated under the National Health Service (NHS) banner were recruited for the study as unlike the voluntary sector (who have more flexibility in treatment modality), NHS operated IAPT services are expected to abide by NICE recommended evidence-based treatments (Clark, 2018b). For the present study, six services had initially signed up to participate, however, two services dropped out due to service restraints in formulating and sharing the datasets. As such, two Trusts (with multiple IAPT services) and two independent IAPT services were included in the study. Details about the services are included in the study and detailed in Table 3.1 along with the ethnic population distribution by region (ONS, 2012). The datasets were collated between 1st January and 31st December 2016 across the four services.

Table 3. 1. *Inclusion of IAPT Service Datasets in Study One*

IAPT Services Included	**Region**	**Overall Regional Ethnic Population Distribution**
Trust 1 (with 7 IAPT services)	North West	Asian 6.2%, Black 1.4%, Mixed 1.6%, Other 0.6%), whilst 3.1% are classified as White Other. The large majority of people identify as White British (87.1%) (ONS, 2011).
Trust 2 (with 3 IAPT services)	East of England	Asian 4.8%, Black 2.0%, Mixed 1.9%, Other 0.5%) and 5.5% White Other. The large majority of people identify as White British (85.3%).
Independent IAPT Service (covering 2 areas)	Midlands	Asian 10.8%, Black 3.3%, Mixed 2.4%, Other 0.9%) and 3.6% White Other. 79.2% of people in this region are reported as White British (ONS, 2011).
Independent IAPT Service	Midlands	As above

3.4.3 Ethical considerations for NHS IAPT datasets

3.4.3.1 Research ethical approval

Ethical approvals were sought in three stages and received full approval. First, approval was received from the researcher's academic institution (Birmingham City University) in April 2017 (Ethics Code: 060/17 Cat A). Since the premise of this study was to offer a service evaluation reviewing therapeutic effectiveness of evidence-based psychological interventions, approval was sought from the Health Research Authority (HRA) through the Integrated Research Application System (IRAS) online application process in July 2018 (Ethics Code: 18/WM/0185). Following HRA approval, each respective IAPT Research & Development (R&D) department was contacted to release the datasets.

3.4.3.2 Informed consent and right to withdraw

Given the nature of retrospective designs, patient informed consent and right to withdraw was not directly requested by the researcher. Instead, patients provided consent for their anonymised data to be included in the Minimum Dataset (MDS) which could be used to monitor clinical outcomes and used as part of independent research studies (NHS Digital, 2019). Thus, approval was sought via HRA and each independent IAPT service that took part rather than at patient level.

3.4.3.3 Confidentiality and data protection

Patient datasets were obtained directly from each IAPT service provider that partook in the study. To maintain patient privacy and confidentiality as directed by the General Data Protection Regulation (GDPR) Data Protection Act 2018, patient data was first anonymized by each respective service provider by omitting patient identifiers such as patient names, NHS numbers, and addresses before data was made available to the researcher (Reuter, 2018). The datasets were transferred to the researcher using a secure encrypted online system which was only accessible by a unique password. Once received, data was stored in password protected zip files on a secure institutional device. Given the nature of the study, the secondary data was further anonymized by the researcher by removing any identifiable data items (e.g., service provider ID) and replaced with a unique patient number to maximize patient confidentiality and anonymity.

3.4.4 Dataset sample selection and quality checks

3.4.4.1 Inclusion and exclusion criteria

The inclusion and exclusion criteria for the study have been displayed in Table 3.2. A total of *N* = 24,758 service user records were retrieved from all four IAPT services (*see* Figure 3.3). Of those, *N* = 3,470 were removed due to service users being under the age of 18 (*N* = 111); patient gender not being recorded (*N* = 48); the diagnosis not meeting the inclusion criteria (*N* = 958), and the first or last appointment date falling outside of the inclusion period (*N* = 994). Moreover, a number of service users included in the dataset did not receive therapy and instead were signposted elsewhere (*N* = 1,359). As the patient data originated from routine clinical practice activity in 2016 (a year before the dataset was collected by the researcher), it was not possible to obtain further information from the service providers about the reasons why patients were found unsuitable for IAPT services. Of a total of *N* = 21,288 service users who had entered treatment, *N* = 7,587 did not complete a course of treatment of which (*N* = 5,777) dropped-out after one appointment session, or rejected the treatment offered (*N* = 1,624), or failed to attend any of their appointment sessions (*N* = 186). To be regarded as completing treatment, there must be at least two paired pre-post treatment scores (Clark, 2011). Thus, the final sample included in the study was $N = 13{,}710$ patients (*see* Figure 3.3).

Figure 3. 3. *Flow Chart Depicting the Final Sample Selection (see Table 3.2 for exclusion criteria).*

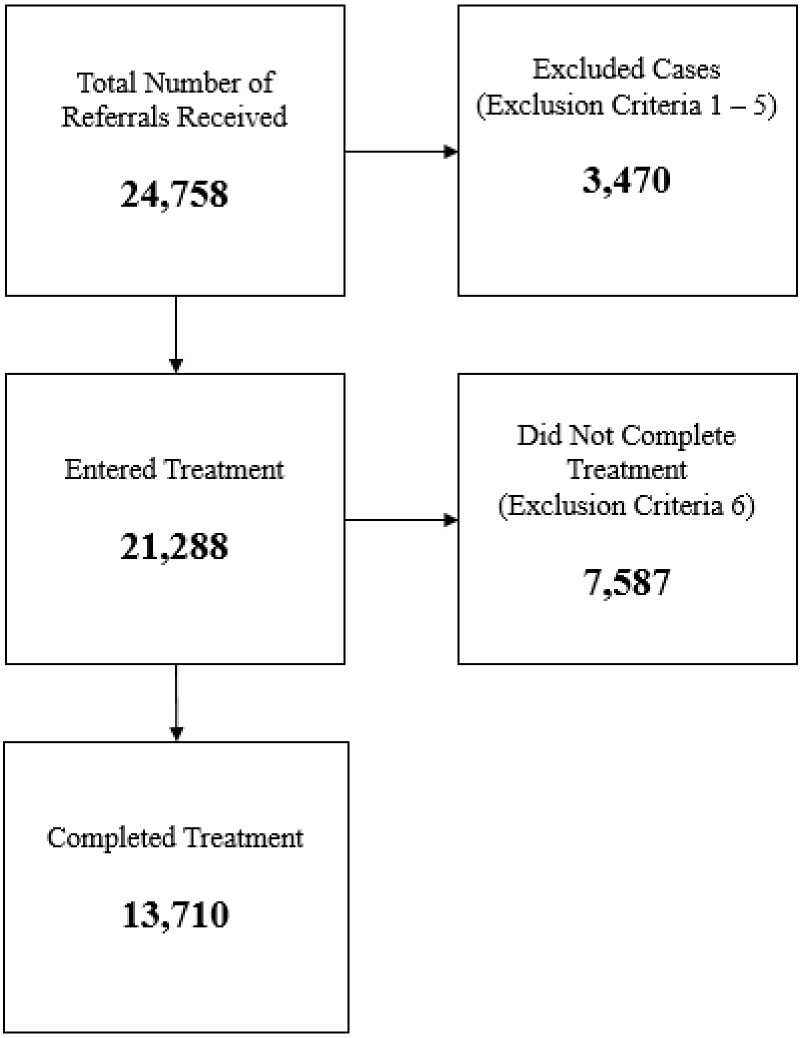


Table 3. 2. *Sample Inclusion and Exclusion Criteria for Study One*

Criteria	**Inclusion**	**Exclusion**	***N* Patient Cases Excluded**
1. Age	Adults over the age of 18	Young people and children under 18	*N* = 111
2. Gender	Male, Female, Other (e.g., transgender)	Those that were reported as ‘unknown’ due to missing information / not recorded	*N* = 48
3. Diagnosis	The following common mental health disorders; Depression, Generalised Anxiety Disorder (GAD), Obsessive Compulsive Disorder (OCD), Panic Disorder, Social Anxiety Disorder (SAD), Mixed Depressive and Anxiety Disorder (MADD), Post-traumatic Stress Disorder (PTSD)	Any disorders that had counts of less than 5 patients of the total sample or were regarded as severe conditions. For example; Schizophrenia, Bipolar, Recurrent Depression, Post-Partum Depression, Anti-Natal Depression, Agoraphobia, Other Non-Specified Phobias	*N* = 958
4. Not Suitable for IAPT Services	Service users eligible for IAPT services and who completed a course of treatment	Service users who had been signposted elsewhere or were not eligible for IAPT services (e.g., due to employment/benefits advice)	*N* =1,359

5. Appointment Dates	For consistency across the different datasets, service users who had attended appointments between 01.01.16 – 31.12.16 were included.	Any service users who had attended their last appointment before 01.01.16 or their first appointment after 31.12.16.	*N* = 994
6. Number of Sessions	In order to calculate recovery outcomes, two paired scores are needed. Therefore patients who had attended 2 or more sessions were included in the final analysis.	Anyone who had attended 0 -1 sessions were excluded from the analysis as pre-post treatment scores were unavailable.	*N* = 7,587

3.4.4.2 Missing data

Missing data in clinical research tends to be unavoidable, particularly in naturally occurring data streams that take place as part of routine clinical practice (Wood, White, & Thompson, 2004). Missing data can raise many questions about the validity of clinical research findings; including potential bias; substantial loss of information; decrease in precision and specificity, and reduced statistical power (Sterne et al., 2009). As such, several researchers have suggested alternative methods to handle missing data, which include replacing missing values with simple imputed means of the observed data [“means substitution”] (Graham, 2009; Vach & Blettner, 1991) through to more rigorous options such as multiple imputation (Sterne et al., 2009). The general rule for considering the use of such approaches tends to be when missing data points exceed 5% of the total number of the sample (Kang, 2013).

3.4.4.3 Approach to dealing with missing data

In the present study, to analyze the patterns of any missing values, the outcome variables (PHQ9, GAD7, and WSAS pre-post treatment) scores were assessed to determine incomplete data. Findings revealed that in the dataset, 47.6% of patients / cases had incomplete data, which ranged from 2.5% to 41.7% missing data based on the type of outcome measure and data collection point. Analysis indicated that the cases were missing at random (MAR) which suggests that that the values were missing based on the number of observed responses, rather than missing completely at random (MCAR) or missing not at random (MNAR) (Kang, 2013). Given the clinical datasets were collected as part of routine clinical practice, it is likely that patient pre and post-treatment scores may have been missing due to naturally occurring reasons such as patient drop-out, incomplete survey responses, or clinician error in entering data.

To retain the integrity of the sample and to increase precision and power of the dataset, first, imputed series of means of observed data was carried out to address the missing values, which was followed up by multiple imputation as a form of sensitivity analysis (Sterne et al., 2009). The reason for this decision was based on the recovery outcome variable which is calculated on complete scores for the PHQ-9 and GAD-7 measures. Given the requirement of this is a priori to calculating recovery, the imputed series means was deemed as the best option to calculate recovery outcomes. However, to ensure that the imputed values were valid, and the variability was minimised, multiple imputation was assessed to ensure the robustness of the results (Graham, 2009). Simple paired samples *t*-tests were carried out for each paired outcome measure to assess variability in the findings. Minimal variance between the imputed series means and pooled means arose from multiple imputation. As such, the imputed series means were used to address the missing values and to calculate the recovery outcomes in order to maintain clinical representation within the dataset. Missing value imputations were reviewed by the researcher’s supervisory team to ensure robustness of the dataset and data quality standards.

3.4.4.4 Dataset quality checks

To ensure that the data had been correctly computed and to assess the quality of the data, a number of checks were carried throughout the data transformation process to ensure that outcomes of this study were not subject to researcher error. Details of this can be found in Table 3.3.

Table 3. 3 *Dataset Quality Check Method*

Source	**Quality Check Method**
IAPT Data Guidance & Documentation	IAPT data specification documents were thoroughly reviewed to ensure that the data structure and variables were understood and correctly interpreted in the data fields. For more information visit https://digital.nhs.uk/data-and-information/
NHS Digital Helpdesk	NHS Digital were contacted to double check any information that was missing or not reported. Interpretation of the coding methods used by NHS Digital were also confirmed and checked (e.g., recovery scores). For more details visit https://digital.nhs.uk/about-nhs-digital/contact-us
Data Analysts	IAPT data analyst were contacted to check whether the data matched in-house data analysis carried out within IAPT services. This was to ensure that when findings were reported they did not over or under exaggerate the data received from the services.

IAPT Clinical Leads	IAPT c linical leads were contacted to check whether the findings were correctly interpreted and analysed. This was to ensure that the results were accessible and understandable to the clinicians working within IAPT.
Expert Opinions	Preliminary findings were discussed in conference proceedings (IAPT Networking Event and BABCP conference) to allow service users, service practitioners and professionals in the field to observe the results and make suggestions. To present, no conflicting commentary or observations were made.
Researcher's Supervisory Team	The datasets were shared with the researcher's supervisory team who comprise of senior researchers and academics to check the dataset in preparation for analysis. The analysis was also checked throughout the study to minimise researcher bias.
Statistical Advisory Service (SAS)	The researcher sought advice from the SAS team at University of Bath to ensure that the robustness of the data analysis and to minimise researcher bias.

3.5 Studies Two & Three: Qualitative methodological approach

Qualitative research has the added benefit to the development of meaning and understanding of complex, dynamic and multi-dimensional features of the phenomenon under investigation (Pope & Mays, 2018). By adopting a qualitative method of inquiry, researchers allow individuals to *"speak in their own voice, rather than conforming to categories and terms imposed on them by others"* (Sofaer, 1999, *p*. 1105). This allows individuals to clarify their personal values, language, experiences, and meanings of the social world, particularly those from distinctive cultures that tend to be alienated from mainstream society and within healthcare settings (Pope & Mays, 2018; Sofaer, 1999). In intervention research, qualitative methods offer opportunity for researchers to evaluate intervention effectiveness in a more wholesome and compelling manner that can help explain outcomes rather than relying on dichotomous conceptualisations of *'it either works or it doesn't'* (Sofaer, 1999). In other words, qualitative methods can offer unique insights into how well evidence-supported practices work in clinical care (Hamilton & Finley, 2020).

3.5.1 Rationale for selecting Reflexive Thematic Analysis (RTA)

When selecting a method for qualitative analysis, it is usually important to consider how well the analytical approach aligns to the epistemological position (Willig, 2013). Reflexive Thematic Analysis (RTA) is a flexible qualitative method which does not confine to particular theoretical frameworks, philosophical positions, or ideologies (Braun & Clarke, 2006; 2021a). Instead, RTA allows research to be conducted from different epistemological standpoints, including critical realism (Braun & Clarke, 2006; Fletcher, 2017). RTA aims to *"explore and develop an understanding of patterned meaning across the dataset"* to produce *"a coherent and compelling interpretation of the data, grounded in the data"* (Braun, Clarke, Hayfield, & Terry, 2019; *p.* 848). In England, there are relatively few studies that have explored the recovery narrative of ethnic minority communities or evaluated whether evidence-based psychological interventions meet their needs (Christodoulou et al., 2019; Memon et al., 2016; Mohammed & Loewenthal, 2009). RTA was considered the most useful analytical approach to explore patients' perspectives by generating meaningful insights into their experiences (Braun & Clarke, 2006; Clarke & Braun, 2013). By offering an exploratory, open, and flexible approach, RTA tends to differ from the more structured approaches of code and theme development (Braun & Clarke, 2019). An example of this is coding reliability TA (Boyatzis, 1998), which is embedded in a pre-determined codebook or frame that uses data that reflects each theme (Braun & Clarke, 2019). Here, multiple coders, reliability measures, and tests for consistency are used to ensure that items observed in the data align to the predetermined codebook or frame. RTA is a subjective process that considers the intersection between the researcher, dataset, and contextual interpretation by answering the ‘Big Q’ (Braun & Clarke, 2019). The ‘Big Q’ qualitative approach allows for researcher subjectivity whilst considering patterns and themes constructed through the data, thus aligning well with the critical realist epistemology (Braun et al., 2019). By adopting an inductive approach, the researcher is able to identify patterns within the data, in order for themes to be driven and connected to the data (Braun & Clarke, 2006; Patton, 2015). Saying this, it would be naïve to claim a purely inductive approach as the themes often do not represent the direct spoken word from the data but are made sense of by the researcher through their understanding of the literature and their own personal experiences and assumptions (Banister et al., 2011; Taylor & Ussher, 2001).

Several alternative analyses were considered before making the decision to use RTA as a methodological approach, this included Grounded Theory (GT), Discourse Analysis (DA), and Interpretative Phenomenological Analysis (IPA) (*see* Table 3.4). GT and DA were considered the least suitable methods for analysis. GT’s focus on a bottom-up approach is more suited to theory development (Blumer, 1969; Glaser & Strauss, 1967). Given the focus of GT on sociological structures, ‘bigger picture’ thinking, and lack of reliance on pre-existing guiding theoretical frameworks, it was rejected as a method of choice. Similarly, DA was rejected based on its focus on the external world rather than internal psychological influences and experiences (Burman & Parker, 1993; Potter & Wetherell, 1987). For the present study, it was deemed important to consider how personal experiences, values, beliefs, and identities influence therapeutic outcomes and delivery. IPA was a close contender as an analytical approach, however, was rejected based on its suitability to homogenous samples which emphasises on each individual’s subjective experience and favours psychological aspects over socio-cultural influences (Smith, 1996; Smith, Flowers, & Osborn, 2013). The understanding of what may give rise to participant experiences (e.g., their social, cultural, psychological context) across the dataset was seen as an important feature of RTA as it allows to make generalisations about participants' *'reality'*, thus suited to understanding BAME service users and practitioners experiences. Whilst it is acknowledged that individual experiences can offer incredible insights, given the lack of research in the area of interest, RTA served as a starting point to understanding therapeutic experiences of service users and practitioners more broadly.

Table 3. 4. *Rationale for Selecting Qualitative Analytical Approach*

Qualitative Analysis	**Philosophy and Purpose**	**Suitability (Accept / Reject)**	**Rationale**
Grounded Theory (Blumer, 1969; Glaser & Strauss, 1967)	Tends to consider social processes and influencing factors that underpin the phenomenon under investigation. Development of new theory using bottom-up approach. Can be time-consuming and complex.	Reject	Focus on sociological structures rather than psychological. Lack of focus on individual experience. Little reliance on pre-existing guiding theoretical frameworks.
Discourse Analysis (Burman & Parker, 1993; Potter & Wetherell, 1987)	Tends to focus on how knowledge is constructed through interaction and discourses such as the use of language. Interested in outer world discourse and is influence on the social world rather than internal. Can be time-consuming and complex.	Reject	Focus on external world and social processes rather than inner psychological influences or experiences.

Interpretive Phenomenological Analysis (IPA) (Smith, 1996; Smith, Flowers, & Osborn, 2013)	Focus on experience, understanding, and perceptions. Resonates with sense-making and psychological concerns. Allows to focus on individual experience. Suitable for time and resource limited research.	Reject	Usually suitable for homogenous samples. Suited to each individual’s subjective experience. Emphasis on the psychological aspect over socio-cultural influences.
Reflexive Thematic Analysis (Braun & Clarke, 2006)	Provides a systematic approach to analysing a reporting patterns and themes across the dataset. Flexibility as it does not prescribe to any theoretical, ontological, or epistemological framework. Can be applied in different ways, from experiential or critical standpoints. Suitable for time and resource limited research.	Accept	Can be used to answer any type of research question. Useful for any sample size. Flexibility in bottom-up or top-down theoretical ideas. Forming themes across dataset to enhance generalisability.

3.5.2 Systematic approach to Reflexive Thematic Analysis

RTA involves reflexive engagement with the dataset, guided by a six-phase process to produce a robust pattern-based analysis (Braun & Clarke, 2019) (*see* Figure 3.4). The six-phase process is used as a guide, rather than a rigid process to help the researcher identify patterns within the data (Braun & Clarke, 2006; 2013). This includes data familiarisation; coding; generating initial themes; developing and reviewing themes; refining, defining, and naming themes; and writing up. Details about each stage can be found in Table 3.5.

Figure 3. 4 *Braun & Clarke's (2006) Six-Phase Process to Reflexive Thematic Analysis*

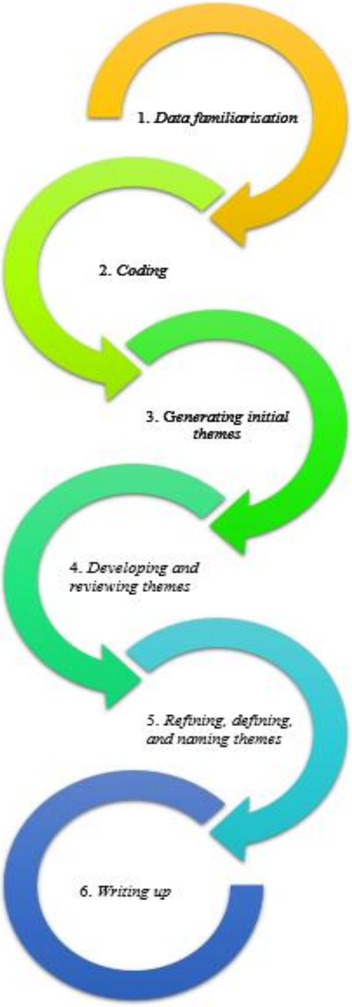


Table 3. 5. *Thematic Analysis Six-Phase Process for Studies Two and Three*

Phase	**Details**	**Action**	**Study Two: BAME Service User Needs**	**Study Three: Practitioner Cultural Competency**
1. *Data familiarisation*	The first phase involves reading and re-reading the data and becoming immersed and familiar with the content (Braun & Clarke, 2006).	I carried out all the interviews and manually transcribed the interviews for each participant to facilitate deep immersion within the data. I read and re-read the entire dataset in order to become familiar with the data. Whilst transcribing the interviews, I listened carefully to each participant and made notes of my initial analytical observations and insights which included participants' feelings, discourse, and understanding of their world.	See Appendix B.1.1 for preliminary notes for service user interviews	See Appendix B.2.1 for preliminary notes for practitioner interviews
2. Coding	In this phase, codes are used to capture important features of the data that might be relevant to the	The second phase entailed coding of the transcripts which was done systematically through the entire dataset by using the 'comments' function in Microsoft Excel to	See Appendix B.1.2 for extract of preliminary coding	See Appendix B.2.2 for extract of preliminary coding

	research question (Braun & Clarke, 2006).	create side margins which highlighted the relevant extract and code. Here, attempts were made to code authentically to the service user narrative to ensure nothing was missed out that could later be useful. I transferred all codes to a Microsoft Excel 2016 document in order to keep track of the iteration process and evolvement of the codes, themes and subthemes (Byrne, 2021).	for service user interviews	for practitioner interviews
3. G*enerating initial themes*	The third phase begins to consider broader patterns, meaning, and theme development (Braun & Clarke, 2006).	I began to generate themes by clustering topic areas by identifying candidate themes. This included a number of themes and subthemes that were apparent in the data and aligned to the research question. As this process was inductive and exploratory, theme generation was at its initial stage before refinement in the next stages.	See Appendix B.1.3 for excerpt of spreadsheet tracking preliminary theme development for service user interviews	See Appendix B.2.3 for excerpt of spreadsheet tracking preliminary theme development for mental health practitioner interviews

4. *Developing and reviewing themes*	The analysis involved developing and reviewing themes against the coded data and entire dataset, which can lead to separating, combining and discarding initial candidate themes (Braun & Clarke, 2006).	Here, themes and subthemes were recursively reviewed to ensure that they addressed the research question and built a narrative between the themes (Braun & Clarke, 2013). Themes and subthemes were revised where needed to ensure that they offered the most meaningful interpretation of the data.	See Figure 5.1 (in Chapter 5) for finalised thematic map demonstrating three themes	See Figure 6.1 (in Chapter 6) for finalised thematic map demonstrating three themes
5. *Refining, defining, and naming themes*	In this phase, detailed analysis of each theme is considered to determine a ‘story’ relating the research question, whilst also using informative names for each theme (Braun & Clarke, 2006).	The themes were further refined and defined to consider the respective research question. Using a recursive approach I went back and forth between the data to ensure that the data tells a ‘story’ that does not drift off topic (Braun & Clarke, 2019). With feedback from my supervisory team, a clinical expert, and engagement with the literature, I further revised the theme titles for the final analysis and selected appropriate extracts to be presented in the report.	See Appendix B.1.4 for example of data extract reported	See Appendix B.2.4 for example of data extract reported

6. *Writing up*	In the phase, the analysis is written up whereby the analytic narrative, data extracts, and data contextualisation were considered in relation to existing literature (Braun & Clarke, 2006).	Finally, the report was written up to offer a narrative account of the topic. Throughout the study, I reflected on my own assumptions before and during the data collection process by keeping a reflective diary and by considering my positionality.	See Appendix B.1.5 for extract of reflective diary and Chapter 5 for the write-up of the report	See Appendix B.2.5 for extract of reflective diary and Chapter 6 for the write-up of the report

3.5.3 Reflexivity

Reflexivity is an important component of RTA as the positionality of the researcher – both as an insider or outsider - can shape research (Braun & Clark, 2019). By being transparent and reflexive about their position, the researcher is able to enhance the credibility of their findings (Willig, 2013). By adopting a critical realist approach, I acknowledged that the research cannot be entirely objective since my personal experiences, values, and beliefs can influence how I connect with the participants, the literature, and interpretation of the data (Clarke & Braun, 2013). I often found myself dabbling between the insider – outsider position when conducting interviews with BAME service users and IAPT practitioners. Here, my ethnic identity, as a Pakistani, Muslim female from an ethnic minority community enabled me to use an insider position whereby my subjectivity was used as a resource when conducting the interviews and data analysis (Gough & Madill, 2012). This helped me to use aspects of my own experience to resonate with the experiences of the participants whereby I was able to actively listen to participant stories with empathy and genuine curiosity. I acknowledge that my subjectivity may have had a direct impact on the knowledge that was co-created as part of the interview process (Griffiths, 1998). However, by being an outsider, someone who is not directly linked to IAPT services, I was able to objectively listen to the experiences and stories of the participants without prior judgment, association or ties to the service. Whilst I acknowledge that this may not have been entirely objective, given my research experience, prior knowledge of inequalities in mental healthcare, and interactions with people of the ethnic minority communities, I was removed from the context of IAPT services which enabled participants to talk openly about their experiences. The uniqueness of my position had added benefits to both service users and IAPT practitioners interview process and data analysis.

My ethnic identity as an insider was suited to research with ethnic minority populations. Whilst the outsider position can have its benefits, whereby the researcher removes oneself from the subject matter to offer a more objective standpoint (Willig, 2013), this can be problematic in ethnic minority research. Previous research has pointed towards reluctance of BAME service users participating in research due to concerns with misunderstanding, racism, and bouts of tokenism within mental healthcare (Adams, 2008; Woodall et al., 2010). By identifying as an ethnic minority woman, service users felt at ease to tell their stories without having to explain what they meant. Service users often made comments such as *"you get it"* and *"you know what it's like"* or used their mother tongue when trying to explain cultural terms such as *"paagal"* (mad). Whilst this was useful, I often found myself consciously shifting to an 'outsider' position to enable service users to explain and offer more in-depth answers. For example, when they spoke about familial pressures, they would say, *"you know what it's like in our community"*, however, I would ask them to explain what that meant for them to avoid assumptions and bias. Moreover, my experience within the mental health field meant that I understood the concerns and mental health inequalities readily in comparison to someone who may not have this background knowledge. However, upon reflection, I considered whether my gender may have influenced that uptake of the participants in the study as most service users were female and from a South Asian background. The uptake by males was poor which may be due to the inherent stigma and reluctance to discuss mental health concerns with others from the same community or opposite gender (Memon et al., 2016; Mohammed & Loewenthal, 2009).

In terms of the mental health practitioner interviews, I found that my outsider position allowed therapists to openly discuss their experiences of delivering therapy to ethnic minority communities, their training needs, and concerns with systemic inequalities. However, my insider position relating to my ethnic identity meant that BAME therapists often felt at ease discussing the challenges they faced within their roles, which included structural inequalities and cultural competency of the IAPT workforce. Whilst White therapists were also able to talk openly about their experiences, I acknowledged that there were instances where some therapist felt uneasy talking about their Whiteness, positions of power, and competency in making cultural adaptations to therapy. This was often visible in their need to apologise for not knowing more about how to deal with the needs of ethnic minority groups. By shifting between my insider and outsider position, I was able to conceive the stories of the therapists in a way that moved beyond simple description, but to interpret what was being said in my own subjective experience, informed by literature and guiding frameworks.

3.5.4 Study Two: Service user recruitment process, ethical approval, and developing the interview schedule

3.5.4.1 Recruitment process

Service users were recruited using purposive sampling methods which is commonly used as part of qualitative research methods (Bricki & Green, 2002). A number of IAPT services were contacted through word-of-mouth, using established contacts (e.g., mental health practitioners), and social media (e.g., Twitter) to help with recruitment of participants and to collaborate on the research project. However, due to Covid-19 restrictions at the time of the research taking place (2020 – 2021) service limitations meant it was difficult to recruit service users who were already receiving therapies at an IAPT service. Most services were unavailable for face-to-face contact, which meant that many service users were restricted to online therapy at the time of the study (Bekes & Aafjes-van Doorn, 2020). The timing of the data collection, restrictions in the timeframe of the research project, and inherent challenges in recruiting BAME participants (Adams, 2008; Woodall et al., 2010) made it difficult to recruit directly through an IAPT service. Given the impact of the global pandemic and the substantial implications for research within healthcare settings (Saberi, 2020) decisions were made to recruit ex-service users who had previously received at least one therapy session at an IAPT service. By using an evaluation approach, service user recruitment was predominately achieved through social media where the study research poster detailing the study participation was made (*see* Appendix B.3.1). Six out of the nine participants made direct contact after seeing the social media posts, whilst three of the service users were recruited through snowball sampling (Bricki & Green, 2002). All of the service users who participated in the study were ex-service users and were not seeking or receiving any treatment at the time of the study taking place. As such, their experiences were reflective of the course of treatment(s) they had received from IAPT services.

3.5.4.2 Inclusion criteria

The inclusion criteria for the study sample were for the service users to be over the age of 18, identify as someone from the BAME background, have sufficient English proficiency, and have received at least one treatment session at an IAPT service. Adult service users were selected based on the service set-up for the adult population (Clark, 2018a) and so that they could provide independent informed consent. Given that evidence-based therapies have been developed using predominately White patients (Kirmayer, 2007; Sue, 2009), BAME service users were selected to establish whether evidence-based interventions are suitable to their needs. Given the poor recruitment of BAME service users in clinical trials (e.g., RCTs) it was deemed important to explore their therapeutic experience. Even though the researcher is bilingual (e.g., speaks a number of languages including Urdu, Punjabi, and Hindko), it was not possible to recruit a more diverse sample due to time limitations in translating the interviews and funding to use established translation services. As such, service users who had sufficient English proficiency were only recruited. Finally, service users who had completed a course of treatment were the primary recruitment focus, however, given previous research indicating high drop-out rates in the BAME population (Harwood et al., 2021), those who had accessed service and received at least one therapy session were also included to establish and explore the reasons why they had not returned for further treatment.

3.5.4.3 Determining the research sample size

The research sample in qualitative methods tends to be varied depending on the type of data analysis strategy, size of the study and purpose (Braun & Clarke, 2019; Bricki & Green, 2002). This variability makes it difficult to ascertain the exact amount needed for a good quality qualitative study as this can range from one to over fifty participants (Braun & Clarke, 2013). In other instances, authors such as Fugard and Potts (2015) adopt a more quantitative approach to determine the power of the sample size used within qualitative studies. Here, depending on the number of desired themes and population theme prevalence, to achieve 80% power, a sample size of up to 740 participants could be required in order to investigate patterns across participants. However, critics such as Hammersley (2015) argue that this approach to qualitative sample size determination is *"misconceived"*, *"worthless"* and *"could have damaging consequences"* (pp. 688). Instead, Hammersley suggests that the number of participants included in qualitative research should be less concerned with *how* many participants to include, but rather *which* ones in order to generate meaningful themes. It appears that the general consensus for small to medium independent studies, using thematic analysis, six to fifteen participants suffice (Baker & Edwards, 2012; Braun & Clarke, 2019). However, the general rule to sampling, particularly in RTA, is dependent on saturation of themes which can be achieved with as little as three participants (Braun & Clarke, 2021b; Isman et al., 2013). The aim of the current study was to reach the maximum number of participants (e.g., fifteen), however, the timing of the study and difficulty in recruiting BAME service users made it challenging to achieve this desired number. Although a number of service users from different ethnic groups (e.g., Black background) showed interest, they were unfortunately unable to participate due to the impact the pandemic was having on their lives at the time of the study. As such, it was important to be mindful of service user challenges and restrictions in participating in the study. Nonetheless, when data was analysed, saturation was achieved at around seven participants, therefore this offered justification to stop further recruitment.

3.5.5 Ethical considerations

Ethical considerations are imperative in ensuring that those who participate in research are protected from any harm, stress, or undesirable consequences (Robson, 2011). The British Psychological Society (BPS) code of conduct, as well as those drawn from the British Association for Counselling and Psychotherapy (BABCP) Ethical Framework (2013) were used to inform best research practice. This included the use of informed consent before collecting data, protecting participant confidentiality, data protection, right to withdraw, and safety and wellbeing. The researcher undertook training prior to undertaking the research, which included the Good Clinical Practice (GCP) training as part of the National Institute for Health Research (NIHR) to ensure participant needs and rights were understood.

3.5.5.1 Approval

This study received approval from Birmingham City University Research Ethic Committee which is an independent panel made of a team of academics in April 2017 (Ethics Code: 060/17 Cat A). The Health Research Authority (HRA) decision making tool was used to establish whether this study required approval. The study was a service evaluation, using participants who were not currently undertaking treatment at an IAPT service, using qualitative methods, and recruited via non-NHS routes, thus HRA approval was not needed.

3.5.5.2 Informed consent

Informed consent is a critical component of research (Department of Health, 2005). Informed consent for service users was obtained by first providing the information sheet which detailed the purpose of the study. Service users were provided with contact details (e.g., researcher’s email address and phone number) should they wish to further enquire about the study. Participants held the right to make their own decision about whether to participate in the study. Once agreed to participate, a consent form was sent and initialled and signed by each participant. Participants were reminded about their right to withdraw at any stage to ensure that they did not feel obliged to participate if they were unsure. All communication with participants was made via email or telephone due to Covid-19 restrictions. Service users who had initially agreed to take part, but did not respond after three emails, or refused participation due to personal circumstances were not contacted any further.

3.5.5.3 Right to withdraw

Participants were informed and reminded about their right to withdraw from the study at any time before and during the interview without giving any reason. Participants were given up to two weeks after the interview took place to withdraw without any reason. Both verbal and written formats about participant’s right to withdraw were provided in the information sheet and the debrief sheet. This ensured that participant safety, wellbeing, and right to privacy were maintained throughout the study.

3.5.5.4 Confidentiality and data protection

The GDPR guidelines were used as a source of reference to help maintain the confidentiality and data protection of participants’ data (Reuter, 2018). Confidentiality was integral to ensure participant right to privacy was protected and they could trust the researcher. Given challenges in research participation by BAME communities (Adams, 2008; Woodall et al., 2010), the researcher felt that it was important to reassure service users that what they say would not be relayed back to any services or therapists. The researcher informed participants from the outset not to mention their own names, the service that they received therapy from, or the name of their therapist. This was to ensure that there were no traces back to any IAPT service that they had been in contact with. Participants were also informed about how the researcher planned on maintaining their anonymity in research by using pseudonyms and removing all identifying information from transcripts, where needed. The researcher was the only one who had access to the full transcripts which were stored in a password protected zip file on the university secure drive. Once interviews were recorded on the recording device, they were transferred to a password protected zip file immediately and deleted from the portable device. This was to ensure that there was no loss of data in transition. Once data was transcribed and thoroughly checked, the audio recordings were confidentially destroyed.

3.5.6 Developing the interview schedule

3.5.6.1 Semi-structured interviews

Semi-structured interviews were selected as it allows researchers to identify a list of questions, whilst also providing scope for participants to raise issues that have not been anticipated (Braun & Clarke, 2013). This approach was deemed more flexible than structured interviews that tend to be confined to predetermined questions (Braun & Clarke, 2013). Semi-structured interviews offer rich and detailed data about participant experiences and perspectives which go beyond the restraints of quantitative analysis (Savin-Baden & Howell-Major, 2013). By embedding this approach, the researcher was able to consider the diverse accounts and experiences of individuals from BAME communities to help inform the understanding of therapeutic effectiveness in real-world clinical settings.

3.5.6.2 Interview schedule formulation

The interview schedule was informed by literature and developed by brainstorming ideas that would enhance and enrich knowledge of service user experiences and needs. The interview schedule comprised of twelve open-ended questions, with use of prompts where needed, to allow participants to discuss their lived experience of the therapeutic services they received from IAPT. Given focus of previous literature on poor access to psychological therapies by BAME communities (Beck & Naz, 2019; Good & Hannah, 2015), this study primarily focused on the therapeutic experiences and needs of service users who had already received treatment.

Particularly in the context of whether Western notions of evidence-based therapy are suitable to their needs. As such, questions around referral, therapeutic engagement, therapists' cultural competency, and therapeutic effectiveness were considered as the core areas of interest. Examples of some questions included *"How well do you feel the therapy was tailored to your needs?"* and *"How well was your therapist able to understand your cultural background, values, and beliefs?"*. The final closing question allowed participants to raise any issues, concerns or ideas that were important to them and that had not been considered as part of the interview schedule (Braun & Clarke, 2013). The researcher was conscious of her own biases as someone who identifies from the BAME background, so took precautions to ask neutral questions that were not led by her own subjective experience or knowledge (Pope & Mays, 2018). As such, questions specifically directed around patient culture, beliefs, practices were not directly asked (apart from question 9 which related to therapists cultural competency) to ensure that service user experience was authentic and not influenced or directed by the interviewer.

3.5.6.3 Piloting the interview schedule

Before the interview schedule was piloted, the researcher sought feedback from her research team and experts in the field (e.g., Clinical Psychologists) to ensure that the language, content, and structure were fluid and free from jargon. The interview schedule was piloted with the first two service users who participated in the study. Both service users were able to easily understand the content of the interview, were able to freely discuss their stories and experiences, and did not report anything that needed to be amended. As such, both interviews were taken forward as part of the final analysis and the interview schedule was retained for the rest of the interviews.

3.5.7 Study Three: Practitioner recruitment process, ethical approval, and developing the interview schedule

3.5.7.1 Recruitment Process

Recruitment for the mental health practitioner interviews took place between 2018 and 2019, thus was not affected by the global pandemic. Mental health practitioners were recruited using purposive sampling methods (Bricki & Green, 2002) as they needed to have worked in an IAPT service. Several services were approached by the researcher and sent the recruitment poster (*see* Appendix B.4.1) to encourage therapists to take part in the study. The poster was also shared via established contacts (e.g. clinicians working in IAPT) and social media (e.g., Twitter). The majority of therapists were recruited via social media. Five out of the sixteen therapists were recruited via snowball sampling (Bricki & Green, 2002). All the therapists recruited were working at an IAPT service at the time of the study taking place and were offering predominately face-to-face therapy. The therapists' locations were nationwide which included services in West Midlands, London, Manchester, and Sheffield. The diversity in therapists' location, ethnic background, clinical experience, and therapeutic role offered a broad range of perspectives to offer enriched accounts of therapist cultural competency, views, and experiences. Clinical roles ranged from newly qualified trainee Psychological Wellbeing Practitioners (PWPs) to senior qualified therapists in supervisory roles.

3.5.7.2 Inclusion criteria

The inclusion criteria for therapists were for them to have worked or working in an IAPT service, and to have delivered evidence-based psychological interventions to individuals from BAME communities. Therapists were recruited from a range of roles and services to explore the experiences of a varied set of participants. Although homogeneity in the sample can be useful (Baker, 2012), for the current study it was important to consider a broader perspective. All therapists offered therapy primarily in English, therefore there were no concerns with language barriers in conversing or analysing the data.

3.5.7.3 Determining the research sample size

Similar to the service user interviews, the aim of this study was to collect between six to fifteen participants for thematic analysis (Braun & Clarke, 2013). A total of sixteen participants were recruited nationwide. Saturation was achieved at around ten participants so further recruitment beyond the sixteen participants was not needed. For RTA it is advisable to focus on when saturation is achieved rather than the number of participants per se (Braun & Clarke, 2019).

3.5.8 Ethical Considerations

Ethical considerations were guided by the BPS code of conduct, as well as those drawn from the BABCP Ethical Framework (2013) which were used to inform best research practice. This included considerations of informed consent, protecting participant confidentiality, data protection, right to withdraw, and safety and wellbeing.

3.5.8.1 Approval

This study received approval from Birmingham City University Research Ethic Committee which is an independent panel made of a team of academics in April 2017 (Ethics Code: 060/17 Cat A). The Health Research Authority (HRA) decision making tool was used to establish whether this study required approval. The study was a service evaluation, using qualitative methods, and therapists recruited via non-NHS routes, thus HRA approval was not needed.

3.5.8.2 Informed consent

Informed consent was obtained by first providing therapists with an information sheet which detailed the purpose of the study. Therapists were provided with contact details (e.g., researcher's email address and phone number) should they wish to enquire about the study further. The participants held the right to make their own decision about participating in the study. Once agreed to participate, a consent form was sent which was initialled and signed by the participants. Participants were reminded about their right to withdraw to ensure that they did not feel obliged to participate if they were unsure. Therapists who showed interest but were not reachable after three emails, or refused participation due to personal circumstances were not contacted any further.

3.5.8.3 Right to withdraw

Participants were informed and reminded about their right withdraw from the study at any time before and during the interview without giving any reason. Participants were given up to two weeks after the interview took place to withdraw without any reason. Both verbal and written formats about participant right to withdraw were provided in the information sheet and debrief sheet. This ensured that participant safety, wellbeing, and right to privacy were maintained throughout the study.

3.5.8.4 Confidentiality and data protection

The GDPR guidelines were used as a source of reference to help maintain the confidentiality and data protection of participant data (Reuter, 2018). Given the nature of the study, the researcher reminded the therapists that she did not have any personal or professional affiliations with IAPT services and the study was solely independent. This was to ensure that participants felt comfortable to share their experience and were assured that what they said would not be reported back to their employer. The researcher informed participants from the outset not to mention their names, the service that they worked in, or the names of any colleagues or service user they had been in contact with. This was to ensure that there were no traces back to any IAPT service and confidentiality was maintained for both the therapist, other mental health practitioners, and any service user. Participants were also informed about how the researcher planned on maintaining their anonymity in research by using pseudonyms and removing all identifying information from transcripts, where needed. The researcher was the only one who had access to the full transcripts which were stored in a password protected zip file on the university drive. Once interviews were recorded on the recording device, they were transferred to a password protected zip file immediately and deleted from the portable device. This was to ensure that there was no loss of data in transition. Once data was transcribed and thoroughly checked, the audio recordings were confidentially destroyed.

3.5.9 Developing the interview schedule

3.5.9.1 Semi-structured interviews

Semi-structured interviews were also selected for this study to offer flexibility to participants to openly discuss their experience, whilst being somewhat guided through the interview with the areas of interest (Braun & Clarke, 2013). By exploring the perspectives and experiences of therapists, the researcher was able to consider an enriched and detailed account of how evidence-based therapies transpire in real-world clinical settings and therapists cultural competency.

3.5.9.2 Interview schedule formulation

The interview schedule was informed by literature and developed by brainstorming ideas that would enhance and enrich our knowledge about therapists’ cultural competency. The interview schedule comprised of twelve open-ended questions, with use of prompts where needed, to allow participants to discuss their experiences of delivering therapy to individuals from BAME communities. The primary focus of the study was to explore how well therapists were able to consider the needs of BAME communities and the therapeutic effectiveness of evidence-based psychological interventions for this population. As such, questions around therapists cultural competency, service user therapeutic engagement, cultural adaptations to therapy, and therapeutic effectiveness were considered as the core areas of interest. Examples of questions included *“How flexible are you in tailoring therapy to the needs of BAME communities?”* and *“Could you tell me about the training you’ve been offered to deal with cultural diversity?”.* The researcher was conscious of her own biases and prior-knowledge of service users’ inequality in mental health (Ahmed & Bradby, 2008; Fernando, 2012) so was conscious not to ask leading questions. This was to ensure that the authentic experience of therapists could be explored.

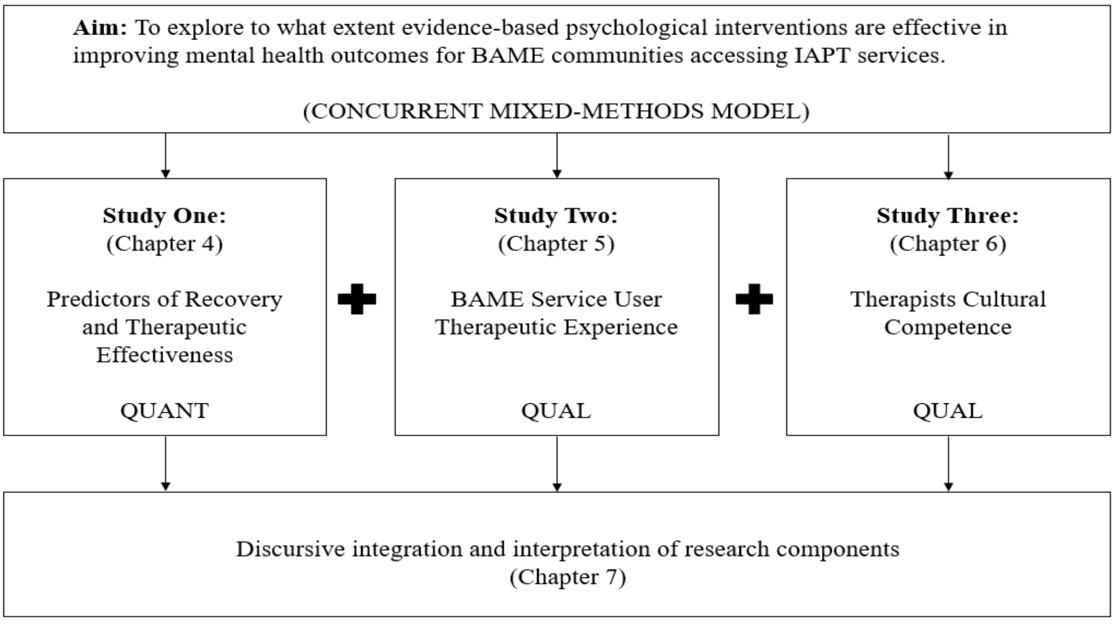
3.5.9.3 Piloting the interview schedule

Before the interview schedule was piloted, the researcher sought peer examination of the interview schedule by gaining feedback from her research team and experts in the field (e.g., Clinical Psychologists) to ensure that the language, content, and structure were fluid and relevant. The interview schedule was piloted with the first two therapists that participated in the study. Both therapists were able to easily understand the content of the interview, were able to freely discuss their experiences, and did not feel that the interview schedule needed to be amended. As such, both interviews were taken forward as part of the final analysis and the interview schedule was retained for the rest of the interviews.

3.6 Chapter summary

This chapter offered a methodological overview for the basis of this thesis. The next chapters will offer the intricacies of the methodological considerations made when conducting each respective study (e.g., participant demographic, procedure). Overview of the next three studies and discursive integration and interpretation of the research components can be found in Figure 3.5.

Figure 3. 5 *Illustrative Overview of the Mixed-Methods Design for this Thesis*



Chapter 4

Study One: Exploring Predictors of Recovery and Therapeutic Effectiveness

4. Study One: Exploring Predictors of Recovery and Therapeutic Effectiveness

4.1 Chapter overview

The systematic review (*see* Chapter 1) and extent literature review (*see* Chapter 2) highlight the paucity of empirically supported research examining the therapeutic effectiveness of evidence-based psychological interventions for ethnic minority communities. Given the vast implementation of the English Improving Access to Psychological Therapies (IAPT) programme, it is unclear how well interventions transpire in real-world clinical settings serving diverse communities. In this retrospective study, clinical data derived from IAPT services will be used to assess a set of research questions. The first will explore what factors are most salient in predicting recovery by considering a number of patient characteristics such as ethnicity, religion, gender, age, and mental health severity. The second research question will explore which evidence-based therapies are most effective in improving mental health outcomes for depression, anxiety and functional impairment. Group comparison between therapeutic modality (non-guided self-help, guided self-help, psychoeducation, counselling, and cognitive behavioural therapy) and ethnicity (White British vs. Black, Asian, and Minority Ethnic groups) will be made to understand if certain therapies are more effective than others.

4.2 Introduction

Growing societal concerns about the surge in common mental health disorders (CMHDs) in modern Britain saw the rise of the English IAPT programme (Clark, 2011; Layard, 2005). A service that offered "*happiness on an industrial scale"* was not easily refused by government representatives (Marks, 2018), thus being regarded as the largest sustained investment since the National Health Service (NHS) (BPS, 2012). By offering evidence-based psychological interventions recommended by the National Institute of Care and Excellence (NICE), IAPT implemented the stepped-care approach to tackle CMHDs (Clark, 2018a). Despite its success, there is growing concern of whether evidence-based psychological interventions offered by IAPT meet the needs of ethnic minority communities (Baker, 2018; Beck & Naz, 2018; Moller et al., 2019). The efficacy of evidence-based interventions are often tested in controlled conditions, using a homogenous set of participants (e.g., White / Caucasian, middle-class), thus when interventions are applied to ‘real-world’ clinical settings, seldom do they produce consistent results (Gordis, 2014; Pawson & Tilley, 2004). These therapeutic disparities become more salient with ethnic minority communities who tend to be excluded from clinical trials and research (Hall, 2001; Hwang et al.,, 2008). In England, the disproportion of empirically supported studies that have considered the needs of BAME communities are profound (*see* Chapter 1), despite comparative, or higher levels of CMHDs than the White British population (e.g., Weich & McManus, 2002; Weich et al., 2004; Rehman & Owen, 2013).

Psychotherapy is a product of the West, thus individuals from non-Western communities may not know what it is, how it can help, or what to expect from therapy (Sue, 2006). By adopting the values, beliefs and principles of the dominant individualistic culture, person-centered care is deemed important for recovery (Laungani, 2007) and for patients to be their own agent to take control of their own lives (Frese III et al., 2001). However, ethnic minority communities tend to originate from collectivist societies, which work hard to instil and preserve cultural norms, values, and traditions of their country of origin (Hofstede, 2011; Tse & Ng, 2014). Here, greater regard is given to others (e.g., family members, clans, tribes) thus the interdependent nature of the self is expected to adjust, restrain and maintain harmony over self-serving desires and expectations (Markus & Kitayama, 1991). This often conflicts with Western notions of therapy which insists on self-sufficiency, independence, and autonomy, often at the expense of risking eternalising factors such as cultural value systems (Al-Krenawi & Graham, 2000; Christopher, 2001; Fernando, 2012). As such, individuals are left feeling misunderstood or even mistreated by mental health service providers (Bristow et al., 2011; Mclean et al., 2003; Mofrad & Webster, 2012) leading to greater drop-out rates (Baker, 2018; Harwood et al., 2021).

Given the preference on empirically guided outcome measures, IAPT tends to "*mark its own homework*" by using in-house data analysts to assess therapeutic effectiveness at a national level (Scott, 2019). Whilst the general service target is for IAPT services to achieve 50% recovery rate for those it serves, seldom do these outcomes transpire when data are reviewed in independent studies (between 9 – 22% recovery) (Griffiths & Steen, 2013b, Marks, 2018; Scott, 2018a) or in ethnic minority populations when compared to the White British population (up to 10% difference in recovery outcomes) (Baker, 2018; Moller et al., 2019). Previous studies have sought to establish what factors are salient in predicting recovery outcomes. They have found greater disorder severity, disorder type (e.g., depression) (Amati et al., 2017; Gyani et al., 2012), age, ethnicity, indices of deprivation (Catarino et al., 2018; Green et al., 2015) and lower functional impairment as predictors of recovery. However, the majority of studies have ignored religious orientation and seldom assess ethnicity as confounding variables to therapeutic success. Given the importance of religion and spirituality within BAME communities (Castillo & Guo, 2011; Fernando, 2005; Mantovani et al., 2017) and the cultural differences observed in ethnic minority populations, the addition of these factors may be important in identifying whether treatment programmes can be personalised to the needs of minority communities (Amati et al., 2017; Catarino et al., 2018).

Moreover, recovery outcomes based on therapeutic modality have seldom assessed or reported what works best for ethnic minority communities. Previous studies examining therapeutic success in the general population have found inconsistent findings based on therapeutic modality, in both low-intensity (e.g., guided self-help, non-guided self-help) and high-intensity treatments (CBT, counselling) (Delgadillo & Gonzalez Salas Duhne, 2020; Gyani et al., 2011; Moller et al., 2019; Pybis et al., 2017) (*see* Chapter 2). In line with NICE guidance, guided self-help has shown greater recovery rates than non-guided self-help for both depression and anxiety related disorders (Gyani et al, 2011). However, the specificity of this for ethnic minority populations is unclear. Given that previous RCTs have primarily focused on psychoeducation for BAME communities (Jacob, 2002; Horell et al., 2014) (*see* Chapter 1) it would be worth assessing which therapeutic format might be most effective. For high-intensity treatments, therapeutic success for CBT vs. counselling have been inconsistent, with some studies reporting little differences between treatment outcomes (Delgadillo & Gonzalez Salas Duhne, 2020; Moller et al., 2019; Pybis et al., 2017). However, it is unclear how effective such interventions are in diverse communities (Woodall et al., 2010). Given such research limitations and lack of understanding of whether evidence-based psychological interventions are effective in real-world clinical settings, this study aimed to examine the following research questions;

Research Question 1: What factors are most salient in predicting recovery?

Research Question 2: Which evidence-based psychological therapies are most effective in improving mental health outcomes for depression, anxiety and functional impairment for White British and BAME groups?

4.3. Methods

4.3.1. Ethics statement

Ethical approvals was sought in three stages and received full approval. First, approval was received from the researcher's academic institution (Birmingham City University) in April 2017 (Ethics Code: 060/17 Cat A), followed by the Health Research Authority (HRA) in July 2018 (Ethics Code: 18/WM/0185), and then by each respective IAPT Research & Development (R&D) department was contacted to release the dataset. Patients provided consent for their anonymised data to be included in the Minimum Dataset (MDS) which could be used to monitor clinical outcomes and used as part of independent research studies (NHS Digital, 2019). Patient privacy and confidentiality was directed by the General Data Protection Regulation (GDPR) Data Protection Act 2018 in order to preserve patient anonymity (*see* Chapter 3 - Ethical considerations for NHS IAPT datasets).

4.3.2. Design

A cross-sectional retrospective study design was employed to collect naturally occurring data as part of routine clinical practice (Talari & Goyal, 2020) (*see* Chapter 3 - Rationale for using cross-sectional retrospective design). The secondary data was collected as part of the MDS in which patients are asked to complete standardized measures of depression, anxiety and functional impairment (along with others where needed) at every session (*see* section 4.3.3. – Outcome measures). Data was collected from two Trusts (with multiple IAPT services) and two independent IAPT services (*see* Chapter 3 - IAPT context and settings). The datasets were collated between 1st January and 31st December 2016.

4.3.3. Outcome measures

IAPT clinicians are instructed to use the Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder Scale (GAD-7) at each appointment session to assess levels of depression and anxiety. Both measures are used to assess recovery outcomes (*see* section 4.3.3.1 – Calculating recovery rates). Over recent years, a push towards data completeness and service evaluation has meant that clinicians are expected to use the measures at each session so that the severity of the disorder can be assessed throughout the treatment and to provide measurable outcomes that can assess the clinical effectiveness of psychological interventions (Clark et al., 2009). The Work and Social Adjustment Scale (WSAS) measure is also used to assess improvement in functional impairment throughout a course of treatment.

Patient Health Questionnaire (PHQ-9): The PHQ-9 depression scale is a 9-item self-report measure to assess the severity of depression (Kroenke, Spitzer, & Williams, 2001). The measure requires the service user to answer a series of questions that may have occurred over the past 2 weeks. For example, the first question requires participants to indicate whether they had *'little interest or pleasure in doing things'* by marking against a 4-point scale ranging from 0 to 3, where 0 indicates *'not at all'* and 3 indicates *'nearly every day'*. Once completed, scores are added to determine the severity of depression. The range of scores are from 0 to 27, where 0 – 4 means no depression, 5 – 9 mild, 10 – 14 moderate, 15 – 19 moderately severe, and 20 – 27 severe. The psychometric properties of the measure have indicated favourable Cronbach's alpha findings (e.g., a = .89) and been supported within literature for its internal consistency and convergent validity (e.g., Cameron, Crawford, Lawton, & Reid, 2008; Dum, Pickren, Sobell, & Sobell, 2008).

Generalized Anxiety Disorder Scale (GAD-7): The GAD-7 is a 7-item self-report scale used to assess generalised anxiety disorder (Spitzer, Kroneke, Williams, & Lowe, 2006). Service users are required to answer a series of questions which ask them to indicate how often they have experienced problems such as *'feeling nervous, anxious or on edge'* on a 4-point scale. The scale ranges from 0 *'not at all'* to 3 *'nearly every day'*. Once completed, scores are added, ranging from 0 to 21, where 0 – 4 means no anxiety, 5 – 9 mild anxiety, 10 – 14 moderate anxiety, and 15 – 21 severe anxiety. The psychometric properties for the measure indicate reliable Cronbach's alpha scores (e.g., .92) and the internal consistency and convergent validity has been supported by other researchers (e.g., Dear et al., 2011).

Work and Social Adjustment Scale (WSAS): The WSAS is a five-item scales which measures functional impairment at work, home management, social leisure activities, private leisure activities, and relationships which are scored from zero to eight, where zero indicates no impairment and eight very severe impairment (Mundt et al., 2002). Total scores from 0 – 10 indicate subclinical impairment, 10 – 20 functional impairment, 20 - 30 moderately severe impairment, and 30 – 40 severe impairment.

4.3.3.1. Calculating recovery rates

IAPT determines recovery based on referrals that start at 'caseness' on *either* the PHQ-9 *or* GAD-7 or *both* measures and end treatment below the 'caseness' threshold for *both* measures (*see* Table 4.1).

Table 4. 1. *IAPT Outcome Measures to Calculate Recovery Rates*

Outcome Measure	**To Assess Levels of**	**Clinical Threshold (Caseness)**	**Score Range**	**Change Index***
Patient Health Questionnaire (PHQ-9)	Depression	> 10	*Range*: 0-27 0 – 4: No Depression 5 – 9: Mild 10 – 14: Moderate 15 – 19: Moderately Severe 20 – 27: Severe	> 6
Generalized Anxiety Disorder Scale (GAD-7)	Anxiety	> 8	*Range*: 0-21 0 – 4: No Anxiety 5 – 9: Mild 10 – 14: Moderate 15 – 21: Severe	> 4

Note. *Refers to the change between pre-post treatment scores to be deemed as reliably improved. Scores above the change index represent greater improvement in disorder severity.

To meet the criteria for recovery, at least two paired scores on PHQ-9 and GAD-7 scores must be present (e.g., pre-post treatment scores). The government target for referrals moving to recovery is set at 50% (NHS Digital, 2019). In order to calculate the recovery rate, IAPT uses the following calculation:

$$\frac{\textit{Number of referrals that moved to recovery}}{\left(\textit{Number of referrals that finished a course of treatment} - \textit{Number of referrals that finished a course of treatment \& started treatment not at caseness}\right)} \text{ X } 100$$

4.3.4. Patient demographics

4.3.4.1. Sample selection to assess predictors of recovery

To assess the predictors of recovery for research question one, a binary logistic regression was selected as the dependent variable contained dichotomous categorical outcomes, and multiple independent variables. A priori power analysis using G*Power software version 3.1.9.7 (Faul, Erdfelder, Buchner, & Lang, 2009) was conducted to determine the minimum sample size required for a binary logistic regression. To achieve 80% power for detecting a small effect using Cohen's (1998) criteria, at a significance criterion of a = .05, a sample size of N = 786 was recommended. For the current study, a total of N = 13,710 patients (out of N=24,750) met the inclusion criteria for research question one (*see* Chapter 3 – Dataset sample selection and quality checks) and exceeded the sample size required for analysis (*see* Table 4.2).

The large majority of patients identified as White British (89.5%). The BAME population made the remainder of the service user demographic (10.5%), of which the Asian group was the largest sample (5.5%). This was followed by the Mixed (2.6%), Black (1.6%), and Other Ethnic group (0.9%). The mean age for the White British group was M = 41.39 (SD = 15.32) years old, whilst for the BAME group it was M = 37.10 (SD = 12.22) years old. The proportion of gender split between the White British and BAME groups was similar. Over 64.4% of White British participants were female and 64.9% of BAME participants were female. Similarly, 35.6% of White British participants were male and 35.1% of BAME participants were male. The largest proportion of service users from the White British group identified their religious orientation as Christian (31.5%) and No religion (35.4%). For the BAME group, the large majority of service users identified as Muslim (33.9%). Other religious orientations are described in Table 4.2. A total of 28.9% of White British service users were diagnosed with depression, whilst this was 35.2% for BAME groups. A greater proportion of service users were diagnosed with an anxiety related disorder. This was 71.1% for the White British group and 64.8% for the BAME group. Anxiety related disorder breakdown can be found in Table 4.2. The baseline pre-treatment scores were adjusted for missing values (*see* Chapter 3 - Approach to dealing with missing data). Mean baseline depression scores (PHQ-9) for the White British group was *M* = 16.05 (*SD* = 5.91), whilst this was *M* = 17.31 (*SD* = 5.68) for the BAME group. Mean baseline anxiety scores (GAD-7) for the White British group was *M* = 14.45 (*SD* = 4.63), whereas this was *M* = 15.40 (*SD* = 4.49) for the BAME group. Finally, the mean baseline score for functional impairment (WSAS) was *M* = 21.74 (*SD* = 8.90), whilst this was *M* = 23.92 (*SD* = 9.01) for the BAME group.

Table 4. 2. *Service User Demographics by Ethnic Group for Study One*

	White British		**BAME**[a]	
Ethnicity (*N*, %)	12,266	(89.5%)	1,444	(10.5%)
Of which;				
Mixed			353	(2.6%)
Asian			758	(5.5%)
Black			216	(1.6%)
Other Ethnic			117	(0.9%)
Age (Mean, *SD*)	41.39	(*15.32*)	37.10	(*12.22*)
Gender (*N*, %)				
Female	7,897	(64.4%)	937	(64.9%)
Male	4,372	(35.6%)	507	(35.1%)
Religion (*N*, %)				
Buddhist	21	(2%)	11	(8%)
Christian	3,865	(31.5%)	264	(18.3%)
Hindu	2	(0%)	62	(4.3%)

Jewish	88	(7%)	1	(1%)
Muslim	11	(1%)	489	(33.9%)
Sikh	0	(0%)	143	(9.9%)
No Religion	4,339	(35.4%)	254	(17.6%)
Other	3,940	(32.1%)	220	(15.2%)
Diagnosis (*N*, %)				
Depression	3,542	(28.9 %)	508	(35.2 %)
Anxiety Related Disorder	8,723	(71.1 %)	936	(64.8 %)
Of which;				
GAD[b]	3,288	(26.8 %)	344	(23.8 %)
OCD[c]	345	(2.8 %)	28	(1.9 %)
SAD[d]	369	(3.0 %)	16	(1.1 %)
MADD[e]	3,836	(31.3 %)	445	(30.8 %)
PTSD[f]	568	(4.6 %)	72	(5.0 %)
Panic Disorder	317	(2.6%)	31	(2.1 %)
Baseline Pre-Treatment Scores (Mean, *SD*)				
PHQ-9[g]	16.05	(*5.91*)	17.31	(*5.66*)
GAD-7[h]	14.45	(*4.63*)	15.40	(*4.49*)
WSAS[i]	21.74	(*8.90*)	23.92	(*9.01*)

Note. [a]Black, Asian, & Minority Ethnic (BAME); [b]Generalised Anxiety Disorder (GAD); [c]Obsessive Compulsive Disorder (OCD); [d]Social Anxiety Disorder (SAD); [e]Mixed Depressive and Anxiety Disorder (MADD); [f]Post-traumatic Stress Disorder (PTSD); [g]Patient Health Questionnaire – 9 (PHQ9); [h]Generalized Anxiety Disorder – 7 (GAD7) Scale; [i]Work and Social Adjustment Scale (WSAS).

4.3.4.2. Sample selection to assess therapeutic effectiveness

To assess the therapeutic effectiveness of evidence-based therapies for research question two, a Multiple Analysis of Covariance (MANCOVA) was selected due to its inclusion of two independent variables (treatment type and ethnicity), multiple dependent variables, and covariates. A priori power analysis using G*Power software version 3.1.9.7 (Faul et al., 2009) was conducted to determine the minimum sample size required for a MANCOVA. To achieve 80% power for detecting a small effect using Cohen's (1998) criteria, at a significance criterion of a = .05, a sample size of *N* = 146 participants per group was recommended. Based on this recommendation, the therapeutic modality per ethnic group was checked to ensure it met the sample size criteria. The dataset showed considerable variability between treatment modalities and ethnicity. For example, for some interventions there were very small number of patients allocated to the treatment type to draw meaningful comparisons (e.g., for behavioural activation); or there was no ethnic groups allocated to a particular type of therapy (e.g., computer-based guided self-help); or therapy type not being specified (e.g., other high-intensity therapy). In addition, due to the small sample size per individual BAME groups, the ethnic minority groups were combined to strengthen the power of analysis. As such, the most common low-intensity (psychoeducation; guided self-help; non-guided self-help) and high-intensity (CBT; counselling) therapies were selected based on the group sample size (*see* Table 4.3). Based on the aforementioned reasons, from the *N* = 13,710 patients in research question one (*see* Section 4.3.4.1) a total of *N* = 3,785 service users were removed from the analysis. This included *N* = 3,562 patients who identified as White British and *N* = 223 patients who identified as BAME background. Thus final sample was *N* = 9,925 service users. Details of the sample size based on ethnicity and treatment type included for research question two can be found in Table 4.3.

Table 4. 3. *Sample Selection for Most Common Therapies by Ethnic Group*

	White British		**BAME**[a]	
Therapy Type (*N*, %)				
LI Guided Self-Help	2894	(34.3%)	270	(22.1%)
LI Non-Guided Self-Help	1278	(14.7%)	370	(30.3%)
LI Psychoeducation	1131	(13.0%)	151	(12.6%)
HI Counselling	1351	(15.5%)	171	(14.0%)
HI CBT[b]	1960	(22.5%)	256	(21.0%)
Total	8704		1221	

Note. LI = Low-intensity; HI = High-intensity; [a]BAME = Black, Asian, and Minority Ethnic (BAME); [b]Cognitive behavioural therapy (CBT)

4.3.5. Procedure

The data was collected as part of routine clinical practice at the participating IAPT services during 1st January and 31st December 2016. Before the datasets were released to the researcher, each respective service removed patient personal identifiers (e.g., name, address, NHS number) for data protection. All datasets were sent in Microsoft Excel 2016 format by patient appointment level (e.g., each row represented one appointment). The datasets were transformed by the researcher using Microsoft Access 2016 so that service user records could be combined at case level (e.g., each row represented a patient case and the number of appointments they had) across the datasets. At this stage, the researcher further removed any identifiable data items (e.g., service provider ID) and replaced them with unique patient numbers to maximise patient confidentiality and anonymity. The final combined dataset was transferred to the IBM Statistical Package for the Social Sciences (SPSS) Statistics version 25 software. Here, the datasets were checked against the inclusion criteria (*see* Chapter 3 – Inclusion and exclusion criteria) and treated for missing data (*see* Chapter 3 – Dealing with missing data). The final dataset was quality checked to minimise researcher error (*see* Chapter 3 – Data quality checks). All analyses were carried out using the IBM SPSS Statistics version 25 software.

4.3.6. Statistical analysis strategy

4.3.6.1. Assessing predictors of recovery: Binary logistic regression

A binary logistic regression was selected to explore which patient characteristics are most salient in predicting recovery. Recovery was the outcome variable which was dichotomous (recovered or not recovered) which was calculated as priori before analysis took place (*see* Sections 4.3.3.1 and 4.4.1). There were eight predictor variables, which included ethnicity (White British, Mixed, Asian, Black, and Other Ethnic), gender (male and female), age range (18 – 35, 36 – 64, and over 65), provisional diagnosis (depression or anxiety related disorders), religion (Buddhist, Christian, Hindu, Jewish, Muslim, Sikh, No Religion, Other), PHQ-9 baseline severity (none, mild, moderate, moderately severe, and severe depression), GAD-7 baseline severity (none, mild, moderate, and severe anxiety), and WSAS baseline severity (subclinical impairment, functional impairment, moderately severe impairment, and severe impairment). Additional patient characteristics such as cultural orientation (Bhugra, 2005; Yan, 2018), race (Ryan & Pritchard, 2004), and migration status (Beck & Naz, 2019) are not collected as part of routine IAPT practice (NHS Digital, 2019), thus could not be included in the current study. The binary logistic regression met the following assumptions; the dependent variable was binary and observations were independent of each other. Given the categorical nature of the dependent variables, the collinearity diagnostic, analysis of residuals, log odds were not applicable (*see* Appendix C.1.1).

To ensure model robustness, a sensitivity analysis was carried out using a mixture of categorical variables (e.g., ethnicity, gender) and continuous variables (e.g., for age, outcome measure scores) to test whether this improved model fit. Whilst the assumptions for binary logistic regression were met, only 7.5% (Nagelkerke $R^2 = .075$) of variance in the outcome variable were explained by the model. Moreover, the Hosmer and Lemeshow Test showed that there was evidence of poor fit between the model and the data ($p < .001$). A possible reason for this may have been due to the large sample size and increased variance in continuous data (Koppe, Meyer-Lindenberg, & Durstewitz, 2021). Thus, the decision was made to retain the categorical grouping of all variables to strengthen the model fit (*see* Section 4.4.2).

4.3.6.2 Assessing therapeutic effectiveness: MANCOVA

A two-way (5 x 2) between-subjects multivariate analysis of covariance (MANCOVA) was carried out to investigate which therapeutic modality (IV1) (guided self-help, non-guided self-help, psychoeducation, counselling or CBT) was most effective in improving mental health outcomes between ethnic groups (IV2) (White British and BAME groups). The dependent variables (DV) were *post-treatment* scores on measures of depression (PHQ-9), anxiety (GAD-7), and functional impairment (WSAS). The covariates included *pre-treatment* scores (initial severity) for each outcome measure (PHQ-9, GAD-7, and WSAS) and age. The covariates were selected due to being identified as significant contributors to recovery (*see* Section 4.4.2). Thus, it was deemed important to understand how effective therapies are after controlling for influences of initial mental health severity and age (Amati et al., 2017; Green et al., 2015).

Preliminary assumption testing was conducted to check for multivariate normality, outliers, linearity, homogeneity of variance covariance matrices, and homogeneity of regression slopes (Field, 2018). Due to the large sample size and distribution of cases, there appeared to be some suspected violations of the assumptions, such as for multivariate normality and linearity. The Box's M value (384.844) was significant (p <.001) indicating that the homogeneity of covariance matrices across groups is not assumed. However, given the conventions of the central limit theorem, it was expected that these violations were driven by the sample distribution rather than violations in the data (Kwak & Kim, 2017). Moreover, given the enhanced statistical power of a large sample size, tests such as MANCOVA are robust to such violations (Warner, 2013). More information about how the assumptions were considered are discussed in the appendices (*see* Appendix C.1.2). The effect size assessment was obtained by using the partial eta squared proposed by Cohen (1998) where .01–.06 = small effect; .06–.14 = moderate effect and a value more than .14 = large effect. Statistical significance was indicated by p < .05 (two-tailed).

4.4 Results

4.4.1 Priori recovery rates

Priori calculations were carried out to determine the recovery outcomes within the sample (*see* Section 4.3.3.1). Results revealed that 35.20% of White British and 30.64% of BAME service users had achieved recovery following a course of treatment (*see* Table 4.4).

Table 4. 4. *Recovery Rate Calculations*

Ethnicity	***N* Recovered**	**Recovery Rate**
White British	4164	35.20%
BAME[a]	432	30.64%

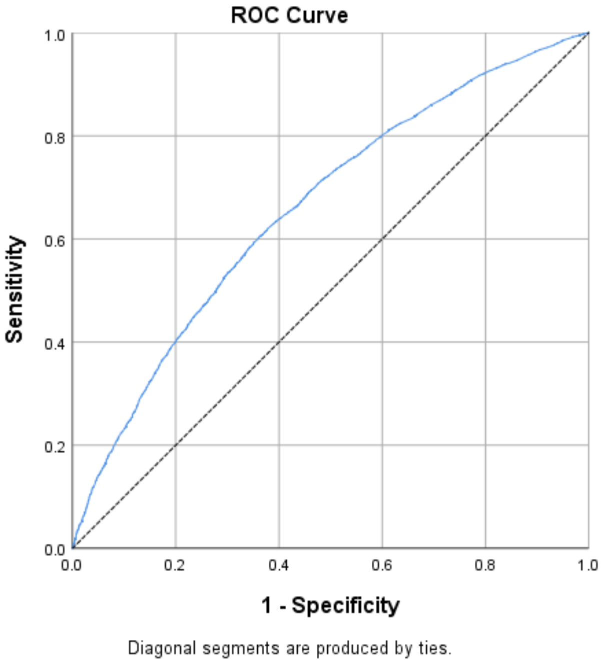
Note. [a]Black, Asian, & Minority Ethnic (BAME)

4.4.2 Findings for research question one: Predictors of recovery

The results for the binary logistic regression are presented as odds ratios Exp(β) and 95% confidence intervals (95% *CI*). The level of significance was set at a *p* value .05. Confidence intervals and standard errors for estimates from the logistic regression were based on 1000 bootstrap samples. A bootstrap method of estimating confidence intervals and significance values was adopted because it was robust and required fewer assumptions. The model explained 9.5% (Nagelkerke R^2 = .095) of the variance in the outcome variable, which showed that it was barely sufficient in explaining the variance (*see* Table 4.5). However, the Hosmer and Lemeshow Test showed good fit between the model and the data (p =.984). The overall model was significant in predicting recovery 67.7% of the time (χ^2 (24) = 967.787, p <.001).

A Receiver Operating Characteristic (ROC) curve (*see* Figure 4.1) showed that the model was significantly better than by chance at predicting recovery (AUC =.660, 95% *CI*=.650-.670, p <.001).

Figure 4. 1. *A ROC Curve for Predicting Recovery*



Note. The dotted line represents chance and the solid line represents the improvement from chance in the model’s capacity to correctly predict recovery.

Table 4. 5. *Binary Logistic Regression Results for Recovery*

Variable	*β*	*SE*	*p*	Exp(*β*)	95% *CI* for Exp(*β*)	
					Lower	*Upper*
Step 1[a]						
Ethnicity			.020			
Ethnicity (Mixed)	-.379	.131	**.004**	.685	.530	.885
Ethnicity (Asian)	-.037	.157	.813	.963	.708	1.312
Ethnicity (Black)	-.089	.154	.562	.914	.676	1.237
Ethnicity (Other Ethnic Group)	-.429	.238	.071	.651	.409	1.038
Gender (Male)	-.027	0.040	.497	.974	.901	1.052
Religion			.000			
Religion (Other)	-.132	.049	**.007**	.877	.797	.964
Religion (Buddhist)	-.254	.419	.543	.775	.341	1.761
Religion (Christian)	.205	.048	**.000**	1.228	1.116	1.350
Religion (Hindu)	.441	.301	.144	1.554	.861	2.806
Religion (Jewish)	.152	.226	.501	1.164	.748	1.813
Religion (Muslim)	.033	.173	.847	1.034	.737	1.450
Religion (Sikh)	.871	.231	**.000**	2.388	1.518	3.757
Provisional Diagnosis (Anxiety)	.044	.044	.309	1.045	.960	1.139
Age			.000			
Age (18 – 35)	-.615	.074	**.000**	.541	.468	.624
Age (36 - 64)	-.462	.071	**.000**	.630	.548	.725
PHQ-9 Baseline			.000			
PHQ-9 Baseline (None)	.458	.119	**.000**	1.581	1.253	1.994
PHQ-9 Baseline (Mild)	.749	.077	**.000**	2.114	1.817	2.460
PHQ-9 Baseline (Moderate)	.897	.060	**.000**	2.452	2.182	2.756
PHQ-9 Baseline (Moderately Severe)	.454	.051	**.000**	1.574	1.424	1.740
GAD-7 Baseline			.000			
GAD-7 Baseline (None)	-.761	.140	**.000**	.467	.355	.615
GAD-7 Baseline (Mild)	.284	.062	**.000**	1.328	1.175	1.501

GAD-7 Baseline (Moderate)	.402	.046	**.000**	1.495	1.365	1.637
WSAS Baseline			.000			
WSAS Baseline (Subclinical)	.366	.069	**.000**	1.442	1.259	1.652
WSAS Baseline (Functional Impairment)	.196	.044	**.000**	1.216	1.115	1.326
Constant	-.942	.089	.000	.390		

Note. Significance represents statistical significance $p < .05$

The model showed that the odds of being from a Mixed ethnic group significantly decreases the likelihood of recovery by 31.5% (Exp(β) =.685; 95% *CI*=.530-.885, p = .004) when compared to the White British group. No significant differences were observed for any other BAME groups.

Religion was compared to those who identified with no faith. Those who identified as Sikh had significantly increased odds of recovery by 138% (Exp(β) =2.388; 95% *CI*=1.518-3.757, p <.001) than those with no faith. These odds were also increased by 22.8% for Christian (Exp(β) =1.228; 95% *CI*=1.116-1.350, p <.001) and 12.3% of Other religious groups (Exp(β) =.877; 95% *CI*=.797-964, p =.007) when compared to those with no faith. No significant differences were observed for any other religious groups.

Gender (Exp(β) =.974; 95% *CI*=.901-1.052, p = .497) and provisional diagnosis (Exp(β) =.1.045; 95% *CI*=.960-1.139, p =.309) did not significantly predict recovery.

For age, results indicated that as age decreased, the odds of recovery decreased. The odds of recovery for those between 18 – 35 year olds significantly decreased by 45.9% (Exp(β) =.541; 95% *CI*=.468-.624, p <.001) and by 37% for 36 – 64 year olds (Exp(β) =.630; 95% *CI*=.548-.725, p <.001) when compared to adults aged over 65 years old.

Baseline severity for depression measured by the PHQ-9 indicated the odds of recovery for those with no depression significantly increased by 58.1% (Exp(β) =1.581; 95% *CI*=1.253-1.994, *p* <.001) when compared to those with severe depression. Those with mild depression had significantly increased odds of recovery by 111% (Exp(β) =2.114; 95% *CI*=1.817-2.460, *p* <.001) whilst this was 145% for those with moderate depression (Exp(β) =2.452; 95% *CI*=2.182-2.756, *p* <.001) when compared to those with severe depression. For moderately severe patients the odds of recovery were significantly increased by 57.4% (Exp(β) =1.574; 95% *CI*=1.424-1.740, *p* <.001) compared to those with severe depression. This suggests that mild to moderate conditions are more successful in achieving recovery than more severe conditions.

Baseline severity for anxiety measured by the GAD-7 revealed that the odds of recovery for those with no anxiety was significantly reduced by 53.3% (Exp(β) =.467; 95% *CI*=.355-.615, *p* <.001) when compared with severe conditions. However, the odds of recovery significantly improved by 32.8% of those with mild (Exp(β) =1.328; 95% *CI*=1.175-1.501, *p* <.001) and 49.5% of moderate (Exp(β) =1.495; 95% *CI*=1.365-1.637, *p* <.001) anxiety when compared to severe conditions. This suggests that mild to moderate conditions are more likely to predict recovery than more severe conditions.

Finally, baseline severity for functional impairment measured using the WSAS revealed that the odds of recovery was significantly improved by 44.2% for those with subclinical severity (Exp(β) =1.442; 95% *CI*=1.259-1.652, *p* <.001) and by 21.6% for those with functional impairment (Exp(β) =1.216; 95% *CI*=1.115-1.326, *p* <.001) than those diagnosed with moderately severe functional impairment. This suggests that as severity increases, the likelihood of recovery decreases.

4.4.3 Findings for research question two: Therapeutic effectiveness

Pillai's Trace criterion was used to offer conservative considerations of the results when normality is not assumed (Field, 2018). Results showed that the combination of DVs (*post-treatment* scores) were significantly different for levels of treatment type (Pillai's Trace = .005, *F*(4, 9911) = 3.84, $p < .001$, partial η2 = .002) and ethnic group (Pillai's Trace = .002, *F*(1, 9911) = 5.25, $p < .001$, partial η2 = .002), after controlling for age and initial *pre-treatment* scores for depression, anxiety, and functional impairment. A significant interaction was found between treatment type and ethnicity (Pillai's Trace = .002, *F*(4, 9911) = 1.81, $p = .041$, partial η2 = .001). To note, whilst the results were significant, the effect size is very small. To investigate this further, on the basis of the significant MANCOVA result, individual two-way analysis of covariance (ANCOVA) tests were conducted (*see* Table 4.6).

Table 4. 6. *ANCOVAs for Depression, Anxiety, and Functional Impairment Post-Treatment Scores*

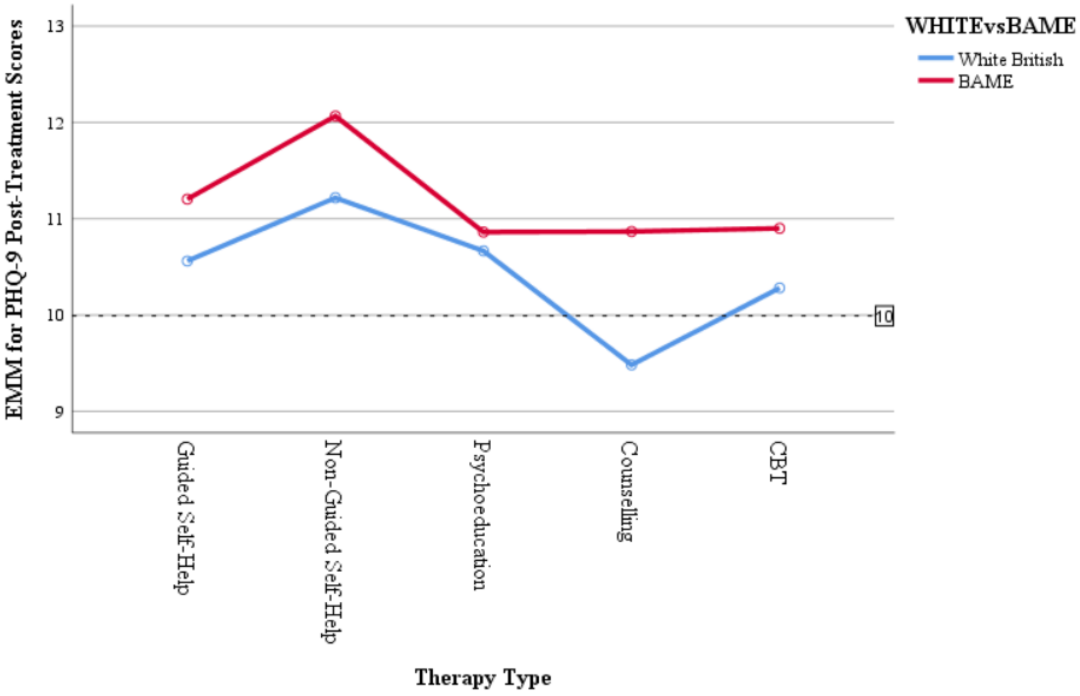
Source	*df*	Mean Square	*F*	*p*	Partial η^2
PHQ-9^a Post-Treatment					
Age (Covariate)	1	700.497	20.332	.000	.002
PHQ-9 Pre-treatment Scores (Covariate)	1	78477.373	2277.780	.000	.187
Ethnicity	1	520.900	15.119	**.000**	.002
Therapy Type	4	261.497	7.590	**.000**	.003
Ethnicity * Therapy Type	4	28.072	.815	.515	. .000
Error	9913	34.453			
Total	9925				

GAD-7^b Post-Treatment					
Age (Covariate)	1	895.255	33.196	.000	.003
GAD-7 Pre-treatment Scores (Covariate)	1	44021.633	1632.334	.000	.141
Ethnicity	1	403.810	14.973	**.000**	.002
Therapy Type	4	160.202	5.940	**.000**	.002
Ethnicity * Therapy Type	4	25.215	.935	.442	.000
Error	9913	26.969			
Total	9925				
WSAS^c Post-Treatment					
Age (Covariate)	1	97.215	1.619	.203	.000
WSAS Pre-treatment Scores (Covariate)	1	74379.816	1239.011	.000	.111
Ethnicity	1	873.626	14.553	**.000**	.001
Therapy Type	4	252.339	4.203	**.002**	.002
Ethnicity * Therapy Type	4	140.752	2.345	052	.000
Error	9913	60.032			
Total	9925				

Note. PHQ-9^a - Patient Health Questionnaire-9, GAD-7^b – Generalized Anxiety Disorder-7, WSAS^c – Work and Social Adjustment Scale

Depression Severity (PHQ-9 Post-Treatment): A two-way ANCOVA was carried out where *post-treatment* depression scores measured by the PHQ-9 served as a DV and treatment type (IV1) and ethnicity (IV2) served as independent variables. Initial depression severity (*pre-treatment* depression scores) and age were included as covariates (*see* Table 4.6). All main effects were statistically significant at the .05 significance level with pairwise comparisons adjusted using Bonferroni corrections (*see* Figure 4.2). The main effect of treatment type yielded a F ratio of $F(4, 9913) = 7.59$, $p < .001$, partial $\eta 2 = .003$), indicating that the mean post-treatment scores were significantly greater for non-guided self-help when compared to guided self-help ($M = .760$, $SE = .255$, 95% $CI = .045\text{-}1.475$, $p = .028$); psychoeducation ($M = .879$, $SE = .306$, 95% $CI = .019\text{-}1.739$, $p = .041$); counselling ($M = 1.467$, $SE = .295$, 95% $CI = .639\text{-}2.296$, $p < .001$); and CBT ($M = 1.051$, $SE = .261$, 95% $CI = .318\text{-}1.784$, $p < .001$) after controlling for initial depression severity and age. The main effect for ethnicity yielded a F ratio of $F(1, 9913) = 15.12$, $p < .001$, partial $\eta 2 = .002$), indicating that the mean post-treatment scores were significantly lower for the White British group when compared to the BAME group ($M = -.738$, $SE = .190$, 95% $CI = -1.110 - -.366$, $p < .001$) after controlling for initial depression severity and age. To note, the effect sizes for treatment type and ethnicity were very small. The interaction effect between treatment type and ethnicity was non-significant $F(4, 9913) = 0.82$, $p = .515$, partial $\eta 2 = .000$).

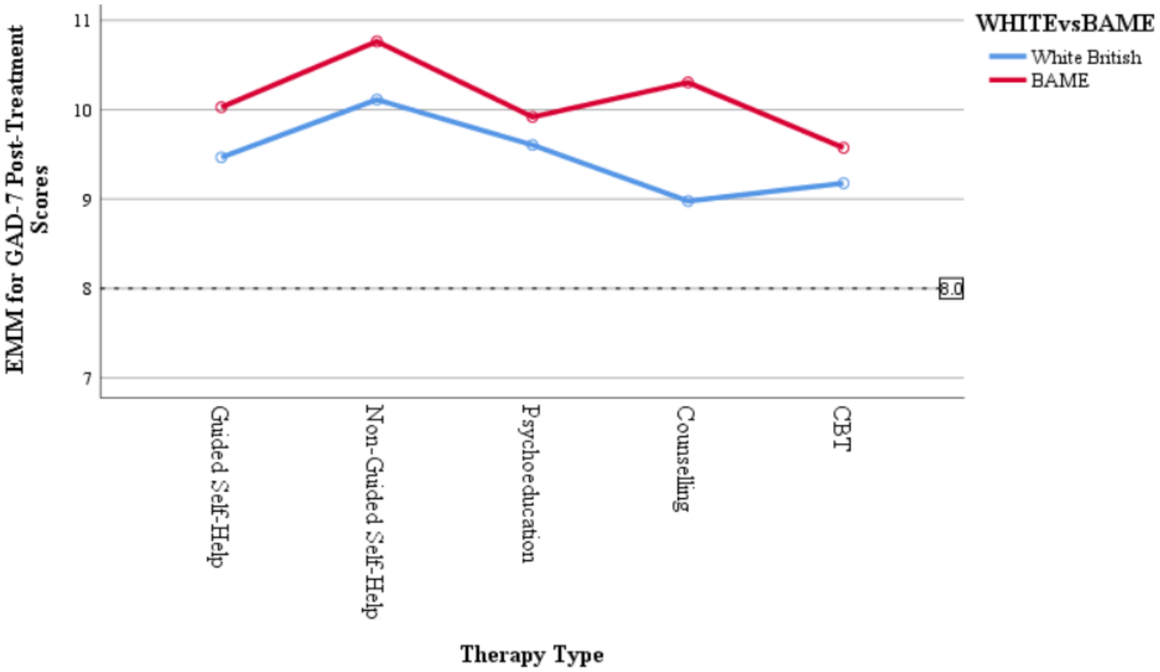
Figure 4. 2. *Estimated Marginal Means (EMM) for PHQ-9 Post-Treatment Scores, including Clinical Threshold for Depression.*



Covariates appearing in the model are evaluated at the following values: Age = 40.73, PHQ-9 Pre-Treatment = 16.57

Anxiety Severity (GAD-7 Post-Treatment): A two-way ANCOVA was carried out where *post-treatment* anxiety scores measured by the GAD-7 served as a DV and treatment type (IV1) and ethnicity (IV2) served as independent variables. Initial anxiety severity (*pre-treatment* anxiety scores) and age were included as covariates (*see* Table 4.6). All main effects were statistically significant at the .05 significance level with pairwise comparisons adjusted using Bonferroni corrections (*see* Figure 4.3). The main effect of treatment type yielded a F ratio of *F*(4, 9913) = 5.94, *p* < .001, partial η2 = .002), indicating that the mean post-treatment scores were significantly greater for non-guided self-help when compared to guided self-help (*M* =.691, *SE* = .255, 95% *CI* = .058-1.323, *p* = .022); counselling (*M* = .796, *SE* = .261, 95% *CI* = .064-1.529, *p* = .023); and CBT (*M* = 1.062, *SE* = .231, 95% *CI* = .414-1.711, *p* < .001) after controlling for initial anxiety severity and age. The main effect for ethnicity yielded a F ratio of *F*(1, 9913) = 14.97, *p* < .001, partial η2 = .002), indicating that the mean post-treatment scores were significantly lower for the White British group when compared to the BAME group (*M* = -.650, *SE* = .168, 95% *CI* = -.976 - -.321, *p* < .001) after controlling for initial anxiety severity and age. To note, the effect sizes for treatment type and ethnicity were very small. The interaction effect between treatment type and ethnicity was non-significant *F*(4, 9913) = 0.94, *p* = .442, partial η2 = .000).

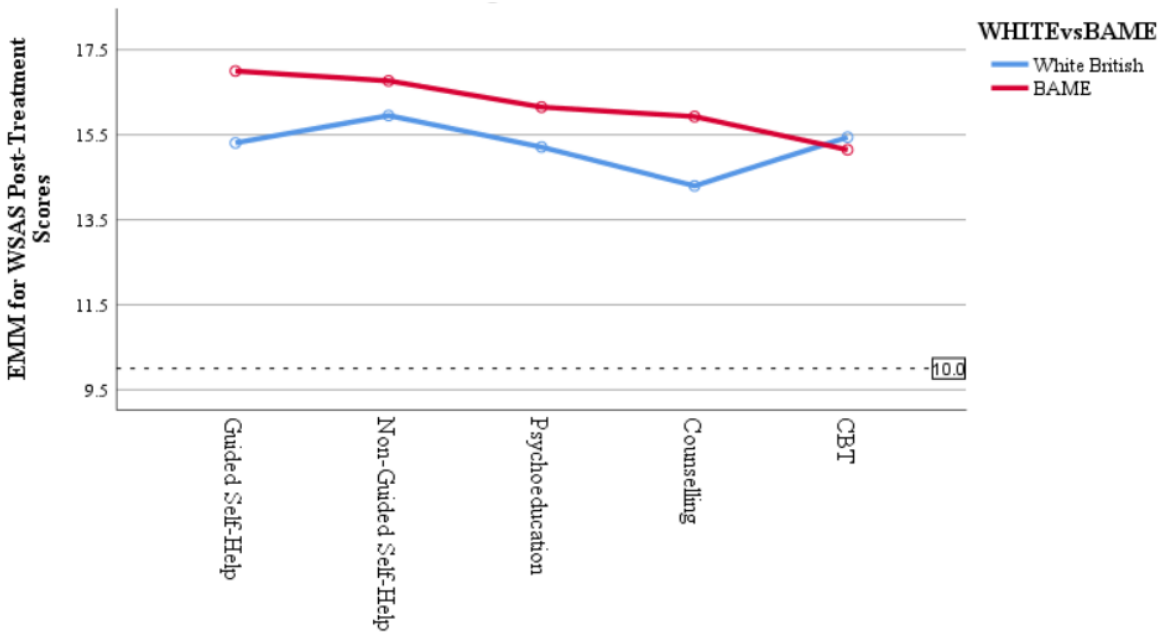
Figure 4. 3. *Estimated Marginal Means (EMM) for GAD-7 Post-Treatment Scores, including Clinical Threshold for Anxiety.*



Covariates appearing in the model are evaluated at the following values: Age = 40.73, GAD-7 Pre-Treatment = 14.80

Functional Impairment Severity (WSAS Post-Treatment): The final two-way ANCOVA was carried out where *post-treatment* scores for functional impairment measured by the WSAS served as a DV and treatment type (IV1) and ethnicity (IV2) served as independent variables. Initial functional impairment severity (*pre-treatment* scores) and age were included as covariates (*see* Table 4.6). All main effects were statistically significant at the .05 significance level with pairwise comparisons adjusted using Bonferroni corrections (*see* Figure 4.4). The main effect of treatment type yielded an F ratio of $F(4, 9913) = 4.20$, $p = .002$, partial η2 = .002), indicating that the mean post-treatment scores were significantly greater for non-guided self-help when compared to counselling ($M = 1.248$, $SE = .389$, 95% $CI = .155\text{-}2.340$, $p = .013$); and CBT ($M = 1.066$, $SE = .344$, 95% $CI = .099\text{-}2.033$, $p = .020$) after controlling for initial functional impairment severity and age. The main effect for ethnicity yielded a F ratio of $F(1, 9913) = 14.55$, $p < .001$, partial η2 = .002), indicating that the mean post-treatment scores were significantly lower for the White British group when compared to the BAME group ($M = -.957$, $SE = .251$, 95% $CI = -1.448$ - $-.465$, $p < .001$) after controlling for initial functional impairment severity and age. To note, the effect sizes for treatment type and ethnicity were very small. The interaction effect between treatment type and ethnicity was non-significant $F(4, 9913) = 2.35$, $p = .052$, partial η2 = .001).

Figure 4. 4. *Estimated Marginal Means (EMM) for the WSAS Post-Treatment Scores, including Subclinical Threshold for Functioning.*



Therapy Type

Covariates appearing in the model are evaluated at the following values: Age = 40.73, WSAS Post-Treatment Score= 22.38

Given that the MANCOVA showed a significant interaction, results were reviewed to investigate the discrepancies. Results showed that there was only a significant interaction between treatment type and ethnicity for functional impairment with a F Ratio of *F*(4, 9911) = 2.73, *p* = .027, partial η2 = .001). Given the very small effect size, it appears that when the ANCOVAs were carried out, the statistical power further weakened thus eliminating the interaction effect.

4.5 Discussion

The aim of this study was twofold; to first identify what factors were most salient in predicting recovery, and secondly to identify which evidence-based psychological therapies were most effective in improving mental health outcomes for depression, anxiety and functional impairment between White British and BAME groups. Findings revealed that ethnicity, religion, age, and initial baseline severity were predictors for recovery. In terms of therapeutic effectiveness, there was no interaction effect between treatment modality and ethnicity, thus suggesting no differences in therapeutic effectiveness between ethnic groups, regardless of treatment type. Based on the main effect of treatment only, the general consensus was that, after controlling for baseline severity and age, non-guided self-help was significantly poorer in improving outcomes for depression, anxiety, and functional impairment when compared to other therapeutic modalities. Moreover, based on the main effect of ethnicity alone, those from the White British group achieved significantly greater reductions in post-treatment outcomes across all domains than the BAME group. However, findings are to be taken with caution as the effect sizes were very small.

4.5.1 Predictors of recovery

Despite reliance on empirically supported outcomes to assess the effectiveness of evidence-based psychological interventions, few studies have assessed what factors are most salient in predicting recovery (e.g., Amati et al., 2017; Gyani et al., 2012; Green et al., 2015). Despite the increased disparities in mental healthcare and treatment for ethnic minority communities (Good & Hannah, 2015; Pybis et al., 2017), to my knowledge, only one study has considered the role of ethnicity as a predictor of recovery within IAPT services (Green et al., 2015). Whilst Green and colleagues (2015) reported ethnicity as a predictor of recovery, specification of ethnic group categories were absent, thus it is unclear whether differences between White British and BAME communities were observed. Researchers acknowledged this limitation and encouraged future research to consider subgroup differences. With psychotherapy being regarded as a product of the West, which adopts the values, beliefs and principles of individualistic societies (Sue, 2006; Keith, 2011), ethnic group comparisons were deemed important to understand whether ethnicity acts as a precursor to therapeutic success. Findings from the present study revealed that the likelihood of recovery was significantly reduced by 35% for those from the Mixed ethnic group when compared to the White British group. Whilst this finding is conservative, it brings to light potential for future research. Previous literature has pointed towards increased cultural conflict and mental health distress in those holding bi-cultural identities (e.g., Allen & Bagozzi, 2001, Gushue & Constantine, 2003). With the Mixed ethnic group in England comprising of those who hold dual identities with the majority White group and minority ethnic groups, individuals from this particular cultural group may experience greater conflicts between their individualistic and collectivist values, beliefs, and expectations. This area of research is scarce therefore needs to be explored further.

Moreover, previous literature has pointed towards religion playing an integral role in help-seeking attitudes and mental health beliefs (Lakeman, 2013), thus being recognised as an additional barrier to therapeutic success by IAPT services (IAPT, 2009). Despite this, no known study has considered the role of religion as a predictor to recovery. In the present study, the most common religious groups were compared to those who identified as having ‘no faith’. Findings revealed that the odds of recovering significantly increased by 138% for those who identified as Sikh, whilst the odds were more conservative for Christian (22.8%) and Other religious groups (12.3%). Whilst previous research exploring the role of religion as a predictor to therapeutic success has been minimal, these findings offer the basis for further investigation, particularly for those who identify as Sikh. According to research by Sandhu (2005), the life-stress model adopted within Sikh communities focus on the experiences of the *"I"*, which is innately different from others. Here, the major source of suffering is seen as cause of ego-centred (ahankar) needs and desires. With this in mind, it may be that Western notions of therapy which are focused on the self may be more innately attuned to Sikhism, thus enhancing engagement and recovery within this group. Given the importance of religion and spirituality, particularly within BAME communities (Castillo, 2011; Fernando, 2005; Mantovani et al., 2017) further research is needed to unpack the reasons behind these outcomes. This may be particularly important for clinical practice in identifying whether the intersectionality between religion and mental wellbeing affect therapeutic success.

Despite previous research indicating poorer treatment outcomes in older adults (Gould, Coulson, & Howard, 2012), the findings from the present study corroborated with that by Catarino and colleagues (2018) showing better clinical outcomes in older adults (above 65). Here, the odds of recovery significantly decreased by 45.9% for 18 – 35 year olds and by 37% for 36 – 64 year olds when compared to older adults. A possible reason for these results may be due to the increased societal pressures on the 'working age' which can lead to greater burnout and absence from work, thus, affecting mental wellbeing more than the older adult population (e.g. Clark et al., 2012; Husain et al., 2014).

In line with previous research, initial severity of depression, anxiety and functional impairment were generally associated with poorer recovery (Amati et al., 2017; Green et al., 2015; Gyani et al., 2012). That is, the greater the initial scores are on the measures of PHQ-9, GAD-7 and WSAS, the less likely patients are to achieve recovery. Interestingly, those recorded with no depression and anxiety at the start of treatment tended to do poorer than those with mild to moderate conditions. The reason for this may be due to conditions worsening during a course of therapy. Unlike previous research, gender and provisional disorder diagnosis did not predict recovery in the present study (Amati et al., 2017; Green et al., 2015; Gyani et al., 2012).

Since IAPT services are serving increasingly diverse populations (Beck et al., 2019; Beck & Naz, 2019), these findings add to the limited literature exploring patient characteristics as key indicators of recovery. Given the reliance on empirical evidence, the recovery narrative, experiences, and therapeutic needs of service users are difficult to ascertain within this one-dimensional therapeutic rhetoric (Williams, 2015). Thus, future research should seek to include patient recovery narratives to offer in-depth understanding what works well, for who, when, and how (Christodoulou et al., 2019; Williams, 2015).

4.5.2 Therapeutic effectiveness

Recovery outcomes based on therapeutic modality have seldom assessed or reported what works well for ethnic minority communities. Given the poor inclusion of BAME communities in clinical trials (Chambles et al., 1996; Woodall et al., 2010) and reliance on evidence-based interventions within IAPT services (Timimi, 2018), this warranted further investigation in real-world clinical settings. Previous studies examining therapeutic success in the general population found inconsistent findings based on therapeutic modality, in both low-intensity (e.g., guided self-help, non-guided self-help) and high-intensity treatments (CBT, counselling) (Delgadillo & Gonzalez Salas Duhne, 2020; Gyani et al., 2011; Moller et al., 2019; Pybis et al., 2017). However, to my knowledge, ethnic group comparisons have not been made. Given the nature of Western notions of therapy developed for individualistic societies (Laungani, 2007; Loewenthal, 2018), it is unclear how well evidence-based interventions transpire in ethnic minority populations.

After controlling for initial disorder severity and age, findings revealed that there was no interaction between treatment type and ethnicity. This is an interesting finding as previous research has suggested poorer treatment outcomes and greater drop-out rates in the BAME population (Baker, 2018; Harwood et al., 2021). It is unclear whether this finding was influenced by the control of confounding variables such as initial disorder severity and age. Previous research has pointed towards greater severity of CMHDs in BAME communities (e.g., Weich et al., 2004; Rehman & Owen, 2013) and poorer therapeutic outcomes in older adults (Catarino et al., 2018). However, as these factors were not dissected by ethnic group, it may have produced different findings. Future research should consider examining the intersectionality between baseline severity, age, and ethnicity.

Furthermore, based on ethnicity alone, findings revealed that the White British group showed significantly greater improvement in all domains of therapeutic outcomes when compared to the BAME group. However, this finding is to be taken with caution as the effect size was very small. On closer inspection, recovery outcomes for the study population were relatively similar, with those from the White British group achieving 35.20% recovery, whilst BAME groups achieving 30.64% recovery. This finding falls short of the government target for IAPT to achieve 50% recovery (Marks, 2018) and corroborates with independent reviews which have identified low recovery rates in the population served by IAPT (Griffiths & Steen, 2013b; Scott, 2018). Given that these findings are based on recovery outcomes for those who completed a course of treatment, those who did not enter therapy or dropped-out may produce even poorer figures (Waltman, 2018). Future research should consider inclusion of these factors to grasp the full extent of whether service users find IAPT suitable to their needs.

When considering therapeutic effectiveness by therapeutic modality only, findings revealed that non-guided self-help, in general, was the least effective therapy when compared to guided self-help, psychoeducation, counselling, and CBT. More specifically, non-guided self-help was least effective for depression than all other treatment types, whilst there was no difference observed for non-guided self-help and psychoeducation for anxiety. In terms of functional impairment, non-guided self-help was least effective than the high-intensity modalities, but not other low-intensity therapies. These findings somewhat align with those observed in previous research and NICE guidance which show greater recovery rates for guided self-help over non-guided self-help for both depression and anxiety related disorders (Gyani et al., 2011). It appears that therapist support during therapy is more suited to the clinical population (Bennet-Levy et al., 2010). Moreover, aligning with previous studies, no differences were observed between CBT and counselling (Delgadillo & Gonzalez Salas Duhne, 2020; Moller et al., 2019; Pybis et al., 2017). Not only this, but high-intensity treatments did not significantly improve mental health outcomes when compared to low-intensity guided self-help or psychoeducation. It is acknowledged that this finding may possibly have been factored by the control of initial disorder severity, however, previous literature assessing therapeutic effectiveness between low-intensity and high-intensity treatments have also found little difference in recovery outcomes (e.g., Chan & Adams, 2014; Richards & Borglin, 2011). Given that baseline severity has not been found as a confounder to therapeutic success, regardless of treatment type (Bower et al., 2013; Vaillancourt, Manley & McNulty, 2015), low-intensity options may offer more cost-effective ways to treat CMHDs in the first instance as they are the least resource intensive (NICE: CG123, 2011). Research by Boyd, Baker and Reilly (2019) found similar results and suggested the implementation of a progressive model, in which low-intensity therapies are offered as the first choice as they may be as clinically effective and more cost-effective than high-intensity alternatives.

4.5.3 Limitations

Despite efforts to treat missing data using imputations of mean average scores, there were a proportion of patients that were excluded from the study due to specific patient characteristics and variables not being available. As this was a retrospective study, it was difficult to mitigate this issue. Even though attempts were made to dissect ethnicity variables to inspect recovery outcomes, this was not possible for the latter study assessing therapeutic effectiveness. Even though the sample size in the present study was large, there was not enough patients within each treatment modality to offer meaningful sub-ethnic group analysis (i.e., for each ethnic group category). Thus, future research may consider larger subsets of ethnic minority populations to make these comparisons. Moreover, given the clinical disparities in BAME communities tend to be based on factors such as baseline severity, age, and gender, the study was not able to consider group analysis by ethnicity for each of these variables which could have been useful in understanding whether they interact with recovery outcomes. Finally, other variables such as number of therapy sessions and use of medication were not included in the present study, but could be considered for future research to understand their predictive value and influence on therapeutic effectiveness.

4.5.4 Conclusion

Given the paucity of empirical research exploring the effectiveness of evidence-based psychological interventions, this study adds to limited literature that has specifically considered the therapeutic effectiveness for BAME populations living in England. Considerable expansion of the English IAPT programme as the leading service to tackle CMHDs (Clark, 2018a) warrants further independent research to understand how well it serves underrepresented communities. Poor recovery outcomes falling short of the government 50% target is a cause for concern. On average, it appears that up to 70% of patients accessing IAPT services do not entirely benefit from treatment. Findings from the present study offer insight into patient characteristics that may be confounding factors to therapeutic recovery. In particular, it highlights a further need to explore the recovery narrative in minority communities to understand how well evidence-based psychological interventions meet their needs. Given the emergence of newly arrived migrants, along with those who have already settled, research exploring whether Western therapies developed on models of individualism suit the needs of different cultural groups. Moreover, in line with previous research, the study identifies that therapeutic modality based on the stepped-care model may not be entirely cost-effective. Whilst non-guided self-help may be the least effective in improving mental health outcomes, other low-intensity options may be offered as a first line treatment option before more resource intensive options are offered. Again, the acceptability of this approach needs to be considered to the needs of the service users and not weighted by the one-dimensional rhetoric of empirical data. Future studies should aim to gather data in more diverse settings, using larger samples that are reflective of the ethnic minority population in order to offer meaningful insights and comparisons based on the intersectionality of factors such as age, gender, and baseline severity of their disorder. Given the detrimental consequences the global pandemic (Covid-19) has had on the society (Williams et al, 2021); increased job losses, time off work, and profound impact on mental wellbeing calls for further research to examine the implications that this has for ethnic minority communities accessing care and seeking treatment.

4.6 Chapter summary

This chapter offers the first of three studies that set to explore whether evidence-based psychological interventions are effective for BAME communities. The findings from the present chapter offers some insight into the predictive value of patient characteristics and recovery, whilst also examining the therapeutic effectiveness based on ethnicity and therapy modality. Whilst this study does not entirely support the cultural differences observed in literature, what it does highlight is the need to understand the recovery narrative in order to dig deeper and understand the patient narrative beyond the confinements of empirical research. It is envisaged that by exploring the needs of service users from ethnic minority communities, the research will be able to further unpack whether evidence-based psychological interventions are suited to the needs of the growing minority population in England.

Chapter 5

Study Two: *“Not a cure, but helpful”* – Exploring the Suitability of Evidence-Based Psychological Interventions to the Needs of BAME Communities

5. Study Two: *"Not a cure, but helpful"* – Exploring the Suitability of Evidence-Based Psychological Interventions to the Needs of BAME Communities

5.1. Chapter overview

Given the limitations of clinical trials assessing the efficacy of evidence-based psychological interventions in ethnic minority communities in the UK (*see* Chapter 1), the findings from the routinely collected data within IAPT services set to explore predictors of recovery and therapeutic effectiveness based on treatment modality and ethnicity (*see* Chapter 4). Whilst findings demonstrated small, but significant differences between the Black, Asian, and Minority Ethnic (BAME) communities and that observed in the White British group, poor recovery outcomes (< 31%) warranted further investigation. Given the profound disparities in access to mental healthcare (Beck & Naz, 2019; Good & Hannah, 2015), attrition rates and therapeutic success (Baker, 2018; Harwood et al., 2021) it was important to explore the recovery narrative in order to understand what works well, what does not, and how therapies can be catered to the needs of ethnic minority communities (Christodoulou et al., 2019; Williams, 2015). Whilst there are benefits to research rooted in quantitatively driven data, particularly in assessing and measuring mental health outcomes (e.g., Leong, 2006; Schreiber, 2013), they seldom offer deeper understanding of 'real-world' experiences of service users receiving therapy. Here, in-depth qualitative interviews with service users from BAME communities are considered as a complementary facet to the empirically driven data to explore whether evidence-based psychological interventions are suited to their needs.

5.2. Introduction

England is a multi-cultural society, with over 7.9 million people identifying from BAME backgrounds (ONS, 2012). Despite the surge in ethnic minority populations, evidence suggests that there are disproportionate inequalities in mental health care and treatment (Fernando, 2012; Good & Hannah, 2015; Harwood et al., 2021). Psychotherapy is a product of the West which tends to adopt the values, beliefs and principles of the dominant individualistic culture (Frese III et al., 2001; Laungani, 2007). Here, clinical trials examining the efficacy of evidence-based interventions routinely offered by Improving Access to Psychological Therapies (IAPT) services use a homogenous set of participants (e.g., White / Caucasian, middle-class), thus when interventions are applied to 'real-world' clinical settings seldom do they produce consistent findings (Gordis, 2014; Pawson & Tilley, 2004). These disparities become more salient in research assessing the recovery outcomes for ethnic minority clinical populations served by IAPT services. Research consistently reports those from BAME communities achieve poorer recovery outcomes than those from the White British backgrounds (e.g., Baker, 2018; Harwood et al., 2021; Moller et al., 2019). Despite acknowledgement of these concerns, IAPT services continues to ground itself in empirical outcome data to quantify its service success. Whilst empirically supported outcomes are useful for planning and monitoring, they often ignore the recovery narrative which is integral to understanding what works well, for who, and when (Christodoulou et al., 2019; Williams, 2015).

Theoretical approaches such as individualism-collectivism (Hofstede, 1980; 2011; Triandis, 1995) and the self-construal theory (Markus & Kitayama, 1991) suggest cultural differences between those living in the West and those who originate from collectivist societies. Namely, those from collectivist societies having an increased desire to preserve cultural norms, values, and traditions of their country of origin (Hofstede, 2011; Tse & Ng, 2014) which places precedence on group cohesiveness (e.g., with family members, clans, tribes) and harmony over self-serving desires and expectations (Markus & Kitayama, 1991). These characteristics often conflict with Western notions of therapy which insist on self-sufficiency, independence, and autonomy, often at the expense of risking eternalising factors such as cultural value systems and norms (Al-Krenawi & Graham, 2000; Christopher, 2001; Fernando, 2012). Furthermore, research suggests that those brought up in the West may hold bi-cultural identities (e.g., Allen & Bagozzi, 2001; Gushue & Constantine, 2003) which may ripen the cultural dissonance experienced between Western therapeutic practices and cultural expectations. A qualitative meta-analysis exploring service user experiences from ‘hard-to-reach’ communities in the UK found that expression of mental illness, differing world-views, barriers to accessing mental health services, and psychological interventions not accounting for patient cultural needs disrupted therapeutic uptake and engagement (Lamb et al., 2012). Increased scepticism about the credibility of psychotherapy can further exasperate therapeutic disparities (Sue, 2006).

Beck and Naz (2019) highlighted a number of fundamental issues that hinder therapeutic success in BAME communities accessing IAPT services. This includes unmet needs due to services not being able to facilitate or recognise distress across cultures; service users failing to attend appointments in fear of therapeutic expectations; disengagement from services due to clinicians not being adequately equipped to deal with culturally specific needs; and poorer therapeutic outcomes due to inadequately adapted cultural requirements. Whilst IAPT services aims to provide culturally sensitive therapies that incorporate issues around ethnicity and culture, rarely do these types of adaptations consider culturally specific factors such as patient idioms of distress and values (Beck, 2016). Qualitative research exploring whether evidence-based psychological interventions offered by IAPT are suitable to the needs of ethnic minority communities have been scarce. A study exploring the experiences of Turkish-speaking service users in London found differing cultural experiences of distress, ambivalent help-seeking, limited self-efficacy, and problems with continuity as some of the central concerns to therapy. Researchers found that guided self-help did not meet the clients' needs due to confusion and anxiety surrounding therapeutic expectations. Often the sessions were too short for clients to make real progress which impacted their recovery process (Christodoulou et al., 2019). In another study, Omylinska-Thurston and colleagues (2019) reported that patients accessing IAPT service found CBT unhelpful to their needs. This included difficulties with grasping CBT concepts, negative perceptions of therapists, patient unhelpful internal patterns, and unhelpful IAPT processes. However, the population sample was majority White British, thus the need for exploration in ethnic minority populations was recommended.

Given the inadequate recruitment of ethnic minority communities in clinical trials (Hall, 2001; Hwang, 2008) and poor treatment outcomes when compared to the White British group (e.g., Baker, 2018; Harwood et al., 2021; Moller et al., 2019), it is unclear whether evidence-based psychological interventions are suitable to the needs of ethnic minority communities. Exploring such needs may be crucial for clinical practice, especially since BAME communities are often left feeling misunderstood or even mistreated by mental health service providers (Bristow et al., 2011; Mclean et al., 2003; Mofrad & Webster, 2012) which leads to greater drop-out rates (Baker, 2018; Harwood et al., 2021). Thus, this study aims to explore whether evidence-based psychological interventions offered by IAPT services are suitable to the needs of BAME communities?

5.3. Methods

5.3.1. Methodological approach

Reflexive Thematic Analysis (RTA) was chosen as it is a flexible qualitative method which does not confine to particular theoretical frameworks, philosophical positions, or ideologies (Braun & Clarke, 2006; 2021a). Instead, RTA allows research to be conducted from different epistemological standpoints, including critical realism (Braun & Clarke, 2006; Fletcher, 2017). In England, there are relatively few studies that have explored the recovery narrative of ethnic minority communities or evaluated whether evidence-based psychological interventions meet their needs (Christodoulou et al., 2019; Memon et al., 2016; Mohammed & Loewenthal, 2009). RTA was considered the most useful analytical approach to explore patients' perspectives by generating meaningful insights into service users' experiences (Braun & Clarke, 2006; Clarke & Braun, 2013). More details about the methodological choice can be found elsewhere (*see* Chapter 3 – Rationale for selecting RTA).

5.3.2. Participants

Participant demographics have been highlighted in Table 5.1. The age range was between 26 – 46 years old, with a mean age of M = 37.33 (SD=5.74). 8 out of the 9 service users were female (88.9%), whilst 1 was male (11.1%). Most service users identified as Pakistani (44.4%), followed by Arab (22.2%). Others included Bangladeshi (11.1%), Chinese (11.1%), and Other (11.1%). The religious orientation of the service users was predominately Muslim (66.7%), followed by Other (22.2%) and No religion (11.1%). The large majority of participants were referred to IAPT via their General Practitioner (GP) (77.8%), followed by self-referral (22%). The most common therapy received was CBT (55.6%), followed by counselling (22.2%) and group CBT (22.2%). Most service users felt that they had not recovered from their condition following a course of treatment (66.7%).

Table 5 1. *Service User Demographics*

Demographics			
Age (Mean, *SD*)	37.33 (5.74)	**Diagnosis** *N* (%)	
		Depression	5 (55.6%)
Gender *N* (%)		GAD	2 (22.2%)
Female	8 (88.9%)	MADD	1 (11.1%)
Male	1 (11.1%)	PTSD	1 (11.1%)
Ethnicity *N* (%)		**Referral Pathway*** *N* (%)	
Pakistani	4 (44.4%)	General Practitioner	7 (77.8%)
Bangladeshi	1 (11.1%)	Self-Referral	2 (22%)
Chinese	1 (11.1%)		
Arab	2 (22.2%)	**Type of Therapy***	
Other	1 (11.1%)	Group CBT	2 (22.2%)
		CBT	5 (55.6%)
Religion *N* (%)		Counselling	2 (22.2%)
Muslim	6 (66.7%)		
Other	2 (22.2%)	**Recovery***	
None	1 (11.1%)	Recovered	3 (33.3%)
		Not Recovered	6 (66.7%)

**Note.* Additional demographics retrieved from service user interviews.

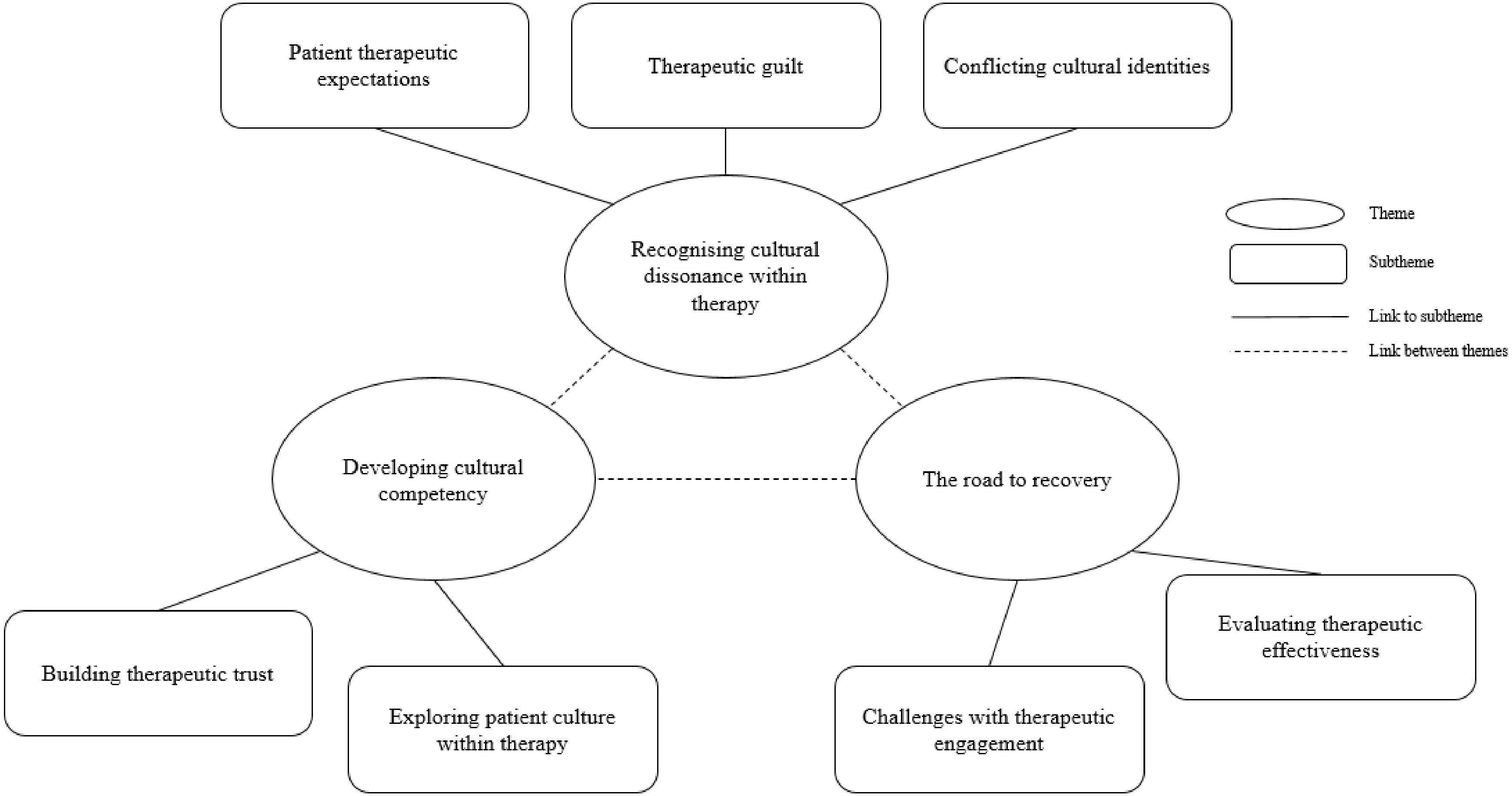
5.3.3. Procedure

A recruitment poster was posted via social media (Twitter) and sent to IAPT clinicians to help with recruitment of service users who had previously accessed IAPT services. Service users who contacted the researcher were sent an email with the information sheet which detailed the purpose of the study and the consent form should they wish to participate or enquire further about the study. Once the participants agreed to take part, they were requested to send details of their availability for a telephone or online interview via Skype, Zoom, or Microsoft Teams. The researcher was flexible with the times of the interview to ensure that they fit around the participants' requirement. All service user interviews were conducted via telephone. None of the service users opted for online interviews, despite being made aware that the interview would be audio recorded only. Before the interview began, the researcher reminded the service users about their right to withdraw and assured them that their personal details will be kept confidential and not referred back to their therapist(s) or IAPT services. To increase patient anonymity, participants were asked to avoid disclosing any personal information, the service they used, or the name of any therapists that they had been in contact with. Participants were given the opportunity to ask questions before, during and after the interview. Participants were requested to conduct the interview in a quiet and private room so that there were no distractions, the audio quality was clear, and they felt comfortable in openly talking about their experiences. The researcher was also situated in a private and quite room with no distractions. This was to ensure that service users could be heard clearly, the audio could be recorded, and service user privacy and confidentiality could be retained. Telephone interviews were recorded via a recording device and lasted between 30 minutes to 1 hour. The interviews agenda was loosely used to guide the interview to ensure that the key topic areas were covered. However, the process was interactive in which the researcher found herself weaving in and out of topics to allow the interviewee the opportunity to talk about what was important and meaningful to them. Participants were given the opportunity to take a break if needed. Once the interview was completed, participants were offered a verbal debrief and given the opportunity to ask any questions. Participants were informed about the researchers contact details should they wish to withdraw from the study at any time, without question, for up to two weeks after the interview had taken place. All participants were emailed a written debrief sheet. Here, participants were provided with contact details for services such as Mind and Samaritans should they feel distressed as they were ex-service users so were not currently seeking any treatment. They were also provided with the researcher's supervisor contact details should they wish to get in contact and raise any concerns. Participation in the study was entirely voluntary and no payment or incentive to participate was offered.

5.3.4. Analysis

RTA involves reflexive engagement with the dataset, guided by a six-phase process to produce a robust pattern-based analysis (Braun & Clarke, 2006; 2019). During the first phase – *data familiarisation* – I carried out all the interviews and manually transcribed the interviews for each participant to facilitate deep immersion within the data. I read and re-read the entire dataset in order to become familiar with the data. Whilst transcribing the interviews, I listened carefully to each participant and made notes of my initial analytical observations and insights which included participants' feelings, discourse, and understanding of their world (*see* Appendix B.1.1). The second phase entailed *coding* of the transcripts which was done systematically through the entire dataset by using the 'comments' function in Microsoft Excel to create side margins which highlighted the relevant extract and code (*see* Appendix B.1.2). Here, attempts were made to code authentically to service users' narrative to ensure nothing was missed out that could later be useful. I transferred all codes to a Microsoft Excel 2016 document in order to keep track of the iteration process and evolvement of the codes, themes and subthemes (Byrne, 2021). For the third phase, I began to *generate initial themes* by clustering topic areas according to their shared meaning. This included a number of themes and subthemes that were apparent in the data and that aligned to the research question. A miscellaneous theme was created to incorporate items that did not directly answer the research question, such as concerns around access to therapies (*see* Appendix B.1.3). Phase four involved *developing and reviewing themes.* Here, themes and subthemes were recursively reviewed to ensure that they addressed the research question and built a narrative between the themes (Braun & Clarke, 2012). Themes and subthemes were revised where needed to ensure that they offered the most meaningful interpretation of the data. The finalised thematic map demonstrating the three theme is shown in Figure 5.1. The fifth phased included *refining, defining, and naming themes.* The themes were further refined and defined to consider the respective research question. Using a recursive approach, I went back and forth between the data to ensure that the data tells a ‘story’ that does not drift off topic (Braun & Clarke, 2019). With feedback from my supervisory team, a clinical expert, and engagement with the literature, I further revised the theme titles for the final analysis and selected appropriate extracts to be presented in the report (*see* Appendix B.1.4). Finally, the report was written up to offer a narrative account of whether evidence-based psychological interventions meet the needs of BAME service users accessing IAPT services. Throughout the study, I reflected on my own prior assumptions before and during the data collection process by keeping a reflective diary and by considering my positionality (*see* Chapter 3 – Reflexivity). I sought involvement from my supervisory team and external clinical expert with experience of RTA to ensure the analysis was credible and aligned with the research question.

Figure 5 1. *Thematic Map of Themes and Subthemes for Service User Interview*



5.4. Results

5.4.1. Theme One: Recognising cultural dissonance within therapy

The first theme considered service users recognition of cultural dissonance within therapy. This was largely between service users' culture and Western notions of therapy and mental health. Three subthemes emerged; therapeutic expectations; therapeutic guilt; and conflicting cultural identities.

5.4.1.1. Therapeutic expectations

The first subtheme refers to the cultural dissonance service users experienced with expectations of therapy. Before entering therapy, several service users discussed the apprehensions they had about therapy which was often rooted in a lack of knowledge about mental health disorders, what to expect from IAPT services, and the purpose of therapy. Several service users discussed that Western concepts of mental health and therapy were not available in their culture, thus *"some disorders, especially around mental health cannot be translated back into the community or the mother tongue"* (SU1) which included depression, anxiety and post-traumatic stress disorder. Service users often lived in multi-generational households, which meant that they found it difficult to discuss and explain their mental distress and therapeutic needs with older family members, who reinforced that they had *"no problem"*. Older family members often held onto non-Western traditions, thus not fully recognising Western concepts of mental health. For some service users such as Bushra (SU6), her mental distress was normalised as everyday stressors and somatised by her family which meant that her disorder was unrecognised for a prolonged period:

> *"You know, in my culture… these things, depression and anxiety, they don't exist. Now they exist, but when I got it didn't exist. It was like there's nothing wrong with you, just shake it off…"*

For others such as Kalsoom, the lack of understanding and support meant she often found herself in conflict with her Western education and upbringing and the traditional expectations from her family:

> *"Because with my family, they were quite, and still are quite ignorant of things like counselling. Yeah, they believe that counselling shouldn't exist because depression doesn't exist. So it's really hard trying to speak to people that already have made up their mind about such things."* (SU5)

Given the close ties with family members and the community, the lack of knowledge about therapy was seen as a concern beyond the patient themselves, but rather seen as a wider issue that needed to be addressed by mental health services. Service users opened up about feeling *"anxious"*, *"afraid"*, *"uncomfortable*" and *"nervous"* about attending their first therapy session. Often this was the first therapeutic encounter they had with mental health services and was a *"big change"* from the traditional route of seeking help from their GP. As therapy was not common practice within their culture, a number of service users talked about not knowing *"what to expect"* despite enquiring about the therapeutic modality, role of the therapist, and what was expected of them. For example, Kalsoom (SU5) mentions; *"I have no idea what I was signing myself up for. So the only thing that I knew about counselling was what I saw off TV at that point"*. Others questioned how talking therapies would help resolve their problems; *"Like in my head, I was thinking… how am I going to talk this problem away?"* (SU6). This was an important implication for therapy as some service users were often unable to explain the reason why they were attending therapy to their family members, which in turn meant that they dropped-out of therapy.

5.4.1.2. Therapeutic guilt

This subtheme describes the therapeutic guilt service users experienced in engaging with therapeutic services. This was a consistent narrative that was brought up by the majority of the service users which had both implicit and explicit consequences for participants and how well therapies were accepted and effective. The dissonance service users experience between their cultural, familial and religious obligations and therapeutic expectations led to feelings of shame, guilt, and entrapment. Most service users came from close-knit families and were confined by their cultural and familial expectations, roles, and responsibilities. Often, participants discussed therapists from White British backgrounds not understanding that they were bound by *"cultural expectations and values"*. For many service users, taking the leap to seek therapy was not a small feat. They often found themselves going against their cultural and familial expectations when seeking therapeutic support. For example, Qadira (SU9) spoke specifically about the negative cultural stigma that was attached to therapy:

> *"I think because it's just a negative stigma attached. Because it is not the thing that you do where you go for therapy. You don't discuss your issues outside of your family, your circle, we tend to keep our issues within family…. It's not something that's looked upon positively."*

Others such as Annie (SU4) felt immense guilt for not being able to deal with her own *"problems"* which was tied into her Chinese cultural expectations to be resilient:

> *"Yeah, we feel guilty that you're going against the way that you're taught to deal with your problems and a lot of that comes from how you're raised and how your upbringing was, I think."*

Often, service users talked about the negative implications the advice offered by therapists would have had on their lives should they have taken it on. For example, Qadira (SU9) was concerned that if she had taken on the advice of her therapist, she may have lost her family which she was not prepared to sacrifice. This led her to dropping out of therapy:

> *"I think some of the advice that she was giving me… is just not possible for me to do in general as part of religious cultural limitations for me. I don't think she understood that. It's not just a straightforward, easy thing for me to make a certain decision or for me to take a certain step. It would have impacted me massively. I possibly would have lost my family as my parents, my siblings. I don't think she realised that side of it. Other than that the religious side, I think certain aspects are like forbidden in Islam. She didn't see it as anything wrong."*

Service users also talked about the religious guilt they felt for not being able to cope with their mental distress and the implications this had on their therapeutic experience when therapists did not understand the gravity of their religious expectations. Some service users discussed the shame they felt in discussing their personal issues because it was *"forbidden"* in their religion. Kalsoom (SU5), in particular, talked about conflicts between her faith, therapeutic experience and mental wellbeing. Kalsoom was often told by her family that if she had *"tawakkul"* [faith] in God she would not have depression:

> *"It's almost like, well, if you believe in God, you shouldn't have depression. That was the information that was fed to us growing up, you know, and having something like*

> *anxiety and depression to people of our culture, it's kind of like, well, you have no faith in God."*

Having felt disappointed by her therapeutic experience because the therapist did not understand her religious confinements, Kalsoom was in conflict between her religious obligations and need for therapeutic support: "*You're kind of like, well, okay, so Muhammad is not going to help me, professionals can't help me, I'm stuck. Now, I believe that had a detrimental effect on my mental health".*

5.4.1.3. Conflicting cultural identities

This subtheme describes the cultural clash service users experienced between Western practices and norms and their own cultural values and expectations. This had a profound impact on participants' therapeutic experience and what was expected of them by the therapist. Some service users felt that by challenging their thought and behaviours, they were having to compromise their own identity. For example, Annie (SU4) felt that Western concepts such as *"self-compassion"* went against the way she was *"taught to deal with your problems":*

> *"…I guess I was getting really hesitant, but one of the things I said was it feels like I'm changing who I am by challenging these thought. I think to some extent I have a massive identity crisis. …I'm incredibly hardworking and my parents have always believed in, like working really hard. And I have a really good education. And I think that is partly a cultural thing. And not to stereotype people like Asian people ever, but I think one thing that she tried to get to was self- compassion and I found that really hard because it almost felt like slacking off."*

Service users talked about their cultural identity, particularly in relation to *"personalities"* and *"masks"* they wore at home, work, and within their social circle. This was something that they had to often interchange due to varying cultural expectations. Most of the service users were British born, and had to continually manage their expectations to abide and serve elders within the family (e.g., parents and older siblings) and the Western notion of independence and self-fulfilment. For example, Khalid (SU1) talked about using different *"masks"* to deal with his internal world at home where he was more vulnerable and the external world where he had to portray a *"strong"* and *"confident"* self:

> *"Because even though they don't understand this at the moment, I have two masks on, one for when I leave the house, basically confident, strong, leader, not discriminated against. The other is for dealing with my issues."*

Khalid felt let down by his White therapist because of the limited understanding he had about his cultural *"expectations"* and *"barriers"*:

> *"...It was a good therapist, but he didn't understand the cultural barriers… I would say that there was partial cultural values, partial UK values and emotions in one. But he couldn't understand the concept that I had three different psychological personalities - one for home, one for work, and one for with friends."*

5.4.2. Theme Two: Developing cultural competency

The second theme considered the importance of developing cultural competency. Service users talked about their therapeutic experiences and the need for therapists to become more culturally competent. Two subthemes emerged; building therapeutic trust; and exploring patient culture within therapy.

5.4.2.1. Building therapeutic trust

This subtheme describes service users concerns relating to confidentiality, mistrust, and cultural misinterpretations by mental health professionals which were deemed important to build a therapeutic relationship. Despite understanding that therapists were *"bound by confidentiality"*, service users felt that a key component of therapy was to build a *"safe space"* where they could *"trust"* the therapists. Given the sensitivity of their personal issues, service users worried that if anything they discussed was to *"come out"* it would not be a *"positive thing"* for them within their family and community. Service users often opted for one-to-one therapy over group therapy formats for fear of being recognised by community members. This was due to the need for *"privacy"* because they wanted to discuss *"sensitive"* and *"private"* matters with the therapist. Despite understanding that group therapy was more readily available, service users decided to wait for one-to-one sessions in order to maintain their need for privacy and confidentiality. For example, Khalsoom (SU5) found that group therapy made her condition *"worse"* so dropped-out of therapy and re-referred back to IAPT a couple of years later opting for one-to-one therapy:

> *"I have to go back to my GP and be like, I can't do this, but they keep sending me to group therapy. It's not something that I can do. And it actually made my panic attack condition worse, my mental health worse. And from that point on, I kind of just withdrew from counselling services, things like that altogether because I just thought, this isn't going to work for me. They don't know what they're talking about."*

Moreover, cultural misinterpretations by therapists often left service users feeling that they could not continue with therapy or trust that their concerns would be fully understood. A couple of service users such as Khalid (SU1) reported that their therapist appeared *"distant"* and misunderstood his cultural expressions as *"angry"* and *"aggressive"* which instantly instilled barriers within the session, leaving him feeling misjudged. Khalid pointed out to his therapist that talking *"loudly"* and *"assertively"* was acceptable within his own culture, yet the therapist failed to understand his cultural expression. Other service users such as Aisha (SU3) felt her White therapist instantly made assumptions based on her appearance which left her feeling uneasy and misjudged before therapy even began. The therapist assumed her hijab [Muslim headscarf] was being enforced by her family members which was not the case. Aisha felt the therapist's mannerisms and expressions were offensive which resulted in her dropping out of therapy:

> *"Yes, I wear a hijab. She spent like maybe two minutes looking at that and then very dismissively, you know, look at me, kind of like a really sorry way and really, like, squinting her eyes and nose… looking at my hijab. ...Instead of saying, tell me about yourself... it was like to tell me, why do you wear this? …Then she obviously pointed towards my hijab and she said that, well, OK, is it like your dad or brother? ...And I was like, no, it's completely my choice. And she wouldn't accept it, that I would make that choice for myself."*

Some service users felt that due to Western thinking, some therapists misinterpreted everyday cultural barriers as *"extreme"* incidents. For example, when talking about her familial pressures, Qadira (SU9) reported that her therapist did not quite understand the cultural norms and expectations within her community, but rather misjudged them to be life threatening. Qadira recalled having to spend quite some time during therapy to educate and reassure her therapist that this was not the case:

> *"…I do remember mentioning it [family pressures], but then I think she took the opposite extreme… I think it was more like honour killing. And I mean, it's nothing like that. I don't think she understood the middle ground, the family, where they just stop*

> *talking to you. And it was either [are they] disowning you or oh, so do you feel you're in danger from them? And I said, no, it's nothing like that. I just felt like she didn't understand it wasn't either. It [therapist understanding] was quite extreme."*

5.4.2.2. Exploring patient culture within therapy

This subtheme considered therapists cultural competency which is deemed an integral part of therapy, particularly when serving BAME communities (Good & Hannah, 2015; Sue, 2006). All service users said that they would have *"valued"* if therapists had asked them about their *"culture"*, *"beliefs"*, *"background"*, and *"values"*. Service users felt that exploring their culture was an important part of their recovery process because *"social traumas"* and everyday inequalities contributed to their mental distress. Therapists who *"personalised"* therapy by asking probing questions such as *"personal interests"* and *"triggers"* helped them to *"open up"*. However, the large body of service users felt that White therapists in particular *"couldn't easily relate because there were cultural differences"* and the therapists were *"scared"* to ask questions about participants' *"experiences growing up"*. For Annie (SU4), exploration of her cultural values by the therapist would have helped in understanding her upbringing, familial circumstances, cultural barriers, and expectations, which in turn would have enhanced her therapeutic experience:

> *"I wish that he'd made a little bit more effort about what I value. That would have helped shape the programme as well, and help shape some of the task and just sort of like. ....But there wasn't very much conversation about it and how much my symptoms are impacting my day to day behaviour routine and say why that made some of the past more difficult. I was made to feel it wasn't relevant. Yeah, it was very much like this is*

> *thing that you need to do. ... Like my practises wasn't taken into account or my values. Yeah, it's what's important to me."*

In instances where this did happen, service users valued the effort that was made by therapists who were culturally curious and sensitive to their needs. For example, Khalsoom (SU5) appreciated her therapist taking the time to find out more about her culture, especially as she did not share the same cultural background. She found that this made her feel extremely comfortable in the sessions and she was able to open up about her concerns - which she struggled to do in the past:

> *"I feel like it was because the lady I went to see wasn't of the same background as me, so she was really interested ...And, you know, from that she picked up that I was talking about my culture and my cultural practises, but she was really engaged in that and I felt that really helped me open up because she actively tried to get to know me. And that was really weird for me because any other counselling sessions I had wasn't like that at all. It was like, well, you have to tell me a problem or you don't. And if you don't, then I can't help. But she actively tried to get to know me."*

Service users, in general, valued having a therapist who shared the same cultural background to them, however felt this not crucial to their care needs. A couple of service users preferred a therapist from a different religious and cultural background for fear of being *"criticized"* or *"judged"*. However, in general, having a therapist from a similar background meant that service users found it *"easier*" to talk to their therapist as they did not have to overtly explain their cultural background, upbringing, religious obligations, familial and cultural pressures, and barriers. For example, Bushra (SU6) valued having a therapist from the same cultural background who *"just got it"* and made her feel at ease during the therapy session:

> *"Like, if someone doesn't understand that [culture], they ask you question, why was this like this? She has a similar background of how I was brought up and, you know, the family rules and everything. But she kind of understood that as well. So it was quite, you know, nice."*

Service users who received therapy from a White therapist wondered if cultural similarity would have improved their therapeutic experience as the therapist would have *"understood"* them better. For example, Qadira (SU9) felt that having a therapist from a similar background might have been useful as they would have understood her cultural and religious *"limitations"* when making therapeutic recommendations:

> *"I think so, definitely because they will understand the limitations and the issues that I face as a Muslim woman, I guess, whereas someone who's not of the same background doesn't understand the full impact, the third hand information that they receive, whereas somebody who has similar background to me, they've been to possibly understand a lot more better than somebody who doesn't have the same background."*

Cultural competence training was deemed important by service users in order for therapists to begin to understand cultural complexities. Service users felt that *"White, middle class"* therapists, in particular, *"seem to be getting no training around cultural competency and how to apply it to different cultures"*. Service users felt that *"representation"* was vital to engage more BAME service users and wondered if *"additional courses"* were needed to enhance cultural competency. A couple of service users described the lack of training as *"systemic discrimination"* and a *"pyramid scheme"* that favoured White therapists in clinical roles and offered *"cheap labour"* by using inexperienced Psychological Wellbeing Practitioners (PWPs) over those who *"cared"* about the profession. Aisha (SU3) was particularly vocal about this matter:

> *“This is actually robbing the system from people who actually care about the profession, people who actually care about somebody. ... A degree got you into, you know, IAPT.”*

5.4.3. Theme Three: The road to recovery

The third theme considered service users experiences of their therapeutic success – the road to recovery. Two subthemes emerged; service user challenges with therapeutic engagement; and their evaluation of therapeutic effectiveness.

5.4.3.1. Challenges with therapeutic engagement

This subtheme considered the therapeutic challenges participants encountered within therapy and the implications that this had on their therapeutic engagement. The majority of service users reported feeling as though therapy was not *“suitable”* to their needs and they were *“going through the motions”*. Service users said they would have valued regularity (e.g., same therapist throughout the course of treatment), option for the choice of therapy, and *“fostering an environment where people can actually talk about things”*. Most service users had disengaged from the service at least once, however, did take up therapy when conditions got worse. Khalid (SU1) was particularly unhappy about his therapy sessions and felt that his therapist did not see him as a *“person”*, but rather a *“number”* in order to meet targets:

> *“It was not tailored to me as an individual, irrespective of culture. So the culture didn’t even come into it. They are not tailored to individuals, they are generalized. They see you as part of their targets, and they see you as a number to get you in and out to hit the target.”*

There was a distinct difference between service users who had received counselling over those who were offered CBT. Service users who received CBT, generally, found it *"prescriptive"* and a *"rigid set of tasks"* where therapists went through the *"process"* and completed *"forms and questionnaires"*. Service users felt that therapy was *"superficial"* whereby therapists were too focused on trying to *"fix"* the problem rather than getting to know their personal history. For example, Annie (SU4) recalled on her therapeutic experience:

> *"I just felt like he was like trying to stick me into a programme. I didn't necessarily feel like that programme was right at the end of the day. And I guess it felt like frigid. ... It it's very much like bring your problem, let's solve your problem."*

For others such as Aisha (SU3), this resulted in her dropping out of therapy:

> *"It's just, you know, I don't trust them. I don't know who they are. I don't feel them. And, you know, as somebody who can actually do something for me and, you know, if I'm stuck, so get me out of that and make me understand where I am. Why am I doing this rather than to explore that, you know, if you can't pick up this mug, just do this and pick it up ...I do believe that, you know, one thing that needs to be addressed is the deep sense of the client rather than the superficial things."*

Often, service users reported homework tasks not being *"tailored"* to their specific needs. They questioned the authenticity of therapy as they felt that therapists were simply following set *"programmes"* without getting to know them or *"modifying"* tasks to their individual needs. Annie (SU4) was particularly unhappy with being made to do *"generic"* tasks before the therapist got to know her:

> *"I don't know if it was tailored at all. You like come to a session and have homework printed out without meeting me. How do you know what homework you're going to give me if we didn't have the session?"*

Service users often found homework tasks inappropriate to their cultural background and circumstances. They found the tasks *“unhelpful”* and *“silly”* which did not consider the *“cultural connotations”* the tasks would have on their lives. For example, Khalsoom (SU5) found tasks that involved her family were particularly challenging and felt that her therapist was dismissive of her cultural limitations:

> *“A lot of parts, I was doing in private, so my family had no at all was doing them. The task that included my family, I obviously didn't approach them with it, so there were times where I had to ask my family some questions about certain things. And again, being of the cultural group I'm a part of, it wasn't something that I do, otherwise I get weird looks like why are you asking me this question? Yeah, so it didn't really look at my cultural side of things. It didn't take that into consideration, which is a bit of a shame because it would have been something I would have liked to do. …They were just like, well, you need to work on these, you know, you need to be able to speak to your family. You need to be able to do this. And it wasn't something I was comfortable doing. So I think that would be more of a negative than a positive.”*

However, some service users understood the importance of the tasks and the benefit that this would have on their recovery process. Although initially hesitant with the homework tasks they understood that without putting in the effort, they would not be able to achieve the desired outcomes. For example, Khadija (SU2) talked about her initial apprehensions with homework but soon realised that for her to achieve wellness, she had to take control of her situation:

> *“…But did you work on it? If you walk up to the session and think someone's going to fix you, you’re not a machine. So I really have a lot of time for people who actually get on with doing the work. And I think that's what makes a very big difference. And I think*

> *partly that was because at the time I thought, well, do you want to be fine? Well, this is what you’ve got to do then.”*

Service users who received counselling valued being able to *“just talk”* as they were not able to do this in their personal lives. Qadira (SU9) preferred being able to *“let everything out”* and felt that *“if it was more interactive or anything like that, I probably would have not attended”*. However, for Zara (SU7) more practical *“advice”* and steps on how to manage her situation would have been beneficial. This resulted in Zara dropping out of therapy after the first session:

> *“But I prefer to get some maybe advice, like something that might make me be better. Yeah, because I'm not better now. I'm just like free from the things I needed to say. But I'm the same, I have the same problem.”*

5.4.3.2. Evaluating therapeutic effectiveness

This subtheme considered how well participants found therapy effective to their recovery process. Recovery is defined as a subjective experience of having gained control over one’s life, in which hope, achievement and social connectedness are some of the benefits to those who recover (Ryan & Pritchard, 2004). The majority of service users, in general, found therapy useful, but reported not being recovered from their symptoms or mental health concerns. Service users reported as *“having the same problem”* following their course of treatment and not feeling *“100 percent”*. A couple of service users said they were *“looking for the cure”* to help them deal with their problems, however, this was not achieved through therapy. Most service users described therapy as *“hit and miss”* by which service users could see the benefits of *“just talking”* or using certain *“techniques”* in order to *“get back into society”*, however, they questioned the long-term benefits of therapy as a whole. For example, Bushra (SU6) reflected on her therapeutic experience:

> *"You know what it is, I think that therapies are just procedures. ...I don't think they can fix you. I think, you know, people need therapy. They need it in their lifetime again and again. I think, you know, to kind of get back into that kind of habit that they're kind of teach you."*

Service users felt that therapy was *"just too short"* and would have preferred more sessions to help them overcome their issues. They understood service demands, however, felt that it was a *"waste of time"* if people were not recovering from their disorder or seeing the full *"benefit"* of therapy. Most service users found the short-term benefits of therapy useful, however, felt that it was *"momentary"* for what was going on at the specific time of being referred to therapy. They reported that therapy did not help resolve past traumas, issues, and concerns. Aisha (SU3) was particularly vocal about the long-term benefit of therapy, particularly CBT, which she found *"situational"* to what was going on at the time of therapy:

> *"...You know, they need to focus on the past and the present for you to move forward. You are constantly stuck in today throughout the therapy ...I just like I'm seeking this to resolve past issues and how I ended up here and how to move forward from here, and none of that was addressed ever."*

Most service users felt that therapy was *"helpful"* and could see *"visible changes"* to their mood and behaviours following a course of treatment. Service users found talking about their problems made them feel *"lighter"* after having *"bottled in"* their concerns and issues for a long time. Most service users said that they would recommend therapy to others and felt that everyone who needed it should *"try it at least once"*. For example, Bushra (SU6) felt that her therapeutic experience challenged her preconceptions of therapy and helped her on the road to recovery. She felt that therapy was *"not a cure, but helpful"* and recommended others from her community to take advantage of therapy, and for services to *"break down barriers"* and *"misconceptions"* of therapy:

> *"I think I would always say, before therapy, if someone said to me go for therapy, I would laugh at them, and say what's talking going to do? You can talk to your family, your friends, you can talk to anybody. But I do think it does help because they're like professionals. They know what to say. They know, you know, they don't judge. You know, anything about you. I would recommend therapy. I think therapy does help."*

5.5. Discussion

The aim of this study was to explore whether evidence-based psychological interventions offered by IAPT services are suitable to the needs of BAME communities. Overall, three themes emerged. The first theme highlighted the importance of recognising cultural dissonance within therapy, which considered patient therapeutic expectations, therapeutic guilt, and conflicting cultural identities. The second theme identified therapists need to develop cultural competency which highlighted the importance of building therapeutic trust and exploring patient culture within therapy. The final theme – the road to recovery - highlighted patient challenges with therapeutic engagement and evaluation of therapeutic effectiveness. In general, it appeared that there were critical areas of concern relating to cultural sensitivity and understanding within therapy which should be considered in order to improve clinical outcomes and experiences for BAME communities.

5.5.1. Recognising cultural dissonance within therapy

The findings from the first theme highlighted the cultural dissonance service users' experience between Western concepts of mental health and therapy and their cultural norms, values, and expectations. Theoretical concepts of individualism-collectivism (Hofstede, 1980; 2011; Triandis, 1995) and self-construal theory (Markus & Kitayama, 1991) have pointed towards the importance of group cohesiveness, harmony, and interdependence for those originating from non-Western societies. These cultural nuances were observed in the study participant sample, who often spoke about the cultural clash between their cultural expectations and those expected within therapy. In line with previous literature, it was apparent that Western concepts of mental health and therapy were not always recognised by service users or their immediate family and community (Loewenthal et al., 2012; Mantovani et al., 2017). Western terminology for common mental health disorders were often unrecognised (e.g. Aggarwal et al., 2016; Mohamed & Lowenthal, 2009) which prolonged access and engagement in therapeutic services. Service users reported the lack of knowledge and explanation of what to expect from therapy as this was not common practice within their culture. The therapeutic guilt that was attached to seeking therapy was not always understood by therapists, particularly those from White backgrounds. Patients often talked about the conflict between their familial and religious expectations and their mental wellbeing. The desire to put others first was synonymous to that identified in collectivist cultures (Hofstede, 1980). The interdependent nature of the self had both implicit and explicit consequences on service user cognitions, emotions, and motivation within therapy (Markus & Kityama, 1991). However, in line with research in the US (e.g., Allen & Bagozzi, 2001; Gushue & Constantine, 2003) it was clear that service users held bi-cultural identities that allowed them to interchange between individualistic–collectivist patterns for living. One participant termed this as wearing *'masks'* which enabled him to interchange between his home, work, and social circle. However, the cultural clash between what was expected within therapy and patient home life was not always understood by therapists (Bhullar et al., 2012; Hong & Woody, 2007). This was problematic for service users as they were often left feeling misunderstood by therapists and dropped-out of therapy (e.g., Mofrad & Webster, 2012). Based on these findings, it was clear that psychoeducation was imperative, but not only at a personal level, but for the wider community. Previous research has identified that enhancing community awareness of mental health services are crucial to normalise mental health disorders and Western concepts of therapy (Evens et al., 2014; Memon et al., 2016). Moreover, previous clinical trials have suggested psychoeducation improves mental health outcomes for BAME communities in England (Jacob et al., 2002; Horell et al., 2014). Thus, a progressive model, which incorporates psychoeducation as a priori before therapy may enhance therapeutic outcomes and engagement with therapy (Boyd et al., 2019). The foundations of this theme were linked to the next theme, the need for therapists to develop cultural competency.

5.5.2. Developing cultural competency

In order to develop cultural competency, service users often discussed the importance of building trust within the therapeutic relationship. In line with previous research, patients worried about confidentiality and their personal issues being let out into the community (e.g., Bristow et al, 2011; Clement et al., 2015). The inherent stigma attached to mental health disorders in the BAME community was apparent, with service users dropping out of group therapy in order to maintain their privacy. Patients felt that it was imperative for therapists to build trust before they divulged their personal issues. Moreover, the cultural misinterpretations were a concerns within therapy. Service users talked about White therapists misjudging their tone of voice, religious garments and cultural norms which instantly built barriers within therapy. Previous literature has alluded to detrimental consequences that such misinterpretations has on BAME communities, thus heightening the ‘circle of fear’ when accessing mental health services (Sainsbury Centre for Mental Health, 2007). As such, all participants said that they would have valued if therapists had asked them about their culture, beliefs, background, and values as this would have helped the therapists to understand their circumstances much better. Cultural competency is deemed imperative for therapeutic success (e.g., Castillo & Guo, 2011; Fernando, 2005; Sue, 1998), however, it appeared that not all therapists actively engaged with this within therapy. Notably, therapists from a White British background were less likely to understand patient needs that may be due to the inherent individualistic values systems which promote self-sufficiency and independence that they adhere to (Al-Krenawi & Graham, 2000; Fernando, 2012). Whilst this mindset is suited to the principles of Western therapy (Laungani, 2007; Loewenthal, 2018), this was often at the expense of really getting to know the service user’s therapeutic needs that were intertwined with their socio-cultural needs and expectations. Whilst patients valued therapists from similar cultural backgrounds to themselves (Naz et al., 2019; Sue, 1991), this was not always deemed important for recovery. In fact, in line with previous research, some patients worried that they would be judged by a therapist from a similar cultural and religious background (Naz et al., 2019). Instead, patients felt that more cultural competency training was needed in order to better understand service user needs, rather than using inexperienced staff in the role of PWPs (Bassey & Malluish, 2012) who may not be fully trained to deal with the needs of BAME communities. This led to the third theme, the road to recovery.

5.5.3. The road to recovery

The final theme first considered the challenges service users' experienced with therapeutic engagement and their evaluation of therapeutic effectiveness. Previous research has highlighted greater attrition rates in BAME communities when compared to the White British population (Baker, 2018; Harwood et al., 2021), however, the reasons for this have been relatively unexplored within the UK. Bassey and Malluish, (2012) referred to this as 'McDonaldization' of IAPT services which was something that was picked up by participants in the present study. Service users worried that therapy sessions were too short, not personalised, and therapists were more concerned with meeting targets at the expense of their needs. CBT was the most common therapy offered to patients, however, service users questioned its authenticity. In line with previous research, patients found CBT prescriptive, rigid, and not tailored to their specific needs (Omylinska-Thurston et al., 2019). Moreover, patients generally found homework tasks unsuitable to their socio-cultural needs and circumstances. Often therapists suggested tasks which had implications for patients outside of the therapy room, which was a concern amongst participants. However, some service users understood the benefit of homework tasks and the need to take control of their situation should they wish to see an improvement in their mental wellbeing. Those who received counselling valued being able to talk about their problems as this was something that was uncommon within their communities. However, the suitability of counselling was mixed with some service users valuing just being able to talk, whilst others wanted practical steps to deal with their problems.

In evaluating the effectiveness of evidence-based psychological interventions, the majority of service users had reported that they did not recover from their mental health concerns, however, generally found therapy helpful. Service users expected to be cured following therapy, however, realised that therapy was a lifelong process and not a short-term fix. In line with previous literature, patients would have valued longer sessions to feel the benefit of therapy (Christodoulou et al., 2019). Some service users found therapies such as CBT were too focused on the present and situational, which did not account for past traumas (Costa & Briggs, 2014; Bristow et al., 2011). Research with ethnic minority communities have highlighted the need to consider the patient as a whole, which includes their cultural, religious, spiritual, and social needs if therapists are to make active changes to their lives and the recovery process (Fenn & Byrne, 2013). Despite the therapeutic challenges, most service users would recommend therapy to others and felt that therapy was *"not a cure, but helpful"*. Thus, services should enhance active engagement with BAME communities to raise awareness should they wish to make services more accessible and equitable to such disadvantaged communities (Beck et al., 2019; Lawton et al., 2021).

5.5.4. Limitations

The main limitation of this study was that the sample size was small (*N* = 9) which may not be sufficient in presenting a comprehensive view of BAME service users therapeutic needs. The sample size was on the lower end of the minimum criteria recommended by Braun & Clarke (2013) due to recruitment difficulties amidst of a global pandemic (Covid-19). However, future research should consider the inclusion of large-scale sample to capture diverse communities. To this end, whilst attempts were made to include a wide range of ethnic minority populations, from all adult age-ranges and genders, the study largely attracted female participants from the South Asian/ Arab communities. The researchers own background may have been a reason why service users felt comfortable in taking part in research, however, the inclusion of more diverse communities, such as the Black and Mixed Ethnic groups is needed to understand a broad range of therapeutic needs. In addition, the current study only included one male participant so the views may not be entirely reflective of the wider male population. Although the narrative echoed that observed in previous research (Mohamed & Lowenthal, 2009), more research is needed. Given that this study was explorative and casted a wider net to engage a broader sample, future research may consider the needs of segments of the BAME community to draw comparisons between the needs of each population.

5.5.5. Conclusion

This study aimed to explore whether evidence-based psychological interventions are suited to the needs of ethnic minority populations in England, UK. Findings from the study raised critical concerns with the conflicting cultural values, needs and expectations of BAME communities and what is expected from Western notions of therapy and practice. Patients identified the importance for therapists to develop their cultural competency skills in order to better serve their needs. Whilst most service users felt that they did not recover from their mental health concerns, they did value therapy and would recommend it to others. It appears that there is a long way to go, yet, it is not unachievable. IAPT services should consider enhancing the cultural competency of its workforce should they wish to actively engage service users from disadvantaged communities. Future research should aim to establish whether IAPT therapists are culturally competent to deal with the needs of BAME communities in order to establish gaps in training needs. Given the poor access to therapy, recovery outcomes, and high attrition rates, IAPT services needs to do more to engage BAME communities through community mental health awareness and psychoeducation. This study is one of a few that have sought to understand the patient recovery narrative, thus more research is needed to investigate service users therapeutic needs with more diverse samples of the population.

5.6. Chapter Summary

This chapter aimed to further enhance our understanding of whether evidence-based psychological interventions are suitable to the needs of diverse communities. A key overarching theme that was identified was the need for more cultural competency training within the IAPT workforce. Thus, the next study will explore whether IAPT practitioners are culturally competent in dealing with the needs of BAME communities.

Chapter 6

Study Three: *"It's been quite a poor show"* – Exploring Whether IAPT Mental Health Practitioners are Culturally Competent to Deal with the Needs of BAME Communities

6. Study Three: *“It’s been quite a poor show”* – Exploring Whether IAPT Mental Health Practitioners are Culturally Competent to Deal with the Needs of BAME Communities

6.1. Chapter overview

This chapter aimed to further extend our understanding of whether evidence-based interventions are suitable to the needs of Black, Asian, and Minority Ethnic (BAME) communities, by exploring whether mental health practitioners are culturally competent to deal with the needs of diverse groups. Cultural competency is considered a core clinical skill in working with diverse communities (e.g., Clegg et al., 2016; Sue, 2009). Given that the vast majority of clinical trials have been carried out with the White population (e.g., Adams, 2008; Pilgrim, 2017), it is unclear how well evidence-based interventions translate in ‘real-world’ clinical settings once services are accessed by BAME communities. To explore this, in-depth qualitative interviews were conducted with mental health professionals working in Improving Access to Psychological Therapies (IAPT) services. Therapist’s roles ranged from trainee Psychological Wellbeing Practitioners (PWPs) to qualified Cognitive Behavioural Therapists in supervisory roles. It is envisaged that the findings from this study will aid in gaining a better understanding of the therapeutic challenges, as well as evidence of good practice that can enhance recovery outcomes for BAME communities living in England.

6.2. Introduction

Cultural competency has received considerable attention in mental healthcare, particularly in relation to its usefulness when working with people from ethnic minority backgrounds (Castillo & Guo, 2011; Sue, 2006). Culturally competent care acknowledges and integrates culture when making considerations about assessment, treatment, and outcomes (Castillo & Guo, 2011; Good & Hannah, 2015). Whilst there is no single definition of the term cultural competency, there has been a number of definitions within literature, including; *‘‘a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations’’* (Cross, Bazron, Dennis, & Isaacs, 1989, pp. iv) and *‘‘as one that acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs.* (Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2016, pp. 294).

Theoretical paradigms such as individualism-collectivism (Hofstede, 1980; 2011; Triandis, 1995) and self-construal theory (Markus & Kitayama, 1991) suggest that there are distinct cultural differences between those who are from Western societies, and those who originate from non-Western cultures. Evidence-based practices are rooted in universal rhetoric and individualistic value systems which seldom consider cultural particularism (Frese III et al., 2001; Fenn & Byrne, 2013; Good & Hannah, 2015; Rogers, 2009). Typically, training programmes and manuals of psychotherapy are developed to the needs of the dominant Western cultural group (Sue, 2009), therefore the needs of clients from diverse communities tend to be absent from traditional theory, processes, and programmes (Kirmayer, 2007). In England, mental health professionals now work in an increasingly multicultural society which necessitates the need for cultural competency to be incorporated within clinical training programmes to equip them to offer culturally informed and empirically supported therapy (Good & Hannah, 2015; Keith, 2011; Leong, 2006; Sue, 1998; Yan, 2018). However, given the inherent overrepresentation of White therapists within UK clinical settings (Lang, 2020), concerns are raised about Eurocentric practitioners lacking an understanding of cultural diversity and expression of mental health which can have detrimental effects on the therapeutic care for ethnic minority communities (Turpin et al., 2008; Good & Hannah, 2015). Thus, mental health practitioners are encouraged to consider patient lived experiences and culturally sensitive issues in order to maximise recovery goals (Dausch et al., 2012; Tse & Ng, 2014).

In recognition of the importance of culturally competent practice, many UK professional bodies such as British Association for Behavioural and Cognitive Psychotherapies (BABCP, 2021) have incorporated cultural competency units as part of their training programmes (Ibrahim & Heuer, 2016). However, there is limited evidence of their success (Bhui et al., 2007; Clegg et al., 2016). Research suggests that mental health practitioners in Western society seldom receive adequate training that equips them to work with diversity (Clegg et al., 2016; Edge & Lemetyine, 2019). Often training programmes and psychological theories dealing with cultural competency fail to consider the role of the therapist, and how their own identity interacts with that of the client, which includes stereotypes, biases, and positions of power and privilege (Bhui et al., 2007; Crawford, 2012; Ibrahim & Heuer, 2016; Sue et al., 1996). Cultural competency training can help improve the quality of care for people from diverse communities (Bhui et al., 2007), therefore, mental health services should regularly reflect and assess the competencies of their workforce in order to provide appropriate services to disadvantaged communities (Clegg et al., 2016). In an attempt to increase cultural sensitivity within IAPT, practitioners are encouraged to consider the world-views and beliefs of service users from diverse backgrounds, which can often differ from the models and treatment options developed for Western populations (Roy-Chowdhury, 2013).

In recognition of an increasingly diverse clinical population, IAPT developed the BAME positive practice guidance to enhance the cultural competency of its workforce (IAPT, 2009; Beck et al., 2019). A key theme throughout the guidance is for therapists to offer culturally adapted and culturally responsive services that meet the needs of the local community (Beck et al., 2019). However, time limitations, lack of training, and ineffective evaluations of therapeutic adaptations make it difficult to assess therapeutic effectiveness (Bassey & Malluish, 2012). Moreover, therapists from BAME backgrounds are often allocated complex caseloads without adequate support or resources (Naz et al., 2019). This can be problematic for BAME therapists, who unlike their White colleagues, are left feeling responsible for the quality of care of ethnic minority patients who tend to be more difficult to engage in therapy. Given such challenges and concerns, coupled with poor recovery outcomes (Baker, 2018; Harwood et al., 2021) and unmet needs of BAME service users (Beck & Naz, 2019; Christodoulou et al., 2019; Lawton et al., 2021) this study aims to explore whether IAPT practitioners are culturally competent to deal with the needs of BAME communities?

6.3. Methods

6.3.1. Methodological approach

Reflexive Thematic Analysis (RTA) was chosen as it is a flexible qualitative method which does not confine to particular theoretical frameworks, philosophical positions, or ideologies (Braun & Clarke, 2006; 2021a). Instead, RTA allows research to be conducted from different epistemological standpoints, including critical realism (Braun & Clarke, 2006; Fletcher, 2017). To my knowledge, there have been limited studies that have specifically explored whether therapists working for IAPT are culturally competent to deal with the needs of ethnic minority communities (Beck et al., 2019; Naz et al., 2019). RTA was considered the most useful analytical approach to explore therapists' perspectives by generating meaningful insights into their experiences (Braun & Clarke, 2006; Clarke & Braun, 2013). More details about the methodological choice can be found elsewhere (*see* Chapter 3 – Rationale for selecting RTA).

6.3.2. Participants

Participant demographics are highlighted in Table 6.1. The age range was between 27 – 56 years old, with a mean age of *M* = 38.56 (*SD* = 9.65). 12 out of the 16 therapists were female (75%), whilst 4 were male (25%). Most therapists identified as Indian (31.3%), followed by Pakistani (25%), White British (25%), and White Other (18.8%). The religious orientation of the therapists was predominately Muslim (31.3%) and Sikh (25%). Others included Christian (12.5%), Hindu (6.3%), Buddhist (6.3%), and No religion (18.8%). The large majority of participants were CBT Therapists (68.8%). Others included Trainee Psychological Wellbeing Practitioners (PWP) (12.5%), and Qualified PWPs (18.8%). The range in years of experience was between 1 – 10 years, with a mean of *M* = 4.44 years (*SD* = 3.44).

Table 6. 1. *Mental Health Professionals Demographics*

Demographics			
Age (Mean, *SD*)	38.56 (9.65)	**Therapist Role** *N* (%)	
		Trainee PWP	2 (12.5%)
Gender *N* (%)		Qualified PWP	3 (18.8%)
Female	12 (75%)	CBT Therapists	11 (68.8%)
Male	4 (25%)		
		No of Years in Role (Mean, *SD*)	4.44 (3.44)
Ethnicity *N* (%)			
White British	4 (25%)	**Religion** *N* (%)	
White Other	3 (18.8%)	Muslim	5 (31.3%)
Pakistani	4 (25%)	Sikh	4 (25%)

Indian	5 (31.3%)	Hindu	1 (6.3%)
		Christian	2 (12.5%)
		Buddhist	1 (6.3%)
		None	3 (18.8%)

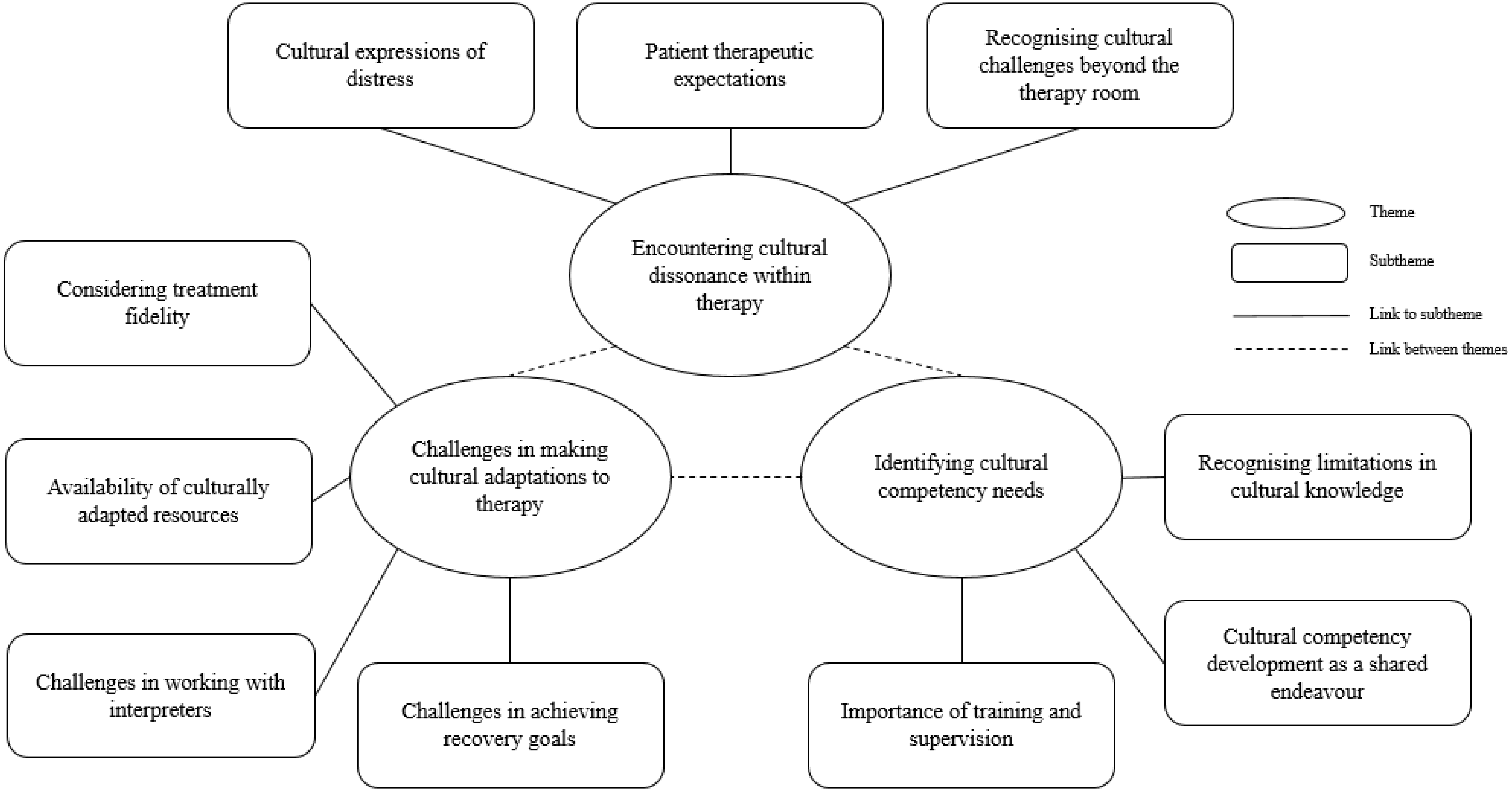
6.3.3. Procedure

A recruitment poster was shared with several IAPT services, via established contacts, and social media (*see* Appendix B.4.1). Therapists who contacted the researcher with interest to participate were sent an email with the information sheet which detailed the purpose of the study, the consent form should they wish to participate, and the researchers contact details should they wish to enquire further about the study. Once the participants had agreed to take part, they were requested to share details about their availability to conduct the interview. All therapists opted for face-to-face interviews. Therapists were requested for the interview to take place in a private and quiet room, free from distractions so they could openly talk about their experiences. As such, they were offered the choice of either being interviewed at the researchers' university or at their service (if they were comfortable with this and privacy could be maintained). All therapists opted to be interviewed at their IAPT service location. Before the interview began, the researcher reminded the therapists about their right to withdraw and assured them that their personal details will be kept confidential and not referred back to their supervisor, or anyone else in IAPT services. As such, participants were encouraged to not disclose any personal information, the service they worked at, or the name of any colleagues or service users they had been in contact with. Participants were given the opportunity to ask questions. Interviews were recorded via a recording device and lasted between 45 minutes to 1 hour 10 minutes. Participants were given the opportunity to take a break if needed. Once the interview was completed, participants were offered a verbal debrief and given the opportunity to ask any questions. Participants were provided with the researchers contact details should they wish to withdraw from the study at any time, without question, for up to 2 weeks after the interview had taken place. Participants were provided with contact details for services such as Mind and Samaritans should they feel distressed. They were also provided with the researcher's supervisor contact details should they wish to get in contact and raise any concerns. All participants were emailed a written debrief sheet with the details aforementioned. Participation in the study was entirely voluntary and no payment or incentive to participate was provided.

6.3.4. Analysis

RTA involves reflexive engagement with the dataset, guided by a six-phase process to produce a robust pattern-based analysis (Braun & Clarke, 2006; 2019). During the first phase – *data familiarisation* – I carried out all the interviews and manually transcribed the interviews for each participant to facilitate deep immersion within the data. I read and re-read the entire dataset in order to become familiar with the data. Whilst transcribing the interviews, I listened carefully to each participant and made notes of my initial analytical observations and insights which included participants' feelings, discourse, and understanding of their world (*see* Appendix B.2.1). The second phase entailed *coding* of the transcripts which was done systematically through the entire dataset by using the 'comments' function in Microsoft Excel 2016 to create side margins which highlighted the relevant extract and code (*see* Appendix B.2.2). Here, attempts were made to code authentically to the therapist's narrative to ensure nothing was missed out that could later be useful. I transferred all codes to a Microsoft Excel 2016 document in order to keep track of the iteration process and evolvement of the codes, themes and subthemes (Byrne, 2021). For the third phase, I began to *generate initial themes* by clustering topic areas according to their shared meaning. This included a number of themes and subthemes that were apparent in the data and that aligned to the research question. A miscellaneous theme was created to incorporate items that did not directly answer the research question (*see* Appendix B.2.4). Phase four involved *developing and reviewing themes.* Here, themes and subthemes were recursively reviewed to ensure that they addressed the research question and built a narrative between the themes (Braun & Clarke, 2012). Themes and subthemes were revised where needed to ensure that they offered the most meaningful interpretation of the data. The finalised thematic map demonstrating the three themes is shown in Figure 6.1. The fifth phase included *refining, defining, and naming themes.* The themes were further refined and defined to consider the respective research question. Using a recursive approach I went back and forth between the data to ensure that the data tells a 'story' that does not drift off topic (Braun & Clarke, 2019). With feedback from my supervisory team, a clinical expert, and engagement with the literature, I further revised the theme titles for the final analysis and selected appropriate extracts to be presented in the report (*see* Appendix B.2.4). Finally, the report was written up to offer a narrative account of whether IAPT mental health professionals are culturally competent to deal with the needs of BAME communities. Throughout the study, I reflected on my own prior assumptions before and during the data collection process by keeping a reflective diary and by considering my positionality (*see* Section 3 – Reflexivity). I sought involvement from my supervisory team and external clinical expert with experience of RTA to ensure the analysis was credible and aligned with the research question.

Figure 6. 1. *Thematic Map of Themes and Subthemes for Mental Health Practitioner Interviews*



6.4. Results

6.4.1. Theme One: Encountering cultural dissonance within therapy

The first theme considered therapists accounts of encountering cultural dissonance within therapy. Three subthemes emerged; cultural expression of distress; patient therapeutic expectations; and recognising cultural challenges beyond the therapy room.

6.4.1.1. Cultural expressions of distress

The first subtheme describes the cultural expression of distress that was brought up in therapy by ethnic minority service users. Therapists discussed how cultural terminology used for mental distress conflicted with Western notions of mental health and therapy. This included somatic symptoms, beliefs in witchcraft, black magic and spiritual possessions. All therapists raised concerns about the way mental health was conceptualised in the West and the lack of terminology available to explain Western concepts to service users from BAME communities. A couple of White therapists worried about how their *"Westernised"* worldview of mental health would project onto patients from ethnic minority communities who may not share the same understanding. For example, Simon (MHP5) mentions; *"...I'm worried about my very Westernised view of depression on the person, which might actually not resonate with them, they might not grasp it".* Certain words such as *"depression"* and *"anxiety" "did not exist in certain cultures"* which made it *"difficult"* to explain mental health conditions and therapies to service users. Therapists discussed how certain cultures had *"very negative words"* to describe mental health, which included *"crazy"*, *"madness"*, or *"paagal [mad]"*, thus holding *"shameful"* and *"very embarrassing"* connotations. For example, Bhavna (MHP1) discussed the barriers she faced in therapy due to not being able to translate depression and anxiety:

> *"A big problem I want to highlight is there's no word for depression and anxiety in certain languages. I think the Punjabi culture, even Muslim culture, because that's a big thing, because it's about how do we communicate these words to people. You know, we can use similar words in the language, but it's not exactly the same word."*

As a result, some therapists had to resort to using *"adjectives"* and *"metaphors"* to describe disorders such as *"feeling stressed"* or *"feeling down"*. For example, Scott (MHP16) talked about *"mirroring"* the patients' language as to how they understood their mental wellbeing:

> *"And I think it's making sure that you're using their words. So that's why you use the word sad, because I think that's probably the most common. How do you feel? I feel sad. Right, I'm going to use that."*

Therapists found younger generations *"a bit more broad minded"* than the older generation, particularly when it came to understanding of mental health. For example, Jess (MHP7) discussed the differences she experienced when working with older and younger BAME clients:

> *"…The younger generation is more accustomed to that [mental health]. Now, if I see them, it's more like normal in that it's like seeing an English person. But when it comes to older community, they don't understand that there is other levels of mental health that you just try to push through. It can be harder in a sense."*

As such, therapists often reported finding it more *"challenging"* to engage older patients from BAME communities as they would often *"somaticize"* their conditions, rather than attributing it to mental illness. Therapists felt that it may be more *"acceptable"* in certain cultures to have somatic symptoms than to get diagnosed with a mental health condition. This included *"my stomach hurts"*, *"I can't concentrate"*, *"my chest hurts"*, *"heart racing"*, *"getting headaches"*, and *"palpitations"*. Older patients were more likely to have the mentality *"go* *doctor and get pills and you're on your way"*. Therapists felt that one of the possible reasons for this was the adoption of the *"medical model"* by many non-Western societies. This meant that there was an inherent reliance on physical sensations and medication. For example, Sophie (MHP11) talked about having to use her own cultural knowledge and experiences as an Indian female to detect signs of mental health distress:

> *"Like, say, for instance, for anxiety, the typical stuff is sort of palpitations, dry mouth, you know, that sort of thing, but then a lot of Asian women would come with, like, burning feet or they would describe it as burning in the head, or it's like needles in the hands of their interpretation of what anxiety was, the way they explained it. So if you look at the IAPT measures, you know, it talks very specifically about certain things they wouldn't necessarily identify with. So your experience came in quite a lot in terms of how you explain that, and even with depression. ...I can't really do anything because it was more acceptable in some ways in their culture to think about it as it was a physical thing rather than it was a mental health issue... So the terminology probably isn't geared towards certain cultures, I would say."*

Most therapists discussed having to explain to service users that *"their thoughts, emotions, physical symptoms and their behaviours are all connected"*. This took up a lot of therapeutic time as therapists often had to offer *"psychoeducation"* before therapy could begin. Therapists felt that it was imperative to make those *"links"* otherwise *"if you're not getting those things, there's no point. You're going to struggle"*. For example, Sidra (MHP14) found that BAME patients often *"externalised"* their symptoms, which conflicted with Western models of mental health which inherently views such issues as internal. This meant that service users often struggled to pick up on *"emotional symptoms"* as it was not something that was *"normal"* in their culture:

> *"…Depression is externalised, is not part of the person, it's not that. Whereas in the Western world, I am depressed. Whereas in our world, in the sort of Asian world, it's like, you know, is all to do with the heart. It's like, oh, physical symptoms, they will pick up the physical symptoms. They won't pick up the emotional symptoms because emotionally it's not normal to feel like this."*

Several therapists talked about the influence and beliefs of witchcraft, black magic, and spiritual possession held by BAME communities. This tended to be prominent in Asian and Black communities, who often brought such concerns into session. Sikander (MHP4) discussed the challenges he faced in therapy, whereby he had to manage Western models of mental health with non-Western belief systems. He found that for some BAME service users, their mental distress went beyond his therapeutic knowledge or training:

> *"… And their mental health is not just mental health, it's something else that's going on, or somebody else has done something. And again, I think that's a barrier because if that's their belief, that person brings that into session,"*

Some therapists were worried about how to approach such subjects because they did not want to *"dismiss their [client] religious or cultural views"*, but equally wanted to ensure service users understood the purpose of therapy. Patients regarded such matters *"as being external problems"* which made it difficult for therapists to navigate conversations around *"self-sufficiency"* and *"taking control of their lives"*. Therapists found this *"challenging"* as they did not know *"how to work with it"*. A few therapists, particularly from BAME backgrounds, worried that their White colleagues may misinterpret views of black magic and *"possession [jinn]"* as *"psychosis"* as this was not something that was readily discussed or included in Western models of mental health or therapy. For example, Bhavna (MHP1) worried that some service users would rather rely on the *"priest"* or *"spiritual healer"* to *"fix"* their problems than to believe they had mental health issues or seek therapy:

> *"There's lots of different viewpoints of what might help. They were taken to this priest, you know, take them to a spiritual healer give them some money and get this person fixed because a lot people might see it, in BME cultures, that it might be down to giving evil eye or something bad might happen or, you know, this person's been jinxed in some way. They rather prefer to believe that then there's mental health involved. So that's quite frightening. Then how do you say there's this therapy that can help?"*

6.4.1.2. Patient therapeutic expectations

This subtheme describes the therapeutic expectations patients from BAME communities had and the challenges therapists faced in trying to explain Western notions of therapy. Most therapists reported that there was a distinct *"lack of awareness"* and *"understanding"* of Western therapy in BAME communities due *"the idea of therapy not existing in different countries"*. For example, Bhavna (MHP1) recalled her experiences of working with BAME clients and found that they often questioned the purpose of therapy and whether it would help them recover:

> *"…What is it [therapy]? I'm going to just sit there and talk to somebody? So I think it can be difficult to encourage the patient to recognise therapy is helpful, especially when they've got external influences and maybe their own beliefs and values as well about what might be useful."*

Most therapists discussed the idea of service users *"expecting a cure"* or a *"magic pill"* when entering therapy. Therapists reported that whilst they encouraged service users to develop *"self-resilience"*, this was sometimes difficult to manage when there was a *"reliance"* on the therapist to *"miraculously change their circumstances"* than to *"find the answer"* for themselves. Therapists reported that it was easier for some service users to get *"an injection or taking medication"* to *"solve"* their problems than to *"sit in sessions for six weeks, for one hour and talk the problem away"*. For example, Sikander (MHP4) talked about the difficulties in managing patient expectations of what he was able to achieve during therapy:

> *"A lot of the times people come in and say, well, fix me, you know, or like wave your magic wand …They give you the power to make them better. And a lot of this is about balancing out the politics and understanding the control is with them to get better, not to say we don't try our best. And some people don't take that very well, actually the idea that you have to do something about your mental health …But it's that mindset that the therapist needs to make me better, not me."*

Some therapists struggled with explaining therapeutic concepts as it was *"foreign"* to service users such as *"metacognitive thinking"*, *"flashbacks"*, and *"hyper vigilance"*. This meant that therapists had to spend at least one to two sessions *"psychoeducating"* patients and *"slowing down the pace of therapy"* in order to explain *"deeper meanings"* of Western models of therapy. Most therapists reported that this was increasingly more difficult with older patients than younger BAME service users. For example, Jess (MHP7) found that younger BAME service users were able to grasp therapeutic concepts, but this became more difficult with first and second generation adults:

> *"If it's a younger generation, it's easier to understand. Older generations start to think, well… it's very hard for them to take it back and link it to belief systems from the past …It is quite hard for them to really get it. They start to get a bit confused."*

Several therapists reported that service users were not fully informed about what to expect from therapy and saw it as *"practical help"* for their *"immigration"*, *"benefits",* and *"social* *services"* issues. This meant that practitioners were often *"signposting"* service users onto other services which in turn made patients *"frustrated"* and *"angry"* with mental health services. For example, Nadia (MHP9) found this particularly frustrating and felt that patients needed to be *"signposted"* earlier on rather than being made to wait for therapy:

> *"Sometimes they think we fix all their problems from the socioeconomic to the needs of children. You know, I can't put food on people's table. I can't fill out benefits forms. I can't you know, if they need to know, like I said, they've migrated or refugee asylum seeker and they're struggling financially. I can't help with that. Other issues. There's so many other issues here. But at the same time, if IAPT was getting it right at the early step of signposting, those issues would be sorted before they enter therapy."*

Therapists felt that this *"wasn't a good experience"* for service users, therefore felt that those who assessed the client (e.g., General Practitioners and PWPs) at the first point of contact needed to *"manage patient expectations"* before referring them for therapy. Some therapists had to create their own *"resource packs"* because it was not readily available from IAPT service. This often meant they had to do *"a lot of research"* in their own time to help service users find the appropriate service. Gina (MHP10) echoed these concerns and felt that it was important to clarify patient *"expectations"* from the start:

> *"...And to the person who's expecting let's say a letter or practical support, and then I start talking about mood and behaviours and emotions they are like, what is this about? I expect you to sort out my benefits because somebody sent them to me. So it is important to clarify that and set the right expectations."*

6.4.1.3. Recognising cultural challenges beyond the therapy room

This subtheme describes therapists' recognition of the cultural challenges that had both implicit and explicit implications on their therapeutic encounter with service users from BAME communities. These factors went beyond the therapy room which made it challenging to deliver Western notions of therapy that value individualised care. Family dynamics played an important role in the uptake of therapy and therapeutic compliance. Therapists reported that the majority of BAME service users discussed *"the family element"* of their lives caused them the most distress. Unlike their White counterparts, therapists reported that service users from minority groups tended to be heavily influenced by their family which made it challenging to *"sell"* concepts of *"autonomy"*, *"self-reliance"* and *"independency"*. Therapists talked about the inherent familial *"expectations"* and *"responsibilities"* that people from BAME communities faced which made it difficult for them to explain and justify their reasons for *"engaging"* in treatment. Alison (MHP6) worried that the limitations of her role and her background as a White therapist made it difficult to gauge the extent of BAME service users' cultural and familial pressures:

> *"I can't picture what it's like for you to be in your environment and that power dynamic within your relationship, within your family, the pressure that you might have from in-laws as well, because people live in sometimes. You know that wider family lives in quite close proximity."*

Bhavna (MHP1) reported the cultural dissonance service users' experienced between Western upbringing and *"traditional"* cultural values which had implications on their therapeutic engagement:

> *"…You know, dad was always like get on with it or, you know, mom wouldn't talk much about it [mental health problems]. Sometimes patients might struggle… because it's*

> *probably family, siblings, or maybe caregivers like grandparents which can influence how they feel and perceive. They [are] almost lost as to what we follow, this culture that we are brought up within or the culture that my parents are inflecting on me, or suggesting I should adhere to keep those traditional values."*

Sidra (MHP14) further discussed how collectivist values meant that Western models of therapy were not so simple to *"fit"* into the lives of individuals from BAME communities:

> *"…Because in the Asian culture, the other thing is the 'I' doesn't exist. 'We' exist in Islam. We as a family, an extended family. The husband or wife don't really exist as a couple. You exist as a part of an extended family that has an impact so that in when they talk about relationships. That can be confusing in the Western world, because in the Asian world, you have 10 caregivers for the child such as the grandmother, the aunties …Whereas the Western world its mom, dad, that's your family. So it's very different. So those things need to be taken on board. All this is really complex."*

Therapists reported that there was often a *"high reliance"*, particularly in Asian and African-Caribbean communities to use their *"faith"* as a *"coping mechanism"* to deal with mental health problems. Service users were often *"conflicted"* by what their religion was suggesting and Western models of mental health. Therapists found it *"tricky"* to *"challenge"* service users' *"world"* when it came to beliefs about mental health and therapy as they *"were not in a position to say no to religion"*. Therapists found that BAME service users often *"refrained from saying anything"* and tried to *"behave in an English way"* because they were *"afraid"* about how it would be perceived by the therapists. Several therapists found that patient's *"culture is based around religion"*, particularly when it came to patient values, expectations, and behaviours. This meant that there was often *"religious guilt"* embedded within the "*psyche"* of BAME service users, who felt that it was *"sinful"* to *"think, feel, and act"* in ways that challenged religion. Service users often relied on *"prayer over therapy"* to *"de-stress"* and show *"devotion"* to God. Bhavna (MHP1) recognised that for some of her patients, going back to religion was the way in which they could move forward:

> *"...And maybe they've been away from religion for so long that they feel depressed. They think about their values and maybe they do need to go back to religion and start praying again just to make them feel more connected to who they are."*

6.4.2. Theme Two: Challenges in making cultural adaptations to therapy

The second theme considered therapists challenges in making cultural adaptations to therapy. Four subthemes emerged; considering treatment fidelity; availability of culturally adapted resources; challenges in working with interpreters; and challenges in achieving recovery goals.

6.4.2.1. Considering treatment fidelity

In this subtheme, therapists discussed the conflict they encountered when considering cultural adaptations to therapy and treatment fidelity. Whilst NICE recognises the need for cultural considerations, therapeutic adaptations are not recommended given the lack of convincing evidence (NICE: CG123, 2011). As such, a couple of therapists such as Simon (MHP5) felt that it was imperative to stick to guidelines to provide *"effective therapy"*:

> *"It's important I stick to the kind of fidelity of the model and not try and get into therapeutic drift and things like that."*

However, when working with ethnically diverse communities who have varying socio-cultural needs, most therapists reported that at times it was *"tricky"* and *"hard"* to *"abide"* by those guidelines. Some therapists felt that *"models"* were *"robotic"* and needed to consider *"how* *well the client will fit the model"*. Generally, therapists understood the importance of evidence-based therapy but felt that there was *"minimal research"* to support its *"effectiveness with diverse communities"*. Therapists felt that Western models of therapy *"doesn't work for everybody",* therefore, it was important for services to recognise that a *"one-size-fits-all"* approach was not always useful. For example, Gina (MHP10) was particularly conscious of this:

> *"So we are working with an American and European model on different cultures with different influences. And even though there is a model and a manual, there's not always a one-size-fits-all."*

Therapists reported that it was *"easier"* to follow guidelines for BAME clients who were *"British born"* or *"Westernised"*, but found this more challenging when clients held more *"traditional values"*. This was often due to patients not understanding *"therapeutic concepts"* the same way as White patients or those who are more assimilated within Western culture. Nancy (MHP15) felt that it was important to recognise that Western models of therapy were not always assessed in diverse populations, therefore knowledge about their effectiveness was limited:

> *"Well, the structured intervention is mainly cognitive behavioural therapy because this was a Western form of therapy that started in the 70s. There hasn't been a lot of research on how effective Western psychological therapy is on Eastern areas and communities ...so what we have is quite minimal, but it does recognise obvious needs ...And I suppose with smaller communities as well, having an understanding of more rural communities, particularly in, for example, Kazakhstan. Where you have particular groups of people who have quite different perspectives of life and some of their neighbours. It's the more sort of intimate detail of communities is often lost, and*

> *there's an assumption that using the Western treatment, that people will get it and understand it."*

Therapists felt that they *"had to learn this the hard way"* during the first years of practice as there was *"minimal guidance and training on how to adapt therapy"* for diverse clients. For example, Jess (MHP7) reflected on some of the challenges she encountered when making adaptations for BAME clients:

> *"I think when it comes to CBT then you look at how will I adapt to BME community, how do I want to make it understandable for them, you know, and this process, because there was nothing within the course we did to kind of say, OK, if you have ethnic minority client how to engage them and the barriers there. There was nothing about, oh, if you do CBT with an ethnic minority client they won't understand some concepts, or maybe the homework, or how, you know, adapt it or work with that. That was more through just me doing my own kind of research into it, kind of looking online."*

Whilst some therapists discussed *"flexibility"* in making IAPT approved adaptations to sessions (e.g., appointment time, arranging an interpreter), others worried that therapy was too *"prescriptive",* thus the "*strict"* compliance to the guidelines saw a number of patients *"disengaging"* from therapy. For example, Scott (MHP16) felt that it was vital to have an *"understanding"* of the needs of the community and not to treat the guidelines as the *"law"*:

> *"I always say guidelines are guidelines. It's not a law. I think there are clinicians who will stick to the theory, to NICE guidance, and whether that's through personal choice, whether that's through the organisation that they work through this model, I don't know. But there's certainly, I think a need to understand your community and have your management and your Trust or whoever it is, whether the third sector or charities,*

> *having an understanding of the needs of the people within the community that you're working with… So to be able to provide a successful treatment, you have to be flexible."*

Others such as Frankie (MHP13) worried that the need to *"meet targets"* meant that practitioners had become *"complacent"* at the expense of the needs of the client:

> *"I see within the system people have become lazy, practitioners have become lazy …we have become like prescribers. We have become automated services and in this enterprise, it doesn't work like that. I believe that the system should allow practitioners to be as creative as they can and to obtain multiple skills if they can ...I believe that the system is too tight, too controlling and somehow constraining practitioners and clients as well. I try to be as good as I can within the framework and code of conduct we have been taught by NICE guidelines. But I believe that we treat them like a religion. We are so afraid of coming out of them. In fact, the cruelty is not to harm anyone and be safe and be genuine, contrary to our beliefs"*

Most therapists felt there was *"no need to reinvent the wheel"* but felt that there were more *"creative"* ways to explain therapy to diverse clients, which only required *"minimal"* adaptations. For example, Gina (MHP10) used a more hands-on approach by incorporating *"play"* within therapy to explain therapeutic concepts to BAME clients:

> *"So in order, for example, to build a therapeutic relationship rather than talking about BA [behavioural activation], well, I would probably ask the patient to think about what they are struggling with for 30 seconds or so and then get up and we would play with a piece of paper throwing it to each other, kind of playing with a balloon or something. And I would ask them after whether they were thinking of their worry or their problems while we were doing that activity or doing a form of activity. And if they were saying*

> *no, that's the rationale for BA to get to do more rather than sitting down and thinking about your problems."*

Similarly, Nancy (MHP15) discussed how she used the concept of the *"pink elephant"* to help her clients think about their cognitions, which was often a difficult concept to explain to BAME service users:

> *"...For example, the pink elephant. I explain when you tell yourself not to think of something like when people worry and they said, oh, I mustn't think about this. So the concept of the pink elephant is if I tell you not to think of the pink elephant you're going to be thinking of that. I explain that our brain latches on to things because what we need to do instead is actually tell our brain what else you want your brain to think about."*

6.4.2.2. Availability of culturally adapted resources

This subtheme describes the challenges therapists experienced with finding culturally adapted resources for BAME clients. Whilst therapists acknowledged that there was a range of material available, including *"self-help books"* and *"translated questionnaires"*, they found it *"really hard"* to readily find resources. As such, therapists felt that there was a need for a *"central repository"* where all resources could be kept and made accessible to all IAPT services. Most therapists discussed the challenges they experienced with BAME service users who had limited reading and writing literacy. This was predominantly related to *"senior"* clients (e.g., first / second generation) and newly arrived migrants and refugees who *"couldn't grasp the language"* of therapy, and often looked at therapists with *"blank"* expressions. Therapists discussed the use of *"pictures"*, *"drawings"*, and *"emojis"* to help patients *"express how they are feeling"*. Even though material was sometimes available in a range of languages, some clients were *"illiterate"* so were unable to read or write in their *"mother tongue"*. This presented greater *"difficulties"* for therapists as they often relied on interpreters and *"family members"* to translate material for them. For example, Sikander (MHP4) discussed the challenges he experienced in finding and utilising *"self-help material"*:

> *"The biggest challenge I think, is utilising appropriate self-help materials for clients and trying to find what suits them. You want to use self-help books, but they don't really like using them because of the language barriers. Videos are hard to get hold of. I'd love it if they were available for different types of therapy interventions in their own language. Especially for those who can't read or write. Erm, so that's a challenge."*

Most therapists spent time doing their *"own research"* in their *"own time"*, which included finding written and video material in *"different languages"*, or trying to *"understand the political context"* of the patients' home country to help build a therapeutic relationship. Some therapists had previous experience of working with diverse communities, such as *"community mental health"* settings which were advantageous in understanding patient *"culture", "values"*, and *"beliefs"*. BAME therapists often used their own personal cultural experiences, and reflected on their *"upbringing"*, understanding of *"cultural expectations" and "religion"* when working with BAME clients. Some therapists reported the knock-on-effect the lack of training had on their confidence. For example, Nadia (MHP8) felt *"burnout"* with the increased pressure to work and research outside her clinical role to cater to diverse communities:

> *"It's been really difficult you know, not just myself but for other therapist too. I've got a lot of burnout. They [therapists] become really unwell because you're expected to work with communities not being fully trained and supported to do the roles. And it knocks your confidence in your core clinical skills. And yeah, just a bit relentless and tiring."*

6.4.2.3. Challenges in working with interpreters

This subtheme describes the challenges therapists' encountered when working with interpreters. Most services catered for clients with little English proficiency by offering interpreters for a diverse range of clients and by incorporating longer sessions to account for the relay of information. Whilst therapists valued the use of interpreters in aiding them to communicate with BAME service users, there were a number of challenges that arose during therapy. Therapists raised concerns about the *"therapeutic relationship"* and loss of *"empathy"* when information was being translated through a *"third person"*. Often patients were likely to get *"attached"* to the interpreter, which strained the therapeutic relationship between the patient and therapist when those *"boundaries were blurred"*. For example, Nadia (MHP9) talked about the *"dynamics"* of the therapy room, which was sometimes difficult to manage:

> *"…There are so many different dynamics happening in the therapy session. Because not only are you trying to deliver the intervention, you're trying to contain the conversation between the interpreter and the service user. You're also trying to translate materials. And you get distracted by so many different things."*

Therapists sometimes found themselves *"psychoeducating"* and offering *"quick training"* to interpreters before the sessions as some interpreters did not have *"mental health knowledge"*. Therapists reported that at times it was difficult to *"convey the message"* because certain terminology was not available in the patient's language, which made it difficult for the interpreter to explain what was meant. For example, Halima (MHP8) recalled on her experience;

> *"I even remember the translator saying to me she couldn't translate what I was trying to say with some of the technical language involved, like the use of the word depression or anxiety or even strategies. It was definitely really tough."*

Most therapists questioned the *"accuracy"* of translation and had to depend on non-verbal cues such as *"body language"* and *"expression"* to gauge how the patient was responding. Therapists often relied on how well the patient was *"engaging"* and *"progressing"* throughout therapy to determine how *"effective"* the sessions were going. Whilst some interpreters were *"good"* at *"asking for further clarity"*, others were worried that *"there may be a loss in translation"* and interpreters tended to *"add bits"*, particularly when the *"conversations were lengthy"*. Some therapists found it *"frustrating"* when those long conversations were relayed back in a *"brief response"*. Therapists felt it was important for interpreters to provide *"verbatim"* responses to help them *"formulate"* effectively. Hannah (MHP2) reflected on her personal experience where she had to terminate the session as she discovered the interpreter was giving personal advice rather than relaying the information she was giving back to the patient:

> *"…Sometimes as well, an interpreter might have their own views. You don't understand what's being portrayed and I've heard that before. Luckily for me at the time, I've had an Indian patient in front of me. I'm not fluent in Punjabi, so I had an interpreter come in. I can understand bits and I picked up on the fact that he was giving his opinion and telling her that she needed to go to the temple and the problem was because she wasn't good enough Sikh that she doesn't need therapy. So luckily, I was able to pause and stop that session and try to explain to the patient that that shouldn't have happened. However, if I didn't say, for example, at and my Polish patient, I wouldn't have a clue that was going on."*

In some instances, due to a *"handful of interpreters in certain languages"* there was likelihood that the patient and interpreter knew each other from the community. This was a *"massive barrier"* as patients did not want to disclose personal information to them due to worries that the *"word may get back to the community".* This meant that service users had to often either rely on family members to translate, or *"wait longer for another interpreter"* to be sought.

6.4.2.4. Challenges in achieving recovery goals

This subtheme describes the challenges therapists encountered in helping BAME clients in achieving recovery. Some therapists talked about BAME service users using therapy as a form of *"counselling"*, regardless of the therapy type. Given the *"practical"* nature of CBT, this presented challenges for therapists who often found patients wanting to *"just talk"* and not *"engage with the programme"*. Clients who *"actively"* interacted with therapy were more likely to achieve therapeutic outcomes, however, this tended to be prominent for BAME clients who had an *"understanding"* of Western concepts, values, and upbringing. Therapists reported service users often brought up *"a lot of stuff from the past"*, which meant that it was difficult to *"move forward"* with therapy which tended to be focused on the *"present"* and ways in which they could manage their *"current situation"*. However, several therapists such as Gina (MHP10) raised concerns that this often led to greater disengagement from therapy:

> *"Yeah, but then sometimes people get it really quickly or they will disengage. You get the bigger figure of people disengaging because they cannot get on board because it's not the right process or they do not get the model."*

Therapists reported that recovery outcomes became more *"difficult"* when clients *"were not willing to make certain changes"* or adhere to *"homework tasks"*. Therapists reported that Western notions of *"independence"* and *"self-care"* were not always *"easy"* to convey with

BAME clients due to *"cultural"* and *"family"* values. Therapists reported that in instances where homework was not completed, they had to spend time explaining the *"principles"* behind why it would be *"helpful"*. In instances where service users continually failed to complete homework, therapists had to discuss *"whether CBT is right for them, whether they need to continue with therapy or stop".* Whilst some patients were *"accepting"* of the homework tasks, they faced barriers and challenges when they *"went back into their home settings"*. This included being *"unable to talk to family about their problems"*, *"going out on their own"*, or *"taking time out for themselves"*. For example, Alison (MHP6) talked about some of the challenges she experienced in setting homework tasks:

> *"I still have lots of clients who are of different cultures and race who have difficulties with like family commitments ...Maybe they don't actually want to get their worksheets out in front of family members at home because they might be ashamed or because, you know, they might get criticised for doing it."*

Therapists felt that *"Western practice is not really kind of working with those cultural needs and the values"*. For example, Sikander (MHP4) discussed the challenges he experienced in delivering Western models of therapy to BAME clients who held *"collectivist"* orientation:

> *"…We're called collectives. You know, you do everything as a family culture…. So, yeah, you do have to kind of tweak your therapy slightly to take into account those responsibilities they have. ...But on the other hand, when you've got so many responsibilities to manage, it's hard to provide very individualised therapy for someone who is part of a collective."*

Bhavna (MHP1) echoed these concerns and felt that the inherent nature of Western society is to *"look after yourself"* and consider *"self-care",* but this tended to be absent in many BAME communities:

> *"I have not been taught to do self-care, whereas in Western cultures, I guess that's very common for yourself and making time for yourself and looking after yourself. We have these cultures [BAME communities], it might not be emphasised so much. So there might be a conflict. So you're telling me something I should be doing, which I've been told all my life not to do. I put myself first whereas I've been always there for others …Sometimes people might find it a bit too much and might not engage with that. So it is, I guess, it really is the client and where they are. And I think that's a big factor, you know, self-care."*

Moreover, therapists felt that service users' found it *"difficult"* to understand homework tasks such as *"challenging thoughts"* and *"putting it down on paper"*. Given the literacy difficulties aforementioned, some therapists found it *"disrespectful"* to get *"senior members of the community to do assignments"*, whereas the *"younger generation took to it very well"*. Therapists felt that BAME patients grasped *"behavioural"* activities *"quite quickly"*, such as *"breathing exercises"* which may be due to the inherent nature to *"just get on and deal with it"*. On the other hand, cognitive tasks were not something that were *"thought about much"*.

Most therapists discussed the importance of *"being realistic"* when thinking about recovery goals. Therapists felt it was more important to consider what was *"achievable"* for the client, even if that meant that they were not always able to *"reach recovery"*. Some therapists had to use *"small goals"* so that clients could achieve *"enough empowerment at the end of therapy"*, even though this may not meet the intended outcomes of therapy. Some therapists felt that the *"high caseloads and fast turnaround"* meant that they could not always get into the *"detail"* when working with BAME clients. Therapists felt that the focus on *"data-collection"* often meant that they were conflicted between service demands and their personal beliefs. For example, Sidra (MHP14) felt that she could not *"compromise clinical work because it was a human relationship with someone"*, even though this meant that she was unable to achieve the same *"recovery targets"* as her White colleagues. Therapists found that BAME clients often needed *"more time to talk about their problems and open up"* which was often difficult when therapy sessions were *"time limited"* and *"short"*. For example, Nadia (MHP9) discussed the limitations of her role and meeting the needs of BAME service users:

> *"IAPT is limited and capped and there's a bit of flexibility. I guess maybe you might offer three or four extra sessions, but it's not enough. So we work with people who aren't necessarily psychologically minded, who have different languages, a different culture, a different religion and, you know, values. And in IAPT there's very little space for that to come in."*

Therapists such as Nadia (MHP9) felt that there was a *"cultural and systemic problem"* within IAPT services which may be the reason why BAME clients were not achieving the *"same recovery rates"* as their White counterparts:

> *"The whole IAPT needs to review this agenda. It's a cultural and systemic problem here because you can't ignore the fact that ten years on, BME people are still underrepresented in primary care and overrepresented in secondary care. And when they enter primary care, they're not getting the same recovery rates or the reliable improvements. You cannot ignore that. And to ignore that is a disservice to the community."*

6.4.3. Theme Three: Identifying cultural competency needs

The final theme considered therapists reflections on identifying cultural competency needs. Three subthemes emerged; recognising limitations in cultural knowledge; cultural competency as a shared endeavour; and the importance of training and supervision.

6.4.3.1. Recognising limitations in cultural knowledge

This subtheme describes therapists' self-reflections and recognition of the limitations in cultural knowledge and understanding that either they or their colleagues had when working with diverse communities. A number of White therapists said they did not *"feel comfortable"* in talking about cultural issues and were not fully equipped to deal with different cultures. White therapists worried about not knowing what certain cultural implications would mean for BAME patients, for example *"if they hadn't prayed"* or if there was experiences of *"racism"*. White therapists *"feared"* that they *"might get it wrong"* or *"come into conflict"* with their patients because these topics were *"taboo"* in certain cultures. For example, whilst Greg (MHP12) understood the importance of cultural considerations, he worried that he may *"offend people"* due to his *"limited knowledge"* of different cultures and backgrounds:

> *"Um, I think our culture in this country, you know, we are kind of very pc. We like to be politically correct. We don't want to offend people. I think sometimes maybe there's too much of that because we are so careful that we don't want to offend people that we might be. Don't ask that question for fear of upsetting or maybe putting our foot in it and so you know, maybe we're causing more harm by not asking those questions and not raising those topics…"*

Given the limited training offered during clinical training programmes, most therapists had to rely on using their own experience when working with clients from BAME backgrounds. Some therapists talked about *"trying to experiment and see what fits for that individual"* or *"wing it"*, which if unsuccessful meant they had to *"go to the drawing board, see what else works"*. However, therapists recognised that this was not always *"good practice"*, but felt that IAPT did not give them enough *"time to reflect and prepare"* for diverse clients given the increased *"service demand"* and *"admin tasks"*. Therapists recognised that *"building a therapeutic relationship took time"*, and often *"time limited sessions"* meant that they were not able to fully *"explore the service user needs"*. For example, Alison (MHP6) felt that due to the *"fast paced"* environment of IAPT she may have *"neglected"* the cultural needs of her clients:

> *"I feel this sounds really bad, but I just I don't know whether, um, we haven't explored that [culture] as much as maybe we could have ...I don't feel that I've had maybe half the opportunity to talk about, you know, what was helpful in her culture and maybe, you know, kind of identify what her cultural needs are ...It's probably been opportunities where I probably could have asked her a little bit more about her culture. But it's hard because, you know, like I say, you've only got 30 minutes or so of the day and it's almost like you've got everything to fit in. So probably I do feel that that side of things can be neglected."*

Whilst therapists recognised that patients from BAME communities shared some similarities in terms of their cultural values and background, they felt it was imperative to acknowledge the *"every patient is different"* and there were *"cultural differences within similar ethnic groups"*. Simon (MHP5) was particularly conscious about this and felt that it was important not to *"generalise"* and *"not to make too many assumptions"* about patients:

> *"I think it's hard because I suppose you can't generalise to somebody that comes from a let's say a Pakistani background that they are going to have these beliefs, this kind of family environment, because everyone lives between the cracks in the pavement and,*

> *you know, no one lives in these neat boxes ...So I think the awareness is really important."*

Nancy (MHP15) echoed the need to avoid generalisations and not to be *"ignorant"* to the needs of clients:

> *"Don't generalize, it really winds me up. Just never assume. Always look at the person as an individual, which is the whole concept of IAPT having started the patient-centred interviewing. Don't assume but also don't be ignorant. Because, you know, the fact that you haven't come across discrimination doesn't mean that somebody else didn't ...You can't assume anything but you have to also not be naive about the possibility of things. But you have to ask and be mindful of certain aspects."*

6.4.3.2. Cultural competency development as a shared endeavour

This subtheme describes the innate responsibility that was placed on BAME therapists to serve ethnic minority communities and the implications that this had for practice. Whilst therapist matching based on characteristics such as ethnicity and gender can be considered useful in developing a therapeutic bond with service users (Sue et al., 1991), therapists' experience of this was mixed. BAME therapists acknowledged the benefits of therapist matching, particularly when service users had *"mistrust"* or a *"bad experience"* with White therapists. They recognised that by sharing similar collective identities, they were able to *"empathise"* with clients' better which made it *"easier"* for patients to explain their situation. Moreover, some BAME therapists were able to *"speak the language"* so did not require an interpreter, and *"understood the clients upbringing"*, *"family structure"*, and *"dynamics"* better than their White colleagues. However, BAME therapists felt that services should not *"make assumptions a brown face or a black face is suited to a black or brown patient"*, but rather consider the client preference first. Some BAME therapists reported that patients *“did not want to be seen by someone from the same background”* because they wanted a *“different viewpoint”*, especially when it came to sensitive topics of *“abuse”*, *“sexuality”* and *“religion”*. Therapists felt that patients may *“fear that they will be judged”* by someone who is from the same religion or culture.

Several BAME therapists felt that the heavy workload to deal with BAME service users were often placed on them because their White colleagues *“didn’t feel comfortable”* or were *“scared”* to deal with *“people from different ethnic origins”*. Nadia (MHP9) for example was particularly frustrated by this and felt that the *“structural inequalities”* in sharing caseloads equally amongst staff had considerable implication on her *“meeting targets”*, *“getting promoted”*, and her *“mental wellbeing”*:

> *“Look, I work with people from all sorts of communities. I work with British people. I tell you what works, you know, that's because I respect them. I understand the culture. You know, I’ve never told them [IAPT] I can't work with White British community because I've not been raised in a White British family. You will never hear me say that. And I very much doubt you would hear any of the BME therapist say that. You do not always shy away from working with White people. We just get on with it. Do you find that White therapists do that too? That I do not feel confident about.”*

BAME therapists felt that it was important for their White colleagues *“to not be afraid”*, but *“understand that there might be challenges”* and to *“seek advice”* when working with diverse communities. BAME therapists felt that it was imperative to be culturally curious about BAME clients *“perspectives”* of their culture by considering *“how things work for them”* and *“why they think in a certain way”*. Some therapists reported that service users were *“quite happy to* *tell you their story if you ask questions"*, but felt that it was important to *"not rush"* the patient if they did not *"feel comfortable"*. BAME therapist felt that to build a *"therapeutic relationship"* with patients, it was first important to gain their *"trust"* and then they would *"start opening up a bit more"*. Sidra (MHP14) felt strongly about this and wanted to remind her White colleagues that *"the expert"* is the patient, so it was important that conversations around *"the client's world"* were not shied away from:

> *"The therapist [White British] will be like, this is very complex, I don't get it. I don't have all this going on. No, it's complex for you because you're not from that culture, but it's not complex for them [client] because that's their world. That's how they live. But they don't get them. They don't understand that because it takes them away from who they are. This gives them some power on the subject that I know what I'm doing. But actually the expert is sat there, it's the patient. So you just need to look at what tools you've got and how to apply it to the client's world."*

Bhavna (MHP1) felt that *"value driven work"* was a core component of getting to know what is *"important"* to the patient, particularly during the *"assessment and formulation"* period. This involved asking *"culturally sensitive"* questions to *"get to know"* the client and how to make appropriate *"adaptations"* where needed:

> *"…We look at what's really important for the patient and I always find value driven work really helps. What are their core values? What do they see family as? What do they view religion as? What do they view spirituality and culture and friendship and relationships and parenting? What do they view that as and how far are they from that? And if it's really far off, we see there's something that's making them feel depressed or anxious about that. So it's about probably bridging that gap and asking the patient what they would like."*

A common concern with BAME therapists was the intrinsic expectation by IAPT to undertake their clinical duties as well as additional outreach work, which vastly differed to their White colleagues. Sidra (MHP14) was particularly concerned about the expectations placed on the ethnic minority workforce to juggle multiple roles:

> *"…You can't expect therapists to be clinician and development workers. It's normally the clinicians who are from a BME background which will end up to do all those extra things, and it's almost expected of them to do it. So it's always our responsibility not their [IAPTs] responsibility. And then they end up becoming clinicians and development workers and access workers and all these other things that come with that."*

Contrary to beliefs, therapists felt there was *"an appetite in the community for people wanting more"*, however, mental health provisions were often geared *"towards the English audience"* and crucial community development worker roles were cut short or non-existent due to *"commissioning"* and *"funding issues"*. Therapists felt that *"regularity"* of *"mental health promotion"* was *"important"* rather than *"tokenistic gestures"* to ensure that the information "*stays in people's minds and more start coming through the door"*. Nadia (MHP9) felt particularly strong about the lack of outreach work that was being done in the community:

> *"And the problem is I work with BAME communities and you go into the community, you create links, and IAPT services are not doing that. So whose responsibility is it? Who's getting the money to do this work? IAPT services. So our services need to factor this into their business plans, into the organisations. They're not. You know, part of IAPT role is to do outreach work and I don't think enough of it is being done … For goodness sake, ten years on, we're still struggling!"*

6.4.3.3. Importance of training and supervision

This subtheme describes the importance of cultural competency training and good supervision to support therapists to effectively cater to the needs of BAME service users. Cultural competency training is deemed an integral part of clinical training programmes, particularly with the growth of ethnic minority populations in the UK (Clegg et al., 2016). However, out of sixteen participants, only nine therapists received one day formal training (often one hour to half a day) throughout their therapeutic career, and seven therapists received no cultural competency training at all. Those who received training, recalled getting a mandatory module on *"working with diversity"*, however, this was not specifically tailored to working with ethnic minority communities in either *"national training or postgraduate diploma"* programmes. Whilst there was some teaching on *"how to work across different communities"*, this varied across clinical training programmes. Generally, therapists discussed being taught about aspects such as *"shame and stigma"*, *"working with interpreters*", and *"access needs"*, however, this was often only *"touched on"* and *"very briefly discussed"* as part of the overall course. Therapists reported that patient *"cultural beliefs"* and *"patient understanding of therapy"* were not considered or discussed as part of training. For example, Halima (MHP8) recalled on the [limited] training she received throughout her clinical career from the role of a PWP to a qualified CBT therapist:

> *"In my PWP training, we did have a session on how to use translators or interpreters. I have to say this one. I was really surprised in the training that nothing on the course was mentioned about culture, which was very surprising because I thought it was a big part of it."*

Having worked in IAPT for over eight years, Scott (MHP16) questioned the intentions of the IAPT programme and lack of training offered to therapists:

> *"I've been a bit bemused in a way. The fact that there hasn't been the investment into providing more support for therapists to be able to have a better understanding for BME groups across the country, you know …I do wonder the way that IAPT was first put together was sort of a lot of very high academic people, predominately White males who sat at the top and said this is how it's going to be and not really taking into account actually the inner cities …I personally don't think they're doing enough and there should be greater investment for the communities in those particular areas."*

Others such as Amira (MHP3) recalled raising such concerns with the teaching team during her clinical training programme:

> *"They did touch upon cultural implications, but it was very you know limited. So we voiced that opinion to them [lecturers] and said that it would be better to have more information about cultural understandings, of what the differences are and how people engage with people from BME community."*

Other therapists, especially from BAME backgrounds, questioned the usefulness and *"authenticity"* of cultural competency training. Most therapists felt the trainers *"did not really know much about culture"* given that training was usually offered by *"White"* lecturers and clinicians. For example, Nadia (MHP9) felt that she had not *"learnt"* anything about culture from her clinical training programme:

> *"When I did my CBT training, we had a one hour lecture, I believe it was delivered by a service manager of a nearby IAPT service. And I just remember thinking, I know more than you and I haven't learnt anything from you. You have given me nothing."*

Most therapists felt that it would have been useful to have service users from minority communities attend training sessions to discuss their experiences. Therapists felt this would be *"more advantageous than to sit through a PowerPoint presentation"*. Simon (MHP5) was particularly vocal about this idea:

> *"So I think maybe getting people coming into training within a service or whether it's within the IAPT training curriculum, someone coming in to discuss actually what they found helpful and what they didn't find helpful ...So more that kind of stuff. You know the expression 'from the horse's mouth' as you move on. You know, a White lecturer learnt about it and then telling us, you know, and that it's all second and third hand."*

A couple of therapists, particularly from the White British background valued the training they received, albeit minimal, as they had lived and trained in *"non-diverse areas"* so it was *"good to learn about marginalised groups and other cultures"*. However, they felt that they were *"unable to flex their muscles"* or *"there wasn't much focus"* on cultural training because their service was not *"very diverse"*. Those who worked in diverse communities, found that the diversity in the workforce was particularly helpful in drawing in on different experiences and cultures. Therapists felt they were readily able to get *"advice"* from their colleagues when needed. Some therapists felt strongly about the need for White therapists to *"experience"* working with diverse communities in order to *"understand their perspective"*. For example, Sidra (MHP14) felt that it was imperative for training programmes to go beyond *"therapy protocols"* so that therapists could become culturally competent in working with different communities:

> *"Working with different cultures, communities needs to be incorporated into the training. Understanding the power dynamics that can occur, whether it be due to gender, whether it be due to colour, whether it be due to an age, those things need to be understood. They need to be part of the training, not just the therapy protocols, because the therapeutic relationship is core to all that work."*

Therapists reported that *"good supervision"* was vital for their development, particularly when working with diverse communities. Some therapists felt they were able to go to their supervisor for assistance when they had *"complex cases"* and usually the supervisor was *"happy to help"*. However, a few therapists felt that there needed to be more *"representation"* in supervisors as this often tended to be from the *"White middle class"* background. This meant that some supervisors were not *"always confident in supervising people from diverse communities"* and there were barriers in understanding *"cultural complexities"* of the patient. Sophie (MHP11) felt that whilst she was fortunate to have a good supervisor, but this was not always the case across the services she worked at:

> *"I think good supervision is actually somebody who's an experienced practitioner, who has some knowledge of working with different cultures, I think it's quite important, um, and we're lucky we do have that here, but I don't think everybody has."*

Overall, all therapists felt the urgent need and desire for more cultural competency training. Given the ongoing concern about the therapeutic needs of BAME service users since the early set-up of IAPT service, more cultural competency training was needed as communities become more ethnically diverse and service demands increase. Scott (MHP16) was particularly vocal about this:

> *"So IAPT has been going since 2008, um, and you know, it's been quite a poor show. I suppose from a national level, there needs to be a lot more specific training being made available. There is more research that's being done, but the actual training is very thin, virtually non-existent."*

6.5. Discussion

The aim of this study was to explore whether IAPT mental health practitioners are culturally competent to deal with the needs of BAME service users. Overall, three themes emerged. The first theme highlighted the cultural dissonance therapists encountered during therapy, which included patient cultural expression of distress, their therapeutic experience, and recognition of cultural challenges beyond the therapy room. The second theme identified the challenges therapists experienced in making cultural adaptations to therapy. This included considerations of treatment fidelity, the availability of culturally adapted resources, challenges in working with interpreters, and challenges in achieving recovery goals. The final theme described therapists' cultural competency needs, which included recognition of limitations in cultural knowledge, the need for culturally competency development to be a shared endeavour, and the importance of training and supervision. Startlingly, out of sixteen participants, only nine therapists received one day formal training (often one hour to half a day) throughout their therapeutic career, and seven therapists received no cultural competency training at all. Overall, it appeared that there was an urgent need and desire for therapists to be offered cultural competency training in order to better serve BAME communities.

6.5.1. Encountering cultural dissonance within therapy

The first theme highlighted the cultural dissonance therapists encountered when working with BAME clients, which included patient cultural expression of distress, their therapeutic experience, and recognition of cultural challenges beyond the therapy room. Given the theoretical concepts of individualism-collectivism (Hofstede, 1980; 2011; Triandis, 1995) and self-construal theory (Markus & Kitayama, 1991), there were evident values, beliefs, and customs that corroborated with collectivist societies and conflicted with individualistic value systems. This often led to a cultural clash between Western practices rooted in notions of individualism and the need for independency (Frese III et al., 2001; Fenn & Byrne, 2013; Rogers, 2009). In line with previous research, therapists discussed the challenges they experienced in explaining mental health concepts and terminology as this was often unrecognised in BAME communities (e.g. Aggarwal et al., 2016; Mohamed & Lowenthal, 2009). Some therapists worried about dismissing client cultural and religious views, and questioned whether Western notions of therapy were appropriate for BAME clients who often externalised their problems (Roy-Chowdhury, 2013). Service users often used somatic symptoms and beliefs in witchcraft, black magic and spiritual possessions when explaining mental health conditions which conflicted with Western notions of mental health and therapy (Kirmayer, 2001; Mallinson & Popay, 2007; Mohamed & Lowenthal, 2009). This was more evident in older adults than the younger generation who seemed to appear more assimilated to Western culture (Ibrahim & Heuer, 2016), which may explain poorer treatment outcomes in older adults (Gould et al., 2012). In line with previous research, there was a distinct lack of awareness of therapy in BAME communities who often questioned the purpose of therapy and were *"expecting a cure"* (Lakeman, 2013). Therapists often found it difficult to navigate between patient therapeutic expectations and the need for them to take control of their lives in order to achieve recovery (Frese III et al., 2001). Previous research has shown that the lack of awareness of therapy can lead to greater drop-out levels, which was challenging for therapists in the present study (Bristow et al., 2011; Mclean et al., 2003; Mofrad & Webster, 2012). One of the main concerns therapists discussed was patient expectations for them to assist with benefits, social services, and immigration issues. Therapists discussed the frustrations that this caused during therapy when patient expectations were not met. It was evident that a more efficient triage service was needed to manage patient expectations from the outset with appropriate signposting before therapy began.

Therapists also discussed the implications that cultural challenges beyond the therapy room had on patient therapeutic experiences. Often, therapists had to not only manage the patient as an individual, but also be considerate of wider cultural, familial and religious factors that interplayed within the therapeutic sessions. In line with theory, therapist recognised the importance of group cohesiveness, harmony, and interdependence that was present in BAME communities which made it difficult to promote notions of self-sufficiency, independence and autonomy which are synonymous to individualistic societies (Hofstede, 1980; 2011; Markus & Kitayama, 1991). Therapists found that the strong cultural stigma and shame towards mental illness slowed the recovery process and often led to patients feeling entrapped (Tse & Ng, 2014). Moreover, the role of religion played an influential role in the lives of BAME service users, particularly those from Asian and Black ethnic groups. This meant that therapists often found it challenging to deliver therapy when patients were bound to religious teachings that conflicted with therapy. This corroborates with previous research which has shown religion to play an integral role in the lives of BAME communities, thus impacting on therapeutic engagement and success (Abouhendy & Jawad, 2013; Bhui et al., 2008; Fenn & Byrne, 2013; Lakeman, 2013; Singh et al., 2015). It was clear from therapists that there was a dire need of psychoeducation and community mental health awareness. Previous research has pointed towards the success of psychoeducation which may help improve therapeutic outcomes and raise mental health literacy and awareness (Jacob et al., 2002; Horell et al., 2014). Moreover, the implementation of a progressive model may be useful in helping triage at an earlier stage, thus being more cost effective and clinically effective (Boyd et al., 2019). However, it is important to recognise that this needs further investigation and trialled with BAME service users to ensure that it is acceptable and applicable to a diverse range of clients.

6.5.2. Challenges in making cultural adaptations to therapy

In this theme, therapists identified the challenges they experienced in making cultural adaptations to therapy. This included considerations of treatment fidelity, the availability of culturally adapted resources, working with interpreters, and challenges in achieving recovery goals. Even though previous studies have considered the role of cultural-adaptations and culturally sensitive therapies, the evidence-base for such studies are still limited and seldom offered or recommended as part of mainstream clinical practice, which includes IAPT services (Hall, 2001; NICE: CG123, 2011). Therapists in the present study often found themselves conflicted between adhering to therapeutic models and guidelines and patient needs from BAME communities. Whilst therapists acknowledged the importance of treatment fidelity (Adams, 2008; Pawson & Tilley, 2004), they questioned whether the *"one-size-fits-all"* approach was suitable for all patients. Therapists argued that there was little evidence to assess the therapeutic effectiveness of evidence-based interventions in ethnic minority populations, thus, protocols and models should be used as a guidance, rather than being treated as the *"law"*. Whilst there was flexibility to cater for minority communities, through the use of interpreters and longer treatment sessions, therapists felt they were not adequately trained to make appropriate clinical adaptations to therapy which would suit the needs of BAME communities. Previous literature has echoed these concerns and reported therapists often not being fully equipped to deal with varying needs of the ethnic minority population, thus more research is needed to explore this further (Naz et al., 2019). Some therapists felt that therapy did not need to be reinvented, but rather considerate of how it can be made more engaging for BAME communities, which included options of incorporating play and simplified terms to make concepts more understandable to patients.

Moreover, therapists discussed the availability of culturally adapted resources. Whilst there was a range of self-help books and questionnaires available in a number of languages, often it was difficult to readily find the resources. Therapists often had to spend their own time to find resources which increased therapist burnout (Westwood et al., 2017). Therapists suggested a centralised repository that could be accessed by all mental health professionals across IAPT would be advantageous. To my knowledge this is not currently available within IAPT services so may be something that is considered as part of the wider service plan. In addition, therapists recognised that despite some culturally adapted resources being available, they were not always useful for those service users who had poor reading and writing proficiency (Beck, 2019). Thus, therapists suggested the use of images and videos being made available to depict emotions, cognitions, and behaviours. Whilst therapists valued the use of interpreters to aid them in translating during sessions, there were a number of challenges that this presented in therapy. Often therapists found it challenging to manage group dynamics within the session and worried about the accuracy of the message that was being relayed back to the service users. Therapists valued interpreters who provided information verbatim, however, this was not always the case. Previous research has echoed these concerns and reported the loss of message and translation between the therapist and client during the triangulation process (Costa & Briggs, 2014). Moreover, therapists often found themselves offering psychoeducation to interpreters as they did not all have mental health knowledge. This presented challenges in explaining therapeutic concepts and terminology to not only the interpreter, but also the patient. This indicates a need for IAPT to offer brief training to interpreters to further enhance the therapeutic experience for not only the service user, but also the therapists. Given the limited availability of interpreters available in certain languages, some service users refused to disclose information in case word would get out in the community (Sainsbury Centre for Mental Health, 2007). This presented a number of challenges, including delayed therapeutic care and disengagement from treatment

(Bristow et al., 2011; Costa & Briggs, 2014). Future research should consider these concerns and the implications that they have on therapeutic uptake and success.

Therapists also reflected on the challenges they experienced in achieving recovery goals with BAME service users. In line with previous research, therapists reported that BAME service users tended to bring along issues from the past which made it difficult to move forward within therapy (Costa & Briggs, 2014; Bristow et al., 2011). Given that therapies such as CBT are focused on the *"here and now"* (Fenn & Byrne, 2013; Williams, 2015), therapists found it difficult to navigate sessions which resulted in patients disengaging from therapy due to unmet therapeutic needs (Beck & Naz, 2019). Homework adherence was also a particular barrier to therapeutic success. Therapists reported that homework tasks which promoted independence and self-care often conflicted with service users' cultural and familial lifestyles and were not always appropriate (Omylinska-Thurston et al., 2019). Some therapists explicitly recognised the collectivist familial implications of being part of a family unit, thus making it difficult to promote individualistic tasks (Hofstede, 2011; Markus & Kitayama, 1991). Therapists felt that some tasks were not appropriate for older patients who did not grasp the concept of homework, which conflicted with Western therapeutic expectations. Therapists felt it was important to be realistic with what was achievable during therapy, even if this meant that recovery targets were not being met. In line with previous research, a common concern was service demands and high caseloads which meant therapists were not able to explore patient needs in more details (Bassey & Malluish, 2012). At times this conflicted with therapists' clinical integrity and the need to meet targets. Some therapists felt that this was doing BAME service users a disservice, which was inherently reflected in poor treatment outcomes for ethnic minority communities (Naz et al., 2019).

6.5.3. Identifying cultural competency needs

The final theme described therapists' cultural competency needs, which included recognition of limitations in cultural knowledge, the importance of culturally competency development as a shared endeavour, and the importance of training and supervision. To be regarded as culturally competent, therapists should possess basic knowledge about the client's culture, which may include their values, norms, and practices (La Roche, 2003; Sue, 1998; Wan, 2013). However, in line with previous research, mental health practitioners seldom received adequate training that equips them to work with diversity (Edge & Lemetyine, 2019). Therapists from White backgrounds recognised that there were gaps in their knowledge and did not fully understand the implications that social, cultural and religious factors would have for BAME patients. White therapists often feared that they would get it wrong which made them reluctant to delve into patient culture during therapy. Previous research has raised concerns about BAME service users worrying about the cultural competency of White therapists which can lead to high degrees of mistrust, suspicion, and disengagement from therapy (Cook & Powell, 2013; Jones, 1997; McCrone, 2013). Given the limited training offered, therapists were often left to rely on their own research or *"wing it"*. Therapists recognised that this was not best practice and were concerned that they were unable to build a therapeutic relationship with patients due to time limitations and demands of the service (Bassey & Malluish, 2012). Whilst therapists acknowledged that they did not know everything about every culture, some therapists urged others not to be ignorant to patient experiences, even if they had not experienced racism or discrimination themselves. Previous research has raised concerns about training programmes and psychological theories failing to consider the role of the therapist, and how their own identity interacts with that of the client, which includes their stereotypes, biases, and positions of power and privilege (Beck & Naz, 2019; Crawford, 2012; Ibrahim & Heuer, 2016; Sue et al., 1996). Here, therapists should recognise and reflect on their own 'isms' and how this may interact and intercede with patients, and manage ways in which to lighten feelings of White guilt (Crawford, 2012). Further research is needed to see how these training deficits interact with therapists who serve ethnically diverse communities.

A common concern that was evident in therapists from BAME backgrounds was the expectation and reliance on them to take on the workload and responsibility for BAME service users. Whilst therapists recognised the importance of therapist matching as they shared similar collectivist identities to their patients (Sue, 1991), they were concerned that assumptions should not be made about patient preference. BAME therapists talked about the innate stigma and fear of judgement in minority communities with someone from the same cultural background (Al-Krenawi & Graham, 2000). Several BAME therapists raised concerns about their White colleagues not taking on ethnic minority clients as they did not feel comfortable in dealing with their issues. BAME therapists felt that the innate reliance to take on complex caseloads compromised their mental wellbeing and opportunities to get promoted as they were not always able to achieve the same recovery targets as their White colleagues. BAME therapists felt it was important to share the responsibility and for White therapists to seek advice, build trust and consider value driven work should they wish to enhance their therapeutic encounters with ethnic minority service users. Moreover, BAME therapists raised concerns about taking on multiple clinical duties, which included outreach work which were not expected from their White colleagues (Naz et al., 2019). It was clear that cultural competence development should be seen as a shared endeavour, which includes shared workload and for IAPT to increase community awareness of the services they offer. Therapists felt that individuals from BAME communities wanted to seek therapy, however, there was a lack of awareness of the services available to them. Previous research has shown that the implementation of community development workers has been advantageous in increasing access to care, thus should be considered as part of the wider IAPT implementation plan (Memon et al., 2016).

Finally, therapists discussed the importance of cultural competency training and good supervision. Out of sixteen participants, only nine therapists received one day formal training (often one hour to half a day) throughout their therapeutic career, and seven therapists received no cultural competency training at all. This corroborates with previous research that has found mental health practitioners in Western society seldom receiving adequate training that equips them to work with diversity (Clegg et al., 2016; Edge & Lemetyine, 2019). Therapists who received training, discussed having a *"working with diversity"* unit as part of their clinical training programme, however this was not tailored specifically to BAME communities. In instances where working with minority communities was included, this was often brief and did not consider cultural beliefs or patient understanding of therapy. Previous research echoes these concerns whereby training programmes promote the universal rhetoric within therapeutic policies and models and seldom consider cultural particularism (Good & Hannah, 2015). Moreover, some therapists worried about the lack of representation within the clinical teaching team meant that some BAME therapists were left feeling as if they had not taken away much from the session, thus relying on their own learning. Therapists suggested including BAME service users to talk about their own experiences would be advantageous to their therapeutic programme. Moreover, whilst White therapists valued training, they felt that it would be advantageous to get experience of working with different communities to help them develop their cultural competency skills. Given that cultural competency development should be a continual and life-long process (La Roche, 2003; Papadopoulos, 2006), IAPT services should actively seek ways to develop the skills of the workforce. Moreover, whilst therapists valued good supervision to help them deal with complex caseloads (La Roche, 2003), they felt more representation in senior roles was needed because supervisors from White backgrounds were not always confident in dealing with issues relating to BAME communities. Overall, cultural competency training appeared to be *"quite a poor show"* and therefore IAPT needed to urgently review its training to better serve its workforce and ultimately the needs of BAME communities.

6.5.4. Limitations

The main limitation of the study was that whilst it captured a broad range of therapists, from varying degrees of experience, it did not capture the specific needs of therapists who may be new to the profession. Given concerns with the training needs of newly qualified PWPs, future research should consider ways in which training programmes can consider the needs of therapists early into their career. Since PWPs tend to be the first point of call within IAPT services, this training may help in triaging BAME clients more efficiently. Moreover, whilst the study had a mixed sample, from a broad range of ethnicities, specific training needs for BAME therapists and White therapists were not made. This could be an important implication for therapy given the inherent individualistic mindset and notions of therapy. Future research should delve into this further to unpack the needs of therapists from different ethnic backgrounds.

6.5.5. Conclusion

This study aimed to explore whether IAPT mental health practitioners are culturally competent to deal with the needs of BAME service users. Findings from the study raised critical concerns about the lack of cultural competency training offered to its workforce. Whilst it is acknowledged that active steps have been taken with the development of the BAME positive practice guidelines (Beck et al., 2019; IAPT, 2009), therapists call for an urgent need and desire for cultural competency training to be offered so that they can better serve BAME communities. It was evident throughout the study that there were cultural clashes between individualist concept and notions of therapy with therapeutic expectations from BAME communities. More research is needed to unpack this further to understand not only the service user positionality, but also that of the therapists serving minority communities. It is clear that cultural competency training is at its infancy within UK mental healthcare (Clegg et al., 2016), despite the surge in ethnic minority populations accessing mental health care. Given such limitations, more investment is needed to diversify the IAPT workforce, provide appropriate training, raise community awareness, and include BAME service users as part of the implementation plans in order to enhance access and recovery rates within ethnic minority communities.

6.6. Chapter summary

Given the sparse inclusion of ethnic minority populations in clinical research (*see* Chapter 1), poor recovery outcomes (*see* Chapter 4) and unmet clinical needs (*see* Chapter 5), this study aimed to further enhance our understanding by exploring whether IAPT mental health practitioners are culturally competent to deal with the needs of BAME service users. This study revealed a stark lack of cultural competency training offered to the IAPT workforce and raised crucial concerns about whether evidence-based psychological interventions are suitable to the needs of BAME communities. The discussion chapter will unpack these findings further.

Chapter 7

Integrated Discussion

7. Integrated Discussion

7.1 Chapter overview

The integrated discussion brings together the key findings from the studies reported in this thesis. In line with the Transdisciplinary Model of Evidence-Based Practice, evidence from empirical research, client's preferences, and clinician's expertise in the context of Improving Access to Psychological Therapies (IAPT) services are brought together to help inform future decision making processes (Satterfield et al., 2009). This includes (where applicable) the systematic review (*see* Chapter 1), the empirical chapter assessing predictors of recovery and therapeutic effectiveness (*see* Chapter 4), the qualitative chapter exploring Black, Asian and Minority Ethnic (BAME) service users' therapeutic needs (*see* Chapter 5), and the qualitative chapter exploring the cultural competency of mental health practitioners (*see* Chapter 6). The purpose is to weave together the findings and discussion points of each study to provide an overall synthesis of key findings and their implications for future research (Smith, 2015). By using the guiding framework by Lewis, Graham, Boland, and Stacey (2021), summary discussion points were first reviewed from each article (*see* Appendix D.1.1) followed by disciplinary implications arising from each study (*see* Appendix D.1.2). The key discussion points were integrated together into three overarching themes to form a cohesive discussion of the main findings and implications for clinical practice, education, leadership, policy, and research concerning IAPT services and BAME communities (*see* Appendix D.1.3). It is envisaged that these findings will not only help offer reflection points and considerations for IAPT services but also provide the grounding to influence future decision making processes.

7.2 Summary of findings

Whilst evidence-based assessment of therapeutic programmes offer legitimate ways to judge therapeutic outcomes, they are limited in understanding broader, more complex dynamics that patients from diverse communities bring to therapy. With increased diversity in clinical populations, it was unclear whether mental health services were appropriately setup to address historic and emergent dynamics of patient identity and cultural characteristics, whilst also considering group dynamics, challenges, barriers, and expectations of therapeutic care (Good & Hannah, 2015). The individualism-collectivism paradigm (Hofstede, 1980; 2011; Triandis, 1995) and self-construal theory (Markus & Kitayama, 1991) were used as guiding frameworks to help understand how and why cultural differences between Western notions of therapy and the BAME service users occur (Hwang et al., 2008). Previous work utilising these theoretical concepts have been largely conducted in the United States and found comparative differences between minority ethnic groups and the majority population, whilst also unpacking cultural complexities in those who hold bi-cultural identities (e.g., Allen & Bagozzi, 2001; Gushue & Constantine, 2003; Phinney & Devich-Navarro, 1997). However, it was unclear how well these models transpose to ethnic minority populations living in England. Western models of psychotherapy delivered in the UK adopt notions of individualism, that is, for patients to be their own therapist and to develop autonomy in dealing with their own life problems (Frese III et al., 2001; Fenn & Byrne, 2013; Rogers, 2009). However, given the cultural influences inherent in ethnic minority populations, it was unclear how effective routinely delivered therapies are effective, or if accepted and suited to the needs of BAME communities. Previous clinical trials assessing the efficacy of evidence-based psychological therapies in English ethnic minority populations have been scarce. In addition, the application of therapies in real-world clinical settings have reported poorer recovery outcomes in BAME populations when compared to the White British group (e.g., Baker, 2018; Harwood et al., 2021). Limited qualitative research has explored service users' therapeutic needs (Christodoulou et al., 2019) or therapists' cultural competency (Bhui et al., 2007; Clegg et al., 2016). Thus, a 'holistic' approach was adopted using a mixed-methodology to incorporate the research evidence from a systematic review and empirical analysis of routinely collected IAPT data, along with interviews with service users and practitioners to explore the extent to which evidence-based psychological interventions were effective in improving mental health outcomes for BAME communities accessing IAPT services. A summary of each respective study will be highlighted first.

7.2.1 Summary: Systematic literature review

Common mental health disorders (CMHDs) are rife in England, with those from BAME communities experiencing similar, if not greater levels of depression and anxiety than the White British group (Weich et al., 2004; Rehman & Owen, 2013). Despite substantial government investment in IAPT services to tackle CMHDs (Clark, 2018a), it remained unclear whether evidence-based psychological interventions were effective in treating BAME communities. Thus, the aim of the systematic review was to explore the issue further (Chapter 1). The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist was followed throughout the systematic review. Following searches across six databases, only two studies met the inclusion criteria which included a total of 217 BAME participants. Both studies examined the efficacy of psychoeducation for depression. No studies were found for any other anxiety-related disorders or any other treatment types. Studies reported that psychoeducation at an early stage of referral was more effective in reducing depression when compared to delayed access, but, these findings are to be taken with caution as both studies were subject to high likelihood of bias. Given the paucity of clinical trials which are context-specific or include BAME populations, further investigation was warranted to establish whether evidence-based psychological therapies were effective in real-world clinical settings.

7.2.2 Summary: Study One - Predictors of recovery and therapeutic effectiveness

Given the poor inclusion of BAME communities in clinical trials, it was unclear how well evidence-based psychological interventions transpire in real-world clinical settings. Previous research indicated poorer treatment outcomes in BAME communities accessing IAPT services when compared to the White British group (e.g., Baker, 2018; Harwood et al., 2021). Thus, the aim of this study was twofold. First, to explore which patient characteristics were most salient in predicting successful recovery, and second to explore which evidence-based psychological therapies were most effective in improving mental health outcomes for depression, anxiety and functional impairment between BAME and White patients. A cross-sectional retrospective study design was employed which used routine clinical practice data from four national IAPT services. For the first research question, a binary logistic regression analysis was carried out comprising of N = 13,710 patients. For research question two, a Multiple Analysis of Covariance (MANCOVA) was carried out using ethnicity and treatment type as independent variables and comprising of N = 9,925 patients. The first set of findings revealed that ethnicity, religion, age, and initial baseline severity were predictors of recovery. In terms of therapeutic effectiveness, there were significant main effects for treatment modality and ethnicity after controlling for baseline severity and age, however, there was no interaction. Based on treatment alone, the general consensus was that non-guided self-help was significantly poorer in improving outcomes for depression, anxiety, and functional impairment when compared to other therapeutic modalities. Moreover, based on ethnicity alone, those from the White British group achieved significantly greater reductions in post-treatment outcomes when compared to the BAME group. However, findings are to be taken with caution as the effect sizes were very small. Whilst the findings from the study provide insight into the therapeutic effectiveness of evidence-based psychological interventions in diverse clinical populations, the disparities between ethnic groups was not as profound as previously reported (e.g., Baker, 2018; Harwood et al., 2021). However, what was of concern was the poor recovery outcomes observed in the whole clinical sample (< 35%). Whilst there are benefits to research rooted in quantitatively derived data, particularly in assessing and measuring mental health outcomes (e.g., Leong & Lee, 2006; Schreiber, 2013), they seldom offer deeper understanding of the 'real-world' experiences of service users receiving therapy. Thus, it was important to incorporate the recovery narrative to explore whether evidence-based psychological interventions meet the needs of BAME communities.

7.2.3 Summary: Study Two – BAME service user therapeutic needs

Given the profound disparities in access to mental healthcare, high attrition rates and poorer therapeutic success (Baker, 2018; Beck & Naz, 2019; Good & Hannah, 2015; Harwood et al., 2021) it was important to explore the recovery narrative to understand what works well, what does not, and how therapies can be catered to the needs of ethnic minority communities (Christodoulou et al., 2019; Williams, 2015). The aim of this study was to explore whether evidence-based psychological interventions offered by IAPT services were suitable to the needs of BAME communities. Semi-structured interviews were conducted with BAME service users (N = 9) who had received an evidence-based treatment at an IAPT service. Reflexive Thematic Analysis (RTA) was used, which included a six-phase process to produce a robust pattern-based analysis (Braun & Clarke, 2006; 2019). Overall, three themes emerged. The first theme highlighted the importance of recognising cultural dissonance within therapy, which considered patient therapeutic expectations, therapeutic guilt, and conflicting cultural identities. The second theme identified the need for therapists to develop cultural competency which highlighted the importance of building therapeutic trust and exploring patient culture within therapy. The final theme considered the road to recovery and highlighted challenges with therapeutic engagement and service users' evaluations of therapeutic effectiveness. In general, BAME service users felt that therapy was not a cure, but found it helpful. However, there were critical areas of concern relating to patient understanding of Western therapeutic interventions and the lack of cultural sensitivity by some mental health practitioners. Thus, it was important to explore whether IAPT practitioners were culturally competent to deal with the needs of BAME communities.

7.2.4 Summary: Study Three – Cultural competency of therapists

Cultural competency is considered a core clinical skill in working with diverse communities (e.g., Clegg et al., 2016; Sue, 2009). However, given the fidelity of treatment programmes, therapists may not be adequately trained to work with service users who present a number of different therapeutic needs and challenges than the White British group (Clegg et al., 2016; Edge & Lemetyine, 2019). Thus, the aim of this study was to explore whether IAPT mental health practitioners are culturally competent to deal with the needs of BAME service users. Semi-structured interviews were conducted with IAPT practitioners (*N* = 16) who ranged from early career Psychological Wellbeing Practitioners (PWPs) to senior qualified Cognitive Behavioural Therapists. The six-phase RTA process was used to produce a robust pattern-based analysis (Braun & Clarke, 2006; 2019). Overall, three themes emerged. The first theme highlighted the cultural dissonance therapists encountered during therapy, which included patient cultural expression of distress, patient therapeutic experience, and recognition of cultural challenges beyond the therapy room. The second theme identified the challenges therapists experienced in making cultural adaptations to therapy. This included considerations of treatment fidelity, the availability of culturally adapted resources, challenges in working with interpreters, and challenges in achieving recovery goals. The final theme described therapists' cultural competency needs, which included recognition of limitations in cultural knowledge, the need for cultural competency development to be a shared endeavour, and the importance of training and supervision. Startlingly, out of sixteen participants, only nine therapists received one day formal training (often one hour to half a day) throughout their therapeutic career, and seven therapists received no cultural competency training at all. Overall, it appeared that there was an urgent need and desire for therapists to be offered cultural competency training in order to better serve BAME communities.

7.3 Integrated findings in the context of evolving literature

With the systematic review offering the grounding to explore whether evidence-based psychological interventions are effective for BAME communities in England, the series of three complementary studies included outcomes from IAPT clinical data, as well as service users' and therapists' experiences. Findings across the four studies indicated a dire need to consider BAME service users' needs in order to enhance therapeutic outcomes. The key findings will consider their contributions to cross-cultural theories by drawing on concepts of individualism – collectivism (Hofstede, 1980; 2011; Triandis, 1995) and the self-construal theory (Markus & Kitayama, 1991) which have been relatively unexplored within the English context. By reflecting on such theories, mental health professionals may be able to better understand BAME service user cultural experiences, values, and patterns for living when decision-making and delivering evidence-based psychological therapies. Finally, implications for clinical practice, education, leadership, policy, and research will be explored.

7.4 Cultural considerations: Implications for therapy

A common thread that was evident throughout the thesis was the cultural dissonance experienced by BAME service users receiving evidence-based psychological interventions. Cultural dissonance is described as *"uncomfortable sense of discord, disharmony, confusion, or conflict experienced by people in the midst of change in their social environment"* (Barden & Cashwell, 2013; Pedersen, 1991). Here, patient value systems, expression of mental health, diagnosis, and acceptability of treatment can conflict with Western notions of mental health, therapy, and Eurocentric practitioners (Flaskerud, 2007; Xu & Flaskerud, 2007). Cross-cultural theories such as individualism – collectivism (Hofstede, 2011; Triandis, 1972) and the self-construal theory (Markus & Kitayama, 1991) challenge assumptions of the self being viewed as independent, autonomous and unique which is synonymous to Western mental healthcare (Cross et al., 2011; Tse & Ng, 2014). Culture plays an important role in the presentation of illness, which can impact the diagnosis, treatment and mental health outcomes for patients from ethnically minoritised communities (Bhugra, 2005; Christopher, 2001; Leighton, 2003; Morrall, 1998). Several key themes were identified which may have implications for clinical practice.

7.4.1 Cultural understanding of mental distress

Service users understanding of mental health and the implications this had within therapy emerged from the recovery narrative explored in studies two (Chapter 5) and three (Chapter 6).

Several service users discussed that Western concepts of mental health and therapy were not available in their culture which meant that *"some disorders, especially around mental health cannot be translated back into the community or the mother tongue".* This presented challenges for therapists who worried about the way mental health was conceptualised in the West and the lack of terminology available to explain Western concepts to BAME service users. White therapists were particularly conscious about their Western worldview of mental health and how this would project onto ethnic minority patients. Certain words such as depression and anxiety *"did not exist in certain cultures"* which made it difficult to explain and communicate certain mental health conditions. Therapists raised concerns about the negative connotations attached to mental health disorders, such as *"paagal [mad]"* which exasperated stigma and shame within BAME communities. This corroborated with previous research which has asserted that culture-based subjective experiences and knowledge about mental health differ from Western understanding of mental health (Castillo, 1997), thus increasing the shame associated with mental health (Bristow, et al., 2011; Buffin, Ahmed, & Singh, 2009; Clement et al., 2015). Moreover, due to language barriers and poor mental health literacy, patients were unable to fully express their feelings which results in a loss of translation, misdiagnosis and delayed access to care (Aggarwal et al., 2016; Buffin et al., 2009; Kirmayer, 2001; Mallinson & Popay, 2007; Mohamed & Lowenthal, 2009). These concerns become more pronounced when idioms of distress are somaticized (Castillo, 1997). Some service users talked about mental distress being normalised as everyday stressors and somatised within their culture, particularly by elder family members. As a result, therapists found it more challenging to engage older patients as they often somaticized their condition as physical sensations such as *"my stomach hurts"*, *"my chest hurts", and "heart racing"* then to recognise mental distress. Therapists felt that one of the possible reasons for this was the adoption of the *"medical model"* by many non-Western societies which meant it was more acceptable to take medication than to seek therapy. These findings echoed previous literature which has reported somatic symptoms being used to describe idioms of distress by minority ethnic communities, thus having implications for therapeutic engagement and practice (e.g., Al-Krenawi & Graham, 2000; Karasz, 2005; Mallinson & Popay, 2007). Thus, it is important to recognise that mental health literacy and presentation of mental distress may not be similar to that described in the Western world.

7.4.2 Religious obligations and therapeutic guilt

Findings from several studies within this thesis indicated that religion played a crucial role in the presentation of mental distress and the recovery process. In study one (Chapter 4), findings revealed that the odds of recovering significantly increased by 138% for those who identified as Sikh, whilst the odds were more conservative for Christian (22.8%) and Other religious groups (12.3%). Given the greater recovery success in those who identify as Sikh, one possible explanation for this finding may be due to life-stress model adopted within Sikh communities (Sandhu, 2005). According to Sandhu (2005), the life-stress model focuses on the experiences of the individual (*"I")* which is inherently different from others. Here, the major source of suffering is seen as cause of ego-centred (ahankar) needs and desires. Given that the nature of the Sikh self may be more attuned to notions of individualism, this may be the reason why greater rates of recovery were observed within this sample. However, this needs further exploration. What is important to note here, is that this finding was not synonymous to all religious groups. For example, some service users talked about the religious guilt they felt for not being able to cope with their mental distress and the implications this had on their therapeutic experience when therapists did not understand the gravity of their religious obligations (Chapter 5). Some service users discussed the shame they felt in discussing their personal issues because it was *"forbidden"* in their religion. For many, low mood, bad fortune and mental distress were seen as inflictions from God, moral failings, or part of innate life's trials and tribulations (Al-Krenwai & Graham, 2000; Mantovani et al., 2017). As observed in previous literature, for some individuals, religious and spiritual coping mechanism such as praying, reciting scriptures, and beliefs in supernatural causes were used to explain deviant behaviours and undesirable life events (Abouhendy & Jawad, 2013; Bhui et al., 2008; Lakeman, 2013; Loewenthal et al., 2012; Singh et al., 2015).

Several therapists found that their patient's *"culture is based around religion"*, particularly when it came to patient values, expectations, and behaviours (Chapter 6). This meant that there was often *"religious guilt"* embedded within the "*psyche"* of BAME service users, who felt that it was sinful to think, act or behave in ways that challenged their religion. Some therapists worried about dismissing client cultural and religious views, and questioned whether Western notions of therapy were appropriate for BAME clients who often externalised their problems (Roy-Chowdhury, 2013). This made it difficult for therapists to navigate conversations around self-sufficiency and self-reliance. Therapists reported that there was a high reliance to use faith as a *"coping mechanism"* in BAME service users, particularly those from Asian and Black ethnic groups. In line with previous research, several therapists talked about the conflict they experienced in explaining Western therapy to BAME service users who held supernatural beliefs about witchcraft, black magic, and spiritual possession to explain mental distress (Bristow et al., 2011; Ryan & Pritchard, 2004). Some BAME therapists worried that due to lack of cultural training and awareness, their White colleagues may misinterpret views of black magic and *"possession [jinn]"* as more serious mental health problems. Previous research has indicated that Eurocentric therapists may not always understand cultural norms, therefore mistake cultural beliefs as signs of serious mental illness (e.g., belief in possession and witchcraft as schizophrenia) (Dein, 1997). Given these findings, it is important for mental health services to recognise the implications of religion on therapeutic engagement and success (Abouhendy & Jawad, 2013; Bhui et al., 2008; Fenn & Byrne, 2013; Lakeman, 2013; Singh et al., 2015).

7.4.3 Generational differences and therapeutic outcomes

Despite previous research indicating poorer treatment outcomes in older adults (Catarino et al., 2018; Gould et al., 2012), those aged over 65 had significantly greater recovery rates than 18 – 35 year olds and 36 – 64 year olds (Chapter 4). One possible reason for these results may be due to the increased societal pressures on the ‘working age’ who in turn may experience greater burnout and absence from work thus affecting their mental wellbeing more than the older population (e.g., Clark et al., 2012; Husain et al., 2014). The general consensus from patient and therapist narratives was that older adults were more likely to hold onto their cultural traditions thus rejecting Western notions of therapy and mental health. Service users discussed the difficulties they experienced with explaining their mental distress and therapeutic needs with older family members, who reinforced that they had *“no problem”* (Chapter 5). Therapists echoed these concerns and reported that it was *“easier”* to provide therapy for younger generations who were *“a bit more broad minded”* than the older generation, particularly when it came to understanding of mental health and therapeutic concepts (Chapter 6). Therapists found that older adults tended to hold on to *“traditional values”* which made it difficult to relate therapeutic concepts back to their belief systems. This corroborates with previous literature which shows that behavioural changes are less likely to occur as part of the acculturation process nor see dramatic shifts to internal beliefs or cultural value systems (Hovey et al., 2006). Due to limitations in recruiting older service users, future research should explore how well Western notions of therapy are suited to the needs of this demographic.

7.4.4 Bi-cultural identities and therapeutic conflict

Given poor recovery outcomes observed in younger generations (Chapter 4), another possible reason for this finding may be due to the cultural conflict service users experience between Western notions of therapy and traditional expectations. This can have implicit and explicit impact on mental wellbeing and lead to greater levels of social anxiety, depression, and self-criticism (Bhullar et al., 2012; Hong & Woody, 2007; Hovey et al., 2006). Service users talked about often having to interchange between their cultural identities, particularly in relation to multiple *"personalities"* and *"masks"* they wore at home, at work, and within their social circle (Chapter 5). Most of the service users were British born, and had to continually manage their expectations to abide and serve elders within the family (e.g., parents and older siblings) and the western notion of independence and self-fulfilment. This had a profound impact on participants' therapeutic experience and what was expected of them by therapists. Some service users felt that by challenging their thought and behaviours to have more *"self-compassion"*, meant that they were having to compromise their own identity and go against their cultural teachings on how to deal with their problems. In line with previous research, it appears that notions of the independent and interdependent self-construal tend to co-exist for British born BAME service users (Cross & Markus, 1991; Kolstad & Horpestad, 2009; Tse & Ng, 2014). This means that regardless of service users being British born, collectivist values are instilled in younger generations to preserve cultural norms and traditions, thus the individualistic nature of the host country is not entirely adopted (Tse & Ng, 2014). As such, service users worried that the cultural clash between what was expected within therapy and patient home life was not always understood by therapists resulting in them dropping-out of therapy (Bhullar et al., 2012; Hong & Woody, 2007; Mofrad & Webster, 2012). For example, one service user talked about the implications that holding onto different identities had on his therapeutic experience:

> *"…It was a good therapist, but he didn't understand the cultural barriers… I would say that there was partial cultural values, partial UK values and emotions in one. But he couldn't understand the concept that I had three different psychological personalities - one for home, one for work, and one for with friends."*

However, some therapists, particularly from BAME backgrounds, recognised these concerns and reported that younger service users' often experienced cultural dissonance between Western values and *"traditional"* cultural values which had implications on their therapeutic engagement (Chapter 6). One therapists reported that younger generations were *"…almost lost as to what we follow, this culture that we are brought up within or the culture that my parents are inflecting on me, or suggesting I should adhere to keep those traditional values."*. Research has shown that obeying authoritarian older adults (e.g., parents, grandparents) and meeting cultural obligations can supress the pursuit for autonomy, thus having consequences for mental wellbeing during a life crisis (Caldwell-Harris & Aycicegi, 2006; Holmes-Eber, 1997; Triandis, 1995). Research in African American populations echoed these findings and found that those living in the West may hold bi-cultural identities, termed *'double consciousness'*, which enables them to interchange between individualistic–collectivist patterns depending on their cultural context (Allen & Bagozzi, 2001; Gushue & Constantine, 2003; Phinney & Devich-Navarro, 1997). This means that whilst individuals may value uniqueness - synonymous to individualistic cultures, they still preserve collectivist values shared by those similar to themselves (Hofstede, 2011). These cultural values remain embedded within an individual's identity regardless of the place of birth or upbringing (Zagefka, 2009). In study one (Chapter 4), findings revealed that the likelihood of recovery was significantly reduced by 35% for those from the Mixed ethnic group when compared to the White British group. Whilst this finding was conservative, it brings to light potential for future research to examine whether bi-cultural identities are more pronounced in the Mixed heritage group. To my knowledge, this has not been explored in previous literature.

7.4.5 Familial influences and therapeutic restrictions

Familial influences on service user therapeutic experiences emerged through the recovery narrative explored in studies two (Chapter 5) and three (Chapter 6). Most service users were from close-knit families which meant that they were often confined by their cultural and familial expectations, roles, and responsibilities. In line with theory, BAME service users were bound to collectivist orientation which is "*…integrated into strong, cohesive in-groups, often extended families…"* (Hofstede, 2011, *p*.11). By adopting a *'We'* consciousness that considers the role of others (Hofstede et al., 2010), service users often felt therapeutic guilt for seeking individualised therapy, which was not always understood by Eurocentric therapists. Many service users found themselves going against their cultural and familial expectations when seeking therapeutic support. This was often rooted in an upbringing of being taught resilience, which conflicted with Western management of mental distress. In line with theory, regulation of emotions are guided by others and deemed important for self-esteem (Markus & Kitayama, 1991; Oyserman et al., 2002). Thus, the interdependent nature of the self is expected to maintain harmony, adjust, and restrain in order to meet group expectations.

Therapists found this particularly challenging during therapy as they had to not only navigate between the patient's needs, but also be considerate of wider cultural, familial and religious factors that interplayed within the therapeutic sessions (Chapter 6). These factors went beyond the therapy room which made it challenging to deliver Western notions of therapy that value individualised care (Williams, 2015). Therapists reported that the majority of BAME service users discussed that *"the family element"* of their lives caused the most distress. Therapists talked about the inherent familial expectations and responsibilities that were placed on BAME service users made it difficult for them to fully engage with therapy. In line with theory, therapists recognised the importance of group cohesiveness and interdependence that was present in BAME communities which made it difficult to promote notions of self-sufficiency, independence and autonomy synonymous to individualistic societies (Hofstede, 1980; 2011; Markus & Kitayama, 1991). Therapists found that the strong cultural stigma and shame towards mental illness slowed the recovery process and often led to patients feeling entrapped (Tse & Ng, 2014). Thus, mental health services should consider the wider implications that Western therapy can have on BAME individuals should they wish to offer culturally sensitive services.

7.5 Therapeutic considerations: Reconsidering the recovery process

Historically, psychology has been developed on a Western medical model, where monocultural application of psychotherapy fails to recognise the importance of cultural meaning and understanding of mental illness, thus, limiting its applicability to diverse communities (Hall, 2001; Ryan & Pritchard, 2004). Western psychological models of mental healthcare tend to be developed for White, middle-class, educated individuals who adopt an individualistic value system, therefore understanding of therapeutic challenges for non-Western cultures are limited (Keith, 2011; Leighton, 2003; Leong & Lee, 2006). It is now more widely accepted that concepts of mental illness are complex as societies become multicultural (Ryan & Pritchard, 2004). However, by adopting the values, beliefs and principles of the dominant individualistic culture, person-centered care is deemed important for recovery (Laungani, 2007). The recovery model emphasises that patients are largely responsible for their own recovery process, by empowering patients to gain control over their lives, in which hope, achievement and social connectedness are some of the direct benefits (Frese III et al., 2001; Ryan & Pritchard, 2004). Despite its benefits, the IAPT programme has received copious criticism about its effectiveness and plans to combat CMHDs in England. Critics have named IAPT a '*silver bullet*' to the mental health crisis, without real consideration of its acceptability for mental health professionals and patients who access the service (Cotton, 2018).

Findings from study one (Chapter 4) revealed that, after controlling for age and initial disorder severity, there was no interaction between treatment type and ethnicity. However, the main effect indicated that those from White British group showed significantly greater improvement in all domains of therapeutic outcomes (depression, anxiety, and functional impairment) when compared to the BAME group. However, this finding is to be taken with caution as the effect size was very small. This is an interesting finding as previous research has suggested poorer treatment outcomes and greater drop-out rates in the BAME population (Baker, 2018; Harwood et al., 2021). It is unclear whether this finding was influenced by the control of confounding variables, particularly as previous research has reported greater severity of CMHDs in BAME communities (e.g., Weich et al., 2004; Rehman & Owen, 2013) and poorer therapeutic outcomes in older adults (Catarino et al., 2018). However, since these factors were not dissected by ethnic group, it may have produced different findings. Future research should consider examining the intersectionality between baseline severity, age, and ethnicity to examine if there are interactions between these facets. On closer inspection, recovery outcomes between the White British group (35.20%) and BAME groups (30.64%) was similar, which may explain the small effect. However, given the economic rationale for evidence-based psychological therapies is for IAPT to achieve 50% recovery rates, this finding falls considerably short of the government targets (Marks, 2018). Previous independent reviews of IAPT echo these concerns and have reported poor recovery rates in the populations served by

IAPT services (Griffiths & Steen, 2013b; Scott, 2018). Given that these findings are based on recovery outcomes for those who complete a course of treatment, those who did not enter therapy or dropped-out may produce even poorer figures (Waltman, 2018). Future research should consider inclusion of these factors to grasp the full extent of whether service users find IAPT suitable to their needs. This is vital as previous research has highlighted greater attrition rates in BAME communities when compared to the White British population (Baker, 2018; Harwood et al., 2021).

To explore the recovery narrative, interviews were carried out with BAME service users. The majority of service users reported that they did not recover from their mental health concerns, however, generally found therapy helpful (Chapter 5). Service users expected to be cured following therapy, however, realised that therapy was a lifelong process and not a short term fix. Despite the therapeutic challenges, most service users said that they would recommend therapy to others. Previous literature has found that there is a desire for certainty and miracles in ethnic minority communities which can lead to a premise of expecting therapies to 'cure' mental distress (Lakeman, 2013). When these expectations are not met, therapeutic experiences and outcomes are culturally assessed and determine future uptake, engagement, and recommendation of therapy to others (Castillo, 1997; Mohr et al., 2006). Therapists corroborated with this finding and found that the expectation for a *"cure"* or a *"magic pill"* was prominent in BAME communities (Chapter 6). As such, therapists found it difficult to navigate between patient therapeutic expectations and the need for them to take control of their lives in order to achieve recovery (Frese III et al., 2001). The majority of service users reported that therapy was not suitable to their needs and they were just *"going through the motions"*. Service users worried that therapy sessions were too short, not personalised, and therapists were more concerned with meeting targets at the expense of their needs (Christodoulou et al., 2019). For example, one service user said:

> *"…They see you as part of their targets, and they see you as a number to get you in and out to hit the target."*

Service users valued regularity (e.g., same therapist throughout course of treatment), option to choose therapy, and *"fostering an environment where people can actually talk about things"*, however this did not always happen resulting in them dropping out of therapy. Whilst service users understood service demands, they felt it was a *"waste of time"* if people were not recovering from their disorder. In line with previous research, a common concern amongst therapists was service demands and high caseloads which meant that they were unable to explore patient needs in more details (Bassey & Malluish, 2012). Most therapists discussed the importance of setting realistic recovery goals so that service users could achieve *"enough empowerment at the end of therapy"*, even though this did not meet the intended outcomes of therapy (Chapter 6). At times, therapists felt conflicted between their clinical integrity and the need to meet targets. Some therapists felt that this was doing a disservice to BAME service users which consequently reflected in poor treatment outcomes (Naz et al., 2019). For example, one therapist worried about BAME service users not achieving the same recovery outcomes as their White counterparts:

> *"The whole IAPT needs to review this agenda. It's a cultural and systemic problem here because you can't ignore the fact that ten years on, BME people are still underrepresented in primary care and overrepresented in secondary care. And when then they enter primary care, they're not getting the same recovery rates or the reliable improvements. You cannot ignore that. And to ignore that is a disservice to the community."*

With IAPT services being one of the most closely monitored workforce within the NHS sector (Rizq, 2011), Binnie (2015) characterised IAPT as an example of 'McDonaldization' on a national scale where patients are put through a system, therapies are delivered and outcomes are measured. Whilst NICE recognises the need for cultural considerations, therapeutic adaptations are not recommended given the lack of convincing evidence (NICE: CG123, 2011). As such, therapists were conflicted on whether they should culturally adapt therapy. Whilst a couple of therapists felt it was important to retain treatment fidelity and avoid *"therapeutic drift"* (Adams, 2008; Pawson & Tilley, 2004), others felt that therapy was too *"prescriptive"* which meant a number of patients disengaged from therapy. Some therapists felt that it was imperative to have an understanding of the community and not to treat guidelines as the *"law"*. As evidenced in the systematic review (Chapter 1), therapists recognised that there was minimal research to support the effectiveness of evidence-based therapies in BAME communities, therefore, it was important for services to recognise that a *"one-size-fits-all"* approach was not always useful.

7.5.1 Low-intensity therapies: Importance of psychoeducation

IAPT services adopts the stepped-care model whereby least intrusive treatments (low-intensity interventions) are offered as a first step, which if unsuccessful, are followed-up by adjusted treatment (e.g., high-intensity interventions) in order to optimise level of care and to offer efficient and cost-effective ways to manage resource limited services (Ekers & Webster, 2012; Glover et al., 2010; Gyani et al., 2012). Since psychotherapy is a product of the West, most service users did not know what it is, how it can help, or what to expect from therapy (Sue, 2006). Service users talked about therapy not being a common practice within their culture which made them feel *"anxious"* and *"nervous"* about attending therapy (Chapter 5). Often service users did not know what to expect from therapy and questioned how talking therapies would help them talk their "*problem away". Given the poor information provided by IAPT services, service users were unable to explain the purpose of therapy to their families which in turn resulted in them disengaging from therapy.

Most therapists reported that there was a distinct lack of awareness and understanding of Western therapy in BAME communities (Chapter 6). Therapists found there was a desire to seek therapy in BAME communities, but often there needed to be more outreach work to explain the purpose of talking therapies (Naz et al., 2019). Most therapists discussed the challenges they faced in having to explain therapeutic concepts and that *"their thoughts, emotions, physical symptoms and their behaviours are all connected"*. This took up a lot of therapeutic time as therapists often had to offer psychoeducation before the allocated therapy could begin. Several therapists reported that service users were not fully informed about what to expect from therapy and saw it as practical help for matters such as immigration needs, seeking benefits and social services matters. This meant that practitioners had to often signpost service users onto other services which caused profound frustration for the service user when expectations were not met. Therapists felt that this *"wasn't a good experience"* for service users, thus more needed to be done to manage expectations before therapy began. In line with previous research, therapists reported that the lack of awareness of psychological therapies and mental health literacy led to greater drop-out rates (Bristow et al., 2011; Mclean et al., 2003; Mofrad & Webster, 2012). It was evident that a more efficient triage service is needed to manage patient expectations from the outset.

Results from the systematic review (Chapter 1) offers support for this finding as the efficacy of psychoeducation at an early stage of referral was more effective in reducing symptoms of depression, anxiety and self-esteem than delayed access to treatment or usual care (Jacob et al., 2002; Horell et al., 2014). However, in the study by Jacob et al., (2002), therapist reported that the psychoeducation leaflets did little to change the way patients' perceived mental health, nor did it improve GP treatment rates, or increase help-seeking from other sources. One of the reasons for this finding may be due to psychoeducation material being provided without therapist support. Research shows that therapist support can enhance recovery outcomes (Bennet-Levy et al., 2010), especially as some individuals from BAME communities may have poorer reading and writing proficiency, regardless of material being provided in their mother tongue (Anderson et al., 2005; Beck, 2019). Findings from study one (Chapter 4) corroborated with this finding and showed that non-guided self-help, in general, was the least effective therapy when compared to guided self-help, psychoeducation, counselling, and CBT. In line with previous research (Chan & Adams, 2014; Richards & Borglin, 2011) low-intensity treatment such as psychoeducation and guided self-help have shown greater recovery outcomes than non-guided self-help (Gyani et al, 2011; NICE: CG90, 2009), yet similar effectiveness to high-intensity therapies such as CBT and counselling (Delgadillo & Gonzalez Salas Duhne, 2020; Moller et al., 2019; Pybis et al., 2017). Given that baseline severity has not been found as a confounder to therapeutic success, regardless of treatment type (Bower et al., 2013; Vaillancourt, Manley & McNulty, 2015), low-intensity options may offer more cost-effective ways to treat CMHDs in the first instance as they are the least resource intensive (NICE: CG123, 2011). With this in mind, a progressive model, whereby low-intensity therapies such as psychoeducation is offered as a priori to therapy (Boyd et al., 2019) may be more clinically-effective and cost-effective way to enhance patient mental health literacy, engagement, and recovery rates. However, this should not be limited to the individual, but the wider community.

Previous research has shown that the implementation of community development workers has been advantageous in increasing access to care, thus should be considered as part of the wider IAPT implementation plan (Memon et al., 2016).

7.5.2 High-intensity therapies: Over-reliance on Cognitive Behavioural Therapy (CBT)

Even though NICE and IAPT services recommends and adopts gold standard evidence-based psychological therapies such as CBT for the treatment of CMHDs, it is argued that the efficacy of such interventions may only be suitable to the population recruited in clinical trials (e.g., White/Caucasian populations) (Bassey & Melluish, 2012; Hall, 2001; Williams, 2015). In the second study (Chapter 5), service users questioned the authenticity of CBT and found it *"prescriptive"*, *"superficial"*, *"rigid",* and not tailored to their specific needs (Omylinska-Thurston et al., 2019). Most service users felt that CBT was *"situational"* and did not account for their personal history, past traumas, or concerns (Bristow et al., 2011; Costa & Briggs, 2014). For example, one service user mentions:

> *"I just felt like he was like trying to stick me into a programme. I didn't necessarily feel like that programme was right at the end of the day. And I guess it felt like frigid. ... It it's very much like bring your problem, let's solve your problem."*

Therapists echoed these concerns (Chapter 6) and reported that BAME service users brought along issues from the past which made it difficult to move forward within therapy. Given that CBT tends to focus on the 'here and now' (Fenn & Byrne, 2013; Williams, 2015), therapists found it was difficult to manage service user needs, resulting in patients disengaging from therapy (Beck & Naz, 2019). Past research has stressed on the need to consider the patient as a whole, which includes their cultural, religious, spiritual, and social circumstances if therapists are to make active changes to patients' lives and recovery process (Fenn & Byrne, 2013).

Moreover, service users reported that CBT homework tasks were *"generic"* and did not consider their socio-cultural needs and circumstances. A key component of developing cultural competency skills is knowing when to generalise and when to individualise care (Sue, 1998). Service users felt that therapists seldom considered the implications that the tasks would have on their life outside the therapy room. Some service users understood the benefits of homework tasks, but felt that the ownership was on them taking control of their situation. This echoes concerns raised by Loewenthal (2018), who worried that therapies such as CBT promote individualistic values that place the responsibility on patients to manage their own wellbeing. As a result, the individual or collective struggles that people encounter are often ignored. Therapists found that homework adherence was a particular barrier to therapeutic success (Chapter 6). Some therapist's recognised that homework tasks were not always appropriate as they promoted independence and self-care which conflicted with BAME service user cultural and familial lifestyles (Omylinska-Thurston et al., 2019). Therapists worried that Western concepts integrated within therapeutic models such as building assertiveness were not culturally appropriate and could have repercussions for BAME clients in their social context (Bassey & Malluish, 2012). Some therapists acknowledged that BAME service users originated from collectivist cultures which meant that it was not easy to carry out individualistic tasks with inherent familial expectations and responsibilities (Hofstede, 2011; Markus & Kitayama, 1991). Therapies such as CBT tend to prescribe what the self is, or ought to be, by insisting on self-sufficiency, independence, and autonomy at the expense of risking eternalising factors such as cultural value systems (Al-Krenawi & Graham, 2000; Christopher, 2001; Fernando, 2012). Patients are taught to be their *own* therapist in order to deal with their own problems (Fenn & Byrne, 2013; Rogers, 2009). However, the interconnectedness and 'we consciousness' of ethnic minority communities tend to rely on the family, thus presenting greater challenges during therapy (Benish et al., 2011). Moreover, due to limited mental health literacy and reading and writing proficiency, therapists felt that some tasks were not appropriate for older patients who could not grasp the concept or purpose of homework. Clients who *“actively”* interacted with therapy were more likely to achieve therapeutic outcomes, however, this was more prominent in BAME clients who had an understanding of Western concepts, values, and upbringing.

Some therapists talked about BAME service users using therapy as a form of *“counselling”*, regardless of the therapy type. Given the *“practical”* nature of CBT, this presented challenges for therapists who often found patients wanting to *“just talk”* and not *“engage with the programme”*. Service users who received counselling valued being able to talk about their problems as this was not something that was common within their communities (Chapter 5). However, the suitability of counselling was mixed with some service users valuing just being able to talk, whilst others wanted practical steps to deal with their problems. Given the concerns aforementioned, it appears that more patient choice is needed in order to select the therapy which is most suited to their own needs. Aligning with previous studies, findings from study one (Chapter 4) found no significant differences between CBT and counselling, thus it appears that this may be a more cost-effective and clinically-effective solution than to enforce CBT as the primary treatment of choice (Delgadillo & Gonzalez Salas Duhne, 2020; Moller et al., 2019; Pybis et al., 2017; Williams, 2015).

7.6 Training considerations: Developing cultural competency

Cultural competency has received considerable attention in mental healthcare, particularly in relation to its usefulness when working with people from ethnic minority backgrounds (Castillo, 2011; Sue, 2006). Culturally competent care acknowledges and integrates culture when making considerations about assessment, treatment, and outcomes (Castillo, 2011; Good & Hannah, 2015). In line with previous research, mental health practitioners seldom received adequate training that equips them to work with diversity (Clegg et al., 2016; Edge & Lemetyine, 2019). Out of sixteen participants, only nine therapists received one day formal training (often one hour to half a day) throughout their therapeutic career, and seven therapists received no cultural competency training at all (Chapter 6). Therapists felt that they *"had to learn this the hard way"* during the first years of practice as there was *"minimal guidance and training on how to adapt therapy"* for diverse clients.

Therapists who received training, discussed having a *"working with diversity"* unit as part of their clinical training programme, however this was not tailored specifically to BAME communities. In instances where working with minority communities was included, this was often brief and did not consider cultural beliefs or patients understanding of therapy. Previous research echoes these concerns whereby training programmes promote the universal rhetoric within therapeutic models and seldom consider cultural particularism (Good & Hannah, 2015). Typically, training programmes and manuals of psychotherapy are developed towards the dominant Western cultural group (Sue, 2009), therefore the needs of clients from diverse communities tend to be absent from traditional theory, processes, and practices (Kirmayer, 2007). In England, mental health professionals now work in an increasingly multicultural society which necessitates the need for cultural competency to be incorporated within clinical training programmes to equip therapists to offer culturally informed and empirically supported therapy (Good & Hannah, 2015; Keith, 2011; Leong, 2006; Sue, 1998; Yan, 2018). In recognition of this, IAPT developed the BAME positive practice guidance to enhance the cultural competency of its workforce (Beck et al., 2019; IAPT, 2009). A key theme throughout the guidance is for therapists to offer culturally adapted and culturally responsive services that meet the needs of the local community (Beck et al., 2019). However despite this guidance, IAPT therapists lack adequate cultural competency training (Bassey & Malluish, 2012). Overall, all therapists felt that there was an urgent need and desire for more cultural competency training (Chapter 6). One therapist mentions:

> *"So IAPT has been going since 2008, um, and you know, it's been quite a poor show. I suppose from a national level, there needs to be a lot more specific training being made available. There is more research that's being done, but the actual training is very thin, virtually non-existent."*

Cultural competency training can help improve the quality of care for people from diverse communities (Bhui et al., 2007), therefore, IAPT should regularly reflect and assess the competencies of its workforce in order to provide effective services (Clegg et al., 2016).

7.6.1 Cultural dissonance between patients and therapists

Given the inherent overrepresentation of White therapists within UK clinical settings (Lang, 2020), previous literature has raised concerns about Eurocentric practitioners lacking an understanding of cultural diversity and expression of mental health which can have detrimental effects on the therapeutic care for ethnic minority communities (Turpin et al., 2008; Good & Hannah, 2015). Previous research has shown that BAME service users felt that practitioners did not listen to them, provided second-class treatment due to their ethnic status, and lacked understanding of their cultural needs (Memon et al., 2016). When clients enter therapy, they do not only bring their presenting concerns, but also their cultural identities which in turn interact with that of the therapist (Crawford, 2012). Cultural misinterpretations was a common concern reported by service users (Chapter 5). Service users talked about White therapists misjudging their tone of voice, religious garments and cultural norms which instantly built barriers within therapy. Previous literature has alluded to detrimental consequences and a 'circle of fear' that such misinterpretations has on BAME communities (Gilbert et al., 2004; Gilbert et al, 2007; Sainsbury Centre for Mental Health, 2007).

In BAME communities, there are often high degrees of mistrust and suspicion with mental health services which in turn results in individuals turning to family, religious or spiritual leaders for mental health support (Brown et al., 2010; Cook & Powell, 2013; McCrone, 2013; McCarthy, 2005). Service users often worried about confidentiality and their personal issues being let out into the community (Chapter 5). The inherent stigma attached to mental health disorders in the BAME community was apparent, with service users dropping out of group therapy in order to maintain their privacy (e.g., Bristow, et al, 2011; Clement et al., 2015). BAME therapists particularly recognised the importance of building therapeutic trust and felt that their White colleagues should *"not be afraid"* to work with diverse communities (Chapter 6). In line with previous literature, therapists felt that cultural curiosity should be proceeded with care, gradually, to avoid feelings of interrogation and suspicion (La Roche & Maxie, 2003). BAME therapists felt that *"value driven work"* was a core component of getting to know what is important to the patient, particularly during the assessment and formulation period.

All service users said that they would have valued therapists asking them about their culture, beliefs, and upbringing as this would have helped them to understand their circumstances better. Research shows that culturally competent therapists are attuned to cultural cues that present in encounters with clients from diverse communities (Engebretson et al., 2008). This includes the way in which patients discuss their beliefs about illness, treatment expectations, and how family structures influence mental wellbeing. Thus, mental health practitioners are encouraged to consider patient lived experiences and culturally sensitive issues in order to maximise recovery goals (Dausch et al., 2012; Good & Hannah, 2015; Tse & Ng, 2014). Cultural competence training was deemed important by service users in order for therapists to begin to understand their cultural complexities (e.g., Castillo, 2011; Fernando, 2005; Sue, 1998). Service users felt that *"White, middle class"* therapists, in particular, *"seem to be getting no training around cultural competency and how to apply it to different cultures"*. Often, service users talked about the negative implications that advice offered by therapists would have had on their lives should they have taken it on. Previous research has echoed these concerns, which can lead to high degrees of mistrust, suspicion, and disengagement from therapy (Cook & Powell, 2013; Jones, 1997; McCrone, 2013).

Given the inherent individualistic value systems adopted within principles of Western therapy (Al-Krenawi & Graham, 2000; Fernando, 2012; Laungani, 2007; Loewenthal, 2018), White therapists were more likely to adopt a Western mindset at the expense of getting to know service users therapeutic needs and expectations. Thus, IAPT practitioners are encouraged to recognise that the world-views and beliefs of BAME service users often differ from the models and treatment options developed for Western populations (Roy-Chowdhury, 2013). White therapists identified that there were gaps in their knowledge and that they did not fully understand the implications that social, cultural and religious factors had for BAME patients (Chapter 6). A number of White therapists said they did not *"feel comfortable"* in talking about cultural issues due to not being fully equipped to deal with different cultures. White therapists often feared that they would *"get it wrong"* which made them reluctant to delve into patient culture during therapy. Therapists recognised that this was not best practice and were concerned that they were unable to build a therapeutic relationship with patients due to time limitations and demands of the service (Bassey & Malluish, 2012). Whilst some therapists acknowledged that they did not know everything about every culture, they felt that it was important not to be ignorant about patient experiences, even if they had not experienced them (e.g., racism or discrimination). Training programmes and psychological theories have been criticised for failing to consider the role of the therapist and how their identity interacts with that of the patient, including their stereotypes, biases, and positions of power and privilege (Beck & Naz, 2019; Crawford, 2012; Ibrahim & Heuer, 2016; Sue et al., 1996). Thus, therapists are encouraged to reflect on their own 'isms' and consider how this may interact and intercede with patients in order to lighten feelings of White guilt (Crawford, 2012).

Given the limited training offered during clinical training programmes, most therapists had to rely on using their own experiences when working with clients from BAME backgrounds. Therapists often talked about not being given enough *"time to reflect and prepare"* for diverse clients given the increased service demands, admin tasks, and time limited sessions. This echoes previous research which found that time-limited services and inadequate clinical training reduces opportunities to make cultural considerations within therapy (Cabassa & Baumann, 2013; Hinton et al., 2012; Lovell et al., 2014). Thus, IAPT should offer therapists' allocated time to reflect on encounters with patients from different cultural backgrounds so that they can consider what works well, and what could be done to improve future treatment sessions (La Roche & Maxie, 2003; Sue, 2006). Moreover, White therapists felt that it would be advantageous to get experience of working with different communities to help them develop their cultural competency skills. Therefore, active steps should be taken to make such opportunities available for clinical staff as part of their continual professional development.

7.6.2 Cultural competency needs to be a shared endeavour

A common concern that was evident from BAME therapists was the expectation and reliance on them to take on the workload and responsibility for the quality of care of ethnic minority patients (Chapter 6). In line with previous literature, BAME therapists felt that the innate reliance to take on complex caseloads compromised their mental wellbeing and opportunities to get promoted as they were not always able to achieve the same recovery targets as their White colleagues (Naz et al., 2019). Moreover, BAME therapists reported that unlike their White colleagues, there was an intrinsic expectation by IAPT services for them to undertake clinical duties as well as additional outreach work, resulting in *"burnout"* (Westwood et al., 2017). BAME therapists felt that the *"structural inequalities"* in sharing caseloads equally amongst staff had considerable implication on their mental wellbeing, ability to meet targets, and getting promoted. A couple of service users' picked up on this and described the lack of training as *"systemic discrimination"* and a *"pyramid scheme"* that favoured White therapists in clinical roles over those who *"cared"* about the profession (Chapter 5).

Whilst BAME therapists recognised the importance of ethnic matching as they shared similar collective identities and upbringing to service users (Sue, 1991), they felt that services should not *"make assumptions a brown face or a black face is suited to a black or brown patient"*, but rather consider client preference first. With innate stigma and fear of judgement in minority communities, therapists recognised that someone from the same cultural background may not be suitable (Al-Krenawi & Graham, 2000). Whilst service users valued therapists from similar cultural backgrounds to themselves this was not always deemed important for recovery (Chapter 5). In fact, some patients worried that they would be judged by a therapist from a similar cultural and religious background (Al-Krenawi & Graham, 2000). However, in general, having a therapist from a similar background meant that service users did not have to overtly explain their cultural background as BAME therapists *"just got it"*. Thus, service users felt that *"representation"* was vital to engage more BAME service users.

7.6.3 Providing resources to work more cultural competently

Service users questioned the authenticity of the resources made available to them as they were seldom tailored to their specific needs nor considered their social, cultural, or familial expectations and limitations (Chapter 5). Therapists recognised that despite some culturally adapted resources being available, such as translated questionnaires and self-help books, they were not always useful for service users, particularly those who had poor reading and writing proficiency (Beck, 2019). Thus, therapists suggested the use of images and videos being made available to depict emotions, cognitions, and behaviours. Therapists often found it difficult to access resources and had to spend their own time to find culturally appropriate material which increased therapist burnout (Westwood et al., 2017). As such, therapists suggested a centralised repository that could be accessed by all mental health professionals across IAPT services would be advantageous (Chapter 6). To my knowledge this is not currently available within IAPT services so could be considered as part of the wider service plan.

Whilst therapists valued the use of interpreters to aid them in translating during sessions, there were a number of challenges that this presented in therapy. Given the limited availability of interpreters available in certain languages, some service users refused to disclose information in case word would get out in the community (Sainsbury Centre for Mental Health, 2007). This presented a number of challenges, including delayed therapeutic care and disengagement from treatment (Bristow et al., 2011; Costa & Briggs, 2014). Often therapists found it challenging to manage group dynamics within the session and worried about the accuracy of the message that was being relayed back to the service users. Therapists valued interpreters who provided information verbatim, however, this was not always the case. Previous research has echoed these concerns and reported the loss of message and translation between the therapist and client during the triangulation process (Costa & Briggs, 2014). Moreover, therapists often found themselves offering psychoeducation to interpreters as they did not all have mental health knowledge. This presented challenges in explaining therapeutic concepts and terminology to not only the interpreter, but also the patient. This indicates a need for IAPT to offer brief training to interpreters to further enhance the therapeutic experience for service users *and* therapists.

7.7 Broader strengths and limitations

The broader thesis strength and limitations are discussed in the context of what the thesis adds to literature. Limitations for each study are presented in each respective chapter, thus will not be repeated here (Lewis et al., 2021).

7.7.1 Methodological considerations: Thinking holistically

Clinical research tends to be rooted in a positivist rhetoric, whereby clinical trials are examined in test conditions and IAPT clinical outcomes are evaluated using empirically driven data (Byman, 2016; Guy et al., 2012; Williams, 2015). Whilst this offers an opportunity to examine the efficacy of treatment programmes, seldom do these findings transpire to real-world clinical settings (Clark et al., 2007; Pilgrim, 2017; Williams, 2015). Critical realism asserts this position (Bhaskar, 1998; Sayer, 2000). By adopting a critical realist epistemology, it was acknowledged that regularities are rare and therefore it is important to explore underlying mechanisms that may explain what is observed in empirical outcomes (Bergin et al., 2008; Ron, 2002). Here, broad philosophical questions, which consider wider factors such as culturally informed empirical investigations are included (Archer et al., 2016). Despite increased demands for psychotherapy to include ethnic minority populations, there is inadequate empirically supported evidence to determine therapeutic efficacy *and* effectiveness for minority populations (Hall, 2001). The methodological pragmatism of critical realism offered a holistic understanding of the phenomenon under investigation, by incorporating empirically driven data using routine clinical outcomes and rich qualitative interviews to understand if there are influencing factors and complexities that need to be considered (Clark et al., 2007; McEvoy & Richards, 2003; Palinkas, 2013). The addition of qualitative methods of enquiry enabled the researcher to explore patients and therapists recovery narrative which was useful in understanding the underlying mechanisms behind the suitability of therapeutic programmes (Savin-Baden & Major, 2013). This was a particular strength of the thesis, as the ongoing debate between the efficacy and effectiveness of treatment outcomes questions how well evidence-based therapies transpire to real-world clinical settings (Guy et al., 2012; McPherson et al., 2009). The Transdisciplinary model of evidence-based practice was useful to this end, and should be considered as part of future assessment, formulation and decision making processes (Mullen, 2015; Satterfield et al., 2009; Spring et al., 2019).

7.7.2 Embedding theoretical models to explore cultural differences

Despite research showing comparable differences between individualistic and collectivist cultures (e.g., Hoffman et al., 2010; Snowden, 2007), the majority of research using concepts of individualism – collectivism and self-construal theory has originated from the United States, used student samples, and compared Caucasian American populations with East Asian cultures (e.g., Norasakkunkit & Kalick, 2002; Oyserman et al., 2002). Previous research examining mental health inequalities and therapeutic effectiveness in BAME communities have been largely reported without adequate theoretical support. The present research adds to the field by considering theoretical concepts of individualism – collectivism and self-construal theory to understand whether Western notions of therapy are suitable to the needs of BAME communities. It is acknowledged that this research is in its infancy, particularly in the context of UK mental healthcare and practice. To my knowledge, only one study has considered cross-cultural theoretical models to explain mental health stigma in the UK population (Papadopoulos, Foster & Caldwell, 2013). Findings revealed that American participants held higher levels of individualism, followed by White English, Chinese and Greek/Greek Cypriot participants – who in turn held higher levels of collectivism. In line with previous research, those with collectivist orientation held greater stigmatizing views of mental health than those with individualistic orientation. Authors concluded that considerations of the individualism–collectivism paradigm are important for mental health services to better understand cultural differences in behaviour, attitudes and values. It is important to note that this thesis does not overtly make claims that cultural disparities are as far polarizing as theorised (Hofstede, 1980; Markus & Kitayama, 1991), instead, what it offers is the opportunity for clinical practice and future research to explore these facets further and to move away from the notion that a *"one-size-fits-all"* can be applied across cultures. This research adds to the sparse literature by attempting to marry up the findings to the theoretical models provided in order to provide a guiding framework for clinical practice. Certainly, it acknowledged that cross-cultural paradigms are contentious, and often questioned within literature, thus a substantial body of research is still needed within this area.

Critics argue that as society's progress, modernise, and become more resourceful, collectivist ideals begin to fade and shift towards individualistic value systems (Jixue, 2009). Previous studies have regarded the cross-cultural dimensions as too simplistic given the diversity of modern societies (Cohen et al., 2016; Yoo & Donthu, 1998). For example, Wang and Tamis-LeMonda (2003) reported that individuals living in collectivist societies such as Taiwan fostered and embraced both collectivistic and individualistic values and were able to utilise strategies from both perspectives to facilitate child-rearing values. A more contentious piece of research that questioned dimensions of individualism and collectivism is that by Oyserman, Coon, and Kemmelmeier (2002). In this meta-analysis, researchers found that European Americans were no more individualistic than African Americans or Latinos, who were no less collectivist than Japanese or Koreans. However, Oyserman and colleagues identified that the vast majority of cross-cultural studies reported were not representative of the general population since research participants were often recruited from student populations who tend to hold more individualistic values, higher levels of education and socioeconomic background - irrespective of culture. To my knowledge, such findings have not been explored in the UK population. Others contest that constructs of collectivism may be further distinguished by considering whether collectivism is based on relational or group level factors (Brewer & Chen, 2007; Brewer & Gardner, 1996; Zheng, Xiao, Wei, Chen, 2018). Here, it is proposed that the relational self is defined by the relationship and connections that one has with significant others, which may also be present in individuals from individualistic societies (e.g., with partner, parents, or children), whilst the collectivist self may be more concerned with broader group identity. Whilst these constructs were not explored within this present research, future studies may seek to unpack these facets further to understand the extent individuals identify and navigate between cultures and societies, particularly in the context of therapeutic expectations and outcomes (Brewer & Chen, 2007; Brewer & Gardner, 1996).

Similarly, critics argue that notions of the independent and interdependent self may co-exist rather than being viewed as far polar dimensions (Cross and Markus, 1991; Kolstad & Horpestad, 2009; Tse & Ng, 2014). Termed *'double consciousness'*, researchers suggest that bi-cultural individuals are able to interchange between individualistic–collectivist patterns depending on their cultural context (Allen & Bagozzi, 2001; Gushue & Constantine, 2003; Phinney & Devich-Navarro, 1997). Research suggests that despite societies becoming more individualistic through time, whereby younger generations may adopt more individualistic values systems, collectivist cultural values continue to remain embedded within an individual's identity regardless of the place of birth or upbringing (Jixue, 2009; Zagefka, 2009). Certainly, this trend was observed in the present study (Chapter 5 and 6) which revealed that ethnic minority service users tend to adopt more bi-cultural identities and have to navigate between individualistic and collectivist orientations, which can have implicit and explicit implications for their wellbeing.

Moreover, given the ever-evolving nature of societies, it is important to note that cross-cultural differences may not only occur across cultures, but *within* cultures too (Allen & Bagozzi, 2001; Bhugra & Bhui, 2001; Gushue & Constantine, 2003; Kolstad & Horpestad, 2009; Yamawaki, 2012). For example, due to the degrees of acculturation, older adults might be more likely to hold onto more collectivist values and less assimilated to the host society, thus widening the gap between cultural practices, beliefs, and values to younger generations (Cardemil & Battle, 2003; Hofstede, 2011; Lee & Mielde-Mossey, 2004; Tse & Ng, 2014). This distinction was observed in the present thesis, whereby service users and practitioners alluded to older adults holding onto more collectivist values than younger generations. Due to the time constraints of this research, it was not possible to recruit older adults to explore their experiences and perceptions of psychological therapies, thus opening up opportunities for future research to delve into this further. Moreover, by ascribing to particular tribes, clans, cast systems, religious ideologies these differences may further widen (Graham et al., 2016; Yamawaki, 2012). This also extends to disparities in other intersecting factors such as socioeconomic status, gender and race (Banks & Kohn-Wood, 2002; Cardemil & Battle, 2003; Guralnik & Leveille, 1997; Mossakowski, 2008; Takeuchi et al., 2007). Thus, whilst theoretical frameworks are useful to guide and enhance cross-cultural understanding, individual differences must be considered in order to understand what adaptation strategies and creative ways to access information can be made when working with diverse communities (Algeria, Alvarez, & DiMarzio, 2017; Cardemil & Battle, 2003; Kirmayer et al., 2011).

7.7.3 Inclusion of diverse clinical samples

Inclusion of BAME communities in clinical trials in the UK is poor. This was evidenced in the systematic review which highlighted the paucity of research that has explicitly explored the effectiveness of evidence-based psychological interventions for ethnic minority populations living in England (Chapter 1). The large body of research examining minority populations tends to originate from the United States which makes it difficult to generalise findings to the UK population distribution (e.g., Antoniades et al., 2014; Griner & Smith, 2006; Tang et al., 2016). This is problematic because when evidence-based therapies are delivered in ‘real-world’ clinical settings, seldom do they produce the same outcomes observed in clinical trials (Hall, 2001; Keith, 2011; Sue, 2009). The reason for this is due to the homogeneous inclusion of participants (e.g., White / Caucasian), which rarely reflects the diverse clinical population. Therapists recognised these shortfalls and questioned whether the *“one-size-fits-all”* approach was suitable for all patients accessing IAPT services (Chapter 6). Although there was evidence from study one (Chapter 4) to suggest little differences based on therapeutic effectiveness and ethnicity, what was apparent was that recovery outcomes across the sample did not meet the

50% target intended by IAPT services. Moreover, whilst the qualitative interviews with BAME service users provided deeper understanding into their therapeutic needs, the sample size was small (N = 9) which may not be sufficient in presenting a comprehensive account or generalisations to all BAME service users accessing IAPT services. The main reason for this was due to recruitment difficulties amidst the global pandemic (Covid-19). However, future research should consider the inclusion of a large-scale sample to capture the needs of diverse communities. This should include a broad age ranges, genders, and ethnicities to offer in-depth accounts of what works well, for who, how, and when (Christodoulou et al., 2019; Williams, 2015).

To note, whilst the term ‘Black, Asian and Minority Ethnic (BAME)’ has been used throughout this thesis, it is acknowledged that this is an imperfect term and does not fully capture the racial, cultural, political, and social disparities that are present between and within ethnic minority groups in the UK. However, being explicit about the reason, context, and limitations of using any collective term to group populations together is important (DaCosta, Dixon-Smith & Singh, 2021). This research does not claim that culture and ethnicity are synonymous (Betancourt & Lopez 1993), however, the use of ethnic classifications can play an integral role in understanding inequalities in mental healthcare and is useful for monitoring and planning service provision and care (Ahmed & Bradby, 2008; Fernando, 2012; Smaje, 1996). For example, the NHS Health Education England Diversity and Inclusion Strategic Framework uses the term ‘Black Minority Ethnic (BME)’ to define ethnic minority communities, whilst the acronym BAME appears multiple times on the site’s search engine (Health Education England, 2018). Similarly, the acronym BAME appears over 6,200 times on NHS England site documentations when referring to ethnic minority research, policy, and guidance (NHS England, 2022). Given that ethnic minority outcomes reported in IAPT services use the acronym BAME (Beck et al., 2019; IAPT, 2009), the decision was made to use this term within the present research to mirror the language used within this field.

Indeed, the researcher acknowledges that the acronyms BAME (and BME) are contentious and can be seen to homogenise and ‘mask’ the disparities between and within ethnic minority communities (Aspinall, 2021; DaCosta et al., 2021; Sewel, 2021). Moreover, given that the term BAME tends to refer to ‘non-White’ ethnic minority populations, those from White minority groups such as Gypsies, Roma, and Travellers tend to be grouped together as ‘White other’ which makes it difficult to differentiate group differences (Khunti et al., 2020; Gov.UK, 2022; Race Disparity Unit, 2022). Owing to the nature of theoretical models that regard Western societies as typically more individualistic (Hofstede, 1980), ethnic classifications make it difficult to separate and define White minority categories in order to understand their cultural orientation (i.e., if they are more individualistic or collectivist). Due to data limitations, lack of ethnic minority reporting within research, and time constraints, it was not possible to unpack the ethnic minority nuances at a micro level to draw group comparisons. Given that this research is in its infancy, and offers a more macro perspective, future research should consider group differences (and similarities) to expand and explore the needs of diverse groups accessing therapeutic services. In addition, future research should consider inclusion of non-English speaking populations to explore if therapeutic disparities become more salient with levels of acculturation and integration (Dhadda & Greene, 2017; Hinton & Lewis-Fernandez, 2011). This may be particularly important as Western therapeutic concepts may be more difficult to grasp by non-English speaking service users and more difficult to explain by mental health practitioners, thus leading to poorer treatment uptake, engagement, and outcomes. Whilst some of these factors may appear as limitations of the present research, it opens up opportunities for future research delve into these gaps further and broaden understanding of diverse clinical populations.

7.8 Clinical psychology implications and considerations for decision-making

The findings from these studies have implications and considerations for decision-making in psychological clinical practice, education, leadership, policy and research.

7.8.1 Clinical psychology practice

Extended therapy sessions: Findings from both service users and practitioners emphasised the need for longer therapy sessions in order to explore the multifaceted cultural aspects that may influence patient mental health (Chapters 5 and 6). Interviews with service users revealed that they often experienced cultural dissonance between Western notions of therapy and their collectivist identities. This included the cultural clash between understandings of mental distress, their religion, and familial expectations. Service users felt that sessions were too short and not personalised therefore questioned the intent of therapy. Therapists echoed these concerns and felt that time limited sessions and increased service demands hindered their ability to explore cultural aspects in more depth. Findings from routinely collected IAPT clinical data indicated that patient characteristics such as ethnicity, religion, age, and initial disorder severity may influence therapeutic effectiveness (Chapter 4). In line with previous research, poor recovery outcomes (< 35%) exemplified that therapies may not be entirely effective when transposed to clinical populations (Griffiths & Steen, 2013b; Scott, 2018a). Thus, by offering extended sessions, therapists may be able to explore service user needs and help embed therapeutic strategies to manage mental distress. This has potential to enhance clinical-effectiveness and cost effectiveness by reducing attrition and relapse rates synonymous to BAME communities (e.g., Baker, 2018; Harwood et al., 2021).

Development of culturally appropriate resources and centralised repository: It is acknowledged that there are active steps undertaken by IAPT to offer culturally appropriate material such as translated questionnaires, self-help books and positive practice guidelines (Beck et al., 2019). However, therapists often found it difficult to access resources and had to spend their own time to find culturally appropriate material which increased burnout (Chapter 6). It was suggested that a central repository should be made available that could be accessed widely across IAPT services. This would help enhance clinical effectiveness by allowing therapists to readily access culturally adapted materials. Therapists suggested that videos and images are developed to help them to depict emotions, cognitions, and behaviours for those with poorer reading and writing proficiency (Beck, 2019). Moreover, service users questioned the authenticity of the resources made available to them as they were often not tailored to their specific needs (Chapter 5). Thus, it is vital that there is flexibility to tailor self-help material to the needs of the individual by considering their social, cultural, and familial expectations and limitations.

7.8.2 Clinical psychology education

Importance of cultural competence training for clinicians: Cultural competency training programmes are seldom reviewed within the UK nor do they offer adequate training to equip mental health practitioners to work with diverse clients (Clegg et al., 2016; Edge & Lemetyine, 2019). This was evident in interviews with therapists (Chapter 6). Out of sixteen participants, only nine therapists received one day formal training (often one hour to half a day) throughout their therapeutic career, and seven therapists received no cultural competency training at all. This is problematic. The IAPT workforce now work in increasingly diverse populations which means that cultural competency training is imperative as part of clinical training programmes and throughout the course of a therapist's career. Given that cultural values and meanings tend to change over time, the process of learning should be continual and life-long (La Roche & Maxie, 2003; Papadopoulos et al., 2006). Theoretical models discussed in this thesis offer a guiding framework for therapists to understand the values and premises of Western therapy and how this may interact with those from ethnic minority communities. Not only do service users' experience cultural dissonance within therapy, but also with mental health professionals (Chapter 5). This can impede clinical effectiveness and slow down the recovery process. Service users recognised that White therapists in particular did not understand their cultural needs and were often unaware of the cultural implications of their advice. IAPT practitioners were keen to learn and welcomed more cultural competency training (Chapter 6). White therapists in particular felt that they would prefer to learn first-hand from BAME service users and have the ability to work in diverse clinical settings. Moreover, there was a clear need for representation of lecturers and clinicians delivering cultural competency training. Therapists often questioned the authenticity of training programmes and felt that cultural knowledge was limited. As such, there is urgent need for IAPT to reflect and assess the competencies of their workforce in order to provide effective services to disadvantaged communities (Clegg et al., 2016).

Mental health training for interpreters: Whilst therapists valued the use of interpreters to aid them to translate during sessions, there were a number of challenges that this presented in therapy (Chapter 6). Often therapists found it challenging to manage group dynamics within the session and worried about the accuracy of the message that was being relayed back to the service users. Therapists often found themselves offering psychoeducation to interpreters as they did not all have adequate mental health knowledge. This presented challenges in explaining therapeutic concepts and terminology to not only the interpreter, but also the patient. Thus, it is important for IAPT to develop brief training programmes as a priori before therapeutic sessions begin. This will not only enhance the therapeutic experience for the service users, but also the therapists.

7.8.3 Clinical psychology leadership

Managing systemic inequalities: A common concern that was evident in therapists from BAME backgrounds was the expectation and reliance on them to take on the workload and responsibility for the quality of care of ethnic minority patients (Chapter 6). In line with previous literature, BAME therapists felt that the innate reliance to take on complex caseloads compromised their mental wellbeing and opportunities to get promoted as they were not always able to achieve the same recovery targets as their White colleagues (Naz et al., 2019). Moreover, BAME therapists were expected to take on clinical duties as well as additional outreach work, which vastly differed to their White colleagues. Working with diversity needs to be a shared endeavour amongst the IAPT workforce. Whilst it is recognised that ethnic matching may be useful (Sue, 1991), it is vital that service user needs are considered as this may not always be the best option (Al-Krenawi & Graham, 2000). Moreover, adequate training needs to be offered to White therapists so that they can develop skills to feel more confident in working with diverse communities, thus providing the opportunity to take on more complex cases.

Representation within the IAPT workforce: Therapists valued good supervision and generally felt that they were able to approach their supervisors for assistance. However, a few therapists felt that more representation in senior management positions was needed as some White supervisors were not confident to deal with cultural complexities presented by ethnic minority clients. The lack of diversity in leadership roles and workforce not only presents a problem within clinical teams, but also the care for diverse communities (Castillo, 2011). Services that are more successful in integrating cultural competency tend to employ multicultural teams, offer diversity training, and consider ways to appropriately adapt therapy (Castillo, 2011; Fernando, 2005). Moreover, given the inherent overrepresentation of White therapists within UK clinical settings (Lang, 2020), inclusion of a more diverse workforce may ease the pressure off BAME therapists. Service users felt that representation was vital should IAPT wish to engage more individuals from ethnic minority communities. Given such concerns, a recent review titled *'Frontline, yet back of the queue'* stressed on the importance of tackling inequalities within IAPT services by enhancing service provisions for minority communities by offering appropriate funding, culturally sensitive training, and inclusion of workforce that represent and reflect the ethnic minority populations being served (Lawton et al., 2021).

7.8.4 Clinical psychology policy

Importance of psychoeducation: Mental health inequalities have a deep-rooted history in the UK which has led to increased stigma, poorer help-seeking attitudes and under-utilisation of mental health services (Baker, 2019; Butler, 1993; Ryan & Pritchard, 2004). A key finding throughout this thesis was the need for psychoeducation in ethnic minority communities. Service users often talked about not knowing what to expect from therapy (Chapter 5) and therapists reported a distinct lack of awareness and understanding of Western therapy in BAME communities which led to increased drop-out (Chapter 6). Both service users and therapists recognised that therapy was useful, but more needed to be done to enhance mental health and therapeutic literacy. Previous research has shown that the implementation of community development workers is advantageous in increasing access to care, thus should be considered as part of the wider IAPT implementation plan (Memon et al., 2016). Moreover, given that most therapists spent therapeutic time to offer psychoeducation before the allocated therapy could begin, this may have clinical and cost implications. With this in mind, a progressive model, whereby low-intensity therapy such as psychoeducation is offered as a priori to therapy may be more clinically-effective and cost-effective in enhancing patient mental health literacy, engagement, and recovery rates (Boyd et al., 2019).

Poor inclusion of BAME service users in clinical trials: Evidence-based interventions recommended by NICE is to provide cost-effective and clinically-effective treatments (e.g., Ekers & Webster, 2012; Pilling et al., 2011). Whilst there is sufficient evidence to suggest that evidence-based psychological interventions are effective in treating CMHDs in the general population, there is limited evidence of its effectiveness in diverse communities (e.g., Hedman et al., 2012; Ekers et al., 2014; Kishita & Laidlaw, 2017). Findings from controlled trials are likely to overestimate treatment effects with little consideration of diverse populations (Ormel et al., 2019). Evidence from the systematic review (Chapter 1) provided evidence to support this assertion. Only two studies considered the needs of BAME communities within English clinical trials which calls to question whether evidence-based interventions adopted by IAPT are effective in diverse clinical populations. Findings from both the service users and practitioners offered clear evidence that Western notions of therapy may not be entirely suited to ethnic minority populations. Thus, it is vital that therapeutic recommendations are reviewed beyond their efficacy of clinical trials and more funding is offered to include diverse communities within the development and implementation of therapeutic policy and practice.

7.8.5 Clinical psychology research

The findings from this thesis are in their infancy in the context of the UK mental health setting, thus, this presents opportunities for further research to develop and inform clinical practice. This includes:

- Clinical trials that specifically cater to the needs of BAME communities. Previous studies have shown poor methodological rigour which have questioned their suitability and implementation in clinical practice (Mirza & Jenkins, 2004; NICE: CG123, 2011; Walpole et al., 2012). Thus, clinical trials need to actively engage more diverse communities and ensure that reporting of service users outcomes are clearly and adequately reported within literature.
- Future research should aim to use a mixed-methods approach to assess whether theoretical facets of individualism-collectivism (Hofstede, 1980) and self-construal theory (Markus & Kitayama, 1991) can be applied across broader ethnic minority samples. The present thesis identified several key barriers which led to cultural dissonance within therapy, which includes familial expectations, generational differences, and religious implications. Thus, by exploring the intersectionality of these aspects with therapeutic effectiveness may help inform practice. Moreover, inclusion of White British populations may help understand whether the recovery narrative is as nuanced as claimed by theoretical models or whether this presents additional therapeutic challenges. Here, cross-cultural measures such as Cultural Orientation Scale (Triandis & Gelfland, 1998), Individualism and Collectivism Scale (INDCOL)

(Singelis, Triandis, Bhawuk, & Gelfand, 1995), and Self-Construal Scale (Singelis, 1994) may begin to unravel to what extent culture influences service users' daily lives.

- Another key finding was the presentation of bi-cultural identities of British born service users which may conflict with Western notions of therapy and their cultural roles, responsibilities and expectations. To my knowledge, this has not been explored within the context of UK mental healthcare or the implications this has on the recovery process. Thus, future research should examine this further, particularly within Mixed heritage communities who may be more likely to experience cultural clash between their cultural identities.
- Recovery outcomes claimed by IAPT do not reflect independent studies that have examined clinical data (e.g., Griffiths & Steen, 2013b; Scott, 2018) or the outcomes produced within the present thesis. Thus, more independent reviews of IAPT are needed, including larger subset ethnic minority samples to examine the effectiveness of evidence-based interventions. Moreover, research needs to consider those who do not attend sessions or who drop-out of therapy to establish the reasons behind why over 70% of service users fail to meet recovery (Waltman, 2018).

7.9 Conclusion

In England, IAPT services has received substantial government investment to help improve mental health outcomes for those diagnosed with CMHDs (Clark, 2018a). However, the implementation of evidence-based psychological interventions as part of routine clinical practice warranted further investigation to explore whether Western notions of therapy are suitable to the needs of ethnic minority populations. Findings from the systematic review revealed the stark lack of research that has included BAME communities in clinical trials, thus limiting the understanding of their applicability to real-world clinical settings. Further investigation of routine IAPT data was conducted which showed that patient characteristics relating to ethnicity, religion, age, and disorder severity may influence therapeutic success. Moreover, poor recovery outcomes falling short of government 50% target questioned therapeutic effectiveness in clinical populations. To understand whether evidence-based interventions meet the needs of BAME communities, interviews with service users largely supported cross-cultural theoretical frameworks by revealing inherent cultural dissonance experienced within therapy. Therapists were also interviewed to explore whether they were culturally competent to meet the needs of BAME communities. Findings revealed a clear need to enhance cultural competency training in order to better serve BAME communities. Overall, it appears that the *'one-size-fits-all'* approach adopted by Western psychotherapy fails to consider the variability in diverse communities, who often have additional barriers and complexities that may affect the effectiveness of treatment programmes. In England, over 7.9 million people identify themselves from BAME backgrounds (ONS, 2012), yet there is a dire amount of research that has considered the needs of those communities. This is problematic in itself, as those from BAME groups often face high rates of CMHDs, poorer access to mental health care, and treatment outcomes. The impact of the global pandemic has meant that rates of CMHDs have soared, thus the intentions of the IAPT programme may already be compromised (Gov.uk, 2020; Williams et al., 2021). Over a decade since the first IAPT BAME Positive Practice Guide was published, it appears that many of the issues remain the same, therefore, more needs to be done to improve outcomes for BAME communities (Beck et al., 2019; Brooks, 2019). The findings from this thesis adds to the sparse literature and calls for future research to investigate the gaps in research in order to enhance the therapeutic experiences and outcomes for BAME communities living in England.

References

References

A

Abouhendy, W., & Jawad, S. (2013). Transcultural perspectives of sensory phenomena in Arab Muslim patients suffering from obsessive–compulsive disorder. *Irish Journal of Psychological Medicine*, *30*(3), 205-207.

Abu-Ras, W. M., & Suarez, Z. E. (2009). Muslim men and women’s perception of discrimination, hate crimes, and PTSD symptoms post 9/11. *Traumatology*, *15*(3), 48-63.

Adams, S. (2008). Naughty not NICE: Implications for therapy and services. In *Clinical Psychology Forum*, 190, 29-32.

Aggarwal, N. K., Pieh, M. C., Dixon, L., Guarnaccia, P., Alegria, M., & Lewis-Fernandez, R. (2016). Clinician descriptions of communication strategies to improve treatment engagement by racial/ethnic minorities in mental health services: a systematic review. *Patient Education and Counselling*, *99*(2), 198-209.

Ahmad, W., & Bradby, H. (2008). Ethnicity and health key themes in a developing field. *Current Sociology, 56*(1), 47-56.

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

Alegría, M., Álvarez, K., & DiMarzio, K. (2017). Immigration and mental health. *Current Epidemiology Reports*, *4(*2), 145-155.

Allen, R. L., & Bagozzi, R. P. (2001). Consequences of the Black sense of self. *Journal of Black Psychology*, *27*(1), 3-28.

Amati, F., Banks, C., Greenfield, G., & Green, J. (2018). Predictors of outcomes for patients with common mental health disorders receiving psychological therapies in community settings: a systematic review. *Journal of Public Health, 40*(3), e375-e387.

American Psychological Association (2006). Evidence-Based Practice in Psychology. APA Presidential Task Force on Evidence-Based Practice. Washington DC: APA. Retrieved from https://www.scirp.org/reference/ReferencesPapers.aspx?ReferenceID=2292502

Anderson, L., Lewis, G., Araya, R., Elgie, R., Harrison, G., Proudfoot, J., ... & Williams, C. (2005). Self-help books for depression: how can practitioners and patients make the right choice?. *Br J Gen Pract*, *55*(514), 387-392

Antoniades, J., Mazza, D., & Brijnath, B. (2014). Efficacy of depression treatments for immigrant patients: results from a systematic review. *BMC Psychiatry*, *14*(1), 176.

Archer, M., Decoteau, C., Gorski, P., Little, D., Porpora, D., Rutzou, T., Smith, C., Steinmetz, G., & Vandenberghe, F. (2016). What is critical realism? Perspectives: A Newsletter of the ASA Theory Section, Fall 2017. Retrieved from: http://www.asatheory.org/current-newsletter-online/what-is-critical-realism

Aspinall, P. J. (2021). BAME (black, Asian and minority ethnic): the 'new normal'in collective terminology. *J Epidemiol Community Health*, *75*(2), 107-107.

Aubuchon-Endsley, N. L., Callahan, J. L., & Scott, S. (2014). Role expectancies, race, and treatment outcome in rural mental health. *American Journal of Psychotherapy, 68*(3), 339-354.

B

Baldwin, J. R., & Lindsley, S. L. (1994). *Conceptualizations of Culture*. Urban Studies Centre, College of Public Programs, Arizona State University.

Baker, C. (2018). Mental health statistics for England: Prevalence, services and funding. Briefing paper 6988. House of Commons Library. Retrieved from https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf

Baker, S. E., & Edwards, R. (2012). How many qualitative interviews is enough. Retrieved from https://eprints.ncrm.ac.uk/id/eprint/2273/4/how_many_interviews.pdf

Banister, P., Bunn, G., Burman, E., Daniels, J., Duckett, P., Goodley, D., ... & Whelan, P. (2011). *Qualitative Methods in Psychology: A Research Guide*. McGraw-Hill Education, UK.

Banks, K. H., & Kohn-Wood, L. P. (2002). Gender, ethnicity and depression: Intersectionality in mental health research with African American women. *African American Research Perspectives*, 174.

Barrera Jr, M., Castro, F. G., Strycker, L. A., & Toobert, D. J. (2013). Cultural adaptations of behavioral health interventions: A progress report. *Journal of Consulting and Clinical Psychology*, *81*(2), 196.

Bassey, S., & Melluish, S. (2012). Cultural competence in the experiences of IAPT therapists newly trained to deliver cognitive-behavioural therapy: A template analysis focus study. *Counselling Psychology Quarterly*, *25*(3), 223-238.

Barden, S. M., & Cashwell, C. S. (2013). Critical factors in cultural immersion: A synthesis of relevant literature. *International Journal for the Advancement of Counselling*, *35*(4), 286-297.

Beck A (2016). *Transcultural Cognitive Behavioural Therapy for Anxiety and Depression: A Practical Guide.* London, UK: Routledge.

Beck, A. (2019). Understanding Black and Minority Ethnic service user's experience of racism as part of the assessment, formulation and treatment of mental health problems in cognitive behaviour therapy. *The Cognitive Behaviour Therapist*, *12*.

Beck, A., & Naz, S. (2019). The need for service change and community outreach work to support trans-cultural cognitive behaviour therapy with Black and Minority Ethnic communities. *The Cognitive Behaviour Therapist*, *12*.

Beck, A., Naz, S., Brooks, M., & Jankowska, M. (2019). Improving Access to Psychological Therapies (IAPT) Black, Asian and Minority Ethnic service user positive practice guide. Retrieved from https://www.babcp.com/files/About/BAME/IAPT-BAME-PPG-2019.pdf

Bee, P., Playle, J., Lovell, K., Barnes, P., Gray, R., & Keeley, P. (2008). Service user views and expectations of UK-registered mental health nurses: A systematic review of empirical research. *International Journal of Nursing Studies*, *45*(3), 442-457.

Bekes, V., & Aafjes-van Doorn, K. (2020). Psychotherapists' attitudes toward online therapy during the COVID-19 pandemic. *Journal of Psychotherapy Integration*, *30*(2), 238.

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: a direct-comparison meta-analysis. *Journal of Counseling Psychology*, *58*(3), 279.

Bennett-Levy, J., Richards, D. A., Farrand, P., Christensen, H., Griffiths, K. M., Kavanagh, D. J., ... & Proudfoot, J. (2010). Low intensity CBT interventions: a revolution in mental health care. *Oxford Guide to Low Intensity CBT Interventions*, *3*, 18.

Bergin, M., Wells, J. S., & Owen, S. (2008). Critical realism: a philosophical framework for the study of gender and mental health. *Nursing Philosophy*, *9*(3), 169-179.

Bernal, G., & Saez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology*, *34*(2), 121-132.

Betancourt, H., & Lopez, S. R. (1993). The study of culture, ethnicity, and race in American psychology. *American Psychologist*, *48*(6), 629.

Bhaskar, R. (1975). *A realist theory of science*. Leeds: Leeds Books.

Bhaskar, R (1989). *Reclaiming reality: a critical introduction to contemporary philosophy*. London: Verso.

Bhaskar, R (1998). Philosophy and scientific realism. In M. S. Archer (ed.), *Critical Realism: Essential Readings*. Routledge.

Bhugra, D. (2005). Cultural identities and cultural congruency: A new model for evaluating mental distress in immigrants. *Acta Psychiatrica Scandinavica*, *111*(2), 84-93.

Bhugra, D., & Bhui, K. (2001). *Cross-cultural psychiatry: A practical guide*. Arnold.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. *BMC health services research*, *7*(1), 1-10.

Bhui, K., Craig, T., Mohamud, S., Warfa, N., Stansfeld, S. A., Thornicroft, G., ... & McCrone, P. (2006). Mental disorders among Somali refugees. *Social Psychiatry and Psychiatric Epidemiology*, *41*(5), 400.

Bhui, K., King, M., Dein, S., & O'Connor, W. (2008). Ethnicity and religious coping with mental distress. *Journal of Mental Health, 17*(2), 141-151.

Bhullar, N., Schutte, N. S., & Malouff, J. M. (2012). Associations of Individualistic-Collectivistic Orientations with Emotional Intelligence, Mental Health, and Satisfaction with Life: A Tale of Two Countries. *Individual Differences Research, 10*(3).

Binnie, J. (2015). Do you want therapy with that? A critical account of working within IAPT. *Mental Health Review Journal*, *20*(2), 79-83.

Blumer, H. (1969). *Symbolic interactionism. Perspective and method*. Englewood Cliffs, NJ: Prentice Hall.

Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: access, effectiveness and efficiency: narrative literature review. *The British Journal of Psychiatry, 186*(1), 11-17.

Bower, P., Kontopantelis, E., Sutton, A., Kendrick, T., Richards, D. A., Gilbody, S., ... & Meyer, B. (2013). Influence of initial severity of depression on effectiveness of low intensity interventions: meta-analysis of individual patient data. *BMJ, 346*, f540.

Boyd, L., Baker, E., & Reilly, J. (2019). Impact of a progressive stepped care approach in an improving access to psychological therapies service: An observational study. *Plos One*, *14*(4), e0214715.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative research in sport, exercise and health*, *11*(4), 589-597.

Braun, V., & Clarke, V. (2021a). 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, 21(1), 37-47.

Braun, V., & Clarke, V. (2021b). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative research in sport, exercise and health*, *13*(2), 201-216.

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). Thematic Analysis. In P. Liamputtong (Ed.), Handbook of Research Methods in Health Social Sciences (1-18). Singapore: Springer.

Brewer, M. B., & Chen, Y. R. (2007). Where (who) are collectives in collectivism? Toward conceptual clarification of individualism and collectivism. *Psychological Review*, *114*(1), 133.

Brewer, M. B., & Gardner, W. (1996). Who is this “we”? Levels of collective identity and self representation. *Journal of Personality and Social Psychology*, 71, 83–93.

Bricki, N., & Green, J. (2002). A guide to using qualitative research methodology. Retrieved from http://hdl.handle.net/10144/84230

Bristow, K., Edwards, S., Funnel, E., Fisher, L., Gask, L., Dowrick, C., & Chew Graham, C. (2011). Help seeking and access to primary care for people from “Hard-to-reach” groups with common mental health problems. *International Journal of Family Medicine, 2011*, 1-10.

British Association for Behavioural and Cognitive Psychotherapies (2010). Diversity & Equalities Statement. Retrieved from https://www.babcp.com/About/Diversity-Equalities

British Association for Behavioural and Cognitive Psychotherapies (2021). Standards of Conduct, Performance and Ethics. Retrieved from https://www.babcp.com/Portals/0/Files/About/BABCP-Standards-of-Conduct-Performance-and-Ethics%20Feb%202021.pdf?ver=2021-02-24-142904-080

British Psychological Society (BPS) (2012). Over a million seen by IAPT programme. Retrieved from http://www.bps.org.uk/news/over-million-people-seen-iapt-programme

Brooks, M. (2019). The importance of using reflective practice when working with refugees, asylum seekers and survivors of torture within IAPT. *The Cognitive Behaviour Therapist*, *12*.

Brown, J. S., Boardman, J., Whittinger, N., & Ashworth, M. (2010). Can a self-referral system help improve access to psychological treatments? *British Journal of General Practice, 60*(574), 365-371.

Bryman, A. (2016). *Social research methods* (5th ed.). UK: Oxford University Press.

Buffin, J., Ahmed, N., & Singh, M. (2009). Using a community engagement approach to ensure equality of access, experience and outcome from the IAPT programme in the North West of England. Retrieved from http://clok.uclan.ac.uk/2569/1/Buffin_20091130_IAPT_Using_a_community_engagement_approach.pdf

Burman, E., & Parker, I. (1993*). Discourse analytic research: Repertoires and readings of texts in action* (Eds.). Taylor & Frances/Routledge.

Butler, T. (1993). *Changing mental health services: The politics and policy*. London, UK: Chapman & Hall.

Byrne, D. (2021). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & Quantity*, 1-22.

C

Cabassa, L. J., & Baumann, A. A. (2013). A two-way street: bridging implementation science and cultural adaptations of mental health treatments. *Implementation Science*, *8*(1), 90.

Caldwell-Harris, C. L., & Aycicegi, A. (2006). When personality and culture clash: The psychological distress of allocentrics in an individualist culture and idiocentrics in a collectivist culture. *Transcultural Psychiatry*, *43*(3), 331-361.

Callan, S., & Fry, B. (2012). Completing the Revolution: Commissioning effective talking therapies. Retrieved from http://www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/TalkingTherapiesPaper.pdf

Cameron, I. M., Crawford, J. R., Lawton, K., & Reid, I. C. (2008). Psychometric comparison of PHQ-9 and HADS for measuring depression severity in primary care. *British Journal of General Practice*, *58*(546), 32-36.

Cardemil, E. V., & Battle, C. L. (2003). Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Professional Psychology: Research and Practice, 34(*3), 278.

Cardemil, E. V., Nelson, T., & Keefe, K. (2015). Racial and ethnic disparities in depression treatment. *Current Opinion in Psychology*, *4*, 37-42.

Carter, M. M., Mitchell, F. E., & Sbrocco, T. (2012). Treating ethnic minority adults with anxiety disorders: Current status and future recommendations. *Journal of Anxiety Disorders*, *26*(4), 488-501.

Castillo, R. J. (1997). *Culture & mental illness: A client-centered approach*. CA: Thomson Brooks/Cole Publishing Co.

Castillo, R. J., & Guo, K. L. (2011). A framework for cultural competence in health care organizations. *The health care manager*, *30*(3), 205-214.

Catarino, A., Bateup, S., Tablan, V., Innes, K., Freer, S., Richards, A., ... & Blackwell, A. D. (2018). Demographic and clinical predictors of response to internet-enabled cognitive–behavioural therapy for depression and anxiety. *BJPsych Open*, *4*(5), 411-418.

Chambless, D. L., Sanderson, W. C., Shoham, V., Johnson, S. B., Pope, K. S., Crits-Christoph, P., ... & McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist*, *49*(2), 5-18.

Chan, S. W., & Adams, M. (2014). Service Use, Drop-Out Rate and Clinical Outcomes: A Comparison Between High and Low Intensity Treatments in an IAPT Service. *Behavioural and Cognitive Psychotherapy*, *42*(06), 747-759.

Chen, H., Cheal, K., McDonel Herr, E. C., Zubritsky, C., & Levkoff, S. E. (2007). Religious participation as a predictor of mental health status and treatment outcomes in older persons. *International Journal of Geriatric Psychiatry: A Journal of the Psychiatry of Late Life and Allied Sciences*, *22*(2), 144-153.

Chowdhary, N., Jotheeswaran, A. T., Nadkarni, A., Hollon, S. D., King, M., Jordans, M. J. D., Rahman, A., Araya, R., & Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: A systematic review. *Psychological Medicine*, *44*(06), 1131-1146.

Christopher, J. C. (2001). Culture and psychotherapy: Toward a hermeneutic approach. *Psychotherapy: Theory, Research, Practice, Training, 38*(2), 115.

Christodoulou, V., Fortune, L., Arslan, G., & Canan, K. (2019). Turkish-speaking service-user experience of guided self-help in an improving access to psychological therapies service: Using discovery interviews to improve services. *Qualitative Report*, *23*(9), 2205-2221.

Clark, A. M., MacIntyre, P. D., & Cruickshank, J. (2007). A critical realist approach to understanding and evaluating heart health programmes. *Health, 11*(4), 513-539.

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, *23*(4), 318-327.

Clark, D. M. (2018a). Realizing the mass public benefit of evidence-based psychological therapies: the IAPT program. *Annual Review of Clinical Psychology*, 14.

Clark, D. M. (2018b). A guide to improving access to psychological therapies. Retrieved from https://www.england.nhs.uk/blog/a-guide-to-improving-access-to-psychological-therapies-services/

Clark, D., Field, S., & Layard, R. (2012). Mental health loses out in the National Health Service. *The Lancet*, *379*(9834), 2315-2316.

Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, *26*(2).

Clegg, S., Heywood-Everett, S., & Siddiqi, N. (2016). A review of cultural competence training in UK mental health settings. *British Journal of Mental Health Nursing*, *5*(4), 176-183.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rusch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(01), 11-27.

Cohen, J. (1998). Statistical Power Analysis for the Behavioral Sciences. 2nd ed. Hillsdale, NJ: Lawrence Erlbaum Associates.

Cohen, A. B., Wu, M. S., & Miller, J. (2016). Religion and Culture: Individualism and Collectivism in the East and West. *Journal of Cross-Cultural Psychology*, *47*(9), 1236-1249.

Collier, A. (1999) *Being and Worth*. London: Routledge.

Cook, C. C., & Powell, A. (2013). Spirituality is not bad for our mental health. *The British Journal of Psychiatry*, *202*(5), 385-386.

Cooper, B. (2009). Strange bedfellows: economics, happiness and mental disorder. *Epidemiologia e Psichiatria Sociale*, *18*(3), 208-213.

Costa, B., & Briggs, S. (2014). Service-users' experiences of interpreters in psychological therapy: a pilot study. International Journal of Migration, *Health and Social Care*, *10*(4), 231-244.

Cotton, E., (2018). The future and quality of mental health services: the organising challenge ahead. Retrieved from https://blogs.lse.ac.uk/politicsandpolicy/the-future-and-quality-of-mental-health-services/

Crawford, D. E. (2012). *Therapists' awareness, identification, and management of culture-based countertransference*. Miami University. Retrieved from https://etd.ohiolink.edu/apexprod/rws_etd/send_file/send?accession=miami1334711065&disposition=inline

Crawford, M. J., Robotham, D., Thana, L., Patterson, S., Weaver, T., Barber, R., ... & Rose, D. (2011). Selecting outcome measures in mental health: the views of service users. *Journal of Mental Health*, *20*(4), 336-346.

Creswell, J. W. (2009). *Research design: Qualitative and mixed methods approaches*. London and Thousand Oaks: Sage Publications.

Cross, T. L., Bazron, B. J., Dennis, K. W., Isaacs, M. R., & Benjamin, M. P. (1989). Monograph on effective services for minority children who are severely emotionally disturbed. *Washington (DC): Georgetown University*.

Cross, S. E., Gore, J. S., & Morris, M. L. (2003). The relational-interdependent self-construal, self-concept consistency, and well-being. *Journal of Personality and Social Psychology*, *85*(5), 933.

Cross, S. E., Hardin, E. E., & Gercek-Swing, B. (2011). The what, how, why, and where of self-construal. *Personality and Social Psychology Review*, *15*(2), 142-179.

Cross, S., & Markus, H. (1991). Possible selves across the life span. *Human Development*, *34*(4), 230-255.

CSIP Choice and Access Team (2007). IAPT Positive Practice Guide. Retrieved from http://iapt.nhs.uk/silo/files/commissioning-a-brighter-future.pdf

Cuijpers, P., Van Straten, A., & Warmerdam, L. (2007). Behavioral activation treatments of depression: A meta-analysis. *Clinical Psychology Review*, *27*(3), 318-326.

D

DaCosta, C., Dixon-Smith, S., & Singh, G. (2021). Beyond BAME: Rethinking the politics, construction, application, and efficacy of ethnic categorization. *Higher Education Research Action Group (HERAG)*. Retrieved from https://pure.coventry.ac.uk/ws/files/41620042/Beyond_BAME_final_report.pdf

Danermark, B. (2019). Applied interdisciplinary research: a critical realist perspective. *Journal of Critical Realism*, *18*(4), 368-382.

Damen, L. (1987). *Culture learning: The fifth dimension in the language classroom*. Addison Wesley Publishing Company.

Dausch, B. M., Cohen, A. N., Glynn, S., McCutcheon, S., Perlick, D. A., Rotondi, A., ... & Dixon, L. (2012). An intervention framework for family involvement in the care of persons with psychiatric illness: Further guidance from family forum II. *American Journal of Psychiatric Rehabilitation*, *15*(1), 5-25.

Dear, B. F., Titov, N., Sunderland, M., McMillan, D., Anderson, T., Lorian, C., & Robinson, E. (2011). Psychometric comparison of the GAD-7 and the PSWQ for measure response during treatment of generalised anxiety disorder. *Cognitive Behaviour Therapy, 40*, 216-227.

Dein, S. (1997). ABC of mental health: Mental health in a multiethnic society. *BMJ, 315,* 473-476.

Delgadillo, J., & Gonzalez Salas Duhne, P. (2020). Targeted prescription of cognitive–behavioral therapy versus person-centered counseling for depression using a machine learning approach. *Journal of Consulting and Clinical Psychology, 88*(1), 14.

Delgadillo, J., McMillan, D., Leach, C., Lucock, M., Gilbody, S., & Wood, N. (2012). Benchmarking routine psychological services: a discussion of challenges and methods. *Behavioural and Cognitive Psychotherapy*, *42*(1), 16-30.

Department of Health (DoH) (2005). Delivering Race Equality in Mental Health Care. London: Department of Health

Devos, T., & Banaji, M. R. (2005). American= white? *Journal of Personality and Social Psychology*, *88*(3), 447.

Dhadda, A., & Greene, G. (2017). 'The Healthy Migrant Effect for Mental Health in England: Propensity-score Matched Analysis Using the EMPIRIC Survey. *Journal of Immigrant and Minority Health*, 1-10.

Dum, M., Pickren, J., Sobell, L. C., & Sobell, M. B. (2008). Comparing the BDI-II and the PHQ-9 with outpatient substance abusers. *Addictive Behaviors, 33*(2), 381-387.

E

Edge, D., & Lemetyinen, H. (2019). Psychology across cultures: Challenges and opportunities. *Psychology and Psychotherapy: Theory, Research and Practice, 92*(2), 261-276.

Ehlers, A., Grey, N., Wild, J., Stott, R., Liness, S., Deale, A., ... & Manley, J. (2013). Implementation of cognitive therapy for PTSD in routine clinical care: Effectiveness and moderators of outcome in a consecutive sample. *Behaviour Research and Therapy*, 51(11), 742-752.

Ekers, D., & Webster, L. (2013). An overview of the effectiveness of psychological therapy for depression and stepped care service delivery models. *Journal of Research in Nursing, 18*(2), 171-184.

Ekers, D., Webster, L., Van Straten, A., Cuijpers, P., Richards, D., & Gilbody, S. (2014). Behavioural activation for depression; an update of meta-analysis of effectiveness and sub group analysis. *PloS One, 9*(6), e100100.

Engebretson, J., Mahoney, J., & Carlson, E. D. (2008). Cultural competence in the era of evidence-based practice. *Journal of Professional Nursing*, *24*(3), 172-178.

Eshun, S., & Gurung, R. A. (Eds.). (2009). *Culture and mental health: Sociocultural influences, theory, and practice*. John Wiley & Sons.

Evans, L., Green, S., Sharma, K., Marinho, F., & Thomas, P. (2014). Improving access to primary mental health services: are link workers the answer?. *London Journal of Primary Care, 6*(2), 23-28.

F

Faul, F., Erdfelder, E., Buchner, A., & Lang, A. G. (2009). Statistical power analyses using G* Power 3.1: Tests for correlation and regression analyses. *Behavior research methods*, *41*(4), 1149-1160.

Fear, N. T., Bridges, S., Hatch, S., Hawkins, V., & Wessely, S. (2016). Adult Psychiatric Morbidity Survey 2014: Chapter 4: Posttraumatic stress disorder. Retrieved from https://files.digital.nhs.uk/pdf/0/8/adult_psychiatric_study_ch4_web.pdf

Fenn, K., & Byrne, M. (2013). The key principles of cognitive behavioural therapy. *InnovAiT*, *6*(9), 579-585.

Fernando, S. (2010). *Mental health, race and culture.* , UK: Palgrave Macmillan

Fernando, S. (2012). Race and culture issues in mental health and some thoughts on ethnic identity. *Counselling Psychology Quarterly*, *25*(2), 113-123.

Field, A. (2018). *Discovering Statistics Using IBM SPSS Statistics*. London: SAGE Publications Ltd.

Flaskerud, J. H. (2007). Cultural competence: what is it?. *Issues in Mental Health Nursing*, *28*(1), 121-123.

Fletcher, A. J. (2017). Applying critical realism in qualitative research: methodology meets method. *International Journal of Social Research Methodology*, *20*(2), 181-194.

Frese III, F. J., Stanley, J., Kress, K., & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric services*, *52*(11), 1462-1468.

Fugard, A. J., & Potts, H. W. (2015). Supporting thinking on sample sizes for thematic analyses: a quantitative tool. *International Journal of Social Research Methodology, 18*(6), 669-684.

G

Gask, L., Rogers, A., Oliver, D., May, C., & Roland, M. (2003). Qualitative study of patients' perceptions of the quality of care for depression in general practice. *Br J Gen Pract*, *53*(489), 278-283.

Gater, R., Tomenson, B., Percival, C., Chaudhry, N., Waheed, W., Dunn, G., ... & Creed, F. (2009). Persistent depressive disorders and social stress in people of Pakistani origin and white Europeans in UK. *Social Psychiatry and Psychiatric Epidemiology, 44*(3), 198.

Gilbert, P., Bhundia, R., Mitra, R., McEwan, K., Irons, C., & Sanghera, J. (2007). Cultural differences in shame-focused attitudes towards mental health problems in Asian and non-Asian student women. *Mental Health, Religion & Culture*, *10*(2), 127-141.

Gilbert, P., Gilbert, J., & Sanghera, J. (2004). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental Health, Religion & Culture*, *7*(2), 109-130.

Gill, V., Husain, F., Vowden, K., Aznar, C. & Blake, M. (2014). Satisfaction with social care services among black and minority ethnic populations. Retrieved from http://www.natcen.ac.uk/media/563048/bme-social-care-satisfaction-main-report-2014.pdf

Givens, J. L., Houston, T. K., Van Voorhees, B. W., Ford, D. E., & Cooper, L. A. (2007). Ethnicity and preferences for depression treatment. *General Hospital Psychiatry*, *29*(3), 182-191.

Glaser, B., & Strauss, A. L. (1967). *The discovery of grounded theory. Strategies for qualitative research.* New York: Aldine.

Glover, G., Webb, M., & Evison, F. (2010). Improving Access to Psychological Therapies: A review of the progress made by sites in the first roll-out year. Retrieved from http://dro.dur.ac.uk/30523/1/30523.pdf

Good, M. J. D, & Hannah, S. D. (2015). “Shattering culture”: perspectives on cultural competence and evidence-based practice in mental health services. *Transcultural Psychiatry, 52*(2), 198-221.

Gould, R. L., Coulson, M. C., & Howard, R. J. (2012). Efficacy of cognitive behavioral therapy for anxiety disorders in older people: a meta-analysis and metaregression of randomized controlled trials. *Journal of the American Geriatrics Society, 60*(2), 218e229.

Gordis, L. (2014). *Epidemiology (*5th ed.). Canada: Elsevier Saunders Inc.

Gough, B., & Madill, A. (2012). Subjectivity in psychological science: From problem to prospect. *Psychological Methods*, *17*(3), 374.

Gov.UK (2020). COVID-19: guidance for the public on mental health and wellbeing. Retrieved from https://www.gov.uk/government/publications/covid-19-guidance-for-the-public-on-mental-health-and-wellbeing

Gov.UK (2022). List of ethnic groups. Retrieved from https://www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups

Gov.UK (2022). Writing about ethnicity. Retrieved from https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity

Graham, J. W. (2009). Missing data analysis: Making it work in the real world. *Annual Review of Psychology*, *60*, 549-576.

Graham, J., Meindl, P., Beall, E., Johnson, K. M., & Zhang, L. (2016). Cultural differences in moral judgment and behavior, across and within societies. *Current Opinion in Psychology*, *8*, 125-130.

Graham, J. R., Sorenson, S., & Hayes-Skelton, S. A. (2013). Enhancing the cultural sensitivity of cognitive behavioral interventions for anxiety in diverse populations. *The Behavior Therapist/AABT*, *36*(5), 101.

Green, S. A., Honeybourne, E., Chalkley, S. R., Poots, A. J., Woodcock, T., Price, G., ... & Green, J. (2015). A retrospective observational analysis to identify patient and treatment-related predictors of outcomes in a community mental health programme. *BMJ Open*, *5*(5), e006103.

Grey, N., Salkovskis, P., Quigley, A., Clark, D. M., & Ehlers, A. (2008). Dissemination of cognitive therapy for panic disorder in primary care. *Behavioural and Cognitive Psychotherapy*, *36*(5), 509-520.

Griffith, A. I. (1998). Insider/outsider: Epistemological privilege and mothering work. *Human Studies*, *21*(4), 361-376.

Griffiths, S., & Steen, S. (2013a). Improving Access to Psychological Therapies (IAPT) Programme: setting key performance indicators in a more robust context: a new perspective. *The Journal of Psychological Therapies in Primary Care, 2*(2), 133-141.

Griffiths, S., & Steen, S. (2013b). Improving Access to Psychological Therapies (IAPT) Programme: scrutinising IAPT cost estimates to support effective commissioning. *The Journal of Psychological Therapies in Primary Care*, 2(2), 142-156.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, *43*(4), 531.

Gushue, G. V., & Constantine, M. G. (2003). Examining individualism, collectivism, and self-differentiation in African American college women. *Journal of Mental Health Counseling*, *25*(1), 1-15.

Guralnik, J. M., & Leveille, S. G. (1997). Race, ethnicity, and health outcomes--unraveling the mediating role of socioeconomic status. *American Journal of Public Health, 87*(5), 728-730.

Guy, A., Loewenthal, D., Thomas, R., & Stephenson, S. (2012). Scrutinising NICE: The impact of the National Institute for Health and Clinical Excellence Guidelines on the provision of counselling and psychotherapy in primary care in the UK. *Psychodynamic Practice, 18*(1), 25-50.

Gyani, A., Shafran, R., Layard, R., & Clark, D. M. (2013). Enhancing recovery rates: lessons from year one of IAPT. *Behaviour Research and Therapy*, *51*(9), 597-606.

Gyani, A., Pumphrey, N., Parker, H., Shafran, R., & Rose, S. (2011). Investigating the use of NICE guidelines and IAPT services in the treatment of depression. *Mental Health in Family Medicine*, *9*(3), 149-160.

H

Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*(3), 502.

Hamilton, A. B., & Finley, E. P. (2020). Reprint of: Qualitative methods in implementation research: An introduction. *Psychiatry Research*, *283*, 112629.

Hammersley, M. (2015). Sampling and thematic analysis: a response to Fugard and Potts. *International Journal of Social Research Methodology, 18*(6), 687-688.

Harwood, H., Rhead, R., Chui, Z., Bakolis, I., Connor, L., Gazard, B., ... & Hatch, S. L. (2021). Variations by ethnicity in referral and treatment pathways for IAPT service users in South London. *Psychological Medicine*, 1-12.

Hatch, S. L., Frissa, S., Verdecchia, M., Stewart, R., Fear, N. T., Reichenberg, A., ... & Medcalf, R. (2011). Identifying socio-demographic and socioeconomic determinants of health inequalities in a diverse London community: The South East London Community Health (SELCoH) study. *BMC Public Health*, *11*(1), 1.

Haverkamp, B. E., Morrow, S. L., & Ponterotto, J. G. (2005). A time and place for qualitative and mixed methods in counseling psychology research. *Journal of Counseling Psychology*, *52*(2), 123.

Haug, T., Nordgreen, T., Öst, L. G., Kvale, G., Tangen, T., Andersson, G., ... & Havik, O. E. (2015). Stepped care versus face-to–face cognitive behavior therapy for panic disorder and social anxiety disorder: predictors and moderators of outcome. *Behaviour Research and Therapy, 71*, 76-89.

Haynes, R. B., Sackett, D. L., Gray, J. M., Cook, D. J., & Guyatt, G. H. (1996). Transferring evidence from research into practice: 1. The role of clinical care research evidence in clinical decisions. *ACP Journal Club, 125*(3), A14–A16.

Health Education England (2018). Diversity and Inclusion: Our Strategic Framework 2018-2022. Retrieved from https://www.hee.nhs.uk/sites/default/files/documents/Diversity%20and%20Inclusion%20-%20Our%20Strategic%20Framework.pdf

Health & Social Care Information Centre (HSCIC) (2015). Mental Health Bulletin: Annual Statistics, 2014-15. Retrieved from http://www.hscic.gov.uk/catalogue/PUB18808/mhb-1415-ann-rep.pdf

Hedman, E., Ljótsson, B., & Lindefors, N. (2012). Cognitive behavior therapy via the Internet: a systematic review of applications, clinical efficacy and cost–effectiveness. *Expert Review of Pharmacoeconomics & Outcomes Research*, *12*(6), 745-764.

Higgins, J. P. T., Savovic, J., Page, M. T., Sterne, J. A. C. (2019). Revised Cochrane risk-of-bias tool for randomized trials (RoB 2). Retrieved from https://methods.cochrane.org/risk-bias-2

Hinton, D. E., & Lewis-Fernandez, R. (2011). The cross-cultural validity of posttraumatic stress disorder: implications for DSM-5. *Depression and Anxiety*, *28*(9), 783-801.

Hinton, D. E., Rivera, E. I., Hofmann, S. G., Barlow, D. H., & Otto, M. W. (2012). Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcultural Psychiatry*, *49*(2), 340-365.

Hofmann, S. G., Asnaani, A., & Hinton, D. E. (2010). Cultural aspects in social anxiety and social anxiety disorder. *Depression and Anxiety*, *27*(12), 1117-1127.

Hofstede, G. (1980). *Culture's Consequences: International Differences in Work-Related Values.* , CA: Sage.

Hofstede, G. (2011). Dimensionalizing cultures: The Hofstede model in context. *Online Readings in Psychology and Culture*, *2*(1), 8.

Hofstede, G. (2015). Dimension data matrix. Retrieved from http://www.geerthofstede.nl/

Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). *Cultures and organizations: Software of the mind.* New York: McGraw-Hill.

Holland, R. (2009). Improving access to psychological therapies: the intention. *London Journal of Primary Care, 2*(1), 50-51.

Holmes-Eber, P. (1997). Migration, urbanization, and women's kin networks in Tunis. *Journal of Comparative Family Studies*, *28*(2), 54-72.

Hong, J. J., & Woody, S. R. (2007). Cultural mediators of self-reported social anxiety. *Behaviour Research and Therapy*, *45*(8), 1779-1789.

Horrell, L., Goldsmith, K. A., Tylee, A. T., Schmidt, U. H., Murphy, C. L., Bonin, E. M., ... & Brown, J. S. (2014). One-day cognitive–behavioural therapy self-confidence workshops for people with depression: randomised controlled trial. *The British Journal of Psychiatry*, *204*(3), 222-233.

Horrell, S. C. V. (2008). Effectiveness of cognitive-behavioral therapy with adult ethnic minority clients: A review. *Professional Psychology: Research and Practice, 39*(2), 160.

Hovey, J. D., Kim, S. E., & Seligman, L. D. (2006). The influences of cultural values, ethnic identity, and language use on the mental health of Korean American college students. *The Journal of Psychology, 140*(5), 499-511.

Hui, C. H., & Triandis, H. C. (1986). Individualism-collectivism: A study of cross-cultural researchers. *Journal of Cross-Cultural Psychology*, *17*(2), 225-248.

Hunot, V., Churchill, R., Teixeira, V., & de Lima, M. S. (2007). Psychological therapies for generalised anxiety disorder. *Cochrane Database of Systematic Reviews*, (1).

Husain, N., Chaudhry, I., & Ahmed, G. R. (2014). Self-esteem and obsessive compulsive disorder. *J Pak Med Assoc*, *64*(1), 64-8.

Hwang, W. C., Myers, H. F., Abe-Kim, J., & Ting, J. Y. (2008). A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model. Clinical psychology review, 28(2), 211-227.

I

IAPT (2009). Black and Minority Ethnic (BME): Positive Practice Guide. Retrieved from https://www.uea.ac.uk/documents/246046/11919343/black-and-minority-ethnic-bme-positive-practice-guide.pdf/5ce78bcd-e046-426a-8f65-93609262520d

IAPT (2011). Commissioning Talking Therapies for 2011/12. Retrieved from http://www.iapt.nhs.uk/silo/files/commissioning-talking-therapies-for-201112.pdf

Ibrahim, F. A., & Heuer, J. R. (2016). Cultural and social justice counseling. *Switzerland: Springer International Publishing, 256.*

Isaac, J. C. (1990). Realism and reality: some realistic reconsiderations. *Journal for the Theory of Social Behaviour*, *20*(1), 1-31.

Isman, E., Mahmoud Warsame, A., Johansson, A., Fried, S., & Berggren, V. (2013). Midwives' experiences in providing care and counselling to women with female genital mutilation (FGM) related problems. *Obstetrics and Gynecology International,* 2013.

J

Jacob, K. S., Bhugra, D., & Mann, A. H. (2002). A randomised controlled trial of an educational intervention for depression among Asian women in primary care in the United Kingdom. *International Journal of Social Psychiatry, 48*(2), 139-148.

Jiaxue, C. A. O. (2009). The analysis of tendency of transition from collectivism to individualism in China. *Cross-Cultural Communication, 5*(4), 42-50.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher*, *33*(7), 14-26.

Jones, J. (1997). *Whites are from Mars, O. J. is from planet Hollywood: Blacks don't support O. J. and Whites just don't get it.* In M. Fine, L. Weis, L. C. Powell, & L. M. Wong (Eds.), Off White: Readings on race, power and society. New York: Routledge

Jones, K. (2010). The practice of quantitative methods. Research methods in the social sciences. Retrieved from https://d1wqtxts1xzle7.cloudfront.net/44500342/The_practice_of_quantitative_methods20160407-6450-vbycim.pdf?1460017243=&response-content-disposition=inline%3B+filename%3DThe_practice_of_quantitative_methods.pdf&Expires=1593973198&Signature=C3FnJFyfqRWg0m~LAvub4cv5rKmPPS4J1IU0xoQ9Wg497w9MpoC2hFxHRW1z4GWkyENu4wFtzwkkkywZTIOoYkP0KnWVvAoUxD-4BoPhQB5teKYI43g6Y3CpmYbRW4TtiFdZY~3ALt8SgMvJf286emCMQGGy56uHfRbmJ6gSZKSAdzHM04WHn4-miUSZpfGjmRdArYalG~c~tQCwVZ7Jgd3QzENnaFOh-3N~r5H4wxRVo0nZtEHk-CfTN4Gpy-QP3SM780Low-ThW31pIoZGSt1Nduge4FKs1gLPxItMK5XF0KpjTu8jkV2bNozCVGy4~lAfb6YdPFOKHeEBmRPn~w__&Key-Pair-Id=APKAJLOHF5GGSLRBV4ZA

K

Kaltenthaler, E., Brazier, J., De Nigris, E., Tumur, I., Ferriter, M., Beverley, C., ... & Sutcliffe, P. (2006). Computerised cognitive behaviour therapy for depression and anxiety update: a systematic review and economic evaluation. In *NIHR Health Technology Assessment programme: Executive Summaries*. NIHR Journals Library.

Kang, H. (2013). The prevention and handling of the missing data. *Korean Journal of Anesthesiology*, *64*(5), 402.

Karasz, A. (2005). Cultural differences in conceptual models of depression. *Social Science & Medicine*, *60*(7), 1625-1635.

Keith, K. D. (Ed.). (2019). *Cross-cultural Psychology: Contemporary themes and Perspectives*. John Wiley & Sons.

Khunti, K., Routen, A., Pareek, M., Treweek, S., & Platt, L. (2020). The language of ethnicity. *BMJ*, *371*.

Kishita, N., & Laidlaw, K. (2017). Cognitive behaviour therapy for generalized anxiety disorder: Is CBT equally efficacious in adults of working age and older adults?. *Clinical psychology review*, *52*, 124-136.

Kim, J. E., Zane, N. W., & Blozis, S. A. (2012). Client predictors of short-term psychotherapy outcomes among Asian and white American outpatients. *Journal of Clinical Psychology*, *68*(12), 1287-1302.

Kirmayer, L.J. (2001). Cultural variations in the clinical presentation of depression and anxiety: implications for diagnosis and treatment, *Journal of Clinical Psychiatry*, *62*(13), 22–3.

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine*, *75*(2), 249-256.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., ... & Pottie, K. (2011). Common mental health problems in immigrants and refugees: general approach in primary care. *CMAJ*, *183*(12), E959-E967.

Kishita, N., & Laidlaw, K. (2017). Cognitive behaviour therapy for generalized anxiety disorder: Is CBT equally efficacious in adults of working age and older adults?. *Clinical Psychology Review*, *52*, 124-136.

Knight, T., & Thomas, P. (2019). Anxiety and depression in the age of austerity: public health’s problems with IAPT. *Perspectives in Public Health*, *139*(3), 128-130.

Kolstad, A., & Horpestad, S. (2009). Self-construal in Chile and Norway: Implications for cultural differences in individualism and collectivism. *Journal of Cross-Cultural Psychology*, *40*(2), 275-281.

Koppe, G., Meyer-Lindenberg, A., & Durstewitz, D. (2021). Deep learning for small and big data in psychiatry. *Neuropsychopharmacology*, *46*(1), 176-190.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606-613.

Kwak, S. K., & Kim, J. H. (2017). Statistical data preparation: management of missing values and outliers. *Korean journal of Anesthesiology*, *70*(4), 407.

L

La Roche, M. J., & Maxie, A. (2003). Ten considerations in addressing cultural differences in psychotherapy. *Professional Psychology: Research and Practice*, *34*(2), 180.

Lang, J. (2020). Analysis and recommendations on diversity of the mental health workforce. Retrieved from https://dleith.co.uk/tavistockandportman.nhs.uk/documents/2099/Analysis_and_recommendations_on_diversity_of_the_mental_health_workforce.pdf

Lamb, J., Bower, P., Rogers, A., Dowrick, C., & Gask, L. (2012). Access to mental health in primary care: a qualitative meta-synthesis of evidence from the experience of people from 'hard to reach'groups. *Health:*, *16*(1), 76-104.

Lakeman, R. (2013). Talking science and wishing for miracles: understanding cultures of mental health practice. *International Journal of Mental Health Nursing*, *22*(2), 106-115.

Laungani, P. D. (2007). *Understanding cross-cultural psychology: Eastern and western perspectives*. London, UK: Sage Publications Ltd.

Lawson, T. (2003). *Reorientating economics.* London: Routledge.

Layard, R. (2005). Mental health: Britain's biggest social problem?. Retrieved from http://eprints.lse.ac.uk/47428/1/__Libfile_repository_Content_Layard_Mental%20health%20Britain%E2%80%99s%20biggest%20social%20problem(lsero)_Mental%20health(lsero).pdf

Layard, R., & The CEP Mental Health Policy Group (2006). The depression report: A new deal for depression and anxiety disorders. Retrieved from http://cep.lse.ac.uk/pubs/download/special/depressionreport.pdf

Leong, F. T., & Lee, S. H. (2006). A cultural accommodation model for cross-cultural psychotherapy: Illustrated with the case of Asian Americans. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 410.

Lawton, L., McRae, M., & Gordon, L. (2021). Frontline yet at the back of the queue–improving access and adaptations to CBT for Black African and Caribbean communities. *The Cognitive Behaviour Therapist, 14*.

Lee, M. Y., & Mjelde-Mossey, L. (2004). Cultural dissonance among generations: a solution-focused approach with east asian elders and their families. *Journal of Marital and Family Therapy*, *30*(4), 497-513.

Leighton, K. (2003). A social conflict analysis of collective mental health care: past, present and future. *Journal of Mental Health*, *12*(5), 475-488.

Lewis, K. B., Graham, I. D., Boland, L., & Stacey, D. (2021). Writing a compelling integrated discussion: a guide for integrated discussions in article-based theses and dissertations. *International Journal of Nursing Education Scholarship, 18*(1).

Loewenthal, D. (2018). IAPT: Also promoting individualism at the expense of the common good?. *European Journal of Psychotherapy & Counselling*, *20*(3), 249-256.

Loewenthal, D., Mohamed, A., Mukhopadhyay, S., Ganesh, K., & Thomas, R. (2012). Reducing the barriers to accessing psychological therapies for bengali, urdu, tamil and somali communities in the UK: Some implications for training, policy and practice. *British Journal of Guidance & Counselling*, *40*(1), 43.

Lovell, K., Lamb, J., Gask, L., Bower, P., Waheed, W., Chew-Graham, C., ... & Dowrick, A. (2014). Development and evaluation of culturally sensitive psychosocial interventions for under-served people in primary care. *BMC Psychiatry*, *14,* 217-217.

M

Maas, J., van Assen, M. A. L. M., van Balkom, A. J. L. M., Rutten, E. A. P., & Bekker, M. H. J. (2019). Autonomy–connectedness, self-construal, and acculturation: Associations with mental health in a multicultural society. *Journal of Cross-Cultural Psychology*, *50*(1), 80-99.

Mallinson, S., & Popay, J. (2007). Describing depression: ethnicity and the use of somatic imagery in accounts of mental distress. *Sociology of Health & Illness*, *29*(6), 857-871.

Mantovani, N., Pizzolati, M., & Edge, D. (2017). Exploring the relationship between stigma and help-seeking for mental illness in African-descended faith communities in the UK. *Health Expectations*, *20*(3), 373-384.

Marks, D. F. (2018). IAPT under the microscope. *Journal of Health Psychology*, 23(9), 1131.

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, *98*(2), 224.

Marsella, A. J., & White, G. (1982). *Cultural conceptions of mental health and therapy* (Vol. 4). Dordrecht: Springer.

Matsumoto, D. (1999). Culture and self: An empirical assessment of Markus and Kitayama's theory of independent and interdependent self-construals. *Asian Journal of Social Psychology*, *2*(3), 289-310.

Mathers, C. D., & Loncar, D. (2005). Updated projections of global mortality and burden of disease, 2002-2030: data sources, methods and results. Retrieved from http://www.who.int/healthinfo/statistics/bodprojectionspaper.pdf

McCarthy, J. (2005). Individualism and collectivism: what do they have to do with counseling?. *Journal of Multicultural Counseling and Development*, *33*(2), 108-117.

Mclean, C., Campbell, C., & Cornish, F. (2003). African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (re)productive of health inequalities. *Social Science & Medicine*, *56*(3), 657-669.

McCrone, P. (2013). IAPT is probably not cost-effective. *The British Journal of Psychiatry, 202*(5), 383-383.

McEvoy, P., & Richards, D. (2003). Critical realism: a way forward for evaluation research in nursing?. *Journal of Advanced Nursing*, *43*(4), 411-420.

McManus, S., Bebbington, P., Jenkins, R., Brugha, T. (2016). Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Retrieved from http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf

McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). Adult psychiatric morbidity in England, 2007: results of a household survey. Retrieved from http://www.esds.ac.uk/doc/6379/mrdoc/pdf/6379research_report.pdf

McPherson, S., Evans, C., & Richardson, P. (2009). The NICE Depression Guidelines and the recovery model: Is there an evidence base for IAPT?. *Journal of Mental Health*, *18*(5), 405-414.

Melnyk, B. M., Fineout-Overholt, E., Giggleman, M., & Cruz, R. (2010). Correlates among cognitive beliefs, EBP implementation, organizational culture, cohesion and job satisfaction in evidence-based practice mentors from a community hospital system. *Nursing Outlook*, *58*(6), 301-308.

Mental Health Foundation. (2016). Fundamental Facts About Mental Health 2016. Retrieved from https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ Open*, *6*(11), e012337.

Mind (2010). We need to talk. Retrieved from https://www.mind.org.uk/media/280583/We-Need-to-Talk-getting-the-right-therapy-at-the-right-time.pdf

Mir, G., Meer, S., Cottrell, D., McMillan, D., House, A., & Kanter, J. W. (2015). Adapted behavioural activation for the treatment of depression in Muslims. *Journal of Affective Disorders*, *180*, 190-199.

Miranda, J., Chung, J. Y., Green, B. L., Krupnick, J., Siddique, J., Revicki, D. A., & Belin, T. (2003). Treating depression in predominantly low-income young minority women: a randomized controlled trial. *Jama*, *290*(1), 57-65.

Mirza, I., & Jenkins, R. (2004). Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. *BMJ*, *328*(7443), 794.

Mofrad, L., & Webster, L. A. (2012). The treatment of depression and simple phobia through an interpreter in the North East of England: a case study. *The Cognitive Behaviour Therapist*, *5*(4), 102-111.

Mohamed, A. D., & Loewenthal, D. (2009). Is it possible to ethically research the mental health needs of the Somali communities in the UK. *Journal of Ethics in Mental Health*, *4*(1), 1-6.

Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med, 6*(7): e1000097.

Moller, N. P., Ryans, G., Rollings, J., & Barkham, M. (2019). The 2018 UK NHS Digital annual report on the Improving Access to Psychological Therapies programme: a brief commentary. *BMC Psychiatry, 19*(1), 252.

Morrall, P. (1998). *Clinical sociology and empowerment*. In P. Barker & B. Davidson (Eds), Psychiatric Nursing – Ethical Strife. London, UK: Arnold.

Mossakowski, K. N. (2008). Dissecting the influence of race, ethnicity, and socioeconomic status on mental health in young adulthood. *Research on Aging, 30*(6), 649-671.

Mullen, E. J. (2014). Evidence-based knowledge in the context of social practice. *Scandinavian Journal of Public Health*, 42(13), 59-73

Mundt, J. C., Marks, I. M., Shear, M. K., & Greist, J. M. (2002). The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *The British Journal of Psychiatry*, *180*(5), 461-464.

Munoz, R. F., & Mendelson, T. (2005). Toward evidence-based interventions for diverse populations: The San Francisco General Hospital prevention and treatment manuals. *Journal of Consulting and Clinical Psychology*, *73*(5), 790.

N

Nash, R. (2005). Explanation and quantification in educational research: the arguments of critical and scientific realism. *British Educational Research Journal*, *31*(2), 185-204.

Naz, S., Gregory, R., & Bahu, M. (2019). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. *The Cognitive Behaviour Therapist*, 12.

NICE (2018). Who we are. Retrieved from https://www.nice.org.uk/about/who-we-are

NHS England (2015). 2015 adult IAPT workforce census report. Retrieved from https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/09/adult-iapt-workforce-census-report-15.pdf

NHS England (2016a). The Five Year Forward View for Mental Health. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

NHS Digital (2016b). Psychological Therapies: Annual Report on the use of IAPT services - England, 2015-16. Retrieved from https://webarchive.nationalarchives.gov.uk/20180328133700/http://digital.nhs.uk/catalogue/PUB22110

NHS England (2022). You searched for: BAME. Retrieved from https://www.england.nhs.uk/?s=bame

NHS Digital (2019). Improving access to psychological therapies data set reports. Retrieved from https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/improving-access-to-psychological-therapies-data-set-reports

NICE: CG90 (2009). Depression in adults: recognition and management. Retrieved from https://www.nice.org.uk/guidance/cg90

NICE: CG113 (2011). Generalised anxiety disorder and panic disorder in adults: management. Retrieved from https://www.nice.org.uk/guidance/cg113

NICE: CG123 (2011). Common mental health problems: identification and pathways to care. Retrieved from https://www.nice.org.uk/guidance/cg123

NICE: CG159 (2013). Social anxiety disorder: Recognition, assessment and treatment. Retrieved from https://www.nice.org.uk/guidance/cg159/evidence/full-guideline-pdf-189895069

National Institute for Mental Health in England (NIMHE) (2003). Inside Outside: Improving mental health services for black and minority ethnic communities in England. Retrieved from http://webarchive.nationalarchives.gov.uk/20130105200229/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019452.pdf

Norasakkunkit, V., & Kalick, S. M. (2002). Culture, ethnicity, and emotional distress measures: The role of self-construal and self-enhancement. *Journal of Cross-Cultural Psychology*, *33*(1), 56-70.

O

Office for National Statistics (ONS) (2012). Ethnicity and National Identity in England and Wales: 2011. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11

Office for National Statistics (ONS) (2018). Overview of the UK population: November 2018. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/november2018

Oh, H. (2014). Additional thoughts on the individualism–collectivism paradigm: familial co-aggregation, the treatment gap, structural competency, and social suffering. *Journal of Psychosocial Rehabilitation and Mental Health, 1*(2), 91-93.

Omylinska-Thurston, J., McMeekin, A., Walton, P., & Proctor, G. (2019). Clients' perceptions of unhelpful factors in CBT in IAPT serving a deprived area of the UK. *Counselling and Psychotherapy Research, 19*(4), 455-464.

Ormel, J., Kessler, R. C., & Schoevers, R. (2019). Depression: more treatment but no drop in prevalence: how effective is treatment? And can we do better?. *Current Opinion in Psychiatry, 32*(4), 348-354.

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin, 128*(1), 3.

P

Palinkas, L. A., Aarons, G. A., Horwitz, S., Chamberlain, P., Hurlburt, M., & Landsverk, J. (2011). Mixed method designs in implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(1), 44-53.

Palinkas, L. A., Mendon, S. J., & Hamilton, A. B. (2019). Innovations in mixed methods evaluations. *Annual Review of Public Health, 40,* 423-442.

Papadopoulos, I. (2006). The Papadopoulos, Tilki and Taylor model of developing cultural competence. *Transcultural health and social care: Development of culturally competent practitioners,* 7-24.

Papadopoulos, C., Foster, J., & Caldwell, K. (2013). 'Individualism-collectivism' as an explanatory device for mental illness stigma. *Community Mental Health Journal, 49*(3), 270-280.

Parsonage, M., & Saini, G. (2017). Centre for Mental Health. Mental health at work: The business costs ten years on. Retrieved from centreformentalhealth.org.uk

Patton, M. Q. (2015). Qualitative research & evaluation methods. fourth. *Thousand Oaks*. CA: Sage.

Pawson, R., & Tilley, N. (1997). *Realistic evaluation*. London: Sage Publications.

Pedersen, P. B. (1991). Counseling international students. *The Counseling Psychologist*, 19, 10-

Phinney, J. S., & Devich-Navarro, M. (1997). Variations in bicultural identification among African American and Mexican American adolescents. *Journal of research on Adolescence*, *7*(1), 3-32.

Pilgrim, D. (2017). *Key concepts in mental health* (4th ed.). London, UK: Sage Publications Ltd.

Pilling, S., Whittington, C., Taylor, C., & Kendrick, T. (2011). Identification and care pathways for common mental health disorders: Summary of NICE guidance. *BMJ*, *342*, d2868.

Plano Clark, V. L., Huddleston-Casas, C. A., Churchill, S. L., O'Neil Green, D., & Garrett, A. L. (2008). Mixed methods approaches in family science research. *Journal of Family Issues*, *29*(11), 1543-1566.

Pope, C., & Mays, N. (2006). *Qualitative research in health care* (Eds.).John Wiley & Sons Ltd.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. Sage.

Pybis, J., Saxon, D., Hill, A., & Barkham, M. (2017). The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2nd UK National Audit of psychological therapies. *BMC Psychiatry*, *17*(1), 215.

R

Race Disparity Unit (2022). Why we no longer use the term ‘BAME’ in government. Retrieved from https://equalities.blog.gov.uk/2022/04/07/why-we-no-longer-use-the-term-bame-in-government/

Rathod, S., Phiri, P., & Naeem, F. (2019). An evidence-based framework to culturally adapt cognitive behaviour therapy. *The Cognitive Behaviour Therapist*, *12*.

Redfern S. (1998). Evaluation: drawing comparisons or achieving consensus?. *Nursing Times Research 3*, 464–475.

Rehman, H., & Owen, D. (2013). Mental Health Survey of Ethnic Minorites: Research Report. Retrieved from https://www.time-to-change.org.uk/sites/default/files/TTC_Final%20Report_ETHNOS_summary_1.pdf

Reuter, P. (2018). The General Data Protection Regulation (GDPR). Retrieved from https://www.epsu.org/sites/default/files/article/files/GDPR_FINAL_EPSU.pdf

Richards, D. A., & Borglin, G. (2011). Implementation of psychological therapies for anxiety and depression in routine practice: two year prospective cohort study. *Journal of Affective Disorders*, *133*(1-2), 51-60.

Richards, D. A., Bower, P., Pagel, C., Weaver, A., Utley, M., Cape, J., ... & Owens, L. (2012). Delivering stepped care: an analysis of implementation in routine practice. *Implementation Science*, *7*(1), 3.

Ridgway, N., & Williams, C. (2011). Cognitive behavioural therapy self-help for depression: an overview. *Journal of Mental Health*, *20*(6), 593-603.

Rizq, R. (2011). IAPT, anxiety and envy: A psychoanalytic view of NHS primary care mental health services today. *British Journal of Psychotherapy, 27*(1), 37-55.

Robson, C. (2011). Real world research: *A resource for social-scientists and practitioner-researchers*. 3rd edition. Oxford: Blackwell Publishing.

Rogers, E. (2009). The need for reappraising psychological therapies in the light of IAPT. *The Journal of Mental Health Training, Education, and Practice*, *4*(1), 19.

Ron, A. (2002). Regression analysis and the philosophy of social science: A critical realist view. *Journal of Critical Realism*, *1*(1), 119-142.

Roy-Chowdhury, S. (2013). How can an IAPT service increase its cultural sensitivity. *Clinical Psychology Forum*, 241, 45-50.

Royal College of Psychiatry (2015). Cultural competency. Retrieved https://elearning.rcpsych.ac.uk/PDF/Cultural_competency_THN.pdf

Ryan, T., & Pritchard, J. (2004). *Good practice in adult mental health* (Vol. 10). London, UK: Jessica Kingsley Publishers.

S

Saberi, P. (2020). Research in the time of coronavirus: continuing ongoing studies in the midst of the COVID-19 pandemic. *AIDS and Behavior*, *24*(8), 2232-2235.

Sainsbury Centre for Mental Health (2007). Mental Health at Work: Developing the Business Case. Retrieved from http://www.scmh.org.uk/pdfs/mental_health_at_work.pdf

Sagiv, L., & Schwartz, S. H. (2007). Cultural values in organisations: insights for Europe. *European Journal of International Management*, *1*(3), 176-190.

Sandhu, J. S. (2005). A Sikh Perspective on Life-Stress: Implications for Counselling. *Canadian Journal of Counselling, 39*(1), 40-51.

Sashidharan, S. P., (2003). Inside Out: Improving Mental Health Services for Black and Minority Ethnic Groups in England. Retrieved from https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084558

Satterfield, J. M., Spring, B., Brownson, R. C., Mullen, E. J., Newhouse, R. P., Walker, B. B., & Whitlock, E. P. (2009). Toward a transdisciplinary model of evidence-based practice. *The Milbank Quarterly, 87*(2), 368-390.

Savin-Baden, M., & Howell-Major, C. (2013). Qualitativeclar research: The essential guide to theory and practice. *Qualitative Research: The Essential Guide to Theory and Practice. Routledge*.

Sayer, A. (2000). *Realism and social science*. London: Sage Publications.

Schimmack, U., Oishi, S., & Diener, E. (2005). Individualism: A valid and important dimension of cultural differences between nations. *Personality and Social Psychology Review*, *9*(1), 17-31.

Schoonenboom, J., & Johnson, R. B. (2017). How to construct a mixed methods research design. *KZfSS Kölner Zeitschrift für Soziologie und Sozialpsychologie*, *69*(2), 107-131.

Schreiber, J. A. (2013). Beyond Evidence-Based Practice-Achieving Fundamental Changes in Research and Practice. *Oncology Nursing Forum*, 40(3).

Scott, M. J. (2018a). Improving Access to Psychological Therapies (IAPT)-The Need for Radical Reform. *Journal of Health Psychology*, *23*(9), 1136-1147.

Scott, M. J. (2018b). Transforming Improving Access to Psychological Therapies. *Journal of Health Psychology*, *23*(9), 1163-1172.

Scott, M. J. (2019). Ensuring IAPT Makes A Real-World Difference. *Ment Health*, *15*, 893-895.

Scott, G., Ciarrochi, J., & Deane, F. P. (2004). Disadvantages of being an individualist in an individualistic culture: Idiocentrism, emotional competence, stress, and mental health. *Australian Psychologist*, *39*(2), 143-154.

Sewel, T. (2021). Commission on Race and Ethnic Disparities: Commission on Race and Ethnic Disparities. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf

Singh, S. P., Brown, L., Winsper, C., Gajwani, R., Islam, Z., Jasani, R., Parsons, H., Rabbie-Khan, F., & Birchwood, M. (2015). Ethnicity and pathways to care during first episode psychosis: the role of cultural illness attributions. *BMC Psychiatry*, *15*(1), 1.

Singelis, T. M. (1994). The measurement of independent and interdependent self-construals. *Personality and Social Psychology Bulletin*, *20*, 580-591.

Singelis, T. M., Triandis, H. C., Bhawuk, D. P., & Gelfand, M. J. (1995). Horizontal and vertical dimensions of individualism and collectivism: A theoretical and measurement refinement. *Cross-Cultural Research*, *29*(3), 240-275.

Smaje, C. (1996). The ethnic patterning of health: new directions for theory and research. *Sociology of Health & Illness*, *18*(2), 139-171.

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

Smith, S. (2015). PhD by published work: A practical guide for success. London, UK: Palgrave.

Smith, L. M., Denzin, N., & Lincoln, Y. (1994). Biographical Method. *The SAGE*.

Smith, J. A., Flowers, P., & Osborn, M. (2013). Interpretative phenomenological analysis and the psychology of health and illness. In *Material discourses of health and illness*. Routledge.

Snowden, L. R. (2007). Explaining mental health treatment disparities: ethnic and cultural differences in family involvement. *Culture, Medicine and Psychiatry, 31*(3), 389-402.

Sofaer, S. (1999). Qualitative methods: what are they and why use them?. *Health Services Research*, *34*(5 Pt 2), 1101.

Spiers, N., Bebbington, P., McManus, S., Brugha, T. S., Jenkins, R., & Meltzer, H. (2011). Age and birth cohort differences in the prevalence of common mental disorder in England: National Psychiatric Morbidity Surveys 1993–2007. *The British Journal of Psychiatry,* 198(6), 479-484.

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine, 166*(10), 1092-1097.

Spring, B., Marchase, S. H., & Steglitz, J. (2019). History and process of evidence-based practice in mental health. *Evidence-based practice in action: Bridging clinical science and intervention,* 9-27.

Sreeharan, V., Madden, H., Lee, J. T., Millett, C., & Majeed, A. (2013). Improving Access to Psychological Therapies and antidepressant prescribing rates in England: a longitudinal time-series analysis. *British Journal of General Practice*, *63*(614), e649-e653.

Stansfeld S, Clark C, Bebbington P, King M, Jenkins R, Hinchliffe S. 'Chapter 2: Common mental disorders' in McManus S, Bebbington P, Jenkins R, Brugha T. (eds) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Retrieved from https://digital.nhs.uk/catalogue/PUB21748

Sterne, J. A., White, I. R., Carlin, J. B., Spratt, M., Royston, P., Kenward, M. G., ... & Carpenter, J. R. (2009). Multiple imputation for missing data in epidemiological and clinical research: potential and pitfalls. *BMJ*, *338*.

Stevenson, D., & Farmer, P. (2017). Thriving at work: The Stevenson/Farmer review of mental health and employers. Department for Work and Pensions and Department of Health and Social Care. Retrieved from https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers

Subramaniam, M., Abdin, E., Vaingankar, J. A., & Chong, S. A. (2012). Obsessive–compulsive disorder: prevalence, correlates, help-seeking and quality of life in a multiracial Asian population. *Social Psychiatry and Psychiatric Epidemiology*, *47*(12), 2035-2043.

Sue, D.W. (l991).A conceptual model for cultural diversity training. Journal of Counseling and Development, 70, 99-105.

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The counseling psychologist*, *29*(6), 790-821.

Sue, D. W., Ivey, A., & Pederson, P. (1996). Multicultural counseling and therapy. *Brooks/Cole*.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American psychologist*, *53*(4), 440.

Sue, S. (2006). Cultural competency: From philosophy to research and practice. *Journal of community Psychology*, *34*(2), 237-245.

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual review of psychology*, *60*, 525-548.

T

Takeuchi, D. T., Alegría, M., Jackson, J. S., & Williams, D. R. (2007). Immigration and mental health: Diverse findings in Asian, Black, and Latino populations. *American Journal of Public Health, 97*(1), 11-12.

Talari, K., & Goyal, M. (2020). Retrospective studies-utility and caveats. *JR Coll Physicians Edinb*, *50*(4), 398-402.

Tang, J. Y., Li, C., Rodgers, R. F., & Ballou, M. (2016). Ethnic differences in the effectiveness of cognitive behavioral therapy combined with medication: Comparing Asian American and white psychiatric patients. *Asian Journal of Psychiatry*, *24*, 46-50.

Tashakkori A, & Teddlie, C. (2003). *Handbook of Mixed Methods in Social and Behavioural Research.* Thousand Oaks: Sage.

Tashakkori, A., & Teddlie, C. (2009). Integrating qualitative and quantitative approaches to research. *The SAGE handbook of applied social research methods*, *2*, 283-317.

Tashakkori, A., & Teddlie, C. (2010). Putting the human back in ‘‘human research methodology’’: The researcher in mixed methods research. *Journal of Mixed Methods Research*, *4*(4), 271-277.

Taylor, G. W., & Ussher, J. M. (2001). Making sense of S&M: A discourse analytic account. *Sexualities*, *4*(3), 293-314.

Timimi, S. (2018). The diagnosis is correct, but National Institute of Health and Care Excellence guidelines are part of the problem not the solution. *Journal of Health Psychology*, *23*(9), 1148-1152.

Triandis, H. C. (1972). *The analysis of subjective culture*. Oxford, UK: Wiley-Interscience.

Triandis, H. C. (1995). *Individualism & Collectivism*. Oxford, UK: Westview Press Inc.

Triandis, H. C. (2001). Individualism and collectivism: Past, present, and future. *The Handbook of Culture and Psychology*, 35-50.

Triandis, H. C., & Gelfand, M. J. (1998). Converging measurement of horizontal and vertical individualism and collectivism. *Journal of Personality and Social Psychology*, *74*(1), 118.

Tse, S., & Ng, R. M. (2014). Applying a mental health recovery approach for people from diverse backgrounds: the case of collectivism and individualism paradigms. *Journal of Psychosocial Rehabilitation and Mental Health*, *1*(1), 7-13.

Turner, J., Hayward, R., Angel, K., Fulford, B., Hall, J., Millard, C., & Thomson, M. (2015). The history of mental health services in modern England: practitioner memories and the direction of future research. *Medical History*, *59*(4), 599-624.

Turpin, G., Richards, D., Hope, R., & Duffy, R. (2008). Delivering the IAPT programme. Retrieved from https://ore.exeter.ac.uk/repository/bitstream/handle/10036/41153/IAPT.pdf?sequence=5&isAllowed=y

V

Vach, W., & Blettner, M. (1991). Biased estimation of the odds ratio in case-control studies due to the use of ad hoc methods of correcting for missing values for confounding variables. *American Journal of Epidemiology, 134*(8), 895-907.

Vaillancourt, K., Manley, J., & McNulty, N. (2015). Why has our recovery rate dropped? An audit examining waiting times, starting scores and length of treatment in relation to recovery within an IAPT service. *The Cognitive Behaviour Therapist*, *8*.

van Loon, A., van Schaik, A., Dekker, J., & Beekman, A. (2013). Bridging the gap for ethnic minority adult outpatients with depression and anxiety disorders by culturally adapted treatments. *Journal of Affective Disorders*, *147*(1-3), 9-16.

Viruell-Fuentes, E. A. (2007). Beyond acculturation: immigration, discrimination, and health research among Mexicans in the United States. *Social Science & Medicine*, *65*(7), 1524-1535.

W

Waheed, W., Husain, N., Allen, G., Atif, N., Aseem, S., Waquas, A., ... & Bower, P. (2015). Recruitment strategies for British South Asians in 5 depression trials: A mixed method study. *Journal of Affective Disorders, 185*, 195-203.

Wainwright, S. P., & Forbes, A. (2000). Philosophical problems with social research on health inequalities. *Health Care Analysis, 8*(3), 259-277.

Wakefield, S., Kellett, S., Simmonds-Buckley, M., Stockton, D., Bradbury, A., & Delgadillo, J. (2021). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. *British Journal of Clinical Psychology, 60*(1), 1-37.

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.

Walsh, D., & Evans, K. (2014). Critical realism: An important theoretical perspective for midwifery research. *Midwifery*, *30*(1), e1-e6.

Waltman, S. H. (2018). Attempting to reconcile large differences in Improving Access to Psychological Therapies recovery rates. *Journal of Health Psychology*, *23*(9), 1153-1158.

Wan, C., & Chew, P. Y. G. (2013). Cultural knowledge, category label, and social connections: Components of cultural identity in the global, multicultural context. *Asian Journal of Social Psychology*, *16*(4), 247-259.

Wang, S., & Tamis-Lemonda, C. S. (2003). Do child-rearing values in Taiwan and the United States reflect cultural values of collectivism and individualism?. *Journal of Cross-Cultural Psychology*, *34*(6), 629-642.

Ward, E. C., & Brown, R. L. (2015). A culturally adapted depression intervention for African American adults experiencing depression: Oh Happy Day. *American Journal of Orthopsychiatry*, *85*(1), 11.

Weersing, V. R., & Weisz, J. R. (2002). Community clinic treatment of depressed youth: benchmarking usual care against CBT clinical trials. *Journal of Consulting and Clinical Psychology*, *70*(2), 299.

Weich, S., Nazroo, J., Sproston, K., McManus, S., Blanchard, M., Erens, B., ... & Tyrer, P. (2004). Common mental disorders and ethnicity in England: the EMPIRIC study. *Psychological Medicine*, *34*(8), 1543-1551.

Weich, S., & McManus, S. (2002). Common mental disorders. *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC)*, 25-46.

Westwood, S., Morison, L., Allt, J., & Holmes, N. (2017). Predictors of emotional exhaustion, disengagement and burnout among improving access to psychological therapies (IAPT) practitioners. *Journal of Mental Health*, *26*(2), 172-179.

Williams, C., & Martinez, R. (2008). Increasing access to CBT: stepped care and CBT self-help models in practice. *Behavioural and Cognitive Psychotherapy*, *36*(6), 675-683.

Williams, C. H. J. (2015). Improving access to psychological therapies (IAPT) and treatment outcomes: epistemological assumptions and controversies. *Journal of Psychiatric and Mental Health Nursing*, *22*(5), 344-351.

Williams, T., Davis, J., Figueira, C., & Vizard, T. (2021). Coronavirus and depression in adults, Great Britain: January to March 2021. Office for National Statistics, 5. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/januarytomarch2021

Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-Hill Education, UK.

Wilson, M. (2009). *Delivering race equality in mental health care: A review*. London, UK: Department of Health/NMHDU.

Wood, A. M., White, I. R., & Thompson, S. G. (2004). Are missing outcome data adequately handled? A review of published randomized controlled trials in major medical journals. *Clinical Trials*, *1*(4), 368-376.

Woodall, A., Morgan, C., Sloan, C., & Howard, L. (2010). Barriers to participation in mental health research: are there specific gender, ethnicity and age related barriers?. *BMC Psychiatry*, *10*(1), 103

X

Xu, Y., & Flaskerud, J. H. (2007). Cultural dissonance between nurse and patient: The other side of the coin. *Issues in Mental Health Nursing*, *28*(10), 1189-1192.

Y

Yamawaki, N. (2012). Within-culture variations of collectivism in Japan. *Journal of Cross-Cultural Psychology*, *43*(8), 1191-1204.

Yan, A. (2018). Cultural Identity in the Perspective of Psychology. *Journal of Psychological Research*, *1*, 25-30.

Yoo, B., & Donthu, N. (1998). Validating Hofstede's five-dimensional measure of culture at the individual level. In *American Marketing Association. Conference Proceedings* (Vol. 9, p. 83). American Marketing Association.

Z

Zagefka, H. (2009). The concept of ethnicity in social psychological research: Definitional issues. *International Journal of Intercultural Relations*, *33*(3), 228-241.

Zheng, Y., Xiao, Z., Wei, L., & Chen, H. (2018). The neural representation of relational-and collective-self: two forms of collectivism. *Frontiers in Psychology*, 9, 2624.

Appendices

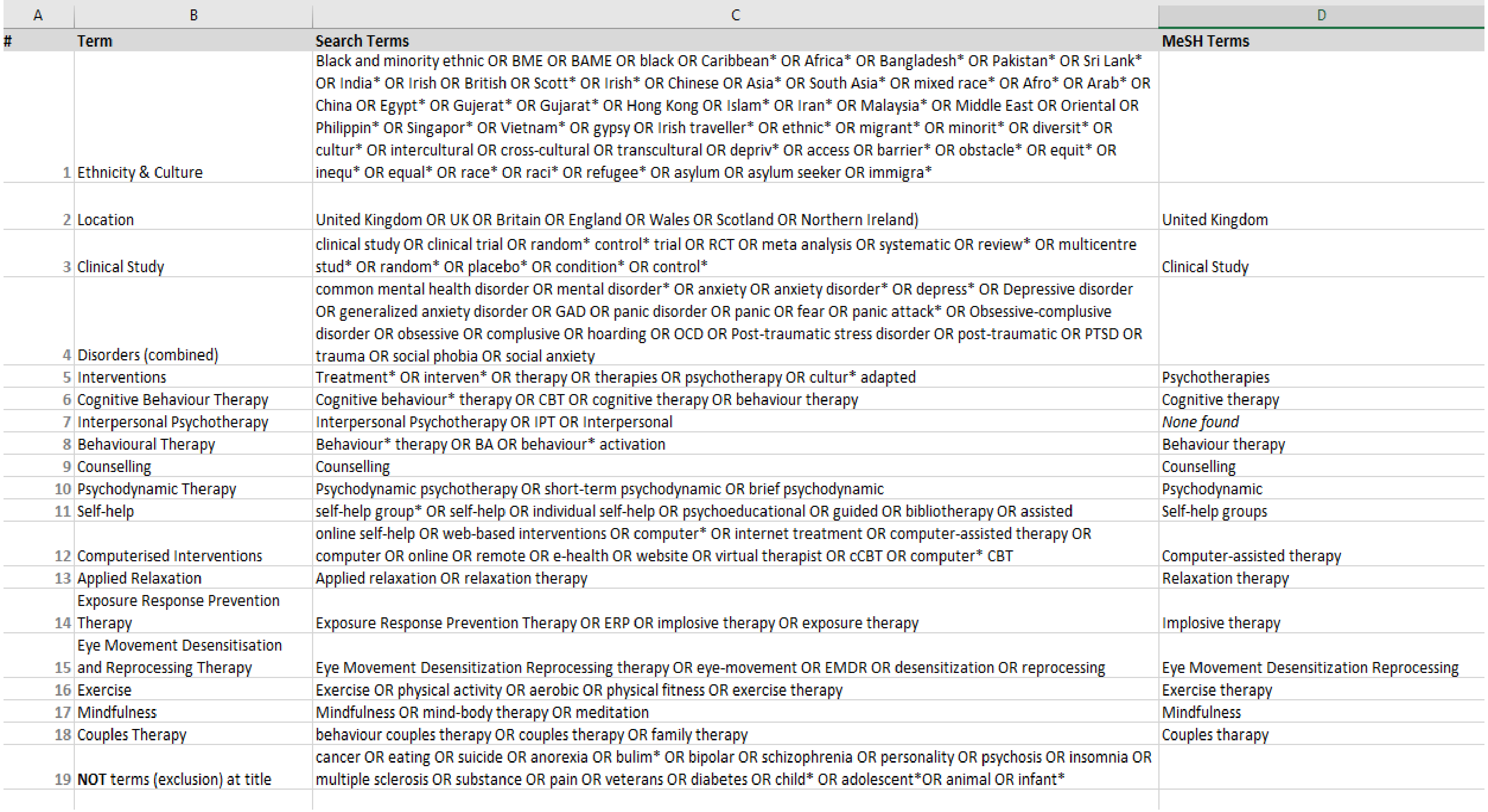
Appendices A

Appendix A1. 1. Summary of NICE recommendations for the psychological treatment of CMHDs

Place in stepped-care service	**Disorder and NICE clinical guideline numbers**	**Recommended intervention**
Step 3: *High-Intensity Services.* Primarily weekly, face-to-face, one-to-one sessions with a suitably trained therapist. In some disorders, such as depression, CBT can also be delivered effectively to small groups of patients. Couples therapy naturally involves the therapist, the depressed client and his/her partner.	Depression, moderate to severe Depression, mild to moderate (CG90, CG91, CG123)*	CBT or IPT each with medication CBT or IPT Behavioural activation Couples therapy Counselling for depression Brief psychodynamic therapy
	Generalized anxiety disorder (CG113, CG123)*	CBT
	Panic disorder (CG113, CG123)*	CBT
	Social anxiety disorder (CG159)*	CBT
	Obsessive-compulsive disorder (CG31, CG123)*	CBT
	PTSD (CG26, CG123)*	CBT EMDR
Step 2: *Low-Intensity Services.* Less intensive clinician input than the high-intensity service. Patients are typically encouraged to work through some form of self-help program with frequent, brief guidance and encouragement from a psychological well-being practitioner who acts as a coach.	Depression (CG90, CG91, CG123)*	Individual guided self-help based on CBT Computerized CBT Behavioural activation Structured group physical activity program
	Generalized anxiety disorder (CG113, CG123)*	Guided self-help based on CBT Psychoeducational groups Computerized CBT
	Panic disorder (CG113, CG123)*	Guided self-help based on CBT Psychoeducational groups Computerized CBT
	Social anxiety disorder (CG159)*	No first-line recommendation
	Obsessive-compulsive disorder (CG31, CG123)*	Guided self-help based on CBT
	PTSD (CG26, CG123)*	No recommendation

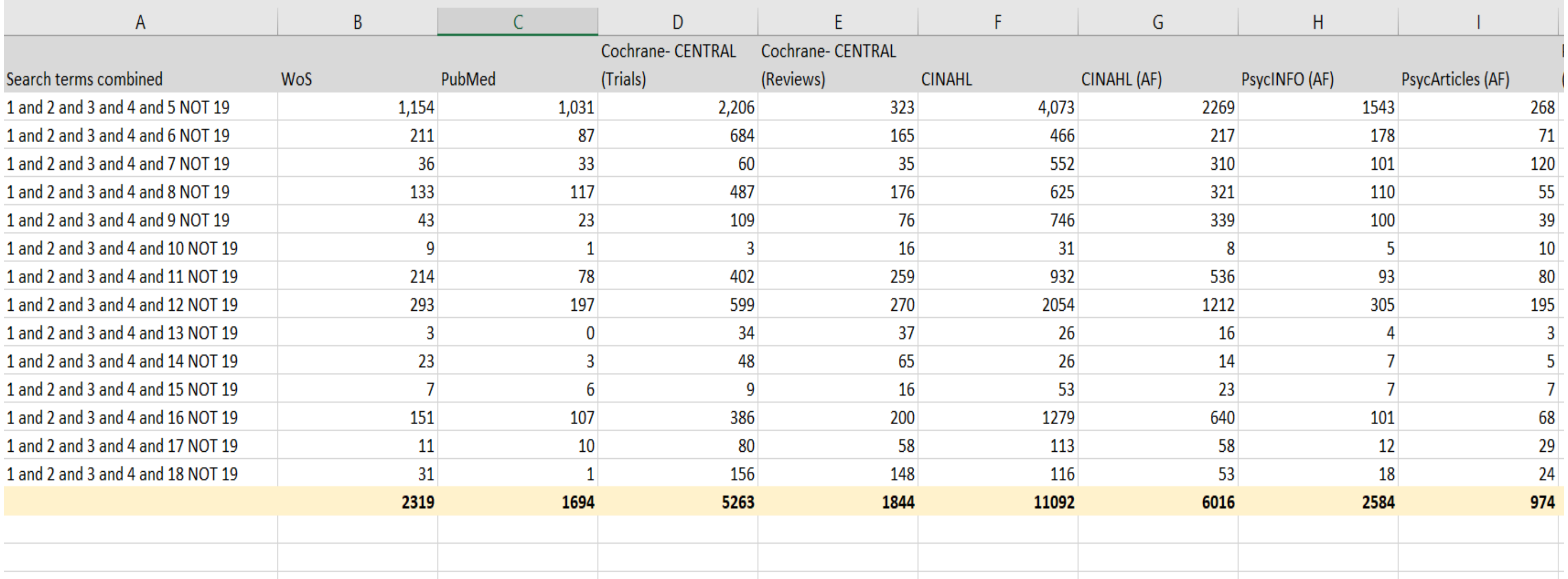
Note: *Refers to the specific NICE guidelines for each respective disorder. Adapted from Clark (2018).

Appendix A1. 2. Search terms used for Web of Science, psycARTICLES, psycINFO and CINAHL Complete



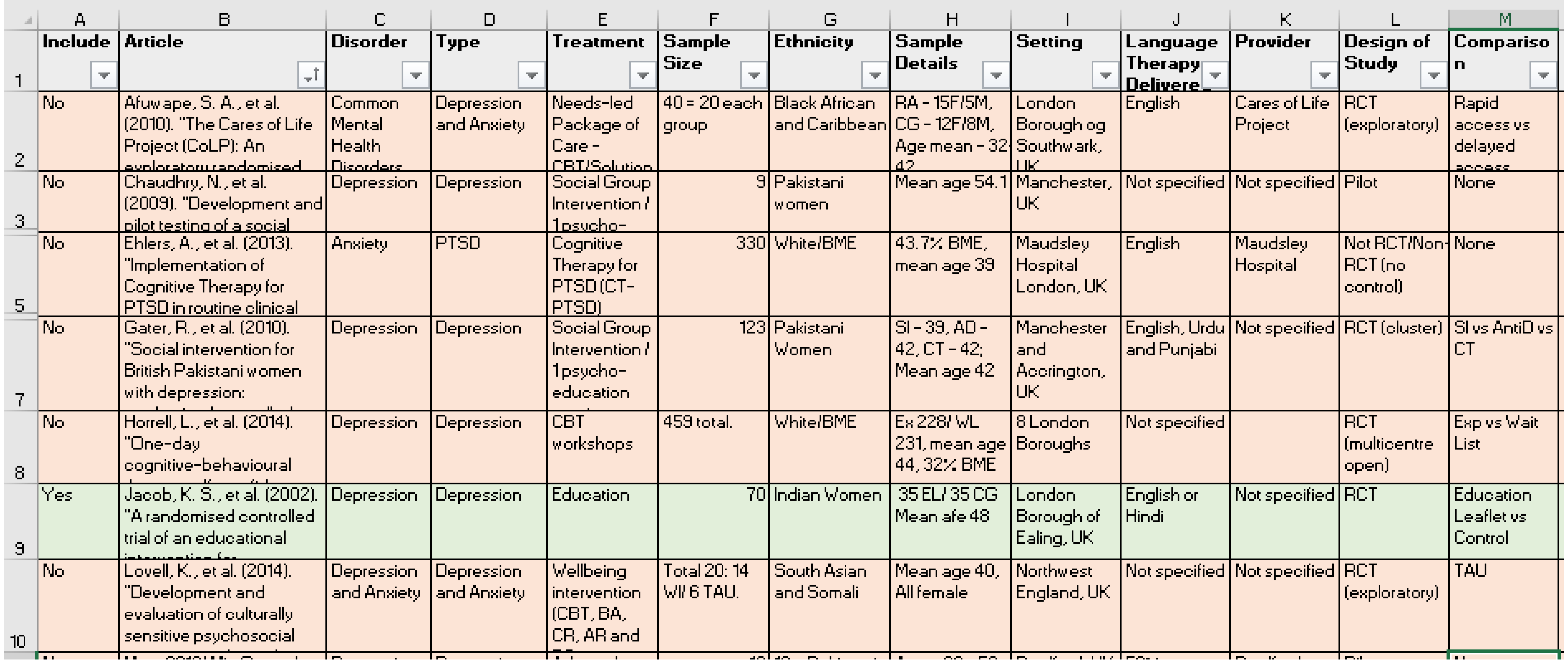
A	B	C	D
#	**Term**	**Search Terms**	**MeSH Terms**
1	Ethnicity & Culture	Black and minority ethnic OR BME OR BAME OR black OR Caribbean* OR Africa* OR Bangladesh* OR Pakistan* OR Sri Lank* OR India* OR Irish OR British OR Scott* OR Irish* OR Chinese OR Asia* OR South Asia* OR mixed race* OR Afro* OR Arab* OR China OR Egypt* OR Gujerat* OR Gujarat* OR Hong Kong OR Islam* OR Iran* OR Malaysia* OR Middle East OR Oriental OR Philippin* OR Singapor* OR Vietnam* OR gypsy OR Irish traveller* OR ethnic* OR migrant* OR minorit* OR diversit* OR cultur* OR intercultural OR cross-cultural OR transcultural OR depriv* OR access OR barrier* OR obstacle* OR equit* OR inequ* OR equal* OR race* OR raci* OR refugee* OR asylum OR asylum seeker OR immigra*	
2	Location	United Kingdom OR UK OR Britain OR England OR Wales OR Scotland OR Northern Ireland)	United Kingdom
3	Clinical Study	clinical study OR clinical trial OR random* control* trial OR RCT OR meta analysis OR systematic OR review* OR multicentre stud* OR random* OR placebo* OR condition* OR control*	Clinical Study
4	Disorders (combined)	common mental health disorder OR mental disorder* OR anxiety OR anxiety disorder* OR depress* OR Depressive disorder OR generalized anxiety disorder OR GAD OR panic disorder OR panic OR fear OR panic attack* OR Obsessive-complusive disorder OR obsessive OR complusive OR hoarding OR OCD OR Post-traumatic stress disorder OR post-traumatic OR PTSD OR trauma OR social phobia OR social anxiety	
5	Interventions	Treatment* OR interven* OR therapy OR therapies OR psychotherapy OR cultur* adapted	Psychotherapies
6	Cognitive Behaviour Therapy	Cognitive behaviour* therapy OR CBT OR cognitive therapy OR behaviour therapy	Cognitive therapy
7	Interpersonal Psychotherapy	Interpersonal Psychotherapy OR IPT OR Interpersonal	*None found*
8	Behavioural Therapy	Behaviour* therapy OR BA OR behaviour* activation	Behaviour therapy
9	Counselling	Counselling	Counselling
10	Psychodynamic Therapy	Psychodynamic psychotherapy OR short-term psychodynamic OR brief psychodynamic	Psychodynamic
11	Self-help	self-help group* OR self-help OR individual self-help OR psychoeducational OR guided OR bibliotherapy OR assisted	Self-help groups
12	Computerised Interventions	online self-help OR web-based interventions OR computer* OR internet treatment OR computer-assisted therapy OR computer OR online OR remote OR e-health OR website OR virtual therapist OR cCBT OR computer* CBT	Computer-assisted therapy
13	Applied Relaxation	Applied relaxation OR relaxation therapy	Relaxation therapy
14	Exposure Response Prevention Therapy	Exposure Response Prevention Therapy OR ERP OR implosive therapy OR exposure therapy	Implosive therapy
15	Eye Movement Desensitisation and Reprocessing Therapy	Eye Movement Desensitization Reprocessing therapy OR eye-movement OR EMDR OR desensitization OR reprocessing	Eye Movement Desensitization Reprocessing
16	Exercise	Exercise OR physical activity OR aerobic OR physical fitness OR exercise therapy	Exercise therapy
17	Mindfulness	Mindfulness OR mind-body therapy OR meditation	Mindfulness
18	Couples Therapy	behaviour couples therapy OR couples therapy OR family therapy	Couples tharapy
19	**NOT** terms (exclusion) at title	cancer OR eating OR suicide OR anorexia OR bulim* OR bipolar OR schizophrenia OR personality OR psychosis OR insomnia OR multiple sclerosis OR substance OR pain OR veterans OR diabetes OR child* OR adolescent*OR animal OR infant*	

Appendix A1. 3. Example of search term combinations used across the different databases



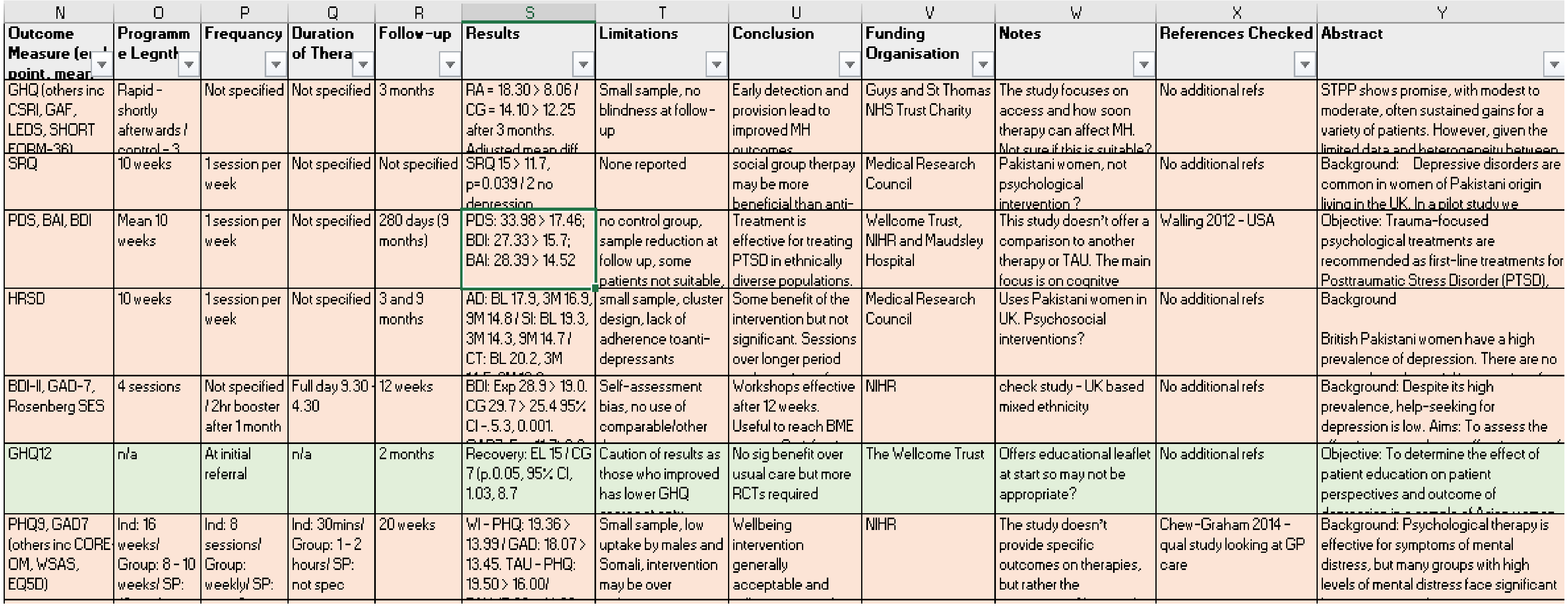
A	B	C	D	E	F	G	H	I
Search terms combined	WoS	PubMed	Cochrane- CENTRAL (Trials)	Cochrane- CENTRAL (Reviews)	CINAHL	CINAHL (AF)	PsycINFO (AF)	PsycArticles (AF)
1 and 2 and 3 and 4 and 5 NOT 19	1,154	1,031	2,206	323	4,073	2269	1543	268
1 and 2 and 3 and 4 and 6 NOT 19	211	87	684	165	466	217	178	71
1 and 2 and 3 and 4 and 7 NOT 19	36	33	60	35	552	310	101	120
1 and 2 and 3 and 4 and 8 NOT 19	133	117	487	176	625	321	110	55
1 and 2 and 3 and 4 and 9 NOT 19	43	23	109	76	746	339	100	39
1 and 2 and 3 and 4 and 10 NOT 19	9	1	3	16	31	8	5	10
1 and 2 and 3 and 4 and 11 NOT 19	214	78	402	259	932	536	93	80
1 and 2 and 3 and 4 and 12 NOT 19	293	197	599	270	2054	1212	305	195
1 and 2 and 3 and 4 and 13 NOT 19	3	0	34	37	26	16	4	3
1 and 2 and 3 and 4 and 14 NOT 19	23	3	48	65	26	14	7	5
1 and 2 and 3 and 4 and 15 NOT 19	7	6	9	16	53	23	7	7
1 and 2 and 3 and 4 and 16 NOT 19	151	107	386	200	1279	640	101	68
1 and 2 and 3 and 4 and 17 NOT 19	11	10	80	58	113	58	12	29
1 and 2 and 3 and 4 and 18 NOT 19	31	1	156	148	116	53	18	24
	2319	**1694**	**5263**	**1844**	**11092**	**6016**	**2584**	**974**

Appendix A1. 4. Example of data extraction form created to record study characteristics



	A	B	C	D	E	F	G	H	I	J	K	L	M
1	**Include**	**Article**	**Disorder**	**Type**	**Treatment**	**Sample Size**	**Ethnicity**	**Sample Details**	**Setting**	**Language Therapy Delivere**	**Provider**	**Design of Study**	**Comparison**
2	No	Afuwape, S. A., et al. (2010). "The Cares of Life Project (CoLP): An exploratory randomised	Common Mental Health Disorders	Depression and Anxiety	Needs-led Package of Care - CBT/Solution	40 = 20 each group	Black African and Caribbean	RA - 15F/5M, CG - 12F/8M, Age mean - 32-42	London Borough og Southwark, UK	English	Cares of Life Project	RCT (exploratory)	Rapid access vs delayed access
3	No	Chaudhry, N., et al. (2009). "Development and pilot testing of a social	Depression	Depression	Social Group Intervention / 1 psycho-	9	Pakistani women	Mean age 54.1	Manchester, UK	Not specified	Not specified	Pilot	None
5	No	Ehlers, A., et al. (2013). "Implementation of Cognitive Therapy for PTSD in routine clinical	Anxiety	PTSD	Cognitive Therapy for PTSD (CT-PTSD)	330	White/BME	43.7% BME, mean age 39	Maudsley Hospital London, UK	English	Maudsley Hospital	Not RCT/Non-RCT (no control)	None
7	No	Gater, R., et al. (2010). "Social intervention for British Pakistani women with depression:	Depression	Depression	Social Group Intervention / 1 psycho-education	123	Pakistani Women	SI - 39, AD - 42, CT - 42; Mean age 42	Manchester and Accrington, UK	English, Urdu and Punjabi	Not specified	RCT (cluster)	SI vs AntiD vs CT
8	No	Horrell, L., et al. (2014). "One-day cognitive-behavioural	Depression	Depression	CBT workshops	459 total.	White/BME	Ex 228/ WL 231, mean age 44, 32% BME	8 London Boroughs	Not specified		RCT (multicentre open)	Exp vs Wait List
9	Yes	Jacob, K. S., et al. (2002). "A randomised controlled trial of an educational	Depression	Depression	Education	70	Indian Women	35 EL/ 35 CG Mean afe 48	London Borough of Ealing, UK	English or Hindi	Not specified	RCT	Education Leaflet vs Control
10	No	Lovell, K., et al. (2014). "Development and evaluation of culturally sensitive psychosocial	Depression and Anxiety	Depression and Anxiety	Wellbeing intervention (CBT, BA, CR, AR and	Total 20: 14 WI/ 6 TAU.	South Asian and Somali	Mean age 40, All female	Northwest England, UK	Not specified	Not specified	RCT (exploratory)	TAU

(Cont.)



N	O	P	Q	R	S	T	U	V	W	X	Y
Outcome Measure (e point, mea	**Programme Legnt**	**Frequancy**	**Duration of Thera**	**Follow-up**	**Results**	**Limitations**	**Conclusion**	**Funding Organisation**	**Notes**	**References Checked**	**Abstract**
GHQ (others inc CSRI, GAF, LEDS, SHORT FORM-36)	Rapid - shortly afterwards / control - 3	Not specified	Not specified	3 months	RA = 18.30 > 8.06 / CG = 14.10 > 12.25 after 3 months. Adjusted mean diff	Small sample, no blindness at follow-up	Early detection and provision lead to improved MH outcomes	Guys and St Thomas NHS Trust Charity	The study focuses on access and how soon therapy can affect MH. Not sure if this is suitable?	No additional refs	STPP shows promise, with modest to moderate, often sustained gains for a variety of patients. However, given the limited data and heterogeneity between
SRQ	10 weeks	1 session per week	Not specified	Not specified	SRQ 15 > 11.7, p=0.039 / 2 no depression	None reported	social group therpay may be more beneficial than anti-	Medical Research Council	Pakistani women, not psychological intervention ?	No additional refs	Background: Depressive disorders are common in women of Pakistani origin living in the UK. In a pilot study we
PDS, BAI, BDI	Mean 10 weeks	1 session per week	Not specified	280 days (9 months)	PDS: 33.98 > 17.46; BDI: 27.33 > 15.7; BAI: 28.39 > 14.52	no control group, sample reduction at follow up, some patients not suitable,	Treatment is effective for treating PTSD in ethnically diverse populations.	Wellcome Trust, NIHR and Maudsley Hospital	This study doesn't offer a comparison to another therapy or TAU. The main focus is on cognitve	Walling 2012 - USA	Objective: Trauma-focused psychological treatments are recommended as first-line treatments for Posttraumatic Stress Disorder (PTSD),
HRSD	10 weeks	1 session per week	Not specified	3 and 9 months	AD: BL 17.9, 3M 16.9, 9M 14.8 / SI: BL 19.3, 3M 14.3, 9M 14.7 / CT: BL 20.2, 3M	small sample, cluster design, lack of adherence toanti-depressants	Some benefit of the intervention but not significant. Sessions over longer period	Medical Research Council	Uses Pakistani women in UK. Psychosocial interventions?	No additional refs	Background British Pakistani women have a high prevalence of depression. There are no
BDI-II, GAD-7, Rosenberg SES	4 sessions	Not specified / 2hr booster after 1 month	Full day 9.30 - 4.30	12 weeks	BDI: Exp 28.9 > 19.0. CG 29.7 > 25.4 95% CI -.5.3, 0.001.	Self-assessment bias, no use of comparable/other	Workshops effective after 12 weeks. Useful to reach BME	NIHR	check study - UK based mixed ethnicity	No additional refs	Background: Despite its high prevalence, help-seeking for depression is low. Aims: To assess the
GHQ12	n/a	At initial referral	n/a	2 months	Recovery: EL 15 / CG 7 (p.0.05, 95% CI, 1.03, 8.7	Caution of results as those who improved has lower GHQ	No sig benefit over usual care but more RCTs required	The Wellcome Trust	Offers educational leaflet at start so may not be appropriate?	No additional refs	Objective: To determine the effect of patient education on patient perspectives and outcome of
PHQ9, GAD7 (others inc CORE-OM, WSAS, EQ5D)	Ind: 16 weeks/ Group: 8 - 10 weeks/ SP:	Ind: 8 sessions/ Group: weekly/ SP:	Ind: 30mins/ Group: 1 - 2 hours/ SP: not spec	20 weeks	WI - PHQ: 19.36 > 13.99 / GAD: 18.07 > 13.45. TAU - PHQ: 19.50 > 16.00/	Small sample, low uptake by males and Somali, intervention may be over	Wellbeing intervention generally acceptable and	NIHR	The study doesn't provide specific outcomes on therapies, but rather the	Chew-Graham 2014 - qual study looking at GP care	Background: Psychological therapy is effective for symptoms of mental distress, but many groups with high levels of mental distress face significant

Appendices B

Appendix B.1 1. Preliminary notes taken during phase one of service user interviews (study two)

“Service users heavily discuss the influence of their family on their therapeutic experience, this is particularly evident between younger service users and older family members”

“Lack of understanding of mental health disorders is evident. Service users struggle to explain disorders as they do not exist in their culture”

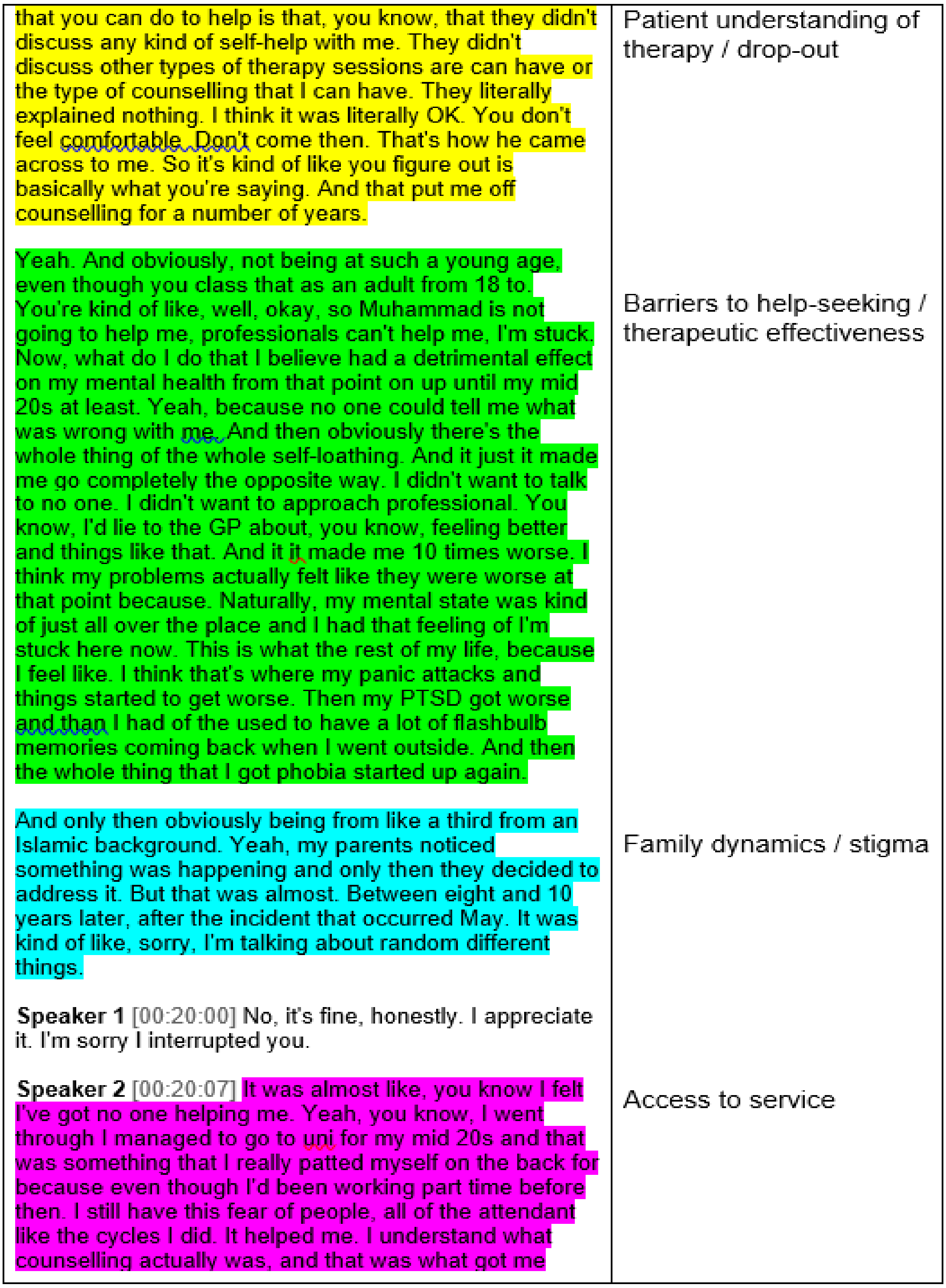
“There is clear evidence of mental health stigma and guilt attached to seeking therapy. Service users worry that they are letting down their family and unable to cope in accordance to how they’ve been taught / brought up within their culture”

“British born service users discuss the cultural dissonance they experience between their collectivist identity (the need to be interdependent) and their Western individualistic identity (the need to be independent) resulting in cultural clash. This has an effect on their mental wellbeing and therapeutic engagement”

“Overall service users appear to find therapy useful to some extent but there are cultural challenges that are not addressed in therapy. Service users don’t feel as though they are free from their worries but value talking to a therapist”

Box B.1. Example of preliminary notes taken during the data familiarisation phase.

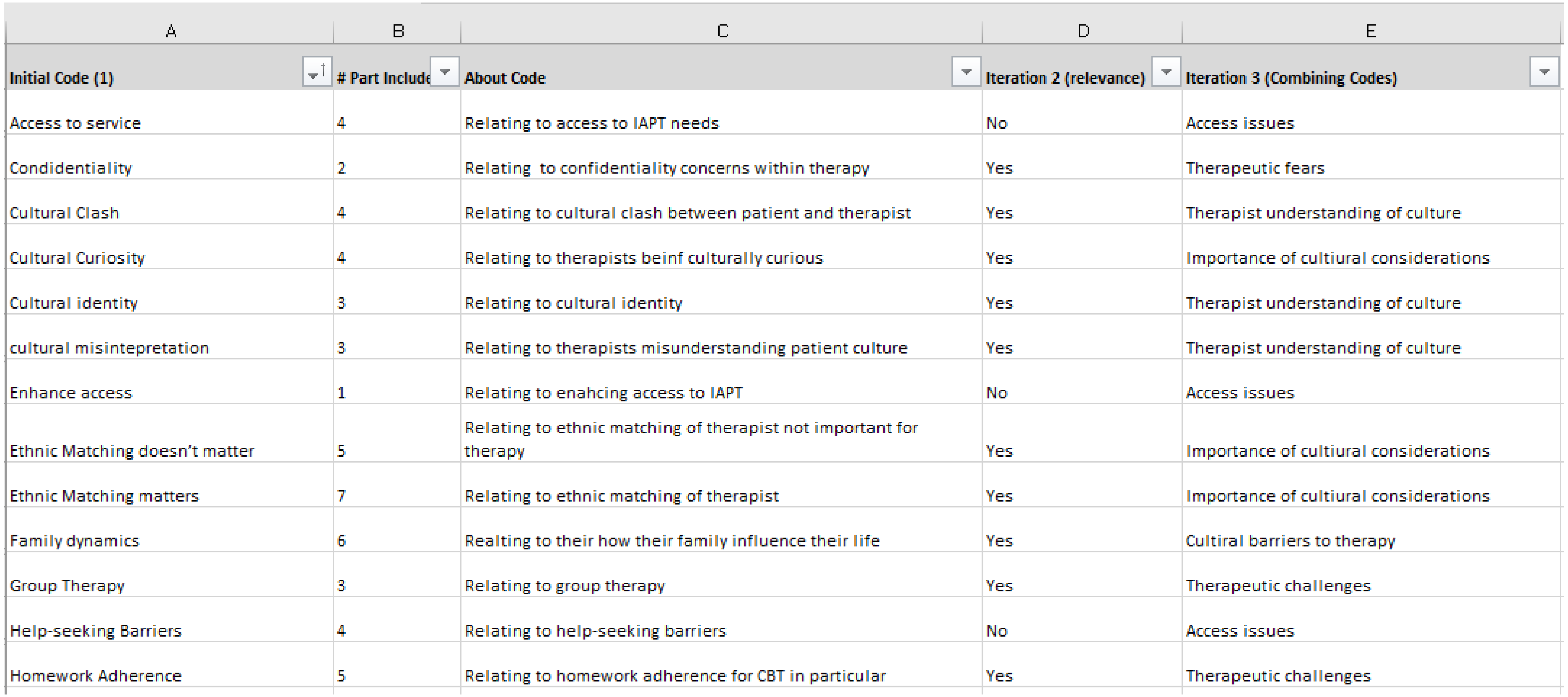
Appendix B.1 2. Extract of preliminary coding for phase two of service user interviews (study two)



that you can do to help is that, you know, that they didn't discuss any kind of self-help with me. They didn't discuss other types of therapy sessions are can have or the type of counselling that I can have. They literally explained nothing. I think it was literally OK. You don't feel comfortable. Don't come then. That's how he came across to me. So it's kind of like you figure out is basically what you're saying. And that put me off counselling for a number of years.	Patient understanding of therapy / drop-out
Yeah. And obviously, not being at such a young age, even though you class that as an adult from 18 to. You're kind of like, well, okay, so Muhammad is not going to help me, professionals can't help me, I'm stuck. Now, what do I do that I believe had a detrimental effect on my mental health from that point on up until my mid 20s at least. Yeah, because no one could tell me what was wrong with me. And then obviously there's the whole thing of the whole self-loathing. And it just it made me go completely the opposite way. I didn't want to talk to no one. I didn't want to approach professional. You know, I'd lie to the GP about, you know, feeling better and things like that. And it it made me 10 times worse. I think my problems actually felt like they were worse at that point because. Naturally, my mental state was kind of just all over the place and I had that feeling of I'm stuck here now. This is what the rest of my life, because I feel like. I think that's where my panic attacks and things started to get worse. Then my PTSD got worse and than I had of the used to have a lot of flashbulb memories coming back when I went outside. And then the whole thing that I got phobia started up again.	Barriers to help-seeking / therapeutic effectiveness
And only then obviously being from like a third from an Islamic background. Yeah, my parents noticed something was happening and only then they decided to address it. But that was almost. Between eight and 10 years later, after the incident that occurred May. It was kind of like, sorry, I'm talking about random different things.	Family dynamics / stigma
Speaker 1 [00:20:00] No, it's fine, honestly. I appreciate it. I'm sorry I interrupted you.	
Speaker 2 [00:20:07] It was almost like, you know I felt I've got no one helping me. Yeah, you know, I went through I managed to go to uni for my mid 20s and that was something that I really patted myself on the back for because even though I'd been working part time before then. I still have this fear of people, all of the attendant like the cycles I did. It helped me. I understand what counselling actually was, and that was what got me	Access to service

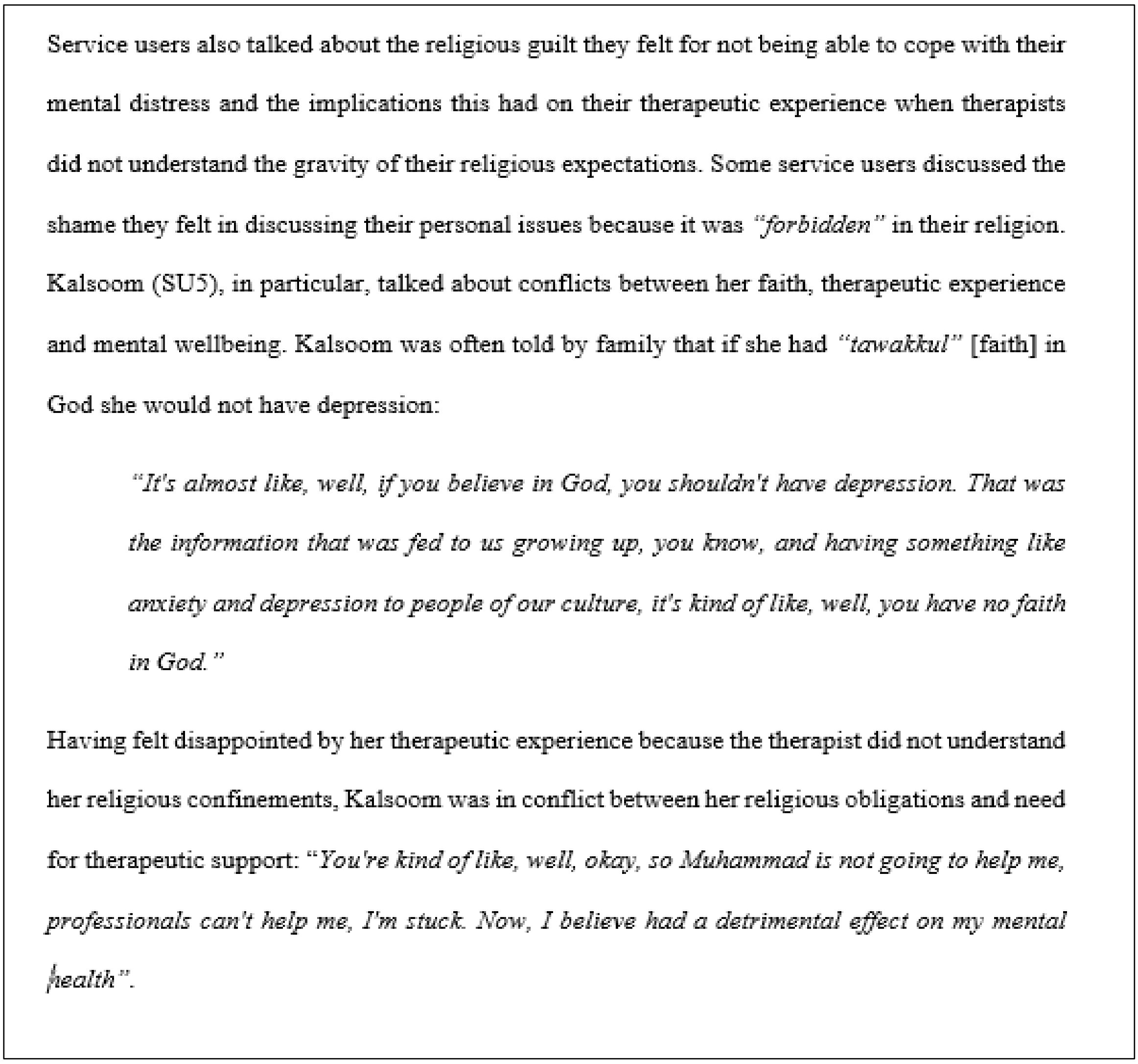
Box B.2. Example of extract of preliminary coding during phase two.

Appendix B.1 3. Expert of spreadsheet tracking code changes for phase three of service user interviews (study two)



Initial Code (1)	# Part Include	About Code	Iteration 2 (relevance)	Iteration 3 (Combining Codes)
Access to service	4	Relating to access to IAPT needs	No	Access issues
Condidentiality	2	Relating to confidentiality concerns within therapy	Yes	Therapeutic fears
Cultural Clash	4	Relating to cultural clash between patient and therapist	Yes	Therapist understanding of culture
Cultural Curiosity	4	Relating to therapists beinf culturally curious	Yes	Importance of cultiural considerations
Cultural identity	3	Relating to cultural identity	Yes	Therapist understanding of culture
cultural misintepretation	3	Relating to therapists misunderstanding patient culture	Yes	Therapist understanding of culture
Enhance access	1	Relating to enahcing access to IAPT	No	Access issues
Ethnic Matching doesn’t matter	5	Relating to ethnic matching of therapist not important for therapy	Yes	Importance of cultiural considerations
Ethnic Matching matters	7	Relating to ethnic matching of therapist	Yes	Importance of cultiural considerations
Family dynamics	6	Realting to their how their family influence their life	Yes	Cultiral barriers to therapy
Group Therapy	3	Relating to group therapy	Yes	Therapeutic challenges
Help-seeking Barriers	4	Relating to help-seeking barriers	No	Access issues
Homework Adherence	5	Relating to homework adherence for CBT in particular	Yes	Therapeutic challenges

Appendix B.1 4. Example of data extract reported for phase five of service user interviews (study two)



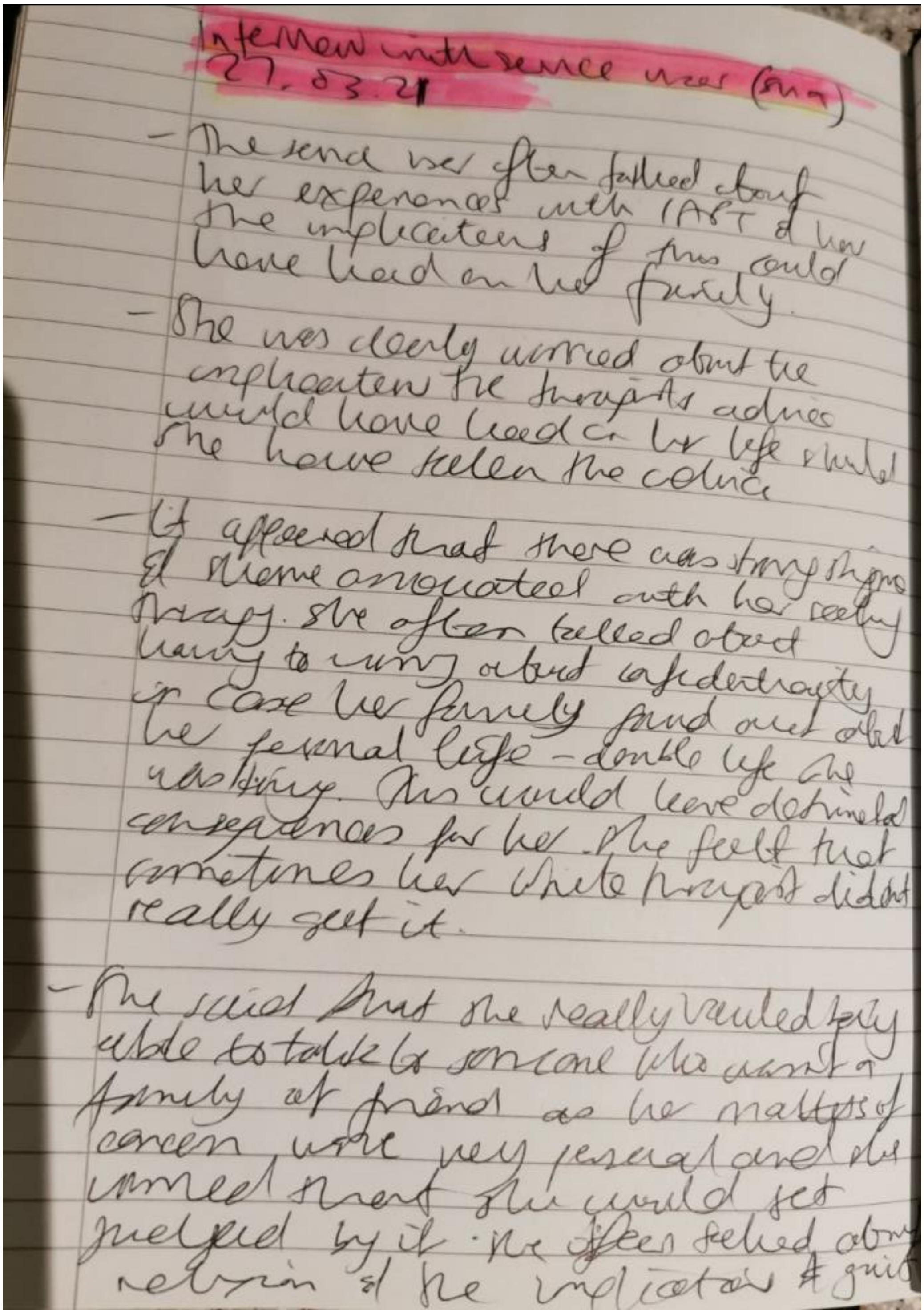
Service users also talked about the religious guilt they felt for not being able to cope with their mental distress and the implications this had on their therapeutic experience when therapists did not understand the gravity of their religious expectations. Some service users discussed the shame they felt in discussing their personal issues because it was *"forbidden"* in their religion. Kalsoom (SU5), in particular, talked about conflicts between her faith, therapeutic experience and mental wellbeing. Kalsoom was often told by family that if she had *"tawakkul"* [faith] in God she would not have depression:

> *"It's almost like, well, if you believe in God, you shouldn't have depression. That was the information that was fed to us growing up, you know, and having something like anxiety and depression to people of our culture, it's kind of like, well, you have no faith in God."*

Having felt disappointed by her therapeutic experience because the therapist did not understand her religious confinements, Kalsoom was in conflict between her religious obligations and need for therapeutic support: "*You're kind of like, well, okay, so Muhammad is not going to help me, professionals can't help me, I'm stuck. Now, I believe had a detrimental effect on my mental health"*.

Box B.3. Example of data extract reported

Appendix B.1 5. Extract of reflective diary for phase six of service user interviews (study two)



Interview with service user (SU7)
27.03.21

- The service user often talked about her experiences with IAPT & how the implications of this could have had on her family.
- She was clearly worried about the implication the therapists advice would have had on her life & should she have taken the advice
- It appeared that there was strong stigma & shame associated with her seeking therapy. She often talked about having to worry about confidentiality in case her family found out about her personal life - double life she was living. This would have detrimental consequences for her. She felt that sometimes her White therapist didn't really get it.
- She said that she really wanted to be able to talk to someone who wasn't a family or friend as her matters of concern were very personal and she worried that she would get judged by it. She often talked about religion & the implications & guilt

Appendix B.2 1. Preliminary notes taken during phase one of mental health practitioner interviews (study three)

“BAME therapists often felt frustrated that they were having to take on the workload for BAME service users and this was not equally shared amongst their White colleagues. The word ‘burnout’ was mentioned a few times”

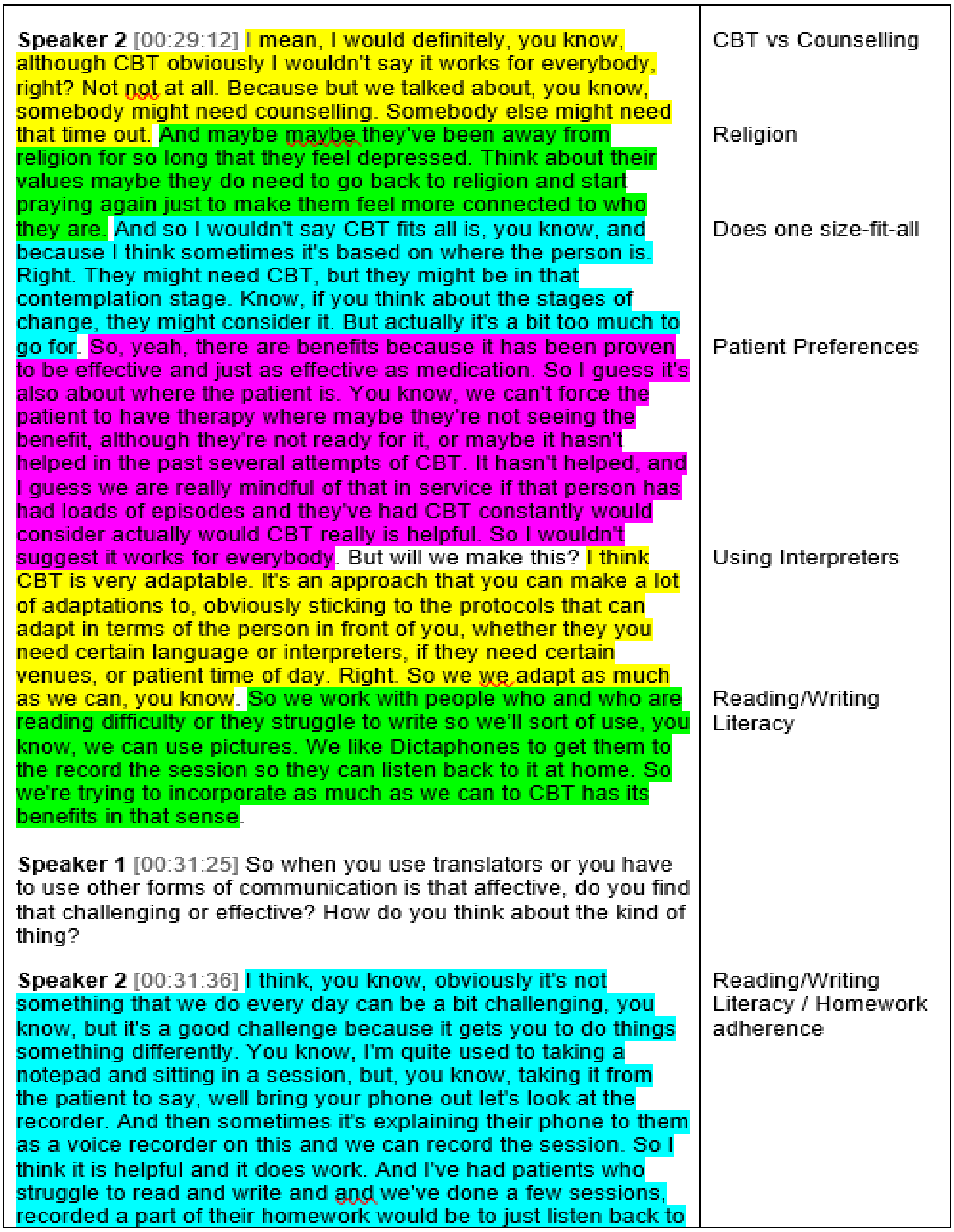
“There was distinct lack of understanding on therapies which meant that a number of sessions were spent to psychoeducate service users. This took up a number of sessions and was quite challenging for the therapist as they couldn’t start therapy”

“Therapists found that family dynamics played a grave role in the lives of BAME service users which made it challenging them to deliver therapy and get service users to do homework”

“Therapists raised concerns about service targets and demands which meant that therapy sessions were too short or not enough time for them to explore culture. Therapists sometimes worried that this wasn’t effective as service users often found therapy rigid and robotic”

Box B.4. Example of preliminary notes taken during the data familiarisation phase.

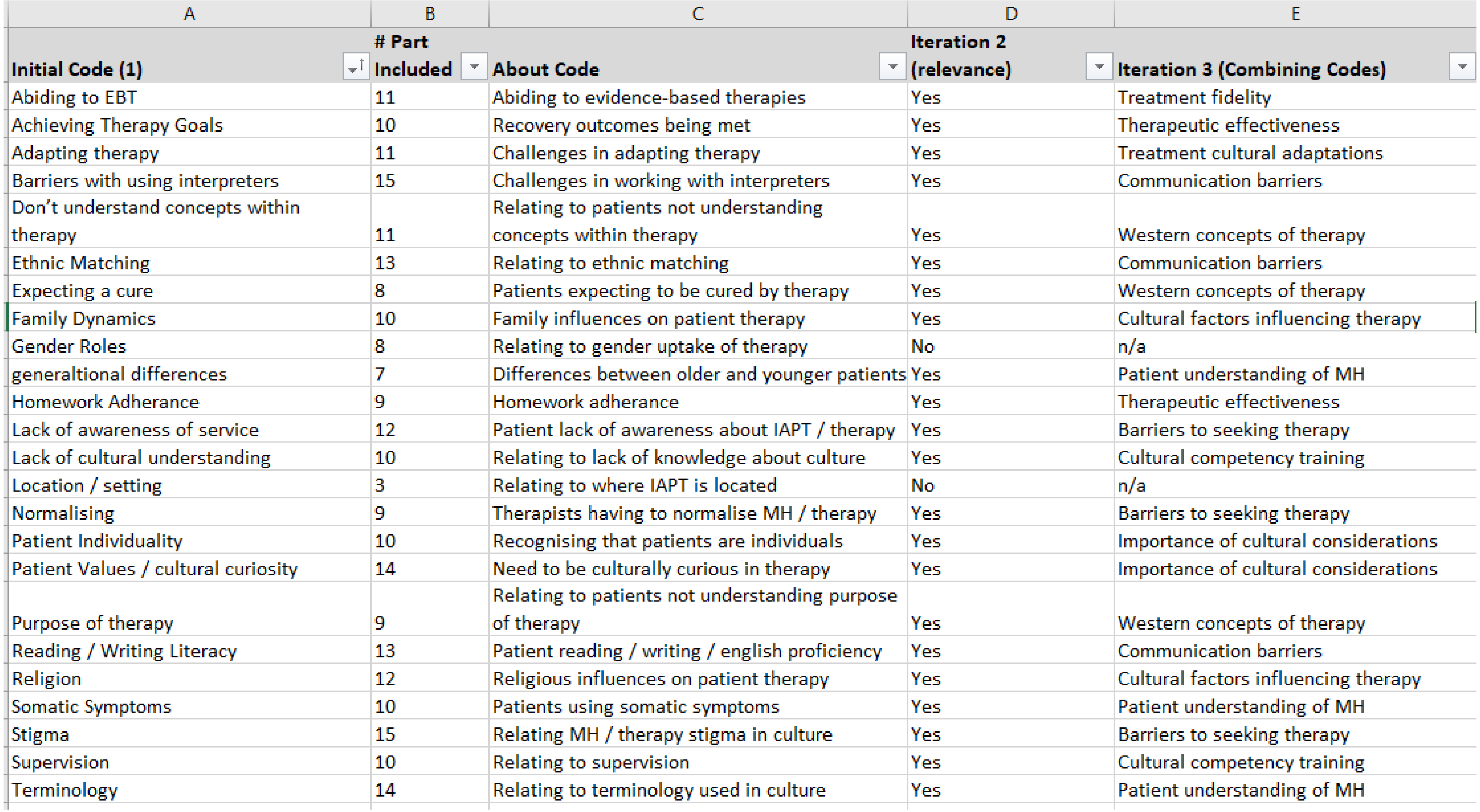
Appendix B.2 2. Extract of preliminary coding for phase two of mental health practitioner interviews (study three)



Speaker 2 [00:29:12] I mean, I would definitely, you know, although CBT obviously I wouldn't say it works for everybody, right? Not not at all. Because but we talked about, you know, somebody might need counselling. Somebody else might need that time out.	CBT vs Counselling
And maybe maybe they've been away from religion for so long that they feel depressed. Think about their values maybe they do need to go back to religion and start praying again just to make them feel more connected to who they are.	Religion
And so I wouldn't say CBT fits all is, you know, and because I think sometimes it's based on where the person is. Right. They might need CBT, but they might be in that contemplation stage. Know, if you think about the stages of change, they might consider it. But actually it's a bit too much to go for.	Does one size-fit-all
So, yeah, there are benefits because it has been proven to be effective and just as effective as medication. So I guess it's also about where the patient is. You know, we can't force the patient to have therapy where maybe they're not seeing the benefit, although they're not ready for it, or maybe it hasn't helped in the past several attempts of CBT. It hasn't helped, and I guess we are really mindful of that in service if that person has had loads of episodes and they've had CBT constantly would consider actually would CBT really is helpful. So I wouldn't suggest it works for everybody.	Patient Preferences
But will we make this? I think CBT is very adaptable. It's an approach that you can make a lot of adaptations to, obviously sticking to the protocols that can adapt in terms of the person in front of you, whether they you need certain language or interpreters, if they need certain venues, or patient time of day. Right. So we we adapt as much as we can, you know.	Using Interpreters
So we work with people who and who are reading difficulty or they struggle to write so we'll sort of use, you know, we can use pictures. We like Dictaphones to get them to the record the session so they can listen back to it at home. So we're trying to incorporate as much as we can to CBT has its benefits in that sense.	Reading/Writing Literacy
Speaker 1 [00:31:25] So when you use translators or you have to use other forms of communication is that affective, do you find that challenging or effective? How do you think about the kind of thing?	
Speaker 2 [00:31:36] I think, you know, obviously it's not something that we do every day can be a bit challenging, you know, but it's a good challenge because it gets you to do things something differently. You know, I'm quite used to taking a notepad and sitting in a session, but, you know, taking it from the patient to say, well bring your phone out let's look at the recorder. And then sometimes it's explaining their phone to them as a voice recorder on this and we can record the session. So I think it is helpful and it does work. And I've had patients who struggle to read and write and and we've done a few sessions, recorded a part of their homework would be to just listen back to	Reading/Writing Literacy / Homework adherence

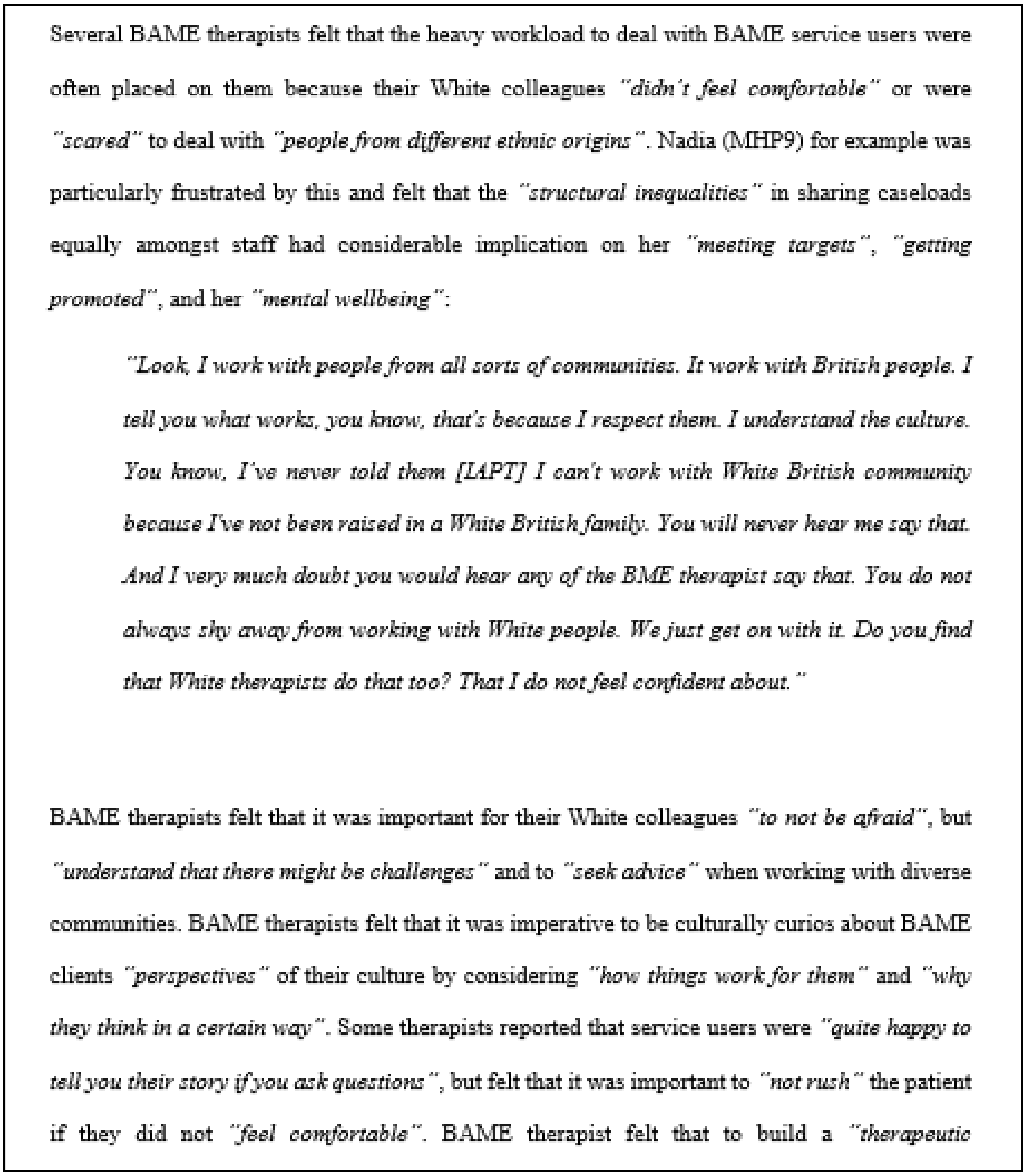
Box B.5. Example of extract of preliminary coding during phase two.

Appendix B.2 3. Expert of spreadsheet tracking code changes for phase three of mental health practitioner interviews (study three)



A	B	C	D	E
Initial Code (1)	**# Part Included**	**About Code**	**Iteration 2 (relevance)**	**Iteration 3 (Combining Codes)**
Abiding to EBT	11	Abiding to evidence-based therapies	Yes	Treatment fidelity
Achieving Therapy Goals	10	Recovery outcomes being met	Yes	Therapeutic effectiveness
Adapting therapy	11	Challenges in adapting therapy	Yes	Treatment cultural adaptations
Barriers with using interpreters	15	Challenges in working with interpreters	Yes	Communication barriers
Don't understand concepts within therapy	11	Relating to patients not understanding concepts within therapy	Yes	Western concepts of therapy
Ethnic Matching	13	Relating to ethnic matching	Yes	Communication barriers
Expecting a cure	8	Patients expecting to be cured by therapy	Yes	Western concepts of therapy
Family Dynamics	10	Family influences on patient therapy	Yes	Cultural factors influencing therapy
Gender Roles	8	Relating to gender uptake of therapy	No	n/a
generaltional differences	7	Differences between older and younger patients	Yes	Patient understanding of MH
Homework Adherance	9	Homework adherance	Yes	Therapeutic effectiveness
Lack of awareness of service	12	Patient lack of awareness about IAPT / therapy	Yes	Barriers to seeking therapy
Lack of cultural understanding	10	Relating to lack of knowledge about culture	Yes	Cultural competency training
Location / setting	3	Relating to where IAPT is located	No	n/a
Normalising	9	Therapists having to normalise MH / therapy	Yes	Barriers to seeking therapy
Patient Individuality	10	Recognising that patients are individuals	Yes	Importance of cultural considerations
Patient Values / cultural curiosity	14	Need to be culturally curious in therapy	Yes	Importance of cultural considerations
Purpose of therapy	9	Relating to patients not understanding purpose of therapy	Yes	Western concepts of therapy
Reading / Writing Literacy	13	Patient reading / writing / english proficiency	Yes	Communication barriers
Religion	12	Religious influences on patient therapy	Yes	Cultural factors influencing therapy
Somatic Symptoms	10	Patients using somatic symptoms	Yes	Patient understanding of MH
Stigma	15	Relating MH / therapy stigma in culture	Yes	Barriers to seeking therapy
Supervision	10	Relating to supervision	Yes	Cultural competency training
Terminology	14	Relating to terminology used in culture	Yes	Patient understanding of MH

Appendix B.2 4. Example of data extract reported for phase five of mental health practitioner interviews (study three)



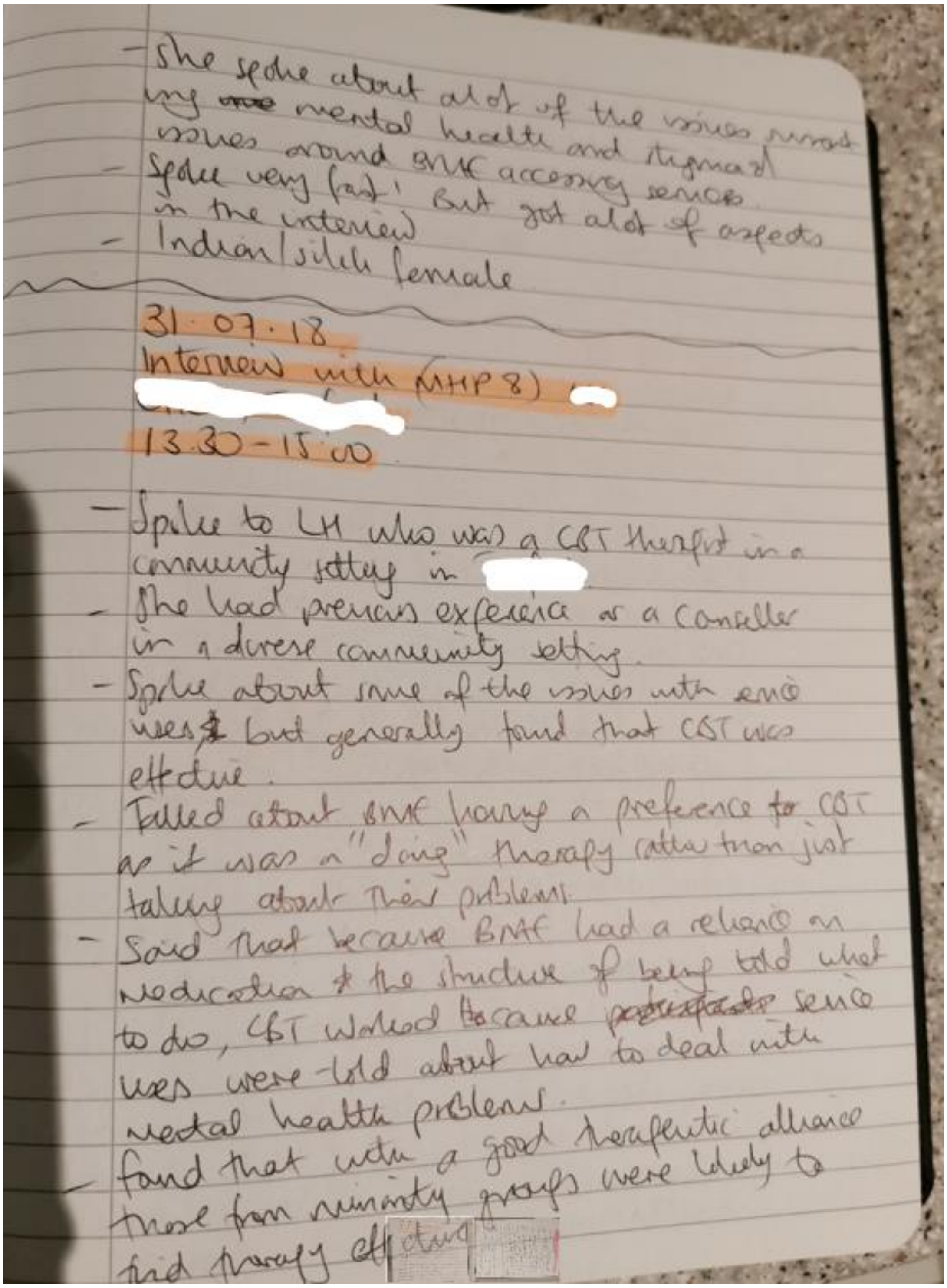
Several BAME therapists felt that the heavy workload to deal with BAME service users were often placed on them because their White colleagues *"didn't feel comfortable"* or were *"scared"* to deal with *"people from different ethnic origins"*. Nadia (MHP9) for example was particularly frustrated by this and felt that the *"structural inequalities"* in sharing caseloads equally amongst staff had considerable implication on her *"meeting targets"*, *"getting promoted"*, and her *"mental wellbeing"*:

> *"Look, I work with people from all sorts of communities. It work with British people. I tell you what works, you know, that's because I respect them. I understand the culture. You know, I've never told them [IAPT] I can't work with White British community because I've not been raised in a White British family. You will never hear me say that. And I very much doubt you would hear any of the BME therapist say that. You do not always shy away from working with White people. We just get on with it. Do you find that White therapists do that too? That I do not feel confident about."*

BAME therapists felt that it was important for their White colleagues *"to not be afraid"*, but *"understand that there might be challenges"* and to *"seek advice"* when working with diverse communities. BAME therapists felt that it was imperative to be culturally curios about BAME clients *"perspectives"* of their culture by considering *"how things work for them"* and *"why they think in a certain way"*. Some therapists reported that service users were *"quite happy to tell you their story if you ask questions"*, but felt that it was important to *"not rush"* the patient if they did not *"feel comfortable"*. BAME therapist felt that to build a *"therapeutic*

Box B.6. Example of data extract reported

Appendix B.2 5. Extract of reflective diary for phase six of mental health practitioner interviews (study three)



- She spoke about alot of the issues surrounding ~~one~~ mental health and stigma and issues around BME accessing services.
- Spoke very fast! But got alot of aspects in the interview
- Indian/Sikh female

31.07.18
Interview with (MHP 8) [redacted]
[redacted]
13.30 - 15:00

- Spoke to LH who was a CBT therapist in a community setting in [redacted].
- She had previous experience as a Counsellor in a diverse community setting.
- Spoke about some of the issues with service users but generally found that CBT was effective.
- Talked about BME having a preference for CBT as it was a "doing" therapy rather than just talking about their problems.
- Said that because BME had a reliance on medication & the structure of being told what to do, CBT worked because ~~participants~~ service users were told about how to deal with mental health problems.
- found that with a good therapeutic alliance those from minority groups were likely to find therapy effective

Appendix B.3 1. Recruitment poster for service users interviews (study two)

Have you received psychological treatment from Improving Access to Psychological Therapies (IAPT) Service?

Are you someone from a Black, Asian and Minority Ethnic (BAME) group?

If so, we are looking for participants to take part in our research!

Why?

To explore what kind of psychological therapies you consider acceptable and suitable to your needs. This will help mental health services to develop and offer more effective therapies in the future.

What will I need to do?

Take part in an interview with the research team to talk about your experiences of receiving therapies and discuss what improvements can be made.

Interested in taking part?

Please contact Afsana Faheem (Researcher) for more information!

Email: afsana.faheem@mail.bcu.ac.uk

thank you!

BIRMINGHAM CITY
University

v.2 23.01.21

Appendix B.4. 1. Recruitment poster for mental health practitioner interviews (study three)

Are you a mental health professional working at an Improving Access to Psychological Therapies (IAPT) Service?

Have you delivered psychological therapies to individuals from Black and Minority Ethnic (BME) groups?

If so, we are looking for participants to take part in our research!

Why?

To explore the experiences and perspectives of mental health professionals delivering therapies to BME groups. This will help mental health services to develop and offer more effective therapies in the future.

What will I need to do?

Take part in an interview with the research team to talk about your experiences of delivering psychological therapy and discuss what improvements can be made.

Interested in taking part?

Please contact Afsana Faheem (Researcher) for more information!

Email:
afsana.Faheem@mail.bcu.ac.uk
or leave your name and contact number with Reception – thank you!

BIRMINGHAM CITY
University

Appendices C

Appendix C.1. 1. Assumption Testing for Binary Logistic Regression

Table C.1. *Assumption Testing for Binary Logistic Regression – Categorical Variables*

Assumption	**Details**	**Assumption Status**	**Additional Notes**
Correlations: Multicollinearity	Independent variables should not be too highly correlated Any correlation that is above 0.7 or below -0.7 is highly correlated.	Accepted	No independent variables were correlated more than 0.7 or below -0.7
Outcome Variable	The outcome variable should be categorical and binary	Accepted	Not recovered = 0 / Recovered = 1
Collinearity Diagnostic	Tolerance value below 0.10 indicates high collinearity / VIF (variable inflation factor) > 10 indicates high collinearity	Not Applicable	There were no continuous variables in the regression model so this was not needed.
Mahalanobis: Residual Statistics	Checking for Outliers	Not Applicable	There were no continuous variables in the regression model so this was not needed.
Continuous Variables Related to Log Odds	To check whether continuous variables are related to the log odds	Not Applicable	There were no continuous variables in the regression model so this was not needed.
Sample size	There should be at least 15 samples per predictor	Accepted	See participant information in Chapter 4.

Appendix C.1. 2. Assumption Testing for the MANCOVA

Table C.2. *Assumption Testing for MANCOVA*

Assumption	**Details**	**Assumption Status**	**Additional Notes**
Missing Data	To check for any missing data within the sample	Accepted	There was no missing data in the sample. Treatment adjustments were made based on the type of treatment offered per ethnic group.
Independence of Observations	Observations are independent of one another and sample completely at random	Accepted	Sample meets this assumption
Multivariate Normality	The dependent variables should be normally distributed	Accepted	Although the test of normality is significant for each DV, the central limit theorem is applied and the normality histograms indicate normality.
Outliers	Should be checked and treated for outliers.	Accepted	Outliers were checked. When removed from the data this made no difference to the normality assumption so kept within the sample.
Linearity	Linearity between dependent variables and covariates	Accepted	The scatterplot matrix does not clearly indicate linearity, however, this may be due to the large sample distribution so central limit theorem is applied.
Homogeneity of Variances of Covariance	Check this using the Box’s M test. Significant value suggests violation of assumption	Accepted	Although this assumption was violated due to a significant finding, the central limit theorem is applied due to the large sample and Pillai’s Trace will be used to offer a more conservative interpretation of the results.
Homogeneity of Regression Slopes	The relationship between the covariate and each separate dependent variable, as assessed by the regression slope, is the same in each group of the independent variable. Interaction effects should be non-significant	Accepted	The test for homogeneity of regression slopes assumption was met, overall, for the all two-way and three-way interactions.

Appendices D

Appendix D.1 1. Extract of summary discussion points from individual studies

Table 1. Summary of discussion points from individual articles

Summary of discussion points from individual articles				
Discussion points: Systematic review	*Discussion points:* Study One – Recovery & Treatment effectiveness	*Discussion points:* Study Two – Service user interviews	*Discussion points:* Study Three – Therapists interviews	Preliminary overarching points for integrated discussion
A1. *psychoeducation at early stage* Results showed that the efficacy of psychoeducation at an early stage of referral was more effective in reducing depression when compared to delayed access. Clinical trials have suggested psychoeducation improving mental health outcomes for BAME communities in England (Jacob et al., 2002; Horell et al., 2014).	B1. *Low-intensity as effective as HI* Moreover, aligning with previous studies, no differences were observed between CBT and counselling (Delgadillo & Gonzalez Salas Dubne, 2020; Moller et al., 2019; Pybis et al., 2017). Not only this, but high-intensity treatments did not significantly improve mental health outcomes when compared to low-intensity guided self-help or psychoeducation.	C1. *Importance of psychoeducation* Based on these findings, it was clear that psychoeducation within was imperative, but not only at a personal level, but for the wider community. Previous research has identified that enhancing community awareness of mental health services are crucial to normalise mental health disorders and Western concepts of therapy (Memon et al., 2016). Progressive model by	D1. *Importance of psychoeducation* In line with previous research, there was a distinct lack of awareness of therapy in BAME communities who often questioned the purpose of therapy and were *"expecting a cure"* (Lakeman, 2013). Therapists often found it difficult to navigate between patient therapeutic expectations and the need for them to take control of their lives	ID1. *Importance of psychoeducation* • SR - Psychoeducation useful at early stage • Study 1 - Psychoeducation and guided self-help as efficient as efficient as HI therapies • Study 2 - Patients wanting psychoeducation due to lack of knowledge • Study 3 - Therapists having to spend time psychoeducating so not cost/clinically effective

Appendix D.1 2. Extract of summary disciplinary implications from individual studies

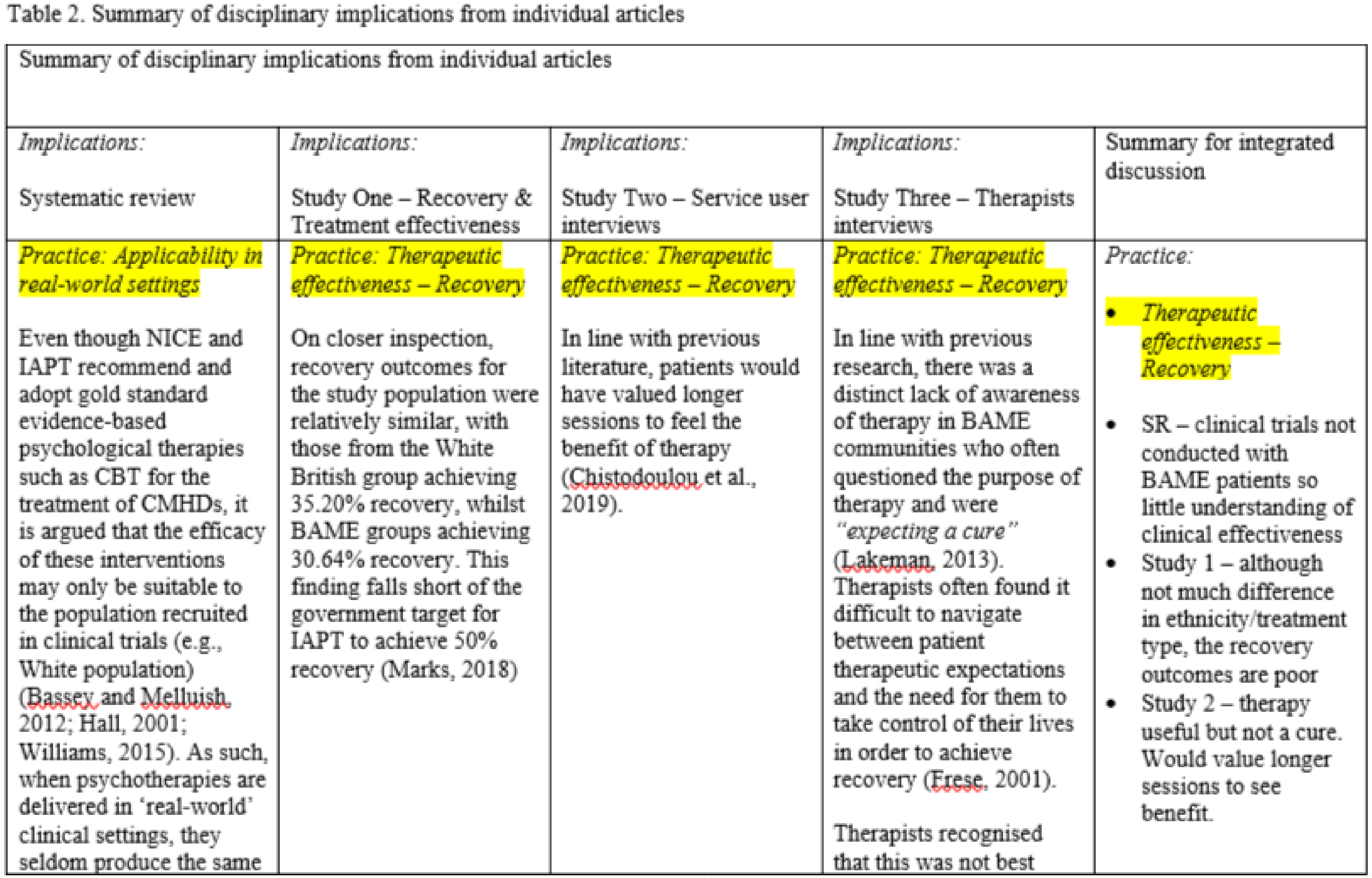
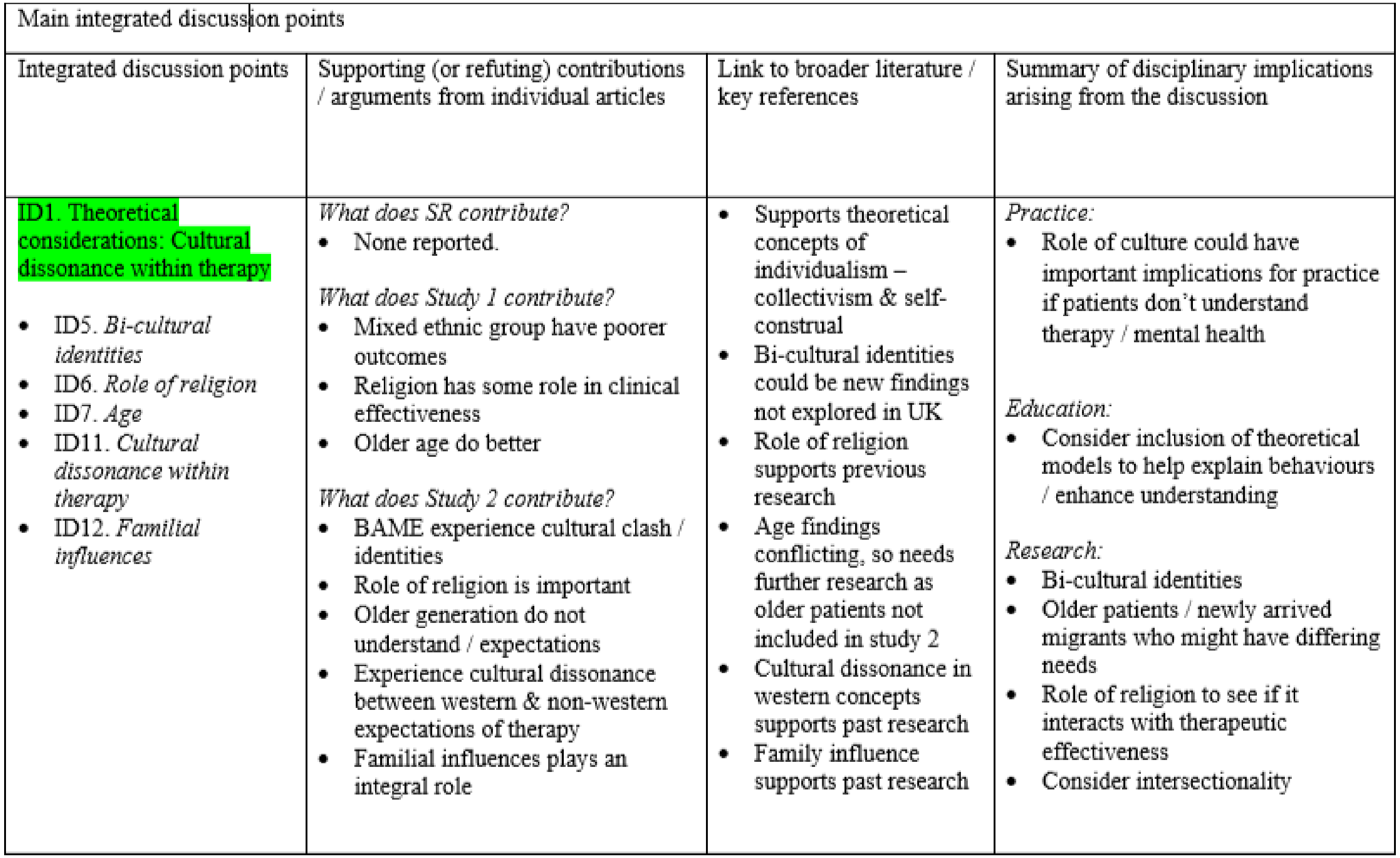


Table 2. Summary of disciplinary implications from individual articles

Summary of disciplinary implications from individual articles				
Implications: Systematic review	*Implications:* Study One – Recovery & Treatment effectiveness	*Implications:* Study Two – Service user interviews	*Implications:* Study Three – Therapists interviews	Summary for integrated discussion
Practice: Applicability in real-world settings Even though NICE and IAPT recommend and adopt gold standard evidence-based psychological therapies such as CBT for the treatment of CMHDs, it is argued that the efficacy of these interventions may only be suitable to the population recruited in clinical trials (e.g., White population) (Bassey and Melluish, 2012; Hall, 2001; Williams, 2015). As such, when psychotherapies are delivered in 'real-world' clinical settings, they seldom produce the same	*Practice: Therapeutic effectiveness – Recovery* On closer inspection, recovery outcomes for the study population were relatively similar, with those from the White British group achieving 35.20% recovery, whilst BAME groups achieving 30.64% recovery. This finding falls short of the government target for IAPT to achieve 50% recovery (Marks, 2018)	*Practice: Therapeutic effectiveness – Recovery* In line with previous literature, patients would have valued longer sessions to feel the benefit of therapy (Chistodoulou et al., 2019).	*Practice: Therapeutic effectiveness – Recovery* In line with previous research, there was a distinct lack of awareness of therapy in BAME communities who often questioned the purpose of therapy and were *"expecting a cure"* (Lakeman, 2013). Therapists often found it difficult to navigate between patient therapeutic expectations and the need for them to take control of their lives in order to achieve recovery (Frese, 2001). Therapists recognised that this was not best	*Practice:* • *Therapeutic effectiveness – Recovery* • SR – clinical trials not conducted with BAME patients so little understanding of clinical effectiveness • Study 1 – although not much difference in ethnicity/treatment type, the recovery outcomes are poor • Study 2 – therapy useful but not a cure. Would value longer sessions to see benefit.

Appendix D.1 3. Extract of integrated discussion points

Table 3. Main integrated discussion points



Main integrated discussion points			
Integrated discussion points	Supporting (or refuting) contributions / arguments from individual articles	Link to broader literature / key references	Summary of disciplinary implications arising from the discussion
ID1. Theoretical considerations: Cultural dissonance within therapy - ID5. *Bi-cultural identities* - ID6. *Role of religion* - ID7. *Age* - ID11. *Cultural dissonance within therapy* - ID12. *Familial influences*	*What does SR contribute?* - None reported. *What does Study 1 contribute?* - Mixed ethnic group have poorer outcomes - Religion has some role in clinical effectiveness - Older age do better *What does Study 2 contribute?* - BAME experience cultural clash / identities - Role of religion is important - Older generation do not understand / expectations - Experience cultural dissonance between western & non-western expectations of therapy - Familial influences plays an integral role	- Supports theoretical concepts of individualism – collectivism & self-construal - Bi-cultural identities could be new findings not explored in UK - Role of religion supports previous research - Age findings conflicting, so needs further research as older patients not included in study 2 - Cultural dissonance in western concepts supports past research - Family influence supports past research	*Practice:* - Role of culture could have important implications for practice if patients don't understand therapy / mental health *Education:* - Consider inclusion of theoretical models to help explain behaviours / enhance understanding *Research:* - Bi-cultural identities - Older patients / newly arrived migrants who might have differing needs - Role of religion to see if it interacts with therapeutic effectiveness - Consider intersectionality

END.