

Beyond the Barriers: South Asian Women's Experience of Accessing and Receiving Psychological Therapy in Primary Care.

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THESIS PORTFOLIO: CANDIDATE DECLARATION

Title of degree programme	Professional Doctorate in Clinical Psychology
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Declaration and signature of candidate
<p>I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.</p> <p>I confirm that the decision to submit this thesis is my own.</p> <p>I confirm that except where explicitly stated, the work has not been submitted for another academic award.</p> <p>I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.</p> <p>Signed:</p> <p></p> <p>Date: 22.07.2019</p>

Disclaimer

The first two papers have been written and referenced using American Psychological Association (APA) referencing style as per the submission guidelines for the proposed journals. The executive summary has also been written using APA referencing for ease of reading a consistent style. Additional material has been included in this thesis, which will be removed from the manuscript prior to submission to the journal for publication.

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Thesis Abstract

This thesis has been written to fulfil the requirements of the University's Doctorate in Clinical Psychology. The thesis contains three papers; a review of the literature to explore the effectiveness and the feasibility of adapting cognitive behavioural therapy (CBT) interventions for Muslim populations, an empirical paper to explore South Asian women's experiences of accessing 'Improving Access to Psychological Therapies' (IAPT) services and an executive summary of the study.

Paper one provides an overview of the literature that explores the feasibility of adapting CBT interventions for Muslim groups with various mental health difficulties. Qualitative, quantitative and mixed methods papers were included for review. Eight papers were reviewed in total. These studies were critically appraised, and the findings synthesised. Religiously adapted CBT was equally as effective as standard CBT. The research found no evidence that religiously adapted CBT was worse than standard CBT. In most cases, it has been shown to reduce symptoms of distress quicker than standard treatment for religious Muslims. This was not the case for non-religious individuals. The outcome of this review could potentially offer some Muslim clients in the United Kingdom (UK) another form of intervention that not only values their religious beliefs but also enables them to use their religious beliefs and value systems to be part of their recovery within an evidence based framework.

Paper two examined South Asian women's experiences of accessing psychological therapy within IAPT services. Ten participants were interviewed. A thematic analysis was conducted and six themes were identified: 'access', 'experience', 'cultural framework', 'therapist characteristics', 'expectations' and 'sticking with it'. The themes identified that cultural and religious exclusion from therapy negatively impacted on therapy. This was only true for those whose cultural context or religion impacted on their mental health. Manualised CBT and CBT based interventions allowed for the reduction of symptoms but left little scope to explore cultural issues. This study reveals the complex interplay between clients' expectations of the service, the therapist characteristics and their cultural framework which services need to be aware of. It was suggested that services may benefit from better integration of religion and culture moving forward.

Paper three is an executive summary that outlines a summary of the empirical paper that is intended to be disseminated to services.

Paper 1: Literature Review
Can Cognitive Behavioural Therapy be effectively adapted for religious Muslim groups?

Word Count: 7, 978 (excluding tables).

Target Journal: This literature review is intended to be submitted to Mental Health, Religion and Culture.

Abstract

The aim of this review is to explore the effectiveness and the feasibility of adapting Cognitive Behavioural Therapy (CBT) interventions for Muslim populations. To gain an insight into the degree of effectiveness that CBT has on this chosen population a review that was conducted systematically was performed. Qualitative, quantitative and mixed method papers were included for review. The results yielded 408 articles, 8 of which were eligible for inclusion. The 8 studies which fell within the scope of the inclusion criteria used cognitive or cognitive behavioural models as the basis for faith-adapted treatment studies. Results from these studies suggest that religiously adapted CBT for some Muslims can be equally as beneficial as standard CBT and psychotherapy. In most cases, CBT has been shown to reduce symptoms of distress quicker than standard treatment. There are also contributory factors such as; client-therapist matching, therapist confidence, social context and religiosity that are discussed and given due consideration within the studies.

Introduction

Understanding Religion and Spirituality

Religion can be defined as having belief in a God or Gods to be worshipped, which is often through rituals involving a code of ethics organised by scripture (Koeing et al., 2012). In contrast there is no single definition of spirituality. Spirituality refers to a broad range of definitions ranging from personal beliefs in the supernatural, to sacred meanings about life and the universe, which is separate from organised religious institutions (Wong, 2008; Garcia & Koeing, 2013; Mcarroll, 2005). For some individuals religion and spirituality are intimately connected; however, there are distinctions to be made between religion and spirituality.

Culture is a complex phenomenon and is a term that is often used interchangeably when associated with religion. Culture contains a number of different elements such as thoughts, beliefs, schemas, shared knowledge and practices about ones way of life (Dinos, 2015). It also considers the influence of age, gender, sexual orientation and socioeconomic status (Hays, 2009). Whilst culture and religion can interlink, it is important to remember religion and culture are separate, but may influence one another.

Fundamentals of Islam

Islam is an Abrahamic monotheistic religious group that is present across the world and is practiced by individuals from a diverse range of ethnic and racial categories. It is the world's second largest religion (ONS, 2001) and it is not only considered as a religion but is a way of life for its followers. The religion of Islam is based on a set of values that are derived from the Quran and the Prophet Muhammad's teachings. Together these provide guidance for Muslims on how they should live their life in aspects relating to family, family law, welfare, politics, economics and finances.

Cognitive Behavioural Therapy in the United Kingdom (UK)

Cognitive Behavioural Therapy (CBT) is a form of therapy that has been recommended in the UK by the National Institute for Health and Care Excellence (NICE, 2009). It has been deemed to be an effective form of psychotherapy for various mental health difficulties such as depression, anxiety, stress, phobias, chronic pain, eating disorders and Post-Traumatic Stress disorder (PTSD) (Chambless & Ollendick, 2001; Pigeon et al., 2012; Byrne, Fursland, Allen, & Watson, 2011). CBT encompasses a broad range of principles primarily based on Cognitive and Behavioural psychology (Beck, 1995).

The aim of CBT is to seek ways to produce change and modification of the client's belief system in order to bring about enduring emotional and behavioural change (Beck, 2011). The theoretical basis of CBT is that individuals have the ability to control their thoughts and emotions (Vera et al., 2003) therefore, CBT places an emphasis on individual change and changing their views on reality (Corey, 1996). There are various techniques which are used to achieve the above aims, which are underpinned by the same principles. Two examples are discussed below.

1. Cognitive Restructuring

Cognitive restructuring is a technique in CBT which aims to teach clients how to identify their own maladaptive thoughts. These thoughts can also comprise of beliefs or automatic negative thoughts which are believed to be at the most superficial level of conditions. Once these thoughts have been identified, the therapist aims to guide the client to reflect and evaluate the thoughts/images in order to develop more helpful thoughts. Core beliefs are also identified and modified through the process of evaluating the evidence, both for and against the individuals' thoughts and beliefs (Beck, 1998).

2. Behavioural Activation

Behavioural Activation (BA) is a technique commonly used to effectively treat Depression (Ekers et al., 2014). BA aims to help clients to rebuild and engage in meaningful activities in order to alleviate the symptoms of depression. Whilst

Behavioural Activation has been described as a type of therapy, its key concepts are based on Skinnerian ideas of operant conditioning through scheduling to encourage individuals to reconnect with their environment (Eckers et al, 2014). BA is based on the idea that if an individual's life consists of too much environmental punishment or too little environmental reinforcement, then symptoms of depression will be present. Its aim is to therefore slowly introduce changes in one's daily routine in order to lift the depression.

Access to CBT in the UK

Evidence has shown that many individuals with high levels of distress do not receive CBT and may potentially be disadvantaged either due to poor access or because care is not available (Hinton & Patel, 2017). Although the government has introduced initiatives to try and improve access to psychological therapies, there continues to be limits and barriers to the access of CBT. In a report "We still need to talk" (Mind, 2013) a number of barriers that limit or hinder access to psychological therapies are highlighted. The report identifies that waiting times, choice of type of therapy and inequalities of access are contributory factors to lower than anticipated uptake. Further evidence suggests that despite government commitment to address unequal access to psychological therapies, access rates for Black and Asian Minority Ethnic (BAME) communities, older people, young people and the homeless remains disproportionate and poor (Mind, 2013).

Cultural Adaptations of Psychotherapy and Religious Psychotherapy

Naeem et al. (2015) and Smith & Draper (2004) advocated that Cognitive Behaviour Therapy is based on Western values of individualism. They argue that this ignores and undermines collectivist values and contextual factors such as socio economic factors, family and community commitments (Smith, 2004). This potentially results in the underutilisation of mental health services and psychological intervention in ethnic minority groups. Subsequently researchers have emphasised the need to incorporate cultural values into psychological interventions in order to increase service utilisation (Wampold, 2001). Until recently, ethno cultural variables in psychotherapy had been neglected (Silverman et al, 2008) and empirical research examining the effect of culture on psychotherapy outcomes had not been examined.

Evidence suggests that psychological interventions can be more effective when the intervention complements the clients own cultural beliefs and practices (Tharp, 1991). Naeem et al. (2015) explored the effectiveness of culturally adapting CBT for psychosis in a Pakistani population. They found that incorporating culturally appropriate homework assignments, using folk stories relevant to the population group and involving family as well as carers in the psychotherapy process was effective in reducing hallucinations, delusions and displayed improvements in positive and negative symptoms, compared to those receiving treatment as usual (TAU).

The effectiveness of adapting CBT for various other mental health difficulties from within ethnic groups has also been identified (Mahr et al., 2015; Grinder & Smith, 2006; Constantino et al., 1994; Kohn et al., 2002; Naeem et al, 2011), resulting in practitioners becoming increasingly familiar with the need to culturally adapt psychological interventions. The need to religiously adapt psychological interventions has been given less attention. Research has shown that spirituality and religion is associated with many positive outcomes such as a reduction in symptoms of depression, anxiety, stress, improved ability to cope with stressful life events and reduction of risk of suicide and the use of drugs and alcohol (Larson et al., 1992; Anderson et al., 2015; Rosmarin, 2010; Hodge & Lietz, 2014). Some clients with mental health difficulties engage in religious coping mechanisms (Mohr et al., 2012) and have expressed an interest in therapists incorporating religion into therapy (Rose, Westefeld, & Ansley, 2001). As such, there has been a growing interest in exploring the impact of integrating religion and spirituality into psychotherapy on mental health and wellbeing (Koenig et al., 2001). Koenig (2007) found that integrating religion into psychotherapy is associated with better mental health outcomes. Lim et al. (2014) carried out a systematic review to explore the extent to which religiously modified CBT can be considered an empirically supported treatment intervention for people from Christian, Muslim and Jewish religious backgrounds. They found that integrating religion into psychotherapy can be a suitable form of treatment for individuals with strong religious beliefs. Previous reviews of faith adapted psychological treatments have found moderately strong evidence of faith adapted interventions that outperform standard interventions for people with Christian, Jewish and Islamic beliefs (Smith, Bartz, & Richards, 2007;

Anderson et al., 2015). Adapting interventions that are congruent with religious and cultural values could in turn increase adherence and improve outcomes (Fraser et al., 2009).

Integrating Islam into CBT

Up until recently, research has focused on exploring the effectiveness of CBT for Christian groups in clinical settings and amongst students (Hawkins, Tan & Turk, 1999; Pecheur & Edwards, 1984; Propst, 1980; Propst et al., 1992; Rosmarin et al., 2011). The available literature on CBT in an Islamic setting suggest that Muslims are more likely to use religious coping strategies than other individuals from other religious groups in the UK (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001). In light of this, researchers have attempted to adapt religious interventions for Muslims presenting with symptoms of depression (Azhar & Varma, 1995), anxiety (Azhar, Varma, & Dharap, 1994) and PTSD (Jalal, Samir, & Hinton, 2017; Mahr et al., 2015).

As CBT is the recommended treatment for various mental health difficulties (NICE, 2009, 2011), researchers have attempted to adapt CBT for Muslims. Given that there is no standardised way of doing this, researchers have aimed to explore and have considered in detail how CBT can be adapted for this client group. Each person's interpretation and narrative of Islam is shaped by their culture, degree of spirituality, race, ethnicity and other contextual factors but the underlying monotheistic principle is consistent despite the differences in narratives and sects (Hodge & Nadir, 2008). In an attempt to increase engagement into therapy researchers have focused on adapting the *assessment* process, adapting *cognitive restructuring* techniques and have *integrated religious behaviours* into therapy. Each of these is discussed in detail below.

1. The Assessment and the introduction of Religious Cognitive Behavioural Therapy (RCBT)

Authors have emphasised the importance of conducting a thorough assessment for therapy which not only explores clients life circumstances, emotional and psychological problems, but also takes their religious beliefs into account (Pearce et al., 2015). It is suggested that assessments should be culturally and religiously

sensitive and should be conducted in a way as to be curious about these beliefs. Furthermore, there is a view that therapists should also be careful not to assume that the client wishes to have religious psychotherapy on the basis of their religious beliefs. The general consensus is that therapists should ask questions to determine clients preferred intervention. In conducting the assessment it is equally important to frame the intervention both accordingly and adaptively to the client's needs in order to improve access, engagement and for better therapeutic outcomes (Jalal et al., 2017; Benish, Quintana & Wampold, 2011).

2. Cognitive reframing

Western psychotherapy, particularly CBT, places value on individualism and the 'self'. Focus is placed on concepts such as self-actualisation, self-worth and self-efficacy in order to help the client to develop a better understanding of the self (Hodge & Nadir, 2008). In contrast, Islam fosters a collectivist approach that emphasises values such as community, self-control & interdependence (Hodge & Nadir, 2008; Jaffari, 1993). Therefore some Muslims tend to look outwards to establish their identity based on religious teachings, culture and family (Hodge & Nadir, 2008). Whilst Western and Islamic values may differ to some extent, they both encourage the importance of challenging cognitions and having healthy cognitions for healthy mental health and wellbeing. In traditional CBT, self-statements are used to replace automatic thoughts. This concept of the individual as the self may be uncomfortable for Muslims as they have the firm belief in surrendering of the self to God to achieve wellness, rather than aiming for an autonomous self. As Hussain & Hodge (2016) highlight, it may not be the cognitive restructuring process that conflicts with Islamic values, but rather the value system through which it is conveyed. To overcome this, practitioners should aim to modify self-statements by replacing them with statements that reflect Islamic values. Hamdan (2008) also sets out ways in which therapists can help Muslim clients to challenge their maladaptive thoughts by focusing on areas such as; understanding the temporal reality of this

world, focusing on the hereafter, recalling the purpose and effects of distress, seeing the blessings in hardship and by developing trust in God.

Another key element of traditional CBT is the process of helping a client to identify alternatives for their automatic thoughts. This is something that resonates highly with Islam:

“If a friend among your friends err, make seventy excuses for them If your hearts are unable to do this, then know that the short coming is in your own selves” (Imam Bayhaqi, Shu’ab al Iman (7:522)).

3. Integration of religious behaviours

Researchers have found that adaptation of activity scheduling or Behavioural Activation is a viable intervention for Muslim communities. Traditionally the therapist would encourage the client to re-engage in rewarding activities that are based on one’s personal values. For example, the client might be encouraged to start seeing family, friends or take up an activity such as going for walks, arts and crafts or taking up a sport. For Muslim clients, they may be encouraged to engage in religious activities such as prayer or supplication referred to as ‘Dua’. Supplication can be a powerful tool that provides comfort and can be used to prevent distress and anxiety. Hamdan (2008) supported this notion and noted that if supplication comes from the heart it can turn distress into calm (Hamdan, 2008). Sabry & Vohra (2013) held a similar view to Hamdan (2008) and pointed out that prayer can be used as a coping mechanism for Depression and Anxiety and can be incorporated into one’s daily activity to reduce symptoms of distress (Sabry & Vohra, 2013). Others have highlighted that praying can be seen as a form of meditation which encourages and promotes relaxation and a general sense of wellbeing through physiological change (Frank, 1991 & Woon, 1984). In view of this, encouraging a Muslim to engage in daily prayer can therefore reduce symptoms of distress as well as act as an effective tool to assist them in re-engaging in meaningful activities.

Aims

Whilst researchers have set out ways to adapt psychological interventions for Muslim groups, there is a notable gap in the review and evaluation of how effective religiously integrated CBT is for Muslims. This review is intended to facilitate and bridge this gap to provide a better understanding of the effectiveness of religiously adapted CBT and to identify areas for possible improvement. The aim of this literature review is to therefore explore the effectiveness of adapting CBT interventions for Muslim populations.

Method

Search Strategies

A systematic search of the literature was conducted. The following databases have been used in the literature search: MEDLINE, PsychINFO, CINAHL, PubMed and Embase. In addition the search engine 'Google Scholar' was utilised as a way of finding literature. The top 20 responses were recorded and formed part of the search results. Articles were also found by searching the references of relevant articles. The initial search was conducted by combining the following terms: Cognitive Behaviour Therapy and Islam*, Religious Cognitive Behavioural Therapy, Religious Psychotherapy, Muslim Psychotherapy, Behaviour or Cognitive Therapy and Muslims and modified Cognitive Behaviour Therapy and Muslims. The search took place between January 2018 - 28th February 2018. (Refer to appendix M for full search terms).

To select the studies an inclusion and exclusion criteria was applied. Table 2 below highlights the eligibility criteria for inclusion in review.

Criteria	Inclusion	Exclusion
Population	Muslim groups with mental health difficulties.	
Study Design	Peer reviewed research articles using either qualitative, quantitative, case studies or mixed methods of data collection.	Commentaries and conference abstracts. Essays, expert opinion or other grey literature (to ensure quality, non-peer reviewed articles were excluded). Studies that did not provide outcome data were also excluded.
Language	English only.	
Intervention type	Adapted Cognitive Behavioural Therapy (CBT) or elements of CBT, CBT based interventions. Religiously informed interventions.	Predominantly culturally informed interventions. Add on therapies from models other than CBT. Therapies that were not based on CBT principles.

Table 2: Eligibility criteria for inclusion for review.

Selection of studies

In order to identify relevant articles the inclusion and exclusion criteria were applied. No exclusions were made according to study design. Quantitative, qualitative experimental designs, case studies and client views were all eligible for inclusion. All articles from the results were hand scanned based on titles and abstracts. Where there was ambiguity, full text articles were scanned further against the inclusion and exclusion criteria.

Figure 1 shows the search yielded 423 articles, which left 332 after removing duplications and 42 after screening titles and abstracts. Of these 42, 34 were discarded after examining full text articles. 8 articles met the inclusion criteria and were included in the final inclusion in this review.

Overall 34 articles were excluded: 4 articles were excluded as the interventions were substantially based on cultural adaptations rather than religiously informed, 12 articles did not report outcomes measures and provided a theoretical framework for adapting CBT for religious populations. Of these 12, two were case studies that gave insufficient detail of outcome scores. Eight studies did not adapt CBT specifically for Muslim populations. Of these eight, three did not report the religion and five studies used religiously adapted CBT for Christians. Three studies used non CBT methods, five studies were conference papers or abstracts and two articles were not in English and were unobtainable. These articles were therefore not translated into English.

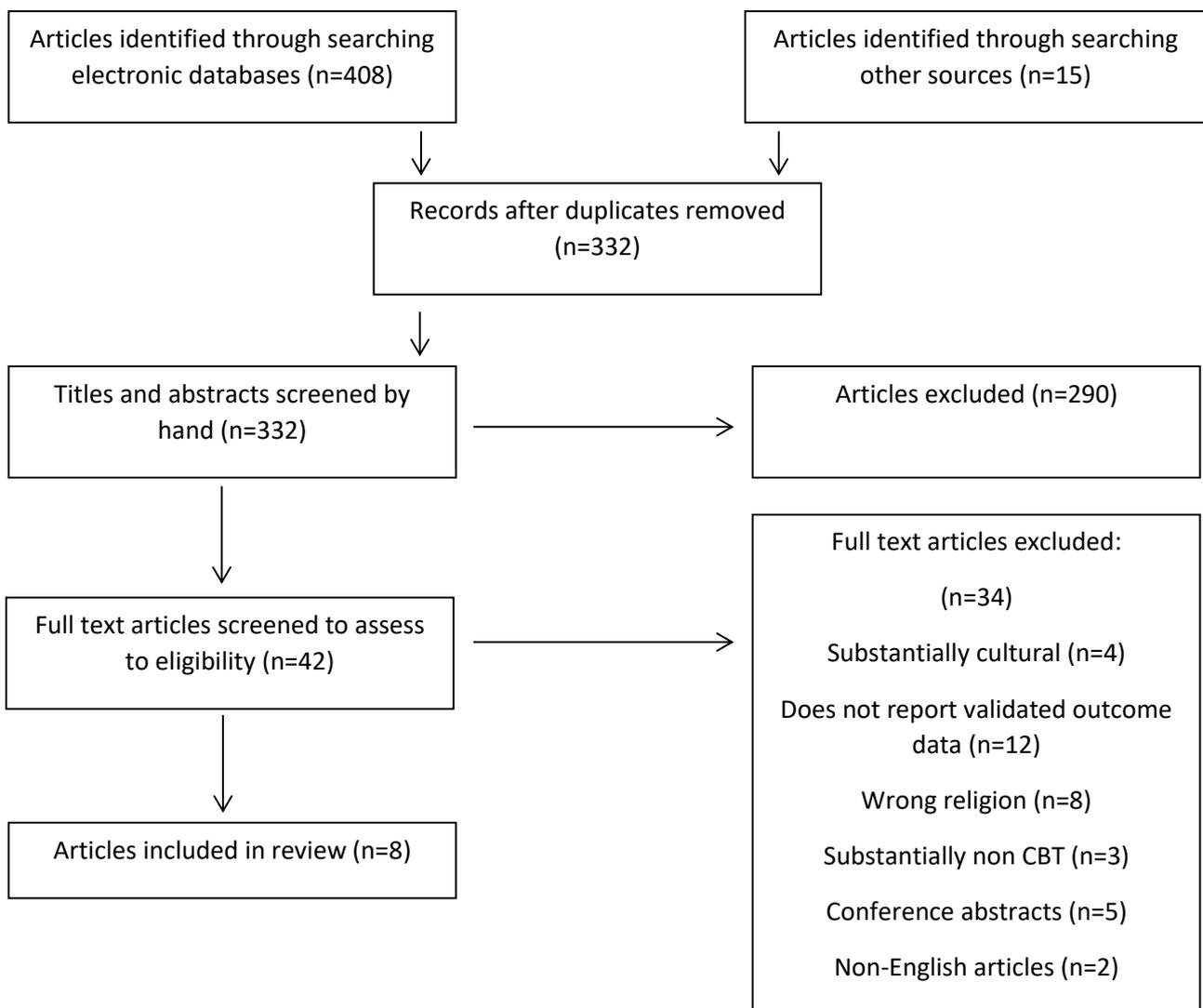


Figure 1: Flow chart of the literature search.

Quality Assessment

To assess the quality of the studies the Mixed Method Appraisal Tool (MMAT) (Pluye, Robert, Cargo, & Bartlett, 2011) was used. The MMAT (Appendix N) is a checklist that has been designed for the appraisal of literature reviews that use a combination of qualitative, quantitative and mixed-methods studies. Compared to other tools such as the Critical Appraisal Skills Programme (Critical Appraisal Skills Programme, 2013) for qualitative and quantitative papers, the MMAT is an efficient tool as it allows researchers to appraise mixed-methods studies using only one appraisal form. The MMAT checklist includes screening questions which are applied across all relevant studies. There are 19 items to assess the quality of five different types of studies (qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies, and mixed methods studies). An overall quality score can be ascertained using this tool for each included study (Pluye et al., 2011). Scores can be presented using descriptors such as *, **, ***, and ****. Scores vary from 25% (*) - one criterion met to 100% (****) - all criteria met. A sub-sample of the articles were critically reviewed by an independent researcher using the MMAT. The interrater reliability was calculated as 92% across the subsamples.

Overview of studies

Eight articles were included in the final review. Mir et al., (2015) was reported as a two part mixed method design; however, they only report on the qualitative aspect of the study. Characteristics for all studies are provided in table 3 below.

Quantitative Papers Author and Title	Sample	Design	Treatment conditions	Outcome	MMAT Rating *= 25% **= 50% ***= 75% **** = 100%
Azhar and Varma (1995a). Religious psychotherapy as management of bereavement.	30 ethnic Malays seeking treatment for major depression associated with bereavement, recruited from a psychotherapy clinic in the Psychiatric Unit of Hospital University Sains, Malaysia.	RCT. Control group n=15 Study group n=15 Measured depression at baseline, 1,3 & 6 months using the Hamilton Depression Rating Scale.	Control group received anti-depressants + weekly supportive therapy. The study group received anti-depressants + weekly supportive therapy + religious psychotherapy, modified CBT. Both groups received 12-16 sessions of therapy	Significant improvement in symptoms at 1 (p<.001, t=45), 3 (p<0.01, t=2.83) & 6 months (p<0.05, t=2.26).	** 50%
Azhar & Varma 1995b. Religious psychotherapy in depressive clients.	64 Ethnic Malays with Depression were recruited from a psychotherapy clinic in the Psychiatric Unit of Hospital University Sains, Malaysia.	RCT Control n=32 Study group n=32 Measured affective symptoms of depression at baseline, 1,3 & 6 months using Hamilton Depression Rating Scale.	The control group received Anti-depressants + weekly psychotherapy for 15-20 sessions The study group received Anti-depressant + weekly psychotherapy + religious psychotherapy in the form of modified CBT for 15-20 sessions.	Significant improvement in symptoms at 1 & 3 months (<0.001). Difference between the groups was non-significant at 6 months. Authors conclude there is faster improvement with religious psychotherapy.	** 50%

Quantitative Papers Author and Title	Sample	Design	Treatment conditions	Outcome	MMAT Rating *= 25% **= 50% ***= 75% **** = 100%
Azhar & Varma 1994. Religious psychotherapy in anxiety disorder clients	62 Muslim clients with Generalised Anxiety Disorder recruited from a psychotherapy clinic in the Psychiatric Unit of Hospital University Sains, Malaysia.	RCT Control n=31 Study Group n=31 Measured symptoms of GAD on Hamilton Anxiety Rating Scale at 1, 3 & 6 months.	Control group were given Benzodiazepines for no more than 8 weeks and received weekly psychotherapy in the form of discussions. The study group were given Benzodiazepines for no more than 8 weeks, weekly psychotherapy + religiously modified CBT for 12-16 sessions, 45 mins long.	Significant at 3 months, $p < 0.001$, $t=4.23$. Non sig at 6 months. Faster response rate to religious psychotherapy than conventional psychotherapy.	** 50%
Razzali et al, 1998. Religious sociocultural psychotherapy in clients with anxiety and depression	Sample1: 100 Malay clients with Depression	RCT Control group n=48 Study Group n=52 Measured depressive symptoms on Hamilton Depression Rating Scale at	The control group received Anti-depressants + Supportive Psychotherapy using relaxation, reassurance and adaptive coping mechanisms/behaviours. The study group received Anti-depressants + supportive	Improvement in symptoms at 1 ($p < 0.001$) & 3 months ($p < 0.01$). The difference between the two groups was non sig at 6 months. The authors conclude	*** 75%

Quantitative Papers Author and Title	Sample	Design	Treatment conditions	Outcome	MMAT Rating *= 25% **= 50% ***= 75% **** = 100%
		baseline, 1, 3 & 6 months.	psychotherapy + religious socio-cultural psychotherapy including CBT based interventions.	there is faster improvement with religious psychotherapy than standard therapy.	
	Sample 2: 103 Malay clients with GAD	RCT Control Group n=49 Study Group n=54 Measured symptoms of GAD on Hamilton Anxiety Scale at baseline, 1, 3 & 6 months	Control Group – Benzodiazepines (no more than 6 months) + supportive psychotherapy Study Group: Benzodiazepines + supportive psychotherapy + religious socio-cultural Psychotherapy with CBT elements. Frequency or duration of treatment not given	Improvement in symptoms at 1 (p<0.002) & 3 months (p<0.01). Similarly, the difference between the two groups was non sig at 6 months, meaning the two groups performed equally well at 6 months.	

Quantitative Papers Author and Title	Sample	Design	Treatment conditions	Outcome	MMAT Rating *= 25% **= 50% ***= 75% **** = 100%
Razzali et al, 2002. Religious-cultural psychotherapy in the management of anxiety clients.	165 Malay clients with GAD recruited from a psychotherapy clinic in the Psychiatric Unit of Hospital University Sains, Malaysia.	<p>RCT</p> <p><u>Religious Group:</u> Control group n=40 Study Group n=45</p> <p><u>Non-religious Group</u> Control n=38 Study n=42</p> <p>Measured on Hamilton Anxiety Rating Scale at baseline, 1, 3 & 6 months.</p>	<p><u>Control Group:</u> Benzodiazepines (for no more than 6 weeks) + weekly psychotherapy and basic relaxation.</p> <p><u>Study Group:</u> Benzodiazepines (for no more than 6 weeks) + weekly psychotherapy and basic relaxation + Religious Cultural Psychotherapy (RCP) using CBT elements.</p> <p>Received therapy weekly for 6 months.</p>	<p>Significant differences between groups at 1 (p<.01, t= 2,96) & 3 months (p<.01, t=2.84).</p> <p>At 6 months no difference between the study and control groups was found. The addition of religiously modified CBT was associated with faster remission of symptoms compared to control group. The intervention had no effect for non-religious groups when assessed at 1, 3 & 6 months.</p>	<p>***</p> <p>75%</p>

Quantitative Papers Author and Title	Sample	Design	Treatment conditions	Outcome	MMAT Rating *= 25% **= 50% ***= 75% **** = 100%
Wahas & Kent, (1997). The modification of psychological interventions for persistent auditory hallucinations to an Islamic culture.	6 clients from Saudi Arabia with a diagnosis of Schizophrenia according to ICD-10.	RCT Control n=3 Study n=3 Severity of hallucinations was measured at baseline, during the study and 3 month post treatment for the intervention group. Measurements were taken at baseline and 3 month post follow up for the control group.	The control group received no therapy and were maintained on their antipsychotics. The study group were maintained on their antipsychotics received adapted CBT (religious psychotherapy). clients were offered three sessions per week for 1 hour over a 9 week period. Max 25 sessions. Adaptions of various CBT methods were used.	Religiously modified CBT was effective for two out of the three clients. These participants reported a reduction in the frequency, loudness and hostility of their voices. Lower distress and fewer emotional reactions were reported by the end of therapy.	*** 75%

Qualitative Papers Author and Title	Sample	Design	Treatment conditions	Outcome	MMAT Rating *= 25% **= 50% ***= 75% **** = 100%
Mir et al, 2015. Adapted behavioural activation for the treatment of depression in Muslims.	The study was conducted in Bradford, in the UK. The sample consisted of 19 clients from Pakistani (n=17), Indian (n=1) and African (n=1) backgrounds, all self-identified as Muslims.	A qualitative study to explore the feasibility to and acceptability of the adapted intervention. The paper focuses on reporting qualitative interviews of those who participated in the study.	Interviews were conducted to explore clients' experience of receiving religiously adapted behavioural activation. Interviews were conducted by the author and lasted for 90 minutes. Results were analysed using Qualitative Framework Analysis.	Religiously adapted Behavioural Activation was more valued than standard approaches. Key themes identified: relevance of the model, client-therapist matching, social context, religion and therapy and family involvement.	** 75%

Mixed Method Paper Author and Title	Sample	Design	Treatment conditions	Outcome	MMAT Rating *= 25% **= 50% ***= 75% **** = 100%
<p>Ebrahimi et al., 2013.</p> <p>Mixed methods qualitative and quantitative design. Randomized clinical trial of spirituality integrated psychotherapy, cognitive-behavioural therapy and medication intervention on depressive symptoms and Dysfunctional attitudes in clients with dysthymic disorder.</p>	<p>62 Muslim clients with Dysthymic Disorder from Iran</p>	<p>Medical intervention n=15 standard CBT group n-16 Study group n=16 Control group n=15</p> <p>Measured symptoms of Depression on the Beck Depression Inventory (BDI-II) and a shortened version of the Dysfunctional Attitude Scale (DAS-26) at baseline, one month, end of treatment and at 3 month follow up.</p>	<p>There were four conditions:</p> <p><u>Medication only:</u> Received medication for Dysthymic Disorder by a psychiatrist</p> <p><u>Standard CBT</u> CBT protocol for chronic depression and dysthymia was used for 8 weekly sessions for 45 mins.</p> <p><u>Religious Psychotherapy</u> Formed through grounded theory and included a religious viewpoint for explaining depression and CBT based interventions. Participants received 8 weekly sessions for 45 mins.</p> <p><u>Waiting List</u> Received no intervention during the trial.</p>	<p>Religious psychotherapy had more efficacy than medication on BDI-II and DAS-26, but not standard CBT. Religious psychotherapy was more effective on modification of dysfunctional attitudes compared with CBT and medication.</p>	<p>Qualitative element: 50% **</p> <p>Quantitative element: 25% *</p> <p>Mixed method: 25% *</p>

Table 3: study summaries of all Quantitative, Qualitative and Mixed Method designs.

Quantitative Papers

Azhar & Varma (1994) received a rating of 50% on the MMAT, making it an average quality paper. Azhar & Varma (1994) examined the effect of religious psychotherapy with individuals with Generalised Anxiety Disorder. The appropriate design was used for the aim of this study. 64 participants were randomly allocated to either the TAU or the study group. There were an equal number of participants in each group. The groups were reported as being similar with no differences in age; however, information on gender or socioeconomic status is not provided. The authors only included participants who completed the full duration of the therapy and excluded the 22% who dropped out of the study. This creates some bias and may have confounded the results as those who completed the therapy were likely to be those who benefitted the most. Those who dropped out were not followed up and therefore a useful source of information could be considered as missing. The authors report results at a 6 month follow up period which is a particular strength as this enables the exploration of the longer term effects of the intervention. The authors provide a clear conclusion linking its aims together with the results and stated they were exploring effects of the intervention for highly religious groups only.

Azhar & Varma (1995a) received a 50% rating on the MMAT. The design of their project was suitable for the aim to assess the effects of religious psychotherapy in clients experiencing depression as a result of bereavement. Some methodological flaws should be highlighted. The authors did not clearly describe the randomisation process, therefore making it difficult to determine whether this was a true randomised controlled trial (RCT). Whilst it is not always possible to blind individuals in trials where there is human interaction, the authors did conceal the independent raters from the participant groups to which they were allocated to. The participants were all recruited from University Malaysia Hospital (USMH) and were all from a religious community. This factor may reduce generalisability and the study can be further criticised for providing limited data. Although significance levels are reported, its effect size is unknown. The authors provide a clear description of the intervention which allows the study to be replicated to further test its validity.

Azhar & Varma (1995b) was rated as 50% and investigated the effect of religious psychotherapy on 32 clients with a diagnosis of Dysthymic disorder. All participants were randomly allocated to either the control (n=32) or study group (n=32). The process of randomisation is not clearly explained. Although blinding is not always possible in these studies, some elements could have been (such as allocation to groups). It is also very unclear whether the intervention was delivered by a member of the research team or an independent therapist. This may potentially increase bias. It is unclear whether the full outcome data is reported. The study had very low attrition rates (n=3), which is a particular strength. Depression was measured using a validated measure, the Hamilton Depression Rating Scale, at 1, 3 and 6 month follow up. The longer-term effect of the intervention was measured, which is a key strength of this study. The study can be criticised for not providing sufficient outcome data as the effect sizes are unknown therefore making it difficult to establish the true effect of the intervention.

Razali et al (1998) is a good quality study with a rating of 75%. The study used a RCT design to show the effectiveness of incorporating religious-sociocultural components of therapy for managing anxiety and depression. The authors clearly identify how participants were selected and used validated measures to measure symptoms of anxiety and depression (Hamilton Depression Rating Scale & Hamilton Anxiety Rating scale). The study reports the interrater reliability between the assessors, which was acceptable. The paper provides a case vignette to illustrate how Quranic verses and Hadith can be incorporated into therapy, making this the only paper that provides this illustration. Some methodological flaws should be highlighted such as the authors' failure to provide a clear description of the randomisation process. Whilst attempts have been made to conceal allocation by using independent raters, it is not clear whether the person carrying out the intervention was separate from the research team. This could have implications on results due to the potential for bias. The dropout rate was disproportionately high for the control group (65%) compared to the intervention group (14% for the anxiety group and 17% for the depression group); however, there is no consideration for why this may have been and the implications of this. The study included a sociocultural component into therapy; however, there are no details of what this component entails.

Razali et al (2002) used a RCT design to determine the effects of religiously based CBT for religious versus non-religious groups. This is the only study that compared the impact of religiously adapted interventions between religious and non-religious groups. Religiosity was measured using a validated adapted measure of religion. The authors provide a clear description of blinding research personnels from the study groups and the interrater reliability of the independent assessors for the rating scales was reported as 'good' (Kappa coefficient greater than .80). The authors fail to provide a clear description of the randomisation process and no method for concealing allocation was provided. Whilst it is not possible to always do this, this increases the risk of bias. There were low dropout rates (17.5%) which increases the generalisability of the study results and reduces risk of biased reporting. The authors recognise that the effect of the intervention could be clarified if it was compared to standard CBT and not medication or supportive psychotherapy. However, this is the usual treatment intervention offered within this context and therefore the authors appropriately compared religiously adapted CBT with TAU.

Wahass & Kent (1997) received a rating of 75%, making it a good quality study but has some limitations. Only 6 participants were recruited into the study, with 3 participants in each group (control and study group). The participants were made up of a small male only population and no information is given about the participants' level of education, marital status or socioeconomic status. The above factors may influence the generalisability of the outcome, particularly if the participants are not homogenous to the local population. To assess outcomes the Structured Auditory Hallucinations Interview (SAHI) and the Visual Analogue Scales (VAS) were used. These measures were taken at baseline and again a further eight times by psychiatric nurses and were supervised by the first author. No measures were taken to assess interrater reliability between the assessors to check for accuracy in recording the outcomes measures. It is also not clear whether the author was blinded from the participant group when completing the assessments. This could potentially introduce risk of bias which could impact outcomes. The authors compared the intervention group with a control group who only received neuroleptics therefore the comparison group is somewhat different to the study group. The authors also do not report the size of the effect making it difficult to establish how effective the intervention was compared to the comparison group.

Yes = 1 No = 0 Can't Tell	Azhar & Varma, 1995a	Azhar & Varma 1995b	Azhar & Varma, 1994	Razalli et al., 1998	Razzali et al., 2002	Wahass & Kent, 1997.
<i>Screening Questions</i> 1. Are there clear quantitative research questions 2. Do the collected data address the research questions	Yes	Yes	Yes	Yes	Yes	Yes
Is there clear description of the randomisation process	0	0	0	0	0	1
Is there a clear description of the allocation concealment	1	1	1	1	1	0
Are there complete outcome data (80% or above)	Can't tell	Can't tell	Can't tell	1	1	1
Is there low withdrawal/dropout rate (below 20%)	1	1	1	1	1	1
Total Rating	** 50%	** 50%	** 50%	*** 75%	*** 75%	*** 75%

Table 4: MMAT ratings for RCT's

Qualitative Papers

Qualitative Papers	Mir et al., 2015
<i>Screening Questions</i> 1. <i>Are there clear quantitative research questions?</i> 2. <i>Do the collected data address the research questions?</i>	Yes
Are the sources of qualitative data relevant to address the research question?	1
Is the process for analysing qualitative data relevant to address the research question?	1
Is appropriate consideration given to how findings relate to the context?	1
Is appropriate consideration given to how findings relate to researchers' influence?	0
Rating	*** 75%

Table 5: MMAT Ratings for Qualitative studies.

Mir et al. (2015), is a good quality paper and focuses on the qualitative part of the study. The aim of this was split into two phases; phase A was to develop a faith sensitive adapted intervention for Muslim clients and phase B was to test the feasibility and acceptability of this intervention. The study recruited 19 participants into phase B of the trial, in addition there were two team managers but the number of therapists is unknown. Of these 19 clients, 13 were interviewed. Of these, only seven completed therapy and five participants withdrew. Therefore the views of those interviewed may not fully reflect the views of everybody. There is no follow up from those who withdrew which therefore vital information is missing from this study. Data was analysed using Qualitative Analysis Framework which is an appropriate method of analysis for the study. 20% of the analysis was double coded thus enhancing the rigour of the study. Having said this, the contributions of the staff members and clients are not separated so it is unclear how similar or different their views are. The authors have also combined themes from phase A of the study, with Phase B,

making it difficult to establish what themes are directly from the clients' experience of the intervention.

Mixed Methods Study

Ebrahimi et al. (2013) is the only mixed method study. It received a rating of 50% (**) for its qualitative component, 25% (*) for its quantitative and 25% (*) for the mixed method component. The quantitative and mixed method papers appear to be of low quality. A key strength of this study is that the author compares differences between three groups; standard CBT, medication only and religiously adapted CBT. Furthermore the study had a wait list group. The authors approached appropriate participants to conduct the interview schedule with and provided clear details of how grounded theory was used to develop the spiritually integrated intervention. The study does however have several methodological flaws. The paper does not report the outcomes from the qualitative interviews, but rather they states the outcomes were used to inform the intervention offered. There is no triangulation of the mixed method approaches and no consideration is given to how the findings relate to the researchers own influence (reflexivity). In relation to the quantitative element, the groups are treated equally and the groups were homogenous, which adds to the validity of the study. The authors do not report the randomisation process although blinding procedures were clearly described. The paper does not report some key considerations such as; how many participants entered the study, the dropout rate and it is unclear whether the outcome data is complete. As with previous papers, this paper does also not report its effect sizes. The lack of data makes it difficult to determine how effective the intervention was and how transferable the results are to the local population in Iran.

Mixed Methods Yes = 1 No = 0 Can't Tell	Ebrahimi et al., 2013.
<i>Screening Questions</i> 1. Are there clear quantitative research questions? 2. Do the collected data address the research questions?	Yes
Qualitative Method Are the sources of qualitative data relevant to address the research question?	1
Is the process for analysing qualitative data relevant to address the research question?	1
Is appropriate consideration given to how findings relate to the context?	Can't tell
Is appropriate consideration given to how findings relate to researchers' influence?	0
Rating	50%
Quantitative Method Is there clear description of the randomisation process?	0
Is there a clear description of the allocation concealment?	1
Are there complete outcome data (80% or above)?	Can't tell
Is there low withdrawal/dropout rate (below 20%)?	Can't tell
Total Rating	25%
Mixed Methods Is the mixed methods research design relevant to address the qualitative and quantitative research questions, or the qualitative and quantitative aspects of the mixed methods question?	1
Is the integration of qualitative and quantitative data (results) relevant to address the research question (objective)?	0
Is appropriate consideration given to the limitations associated with this integration, e.g, the divergence of qualitative and quantitative data (or results) in a triangulation design?	0
Total Rating	25%

Table 6: MMAT ratings for mixed methods study

Findings

Study Characteristics

Out of all the studies reviewed comparing religiously adapted CBT with control conditions, 4 studied Depression (Azhar & Varma, 1995a; 1995b; Mir et al., 2015; Ebrahimi et al., 2013), 2 studied GAD (Azhar et al., 1994; Razali et al., 2002), 1 studied both Anxiety and Depression (Razali et al., 1998) and 1 studied people with persistent auditory hallucinations (Wahass & Kent, 1997).

Methods of incorporating religion into Islamic-modified treatment generally consisted of the following combinations:

- Incorporation of religious practice such as prayer and supplication.
- Use of religious teachings from the Quran, Sunnah and Hadith as evidence to support positive behavioural change.
- Use of religious teachings from the Quran, Sunnah and Hadith as evidence to modify and challenge unhelpful thoughts and belief systems.
- Promoting the clients belief systems and values.
- Discussions of religious issues specific to the client.

On average 15 sessions of adapted CBT was offered. These ranged from 8-25 weeks and were conducted weekly for 45-60 minutes. Two studies did not report the number and length of sessions (Razali et al., 2002; Razali et al., 1998). Two studies used face-to-face group and individual sessions (Azhar & Varma, 1994; Azhar & Varma, 1995b) and five studies (Mir et al., 2015; Azhar & Varma, 1995a; Razali et al., 2002; Razali et al., 1998; Wahass & Kent, 1997) provided individual face-to-face sessions.

Methodological observations

Randomisation

Only one study (Wahass & Kent, 1997) appropriately described the method of randomisation or an appropriate sequence generation to randomise participants.

Blinding

Seven out of the eight studies reported a brief summary of blinding. All the studies with the exception of Wahass & Kent, (1997) gave a brief summary of allocation concealment, but details of how this was done was not fully described. Having said this, blinding of therapists in psychotherapy trials is not always possible and this increases the risk of performance bias.

Attrition

Five studies reported sufficiently low levels of attrition rates of <20% (Wahass & Kent, 1997; Razzali et al. 1998; 2002; Azhar & Varma, 1995b; Azhar & Varma, 1994). Ebrahimi et al. (2013) and Mir et al. (2015) do not report attrition rates. One study (Azhar & Varma, 1995a) did not clearly state how many participants initially entered the study and how many dropped out, but they do report outcomes of those who completed the study and therefore formed part of the analysis. Despite low attrition rates, it was not possible to confidently judge how the attrition rates impact on the reported outcomes and study power.

Discussion

When compared with standard CBT and other usual treatments seven out of eight of the studies reviewed reported that religiously adapted CBT or psychotherapy resulted in significant improvement in symptoms of anxiety, depression and persistent auditory hallucinations. Wahass & Kent (1997) found that only two out of the three clients benefited from the religiously adapted intervention for persistent auditory hallucinations. Five studies (Azhar et al., 1994; Azhar & Varma, 1995a; Azhar & Varma, 1995b; Razali et al., 2002; Razali et al., 1998) found that clients receiving religiously adapted CBT reported an improvement in symptoms at one and three months. The difference between the control groups and religiously adapted CBT group was non-significant at six month follow up, with the exception of Azhar & Varma (1995a) who found differences even at six months. This suggests that individuals who receive religiously adapted CBT improve at a significantly faster rate

than standard CBT; however, both groups perform equally well at six month follow up. In contrast, Ebrahimi et al. (2013) found that the standard CBT group and spiritually adapted CBT group were not significantly different to one another at one month after starting the intervention and at the end, but there was a significant difference between the groups at three month follow up. Indeed, religious psychotherapy was not an effective intervention for non-religious clients (Razali et al., 2002).

The findings here appear to support previous literature (Propst et al., 1992; Tan & Turk, 1999; Hodge & Lietz, 2014) that suggest that CBT can be effectively adapted to some religious individuals and can significantly improve symptoms of distress. When Biblical teachings and prayers for Christian participants are included in CBT this had a significant positive difference when compared to standard CBT (Propst et al., 1992; Hawkins et al., 1999). The studies reviewed incorporated Quranic teachings, teachings from the Prophet Muhammad, ritualistic prayers and also used Islamic discussions to deliver a faith adapted CBT intervention for Muslim clients. By tailoring the interventions to the clients' needs, the intervention was more consonant with the participants own religious beliefs, thus increasing the religious congruence between the therapist and the client. This further enhances the ecological validity of the intervention offered.

The evidence here does not support the notion that religiously adapted CBT is superior to standard CBT. The results should be interpreted with extreme caution given that only one study compared religious CBT with standard CBT (Ebrahimi et al., 2013). The remaining studies had various comparators such as medication only (Wahass & Kent, 1997) or supportive psychotherapy, whilst Mir et al. (2015) had no comparator. In addition to this, religiously modified CBT was provided in conjunction with medication (for a period of six weeks), with the exception of Mir et al. (2015) and Ebrahimi et al. (2013). It is also important to note that the findings have not been replicated by other authors and are largely from the Malay population. Combining these factors with other methodological flaws previously discussed such as; small sample sizes, lack of clear detail of the randomisation process, poor description of the blinding and allocation concealment process and missing effect sizes, the findings from this review suggest that further research is required to determine the true efficacy of religiously adapted CBT. Although the studies have methodological

flaws that may impact on the scientific rigour of the study, the findings do not suggest that religiously adapted CBT is inferior to other treatment modalities. The articles do suggest that, at the very least, religiously adapted CBT can be considered as an acceptable treatment intervention for some religious populations, which is also consistent with other reviews (Anderson et al., 2015).

Given there are a number of methodological flaws in these studies, it is important to consider other factors that may underline the mechanism of change when delivering religiously adapted CBT. These are considered below.

Client-therapist matching

Traditionally psychotherapists' skills have been assumed to be globally suited for all clients from all backgrounds. Furthermore, therapist's personality and identity played no role in the mechanism of behavioural change in therapy. Although empirical research does not adequately and consistently support the view that client-therapist matching results in better therapy outcomes, research has found that client-therapist matching can enhance the therapeutic process (Seidman, 1971 & Peteet, 2009). In line with previous research, Mir et al. (2015) found there were mixed views about the need for client-therapist matching. Key informants felt that clients may develop trust quickly if the therapist shared the same religion as the client. This meant the client may not need to explain and justify their behaviours and values. It is therefore likely that the therapists own identity and assumed shared understanding of one's culture and religion could play a role in the success of the intervention.

Therapeutic relationship

The importance of ensuring a good therapeutic relationship with clients was one of the key things that all eight studies highlighted. Part of client-centred care involves delivering interventions that are respectful to the client's needs, wants and preferences. Common factor skills such as warmth, empathy and the therapeutic relationship have been shown to correlate more highly with outcomes than the intervention itself (Lambert & Barley, 2001). Razali et al. (1998) reported they were able to strengthen the therapeutic relationship by incorporating cultural and religious components into therapy. Mir et al. (2015) highlighted that clients found it helpful when therapists understood and respected Islam and when therapists genuinely accepted the adapted approach as potentially helpful. Razali et al. (1998; 2002),

Azhar & Varma (1994; 1995a & 1995b) acknowledge that acceptance of one's cultural and religious beliefs are key to developing a good therapeutic relationship which may well be a contributing factor. Malay clients strongly believe in supernatural causes of mental illness, hence seek support from traditional medicine practitioners (Bomoh's/Peers). The role of the therapists was therefore not to challenge their beliefs around the causes of mental illness or help seeking behaviours, but to enable them to use their religious beliefs to revive their spiritual strength in coping with the illness.

Therapist confidence and characteristics

Mir et al. (2015) highlighted that therapists did not often follow up the use of religion as a therapy resource when the client mentioned religious beliefs to their therapists. This was found to be because therapists who had poor familiarity with Islam did not feel confident in using it. Some therapists; however, found that their confidence increased with practice. It appears that the therapists own fears and guilt around imposing religious views onto their clients may also have been a reason why therapists did not incorporate religion into therapy and therefore they did not use religion as a coping resource. Interestingly, clients stated that poor familiarity with Islam should not stop therapists from using Islamic teaching to develop therapy goals, and offering Islamic teachings as a coping resource is a sign of acceptance of the Muslim identity. Whilst therapist confidence and therapeutic relationship was not directly measured in the studies reviewed, a therapist's familiarity with Islam may have helped to build a therapeutic relationship and therefore contributed to positive therapy outcomes. Ackerman & Hilsenroth (2003) explored the impact of therapist characteristics on therapeutic alliance and found that personal attributes such as honesty, warmth, being respectful, confident and openness contributed positively to alliance. Although not directly measured, these factors could also impact on therapy outcomes.

Religion and Religiosity

Religiously adapted CBT only appears effective for religious individuals and does not have the same impact for non-religious individuals (Razali et al., 2002). Five studies (Azhar & Varma 1994, 1995a, 1995b; Razali et al., 1998, 2002) measured participants degree of religiosity and commented on how their values may impact on the outcomes of therapy. For many people religion provides support and can help people cope in difficult situations by providing meaning, purpose, hope and self-esteem (Musick, Koenig, Hays, & Cohen, 1998; Worthington, Kurusu, McCullough, & Sandage, 1996). It is these religious values that potentially influence individual characteristics and can help an individual to decide on behavioural options. As Azhar et al. (1994) points out, a dissonance between ones ideal self (or values) and actual self may result in emotional distress. The aim of the intervention in five of the studies was to help the client to explore their value system and to search for the right ideal values, thus reducing dissonance and decreasing symptoms of distress. Once this had been achieved, therapists were able to use their values strategically in cognitive restructuring, behavioural activation or relaxation (through the use of prayers and meditation) to bring about meaningful change that coincides with their clients values. It is noteworthy that some Muslim clients have held their religious beliefs and values for a long period of time and therefore incorporating these belief systems is likely to improve the effectiveness of therapy faster as they already are committed to the support notion of God. A strong religious background and their commitment to religion may well be attributed to the faster rate of symptom improvement, compared to those who are non-religious.

Social Context

All of the studies reviewed, with the exception of Ebrahimi et al. (2013) highlighted the importance of family involvement. It was noted that family involvement helped facilitate change outside the therapy sessions. Mir et al. (2015) found that clients confirmed the added value of involving family and carers to help raise awareness of depression and was helpful for their own personal support. The role of relatives appears to be vital in ensuring treatment compliance. The literature suggested that the interventions also compliments the values of the family and therefore encouraged the client to adhere to the therapeutic intervention and encouraged the

individual to engage in behaviours that were psychologically beneficial (Azhar et al., 1994, 1995a, 1995b; Razali et al., 1998 & 2002; Wahass & Kent, 1997). This echoes literature that highlights the importance of family involvement in mental health interventions that can lead to better therapy outcomes (Garety et al., 2008; McKenna, Salvador, Lynch, & Laws, 2008).

Clinical implications

This literature review suggests that adapting CBT for some religious Muslims can be equally as beneficial as standard CBT and psychotherapy. In most cases, it has been shown to reduce symptoms of distress quicker than standard treatment. The outcome of this review could potentially offer some Muslim clients in the UK another form of intervention that not only values their religious beliefs but enables them to use their religious beliefs and value systems to be part of their recovery within an evidence based framework. Being curious about Muslim beliefs about the self, causation of mental distress, coping strategies as well as taking steps to adapt these religious beliefs into mental health services can result in these services being more accessible for some Muslim clients, thereby increasing overall access.

Weatherhead & Daiches (2015) completed a review to explore key issues to consider in therapy with Muslim clients. They suggest understanding Muslim clients concept of the 'self', which is different to the Western concept of the 'self', family dynamics, gender roles and beliefs about the causes of mental distress are key to potential engagement. Identified barriers such as Western therapies being seen as inaccessible due to differing world views (Al-Mateen & Afzal, 2004) or inability to incorporate Muslim perspectives into therapy (Daneshpour, 1998) can be overcome by involvement of community leaders and outreach work in addition to professional training. Training clinicians not from an Islamic faith to make simple adaptations could result in better access, engagement and positive outcomes for religious Muslims in the UK. Parry, Bustinza, Vendrell-Herrero, & O'Regan, (2016) argue that with the changing consumers and the need for consumers to feel valued, service providers need ways to engage and retain hard to reach groups, which can be achieved by co-creating services. Similarly, mental health services can facilitate services for hard to reach groups by co-creating a service tailored to their needs which could increase engagement with therapy for these groups. As echoed by

Weatherhead & Diaches (2015) this is particularly pertinent in the current political climate that is creating a divide between Western and Islamic cultures in the UK.

Implications for future research

The quantitative studies had various methodological flaws such as, small sample sizes, limited information on the randomisation process and provided limited outcome data. The evidence suggests it may be appropriate to consider further research that addresses the methodological flaws identified above to establish whether religiously adapted CBT is an effective mode of treatment for religious Muslims in the UK. Wetherhead & Diaches (2015) propose that quantitative methodology and design is inappropriate to this research area. Western approaches to therapy and research may be incompatible with Muslim clients, which may explain the paucity of studies that directly compare standard CBT with religiously adapted CBT for Muslims. The complex interplay of religion, culture, concepts of the 'self' and 'togetherness' may be better explored through qualitative research to allow more room for the exploration of religious and cultural discourses (Weatherhead & Daiches, 2015). Further research should also aim to explore the client-therapist factors that may well act as a mechanism of change in the therapy process, such as therapist identity, therapist confidence and the therapeutic relationship.

Strengths and Limitations

Conducting a literature review allows one to deliver a summary and to critique all available primary research in relation to the research question. This method helped ensure that research studies from relevant databases were researched to answer the research question. The review excluded non-English articles and articles that had add-on therapies. This exclusion meant there were potentially some valuable studies that were omitted that could have provided relevant information. When selecting the studies the researcher made every effort to avoid bias, but given the researcher also identifies as a Muslim, this may leave some scope for bias. The researcher has considered the impact this may have on the review.

All of the studies with the exception of one were conducted across Malaysia, Saudi Arabia or Iran, making it difficult to determine whether acculturation will impact on the effectiveness of R-CBT for some British born or migrant Muslims living in the UK. The review also included a small sample of studies, which further reduces the

generalisability of the findings. It is important to note that the MMAT only assesses the design of the study and does not allow one to critically review other elements such as the aims, sampling method, ethics and interpretation/implication of the findings. In spite of these limitations, the review followed a systematic process in the selection of studies and examined an area that has not been widely researched. The findings of this review highlight that CBT can be religiously adapted for Muslim populations, but there is a need for further UK based research to explore the efficacy of religiously adapted CBT for Muslims.

Conclusion

This review looked at a small sample of studies that explored the effect of using religiously adapted CBT with clients experiencing Anxiety, Depression and Schizophrenia. The quality of the studies varied; between 25-75% on the MMAT. The evidence from this review suggests that religiously adapted CBT (R-CBT) can be considered to be an effective method for managing distress for some Muslims. When therapy is co-ordinated with cultural, religious and spiritual needs for the clients' acceptance and response of the therapy is improved. The results need to be taken with caution, as only one study directly compared R-CBT with standard CBT, and most of the studies compared R-CBT with medication and supportive psychotherapy.

The findings do suggest that whilst R-CBT can be an effective intervention in reducing symptoms of distress other factors such as the therapeutic relationship, therapist confidence in delivering the intervention and client-therapist matching may be at play. Qualitative research may help to explore the impact of these factors on therapy outcomes. In line with NICE guidelines, R-CBT might be a good way for mental health services to improve access for hard to reach religious groups.

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Paper 2: Empirical Paper
**Beyond the Barriers: South Asian Women's Experience of Accessing and
Receiving Psychological Therapy in Primary Care.**

Word Count: 7,997

Target Journal: British Journal of Clinical Psychology

Abstract

Objectives: A number of initiatives have been developed to ensure easy access to mental health services for Black and Minority Ethnic (BME) communities. Improving Access to Psychological Therapies (IAPT) is a service that delivers first line interventions for South Asian women; however, little is known about what makes IAPT accessible for this population. This study aims to explore South Asian women's experiences of accessing psychological therapy and whether therapy within IAPT helps individuals to re-frame their experiences within their own cultural context.

Method: Semi-structured interviews were carried out with South Asian women who accessed IAPT. Ten participants took part in the study and interviews were analysed using Thematic Analysis.

Results: Six themes were identified; access, experience, cultural framework, therapist characteristics, expectations and 'sticking with it'. Having a good therapeutic relationship with the therapist was key. Manualised Cognitive Behavioural Therapy (CBT) led to a sense of dissatisfaction for some. Cultural and religious exclusion had a negative impact on therapy particularly for those whose difficulties were related to their cultural or religious context.

Conclusion: Culture and religion continues to be excluded from psychological therapy for South Asian Women. A cultural shift is required within IAPT services in order to maintain engagement for this group. Clinical implications are discussed.

Introduction

The current context in the United Kingdom (UK)

The United Kingdom (UK) is a multicultural society with approximately 12% of the population from ethnic minority groups, according to the Office for National Statistics (ONOS, 2011). South Asian ethnic groups (Pakistan, Indian, Bangladesh and Sri Lankan) form the biggest Black and Asian minority ethnic (BAME) groups in the UK. UK born and Non UK born South Asian populations account for 32.6% of the total population (ONS, 2011); however, research suggests they underutilise mental health services (Bhui et al., 2003, Bui & Takeuchi, 1992).

Due to the underrepresentation of BAME communities in mental health services, the UK government has developed initiatives to improve the provision of services for BAME communities. In 2007 the government announced the 'Improving Access to Psychological Therapies (IAPT) initiative in a bid to provide access to psychological therapies for those with mild-moderate depression and anxiety. IAPT aims to provide psychological therapy that is not hindered by ones' ethnicity, culture or language (Department of Health, (DoH) 2008). Although, undoubtedly, a large number of individuals have accessed and benefitted from access to psychological therapies, the IAPT model has been critiqued for its eurocentric approach (Bassey & Melluish, 2012) and for some this can result in privileging a western version of mental health (Masud, 2007). Both these factors can further act as a barrier for BAME communities.

Although historically the focus of research on ethnic inequalities in mental health services has been on the African-Caribbean community, more research has identified that members of the South Asian community also experience significant levels of mental health difficulties. They tend to not make use of first line services compared to the White population (Koffman, et al., 1997) and often report dissatisfaction with services offered to them (Bhui et al., 2002).

Barriers to accessing mental health services

Despite initiatives to increase the uptake of psychological therapy for BAME communities (DoH, 2007), access to psychological therapy services remains poor in South Asian communities (Mind, 2013). Asian or Asian British individuals are also less likely to complete treatment compared to the White British population (Baker, 2018). In recent years, extensive research has aimed to explore the barriers that South Asian women face when attempting to access mental health services. Some of these barriers are discussed below.

Stigma

Whilst stigma associated with mental health is not an exclusive issue for BAME communities, it is one of the biggest barriers that South Asian communities face when accessing services (Gilbert, Gilbert & Sanghera, 2004). For some women, having a mental health difficulty is a form of 'loss of face'. Beliefs around family honour, shame, subordination and entrapment may further prevent people from accessing services in order to preserve the family reputation and minimise community gossip (Time to change, 2010; Ahmad Macaskill & Tabassum, 2009; Corrigan, 2014; Hinshaw 2007). Maintaining family relationships plays a particularly important role in their lives and appears to influence access to psychological therapies, more so than their Western counterparts (Lavender, Khondoker & Jones, 2006).

The concept of 'double stigma' has also been noted in literature, wherein individuals from ethnic minority groups with mental distress may experience stigma and discrimination not only because of their background, but also because of their mental health concerns (Gary, 2006). In an effort to avoid public and self-stigma, individuals may delay or avoid help seeking.

Language

Language and communication are essential tools to communicate and are key to psychological therapies; through being able to express one's thoughts and feelings and share experiences. No access to their own language creates further barriers that prevent individuals from seeking support (Murray & Buller, 2007; Lowenthal, Mohamed & Mukhopadhyay et al, 2012). Although interpreters can be made available for therapy, language differences between a therapist and a client have been shown to negatively impact therapy sessions (Tribe, 1999).

Confidentiality

In collectivist cultures where strong feelings of shame and stigma are present, the issue of confidentiality poses another barrier to help seeking. People are often reluctant to speak to their GP for fear of their confidentiality being breached. This is the case especially where the GP or the health professional is of the same ethnicity as the client or when the GP or health professional is a family relative or is known to the family (Cinnirella & Loewenthal, 1999; Newham South Asian Women's Project, 1998). As such, access, engagement and clinical outcomes are impacted.

Awareness of the problem and help seeking pathways

South Asians' underutilisation of mental health services can be better understood through their perception and conceptualisation of mental health and help-seeking behaviours. Meltzer, Bebbington and Brugha et al. (2000) found a number of reasons that influence help-seeking behaviours: they did not think anyone could help, they thought that the problem would 'get better by itself', they did not think 'it was necessary to contact a doctor', or were 'afraid of the consequences', such as, being admitted into hospital, having tests or unfamiliar treatments. In another study by Sheikh and Furnham (2000), causal beliefs of mental distress, such as

supernatural causes, was a significant predictor of help-seeking behaviours for British Asian and Asian Pakistani groups.

Current literature on accessibility of psychological services for South Asian women

Research has shifted its focus from the barriers to access towards understanding the factors that influence engagement in psychological therapy. Sandil (2008) carried out an exploratory study looking at expectations of Asian Indian women in the United States of America. She found that Asian Indian women preferred counsellor characteristics such as genuineness, trustworthiness, tolerance, confrontational and nurturance, and favoured counselling that was concrete and immediate in nature. Asian Indian women with higher levels of acculturation wanted counsellors who were direct and empathic, regardless of their ethnic background. In contrast, Argo (2010) found they preferred a non-Indian therapist due to the fear of judgment from their therapist.

There is very limited research on South Asian women's views of accessing talking therapies. Agoro (2014) conducted a service evaluation in a secondary care psychotherapy service in order to explore the experiences of BAME groups engaging in therapy. They found that clients emphasised the importance of having a therapist who was warm and empathic and tailored therapy to their individual needs, which led to a sense of satisfaction. In contrast, cultural and socio-economic exclusion led to a sense of dissatisfaction (Bowl, 2007). This indicates that wider contextual issues affecting engagement in psychological services are at play.

The views and experiences of accessing therapy amongst this group are underrepresented in published work. Little has been done to explore what makes services accessible for South Asian women. It is time to explore what aspects of the process enable some South Asian women to access and remain engaged in therapy, despite some of the barriers they may face.

Research Questions

Firstly, the aim of the project is to explore South Asian women's experience of accessing and receiving psychological therapy that uses an IAPT model. What aspects of the service make psychological therapy accessible for South Asian women? Secondly, does therapy within IAPT enable individuals to frame their experiences within their own cultural context?

An exploration of what makes services accessible for South Asian women can further develop our understanding of how services can be further adapted and evolved to continue increasing access to services and to maintain engagement for hard to reach groups.

Method

Design

This study used semi-structured interviews to facilitate an in-depth discussion and exploration of individuals' experiences of accessing IAPT services. It was felt that a qualitative approach was best suited to capture the detail and richness of South Asian women's experiences of accessing psychological therapy.

Recruitment

Purposive sampling methods were used and geographic areas were targeted based on the large numbers from the South Asian population who reside there. IAPT services across NHS Trusts were approached to assist with recruitment. One non-NHS organisation that uses an IAPT model was also approached. Managers, clinical leads and directors of psychological services were initially contacted to explain the purpose of the research project. Once agreement was sought, clinical leads

disseminated the study information and promotional materials to all staff. Psychological Wellbeing Practitioners (PWP's) and Therapists were encouraged to identify and approach potential participants from their caseload who met the inclusion criteria. Consent was obtained from participants to allow the researcher to also contact them directly. Flyers (Appendix C) were also left in client waiting areas so participants could contact the researcher directly.

To ensure the experiences and the voices of South Asian women were fully represented the promotional leaflet was posted online through social media (Facebook, Twitter and Instagram). Religious establishments such as the Mosque's, Gudwara's and Temples were also approached to be identified as promotional sites. Materials were not translated into other languages for participants whose first language is not English.

Participants

Inclusion criteria

Participants were included in the study if they were:

- Of a Pakistani, Indian or Bangladeshi ethnic background
- Female and at least 18 years of age
- Accessed (completed treatment in the last six months) or currently accessing face-to-face psychological therapy at either Step 2 or Step 3 (CBT or Counselling) within a service that offers an IAPT model.
- Must be able to speak English, Urdu, Punjabi or Mirpuri.

Procedure

The interview schedule (Appendix A) was informed through previous research (Rabiee & Smith, 2014). The interview schedule was chosen as it explored both positive and negative aspects of accessing mental health services for BME communities (Appendix B). Through informal networks the researcher made contact with South Asian women who accessed IAPT and they were involved in reviewing the interview schedule. This was then adapted to include questions on how

individuals experienced access to therapy, rather than access to mental health services in general.

Once participants expressed an interest they were contacted by the researcher and were given additional information about the study. An invitation letter (Appendix D) and a study information sheet (Appendix E) was sent either via email or post and participants were given 24 hours as the shortest amount of time before making an informed decision. Before taking part in the interview written consent was obtained (Appendix F).

Interviews were conducted face-to-face or over the telephone. All interviews lasted between 30-60 minutes. Participants did not receive any monetary payments for taking part. All interviews were audio recorded and were deleted immediately after being transcribed verbatim.

Overall Sample

Sample size for a Thematic Analysis is dependent on several factors. Turpin et al. (1997) state that for the purpose of completing a Doctorate in Clinical Psychology thesis, a sample of eight is appropriate. A target of eight was set for recruitment. Overall, four participants responded to the social media advertisements and all agreed to take part. An additional 16 clients were identified from staff within IAPT teams and were invited to take part in the study. Of these 16, 10 did not respond to the invitations and six agreed to take part. A total of 10 participants were recruited into the study. All participants were informed of their right to withdraw from the study, until data analysis took place (February 2019).

Participants were recruited from IAPT services across the West Midlands, Central, North, East and West London. Demographic information for the 10 participants can be found below in table 1.

<i>Pseudonym</i>	<i>Age</i>	<i>Ethnicity</i>	<i>Treatment received</i>	<i>Other background information</i>
Tam	32	Indian	1:1 Step 3 CBT	UK born. Received treatment for recurrent depression. First contact with IAPT.
Ashi	39	Indian	1:1 Step 3 CBT	Non UK born, lived in the UK for 15 years. Presented with low mood and stress.
Bal	31	Indian	1:1 Step 2	Non UK born, residing in the UK for over 10 years. Working full time. Sought help for anxiety and low mood. First episode and first contact with IAPT.
Aliyah	20	Bengali	1:1 Step 3 CBT	UK Born. Student. Experiencing depression. Depression has been ongoing for 2 years. First contact with IAPT.
Kam	40	Indian	1:1 Step 2	UK born, working full time. Sought help for anxiety and low mood. First contact with IAPT.
Sara	34	Bengali	1:1 Step 3 CBT	UK born, full time carer. Received support for depression and bereavement. First referral into IAPT.
Nish	53	Indian	1:1 Step 3 Counselling	Non UK born, residing in the UK for over 20 years. History of depression has accessed IAPT five times and has received CBT and counselling in the past with IAPT.
Halimah	47	Bengali	1:1 Step 3 CBT	Non UK born, residing in the UK for over 25 years. One previous referral to IAPT. Sought help for depression.
Amira	23	Pakistani	1:1 Step 2	UK Born, full time student. Received support for low mood. First contact with IAPT.

Aisha	27	Pakistani	1:1 Step 3 CBT	UK born. Received support for depression triggered by difficult family dynamics. First contact with IAPT.
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Table 1: Demographic information for participants

Ethical Approval and considerations.

Independent peer review approval for the study was granted by Staffordshire University (see Appendix G). Additional ethical approval was granted by the West Midlands South Birmingham Research Ethics Committee (Appendix H). Further approval was also sought and granted by each of the NHS Trust Research and Development Departments in which the study took place (Appendix I). Full written informed consent was obtained from each participant and the data was anonymised to protect the privacy and identity of each person.

Data Analysis

The data collected was analysed using Thematic Analysis, which aims to systematically identify, organise and offer insight into patterns and report patterns or themes across a data set (Braun & Clarke, 2012). Thematic Analysis was chosen over other methods for its flexibility as it allows the researcher to make sense of shared meanings, rather than individual experiences as in Interpretative Phenomenological Analysis (IPA). Given the limited research in this area, an inductive approach was used to identify themes at a semantic level. This means that the themes identified are strongly linked to the data themselves (Patton, 1990), rather than being driven by predetermined concepts. Coding at a semantic level means themes are derived within the explicit or surface meanings of the data, rather than looking beyond what the participant has said. In this way participants are giving a voice to the experiences of the world around them (Braun & Clarke, 2013). The researcher also takes an essentialist/realist epistemological approach to help describe experiences.

In Thematic Analysis patterns are identified through a rigorous process of data familiarisation, data coding, theme development and revision of themes. Data collected from the interviews was initially transcribed (Appendix K) and was then analysed using Braun and Clarke's (2006) six-phase method (Appendix J). Each interview was read and re-read three or four times to develop familiarisation with the data and initial codes were generated. Themes and sub-themes were then generated from these codes. Each theme was reviewed, defined and re-named in relation to the data across the whole data set (Appendix L). Quotes were identified to support each theme and the final quotes used were selected to represent a range of participants' views. Throughout analysis a reflexive journal was maintained to allow the researcher to consider how biases may have impacted the findings. To ensure rigour an independent researcher reviewed a sample of the data set and the themes to check their credibility.

Appendix Q illustrates the theme development process which contributed towards the final themes and subthemes, along with the participants who were included in each theme.

Results

A total of six themes were identified: "Access", "Experience", "Cultural Framework", "Therapist characteristics", "Expectations" and "Sticking with it". Figure 1 below illustrates these themes and the relationships between them.

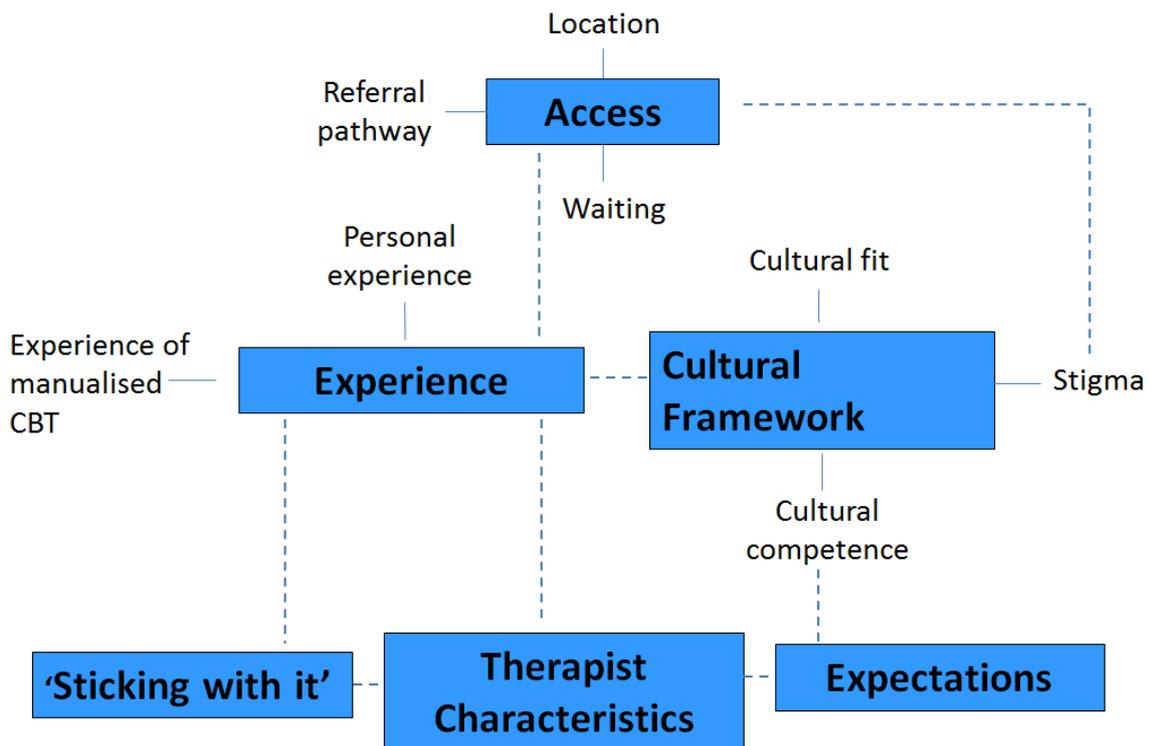


Figure 1: Thematic Map of themes and subthemes. Links between themes and subthemes are identified by the dotted lines.

Access

All participants spoke of their experience of entering the IAPT service, which was mainly perceived as positive and allowing easy access into the service. This theme was divided into three sub-themes: referral pathway, location and waiting.

Referral pathway

Most participants reported that they had sought help when things reached 'crisis point'. Participants either chose to seek help through the self-referral pathway, asked their GP to be referred into IAPT or were told by their GP to self-refer into IAPT.

“Things got to the point where I had a lot of stress from work as well so I broke down and I thought I needed actual help...So I went to my doctor and I said I am feeling really anxious and stressed...so I asked for medication and CBT therapy. I was very specific as to what I wanted because I knew I [inaudible] just wanted to get better”.

Aisha, 27.

Some participants reported reluctance from the GP to make a referral for Psychological Therapy even when they asked to be referred.

“...I went to the doctor and he told me but I feel he was very reluctant even when he did tell me [about IAPT]. It was almost as if I have to have the knowledge first and I have to go to the doctor and then tell the doctor ‘oh by the way I have heard about this therapy, can you do something about it?’ Then they would say, oh yes, we will refer you”.

Ashi, 39.

The self-referral process was described as fairly straightforward and easy for most participants. Although this process was smooth, some participants felt it added to their difficulties and was described as another hurdle to overcome. For these individuals, they would have preferred the GP to make the referral to IAPT on their behalf.

“When I had to self-refer I still did it but I don’t think it’s ideal because you are depressed and you lack motivation and you are...er...and you are trying to seek help...It doesn’t really help to be in that mental condition and then actively phoning to do that assessment. It is a big leap.

Halimah, 47.

“I saw that they had a self-referral form that you could fill out online, so I filled that out and just waited to hear back...I mean, it was really straightforward. It wasn’t too long and they didn’t ask me difficult questions. In fact, I thought it

was quite good”

Kam, 40.

Location

All participants reported that the IAPT service was easily accessible due to the location of the therapy sessions. These were in community buildings or at the GP practice. Eight of the ten participants found that the service was very flexible and were offered therapy sessions that fitted around work and family commitments. Some participants reported there was a lack of flexibility with appointment days/or times but it was recognised that this was because the participant required a particular therapist, or the therapist could only offer therapy at a particular location on certain days.

“The lady who I am seeing said she can only see me on Mondays because she offers the CBT”.

Amira, 23.

“To be fair I think the location was quite good, I thought it was quite good that they had options of being seen in different locations...I think they were quite structured and quite rigid because they said that I needed a particular type of therapist...not all of them could come to my location so that narrowed it down quite a lot which meant I had less flexibility”.

Tam, 32.

“It was a few minute’s walk from my work...It’s literally down the road.

Halimah, 47.

Waiting

Most participants described waiting for the outcome of their assessment as anxiety provoking and frustrating.

“Somebody is deciding whether or not you are sick enough to have support... You also have to think do you have to exaggerate your difficulties

so they can offer you some support...It's probably the system behind it so maybe after the assessment they need to give you some sort of feedback, you know?...it's almost like a waiting game. You don't know if you are going to get accepted or not".

Ashi, 39.

"It takes a bit of time to get going. It's frustrating just waiting and not knowing what is going to happen".

Sara, 34.

Eight of the ten participants reported a long waiting period between having their assessment and having their first one-to-one therapy appointment.

"I mean, it took a very very long time. The first time I went to counselling I think it took me about four or five months. Having CBT was even worse, I had to wait a little more than six months".

Ashi, 39.

Waiting for therapy often led to the development of unhealthy coping mechanisms or a deterioration in participants' mental wellbeing.

"So the fact that I was waiting for however many weeks I was waiting, it was...in that times, like, I kind of developed my own coping mechanisms, which weren't exactly helpful for myself".

Aliyah, 20.

Experience

Participants reported mixed feelings about their experiences of accessing IAPT. This theme has two sub-themes: Personal experience and Experience of manualised CBT.

Personal Experience

For some participants there was a sense that they did not feel that they were unwell enough to access therapy and that appointments should be offered to people who

really needed it, thus demoting their own importance. Some described not feeling worthy of having therapy and experienced a sense of 'not belonging' when they accessed therapy.

"I mean, I thought they were always booked out so give it to someone who needs it more"

Aliyah, 20.

"My biggest problem was that I used to tell myself that I am not really sick enough, and that I should be at work".

Ashi, 39.

When participants felt disappointed in the therapy, they felt they could not openly discuss their concerns with the therapist as to not upset or worry the therapist. Instead, there was a sense that participants should be grateful for receiving a free service, rather than expecting more.

"There's no way I could explain to her that it's not helping and the reason why is because your counselling is rubbish, or whatever. I couldn't say that".

Aliyah, 20.

"When you go for counselling, especially in the NHS, maybe sometimes you feel I should be grateful that I am getting this for free and I should just accept this".

Ashi, 30.

Within IAPT, cut off scores indicate whether a person's symptoms are sufficiently severe to be considered a clinical problem (caseness). Participants found that the interventions they were offered and the level of support they received was very much based on caseness. This left some feeling less prioritised compared to those with higher levels of perceived risk.

"I know there are so many people to help, so it's like, they have to be prioritised, the people who are suicidal...I did have suicidal thoughts but it's not something that I am going to act upon, so that makes me not so

threatening in their world. So maybe that's why they pushed me down".

Bal, 31.

For some, they had little control over what treatment interventions they could receive as interventions were based on the severity of mental health difficulties. This did not always meet the needs of the participant.

"I got the impression, well...erm the lady said that I was almost too low risk to be having face-to-face first so it meant I had to have a workshop first. I wasn't happy but I needed the help, so I did".

Kam, 40.

Participants described the therapeutic environment as clean and welcoming. For two individuals it was uninviting and the therapy rooms felt very clinical and formal.

"The therapy rooms were also quite tidy".

Ashi, 39.

"To me, that..er...I just felt it was like a...er...interview setting, not like an informal chat but an interview. So I felt pressure with what I was saying...it was like when you go into an interview and you sit opposite one another..."

Aliyah, 20.

Experience of manualised CBT

Participants spoke of their cultural experience in the context of the therapy models, such as CBT and counselling. Participants who received CBT found that this offered them practical advice and support on how to manage their difficulties. It helped participants to understand the connection between their thoughts and behaviours in order to bring about change.

"I am enjoying CBT, I am learning a lot more about my own issues...I knew the principles of CBT but I didn't connect the dots together, like, connecting my thoughts to these behaviours".

Amira, 23.

Although manualised CBT treated the symptoms of mental health difficulties, CBT and the IAPT model was perceived to be a eurocentric model that does not cater to

issues faced by South Asian women, even if manualised CBT was delivered by a South Asian therapist.

“I don’t think those steps were made for people of colour. These are modelled upon White people, come on! Those are not models of people for colour, those are standard procedures that were not tried and tested or based on the context of what brown people face...like, immigration, detention centres, non-papers...those are our mental health issues...I don’t think those models were based on brown people’s mental health concerns”.
Bal, 31.

“Maybe the person who is running IAPT or is designing things is probably a White man or a White woman. I don’t think there’s somebody on board who thinks, for example, London is a hotbed of different cultures so we should integrate that into our counselling...They need to remember that one model of one solution doesn’t fit all”.
Ashi, 39.

“The thing is if the South Asian practitioner is bound to follow the rules that are given to her, it will still not work. There will be empathy, sympathy, there will be understanding but she will still have to follow the rule book, right?”
Bal, 31.

Manualised CBT was perceived as very structured and goal orientated which was often experienced as ‘textbook therapy’. Due to the structure and rigidity of CBT, there was little scope to discuss cultural issues that were related to mental health. This felt very limiting. One participant spoke of searching for additional therapy outside of IAPT that would incorporate her cultural needs.

“I was in a very depressed state at that moment and he was so obsessed with his paperwork [homework], I didn’t feel like we were getting to the root of the problem. It was sort of like textbook therapy”.
Sara, 34.

“The therapy sessions are quite structured so there’s no time to talk about those things. At the moment I am purely looking at how I can respond to the

thoughts that I have...culture is irrelevant right now” [to the therapist].

Halimah, 47.

“For the cultural stuff I think I might just have to look online to see if there's any groups or if there's anyone in particular I can talk to elsewhere”.

Aisha, 27.

The structure of CBT met the needs and expectations of participants who wanted a more practical approach to overcoming their difficulties and whose mental health was not related to their culture.

“She gave me homework too, which I quite liked”.

Tam, 32.

“I like that structure, especially with CBT...each session we start off with an agenda and I really like that structure. It feels less wishy washy, feels like a solid step-by-step thing that will help me”.

Amira, 23.

Cultural Framework

Culture and religion were a part of participant’s mental health difficulties and for some, a part of their identity; however, culture and religion was almost always not included in the therapy. This theme contains 3 sub-themes: cultural fit, cultural competence and stigma.

Cultural fit

To effectively access psychological therapies participants made a forced choice to either; deny their culture completely or say that the culture was not related to their mental health difficulties; to leave their culture outside of therapy even though it was part of their identity; or to bring their culture and religion into the therapy as it was seen as part of their identity.

“I suppose it would have been nice to have my culture recognised. I mean, it’s a part of who I am. But I just didn’t think the two could go together. I couldn’t see how my culture could be brought into therapy to help me with

my depression so I just never spoke of it”.

Kam, 40.

Cultural competence

Eight out of ten participants reported that their therapist or counsellor had very little understanding or awareness of the client’s own cultural context and this negatively impacted on their experience of therapy.

“We have a good relationship but she just cannot understand the context from which I am speaking, so that makes the therapy not effective. That’s the thing. Like, my relationship with her is fine but my problem is that the therapy is not effective because she does not understand the context from which I am coming from, and that’s my problem”.

Bal, 31.

“If the person understood my cultural background better then that might have an effect on the therapy that I am having. Unless you are coming from that community it’s hard to grasp where I am coming from. For example, when talking about issues such as arranged marriage, you can’t understand that impact unless you understand the community”.

Halimah, 47.

This was not the case for one participant who felt her therapist was culturally aware and was able to respond appropriately because he was from a similar cultural background and shared the same religious beliefs.

“I think his approach and the way he did things, he did see it from a cultural perspective and he started from there. He did ask about my religious feelings because I was very suicidal and he was exploring that with me...I think it’s good he worked with that”.

Sara, 34.

Participants who described their faith as central to their identity felt disappointed by the therapist’s lack of understanding of the importance of religion and the significant

role this has as a protective factor. This played a part in the client discontinuing therapy.

“She was asking me if I had any thoughts about death or self-harm and I said yeah. When she asked what was stopping me, I said God. She obviously didn’t understand why and the relationship a Muslim has with God and the fear of carrying out certain acts.

Aliya, 20.

Participants reported that explaining their cultural context to the therapist took up a lot of time, which could have been spent focusing on their main difficulties.

“I tried to explain a lot of things to her. Like, I tried to explain why we do this and why that happens. I tried to give her context to everything...And then I found I wasn’t even talking about my problems”.

Bal, 31.

“You have to set the basis of your culture and then you tell them about the problems you have. By the time you have done that four sessions have gone”.

Ashi, 39.

Cultural experiences were pathologised and experiences were only seen through the lens of a western understanding of mental health. Participants felt that therapists from White British backgrounds were unaware of their cultural context which differed to that of the participants.

“...But she doesn’t understand the context that that is what the government is doing to people of colour...She thought what I said, based on evidence, was something of paranoia...her experience has been there are White people who may be paranoid about the authority and so she has categorised me into that box”.

Bal, 31.

“I couldn’t really remember my parents hugging me, giving me a kiss or expressing their love by saying I love you. It was something that was very alien...The only time you would feel a lot of love is when they try and stuff you with food...That was the way they showed their love. So if you were to go to counselling and tell your therapist that, for them that’s probably something they wouldn’t understand and maybe assume that’s why she is like that now. She is like this because her parents never hugged her or told her they loved her”.

Ashi, 39.

Culture and religion were excluded from therapy even when this appeared to play a significant role in the participant’s mental health difficulties. This led to participant’s feeling as though only a small part of them was being understood.

“We spent a lot of time talking about the difficulties I have with the men in my life but this wasn’t from a cultural perspective. Nothing like that was talked about”.

Nish, 53.

“The fact that my culture is related to my mental health is not really talked about at all in the 1:1...I mean it’s a shame but I managed to work around it but it’s a shame because it’s a big part of my identity.

Aisha, 27.

When therapists did attempt to make cultural adaptations they did not meet participants’ cultural needs, instead these were seen as poles apart.

“There was no correlation between the CBT techniques and it being tailored to me....I don’t think she could even provide any culturally appropriate examples of ways to deal with the things I was going through...The strategies were very much poles apart”

Aliyah, 20.

“No, I think they are very generic”.

Halimah, 47.

Stigma

All participants reported that stigma around mental health was still a very topical issue in their lives. Stigma was experienced from others such as family, friends, the workplace and even the GP.

“I never really told anyone, I mean I couldn’t tell me mum or my aunt...if I told them and al’ve got the help and I got better that would be attached to me for the rest of my life”.

Aisha, 27

Some participants recognised that self-stigma, such as self-judgment, impacted on engagement with the therapist which was perceived as very confusing and conflicting.

“When you are having somebody doing an assessment on you, you might be thinking that they are thinking the same thing that you think. It can make you feel as though somebody is judging you, but maybe it’s in your own head not believing in yourself. This can be very conflicting and very confusing”.

Ashj, 39

Despite the stigma people faced, this did not prevent them from accessing psychological therapy. Motivation to get better seemed to override the feelings of shame and stigma which allowed all participants to access therapy.

“Even though I worry about that and there is shame and stigma, I know I have to go and do this and do this for myself so that I can get better. Otherwise, I suffer”.

Sara, 34.

Therapist Characteristics

Therapists were described as knowledgeable, warm, trusting, empathic, non-judgmental and as good listeners. They were good at offering participants practical

advice and support to manage their mental health difficulties. For three participants their therapists were seen as inflexible and rigid. For some therapists, this appeared to be mediated by the rigidity of the manualised approach.

“They gave me lots of information to help me with my feelings and that was really helpful”.

Nish, 53.

“She is very warm and I trust her”

Amira, 23.

“My current therapist is just very understanding and that’s why we have a good relationship”.

Tam, 32.

“She didn’t seem to be flexible...I think she was just too rigid and TOO structured. She told me that erm, if I didn’t attend an appointment I would be discharged”

Kam, 40.

Four participants reported that their therapists were seen as dynamic and flexible in their approach to therapy which fit the needs of the participant.

“...So he is very, erm, I don’t know the word, erm, dynamic. He just sort of works with me and says ok if you don’t to do this can you do this?”

Sara, 34.

“I think the fact that she was able to adapt rather than fix something that isn’t the main issue...the fact that she was able to jump to the main issue, it helped me to realise what my own problems were”.

Aisha, 27.

Age differences between the therapist and the participant had a negative impact on the therapeutic relationship for two participants. Some participants perceived White British therapists as privileged and therefore felt they could not understand the cultural issues and context of South Asian Women.

“She’s [therapist] black...I think it’s been helpful to talk to someone who is not from a privileged background, if that makes sense”.

Aisha, 27.

“He was really young...the problems that I am talking to you about you haven’t really experienced them, so you won’t get where I am coming from”.

Sara, 34.

“I don’t want to sound condescending but a White woman can’t understand our problems and that’s it.

Bal, 31.

Five participants felt they needed to be seen by a South Asian therapist who could understand their cultural context and their needs. Three participants spoke of preferring to have a therapist who was warm, trusting, adaptive and who could tailor therapy to meet their needs, regardless of their ethnicity.

Expectations

Participants spoke of their expectations of the service which were either met and led to a satisfaction with the service, or unmet, leading to a sense of dissatisfaction and disengagement with therapy. One participant spoke of the mismatch between what they attended therapy for and the therapist’s own agenda. For example, wanting to focus on the here and now versus childhood experiences. This resulted in the participant dropping out of therapy.

“She looked more into my childhood rather than the issues that I was currently facing...Like, she looked deeper into that than I personally was attending counselling for...I don’t feel like we spoke about it enough, hence why I cancelled my sessions after three or four sessions”.

Aliyah, 20.

Expectations were met when therapy was focused on issues relevant to the clients, where appropriate cultural or religious adaptations were made for those who felt it was necessary and when participants had a good relationship with the therapist.

‘Sticking with it’

Participants spoke of the key motivators that kept them engaged in therapy, despite the feelings of shame and stigma that were attached to accessing support. There was a sense that when the expectations of the service or the therapy were not met participants just ‘stuck with it’ as therapy was seen as the only option to improve their mental wellbeing.

“I think I just stuck it out because I needed the face-to-face. To be fair, erm, I think I stayed for myself, knowing I needed the help. That was important for me”.

Kam, 40.

“I know my mental health has deteriorated for the past one year and I have to take care of it. This is the only option that’s why I have to stay...if I get out I’ll probably have to wait for another year to get into something...”.

Bal, 31.

Through their interviews participants were able to tell a ‘story’ about their process of accessing therapy. Figure 2 below highlights the interplay between participants’ cultural fit, their expectations and the impact on engagement.

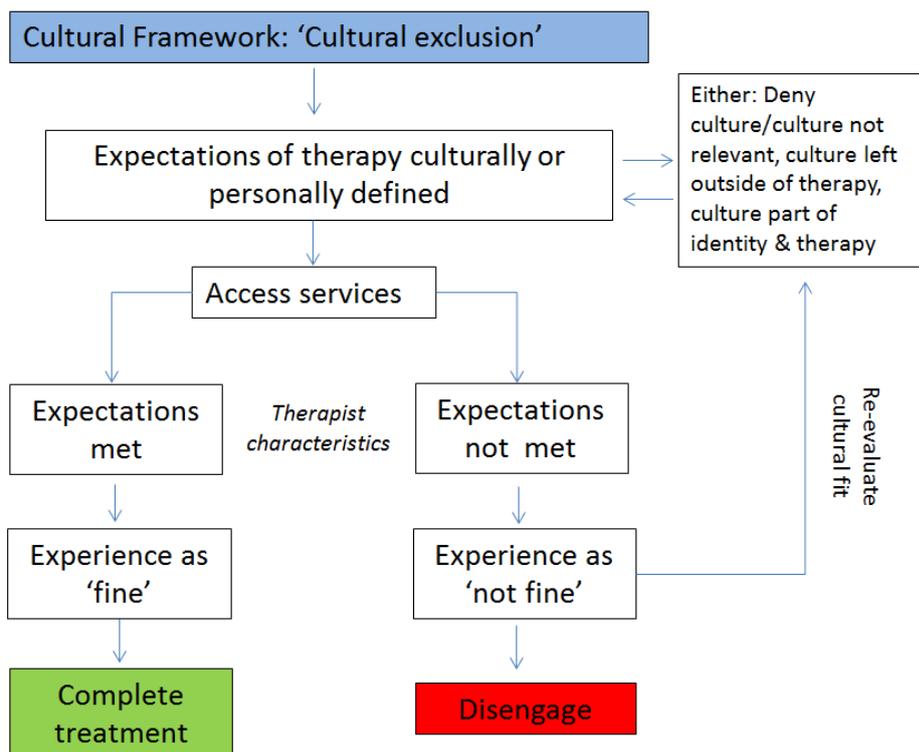


Figure 2: Flow chart of the process of accessing and engaging in psychological therapy.

From all the participants there was a sense that expectations of therapy were either culturally or personally defined. This involved making a decision to either: deny their culture or argue that culture was not relevant to their mental health difficulties; to acknowledge that culture was part of mental health but to leave culture out of the therapy; or to attempt to integrate culture into therapy. This would lead individuals to then access therapy. If expectations were met the therapy was experienced positively; however, if therapy did not meet expectations then this was experienced as 'not fine'. Individuals would then either disengage from therapy or re-evaluate their cultural fit. The therapist characteristics and the therapeutic relationship with their therapist also influenced the experience of therapy.

Discussion

The aim of this study was to explore the experiences of South Asian Women who have accessed psychological therapies with IAPT. The results have successfully shown both positive and negative experiences of accessing therapy and have highlighted what aspects of the service make therapy accessible for this population. A thematic analysis of the data yielded six main themes: access, experience, cultural framework, therapist characteristics, expectations and 'sticking with it'. The findings provide a current and up-to date insight into the processes that South Asian women face in therapy. The interactions between the themes and sub-themes are a clear reflection of the complex experiences that South Asian women face when engaging in talking therapies within IAPT.

Whilst participants' experiences were being explored as a whole, it is likely that some themes, such as, access and therapist characteristics and stigma may reflect experiences across other ethnic groups. Stigma towards mental health is not unique to this group; however, BME populations tend to have higher levels of stigma compared to Caucasians, which impacts help seeking (Brown et al., 2010). The impact of positive therapist characteristics on therapy outcomes has also been found across various ethnic groups (Ackerman, Hilsenroth, Baity & Blagys, 2000; Ackerman & Hilsenroth, 2003; Martin, Garske, Davis, 2000). Themes such as, cultural fit, personal experience and, experience of CBT appear to be unique experiences to this group. The process of accessing psychological therapy, which is mediated by the clients' expectation and cultural fit, is also particularly unique to this study and has not been reported elsewhere.

In-therapy processes were linked to their experience of being in therapy. A positive therapeutic experience was underpinned by factors such as: a good therapeutic relationship with the therapist; the expectations and the needs of the client being met by the therapist; whether the therapy is congruent with their cultural fit; and whether the therapist was perceived to be culturally competent.

There are specific cultural issues that may impact on engagement that need to be acknowledged. The increased political sensitivity in the area of race relations means that some people may fear talking about racial stereotypes and discrimination. For some South Asian women, therapists may be seen as figures of authority. Within a

South Asian culture figures of authority tend not to be challenged as they are seen as individuals with wisdom and knowledge. This places the power in the hands of the therapist thus creating a dynamic that puts the client in a difficult position to voice their concerns in therapy. Transcultural therapy recognises that the individuals' experiences are intrinsically linked to the wider social and political context. Bringing these into the open and addressing the impact of power imbalance on the therapeutic process in therapy ensures that a level playing field of shared power exists.

In transcultural therapy professionals have a duty to increase their understanding of the culture, life history and social circumstances of the people they are working with, without being the expert (Johnson, 1993). Being culturally competent not only requires the therapist to have an *understanding* and *awareness* of the client's cultural context, but it is about being actively attuned to the participant's culture and being able to appropriately respond to their cultural context and *adapt* evidence based treatments for different groups. This was essential only for those who felt their culture was part of their identity or where mental health was directly related to their culture. Similarly, clients who perceived themselves to be religious, experienced satisfaction with therapy when their religion was incorporated or addressed in therapy. This did not apply to individuals who perceived themselves to be non-religious.

Mclean, Campbell & Cornish (2003) saw cultural exclusion as the "inability of mental health services to offer appropriate understanding to clients who are not from the majority white population" (Bowl, 2007, pg. 4). Whilst cultural exclusion and insensitivity has been found in psychiatric and mental health services (Bowl, 2007), it appears that psychological services, such as IAPT, have also not escaped this. This study has found that cultural exclusion led to a sense of dissatisfaction for eight participants. In contrast, a small minority did not think cultural inclusion was necessary as they did not see the connection between their mental health and culture. Services must therefore create a context of being openly curious and responsive about individuals' cultural fit in order to be truly culturally inclusive and to provide meaningful services for South Asian communities.

Manualised CBT and CBT based interventions that are not culturally/religiously adapted appears to be ineffective for individuals whose culture and cultural context is an integral part of their identity and, to some extent, is related to their mental health difficulty. These findings are not unique to this study. Rathod et al. (2010) found that therapists would often avoid issues around culture for fear of saying the wrong thing or for being politically incorrect. They found that white therapists felt that therapy was the same for everyone, and as such, cultural adaptation was unnecessary. Findings suggest that manualised CBT appeared to leave little scope to incorporate culture; leading participants to feel their cultural values were being ignored and misunderstood, even when delivered by a South Asian therapist. In contrast, counselling approaches were perceived more positively from participants who preferred to tell their story rather than to treat the symptoms. These findings can be best understood through understanding the models of ill health. In the West the goal of therapy is to control or get rid of its symptoms through insight and action. In the East (Asia) distress is seen as lack of harmony and so the goal of therapy is enlightenment through individual striving and seeking, and personal, subjective experiences rather than taking action (Fernando, 1991). In order for therapy to be truly individualised it is necessary to understand the cultural context and to adapt approaches accordingly.

The 'Improving Access to Psychological Therapies Manual' (2018) sets very clear guidance on developing local IAPT services. The guidance details the need to conduct thorough assessments for the appropriate treatment intervention but what is missing is the exploration of the impact of one's culture, cultural context and religion on mental health difficulties. Little thought has been given to the need for cultural and religious adaptation of therapeutic interventions. In-therapy processes that can lead to either engagement or disengagement within services therefore also need to be addressed.

In this instance, therapy within IAPT has not enabled clients to re-frame their experiences within their own cultural context, given how culture has been excluded from therapy for most participants.

Strengths and Limitations

The complexity of the experiences of those who accessed IAPT services may be a feature of the group of people who took part. The approach to recruitment may mean that only those with certain experiences may want to take part in the study. In addition to this, the lack of translated materials and interpreters may mean that these results are not generalizable. Due to limited resources materials could not be translated into various South Asian languages. Difficulties in using a translator for non-English speaking individuals meant only those who were fluent in English were able to take part. This means the views of first or second generation migrant South Asian women or non-English speaking women may differ, particularly if so little acculturation has occurred. It is important to note that the views here are taken from six different IAPT services, with each service likely to have its own processes and policies which may impact on experience. Furthermore, only one extra interview was analysed to ensure that there was no more new information before concluding the data to be saturated.

Using thematic analysis has its limitations. Unlike IPA, Thematic analysis does not allow for in depth analysis and flexibility with its processes makes it difficult to concentrate on what aspect of the data to focus on. Another consideration is the role of the researcher in the interpretation of the data. The researcher's own ethnicity and assumptions about the data can influence the selection and interpretation of the data. To ensure that bias was reduced all participants' views were represented in the paper. To further ensure quality control analysis was reviewed with a peer group and a reflective journal was also maintained. These factors should be taken into consideration when interpreting the findings. To improve quality control it may have been helpful to review the themes with the clients who participated in the study.

Implications for Clinical Practice

The findings here are important for key stakeholders, commissioners and clinicians within IAPT. The findings highlight the need for clinicians to explore the extent to which culture and religion impact upon mental health, and the extent to which individuals wish for their culture or religion to be integrated into therapy. Exploring this at the assessment stage can ensure the individuals' expectations for therapy are

congruent with what the clinician (and the service) can offer. Immediate feedback from assessments should also be given to reduce the anxiety of whether they have met the criteria to receive support.

The findings suggest that approaches within IAPT which seek to treat symptoms rather than to consider the individual in the context of the community may be particularly inappropriate for this group. Clinicians within IAPT are evidently well trained at delivering evidence-based psychological interventions. There is however, a need to further train clinicians to provide culturally or religiously adapted evidence-based treatment for those whose mental health is significantly impacted by their culture. Making adjustments to manualised CBT based interventions to incorporate ones culture and religion ensures a sensitive service is being offered. Sensitive services require organisations to make a fundamental shift in their culture in order to accommodate the needs of this population (Moodley, 1993). These recommendations have been noted elsewhere (Hussain & Cochrane, 2002). Providing a sensitive service may also involve consultation with members of the South Asian community with regards to planning and service delivery. Offering a wider range of treatment options than what is currently being offered, for example, developing group sessions solely for South Asian women would also be beneficial. The study has identified that there are a range of ways in which people identify with their culture. In the context of their therapeutic relationship it would be important for therapists to be aware of how a person identified themselves not only at the point of access, but throughout the whole therapy process and to actively engage with this in therapy.

Researcher reflections

A reflexive journal was maintained throughout completing this research. From the researcher's own experience of working in IAPT services, delivering interventions that were inclusive of one's own culture meant it was possible to incorporate religion into therapy and be flexible when delivering CBT based interventions. It was surprising to find that cultural and religious exclusion still exists in mental health

services. This highlights that further change is required on a larger scale in order for all services to be culturally sensitive and inclusive, where necessary.

Conclusion

South Asian women reported the importance of having a good therapeutic relationship with their therapist or counsellor. Having a warm, trusting, non-judgmental and dynamic therapist led to a sense of satisfaction and feeling 'listened to'. Whilst manualised CBT offers practical ways to treat the symptoms of mental distress, it was criticised for being Eurocentric and leaving little scope for clients to address cultural and religious needs. Even within IAPT, some clients experienced cultural and religious exclusion which negatively impacted on their experience of accessing psychological therapies. This study reveals the complex interplay between the clients' expectations of the service, the therapist characteristics, their cultural framework and cultural fit, which services need to be aware of. These need to be addressed in order to keep clients engaged with therapy.

It is evident that experiences of clients vary greatly, and that more work needs to be done with services to ensure that the right treatments are offered within IAPT services which are truly culturally appropriate for South Asian women in the UK.

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Paper Three: Executive summary
**Beyond the Barriers: South Asian Women's Experience of Accessing and
Receiving Psychological Therapy in Primary Care**

Saimah Yasmin-Qureshi

Word count: 2, 411.

Background Information

The UK born and Non UK born South Asian population account for 32.6% of the total population (ONS, 2011); however, research suggests they underutilise mental health services (Buhi et al, 2003; Bui & Takeuchi, 1992).

To improve mental health services for Black and Asian minority ethnic (BAME) communities the UK government has developed several initiatives. In 2007 the government announced the 'Improving Access to Psychological Therapies' (IAPT) initiative in a bid to provide access to psychological therapies for those with mild-moderate depression and anxiety. IAPT aims to provide psychological therapy that is not hindered by one's ethnicity, culture or language (Department of Health, 2008).

To understand why uptake of mental health services are low for South Asian communities a number of barriers have been identified that prevent South Asian Women from accessing mental health services. These include stigma, confidentiality, language barriers, awareness of mental health problems and awareness of treatment options (Meltzer, Bebbington & Brugha et al., 2000; Cinnirella & Loewenthal, 1999; Murray & Buller, 2007 and Amri & Bemak, 2012). Despite these barriers, a large number of individuals have accessed and benefitted from access to psychological therapies with IAPT; however, little is known about their experiences. As little has been done to explore what makes services accessible for South Asian women, it is time to explore what enables some South Asian women to access and to maintain engaged in therapy, despite some of the barriers they may face.

Research Questions

The aim of the project was to:

1. To explore and understand South Asian women's experience of accessing and receiving psychological therapy that uses an IAPT model. What aspects of the service make psychological therapy accessible for South Asian women?

2. Does therapy within IAPT enable individuals to frame their experiences within their own cultural context?

These aims can develop our understanding of how services can be further adapted and evolved to continue increasing access to services and to maintain engagement for this group.

Method

This study used semi-structured interviews to facilitate an in-depth discussion of individuals' experiences of accessing IAPT services. It was felt that a qualitative approach was best suited to capture the detail and richness of South Asian women's experiences of accessing psychological therapy.

Participants

Participants were recruited from IAPT services across the West Midlands, Central, North, East and West London. Participants were also recruited through social media, such as, Facebook and Twitter. Religious establishments such as the Mosque's, Gudwara's and Temples were also approached.

Participants were included in the study if they were:

1. Of a Pakistani, Indian or Bangladeshi ethnic background
2. Were female (aged 18+).
3. Have accessed (completed treatment in the last six months) or currently accessing face-to-face psychological therapy within a service that offers an IAPT model.

The sample consisted of 10 participants, four of which were recruited through social media and six were recruited from within IAPT services.

Procedure

Ethical approval was obtained prior to starting the research.

Once participants expressed an interest they were contacted by the researcher and were given additional information about the study. Informed consent was gathered

before completing the interviews. Interviews were conducted face-to-face and over the phone. All interviews lasted between 30-60 minutes. Participants did not receive any payments for taking part and all interviews were audio recorded.

Analysis

The data collected was analysed using Thematic Analysis, which aims to offer insight into patterns and themes across a data set (Braun & Clarke, 2012).

Key Findings

A total of six themes were identified: “Access”, “Experience”, “Cultural Framework”, “Therapist characteristics”, “Expectations” and “Sticking with it” (Figure 1 below).

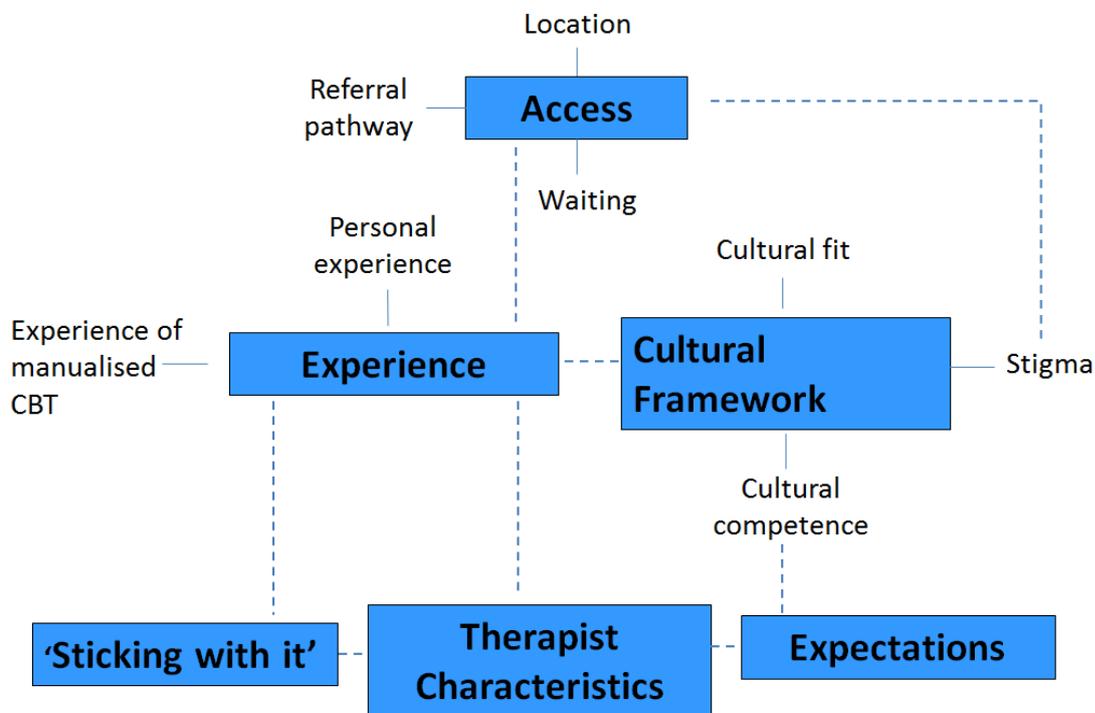


Figure 1: Thematic Map of themes and subthemes. Links between themes and subthemes are identified by the dotted lines.

Access



All participants spoke of their experience of entering the IAPT service. This was mainly perceived as positive and allowed easy access into the service.

Referral pathway

- Most participants reported that they had gone to seek help when things reached 'crisis point'. Participants either: chose to contact the IAPT team directly and self-referred, asked their GP to be referred into IAPT or were told by their GP to self-refer into IAPT.
- The self-referral process was described as fairly straightforward and easy for most participants. Although this process was smooth, some participants felt it added to their difficulties and was described as another hurdle to overcome.

"...it was OK. I mean, it was really straight forward. It wasn't too long and they didn't ask me difficult questions. In fact, I thought it was quite good." Kam, 40.

Location

- The therapy sessions were located in community buildings or at the GP practice. This made the service much more accessible for all participants.
- A lack of flexibility with appointment days/or times was because the participant required a particular therapist, or the therapist could only offer therapy at a particular location on certain days.

"To be fair I think the location was quite good, I thought it was quite good they had options of being seen in different locations. I think they were quite structured because they said I needed a particular type of therapist..." Tam, 32.

Waiting



- Not having immediate feedback from assessments was described as anxiety provoking and frustrating.
- Eight of the ten participants reported a long waiting period between having their assessment and having their first one-to-one therapy appointment. This led some people to develop unhelpful coping strategies and led to deterioration in their mental wellbeing.

“So the fact that I was waiting for however many weeks I was waiting, it was...in that times, like, I kind of developed my own coping strategies, which weren't exactly helpful for myself.” Aliyah, 20.

Experience



Clients spoke of their *personal experience* and *experience of manualised CBT*.

Personal experience

- For some participants, there was a sense that appointments should be offered to people who really needed it, and so they appeared to demote their own importance. Some described not feeling worthy of having therapy and experienced a sense of ‘not belonging’ when they accessed therapy.



- Participants found that the interventions they were offered and the level of support they received was very much based on ‘caseness’, and how ‘sick’ and ‘risky’ they were. This left some feeling less prioritised compared to those with higher levels of perceived risk.
- Most participants did not have control over the interventions offered. The interventions offered did not always meet the needs of the client. For example, being told to attend a group before they could have one-to-one therapy.

“I got the impression, well...erm, the lady said I was almost too low risk to be having face-to-face so it meant I had to have a workshop first. I wasn’t happy but I needed the help, so I did.” Kam, 40.

Experience of manualised CBT



- Participants who received CBT found that this model offered them practical advice and support on how to manage their difficulties. In particular, it helped participants to understand the connection between their thoughts and behaviours in order to bring about change.
- The structure of CBT met the needs and expectations of participants who wanted a more practical approach to overcoming their difficulties and whose mental health was not related to their culture.

Cultural competence

- Eight out of ten participants reported that their therapist or counsellor had very little understanding or awareness of the clients own cultural context and this negatively impacted on their experience of therapy.
- Culture and religion was excluded from therapy even when this appeared to play a significant role in the participant's mental health difficulties. This led to participant's feeling as though only a small part of them was being understood.
- Cultural experiences were treated as abnormal and experiences were only seen through the lens of a Western understanding of mental health.

*"If the person understood my cultural background better then that might have an effect on the therapy that I am having. Unless you are coming from that community it's hard to grasp where I am coming from."
Hamilah, 47.*

*"The fact that my culture is related to my mental health is not really talked about at all in the 1:1...I mean, it's a shame but I managed to work around it but it's a shame because it's a big part of my identity."
Aisha, 27.*

Stigma

All participants spoke of experiencing stigma from friends and family. Participants recognised that self-stigma, such as self-judgment, impacted on engagement with the therapist. Despite this, motivation to get better seemed to override the feelings of shame and stigma which allowed all participants to access therapy.

Therapist characteristics

Participants spoke of having a good relationship with their therapist who were all seen as highly skilled at delivering therapeutic interventions.

- Therapists were described as knowledgeable, warm, trusting, empathic, non-judgmental and as good listeners. They were good at offering participants practical advice and support to manage their mental health difficulties.

- Some participants perceived White British therapists as privileged and therefore felt they could not understand the cultural issues and context of South Asian Women.
- Five participants felt they needed to be seen by a South Asian therapist who could understand their cultural context and their needs. Three participants spoke of preferring to have a therapist who was warm, trusting, adaptive and who could tailor therapy to meet their needs, regardless of their ethnicity.

“She is very warm and I trust her.” Amira, 23

“My current therapist is just very understanding and that’s why we have a good relationship.” Tam, 32.

“She’s [therapist] black...I think it’s been helpful to talk to someone who is not from a privileged background.” Aisha, 27.

Expectations

Participants spoke of their expectations of the service which was either met and led to a satisfaction with the service, or unmet, leading to a sense of dissatisfaction and disengagement with therapy. Expectations were met when therapy was focused on issues relevant to the client, when appropriate cultural or religious adaptations were met for those who felt it was necessary and when participants had a good relationship with the therapist.

‘Sticking with it’

The key motivator that kept people engaged in therapy was to get better for themselves, even if they were dissatisfied with the therapy. Participants spoke of ‘sticking with it’ as therapy within IAPT seemed like the only option to improve their wellbeing.

A process of accessing and engaging in psychological therapy was identified through the interviews. This process highlights the complex relationship between participants’ cultural fit, their expectations and the impact on engagement (Figure 2)

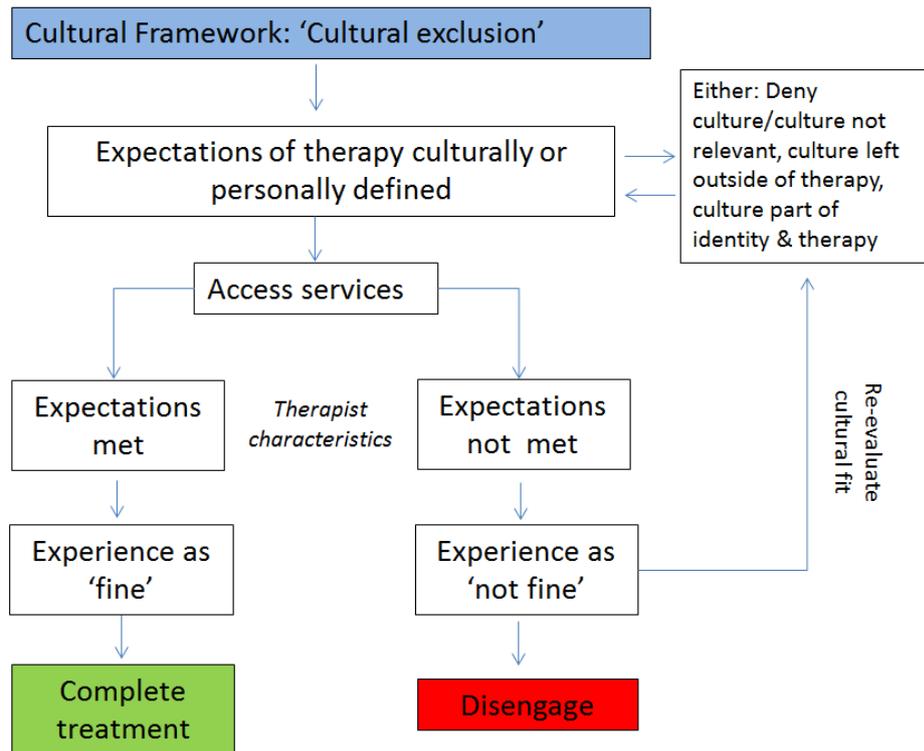


Figure 2: Flow chart of the process of accessing and engaging in psychological therapy.

In order to access and maintain engagement in therapy individuals were forced to make a decision to either: deny their culture or argue that culture was not relevant to their mental health difficulties; to acknowledge that culture was part of mental health but to leave culture/religion out of the therapy; or to attempt to integrate culture into therapy. This would lead individuals to then access therapy. If clients' expectations of therapy were met the therapy was experienced positively; however, if therapy did not meet expectations then this was experienced as 'not fine'. Individuals would then either disengage from therapy or re-evaluate their cultural fit. Positive experience of therapy was also influenced by therapeutic characteristics.

Conclusion

Six themes were identified: "Access", "Experience", "Cultural Framework", "Therapist characteristics", "Expectations" and "Sticking with it". Overall, participants reported that IAPT services were easily accessible using the online and self-referral options. For some, access was difficult particularly if they experienced some resistance from

their GP to refer them into IAPT. Individuals who felt their mental health was related to their culture felt dissatisfied with therapy as it appeared to exclude their culture. This was not the case for individuals whose mental health was not related to culture/religion or if culture was not seen as part of their identity.

Manualised CBT and CBT based approaches offered clients practical advice and strategies to improve symptoms of distress. It seems that this left little scope to incorporate cultural or religious issues. Manualised CBT therefore appears to be ineffective for individuals whose culture and cultural context is an integral part of their identity and, to some extent, is related to their mental health difficulty.

Having a therapist who is warm, open, trusting and who is able to adapt therapy to meet the individuals' needs was important for all participants.

Overall, a positive therapeutic experience was determined by three main factors

1. A good therapeutic relationship with the therapist
2. Expectations and the needs of the client being met by the therapist
3. Whether the therapy is congruent with their cultural fit and whether the therapist was perceived to be culturally competent.

In this instance, therapy within IAPT did not appear to allow participants to frame their experiences within their own cultural context as this was almost always excluded from therapy.

Whilst participants' experiences were being explored as a whole, it is likely that some themes, such as, access and therapist characteristics and stigma may reflect experiences across other ethnic groups. Themes such as, cultural fit, personal experience and, experience of CBT appear to be unique experiences to this group. The process of accessing psychological therapy, which is mediated by the clients' expectation and cultural fit, is also particularly unique to this study and has not been reported elsewhere.

Recommendations

- 🚩 At present, individuals are not asked about the extent to which their mental health difficulties are affected by their cultural or religious beliefs and whether

or not it would be important for them to incorporate these into therapy. Doing so, would ensure that the client's expectations of therapy are met.

- ✚ It is important that therapists are open and display genuine curiosity about a client's cultural context and religion, and where possible, to incorporate these into therapy.
- ✚ For IAPT services to offer flexible treatment options that are not solely based on 'caseness' but that also incorporate clients' needs and goals for therapy.
- ✚ For services to ensure that information sheets and reading materials are culturally appropriate and addresses issues specific to South Asian Women. This would create a sense of inclusion and belonging.
- ✚ As some participants felt their therapists lacked cultural awareness it may be helpful to offer matching therapists to the client's own ethnicity.
- ✚ To offer staff the opportunity for further training to understand ways in which religion and culture can be incorporated in therapeutic CBT based interventions such as, Behavioural Activation and Cognitive restructuring
- ✚ It would be helpful to conduct the study with non-English speaking individuals to explore their experiences of using IAPT.

Distributing the findings

The study has been written in part fulfilment of the researchers' professional qualification in Clinical Psychology. This executive summary can be shared with all NHT trusts from which the participants were recruited and will be shared with all the participants who have requested a summary of the results.

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Appendix A: Interview Schedule



Interview Schedule – Users

“Beyond the Barriers: South Asian women’s experience of accessing and receiving psychological therapy in Primary Care”.

Greeting, Introduction

Setting ground rules and explaining issues around confidentiality and risk.

Ice Breaking Question: “Tell me about yourself”

Main Questions

Can you tell me about the psychological therapy service you use/previously accessed?

(probes – how long have they been under the team, what type of therapy they are seeking, the place they access the therapy).

Can you tell me about your experience of using this service (probe- statutory? voluntary? Pick up any positive or negative aspect)

Can you tell me about the positive aspects of using ... service (probe – explore the process of access, assessment process and engagement in therapy. Ask for an example)

Can you tell me about the negative aspects of using ... service (probe-explore negative aspect in relation to access to the service, assessment process and engagement in therapy. Ask for an example)

How easy is it for you to get help from this service? (probe- explore issues of language, religious belief, racism and discrimination. Consider barriers to access such as location of service, childcare, family. Ask for me some positive and negative examples).

What part of the service made therapy accessible for you? (Probe – consider issues around therapist characteristics, ethnic background of therapist, location of therapy, integration of beliefs/culture/religion and issues around shame/stigma).

How culturally appropriate is this service for you as a South Asian Woman? (probe- explore issues of language, religious belief, racism, shame and discrimination. Ask for some positive and negative examples).

What aspects of your experience of.... service kept you in therapy? (Probe – consider issues around therapist characteristics, ethnic background, importance of integrating religious beliefs/culture/religion).

What changes, if any, do you feel are needed to improve access to psychological therapy for South Asian Women? (Probe-Explore steps needs to be taken).

Thank you for giving us your time and views.

Appendix B: Interview schedule from previous research

An evaluation of the statutory and voluntary mental health service provision in Birmingham for members of the Black African and Black African-Caribbean communities

Interview schedule – Users*

Greeting

Introduction

Setting Ground Rules

Ice Breaking Question:
Tell me about yourself

Main Questions:

Can you tell me about the range of mental health services you use (*probe- types of service, number of years they have used, the place they access these services; voluntary/ statutory?*)

Can you tell me about your experience of using these services (*probe- statutory? voluntary? Pick up any positive or negative aspect*)

Can you tell me about the positive aspects of using ... service (*probe- statutory? Voluntary ask for an example*)

Can you tell me about the negative aspects of using ... service (*probe- statutory? voluntary? ask for an example*)

Can you tell me whether current provision of mental health addresses your needs as a user? (*probe- if not in what way?*);

How easy is it for you to get help from this service? (*probe- explore issues of language, religious belief, racism and discrimination. Ask for me some positive and negative examples*).

How culturally appropriate is this service for you as a Black person? (*probe- explore issues of language, religious belief, racism and discrimination. Ask for me some positive and negative examples*).

In your opinion, what steps should be taken to provide a mental health service for Black people?

What changes, if any, do you feel are needed to improve provision of a good mental health service for Black people? (***Probe-Explore steps needs to be taken***)

In your opinion, what role could users play in improving mental health services for Black people?

Are there any other points that you would like to make about mental health services for Black people?

Thank you for giving us your time and views.

*- Please note that the interview schedule will be piloted amongst 2 users of mental health services, and data generated will be analysed prior to the main study. This step will be taken to ensure that the questions are clear, the timing proposed for the interview is sufficient, and the data generated are able to answer the aims and objectives set out for this study.

Also, please note that this is just a guide to remind us the type of issues needs exploring. Like any interview situations, not all questions set out in this schedule will be asked. Often participants' answers to some of the earlier questions covers the later questions.

Participants Needed Are you a South Asian Woman accessing an IAPT service?

If yes, then we would love to speak with you.

We are looking for volunteers who would be willing to take part in our study.

Summary of study: You will be asked to take part in a 1 hour interview to explore your experience of accessing psychological therapy in the IAPT service.

Eligibility: To take part you must be female (18+) and of an Indian, Pakistani or Bengali ethnic background, accessing or have accessed individual psychological therapy with IAPT. If you are unsure if you meet our criteria please do not hesitate to contact me on my email below.

To take part, or if you would like to any further information please contact Saimah on:

y025086g@student.staffs.ac.uk

Or contact your GP /Therapist.

धन्यवाद شکریہ धन्यवाद



Participants Needed Are you a South Asian Woman accessing an IAPT service?

If yes, then we would love to speak with you.

We are looking for volunteers who would be willing to take part in our study.

Summary of study: You will be asked to take part in a 1 hour interview to explore your experience of accessing psychological therapy in the IAPT service.

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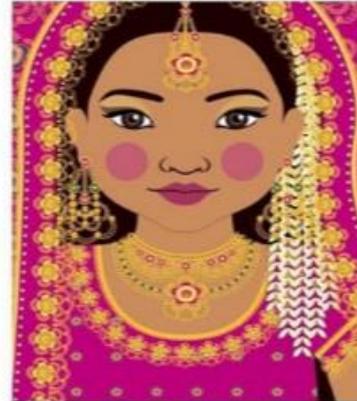
To take part, or if you would like to any further information please contact Saimah on:

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Or contact your GP /Therapist.

धन्यवाद شکریہ

ਤੁਹਾਡਾ ਧੰਨਵਾਦ



Appendix D: Participant invitation letter



Participant Invitation Letter for study: 251189

To whom it may concern,

I am writing to formally invite you to take part in a study which is currently being conducted as part of a student project. You have been invited to participate because you have recently accessed psychological therapy from a service that offers an Improving Access to Psychological Therapies (IAPT) model of therapy.

The aim of the study is to explore your experience of accessing therapy with this service.

Please take your time to read the information sheet which provides further details about the study, and what you can expect should you wish to take part.

If you are interested in taking part, or if you would like further information then please do not hesitate to contact me on: y025086g@student.staffs.ac.uk or you can get in touch with the IAPT team you accessed and I will return your call.

Kindest Regards

Saimah Yasmin-Qureshi

Trainee Clinical Psychologist

Appendix E: Participant Information sheet



Participant Information Sheet. IRAS ID: 251189

Title of study: Beyond the Barriers: Exploring South Asian women's experiences of accessing and receiving psychological therapy.

You have been invited to take part in a research study that is taking place in a service that offers an 'Improving Access to Psychological Therapies' (IAPT) service. Before you decide if you want to take part, it is important that you understand what the research is about and what it involves. Please read the following information sheet which explains the purpose of the study and what will happen should you agree to take part.

Please do not hesitate to ask any questions or if you would like any further information.

What is the purpose of the study?

There is very little literature which explores how South Asian Women experience the process of receiving psychological therapy from an IAPT service. Much of the literature has explored the barriers that South Asian Women experience when accessing therapy, however little is understood about what enables South Asian Women to access services. The study aims to explore what part of services have made psychological therapy accessible to South Asian Women, and what part of the process is experienced as positive to help individuals to stay in therapy. By doing so, we hope to better understand how services can be further adapted to make mental health services easier to access for South Asian Women. The study is a student project being conducted as part fulfilment of a Doctorate Training in Clinical Psychology with the University of Staffordshire.

Who can take part?

You can take part if you meet the following criteria:

1. You are a woman
2. You are from a South Asian ethnic background. This includes Pakistan, India and Bangladesh
3. If you have accessed Psychological therapy with an IAPT service in the last 6 months, or currently in an IAPT service

Do I have to take part?

No, you do not have to agree to take part in this study. Your decision will not affect the care that you are currently receiving. If you decide to take part, you are still free to withdraw at any time, without giving a reason, and you may choose to have your data discarded/destroyed. You can withdraw consent until data analysis is completed which will be **28th February 2019**.

What would I have to do?

If you agree to take part you will be asked to sign a consent form. You will then be asked to take part in an interview lasting for up to one hour. The interview will be conducted by Saimah Yasmin-Qureshi. The interview will be audio recorded, but you will not be identified by your name on the audio recording. We may decide to include direct quotes from the interview in the final report, however your identifiable information will be removed.

Will this interview be kept confidential from my therapist?

Yes. Everything you tell me in the interview will be kept confidential. This means that your therapist, friends or family will not know what you have told me. This is an opportunity for you to be open about your experience, without worrying about what your therapist and others will think.

If during the interview there are any concerns for your safety or the safety of others, please note I will be obliged to share these concerns with the most appropriate professional such as your GP or your therapist.

How will the study benefit me?

This will be an opportunity for you to share your experience of having therapy with IAPT. We hope that your participation will enable us to better understand how services are currently being experienced by South Asian Women and how services can further adapt in order to make psychological therapy more accessible. This may help change how therapy is delivered for the future.

Are there any risks in taking part?

We don't anticipate that this study will create anybody any harm. However talking about your experience may be a difficult process. During the interview, you do not have to answer any questions that you do not wish to. You can also choose to end the interview at any point, without giving a reason and this will not affect the care you already receive. If you feel you require any further support after the interview, this can be offered by the interviewer or we can provide you with details where you can access support, if you wish.

Who do I contact if there is a problem or if I need support?

people who analyse the information will not be able to identify you and will not be able to find out your name, NHS number, or contact details.

NHS/Health Exchange will keep identifiable information about you from this study until the study has come to an end.

If you have any further queries, please do not hesitate to contact me. I am happy to answer any further questions you may have about the study.

Saimah Yasmin-Qureshi
Trainee Clinical Psychologist

y025086g@student.staffs.ac.uk

[] This has been revised since recruitment has been completed. The university will retain identifiable information for 10 years after the study has been completed.*

Appendix F: Consent Form



Consent Form

IRAS ID: 251189

Title of research study: Beyond the Barriers: Exploring South Asian women's experiences of accessing and receiving psychological therapy.

Participant number:

1. I confirm I have read and understand the information sheet for the above study. I have had my questions about the research answered, and I understand I have the opportunity to ask further questions at any time
2. I understand that taking part in this study is voluntary and that I may withdraw at any time, without providing a reason, up until data analysis begins (31st December 2018).
3. I am willing for this interview to be sound recorded.
4. I understand that care professionals (i.e. my therapist or my GP) will be informed that I have participated in this study, especially if there are concerns about my safety or the safety of others.
5. I understand that the information I provide to the researchers will be kept confidential and anonymous. The information I supply will only be used for the purpose of the study and the data collected will

only be accessed by the researcher (Saimah Yasmin-Qureshi) and her supervisor (Sue Ledwith).

Name of Participant

Researcher:

Date

Date:

Signature

Signature:

V 3 14.08.2018. IRAS ID: 251189

Appendix G: Ethical Approval from Staffordshire University



INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name Saimah Yasmin-Qureshi
Title of Study South Asian Women's Experience of Psychological Therapy.
Award Pathway DClinPsy
Status of approval: **Approved**

Thank you for forwarding the amendments requested by the Independent Peer Review Panel (IPR)

Action now needed:

You must now apply through the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without this second approval. Please note that for the purposes of the IRAS form, the university sponsor is Professor Nachi Chockalingam, N.Chockalingam@staffs.ac.uk.

Please forward a copy of the letter you receive from the IRAS process to ethics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received approval you can commence your study. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

When your study is complete, please send the the IPR coordinator (Dr Peter Kevern) an end of study report. A template can be found on the ethics BlackBoard site.

Comments for your consideration:

A handwritten signature in black ink that reads 'P M Kevern'.

Signed: Dr Peter Kevern
University IPR coordinator

Date: 3.5.18

Appendix H: Approval by Health Research Authority



Mrs Saimah Yasmin-Qureshi



05 November 2018

Dear Mrs Yasmin-Qureshi

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title: Beyond The Barriers: South Asian Women's Experiences of Accessing and Receiving Psychological Therapy
IRAS project ID: 251189
REC reference: 18/WM/0263
Sponsor: Staffordshire University

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should formally confirm their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).



Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

IRAS project ID	251189
-----------------	--------

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Dr Nachi Chockalingam

Tel: 01782 294000

Email: N.Chockalingam@staffs.ac.uk

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 251189. Please quote this on all correspondence.

IRAS project ID	251189
-----------------	--------

Yours sincerely

Kelly Rowe

Assessor

Email: hra.approval@nhs.net

Copy to: *Dr Nachi Chockalingam, Staffordshire University, Sponsor contact*
Mrs Audrey Bright, Midlands Partnership Foundation Trust, Lead NHS R&D contact

Appendix I: Local NHS Trusts R&D Approval



From: Midlands Partnership NHS Foundation Trust

To: Samiah Yasmin-Quershi. Samiah.yasmin-quershi@mpft.nhs.uk

Cc:

Subject: Confirmation of Capacity and Capability at Midlands Partnership NHS Foundation Trust

Attachment: Agreed statement of activities.

Date: 26 November 2018

Dear Samiah

RE: IRAS No: 251189

Confirmation of Capacity and Capability at Midlands Partnership NHS Foundation Trust

Full Study Title: South Asian Women's Experiences of Accessing Psychological Therapy

This email confirms that **Midlands Partnership NHS Foundation Trust** has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation.

We agree to start this study on **26 November 2018**, If you wish to discuss further, please do not hesitate to contact me.

Kind regards

Ruth Lambley-Burke,

Head of Research and Innovation

Block 7, St George's Hospital, Corporation Street, Stafford ST16 3AG

Cc

Appendix J: Braun & Clarke (2006) 6-phase Method of Analysis

Phase	
1. Familiarisation with data	Immersing self in the data to the extent that you are familiar with the depth and breadth of the content. This involves repeated reading in an active way – searching for meanings and patterns
2. Generating initial codes	Coding interesting features across the entire data set. Ensure equal attention is given to each data set and identify items that may form the basis of repeated patterns across the data set.
3. Searching for themes	Re-focus the analysis at the broader levels of themes, sorting codes into potential themes and collate all the relevant coded extracts within the identified themes.
4. Reviewing themes	Refine the themes. Consider the validity of the individual themes in relation to the data set as a whole. Develop a ‘thematic map’
5. Defining and reviewing themes	Refine the themes and analyse the data within them. Ensure themes are not too complex or too diverse.
6. Producing the report	Ensure the write up provides a concise, coherent, logical and non-repetitive account of the story of the data set.

Appendix K: Sample of Transcript – taken from Interview 3 ‘Bal’.

2, 3, 4 step to help her’. In the end I had to tell her I am not being paranoid but this is exactly what was written to me by the authority and that is what is happening to thousands of other people in detention centres. She didn't even reply to that because this just isn't part of her experience and has never come across this in her life to her own friends or family, maybe. *Dismissed by therapist.*

Interviewer: It sounds like that has been really upsetting for you.

Bal: it's just very frustrating because she has a very different life experience to me. it's like I was born in India and a white woman born in the UK will have very different experiences about patriarchy and we will not understand what each of us mean if we talk about patriarchy. It's the same thing with my therapist.

Interviewer: So in terms of your experience of the service you said there are some good aspects of the service but your relationship with your therapist has been tricky?

not culturally competent nor understood competence!

Bal: I mean, we have a good relationship but she just cannot understand the context from which I am speaking, so that makes the therapy not effective. That's the thing. Like, my relationship with her is fine but my problem is that the therapy is not effective because she does not understand the context from which I am coming from, and that's my problem... we need... I need someone who is from a South Asian background who knows what south Asians are facing in this country because of immigration etc, just someone who is aware of these things. She is not. We need someone who can understand us [laughs].

Therapist always pres of SA issues in UK. i.e. Immis

Interviewer: [laughs]. Thank you, you have raised some really valid points. I would like to just pick up something you said. You said the therapy is not effective...

Bal: no...

Interviewer:because the therapist does not understand you or the cultural context which you come from. So do you feel it is because of the therapist' own lack of understanding or do you feel it is the model itself which makes the therapy ineffective.

CBT as Eurocentric?

Bal: Definitely both. Both. Because I feel the model and therapy was not obviously based on any South Asian women's' experiences or on issues such as immigration. Although, I guess South Asian women have been immigrating here since 1980's or something. I don't think the model was based on their needs, their experiences, it wasn't based on their culture, it wasn't based on their cultural context. Imagine if someone goes there with issues around forced marriage. Forced marriages are really high in London, so imagine she went for help, I wonder what would happen. They... a white women won't be able to help her. They might think 'oh this is a poor brown girl from a poor country because exploited'. But that is not the culture and context, right? There are a lot of other nuances in this cultural context that they won't get. So the model wasn't based on any South Asian culture or experiences.

Model not based on SA issues

Appendix L: Development of codes themes

Initial themes that were identified from the all ten transcripts were put onto an Excel spreadsheet. Codes were cross referenced across all the data set for duplicates, once duplicates were removed the remaining codes analysed and organised into themes. A thematic map was finally developed.

Initial codes from all transcripts:

	A	B	C	D	E	F	G
1	Interview 1		Interview 2		Interview 3		
2	<i>General comments</i>	<i>Code</i>	<i>General comments</i>	<i>Code</i>	<i>General comments</i>	<i>Code</i>	<i>General comments</i>
3	access via GP	Access - being told to go	access via GP - being told to go	Access -being told to go	Long waiting period	Waiting	access via GP
4	Self-referred	Access - choosing to go	connecting with therapist	connecting with therapist	Long waiting period	Waiting	not well enough
5	Therapy not appropriate support	Expectations of therapy	Style of therapy	Style of therapy met expectations	Self-referred	Access - choosing to go	long waiting period
6	Not well enough/wasting time	Not valued/worthy	Style of therapy	Style of therapy met expectations	Not being seen as 'se	Caseness	Location of therapy
7	waiting until crisis point	Not valued/worthy	Style of therapy	Style of therapy met expectations	1st world country sh	Expectations of service	Flexible appointment
8	other people deciding if 'eligible'	Caseness	needing longer therapy session	session duration	Therapist not understood	Lack of cultural understanding	therapy as client
9	long waiting period	Waiting	Therapist changing jobs		lack of contextual understanding	Lack of understanding of contextual	Materials given
10	impact of waiting for treatment	Waiting	long waiting period	Waiting	IAPT model not fit for	Model not fit for POC	not very hopeful
11	Supportive therapist/counsellor	Therapist is supportive	long waiting period	Waiting	experiences were painful	Lense of therapist	therapy gives
12	impact of waiting for treatment	Waiting	Poor communication	Communication	Dismissed	Therapist as dismissive	long waiting period
13	seating arrangement felt like an 'interview'	Formal Setting	long waiting period	Waiting	lack of contextual understanding	Lack of understanding of contextual	therapist relationship
14	Differing agendas between client and therapist	mismatch between expectations	self-referral	self-referral process	IAPT model not fit for	Model not fit for POC	CBT as structure
15	unable to open up - worry about therapist	Wanting to conform	online process as easy	self-referral process	Need for patient therapy	Future Recommendations	therapist not
16	therapist age as barrier	Therapist Age	fear of being judged	Stigma	Self-referral process	Self-referral as straightforward	Culture related
17	fear of being judged	Stigma	Not well enough/waiting until	Not valued/worthy	Not being seen as 'se	Caseness	No scope for
18	therapist age as barrier	Therapist Age	Assessment as anxiety provoking	self-referral process	Stigma from GP	Stigma from GP	CBT as structure
19	therapist/counsellor relationship	Therapist Relationship	Not well enough/waiting until	Not valued/worthy	Long waiting period	Waiting	No scope for
20	Differing agendas between client and therapist	mismatch between expectations	other people deciding if 'eligible'	Caseness	wasting time explaining culture	Explaining culture	No cultural ac
21	fear of being judged	Stigma	waiting to get feedback from a	Poor communication	CBT offers advice/practical	CBT offers advice/practical support	CBT not meet
22	therapist age as barrier	Therapist Age	connecting with therapist	connecting with therapist	Therapist not understood	Lack of cultural understanding	Culture related
23	differing cultural backgrounds	Culture excluded	CBT offers advice/practical support	CBT offers advice/practical support	IAPT as only option	IAPT as only option	CBT not meet
24	culture being excluded from therapy	Culture excluded	wasting time explaining culture	Explaining culture	Remain in therapy for	Motivation to engage	CBT offers ad
25	religion excluded from therapy	Religion excluded	lack of cultural understanding	Lack of cultural understanding	Religion not discussed	Religion excluded	self-referral r

	D	E	F	G	H	I	J
1	Interview 4	Interview 5	Interview 6	Interview 7	Interview 8	Interview 9	Interview 10
2	"I should be grateful"	Access - asking to go	Access - being told to go	Access - choosing to go	Access - being referred	"I don't belong"	Access - asking to go
3	Access - being told to go	Caseness	Caseness	CBT as structured/rigid	Communication	Access - choosing to go	CBT met needs
4	Caseness	CBT offers advice/practical support	Communication	CBT met needs	Culture excluded	Caseness	Culture excluded
5	CBT as structured/rigid	content of therapy	culture excluded	CBT not meeting cultural needs	Culture left at the door	CBT as structured/rigid	Culture left at the door
6	CBT excludes culture	Culture excluded	Culture not relevant to MH	Communication	Expectations of service	CBT culturally adapted	Engagement
7	CBT not meeting cultural needs	culture left at the door	Engagement	Cultural awareness	Expectations of therapy met	CBT offers advice/ practical support	Flexible apts
8	CBT offers advice/practical support	Culture part of identity	Flexible	Culture included in therapy	Flexible apts	Communication	Future Recommendations
9	Communication	Engagement	Future recommendations	Culture was part of MH	Future recommendations	Culture not relevant to MH	Hopes
10	Culture excluded	Future recommendations	GP as not understanding	Engagement	Location	Curiosity about culture	Location
11	Culture part of MH	IAPT as structured/rigid	Impact of waiting	Expectations of therapist	Practical advice given	Discussing expectations	MH related to culture
12	Engagement	lack of flexibility	Location	Expectations of therapy not met	referral process as easy	Future recommendations	Seeking help elsewhere
13	Expectations of therapist	let down	option to not disclose this	Flexible apts	Therapist as good listeners	lack of choice for treatment	Self-referral
14	Expectations of therapy	Location	Phone access	Future recommendations	Therapist as knowledgeable	Online form as straightforward	Stigma from other
15	Flexible appointments	Reading materials	Self-referral as positive	Lack of choice of intervention	Therapist as non-judgmental	Religion excluded by choice	Therapist as adaptable
16	Formal setting	Religion excluded	Stigma	Location	Therapist as supportive	Self-referral as accessible	Therapist as flexible
17	Future recommendations	Self-referral process as easy	Therapist as flexible	not belonging/fit in		Style of therapy met expectations	Therapist ethnicity
18	Impact of therapy	self-referral excludes english	Therapist as genuine	patient therapist matching		Strict policies	Waiting
19	Lack of cultural adaptation	Therapist as good listener	Therapist as helpful	Religion included in therapy		Therapist as attentive	waiting until crisis
20	lack of cultural understanding	Therapist as knowledgeable	Therapist as non-judgmental	Self-stigma		Therapist as good listener	
21	Location	Waiting	Therapist as understanding	Stigma		Therapist as trusting	
22	materials unhelpful		Therapist building therapeutic relationship	style of therapy met expectations/needs		Therapist as warm	
23	Self-referral as negative		Therapist relationship	Therapist as dynamic		Therapy meets expectations	
24	Therapist not understanding culture		Waiting	Therapist as knowledgeable		Waiting	
25	Therapist relationship			Therapist as non-judgmental			

Combined Codes

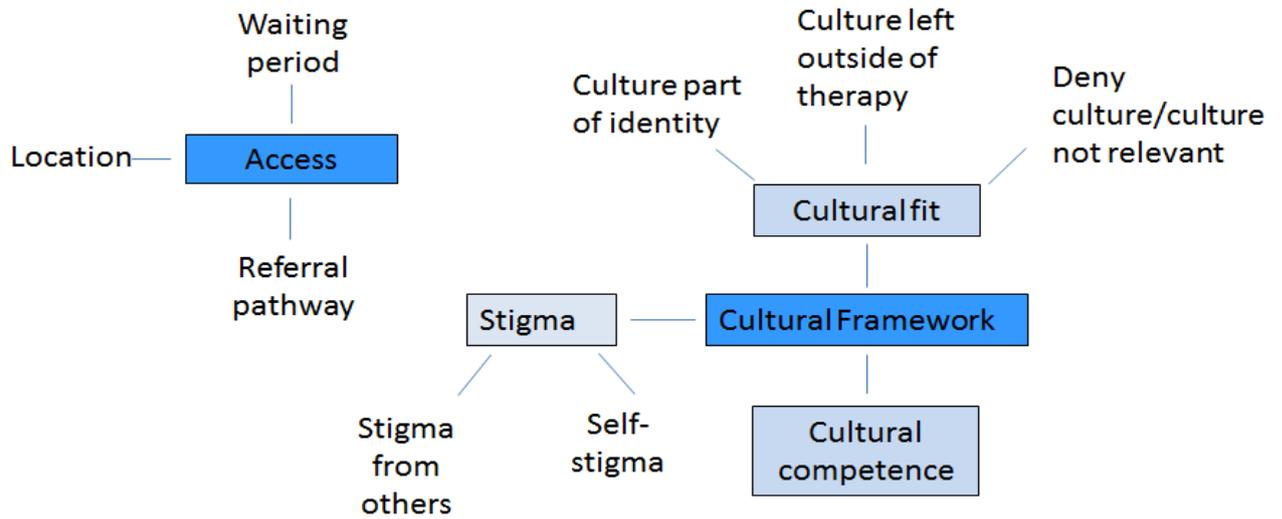
"I don't belong"
 "I should be grateful"
 "not fitting"
 Access
 Access - asking to be referred
 Access - being referred
 Access - being told to go
 Access - choosing to go
 Caseness
 CBT as structured/Rigid
 CBT culturally adapted
 CBT excludes culture
 CBT met needs
 CBT not meeting cultural needs
 CBT offers advice/practical support
 Clean environment
 Communication
 Communication
 Conforming
 connecting with therapist
 content of therapy
 Cultural Adaptation
 Cultural awareness
 Culture excluded from therapy
 Culture included in therapy
 culture left at the door
 Culture not relevant to MH
 Culture part of identity
 Culture part of MH
 Curiosity about culture
 demoting importance
 Discussing expectations
 Eastern vs Western cultures
 Engagement
 Expectations of service
 Expectations of therapist
 Expectations of therapy
 Expectations of therapy met
 Expectations of therapy not met
 Explaining culture
 Explaining culture to therapist
 Flexible
 Flexible appointments
 Form as easy but long
 Formal Setting

GP as not understanding
 Hopes
 IAPT as only option
 IAPT as structured/rigid
 Impact of therapy
 Impact of waiting
 lack of choice for treatment
 Lack of cultural adaptation
 Lack of cultural understanding
 lack of flexibility
 Lack of understanding of contextual issues
 Language as barrier
 Lens of therapist
 let down
 Location
 materials unhelpful
 MH related to culture
 mismatch between expectations and client response
 Model not fit for POC
 Motivation to engage
 not belonging/fit in
 Not valued/worthy
 Online form as straightforward
 option to not disclose this to GP
 patient therapist matching
 Phone access
 Poor communication
 Practical advice given
 Raising awareness of culture
 Reading materials
 Referral process as easy
 Religion excluded
 Religion excluded by choice
 Religion excluded from therapy
 Religion included in therapy
 Seeking help elsewhere to incorporate culture into therapy
 Self-referral process as easy
 Self-referral as accessible
 Self-referral as negative
 Self-referral as positive
 Self-referral as straightforward
 self-referral enables access
 self-referral excludes English

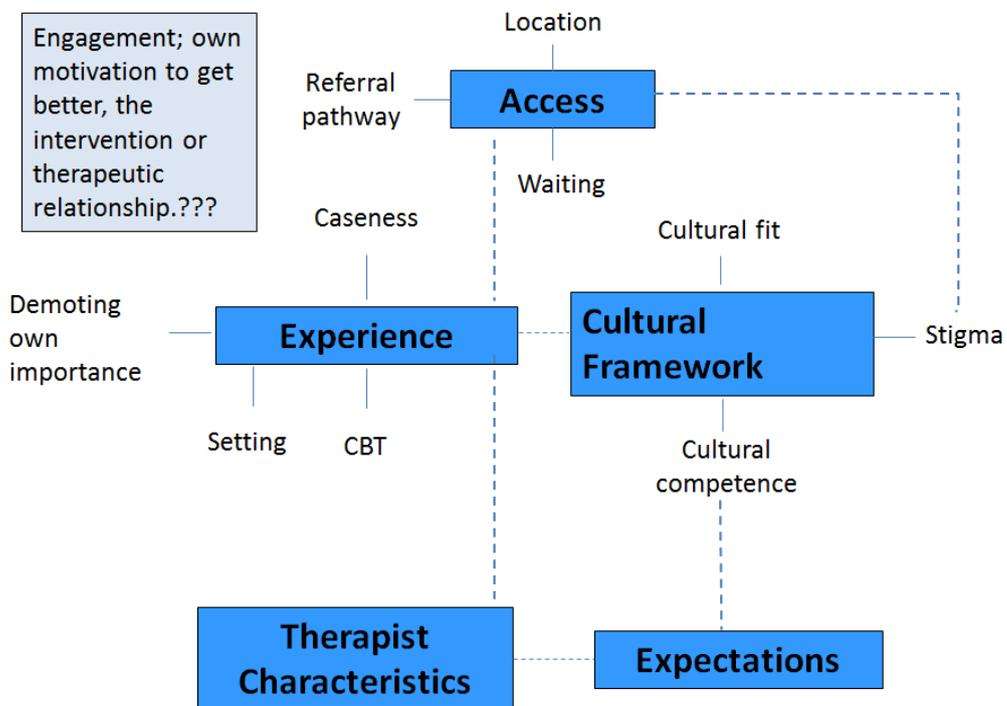
<p>Future Recommendations</p> <p>Self-stigma</p> <p>services indirectly discriminate</p> <p>session duration</p> <p>Stigma</p> <p>Stigma from family</p> <p>Stigma from GP</p> <p>Stigma from others</p> <p>Strict policies</p> <p>style of therapy met expectations/needs</p> <p>Therapist Age</p> <p>Therapist as adaptive</p> <p>Therapist as attentive</p> <p>Therapist as dismissive</p> <p>Therapist as dynamic</p> <p>Therapist as flexible</p> <p>Therapist as genuine</p> <p>Therapist as good listener</p> <p>Therapist as helpful</p> <p>Therapist as knowledgeable</p> <p>Therapist as non-judgmental</p> <p>Therapist as supportive</p> <p>Therapist as trusting</p> <p>Therapist as understanding</p> <p>Therapist as warm</p> <p>Therapist building therapeutic relationship</p> <p>Therapist culturally aware</p> <p>Therapist Ethnicity</p> <p>Therapist is supportive</p> <p>Therapist knowledge</p> <p>Therapist meeting needs</p> <p>Therapist not understanding culture</p> <p>Therapist Relationship</p> <p>Therapist unable to adapt CBT</p> <p>Therapy meeting expectations/needs</p> <p>Therapy meets expectations</p> <p>Waiting</p> <p>waiting until crisis</p> <p>Wanting to conform</p>	<p>speaking people</p> <p>Self-referral</p> <p>self-referral process</p> <p>Access/Pathway</p> <p>Therapist Characteristics</p> <p>Experience of CBT</p> <p>Cultural competence/fit</p> <p>Expectations of service/therapist</p> <p>Experience of being in therapy/personal exp.</p> <p>Engagement – ‘stick with it’</p>
--	--

Development of thematic map

Version 1.

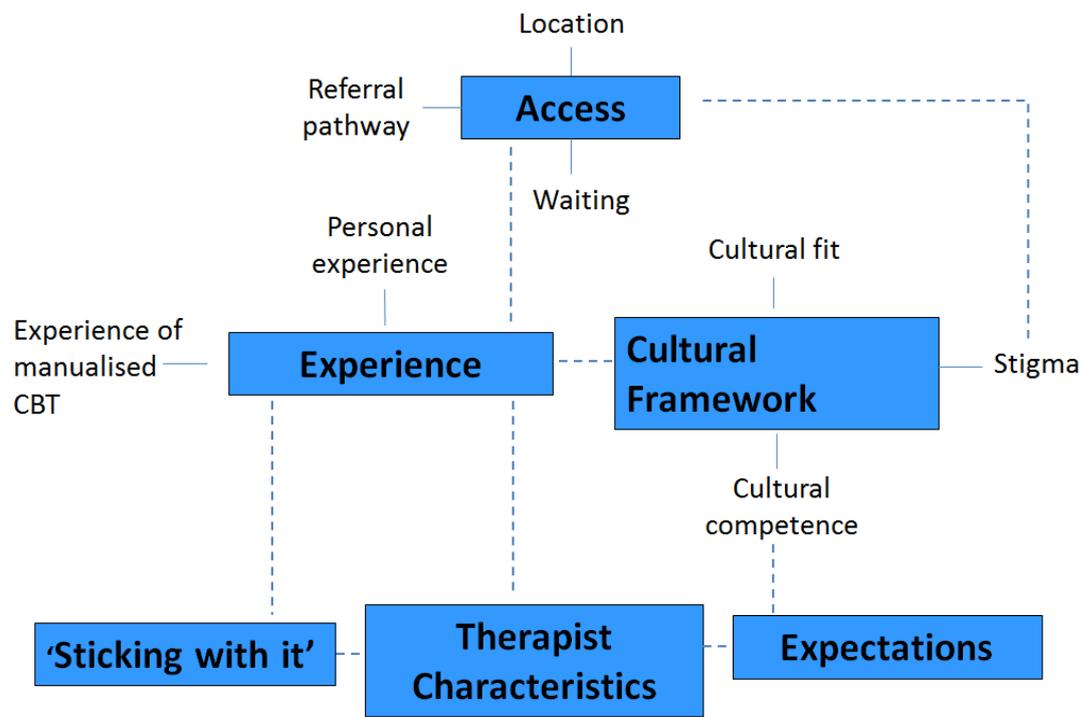


Version 1.1



Thematic Map of themes and subthemes. Links between themes and subthemes are identified by the dotted lines

Final thematic Map



Appendix M: Full Search strategy

Database	Search terms
Psych Info	<p>~("RELIGIOUS GROUPS"/ OR MUSLIMS/ OR "MUSLIM AMERICANS"/ OR ISLAM/) AND (PSYCHOTHERAPY/ OR "COGNITIVE BEHAVIOR THERAPY"/ OR "BEHAVIOR MODIFICATION"/ OR "BEHAVIOR THERAPY"/ OR "COGNITIVE RESTRUCTURING"/ OR "COGNITIVE THERAPY"/)"</p>
Embase	<p>~("COGNITIVE BEHAVIORAL THERAPY"/ OR "COGNITIVE BEHAVIORAL TREATMENT"/ OR "COGNITIVE BEHAVIOUR THERAPY"/ OR "COGNITIVE BEHAVIOUR TREATMENT"/ OR "COGNITIVE BEHAVIOURAL TREATMENT"/) AND ("RELIGIOUS GROUP"/ OR MUSLIM/ OR MUSLIMS/ OR "MUSLIM RELIGION"/)"</p> <p>~("COGNITIVE BEHAVIORAL THERAPY"/ OR "COGNITIVE BEHAVIORAL TREATMENT"/ OR "COGNITIVE BEHAVIOUR THERAPY"/ OR "COGNITIVE BEHAVIOUR TREATMENT"/ OR "COGNITIVE BEHAVIOURAL TREATMENT"/) AND (RELIGION/ OR ISLAM/)"</p> <p>"COGNITIVE BEHAVIORAL THERAPY"/ OR "COGNITIVE BEHAVIORAL TREATMENT"/ OR "COGNITIVE BEHAVIOUR THERAPY"/ OR "COGNITIVE BEHAVIOUR TREATMENT"/ OR "COGNITIVE BEHAVIOURAL TREATMENT"/ AND "RELIGIOUS GROUP"/ OR MUSLIM/ OR SHIITE/ OR SUNNI/ OR MUSLIMS/</p>

PubMed	~(("Muslim" OR "Muslims").ti,ab OR ("Islam").ti,ab) AND ("CBT" OR "Cognitive Behavior?r*").ti,ab" ~(("Cognitive" AND "Behaviour") AND "Therapy").ti,ab AND (("Muslim" OR "Muslims").ti,ab OR ("Islam").ti,ab)"
Medline	~(RELIGION/ OR ISLAM/ OR ARABS/ OR ("Muslim" OR "Muslims").ti,ab) AND ("CBT" OR "Cognitive Behavior?r*").ti,ab"
CINHAL	~((((("RELIGION AND RELIGIONS"/ AND "RELIGION AND PSYCHOLOGY"/) AND SPIRITUALITY/) AND ISLAM/) OR ("RELIGION AND RELIGIONS"/ OR "RELIGION AND PSYCHOLOGY"/ OR SPIRITUALITY/ OR ISLAM/) OR ("Muslim" OR "Muslims").ti,ab) AND ("CBT" OR "Cognitive Behavior?r*").ti,ab"
EMBASE	~("Muslims" OR "Muslim").ti,ab AND (PSYCHOTHERAPY/ OR "BEHAVIOR MODIFICATION"/ OR "BEHAVIOR THERAPY"/ OR "COGNITIVE BEHAVIORAL THERAPY"/ OR "COGNITIVE THERAPY"/ OR "SHORT TERM PSYCHOTHERAPY"/)"
AMED, BNI, CINAHL, EMBASE, HBE, HMIC, Medline, PsycINFO, PubMed	(Religious psychotherapy in anxiety disorder patients).ti,ab
AMED, BNI, CINAHL, EMBASE, HBE, HMIC, Medline, PsycINFO, PubMed	(The Modification of Psychological Interventions for Persistent Auditory Hallucinations to an Islamic Culture).ti,ab
AMED, BNI, CINAHL, EMBASE, HBE, HMIC, Medline, PsycINFO, PubMed	(Religious psychotherapy in depressive patients).ti,ab
AMED, BNI, CINAHL, EMBASE, HBE, HMIC, Medline, PsycINFO, PubMed	(Religious psychotherapy as management of bereavement).ti,ab
Google Search	"Adapted CBT" "adapted CBT for muslims" "Faith adapted CBT for Muslims"

Appendix N: Mixed Method Appraisal Tool (MMAT)

Pluye, P., Robert, E., Cargo, M., & Bartlett, G. (2011). Proposal: A mixed methods appraisal tool for systematic mixed studies reviews. *Montréal: McGill University, (Part I)*, 1–8.

Types of mixed methods study components or primary studies	Methodological quality criteria (see tutorial for definitions and examples)	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	• Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?				
	• Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).				
<i>Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>					
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?				
	1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?				
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?				
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?				
2. Quantitative randomized controlled (trials)	2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?				
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?				
	2.3. Are there complete outcome data (80% or above)?				
	2.4. Is there low withdrawal/drop-out (below 20%)?				
3. Quantitative non-randomized	3.1. Are participants (organizations) recruited in a way that minimizes selection bias?				
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?				
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?				
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?				
	4.2. Is the sample representative of the population under study?				
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?				
	4.4. Is there an acceptable response rate (60% or above)?				
5. Mixed methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?				
	5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?				
	5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?				
<i>Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied.</i>					

*These two items are not considered as double-barreled items since in mixed methods research, (1) there may be research questions (quantitative research) or research objectives (qualitative research), and (2) data may be integrated, and/or qualitative findings and quantitative results can be integrated.

Appendix O: Mental Health, Religion and Culture Journal Requirements

About the Journal

Mental Health, Religion & Culture is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's [Aims & Scope](#) for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

Mental Health, Religion & Culture accepts the following types of article: original articles.

Mental Health, Religion & Culture considers all manuscripts on the strict condition that:

The manuscript is your own original work, and does not duplicate any other previously published work, including your own previously published work.

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Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper.

A typical paper for this journal should be no more than 6000 words, inclusive of tables, references, figure captions, footnotes, endnotes.

Style Guidelines

Please refer to these [quick style guidelines](#) when preparing your paper, rather than any published articles or a sample copy.

Please use British (-ise) spelling style consistently throughout your manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”. Please note that long quotations should be indented without quotation marks.

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Papers may be submitted in Word format. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

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References

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An [EndNote output style](#) is also available to assist you.

Checklist: What to Include

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Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. [Read more on authorship](#).

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Between 3 and 7 keywords. Read [making your article more discoverable](#), including information on choosing a title and search engine optimization.

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For multiple agency grants

This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

Disclosure statement. This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. [Further guidance on what is a conflict of interest and how to disclose it.](#)

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Equations. If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about [mathematical symbols and equations.](#)

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Appendix P: British Journal of Clinical Psychology Journal Requirements

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The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

The word limit for papers submitted for consideration to BJCP is 5000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, figures, or tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length. In such a case, the authors should contact the Editors before submission of the paper.

3. Submission and reviewing

All manuscripts must be submitted via [Editorial Manager](#). The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in

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4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use [this template](#). When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the [Project CRediT](#) website for a list of roles.
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.
- All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

- All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading ‘Practitioner Points’.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
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5. Brief reports and comments

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Appendix Q: Summary of theme development process

Themes	Subthemes	Codes	Participants
Access	Referral pathway	GP – Choosing to go	All ten participants
		GP – Being told to go	
		GP – Asking to be referred	
	Self-referral process	Referral process as straightforward	Ashi, Bal, Halimah, Kam, Tam, Nish, Amira and Aisha
		Self-referral as negative	
	Location	Ideal location	Aliyah, Ashi, Halimah, Kam, Tam, Sara, Nish & Aisha
		Easy to get to	
	Waiting	Long waiting period	Aliyah, Ashi, Bal, Halimah, Kam, Tam, Amir & Aisha
		Impact of waiting	
		Developing unhelpful strategies whilst waiting	
Experience	Personal Experience	Informal setting	Aliyah, Ashi, Kam, Halimah, Tam, Bal & Amira
		Clinical setting	
		Clean environment	
		“I don’t belong”	
		“Not fitting”	
		Not valued/worthy	
		Conforming to cultural norms	
		“I’m not unwell enough”	
		Potential for harm to selves/others affected how they	

		were treated		
		Treatment options based on severity of MH		
	Experience of manualised CBT	CBT as structured/rigid	Aliyah, Ashi, Bal, Halima, Kam, Tam, Sara, Amira & Aisha	
		CBT excludes culture		
		CBT meeting needs		
		CBT not meeting needs		
		CBT offers good practical advice/support		
Cultural Framework	Stigma	Self-stigma	Aliyah, Ashi, Bal, Tam, Sara & Aisha	
		Stigma from others		
	Cultural Fit	Deny culture	All ten participants	
		Culture not part of mental health		
		Culture part of identity		
		Culture left outside of therapy		
	Cultural Competence	Lack of cultural understanding	Aliyah, Ashi, Bal, Sara, Nish, Aisha and Halimah	
		Lack of cultural awareness		
		Lack of cultural adaptation		
		Culture excluded from therapy		
		Explaining culture to therapist		
		Raising awareness of culture		
	Therapist	Therapist	Therapist age and	All ten

Characteristics	Characteristics	ethnicity	participants
		Therapist as supportive, knowledgeable and adaptive	
		Therapist as non-judgmental	
		Therapist building therapeutic relationship	
		Therapist relationship	
		Therapist as warm and trusting	
Expectations		To be given treatment options	Bal, Halimah, Nish & Sara
		Waiting time	
		To be adaptive	
		To be flexible to meet needs	
		Respond to needs	
		Mismatch between therapist goals and client goals	
"Sticking with it"		IAPT as only option	Bal, Kam, Sara, & Halimah