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An exploration into the evidence base, experiences and practices concerning anxiety, depression and wellbeing among BAME populations

Thesis submitted by:

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AAME African, Asian & Minority Ethnic 32
ABT Acceptance Based Therapy 96
ANOVA Analysis of Variance 142
ASI Anxiety Sensitivity Index 96
ASS Anxiety Sensitivity Scale 96
BA Behavioural Activation 96
BAI Beck Anxiety Inventory 96
BAME Black, Asian & Minority Ethnic 16
BBC-SWB BBC Subjective Wellbeing Scale 139
BDI Beck Depression Inventory 96
BFPM Big Five Personality Model 39
BME Black & Minority Ethnic 32
BSAS British Social Attitudes Survey 50
BUPA British United Provident Association 32
BWRP Brief Worry Reappraisal Programme 96
CA – IPT Culturally Adapted Interpersonal Therapy 118
CA Culturally Adapted 116
CA-CBT Culturally Adapted Cognitive Behaviour Therapy 65
CAP Culturally Adapted Psychotherapy 60
CBT Cognitive Behaviour Therapy 34
CC Colaborative Care 118
CES-D Centre for Epidemiological Studies 96
Covid-19 Corona Virus Disease 2019 30
CRED Commission on Race & Ethnic Disparities 32
CRQ Cultural Relevance Questionnaire 106
CT Cognitive Therapy 118
DALY Disability Adjusted Life Years 35
DASS Depression Anxiety & Stress Scale 96
DISC Discrimination & Stigma Scale 137
DISC-12 Discrimination & Stigma Scale - 12 139
DMBI Dejian Mind-Body Intervention 96

DWP Department of Work & Pentions	53
ECPSMS Educational Course in Psychological Stresses & Managment Skills	96
EHRC Equality & Human Rights Commission	50
EHS England Housing Survey	49
EM Expectation Maximisation	141
EPDS Edinburgh Postnatal Depression Scale	96
FMAP Formative Method for Adapting Psychotherapy	125
FRAME Framework For Reporting Adaptations & Modifications to Evidence-Based Interventions	273
GAD Generalised Anxiety Disorder	280
GAD-7 General Anxiety Disorder - 7	112
GADS-7 Generalised Anxiety Disorder Scale-7	96
GBD Global Burden of Diseases	35
GCSE General Certificates of Secondary Education	45
GET Group Experiential Themes	194
GHQ General Health Questionnaire	96
GHQ28 General Health Questionnaire-28	96
GP General Practitioner	37
HADS Hospital Anxiety & Depression Scale	96
HDS Hamilton Depression Scale	96
HRSD Hamilton Rating Scale for Depression	96
HSCL Hopkins Symptoms Checklist	96
HTQ Harvard Trauma Questionnaire	96
IAPT Improving Access to Psychological Therapies	236
IPA Interpretative Phenomenological Analysis	28
IPT Interpersonal Therapy	118
IRR Institue of Race Relations	32
JRF Joseph Rowentree Foundation	48
K6CM Kessler 6 Symptom Checklist	96
MOCI Maudsley Obsessive-Compulsive Inventory	96
MRC Medical Research Council	124
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ABSTRACT

Health inequality can be defined as preventable variations in health of a population and amongst different groups within a society. Yet, in the UK, despite these preventable variations, Black, Asian and Minority Ethnic (BAME) groups experience reduced access to health care, and less favourable health outcomes. Consequently, BAME populations are at an increased risk of being multi-morbid, experiencing mitigated quality of life and premature mortality. This thesis investigated the impact of health inequalities on mental wellbeing among BAME groups living in the UK. At present, there is limited research on how to reduce health disparities through evidence-based practice. The aims of this research were (i) to identify psychotherapeutic approaches to mental health in BAME populations (Chapter 2); (ii) to examine differences in stigma, depression, anxiety and subjective wellbeing between ethnicities and age groups (Chapter 3); (iii) to assess the relationship between stigma, anxiety, depression, subjective wellbeing and sociodemographic variables (Chapter 3); (iv) to explore perceptions and experiences of mental health and wellbeing, psychotherapeutic practices and healthcare, including any associated stigma, within BAME populations (Chapter 4); (v) to explore the experiences and challenges that health professionals have regarding health and mental wellbeing practices among BAME patients (Chapter 5); and (vi) to unify key findings for how to address health inequalities in BAME mental health to inform future policy and practice for the public and private sector (Chapter 6). Chapter 2 was a systematic review of n=64 psychotherapeutic interventions applied to BAME populations, showing that Cognitive Behaviour Therapy (CBT) and Culturally Adapted CBT (CA-CBT) were the most common and effective interventions. Chapter 3 presented quantitative results from n=204 participants highlighting increased stigma severity in Black African/Caribbean relative to other BAME populations, whilst Asian populations had higher levels of anxiety, depression and low levels of subject wellbeing than other groups. Chapter 4, using the Interpretative Phenomenological Analysis (IPA) method, explored the experiences of n=14 BAME service users with service providers, highlighting the prevalence of stigma among different ethnic cohorts and their desire for cultural adaptations. Chapter 5 was also a qualitative study, using IPA, and explored the experiences of n=10 health care practitioners working with BAME patients. It was found that a tension exists between adaptations that improve therapy outcomes versus adaptations that help reduce costs for running the practice and are scalable. Chapter 6 recommends that future research should focus on identifying effective adaptations for specific BAME populations and explore economic models to help policymakers and researchers assess the costs of implementing these cultural adaptations. This recommendation could be achieved by conducting randomised controlled trials, examining which specific cultural adaptation is more effective in eliciting desirable psychotherapeutic outcomes for BAME populations. Additionally, a cost-benefit analysis could be carried out to conclude the benefits versus costs of implementing specific adaptations to therapy for different ethnic minority groups.

Keywords: Health Inequalities, Mental Wellbeing, Cognitive Behaviour Therapy, Cultural Adaptations, Public Health Policy

CHAPTER 1 – INTRODUCTION, LITERATURE REVIEW & THESIS AIMS

1.1 ONTOLOGICAL & EPISTEMOLOGICAL STANCE

The topic I am exploring focuses on health inequalities and its impact on mental wellbeing in Black, Asian, and Minority Ethnic (BAME) populations. However, before "unpacking" BAME-related research, forgoing literature (Brooke, 2013) has suggested that it is important for researchers to clearly articulate their ontological, epistemological and axiological views, how this may influence research methodology and thus, their methods. Specifically, Brooke (2013) argues that the worldviews through which researchers execute their tasks are represented in their ontological and epistemological positionality. Providing a comprehensive "snapshot" into the researcher's underlying thought process and philosophy acts as additional insight for the reader into what the researcher believes about reality and how this may have influenced research decisions (Brooke, 2013; Otoo, 2020).

Ontology is the philosophical study of the nature of being, existence, or reality (Otoo, 2020) whilst epistemology is the philosophical study of knowledge and how individuals acquire knowledge (Whaley & Krane, 2011). Ontology and epistemology help individuals understand the fundamental concepts underlying their physical world and the relationships between different entities within it (Moon & Blackman, 2014; Whaley & Krane, 2011). By exploring ontology and epistemology, individuals can develop a better understanding of the universe, one's place within it, how they know what they know and the limitations of their knowledge (Moon & Blackman, 2014; Whaley & Krane, 2011). Additionally, by comprehending ontology and epistemology, the researcher can develop a more sophisticated and nuanced understanding of his/her research which can vicariously be communicated more clearly to the reader (Otoo, 2020; Whaley & Krane, 2011). Furthermore, ontology and epistemology can also help justify findings and conclusions by providing a framework for understanding the nature of reality for the researcher and the justification for the chosen method (Otoo, 2020; Whaley & Krane, 2011).

There are two distinct ontological/epistemological stances in research, realism (positivism) and relativism (constructivism/interpretivism) – with each stance providing its own unique perspective on reality and how individuals should go about investigating it. A realist (positivist) approach to ontology and epistemology maintains that there is an objective/singular truth to reality, and that reality exists independently of our perceptions of it (Moon & Blackman, 2014;

Otoo, 2020). Researchers who take this stance believe that it is possible to study and understand this reality through quantitative methods such as measurement and statistics (Moon & Blackman, 2014; Otoo, 2020). According to Hitchcock and Hughes (2002), realism (positivism) can be traced back to the early 1800s. Back then, researchers would use a pre-made checklist of traits to assess a society's level of development from an "etic" or outsider perspective (Hitchcock & Hughes, 2002). On the other hand, a relativist (constructivist) approach to ontology and epistemology maintains that there is no such thing as an objective reality (i.e., a "singular truth") – reality is ultimately created by the individual. Researchers who take this stance believe that it is not possible to study or understand reality in any objective sense, that all knowledge is ultimately an individual's perception of reality and usually is explored through qualitative research methodologies that act as the "landscape" for in depth understanding such as one-to-one interviews and focus groups (De Gialdino, 2009). The relativist (constructivist) tradition is primarily aligned with critical thinkers, such as Max (1818-1883), Nietzsche (1844-1900), Manheim (1893-1947) and Weber (1864-1920). For example, Weber mentioned "Verstehen" or "understanding" rather than "Erklaren" or "explanation". Brooke (2013) stated that researchers should focus on the process of the why and how instead of simply on the where, the what, the who and when. Relativists (constructivists) use an insider's perspective to understand that there are differing realities in the world (De Gialdino, 2009; Otoo, 2020). Consequently, researchers need to take human situations, behaviours, and experiences into account to construct inherently subjective realities (De Gialdino, 2009; Moon & Blackman, 2014; Otoo, 2020).

Both realist and relativist approaches' present interesting ontological and epistemological stances on the subject matter of BAME populations and mental health as after reviewing the literature on both stances, I can observe challenges in implementation, generalisability and whether either approach best answers the research question *"How does health inequalities impact the mental wellbeing of BAME populations?"*. Specifically, it is doubtful that one may acquire 'depth' and 'insight' through statistics, measures or surveys that are frequently employed in quantitative approaches alone (Otoo, 2020) or achieve generalisability for "population level" application from qualitative investigation/interviews alone (Boffa et al., 2013). Therefore, more inquiry towards my ontological and epistemological stance was needed. Subsequently, the ontological and epistemology stance of "pragmatism" became apparent to me. A pragmatist ontology and epistemology maintain that pragmatic researchers seek truth in the form of “what works” (Maarouf, 2019; Pratt, 2016). Researchers who take this stance believe that the most important thing is that their methods are effective – they don’t necessarily need to adhere to any specific theoretical framework (Maarouf, 2019; Pratt, 2016), which allows for increased flexibility and adaptability. However, according to the notion of “ontological foundationalism,” a researcher must have a clear vision of reality to make the appropriate methodological choices (Lohse, 2017). Pragmatism presents clear epistemological and methodological stances (i. e. to utilise whichever approach best answers the research question), yet its agreed upon ontology (beliefs that guide action) and axiology (ethics) remain ambiguous (Maarouf, 2019; Pratt, 2016). Moreover, despite an ontology that seems to place itself in the middle of the realist vs relativist continuum, the pragmatist ontology is not without its critiques (Maarouf, 2019).

Pragmatism is subjected to significant criticism for its basic premises. For example, Biddle and Schafft (2015) have condemned pragmatic researchers for utilising “any research approach” as the authors argue that philosophy is not independent from methodology or methods. Moreover, Sale et al. (2002) claimed that pragmatism cannot manage the conflicting assumptions of the quantitative and qualitative paradigms. Sale et al. (2002) maintains the notion that these contrasting presumptions reveal that quantitative and qualitative methods are not studying identical things, which makes it unreasonable to use a mixture of both approaches for cross-validation or triangulation purposes. Mixed researchers must clearly state their philosophical or paradigmatic views to defend their methodological choices (Cameron, 2011). Given this need, the researcher in this Ph.D. conceives of the ontological, epistemological, and axiological pragmatist positions as two interconnected but not competing philosophies that combine both quantitative and qualitative paradigms’ perspectives. The ontological differences between the two paradigms for pragmatism have been widely discussed by many researchers. Morgan (2007) argues that pragmatic research must be “intersubjective,” meaning it should consider both subjective and objective perspectives and accept that there is one reality, but individuals can interpret this reality in different ways. According to Saunders et al. (2009), pragmatism implies that reality is both external and diverse at the same time, and that a researcher chooses the perspective that best serves his research goals. Similarly, Johnson and Christensen (2012) have stated that to do a mixed study, it’s critical to understand both the objective and subjective viewpoints of reality. Even though it is critical not to be subjective or influenced by the subject of study, it is also crucial to comprehend the point of view of social actors (Johnson &

Christensen, 2012). Despite all these viewpoints, many scholars have claimed that pragmatism's ontological problem was overlooked by researchers. Pragmatists, according to Morgan (2007), argue that the metaphysical preconceptions should not be imposed from above and believe that epistemological and methodological concerns should be kept separate from ontology. Also, Pratt (2016) has condemned pragmatic researchers for concentrating on pragmatism as epistemology and methodology while ignoring it as a philosophy. Furthermore, Lohse (2017) has mentioned the same concept in his theory of "anti-ontological pragmatism," which is the act of research without taking an ontological stance. While these authors (and many others) argue that pragmatism has fostered an "anti-philosophical" attitude that avoids discussing reality issues to maximise research benefits through the idea "what works," Hathcoat and Meixner (2017) argue that pragmatic philosophers are driven by a desire for utility rather than truth. They claim that despite all the efforts of pragmatists to define their philosophy, it is not clear how pragmatism influences social inquiry methodology, resulting in an "anything goes" attitude. Given that pragmatic researchers need to be able to move between an objective and subjective ontological stance depending on the situation, it is clear that pragmatism needs an ontological position located in the middle of the objectivity-subjectivity continuum. The researcher in the Ph.D. adopts the ontological stance of pragmatism as the "reality cycle" (Morgan, 2014; Maarouf, 2019; Pratt, 2016).

> *"The reality cycle is based on the idea of the existence of one reality and multiple perceptions of this reality in the social actors' minds. According to the reality cycle, there is only one reality that exists in a certain context at a certain point of time. Reality depends on the context to exist and continue existing, which means that changing the context changes the reality and the existence of multiple contexts means the existence of multiple realities. However, this reality is perceived differently by the social actors which causes reality to change in a continuous process that goes as follows: reality is perceived by humans or social actors differently, humans' perceptions of reality control their behaviours, interactions among these behaviours construct a new context over the time, and constructing a new context generates a new reality. Although these changes in the context happen continuously it does not have an immediate practical effect, however, it creates notable changes in reality after a considerable period of time, exactly like the ageing process of a human being that happens every second but it may take years to be notable. In consequence, the reality cycle adopts a practical pragmatic point of view*

> *assuming that reality is stable most of the time and changes periodically."* (Maarouf, 2019, p. 7)

The reality cycle assumption enables the pragmatic researcher to move between the two views of external reality (one vs. multiple perceptions) and thus switch between quantitative and qualitative research approaches and methods (Morgan, 2014; Maarouf, 2019) – this allows for a more well-rounded understanding of any given topic. The reality cycle permits the researcher to study one phenomenon in depth while keeping other contextual factors constant (Morgan, 2014; Maarouf, 2019). Adopting this strategy provides researchers with a theory to test, which in turn generates new knowledge about the subject under investigation (Morgan, 2014; Maarouf, 2019). This knowledge will enable future researchers to build upon existing research and add vital insights that contribute to our understanding of reality (Morgan, 2014; Maarouf, 2019). In this scenario, the pragmatic researcher might describe the situation in low-level generalisations, which is practical enough to fit the pragmatic notion "what works". Second, the pragmatic researcher also considers that any generalisations made will eventually become obsolete as reality changes (Morgan, 2014; Maarouf, 2019). They need to frequently review social science theories and make sure they are still accurate to produce valid results (Morgan, 2014; Maarouf, 2019). If a theory becomes outdated, the researcher needs to either update it or create an entirely new one altogether (Morgan, 2014; Maarouf, 2019). This could happen when studying something new or conducting research in novel contexts (Morgan, 2014; Maarouf, 2019). In some cases, we do not have the required knowledge to form a theory. We also don't know which variables could be affecting or explaining what is happening (Morgan, 2014; Maarouf, 2019). When this occurs, researchers are allowed to use a qualitative approach that examines people's perceptions of reality (Morgan, 2014; Maarouf, 2019). By examining the social actor's perceptions, the researcher can develop a strong understanding of the context that generated reality (Morgan, 2014; Maarouf, 2019). This will then help them to create new theories or make significant developments to current ones (Morgan, 2014; Maarouf, 2019). Once theory is developed, researchers can switch back to their original position and test it through quantitative research (Morgan, 2014; Maarouf, 2019).

For transparency, the reality cycle is built on the existence of one objective reality, which is then perceived and interpreted by different individuals (Morgan, 2014; Maarouf, 2019). Researchers are looking for truth–the idea of what works in a certain context (Morgan, 2014; Maarouf, 2019). A pragmatic researcher only wants to know about the single truth that works, without any subjectivity or interpretation (Morgan, 2014; Maarouf, 2019). The objective of employing qualitative approaches is not to fabricate the situation as a personal vision of the researcher, but to discover the reality – this singular truth that already exists – by investigating social actors' views (Morgan, 2014; Maarouf, 2019). Qualitative methods assist researchers in obtaining information that will be investigated and evaluated through quantitative study to acquire a thorough knowledge of the issue and develop a theory that can be tested with quantitative research (Morgan, 2014; Maarouf, 2019). Second, the reality cycle does not back up the claim that qualitative study is unscientific and as a result it should be validated with quantitative scientific research (Morgan, 2014; Maarouf, 2019). On the contrary, the reality cycle states that every method has a part to play in theory development (Morgan, 2014; Maarouf, 2019). The pragmatic researcher only favours confirming qualitative research findings with quantitative research because it allows us to comprehend reality in a simpler way that is more applicable to pragmatism and the phrase "what works" (Morgan, 2014; Maarouf, 2019). In this sense, the reality cycle serves as a foundation for both sequential and parallel mixed research methods (Morgan, 2014; Maarouf, 2019). First, it aids researchers by instructing them on how to move back and forth between being objective or subjective, which is useful for conducting sequential mixed research approaches (Morgan, 2014; Maarouf, 2019). Second, it claims that both quantitative and qualitative approaches are examining the same phenomena from two different vantage points: directly while testing a theory explaining the phenomenon or indirectly through studying social actors' perceptions that shape the context in which this phenomenon occurs (Morgan, 2014; Maarouf, 2019). Knowing that the same phenomenon is being studied from two diverse viewpoints explains why a mixed methodology is justified, logical and appropriate (Morgan, 2014; Maarouf, 2019).

In summary, the ontology and epistemology of pragmatism (Morgan, 2014; Marrouf, 2019) best answers the research question of "*"How does health inequalities impact the mental wellbeing of BAME populations?* As (i) an inductive approach can be applied to uncover meaning, experience and relationships between BAME populations, health inequality and mental wellbeing alongside (ii) a deductive approach to applying a-priori predictions associated with BAME populations and mental health, that can be tested through quantitative means, for example if "mental health stigma is associated with increased anxiety/depressive scores and mitigated wellbeing measures in BAME populations'' and (iii) by adopting inductive and deductive paradigms of practice, the researcher in this Ph.D. would be able to best contribute to the ever-evolving subject matter of BAME research.

1.2 AXIOLOGICAL STANCE – PRAGMATISM

Axiology is the philosophical study of value (Hart, 1971; Handoyo, 2015; Killam, 2013; Monticelli, 2022). In other words, axiology is the study of what makes something good or bad, valuable, or not valuable (Hart, 1971; Handoyo, 2015). Axiology is important in research because it helps researchers make ethical decisions and facilitates understanding the nature of value (Hart, 1971; Handoyo, 2015). The term “axiology” was first used in 1902 by Paul Lapie however, influential philosophical thinkers can be traced back till the time of Aristotle and Plato (383 BC) to later thinkers such as Georg Hegel (1770) and Immanuel Kant (1724) to more modern thinkers such as Carl Jung (1875) and Friedrich Nietzsche (1884) (Hart, 1971; Handoyo, 2015). Several aforementioned philosophers have made significant contributions to the field of axiology, including Aristotle, Kant, and Hegel. Aristotle was one of the first philosophers to study the concept of value systematically (Hart, 1971; Handoyo, 2015). Aristotle developed the theory of “Virtue Ethics”, which holds that the “good life” consists in living according to virtues such as wisdom, courage, justice, and temperance (Hart, 1971; Handoyo, 2015). Kant was one of the fathers of “Deontology”, which holds that certain actions are morally required regardless of their consequences (Hart, 1971; Handoyo, 2015). Hegel was one of the first philosophers to develop a theory of “Dialectical Reasoning”, which holds that reality is constantly in flux and can only be understood through contradiction and synthesis (Hart, 1971; Handoyo, 2015). The main point that axiology tries to capture is that value is not a simple concept. It has many dimensions and can be interpreted in many ways.

Specifically, as “value” is a complex concept, axiology provides researchers with a framework for understanding it (Hart, 1971; Handoyo, 2015; Killam, 2013; Monticelli, 2022). This “framework” can be broken down into different branches of axiology including normative ethics, meta-ethics, and applied ethics (Hart, 1971; Handoyo, 2015; Killam, 2013; Monticelli, 2022). Normative ethics is the branch of ethics that deals with moral norms or standards (Killam, 2013; Monticelli, 2022). Meta-ethics is the branch of ethics that deals with the nature of ethical language and judgments (Killam, 2013; Monticelli, 2022). Applied ethics is the branch of ethics that deals with the application of moral principles to specific situations (Killam, 2013; Monticelli, 2022). Each of these branches of axiology has its own set of theories about value (Killam, 2013; Monticelli, 2022). Normative ethics, for example, has theories about what constitutes a good life and how we should behave to live a good life (Killam, 2013; Monticelli, 2022). Meta-ethics has theories about the meaning of ethical terms and how we make ethical judgments (Killam, 2013; Monticelli, 2022). Applied ethics has theories about how to resolve ethical conflicts in specific situations (Killam, 2013; Monticelli, 2022). Philosophers use a variety of methods to investigate value, including analytical philosophy, phenomenology, and hermeneutics (Killam, 2013; Monticelli, 2022). Analytical philosophy is a method of philosophy that uses logic and reason to analyse abstract concepts (Killam, 2013; Monticelli, 2022). Phenomenology is a method of philosophy that uses first-person experiential data to explore philosophical concepts (Killam, 2013; Monticelli, 2022). Hermeneutics is a method of philosophy that uses interpretation to understand philosophical concepts (Killam, 2013; Monticelli, 2022). Each of these methods has its own strengths and weaknesses. For example, analytical philosophy is good at analysing complex concepts and drawing logical conclusions from them (Killam, 2013; Monticelli, 2022). Phenomenology is good at exploring the subjective experience of value (Killam, 2013; Monticelli, 2022). Hermeneutics is good at interpreting difficult texts and understanding their underlying meanings (Killam, 2013; Monticelli, 2022).

There are several major debates within the field of axiology, including the debate between consequentialism and deontology, the debate between teleology and deontology, and the debate between egoism and altruism (Hart, 1971; Handoyo, 2015; Killam, 2013; Monticelli, 2022). Consequentialism is the view that the rightness or wrongness of an action is determined by its consequences (Hart, 1971; Handoyo, 2015; Killam, 2013; Monticelli, 2022). Deontology is the view that there are certain moral rules that we ought to follow regardless of the consequences (Hart, 1971; Handoyo, 2015; Killam, 2013; Monticelli, 2022). Teleology is the view that actions are right or wrong depending on whether they promote some overall goal or good (Hart, 1971; Handoyo, 2015; Killam, 2013; Monticelli, 2022). Egoism is the view that we should act in our own self-interest (Hart, 1971; Handoyo, 2015; Killam, 2013; Monticelli, 2022). Altruism is the view that we should act in the interests of others (Hart, 1971; Handoyo, 2015; Killam, 2013; Monticelli, 2022). These are just a few examples of the many different debates that take place within axiology (Hart, 1971; Handoyo, 2015) that vicariously create interesting paradigms of practice for a set of ethics that should guide researcher action (Killam, 2013; Monticelli, 2022; Morgan, 2014; Marrouf, 2019).

Based on the former ontological and epistemological stances that allow researchers to deal with both observable and unobservable knowledge using quantitative and qualitative methods – a pragmatic researcher should only be biased by the degree necessary to enhance the research and answer research questions (Morgan, 2014; Marrouf, 2019; Pratt, 2016). This is what the term "necessary bias" refers to (Morgan, 2014; Marrouf, 2019). The notion, "necessary bias", in social-scientific studies is meaningful before the study begins, unlike natural sciences (Morgan, 2014; Marrouf, 2019). Specifically, both quantitative and qualitative research are driven by this preconceived notion, which guides researchers' selection of research questions and variables (Ma, 2012) thus, there is an argument to suggest that there is no such thing as value-free or bias-free research, not even from a realist (positivist) standpoint (Morgan, 2014; Marrouf, 2019). This argument agrees with the thoughts of numerous researchers who have said that quantitative researchers' values can influence their research. Specifically, Johnson and Onwuegbuzie (2004), Ma (2012) and Saunders et al. (2009) maintain that it is impossible to be unaffected by our own values and experiences.

Realist's (positivists) values have an influence on their choice of study topic, aims, data collection, analysis and conclusion (Johnson & Onwuegbuzie 2004; Ma, 2012; Saunders et al., 2009). Furthermore, Weber (2004) stated that as a realist (positivist), he is aware that the variables he selects in his research are based on his pre-conception of reality and the main goal of gathering and analysing data is to evaluate this preconception. Consequently, almost every decision realist's (positivists) make during research is reliant on the researcher's individual values and past experiences (Morgan, 2014; Marrouf, 2019). Even if bias could be removed from the equation, there would always remain a lack of validity or reliability in measurements taken – meaning accuracy would never reach the desired level as warranted in natural sciences (Morgan, 2014). Conversely, the value-laden principle in qualitative research does not mean that qualitative research is unscientific and can be manipulated by researchers (Morgan, 2014; Marrouf, 2019). Ma (2012) refers to the concept of "shared reality", which she defines as the meanings given to communicative actions that make them understandable. This reality is what should be discovered through qualitative research (Morgan, 2014; Marrouf, 2019). Thus, the researcher in this Ph.D. argues that previous knowledge or perceptions can only enrich qualitative research by helping the researcher to add more insights and discover more sides of this shared reality, not manipulate research results in a certain direction – which would constitute a "egoistic" axiology (Hart, 1971). In total, the researcher argues that regardless of what research paradigm is used, there will be some sort of unavoidable bias (Morgan, 2014; Marrouf, 2019). However, researchers' values, experiences, beliefs and ideas should be a source of reinforcing research instead of an obstacle in the way of reaching the truth (Morgan, 2014; Marrouf, 2019). Therefore, a pragmatic researcher's axiology should focus on the objectives of his research, embody an "altruistic" axiology (Hart, 1971) and use his values and experiences in a way that will serve these objectives and improve the research results. In other words, a pragmatic researcher should be biased only to the degree necessary to meet the requirements of the research (Marrouf, 2019). It is essential here to state that "the necessary bias principle" does not mean that any form of bias is acceptable (Marrouf, 2019). Unacceptable bias happens when the researcher allows their personal beliefs to shape the research results in a predetermined way (Marrouf, 2019). For example, it is acceptable for ethical or religious values to affect the researcher's choice of some research topics or questions over others, as is often the case with transformative research or Islamic finance (Marrouf, 2019). However, it is not acceptable for these values to extend to further stages of research and skew the results (Marrouf, 2019). With that being said, clear ontological, epistemological and axiological stances have been illustrated, that act as paradigms of belief that guide the action/choice of methodology and methods that are most effective in exploring the Ph.D.'s subject matter.

1.3 RESEARCH METHODOLOGY & METHODS

Methodology is the systematic, theoretical and methodological foundation for conducting research (Crotty, 1998; Goddard & Melville, 2004). Specifically, methodology can be defined as *"the strategy or plan of action which lies behind the choice and use of particular methods"* (Crotty, 1998, p. 3). Methods, on the other hand, can be defined as *"specific techniques and procedures used to collect and analyse data"* (Crotty, 1998, p. 3). There are two distinct methodologies in research, quantitative and qualitative (Goddard & Melville, 2004). Qualitative approaches typically don't test hypotheses that are based on prior research (Flick, 2007). Instead, they're useful for coming up with concepts and theories from data gathered (Bryman, 2012; Denzin & Lincoln, 2011). Quantitative research methodologies, however, usually test specific hypotheses or ideas that were defined before the research was conducted (Murphy et al., 1998). Qualitative research, unlike quantitative research, does not inquire about the amount or quantity of something (Green & Thorogood, 2009) or enumerate a phenomenon. Instead, it seeks to understand data that are subjective since they are based on personal experiences and constructions (Mason, 2002). This emphasises the importance of depth, context, information, as well as procedures and meanings (Denzin & Lincoln, 2011), which can't be obtained via a quantitative approach.

To note, the phenomena which is being studied should dictate the choice of method, not vice versa (Marrouf, 2019). As Flick (2002) pointed out, choosing a methodological approach is dependent on which method is most appropriate to answer the research question(s). Based on the ontological, epistemological and axiological stances illustrated previously for pragmatism (Morgan, 2014; Marrouf, 2019) and the notion that the relationship between health inequalities and mental health in BAME populations is an under researched subject matter - the first step, owing to the exploratory nature of the study, was to conduct preliminary work in order to gain a deeper understanding of various meanings and viewpoints with regards to the two populations under consideration - clinicians who treat mental health in BAME populations and individuals from BAME backgrounds. With that being said, a qualitative research approach was considered the most suitable paradigm of practice. Additionally, a qualitative approach enabled me to explore different perspectives (such as people with different levels of experience) and personal accounts constructed by participants. It also allowed me to probe for more reflection and meaning from participants while facilitating active reflection on their accounts. Furthermore, utilising qualitative research approaches, such as semi-structured interviews, allowed for a deeper exploration of key themes and provided a substantive dataset that would have been difficult to obtain quantitatively. Still, despite the many ambiguous contextual topics surrounding the subject matter of BAME research that would benefit from a qualitative methodology, one prevalent subject matter associated with BAME research that would benefit from a “top down” quantitative approach would be mental health stigma in BAME populations (Cheng et al., 2018). As there seems to a correlation between increased mental health stigma and ill-mental health (Cheng et al., 2018), systematic reviews exploring BAME populations and psychotherapy have suggested that psychotherapeutic interventions that tackle and aim to undermine these mental health stigma beliefs in BAME populations must be investigated, developed and further improved (Codjoe et al., 2021). Thus, a clear relationship and comprehensive understanding of the “impact” of stigma on mental health in specific BAME groups are warranted (Cheng et al., 2018). Therfore this Ph.D. thesis, based on the ontological, epistemological, axiological and methodological stances, chose to adopt an exploratory stance but a combination of different methodological approaches to answer the research question.

1.4 QUALITATIVE ANALYSIS

Qualitative data analysis methods are used to analyse data in qualitative research studies (Tracy, 2013). There are many different types of qualitative data analysis methods, but some of the most commonly used include thematic analysis (Braun & Clarke, 2006), narrative analysis (Labov & Waletzky, 2003), discourse analysis (Lupton, 1992), content analysis (Downe-Wamboldt, 1992; Harwood & Gary, 2003), interpretative phenomenological analysis (IPA) (Eatough & Smith, 2008; Larkin et al., 2006; Pietkiewicz & Smith, 2014) and grounded theory (Mills et al., 2006). Based on the pragmatic ontology, epistemology, axiology and methodology, different methodologies were considered to decide (i) which method best achieves the research objectives (see heading 1.16) and (ii) describe to the reader what “stance” the researcher is adopting when analysing the data in study 3 (Chapter 4) and 4 (Chapter 5) to ensure reliability and trustworthiness.

Thematic analysis is a qualitative data analysis method that involves identifying, analysing and reporting patterns within data (Braun & Clarke, 2006). The purpose of thematic analysis is to discover the underlying meanings that inform the data (Braun & Clarke, 2006). The process of thematic analysis begins with reading all of the data, followed by generating initial codes and themes (Braun & Clarke, 2006). These are then subjected to further analysis and refinement until a final set of themes is identified (Braun & Clarke, 2006). Narrative analysis is a qualitative data analysis method that involves the examination of stories and narratives (Labov & Waletzky, 2003). The intent of narrative analysis is to understand the meaning and structure of individual stories, as well as the ways in which they interact with each other (Labov & Waletzky, 2003). The procedure of narrative analysis begins when all the data is read and followed by the generation of initial codes and themes (Labov & Waletzky, 2003). These are then subjected to further study and refinement until a final set of themes is discovered (Labov & Waletzky, 2003). Discourse analysis is a qualitative data analysis method that involves the examination of spoken and written language (Lupton, 1992). The goal of discourse analysis is to understand the meaning and structure of communication (Lupton, 1992). Discourse analysis follows a process of reading data, generating initial codes and themes, further analysing and refining these themes, and finally identifying a final set of themes (Lupton, 1992). Content analysis is a qualitative data analysis method that involves the examination of text data to identify and analyse themes (Downe-Wamboldt, 1992; Harwood & Gary, 2003). The aim of content analysis is to understand the meaning and structure of communication within a given context (Downe-Wamboldt, 1992; Harwood & Gary, 2003). The procedure for content analysis begins with reading all the data, followed by the formation of initial codes and themes (Downe-Wamboldt, 1992; Harwood & Gary, 2003). These are then subjected to additional study and refinement until a final set of themes is discovered (Downe-Wamboldt, 1992; Harwood & Gary, 2003). IPA is a qualitative data analysis method that involves the examination of lived experience (Eatough & Smith, 2008; Larkin et al., 2006; Pietkiewicz & Smith, 2014). The rationale of IPA is to understand the meaning and structure of subjective experience (Eatough & Smith, 2008; Larkin et al., 2006; Pietkiewicz & Smith, 2014). The first step in the IPA method is to go through all the data (Eatough & Smith, 2008; Larkin et al., 2006; Pietkiewicz & Smith, 2014). Subsequently, initial codes/themes are generated and subjected to additional refinement until a final cluster of meaning/themes can be reached (Eatough & Smith, 2008; Larkin et al., 2006; Pietkiewicz & Smith, 2014). Grounded theory is a qualitative data analysis method that involves the development of a theoretical framework based on the data (Mills et al., 2006). The purpose of ground theory is to understand the meaning and structure of communication within a given context (Mills et al., 2006). The process of ground theory begins with reading all the data, followed by generating initial codes and themes (Mills et al., 2006). These are then subjected to further analysis and refinement until a final set of themes are identified (Mills et al., 2006).

Each data analysis method has its own strengths and weaknesses. Thematic analysis is flexible however, it has several disadvantages which are more apparent when contrasted with other qualitative research methods (Nowell et al., 2017). For example, there is relatively little literature on thematic analysis compared to that of grounded theory, ethnography, and phenomenology (Nowell et al., 2017). Thus, this lack of resources may make novice researchers feel unsure about how to conduct a rigorous thematic analysis (Nowell et al., 2017). Additionally, although thematic analysis is flexible, this trait can sometimes result in inconsistency and lack of coherence while developing themes from research data (Nowell et al., 2017). Thus, empirical claims should be underpinned by an epistemological position that is consistent, transparent and cohesive (Holloway & Todres, 2003). Limitations associated with narrative analysis are that this research technique is based on several initial experiences: listening, telling, transcribing, analysing, and reading (Labov & Waletzky, 2003). Consequently, these sorts of representations all contain text and talk that may either completely or partially represent the narrative (Labov & Waletzky, 2003). Additionally, this research approach's information may get its understanding of the key issues distorted by subjectivity, target audience self-selection, and generalisation of results (Labov & Waletzky, 2003). Limitations associated with discourse analysis are that there are several kinds of discourse analysis, so picking the best approach for a certain scenario may be difficult (Reed, 2000; Lupton, 1992) while content analysis risks capturing "word count" as a "measure" of relevance and may skew/obscure meaning and depth (Downe-Wamboldt, 1992; Harwood & Gary, 2003). IPA is good at understanding the subjective experience of individuals; however, it can be difficult to identify the shared experiences of a group of people (Eatough & Smith, 2008; Larkin et al., 2006; Pietkiewicz & Smith, 2014). Grounded theory does not consider the researcher's subjectivity, which can skew data construction and interpretation (Olesen, 2007). Other comments gathered from the research for grounded theory are that (i) grounded theory approaches generally produce a lot of data, which is sometimes difficult to handle, (ii) researchers must be competent in utilising grounded theory methods and (iii) there are no set rules for identifying categories using grounded theory methodologies (Olesen, 2007).

Whilst considering each qualitative method of analysis, the most suitable method of data analysis was one that examines "personal lived experience" as many underlying barriers towards mental health services in BAME populations have been reported as antagonistic, mistrust or negative (Cheng et al., 2018). Thus, the most appropriate analysis for investigating the personal lived experiences of BAME participants with mental health services was a "stance" on exploration aimed at further trying to understand the participants personal lived experience and provide additional insight to provide a clearer picture on how future researchers and policy makers could (i) improve psychotherapeutic practice in BAME populations and (ii) resolve barriers for mental health engagement. As study 3 and 4 are concerned with "unpacking" the meaning of mental health, from the stance of BAME populations (study 3) and from the perspective of clinicians (study 4), a qualitative analysis was chosen such as the IPA to provide a detailed account for personal lived experience (Eatough & Smith, 2008; Pietkiewicz & Smith, 2014). The IPA differs from both ground theory (Mills et al., 2006) and thematic analyses (Braun & Clarke, 2006) in that its principal theoretical starting point is the person/speaker and their affective, mental, and physical states (Eatough & Smith, 2008; Larkin et al., 2006; Pietkiewicz & Smith, 2014). Additionally, the IPA approach assumes the researcher's epistemological stance is concerned with the "personal lived experience and how participants make sense of that experience" (Larkin et al., 2006) which based on the previously depicted “reality cycle” (Maarouf, 2019) the researcher in this Ph.D. could embody. In this case, the IPA stance aimed to explore how participants make sense of mental health, stigma, attitudes towards diagnosis and treatment. Furthermore, due to its idiographic commitment, this method is particularly useful in interpreting topics which are opaque, complex and emotionally laden (Eatough & Smith, 2008; Larkin et al., 2006; Pietkiewicz & Smith, 2014) thus this approach was deemed most appropriate to answer the research question. Detailed description of the analysis for each IPA stage can be found in Chapter 4 (see heading 4.2.5). To note, each stage was guided by Eatough and Smith (2008), Larkin et al. (2006) and Pietkiewicz and Smith (2014).

1.5 PERSONAL STORY - RATIONALE FOR PURSUING THIS PH.D.

There are a multitude of reasons, both professionally and personally, that sparked my underlying motives to pursue the subject matter of health inequality and its impact on mental wellbeing in BAME populations for my thesis.

Professional reasons stem from my undergraduate and master's degrees, both disease management focused, where constant themes of discussion revolved around aiming to effectively reduce health inequalities as a proxy for inhibited disease prevalence. However, it was my master's degree where the focus of mental health disparities manifested as a direct and indirect consequence of the Corona Virus Disease 2019 (Covid-19) pandemic. My master's dissertation investigated self-care behaviours for anxiety management during the Covid – 19 pandemic which revealed that ongoing peer support (specifically familial) acted as a deterrent for anxiety symptoms. However, despite this research being published, a small proportion of the participants sample were from minority populations, which I knew at the time was a cohort of interest for public health interventions (Codjoe et al., 2019). This “gap” fuelled further curiosity that was amplified when I attended my master's placement at a National Health Service Smoking Cessation Clinic. In this clinic, there were multiple psychological wellbeing practitioners who commented on (i) how much their workload had increased since the peak of the pandemic and (ii) how cultural issues/lack of understanding between service users and providers seemed to be the main theme of concern when working with disadvantaged populations. I was aware that culture seems to play a role in psychotherapeutic outcomes (Bhugra & Bhui, 1998; Bhui, 2010; Barrera et al., 2013; Edge et al., 2016; Rathod & Kingdon, 2014; Sue et al., 2009) yet it was then and still now a point for further investigation.

Personal reasons for pursuing health inequalities and mental illness in BAME populations are nested in my ongoing memories with my father. Specifically, his struggles with gout, diabetes, hypertension and as a result mental illness. My father, of English/Bangladeshi origin, was diagnosed with gout in 1992 and since then, the insidious nature of gout had increased his risk of multi-morbidity to the point where, in 2017 and 2020, my dad was immobile, bedridden and wheelchair bound. Consequently, he lost his independence, identity and sense of purpose yet in my own ignorance, I could see physical changes in my father but not the additional issues of mental illness. I thought that by, "going through the motions" we could "get through the dark times" however, it was not until my father, and I had a conversation in late 2020 that I fully empathised with what he was feeling. Unbeknownst to me, my father reached a point in time where suicide ideation was apparent. Not being able to walk, take care of himself or others and feeling as if he was a burden were all underlying reasons for his suicide ideation. I was clearly overwhelmed, but I did my best to empathise and listen to why he felt talking to me about his mental health was difficult as, up until that point, I was not aware such negative feelings were plaguing my father. My father told me that (i) due to his cultural heritage, mental illness was a taboo topic, not spoken about and carried stereotypical views; (ii) my father felt that by "opening up" and showing vulnerability, this would create an incongruence between his desired self-conceptualisation and his actual state of being; and (iii) negative experiences with mental health services (again something I was unaware of) in the 1990's still had a "firm grip" on my father's attitude towards seeking help. I am and will always be grateful for my father's courage in sharing his feelings and since then, my father is at present walking (with a walking stick), however, the themes of concern that my father felt never really left me.

Linking my professional and personal experiences with research conducted in BAME populations, stigma (Cheng et al., 2018), negative experiences (Codjoe et al., 2019) and language issues (Memon et al., 2016) are just a fraction of factors in a continually growing list of variables that demand further research and exploration (Public Health England, [PHE], 2018a, 2018b).

The factors I have illustrated above, which include both my personal and professional experiences, alongside the research interest in reducing health inequalities, have influenced my decision to conduct this study with BAME populations and to explore the contemporary impact of health inequalities on their mental wellbeing to help inform future mental health policy and interventions.

1.6 POSITIONALITY STATEMENT

According to Yip (2024), positionality is concerned with the researcher's worldview and stance within the context of their research. Positionality encloses the broader political and social factors that underpin interpersonal relationships (Savin-Baden & Major, 2013), the qualitative research process (Yip, 2024) and is moulded by various factors such as beliefs, values, personal experiences, race and gender (Bradbury-Jones, 2007; Hamzeh & Oliver, 2010). Positionality also reflects the stance a researcher takes in relation to their participants, defined as "the position the researcher has chosen to adopt within a given research study" (Savin-Baden & Major, 2013, p. 71). It is suggested that the 'position' the researcher chooses influences the research focus, methodology and outcomes (Coghlan & Brydon-Miller, 2014). Additionally, positionality refers to how researchers understand their own identities and how they are perceived by others, considering factors such as insider (perceived as being part of the group) or outsider (perceived as not being part of the group) perspective, power dynamics, and social privilege or disadvantage (Ozano & Khatri, 2018). These different identifies and modes of perception, affect the researcher's assumptions, access to participants, interactions, the framing of questions, and the interpretation of findings (Patton, 2014).

Research has established that illustrating a fixed position on a subject is challenging, as a researcher's stance (e.g., insider vs. outsider) often shifts depending on the context (Milligan, 2016). In particular, researchers sit on a continuum of, for example 'insidness' and 'outsidness', during a research process as their life changes, experiences unfold and knowledge improves with the subject matter (Hellawell, 2006) - a process coined as 'liquid identity' (Thomson & Gunter, 2011). This implies that researcher's positionalities are multiple and given that positionality underpins various aspects of the research process (Dhillon, & Thomas, 2019), researchers should report their own positionality in relation to the subject matter to enhance reliability and trustworthiness of the findings nested within it (Yip, 2024).

Prior to embarking on this doctoral research, I approached the subject of black, Asian and minority ethnic (BAME) disparities rotted in my lived experience with my father's suffering from illness, incongruence between his desired state of fatherhood versus his actual state of being and as a consequence, his struggles with suicide ideation. This, coupled with my overall awareness of health inequalities that plagued BAME populations at the height of the Covid-19 pandemic (Otu, 2020), shaped my assumptions and research questions. For example, my initial assumptions about the causes of mental health disparities within BAME populations were nested in the intersection of sociocultural factors. Specifically, I assumed that outcomes in mental health manifested, at least in part, as a consequence of cultural stigma around mental illness (as my father had disclosed aspects of this in his lived experience), leading to underreporting, delays in seeking mental health aid and producing a cycle of poor mental wellbeing. I also assumed that there may have been a generalised mistrust towards health practitioners due to well-known historical mistreatment of mental health patients (e.g., lobotomy procedure) (Turner et al., 2015) and ongoing experiences of discrimination (Cheng et al., 2018) further fragmenting the therapeutic alliance.

Consequently, the assumptions underpinning my research questions were rooted in the notion that effective mental health care for BAME populations required both an improved understanding of the cultural context present in therapy and the potential necessity to adapt psychotherapeutic approaches to accommodate for these considerations. Additionally, a key question in my research was how current mental health services and interventions could be adapted to meet the needs of these populations more effectively. Furthermore, I assumed that there was a gap in the literature regarding the specific experiences of BAME sub-groups in relation to psychotherapeutic services and their perceptions of mental health care - a stance echoed by the Commission on Race & Ethnic Disparities (CRED, 2021) report. This assumption guided my exploration of not just the effectiveness of interventions, but also the experiences and perspectives of service users and providers (i.e., how both parties make sense of themselves and each other during mental health recovery). I believed that understanding both sides of this dynamic could offer valuable insights into how to bridge the gap in mental health outcomes and forge a stronger therapeutic alliance.

Whilst I was personally invested in addressing mental health disparities in BAME populations (due to my father's struggles), I saw myself as an outsider to the experiences of those in the populations I studied. I believed I was an outsider as I had not personally experienced a mental health disorder of similar severity, and this 'distance' from lived experience may have impacted the way my research was perceived by my participants. I also believed that my lack of personal experience with suffering or pain related to mental health disparities might pose challenges. Specifically, I was concerned that (i) I might struggle to fully empathise with participants, and (ii) I would need to exercise heightened caution and sensitivity in framing questions to account for this limitation in lived experience. On the other hand, given this awareness, I strived to build trust, care and support with every participant throughout the research process, to ensure that their stories are accurately represented and point out insights that best answered areas of ambiguity in the subject matter.

In my research, I believe and thus emphasise the importance of critical thinking, transparency and ‘distance’ between the researcher and his findings. Additionally, I view the research process as one driven by evidence and believe that it is the responsibility of the researcher to remain impartial, ensuring that the data's reliability and validity are preserved. Consequently, I was and still am committed to providing an honest and accurate account of my findings, acknowledging that my position as a researcher may influence my interpretation of data, but also striving to minimise any potential biases that might arise and report this to the reader for their insight. Finally, I believe that by being transparent about my position and biases, I can better engage with participants and provide insights that contribute to more equitable mental health practices and policies for BAME populations.

1.7 DEFINITIONS & BAME TERMINOLOGY

A current debate exists amongst researchers, organisations and policy makers about the “correct” terminology to delineate BAME populations (Aspinall, 2020; CRED, 2021; Institute of Race Relations [IRR], 2022; PHE, 2020b). There are several distinct terms for BAME communities in the United Kingdom (UK), such as BAME (Black, Asian and Minority Ethnic), BME (Black and Minority Ethnic) and AAME (African, Asian and Minority Ethnic) however, the most recent CRED (2021) report on “COVID - Disparities” recommended that the UK government is advised to stop using the term “BAME and BME” due to the risk of misleading data interpretations, obscurity on disparities between ethnic groups and exclusion of other ethnic groups (mixed, other and white ethnic groups). Additionally, the CRED (2021) emphasised that future researchers should refer to each ethnic group individually than as a collective. Despite this initiative, the term BAME is still popular among organisations dedicated to racial equality, such as the IRR (2022), private sectors (British United Provident Association, [BUPA], 2020), and civil services departments (PHE, 2020b). Furthermore, it has been argued that the terminology, BAME, still presents utility in that (I) "BAME" is a more inclusive phrase that refers to all ethnic minorities in the UK (Aspinall, 2020) and (ii) this might describe a group of people who identify with one another due to a shared heritage, which frequently includes a common language and culture as well as religion or an ideology that emphasises a common genealogy (IRR, 2022). Still, with widening health disparities amongst ethnic minority populations (Graham, 2009), exacerbated by Covid-19 (CRED, 2021), a “step towards” ethnic specific recommendations are warranted.

The present thesis uses the term BAME with the aim of further exploring this umbrella term to provide ethnic specific recommendations. Specifically, in this thesis BAME is defined as per the PHE (2020b) census data, with 5 clusters of 18 ethnicities, of which 4 clusters and 14 ethnicities can be categorised as BAME. For example, “Mixed or multiple ethnic groups” (white and black Caribbean; white and black African; white and Asian; any other mixed or multiple ethnic background), “Asian or Asian British” (Indian; Pakistani; Bangladeshi; Chinese; any other Asian background), “Black, African, Caribbean or Black British” (African; Caribbean; any other black, African, or Caribbean background) and “Other ethnic group” (Arab; any other ethnic group). Each sub-division of ethnicity present their own barriers and facilitators for positive psychotherapeutic outcomes and acceptance of diagnosis (Patel et al., 2017) and thus, this thesis will aim to address each subgroup and provide ethnic specific recommendations where possible.

1.8 HISTORY OF MENTAL HEALTH MANAGEMENT

Mental health management is the process of managing and treating mental illness (Turner, 2015). Exploring the history and story behind mental health management provides an opportunity to understand contextual factors towards treatment (i. e., culture, attitudes, social norms - to name a few), the evolution of how practices have changed over time and what contemporary issues are prevalent.

In the early 1800s, mental health management was in its infancy. There were no effective treatments for mental illness, so people with mental illness were typically treated in hospitals known as asylums (Turner et al., 2015). The conditions in asylums were often barbaric, and patients were often confined to cells for prolonged periods of time with little autonomy (Turner et al., 2015). Many people with mental illness were also subjected to cruel and inhumane treatments, such as lobotomies (Turner et al., 2015). Additionally, people with mental illness were often seen as crazy or dangerous (Turner et al., 2015). Furthermore, there was a lack of understanding of mental illness, and many people believed that mental illness was contagious (Turner et al., 2015). Mental illness was often seen as a sign of weakness, and people with mental illness were repeatedly ridiculed, stigmatised and shunned by society (Turner et al., 2015). Mental illness was also viewed as a sin, and people with mental illness were frequently thought to be possessed by the devil (Turner et al., 2015). Mental illness was often seen as a taboo topic, and many people were reluctant to talk about it (Turner et al., 2015).

Over time, our understanding of mental illness grew, and consequently, so had less invasive and inhuman treatments. In the mid-1900s, the use of medication became more frequent in the treatment of mental illness (e. g. benzodiazepine for depression/anxiety) (Turner et al., 2015). This was a breakthrough, as medication played a role in effective mental health treatment (Turner et al., 2015). In addition, psychotherapy had also become an important part of mental health management, first pioneered by early psychoanalysts such as Sigmund Freud (Freud & Chase, 1925) and Carl Jung (Jung, 1936), to later psychotherapists such as Carl Rogers (Rogers, 1986) and Aron Beck (Beck, 1993). Psychotherapy is a type of "talking therapy" that involves facilitating dialogue around individual, situation-specific multi-faceted topics associated with anxiety, depression, and many other forms of mental health disorders with the aim of effectively treating these conditions (Royal College of Psychiatrists [RCP], 2021).

Conversely, the current "patient journey" is substantially different due to the implementation of comprehensive policies (e. g. "2007 Mental Health Act" – introducing the "improving access to psychological therapies" initiative), medications (e. g. serotonin reuptake inhibitors for depression) and improvements with psychotherapies (e. g. cognitive behaviour therapy) (Rachman, 2015; Turner et al., 2015). However, despite substantial progress, within the psychotherapeutic domain, an inordinate number of approaches has been developed thus resulting towards difficulty in navigating the evidence base to comprehend which psychotherapies are most common in today's practice. Although it seems Cognitive Behavioural Therapy (CBT) is the most used psychotherapy overall (RCP, 2021), no global taxonomy of common psychotherapies has been created in addition to no taxonomy of common psychotherapies for BAME groups. Thus, a taxonomy of common psychotherapeutic practices for BAME groups is warranted to amalgamate the evidence base, understand which mechanisms are targeted to manage the associated symptoms of common mental health disorders such as anxiety and depression (Bolier et al., 2013) and examine which psychotherapeutic treatment/s is/are most effective in BAME populations. Moreover, a taxonomy of common, most effective psychotherapeutic practices for anxiety and depression in BAME groups will help inform future self-care interventions for BAME populations.

1.9 MENTAL HEALTH – A GLOBAL ISSUE

With advancements in technological innovation in healthcare and health policy, population health outcomes, such as prolonged life expectancy, quality of life and reductions in infectious disease prevalence have improved significantly over the last century (Huber et al., 2011). However, despite significant progress, different health issues have manifested, specifically chronic diseases, such as mental health conditions. Whilst health is defined as a state of complete physical, mental and social well-being (Huber et al., 2011), mental health is defined as “a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (World Health Organisation [WHO], 2020a). Mental health conditions have become a major public health concern as (i) contemporary burden of mental illness currently sits at around 792 million internationally (Dattanni et al., 2017) and (ii) global mental health costs are currently estimated at £1.6 trillion per annum with predictions reaching £4.8 trillion per year by 2030 (The Lancet Global, 2020).

Mental illnesses were the primary causes of global health-related suffering prior to 2020, with depressive and anxiety disorders being the most important contributors to this burden (Santomauro et al., 2021). The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2019 revealed that depressive and anxiety disorders were the two most debilitating mental illnesses, both of which were among the top 25 leading causes of burden worldwide in 2019 (Vos et al., 2020). Additionally, despite considerable evidence that existing programmes reduce the impact of anxiety and depression, no reduction in global prevalence or burden was observed for either illness since 1990 (Patel et al., 2016).

The outbreak of the Covid-19 epidemic in 2020 has prompted many concerns about its immediate psychological consequences as well as long-term economic and social ramifications (Kola et al., 2021). With the direct consequences of Covid-19 augmenting morbidity and mortality (Santomauro et al., 2021; Vos et al., 2020), indirect consequences can also be observed. Specifically, the pandemic has had a significant impact on many social determinants that influence mental health (Santomauro et al., 2021). Social restrictions, lockdowns, education attainment, school and business closures, job loss, economic recession, and altered government priorities in the face of the Covid-19 crisis all have the capacity to severely affect people's mental well-being (Patel et al., 2016; Santomauro et al., 2021; Vos et al., 2020).

A systematic review and meta-analyses published in The Lancet (Santomauro et al., 2021) investigated the global impact of Covid-19 on disease burden of depression and anxiety disorders. The studies were eligible if they revealed the prevalence of depressive or anxiety disorders in the general population and had a pre-pandemic baseline. Data from eligible studies were used to calculate changes in prevalence of major depressive disorder and anxiety disorders due to Covid-19 based on age, sex, and area using a disease modelling meta-analysis tool. Estimates of the daily infection rate, Disability adjusted life years (DALY's), a measure used to assess healthy life lost due to morbidly or mortality, and movement of people were utilised as indicators of the impact of the epidemic on populations were collected via survey data from 48 studies. Of the 5,683 unique data sources identified during the systematic review, 48 (one of which provided data across two countries) met the inclusion criteria. The largest number of studies came from Western Europe (22), North America (14), followed by Australasia (5), high-income Asia Pacific (5), East Asia (2), and central Europe (1). Increased Covid-19 infection rate and reduced movement of people were linked to higher prevalence of major depressive disorder and anxiety disorders, according to the meta-analyses. Furthermore, there would have been 298 million anxiety disorders (3,825 per 100,000 population) in 2020 had the epidemic not occurred, according to modelling estimates. The data revealed that there were 374 million cases (4,802 per 100,000 people), a 26% rise (76 million additional cases). In respect to gender, 52 million extra cases were female whereas around 24 million were male. Also, young people (aged 20 – 24), reported augmented rates of depression (1,118 per 100,000 people) and anxiety (1,331 per 100,000 people) compared to older demographics, indicating a warrant for further investigation in this age group.

Another point of discourse is the fact that BAME populations, both prior and after the peak of the Covid-19 pandemic, presented the highest rates of common mental health disorders (such as anxiety or depression) compared to non-BAME populations in leading developing countries such as the UK and United States (US) (Smith et al., 2020). Moreover, 1 in 6 people in England suffer from common mental health disorders (such as anxiety or depression) with the National Health Service (NHS) spending £16 billion per annum in 2022/23 (Baker & Wade, 2024) which is £1.7 billion more than the previous year 2021/22 (Baker, 2021) and £3 billion more than the year there after (Baker, 2020). Additionally, in the 2022/23 mental health report (Baker & Wade, 2024), BAME populations presented the highest levels of "mental health disorders in the last week" with "black & black British" presenting 23%, "mixed other" demonstrating 20% and "Asian & Asian British" showcasing 18%. Furthermore, specific ethnic groups present their own augmented morbidities for example, Afro-Caribbean populations are five times more likely to suffer from schizophrenia than white populations and Afro-Caribbean men are far more likely to experience psychosis than their white counterparts (PHE, 2018a). Additionally, depression is far more prevalent in South Asian women than all other populations (Rees et al., 2016). The increased mental health prevalence among BAME populations is problematic as consequences of mental health disparities increase in direct proportion to elevated mental health prevalence rates (Baker & Wade, 2024). As a result, exploration into the consequences of mental health disparities among BAME groups are necessary to understand the gravity of the health risks BAME populations experience.

1.10 CONSEQUENCES OF MENTAL HEALTH DISPARITIES IN BAME POPULATIONS

At present, clear disparities exist in mental health outcomes between BAME and non-BAME populations and especially between black and white communities in the UK (Proto & Domeque, 2021). People of African or mixed ethnicity have worse health outcomes, a shorter life expectancy, and greater difficulty in gaining access to healthcare than the average person, and accessibility to mental health treatment is an issue (Keating et al., 2002; National Institute of Mental Health 2003; Proto & Domeque, 2021). Additionally, the mental health services available in the UK are not equally accessible to all ethnic groups, and adverse events, such as relapse, rehospitalisation and multimorbidity are common among BAME service users (Memon et al., 2016; Proto & Domeque, 2021). The UK government has established policies and action plans (for example, The National Service Framework for Mental Health; Delivering Race Equality in Mental Healthcare Action Plan) to tackle racial disparities in access to services, promote mental wellbeing, and enhance basic, secondary, and community-based mental health care (Craig et al., 2012). Despite this, the incidence of frequent mental health issues varies considerably across different BAME groups (McManus et al., 2009; Proto & Domeque, 2021). South Asian women have a significantly higher rate of anxiety and depression (63.5 percent compared to 28.5 percent of white women) (Weich et al., 2004), as well as psychotic illnesses in black Afro-Caribbean males (3.1 percent versus 0.2 percent of white males) (McManus et al., 2009). There is also a substantial amount of diversity in the methods and patterns of engagement and use of mental health services in BAME populations (Bhiu et al., 2003; Morgan et al., 2005). People from ethnic minorities are less likely than white

British individuals to have visited their general practitioner (GP) about mental health concerns in the previous year, to be given antidepressants, or referred to specialised mental health services (Bhiu et al., 2003; Morgan et al., 2005). Additionally, there is evidence to suggest that minorities are less likely to get adequate mental care and may be disadvantaged because they are unable to access services or receive substandard medical assistance (Bhui et al., 2003). Reduced engagement with mental health services could be partly explained by Appleby et al. (2020) study which conducted a national UK survey in 2019 (n = 3224) examining the "public satisfaction with the NHS and social care" and found 68% of UK public satisfied with the NHS. Yet, despite satisfaction scoring at 68%, this result is one of the three lowest satisfaction scores among the UK population since the survey began in 1980 (80%) (Appleby et al., 2020). Conversely, factors that contributed towards dissatisfaction were "not enough NHS staff/facilities" (62%), "it takes too long to get a GP or …" (57%) and "the government doesn't spend enough money on the NHS" (49%); with similar findings presented in the most recent "public satisfaction with the NHS" survey (The Kings Fund, 2021b). More importantly, the population that was least satisfied were individuals from a black and mixed other background (Appleby et al., 2020; The Kings Fund, 2021). Similarly, qualitative findings investigating the perception/experiences of BAME groups in mental health report feeling ostracized by the BAME community for "seeking medical aid" or attending a mental health programme (Wainwright et al., 2019); being subjected to prolonged NHS waiting times leading to feelings of abandonment, prejudice treatment, mistrust, public suspicion (Codjoe et al., 2019); and additional barriers such as low mental health literacy, inability to acknowledge and accept mental health disorders, fear, cultural clashes, language issues (Memon et al., 2016). Correspondingly, a persistent barrier for mental health engagement among BAME groups reported across a multitude of research studies seems to be the phenomenon of mental health stigma (Codjoe et al., 2019; Gary, 2005; Knifton et al., 2010; Memon et al., 2016; Wainwright et al., 2019).

1.10.1 MENTAL HEALTH STIGMA IN BAME POPULATIONS

Mental health stigma is a social phenomenon that refers to the negative attitudes and perceptions that society has about mental illness (Cheng et al., 2018; PHE, 2018a, 2018b). Specifically, negative stereotyping, mistrust of public services, differences in problem-recognition and strategies to solve mental health predicaments are all components of a larger multivariate equation that predicts "mental health stigma" in BAME groups (Cheng et al., 2018; PHE, 2018a, 2018b). Mental health stigma can lead to discrimination and prejudice against people who experience mental illness, which can in turn impede their access to care and support (Cheng et al., 2018; PHE, 2018a, 2018b). Mental health stigma can also be internalized by those who experience mental illness, leading to feelings of shame, isolation, and self-stigma (Bharadwaj et al., 2017). With, BAME groups, specifically groups of black heritage, experience mental health stigma and prejudice at a higher rate than non-BAME groups (British Social Attitudes Survey [BSAS], 2019; PHE, 2018a, 2018b). This may be due to the complex interplay of cultural beliefs and historical mistreatment associated with Black African & Asian individuals having a mental health disorder that manifests during adolescence (i. e. bullying and neglect) (Rose et al., 2011a) and persists into adulthood (i. e. being ostracised, considered weak) (Alvidrez et al., 2008; Chatmon, 2020; Okeke, 2013). Consequently, exacerbated stigma and taboo beliefs associated with mental health led to a reluctance in seeking treatment, risk of amplified symptoms associated with common mental health disorders (e. g., anxiety and depression), morbidity, mortality and augmented NHS costs (Cheng et al., 2018; PHE, 2018a, 2018b). Whilst education-based interventions show promising results for reducing mental health stigma adolescents (Song et al., 2023) and contact-based interventions for reducing mental health stigma in adults (Corrigan et al., 2012), Codjoe et al. (2021) systematic review suggested that psychotherapeutic interventions that tackle and aim to undermine these mental health stigma beliefs in Black African and Asian populations must be investigated, developed and further improved.

1.10.2 SOCIAL ISOLATION AND LONELINESS IN BAME POPULATIONS

Social isolation and loneliness have also been identified as disproportionate consequences towards ill mental health in BAME groups compared to white groups (Lewis & Cotterell, 2018; PHE, 2018a). Despite the two terms used interchangeably, research demonstrates that social isolation and loneliness are not always significantly associated (Coyle & Dungan, 2012; Perissinotto & Covinsky, 2014) therefore suggesting that these two entities are independent of each other. This can be seen in the personality trait “Extraversion” from the “Big Five Personality Model” (BFPM) where some individuals may be content being isolated with no contact (i. e. individuals being low on the extraversion distribution) whereas others may have numerous social interactions but still feel lonely (i. e. individuals being high on the both the extraversion and neurotic distribution) (McCabe & Fleeson, 2012). Nevertheless, social isolation is defined as an objective measure aimed at capturing an individual's absent or limited number of social interactions amongst family, friends and acquaintances whereas, loneliness is a subjective feeling of perceived incongruence between the actual and desired level of social interaction (Lewis & Cotterell, 2018). Exploration into these social determinants of health is important as evidence highlights that both social isolation and loneliness are independent risk factors for premature mortality (Holt et al., 2015) and are independently associated with a diagnosis of cardiovascular disease and Type II Diabetes Mellitus (T2DM) at 5-year follow-up (Christiansen et al., 2020). Additionally, in Holt et al. (2015) meta-analyses (n = 70) investigating the risk of social isolation and loneliness on premature mortality, they highlighted a medium effect size risk ($d = 0.79$) and a relative increased risk of 29% (social isolation) and 26% (loneliness) that further augments with increased aged. Moreover, maladaptive behaviours included in the analyses can further emphasis premature mortality risk such as withdrawal or substance misuse (Christiansen et al., 2020; Holt et al., 2015). These findings explain the gravity of social isolation and loneliness on health and thus must be acknowledged. In relation to BAME groups, research exploring the feeling of loneliness in minority ethnic elderly (Indian, Pakistani, Bangladeshi, African Caribbean & Chinese; ≥ 65 years; n = 300) populations in the UK highlighted clear dispersion in loneliness levels between the majority and minority ethnicities, with all minority ethnic groups, except Indians, reporting 24%-50% in contrast to 8-10% in British elderly populations (Victor et al., 2012). Similarly, Lewis and Cotterell (2018), who investigated levels of social isolation and loneliness in Manchester, stressed the disproportionate prevalence of social isolation and loneliness amongst the BAME populations however, that group identity (i. e. belonging to various social groups withing the community) such as social groups or religion have protective elements against the insidious nature of loneliness despite the group’s temperament. Furthermore, Rob et al. (2020) conducted a national survey in the UK, exploring the impact of social isolation with anxiety and depression and found significant negative association between the former and the latter. Nevertheless, there are limits to how far the concept of social isolation and loneliness can be taken. One of the issues associated with the instruments used to capture and measure social isolation and loneliness (surveys/questionnaires) is that it does not account for differences in cultural/social norms between the minority ethnic groups alongside the issue of inaccurate reports due to the nature of self-reporting (Lewis & Cotterell, 2018; Victor et al., 2012).

Additionally, language barriers and ambiguity surrounding the proper interpretation of social isolation and loneliness may further increase the risk of associated inaccuracies with measurement and self-report. Furthermore, overgeneralisation of "BAME group research" without specific direction and focus on a particular group creates an evidence based that may be confusing as study outcomes of BAME research may not apply to other minority groups thus rationalising the need for more specific investigation. Despite this, social support through a community effort seems to be the approach of most utility to inhibit the risk of social isolation and loneliness among BAME groups (Lewis & Cotterell, 2018) however, more interventions, validated measuring techniques and strategies for supporting mental health in BAME populations is warranted.

1.10.3 PHYSICAL CONDITIONS AMONG BAME POPULATIONS

The physical health consequences of mental health in England are worsening with clear disparities of morbidity and mortality between the minority and majority ethnic groups (Graham, 2009). This can be seen in a national survey capturing obesity rates from 2015 to 2019 in England with BAME populations scoring the highest prevalence across the 4-year period (PHE, 2020a). Additionally, Afro-Caribbean's present the highest rates of mean hypertension thus increasing their risk for stroke and coronary heart disease (Lane et al., 2002). Furthermore, BAME populations, specifically Bangladeshi groups are up to 6 times more likely to develop T2DM than individuals from a white ethnic origin (Diabetes UK, 2020; Gujral et al., 2013). Additional consequences of mental health in BAME groups can be found with musculoskeletal conditions such as, bone fractures, osteoporosis, osteoarthritis (Heikkinen et al., 2019), pulmonary disorders such as chronic obstructive/restrictive pulmonary disease and asthma (Tselebis et al., 2016). As physical health issues further exacerbate mental illness and all-cause-premature mortality (Graham, 2009; PHE, 2018b), it is apparent that BAME populations need further support and investment.

In the final analyses, the consequences of mental health disparities in BAME groups are clear however, underlying reasons for these remain unclear. It is hypothesised that healthy inequity (Arcaya et al., 2015), inequality (Codjoe et al., 2019), and its social determinants (PHE, 2018b) are the main predictor variables for increased mental health prevalence in BAME populations. Still, all the former predictor variables remain perplexing, opaque, equivocal and insufficiently understood.

LITERATURE REVIEW

1.11 HEALTH INEQUALITY

In most developed countries, the health inequalities and inequities have been thought to be the variables that most explain the disproportionate high rates of mental health in BAME populations (Arcaya et al., 2015; Codjoe et al., 2019). Health inequity is defined as 'the unfair and avoidable differences in health status between different groups of people' (Arcaya et al., 2015). Health inequality can be defined as preventable variations in health throughout the population and amongst different groups within society with socioeconomic status and deprivation (e. g. unemployment, low income, poor education, people living in deprived areas and poor housing) being one of many increasing issues (NHS, 2020a). Furthermore, health outcomes between different groups in a given population are used to measure health inequality (The Kings Fund, 2021a). Specifically, life expectancy, healthy life expectancy, and disease incidence are compared using groupings such as gender, ethnicity, social class, area deprivation, employment status and education (The Kings Fund, 2021a). Literature suggests that health disparities should be reduced on the grounds of (i) inequalities are unfair, (ii) inequalities affect all populations, (iii) inequalities are largely avoidable and (iv) cost effective public health preventative measures could be employed (Woodward & Kawachi, 2000).

Furthermore, social exclusion is perceived as one of the main issues received in numerous forms such as socioeconomic, cultural and institutional (Mclean et al., 2003). Additionally, poor living conditions, income disparities and types of employment, with most low paid jobs being occupied by BAME ethnicities, act as further determinants for health inequality between the majority and minority ethnic groups (Codjoe et al., 2019; Mclean et al., 2003). Moreover, bereavement, family breakups, socio-economic decline and experiencing racism have also been captured as contributing factors (Latif, 2014). Consequently, these health inequality determinants create negative perceptions among the BAME groups (mistrust of public health services, lack of engagement, stigma) thus increasing their mental health risk (Mclean et al., 2003). More importantly, negative personal experiences with medical institutions make BAME populations less likely to contact their general practitioner thus reducing the opportunity to express and treat mental health conditions with anti-depressants or referral to a mental health specialist (Becares, 2015; Codjoe et al., 2019). Thus, exploration into the contemporary social determinants that contribute towards ill mental health in BAME populations must be further investigated to better understand the personal experiences that are influencing the likelihood of mental health treatment and support. As a result, the following sections will aim to discuss each identified social determinant in detail, discuss its surrounding issues, aim to explain the aetiology of its occurrence and how it effects BAME populations.

1.12 SOCIAL DETERMINANTS OF HEALTH INEQUALITIES

Social determinants of health can be defined as “conditions or circumstances in which people are born, grow, live, work and age” (Islam, 2019) with these variables being moulded by economic, political and social factors (Marmot et al., 2008). Moreover, it can be hypothesised that populations exposed to chronic pernicious combinations of mediocre policies, inequitable economic activities and bad governance may have greater likelihood to experience undesired health outcomes (Islam, 2019). Admittedly, it would be more favourable if people within a society were exposed to an equitable fair share of socio-politico-economic resources as the volume and richness of this distribution would undoubtedly play a key role in determining an individual’s health status (Islam, 2019). Specifically, opportunities for proper education (including education attainment), nutrition, healthy living environments/conditions, healthcare and employment are a few of those socio-politico-economic resources (Islam, 2019). Despite this, contemporary issues surrounding the true meaning of what a social determinant is and how it is defined, remains unclear. Rose et al. (2008) argues that public policy acts as an underlying mechanism for the social determinants of health as it regulates and shapes the outcome of major domains within social health such as education, employment, living conditions and healthcare. Thus, rationalising the needed investment into public policy over other areas of interest. However, other areas of research into social determinants of health do not cover public policy and usually stress the need for development in education, housing and employment (Raphael, 2006). Conversely, Graham (2004) contends that “the social determinants of health concept has acquired a dual meaning referring both to the social factors promoting or undermining the health of individuals and populations as well as to the social processes underlying the unequal distribution of these factors between groups occupying unequal positions in society”.

It is speculated that the dual focus of the social determinants of health is to improve the social factors effecting health (e. g. healthy living conditions) and to strive for equal dispersion of those factors (e. g. all populations to live in healthy living conditions) (Graham, 2004). However, this argument presence a new issue with respect to which of the two concepts should be prioritised for improving health outcomes and if the two concepts are positively associated.

Additionally, it is not necessarily clear that equal opportunity for all populations within a society will produce equal health outcomes (Ferreira & Peragine, 2016). On the other hand, the list of factors considered to be a social determinant of health has become exhaustive, confusing and presents itself as being an almost impossible task for researcher's, policy makers and practitioners to address and who should manage them all (Islam, 2019). Some of the most significant social determinants of health currently dominating the evidence base are education (Shankar et al., 2013), housing and living conditions (Bambra et al., 2010), the allocation of income (Mikkonen & Raphael, 2010), food availability, stress, social exclusion, unemployment (Wilkinson & Marmot, 2003), culture/social norms (including cultural resistance towards accepting mental health as an additional component of health alongside physical health) (Olson & Anderson, 2013), media, discrimination and stigma (Hatzenbuehler et al., 2013), social capital (Bravo, 2017), law, racism, racialised legal status (Asad & Clair, 2018), immigration (Castaneda et al., 2015), marginalisation (Lynam & Cowley, 2007), family and religion (Idler, 2014). Due to such an extensive and continually growing list, it remains unclear as to which factor should be prioritised and which metric should be used to measure them. Moreover, as there are more metrics than social determinants, this is an adjunct issue to the ever-growing list of registered social determinants that needs regulation and further peer review (Islam, 2019). Nevertheless, PHE (2018b) has synthesised a list of what seem to be the most prominent social determinants of health inequalities in BAME populations in England and will be discussed in detail below.

At present, gaps in education attainment (PHE, 2018b), unemployment, income and poverty, housing, socio-economic status (Baker, 2014), racial discrimination, and location variation have all been identified in the literature as the most prominent variables contributing towards heath inequalities between the majority and minority ethnic groups in England (Baker, 2020, 2021; PHE, 2018a, 2018b). Additionally, based on NHS hospital mortality data and the presence of Covid-19, this phenomenon (Covid-19) further widens the gap across all the previous dimensions with the proposed reasons being due to socio-economic status, poverty and health-debilitating behaviours (Aldridge et al., 2020). Conversely, observational research including BAME and non-BAME groups ($n = 4510$) suggests that there are no significant associations between cardiometabolic risk, reduced socioeconomic status, socialisation habits and augmented Covid-19 risk in BAME populations (Raisi et al., 2020). However, Raisi et al. (2020) reaches this conclusion with participants ≥60 years old thus lacking generalisability for other age ranges in BAME populations. Still, due to the complex interplay between all the social determinants of health, an in-depth analysis is necessary to uncover the aetiology of these factors and how they contribute towards health inequalities between BAME, non-BAME and amongst the sub-ethnicities of BAME populations. Thus, the following sections will provide an overview of each prominent social determinant as per PHE (2018b).

1.12.1 EDUCATION

Education has been identified as a key social determinant of health for a multitude of suggested reasons (PHE, 2018b). Higher education attainment has been associated with improvements in heath literacy, reduced risk of unemployment, increased proclivity for higher income thus leading towards an augmented health-related quality of life (PHE, 2018b). Moreover, increased education attainment provides the opportunity of access to better healthcare, participate in health-promoting behaviours (such as access to healthier food, engagement in exercise) and a sense of empowerment/achievement thus leading towards increased self-efficacy (Albert & Davia, 2011; Cohen & Syme, 2013; Hahn & Truman, 2015; Health, 2020). It is not clear that higher education attainment has a causal effect on these outcomes (i.e., reduced risk of unemployment, increased income, health –related quality of life) however education attainment seems to be act as a "mediator (i.e., higher education attainment reduces the risk of unemployment therefore attenuating the risk of ill mental health) (PHE, 2018a, 2018b). Additionally, how education attainment is measured can also be put into question as it is not obvious that volume of education (I. E. education attainment; number of years spent to achieve a General Certificates of Secondary Education [GCSE], University Degree, Doctor of Philosophy) and quality of education are the same entities, despite the former measure being most utilised (PHE, 2018a, 2018b). Nevertheless, some plausible explanations as to how higher education attainment attenuates the risk of mental health conditions are that individuals who are more educated are more employable thus potentially reducing the risk of mental illness (Albert & Davia, 2011) and by default increasing the chance of sustainable income. Additionally, it has been suggested in a recent systematic review of 8 cross sectional studies (Neter & Brainin, 2019) examining the relationship between health literacy and health outcomes in patients with chronic health conditions (Asian and Caucasian ethnicities; n = 5076) that healthy literacy, as a consequence of education attainment, provides low to moderate associations for health-behavioural outcomes (medication adherence, engagement with health services, physical activity). However, no experimental studies were included in Neter and Brainin (2019) systematic review thus no causal associations can be inferred. Additionally, all studies included in the review adopted self-report to measure health literacy therefore limiting the reliability of findings (Neter & Brainin, 2019). Furthermore, the search term used in the systematic review was “health literacy” which assumes that this is a widely used term however, this may have missed out on certain studies if the search term integrated the name of well know health literacy tests (e. g. test of functional health literacy) (Neter & Brainin, 2019). In relation to employability prospects, higher education attainment increases the likelihood for individuals to work in safer jobs/environments thus resulting in those who are not as educated to adopt jobs with numerous safety and health hazards (e.g., construction) that may be contributing towards the inequality in health outcomes (Albert & Davia, 2011; Health, 2020). In relation to BAME groups, there is considerable variation in education attainment amongst the majority vs minority ethnic groups but also between the minority ethnic populations. According to the PHE (2018a) and Hutchinson et al. (2020), students who identify as Gyps/Roma, Black Caribbean, White and Black Caribbean, Pakistani, Bangladeshi, Any Other Ethnic Backgrounds and Any Other White Backgrounds score lower on average on General Certificates of Secondary Education (GCSE) than their White British peers. Interestingly, this is not the case for pupils from Chinese or Indian backgrounds as these ethnicities score higher on GCSE scores on average than White British pupils (Hutchinson et al., 2020). Conversely, it is important to recognise that these ethnic groups represent a small total proportion of the England GCSE cohorts with Chinese students representing 0.4% in contrast to White British pupils who represent 69% thus potentially due to outliers may lead to skewness in data from the Chinese ethnicities (Hutchinson et al., 2020). Still, proposed reasons for this gap in education attainment, that widens as time progress, could be due to some cohorts of minority ethnic groups being recent entrants to educational institutions thus having the “English Language” as an additional barrier to achievement alongside mediators such as socioeconomic backgrounds and family relationships (Hutchinson et al., 2020). Although it is unclear which factor/combination of factors accounts for most of the outcome variance in education attainment, individuals from the afore mentioned ethnicities (e. g. Black Caribbean, etc.) are likely to be at an increased risk of mental health illness due to social disadvantages that are preventable and thus may need more health support than individuals from majority ethnic groups (PHE, 2018a, 2018b).

1.12.2 UNEMPLOYMENT

Unemployment, which has been previously linked to low education attainment (Shankar et al., 2013; Wilkinson & Marmot, 2003), shows clear unequal dispersion in rates between the majority and BAME populations. The Office for National Statistics (ONS, 2020) and Foley (2020) both revealed that as of September 2020, BAME populations had higher rates of unemployment in contrast to White ethnic groups (8.5% vs 4.5%). Additionally, there was variance in unemployment rates between the ethnic minorities with Black (11.6%), Pakistani (11.1%), Mixed ethnic (9.9%) and Bangladeshi (8%) groups reporting the highest prevalence of unemployment rates with Chinese (4.8%) and Indian (5.3%) groups presenting the lowest unemployment rates, which were similar to the White ethnic groups (4.5%) (Foley, 2020; ONS, 2020). Furthermore, amongst the BAME populations, young people (aged 16 – 24 years) presented the highest rates of unemployment with Pakistani/Bangladeshi (26%) or Black backgrounds (27%) being the most prevalent. Lastly, from the perspective of gender, in BAME groups males presented slightly higher rates of unemployment compared to females (6.8% vs 6.5%). This is important to consider as all the previous findings from the ONS (2020) and Foley (2020) help guide which BAME group and specific sub-category (age/gender) may need more support, attention and investment.

The factors contributing towards high unemployment rates in BAME groups are multifaceted and complex. The "Five Year Forward View for Mental Health" (Department of Health & Social Care, 2019) suggests that "stable employment and housing are both factors contributing to someone being able to maintain good mental health and are important outcomes for their recovery if they have developed a mental health problem" (PHE, 2018b). However, it is difficult to differentiate whether unemployment increases the risk of mental illness or if mental illness increases the risk of unemployment or perhaps it is a complex interplay of both. A potential reason for high levels of unemployment amongst BAME groups is elevated work stress associated with racial discrimination (Opara et al., 2020), higher effort reward imbalance, greater job demand and lower control over work (PHE, 2018a) thus leading towards reduced job retention, resignment or leave. Additionally, minority ethnic groups are likely to experience employee-employer power imbalances thus further facilitating negative workplace environments (Seifert & Wang, 2018). Furthermore, and potentially due to low education attainment, working in hazardous environments (e. g. construction) increases the risk of work-related death and work stress (PHE, 2018a). Lastly, 21% of NHS Covid-19 frontline workforce comprise of BAME groups which inevitably elevates their risk of unemployment due to work-related stress, increased mental health risk and infection (Out et al., 2020). McQuaid et al. (2016) suggested that negative experiences at work and unemployment in BAME youths create "mental health scarring" that affect employment in later life, however, no casual effect has been linked. Nevertheless, more research in BAME males may be needed as it is suggested that BAME males experience higher life dissatisfaction as a result of unemployment than females potentially due to the loss of work-identity ("how important work is to who you are") (Longhi et al., 2017).

1.12.3 INCOME & POVERTY

The Department of Work and Pensions (DWP, 2019) revealed 15% of the current UK population living on "relative low income", which has been defined as anything less than 60% of the current national median income (i. e. £308 per week). More importantly, of that total 15%, 35% of individuals living in households headed by someone of Bangladeshi or Pakistani background are on "relative low incomes" compared to 14% of the White population (DWP, 2019; PHE, 2018a). Additionally, these disparities further increase when household costs are integrated into the equation, thus leading towards low quality of life amongst the ethnic minorities (DWP, 2019; PHE, 2018a). Furthermore, the income gap can also be seen amongst children living in "relative low income" BAME households with Pakistani (42%), Bangladeshi (42%), Chinese (33%) and Black (26%) backgrounds revealing significantly higher rates of low income in contrast to White households (15%) – with values increasing once household costs are included (Pakistani – 48%; Bangladeshi – 58%; Chinese – 47%; Black – 47%) (DWP, 2019; PHE, 2018a). These statistics are important as children living in "relative low income" households are also likely to experience profound inequality in future income/job opportunity towards adulthood due to previous financial inequalities experienced in childhood. Furthermore, it would be reasonable to hypothesise that BAME children living in "relative low income" households would be at an increased future risk of ill mental health due to familial financial difficulties (McQuaid et al., 2016; PHE, 2018a).

In respect to poverty, considerable gaps can be observed between the ethnicities. The Joseph Rowntree Foundation (JRF, 2017), a UK charity investigating the issues of poverty, showed that the highest rates of poverty were experienced in Pakistani (37%), Bangladeshi (24%), Caribbean (23%) and African (31%) groups in contrast to White (13%) populations. Additionally, significant proportions of Black (20%), Indian (25%), Pakistani (38%), Bangladeshi (52%), Chinese (28%) and other Asian ethnic groups are earning less that the "living wage" thus resulting in many of these individuals not being able to meet the standard of basic human needs (JRF, 2017; PHE, 2018a). Predictor variables driving the disproportionate rates of income and poverty among BAME, and majority ethnic groups seems to be a compounded interaction of unemployment, inactivity rates in the UK labour market (economic inactivity) (ONS, 2021), types of employment, levels of pay and lack of a return on education attainment (Gilchrist & Kyprianou, 2011; Cribb et al., 2018; JRF, 2017). Inactivity rates in the UK labour market are particularly important to acknowledge as there is a relationship between augmented poverty rates and disease (Gilchrist & Kyprianou, 2011). Consequently, resulting in increased at-home caring responsibilities, familial tension/stress and ultimately reducing the opportunity to engage with health services despite ill mental health being at an increased risk and need for attention (Gilchrist & Kyprianou, 2011).

In contrast, there seems to be clustering in low-paid jobs for specific BAME groups with an over presentation in employment-sectors such as sales, textiles, clothing, catering and hairdressing that by nature have poor progression opportunities, -lack of flexibility and long hours (Gilchrist & Kyprianou, 2011; JRF, 2017). Specifically, Black workers are focused on the production line work, Other Asian and Indian groups populate the health and social care sector, and Chinese groups are concentrated in the food industry (JRF, 2017); jobs that are all associated with long hours, stress and demand (Cribb et al., 2018). Additionally, whilst in employment, evidence suggests that BAME groups are more likely to receive income under the living wage than non-White populations, which seems to be driven by an underlying issue of social exclusion through racial discrimination (JRF, 2017). Yet, more clarity surrounding social exclusion and racial discrimination is needed as metrics used to uncover this information were surveys which present limitations (Andrade, 2020). Specifically, online surveys are frequently afflicted with two methodological flaws: (I) the population to which they are distributed cannot be described (I. E. it cannot be assumed that respondents from surveys are representative to their population demographics), and (ii) respondents with biases may self-select themselves into the sample, leading to an overrepresented biased sample, skewed findings and rendering results unreliable (Andrade, 2020). Additionally, as there is limited insight in understanding the motives of participants, the extent to which bias is present in a survey remains opaque, thus lacking depth (Andrade, 2020). Furthermore, (it is not clear how much variance social exclusion and racial discrimination accounts for income disparities

(Andrade, 2020; Manduca, 2018). Despite this, there are significant disparities in income and poverty amongst the majority and minority ethnic groups.

1.12.4 HOUSING

Housing has also been identified as a factor contributing towards health inequalities amongst the ethnicities with the two key issues being inadequate housing conditions and overcrowding (PHE, 2018a, 2018b). The England Housing Survey (EHS, 2019) revealed that around 30% of BAME populations are housed in the private rental sector in contrast to white populations (18%) with Arabs having the highest rental residency among the BAME groups (49%). This is important as the private rental sector is the housing sector most associated with numerous poor housing conditions such as dampness and disrepair thus inhibiting appropriate hygiene and quality of life (Barnes et al., 2013). Additionally, overcrowded households (defined as having more individuals than the number of bedrooms) has become a major issue with Bangladeshi (24%), Pakistani (18%), Black African (16%), Arab (15%) and Mixed White and Black African (14%) households presenting the highest prevalence which is significantly higher than in White British households (2%) (EHS, 2019; Wilson & Barton, 2020). These housing issues have been associated with numerous issues such as increased risk of physical and mental morbidity, inhibited physical activity, sleep deprivation and poor education attainment among children (Barnes et al., 2013; PHE, 2018a). Furthermore, housing issues are strongly associated with life-satisfaction thus further fuelling the risk of ill mental health (EHS, 2019). It is important to acknowledge that as this data provided by the EHS (2019) has been collected via surveys, consequently, there may be come inaccuracies due to self-report bias (Lefever et al., 2007; Wright, 2005). Nevertheless, the reasons for BAME populations being over-represented in the private rental sector in conjunction with overcrowding is likely a result of a complex relationship between reduced education attainment among specific BAME groups (Hutchinson et al., 2020), reduced prospects for secure employment (Foley, 2020), lower levels of pay (Cribb et al., 2018) and racial discrimination (JRF, 2017). Moreover, all these variables are further amplified by the presence of Covid-19 (Aldridge et al., 2020) manifesting an unstable, inequitable economy.

1.12.5 RACIAL DISCRIMINATION

Racial discrimination is defined as unfair treatment of individuals based on their ethnic characteristics (Equality & Human Rights Commission [EHRC], 2020). There are four types of racial discrimination such as “direct discrimination” (I.e., a direct act or behaviour that treats an individual worse than another due to their race), “indirect discrimination” (I.e., an organisational work policy that excludes a particular ethnic group or puts them at a disadvantage , “harassment” (a behaviour resulting in an individual or group of individuals to feel degraded, humiliated or offended e. g. being called racial slurs at work) and “victimisation” (when an individual is treated inappropriately after a complaint of race being made under the Equality Act) (EHRC, 2020). According to the BSAS (2019), 30% (n = 1140/3802) of the UK population felt “very” (3%) or “a little” (27%) prejudice towards other ethnic groups. Additionally, 13% of BAME populations felt subjected to indirect forms of racial discrimination concluding it to be a “very big” (10%) or “fairly big” (3%) problem in their borough (BSAS, 2019). Bangladeshi (18%) and mixed (13%) ethnic groups showed the highest rates of “feeling racially discriminated” in contrast to white (6%) groups (BSAS, 2019).

Investigation into the relationship between racial discrimination and health is important as continual exposure to such treatment increases the risk of mental health conditions such as chronic stress, anxiety, depression (Bhui, 2016; Pascoe & Richman, 2009) and further “by-products" such as low self-efficacy (Wallace et al., 2016). Karlsen et al. (2005) examined the relationship between racial discrimination on mental health outcomes in BAME groups and highlighted a positive association between ethnic minorities experiencing racial discrimination (direct/indirect self-report measures - 36% of Caribbean, 19% of Indian, 16% of Pakistani and 8% of Bangladeshi) and increased risk of anxiety, depression and psychosis. Similarly, Assari et al. (2017) conducted a cross-sectional follow up study aiming to highlight determinants of future mental health deterioration among black male and female youths (n = 681). They found that perceived racial discrimination in youth was associated with depressive symptoms (anxiety, low self-esteem, low self-worth) in adulthood among black males but not in females thus facilitating a rationale for investigation into young black males. This finding may be explained by moderating processes such as “masculine norms” where restrictive emotional expressiveness has been associated with higher depressive-like symptoms in black males (Hammond, 2012). Additionally, males and females seem to develop different coping strategies once subjected to racial discrimination were males exhibit more “combative/confronting” approaches during times of distress than females who lean towards social support from family and friends, which would suggest that social support has protective moderating elements (Lewis et al., 2013). As a result, it seems probable that the insidious mental health debilitating effects of racial discrimination, that manifest in adulthood, are accelerated for males who adopt strong masculine ideologies, behaviours and values (Caldwell et al., 2013).

A systematic review examining 121 studies on self-reported racism and health in children and young people, again, showed positive correlations between racial discrimination and depressive symptoms (e. g. anxiety) however, limitations in sampling techniques, study design, heterogeneity of metrics used to measure “perceived racial discrimination”, heterogeneity of study health outcomes and a lack of clarity around the definition on what “racial discrimination is” should be acknowledged (Priest et al., 2013). Most of the studies in the systematic review used convenience sampling (Priest et al., 2013, n = 100/121) with this approach also being adopted in both Asssari et al. (2017) and Karlsen et al. (2005) thus limiting generalisability of results and potentially showing a consistent bias in sampling methodology. Additionally, all studies covering racial discrimination were observational (mostly cross-sectional, e. g. n = 94/121) thus attenuating the opportunity for causality to be established. Furthermore, substantial variability in scales/questionnaires (e. g. large differentiation in number of items measured between scales per study) used to measure racial discrimination and outcome measures of mental health makes study replicability difficult but, more importantly, creates considerable heterogeneity in study outcomes, (Priest et al., 2013). Moreover, one major criticism of much of the literature on racial discrimination and health is questioning whether capturing the “total amount of racial encounters” per person is the correct measure to predict negative health outcomes as one “unit” of direct racial discrimination may account for three “units” of indirect racial discrimination or vice versa. Lastly, Priest et al. (2013) emphasises inconsistencies in respect to the definition of racial discrimination as only a third (n = 38/121) of studies in the review clearly define racial discrimination, thus leaving room for ambiguity and a different understanding for what racial discrimination is. This could be problematic as despite a huge “pool” of studies claiming to examine the effects of racial discrimination on health, these studies may be examining an incorrect measure (i.e., units of direct vs indirect racial encounters) or be focusing on an area that does not accurately represent racial discrimination in accordance with its definition, as defined by the EHRC (2020). Despite this, racial discrimination plays a key role in determining health outcomes in BAME groups therefore, investment is needed for more experimental study designs and identification of determinants to best manage the insidious nature of racial discrimination.

1.13 THE ONGOING INFLUENCE OF COVID-19 ON THE UK SOCIOECONOMIC LANDSCAPE & ITS IMPACT ON MENTAL HEALTH RISK IN BAME GROUPS

It is paramount to acknowledge that the sudden contemporary occurrence of Covid-19 has further highlighted the depth of health inequality among BAME populations across all the previously mentioned social health determinants and as a result, increases their risk of mental health conditions (Aldridge et al., 2020; Iob et al., 2020). Perhaps the most important indirect influence on mental health in BAME groups is the significant financial loss within important building blocks of society such as the education sector (Ahlburg, 2020), income (Baena et al., 2020) and occupation (Mayhew & Anand, 2020). Consequently, this produces an increased indirect pressure and stress on BAME groups due to the already existing inequality (PHE, 2018a), risk of long-term unemployment and poverty (Langella & Manning, 2019). However, to which extent and how these current issues will be rectified are still in question. For example, Universities UK (UUK, 2020) have comprised a document outlining a £6.9 billion pound loss in HE institutions during the academic year of 2020 as a result of discontinued or a reduced enrolment on international students. Additionally, this loss of funding drastically effects teaching institutions that are heavily reliant on student fees thus risking quality of research/teaching/training facilities, teaching/student experience and higher education teaching jobs (UUK, 2020). Consequently, this is likely to augment the lack of highly trained workers to provide public services and meet the national demands (i. e., lecturers, nurses, medical professionals, public health practitioners, artificial intelligence engineers, data analytics) resulting in a volatile socioeconomic environment (Mayhew & Anand, 2020; UUK, 2020). Moreover, student university experience among BAME groups, which already receive disproportionate enrolment and academic achievement, are at risk of experiencing further widening disparities (Ahlburg, 2020; UUK, 2020).

Student university experience among BAME groups warrants consideration as individuals with an undergraduate university degree, across the lifespan, earn higher salaries on average than those who do not have a university undergraduate degree (Ahlburg, 2020) thus increasing the risk of long-term low income and poverty for BAME populations which was already apparent before Covid-19 (DWP, 2019; JRF, 2017; PHE, 2018a). Moreover, as the UK labour market has predicted to experience an increase in unemployment levels by 20% if the national lockdown lasts 12 months (Mayhew & Anand, 2020); younger individuals (aged 18-24) are likely to experience “the brunt” of the unemployment upheaval as they are disproportionately represented in low-paid jobs, such as retail and hospitality, that cannot be done at home and risk being made redundant and unemployed (Hensvik et al., 2020; Mayhew & Anand, 2020). Furthermore, as stable employment is necessary for good mental health (PHE, 2018), it would be safe to hypothesis that youth BAME groups at risk of long-term redundancy/unemployment are at an augmented risk of mental health conditions. Correspondingly, as youth individuals from black backgrounds (16 - 24) reported the highest levels of unemployment prior to the Covid-19 lockdown (27%) (Foley, 2020; ONS, 2020) and that BAME males seem to display higher levels of life dissatisfaction as a result of unemployment than females (Longhi et al., 2017), this could guide future focus as to which specific BAME cohort could be at most risk of ill mental health and in need for ongoing support. This suggestion for future research is further strengthened by new findings exploring the relationship between Covid-19 and mental health deterioration among BAME groups in the UK (Proto & Quintana, 2020). This study used a longitudinal data set sample (n = 28,578) measuring the same cohort for mental health risk pre and post Covid-19 (April 2020) using the 12 item "General Health Questionnaire" (Proto & Quintana, 2020). The study revealed that BAME males experienced 0.13 - 0.14 standard deviations higher mental health deterioration rates than white British males with Bangladeshi, Pakistani and Indian ethnicities mainly driving the standard deviation difference (Proto & Quintana, 2020). However, their study does involve a potential measurement error as 86% of their sample size were white British thus leaving room for outliers to generate skewness in the BAME data output and drastically influencing the mean between the two groups (non-white vs white males). Furthermore, the study would have been more useful if potential causal mechanisms for ill mental health among BAME groups were explored as this could have informed future research. Nonetheless, acting as an adjunct to Proto and Quintana (2020), Smith et al. (2020) advocate that mental health risk for BAME groups have been increased due to the national lockdown restrictions leading to reduced face-to-face support for individuals from disadvantaged backgrounds. Consequently, increasing the risk for mental health conditions to reach critical levels. Moreover, the author emphasis that this "new normal" raises challenges to encourage disadvantaged groups to engage in mental health services due to stigma, mistrust or lack of literacy surrounding what mental health services can provide (Smith et al., 2020). With this information put into consideration, strategies for the management of mental health risk among BAME populations must be put into dissemination to mitigate the future potential overwhelming pressure on the NHS. Despite this, new research indicates discrepancies and dissatisfaction between BAME groups and the NHS that should be further explored to highlight what variables are fuelling discontent to then amalgamate a future strategy for effective management of at-risk mental health populations.

1.14 BAME GROUPS' PERCEPTION OF UK HEALTHCARE

It has been emphasised that perceived social exclusion is one of the main underlying mechanisms for health inequalities in BAME populations, received particularly from institutions (Mclean et al., 2003). Consequently, such perceived negative experiences fragments rapport between practitioner's vs patients, augments stigma beliefs and mistrust of public services, reduces engagement and treatment acceptability (Mclean et al., 2003). With additional national surveys showcasing increased dissatisfaction from BAME towards the NHS (Appleby et al., 2020; The Kings Fund, 2021b - more information found in "1.9 Consequences of Mental Health Disparities in BAME populations"), more investigation in understanding the source of these discrepancies is warranted.

It is important to acknowledge that what drives public views about the NHS are multifaceted, contextual and are unlikely to all be captured in an online survey (Appleby et al., 2020; Robertson et al., 2019). Similarly, it is essential to not assume that current public views accurately represent actual NHS performance outcomes as it is likely that public opinion about the NHS is comprised of personal experience, politics and distorted beliefs about the institution (Appleby et al., 2020; Robertson et al., 2019). However, strengths associated within this study are the survey questions (driven be objective key performance indicator issues within the NHS; e. g. hospital waiting times – thus allowing for easy comparisons between current and previous years), randomisation of sampling techniques leading to reduced bias, appropriate sample size (Kotrlik & Higgins, 2001) and follow up interviews with individuals that were also randomly selected (Appleby et al., 2020). The population that was least satisfied were individuals from a black and mixed other background (Appleby et al., 2020). These findings were consistent with Appleby et al. (2020) finding coincides with Codjoe et al. (2019) who explored the experiences of black faith communities and mental wellbeing services and emphasised that prolonged hospital waiting times fuelled frustration between the two parties as individuals from the black faith community did not feel prioritised. Similarly, Wainwright et al. (2019) investigated BAME mental health survivors (n = 25) who had attended a mental health service and revealed that individuals who attended mental health services felt ostracized in the BAME community. Thus, rationalising the need for post-therapy support due to the risk of relapse and rehospitalisation (Baker, 2020, 2021). Kang and Moran (2020) conducted qualitative research on NHS mental health staff (n = 9) and highlighted a lack of confidence and comprehension in meeting the cultural and religious needs of BAME groups (Kang & Moran, 2020). Furthermore, they attributed this discrepancy to the idea that there is no universal tool to identify cultural/religious needs and that more guidance and training was needed for NHS mental health staff to help solve this discrepancy (Kang & Moran, 2020). Most importantly, research investigating the barriers between BAME communities and health care providers identified personal and environmental barriers with personal being an inability to acknowledge and accept mental health disorders, reluctance to discuss mental illness amongst men and cultural identity being most prominent (Memon et al., 2016). In respect to environmental, prolonged waiting times, language barriers and a general lack of engagement leading to potential mental health issues going undiagnosed are further areas of concern that need attention (Memon et al., 2016). Given the circumstances, issues between BAME groups and mental health services are present, however, strategies for how this will be rectified remains unclear. BAME communities need significant mental health literacy and practical support to raise recognition of mental health disorders and tackle “cultural taboo” and stigma to improve information about services and increase access to pathways (Memon et al., 2016). Additionally, addressing under-resourcing of tailored BAME healthcare would be offset by a reduction in NHS costs, as around £13 billion is spent annually on Mental Health Services which equates to a total of 14% financial allocation from local NHS budgets, and it is therefore clear that action is needed to tackle this growing issue (Baker, 2020, 2021). Furthermore, most studies in the field of “exploring BAME mental health barriers towards health services” have only focused on trying to mitigate this issue through encouraging increased engagement with mental health services however, as the NHS service is currently operating way past its own capacity (Appleby et al., 2020; Robertson et al., 2019), the focus should not merely be on “urging people to engage with mental health services” but more importantly to “help people help themselves” with the NHS acting as a “vessel”. Consequently, it has been suggested that health professionals need to capitalise on facilitating self-care among the BAME community (Bignall et al., 2020).

1.15 THE NEED FOR SELF-CARE IN BAME POPULATIONS

Self-Care was originally a concept conceptualised in the 1970’s alongside health promotion as an idea to deal with past inadequacies in the UK health-care system (Bhuyan, 2004) such as the change from infectious to chronic disease occurrence (Dean & Kickbusch, 1995); an escalation in the price of medication (Levin, 1980); a shift from management to a prevention philosophy and the political rise of individualism (individual identity) and self-reliance (Padula, 1992). At present, Self-Care is defined as "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider" (WHO, 2019). Self-care represents an idea and philosophy for people to be more proactive about their own health (Bhuyan, 2004; Dean & Kickbursch, 1995). A current limitation in literature surrounding Self-Care is that there is no consensus in respect to what exact behaviours encompass Self-Care, however, four broad self-care categorisations can be recognised such as "regulatory" self-care which involves behaviours for health maintenance (food intake, personal hygiene, sleep), "preventive self-care" which consists of health promoting behaviours (dieting and exercise), "reactive self-care" acting on symptoms or responses that have not yet been intervened by a medical professional and "restorative self-care" which implicates obedience to prescribed medication (Bhuyan, 2004; Dean & Kickbusch, 1995; WHO, 2019). Therefore, due to its breadth, self-care may be better understood as a philosophy and lifestyle approach than a systematic strict regimented protocol (Golinowska et al., 2016). Specifically, its advantage lies in its malleable applicability whilst still reciprocating differently for individuals of different ethnicities, genders and temperaments. For instance, females score consistently and significantly higher in the personality trait "agreeableness" (Costa et al., 2001; Weisberg et al., 2011), which refers to the proclivity for people to express kindness, empathy and is associated with group cohesion, maintenance of social harmony and thoughtfulness for others (DeYoung et al., 2007). Thus, females may be more driven than males to nurture social and emotional relationships due to the agreeableness trait (DeYoung et al., 2007; Weisber et al., 2011). Thus, as social support acts as a determinant for positive mental health outcomes (Harandi et al., 2017), females may identify with aspects of self-care differently to males. Males tend to have an independent self-conceptualisation, or an idea of oneself that is independent of the subjective cognitive presentations of others (due to lower agreeableness levels) (DeYoung et al., 2007; Weisber et al., 2011). Therefore, augmenting the propensity to identify with aspects of SC that are driven by individual goal-directed behaviour (e. g. exercise goals). Regardless of the conceptual environment of self-care, its flexible nature may increase the chance for its utility and application to all BAME populations in managing mental health, the adoption of health-promoting behaviours (Golinowska et al., 2016), being more cost effective and accessible to BAME communities. Few studies have investigated the use of Self-Care within different BAME communities to promote well-being and manage chronic mental health conditions. For instance, Perera and Agboola (2019) conducted a systematic review of 16 Self-Care interventions on wellbeing and quality of life in adult BAME and Caucasian populations and suggested that self-care behaviours (exercise and nutrition) presented inconsistent findings due to 8 of the 16 self-care interventions presenting small sample sizes, convenience sampling, trials mostly being from the 1980's and an overlap in self-care terminology (i. e., self-help, self-care, self-management health education had all become synonymous). Similarly, Turnbull et al. (2020) carried out a systematic review of 18 web-based self-care interventions (experimental and observational) with chronic disease sufferers (BAME and non BAME participants). The findings suggested that self-care may be "advantageous" for some minority populations (minority ethnic groups) and disadvantaged groups (unemployed, low education attainment) (Turnbull et al., 2020) yet study outcomes should be interpreted with caution due to similar limitations found in previous reviews (Perera & Agboola, 2019). Additional research has been conducted by the Prince's Responsible Business Network (2021), a business community outreach charity, on producing a SC toolkit for ethnically diverse women however, its origin of development is questionable. Thus, as self-care is more of a concept than a pragmatic toolkit, specific behaviours and expectations of what self-care is, is perceived differently between both patients and practitioners thus leading to different health outcomes (Bhuyan, 2004; Holmes et al., 2020); and difficulty in estimating the efficacy of self-care for the management of mental health conditions (Benham et al., 2017). Consequently, investigation into the current interventions and approaches being utilised to manage mental health in BAME communities is necessary to identify potential strengths and issues with contemporary practice.

1.16 CONTEMPORARY INTERVENTIONS FOR MENTAL HEALTH IN BAME POPULATIONS

There are a variety of interventions available to all populations, including BAME in the UK when it comes to mental health. These interventions can be broadly classified into three categories: pharmacological interventions, psychological interventions, and community interventions.

Pharmacological interventions involve the use of medication to treat mental health problems (WHO, 2009). Systematic review examining pharmacological interventions on treating mental health conditions (post-traumatic stress disorder, anxiety, depression) have been carried out but not exclusively in BAME populations (Coventry et al., 2020; Hiluy et al., 2019; Murphy et al., 2006; Taylor et al., 2017). Hiluy et al. (2019) (n = 14) and Taylor et al. (2017) (n = 54) both conducted systematic reviews on experimental studies examining the effectiveness of medications in treating common co morbidities in mental ill patients such as weight gain (Hiluy et al., 2019), T2DM (Taylor et al., 2017) and found the use of medication to treat co morbidities effective. Coventry et al. (2020) carried out a systematic review of n = 116 experimental and observational studies to examine the effectiveness of pharmacological interventions in treating post-traumatic stress disorder patients and concluded the pharmacological approach to be effective yet emphasised the need for more “multi-component” interventions (i.e., a holistic approach). Murphy et al. (2006) investigated the effectiveness of medication in n = 17 randomised controlled trials on treating schizophrenia with serotonin reuptake inhibitors being the most used medication and demonstrating effective outcomes post intervention. Despite pharmacological approaches showing promising outcomes, results from preceding systematic reviews cannot be applied to BAME populations particularly due to (i) sampling strategy and (ii) participant characteristics. Moreover, all authors emphasised that pharmacological approaches to treating mental health may not target underlying behavioural mechanisms that could be achieved through psychotherapy (Coventry et al., 2020; Hiluy et al., 2019; Murphy et al., 2006; Taylor et al., 2017). However, some people with severe mental illness might need a combination of pharmacological and psychological interventions to reduce illness severity.

Psychological interventions involve the use of psychological therapies, such as psychotherapies, to treat mental health problems (NHS, 2022a). Psychotherapy is a type of “talking therapy” that involves facilitating dialogue around individual, context specific topics, associated with common mental disorders (e. g. anxiety and depression) to effectively bring such conditions into remission (NHS, 2022a). Numerous systematic review’s examining psychotherapeutic effectiveness on treating mental health disorders (such as anxiety and depression) exclusively in BAME populations (Arundell et al., 2021; Anik et al., 2021) and in a mix of BAME and non-BAME populations (Barkowski et al., 2019; Huhn et al., 2014; Linardon et al., 2019; Thomas et al., 2020) have demonstrated psychotherapy to be an effective approach during treatment however, limitations exist particularly in sampling methodologies (Barkowski et al., 2019; Huhn et al., 2014) difficulty in controlling singular mental health conditions due to underling comorbidities (Arundell et al., 2021; Anik et al., 2021 Barkowski et al., 2019; Huhn et al., 2014; Linardon et al., 2019; Thomas et al., 2020), adherence issues (Linardon et al., 2019), incomplete reporting of drop out issues (Linardon et al., 2019) and moderating effects of cultural barriers (Arundell et al., 2021; Anik et al., 2021).

Community interventions, (such as those delivered in a public setting, by the community or voluntary sector) involve the provision of support or services to improve mental health outcomes (Vahdaninia et al., 2020). Baskin et al. (2020) (n = 7) and Vahdaninia et al. (2020) (n = 13) both conducted scoping reviews on community mental health interventions/services designed for BAME populations, such as refugee centres, talking groups, and a growing presence of culturally adapted community centres (using cognitive behaviour therapy) to tackle, stigma, taboo and to promote acceptance of diagnosis and subjective wellbeing. Studies from both scoping reviews were heterogenous, with non-randomised trials embodying the "bulk" of the study pool alongside observational and qualitative research however, despite high heterogeneity, positive outcomes were emphasised (Baskin et al., 2020; Vahdaninia et al., 2020). Still, more randomised controlled trials are warranted to fully understand the degree of effectiveness in community-led interventions for treating mental health in BAME groups.

1.16.1 TREATMENT APPROACHES, ENGAGEMENT AND REDUCING HEALTH INEQUALITIES

As observed, all three types of interventions (pharmacological interventions, psychological interventions, and community interventions) have demonstrated varying degrees of effectiveness in treating mental health outcomes in BAME populations (Anik et al., 2021; Baskin et al., 2020; Taylor et al., 2017) however, emphasis has been placed on the development of psychotherapeutic practices, both in clinical and community settings, for BAME populations (Holmes et al., 2020) as "a call to action" to resolve widening mental health predicaments. The primary reason for this is because adapted interventions for BAME communities often seek to meet the needs of these groups specifically by considering cultural differences that affect psychotherapeutic outcomes (Bhugra & Bhui, 1998; Bhui, 2010; Barrera et al., 2013; Edge et al., 2016; Rathod & Kingdon, 2014; Sue et al., 2009). For example, some interventions may target religious or ethnic communities to better connect with them (Hall et al., 2016). Additionally, interventions may aim to increase awareness of mental health conditions within these groups, promote help-seeking behaviour and seek to address stigma and discrimination within BAME communities around mental health issues (Arundell et al., 2021).

Pre-existing literature investigating the effectiveness of adapted therapies for BAME populations have suggested that adapted therapies could be beneficial for treating common mental health conditions in BAME populations (such as anxiety and depression) (Arundell et al., 2021; Anik et al., 2021) specifically culturally adapted therapy. Culturally Adapted Psychotherapy (CAP) is a form of “talking therapy” that is designed specifically for use with culturally diverse populations (Naeem et al., 2019). It considers the cultural context in which the therapy is taking place, and the cultural beliefs and norms of the client population (Naeem et al., 2019). CAP can be used to help clients who are experiencing mental health stigma to feel more comfortable and understood in the therapy session (Bhui, 2010). It can also be used to help therapists to better understand their clients' cultural background and how it may be impacting their mental health (Barrera et al., 2013; Edge et al., 2016). Systematic reviews by Anik et al. (2021) (n = 15) and Arundell et al. (2021) (n = 57) investigated the effectiveness of CA psychological interventions in reducing anxiety and depression symptoms in BAME populations. Anik et al. (2021) contained Asian, African and Hispanic populations whilst Arundell et al. (2021) presented East Asian, African and Hispanic populations. Both Anik et al. (2021) and Arundell et al. (2021) emphasised that CAP was more effective at reducing anxiety and depressive symptoms, with moderate effect sizes presented in Arundell et al. (2021) study. Likewise, a systematic review by Hall et al. (2016) (n = 78) presented moderate effect sizes in favour of CAP over un-adapted therapies for anxiety. Arundell et al. (2021) also provided a conceptual typology of common adaptions used in CAP, illustrating those therapies either adopted (i) content related adaptations (cultural adaptations [metaphors], language translations, use of religion), (ii) therapist related adaptations (training for therapists, ethnic vs ethnic matching, interpreters) and (iii) organisation related adaptations (location of treatment, mode of delivery [in person vs online vs group], time/length of intervention). Another point to consider is that over 90% of the included studies adopted content and therapist related adaptations whilst organisation related adaptations were less common. Aspects of these conceptual typologies have been registered in previous systematic review, such as with Anik et al. (2021) and Hall et al. (2016) both articulating content related adaptations (translation of texts) and therapist related adaptations (ethnic vs ethnic matching) but little organisation related adaptations. However, despite CAP reported effectiveness and conceptual typologies, predicaments in the evidence base still exist such as (i) the degree of CAP effectiveness remains questionable as effect sizes in favour of adapted therapies are based on high heterogeneity studies (Hall et al., 2016), (ii) ambiguity exists regarding what therapies are considered "culturally adapted" (Arundell et al., 2021; Anik et al., 2021; Hall et al., 2016), (iii) continual debate on what underlying cultural components needs to be adapted and the degree of alteration (i. e. content related adaptations vs therapist related adaptations or a combination of adaptations) (Arundell et al., 2021; Anik et al., 2021; Hall et al., 2016) and (iv) a demand exists to understand which adapted therapy is most common and effective to help future researchers, policy makers and practitioners to further pioneer this subject matter forward (Arundell et al., 2021; Anik et al., 2021; Hall et al., 2016). Doing so would help to reduce the current incongruence between mental health services and BAME populations. Based on the review of different interventions and the limitations of previous literature, a systematic review is warranted to investigate contemporary psychotherapeutic interventions used with BAME populations to close the gaps left in previous research.

1.17 THESIS AIMS

There is limited literature relating to mental health interventions that target mental health outcomes in BAME communities. For such an intervention to be effective, community consultation is needed within BAME groups and health professionals to break down barriers with these communities (Bignall et al., 2020), increase BAME satisfaction scores (see heading 1.13) towards the NHS (Appleby et al., 2020) and reduce mental health disparities. To overcome the problems with treatment and stigma, collaborative efforts among academics, clinicians, and BAME communities are required to find a common ground and share coherent insights. Identifying effective and culturally tailored interventions focusing on health disparities in mental health would potentially help towards the improvement of public health outcomes among BAME communities.

The overall aims and objectives for the PhD are as follows:

- To create a taxonomy of common psychotherapies used in distinct BAME populations and to determine their effectiveness (Chapter 2)
- To explore differences in stigma, anxiety, depression and subjective wellbeing amongst BAME groups using a quantitative approach (Chapter 3)
- To explore perceptions and experiences of mental health and wellbeing, psychotherapeutic practices and healthcare within BAME communities (Chapter 4)

- To explore the experiences that health professionals have regarding health and mental wellbeing practices among BAME patients (Chapter 5)
- To consolidate findings and provide recommendations for addressing health inequalities in BAME mental health within future policy and practice (Chapter 6)

CHAPTER 2 – PSYCHOTHERAPEUTIC INTERVENTIONS FOR ANXIETY AND DEPRESSION OUTCOMES IN BLACK, ASIAN & MINORITY ETHNIC POPULATIONS: A SYSTEMATIC REVIEW

OVERVIEW

The previous chapter (Chapter 1) illustrated a comprehensive literature review on key aspects affecting the psychological wellbeing of BAME groups. Specifically, the literature review i) defines health inequality ii) defines social determinants of health alongside grappling with the underlying issue of whether practitioners should focus on improving social determinants affecting health (e. g. make contemporary living conditions healthier) or if practitioners should strive for equal dispersion of social determinants (e. g. all populations to live in healthy living conditions) iii) explores what seems to be the most prominent social determinants of health affecting psychological wellbeing in BAME groups (i. e. low education attainment, chronic unemployment and low income/poverty) (PHE, 2018b). In conjunction to social determinants, a key theme fuelling health inequalities among BAME groups was BAME groups dissatisfaction with the NHS (Appleby et al., 2020). Furthermore, literature suggests that if this dissatisfaction were to be resolved, a step towards this would be to tackle “cultural taboo/stigma” associated with mental health conditions in BAME populations as these mental health stigma beliefs effect psychotherapeutic outcomes and inhibit the likelihood of seeking access to mental health services (Memon et al., 2016). Thus, this chapter aims to systematically explore contemporary interventions aimed at mitigating common mental health disorders in BAME groups, unveil which interventions seem to be most effective and if any psychotherapeutic interventions have in-built components to tackle pre-existing mental health stigma in BAME groups.

2.1 INTRODUCTION

Mental health is a major public health concern (World Health Organisation [WHO], 2020a), with conditions such as anxiety and depression being amongst the most prevalent (National Health Service [NHS], 2018; WHO, 2020b). Pre-Covid-19, 1-in-10 (9%) adults were at risk of developing depressive symptoms; however, this statistic rose to 1-in-5 (19%) due to the pandemic (Office of National Statistics [ONS], 2021). Black, Asian and minority ethnic (BAME) communities are at an increased risk of mental health conditions when compared to non-BAME populations (ONS, 2021). This is thought to be due to underlying factors such as poor physical health (Codjoe et al., 2019; Diabetes UK, 2020; Gujral et al., 2013; ONS, 2021; Public Health England [PHE], 2020a) and persistent health inequalities experienced by BAME individuals (British Social Attitudes Survey [BSAS], 2019; Department of Work & Pensions [DWP], 2019; Foley, 2020; Lewis & Cotterell, 2018; PHE, 2018b). Findings from University College London's Social survey revealed that anxiety and depression are the two most common mental health diagnoses within BAME groups currently (UCL, 2020). However, research in BAME populations lacks focus on individual ethnicities, which may lead to ineffective mental health strategies tailored to these groups (Abuelgasim et al., 2020; Fierros & Smith, 2006; Laungani, 2004; Naeem et al., 2019). Culture plays a key role in psychotherapeutic outcomes, such as reduced treatment severity and enhanced wellbeing (Bhugra & Bhui, 1998; Bhui, 2010; Barrera et al., 2013; Edge et al., 2016; Rathod & Kingdon, 2014; Sue et al., 2009). Therefore, more culture specific approaches must be explored to achieve meaningful progress in terms of BAME mental health management and treatment.

Considering preceding literature, Anik et al. (2021) conducted a systematic review and meta-analysis of randomised controlled trials to examine the effectiveness of CAP in depressed ethnic minority groups including Asian, African, and Hispanic. Results showed that Culturally Adapted Cognitive Behaviour Therapy (CA-CBT) was more efficacious in reducing depression symptoms compared to control (i.e., treatment as usual; enhanced treatment as usual; waitlist; CBT). However, Anik's et al. (2021) systematic review and meta-analysis did not include studies that reported positive psychology measures (Bolier et al., 2013) such as subjective wellbeing (SWB) and psychological wellbeing (PWB). These measures are essential for a holistic understanding of mental health as other than the absence of illness, mental illness involves the notion of positive functioning in society (Bolier et al., 2013; WHO, 2020a). Hall et al. (2016) has also studied the efficacy of CAPs with regards to reducing anxiety, depression, and psychotic symptoms in Asian, African, and Hispanic populations. They reported a moderate effect size upon comparing CAPs against (i) assessment only/waitlist control, (ii) treatment as usual, (iii) another un-adapted manualized intervention (i.e., applied muscle relaxation), and (iv) direct comparison of the non-adapted form of the culturally adapted intervention (e.g., CBT vs CA-CBT). Nevertheless, they questioned whether culture truly moderated psychotherapeutic outcomes (i.e., anxiety, depression, and psychotic symptoms) since un-adapted therapies still produced satisfactory results in diverse ethnic populations. Opposing research to Hall et al. (2016) has emphasised the utility of CAP due to findings which suggest that "culture" can significantly affect psychotherapeutic outcomes in BAME populations (Bhugra & Bhui, 1998; Bhui, 2010; Barrera et al., 2013; Edge et al., 2016; Rathod & Kingdon, 2014; Sue et al., 2009). Nonetheless, both Hallet al. (2016) and research cited (Bhugra & Bhui, 1998; Bhui, 2010; Barrera et al., 2013; Edge et al., 2016; Rathod & Kingdon, 2014; Sue et al., 2009) similar studies have failed to consider positive psychology outcomes such as SWB and PWB which could expand our understanding on what is currently considered effective by psychotherapeutic standards.

2.1.1 RATIONALE FOR THE STUDY & AIMS

Current gaps in the literature revolve around the absence of a psychotherapeutic taxonomy for BAME groups and a lack of understanding of the measures used to assess anxiety and depression. Therefore, the objectives of the present systematic review were: i) to create a taxonomy of common psychotherapies used with BAME populations; ii) to determine the most effective psychotherapy for these populations; and iii) to assess the most common outcome measures used for anxiety and depression.

2.2 LITERATURE SEARCH

2.2.1 SEARCH STRATEGY AND SEARCH TERMS

A systematic review was conducted between April 2021 and November 2021, using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA, 2021) guidelines with the search terms presented in the supplementary material. Four databases were investigated: The Cochrane Library, British Medical Journal, PubMed and Science Direct. The search included only peer-reviewed journal articles written in English from January 2000 to November 2021, as specific modes of therapy have been prominent since this time (e.g., self-care and ethno-psychotherapy) (Naeem et al., 2019). Reference lists of the studies identified were also examined individually. The present systematic review only included randomised controlled trials aimed at reducing anxiety and/or depression, including group, face-to-face and web-based interventions. Non-randomised trials, systematic reviews, meta-analyses, observational studies and qualitative studies were excluded from the review.

Table 2.1

List of search terms

Mode of Therapy	**Search Term**
Traditional psychotherapies	“psychotherapy” OR “psychotherap$” OR “psychotherapeutic” OR “cognitive therapy” OR “behaviour therapy” OR “cognitive behaviour therapy” OR “CBT” OR “cognitive analytical therapy” OR “psychoanalytic therapy” OR “psychodynamic therapy” OR “systemic therapy” OR “humanistic therapy” OR “interpersonal psychotherapy” OR “dynamic interpersonal psychotherapy”, dialectic behaviour therapy” OR “problem solving therapy” OR “graded exposure therapy” OR “acceptance and commitment therapy” OR “mindfulness based cognitive therapy” OR “functional analytic psychotherapy” OR “metacognitive” OR “compassion focused therapy” OR “therapy” OR “intervention” OR “mental health”
	OR
Ethnopsychotherapy	“culturally adapted cognitive behaviour therapy” OR “culturally adapted CBT“ OR “ethnopsychotherapy” OR “cultural adaptation” OR “CA-CBT” OR “culture” OR “adaptation” OR “CaCBT”
	OR
Self-Care	“self-care” OR “everyday functioning” OR “mental health self-care” OR “self-help” OR “personal care” OR “self-aid”

	AND
Anxiety/Depression	“anxiety” OR “fear management” OR “general anxiety disorder” OR “GAD” or “anxiety management” or “depression”
	AND
Mixed or Multiple Ethnic Groups	“mixed” OR “white and black Caribbean” OR “white and black African” OR “white and Asian”
	OR
Asian or Asian British	“Asian” OR “Asian British” OR “Indian” OR “Pakistani” OR “Bangladeshi” OR “Chinese”
	OR
Black, African, Caribbean or Black British	“black” OR “African” OR “Caribbean” or “Black British”
	OR

Other ethnic group	“Arab”

Key: $ **denotes word truncation**

2.2.2 INCLUSION/EXCLUSION CRITERIA

Participants. Studies that reported BAME adults diagnosed with anxiety and/or depression, aged 18-65 years, male or female were included. BAME populations comprised of "Mixed or multiple ethnic groups" (white and black Caribbean; white and black African; white and Asian; any other mixed or multiple ethnic background), "Asian or Asian British" (Indian; Pakistani; Bangladeshi; Chinese; any other Asian background), "Black, African, Caribbean or Black British" (African; Caribbean; any other black, African, or Caribbean background) and "Other ethnic group" (Arab; any other ethnic group) according to PHE (2020b) "list of ethnicities" report.

Outcome measures. Studies including measures for anxiety, depression, PWB and SWB were included.

Study selection process and tabulation of studies. A total of 80,202 articles were identified through searching PubMed, Science Direct and the Cochrane Library (Figure 2.1). After removing duplicates (n = 36,095), 44,107 studies remained. After screening for titles 36,248 studies remained. After titles and abstracts were manually checked, 669 full texts were eligible for inclusion. Many eligible full texts were excluded as participants were not from BAME cohorts thus could not be considered for review (n = 605). Therefore, 64 articles were included for narrative synthesis. Data extracted from all studies are presented in the supplementary material. Table 2.3 shows the magnitude of effect sizes for all studies, apart from Klein and Richards (2001) due to inadequate reporting of data and methodology. Lastly, a taxonomy of most common psychotherapies used in BAME groups is presented in Table 2.5.

Figure 2.1

Study selection process (PRISMA, 2021)

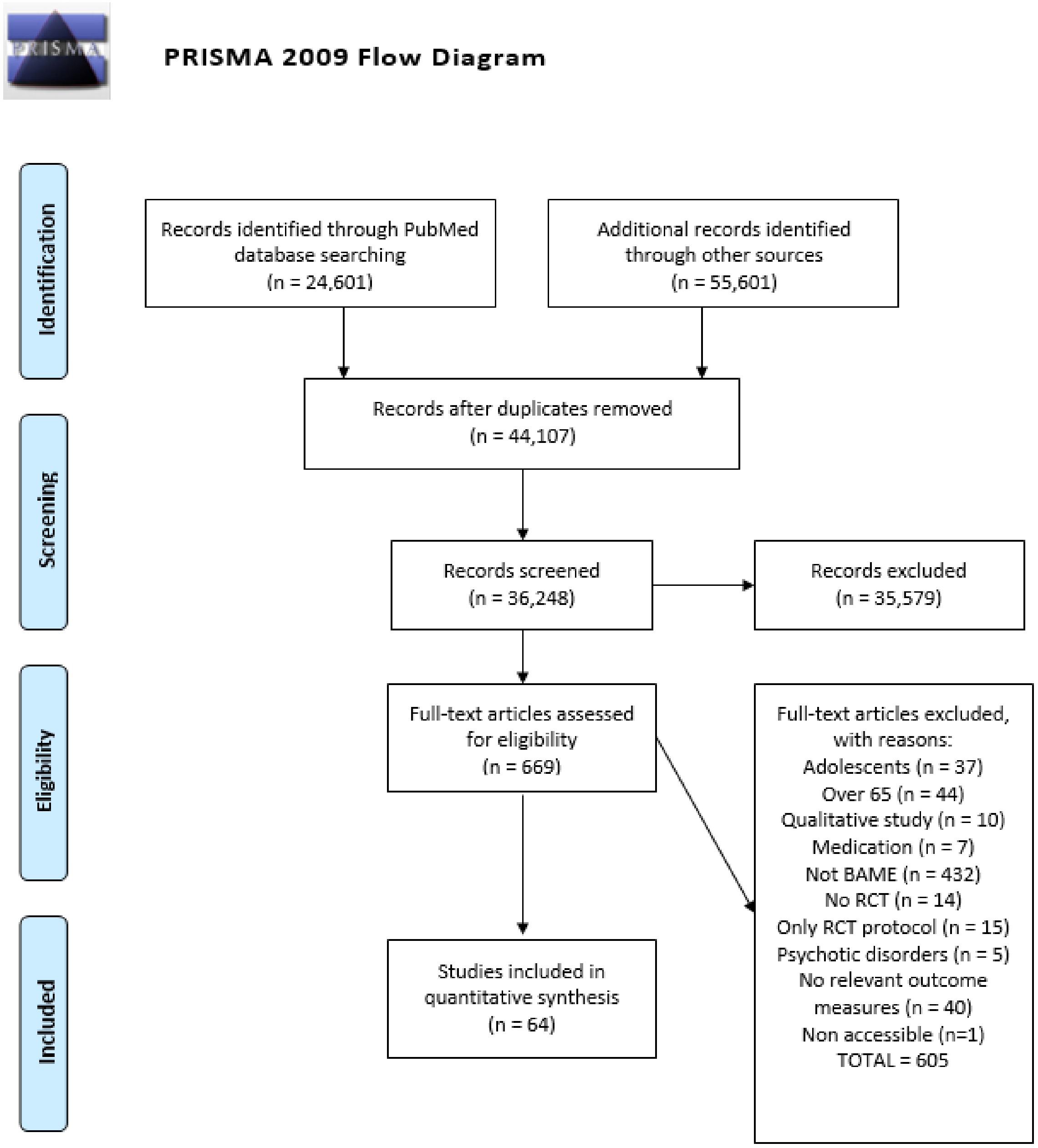

Table 2.2

Contemporary psychotherapies administered on different adult (18-65y) BAME groups (sixty-four studies)

Author	Sample Study population	Country	Type of Therapy	Study design	Outcome measures	Main findings	Treatment acceptability
Andersson et al. 2013	Sample size: 88 Female: 57 Male: 31 Mean age: 39 ± 12.4 Ethnicity: China Health: Mild Anxiety/Depression	China	Internet CBT (Community)	8-week internet-based CBT vs treatment as usual (medication). 1x week. 3.5 year follow up.	Anxiety; Depression (Beck Anxiety Inventory; Beck Depression Inventory) (BAI; BDI)	Internet CBT produced larger reductions on anxiety (M = 14.8 ±7.9 – 6.8 ± 6.1) and depression (M = 22 ±5.3 – 10 ± 5.1) vs control (M = 15.4 ± 7.7 – 8.8 ± 6.3; 21.9 ± 6.3 – 12.3 ± 7.3) post intervention (p < 0.05) and vs baseline at 2 months. (p < 0.05). At 3.5 year follow up, still reduced but no significant differences between groups or vs 2month measure (p > 0.05)	Treatment acceptability was not reported
Afuwape et al. 2010	Sample size: 40 Female: 27 Male: 13 Mean age: 33 ± 11.4 Ethnicity: Black Health: Mild Anxiety/Depression	UK	CA-CBT	12-week CBT intervention vs waitlist (control). 3 –month follow up.	Anxiety; Depression (GHQ-28)	Intervention group showed significantly lower scores in anxiety and depression (M = 18.8 ± 5.9 - 8.06 ± 8.32; p < 0.05) compared to control group (M = 14.2 ± 7.1 – 12.25 ± 9.31) post intervention and at follow up (p < 0.05).	Treatment acceptability was not reported.

Alavi & Hirji, 2020	Sample size: 80 Female: 68 Male: 12 Mean age: 32 ± 9.2 Ethnicity: Iranian Health: Mild Anxiety	Canada	CA-CBT (Internet – PowerPoints)	12-week PowerPoint, self-guided CBT intervention vs control group (no treatment). 6-month and 1-year follow up.	Anxiety (BAI)	Intervention group showed significantly lower scores in anxiety post intervention (M = 26 ± 5.2 – 16 ± 4.6; $p < 0.05$) compared to control (M = 28 ± 7 – 19 ± 9.2) and at follow up.	Treatment acceptability was not reported.
Ashing & Rosales, 2014	Sample size: 199 Female: 199 Mean age: 30 ± 12.5 Ethnicity: Hispanic (Latina) Health: Mild/Moderate Depression	USA	CA-CBT (via Telephone)	8-week tele-health intervention vs control. 1-month follow up	Depression (CES-D)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 14.2 ± 12 vs 17.1 ± 16; $p < 0.05$) and at follow up compared to control group.	Treatment acceptability was reported as trial completion rates which was 90% (179/199).
Bolton et al. 2003	Sample size: 224 Female: 116 Male: 108 Mean age: Ethnicity: Black African Health: Moderate Depression	Uganda	Interpersonal psychotherapy (Clinical)	16-week group interpersonal psychotherapy vs control (no therapy). 1x week. 90min sessions. No follow up	Depression (Hospital Anxiety and Depression Scale) (HADS)	Significant reductions in depressive symptoms at 16-week in experimental group vs baseline (M = 23.6 ± 6.5 – 6 ± 6.3; $p < 0.05$). Significantly lower rates of depressive symptoms vs control group (M = 6 ± 6.3 vs 20.64 ± 9; $p < 0.05$).	Treatment acceptability was not reported.
Bedoya et al. 2014	Sample size: 118 Female: 81 Male: 37 Mean age: 33 ± 11.4 Ethnicity: Black	USA	CA-CBT + Psychoeducation	2-week CBT + psychoeducation vs control. 6-month follow-up.	Depression (QIDS)	Intervention group showed significantly lower scores in primary outcome measures post intervention	Treatment acceptability was reported as attrition rates which was 10.62% (18/118).

	Health: Severe Depression					compared to control (M = 11.8 ± 5.3 vs 13.8 ± 4.6; $p < 0.05$) but not at follow up compared to control group ($p > 0.05$).	
Beeber et al. 2010	Sample size: 80 Female: 80 Mean age: 36 ± 8 Ethnicity: Hispanic (Latina) Health: Severe Depression	UK	CA-IPT	16-week culturally adapted IPT intervention vs control (usual care). No follow up.	Depression (CES-D)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 10.3 ± 9.2 vs 16 ± 6.4; $p < 0.05$).	Treatment acceptability was assessed using a self-efficacy scale. Participants in intervention displayed an 8% increase compared to baseline vs 5% increase in the control group.
Chan et al. 2012	Sample size: 75 Female: 42 Male: 33 Mean age: 45 ± 8.2 Ethnicity: Asia; China Health: Sever Depression	China	CBT vs Chinese Chan-based Dejian Mind-body intervention (DMBI) vs Waitlist (Clinical)	10-week intervention comparing CBT and DMBI on reducing depressive symptoms. 1x week. 1h sessions. No follow up	Depression (Hamilton Rating Scale for Depression; Becks Depression Inventory) (HRSD; BDI)	Both groups showed significant reductions in depressive symptoms compared to baseline with the CBT group showing larger effect size compared to DMBI and Waitlist (g = 1.03 vs 0.93 vs 0.25*;* $p < 0.05$). Significant difference in depressive scores compared to control post intervention for both intervention groups (M = CBT ~ 6.82 ± 5.73 & DMBI ~ 6.88 ± 4.47 vs 10 ± 4.41; $p < 0.05$)	Treatment acceptability was reported as a measure of concentration levels post intervention with DMBI showing significant improvement vs baseline ($p < 0.05$) vs CBT and waitlist which showed insignificant improvement in concentration levels compared to baseline ($p > 0.05$).

Chaves et al. 2017	Sample size: 96 Female: 96 Mean age: 46 ± 10.2 Ethnicity: Spain Health: Moderate/Sever Depression	Spain	CBT vs Positive psychology (Community)	10-week intervention comparing CBT vs positive psychology principles. 1x week. 2h sessions. No follow up	Depression (Hamilton Depression Scale; Psychological well-being Scale) (BDI; PWBS)	Both groups significantly reduced depressive symptoms compared to baseline ($d = -1.09$; -0.96) and augmented well-being ($d = 0.27$) however at 10 weeks, no significant difference found between groups for either outcome measures (M = BDI ~ 22.42 ± 14.01 vs 23.43 ± 12.39; PWBS ~ 0.14 vs 0.27; $p > 0.05$)	Treatment acceptability was not reported.
Choi et al. 2012	Sample size: 79 Female: 50 Male: 29 Mean age: 39 ± 8.1 Ethnicity: Asia; China Health: Moderate Anxiety/Depression	Australia	CA-CBT (Internet)	8-week internet-based CA-CBT intervention vs control group. 3-month follow up.	Depression (BDI)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 13.48 ± 9.28 vs 21.27 ± 7.86; $p < 0.05$) compared to control group. Data at 3-month follow up was not reported thus no comparison utilised for intervention group.	Treatment acceptability was not reported.
Collado et al. 2016	Sample size: 46 Female: 40 Male: 6 Mean age: 40 ± 10 Ethnicity: Hispanic (Latino)	USA	CA-BA	10-week culturally adapted BA intervention vs control. 1-month follow up	Depression (BDI)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M =	Treatment acceptability was reported as treatment satisfaction which presented significant increases post-

	Health: Moderate Depression					9.41 ± 6.74 vs 12.02 ± 6.92; p < 0.05) compared to control group, and at follow up.	intervention compared to baseline for the intervention group (β= 0.59, SE= 0.18, p < 0.05)
Chien et al. 2012	Sample size: 79 Female: 50 Male: 29 Mean age: 39 ± 8.1 Ethnicity: Asia; China Health: Moderate Anxiety/Depression	China	Psycho-education programme (Community)	6-week psycho-education programme vs control (treatment as usual). 1x week. 1h sessions. 3-week follow up	Anxiety; Depression (Hospital Anxiety and Depression Scale) (HADS)	Significant reduction in anxiety and depressive symptoms post intervention vs baseline and control (M = 9 ± 7.2 vs 11 ± 6.5; p < 0.05) Lower levels at 3-weeks but not significant (p > 0.05)	Treatment acceptability was not reported.
Cooper et al. 2013	Sample size: 132 Female: 110 Male: 22 Mean age: 31 ± 7 Ethnicity: Black African Health: Moderate Depression	USA	Collaborative Care	12-month collaborative care intervention vs control. No follow-up	Depression (CES-D)	Intervention group showed significantly lower scores in primary outcome measures post intervention (p < 0.05), compared to baseline but not compared to control at 12 months (M = 12.9 ± 4.3 vs 10.5 ± 6.5, p > 0.05).	Treatment acceptability was reported as the *"rating of care managers and adherence to case managers"* with significantly higher scores in the intervention group vs control post intervention (p < 0.05).
Crockett et al. 2008	Sample size: 36 Female: 36 Mean age: 31 ± 5.3 Ethnicity: Black African Health: Mild/Moderate/Severe Depression	Africa	ROSE Program (Reach Out, Stay Strong, Essentials for new mothers) (Community)	5-week ROSE vs control intervention. 1x week. 1h sessions. 3-month follow up	Depression (Edinburgh Postnatal Depression Scale) (EPDS)	Participants showed no significant reductions in depressive symptoms post intervention (M = 1.97 ± 0.13 vs 1.92 ± 0.11; p > 0.05) and at three months	Treatment acceptability was not reported.

						compared to baseline and control (p > 0.05).	
De Graaff et al. 2020	Sample size: 98 Female: 80 Male: 18 Mean age: 28.5 ± 9 Ethnicity: Syria Health: Sever Anxiety/ Depression	USA	CA – Problem Management	6-week problem management intervention vs control. No follow up	Anxiety (HSCL) Depression (HSCL)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 1.86 ± 0.58 vs 2.38 ± 0.65; p < 0.05), compared to control group.	Treatment acceptability was not reported.
Dwight-Johnson et al. 2011	Sample size: 101 Female: 82 Male: 19 Mean age: 40 ± 12.5 Ethnicity: Hispanic (Latino) Health: Sever Anxiety/ Depression	USA	CA-CBT (telephone)	6-week CA-CBT telehealth intervention vs control. 3 and 6-moothn follow up	Depression (PHQ)	Intervention group showed significantly lower scores in primary outcome measures at 6 month follow up compared to control (M = 5.81 ± 0.88 vs 9.64 ± 0.95; p < 0.05) but not at 3-month follow up or at 6-weeks post-intervention compared to control (p > 0.05).	Treatment acceptability was reported as treatment satisfaction which significantly increased from baseline to 6-months in the intervention group.
Ezeudu et al. 2020	Sample size: 24 Female: 14 Male: 10 Mean age: 22.25 ± 2.8 Ethnicity: Africa; Nigeria Health: Sever Depression	Nigeria	Rational-emotive behaviour therapy (REBT) – (Community)	12-week REBT intervention vs control. 1x week. 1h sessions. 1-month follow up.	Depression (Beck Depression Inventory) (BDI)	Intervention group showed significantly lower scores in primary outcome measures compared to control post intervention (M = 24.2 ± 14 vs 42.7 ±	Treatment acceptability was not reported.

						16; p < 0.05 and at follow up (p < 0.05).	
Ebrahimi et al. 2013	Sample size: 62 Female: 34 Male: 28 Mean age: 31 ± 10.31 Ethnicity: Iran Health: Severe Depression	Iran	Spiritual (Islamic approach) psychotherapy (SIPT) vs CBT vs Medication vs Control (Clinical)	8-week intervention. 1-2-1. 45 minutes. 3-month follow up	Depression (Beck Depression Inventory) (BDI)	Significant difference in the SIPT group compared to baseline (M = 7.3 ± 4.9 vs 28.35 ± 7.98), medication (M = 7.3 ± 4.9 vs 15.2 ± 8.68) and control group (M = 7.3 ± 4.9 vs 28.6 ± 8.3; p < 0.05) post intervention. No significant difference compared to CBT group post intervention (M = 7.3 ± 4.9 vs 8.7 ± 3.84) and at 3-month follow up (p>0.05). Sustained reductions in both SIPT and CBT at follow up compared to baseline.	Treatment acceptability was not reported.
Gallagher et al. 2007	Sample size: 55 Female: 55 Mean age: 42 ± 15.2 Ethnicity: Asia; China Health: Severe Depression	USA	In-home Behavioural Management Program	16-week in-home Behavioural Management Program vs control (telephone support group). No follow-up	Depression (CES-D)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 11.3 ± 13.2 vs 17.3 ± 15.5; p < 0.05), compared to control	Treatment acceptability was not reported.

						group post intervention.	
Gao et al. 2015	Sample size: 180 Female: 180 Mean age: 28 ± 2.73 Ethnicity: Asia; China Health: Moderate/Severe Depression	China	Interpersonal Psychotherapy (IPT) (Clinical)	1h IPT vs control. 6 week follow up (Telephone call)	Depression (Edinburgh Postnatal Depression Scale) (EPDS)	Significantly lower depressive symptoms vs control post intervention (M=7.61 ± 3.43 vs 8.96 ± 4.55, t=-2.24, p < 0.05) and at 6-week follow up (t=-2.24, p < 0.05).	Treatment acceptability was scored as a validated *"perceived social support scale"* with the experimental group demonstrating significantly higher scores compared to control post intervention (p < 0.05).
Ghawadra et al. 2020	Sample size: 224 Female: 213 Male: 11 Age range: 20-31 Ethnicity: Malaysia; India; China Health: Mild/Moderate Anxiety/Depression	Malaysia	Internet Mindfulness (Community)	One 2h workshop followed by 4 weeks of guided self-help mindfulness online.	Anxiety; Depression; (Depression, anxiety and stress scale) (DASS)	A significant reduction in anxiety and depression symptoms found in the intervention group (M ~ anxiety = 13 ± 12.2 vs 16 ± 14.9; p < 0.05); (M ~ depression = 14.6 ± 14.1 vs 18.8 ± 13.2; p < 0.05)	Treatment acceptability was assessed using a *"job satisfaction scale"* which showcased significant increases compared to baseline in the experimental group (p < 0.05).
Hall et al. 2018	Sample size: 101 Female: 70 Male: 31 Mean age: 22.3 ± 2.68 Ethnicity: Asia; China Health: Mild/Moderate Anxiety/Depression	China	Internet mindfulness intervention (Community)	7-week internet mindfulness-based intervention with Group 1: control group, Group 2: mindfulness only group, Group 3: mindfulness + plain-text reminder group, and Group 4:	Anxiety; Depression (Depression Anxiety Stress Scale) (DASS)	After the intervention at week 4, compared to controls, completers in group 2, 3 and 4 (*n* = 42) showed significantly reduced depression (Cohen's *d* = 0.83),	Treatment acceptability was not reported.

				mindfulness + enhanced text reminder with animal meme group vs control. 1x week. 1.5h sessions. No follow up.		anxiety (Cohen's *d* = 0.84).	
Han et al. 2020	Sample size: 75 Female: 65 Male: 10 Mean age: 46.94 ± 6.54 Ethnicity: Asia; China Health: Mild/Moderate/Sever Depression	China	Dejian Mind Body Intervention (DMBI) vs CBT vs Control (Community)	10-week DMBI intervention vs CBT vs control. 1x week. 90 min sessions. No follow up.	Depression (Hamilton Rating Scale for Depression) (HRSD) (Beck Depression Inventory) (BDI)	Significantly lower depressive symptoms at 10 weeks in favour of CBT (M = 7.69 ± 3.16 vs 5 ± 2.48; 10.20 ± 8.44 vs 17.64 ± 11.95) and DMBI (3.94 ± 2.84 vs 5 ± 2.48; 12.65 ± 9.85 vs 17.64 ± 11.95) groups vs control ($p<0.05$).	Treatment acceptability was not reported.
Hinton et al. 2004	Sample size: 12 Female: 12 Mean age: 30 ± 8 Ethnicity: Asia, Vietnamese Health: Sever Anxiety/PTSD	USA	CA-CBT	11-week CA-CBT intervention vs control group. No follow-up.	Anxiety (HTQ)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 1.7 ± 0.5 vs 3.3 ± 0.8; $p < 0.05$), compared to control group.	Treatment acceptability was not reported.
Hinton et al., 2005	Sample size: 40 Female: 22 Male: 18 Mean age: 50 ± 6.11 Ethnicity: Asia; Cambodia Health: Moderate Anxiety/PTSD	USA	CBT (Community)	12-week CBT vs control intervention. 1x week. 1h sessions. No follow up	Anxiety (Anxiety Sensitivity Scale) (ASS)	Significant reductions in anxiety for intervention group at 12 weeks (M = 1.65 ± 0.45 vs 3.19 ± 0.36; $p < 0.05$, *d*=3.78)	Treatment acceptability was not reported.

Hinton et al., 2011	Sample size: 24 Female: 24 Mean age: 47.6 ± 8.2 Ethnicity: Latino Health: Moderate Anxiety/PTSD	USA	CA-CBT (Community)	14-week CA-CBT vs applied muscle relaxation. 1x week; 12 week follow up	Anxiety (Symptoms checklist 90 Revised) (SCL-90-R)	CA-CBT produced significantly more reductions anxiety symptoms at 14 weeks vs baseline and post intervention compared to control (M = 2.2 ± 0.7 vs 1.5 ± 0.7 vs; $p < 0.05$; *d* = 1.1).	Treatment acceptability was not reported.
Huey & Pan, 2006	Sample size: 12 Female: 12 Mean age: 47.6 ± 8.2 Ethnicity: Asia, Chinese Health: Moderate Anxiety/Phobia	USA	Culturally tailored one-session treatment (psychoeducation)	A one-session culturally tailored session intervention group vs control (self-help). No follow-up	Anxiety (BAI)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 7.02 ± 5.2 vs 11.15 ± 5.4; $p < 0.05$), compared to control group.	Treatment acceptability was not reported.
Hwang et al. 2015	Sample size: 50 Female: 36 Male: 14 Mean age: 45.2 ± 11.5 Ethnicity: China/American Health: Severe Depression	USA	CA-CBT (Community)	12-week CA-CBT vs CBT intervention. 1x week. No follow up	Depression (Hamilton Depression Scale) (HDS)	CA-CBT and CBT groups produced similar reductions in depressive symptoms. Slight in favour of CA-CBT but no sig dif. (M = 15.8 ± 15 vs 17.7 ± 18; $p > 0.05$)	Treatment acceptability was not reported.
Hendriks et al. 2020	Sample size: 173 Female: 135 Male: 38 Mean age: 41 ± 12.2 Ethnicity: Black Caribbean Health: Moderate/Severe Anxiety/Depression	Caribbean	CA-Positive Psychology	6-week CA-Positive Psychology intervention vs control. 3-month follow up	Anxiety (DASS) Depression (DASS)	Intervention group showed significantly lower scores in primary outcome measures (Anxiety ~ M = 1.49 ± 0.37 vs 1.63 ± 0.46; $p < 0.05$) (Depression ~ M = 1.50 ± 0.33 vs 1.64 ± 0.41; $p < 0.05$) post	Treatment acceptability was scored as a validated *“resilience scale”* with the experimental group demonstrating significantly higher scores compared to control post

						intervention (p < 0.05), and at follow-up compared to control group.	intervention (p < 0.05).
Jacob et al., 2002	Sample size: 70 Female: 70 Mean age: 47 ± 10.8 Ethnicity: Asian British Health: Mild/Moderate Depression	UK	Education Intervention (EI) (Community)	1-day education intervention vs control. 2-month follow up	Depression (General Health Questionnaire) (GHQ)	Significant reduction in depressive symptoms post intervention between groups (M = 3.4 ± 3.1 vs 7.1 ± 6.9; p < 0.05) and at 2 month follow up for experimental group (p< 0.05)	Treatment acceptability was not reported.
Jones & Warner, 2011	Sample size: 58 Female: 58 Mean age: 41 ± 12.2 Ethnicity: Black Caribbean Health: Severe Depression	USA	CA-CBT	10-week CA-CBT intervention vs control. No follow-up	Depression (CES-D)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 12.5 ± 10.7 vs 16.7 ± 14.5; p < 0.05), compared to control group.	Treatment acceptability was not reported.
Jalal et al. 2020	Sample size: 20 Female: 10 Male: 10 Mean age: 28 ± 3.2 Ethnicity: South African Health: Moderate Anxiety/PTSD	South Africa	CA-CBT (Community)	7-week CA-CBT vs applied muscle relaxation. 2x week. 1-2-1 treatment. No follow up.	Depression (Hospital Anxiety and Depression Scale) (HADS)	CA-CBT showed significantly more reductions depression (M = 12 ± 6.53 vs 24.50 ± 9.54; p < 0.05) symptoms at 7-week vs control post-intervention.	Treatment acceptability was not reported.
Knaevelud et al. 2015	Sample size: 159 Male: 45 Female: 114 Mean age: 28.1 ± 7.43	USA	CA-CBT	5-week CA-CBT Internet intervention vs control; 3-month follow up.	Anxiety (BAI)	Intervention group showed significantly lower scores in primary outcome measures post	Treatment acceptability was not reported.

	Ethnicity: Afghanistan; Iran Health: Moderate Anxiety/PTSD					intervention (M = 1.91 ± 0.74 vs 2.91 ± 0.54; $p < 0.05$), and at follow up compared to control group.	
Kananian et al. 2020	Sample size: 24 Male: 24 Mean age: 22.1 ± 3.6 Ethnicity: Afghanistan; Iran Health: Moderate Depression/Trauma	Germany	CA-CBT + problem solving therapy (Clinical)	6-week intervention, 2x a week CA-CBT + problem solving therapy vs control group; 1 year follow up on both groups	Psychological wellbeing (General Health Questionnaire) (GHQ-28) Depression (Patient health questionnaire) (PHQ -9)	Intervention group showed a significant reduction in depressive symptoms at post intervention compared to control (M = 9 ± 7.6 vs 17.1 ± 3; $p < 0.05$) and improvements in psychological wellbeing (GHQ-28 = 48 vs 38). Follow up scores compared to baseline was significant for depression and psychological wellbeing ($p < 0.05$)	Treatment acceptability was not reported.
Karasz et al. 2015	Sample size: 42 Female: 42 Mean age: 29.4 ± 7.8 Ethnicity: Asia, Bangladesh Health: Moderate Depression	USA	CA-CBT	12-week CA-CBT intervention vs control; 6-month follow up.	Depression (PHQ)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 4.26 ± 3.9 vs 8.4 ± 7.8; $p < 0.05$), compared to control group. 6-month follow up compared to baseline was showcased as	Treatment acceptability was not reported.

						significant (p < 0.05).	
Kanter et al. 2015	Sample size: 43 Male: 9 Female: 34 Mean age: 38.1 ± 10.8 Ethnicity: Latino/Hispanic Health: Moderate Depression	USA	Behavioural Activation (BA) vs Treatment as usual (TAU) (Clinical)	12-week intervention, 2x a week, 1-2-1 sessions, 50 min sessions; 1 month follow up	Hamilton Rating Scale for Depression (HRSD) Beck Depression Inventory (BDI)	Intervention group showed significant reduction in depressive symptoms compared to control group post intervention (M ~ HRSD = 6.89 ± 7.24 vs 15 ± 12.49; p < 0.05) (M ~ BDI = 11.40 ± 17.48 vs 17.33 ± 20.36; p < 0.05). 1 month follow up deemed significant compared to baseline for the intervention group (p < 0.05).	Treatment acceptability was not reported.
Kim et al. 2017	Sample size: 60 Female: 60 Mean age: 38 ± 5.8 Ethnicity: South Korean Heath: Breast Cancer, Mild/Moderate Depression	South Korea	Psychological intervention programme (Clinical)	6-week nurse led psychological intervention vs control for cancer patients. 1x week. 1h sessions. 3 week follow up	Anxiety; Depression (Hospital Anxiety and Depression Scale) (HADS)	Significant reductions in anxiety (M = 6.4 ± 2.8 vs 8.9 ± 3.7; p < 0.05) and depressive (M = 6.4 ± 2.8 ± 9.8 ± 4.2; p < 0.05) symptoms post intervention for intervention group vs control. Post intervention scores significant for the intervention group (p < 0.05)	Treatment acceptability was not reported.

Klein & Richards, 2001	Sample size: 22 Female: 19 Male: 3 Mean age: 43. ± 2.3 Ethnicity: white and Asian; mixed Health: Moderate Anxiety	Australia	Internet CBT (Community)	3-week internet delivered CBT vs Control. No follow up	Anxiety (Anxiety Sensitivity Index) (ASI)	Significant reduction in anxiety symptoms at 3 weeks in favour of experimental group. (p ‹ 0.05; *d* = 0.32)	Treatment acceptability was not reported.
Li et al. 2018	Sample size: 281 Female: 281 Mean age: 47.3 ± 8.80 Ethnicity: Asia; China Health: Breast Cancer	China	Educational course in psychological stresses and management skills (ECPSMS) (Community)	3h Ed course vs control group. No follow up	Anxiety; Depression (Hospital Anxiety and Depression Scale) (HADS)	Insignificant changes in anxiety (M = 25 ± 17.2 vs 23 ± 16.9; p > 0.05) and depression (23 ± 15.9 vs 30 ± 22.1; p > 0.05) post intervention compared to control.	Treatment acceptability was not reported.
Lindegaard et al. 2019	Sample size: 50 Male: 10 Female: 40 Mean age: 35.5 ± 9.8 Ethnicity: Middle East; Kurdish Health: Moderate Depression	Sweden	CA-CBT	8-week CA-CBT intervention vs control group; 11-month follow-up.	Depression (BDI)	Intervention group showed significantly lower scores in primary outcome measures post intervention and compared to control (M = 15.10 ± 14.55 vs 37.75 ± 12.41; p < 0.05) and at follow-up compared to baseline.	Treatment acceptability was not reported.
Lindegaard et al. 2020	Sample size: 59 Male: 34 Female: 25 Mean age: 37.5 ± 11.4 Ethnicity: Middle East; Iraq; Syria Health: Moderate Depression	Sweden	CA-CBT	8-week CA-CBT self-help internet-based intervention vs control; No follow-up	Depression (BDI)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 11.67 ± 6.05 vs 17.33 ± 5.29; p < 0.05), compared to control.	Treatment acceptability was measured using "*quality of life*" scores which was significant post intervention compared to control and at baseline (p < 0.05).

Marcks & Woods, 2005	Sample size: 103 Female: 72 Male: 31 Mean age: 21.55 ± 5 Ethnicity: African American; Asia; Hispanic Health: Mild/Moderate Anxiety/Depression	USA	Acceptance Based Therapy (ABT) (Community)	1-day acceptance-based therapy vs control intervention. No follow up	Anxiety (State-Trait Anxiety Inventory) (STAI); Depression (Beck Depression Inventory) (BDI)	Significant reductions in anxiety ($M = 5.3 \pm 4.1$ vs 8.4 ± 6.2; $p < 0.05$) and depressive ($M = 9.1 \pm 5.1$ vs 15.34 ± 5.6; $p < 0.05$) symptoms for the intervention group post intervention compared to control.	Treatment acceptability was not reported.
Mashal et al. 2019	Sample size: 98 Female: 46 Male: 52 Mean age: 22 ± 2 Ethnicity: Asian; Asian American; Black; Black African American; African Health: Mild/Moderate Anxiety	USA	Brief Worry Reappraisal Programme (BWRP)(Community)	A brief 1-day worry reappraisal programme administering a questionnaire and task for the intervention group vs control group. No follow up	Anxiety (Penn State Worry Questionnaire) (PSWQ)	Reductions in anxiety symptoms but not significant compared to control ($M = 45 \pm 15$ vs 39 ± 17.2; $p > 0.05$)	Treatment acceptability was not reported.
Musa et al. 2021	Sample size: 101 Female: 52 Male: 49 Age range: 18 – 60 Ethnicity: Africa; Nigeria Health: Intellect. Disabled	Nigeria	Mindfulness based cognitive therapy (MBCT) (Community)	8-week group MBCT vs control intervention. 1x week. 2h 15min sessions. 2-month follow up	Depression (Beck Depression Inventory) (BDI)	No significant difference between the intervention and control group pre-test vs 8 week ($M=33$ vs 30, 23 vs 25, $p > 0.05$). Sig difference between groups at 2month follow up in favour of intervention group. ($M=18$ vs 24, $p<0.05$)	Treatment acceptability was not reported.

Muto et al. 2011	Sample size: 70 Female: 44 Male: 26 Mean age: 23.6 ± 2.2 Ethnicity: Japan Health: Mild Anxiety	USA	Self-Care Acceptance and Commitment Bibliotherapy (Community)	8-week self-help intervention vs control. 2-month follow up	Anxiety; Depression (General Health Questionnaire) (GHQ)	Significant reductions in anxiety (M = 10.03 ± 5.12 vs 13.13 ± 7.31; $p < 0.05$) and depression (M = 11 ± 5.05 vs 15.12 ± 5.40; $p < 0.05$) in the intervention group at 8 weeks and at follow up ($p < 0.05$).	Treatment acceptability was not reported.
Naeem et al. 2014	Sample size: 192 Female: 111 Male: 81 Mean age: 34 ± 12 Ethnicity: Pakistan Health: Moderate Anxiety/Depression	Pakistan	CA-CBT Self-Care (Community)	12-week CA-CBT self-help (portrayed as a story in a book) vs treatment as usual (medication). No follow up	Anxiety; Depression (Hospital Anxiety and Depression Scale) (HADS)	CA-CBT demonstrated significant lower rates of anxiety (M = 6.2 ± 3.6 vs 10.4 ± 3.9; $p < 0.05$) and depressive (M = 7.5 ± 3.5 vs 11.2 ± 4; $p < 0.05$) symptoms at 12 weeks compared to control.	Treatment acceptability was not reported.
Naeem et al. 2015	Sample size: 137 Female: 82 Male: 55 Mean age: 31 ± 11.1 Ethnicity: Pakistan Health: Mild/Moderate Anxiety/Depression	Pakistan	CA-CBT (Clinical)	6-week CA-CBT vs treatment as usual. 1x week. Measurements taken at 3 month and 9 months after baseline.	Anxiety; Depression (Hospital Anxiety and Depression Scale) (HADS)	CA-CBT produced more significant reductions in anxiety (M = 5.7 ± 3.7 vs 9.7 ± 3; $p < 0.05$) and depression (M = 4.4 ± 3.8 vs 7.6 ± 3.6; $p < 0.05$) at 3 month and 9-month vs control group ($p < 0.05$).	Treatment acceptability was reported as *"treatment satisfaction"* scores, with the intervention group demonstrating significantly higher satisfaction scores post intervention compared to control ($p < 0.05$).

Nakao et al. 2018	Sample size: 40 Female: 20 Male: 20 Age range: 20-65 Ethnicity: Asia; Japan Health: Moderate Depression	Japan	Web-based blended CBT (Community)	12-week Web-based CBT vs control (Treatment as usual – medication). 1x week. 45min sessions. No follow up	Depression (Hamilton Depression Scale) (HDS)	Significantly lower depressive symptoms at 12 weeks in favour of intervention group compared to control (M = 9.4 ± 5.2 vs 15.5 ± 3.6; p < 0.05).	Treatment acceptability was reported as *"engagement scores"* (i.e., adherence rates), with all participants in the intervention and control group completing the trial.
Neuner et al. 2004	Sample size: 43 Female: 27 Male: 16 Mean age: 41 ± 6.2 Ethnicity: Sudan Health: Moderate Anxiety	Uganda	Narrative Exposure Therapy (NET) (Community)	4-week NET vs supportive counselling vs psychoeducation. 1x week. 1h sessions. 1 year follow up	Anxiety (Post-Traumatic Stress Diagnostic Scale) (PTSDS)	The NET group showed the most significant reductions in anxiety scores post-intervention compared to supportive counselling (M = 19.1 ± 11.7 vs 21.2 ± 9.4; p < 0.05) and psychoeducation (M = 19.1 ± 11.7 vs 21.2 ± 9.4; p < 0.05) and at 1-year follow up compared to baseline (p < 0.05).	Treatment acceptability was not reported.
Neuner et al. 2008	Sample size: 43 Female: 27 Male: 16 Mean age: 35 ± 14.5 Ethnicity: African; Somali Health: Moderate Anxiety/PTSD	Sudan	NET	3-week NET intervention vs control (usual care); 9-month follow up.	Anxiety/PTSD (Post-Traumatic Stress Diagnostic Scale) (PTSDS)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 6.1 ± 6.8 vs 10.1 ± 8.1; p < 0.05), compared to control and at follow-up compared to baseline (p < 0.05).	Treatment acceptability was not reported.

Pan et al. 2011	Sample size: 30 Female: 30 Mean age: 22 Ethnicity: Asia; Chinese Health: Moderate Anxiety/Phobia	USA	CA – one session treatment (Psychoeducation)	1-week CA-one session treatment vs control. 6-month follow up.	Anxiety/Phobia (BAI)	Intervention group showed significantly lower scores in primary outcome measures post intervention (M = 83.70 ± 16.25 vs 170.22 ± 16.28; $p < 0.05$) compared to control, and at follow-up compared baseline ($p < 0.05$).	Treatment acceptability was not reported.
Rezvan et al. 2009	Sample size: 36 Female: 36 Mean age: 20.3 ± 1.5 Ethnicity: Iran Health: Moderate Anxiety	Iran	CBT vs CBT + interpersonal psychotherapy vs Control (Community)	8-week CBT vs CBT + interpersonal psychotherapy vs control intervention. 1x week. 1.5h sessions. 1 year follow up	Anxiety (Penn State Worry Questionnaire) (PSWQ)	Significant reductions in anxiety in favour of both intervention groups compared to control (M ~ CBT = 43.08 ± 5.33 vs 58.83 ± 4.60; $p < 0.05$); (M ~ CBT+IPT = 43.50 ± 5.58 vs 58.83 ± 4.60; $p < 0.05$). Intervention group demonstrated significant reductions at follow-up compared to baseline ($p < 0.05$).	Treatment acceptability was not reported.
Razali et al. 2002	Sample size: 36 Female: 36 Mean age: 20.3 ± 1.5 Ethnicity: Iran Health: Moderate Anxiety	Malaysia	Religious cultural psychotherapy (RCP)	6-month Religious cultural psychotherapy vs control intervention (non-religious treatment). 6-month follow up.	Anxiety (HADS)	Intervention group showed lower scores in primary outcome measures post intervention (M = 2.9 ± 2.1 vs 2.2 ± 1.9; $p > 0.05$), and at follow-up compared to control group but the difference was	Treatment acceptability was not reported.

						not significant. Significant ingroup differences were observed in the intervention group compared to baseline ($p < 0.05$).	
Salamanca-Sanabria et al. 2020	Sample size: 214 Female: 153 Male: 61 Mean age: 22.15 ± 4 Ethnicity: Colombia Health: Moderate Anxiety/Depression	Colombia	Internet CA-CBT (Community)	7-week internet CA-CBT vs control group intervention. 1x week. 45 min sessions. 3-month follow up	Anxiety (GAD-7); Depression (Patient Health Questionnaire) (PHQ)	Intervention group showed significantly lower scores in depression (M = 8.33 ± 5.71 vs 13.09 ± 5.06; $p < 0.05$) post intervention, compared to control group. Within group follow-up scores significant compared to baseline in the intervention group ($p < 0.05$). Anxiety scores significant post intervention compared to baseline ($p < 0.05$).	Treatment acceptability was not reported.
Shaw et al. 2018	Sample size: 29 Female: 29 Mean age: 32.7 ± 7 Ethnicity: Asia; Malaysia Health: Moderate Anxiety/Depression	Malaysia	CA-CBT	8-week CA-CBT intervention vs control group; No follow-up	Anxiety (BAI) Depression (BDI)	Intervention group showed significantly lower scores in anxiety (M = 2.79 ± 0.61 vs 3.30 ± 0.39; $p < 0.05$) and depression (M = 2.76 ± 0.49 vs 3.20 ± 0.39; $p < 0.05$) post intervention ($p < 0.05$), compared to control group	Treatment acceptability was not reported.

Soleimani et al. 2015	Sample size: 27 Female: 20 Male: 7 Mean age: 22 ± 2.3 Ethnicity: Middle East; Iran Health: Mild/Moderate Depression	Iran	Behavioural Activation (BA) vs Cognitive Therapy (CT) (Community)	8-week BA vs CT intervention. 1x week. 1h sessions. No follow-up	Anxiety; Depression (Depression, Anxiety & Stress Scale) (DASS)	BA produced significant reductions in depressive symptoms vs CT post-intervention (M = 12.36 ± 5.98 vs 16.46 ± 4.52; $p < 0.05$). Similar reductions in anxiety symptoms for both groups in favour of BA but not significant ($p > 0.05$).	Treatment acceptability was not reported.
Tol et al. 2020	Sample size: 694 Female: 694 Mean age: 30 ± 10.9 Ethnicity: Africa; Sudan Health: Mild anxiety	Uganda	Self-help (Self-Care) acceptance and commitment therapy (Community)	5-week self-help intervention vs control. 1x week. 2h workshops. 3-month follow up	Anxiety (Kessler 6 symptom checklist) (K6SC)	Significant reduction in anxiety symptoms vs control at 5 weeks (M = 10.4 ± 4.9 vs 13.5 vs 4.8; $p < 0.05$) and at 3-month follow up ($p < 0.05$) compared to control and baseline.	Treatment acceptability was not reported.
Wenhua et al. 2016	Sample size: 64 Female: 44 Male: 20 Mean age: 36 ±8.2 Ethnicity: Asia; China Health: Mild Depression	China	CBT (Clinical)	6-week CBT vs medication intervention. 1x week. 1h sessions. 2 and 6 week follow up	Depression (Hamilton Depression Scale) (HDS)	Both modalities produced significant decreases in depressive symptoms post intervention compared to baseline ($p < 0.05$). No significant difference between groups post intervention (M = 9.4 ± 7.8 vs 10.2 ± 10.1; $p > 0.05$) or at follow-up ($p > 0.05$).	Treatment acceptability was not reported.

Wong et al. 2008a (Fu Keung Wong)	Sample size: 347 Female: 250 Male: 97 Age range: 42.72 ± 8.7 Ethnicity: Asia; China Health: Mild/Moderate Depression	China	Group CBT (Community)	10-week Group CBT vs control intervention. 1x week. No follow up	Depression (Beck Depression inventory) (BDI);	Experimental group showed significantly lower levels of dep symptoms at 10 weeks compared to control (M = 0.54 ± 0.48 vs 0.90 ± 0.49; p < 0.05).	Treatment acceptability was not reported.
Wong et al. 2008b	Sample size: 96 Female: 75 Male: 21 Mean age: 37.4 ± 9.4 Ethnicity: Asia; China Health: Mild/Moderate Depression	China	Group CBT (Community)	10-week CBT vs control. No follow up.	Depression (Beck Depression inventory) (BDI)	Experimental group showed significantly lower depressive symptoms at 10-weeks vs control (M = 13.1 ± 11.1 vs 22.4 ± 13.3; p < 0.05)	Treatment acceptability was not reported.
Yeung et al. 2017	Sample size: 67 Female: 48 Male: 19 Mean age: 54 ± 11 Ethnicity: Chinese/American Health: Moderate Depression	USA	Tai-Chi (Community)	12-week Tai-Chi vs education vs control group intervention. 1x week. 45min session. No follow up	Depression (Hamilton Depression Scale) (HDS)	Significant reduction in depression scores at 12 weeks for experimental group compared to education (M = 2.11 ± 5.1 vs 8.90 ± 10.9; p < 0.05) and control (M = 2.11 ± 5.1 vs 5.40 ± 7.9; p < 0.05).	Treatment acceptability was reported as *"remission rates"* with the experimental demonstrating the highest level of remission rates post intervention compared to education and control group.
Zhao et al., 2017	Sample size: 352 Female: 352 Mean age: 30 ± 3.68 Ethnicity: Asia; China Health: Prenatal Depression;	China	Pre-natal depression intervention (Community)	6-week pre-natal depression intervention vs control (waitlist; routine care). 1x week. 45min	Depression (Edinburgh Postnatal Depression Scale) (EPDS)	Intervention group experienced significantly lower depressive symptoms post intervention compared to control	Treatment acceptability was not reported.

	Mild/Moderate Depression			sessions. 3 day & 42 day follow up		(M = 20.1 ± 12.2 ± 24.2 ± 14.5; $p < 0.05$) and at 42 day follow up compared to baseline ($p < 0.05$).	
Zu et al. 2014	Sample size: 180 Female: 133 Male: 47 Mean age: 41.3 ± 11.5 Ethnicity: Asia, China Health: Mild/Moderate/Severe Depression	China	CBT (Community)	6-month CBT vs medication vs CBT + medication vs standard treatment. 1x week. 1h sessions. No follow up.	Depression (Hamilton Rating Scale for Depression) (HRSD)	CBT was the only group with significant reductions in depressive symptoms at 6months post intervention compared to baseline. ($p < 0.05$; *d*=0.47). Significant reduction in CBT scores compared to medication, CBT + Medication and standard treatment. Largest difference in CBT and standard treatment at 6-months (M = 2.4 ± 2.3 vs 6.2 ± 6.6; $p < 0.05$).	Treatment acceptability was not reported.
Zucker et al. 2006	Sample size: 85 Female: 62 Male: 23 Mean age: 19 ± 1.11 Ethnicity: Asian; Latino; African American; Indian Health: Mild Anxiety	USA	CBT (Community)	3h CBT workshop vs control. 5 month follow up.	Anxiety (Maudsley obsessive-compulsive inventory) (MOCI)	Significant reductions in anxiety at 5 month follow up compared to control (M = 23.1 ± 13.38 vs 31.33 ± 11.78; $p < 0.05$).	Treatment acceptability was not reported.

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Key: ABT: Acceptance Based Therapy; ASS: Anxiety Sensitivity Scale; ASI: Anxiety Sensitivity Index; BAI: Beck Anxiety Inventory; BDI: Beck Depression Inventory; BA: Behavioural Activation; BWRP: Brief Worry Reappraisal Programme; CES-D: Centre for Epidemiological Studies; CT: Cognitive Therapy; CBT: Cognitive Behaviour Therapy; CA-CBT: Culturally Adapted Cognitive Behaviour Therapy; DMBI: Dejian Mind-Body intervention; DASS: Depression Anxiety and Stress Scale; EI: Educational Intervention; ECPSMS: Educational Course in Psychological Stresses and Management Skills; EPDS: Edinburgh Postnatal Depression Scale; GHQ: General Health Questionnaire; GHQ28: General Health Questionnaire-28 GADS-7: Generalized Anxiety Disorder Scale-7; HTQ: Harvard Trauma Questionnaire; HSCL: Hopkins Symptoms Checklist; HDS: Hamilton Depression Scale; HRSD: Hamilton Rating Scale for Depression; HADS: Hospital Anxiety and Depression Scale; K6CM: Kessler 6 symptom checklist; MBCT; Mindfulness Based Cognitive Therapy; MOCI: Maudsley Obsessive-Compulsive Inventory; NET: Narrative Exposure Therapy; PDSS: Postpartum Depression Screening Scale; PHQ: Patient Health Questionnaire; PHQ9: Patient Health Questionnaire-9; PWBS: Psychological Well-Being Scale; PTSDS: Post-Traumatic Stress Diagnostic Scale; PSWQ: Penn State Worry Questionnaire; QIDS: Quick Inventory Depression Symptomatology; REBT: Rational Emotive Behaviour Therapy; ROSE: Reach Out, Stay Strong, Essentials For New Mothers; SIPT: Spiritual (Islamic approach) Psychotherapy; STAI: State-Trait Anxiety Inventory; SCL-90-R: Symptoms checklist 90 revised; TAU: Treatment As Usual

Table 2.3

Magnitude of pre-post intervention changes in anxiety and depression based on effect sizes and 95% confidence intervals

Author	**Duration**	**Measure**	**Hedges (g)**	**95% Confidence Interval**	
				Lower bound	**Upper bound**
Andersson et al. 2013	8-weeks	BAI	0.31*	-0.20	0.84
		BDI	0.32*	-0.21	0.84
Afuwape et al. 2010	12-weeks	GHQ-28	0.47*	-0.28	1.17
Alavi & Hirji, 2020	12-weeks	BAI	0.40*	0.01	0.80
Ashing & Rosales, 2014	8-weeks	CES-D	0.20*	-0.06	0.49
Bolton et al. 2003	16-weeks	HADS	1.87*	1.55	2.18
Bedoya et al. 2014	2-weeks	QIDS	0.40*	0.03	0.76
Beeber et al. 2010	16-weeks	CES-D	0.57*	0.10	1.05
Chan et al. 2012	10-weeks	HRSD (CBT; DMBI)	0.60*; 0.70*	-0.07; -0.01	1.30; 1.40
		BDI (CBT; DMBI)	2.70*; 1.52*	1.78; 0.74	3.60; 2.29
Chaves et al. 2017	10-weeks	HDS	0.07	-0.30	0.47
Choi et al. 2012	8-weeks	BDI	0.93*	-4.57	1.88
Collado et al. 2016	10-weeks	BDI	0.38*	-0.20	0.96
Chien et al. 2012	6-weeks	HADS	0.29*	-0.15	0.73
Cooper et al. 2013	12-months	CES-D	-0.43	-0.79	-0.08
Crockett et al. 2008	5-weeks	EPDS	-0.41	-1.17	0.34
De Graaff et al. 2020	6-weeks	HSCL	0.54*	0.29	0.61
Dwight-Johnson et al. 2011	6-weeks	PHQ	1.59	1.14	2.03
Ezeudu et al. 2020	12-weeks	BDI	1.23*	0.34	2.12
Ebrahimi et al. 2013	8-weeks	BDI (SIPT; CBT)	3.15*; 3.11*	2.09; 2.06	4.20; 4.15
Gallagher et al. 2007	16-weeks	CES-D	0.41*	-0.11	0.95

Gao et al. 2015	1-day	EPDS	0.33*	0.04	0.62
Ghawadra et al. 2020	1-day	DASS (Anxiety)	0.22*	-0.04	0.48
		DASS (Depression)	0.30*	0.03	0.50
Hall et al. 2018	7-weeks	DASS (Anxiety)	0.84*	0.19	1.52
		DASS (Depression)	0.83*	0.18	1.50
Han et al. 2020	10-weeks	HRSD (CBT; DMBI)	0.62*; 0.39*	-0.07; -0.29	1.3; 1.08
		BDI (CBT; DMBI)	0.72; 0.45	0.01; -0.23	1.42; 1.14
Hinton et al. 2004	11-weeks	HTQ	2.39*	0.91	3.8
Hinton et al. 2005	12-weeks	ASS	3.87*	2.74	4.8
Hinton et al. 2011	14-weeks	SCL	1.1*	0.15	1.84
Huey & Pan, 2006	1-day	BAI	0.77*	-0.50	2.06
Hwang et al. 2015	12-weeks	HDS	0.11	-0.44	0.67
Hendriks et al. 2020	6-weeks	DASS (Anxiety)	0.50*	0.19	0.82
		DASS (Depression)	0.32*	0.01	0.64
Jacob et al. 2002	1-day	GHQ	0.69*	0.20	1.17
Jones & Warner, 2011	10-weeks	CES-D	0.33*	-0.18	0.84
Jalal et al. 2020	7-weeks	HADS	1.59*	0.80	2.23
Knaevelud et al. 2015	5-weeks	BAI	1.54*	1.19	1.90
Kananian et al. 2020	6-weeks	PHQ	1.40*	0.50	2.29
Karasz et al. 2015	12-weeks	PHQ	0.67*	0.05	1.29
Kanter et al. 2015	12-weeks	HRSD	0.82*	0.04	1.60
		BDI	0.33*	-0.43	1.07
Kim et al. 2017	6-weeks	HADS (Anxiety)	0.76*	0.23	1.28
		HADS (Depression)	0.95*	0.41	1.48
Li et al. 2018	1-day	HADS (Anxiety)	0.11	-0.11	0.35

		HADS (Depression)	-0.36	-0.60	-0.12
Lindegaard et al. 2019	8-weeks	BDI	1.27*	0.64	1.86
Lindegaard et al. 2020	8-weeks	BDI	0.85*	0.29	1.41
Marcks & Woods, 2005	1-day	STAI	0.65*	0.12	1.29
		BDI	0.51*	0.02	1.13
Mashal et al. 2019	1-day	PSWQ	-0.37	-0.77	0.02
Musa et al. 2021	8-weeks	BDI	0.49	0.09	0.89
Muto et al. 2011	8-weeks	GHQ (Anxiety)	0.48*	-0.01	0.99
		GHQ (Depression)	0.78*	0.27	1.30
Naeem et al. 2014	12-weeks	HADS (Anxiety)	1.12*	0.80	1.43
		HADS (Depression)	0.98*	0.67	1.29
Naeem et al. 2015	6-weeks	HADS (Anxiety)	1.18*	0.82	1.55
		HADS (Depression)	0.86*	0.51	1.21
Nakao et al. 2018	12-weeks	HDS	1.36*	0.67	2.05
Neuner et al. 2004	4-weeks	PTSDS (Supportive Counse	0.06*	-0.64	0.76
		PTSDS (Psychoeducation)	0.19*	-0.54	0.93
Neuner et al. 2008	3-weeks	PTSDS	0.55*	0.22	0.88
Pan et al. 2011	1-week	BAI	5.31*	3.45	7.18
Rezvan et al. 2009	8-weeks	PSWQ (CBT + IPT)	0.07	-0.72	0.87
		PSWQ (Control)	3.16*	1.96	4.36
Razali et al. 2002	6-months	HADS	-0.34	-0.77	0.08
Salamanca-Sanabria et al. 2020	7-weeks	PHQ (Depression)	0.90*	0.38	1.4
Shaw et al. 2018	8-weeks	BAI (Anxiety)	0.92*	0.13	1.72
		BDI (Depression)	0.95*	0.15	1.75
Soleimani et al. 2015	8-weeks	DASS (Anxiety)	-0.23	-0.99	0.51

		DASS (Depression)	0.76*	-0.01	1.55
Tol et al. 2020	5-weeks	K6SC	0.63*	0.48	0.79
Wenhua et al. 2016	6-weeks	HDS	0.08	-0.40	0.57
Wong et al. 2008a	10-weeks	BDI	0.74*	0.52	0.96
Wong et al. 2008b	10-weeks	BDI	0.75*	0.34	1.17
Yeung et al. 2017	12-weeks	HDS (Education group)	0.79*	0.28	1.29
		HDS (Control group)	0.49*	0.04	0.97
Zhao et al. 2017	6-weeks	EPDS	0.30*	0.09	0.51
Zu et al. 2014	6-months	HRSD (standard treatment)	0.72*	-0.04	1.49
Zucker et al. 2006	1-day	MOCI	0.65*	0.21	1.08
Mean Total Effect Size (SD)	**N/A**	**N/A**	**0.82 (± 0.92)**	**0.62**	**1.01**

A positive effect size indicates the magnitude of pre-post intervention changes in anxiety and depression.

* Indicates statistical significance ($p < 0.05$)

Table 2.4

Adaptations to all CA-CBT interventions (N = 20 - Table adapted from Arundell et al. 2021)

Study ID (first author +publication date)	**Target population**	**Target condition(s)**	**Adaptation area**	**Specific adaptation types**	**Common factors: Acceptability & suitability**	**Common factors: Therapeutic relationship**	**Common factors details**
Alavi 2020	Middle Eastern	Anxiety	*Therapist-related*	Language translation		Alliance; Patient feedback	Participants had opportunity to feedback to facilitator throughout; A designated therapist providing feedback support and simplified communication throughout to reduce barriers traditionally experienced by target population
			Content-related-related	Cultural; Language translation;	Cultural adaptations		Cultural background of the target population was considered
			Organisation-specific	Form used to provide treatment (online/email)			
Afuwape 2010	Black or mixed race	Anxiety; Depression	*Therapist-related*	Provider of treatment			
			Content-related		Education		Health education as part of the intervention package
			Organisation-specific	Method of access			
Ashing 2014	Latino	Depression	*Therapist-related*	Training for provider; Provider of treatment; Language translation		Alliance	Therapist-related by paraprofessionals with sociocultural similarities to participants
			Content-related	Cultural	Cultural adaptations; Treatment structure		Culturally sensitive, culturally competent facilitators, culturally sensitive resources; Order of the treatment domains was flexible
			Organisation-specific				

Bedoya 2014	Latino	Depression	*Therapist-related*	Training for provider; Language translation		Alliance	Adopted the Engagement Interview Protocol and the DSM5 OCF at first visit
			Content-related	Cultural: Language translation	Cultural adaptations; Education		Culturally focussed; Facilitation of patient's knowledge of and resources for getting treatment
			Organisation-specific				
Choi 2012	East Asian	Depression	*Therapist-related*	Language translation			
			Content-related	Cultural; Language translation	Cultural adaptations		Culturally attuned re terms of reference and images
			Organisation-specific				
Dwight-Johnson 2011	Latino	Depression	*Therapist-related*	Language translation; Provider of treatment (ethnic match)		Alliance	Methods taken specifically to elucidate trust and respect patients
			Content-related	Cultural; language translation	Cultural adaptations; Treatment structure		
			Organisation-specific	Location of treatment; Form used to provide treatment (phone); Method of access; Time of length of treatment			
Hinton 2004	Refugees/asylum seekers; East Asian	PTSD; Panic Disorder; Anxiety	*Therapist-related*				
			Content-related	Cultural	Cultural adaptations		Culturally appropriate visualisation representing cultural values and cultural modifications
			Organisation-specific				
Hinton 2011	Latino	PTSD; Anxiety	*Therapist-related*	Language translation			
			Content-related	Cultural	Cultural adaptations; Education		Culturally appropriate and specific analogies and imagery, culturally appropriate visualization representing

							cultural values; Education about PTSD using imagery
			Organisation-specific				
Hwang 2015	East Asian (China/American)	Depression	*Therapist-related*	Language translation		Alliance; Collecting patient feedback	Improving the client-therapist relationship is part of framework; reviewing and refining adaptions and testing the adapted interventions with stakeholders
			Content-related	Cultural	Cultural adaptations; Preparation of the patient		Incorporates cultural beliefs about mental illness
			Organisation-specific				
Jalal 2020	South African	Depression	*Therapist-related*			Expectations of treatment; Alliance	
			Content-related	Cultural	Cultural adaptations		The study developed local expressions to address the stigma associated with trauma, such as interpreting it as a sign of spirit possession. Furthermore, for the therapy's effectiveness and acceptability, culturally appropriate metaphors were used; connecting nightmares and sleep paralysis to participant's symptom presentation. The study particularly highlighted somatic and sensorial elements to create more meaningful experiences for our participants.
			Organisation-specific				
Jones 2011	Black or mixed race	Depression	*Therapist-related*	Provider of treatment			
			Content-related	Cultural	Cultural adaptations		
			Organisation-specific	Form used to provide treatment (group)			

Kananian 2020	Refuges/asylum seekers	Depression	*Therapist-related*	Training for provider; Language translation		Alliance	Steps to ensure safe, comfortable environment
			Content-related	Cultural; Language translation	Cultural adaptations; Education		Culturally adapted imagery and terms of reference; Each session started with psychoeducation
			Organisation-specific	Form used to provide treatment (group)			
Karasz 2015	South Asian	Depression	*Therapist-related*			Agreement of treatment goals	Group goal-getting
			Content-related	Cultural	Cultural adaptations; Education		Culturally synchronous approach; Educational component of each session
			Organisation-specific	Form used to provide treatment (group)			
Knaevelsrud 2015	Middle Eastern	PTSD	*Therapist-related*	Language translation; Training for provider/facilitator		Expectations of treatment	Therapists responded to patient expectations of healthcare professional - provided straight instructions and decisiveness;
			Content-related	Cultural; Language translation; Religious/faith based	Cultural adaptations		Explicit respect towards the concept of family in line with cultural views
			Organisation-specific				
Lindegaard 2019	Middle Eastern; Refugees/asylum seekers	Depression	*Therapist-related*	Language translation			
			Content-related	Cultural; Language translation	Cultural adaptations		Modifications made to ensure cultural appropriateness included focus on positive social reinforcers and making the intervention more in line with collectivistic orientation of the target population's culture

			Organisation-specific	Form used to provide treatment (online); Method of access		
Lindegaard 2020	Refugees/asylum seekers	Depression	*Therapist-related*			
			Content-related	Cultural; Language translation	Cultural adaptations; Treatment structure	Culturally adapted in line with cultural stigma about mental health; Treatment format adapted for participant group
			Organisation-specific	Form used to provide treatment (online)		
Naeem 2014	South Asian (Pakistan)	Depression	*Therapist-related*			
			Content-related	Cultural; Religious/faith-based	Cultural adaptations; Education	Culturally-relevant terms of reference and stories; Psychoeducation provided at start
			Organisation-specific			
Naeem 2015	South Asian (Pakistan)	Depression	*Therapist-related*			
			Content-related	Cultural; Religious/faith-based	Cultural adaptations; Treatment structure	Culturally appropriate terms of reference, involvement of family member in care enhances acceptability; Added session or the family, family member of co-therapist, flexibility of structure
			Organisation-specific			
Shaw 2018	Refugees/Asylum seekers; Middle Eastern	Depression; Anxiety	*Therapist-related*	Provider of treatment; Training for provider/facilitator		
			Content-related	Cultural	Cultural adaptations; Education	Incorporated culturally and religiously appropriate symbols and imagery; Initial education on trauma-related disorders and emotion
			Organisation-specific	Time or length of treatment		

Salamanca-Sanabria 2020	Colombian	Anxiety; Depression (MDD)	*Therapist-related*			Alliance	Methods taken specifically to elucidate trust and respect patients
			Content-related	Cultural; Religious adaptations	Cultural adaptations; Education		In the initial stage of adaptation, the study translated the program from English to Spanish and enriched it with culture-specific expressions, samples, and anecdotes. The study then assessed the nascent program's efficacy by way of the Cultural Relevance Questionnaire (CRQ). This questionnaire, crafted specifically for the study, was built on theories and principles from cross-cultural assessment research. Its core focuses are cultural sensitivity and ecological validity. The third phase of the program incorporated cultural feedback and sought to further integrate this into the program.
			Organisation-specific				

Table 2.5.

Taxonomy of Common Psychotherapies applied to BAME groups

Psychotherapy	**Number of times used in BAME interventions**
Miscellaneous Psychotherapies (ABT; BA; BMP; BWRP; CC; CAPE; CT; EI; ECPSMS; NET; PNDI; PP; PEP; PM; PI; ROSE; RCP; REBT; SIPT)	18
CA-CBT	20
CBT	12
Complimentary therapies (DMBI; MBCT)	5
Other CA Therapies	4
IPT	3
Self-Care (Self-Help) Interventions	2

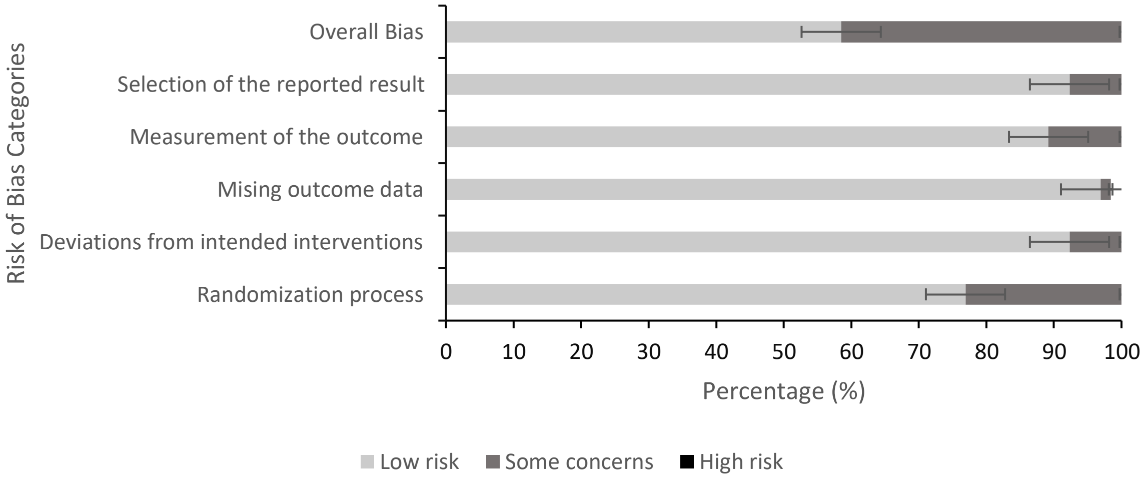
Key: ABT: Acceptance Base Therapy; **BA:** Behavioural Activation; **BMP**: Behavioural Management Programme: **BWRP**: Brief Worry Reappraisal Programme; **CA-CBT**: Culturally Adapted Cognitive Behaviour Therapy; **CBT**: Cognitive Behaviour Therapy; **CC**: Collaborative Care; **CAPE**: Culturally Adapted Psychoeducation; **CT**: Cognitive Therapy **DMBI**: Dejain Mind Body Intervention; **ECPSMS**: Educational Course in Psychological Stresses and Management Skills; **EI**: Educational Intervention; **IPT**: Interpersonal Psychotherapy; **NET**: Narrative Exposure Therapy; **PEP**: Psycho-education Programme; **PP**: Positive Psychology; **PM**: Problem Management; **PNDI**: Pre-Natal Depression Intervention; **PI**: Psychological Interventions; **PST**: Problem Solving Therapy; **REBT**; Rational Emotive Behaviour Therapy; **RCP**: Religious Cultural Psychotherapy; **ROSE**: Reach Out, Stay Strong, Essentials for New Mothers; **SIPT**: Spiritual (Islamic approach) Psychotherapy

2.2.3 QUALITY ASSESSMENT

The Cochrane risk-of-bias tool for RCTs (RoB2; Cochrane, 2019) was employed in the present systematic review to assess quality of studies. This tool is preferable over others such as GRADE rating of quality evidence and Outcome Reporting Bias in Trials as it considers randomisation process, deviation from intended intervention, missing outcome data, measurement of the outcome, selection of reported results and overall bias (Cochrane, 2019). Figure 2 shows that 58.5% of studies had a low risk, 41.5% a moderate risk of bias with no high-risk presence. All the studies were assessed for risk of bias by the corresponding author and a percentage (i.e., 10%; n = 7) of studies were assessed by the authors independently to reduce the level of subjectivity and to ensure the tool was used according to the guidelines. Disagreements were resolved by consensus between the authors.

Figure 2.2

Shows depicts the presence of bias in each aspect of trial conduct.



2.3 RESULTS

2.3.1 STUDY SUMMARY CHARACTERISTICS

Age. The age range of participants in all studies was between 18 – 60 years. Most studies in the systematic review included participants from the age ranges 30 – 39 years (n = 30) and 40 – 49 years (n = 20). Limited studies were conducted in participants aged 18 – 29 (n = 3), 50 – 59 (n = 8) and 60 years (n = 3).

Gender. There were 49 studies that presented equitable gender results for both males and females with differences between male and female participant number ranging from 10 – 50 (i.e., no more than 50 participants in favour of either sex) although nine studies included more females than males (Hall et al., 2008; Hendriks et al., 2020; Klein & Richards 2001; Salamanca-Sanabria et al., 2020; Wong et al., 2008a, 2008b; Yeung et al., 2017; Zucker et al., 2006; Zu et al., 2014). . Fourteen studies included female participants exclusively (Ashing & Rosales, 2014; Crockett et al., 2008; Chaves et al., 2017; Gao et al., 2015; Hinton et al., 2004, 2011; Jones & Warner, 2011; Jacob et al., 2002; Karasz et al., 2015; Kim et al., 2017; Rezvan et al., 2009; Shaw et al., 2018; Tol et al., 2020; Zhao et al., 2017) and one study exclusively recruited male participants (Kananian et al., 2020).

Outcome measures. The most common measure used to assess anxiety and depression was the Beck Depression Inventory (BDI) (n = 16) (Anderson et al., 2013; Chaves et al., 2017; Choi et al., 2012; Collado et al., 2016; Chan et al., 2012; Ebrahimi et al., 2013; Ezeudu et al., 2020; Han et al., 2020; Kanter et al., 2015; Lindegaard et al., 2019, 2020; Marcks & Woods, 2005; Musa et al., 2021; Shaw et al., 2018; Wong et al., 2008a, 2008b) followed by the Hospital Anxiety and Depression Scale (HADS) (n = 8) (Bolton et al., 2003; Chien et al., 2011; Jalal et al., 2020; Kim et al., 2017; Li et al., 2018; Naeem et al., 2014, 2015; Razali et al., 2002), the Beck Anxiety Inventory (BAI) (n = 6) (Alavi & Hirji, 2020; Andersson et al., 2013; Huey & Pan, 2006; Knaevelud et al., 2015; Pan et al., 2011; Shaw et al., 2018), the Centre for Epidemiological Studies (CES-D) (n = 5) (Ashing et al., 2014; Beeber et al., 2010; Cooper et al., 2013; Gallagher et al., 2013; Jones & Warner, 2011) and the Hamilton Depression Scale (HDS) (n = 4) (Hwang et al., 2015; Nakao et al., 2018; Wenhua et al., 2016; Yeung et al., 2017). Additional measures used were the Depression Anxiety and Stress Scale (DASS) (n = 4) (Ghawadra et al., 2020; Hendriks et al., 2020; Hall et al., 2018; Soleimani et al., 2015), 9-item Patient Health Questionnaire (PHQ-9) (n = 4) (Dwight-Johnson et al., 2011; Karasz et al., 2015; Kananian et al., 2020; Salamanca-Sanabria et al., 2020), General Health Questionnaire (GHQ) (n = 4) (Afuwape et al., 2010; Jacob et al., 2002; Kananian et al., 2020; Muto et al., 2011), Edinburgh Postnatal Depression Scale (EPDS) (n = 3) (Crockett et al., 2008; Gao et al., 2015; Zhao et al., 2017), and the Hamilton Rating Scale for Depression (HRSD) (n = 4) **(**Chan et al., 2012; Han et al., 2020; Kanter et al., 2015; Zu et al., 2014). The Psychological Wellbeing Scale (PWBS) (Chaves et al., 2017), Hopkins Symptoms Checklist (HSCL) (De Graaff et al., 2020), Anxiety Sensitivity Scale (ASS) (Hinton et al., 2005), Symptoms Checklist 90 Revised (SCL-90-R) (Hinton et al., 2011), Quick Inventory Depression Symptomatology (QIDS) (Bedoya et al., 2014), State-Trait Anxiety Inventory (STAI) (Marcks & Woods, 2005), Post-Traumatic Stress Diagnostic Scale (PTSDS) (Neuner et al., 2004, 2008), 7-item Generalised Anxiety Disorder (GAD-7) (Salamanca-Sanabria et al., 2020), Kessler-6-Symptom Checklist (K6SC) (Tol et al., 2020), Harvard Trauma Questionnaire (HTQ) (Hinton et al., 2004), Postpartum Depression Screening Scale (PDSS) (Zhao et al., 2017) and Maudsley Obsessive-Compulsive Inventory (MOCI) (Zucker et al., 2006) were measures that were used once in each of the studies. The PWBS (Chaves et al., 2017) and GHQ (Kananian et al., 2020) were used to measure PWB in two studies (n = 2) whilst there were no studies that measured SWB in this systematic review.

Length of interventions. Intervention duration ranged from 1 day to 6 months with the most common intervention continuance between 6 – 12 weeks (n = 42). Additionally, 9 studies lasted 6 weeks (Chien et al., 2012; Dwight-Johnson et al., 2011; De Graaff et al., 2020; Hendriks et al., 2020; Kananian et al., 2020; Kim et al., 2017; Naeem et al., 2015; Wenhua et al., 2016; Zhao et al., 2017), 3 studies lasted 7 weeks (Hall et al., 2018; Jalal et al., 2020; Salamanca-Sanabria et al., 2020), 11 studies lasted 8 weeks (Ashing & Rosales, 2014; Andersson et al., 2013; Choi et al., 2012; Ebrahimi et al., 2013; Lindegaard et al., 2019, 2020; Musa et al., 2021; Muto et al., 2011; Rezvan et al., 2009; Shaw et al., 2018; Soleimani et al., 2015), 7 studies lasted 10 weeks (Chan et al., 2012; Chaves et al., 2017; Collado et al., 2016; Han et al., 2020; Jones & Warner, 2011; Wong et al., 2008a, 2008b), 1 study at 11 weeks (Hinton et al., 2004) and 10 studies lasted 12 weeks (Afuwape et al., 2010; Alavi & Hirji 2020; Ezeudu et al., 2020, Hinton et al., 2005; Hwang et al., 2015; Karasz et al., 2015; Kanter et al., 2015; Nakao et al., 2018; Naeem et al., 2014; Yeung et al., 2017). Sixteen studies in this systematic review lasted less than 6 weeks (Bedoya et al., 2014; Crockett et al., 2008; Gao et al., 2015; Ghawadra et al., 2020; Huey & Pan, 2006; Jacob et al., 2002; Knaevelsrud et al., 2015; Klein & Richards, 2001; Li et al., 2018; Marcks & Woods, 2005; Mashal et al., 2019; Neuner et al., 2004, 2008; Pan et al., 2011; Tol et al., 2020; Zucker et al., 2006 –) with x amount of studies lasting only for 1 day (mention which ones). Seven studies in the systematic review lasted more than 12 weeks (Beeber et al., 2010; Bolton et al., 2003; Cooper et al., 2013; Gallagher et al., 2007; Hinton et al., 2011; Razali et al., 2022; Zu et al., 2014). Forty-four studies included a follow up and this ranged from one month to 3.5-years.

Ethnic groups. Various ethnic groups were included yet the most common being the Asian ethnic group (mainly Chinese) (n = 28). Additional ethnic groups were African (n = 13), Mixed ethnic groups (i.e. Asian/British; Asian/American; African/American; Asian/Australian) (n = 7) and other ethnic groups (i.e. Hispanic – Spanish, Colombian & Middle Eastern – Iran/Afghanistan) (n = 17).

Treatment acceptability. Fourteen of the 64 studies reported treatment acceptability (Ashing & Rosales, 2014; Bedoya et al., 2014; Beeber et al., 2010; Chan et al., 2012; Collado et al., 2016; Cooper et al., 2013; Dwight-Johnson et al., 2011; Gao et al., 2015; Ghawadra et al., 2020; Hendriks et al., 2020; Lindegaard et al., 2020; Naeem et al., 2015; Nakao et al., 2018; Yeung et al., 2017). Various measures were used to measure treatment acceptability such as "trial completion rates" (Ashing & Rosales, 2014), "attrition rates" (Bedoya et al., 2014), "validated self-efficacy scales" (Beeber et al., 2010), "concentration levels" (Chan et al., 2012), "treatment satisfaction" (Collado et al., 2016; Dwight-Johnson et al., 2011; Naeem et al., 2015), "rating of care managers" (Cooper et al., 2013), "perceived social support" (Gao et al., 2015), "job satisfaction scale" (Ghawadra et al., 2020), "resilience scale" (Hendriks et al., 2020), "quality of life scores" (Lindegaard et al., 2020), "engagement scores" (Nakao et al., 2018) and "remission rates" (Yeung et al., 2017).

Effect size. Mean total effect size was calculated with the "Statistics Package for Social Sciences" (Sen & Yildirim, 2022) and results were further checked with effect size equations provided by Lenhard and Lenhard (2016). Mean effect size and 95% confidence intervals for CBT and CA-CBT were calculated with Microsoft Excel 365, using the "descriptive statistics" feature, and manually calculating the upper and lower bands of the 95% confidence interval. Classification of effect sizes was guided by Sullivan and Feinn (2012), illustrating that effect sizes should correspond as small ($d = 0.2$), medium ($d = 0.5$) and large ($d \geq 0.8$). A mean post intervention between group large positive effect size was observed in this systematic review (n = 63 out of 64) (Hedge's $g = 0.82$ [95% CI: 0.62 to 1.01; ± 0.92]) (Table 2). A positive effect size meant that favourable reductions in anxiety and depression were found in the experimental group post intervention compared to control. Effect size could not be calculated for the Klein and Richards' study (2001) due to limited data.

This section details the type of therapies most commonly used.

2.3.2 CULTURALLY ADAPTED COGNITIVE BEHAVIOURAL THERAPY (CA-CBT)

A total of twenty studies used CA-CBT. There were eight studies that used CA-CBT as a single intervention typology with no adjunct therapies or variations in delivery (Afuwape et al., 2010; Hwang et al., 2015; Hinton et al., 2004, 2011; Jalal et al., 2020; Knaevelsrud et al., 2015; Naeem et al., 2015; Shaw et al., 2018). Five studies used web-based CA-CBT (Alavi & Hirji, 2020; Choi et al., 2012; Lindegaard et al., 2019, 2020; Salamanca-Sanabria et al., 2020). Three studies used CA-CBT face to face combined with psychoeducation (Bedoya et al., 2014), self-care (Naeem et al., 2014) and PST (Kananian et al., 2020). Three studies used telecommunications (Ashing & Rosales, 2014; Dwight-Johnson et al., 2011; Karasz et al., 2015) and one used group-based CA-CBT (Jones & Warner, 2011). With regards to face to face CA-CBT interventions, studies focused on Asian (Hwang et al., 2015; Hinton et al., 2004; Shaw et al., 2018), Hispanic (Hinton et al., 2011), African (Afuwape et al., 2010; Bedoya et al., 2014; Jalal et al., 2020; Jones & Warner, 2011) and Pakistani/Iranian populations (Naeem et al., 2014, 2015; Knaevelsrud et al., 2015; Lindegaard et al., 2019, 2020) and Middle Eastern populations (Afghanistan & Iran) (Kananian et al., 2020) whilst the web/telecommunication based CA-CBT studies were observed with Asian (Choi et al., 2012; Karasz et al., 2015), Hispanic (Ashing & Rosales, 2014; Dwight-Johnson et al., 2011; Salamanca-Sanabria et al., 2020) and Pakistani/Iranian (Alavi & Hirji, 2020). Most common outcome measures used for face to face CA-CBT was the BDI (Lindegaard et al., 2019, 2020; Shaw et al., 2018), followed by the HADS (Jalal et al., 2020; Naeem et al., 2015), BAI (Knaevelsrud et al., 2015; Shaw et al., 2018), followed by the CES-D (Jones & Warner, 2011), PHQ (Karasz et al., 2015), HTQ (Hinton et al., 2004), GHQ (Afuwape et al., 2010), HDS (Hwang et al., 2015) and SCL-90-R (Hinton et al., 2011). The most common outcome measures used for web-based CA-CBT studies were the PHQ-9 (Dwight-Johnson et al., 2011; Kananian et al., 2020) followed by the BDI (Choi et al., 2012), QIDS (Bedoya et al., 2014), BAI (Alavi & Hirji, 2020), CES-D (Ashing & Rosales, 2014), GAD-7 (Salamanca-Sanabria et al., 2020) and HADS (Naeem et al., 2014). Excluding Hwang et al. (2015) and Dwight-Johnson et al. (2011) all other 18 studies found significant reductions in anxiety and depression in favour of the intervention group (CA-CBT) compared to the control group post intervention. Additionally, CA-CBT interventions showcased a large between group post intervention effect size in favour of the intervention group (Hedge's g = 0.96 [95% CI: 0.73 to 1.19]). Kananian et al. (2020) was the only study that measured PWB and found significant enhancements in PWB using the GHQ post intervention. Moreover, various cultural adaptations were used (see table 2.4) of which the most common type of adaptations were "content-specific" adaptations being recorded in all twenty CA-CBT interventions. Out of the twenty CA-CBT studies, thirteen included follow-ups (1 month – 1 year) whilst seven studies did not (Hwang et al., 2015; Hinton et al., 2004; Jalal et al., 2020; Jones & Warner, 2011; Lindegaard et al., 2020; Naeem et al., 2014; Shaw et al., 2018). Out of the thirteen interventions that included follow-up, ten presented significant results (Afuwape et al., 2010; Alavi & Hirji, 2020; Ashing & Rosales, 2014; Hinton et al., 2011; Knaevelsrud et al., 2015; Kananian et al., 2020; Karasz et al., 2015; Lindegaard et al., 2019; Naeem et al., 2015; Salamanca-Sanabria et al., 2020), whilst three presented insignificant results (Bedoya et al., 2014; Choi et al., 2012; Dwaight-Johnson et al., 2011). Lastly, only five CA-CBT studies reported measures of acceptability in their trials (Ashing & Rosales, 2011; Bedoya et al., 2014; Dwight-Johnson et al., 2011; Lindegaard et al., 2020; Naeem et al., 2015), with Ashing and Rosales (2011) reporting 90% completion rates, Bedoya et al. (2014) revealing 10% attrition rates, Dwight-Johnson et al. (2011) and Naeem et al. (2015) showcasing significant increases in treatment satisfaction compared to baseline in the intervention group and Lindegaard et al. (2020) outlining significantly increased quality of life scores post intervention compared to control and baseline. The remainder of the CA-CBT studies did not directly report acceptability measures but reported low drop-out rates, with the exemption of Salamanca-Sanabria et al. (2020), who reported high drop-out rates.

A list of cultural adaptations, as presented in the supplementary material, was used to classify the different types of adaptations added to traditional CBT interventions for BAME groups. This classification was guided by Arundell et al.'s (2021) systematic review and each study was categorised according to the reported modifications and the overarching adaptation area. The adaptation areas were divided, based on Arundell et al. (2021) categories, into (i) "content-specific", (ii) "therapist-specific" and (iii) "organisation-specific," and additional differentiation of adaptations was made based on common factors (related to the therapeutic relationship, acceptability, and suitability) and specific adaptations targeting either the therapeutic relationship or acceptability/suitability was coded at the content, treatment, or organisational level. The "common factors" section [see supplementary material] refers to adaptations made, at the content, treatment or organisational level that aimed to foster the therapeutic relationship between patients and practitioners and/or improve treatment acceptability/suitability for service users. Furthermore, most studies (n = 14) included more than one adaptation across various areas. All20 CA-CBT interventions included content-specific adaptations, 16 included treatment-specific adaptations and nine included organisation-specific adaptations. Hinton et al. (2004) and Naeem et al. (2014, 2015) studies included one mode of adaptation (i.e., content-specific adaptations).

Content specific adaptations (including "specific adaptation types" and "common factors" section): All CA-CBT interventions made explicit reference to cultural adaptations through content-specific means. This included modifications to intervention materials and resources to better reflect the local life of the target population, such as adapting vignettes to improve their relatability (Alavi & Hirji, 2020). Other adaptations involved using culturally appropriate language, including metaphors, or emphasising cultural norms, practices, and expectations of the target population (Knaevelsrud et al., 2015). Additionally, two studies reported that the theoretical framework of their intervention was culturally informed, drawing upon existing models or adaptation frameworks (Bedoya et al., 2014; Kananian et al., 2020). The explicit nature of these cultural adaptations was considered both as a component of the common factors model and as a distinct type of adaptation, which was explored further in the subsequent analyses.

***Language translation – content related*:** Among the 20 studies examined, eight reported intervention materials and resources that had been translated into a different language (Alavi & Hirji, 2020; Bedoya et al., 2014; Choi et al., 2012; Dwight-Johnson et al., 2011; Kananian et al., 2020; Knaevelsrud et al., 2015; Lindegaard et al., 2019, 2020).

Religious adaptations: Out of the 20 interventions, four interventions incorporated religious, faith-based, or spiritual beliefs (Knaevelsrud et al., 2015, Naeem et al., 2014, 2015; Salamanca-Sanabria et al., 2020). This involved making faith-based modifications to treatment materials or resources, involving a religious figure such as a Pastor, or incorporating religious texts or doctrine into the intervention.

Acceptability and suitability (common factors element): All 20 studies included in the review made adaptations to enhance the acceptability and suitability of interventions for their target population. These adaptations included modifications to the treatment structure by incorporating a flexible presentation of content or adding treatment modules (Naeem et al., 2014, 2015). Three studies included an educational component as part of the intervention (Karasz et al. 2015; Shaw et al., 2018; Salamanca-Sanabria et al., 2020), whereas others included components to prepare patients for treatment, particularly if the target population was unfamiliar with the treatment approach and concepts (Hinton et al., 2011).

Therapist related adaptations (training for facilitator/provider/therapist): In five CA-CBT interventions, adaptations were made by providing training to the therapist, provider or facilitator of the intervention (Ashing & Rosales, 2014; Bedoya et al., 2014; Kananian et al., 2010; Shaw et al., 2018; Knaevelsrud et al., 2015). The training was specifically designed to improve the quality of care provided to the target population. For instance, Kananian et al. (2020) and Shaw et al. (2018) provided training to professionals, while Ashing and Rosales (2014) and Bedoya et al. (2014) trained lay or community members. Another example of training provision was to help set treatment expectations, as reported by Knaevelsrud et al. (2015).

Language translation-therapist related: Ten CA-CBT interventions reported deliberate strategies to ensure that treatment was delivered by a same-language or bilingual provider or an interpreter was used during intervention delivery (Alavi & Hirji, 2020; Ashing & Rosales, 2014; Bedoya et al., 2014; Choi et al., 2018; Dwight-Johnson et al., 2011; Hinton et al., 2011;

Hwang et al., 2015; Kananian et al., 2020; Knaevelsrud et al., 2015; Lindegaard et al., 2019). This adaptation was intended to improve communication between the provider and the client, especially when linguistic or cultural barriers existed.

Provider of treatment: Five interventions (Afuwape et al., 2010; Ashing & Rosales, 2014; Dwight-Johnson et al., 2011; Jones & Warner, 2011; Shaw et al., 2018) demonstrated changes to the practitioner or facilitator, such as when ethnic matching was executed (i.e., having a similarly identified individual provide treatment) (Afuwape et al., 2010; Dwight-Johnson et al., 2011). Provider adaptations additionally involved employing non-professionals like paraprofessionals and laypersons to organise/lead therapy sessions (Ashing & Rosales, 2014; Jones & Warner, 2011; Shaw et al., 2018).

Therapy-patient relationship (common factors element): Ten interventions were identified that involved adaptations aimed at enhancing the therapeutic relationship. These adaptations were designed to improve empathy and promote a stronger therapeutic alliance between the intervention provider and the patient. Examples of such interventions included those reported by Alavi and Hirji (2020), Bedoya et al. (2014), Kananian et al. (2020), and Salamanca-Sanabria (2020). Other interventions were based on previous work with demographically similar patient groups, as in the case of Ashing and Rosales (2014) or involved using a treatment provider who had a shared experience with the patient(s), such as experience of displacement, as reported by Dwight-Johnson et al. (2011). Additionally, interventions that focused on fostering agreement between the patient and the intervention provider on treatment goals, such as those described by Karasz et al. (2015), were also included in this category. Some interventions involved efforts to establish clear expectations for the treatment and collect structured feedback from patients, as reported by Jalal et al. (2020), Knaevelsrud et al. (2015), and Hwang et al. (2015), respectively.

Organisation specific adaptations (location of treatment): Only one study reported adaptation that involved changes to the intervention setting, such as providing therapy in community centres and primary care clinics (Dwight-Johnson et al., 2011).

Form used to provide treatment: Ten CA-CBT interventions made changes to the format in which treatment was delivered. Five interventions were delivered digitally, Alavi and Hirji (2020), Choi et al. (2012), Lindegaard et al. (2019, 2020), and Salamanca-Sanabria et al. (2020), while others were provided in-person or over the telephone (n=3) (Ashing & Rosales, 2014; Dwight-Johnson et al., 2011; Karasz et al., 2015). Additionally, two interventions were adapted to be group-based rather than on a one-to-one basis, (Jones and Warner (2011) and Kananian et al. (2020)).

Time or length of treatment. Only two CA-CBT interventions reported deliberate modifications to the length and timing of individual sessions. Dwight-Johnson et al. (2011) involved increasing or decreasing the duration of individual sessions based on medical necessity and service user preference, and Shaw et al. (2018) changed the time of day that the intervention was provided to meet patient preferences.

2.3.3 OTHER CA INTERVENTIONS

Four interventions that used cultural adaptations without use of the CBT method were reported across the study sample. These therapies were, Culturally Adapted (CA) Problem Management including therapist level adaptations (De Graaff et al., 2020), Culturally tailored one-session treatment including content level adaptations (Huey & Pan, 2006), CA – Positive Psychology including content translation & integrating cultural concepts into materials (Hendriks et al., 2020), CA – one Session Treatment including content level adaptations delivered (Pan et al., 2011). One study was conducted with Middle Eastern (Iran) ethnicities (De Graaff et al., 2020), two studies with Asian groups (Huey & Pan, 2006; Pan et al., 2011) and one study with African heritage (Hendriks et al., 2020). Measures used included the HSCL scale (De Gragg et al., 2020), BAI (Huey & Pan, 2006; Pan et al., 2011) and DASS (Hendriks et al., 2020). All studies showed significant reductions in anxiety and depression post intervention (De Graaff et al., 2020; Huey & Pan, 2006; Hendriks et al., 2020; Pan et al., 2011)., Control groups were care-as-usual (de Graaff et al., 2020), manualised self-help (Huey & Pan, 2006), wait-list control group (Hendriks et al., 2020) and standard one-session treatment (Pan et al., 2011). All four CA interventions were face-to-face and one-to-one (De Graaff et al., 2020; Huey & Pan, 2006; Hendriks et al., 2020; Pan et al., 2011). Only one study (Hendriks et al., 2020) reported significantly higher treatment acceptability scores in the intervention group compared to control post intervention and the other three studies did not report acceptability of interventions.

2.3.4 COGNITIVE BEHAVIOURAL THERAPY

A total of twelve CBT interventions were identified in this systematic review. CBT appeared in seven studies as a single intervention typology (Chan et al., 2012; Chaves et al., 2017; Hinton et al., 2005; Rezvan et al., 2009; Wenhua et al., 2016; Zu et al., 2014; Zucker et al., 2006), in three studies CBT was delivered remotely (Andersson et al., 2013; Klein & Richards, 2001; Nakao et al., 2018), and two studies used group based CBT interventions (Wong et al., 2008a, 2008b). Regarding traditional face-to-face CBT, four studies were conducted on Asian ethnicities (Chan et al., 2012; Hinton et al., 2005; Wenhua et al., 2016; Zu et al., 2014); one on Spanish ethnicities (Chaves et al., 2017); one on Middle Eastern (Iran) (Rezvan et al., 2009) and one on a mixture of Asian, African and Hispanic (Zucker et al., 2006); while all five web based CBT studies were focused only on Asian ethnicities. Additionally, most common outcome measures used in the traditional face to face CBT studies were BDI (Chan et al., 2012; Chaves et al., 2017) and HDS (Wenhua et al., 2016) followed by less common outcome measures such as ASS (Hinton et al., 2005), PSWQ (Rezvan et al., 2009), HRSD (Zu et al., 2014), MOCI (Zucker et al., 2006). Most common outcome measures used for web-based CBT were BDI (Anderson et al., 2013; Wong et al., 2008a, 2008b) followed by BAI (Anderson et al., 2013), ASI (Klein & Richards, 2001) and HDS (Nakao et al., 2018). All CBT interventions resulted in significant reductions in neurotic symptoms compared to baseline in favour of the experimental groups (CBT) compared to control irrespective of the mode of delivery. Additionally, CBT interventions, excluding Klein and Richards (2001) due to incomplete data reporting, showcased a large between group post intervention effect size in favour of the intervention group (Hedge's g = 1.10 [95% CI: 0.48 to 1.71]). Only one study measured PWB, (Chaves et al., 2017) and presented an inverse relationship between depression and PWB scores. Only two studies (Chan et al., 2012; Nakao et al., 2018) assessed acceptability with Chan et al. (2012) significantly reporting improvements in acceptability scores compared to baseline in the intervention group versus Nakao et al. (2018) who found no significant difference in "engagement scores" between groups in the intervention.

2.3.5 COMPLIMENTARY THERAPIES

A total of five complimentary therapies were investigated in the systematic review, including mindfulness-based therapy (Ghawadra et al., 2020; Hall et al., 2018; Musa et al., 2021) and Tai-Chi style therapy (Han et al., 2020; Yeung et al., 2017). Of the five studies, four were conducted on Asian populations (Ghawadra et al., 2020; Han et al., 2020; Hall et al., 2018; Yeung et al., 2017) with the last one focusing on African populations (Musa et al., 2021). The most common outcome measures used across all studies included the DASS (Ghawadra et al., 2020; Hall et al. 2018) and BDI (Han et al., 2020; Musa et al. 2021). Results showed that four out of the five studies found significant reduction of neurotic symptoms in favour of the intervention group post-intervention (Ghawadra et al. 2020; Han, et al. 2020; Hall et al. 2018; Yeung et al. 2017), whilst Musa et al. (2021) found no significant reductions in anxiety and depression post intervention, though changes were observed at two month follow up. Only Ghawadra et al. (2020) and Yeung et al., 2017 reported acceptability measures with Ghawadra et al. (2020) showing significant increase in “job-satisfaction” compared to baseline in the experimental group and Yeung et al. (2017) showcasing the highest remission rates in the experimental group.

2.3.6 INTERPERSONAL PSYCHOTHERAPIES

Three studies integrated IPT into their interventions (Beeber et al., 2010; Bolton et al., 2003; Gao et al., 2015). Beeber et al. (2010) administered a CA – IPT (i.e., use of an interpreter & translation of materials) on Hispanic Latina populations using CES-D, Bolton et al. (2003) conducted a trial on African populations using HADS and Gao et al. (2015) focused on Asian populations using EPDS. All three studies observed significantly lower reductions in neurotic symptoms in favour of the experimental group post intervention. Only Beeber et al. (2010) and Gao et al. (2015) reported acceptability scores, with Beeber et al. (2010) using a “self-efficacy” scale, with favourable scores post intervention in the experimental group compared to baseline and Gao et al. (2015) using a “perceived social support” scale with significantly higher scores in the experimental group compared to control post intervention.

2.3.7 MISCELLANEOUS THERAPIES

There were eighteen miscellaneous, interventions that did not fit in any of the above type of interventions. Studies included Acceptance Based Therapy (ABT) (Marcks & Woods, 2005), Cognitive Therapy (CT) and Behavioural Activation (BA) (Collado et al., 2016; Kanter et al., 2015; Soleimani et al., 2015), Collaborative Care (CC) (Cooper et al., 2013), In – Home Behavioural Management Programme (Gallagher et al., 2007), Narrative Exposure Therapy (NET) (Neuner et al., 2004, 2008), Religious Cultural Psychotherapy (RCP) (Razali et al., 2002), Brief Worry Reappraisal Programme (BWRP) (Mashal et al., 2019), Educational Intervention (EI) (Jacob et al., 2002), Educational Course in Psychological Stresses and Management Skills (ECPSMS) (Li et al., 2018), Psych-educational Programme (PEP) (Chien et al., 2012), Psychological Intervention (PI) (Kim et al., 2017), Rational Emotive Behaviour Therapy (REBT) (Ezeudu et al., 2020), Pre-Natal Depression Intervention (PNDI) (Zhao et al., 2017), Reach Out, Stay Strong, Essentials for new mothers (ROSE) programme (Crockett et al., 2008) and Spiritual (Islamic approach) Psychotherapy (SIPT) (Ebrahimi et al., 2013). Of the eighteen therapies, six were conducted on Asian ethnicities (Chien et al., 2012; Gallagher et al., 2007; Jacob et al., 2002; Kim et al., 2017; Li et al., 2018; Zhao et al., 2017), five with African heritage (Cooper et al., 2013; Crockett et al., 2008; Ezeudu et al., 2020; Marcks & Woods, 2005; Neuner et al., 2004, 2008), one with a mixture of both African and Asian ethnicities (Mashal et al., 2019), three on middle eastern (Iran) ethnicities (Ebrahimi et al., 2013; Razali et al., 2002; Soleimani et al., 2015) and two on Latino populations (Collado et al., 2016; Kanter et al., 2015). Most common outcome measures used were BDI (n = 5) (Collado et al., 2016; Ezeudu et al., 2020; Ebrahimi et al., 2013; Kanter et al., 2015; Marcks & Woods, 2005) and HADS (n = 4) (Chien et al., 2012; Kim et al., 2017; Li et al., 2018; Razali et al., 2002). Fourteen studies showed significant reductions in neurotic symptoms post intervention (Collado et al., 2016; Cooper et al., 2013; Chien et al., 2012; Ebrahimi et al., 2013; Ezeudu et al., 2020; Gallagher et al., 2007; Jacob et al., 2002; Kanter et al., 2015; Kim et al., 2017; Marck & Woods, 2005; Neuner et al., 2004, 2008; Soleimani et al., 2015; Zhao et al., 2017) whilst four studies found no significant changes post intervention (Crockett et al., 2008; Li et al., 2018; Mashal et al., 2019; Razali et al., 2002). Only two studies (Collado et al., 2016; Cooper et al., 2013) reported acceptability with Cooper et al. (2013) reporting significantly higher scores in the intervention group compared to control post intervention compared to Collado et al. (2016) who reported significantly higher scores post intervention compared to baseline in the experimental group but not between groups post intervention.

2.4 DISCUSSION

The aim of the present systematic review was to i) create a taxonomy of common psychological interventions used in BAME groups; ii) identify the psychotherapy with the strongest evidence of effectiveness; iii) synthesise the most common outcome measures that have been used to treat anxiety and depression. The review found that CA-CBT was the most frequently used intervention among BAME populations. Additionally, both CA-CBT (Hedge's $g = 0.96$; n = 18/20) and CBT (Hedge's $g = 1.10$; n = 12) demonstrated reductions in anxiety and depression post intervention. Additionally, fourteen out of eighteen miscellaneous therapies demonstrated significant decreases in anxiety and depression.. Overall, 58 out of the 64 studies, excluding Klein and Richards (2001), demonstrated significant improvements in anxiety and/or depression post intervention with the experimental group showing greater improvement than the control group, demonstrating a large between-group effect size.

2.4.1 CA-CBT & CBT INTERVENTIONS FOR BAME POPULATIONS

Consistent with previous findings (Anik et al., 2021; Arundell et al., 2021; David et al., 2018; Hofmann et al., 2012; Hall et al., 2016) CA-CBT and CBT were the most frequently used psychological interventions for attenuating anxiety and depressive symptoms in BAME populations. Although CBT is considered a "gold standard," this systematic review found an increased number of CA-CBT studies that is congruent with similar increases of CA-CBT studies in preceding research (Anik et al., 2021; Arundell et al., 2021; Hall et al., 2016). There were only two studies (Dwight-Johnson et al., 2011; Hwang et al., 2015) that did not find support for CA-CBT. Dwight-Johnson et al. (2011) insignificant results may be explained by (i) sample size and (ii) that only 44% of the participants completed >6 sessions (out of 8 sessions). Hwang et al. (2015) insignificant result could be explained by (i) small sample size and (ii) although separate therapists in Hwang et al. (2015) study were used to deliver both modes of treatment (i.e., CBT vs CA-CBT), all therapists had experience in ethnic specific clinics thus increasing the possibility that therapists in the control group (CBT) may have inherently altered some underlying components despite being told not to. To note, among the 20 CA-CBT studies reviewed, only one study (Hwang et al., 2015) directly compared CA-CBT against traditional CBT. The remaining studies included control groups consisting of waiting lists or treatment as usual Therefore, results should be treated with caution since there was no active CBT control group in most of the studies. More studies comparing CA-CBT vs CBT are necessary to determine if CA-CBT is more effective than CBT in reducing anxiety and depression symptoms in BAME populations. To note, out of the twenty CA-CBT studies, thirteen included follow-ups (1 month – 1 year) whilst seven studies did not (Hwang et al., 2015; Hinton et al., 2004; Jalal et al., 2020; Jones & Warner, 2011; Lindegaard et al., 2020; Naeem et al., 2014; Shaw et al., 2018). Out of the thirteen interventions that included follow-up, ten presented significant results (Afuwape et al., 2010; Alavi & Hirji, 2020; Ashing & Rosales, 2014; Hinton et al., 2011; Knaevelsrud et al., 2015; Kananian et al., 2020; Karasz et al., 2015; Lindegaard et al., 2019; Naeem et al., 2015; Salamanca-Sanabria et al., 2020), whilst three presented insignificant results (Bedoya et al., 2014; Choi et al., 2012; Dwaight-Johnson et al., 2011). There were only four studies which included CBT interventions with follow up (range from 2 weeks – 3.5 years) (Andersson et al., 2013; Rezvan et al., 2009; Wenhua et al., 2016; Zucker et al., 2006) and only two out of these four interventions found that changes were maintained at follow up (Rezvan et al., 2009; Zucker et al., 2006).

However, as suggested by Hwang et al. (2015) direct comparisons between CBT and CA-CBT present an issue of whether CBT is being compared to CA-CBT with “surface structure adaptations”, such as the translation of texts, ethnic vs ethnic matching or “deep structure adaptations”, such as considering the cultural-specific values, beliefs, ideas and brining that into treatment (Hwang et al., 2015). Therefore, it is not clear whether trials are comparing (i) CBT vs "surface structure adaptations" of CA-CBT or (ii) CBT vs "deep structure adaptations" of CA-CBT which risks creating incongruency with the evidence base. Despite this, all CA-CBT studies apart from one (Salamanca-Sanabria et al., 2020) found high acceptability and low dropout rates which may indicate CA-CBT trustworthiness among BAME communities, consistent with previous literature (Anik et al., 2021; Arundell et al., 2021). All CBT studies reported low dropout rates, but treatment acceptability was only reported in two studies (Chan et al., 2012; Nakao et al., 2018), with one showcasing significant improvement in acceptability post intervention (Chan et al., 2012) whilst the other did not (Nakao et al., 2018). This underscores the need for studies to consistently incorporate treatment acceptability for better intervention comparisons. Nevertheless, factors other than patient acceptability may explain low dropout rates such as (i) study design: studies that have fewer demanding requirements such as fewer study visits or less invasive procedures alongside appropriate incentives or compensation for participation can encourage participants to remain engaged in the study and result in lower dropout rates (Brueton et al., 2013; Gillies et al., 2021); ii) study conduct: poor RCT conduct such as data manipulation, ethical violations and conflicts of interest can also contribute to high dropout rates (Caldwell et al., 2010); and (iii) lack of auditing: the lack of quality assurance measures within the study design, including monitoring and auditing processes, could augment drop-out rates (Brueton et al., 2013; Gillies et al., 2021).

CBT was identified as the most consistently effective psychotherapy for attenuating anxiety and depression in BAME groups. All CBT studies included in the present systematic review resulted in significantly reduced anxiety and depression scores post-intervention, and these reductions were sustained over periods of follow-up ranging from 2 weeks to 3.5 years (Andersson et al., 2013; Rezvan et al., 2009; Wenhua et al., 2016; Zucker et al., 2006) with these studies reporting a large effect size. The efficacy of CBT can be attributed to a range of mechanisms, such as rational emotive behaviour therapy, graded exposure therapy, journaling/thought recording, role playing, behavioural practice, relaxation, and stress reduction techniques (Cuijpers et al., 2016). However, there is evidence to suggest that CBT does not consider the cultural factors (e.g., societal norms) that may influence psychotherapeutic outcomes (Naeem et al., 2015, 2019). This may explain why CBT was chosen as the foundation for cultural adaptation – it is efficient (Aguilera et al., 2018; Leung et al., 2013; Roland, 2014) and cost effective to implement in low-income minority populations (Bennett et al., 2014), it is less complex than other therapies such as IPT (Jesse et al., 2015), and is recommended by National Treatment Guidelines in the US and UK (Naeem et al., 2015).

With regard to interventions that used cultural adaptations without use of the CBT, all four (De Graaff et al., 2020; Huey & Pan, 2006; Hendriks et al., 2020; Pan et al., 2011) showcased significant post intervention outcomes. To note, comparisons to previous research is challenging due to the unique therapy adaptation used in each study. Specifically, CA-Problem Management for Syrian providers (De Graaff et al., 2020), content translation (Hendriks et al., 2020), integration of culturally specific values into therapy (Hendriks et al., 2020; Huey & Pan, 2006) and education for patients (Pan et al., 2011), all differed in methodology and target population. Nonetheless, there are overlapping therapeutic principles between these CA's and CBT which may partly explain their effectiveness. Specifically, psychoeducation, which was present in some form in all four CA interventions, is an element in both CA-CBT (Naeem et al., 2019) and CBT (Hwang et al., 2015), indicating that educational components may have applicability across cultural contexts. Likewise, content translation and integrating cultural values such as "forgiveness" (Hendriks et al., 2020), overlaps with CA-CBT (Naeem et al., 2019) approaches where cultural context is embedded within psychological therapy. As a result, each intervention unveils unique therapeutic designs; however, their underlying principles and components appear similar to well-researched psychological therapies (i.e., CA-

CBT and CBT). Consequently, this similarity attenuates researchers from determining whether the therapy itself was effective or if they were merely simplified versions of more established therapies like CBT (Hwang et al., 2015) and CA-CBT (Naeem et al., 2019).

2.4.2 FROM BROAD TO SPECIFIC: FINE-TUNING CA-CBT FOR INDIVIDUAL BAME POPULATIONS

CA-CBT, which combines ethno-psychotherapy and traditional Western-style CBT, has received a growing interest in in research and practice (Naeem et al., 2019) and clinical practice (e.g., Nafsiyat Intercultural Therapy Centre, 2023), particularly due to the need for a way to accommodate different cultural groups within CBT therapy (Memon et al., 2016). However, challenges remain regarding its costs and adaptation, including determining which elements should be adapted (surface or deep structure) and to what degree (Naeem et al., 2019). Cost effectiveness has not been explored at institutional level for CA-CBT (Naeem et al., 2019) and thus it is unclear whether CA-CBT exceed costs of CBT or other treatment modalities which are important aspects to consider from an organisation standpoint. Moreover, deep structure adaptations (i.e., values, beliefs) compared to surface structure adaptations (i.e., text, ethnicity matching between practitioners and patients) are suggested to have superior results for anxiety and depression as they do not only account for language and ethnic identity matching but also cultural variables such as mental health stigma that un-adapted psychological interventions do not consider (Graham et al., 2014; Memon et al., 2016; Naeem et al., 2019; Sue, 2001). CA-CBT provides clinicians with the opportunity to adopt a multidimensional model of cultural competence that helps them to develop a more suitable therapeutic stance when dealing with marginalised groups by considering their personal lived experiences, values, and perceptions (Sue, 2001). This can serve to bridge the gap between traditional psychotherapeutic axioms and those of different cultures. To note, it is likely that surface structure adaptations were used amongst the included CA-CBT studies, and little is known about which specific type of adaptation incur the most benefits for reducing anxiety, depression or improving PWB.

A key point of consideration is that there is a lack of theoretical underpinning in the development of culturally adapted interventions. Specifically, it is yet unclear, what cultural beliefs/values should researchers/practitioners adapt, or the degree of alteration, to best produce a reduction in psychological outcomes for the ethnic group in question. The Medical Research Council (MRC) (Craig, 2008) framework for development of complex interventions appears to be a compulsory component of CAP, yet it is not obvious how much variance is explained with the structure of the MRC framework towards its effects on the ethnic-specific culture and values of a particular group. Moreover, there was no mention of this framework in the studies included in this systematic review which limits study replicability. Furthermore, specific cultural adaptations, such as ethnic-vs-ethnic matching which was observed in this and previous systematic reviews (Anik et al., 2021; Arundell et al., 2021; Hall et al., 2016) may not provide desirable intervention outcomes. For instance, Smith and Cabral (2011) who examined mental health outcomes across 53 studies demonstrated that achieving an ethnic vs ethnic match between practitioner and client led to a small effect size of client outcomes in mental health treatment which indicates almost no benefit from racial/ethnic matching therapy sessions. Moreover, Rojas-Garcia et al. (2015) studied mental health interventions adapted for minorities with low socioeconomic status which presented lower effect sizes than those shown by majority populations, further emphasising the need to find more effective ways of culturally adapting therapies other than simply manipulating minor changes such as therapist-client ethnic match or language transition alone.

In light of these findings, Hall et al. (2016), suggested that cultural adaptation should focus more on manipulating cultural content or values, but so far there has been no concrete evidence pointing towards better outcomes achieved through such methods. Consequently, making it imperative to develop a new CA framework specifically designed to cater higher levels of cultural specificity needs or refine existing generic frameworks like MRC (Craig, 2008) and conceptual typologies (Arundell et al., 2021) to be geared more towards specific sub-ethnicities in BAME populations. While existing typologies help researchers understand CA at content, therapist, and organisational levels (Arundell et al., 2021), there is no typology that clearly links each adaptation to its effectiveness for the relevant population. Future research should strive towards developing a framework similar to the COM-B model (Michie et al., 2011), that links each CA to different ethnic groups. The utility of such a framework could help practitioners include CA into traditional therapy, such as CBT (Naeem et al., 2016), to amplify treatment adherence, improve therapeutic alliance and treatment outcomes. Additionally, further research is needed to determine whether changes made at a value level yield better results than those achieved through basic manipulations such as translating texts or bridging connections with the same ethnicity. To note, most CA-CBT interventions included in this review either reported using a different framework for cultural adaptation, such as "the formative method for adapting psychotherapy" (FMAP) (Hwang et al., 2015) or described that changing language of a SC manual was considered "cultural adaptation" (Naeem et al., 2014).

Previous systematic reviews such as Anik’s et al. (2021) and Hall’s et al. (2016) mostly focused on the MRC framework for culturally adapting therapies and Arundell et al. (2021) provided a list of common adaptations for various cultural contexts, however no specific advice on how to tailor interventions, nor the degree of adaptation, according to certain values held by certain groups had been provided.

2.4.3 MISCELLANEOUS THERAPIES

Fourteen miscellaneous interventions demonstrated significant reductions in anxiety and depression post intervention (Collado et al., 2016; Cooper et al., 2013; Chien et al., 2012; Ebrahimi et al., 2013; Ezeudu et al., 2020; Gallagher et al., 2007; Jacob et al., 2002; Kanter et al., 2015; Kim et al., 2017; Marck & Woods, 2005; Neuner et al., 2004, 2008; Soleimani et al., 2015; Zhao et al., 2017) whilst four studies did not (Crockett et al., 2008; Li et al., 2018; Mashal et al., 2019; Razali et al., 2002). The miscellaneous therapies that presented significant results exist in agreement to previous research. For instance, previous interventions that looked at the effectiveness of ABT (Vollestad et al., 2012), CT (McManus et al., 2008), BA (Chartier & Provencher, 2013), NET (Lely et al., 2019) and REBT (Noormohamadi et al., 2022) all found significant reductions in anxiety and depression symptoms. To note, Chartier and Provencher (2013), Lely et al. (2019), McManus et al. (2008) and Vollestad et al. (2012) were systematic reviews, included BAME and non-BAME populations thus did not fit the inclusion criteria of this review. Moreover, Noormohamadi et al. (2022) was an RCT lasting 9 weeks but included both BAME and non-BAME populations, thus also did not fit the inclusion criteria. While each of the aforementioned therapies are distinctly named, they likely share mechanisms of action that mitigate anxiety and depression in BAME populations, which may explain the significant outcomes found in this study and previous research (Chartier & Provencher, 2013; Lely et al., 2019; McManus et al., 2008; Noormohamadi et al., 2022; Vollestad et al., 2012). For instance (i) cognitive restructuring – both CT (McManus et al., 2008) and (Noormohamadi et al., 2022) encourage identifying, challenging and replacing maladapting/irrational thoughts and beliefs; (ii) behavioural activation – both CT (McManus et al., 2008) and REBT (Noormohamadi et al., 2022) emphasise increased engagement in activities that exist in opposition to anxiety and depression symptoms; (iii) mindfulness and acceptance – ABT (Vollestad et al., 2012) and CT (McManus et al., 2008) integrates such strategies to help patients manage anxiety and depressive symptoms; and (iv) exposure: NET (Lely et al., 2019) encompasses graded exposure to past experiences similar to aspects of CT (McManus et al., 2008). Conversely, the miscellaneous therapies that presented non-significant results may also be explained by previous research. For example, preceding ROSE studies (Kao et al., 2015) did not find significant reductions in depression like the ROSE study in this intervention (Crockett et al., 2008). Additionally, both authors suggested that study duration may have been an underling reason (3months & 5 weeks, respectively) although more longitudinal findings for ROSE is warranted. On the other hand, the remaining three non-significant miscellaneous therapies (Li et al., 2018; Mashal et al., 2019; Razali et al., 2002) were not standardised (i.e., they are unique or new and have not been replicated in the same manner in preceding research), making direct comparisons to preceding research challenging. Moreover, the lack of significant outcomes in these four miscellaneous therapies collectively may be explained by several factors, including intervention fidelity (Crockett et al., 2008; Li et al., 2018; Mashal et al., 2019; Razali et al., 2002), participant engagement (i.e., attrition rates and challenges in transportation to the intervention site) (Crockett et al., 2008), study duration being less than 6 weeks (Crockett et al., 2008; Li et al., 2018; Mashal et al., 2019) or sample size (Crockett et al., 2008). In comparison, the significant outcomes of interventions like ABT, CT, BA, NET and REBT in BAME populations may be attributed to their long-standing therapeutic principles, shared mechanisms of action and may be more robust across different cultural contexts compared to interventions that are new, have less research behind thus requiring a more nuanced approaches to achieve similar effectiveness in BAME populations, such as ROSE, ECPSMS, BWRP and RCP. While most miscellaneous interventions demonstrated significant reductions in anxiety and depression post intervention, the variability in study outcomes underscore the necessity for continued investigation into the more nuanced therapies (ROSE, ECPSMS, BWRP & RCP) to assess their effectiveness in reducing anxiety and depression in BAME populations.

2.4.4 NEED FOR SUBJECTIVE-WELLBEING MEASURES IN PSYCHOLOGICAL INTERVENTIONS

All studies included in this systematic review, excluding Chaves et al. (2017) and Kananian et al. (2020), and previous reviews (Anik et al., 2021; Arundell et al., 2021; Hall et al., 2016) did not include any studies that used PWB or SWB measures when assessing effectiveness of therapies to mitigate anxiety and depression symptomatology, despite common knowledge that mental health is not merely the absence of disease but also “positive functioning in society” (Boiler et al., 2013; WHO, 2020a) which hints towards an unidimensional view of what is perceived effective in the psychotherapeutic evidence base. With the growing adoption of CA-CBT in the psychotherapeutic setting due to its low attrition rates (Hwang et al., 2015; Jalal et al., 2020; Kananian et al., 2020; Naeem et al., 2014, 2015) and presence of culture as a moderator of psychotherapy (Edge et al., 2016) more RCTs should be conducted, with wellbeing measures, comparing CBT and CA-CBT to determine whether CA-CBT replicates CBT effectiveness for BAME groups. To ensure reliability and validity of the evidence base, it is recommended that the 24-item 5-point BBC Subjective Wellbeing Scale (BBC-SWB) (Pontin et al., 2013) be integrated into interventions alongside the commonly used BDI and HADS measures of anxiety and depression to assess holistically the effects of psychological interventions on mental health. The BBC-SWB scale encompasses three domains of "positive functioning in society" such as "PWB," "physical health and wellbeing" and "relationships'' as well as achieving near perfect reliability coefficients and moderate/strong construct validity measurements for all three wellbeing domains (Pontin et al., 2013). Additionally, this measure has been found to present a moderate/strong inverse relationship with anxiety and depression (Pontin et al., 2013).

2.4.5 EVALUATION OF COMPLEMENTARY, INTERPERSONAL & SELF-CARE BASED THERAPIES

Four out of five complementary (Ghawadra et al., 2020; Hall et al., 2018; Han et al., 2020; Yeung et al., 2017), all IPT (Beeber et al., 2010; Bolton et al., 2003; Gao et al., 2015) and all self-care interventions (Muto et al., 2011; Tol et al., 2020) showcased significant reductions in anxiety and depression post intervention. Conversely, Musa et al. (2021) did not find significant reductions in anxiety and depression, although a gradual reduction was observed at two-month follow-up. Comparing these outcomes to previous research demonstrates consistency in the efficacy of mindfulness-based therapy and Tai-Chi in reducing anxiety and depression (Hofmann et al., 2010; Wang et al., 2014). Additionally, the preceding IPT interventions further emphasise the effectiveness of IPT in diverse cultural settings (Cuijpers et al., 2011), although further trials are warranted to substantiate such claims. Similarly, the findings from the self-care intervention studies align with research endorsing self-help modalities for mitigating anxiety and depression (Farrer et al., 2011). On the other hand, the non-significant outcomes of Musa et al.'s study (2021) exist in opposition to the overall positive trend in mindfulness-based therapies (Hofmann et al., 2010). This may be party explained by variations in study design, sample characteristics or intervention fidelity (Musa et al., 2021). Additionally, there may be possible selection bias as participants who volunteered had pre-existing interest in mindfulness, potentially increasing the likelihood for improvement in the intervention and control group respectively (Musa et al., 2021). Self-care therapies presented promising findings and have clear advantages of low-cost and scalability, key questions still remain regarding its effectiveness (Cuijpers & Schuurmans, 2007; Pilkington & Wieland, 2020). Specifically, (i) the effectiveness of therapist-guided vs. unguided interventions in reducing anxiety and depression in BAME populations (Cuijpers & Schuurmans, 2007; Pilkington & Wieland, 2020); (ii) the optimal amount of therapist intervention needed for significant reductions in anxiety and depression symptoms (Cuijpers & Schuurmans, 2007; Pilkington & Wieland, 2020); and (iii) whether therapist experience influences the effectiveness of self-care interventions (Cuijpers & Schuurmans, 2007; Pilkington & Wieland, 2020). Despite these avenues, integrating self-help (care) interventions into stepped care models is a promising approach to optimise health care delivery and outreach when treating anxiety and depression but should not "replace" traditional therapy or therapists as a first-line treatment.

Given the evidence above, key conclusions can be observed in accordance with aims of this review. In particular, (i) CA-CBT was observed as the most common intervention typology; (ii) both CBT and CA-CBT interventions showcased large between group post intervention effect sizes in favour of the intervention group, however, CA-CBT takes into account culture which is a known moderator of psychological therapy outcomes whereas CBT does not; (iii) BDI and HADS were the most common outcome measures used in this review but future interventions should also consider the BBC-SWB scale, or any other wellbeing measures, to improve the reliability and validity of the psychotherapeutic evidence base.

2.4.6 LIMITATIONS & FUTURE RECOMMENDATIONS

This systematic review adds to previous knowledge by providing a taxonomy of common psychotherapeutic approaches for the management of anxiety and depression in BAME populations – building on the conceptual typology of Arundell et al. (2021). However, this systematic review is not without limitations. Studies included a high female-to-male ratio which may limit generalisability. Additionally, a moderate risk of bias was highlighted, thus outcomes should be interpreted with caution. Furthermore, CA-CBT designs varied making it difficult for replicability. Also, examining psychological interventions in UK BAME groups may not directly inform cultural adaptation in their countries of origin, affecting generalisability (Vahdaninia et al., 2020). Previous researchers have highlighted that studying minority populations in the UK, compared to those in other countries or their own country of origin, is likely to yield distinct scientific results, potentially limiting generalisability (Vahdaninia et al., 2020). While these studies offer valuable insights into potential strategies for effectively reducing anxiety and depression symptomology with BAME populations, the applicability of specific cultural adaptations in the UK context is limited. Consideration should be given to the unique cultural, social, and healthcare systems of the target population to ensure the effectiveness and relevance of cultural adaptations in addressing health inequalities. Nevertheless, future research should (i) utilise more RCTs comparing CBT against CA-CBT to determine if CA-CBT replicates CBT effectiveness for certain minority populations; (ii) prioritise interventions geared towards specific ethnic groups within BAME as “BAME” is not a homogenous group; (iii) identify which cultural adaptation or combination, and degree of alteration, is more effective at mitigating common mental health disorders in BAME populations.

2.5 CONCLUSION

In summary, this systematic review identified effectiveness of psychotherapy in alleviating anxiety and depression among BAME groups. CBT and CA-CBT emerged as the most commonly used treatments for reducing anxiety and depression in BAME populations with both of them showing effectiveness in reducing anxiety and depression Nevertheless, there remains a significant knowledge gap in tailoring interventions to specific ethnicities and addressing cultural taboos and mental health stigma. Understanding the nuances of deep versus surface adaptations, or their combination, is crucial for explaining health outcomes, acceptability, and engagement with mental health services. Rigorous, well-designed RCTS with adequate sample sizes, incorporating fidelity measures and well-being measures are required. Future research should explore health professionals' perspectives on culturally adapted interventions and the challenges associated with their real-world implementation, and their cost-effectiveness.

CHAPTER 3 – STIGMA, ANXIETY, DEPRESSION & SUBJECTIVE WELLBEING IN BAME POPULATIONS: A CROSS-SECTIONAL STUDY

OVERVIEW

This study follows on from findings of the study presented in Chapter 2. The previous chapter (Chapter 2) showcased the findings from a systematic review of psychotherapeutic approaches to mental health in BAME populations. It highlighted three key areas of interest, i) the growing efficacy, usage and implementation of CA-CBT, which is congruent with demographic changes, the presence of diverse societies and a need to accommodate different cultural groups in CBT therapy, where they might otherwise experience barriers to access, ii) calls for the implementation of the developed 24-item 5-point BBC Subjective Wellbeing Scale (BBC-SWB) or any other measure for subjective wellbeing (Pontin et al., 2013) as wellbeing measurements are not sufficiently captured in psychotherapeutic interventions and iii) the need for further psychotherapeutic interventions within BAME groups, black African, black British, black Caribbean were among the least studied ethnic groups.. The systematic review also highlighted that a variable that may exacerbate the challenges of mental illness in BAME groups is negative perceptions towards mental health acknowledgment, acceptance of diagnosis and encouragement towards seeking medical aid (Cheng et al., 2018; Naeem et al., 2019). Additionally, negative stereotyping, mistrust of public services, differences in problem-recognition and strategies to solve mental health predicaments are all components of a larger multivariate equation that predicts "mental health stigma" in BAME groups (Cheng et al., 2018). It is important to note that historically, BAME groups generally held poor perceptions of mental ill-health in the UK as well as in ethnic groups and other countries, in addition to the poor practices, lack of understanding and extreme treatment protocols that befell anyone who was diagnosed (e.g., lobotomy procedure) (Turner et al., 2015). Therefore, stigmatization, lack of acceptance of own and family members mental ill-health is not new. However, with increased understanding of the importance of acknowledging mental ill-health, things have slowly improved over recent decades (PHE, 2018a, 2018b), however in some ethnic groups in the UK, there is a suggestion that this acceptance lags behind (Cheng et al., 2018). Therefore, mental health interventions should consider strategies to overcome the underlying themes of stigma/taboo to improve psychotherapeutic outcomes. The first step towards this could be by examining stigma severity across diverse BAME ethnicities and enhancing comprehension of mental health perceptions within these populations. The resulting insights are anticipated to buttress the macro argument of aiding future researchers to develop a "culturally adapted" (CA) component as an adjunct to CBT for individuals of a specific BAME heritage (e.g., black

African exclusively as opposed to adaptations for BAME populations as one entity – see CRED [2021] report) to undermine barriers and improve psychotherapeutic outcomes. The study presented in this chapter aims to facilitate a closer investigation of stigma between BAME populations and its relationship with anxiety, depression and subjective wellbeing.

3.1 INTRODUCTION

As discussed in Chapter 1 (refer to section 1.9.1 on Mental Health Stigma in BAME populations), stigma refers to a collection of unfavourable attitudes and actions that society holds toward a particular topic (Thornicroft et al., 2007), while mental health stigma pertains specifically to negative perceptions and behaviours directed towards mental illness (Cheng et al., 2018). Whilst many modes of stigma have been reported throughout literature (Bharadwaj et al., 2017; Cheng et al., 2018; PHE, 2018a, 2018b), for instance perceived stigma which is associated with an awareness that society holds negative attitudes or stereotypes towards a specific identity or group (Memon et al., 2016); or internalised stigma which refers to an individual's acceptance of societal stereotypes as their own identity (Clement et al., 2015); Thornicroft et al. (2007) proposed stigma to be a three-factor model. Specifically, Thornicroft et al. (2007) defined stigma as being: (i) problems of knowledge (amplified ignorance or misinformation); (ii) problems of attitudes (prejudice); (iii) problems of behaviour (discrimination). Given the prevalence of discriminatory experiences amongst BAME populations (see Chapter 1 – 1.11.4 Racial Discrimination) and the need to undermine barriers to psychotherapeutic practice with BAME populations (Naeem et al., 2019), problems of behaviour (i.e., discrimination) was emphasised as being a key issue with BAME populations in need of further investigation (Thornicroft et al., 2009). Furthermore, the relevance between mental health stigma and BAME populations is apparent as approximately 1 in 5 adults in the UK are at risk of anxiety and depression symptoms, with these proportions likely even higher among BAME communities (ONS, 2021) due to pre-existing health inequalities. (Codjoe et al., 2019; see Chapter 2 - Introduction section).

Addressing stigma in BAME populations has been illustrated to be important by previous researchers (Farrelly et al., 2014) as insights from three large-scale interventions consistently suggested elevated prevalence of discrimination linked to exacerbated mental illness, amplified health-care costs and reduced life expectancy (Henderson & Thornicroft, 2009; Lasalvia et al., 2013; Thornicroft et al., 2009). The INDIGO schizophrenia study encompassed 732 individuals from various ethnic groups diagnosed with schizophrenia across 27 countries, revealing pervasive discrimination experiences using the Discrimination and Stigma Scale (Thornicroft et al., 2009). The findings showed that 47% encountered discrimination in social relationships, 43% within their families, and 29% in employment-related contexts. Similarly, a study involving 1087 individuals diagnosed with major depressive disorder in 35 countries unveiled that 79% faced discrimination in various aspects of life using the Discrimination and Stigma Scale Version 12 (Lasalvia et al., 2013). Furthermore, the Viewpoint annual survey of users of secondary mental health services in England indicated ongoing challenges (Henderson & Thornicroft, 2009), with 88% reporting discrimination in at least one life domain over the preceding 12 months (Corker et al., 2013) (see section 1.9.1 Mental Health Stigma in BAME populations) – Chapter 1.

Research has also evaluated the relationship between anticipated discrimination and encountered discrimination on individuals in the domains of employment, education, and interpersonal relationships (Henderson & Thornicroft, 2009; Lasalvia et al., 2013; Thornicroft et al., 2009). Whilst literature showcased a positive correlation between anticipated discrimination and previous encounters of discrimination (Henderson & Thornicroft, 2009; Lasalvia et al., 2013), this association was not consistent across all cases (Thornicroft et al., 2009). For instance, in the INDIGO schizophrenia study (Thornicroft et al., 2009), one-third of participants foresaw discrimination in the workplace, despite lacking prior experiences of discrimination in this context. This shows that even without previous experiences, individuals may still fear the experience of discrimination, facilitating unnecessary burden, stress and risk of disease (Thornicroft et al., 2009). Moreover, the consequences of both encountered and anticipated discrimination can be substantial. For instance, in a qualitative examination within the context of the INDIGO schizophrenia study (Rose et al., 2011b), numerous participants articulated sensations of being 'ostracised' and 'ridiculed' by their communities, leading to or intensifying social withdrawal. Moreover, two meta-analyses suggested that encountered discrimination (attributed to any social factor) is associated with diminished mental and physical health (Mak et al., 2007; Pascoe et al., 2009).

Previous research (Henderson & Thornicroft, 2009; Lasalvia et al., 2013; Thornicroft et al., 2009; Rose et al., 2011b) has played a crucial role in comprehending the global scope of experienced discrimination; nevertheless, the applicability of these findings remains uncertain due to relatively small sample sizes in studies (Lasalvia et al., 2013; Thornicroft et al., 2009), low response rates (Corker et al., 2013) and limited participation from BAME populations. Additionally, limited insight exists into the predictors of discrimination, including which BAME population with mental ill-health face a higher likelihood of discrimination, or if there are gender-based or age-based differences in perceived discrimination. Lastly, there are lingering questions regarding the impact of perceived discrimination on psychological functioning (i.e., subjective wellbeing) (Jorm & Reavley, 2013; Ucok et al., 2012). The potential relationship of perceived discrimination on psychological functioning encompasses inquiries into whether BAME populations with low subjective wellbeing report higher levels of perceived stigma severity and whether increased anxiety/depression is associated with increased reports of discrimination.

3.1.1 PERCEIVED ETHNIC DISCRIMINATION

Perceived ethnic discrimination (PED) holds significance in the context of mental health stigma within BAME populations, where it is viewed as a subordinate component of mental health stigma (Gee et al., 2009). Specifically defined as prejudice or unjust treatment based on an individual’s skin colour (Ikram et al., 2015), PED encompasses subtle stigmatising encounters in day-to-day life, particularly affecting individuals from BAME groups (Ikram et al., 2015). This phenomenon is recognised as a chronic source of stress (Williams et al., 2003), demonstrating heightened pernicious effects on BAME populations already diagnosed with pre-existing mental illnesses (Tummala-Nara et al., 2012). Aforementioned literature has emphasised the persistent presence of PED in mental ill-health (Gee et al., 2009; Pascoe et al., 2009; Tummala-Nara et al., 2012; Williams et al., 2003) but, to note that these findings have been derived from studies in the US and thus generalisability to England or European BAME populations is questionable.

In European investigations, a connection has been established between PED and health outcomes. For example, a UK study revealed an association between perceived discrimination and racial harassment with lower self-rated health among ethnic minority groups (Karlsen & Nazroo, 2002a). However, the European Social Survey, spanning 26 countries, did not find an association between PED and self-rated health; notably, this analysis considered the total sample, including both ethnic majority and minority groups (Alvarez-Galvez & Salvador-Carulla, 2013). While fewer studies focused on the relationship between PED and mental health, studies with Spanish and Dutch individuals, albeit on non-random or small adolescent samples, identified associations between PED and adverse mental health outcomes (Agudelo-Suárez et al., 2011; Dijk et al., 2011). Additionally, two UK studies reported a positive association between racial harassment and common mental disorders in ethnic minority groups (Bhui et al., 2005; Karlsen & Nazroo, 2002b) although Hamilton et al. (2016) emphasised that PED may not be the only factor predicting amplified mental health disorders, indicating that long-term unemployment may be an additional factor. Nevertheless, given the positive associations that have been unveiled between PED, common mental health disorders (Bhui et al., 2005; Ikram et al., 2015; Karlsen & Nazroo, 2002b) and mental health stigma (Farrelly et al., 2014) further examination into the interplay between such phenomena is warranted.

3.1.2 IMPACT OF STIGMA ON HEALTH-SEEKING BEHAVIOUR

Mental health stigma leads to delayed health seeking behaviour, further amplifying the risks of adverse health consequences (Codjoe et al., 2019; Memon et al., 2016). More specifically, delays in searching for care in BAME populations may amplify unfavourable treatment outcomes, such as the risk of psychosis, bipolar disorder, major depressive, and anxiety disorders (Boonstra et al., 2012; Dell'Osso et al., 2013; Morgan et al., 2004). Consequently, common occurrences such as non-adherence to treatment plans and early withdrawal from services are associated instances of the delayed onset to start care (Barrett et al., 2008; Nose et al., 2003). Additionally, in low-income populations, popularised in majority with BAME groups, even more individuals are deterred and not treated for mental illness (Wang et al., 2007).

Clement et al. (2015) conducted a systematic review and meta-analysis of quantitative and qualitative studies (n=144) to ascertain the strength and direction between mental health stigma and health-seeking behaviour. The study revealed a small negative effect size between mental health stigma and health-seeking behaviour with internalised (i.e., negative self-perceptions about oneself) and treatment stigma (i.e., stigma associated with seeking aid) being the most associated modes of stigma with attenuated health-seeking behaviour (Clement et al., 2015). Similarly, Schnyder et al. (2017) conducted a systematic review and meta-analysis (n=27) on mental health stigma and active-help seeking and negative relationship between mental health stigma and active-help seeking but emphasised that the strength of the relationship was dependent on the mode of stigma. For example, personal stigma (i.e., personal attitudes towards individuals diagnosed with mental illness), and attitudes towards help-seeking (i.e., stereotypes to those who wish to seek aid) were negatively associated with active-help seeking behaviour compared to self-stigma (i.e., self-directed stereotypes as a consequences of a mental health diagnoses) and public self-stigma (i.e., how individuals perceived to be viewed by their societal group) which revealed no significant associations with active-help seeking (Schnyder et al., 2017). These modes of stigma were also investigated by qualitative research (Mantovani et al., 2017) in African-faith communities in the UK, which highlighted themes of increased perceived difficulty in seeking mental health aid as a consequence of anticipatory judgment and internalised stigma. This frustration among BAME service users often lead them to use Church as the first line of treatment rather than mental health services, mirroring quantitative findings of Schnyder et al. (2017). However, to note that both Clement et al. (2015) and Schnyder et al. (2017) conducted systematic reviews that were not exclusively focused on BAME populations. Therefore, caution should be exercised in applying their outcomes directly to BAME populations. Additionally, Clement et al. (2015) highlighted that the majority of studies included in their synthesis were from high-income countries, limiting the generalisability of their findings. Although Mantovani et al. (2017) investigated African populations, its study design does not establish causality, and it did not specifically address other BAME populations. As a result, further research is needed to understand the nature of stigma severity in BAME populations.

3.1.3 MENTAL HEALTH STIGMA MEASUREMENTS

While published research on mental health stigma has increased over the last two decades (Cheng et al., 2018), there is still a gap on how measures in this field are developed and assessed. A systematic review by Fox et al. (2018) was conducted to critically review the contemporary landscape of mental health stigma measures. Of 957 articles, where at least a single stigma measure was used, Fox et al. (2018) identified 140 stigma measures, comprising of 330 scales or sub-scales, with an average of 36 stigma measures developed per annum since 2004. Additionally, of the 330 scales or sub-scales, two-thirds had not undergone thorough psychometric evaluation (Fox et al., 2018). Furthermore, preceding mental health research has typically investigated stereotypes and discrimination associated with ill mental health, whereas aspects like how individuals with mental illness perceive stigma have been relatively overlooked in research (Fox et al., 2018). In contrast, other research (Borhan et al., 2010a) argued that perceived sigma was well researched, with systematic reviews (Brohan et al., 2010b) (n = 56 studies) showcasing 79% of measurements used targeted perceived stigma, 46% assessed experienced stigma and 33% aimed at discerning self-stigma. Whilst comparison of figures between Fox et al. (2018) and Brohan et al. (2010b) reviews should be interpreted with caution due to differences in study pool size, inclusion and exclusion criteria, these outcomes suggest that whilst aspects of experienced stigma is being measured, there is limited psychometrically valid measures that reliably and validly measure problems in behaviour (i.e., discrimination) associated with mental health stigma (Thornicroft et al., 2007) as discriminatory experiences are perceived as amplified in BAME populations (Lasalvia et al., 2013).

The Discrimination and Stigma Scale (DISC) was developed to reliably and validly measure and address problems in behaviour (i.e., discrimination) and was created by Thornicroft et al. (2009) who showcased stigma as being a three-dimensional model (see introduction section - Thornicroft et al., 2007). The DISC measure focuses on the third model (i.e., discrimination) and further development of the DISC scale was pioneered by Brohan et al. (2011, 2013) in patients who had a diagnosed mental illness of which anxiety and depression were most common (see DISC, 2013 user manual). Consequently, the DISC version 12, a 32-item 4-point Likert scale questionnaire was developed with strong reliability (α = 0.78) and moderate validity coefficients (r = 0.3) for measuring the presence of discrimination and stigma (Brohan et al., 2011, 2013) and thus was utilised in the present study.

3.1.4 RATIONALE FOR THE STUDY

Interventions for BAME populations should consider strategies to overcome the underlying barriers to engagement (provided in Chapter 1 & 2) and negative attitudes towards mental health to improve psychotherapeutic outcomes. To note, while there is substantial research focusing on BAME populations, (i) there is a notable scarcity of studies that specifically investigate individual ethnicities within the BAME umbrella and (ii) stigma and discrimination are factors that are linked with engagement with mental health services but research in stigma and its relationship in individual ethnicities within the BAME is lacking. Specifically, identifying stigma severity between BAME populations would not only support government level initiatives (CRED, 2021) to move away from BAME terminology towards more ethnically centred research outcomes but also provides the opportunity to explore relationships between stigma severity and other common mental health conditions that BAME groups are subject to, such as anxiety and depression, alongside subjective wellbeing as a proxy for health-related quality of life. These outcomes could buttress the macro argument of aiding future researchers to develop a CA component to existing psychotherapy for individuals of a specific BAME group to include culturally acceptable terms and provide motivators that speak to and engage these hard-to-reach communities as there are no studies that provide a comprehensive "plethora" of culturally adapted components for each BAME group. This study aims to ascertain stigma severity between BAME populations by recruiting BAME individuals who have had experience with mental health services to assess stigma severity and its relationship with anxiety, depression and subjective wellbeing.

3.1.5 AIMS & OBJECTIVES

The aims of the present study were to (i) examine differences in stigma, depression, anxiety and subjective wellbeing between ethnicities and age groups and (ii) to assess the relationship between stigma, anxiety, depression, subjective wellbeing and sociodemographic variables.

3.2 METHODS

3.2.1 STUDY DESIGN

The present study used a cross-sectional survey.

3.2.2 PARTICIPANTS

Following approval from the St. Mary's Ethics committee (Appendix 3.8), recruitment commenced in June of 2022 where participants were recruited for the online survey via social media (e.g., Facebook, Instagram, Linked-in), email, word of mouth (Snowball sampling), posters (Appendix 3.3) and were invited to partake based on their ethnic background (i. e. BAME populations), age (i. e. aged 18 and above) and sex (i.e. male or female). Participants were included if (i) they had BAME heritage, (ii) were aged 18 years and above and (iii) confirmed that they had experienced signs of anxiety and/or depression in the last year and had sought out help for this. Participants were excluded if (i) they did not have BAME heritage, (ii) were under the age of 18 and (iii) had not had any experience of anxiety and/or depression and did not seek any help. Participants who did not pass the screening question were thanked for the time and were informed that they could not take part in the study. Participants who were eligible were asked to give consent that they were aged 18 and above prior to participating in the survey (Appendix 3.1). The survey aimed for an estimated sample size of 100 participants as this sample size was used in similar survey-style studies to ensure reliability and validity of data captured (Kotrlik & Higgins, 2001).

3.2.3 MEASURES FOR THE SURVEY

The online survey comprised of three questionnaires: the "Discrimination & Stigma Scale (DISC-12)" (Brohan et al., 2011, 2013) (appendix 3.5), BBC-Subjective Wellbeing Scale (BBC-SWB) (Pontin et al., 2013) (appendix 3.7) and Hospital Anxiety and Depression Scale (HADS) (Wu et al., 2021) (appendix 3.6). Additionally, demographic data was captured such as age, gender, ethnic subgroup (e. g. Black British; Black African; White Asian) and socio-economic status as to substantiate the government's position on transitioning beyond exclusively BAME-related outcomes (i.e., research outcomes that provide recommendations for BAME populations but fail to suggest guidance for the sub-ethnicities within BAME as BAME does not represent a homogeneous group) (CRED, 2021).

The DISC-12 questionnaire was scored as: (i) a mean severity score (0-3) and (ii) a total count score per sub-scale [i.e., unfair treatment scale (0-21), stopping self-scale (0-4), overcoming stigma scale (0-2), positive treatment scale (0-5)] as per Brohan et al. (2011, 2013) study and the DISC-12 user manual (DISC, 2013). The total count score was calculated by recoding all reported instances of stigma to a score of "1" and circumstances with no discrimination to a score of "0". The total count score was calculated as the sum of reported instances of stigma divided by the number of available items (i.e., the number of questions answered) and multiplied by 100, obtaining a percentage of questions in which stigma and discrimination were reported. For instance, if a participant disclosed discrimination/stigma in 19 out of 21 questions in the unfair treatment scale with no missing (i.e., un-answered) items, then the count score would be (19/21) x 100 = 90%. To note, this binary scoring method was recommended as an alternative approach to scoring the DISC scale in the DISC-12 user manual (DISC, 2013) and was utilised in previous research (Henderson et al., 2014). There are no scoring thresholds for the total count score (i.e., higher scores equate to higher perceived stigma levels) (Brohan et al., 2011). With regards to the severity score, there are four classification categories: <1 = minimal discrimination; 1-1.5 = low discrimination; >1.5-2 moderate discrimination; >2 = high discrimination (Brohan et al., 2011, 2013).

The BBC-SWB is a questionnaire by Pontin et al. (2013) and was developed in the UK for populations exposed to common mental health disorders to supply the demand for reliable and valid wellbeing measures to predict subjective wellbeing, as previous measures were considered poor (Pontin et al., 2013) with regards to reliability and validity scores such as: The World Health Organisation Quality of Life Assessment (WHOQOL) (WHO, 1998a), The World Health Organisation Quality of Life Assessment – BREF (WHOQOL – BREF) (WHO, 1998b) and the Euroqol (EuroQol, 1990). The BBC-SWB is comprised of the physical health and wellbeing sub-scale (PHWB), the psychological wellbeing sub-scale (PWB), the relationship sub-scale and total wellbeing scale (BBC-SWB). The total wellbeing scale and each sub-scale were all scored between 1 (low) - 5 (high) and final scores were calculated by summing all answered items per participant to ascertain each case score (Pontin et al., 2013). Subsequently, each case score was summed and then divided by the total number of participants in the study to conclude the sample mean for each sub-scale and total wellbeing scale. There are no scoring thresholds for neither the sub-scales nor total wellbeing scale (i.e., higher scores reflect better levels of well-being within each sub-scale as well as in the overall subjective well-being scale) (Pontin et al., 2013).

The HADS measure is a validated and widely used in both diagnostic and trial-based settings to assess anxiety and depression (Wu et al., 2021) however, to note this survey did not use any of the former measures to diagnoses mental illness. The Anxiety (0-21) and Depression (0-21) sub-scales scores were calculated by summing all answered items per participant to ascertain each case score (Wu et al., 2021). Subsequently, each case score was summed and then divided by the total number of participants in the study to conclude the sample mean for the Anxiety and Depression (HADS) sub-scales. There are three classification categories for the HADS sub-scales: 0-7 = normal; 8-10 = borderline; 11-21 = abnormal case (Wu et al., 2021).

3.2.4 PROCEDURE

The tool for data collection was an online JISC survey, comprised of the “Discrimination & Stigma Scale (DISC-12)” (Brohan et al., 2011, 2013) (Appendix 3.5), BBC-Subjective Wellbeing Scale (BBC-SWB) (Pontin et al., 2013) (Appendix 3.7) and Hospital Anxiety and Depression Scale (HADS) (Wu et al., 2021) (Appendix 3.6). The research took place in England.

3.2.5 STATISTICAL ANALYSIS

Data analysis was carried out using the IBM Statistical Package for Social Sciences (SPSS) version 29 for Windows 11. The significance level was allocated at $p < 0.05$. Raw data was exported from JISC into Microsoft Excel for data cleaning prior to importing into SPSS. Once imported, additional data cleaning and inspection was carried out alongside reverse coding of necessary scale and sub-scale items (Brohan et al., 2011; Pontin et al., 2013; Wu et al., 2021). To enable inferential statistics, the Expectation Maximisation (EM) (Pallant, 2020) technique was used to predict and populate missing data cells as the EM technique is particularly powerful when dealing with data sets that have missing values. The Cronbach's alpha reliability analysis was carried out for all scales to ensure internal consistency scores were appropriate. Frequency statistics were conducted on the entire sample to ascertain percentages (n=%) for categorical sociodemographic variables. Descriptive statistics (means ± SD's) were performed on the total sample and for each ethnicity per sub-scale. Normality tests were performed using the Shapiro-Wilks test (Pallant, 2020) alongside visual inspection of histograms and checking for outliers.

One-way analysis of variance (ANOVA) tests (Pallant, 2020) were carried out to ascertain (i) differences in mean sub-scale scores (i.e., HADS, BBC-SWB, DISC-12) between four ethnic groups (i.e., "Asian & Asian British; Black, Black British", "Caribbean or African"; "Mixed or Multiple Ethnic"; "Arab or Any Other Ethnic Group") and (ii) between different age groups (i.e., 18-29; 30-39; 40-49; 50-59; 60-65 years). Homogeneity of variance was assessed using the Levene's test for equal variance. Post-hoc comparisons were performed using the Bonferroni test. Pearson's Product moment correlations were conducted to ascertain relationships between all variables. To facilitate a regression analysis, dummy variables were created for sociodemographic categorical variables with more than two levels (age, gender, ethnicity, employment status). Multiple enter method linear regressions were performed predict stigma and associated sub-scales (i.e., unfair treatment, stopping self, overcoming stigma, positive treatment) from sociodemographic variables, depression, anxiety and subjective wellbeing. Collinearity was assessed with the Tolerance and Variance of Inflation Factors (VIF), with acceptable Tolerance levels as > 0.1 and VIF levels as < 10 (Pallant, 2020). Assumptions of linearity, normality and homoscedasticity were also checked.

3.3 RESULTS

A total of two-hundred-and-six BAME participants took part in the survey. Two participants were excluded due to not meeting the inclusion criteria and data from two-hundred-and-four participants were used for analysis. Sociodemographic information for the sample is provided in Table 3.1. The majority of the sample were aged 40-49 years, were female, Asian or Asian British and unemployed (Table 3.1).

SAMPLE CHARACTERISTICS

Frequency statistics for the entire sample (n = 204), divided by age , gender, ethnicity groups and employment status are presented in Table 3.1. Specifically, 55.9% of the total sample was between the ages of 40-49 years, 92% of the total sample were female, 51% of the sample were from Asian or Asian British heritage and 37% of the sample reported as being unemployed.

Table 3.1

Participants sociodemographic information (n = 204)

Age Range	**Frequency (n/%)**
18-29 years	6 (2.9)
30-39 years	36 (17.6)
40-49 years	**114 (55.9)**
50-59 years	42 (20.6)
60-65 years	6 (2.9)
Gender	
Male	15 (7.4)
Female	189 (92.6)
Ethnicity Groups	
Asian or Asian British	**104 (51)**
Black, Black British, Caribbean or African	95 (46.6)
Mixed or multiple ethnic groups	2 (1)
Other ethnic group	3 (1.5)
Employment Status	
Employed	49 (24)
Self-employed	41 (20.1)
Unemployed	**76 (37.3)**
Retired	9 (4.4)
Student	3 (1.5)
At-home worker	25 (12.3)
None of the above/other	1 (0.5)

SAMPLE STATISTICS

Table 3.1 presents the means and total scores of perceived stigma and discrimination (DISC-12) for the total sample (n = 204) and according to different ethnic groups. Both the “Asian, or Asian British” and “Black, Black British, Caribbean or African” populations presented > 90% perceived stigma and discrimination across all sub-scales, with 100% percentage scores in the Unfair Treatment (i.e., Asian, or Asian British) and the Stopping Self - for the Black, Black British, Caribbean or African group. The “Mixed or Multiple Ethnic Group” presented 67% percentage scores across all sub-scales and 53% in the Positive Treatment. Lastly, the “Other Ethnic Group” presented > 65% across all sub-scales with 100% percentage scores in the Overcoming Stigma.

Table 3.2

Mean and total scores of perceived stigma and discrimination (DISC- 12) for the total sample (n = 204) and per ethnicity

Sub-Scales (n = 204)	Mean Score	Total Score (%)	Number of Applicable Items	Number of missing items
Unfair Treatment	21	98	4284	0
Stopping Self	4	99	816	0
Overcoming Stigma	2	98	408	0
Positive Treatment	5	93	1020	0
Asian & Asian British (n = 104)				
Unfair Treatment	21	100	2184	0
Stopping Self	4	99	416	0
Overcoming Stigma	2	99	208	0
Positive Treatment	5	95	520	0
Black, Black British, Caribbean or African (n = 95)				
Unfair Treatment	21	99	1995	0
Stopping Self	4	100	380	0
Overcoming Stigma	2	97	190	0
Positive Treatment	5	93	475	0
Mixed or Multiple Ethnic Groups (n = 2)				
Unfair Treatment	21	67	63	0
Stopping Self	4	67	12	0
Overcoming Stigma	2	67	6	0
Positive Treatment	2	53	15	0
Other Ethnic Group (n = 3)				
Unfair Treatment	17	83	63	0
Stopping Self	3	83	12	0
Overcoming Stigma	2	100	6	0
Positive Treatment	3	67	15	0

MEAN DIFFERENCES IN STIGMA, ANXIETY, DEPRESSION, SUBJECTIVE WELLBEING AMONG BAME POPULATIONS

Table 3.3 presents the mean differences in stigma, its subscales, anxiety, depression, and subjective wellbeing among the different ethnic groups. Homogeneity of variance was not assumed for the DISC-12 severity score ($F = 2.86$, $p < 0.05$). The Black, Black British, Caribbean or African populations presented the highest stigma severity score (*M* = 2.11, *SD* = 0.38) and was significantly higher to the Asian or Asian British group (*M* = 1.95, ±*SD* = 0.39, $p < 0.05$) but was not significantly higher to Mixed or Multiple Ethnic groups and the Other Ethnic Group ($p > 0.05$). Homogeneity of variance was not assumed for the Anxiety sub-scale ($F = 2.78$, $p < 0.05$). Anxiety scores were not significantly different between ethnic groups ($p > 0.05$) however, the Asian or Asian British group presented the highest mean anxiety score (*M* = 9.88, ±*SD* = 1.55). Homogeneity of variance was not assumed for the Depression sub-scale ($F = 7.48$, $p < 0.05$). The Asian or Asian British group presented the highest depression score (*M* = 9.31, ±*SD* = 1.41) and was significantly higher compared to the Black, Black British, Caribbean or African group (*M* = 8.43, ±*SD* = 1.53) and the Other Ethnic Group (M = 6.33, ±*SD* = 5.03) but not the Mixed or Multiple Ethnic group ($p > 0.05$). Homogeneity of variance was not assumed for the BBC-SWB scale ($F = 5.36$, $p < 0.05$). The Asian or Asian British group presented the lowest total wellbeing score (*M* = 2.11, ±*SD* = 0.23) and was significantly lower to the Black, Black British, Caribbean or African (*M* = 2.35, ±*SD* = 0.28) and the Other Ethnic Group (*M* = 2.54, ±*SD* = 0.78) but not significantly different to the Mixed or Multiple Ethnic group ($p > 0.05$).There were significant differences between ethnic groups in the Unfair Treatment ($F = 6.615$, $p < 0.05$), Stopping Self ($F = 8.132$, $p < 0.05$), Positive Treatment ($F = 4.707$, $p < 0.05$), Depression ($F = 8.638$, $p < 0.05$), Physical Health & Wellbeing ($F = 6.140$, $p < 0.05$), Psychological Wellbeing ($F = 17.622$, $p < 0.05$), Relationships ($F = 12.380$, $p < 0.05$) and the total BBC-SWB scores ($F = 14.819$, $p < 0.05$). There were no significant differences between groups in the Overcoming Stigma scale ($F = 0.721$, $p > 0.05$) and Anxiety scale ($F = 0.597$, $p > 0.05$). For the Unfair Treatment and the Stopping Self scale, scores were significantly higher for the Asian or Asian British (*M* = 20.94, ±*SD* = 0.34; *M* = 3.95, ±*SD* = 0.25), the Black, Black British, Caribbean or African (*M* = 20.71, ±*SD* = 1.77; *M* = 3.98, ±*SD* = 0.10) and the Mixed or Multiple Ethnic Groups (*M* = 21, ±*SD* = 0.01; *M* = 4, ±*SD* = 0.01) compared to the Other Ethnic Group ($p < 0.05$). For the Positive Treatment scale, scores were significantly higher for the Asian or Asian British (*M* = 4.74, ±*SD* = 0.60) and the Black, Black British, Caribbean or African groups (*M* = 4.66, ±*SD* = 0.66) compared to the Other Ethnic Group (*M* = 3.33, ±*SD* = 2.88; $p < 0.05$) but not for the Mixed or Multiple Ethnic Group ($p > 0.05$). In the Physical Health & Wellbeing sub-scale, the Psychological Wellbeing sub-scale and Relationships sub-scale, scores were significantly lower in the Asian, or Asian British group (*M* = 2.11, ±*SD* = 0.23; *M* = 2.11, ±*SD* = 0.26; *M* = 2.09, ±*SD* = 0.30) compared to Black, Black British, Caribbean or African group (*M* = 2.27, ±*SD* = 0.32; *M* = 2.38, ±*SD* = 0.30; *M* = 2.37, ±*SD* = 0.31; $p < 0.05$). Additionally, for the Psychological Wellbeing scale, scores were significantly lower in the Asian or Asian British group compared to the Other Ethnic Group (*M* = 2.42, ±*SD* = 0.86; $p < 0.05$) however, no other significant differences between groups were found. For the total subjective wellbeing scores were significantly lower for the Asian or Asian British (*M* = 2.11, ±*SD* = 0.23) group compared to the Black, Black British, Caribbean (*M* = 2.34, ±*SD* = 0.28) and the Other Ethnic Group (*M* = 2.54, ±*SD* = 0.78; $p < 0.05$) but no other significant differences between groups were found.

Table 3.3

Differences in mean and SD scores across all scales & sub-scales for the total sample (N=204) and across the four ethnic groups

Sub-scale	**Total sample (n=204)**	**Asian or Asian British (n = 104)**	**Black, Black British, Caribbean or African (n = 95)**	**Mixed or multiple ethnic groups (n = 2)**	**Other ethnic group (n = 3)**
Unfair Treatment	2.20 (0.49)	2.14 (0.47)	2.27 (0.48)	2.12 (0.03)	1.87 (1.18)
Stopping Self	1.98 (0.53)	1.83 (0.51)	2.15 (0.50)	2 (0.01)	2.08 (0.72)
Overcoming Stigma	1.73 (0.58)	1.72 (0.53)	1.74 (0.64)	1.50 (0.02)	1.83 (0.76)
Positive Treatment	1.43 (0.54)	1.35 (0.43)	1.55 (0.60)	1 (0.05)	0.67 (0.58)
Total - DISC (0-3) – Severity Score	2.02 (0.40)	1.95* (0.39)	2.11* (0.38)	1.89 (0.02)	1.71 (0.84)
Anxiety	9.84 (1.79)	9.88 (1.55)	9.84 (1.98)	9 (1.41)	8.67 (3.51)
Depression	8.84 (1.63)	9.31* (1.41)	8.43* (1.53)	7.50 (0.71)	6.33* (5.03)
Physical Health & Wellbeing	2.19 (0.31)	2.11 (0.23)	2.27 (0.33)	2.50 (0.30)	2.43 (0.87)
Psychological Wellbeing	2.25 (0.33)	2.11 (0.27)	2.39 (0.31)	2.13 (0.06)	2.81 (0.79)
Relationships	2.23 (0.35)	2.10 (0.30)	2.37 (0.32)	2.40 (0.57)	2.07 (0.83)
Total subjective wellbeing	2.23 (0.29)	2.11* (0.23)	2.35* (0.28)	2.29 (0.18)	2.54* (0.78)

Note: DISC = Discrimination & Stigma Scale; HADS = Hospital Anxiety & Depression Scale; BBC-SWB = Subject Wellbeing Scale. * Denotes a significance level of $p < 0.05$.

MEAN DIFFERENCES IN STIGMA, DEPRESSION, ANXIETY, SUBJECTIVE WELL-BEING AMONG AGE GROUPS

Table 3.4 represents mean differences in stigma, its subscales, anxiety, depression, subjective wellbeing among the different age groups. Homogeneity of variance was assumed for the DISC-12 severity score ($F = 1.29$, $p > 0.05$). The 60–65-year-olds presented the highest levels of stigma ($m = 2.21$) however this was not significant compared to all other age groups. There were significant differences between age groups and Unfair Treatment ($F = 5.193$; $p < 0.05$), the Stopping Self ($F = 13.263$; $p < 0.05$), the Overcoming Stigma scale ($F = 4.492$; $p < 0.05$), Depression scale ($F = 4.106$; $p < 0.05$), Physical Health & Wellbeing scale ($F = 4.267$; $p < 0.05$), Psychological Wellbeing scale ($F = 4.266$; $p < 0.05$) and the total BBC-SWB scores ($F = 4.636$; $p < 0.05$). No significant differences between age groups were found in the DISC-12 severity score ($F = 0.87$, $p > 0.05$), Positive Treatment scale ($F = 1.369$; $p > 0.05$), and the Relationships scale ($F = 2.179$; $p > 0.05$). The overall ANOVA score for the Anxiety scale was not significant ($F = 2.346$; $p > 0.05$) however, post-hoc tests revealed that scores were significantly higher in the 40-49 years group compared to the 18 – 29 years group ($p < 0.05$). In the Unfair Treatment scale and the Stopping Self scale, scores were significantly lower for the 18-29 years group compared to the 30-39 years, 40-49 years, 50-59 years, and 60-65 years group ($p < 0.05$) but for the BBC-SWB scale, scores were significantly higher in the 18 – 29 years group compared to all other age groups ($p < 0.05$). In the Overcoming Stigma scale, scores were significantly lower in the 60-65 years group compared to the 40-49 years, 50-59 years group ($p < 0.05$). In the Depression scale, scores were significantly higher for the 40-49 years, 50-59 years, 60-65 years group compared to the 18 – 29 years group ($p < 0.05$). In the Physical Health & Wellbeing and the Psychological Wellbeing scale, scores were significantly lower for the 40-49 years, 50-59 years, 60-65 years group compared to the 18 – 29 years group ($p < 0.05$). In the total BBC-SWB scale, scores were significantly lower for the 30-39 years, 40-49 years, 50-59 years, 60-65 years group compared to the 18 – 29 years group ($p < 0.05$).

Table 3.4

Differences in mean and SD scores across all scales & sub-scales for the total sample (N=204) and across age ranges

Sub-Scales	Age Ranges	Number (n)	Mean (m)	Standard Deviation (SD)
Unfair Treatment	18-29	6	18.5	4.3
	30-39	36	20.4	2.9
	40-49	114	21	0.2
	50-59	42	20.9	0.3
	60-65	6	21	0
Stopping Self	18-29	6	3.3	1
	30-39	36	4	0.2
	40-49	114	4	0.2
	50-59	42	4	0
	60-65	6	4	0
Overcoming Stigma	18-29	6	1.8	0.4
	30-39	36	1.9	0.3

	40-49	114	2	0.1
	50-59	42	2	0.2
	60-65	6	1.7	0.8
Positive Treatment	18-29	6	4.5	0.8
	30-39	36	4.4	1.1
	40-49	114	4.7	0.6
	50-59	42	4.7	0.6
	60-65	6	4.8	0.4
Total - DISC (0-3) – Severity Score	18-29	6	1.80	0.63
	30-39	36	2.02	0.43
	40-49	114	2.03	0.37
	50-59	42	2	0.39
	60-65	6	2.21	0.48
Anxiety	18-29	6	7.8	1.9
	30-39	36	9.6	2

	40-49	114	10	1.5
	50-59	42	9.9	2.1
	60-65	6	9.7	2.3
Depression	18-29	6	6.7	4.4
	30-39	36	8.5	1.5
	40-49	114	8.9	1.4
	50-59	42	9.2	1.3
	60-65	6	9.5	1.5
Physical Health & Wellbeing	18-29	6	2.6	0.6
	30-39	36	2.3	0.4
	40-49	114	2.2	0.3
	50-59	42	2.2	0.2
	60-65	6	2	0.4
Psychological Wellbeing	18-29	6	2.7	0.8
	30-39	36	2.3	0.4

	40-49	114	2.2	0.3
	50-59	42	2.2	0.3
	60-65	6	2.1	0.4
Relationships	18-29	6	2.6	0.9
	30-39	36	2.3	0.4
	40-49	114	2.2	0.3
	50-59	42	2.2	0.3
	60-65	6	2.1	0.3
Total Subjective Wellbeing (BBC-SWB)	18-29	6	2.7	0.7
	30-39	36	2.3	0.4
	40-49	114	2.2	0.2
	50-59	42	2.2	0.2
	60-65	6	2.1	0.3

PEARSON'S CORRELATION COEFFICIENT BETWEEN ALL VARIABLES

Unfair Treatment scores were positively associated with Stopping Self sub-scale scores (*r* = 0.38, p < 0.05), Overcoming Stigma (*r* = 0.25, p < 0.05), Positive Treatment (*r* = 0.26, p < 0.05), and Depression scores (*r* = 0.19, p < 0.05) and was negatively associated with Psychological Wellbeing scores (*r* = -0.13, p < 0.05) (Table 3.5). Stopping Self subscale scores were positively associated with Anxiety (*r* = 0.19, p < 0.05) and Depression scores (*r* = 0.43, p < 0.05), and negatively associated with Physical Health & Wellbeing (*r* = -0.40, p < 0.05), Psychological Wellbeing (*r* = -0.42, p < 0.05) and Relationships scores (*r* = -0.40, p < 0.05) (Table 3.5). Overcoming Stigma scores were positively associated with Physical Health & Wellbeing (*r* = 0.19, p < 0.05), Psychological Wellbeing (*r* = 0.14, p < 0.05) and Relationships scores (*r* = 0.20, p < 0.05) (Table 3.5). Positive Treatment scores were positively associated with Physical Health & Wellbeing (*r* = 0.17, p < 0.05), and Relationships scores (*r* = 0.10, p < 0.05) (Table 3.5). Anxiety was positively associated with Depression scores (*r* = 0.31, p < 0.05), and negatively with Physical Health & Wellbeing (*r* = -0.26, p < 0.05), Psychological Wellbeing (*r* = -0.25, p < 0.05), and Relationships scores (*r* = -0.16, p < 0.05) (Table 3.5). Depression was positively associated with physical health & Wellbeing (*r* = -0.34, p < 0.05), Psychological Wellbeing (*r* = -0.40, p < 0.05), and negatively associated with Relationships scores (*r* = -0.31, p < 0.05) (Table 3.5). Physical Health & Wellbeing scores cale were positively associated with Psychological Wellbeing (*r* = 0.66, p < 0.05) and Relationships scores (*r* = 0.65, p < 0.05) (Table 3.5). Psychological Wellbeing scores were positively associated with the Relationships scores (*r* = 0.69, p < 0.05) (Table 3.5).

Table 3.5

Correlation matrix demonstrating the relationships between all psychological variables

Correlations	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
1. Unfair Treatment	-							
2. Stopping Self	0.38^{**}	-						
3. Overcoming Stigma	0.25^{**}	-0.03	-					
4. Positive Treatment	$.026^{**}$	-0.05	0.08	-				
5. Anxiety	0.00	0.19^{**}	0.08	-0.06	-			
6. Depression	0.19^{**}	0.43^{**}	-0.03	-0.01	0.31^{**}	-		
7. Physical Health & Wellbeing	0.01	-0.40^{**}	0.19^{**}	0.17^{*}	-0.26^{**}	-0.34^{**}	-	
8. Psychological Wellbeing	-0.13^{*}	-0.42^{**}	0.14	0.00	-0.25^{**}	-0.40^{**}	0.66^{**}	-
9. Relationships	-0.08	-0.40^{**}	0.20^{**}	0.10	-0.16^{*}	-0.31^{**}	0.65^{**}	0.69^{**}

RELATIONSHIPS BETWEEN SOCIO-DEMOGRAPHIC, PSYCHOLOGICAL VARIABLES & STIGMA (TOTAL SEVERITY SCORE)

The regression model revealed that predictor variables accounted for 7% of variance observed in stigma severity ($R^2_{adj}=0.07$) and was significant ($F=1.85$, $p < 0.05$). At home workers were more likely to report perceived discrimination/stigma compared to employed individuals (($p < 0.05$). Additionally, Black, Black British, Caribbean or African were more likely to report higher stigma compared to Asian & Asian British populations ($p < 0.05$) with unstandardized beta coefficients indicating a positive relationship with the outcome variable (Table 3.6).

Table 3.6

Multiple regression analysis summary predicting stigma severity score from sociodemographic and psychological variables

Subscales	Unstandardized Coefficients (β) ± (Std. Error)	t	Sig.	95% Confidence Interval (β)	
Anxiety	0.01 (0.02)	0.34	0.74	-0.03	0.04
Depression	0.00 (0.02)	-0.02	0.99	-0.04	0.04
Physical Health & Wellbeing	0.00 (0.13)	0.02	0.98	-0.26	0.27
Psychological Wellbeing	0.04 (0.14)	0.31	0.76	-0.23	0.32
Relationships	-0.22 (0.13)	-1.72	0.09	-0.47	0.03
30-39 years	-0.06 (0.19)	-0.30	0.76	-0.42	0.31
40-49 years	0.06 (0.18)	0.32	0.75	-0.29	0.41
50-59 years	-0.04 (0.19)	-0.23	0.81	-0.41	0.32
60-65 years	0.08 (0.28)	0.27	0.78	-0.48	0.64
Gender	0.18 (0.11)	1.66	0.10	-0.03	0.40
Self-employed	-0.08 (0.08)	-0.91	0.36	-0.24	0.09
Unemployed	0.03 (0.07)	0.40	0.69	-0.11	0.17
Retired	0.06 (0.19)	0.34	0.73	-0.31	0.44
Student	-0.30 (0.25)	-1.20	0.23	-0.80	0.20
At-home worker	0.21 (0.10)	2.12	0.04*	0.01	0.40
None of the above/other	-0.48 (0.39)	-1.21	0.23	-1.25	0.30
Black, Black British, Caribbean or African	0.26 (0.07)	3.71	0.00*	0.12	0.40
Mixed or multiple ethnic groups	-0.03 (0.28)	-0.12	0.91	-0.59	0.52
Other ethnic group	-0.18 (0.25)	-0.71	0.48	-0.68	0.32

Note: HADS = Hospital Anxiety & Depression Scale; BBC-SWB = Subject Wellbeing Scale. * Denotes a significance level of $p < 0.05$

RELATIONSHIPS BETWEEN SOCIO-DEMOGRAPHIC, PSYCHOLOGICAL VARIABLES & PERCEIVED UNFAIR TREATMENT

The regression model revealed that predictor variables accounted for 20% of variance observed in perceived unfair treatment (R^2_{adj}=0.20) and was significant (F=3.67, $p < 0.05$). Those in the 40-49 year ($p < 0.05$), 50 – 59-year group ($p < 0.05$), and females $p < 0.05$) were more likely to report perceived unfair treatment compared to their 18-29 years old group and males). Additionally, the Other Ethnic Group ($p < 0.05$) was less likely to report perceived unfair treatment compared to its Asian or Asian British). Physical health and wellbeing was a significant predictor of unfair treatment indicating a positive relationship (Table 3.7).

Table 3.7

Multiple regression analysis summary predicting stigma severity score from sociodemographic and psychological variables

Subscales	Unstandardized Coefficients (β) ± (Std. Error)	t	Sig.	95% Confidence Interval (β)	
Anxiety	-0.07 (0.06)	-1.27	0.21	-0.19	0.04
Depression	0.09 (0.07)	1.31	0.19	-0.05	0.22
Physical Health & Wellbeing	1.20 (0.45)	2.63	0.01*	0.30	2.09
Psychological Wellbeing	-0.07 (0.48)	-0.14	0.89	-1.01	0.88
Relationships	-0.82 (0.44)	-1.88	0.06	-1.68	0.04
30-39 years	1.19 (0.63)	1.88	0.06	-0.06	2.44
40-49 years	1.84 (0.61)	3.02	0.00*	0.64	3.03
50-59 years	1.51 (0.64)	2.37	0.02*	0.25	2.77
60-65 years	1.44 (0.97)	1.49	0.14	-0.47	3.35
Gender	1.57 (0.37)	4.20	0.00*	0.83	2.31
Self-employed	-0.16 (0.28)	-0.56	0.58	-0.72	0.40
Unemployed	-0.09 (0.25)	-0.37	0.71	-0.58	0.39
Retired	0.19 (0.64)	0.29	0.77	-1.08	1.46
Student	-0.20 (0.86)	-0.23	0.82	-1.90	1.50
At-home worker	0.08 (0.33)	0.23	0.82	-0.58	0.74
None of the above/other	-0.04 (1.34)	-0.03	0.98	-2.69	2.61
Black, Black British, Caribbean or African	0.17 (0.24)	0.73	0.47	-0.30	0.64
Mixed or multiple ethnic groups	-0.24 (0.96)	-0.25	0.80	-2.14	1.66
Other ethnic group	-2.68 (0.86)	-3.12	0.00*	-4.38	-0.99

Note: HADS = Hospital Anxiety & Depression Scale; BBC-SWB = Subject Wellbeing Scale. * Denotes a significance level of $p < 0.05$

RELATIONSHIPS BETWEEN SOCIO-DEMOGRAPHIC, PSYCHOLOGICAL VARIABLES & PERCEIVED SELF-CENSORSHIP/RESTRICTION

The regression model revealed that predictor variables accounted for 48% of variance observed in self-censorship ($R^2_{adj}=0.48$) and was significant ($F=10.92$, $p < 0.05$). Those in the 30–39-year group ($p < 0.05$), 40-49 year group ($p < 0.05$), 50-59 year group ($p < 0.05$) and the Black, Black British, Caribbean or African group ($p < 0.05$) were all more likely to report perceived self-censorship compared to the 18-29 years old group and the Asian or Asian British group). Additionally, the Other Ethnic Group ($p < 0.05$) was less likely to report perceived self-censorship compared to the Asian or Asian British group). Depression ($p < 0.05$) and Relationships ($t = -3.64$, $p < 0.05$) were significant predictors of self-censorship. Higher depression was associated with higher perceived self-censorship and higher relationships scores were associated will lower self-censorship (Table 3.8).

Table 3.8

Multiple regression analysis summary predicting stigma severity score from sociodemographic and psychological variables

Subscales	Unstandardized Coefficients (β) ± (Std. Error)	t	Sig.	95% Confidence Interval (β)	
Anxiety	-0.01 (0.01)	-0.79	0.43	-0.02	0.01
Depression	0.04 (0.01)	4.79	0.00*	0.03	0.06
Physical Health & Wellbeing	-0.06 (0.06)	-0.98	0.33	-0.18	0.06
Psychological Wellbeing	-0.04 (0.06)	-0.66	0.51	-0.17	0.08
Relationships	-0.21 (0.06)	-3.64	0.00*	-0.33	-0.10
30-39 years	0.31 (0.08)	3.73	0.00*	0.15	0.48
40-49 years	0.33 (0.08)	4.15	0.00*	0.18	0.49
50-59 years	0.32 (0.08)	3.78	0.00*	0.15	0.49
60-65 years	0.21 (0.13)	1.60	0.11	-0.05	0.46
Gender	0.01 (0.05)	0.21	0.83	-0.09	0.11
Self-employed	-0.03 (0.04)	-0.70	0.49	-0.10	0.05
Unemployed	-0.01 (0.03)	-0.21	0.83	-0.07	0.06
Retired	0.04 (0.09)	0.46	0.65	-0.13	0.21
Student	-0.22 (0.11)	-1.93	0.05	-0.45	0.00
At-home worker	-0.02 (0.04)	-0.40	0.69	-0.11	0.07
None of the above/other	0.13 (0.18)	0.74	0.46	-0.22	0.48
Black, Black British, Caribbean or African	0.15 (0.03)	4.73	0.00*	0.09	0.21
Mixed or multiple ethnic groups	0.18 (0.13)	1.42	0.16	-0.07	0.43
Other ethnic group	-0.37 (0.11)	-3.20	0.00*	-0.59	-0.14

Note: HADS = Hospital Anxiety & Depression Scale; BBC-SWB = Subject Wellbeing Scale. * Denotes a significance level of $p < 0.05$

RELATIONSHIPS BETWEEN SOCIO-DEMOGRAPHIC, PSYCHOLOGICAL VARIABLES & OVERCOMING STIGMA

The regression model revealed that predictor variables accounted for 19% of variance observed in the overcoming stigma scale ($R^2_{adj}=0.19$) and was significant ($F=3.51$, $p < 0.05$). Those in the 40-49 year ($p < 0.05$) and retired ($p < 0.05$) were more likely to report higher overcoming stigma scores compared to the 18-29 years old group and those in employment. Additionally, those in the 60–65-year group ($p < 0.05$) and the Black, Black British, Caribbean or African ($p < 0.05$) were less likely to report higher overcoming stigma scores compared to the 18-29 years and the Asian or Asian British group (Table 3.9).

Table 3.9

Multiple regression analysis summary predicting stigma severity score from sociodemographic and psychological variables

Subscales	**Unstandardized Coefficients (β) ± (Std. Error)**	**t**	**Sig.**	**95% Confidence Interval (β)**	
Anxiety	0.01 (0.01)	1.39	0.17	-0.01	0.03
Depression	-0.01 (0.01)	-0.50	0.61	-0.03	0.02
Physical Health & Wellbeing	0.09 (0.07)	1.28	0.20	-0.05	0.22
Psychological Wellbeing	0.06 (0.07)	0.77	0.44	-0.09	0.20
Relationships	0.11 (0.07)	1.67	0.10	-0.02	0.24
30-39 years	0.17 (0.10)	1.82	0.07	-0.01	0.36
40-49 years	0.24 (0.09)	2.59	0.01*	0.06	0.42
50-59 years	0.20 (0.10)	2.06	0.04	0.01	0.39
60-65 years	-0.32 (0.15)	-2.16	0.03*	-0.60	-0.03
Gender	0.09 (0.06)	1.68	0.10	-0.02	0.21
Self-employed	-0.02 (0.04)	-0.41	0.68	-0.10	0.07
Unemployed	-0.05 (0.04)	-1.43	0.15	-0.13	0.02
Retired	0.32 (0.10)	3.26	0.00*	0.12	0.51
Student	-0.12 (0.13)	-0.95	0.34	-0.38	0.13
At-home worker	0.00 (0.05)	0.01	0.99	-0.10	0.10
None of the above/other	-0.06 (0.20)	-0.31	0.75	-0.46	0.34
Black, Black British, Caribbean or African	-0.08 (0.04)	-2.10	0.04*	-0.15	0.00
Mixed or multiple ethnic groups	-0.04 (0.15)	-0.26	0.79	-0.33	0.25
Other ethnic group	0.06 (0.13)	0.47	0.64	-0.20	0.32

Note: HADS = Hospital Anxiety & Depression Scale; BBC-SWB = Subject Wellbeing Scale. * Denotes a significance level of $p < 0.05$

RELATIONSHIPS BETWEEN ALL SCALES, SUB-SCALES, SOCIO-DEMOGRAPHIC VARIABLES & ITS SIGNIFICANCE IN PREDICTING THE PERCEIVED EXPERIENCES OF POSITIVE TREATMENT

The regression model revealed that predictor variables accounted for 8% of variance observed in positive treatment scores ($R^2_{adj}=0.08$) and was significant ($F=1.95$, $p < 0.05$). The Mixed or Multiple Ethnic Group ($p < 0.05$) and those in the Other Ethnic Group ($p < 0.05$) were less likely to report higher positive treatment scores compared to the Asian or Asian British group. Physical health and wellbeing ($p < 0.05$) was a significant predictor of for positive treatment. Higher Physical health and wellbeing was associated with higher positive treatment (Table 3.10).

Table 3.10

Multiple regression analysis summary predicting stigma severity score from sociodemographic and psychological variables

Subscales	Unstandardized Coefficients (β) ± (Std. Error)	t	Sig.	95% Confidence Interval (β)	
Anxiety	-0.02 (0.03)	-0.53	0.60	-0.08	0.04
Depression	-0.02 (0.04)	-0.62	0.54	-0.09	0.05
Physical Health & Wellbeing	0.80 (0.24)	3.36	0.00*	0.33	1.27
Psychological Wellbeing	-0.30 (0.25)	-1.19	0.24	-0.79	0.20
Relationships	-0.04 (0.23)	-0.18	0.85	-0.49	0.41
30-39 years	0.04 (0.33)	0.11	0.91	-0.62	0.69
40-49 years	0.35 (0.32)	1.10	0.27	-0.28	0.98
50-59 years	0.28 (0.33)	0.85	0.40	-0.37	0.94
60-65 years	0.55 (0.51)	1.09	0.28	-0.45	1.55
Gender	-0.04 (0.20)	-0.18	0.86	-0.42	0.35
Self-employed	-0.01 (0.15)	-0.09	0.93	-0.31	0.28
Unemployed	-0.08 (0.13)	-0.65	0.51	-0.34	0.17
Retired	-0.04 (0.34)	-0.12	0.90	-0.70	0.62
Student	-0.12 (0.45)	-0.28	0.78	-1.01	0.76
At-home worker	0.13 (0.17)	0.75	0.45	-0.21	0.48
None of the above/other	0.01 (0.70)	0.02	0.99	-1.37	1.40
Black, Black British, Caribbean or African	-0.05 (0.12)	-0.43	0.67	-0.30	0.19
Mixed or multiple ethnic groups	-1.06 (0.50)	-2.09	0.04*	-2.05	-0.06
Other ethnic group	-1.35 (0.45)	-3.01	0.00*	-2.24	-0.47

Note: HADS = Hospital Anxiety & Depression Scale; BBC-SWB = Subject Wellbeing Scale. * Denotes a significance level of $p < 0.05$

SUMMARY OF RESULTS:

TOTAL SAMPLE CHARACTERISTICS

- The total sample showcased high levels of discrimination (severity score >2 = high discrimination; Brohan et al., 2011, 2013; Table 3.3).
- The total sample showcased borderline abnormal anxiety and depression levels (HADS score 8-10 = borderline abnormal; Wu et al., 2021; Table 3.3).
- The total sample showcased below median subjective wellbeing scores (SWB score < 3 = below median; Pontin et al., 2013; Table 3.3).

DIFFERENCES:

ETHNICITY DIFFERENCES:

- Black, Black British, Caribbean or African populations presented the highest levels of stigma compared to all other ethnicities and was significantly higher to the Asian or Asian British group.
- For the Unfair Treatment and the Stopping Self scale, scores were significantly higher for the Asian or Asian British, the Black, Black British, Caribbean or African and the Mixed or Multiple Ethnic Groups compared to the Other Ethnic Group.
- For the Positive Treatment scale, scores were significantly higher for the Asian or Asian British and the Black, Black British, Caribbean or African groups compared to the Other Ethnic Group.
- No significant differences between ethnic groups were observed for anxiety.
- The Asian or Asian British population presented the highest levels of depression compared to all other ethnicities and was significantly higher to the Black, Black British, Caribbean or African populations and the Other Ethnic Group.
- The Asian or Asian British population presented the lowest levels of subject wellbeing compared to all other ethnicities and was significantly lower compared to the Black, Black British, Caribbean or African populations and the Other Ethnic Group.
- In the Physical Health & Wellbeing sub-scale, the Psychological Wellbeing sub-scale and Relationships sub-scale, scores were significantly lower in the Asian, or Asian British group compared to Black, Black British, Caribbean or African group ($p < 0.05$).
- Additionally, for the Psychological Wellbeing scale, scores were significantly lower in the Asian or Asian British group compared to the Other Ethnic Group ($p < 0.05$).

AGE GROUP DIFFERENCES:

- In the Unfair Treatment scale and the Stopping Self scale, scores were significantly lower for the 18-29 years group compared to the 30-39 years, 40-49 years, 50-59 years, and 60-65 years group.
- In the Overcoming Stigma scale, scores were significantly lower in the 60-65 years group compared to the 40-49 years, 50–59-year group.
- In the Anxiety scale, scores were significantly higher in the 40-49 years group compared to the 18 – 29 years group.
- In the Depression scale, scores were significantly higher for the 40-49 years, 50-59 years, 60-65 years group compared to the 18 – 29 years group.
- In the Physical Health & Wellbeing and the Psychological Wellbeing scale, scores were significantly lower for the 40-49 years, 50-59 years, 60-65 years group compared to the 18 – 29 years group.
- In the BBC-SWB scale, scores were significantly higher in the 18 – 29 years group compared to all other age groups.

ETHNICITY ASSOCIATIONS

- Black, Black British, Caribbean or African populations were more likely to report stigma and self-censorship but less likely to report overcoming stigma, compared to Asian or Asian British populations.
- The Mixed or Multiple Ethnic Groups and Other Ethnic group were less likely to report higher positive treatment scores compared to Asian or Asian British groups.
- Higher Anxiety was associated with higher stopping self-scores.
- Higher Depression was associated with higher stopping self (self-censorship) and unfair treatment scores.
- Anxiety and Depression was negatively associated with the PHWB, PWB and Relationships sub-scales.
- The PHWB, PWB and Relationship sub-scales were inversely related with Unfair treatment and Stopping-Self sub-scales compared
- Overcoming stigma was positive associated with the Positive Treatment sub-scale.

SOCIODEMOGRAPHIC VARIABLE ASSOCIATIONS:

- Those in the 40-49 year and 50 – 59-year group were more likely to report perceived unfair treatment compared to the 18-29 year group.

- Those in the 40–49-year-olds were more likely to report overcoming stigma scores compared to 18-29 year old whilst 60-65 year olds were less likely.
- Those who were retired were more likely to report overcoming stigma than being in employment.
- Females were more likely to report perceived unfair treatment compared to males.

3.4 DISCUSSION

The aims of the present study were to (i) examine differences in stigma, depression, anxiety and subjective wellbeing between ethnicities and age groups and (ii) to assess the relationship between stigma, anxiety, depression, subjective wellbeing and sociodemographic variables.

Additionally, this study offers novel insights into psychometric differences between distinct BAME groups. Results showed high stigma and discrimination levels, borderline abnormal anxiety and depression, and below median subjective wellbeing levels for the whole sample (i.e., indicating that, on average, the level of wellbeing within the sample was relatively low). Black, Black British, Caribbean or African groups presented significantly higher stigma severity score compared to compared to the Asian or Asian British group. The Asian or Asian British group reported, significantly higher depression and slower wellbeing scores compared to the Black, Black British, Caribbean or African group. Additional results showcased a significant positive relationship between unfair treatment with depression and psychological wellbeing sub-scales and a significant negative relationship with the psychological wellbeing sub-scale; a significant positive relationship between the stopping self-scale with anxiety, depression and a significant negative relationship with physical health, psychological wellbeing and relationships sub-scales; a significant positive relationship between the overcoming stigma sub-scale with the physical health, psychological wellbeing and relationships sub-scales; and a significant positive relationship between the positive treatment sub-scale with the physical health and relationships sub-scale. Furthermore, working from home and being in the Black British, Caribbean or African group was significantly associated with higher perceived stigma compared to employed individuals and Asian and Asian British groups, respectively. Additionally, being between the ages of 40-59 years and being female was significantly associated with higher unfair treatment compared to the 18-29 years male group. Moreover, the Other Ethnic group was significantly associated with higher unfair treatment compared the Asian or Asian British group. Being 40–49-years and retired was significantly associated with higher overcoming stigma scores compared to the 18-29 year and employed groups. Conversely, being 60–65-years and Black British, Caribbean or African populations was significantly associated with lower overcoming stigma scores compared to the 18-29 years and Asian or Asian British groups. For self-censorship (48% explained variance), Being between the ages of 30-59 year and Black British, Caribbean or African was significantly associated with higher perceived self-censorship compared to 18-29 years and Asian or Asian British groups. On the other hand, the Other Ethnic group was significantly associated with lower perceived self-censorship compared to the Asian or Asian British group. Moreover, higher depression was significantly associated with increased self-censorship, while higher relationship scores were significantly associated with reduced self-censorship. The Mixed or Multiple Ethnic groups and the Other Ethnic group was significantly associated with lower positive treatment scores compared to the Asian or Asian British group. Furthermore, higher PHWB scores were significantly associated with positive treatment.

3.4.1 STIGMA SEVERITY, ANXIETY, DEPRESSION & WELLBEING ACROSS BAME ETHNICITIES & AGE GROUPS

The present study found that the Black, Black British, Caribbean, or African group had the highest stigma severity scores among the distinct BAME groups, alongside being significantly higher than the Asian or Asian British group. However, other studies have shown conflicting results. Ikram (2015) conducted a cross-sectional study that aimed to quantify the contribution of perceived ethnic discrimination to depression among five ethnic groups (ethnic Dutch, South Asian Surinamese, African Surinamese Ghanaians, Turkish; n = 6546), in Amsterdam. They found that the African Surinamese group presented the highest level of perceived ethnic discrimination, but the Asian Surinamese and Turkish group to have the highest prevalence of depressive symptoms and major depressive disorder (Ikram, 2015). Similarly, Bhui et al. (2015) study aimed to examine the association between perceived ethnic discrimination and common mental disorders among six ethnic groups (White British, Black Caribbean, Indian, Pakistani, Bangladeshi, Irish) in the UK using a national sample (n = 2054). Strongest associations between reported unfair treatment and mental health risk were observed in the Black Caribbean, Indian, Bangladeshi and Irish groups, with the Indian and Bangladeshi groups presenting the highest odds ratios (Bhui et al., 2015). Eylem et al. (2020) study aimed to systematically review (n = 29) and meta-analyse the literature on differences in mental illness stigma between racial minorities and majorities, using cross-sectional studies. They found that racial minorities (i.e., Black African, Asian, Hispanic) experienced higher levels of mental illness stigma compared to racial majorities (i.e., White & Caucasians) but found no variability in mental health stigma between distinct races (Eylem et al., 2020). From the preceding evidence (Bhui et al., 2005; Eylem et al., 2020; Ikram et al., 2015) racial minorities (BAME) clearly face more stigma and discrimination than racial majorities (non-BAME). However, it remains unclear which specific ethnicity experiences the highest stigma and, consequently, the greatest risk of disease.

It is challenging to ascertain the underlying reasons for the conflicting results between previous research (Bhui et al., 2005; Eylem et al., 2020; Ikram et al., 2015) and the present study due to a variety of reasons. While Bhui et al. (2005) conducted their study in the UK, making their findings more relevant to this study's outcomes due to regional similarities, the intervention of Ikhram (2015) does not offer the same level of applicability. Moreover, the lack of distinct racial differences in mental health stigma in Eylem et al. (2020) systematic review may be explained by other moderating factors, such as acculturation, which could have affected the analysis. Furthermore, the DISC-12 was not used in any of the preceding studies thus, results should be interpreted with caution. To note, Eylem et al. (2020) review did included studies that utilised the Internalised Stigma Scale, Community Attitudes Towards Mental Illness Scale, Perceived Devaluation and Discrimination Scale, and Depression Stigma Scale which are all scales that may measure similar aspects to the DISC-12 (e.g., unfair treatment), enhancing the applicability of their findings to the current study. Still, as suggested by Brohan (2011), what may explain the inconsistent ethnic discrimination (Bhui et al., 2005; Ikram et al., 2015) and stigma severity outcomes (Eylem et al., 2020) of the former studies and current study is likely to be multifaceted and complex. For instance, preceding literature has suggested that stigma severity varies amongst individual ethnicities within the BAME umbrella (CRED, 2021). In particular, the degree of variation in stigma severity is mediated by cultural context (Codjoe et al., 2021), historical experiences (Cheng et al., 2018) and societal perceptions (Memon et al., 2016). Therefore, it is likely that what may explain higher stigma severity in Black, Black British, Caribbean, or African group in this study is a consequence of multivariate phenomena. Alongside external factors, a change in self-identity (i.e., seeing oneself as mentally ill as opposed to healthy) and perceived unique challenges associated with this identity may also partly explain the stigma severity score (Conner et al., 2010). For example, Conner et al. (2010) reported findings of unique challenges, such as seeking aid as a last resort, myths associated with mental health treatment, historical mistreatment/racism in black African individuals seeking mental health advice that may amplify perceived stigma severity compared to other ethnicities. These findings could be further applied to the underlying context of the present study however, Conner et al. (2010) was qualitative in nature and thus, no causality may be established. For context, having a high stigma severity score (>2), has no defined meaning but is suggested by Brohan et al. (2011) but suggests there is additional empirical support (West et al., 2010) indicating that the severity of stigma exerts a pervasive impact across various aspects of the lives of individuals grappling with mental illness such as low self-esteem (Corrigan et al., 2006, Lysaker et al., 2008; Werner et al., 2008), fragmenting social relationships (Yanos et al., 2008), reducing treatment adherence (Fung et al., 2008), and the inclination to seek professional assistance (Vogel et al., 2007). Nevertheless, the high stigma severity outcomes observed in the Black, Black British, Caribbean or African populations aligns with the broader research narrative on the complex interplay of cultural, historical and societal factors influencing stigma experiences among diverse BAME communities (CRED, 2021) and thus warrants further investigation.

The present study also found that the Asian or Asian British group reported higher anxiety, significantly higher depression and significantly lower wellbeing scores compared to the Black, Black British, Caribbean or African group. Similar findings have been observed in previous research (Ikram et al., 2015) demonstrating higher perceived stigma and discrimination levels in Black African populations, but higher anxiety/depressive symptoms amongst Asian populations comparatively. In contrast to the current study, Tummala-Nara et al. (2012) conducted a cross-sectional study examining the relationship between perceived discrimination, acculturative stress and depression among South Asians (Chinese, Filipino, Vietnamese; n = 169). They found South Asian populations to experience the highest levels of perceived stigma and discrimination with higher stigma being associated with higher depressive symptoms when compared to Caucasians (Tummala-Nara et al., 2012). Furthermore, Tummala-Nara et al. (2012) found that familial support, or the lack there of, moderated the relationship between stigma/discrimination and depressive symptoms in South Asian populations which may explain the difference in stigma scores compared to this study and Ikram et al. (2015). Furthermore, in the present study, not all dimensions of stigma were correlated with anxiety and depression, with overcoming stigma and positive treatment revealing insignificant associations versus perceived discrimination and self-censorship (i.e., stopping self) showcasing significant associations. Conversely, previous research (Farrelly et al., 2014; Ikram et al., 2015) found significant positive correlations between stigma and anxiety/depression. To note, Ikram et al. (2015) and Tummala-Nara et al. (2012) studies were not in the UK and thus outcomes should be interpreted with caution. Farrelly et al. (2014) study, while conducted in the UK and utilising the DISC measure, had several limitations. Participants were aware of the study's focus on discrimination, introducing the possibility of overrepresentation among those who had experienced discriminatory incidents. It is possible, that both in the current study and preceding research (Farrelly et al., 2014; Ikram et al., 2015; Tummala-Nara et al., 2012) that individuals with high levels of reported stigma may exacerbate feelings of anxiousness and low self-worth (Farrelly et al., 2014) and on the other hand, high levels of anxiety/depression may create an ontological lens that perceives unfavourable "every-day" experiences as stigmatic or discriminatory (Farrelly et al., 2014). However, given the cross-sectional nature of the present study, the direction of causality between anxiety/depression and stigma remains unclear. Nevertheless, other factors might have contributed to the observed findings of the present study. Existing research underscores the influence of cultural nuances, perceived stigma, and acculturation challenges on mental health outcomes across diverse ethnic groups (Koneru, 2007). Specifically, studies have indicated that mental health stigma tends to deter help-seeking behaviours in Asian populations, where familial expectations and the concept of "saving face" are prominent (Ryder et al., 2008). The latter, a prevalent notion in Asian cultures, particularly those with a more collectivist orientation, such as socio-centric tendencies (Bhugra, 2005), could potentially contribute to heightened levels of anxiety and depression compared to Black African/British populations (Codjoe et al., 2021). To enhance our understanding, forthcoming research should focus on discerning and unravelling the intricate factors that contribute to mental health disparities among distinct ethnicities within the BAME umbrella. Employing larger sample sizes, adopting longitudinal approaches, and integrating experimental designs are imperative elements for investigating the cultural, social, and systemic determinants that influence the multifaceted nature of stigma severity and its repercussions on mental health outcomes.

The present study found higher levels of unfair treatment, self-censorship, anxiety, and depression among BAME individuals aged over 40 compared to those aged 18-29. Additionally, BAME individuals aged over 40 reported significantly lower scores in Physical Health & Wellbeing, Psychological Wellbeing, and overall Subjective Wellbeing compared to those aged 18-29. To the author's knowledge, there is limited evidence examining generational differences in mental health stigma, anxiety, depression and wellbeing in BAME populations. Furthermore, recent literature present contradictory views to the findings which observed BAME individuals aged over 40 showcasing higher dimensions of stigma. There are inconsistencies between studies with regards to older versus younger BAME populations and mental health stigma. For example, some studies are in favour of older BAME populations exhibiting higher degrees of mental health stigma (Pescosolido et al., 2021; Rawlings & Bains, 2020) whilst others indicate younger populations showcase higher degrees of mental health stigma (Bradbury, 2020; Henderson et al., 2020). Nevertheless, the present study aimed to examine contextual knowledge and propose potential mechanisms for the current study's findings may be hypothesised. For instance, Pescosolido et al. (2021) investigated US National Stigma studies and face-to face interviews (n = 4129) to ascertain shifts in the prevalence, trends, and intensity of mental illness stigma in the US over a span of 22 years (1996-2018). They concluded that since 1996, there has been a significant annual decrease in the average levels of stigma associated with mental health issues, particularly depression in individuals with a mean age of 40 (SD = 17 years) (Pescosolido et al. 2021). Additionally, there was an increase in acknowledging mental illness (i.e., depression and schizophrenia) as a biomedical issue, indicating amplified mental health literacy (Pescosolido et al. 2021). Furthermore, social distancing from individuals with depression or schizophrenia remained unchanged since 1996 (Pescosolido et al. 2021). Moreover, sociodemographic characteristics (i.e., education attainment, age groups, employment) offered no significant between group differences in attitudes towards the aforementioned points (Pescosolido et al., 2021). Pescosolido et al. (2021) found a yearly decrease in mental health stigma among those aged 40 and above. In contrast, this study showed that BAME individuals over 40 exhibit higher levels of stigma compared to younger generations. This discrepancy could be linked to younger generations having greater exposure to Westernised values and technological innovation, leading to repeated opportunities for improved health literacy and consequently a general decline in mental health stigma compared to their older counterparts (Pescosolido et al., 2021). Still, Pescosolido et al. (2021) study has several limitations to consider; (i) the survey responses represent individual opinions and beliefs rather than their actual behaviour; (ii) study participants were not exclusively from BAME backgrounds and (iii) the longitudinal data track changes in attitudes over time in the US thus generalisability to the UK may be limited. Comparatively, further similarities to Pescosolido et al. (2021) research can be observed in Rawlings and Bains (2020) study who carried out a thematic synthesis of qualitative studies (n = 12) exploring experiences of depression in non-white and ethnic minority groups. Eight of the twelve studies were conducted in the US and four were carried out in Asia (i.e., Thailand & China) (Rawlings & Bains, 2020). They found that (i) older BAME populations often had limited understanding for depression, perceiving it as a consequence of life stressors rather than a medical condition thus leading to internalised stigma, shame and reluctance to seek health aid; (ii) sociocultural norms influenced older BAME adults to adopt spiritual/religious practices as coping mechanisms of depression over medical aid (again, delaying effective treatment and care); (iii) keeping depression hidden in fear of losing social status was commonplace among older BAME populations; (iv) ageist beliefs and general mistrust of mental health services generally deterred from seeking health treatment; and (v) older BAME populations seemed to be more culturally sensitive and valued respect for their language/cultural norms thus gravitating towards practitioners who were from the same ethnic origin (Rawlings & Bains, 2020). In relation to the current study, it is probable that older BAME populations potentially exhibit ageist beliefs, general mistrust and secretive behaviour manifesting higher proportions of stigma, anxiety, depression and lower wellbeing (Rawlings & Bains, 2020). Conversely, Bradbury (2020) conducted a survey on 178 individuals in the UK investigating the impact of age on attitudes towards mental health stigma (i.e., anxiety and schizophrenia) and found that younger populations (16-18) had higher stigma beliefs compared to older adults (> 40). These findings are further confirmed by Henderson et al. (2020) who analysed data (n = 19,104) from 2008 - 2019 in individuals in the UK to ascertain differences in attitudes towards individuals with mental illness. The study concluded that younger individuals (16-24 years) presented less accepting attitudes (i.e., higher stigmatic views) towards those who were diagnosed with mental illness (Henderson et al., 2020). Moreover, both Bradbury (2020) and Henderson et al. (2020) suggested that younger populations over time develop better health literacy and thus more accepting of others who struggle with disease, contradictory to the findings of this study and aforementioned research (Pescosolido et al., 2021; Rawlings & Bains, 2020). To note, both Bradbury (2020) and Henderson et al. (2020) present several limitations. For instance, Bradbury (2020) failed to provide a balanced sample of males and females and did not examine race, status or education attainment which can all influence attitudes towards mental health. Additionally, Henderson et al. (2020) study utilised a quota sample (non-probability sample) potentially introducing sampling bias and did not account for external variables that may influence public perception of mental health (such as the rise of anxiety disorders in adults, increasing exposure and familiarity). In light of the contradictory literature, the findings of the present intervention remain inconclusive and warrants for further research. Longitudinal designs to track changes over time alongside RCTs to ascertain causal mechanisms of stigma could provide deeper insights into the complexities of mental health stigma across different age groups within BAME populations. Lastly, it is likely that the underlying mechanisms explaining mental health stigma across different age groups in BAME populations is likely to be the result of a complex interplay amongst various biopsychosocial factors as indicated by previous research (Bradbury, 2020; Henderson et al., 2020; Pescosolido et al., 2021; Rawlings & Bains, 2020).

3.4.2 RELATIONSHIP BETWEEN STIGMA SEVERITY, ANXIETY, DEPRESSION & WELLBEING

Perceived self-censorship can be defined as the act of supressing one's thoughts and actions out of fear, perceived or actual, without any direct pressure from a specific party or authority (Bar-Tal, 2017; Brohan et al., 2011, 2013). This means that individuals who score high in perceived self-censorship scores in the present study are more likely to be avoidant of seeking friendships, relationships and career opportunities. In this study, perceived self-censorship was associated with higher anxiety and depression, but lower associations with PHWB, PWB and relationship sub-scales. In comparison to previous research, consistencies can be observed. Schnyder et al. (2017) conducted a systematic review (n = 27) on RCT's and cross-sectional studies in the aim of investigating the impact of different types of stigma (public stigma, personal stigma, attitudes towards help-seeking) on active help-seeking for mental illness in BAME and non-BAME populations in North American and Europe. They concluded that individuals with more negative attitudes towards help seeking and personal stigma (beliefs about mental illness) were less likely to seek aid and actively socially distance (Schnyder et al., 2017). In comparison, public stigma did not show any associations with help-seeking behaviour (Schnyder et al., 2017). These results offer tentative links to the present study as Shnyder et al. (2021) amalgamated BAME and non-BAME populations into their analysis thus potentially missing important sub-group variances. Additionally, further variances could have been affected by region, gender and age. Thornicroft et al. (2009) conducted a cross-sectional study that aimed to ascertain the prevalence and impact of anticipated and experienced discrimination in twenty-seven countries (n = 732) with individuals suffering with schizophrenia, bipolar disorder and major depressive disorder. The study showcased high levels of anticipated and experienced discrimination among all three mental illnesses (Thornicroft et al., 2009). The discrimination manifested across multiple areas of life, including friendships, family, employment and relations (Thornicroft et al., 2009). Consequently, participants often felt the need to self-censor their behaviour, socially distance and hide their diagnoses (Thornicroft et al., 2009). Additionally, reports of lower subject wellbeing because of prolonged secrecy were noted (Thornicroft et al., 2009). Whilst no significant differences in anticipated and experienced discrimination between the three mental illnesses were observed, the authors stated that factors like ethnicity (ethnic minority) and gender influenced the level of discrimination acknowledged (Thornicroft et al., 2009). Thornicroft et al. (2009) finding on the need to self-censor and lower wellbeing being experienced exists in harmony with the findings of the present study although, specific ethnicities were not explored by the study. Thornicroft et al. (2009) study was replicated by Üçok et al. (2012) which also investigated anticipated and experienced discrimination but in schizophrenia alone. Üçok et al. (2012) also found anticipated discrimination in employment, friends and relationships although, did not find this to be true for experienced discrimination in the same areas of life. Nevertheless, Ucok et al. (2012) reported lower wellbeing and participants, once again, hiding their diagnosis from peer groups out of fear and marginalisation. Thornicroft et al. (2009) and Üçok et al. (2012) suggested that negative relationships between perceived self-censorship and anxiety/depression may be partly explained by internalisation of prejudice and societal stereotypes. Specifically, BAME individuals may accept negative stigmas about mental health associated with their ethnicity to be true, leading to feelings of shame, guilt and self-censorship (Thornicroft et al., 2009; Üçok et al., 2012). Consequently, this may further exacerbate anxiety symptoms, mitigate physical, psychological and subject wellbeing and may explain the finding observed in this thesis. An important point to consider for self-censorship in BAME groups is that self-censorship may manifest as somatic symptoms when experiencing mental illness. For instance, Ryder et al. (2008) conducted a longitudinal study that aimed to compare somatic and psychological symptom presentation during depression between Chinese and Euro-Canadian outpatients (n = 282). The study presented those Chinese outpatients reported more somatic symptoms (fatigue, unspecified pain & digestive issues) compared to Euro-Canadians, who illustrated more psychological symptoms (sadness & anxiety). The authors further suggested that these findings could be explained by cultural differences that likely affect individuals coping strategies, particularly with Chinese participants concerned with more "externalised thinking" (what people think of them), moderating coping mechanisms. This may apply to the BAME groups in this study although associations with self-censorship and somatic symptoms were not directly explored. Nevertheless, all aforementioned research (Ryder et al., 2008; Schnyder et al., 2017; Thornicroft et al., 2009; Üçok et al., 2012) offer insights that strengthen the self-censorship finding in this study however, both this and previous research were cross-sectional in design thus warranting the need for more trials to confirm causalities.

The unfair treatment scale was significantly positively associated with depression but not anxiety. Additionally, unfair treatment demonstrated a significant negative correlation with psychological well-being. Pascoe et al. (2009), Ryder et al. (2008), Rose et al. (2011) and Schnyder et al. (2017) articulated that experiences of reported unfair/discriminatory treatment are further associated with chronic stress, evoking psycho-physiological pathways increasing the risk of depressive symptoms. This means that perceived accounts of negative treatment, increases the experiences of negative emotions, further contributing to amplified depression symptoms which may partly explain the finding of this study. Overcoming stigma presented a significant positive correlation with physical health, well-being, and the relationships sub-scales. Additionally, positive treatment displayed a significant positive correlation with physical health and relationship sub-scale. Dempster et al. (2013, 2015) echoes the findings of this study that (i) overcoming stigma is positively associated with physical and psychological wellbeing including relationships and (ii) perceived positive treatment amplifies the perception of increased physical health and positive relationships. Dempster et al. (2013, 2015) suggested that the potential mechanism for explaining the positive relationship between overcoming stigma and perceived positive experiences is that individuals who score higher on these dimensions may foster more effective coping strategies to attenuate mental ill-health. This underscores the importance of resilience and positive interactions/support networks as coping strategies to combat mental ill health in BAME populations (Dempster et al., 2013, 2015). This suggests that BAME populations who scored higher in overcoming stigma and perceived positive treatment likely had better coping mechanisms and support systems, leading to improved physical and psychological well-being, as well as healthier relationships. Nevertheless, the existing accounts of previous literature (Dempster et al., 2013, 2015; Pascoe et al., 2009; Rose et al., 2011; Ryder et al., 2008; Schnyder et al., 2017; Thornicroft et al., 2009; Üçok et al., 2012; Vogel et al., 2007) should be interpreted with caution due to differences in measurement tools, many being cross-sectional design and contextual differences. Consequently, more randomised controlled trials are needed to substantiate such claims. Additionally, future studies should employ, methodological consistency, particularly around measurement of stigma, anxiety and depression to allow for more reliable and valid conclusions as anxiety and depression symptoms seem to be underpinned by experienced and anticipatory mental health stigma.

Black African groups and at home workers were more likely to report instances of stigma compared to Asian groups and employed individuals. Moreover, the 30 - 59-year group and the Black African population were more likely to report perceived self-censorship compared to 18 – 29 years group and Asian populations. Comparing these findings to previous research

(Farrelly et al., 2014; Jaspal et al., 2021a, 2021b), mixed insights can be observed. Farrelly et al. (2014) aimed to determine the levels and associated factors of anticipated and experienced discrimination among individuals (White, Black, or Mixed) with schizophrenia, bipolar disorder, and major depressive disorder in South London (n = 202) using the DISC measure. They found that females experienced the highest anticipated discrimination, and the mixed ethnicity the highest discrimination and strongest associations between depression, anticipated and experienced discrimination. Furthermore, Farrelly et al. (2014) also found that those in the older groups were more likely to report stigma severity. Whilst Farrelly et al. (2014) differs from the current study in respect to the inclusion criteria (i.e., including Caucasian ethnicity, psychotic illness) the author suggested that people of mixed heritage (i.e., Black & White) may be subject to additional stereotypes in education, healthcare and the workplace that people of a non-mixed heritage may not experience. This offers tentative links to the BAME groups in this study, who had reported different aspects of stigma being present in day-to-day interactions. Jaspal et al. (2021a) conducted a cross-sectional study to identify the predictors of depressive symptomatology among BAME (Indian, Pakistani, Bangladeshi, Chinese, African, Caribbean & Mixed) and non-BAME (White & Caucasian) groups in the UK (n = 289). Whilst BAME groups experienced more rejection, homophobia, and discrimination leading to increased depressive symptoms compared to non-BAME groups, the study did not analyse distinct BAME groups, inhibiting the identification of patterns or variations in rejection, homophobia, discrimination and therefore depression among the different BAME ethnicities. However, BAME groups did express the need to socially distance themselves from people with mental illness which is an aspect of stigma observed in the Black African & Caribbean groups in the present study (i.e., self-censorship). Further research by Jaspal et al. (2021b), a cross-sectional study aimed at examining the Covid-19 outbreak on mental health levels in Black African and South Asian groups in the UK (n = 226), revealed that Black African populations reported significantly higher ethnic discrimination and instances of stigma in mental health compared to South Asian groups. Moreover, Black African groups often turned to religion as a “protective” mechanism against mental illness during the pandemic to foster a sense of identity, belonging and cohesion (Jaspal et al., 2021b). Whilst the religious aspect could not be confirmed in this study, the underlying reasons for increased discrimination and stigma related to mental health in Jaspal et al. (2021) study echoed that of Farrelly et al. (2014) study (stigma in education, work and healthcare) that may also underpin the findings of the present study. On the other hand, observed inconsistencies were noted between the present study and aforementioned literature. Contrary to the findings of Jaspal et al. (2021b), the Asian group in this study was not significantly associated with stigma severity. Jaspal et al. (2021b) suggested that religious discrimination might be more relevant to Asian populations compared to Black African populations, indicating that there are different factors that can influence stigma and discrimination outcomes between studies. Additionally, being female was not associated with stigma severity or self-censorship in the present study. However, being female was significantly associated with increased unfair treatment. This finding is corroborated by Farrelly et al. (2014) who emphasised increasing age and the female gender to report higher levels of unfair treatment compared to males. To note, all three studies (Farrelly et al., 2014; Jaspal et al., 2021a, 2021b) were cross sectional in nature limiting causality, used different measures and explored sub-divisions within race by sexual orientation (i.e., lesbian, gay, bisexual) (Jaspal et al., 2021a) and thus, generalisability to the current study should be interpreted with caution. Still, the observed inconsistencies between the current study and previous research may be partly explained by the following: (i) whilst the current study measured stigma severity alongside various other aspects of stigmatic behaviour (DISC-12; Brohan et al., 2011), the DISC-12 measure did not exclusively measure religious stigma/discriminatory behaviour; (ii) gender (i.e., females) have different coping mechanisms compared to males, where males tend to employ more confrontational or combative approaches during periods of distress, while females tend to lean towards seeking social support from family and friends - with these findings demonstrating consistency cross-culturally (Lewis et al., 2013). Moreover, literature indicates that females tend to perceive more threats than males and feel less inclined to believe in positive outcomes (Flynn et al., 1994, Gustafsod, 1998). These insights may explain why females in the current study, registered as a significant predictor for unfair treatment but not self-censorship. Furthermore, this observation may imply that social support may possess protective moderating elements, contributing to gender-based variations in coping mechanisms in response to stigmatic/discriminatory behaviour (Lewis et al., 2013). Nevertheless, these disparities highlight the complexity of the factors influencing stigma severity within BAME populations and underscore the need for nuanced investigations that consider contextual and population-specific dynamics. Future research should delve into the potential cultural, social, or contextual factors contributing to these divergent findings across studies.

The present study also found BAME individuals, aged > 40 years, more likely to report unfair treatment and overcoming stigma compared to 18–29-year-olds. However, 60–65-year-olds were less likely than 18–29-year-olds to report overcoming stigma. Research presents mixed findings regarding the association between age and perceived unfair treatment. Specifically, some studies showcase older individuals to be more at risk of discrimination as a consequence of stereotypes and prejudices (Livingston et al., 2010; Temple et al., 2021) whilst other studies have showcased unfair and discriminatory treatment across younger age groups, particularly in the context of employment and education (Beukering et al., 2021). Moreover, these disparities are suggested to stem from a variety of factors including generational norms, geographic region, societal perceptions, workplace and educational practices (Beukering et al., 2021; Livingston et al., 2010; Temple et al., 2021). It is possible that older populations in this study may have encountered discrimination more often than younger populations (Livingston et al., 2010; Temple et al., 2021) thus increasing the likelihood of reporting unfair treatment. However, this only partly explains the findings of the current study that individuals aged 40-49 were more likely to report overcoming stigma scores compared to those aged 18-29, while 60–65-year-olds were less likely, suggesting a nuanced interplay of factors. Specifically, the middle-aged participants of this study may have exhibited higher resilience and coping mechanisms to combat stigma (Mlinac & Schwabenbauer, 2018) thus leading to augmented “overcoming stigma” scores compared to 60–65-year-olds who may face entrenched societal attitudes and ageism (Livingston et al., 2010; Temple et al., 2021), leading to greater challenges in overcoming stigma. However, the differences found in perceived unfair treatment and lower overcoming stigma scores among 60–65-year-olds compared to 18–29-year-olds may be due to sample size limitations. While the total sample comprised 204 individuals, both the 18-29- and 60-65-year age groups only included 6 participants each, falling short of the desired threshold of >100 participants per group category recommended for robust statistical analysis (Kotrlik & Higgins, 2001). Such a limited sample size within these age categories elevates the risk of skewed means and may consequently undermine the reliability and generalisability of the study findings (Kotrlik & Higgins, 2001).

The present study also found retirees were more likely to report overcoming stigma than individuals in employment and females were more likely to report unfair treatment compared to males. Antecedents to this research have showcased employment-related stigma with employed individuals frequently subject to workplace-related stigma (Behtoui & Neergaard, 2009) and discrimination (Tóth et al., 2023), while retired individuals may encounter social exclusion (Jose & Cherayi, 2017) or marginalisation due to age-related factors (Allen et al., 2023). The contemporary study’s findings of retired individuals being more likely to report overcoming stigma than employed individuals may be partly explained by the potential for retired individuals to experience greater agency and more autonomy in managing stigma (Romaioli & Contarello, 2019). Retirement may facilitate opportunities for social reintegration (Wittenberg & Wedegaertner, 2021), reduce stress (Rose, 2020) and enhance self-esteem (Rose, 2020) which may all contribute to a more positive stigma outlook. In respect to between-sex differences in unfair treatment, the contemporary study’s findings exist in agreement to preceding research with females often reporting augmented levels of perceived unfair treatment across various contexts, including healthcare (Holliday et al., 2015), education (Bell & Juvonen, 2020) and the workplace (Triana et al., 2019). Furthermore, research investigating gender-differences in depression levels further confirmed that females on average display twice as many levels of depression than males in depression (Hyde & Mezulis, 2020), leading to increased reporting in unfair treatment, discrimination and harassment (Hyde et al., 2008). Like depression, the elevated likelihood of females reporting unfair treatment compared to males is likely influenced by a complex interplay of biological, psychological, and social factors (Hyde et al., 2008; Hyde & Mezulis, 2020). For instance, reported biological mechanisms may be ovarian, adrenal changes during puberty and menstrual cycles (Kouros et al., 2014) alongside personality differences with females exhibiting higher levels of personality trait “neuroticism” - which is a precursor for the likelihood of experiencing negative emotion (DeYoung et al., 2007; Weisber et al., 2011). Psychological factors may be greater rumination in females (Hyde et al., 2008; Hyde & Mezulis, 2020; Nolen-Hoeksema, 1994) which involves repetitive focusing on negative events/thoughts further exacerbating negative feelings. Social factors may be traditional gender norms, where males are expected to express stoicism and self-reliance (Aube et al., 2000), while females may face expectations related to caretaking and emotional nurturance (Hyde et al., 2008; Hyde & Mezulis, 2020). Thus, given the complex interplay of bio-psycho-social variables, it is likely that a combination of all aspects played a role in contributing to females' heightened vulnerability to unfair treatment thus augmented risk of reporting.

3.4.3 STRENGTHS & LIMITATIONS

The present study adds to previous literature (Dempster et al., 2013, 2015; Farrelly et al., 2014; Ikram et al., 2015; Schnyder et al., 2017; Thornicroft et al., 2009) in advancing subject matter understanding in between group differences and relationships in key psychometrics known for predicting multi-morbidity (Felez-Nobrega et al., 2022). Additionally, the present study adds novel results by identifying between group differences in stigma severity, anxiety, depression and wellbeing in individual ethnicities under the BAME umbrella to potentially inform UK government level initiatives (CRED, 2021) and advance the macro argument that how each psychometric (i.e., stigma severity, anxiety, depression and wellbeing) is experienced between ethnicities likely differ and thus requiring adaptation to psychotherapeutic design .

However, this study is not without its limitations. The cross-sectional nature of the study design does not allow to infer causality. Although the sample size was deemed sufficient for the intended scope of the study (Kotrlik & Higgins, 2001) and aligned with the recommendation of investigating individual ethnicities within the BAME umbrella as outlined in the CRED report (2021), it may not comprehensively capture the intricate diversity inherent to specific ethnicities. Notably, there is a potential that subgroups within individual ethnicity classifications remain underrepresented. Reliance on self-reported measures risks the presence of response bias. In addition, given that this study focused on BAME populations in the UK, generalisation to other regions may be limited.

3.5 CONCLUSION

In conclusion, the present study offers contributions to aforementioned research by investigating the presence of stigma severity in BAME populations but also provides novel insights into between group patterns of stigma severity, anxiety, depression and wellbeing amongst individual ethnicities within the BAME umbrella, thus supporting UK government level initiatives (CRED, 2021). Additionally, the novel insights into the individual BAME ethnicities could potentially inform future policy makers and research on how to support disadvantaged populations through more tailored psychotherapies. Future research would benefit from (i) longitudinal research interpreting the complex interplay between stigma severity, anxiety, depression, wellbeing over time within individual ethnicities; (ii) expanding the research scope to gain an understanding of how stigma severity, anxiety, depression and wellbeing vary for different ethnicities, comparing experiences of both ethnic minorities within their home countries to those living abroad; and (iii) a qualitative exploration of lived experiences of distinct BAME mental health service users to compliment the quantitative results and provide a further insight into strategies for undermining stigma severity levels.

CHAPTER 4 - PERCEPTIONS & EXPERIENCES OF MENTAL HEALTH, WELLBEING & PSYCHOTHERAPEUTIC PRACTICES WITHIN BAME COMMUNITIES: A QUALITATIVE STUDY

OVERVIEW

This study builds on from the findings illustrated in Chapter 3, a quantitative study examining stigma severity, anxiety and depression between BAME populations. It delineated three principal domains of inquiry: i) high stigma severity in Black African/Caribbean groups relative to other BAME populations; ii) high levels of anxiety and depression, coupled with lower subjective well-being, in Asian or Asian British populations within the BAME cohort; iii) a rationale for investigating cultural idiosyncrasies and their potential integration into established psychological therapy approaches. Considerable discourse surrounds the efficacy of CAP for BAME populations, yet a notable gap exists in understanding the specific cultural adaptations that may yield optimal effectiveness for distinct BAME groups. Moreover, there is a paucity of clarity regarding the variations in the perception of mental health among different BAME populations, Additionally, there is limited insight into which cultural adaptations BAME service users perceive as most effective within the context of their respective cultures. These insights hold significant potential for informing policymakers and researchers in developing a framework for CAP (Arundell et al., 2021). The study endeavours to address this gap through one-on-one, online interviews with BAME service users in the United Kingdom.

4.1 INTRODUCTION

Despite evidence favouring CAP, the process of cultural adaptation varied considerably in previous research (Anik et al., 2021; Arundell et al., 2021; Benish et al., 2011; Chowdhary, et al., 2014; Hall et al., 2016; Loon et al., 2013) and in Chapter 2, with most studies not reporting their process in sufficient detail, incorporating “psychoeducation” (e.g., raising awareness of mental health) as a mode of cultural adaptation including the translation of texts, ethnic vs ethnic client-practitioner matching (Anik et al., 2021; Arundell et al., 2021; Benish et al., 2011; Chowdhary, et al., 2014; Hall et al., 2016; Loon et al., 2013), using the MRCF (Anik et al., 2021; Shahsavari et al., 2020) or a conceptual typology of common adaptations (Arundell et al., 2021). Moreover, increased utilisation of MRCF (Shahsavari et al., 2020) to guide practitioners in “how to create CAP” is present in previous research (Anik et al., 2021; Shahsavari et al., 2020) yet it is not clear how much variance this framework explains towards psychotherapeutic outcomes in BAME populations. Furthermore, a drawback of cultural adaptation (CA) is the uncertainty about which aspects of a culture need to be altered and to what extent. Since the most common modes of CA are either the translation of texts or ethnic vs ethnic matching (Anik et al., 2021; Arundell et al., 2021; Benish et al., 2011; Chowdhary, et al., 2014; Hall et al., 2016; Loon et al., 2013), further investigation into its utility for BAME populations is warranted.

4.1.1 LANGUAGE

Language has been identified as a significant barrier to inclusion of people from BAME backgrounds in research studies (De La Nueces et al., 2012; Gill et al., 2012; Hoopman et al., 2009; Rooney et al., 2011; Vickers et al., 2012). Still, the barrier may be overcome by locating a researcher/practitioner/interpreter who can speak the same language as the participants. A study addressed methodological difficulties when working with Turkish and Moroccan ethnic minority cancer patients in the Netherlands (Hoopman et al., 2009). Morocco is home to a wide range of distinct languages, all of which differ depending on participants' level of education in their country of origin (Hoopman et al., 2009), presenting a similar situation as exists in the diverse first languages in the UK South Asian community. It is not practical or, in certain situations, even possible to find linguists that can accommodate all languages and dialects (Hoopman et al., 2009). The authors therefore decided on the most popular Moroccan language spoken in the Netherlands (Hoopman et al., 2009). After locating suitable researchers, an iterative forward-backward translation method was required, which incurred additional expenditures to the study alongside privacy laws restricting data collection on ethnicity (Hoopman et al., 2009). Additional language issues can be observed in examining the trustworthiness of translations and the need for “culturally appropriate questions” (Gill et al., 2012). People from BAME communities frequently have difficulty with long (complex) questions, especially when they contain lengthy or diverse response choices, (Hoopman et al., 2009). Translation of research instruments must consider both cultural and linguistic aspects into account. The requirement for cultural sensitivity in research is emphasized by the need to transmit accurate meaning from participants to researchers, for participants' broader contexts to be comprehended, and for researchers not to inadvertently cause harm or offense to participants or other members of the target group (Papadopoulos, 2006). Therefore, "Bottom-up" research, according on De La Nueces et al. (2012), necessitates that community members become involved from the onset of research for appropriate research questions to be formed thus facilitating cultural sensitivity. The usage of interpreters has also been a point of contention. According to Gill et al. (2012), the attendance of an interpreter might make people feel intimidated and uncomfortable. However, Rooney et al. (2011) suggested that in South Asian participants, feelings of acceptance and rapport can be experienced as the “interpreter” is seen as the “bridge” between practitioner and patient (Rooney et al., 2011). Some literature suggests using family members as translators (Jutlla & Raghavan, 2017), but social care practitioners are hesitant to do so in therapy because they may not translate in the way that the researcher intended and there is a risk of omitting, adding, compressing, or changing information (Atkin et al., 2009; Mir & Tovey 2003). In some cases, interpreters may cloud the richness of qualitative data unless appropriate precautions are taken in the preparation and instruction of such workers. It is advised to employ bi-lingual researchers/practitioners for data collection and analysis alongside fidelity practices to ensure such translations are reliable and trustworthy (Dana-Farber Cancer Institute, 2005; Waheed et al., 2015) however, such practices are time-consuming and not always cost-effective (Hoopman et al., 2009). It is critical to consider language difficulties and how they might be overcome (i.e.., translation of texts, hiring an interpreter or a bi-lingual speaking practitioner). According to Gill et al. (2012) the main facilitators and incentives for participation of members of the BAME community in primary research are determined by the availability of suitable language (both during recruitment and while conducting research). Still, the predictive value of text translations or the use of interpreters for anxiety, depression or subjective wellbeing is not yet established (Kalibatseva & Leong, 2014).

4.1.2 ETHNIC VS ETHNIC MATCHING

Previous systematic reviews investigating the utility of CAP on mental illness have consistently reported that ethnic vs ethnic client-practitioner matching was common amongst interventions (Anik et al., 2021; Arundell et al., 2021; Shahsavari et al., 2020) with additional literature arguing that this mode of adaptation will enhance recruitment, drive outcome measures for success and improve the overall research experience (Brown et al., 2014; Hoopman et al., 2009; Sheikh et al., 2009). For example, there is a suggestion that a “white” person coming to speak to any ethnic group could be seen as “patronising and telling them what to do” whereas having a role model from a similar culture, could be seen more as working with them (Brown et al., 2014; Hoopman et al., 2009; Sheikh et al., 2009). Conversely, Cronin and Ward (2004) proposed that researchers should be “culturally competent”. Cultural competence is the ability to communicate effectively and ethically with people of varied cultural backgrounds while maintaining an appropriate degree of cultural awareness (Cronin & Ward, 2004). Cultural competence includes having the knowledge, self-awareness, and skills required to establish culturally effective and ethical interactions with individuals from various cultures (Cronin & Ward, 2004). Although some may claim that researcher-participant ethnic identity matching may overcome language and cultural barriers, Burlew et al. (2011) emphasises the necessity for further studies to determine whether this technique improves outcomes. Smith et al. (2011) presented a systematic review and meta- analysis of quantitative research (n = 154 examining preferences and perceptions of BAME cohorts (i. e. black, Asian, Hispanic) for their belief in the utility of ethnic vs ethnic matches). Across 52 studies of preferences, the average effect size (Cohen's *d*) was 0.63, indicating a moderately strong preference for a therapist of one's own race/ethnicity. Across 81 studies of individuals' perceptions of therapists, the average effect size was 0.32, indicating a tendency to perceive therapists of one's own race/ethnicity somewhat more positively than other therapists (Smith et al., 2011). However, across 53 studies of client outcomes in mental health treatment, the average effect size was 0.09, indicating almost no benefit to treatment outcomes from racial/ethnic matching of clients with therapists. Thus, it is suggested that ethnic vs ethnic matches may not be the most efficient CA component to be added to psychotherapy.

Moreover, Gill et al. (2012) findings suggest that profession, age, and ethnicity of the researcher were irrelevant to participants in regards to their belief in the utility of ethnic vs ethnic matching. However, Hoopman et al. (2009) found that gender may be a significant factor for ethnic vs ethnic matching and implied that women researchers/practitioners are often more accepted by the same and opposite sex during therapy because in many cultures (e. g., Moroccan culture) it is more acceptable for a woman to interview a man than vice versa. Nevertheless, it seems that the “cultural competence” of a researcher outweigh these personal characteristics (Gill et al., 2012). In particular, a culturally competent researcher/practitioner will actively develop and practice suitable, relevant, and sensitive methods/skills while working with people from diverse backgrounds regardless of gender (Cronin & Ward 2004). Ahmed et al. (2018) conducted a scoping review of 16 studies on how to measure cultural competence during patient centred care and emphasised the use of “person centred quality indicators" (PCQI) to help patients assess their quality of care as a proxy for practitioner cultural competence. PCQI measures can be used to measure the structure of delivery (e. g. context in which healthcare is given), process of delivery (interaction from the practitioners towards patients) and outcome indicators (quality of care associated with patient centred care) (Santana et al., 2020). PCQI's could be a feasible, cost-effective, evidence-based approach to improving cultural competence and thus psychotherapeutic outcomes (Ahmed et al., 2018; Santana et al., 2020). Furthermore, using modalities that are in line with the participants' life experiences and cultural beliefs fosters trust and rapport, which is critical to conducting research among BAME groups. It has been suggested that a potential effective mode of CA for BAME populations is to promote group identity, interdependence and cohesion as it is well understood that these cultural values differ from western ideology where autonomy and individuality is paramount (Naeem et al., 2019).

4.1.3 RATIONALE FOR THE STUDY

Interventions for BAME populations should consider strategies to overcome the underlying barriers to engagement (provided in Chapter 1, 2 & 3) and negative attitudes towards mental health to improve psychotherapeutic outcomes. Specifically, ascertaining which cultural adaptation may be more effective in amplifying psychotherapeutic outcomes for individuals of a specific BAME group would be beneficial to the psychotherapeutic evidence base as there are no studies that provide insight on which cultural adaptation may be effective for each BAME group. This study aims to achieve this by facilitating comprehensive dialogue with BAME individuals who have had experience with mental health services using 1-2-1 interviews in communities with BAME heritage to "explore" their experiences with mental health, wellbeing, prior psychotherapy and health care experiences.

AIMS & OBJECTIVES

The aims of the present study were two-fold: To explore the perceptions of mental health, mental wellbeing, psychotherapeutic practices and experiences in health care by BAME communities.

Objectives:

- To gain insight into perceptions and experiences of using mental health services in the UK by BAME populations.
- Identify key barriers and facilitators for engagement with UK mental health services.
- To distinctly explore Asian, African and Caribbean BAME groups' perceptions and attitudes towards mental ill-health.
- To distinctly elicit perspectives from Asian, African and Caribbean BAME participants on an established mental health initiative, namely CA-CBT, aiming to gain an insider's viewpoint.

4.2 METHODS

4.2.1 STUDY DESIGN

The present study was a qualitative exploratory research study.

4.2.2 PARTICIPANTS

Following approval from the St. Mary's Ethics committee (Appendix 3.8), recruitment commenced in June of 2022. Online Zoom interviews were recruited from participants who indicated their willingness to participate in future interviews via a follow-up question included in the survey administered in Chapter 3 (Appendix 3.1). In addition, the help of pastors in relevant congregations were approached to see if they were happy to send recruitment information, specifically the participant recruitment posters (Appendix 3.3), out to their congregation. Further recruiting strategies for the online interviews were all the former (social media, emails, word of mouth and posters [Appendix 3.3]). Participants were included in the interviews if (i) they had BAME heritage, (ii) were aged 18 years and above and (iii) passed the screening question by answering option "E" (Appendix 3.1 - "I have experienced signs of anxiety and/or depression in the last year and have sought out help for this"). Participants were excluded if (i) they did not have BAME heritage, (ii) were under the age of 18 and (iii) did not pass the screening question (Appendix 3.1). Participants who did not pass the screening question were thanked for their time and were informed that they did not meet the inclusion criteria for the study and thus could not partake. Participants who were eligible were asked to give consent that they were aged 18 and above prior to participating in the online interviews (Appendix 3.1). Fourteen participants volunteered to take part in the study, all of them met the inclusion criteria and were invited to the online interview. A sample size of fourteen is considered appropriate for qualitative research and recruitment was completed once data saturation was achieved. For transparency, the term "data saturation" refers to the moment in a research project when no new themes emerge during data analysis, and this redundancy signals researchers that data gathering may come to an end (Saunders et al., 2018).

4.2.3 PROCEDURE

Semi-structured, online audio-recorded interviews were used for data collection. Participants were recruited through the online survey described in Chapter 3 where after passing the screening question (see section 3.3.2 - Chapter 3), participants voluntarily signed up to the interviews. Demographic data such as age, gender, ethnic subgroup (e. g. Black British; Black African; White Asian) and socio-economic status was captured through the survey. The interview questions (Appendix 4.4) were adapted based on Pietkiewicz and Smith (2014) and Tracy (2013) who had provided a broad analogy of how a qualitative interview should be conducted. Furthermore, a pilot test was carried out with the corresponding Ph.D. supervisors to ensure the interview questions were trustworthy and reliable

4.2.4 INTERVIEW STANCE & TYPE

The interview stance of the researcher was “deliberate naivete”, which meant that the researcher discarded any prejudice thinking and judgment whilst still being open-minded to new findings (Tracy, 2013). The interview type was a narrative interview, to stimulate storytelling and discussion to best answer the research question (Tracy, 2013).

4.2.5 QUALITATIVE ANALYSIS

The IPA method of qualitative analysis was chosen to provide a detailed account for personal lived experiences (Eatough & Smith, 2008; Pietkiewicz & Smith, 2014). The IPA differs from both Grounded Theory (Mills et al., 2006) and Thematic Analysis (Braun & Clarke, 2006) in that its principal theoretical starting point is the person/speaker and their affective, mental, and physical states (Eatough & Smith, 2008; Larkin et al., 2006; Pietkiewicz & Smith, 2014). Additionally, the IPA approach assumes the researcher’s epistemological stance is concerned with the “personal lived experience and how participants make sense of that experience” (Larkin et al., 2006). In this case, the IPA stance aimed to explore how participants made sense of mental health, attitudes towards diagnosis and treatment. Furthermore, due to its idiographic commitment, this method was particularly useful in interpreting topics which are opaque, complex and emotionally laden (Eatough & Smith, 2008; Larkin et al., 2006, 2009; Pietkiewicz & Smith, 2014) thus this approach was most appropriate to answer the research question. The analysis included the stages as seen in Table 4.1 and guided by Larkin et al. (2006, 2009). “Member checking” was conducted with one of the participants to ensure the codes are interpretable and trustworthy (phase 1 & 2). Furthermore, themes were “data driven” (inductive) and an initial thematic map was conceptualised (phase 3). Moreover, the thematic map was then refined to be more concise after the review of themes in phase 4. Correspondingly, themes were defined in accordance with the authors interpretation (phase 4) alongside a “write up” strategy (phase 4). Lastly, all participants were assigned pseudonyms to protect anonymity (phase 4).

Table 4.1

Interpretative Phenomenological Analyses – Data Analysis Process (Larkin et al., 2006, 2009)

Non-technical Description	META-Description	Technical Description
Step 1 Get to **know the data.**		Reflexive reading
Step 1a Get to **know your interests** and preconceptions.		
Step 2 Conduct **detailed exploratory analysis**, staying close to the account.	***Phase 1:*** ***Working towards experiential statements***	Exploratory notes (incl. list of some useful strategies)
Step 3 **Articulate the main claims** being made about the meaning of the person's experience on the basis of their account.		Experiential statements
Important steppingstone **Step 4**		Preliminary clustering of statements (candidates of themes) Supplementary annotation

Organise the work being done around the main claims, and **supplement** it with "at a glance" annotation [Start by shuffling on screen, or on physical desktop]	***Phase 2:*** ***Working towards case-level summaries***	Reflexive threads
Step 5 **Consolidate your case analysis** in a case-level summary ***Consolidation point***		Structured consolidation of case-level work mapping to Person Experiential Themes (ensure there is a link back to key data extracts in this document: either direct quotes or page number) (include sub-themes; linked to key examples, reflections on language, metaphor, narrative, etc).
Step 6 Repeat 1-5 for each case, allowing time and space to add, go back a step, and add further reflection, interpretations or notes		**Group Experiential Themes (GET) and Personal Experiential Themes (PETS)** **(Drawing on the PETS to begin with, but examining clustered material underneath them too, for potential cross-cutting themes)** Shuffle and sort the components for developing cross-case theme (use colour to help you keep track)
Step 7 Review the case-level summaries and **identify candidate themes** which cut across the individual cases. **Step 7b**	***Phase 3:*** ***Working towards cross-case themes***	

Review the emerging analytic structure in supervision, with research team or reference/advisory group. Add further reflections, interpretations or notes Revise themes as appropriate		**Discuss** your proposed structure and revise it accordingly
Step 8 **Finalise** the analytic structure		**Finalise sub-themes and structure** Use structure to make a plan for writing up each section; use your PETs to identify quotes to support each theme
Consolidation point	***Phase 4:***	
Step 8b Review work for **audit** trail	***Working towards a linear account of the thematic structure***	Make sure your plan includes opportunities to reflect on variations across cases
Step 9 Work with supervisors, research team, or reference/advisory group to **decide how to present** some or all of the structure in a linear, written report.		Make sure your plan includes opportunities to reflect on variation across cases Reflect on the level of granularity you can include, given the document you're writing
Outcome		

4.3 FINDINGS

Fourteen BAME individuals participated in 1-2-1 interviews, to which three ethnic distinct cohorts were subsequently categorised, specifically, African (n = 4; Table 4.3), Asian (n = 6; Table 4.4) and Caribbean (n = 4; Table 4.5). Several connected superordinate and subordinate themes emerged from the analysis with, *"mental health stigma", cultural leaders and generalised dissatisfaction with mental health treatment* presenting themselves as consistent themes across the three cohorts (Table 4.3, Figure 4.1; Table 4.4, Figure 4.2; Table 4.5, Figure 4.3). Additionally, each subordinate theme is complemented by direct quotes from the transcript to illustrate its purpose.

Table 4.2

Demographic characteristics for African, Asian and Caribbean cohort

Cohort	Factor	Total Sample
African	Age	
	N	4
	Male Age	49
	Mean Female Age (±SD)	38 (± 3.6)
	Total Mean Age (±SD)	40.75 (± 6.2)
	Gender	
	Male	1
	Female	3
	Race	
	Nigerian	4
Asian	Age	
	N	6
	Mean Male Age (±SD)	28 (± 1.4)
	Mean Female Age (±SD)	28 (± 6.3)
	Total Mean Age (±SD)	28 (± 4.9)
	Gender	
	Male	2
	Female	4
	Race	
	China	1
	Philippines	5

Caribbean	Age	
	N	4
	Male Age	40
	Mean Female Age (±SD)	41 (± 4.1)
	Total Mean Age (±SD)	41 (± 3.5)
	Gender	
	Male	1
	Female	3
	Race	
	Jamaica	4

Table 4.3

Superordinate and subordinate themes for African cohort

Superordinate	**Subordinate**
1. From Struggle to Strength: Embracing MH Identity	N/A
2. Mental Health Stigma in African Culture	2.1. Cultural Stigma: Perspectives on Judgment & Weakness 2.2. Rooted Stigma: Exploring Mental Health Stigma in African Culture
3. Echoes of Discontent: Unheard Patients, Unseen Injustice	3.1. The Patient-Doctor Communication Gap 3.2. Patients Plight for Justice & Dignity
4. Overcoming Barriers: The Power of Education & Community Trustee’s	4.1. Shattering Stigma: Effective Education & Awareness 4.2. Building Bridges: Community Trustee
5. The Future: Culturally Adapted Therapy	5.1. The Power of Language in Therapy 5.2. Navigating Ethnicity & Gender in Therapy

Figure 4.1

Thematic Map – African Cohort

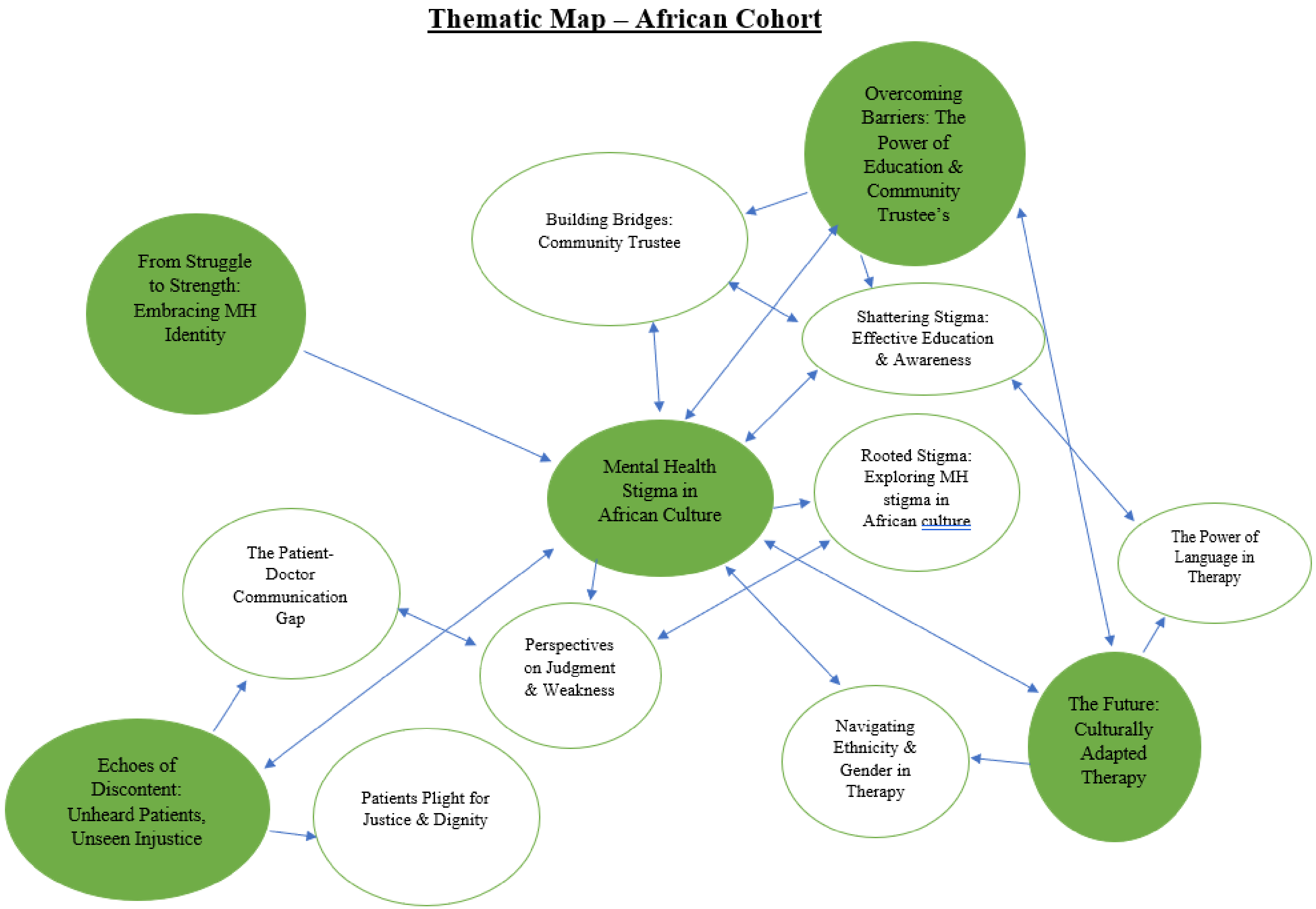


Table 4.4

Superordinate and subordinate themes for Asian cohort

Superordinate	**Subordinate**
1. The Burden of Achievement: Family Pride vs Personal Achievement	N/A
2. Mental Health Stigma in Asian Culture	2.1. Mental Health is Taboo & Perceived as Being Weak 2.2. Dismissal & Denial: The Hidden Tole of Mental Health Stigma 2.3. Mental Health Stigma Increases with Age 2.4. Gendered Struggles: Unmasking Mental Health Taboo in Asian Culture
3. Empowering Minds: The Call for Education on Mental Health in Asian Culture	N/A
4. Guiding Lights: The Role of Community Champions in Advocating Mental Health	N/A
5. Looking Ahead: Culturally Adapted Therapy	5.1. The Role of Language in Therapy 5.2. The Utility of Ethnicity in Therapy 5.3. Navigating Age in Therapy
6. Cultural Training Is Not Everything	N/A

Figure 4.2

Thematic Map – Asian Cohort

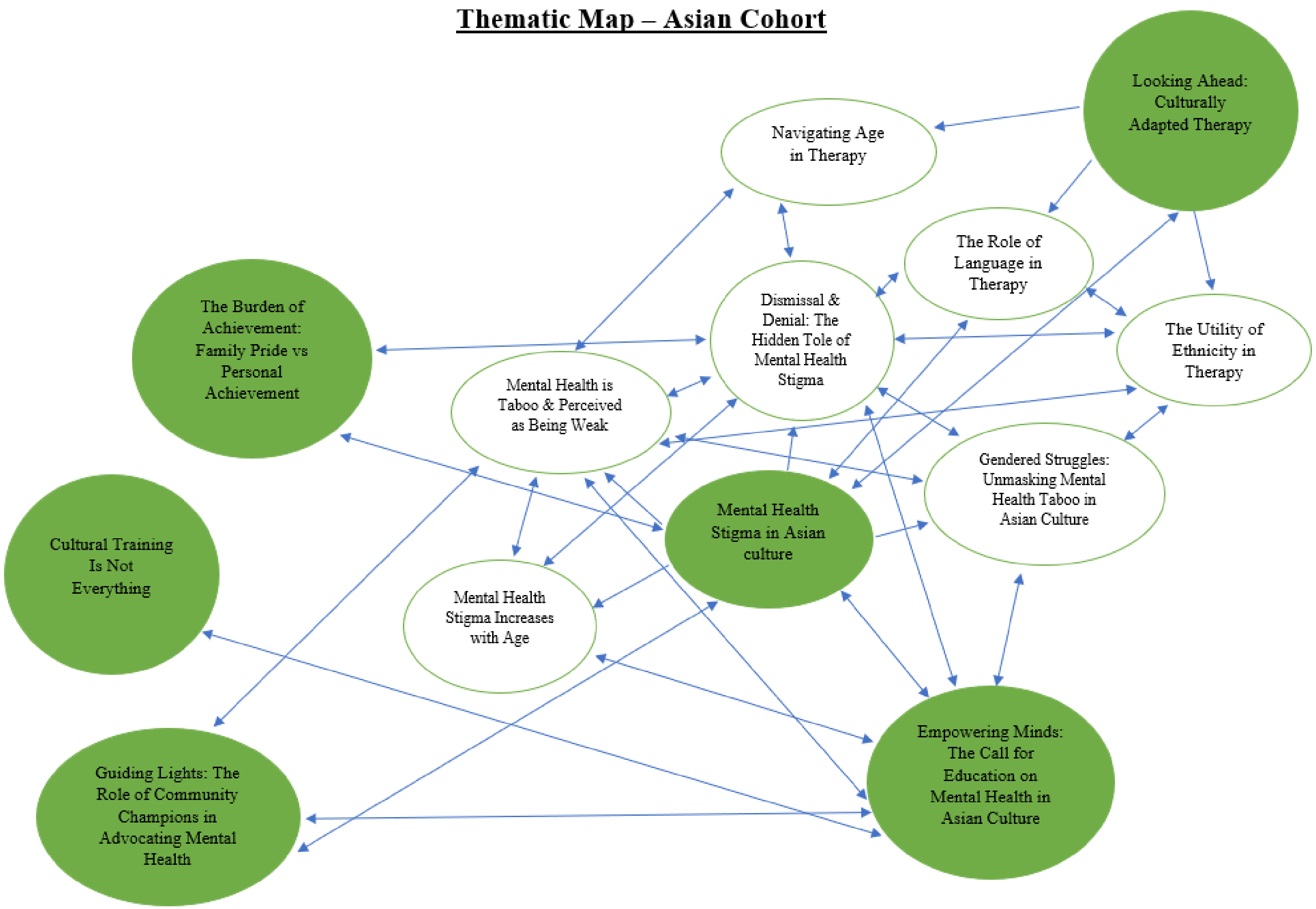


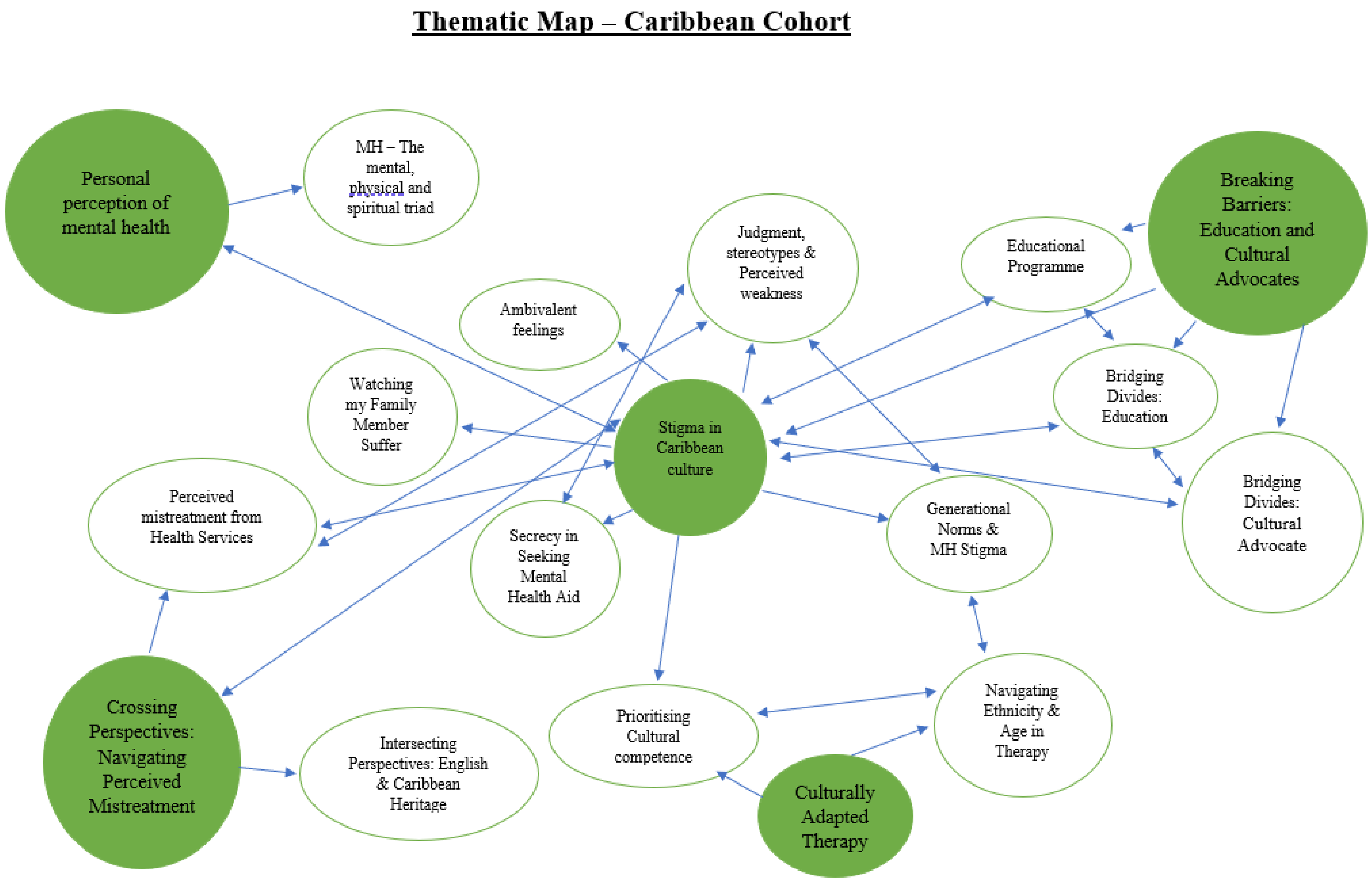
Table 4.5

Superordinate and subordinate themes for Caribbean cohort

Superordinate	Subordinate
1. Personal Perception of Mental Health	1.1. Mental health – the mental, physical and spiritual triad
2. Stigma in Caribbean Culture	2.1. Ambivalent Feelings Towards Mental Health 2.2. Watching My Family Member Suffer 2.3. Secrecy in Seeking Mental Health Aid 2.4. Generational Norms & Mental Health Stigma 2.5. Judgment, Stereotypes & Perceived Weakness
3. Crossing Perspectives: Navigating Perceived Mistreatment	3.1. Perceived Mistreatment of Health Services 3.2. Intersecting Perspectives: English & Caribbean Heritage
4. Breaking Barriers: The Power of Education & Cultural Advocates in Uniting Minds	4.1. Shattering Stigma: The Utility of Mental Health Education 4.2. Bridging Divides: Uniting Communities Through Education 4.3. Bridging Divides: Uniting Communities Through Cultural Advocates
5. Looking Forward: Culturally Adapted Therapy	5.1. Navigating Ethnicity & Age in Therapy 5.2. Prioritising Cultural Competence

Figure 4.3

Thematic Map – Caribbean Cohort



4.3.1 AFRICAN COHORT

1. FROM STRUGGLE TO STRENGTH: EMBRACING MENTAL HEALTH IDENTITY

In this theme, participants portrayed their personal mental health story and how their struggles vicariously forged their self-identity.

> *"It [having to take care of mum] took its toll on me. Like as a "by-product" of helping her I noticed that I my mental health was compromised you know. I wasn't motivated to do things that I would usually do, or better yet, things that I would usually do without any issue became almost impossible. (pause)... You know, not to going into too much detail, but you know personal hygiene, if that makes sense [not maintaining personal hygiene] and so. I think that's something, (pause) that's an experience that shaped me a lot to who I am today. [teary eyes]." (Interview 1 – Ashley)*

Stories of personal struggle associated with mental health was commonplace for most participants in this cohort. Ashley, for instance, recounted how caring for her mother affected her own mental well-being, shaping her identity and perspective on mental health. Additionally, this ontological shift resulting from mental health struggles was a common thread among all participants in this African cohort.

2. MENTAL HEALTH STIGMA IN AFRICAN CULTURE

In this theme, participants strongly suggested the presence of *"cultural mental health stigma beliefs"*, how stigma/group belief guide individual action, the presence of dismissal, denial and judgment. The subordinate themes are presented as follows:

2.1 CULTURAL STIGMA: PERSPECTIVES ON JUDGMENT AND WEAKNESS

Participants forthrightly articulated that mental health, in African culture, specifically Nigerian, is plagued with judgment-like stigma beliefs such as being viewed as *"weak"* and "*broken"* should a mental health diagnosis ensue.

> *"I know there is a sense of "hesitancy" [amongst the collective] to talk or even acknowledge mental health back in my country [Nigeria] because it is often seen as "crazy talk". Like, some common ways that Nigerian people describe their feelings about mental health are like, "Mental health is a personal issue that should be kept private"; Mental health is a Black issue that isn't talked about enough"; "Mental health is something that we don't talk about because we're afraid of being judged"; "Mental health is often seen*

> *as a weakness"; "Mental health is often ignored or misunderstood".." (Interview 2 – Harry)*
>
> *"Okay, from my cultural heritage? Mental health is seen as if you're crazy, because it is believed that mental health is crazy talk. Do you understand? ... Most people wouldn't want to come out clearly to talk about mental health for fear of being judged. So the problem is because mental health is seen as a negative thing, people don't want to open up about it."* (Interview 3 – Ayofemi)

The narratives of Harry and Ayofemi applied to other participants in the cohort who felt similarly the issue of mental health stigma. Specifically, these judgment-like mental health stigma beliefs were described as modern, widespread, and deeply harmful, with Ayofemi illustrating that fear of judgment often prevents individuals from seeking mental health aid. All participants felt the weight of these stigma beliefs and collectively desired change.

2.2 ROOTED STIGMA: EXPLORING MENTAL HEALTH STIGMA IN AFRICAN CULTURE

Participants provided a detailed account on the origin of stigma, its insidious nature, and how historical views/mistreatment likely shaped views on mental health today in Nigerian culture.

> *"I'm not sure if you covered this in your writing and so forth, but you know, lobotomy, and, mental health asylums, was the norm way back then for people who were mentally ill. Then in African culture, in particular tribes and so forth, if people were seen as acting weird or different, they were subjected to some form of witchcraft and, you know, being ostracised as a result. So, considering my parents and my grandparent's view, ... because they had seen how people were treated back home [Nigeria], particularly around lobotomy, mental health asylums, there's still that sense that they or members of their family would be treated similarly."* (Interview 1 – Ashley)

Ashley's narrative vividly captures why many others share the belief that mental health stigma is deeply ingrained in African, particularly Nigerian, culture. Drawing on historical context and the experiences of parental figures who endured inadequate mental health treatment during formative years, most participants concluded that this historical legacy contributes to the stigma surrounding mental health in Nigerian culture. Other participants also suggested that they may inherit generational apprehensions about mental health, possibly influenced by their parents' similar concerns.

3. ECHOES OF DISCONTENT: UNHEARD PATIENTS, UNSEEN INJUSTICE

In this theme, participants emphasised their stories of not feeling heard by service providers and the persistent and pernicious injustice/mistreatment that they perceive to exist at an institutional level. The subordinate themes are presented as follows.

3.1 THE PATIENT-DOCTOR COMMUNICATION GAP

Participants highlighted their dissatisfaction with health-care practitioners, particularly lack of interpersonal communication skills on the part of the practitioner and not feeling heard, prioritised or understood.

> *"Yeah, sure. So, when I was going through the issue that I spoke to you about previously [mental health struggles]. I did see a GP at the time, who, I would say was helpful, but I don't think he understood me that much or maybe I didn't explain myself in way that called for a sense of "urgency". Like, I explained what I was going through in short, and how I was feeling and that I wasn't really doing my "usual routine" and, basically, I was told that "this will pass" and "to not worry". To me, it's the doctor's responsibility to "pick up" on the cues and help people appropriately." (Interview 1 – Ashley)*

Ashley's story replicated most of the participants in this cohort. Despite overcoming cultural barriers to seeking mental health support, participants expressed frustration at not feeling heard or understood by service providers. This lack of recognition led many to perceive their efforts to address mental health issues as futile. Many participants also felt that this dynamic between service users and providers reinforces stereotypes in African culture.

3.2 PATIENTS PLIGHT FOR JUSTICE AND DIGNITY

In this theme, participants articulated their perception of continued institutional injustice and mistreatment that continues to plague individuals of African heritage.

> *"I think there's a number of things that hold people back from Nigerian communities. I think obviously the stigma is prevalent but ... especially in what I can tell, ... the healthcare systems, there's continued injustice, where patients are not feeling prioritised or heard or being mistreated. When I go to the clinic, it's an overall negative experience, then I don't feel like I want to go back because it was kind of a waste of time." (Interview 2 – Harry)*

> *"There's also quite you know, an unfortunate side that holds people back. There's a lot of injustices in our healthcare system that also plays a role in holding people back or*

> *prioritizing mental health because they don't want to be subject to continual mistreatment." (Interview 4 - Ngozi)*

Both Harry and Ngozi illustrated strong stances on the notion that continued mistreatment, and injustices exist at institutional level. Many participants attributed this mistreatment and injustice as a consequence of not feeling heard or prioritised, with other participants hinting at historical injustice and mistreatment that has simply gone unresolved till present day and has become normalised.

4. OVERCOMING BARRIERS: THE POWER OF EDUCATION AND COMMUNITY TRUSTEE'S

In this theme, participants emphasised what factors could encourage them and other members of their heritage to engage with mental health services. With a focused importance in improving education on stigma, increasing awareness and utilising a key member of the community to act as a "third party" for the rapport process between practitioners and Nigerian citizens. The subordinate themes are presented as follows.

4.1 SHATTERING STIGMA: EFFECTIVE EDUCATION & AWARENESS

Participants illustrated a unified call for more education, particularly around *"how to break down stigma"* in Nigerian culture.

> *"Increasing awareness and education is a common thing and to be honest, you can always google anything you want these days to get your answer,… so when I say more education,… I mean more education on not just "what mental health is", but more education on "how to deal with mental health" and "education on how to breakdown barriers of stigma" and try to increase relatedness between people who have a mental health condition and between patients and practitioners. So perhaps if there was, you know, some work done for doctors on culture, then it's just about finding that middle ground for people to come together." (Interview 2 – Harry)*

Harry's story speaks to the notion of wanting to change the lens of how mental health is viewed, to vicariously introduce the importance of mental health in Nigerian culture and raise general awareness due to the closed off nature of the community. Additionally, Harry yearns for an effective educational component that not only illustrates the general importance of mental health but how to break down barriers of stigma that, to the participants, seem deeply rooted in their culture. Lastly, an emphasis was placed by all participants in this cohort to delineate education or cultural training to service providers to further combat pernicious cultural stereotypes.

4.2 BUILDING BRIDGES: COMMUNITY TRUSTEE

As an adjunct to education and raising awareness, “community trustee” was called upon to act as a bridge between members of the Nigerian community and health practitioners to compensate for mistreatment and contemporary injustices.

> *“Maybe even getting “key people in the community” who could encourage other members of the community to engage with hospitals and charities. So, the “key member” could act as a “ongoing referral”- to act as a signpost of reassurance for people.” (Interview 1 – Ashley)*

> *“So, having somebody who's in the community and who's trusted is a good thing because at least in the Nigerian community, anyone who's not from the community is kind of viewed as an outsider. So having someone who is from the Nigerian community as a representative to kind of lead that process is something that I think again, would reduce the amount of distrust towards let's say… outsiders. So, so yeah, that's what I would say.” (Interview 4 - Ngozi)*

Ashley and Ngozi called for the implementation of key representatives in the Nigerian community to act as a liaison between service users and providers, with all participants echoing a similar stance. Additionally, Ngozi, provided a unique insight in that people of the Nigerian community tend to view others who are not from that circle as an outsider and thus potentially fragmenting rapport and trust. While others in the cohort shared this view, Ngozi was the only one to delve into the concept of insider versus outsider group identity.

5. THE FUTURE: CULTURALLY ADAPTED THERAPY

In this theme, participants presented their feelings towards the significance of language in therapy and ethnic-vs-ethnic matching. The subordinate themes are presented as follows:

5.1 THE POWER OF LANGUAGE IN THERAPY

Participants articulated that being able to speak the same language as the practitioner or be given translated texts could improve psychotherapeutic rapport, as stated:

> *“It's very, very important [translation of text or the use of an interpreter for langauge]. So, language or dialect definitely is important, maybe even the most important thing you know.” (Interview 3 – Ayofemi)*

> *“I think the translation of texts, or the use of interpreters or languages is a big one. And you know, there is many people who I know from the Nigerian community including myself, who speak English, but because of our strong accents and our experience with English people not understanding what we're saying, ... It can make me and even some of my friends feel quite self-conscious about talking in English and trying to express ourselves. So and having the roles switched where the practitioners are the ones reaching out to us in our language, can help us with feeling more comfortable and opening up.” (Interview 4 - Ngozi)*

Both Ayofemi and Ngozi illustrated that common lexicology could act as a mechanism for vicarious expression of emotion and mitigate discomforting feelings in addition to the probable utility of text translations, and the use of interpreters. Speaking a shared language reduces the sense of judgment and enhances feelings of acceptance, as noted by the participants. Additionally, they expressed that therapy conducted in their native language enables them to articulate complex and nuanced emotions more effectively, which might otherwise be challenging in a non-native language.

5.2 NAVIGATING ETHNICITY AND GENDER IN THERAPY

Participants articulated that having the practitioner be of the same ethnicity was advantageous to help build common experience and rapport. However, they also underscored the potential challenge of implementing this adaptation when the therapist is of the opposite gender.

> *“Hard to say really. I mean, I think it's quite important to have a health professional, be of the same ethnicity as the patient. Because I think that would create an opportunity for people to relate better. I mean, that would be my assumption. So, I think out of everything that you said that [ethnic vs ethnic matching] seems to be a particular feature that's quite important to me from what I picked up on. Now, whether that actually helps or by how much it helps I'm not too sure, but I think for me personally, if I was to see someone who is of Nigerian descent and perhaps also female, that would maybe be slightly easier to relate with one another.” (Interview 2 – Harry)*

Narratives of gender-matching the service user to the serve provider was commonplace amongst the cohort. According to the participants, certain topics of discussion during therapy, would be difficult to discuss with the opposite gender, potentially weakening the therapeutic alliance. This awareness of gender-matching was seen as inherent in Nigerian culture, where females may feel more comfortable discussing female-related issues with female practitioners, and vice versa for males.

4.3.2 ASIAN COHORT

1. THE BURDEN OF ACHIEVEMENT: FAMILY PRIDE VS PERSONAL ACHIEVEMENT

Participants in this theme highlighted their upbringing and the common tension between balancing family expectations and personal achievement.

> *“When I was younger, ... (pause) there was tremendous pressure to perform, and if you didn't perform, (pause) to excel in levels in terms of grades, then you're seen as a “disappointment” to the family to some extent because… if a child has less desirable grades compared to other children, (pause) then the child’s parents are seen as a failure just as much the child. So, it's sort of, and this will sound very stereotypical, but it is sort of bringing shame to one's family. And, ... (pause) I love my parents, but other parents were and still are very “prideful” and sometimes that’s seen as more important than anything else, ... (pause) which is sad.” (Interview 2 - Jake)*

Jake’s story illustrates the complex interplay between balancing group identity, (i.e., familial status) vs individual identity (i.e., individual status). This dynamic was illustrated cogently by all participants in the Asian cohort, with all participants pointing out that, in many cases, how the family is perceived holds significant importance and influences various aspects of family dynamics, including mental well-being. All participants expressed that their parents placed great importance on the family's social standing, influenced by their child's achievements.

2. MENTAL HEALTH STIGMA IN ASIAN CULTURE

In this theme, participants showcased their views on mental health stigma, with comments on how mental health is viewed, the burden of admitting a diagnosis and the shift in attitude between younger and older Asian generations towards mental health. The subordinate themes are presented as follows.

2.1 MENTAL HEALTH IS TABOO AND PERCEIVED AS BEING WEAK

Most participants vividly portrayed a clear message that for an individual to admit to having a mental health diagnosis or problem, they are likely to be viewed as being weak in addition to mental health being a taboo subject.

> *"I think it's just because I've grown up in a family, where we've always believed that "mental health is weakness". It's like (pause) we've always believed that "being resilient" is more important than "talking about mental health", and, in a sense, if I talk about my mental health, (pause) it's like "oh you're being very emotional" you're "pouring out your feelings too much." (Interview 3 - Jeremy)*

> *"So, (pause) as you may have guessed you know, (pause) mental health is understood in my family as a "taboo" topic and something that's "uncomfortable" to talk about. With that family environment being, (pause) unpredictable, coupled with Asian culture where "mental health" is stigmatised and those who are having a mental health problem are seen as "weak", (pause) "broken" or like, (pause) "judged", (pause) discussing mental health is simply not well received by others." (Interview 6 - Nari)*

All participants in the Asian cohort underscored the persistent notion of mental health being a "taboo" alongside the common notion of being viewed as weak or inferior compared to others. Social perception manifested itself as an important determinant for participants behaviour, with all participants expressing a rugged stance to avoid being viewed as weak individuals. Seemingly, portraying a facade of resilience in exchange for preserving self-image in the presence of family and friends was a main driver of motivation for behaviour. Furthermore, the fear of being labelled with negative stereotypes, as depicted in Nari's narrative, further reinforced their reluctance to engage in conversations about mental health.

2.2 DISMISSAL AND DENIAL: THE HIDDEN TOLE OF MENTAL HEALTH STIGMA

Participants detailed the common notion of being subject to different treatment if diagnosed with a mental health disorder:

> *"I guess, the "common attituded" towards mental health is really, "dismissive" and doesn't encourage "story telling" or "open discussion" which I know are things that help people manage mental health. Like, (pause) if someone was diagnosed with a mental health disorder, in an Asian community, (pause) there wouldn't be a "riot" outside someone's house rather, there would be a day-to-day change in interactions between people that*

> *would affect how the person feels, (pause) like "passive aggressive" or better to say, "passive dismissive" way people behave." (Interview 4 - Aidan)*

Aidan's story highlighted the insidious nature of how others would act towards someone who has a known mental health diagnosis. All participants in the Asian cohort indicated this phenomenon to be true although they found it challenging to articulate specific changes in treatment by other members of their group (i.e., family, friends, co-workers). However, they noted that people around them would often begin to distance themselves, behave less authentically, and adopt a condescending attitude.

2.3 MENTAL HEALTH STIGMA INCREASES WITH AGE

Participants illustrated that older generations in Asian culture seem to hold stronger views of mental health stigma:

> *"Okay um the attitude towards it [mental health]. I would say among young people in my culture it [mental health] is definitely something more talked about. But I would say in the older generation of my culture it [mental health] is still something very "taboo" and not talked about or even seen as important. Nobody in the older generation dives into mental health, so I think there's two kinds of like "age group attitudes" towards it which is why that difference in attitude towards mental health between generations creates a lot of friction and misunderstanding." (Interview 5 – Sam)*

All Asian participants reported that there are age differences in how mental health is viewed in Asian Culture. Specifically, younger generations were more accepting of mental health issues, while older generations viewed them as taboo. While factors like contrasting upbringings and technological shifts were cited as potential explanations, many participants attributed the negative view of mental health among older generations to their own parents' (and elders') challenging and deprivation-filled lives. In such poverty-stricken environments, mental illness was often perceived as a "luxury" that hindered survival in the face of harsh realities.

2.4 GENDERED STRUGGLES: UNMASKING MENTAL HEALTH TABOO IN ASIAN CULTURE

Participants articulated that alongside age-related dynamics, gender specific stereotypes also exist in Asian culture:

> *Like, ... (pause) you know men, men in Asian culture, like, I'm a woman and "mental health" is not encouraged even amongst us [women] let alone Asian men. So, there are,*

> *different social norms for the men and women in Asian culture that further exacerbate the issue of "mental health stigma"." (Interview 1 – Maya)*

Narratives of gender specific stereotypes fuelled by societal pressures were articulated by most of the participants in the Asian cohort. Both male and female participants were hesitant to seek health care due to the fear of being judged by their social peers. However, male participants whilst reporting this hesitation, experienced compounded societal expectations to embody a "masculine" persona devoid of emotional vulnerability. Specifically, seeking mental health support as a man was perceived as incongruent with the desired masculine image, creating internal conflict between societal norms and personal needs.

3. EMPOWERING MINDS: THE CALL FOR EDUCATION ON MENTAL HEALTH IN ASIAN CULTURE

Most participants strongly recommended the increased utilisation of *"education"* as a tool for amplifying mental health engagement.

> *"Like, more education… so it [mental health] should be seen as something that requires, early detection and early management at best." (Interview 2 - Jake)*
>
> *"I do think there are ways of talking it [mental health.] Like, (pause) I think the most important thing is just kind of "defining" what mental health is [for people of Asian descent] as people don't have much of an understanding of it and, the people who are in "most need" of it I think are the "older generations" as they've been "shaped" by their upbringing." (Interview 4 - Aidan)*

Participants felt that stigma seemed to be born of generational upbringing and general ignorance. Consequently, participants supported the idea that increased education, specifically for older generations, is needed to challenge stereotypical views in Asian culture. Additionally, participants illustrated that whilst physical health has clearly defined parameters, mental health does not. Participants suggested that defining mental health concepts for generations unfamiliar with Western culture could promote behavioural changes and improve mental wellbeing practices. Specifically, mental health definitions including early detection (i.e., signs or warnings) were of interest to all Asian participants.

4. GUIDING LIGHTS: THE ROLE OF COMMUNITY CHAMPIONS IN ADVOCATING MENTAL HEALTH

Participants presented their desire for a *"community champion",* a trusted member of the community to represent the Asian community and be the *"first line"* of contact for health services and community members.

> *"I don't know if this is something that's done but having a key "influencing member of the community", like a pastor in a church or something could help people "come together" and like "build a programme" [practitioner and pastor] or something that people from my culture would feel more inclined to trust that program. In Asian culture specifically, everything is done by "example". And you know, if a key person or trusted pastor or member of the community is engaging with key stakeholders per say, then that's something that I think would really help get people "to come".* (Interview 1 - Maya)

> *"As most of the people I know are all religious so like, (pause) if a pastor was to "take charge" in that education session, perhaps alongside a healthcare professional, then maybe trust and acceptance could be established."* (Interview 4 - Aidan)

Maya and Aidan emphasised the utility of pastors or influencing figures within Asian communities to serve as links between mental health service users and providers, a notion echoed by all participants. Additionally, Maya offered a distinctive perspective, highlighting that if key individuals engaged with mental health practices/professional, then others would be more likely to follow along. This strategy also seemed to participants as if it could act as a "buy in" for older generation and vicariously attenuate barriers to mental health education and thus, therapy acquisition.

5. LOOKING AHEAD: CULTURALLY ADAPTED THERAPY

In this theme, participants expressed their thoughts on *"culturally adapted therapy"*, indicating that they believed *"culturally adapted therapy"* was a *"good initiative"* with further consideration of adaptations and the necessity for cultural training. The subordinate themes are presented as follows.

5.1 THE ROLE OF LANGUAGE IN THERAPY

Participants articulated that at content level, text translations and common dialect are preferrable tools to forge group cohesion and rapport during therapy.

> *"You know the "text translations" would be useful and could be good for an Asian group who may need to change the dialect. So, ... steering the course of discussion in that, "light" might help increase the relationship between both parties [practitioner and patient]. So, I would say that the "text translation" that helps patients to develop a good knowledge base, are, ... (pause) I think really important points" (Interview 1 - Maya)*
>
> *"If you added the therapy in "Tagalog" [Filipino dialect], then that would make people more comfortable for sure because most Filipino's who are older, either don't speak English or find it difficult to express themselves fully in English so, having it in their own language would make things more flexible I think." (Interview 5 - Sam)*

Participants highlighted the importance of text translations and common dialect for elderly populations in Asian culture, in particular how this could build trust and rapport amongst a cohort with unidimensional views. Many participants emphasized the increasing value of language and dialect, especially for older individuals who may be less forthcoming about mental health issues and constrained by language barriers. Therefore, adapting therapy to native dialects where feasible was viewed as a meaningful gesture by therapists, fostering rapport with older generations.

5.2 THE UTILITY OF ETHNICITY IN THERAPY

Participants highlighted their stance of ethnic matching, with all participants being in favour of its implementation:

> *"I find sometimes that it's easier for me to talk to someone who knows what I've been through, and the only way that can be done sometimes is with somebody who's Filipino. I do feel that in order for some therapy like this to work I think ethnic matching would be a good thing." (Interview 3 - Jeremy)*
>
> *"Like, (pause) having someone from the same background as you can definitely help. Especially like, if they're a healthcare practitioner because people would be more likely to trust them. Which sounds kind of counterproductive because it's the "same people" who would have experienced the same level of stigma, but I think in a healthcare setting, (pause) people are their because they need help and having someone from the same*

> *background would create that initial "trust" that most people find difficult to build from our culture." (Interview 6 – Nari)*

All participants expressed a preference for matching ethnicities between patients and practitioners, emphasizing that sharing the same ethnicity, from the patient's standpoint, implies that the practitioner has undergone similar struggles, fostering empathy. In the view of the participants in this cohort, having the same ethnicity created a zone of safety and comfort, especially among "outsiders" who might not comprehend the daily challenges and stereotypes. Moreover, participants believed that such circumstances would likely cultivate a more therapeutic environment and enhance adherence to therapy.

5.3 NAVIGATING AGE IN THERAPY

Many participants illustrated that despite the utility of ethnic-matching, age-differences should be considered in future adjustments to therapy:

> *"I know this isn't really "adapted" but something to be aware of is that "age" plays a part in "how good" the session would be because most elders won't really listen to anyone who is younger than them or maybe, (pause) they'd have a slightly harder time accepting information coming from someone who is younger as they see that as "why is younger person telling me what to do and not respecting me" kind of thing." (Interview 4 - Aidan)*

> *"If you had a young "20-year-old Filipino" therapist speak to a "60-year-olrd Filipino" patient, chances are the patients will not see them with the same level of respect because of that whole "respect your elder" thing and any advice given by the patience could be seen as "disrespectful" as the patient would feel that their being "told what to do"." (Interview 5 - Sam)*

All participants highlighted that age differences between the patient and practitioner matter in Asian culture as if the practitioner is younger than the patient, the counsel might be interpreted as patronising and undermining the patient's authority, instigating a sense of disrespect. In Asian culture, participants explained that importance is nested on "respecting your elders" and adhering to a social hierarchy, where older individuals typically occupy higher positions than the younger ones. Therefore, participants believed this social norm inculcates itself in psychotherapy and may affect the therapeutic alliance.

6. CULTURAL TRAINING IS NOT EVERYTHING

"Cultural Training" was a polarising topic of discussion, with participants calling for its implementation:

> *"I think something that may help, ... (pause) is like some sort of training to give people with non-Asian backgrounds the opportunity to learn about the culture and the specific stigma around mental health and to then be more skilled at working with people from Asian backgrounds. The training can also service people from Asian culture the opportunity to "break down" barriers of stigma, and why these should change." (Interview 2 - Jake)*

Whilst other participants felt that *"cultural training"* alone is no substitute for *"communication skills"* and that it would be difficult to *"culturally train"* someone.

> *"I find that this [cultural training alone] would be very difficult [to improve therapy outcomes] because what is just as important as the "cultural training" is the person's ability to use their communication skills to relate in the first place so it's not like "cultural training" could be a substitute for that alone. (Interview 3 - Jeremy)*

> *"I think you can try to culturally train people but it really depends on what kind of training,. Specifically, what are is this training in culture? ... What is involved in the cultural training programme because you can't really train a person to know somebody else's culture. For example, I've moved here from the Philippines, although I've not "trained myself", I still don't think that my culture is "British" does that make sense. I think, it's really difficult to "train someone" not to mention it is not substitute for communication." (Interview 6 - Nari)*

As illustrated, cultural training manifested itself as a polarising subject matter, with most participants believing in its utility expressing reservations due to uncertainty about its content. Participants emphasised that training could not replace effective communication but may reduce cultural ignorance. Some participants were in favour of focusing on conveying concepts like social hierarchy to outsiders, believing it could improve their understanding of cultural dynamics.

4.3.3 CARIBBEAN COHORT

1. PERSONAL PERCEPTION OF MENTAL HEALTH

In this theme, participants emphasised their personal relationship with mental health, with insight in what mental health means to them in addition to mixed feelings being present whilst contemplating on the subject matter.

1.1 MENTAL HEALTH – THE MENTAL, PHYSICAL AND SPIRITUAL TRIAD

Participants articulated the meaning of mental health which was akin to being perceived as a *"triad"* of components.

> *"Mental health to me means being at peace with yourself physically, mentally and spiritually. Being a spiritual person,… So that aspect to "who we are" is really important to me and what I mean by "at peace", I mean in full acceptance of who we are, physically, in terms of looks, mentally in terms of our relationship with our mind and spiritually, in terms of our relationship with God. And to add to that, I really believe that even though "mental health" implies only the "mental" aspect to health, the "mind" is nothing without a healthy body and soul. Haha,… I know, very deep but I truly believe that. So, that's what mental health means to me,…mind, body and spirit [that all three themes should be "intact"]." (Interview 1 – Samira)*

Samira's description of maintaining a healthy relationship with her body image, thought process and spirituality emphasised the interconnectedness of each phenomenon suggesting a holistic approach where each component cannot operate without the other. This message seemed to be core to what she believed mental health to be, and she challenges the notion that mental health is exclusively related to cognitive processes. Her passage also echoed resemblance with other participants perspectives, indicating a shared belief in the multifaceted nature of mental health and the necessity of addressing all domains for comprehensive well-being.

2. STIGMA IN CARIBBEAN CULTURE

In this theme, participants articulated their experience with mental health stigma in Caribbean culture, and the insidious nature it has in affecting multiple domains of life. Specifically, mixed feelings with mental health due to negative stereotypes, frustration with mental health services, views of mental health with family and the common nonchalant attitude towards seeking mental health aid. The subordinate themes are presented as:

2.1 AMBIVALENT FEELINGS TOWARDS MENTAL HEALTH

Participants highlighted *"mixed"* feelings towards mental health due to mental health stigma presenting itself during upbringing. One participant provided a detailed story of how and why such feelings exist.

> *"Well, I think my feelings now towards mental health are more positive as I'm getting older and more exposed to the culture here in the UK but when I was younger, growing up in a Jamaican household, my feelings were more negative and "shameful" whenever I thought about "how I felt" as, at the time and even now to some degree, uhm… (pause), admitting that you have a "mental problem" was thought to be "shameful", "broken", or "being crazy". So, yeah, it wasn't easy as I remember growing up and mental health being understood that way [negative way]. So its complicated but those negative feelings from when I was growing up for the mental health side was definitely sort of a common thing because of negative stereotypes, like "fear of being judged" and "seen as differently by others", being seen as weak" – so it really wasn't anything to be proud of really. That's how I would describe my feelings back then and pretty much how they are now. Overall "mixed" but still work in progress I guess." (Interview 2 – Magnus)*

Magnus illustrated a change in stance towards mental health through the decades of acculturation in UK. Despite this evolution, he expressed self-deprecating sentiments when contemplating his own well-being and highlighted the social stigma surrounding mental health disclosure within his community. This transition from a negative to positive state seemed to be common among Caribbean participants, though varying levels of comfort were evident due to past negative experiences. Moreover, the pervasive negative connotations associated with mental health seemed to shape individuals' self-identity, leading them to avoid association with mental health issues due to societal stigma.

2.2 WATCHING MY FAMILY MEMBER SUFFER

Participants shared comprehensive personal stories of mental health, with one participant providing a picture of how they were affected mentally by struggles of their younger sister and how the insidious nature of mental health stigma in Caribbean culture played a role in exacerbating the issue.

> *"To be honest with you, (pause) my mental health experience was felt through watching the mental health struggles of my younger sister. She had been through her own mental*

> *health issues of anxiety and depression which affected my feelings and even came to the point of impeding, everyday activity because I was so worried about her health and there was nothing I could do to help her directly. All I could do was to pray, be patient and hope that everything turns out okay. But that hasn't been the case for my sister, because we have a close "sibling-ship" you don't want to watch her go through some of the trials and tribulations you know people who have diagnosed with depression go through. From the suicidal thoughts to her isolation and losing her independence, … (pause) it was tough. So, one of the motivations that brought me here today is to try to bring light on that story. I'm not too comfortable going into the specifics of what my sister been through because, it is her story and stuff, but I guess at the same time some of the things that I you spoke to about before for the "stigma" and "negative stereotypes" were definitely present things whilst my sister was going through her health issues." (Interview 3 – Bruna)*

Stories about individual suffering as a consequence of observing other family members struggle with mental health was common amongst the cohort. Bruna's account was particularly poignant, imbued with deep care, emotion, and significance as she recounted her sister's deteriorating mental health. This theme of familial impact was prevalent among other participants, highlighting the additional layer of suffering and discomfort imposed by societal stigma surrounding mental illness. Furthermore, the constant presence of mental health stigma experienced by Bruna's sibling, profoundly impacted Bruna's experience and fuelled her desire to highlight the burden of mental health and stigma within Caribbean culture, giving her a strong sense of purpose and meaning.

2.3 SECRECY IN SEEKING MENTAL HEALTH AID

Participants were quick to illustrate an attitude of secrecy towards seeking mental health aid in an attempt to not be judged by their peers.

> *"I don't know, actually because it [talking about seeing a therapist for your mental health] is not, you know something that's spoken about a lot. (pause) I mean, most people don't really disclose when they go to GP, let alone when they seek a therapist. So, I think even the whole connotation of seeking mental health therapy specifically is quite stereotypical. So, you can imagine how I felt, and obviously none of my family, … (pause) and even if most of my close friends don't even know that that's what I did [went to a therapist], you know?" (Interview 2 – Magnus)*

Stories of secrecy in the name of preserving ones social/familial identity was point of both importance but also self-distain for most participants. Magnus, much like the other participants, emphasised the significance of maintaining privacy regarding mental health matters, yet lamented the lack of openness within social and familial circles. The pervasive secrecy surrounding mental health, , appeared deeply entrenched within Caribbean culture, emerging as a societal norm. It was apparent through dialogue with other participants and Magnus that there was a shared desire for societal change, reflecting a collective consensus to challenge the dismissive attitudes towards mental health within social and familial contexts.

2.4 GENERATIONAL NORMS & MENTAL HEALTH STIGMA

Participants illustrated stories of how generational views on mental health shaped their ontological lens with the subject matter.

> *"My family and particularly my parents and older generation, due to their upbringing and strong cultural values about "mental health" have very narrowminded and different views from my personal understanding [with mental health], and by different I mean,… "closed off", "hesitant", and just a general lack of acknowledging its "existence or importance", basically." (Interview 1 – Samira)*

> *"When I was growing up,… mental health was understood within family as a "taboo topic" and not something that was very much touched on or talked about in a lot of detail." (Interview 2 – Magnus)*

Narratives of generational views on mental health largely influenced the contemporary psyche of most participants in this cohort. Participants express a strong affinity with parental figures, yet these connections are tempered by the antiquated viewpoints held by previous generations regarding mental health. Consequently, the prevailing sentiment suggests that the generational dismissal or neglect of mental health issues by parental figures has engendered a pervasive stigma surrounding the topic within the cohort.

2.5 JUDGMENT, STEREOTYPES AND PERCEIVED WEAKNESS

Participants illustrated the common place issue of mental health stigma in Caribbean culture. One participant provided comments on the "origin" of mental health stigma in Caribbean culture.

> *I think, there is a fear of being seen as "weak" and maybe,…"Incompetent?" Or "broken". I'm not sure myself,… but, in my experience, common things that are on the opposite end of the spectrum [to being positive with mental health], are …, for example,… mental health is seen as a "trivial" issue or just a "phase" or it's like "suck it up", "get over it" or "it's not that big of a deal" or "your just looking for attention". (Interview 1 – Samira)*

Closely associated with the preceding themes "generational norms & mental health stigma", participants unanimously emphasised the notion of being viewed as "weak" or "broken" if admitting to mental health issues or being seen as having ill mental health. The resulting judgmental atmosphere, coupled with the fear of being perceived as weak, served as important drivers for maintaining secrecy surrounding mental health concerns.

3. CROSSING PERSPECTIVES: NAVIGATING PERCEIVED MISTREATMENT

In this theme, participants showcased strong feelings of discontent towards the notion of perceived mistreatment on the part of health institutions and cultural incongruencies between English and Caribbean culture.

3.1 PERCEIVED MISTREATMENT OF HEALTH SERVICES

Participants noted their frustration with health services, feeling, judged and not receiving adequate support. One participant painted a story for their negativity towards health services in addition to not feeling *"heard"*.

> *"I It [experience with health services] hasn't been positive and that's primarily why I look towards meditation as my coping mechanism for stress basically., Even when I've managed to get in contact with a healthcare professional, I don't feel heard or listened to or our ability to connect is limited. And I know that a lot of people need to be seen and not all doctors have a lot of time to spend with their patients but, quality over quantity in my opinion! [best to see less people and have an impact then more people and not have an impact].." (Interview 1 – Samira)*

Numerous participants expressed dissatisfaction with the healthcare system in the UK, highlighting a profound longing to feel understood and valued, yet often encountering the opposite. Samira's account specifically addresses the challenge of establishing meaningful connections and rapport with healthcare providers, which she believes exacerbates feelings of discontent. Similar sentiments were echoed by many other participants, who also harboured reservations about seeking assistance due to perceived mistreatment by medical professionals.

3.2 INTERSECTING PERSPECTIVES: ENGLISH & CARIBBEAN HERITAGE

In this theme, participants provided a detailed account of the different cultural nuances between English and Caribbean culture and why cultural incongruency associated with mental health holds individuals back from engaging with health services.

> *"Yeah, another interesting one [what holds people back], I think it might be a slight disconnect in how people perceive their mental health, and you know what it means in their culture. It is likely that those who are diagnosed view their world differently and due to ignorance, perceive the world and their place in it differently.. Like someone who has grown up you know with English heritage,…(pause) he's never had to do deal with "negative mental health stereotypes" or doesn't understand where that person [from Caribbean heritage] has been in terms of their experience. They [English heritage] may not understand the underlying reasons for mental health issues in the Jamaican community because the "struggles" were different, you know.." (Interview 4 – Chase)*

Many participants highlighted a significant barrier to building rapport between English and Caribbean individuals—the disparity in upbringing and cultural experiences. According to Chase, the cultural struggles unique to the Caribbean community are often misunderstood by those from an English heritage. Chase emphasized that individuals from English backgrounds may struggle to grasp the negative mental health stereotypes prevalent in Caribbean culture. This misunderstanding contributes to ongoing tension and reluctance to seek healthcare assistance.

4. BREAKING BARRIERS: THE POWER OF EDUCATION & CULTURAL ADVOCATES IN UNITING MINDS

In this theme, participants showcased in their view the utility of education in combating stigma beliefs and education serving as a tool for brining communities together. . The subordinate themes are presented as follows.

4.1 SHATTERING STIGMA: THE UTILITY OF MENTAL HEALTH EDUCATION

Participants highlighted the value of education to fragment stereotypes and provide clarity amongst citizens of Caribbean heritage.

> *"I think what would help would be some form of education given to people of Jamaican communities to break down barriers of stigma and understand the importance of mental health and why it [mental health] needs to be managed seriously. Perhaps equally important is to have programme that's really relatable to the community in terms of culture, common struggles, experiences,… basically, have a "common ground" for people to talk things through and help tackle some of those negative associations.." (Interview 1 – Samira)*

Stories of education as a tool to combat the pervasive nature of stigma and stereotypes was commonplace amongst participants who desired change. Samira's stance on integrating an educational programme is of idiosyncratic nature compared to the other participants as she emphasized not only the notion to tackle stereotypes but that the educational programme should be culturally relatable to facilitate a common-talking-ground fostering an environment where individuals feel more comfortable in addressing sensitive topics openly.

4.2 BRIDGING DIVIDES: UNITING COMMUNITIES THROUGH EDUCATION

Participants highlighted the usefulness of education in facilitation group cohesion. Specifically, one participant shared a comprehensive account on how education could be used as a vehicle to patients and practitioners together whilst breaking down stigma beliefs.

> *"I think you won't get a one sentence answer on this if you've asked this to others, but I think that what would help would be more education and insight into the culture you know, … (pause) into Jamaican culture and how Jamaican culture "understands" mental health. And education can be in the form of courses being made available for patients of Jamaican descent and for all NHS staff because there are people who have Jamaican ethnicity in the NHS of course, but the NHS staff who don't have Jamaican ethnicity may not be able to have an inherent insight into how Jamaican culture may perceive mental health. So, if there was some form of training courses being put in place for NHS staff who don't have Jamaica ethnicity to attend this training to enhance their understanding." (Interview 3 – Bruna)*

Bruna's story was illustrated in a passionate tone, indicating that necessity for education to not only bring people of various age groups within the Caribbean community together but to forge a stronger patient-practitioner relationship to compensate for the general tension between parties. She emphasized that such initiatives could enhance cultural understanding, providing non-Caribbean NHS staff with valuable insights into the cultural nuances surrounding mental health experiences in the community.

4.3 BRIDGING DIVIDES: UNITING COMMUNITIES THROUGH CULTURAL ADVOCATES

In addition to the potential utility of education, participants also highlighted the use of a *"lead member",* from the local community to act as a "bridge" between practitioners and patient to help with engagement, uptake and acquisition.

> *"The educational programme should get in touch with a "lead member" [influential person] in the community that people look up to and trust because that will help engage people from a culture with something "outside of the culture" if that makes sense. And it would allow the education to be more reciprocated because the "lead member" could educate people on mental health and people from the Caribbean community would be more inclined to listen as its coming from someone who they could relate too." (Interview 3 – Bruna)*

Bruna alongside all participants of the Caribbean cohort emphasised a keen desire for the integration of cultural catalysts to act as pillars of support between patients and practitioners in combating cultural stereotypes and expediting the learning process of mental health. Bruna highlighted that having a trusted community member deliver or collaborate with practitioners would increase the acceptance of advice, as individuals would be more receptive to guidance from someone who has experienced similar struggles.

5. LOOKING FORWARD: CULTURALLY ADAPTED THERAPY

In this theme, participants showcased their stance on *"culturally adapted therapy"*, with a particular focus on therapist level adaptations, training and the utility of a *"community champion"*. The subordinate themes are presented as follows:

5.1 NAVIGATING ETHNICITY & AGE IN THERAPY

Participants shared their insights towards therapist level adaptations, with attention directed at ethnic matching however, with considerations for the contextual variables of age.

> *"For the whole "ethnic matching" you had mentioned before. I think something like that [ethnic matching] would really help. But I also think there may be a bit of a clash in terms of age [for ethnic vs ethnic matching] though, because you can get a young person from Jamaica talk to a group of elders, but they [the elders] are not really gonna listen to the advice because they'll just see him as a kid, basically. So, I think age is something that should also be taken into account, but at the very least being of the same ethnic background could probably help with building connections between patients and practitioners." (Interview 1 – Samira)*

All participants from the Caribbean cohort emphasised a strong desire for the matching ethnicity between patients and therapists. However, Samira brought attention to a practical concern: if the therapist or cultural advocate is younger than the patient, there may be resistance due to traditional values emphasizing respect for elders. This perspective was idiosyncratic to Samira but it underscored the potential benefits of shared ethnicity in fostering rapport between service users and providers.

5.2 PRIORITISING CULTURAL COMPETENCE

One participant noted and interesting stance, suggesting that *"competence"* is essential and that just because individuals are of the same skin colour, does not imply improved rapport.

> *"Yeah [competence more important than ethnic background], just because you've got a certain amount of skin colour doesn't mean you'll actually be good at what you do. It can help, you know, to have the same skin colour or background as the patient, but I don't think we should lose sight of people competence. (Interview 4 – Chase)*

Chase highlighted a perspective, emphasizing that the cultural competence of the practitioner should not be overshadowed by the emphasis on matching ethnicity. His message underscores the importance of not reducing individuals to the skin colour or race, and that other variables must be considered when attempting to improve psychotherapeutic outcomes.

4.3.4 SUMMARY OF FINDINGS

The findings of the three groups have been considered separately. There were some similarities and idiosyncrasies between ethnic groups with respect to mental health and their views on cultural adaptations These points have been further elaborated in the discussion section.

4.4 DISCUSSION

The aim of the present study was to (i) gain insight into perceptions and experiences of using mental health services in the UK; (ii) identify key barriers and facilitators for engagement with UK mental health services; (iii) explore Asian, African and Caribbean BAME groups' perception and attitudes towards mental ill-health and (iv) to elicit perspectives from Asian, African and Caribbean BAME participants on cultural adapted therapies. These aims were achieved through interviews with 14 participants (6 Asian, 4 Caribbean, 4 African) who delineated their opinions on which cultural adaptation may be effective alongside cognizance on the general perception of mental ill-health in their respective cultures including barriers/facilitators for mental health service user engagement. Whilst the study's aim was to recruit a variety of representative from Asian, African and Caribbean ethnicities, the study sample included mainly Chinese and Filipino participants for the Asian group, Nigerian participants for the African group, and Jamaican participants for the Caribbean group. Whilst this selective representation may affect generalisability, the discussion aims to draw cultural comparisons across BAME ethnicities and regions to offer insight and ascertain probable mechanisms behind perceived mental health stigma observed in this study.

Moreover, the qualitative outcomes of this study are in agreement with past literature, specifically that psychological therapy may require adaptation at content, therapist, and organisation level to suit clients from Asian backgrounds (Algahtani et al., 2019; Hwang, 2006; Hechanova & Waelde, 2017; Hays & Iwamasa, 2006; Jameel et al., 2022; Naeem, et al., 2010) and African/Caribbean backgrounds (Bhui, 2002; Chatters et al., 2011; Hankerson et al., 2015; Rathod et al., 2010; Scott et al., 2019). Furthermore, these adaptations to therapy seem to be underpinned by bio-psycho-social idiosyncrasies in culture between the Asian (Algahtani et al., 2019; Hwang, 2006; Hechanova & Waelde, 2017; Hays & Iwamasa, 2006; Jameel et al., 2022; Naeem, et al., 2010) and African/Caribbean (Bhui, 2002; Chatters et al., 2011; Hankerson et al., 2015; Rathod et al., 2010; Scott et al., 2019). Moreover, the participants who participated in the interviews emphasised the need for sensitivity towards cultural, religious, and other associated factors (e.g., empathy and communication skills) while administering therapy.

4.4.1 Stigma in Mental Health in Asian versus African/Caribbean Populations

The individuals who participated in the interviews claimed to be exposed to mental health stigma and familial pressure as a consequence of being associated with a mental health condition. Additionally, participants from Asian and African/Caribbean backgrounds conceptualised mental health stigma differently. Asian participants in this study seemed to associate the acknowledgment of mental health as weakness, flawed characteristics, and as a result being viewed “lower” in a status hierarchy. Comparatively, African/Caribbean participants viewed mental health as a consequence of a combination of social norms, institutional and historical mistrust, mistreatment and racism. Further qualitative findings in African/Caribbean populations confirm the notion of mistrust and injustice towards health services which was not a theme observed in the Asian cohort of this study (Rathod et al., 2010). These differences in perceived stigma between Asian and African/Caribbean cultures are consistent with previous literature. For instance, in Asian and African/Caribbean cultures, those with mental health conditions may internalise societal perceptions, experiencing shame and concealing their symptoms, which can lead to reduced self-worth and a delay in seeking assistance (Corrigan & Penn, 1999; Sussman et al., 1987; Wahl, 1999). However, in certain Asian cultures (Chinese specifically), mental illness carries such a pronounced sense of stigma (i.e., prevalent prejudice, stereotypical and marginalised treatment) that it is believed to reflect negatively on one's family lineage, which can diminish the marriage and economic prospects of other family members (Hechanova & Waelde, 2017; Ng, 1997). This perception of mental illness has also been confirmed in other Asian cultures, such as Filipino (Martinez et al., 2020), Japanese (DeVylder et al., 2020) and Indian (Kaur et al., 2021). Moreover, studies have shown that in Asian cultures, there is often a strong emphasis on emotional restraint (Tang, 2013, 2015) and collectivism (DeVylder et al., 2020; Hechanova & Waelde, 2017; Kaur et al., 2021; Martinez et al., 2020), which could lead to a reluctance to seek help for mental health issues due to concerns about negative perceptions from others (Kleinman, 1982; Leung et al., 2012). Additionally, traditional beliefs about mental health and illness, such as the concept of "shenjing shuairuo" (i.e., neurasthenia) (Kleinman, 1982) in Chinese culture, with similar references in Filipino, Japanese and Indian cultures, may lead to stigmatisation of those with mental health issues as being weak or lacking in willpower (Kleinman, 1982; Leung et al., 2012). This perceived experience of stigma may have manifested due to a lack of social support and social exclusion, which could further exacerbate the mental health condition (Cheng et al., 2018). In contrast, African/Caribbean cultures have been found to have a more spiritual approach to mental health, with beliefs that mental health issues could be the result of spiritual or supernatural causes (Codjoe et al., 2021). For example, a study with Nigerian participants found that spiritual beliefs were perceived as probable causes of mental ill-health, viewing it as contagious or caused by bad behaviour, which led to social distancing (Pederson et al., 2023). Similarly, a systematic review investigating the impact of mental health stigma on help-seeking behaviour in Caribbean populations (Gallimore et al., 2023) also found spiritual/moral misfortunes underpinning mental ill-health thus leading to increased health-seeking from religious institutions versus hospitals or clinics. Wisdom and Bowie's (2023) study further observed that religiosity positively influenced help-seeking behaviour as this was deemed the perceived cause for most Jamaican participants. Moreover, perceived divine intervention in African (Pederson et al., 2023) and Caribbean (Gallimore et al., 2023) cultures could lead to mental health issues in individuals perceived as being possessed by evil spirits or as being punished by a higher power (Codjoe et al., 2021). Additionally, the strong influence of religion in African/Caribbean cultures could lead to a perception that mental health issues are a result of a lack of faith or spiritual weakness (Codjoe et al., 2021) although this specific phenomenon was not strongly emphasised by the participants in this study.

To note, these cultural perceptions of stigma in mental health are not absolute, and there may be individual differences within cultures (Hechanova & Waelde, 2017; Ng, 1997). Taras et al. (2009) conducted a systematic review to examine the challenges, approaches and limitations to accurately measure “culture” (or stigma for that matter) based on 121 instruments for quantifying culture. Taras et al. (2009) emphasised that (i) there is a great bio-psycho-social diversity within cultures, which makes it challenging to accurately measure cultural differences between different ethnic groups; (ii) cultural boundaries are not always clear-cut and can be fluid, making it difficult to define and measure cultural groups; (iii) cultural practices and beliefs are often shaped by contextual factors, such as historical events, economic conditions, and political systems, which can vary widely across different regions and time periods; (iv) translation of words, phrases, and concepts from one language to another can be challenging and can lead to inaccurate interpretations of cultural beliefs and practices; (v) researchers may have preconceived notions or biases about certain cultures, which can impact the interpretation of research findings; (vi) cultural differences in communication styles and social norms can impact the accuracy of self-reported data, making it challenging to compare cultural groups (vii) there is often a lack of consensus among researchers about what constitutes "culture" and how best to measure it; (viii) cultural identity is not the only factor that shapes a person's beliefs and behaviours - other factors, such as gender, socioeconomic status, and sexual orientation, can also intersect with culture and impact the measurement of cultural differences; (ix) several empirical investigations (Furnham, 1984; Hofstede & McCrae, 2004) have revealed considerable correlations between personality characteristics and diverse value systems. This has led to inquiries into the degree to which these two fields (i.e., personality and culture) are separate, as an evaluation of tools for measuring personality and culture uncovers minimal divergence in methodological and empirical aspects despite obvious conceptual differences. Nevertheless, as it has been well established that cultural perceptions of mental health play a role in shaping stigma and thus moderating psychotherapeutic outcomes (Bhugra & Bhui, 1998; Bhui, 2010; Barrera et al., 2013; Edge et al., 2016; Rathod & Kingdon, 2014; Sue et al., 2009), it is important for mental health professionals to consider potential differences in culture and perceived stigma between ethnic populations when working with individuals from different backgrounds. Understanding the cultural differences in the experience of mental health stigma is essential for mental health professionals to provide effective and culturally sensitive care to individuals from diverse backgrounds (Codjoe et al., 2021; Cheng et al., 2018; Memon et al., 2016).

To note, the findings on perceived stigma in mental health highlight the importance of unpacking distinct ethnic differences on BAME populations. Despite clear similarities in mental health stigma (i.e., mental health stigma being a prevalent issue), this phenomenon manifested differently in Asian vs African/Caribbean populations, highlighting the need for tailored approaches to psychological therapy. This has implications on how health bodies could use this data to inform policy and practice, and they support the CRED's (2021) stance on prioritizing ethnic-specific research over treating BAME populations as a homogeneous group.

4.4.2 CULTURAL ADAPTATIONS TO PSYCHOLOGICAL THERAPY FOR ASIAN VERSUS AFRICAN AND CARIBBEAN POPULATIONS

Participants in this study, from both Asian and African/Caribbean backgrounds, universally expressed their desire for integrating cultural adaptations to psychological therapy, specifically language translations, ethnic-vs-ethnic matching, cultural training, and the use of community members as a “vehicle” to reduce mistrust and improve rapport between mental health service users and service providers. Comparing these findings to previous literature, Algahtani et al. (2019) (n = 69), Naeem et al. (2016a) (n = 92) and Jameel et al. (2022) (n = 11) all explored qualitative aspects to mental health perceptions amongst BAME users (i.e., Saudi Arabian, Pakistani and Indian participants respectively) and demonstrated patients' convincing desire for and perceived utility of language translation, ethnic matching, and cultural training. However, despite the perceived utility of these cultural adaptations to psychological therapy, it is not clear which ones are most effective for each population nor is it obvious the degree of alteration needed to achieve effectiveness. For example, Smith and Cabral (2011) who examined mental health outcomes across 53 studies demonstrated that achieving an ethnic vs ethnic match between practitioner and client led to (i) a moderate/large effect size for perceived utility in ethnic-vs-ethnic matching (i.e., patience believed ethnic matching would be beneficial) yet (ii) a small effect size of objective client outcomes was observed in mental health treatment which indicates almost no benefit from racial/ethnic matching therapy sessions. Moreover, the common usage of content related adaptations observed in Arundell et al. (2021) systematic review may be a consequence of mere convenience rather than a demonstrated track-record of improved treatment outcomes (Naeem et al., 2016b). Furthermore, it is well known that there is a “tension” between adjusting therapies to be effective for BAME groups compared to ensuring therapies are cost-effective and scalable (Naeem et al., 2016b). Specifically, cultural adaptations that may produce therapeutic effectiveness does not mean these adaptations are also low-cost and scalable (Naeem et al., 2016b). In respect to general considerations, what may explain Smith and Cabral (2011) small effect size in treatment outcomes may be as (i) high heterogeneity was observed and (ii) cultural adaptations to psychological therapy for Asian and African populations may need to differ due to the distinct cultural and historical backgrounds of these ethnic groups. For example, research suggests that collectivism, respect for authority/elders, and emotional suppression are common cultural values among many Asian populations (Hechanova & Waelde, 2017). Thus, it has been reported that content related adaptations to problem-solving, behavioural activation and behavioural experiments are useful modes of practice with Asian populations (Naeem et al., 2021). Jameel et al. (2022) also observed that Asian participants tend to view their therapists in a higher position within a status hierarchy thus creating pressure on therapists to “not be wrong” which is an idiosyncratic consideration for this population. Therefore, cultural adaptations for Asian populations may need to focus on addressing family dynamics, social support, and hierarchical communication patterns (Jameel et al., 2022) given that the lack of social support moderates the relationship between stigma and depressive symptoms (Tummala-Nara et al., 2012) and thus psychological outcomes. Comparatively, African/Caribbean cultures tend to prioritise communalisms and spirituality (Chatters et al., 2011). Consequently, interventions for African/Caribbean populations may need to prioritise addressing community-level factors, including religiosity/spirituality, social connectedness, and racial discrimination (Chatters et al., 2011). Alternatively, it may be the case the content-related adaptations (i., educational content) should be integrated to tackle mistrust of public services (Rathod et al., 2010) and awareness issues around mental health (Scott et al., 2019). Other research has illustrated that interventions for African/Caribbean populations may benefit from the integration of spiritual practices, such as prayer or meditation, into the treatment process to help address mental health concerns (Hankerson et al., 2015).

Thus, cultural adaptations in psychological therapy may differ for Asian and African/Caribbean populations due to differences in cultural values, beliefs, and stigma surrounding mental health. These differences highlight the importance of culturally informed approaches to mental health interventions, which account for the unique needs and preferences of different ethnic groups. As a result, it is necessary for interventions to continually test specific adaptations to psychological therapy to create a tailored network of appropriate adaptations to its targeted ethnicity.

4.4.3 REFLEXIVITY

As a researcher, my personal experiences likely influenced the qualitative analysis. Specifically, my father's struggles with suicidal ideation shaped my sensitivity to individual narratives within themes of mental health in BAME populations. Additionally, whilst I did not identify as BAME, my own experiences of diversity (having moved from Serbia to the UK in my teens) had informed my understanding of cultural displacement, identity, and the challenges of navigating different societal norms. Nevertheless, whilst this sensitivity enhanced my engagement with participant experiences, it may have led me to overlook broader structural factors, such as intersectionality, that were present but not explicitly addressed during the interviews.

To mitigate these risks, I adopted strategies to balance power dynamics and enhance rigor. For example, interviews were conducted conversationally (Anyan, 2013), allowing participants to guide discussions and challenge my assumptions. Reflexivity was further operationalised through regular dialogue with my supervisory team, which served as a form of "collaborative reflexivity" (Arvay, 2003). These discussions critically examined how my personal history and philosophical assumptions (e.g., prioritising lived experience over structural critique) might skew interpretation. While formal reflexive journals (Olmost-Vega et al., 2023) were not maintained, discussions with my supervisory team helped highlight structural factors like intersectionality that participants implied but did not explicitly emphasise.

Methodologically, participant agency was central. Comprehensive information sheets and iterative consent processes ensured transparency, while member checking (Birt et al., 2016) empowered participants to verify transcripts, affirming narrative accuracy, though no revisions were requested. To note, Munthe-Kaas et al. (2019) identified over 102 critical appraisal tools designed to review the methodological strengths and limitations of qualitative research, broadly categorised as frameworks or checklists. To ensure a comprehensive evaluation of the qualitative research nested in this thesis, two complementary tools were selected: Leonidaki's (2015) checklist and Yardley's (2017) framework. This dual approach addresses distinct aspects of qualitative research. Leonidaki's (2015) tool includes domains such as ethical rigor and recruitment that are not included specifically in Yardley (2017) framework. Conversely, Yardley (2017) emphasises transparency and coherence which are not explicitly stated in Leonidaki's (2015) tool. Their combined use mitigates gaps inherent in relying on a single tool/framework, enhancing the depth and balance of the appraisal. Leonidaki's (2015) appraisal tool (Appendix 5.7) is used to evaluate qualitative research quality across nine domains: (Context and Purpose, Recruitment, Situating the Sample, Data Collection, Analysis/Findings, Auditability/Credibility, Impact and Value, Reflexivity and Ethics). Each domain contains questions assessing methodological rigor at key stages of the research process. The tool includes 56 items, scored as 0 (No) or 1 (Yes), with the final score calculated by dividing the number of "yes" responses by the total applicable items (excluding "Non Applicable" questions) (Leonidaki, 2015). Scores are categorised as poor (0–0.45), fair (0.46–0.69), or high (≥0.70) quality. Yardley (2017) criteria for appraisal, whilst not a checklist, outline broader principles for evaluating research quality: Sensitivity to Context, Commitment and Rigor, Transparency and Coherence, and Impact and Importance (Appendix 5.8.). The analysis resulted in a score of 0.88 (i.e., high quality; Appendix 5.7) (Leonidaki, 2015), supported by qualitative reflections against all nine criteria (see Appendix 5.6.). In particular, Leonidaki's (2015) reflexivity criterion (section 8; Appendix 5.6 – 5.7) emphasises documenting researcher assumptions throughout the study. While collaborative reflexivity with my supervisory team (Arvay, 2003) helped mitigate biases during analysis, maintaining a contemporary reflective journal (Olmos-Vega et al., 2023) could have strengthened rigor. For example, a journal would have captured my initial assumptions, such as conflating health practitioners' challenges with cultural ignorance, rather than relying on post-hoc recollections. This real-time documentation might have revealed subtle biases (e.g., over-attributing patient-practitioner miscommunication to individual failings) earlier, prompting deeper interrogation during analysis. While supervisory dialogues ensured accountability, a journal would have provided a richer, more granular record of how my evolving perspectives influenced interpretive choices, particularly in reconciling practitioner constraints with systemic critiques. In respect to Yardley's (2017) framework, the 'Sensitivity to Context' (Section 1; Appendix 5.8) was a point of deep insight. In one aspect, this thesis demonstrated sensitivity to the cultural nuances of BAME participants, particularly in contextualising psychotherapeutic experiences. During data collection, participants were encouraged to lead interviews, articulating their mental health journeys in relation to cultural norms, ethnic heritage, and social identities. Narratives were rigorously compared to ensure a data-driven analysis, aligning with Yardley's (2017) emphasis on sensitivity to context by prioritising participant voices over preconceived frameworks. However, retrospective application of Yardley's criterion revealed that deeper engagement with systemic inequities, such as housing insecurity, racialised healthcare barriers, or post-therapy support gaps, could have further clarified how structural realities actively shape BAME patients' interpretations of mental health. While the study captured individual and cultural dimensions, integrating this structural lens would have offered a more holistic understanding of the interplay between lived experience and systemic vulnerability. The lack of deeper intersectional analysis is a limitation I attribute to my initial focus on individual narratives. Consequently, this reflexive journey underscores the need for explicit, structured frameworks to reconcile personal empathy with structural critique in future work.

4.4.4 LIMITATIONS & FUTURE RESEARCH SUGGESTIONS

The present study adds to previous research (Algahtani et al., 2019; Jameel et al., 2022; Rathod et al., 2010) in exploring BAME perceptions of mental health, stigma and insight associated with cultural adaptations (Arundell et al., 2021). Additionally,, this study provides novel insights by examining perceived stigma between different populations. It advances the argument that while mental health stigma is a prevalent issue in BAME populations, its experience varies between ethnicities, necessitating tailored adaptations (CRED, 2021). However, the study does have limitations. Extracting specific components of culture, stigma and cultural adaptation is difficult due to the multifaceted, multidimensional nature of culture and stigma (Taras et al., 2009). Additionally, despite following UK guidelines for ethnic categorisation (PHE, 2020b), this study is limited in its generalisability as the term "Asian" and "African/Caribbean" do not refer to a homogenous group and thus data should be interpreted with caution. Furthermore, limited generalisability of findings may exist here due to the small participant pool from a single geographical region. Moreover, response bias (as participants may convey answers to satisfy pre-conceived expectation), selection bias (as the sample consists of participants who were willing to engage in mental health services) and recall bias (as retrospective reports may include inaccuracies and exaggerations) are all modes of bias that may have played a role in this study. Future research would benefit from studies conducted in various geographical regions to amplify generalisability and potentially ascertain regional variations in perceptions and experiences of mental health services. Additionally, carrying out longitudinal interventions with BAME individuals who have chosen to discontinue therapy may uncover therapy challenges associated with discontinuation. Furthermore, RCT's comparing traditional CBT to "content specific" or "therapist specific" or "organisational specific" CA-CBT in a particular BAME ethnicity (e.g., Asian); (i) RCT comparing "content specific" vs "therapist specific" vs "organisational specific" vs traditional (non-adapted) CBT in a in a particular BAME ethnicity. Lastly, qualitative exploration of mental health practitioners and their insights into their professional experiences when working with BAME patients and which cultural adaptation may be most effective for the ethnicity in question.

4.5 CONCLUSION

In summary, this research adds novel insights into the perceptions of mental health by unveiling how mental health is perceived between Asian and African/Caribbean, thus necessitating culturally tailored interventions. Furthermore, the findings from this study could be used to improve underlying key performance indicators for the Advancing Mental Health Equalities Strategy - 2020 (NHS, 2020b) by supporting local health systems to address inequalities in mental health. Future research would benefit from investigating mental health perceptions of BAME populations from various regions, longitudinal studies with discontinued service users, viewing specific ethnicities as BAME is not a homogenous group, and comparing distinct cultural adaptations to ascertain which one may be most effective for improving mental health outcomes in minority populations.

CHAPTER 5 - EXPLORING HEALTH PROFESSIONALS' EXPERIENCES REGARDING MENTAL HEALTH & WELLBEING PRACTICES AMONG BAME PATIENTS

OVERVIEW

This study follows on from findings of the studies presented in Chapter 3 and 4. Chapter 3 was a quantitative study that aimed to examine differences in stigma, depression, anxiety and subjective wellbeing between distinct BAME ethnicities and age groups. Chapter 3 revealed that i) Black African/Caribbean populations had the higher stigma severity compared to all other BAME populations; ii) Asian or Asian British populations reported higher anxiety, depression and lower subjective wellbeing compared to all other BAME populations; iii) BAME populations aged 30 - 65 years reported higher unfair treatment and self-censorships scores compared to the 18 – 29 age group. Chapter 4 was a qualitative study that aimed to explore the perceptions of mental health, mental wellbeing, psychotherapeutic practices and experiences in health care by BAME populations. Chapter 4 demonstrated that Asian participants tended to view acknowledging mental health issues as a sign of weakness and flawed characteristics, leading to a perceived lower position in a social hierarchy. African/Caribbean participants tended to conceptualise mental health stigma as a consequence of social norms, institutional and historical mistrust, mistreatment and racism. Moreover, both Asian and African/Caribbean participants universally expressed their desire for integrating more cultural adaptation into existing talking therapies, with perceived utility focused on text translations, ethnic-vs-ethnic matching, cultural training and community champions. The present chapter aims to explore the experiences that health professionals have regarding health and mental wellbeing practices among BAME patients. This objective aims to further built on the insights of Chapter 4, by capturing the lived experiences of mental health practitioners when working with distinct BAME populations. Additionally, research has indicated that therapist effects (i.e., the influence a therapist's individual characteristics and skills have on a patients' treatment outcome) explain between 5-9% (Green et al., 2014) variance in patient outcomes in the context of the Increasing Access to Psychological Therapies (IAPT) program – a frequently used talking therapy service. Hence, understanding the factors that influence therapists' abilities to work with BAME populations effectively is crucial. Moreover, counsel on which cultural adaptations may be effective in improving psychological outcomes in BAME populations and understanding the lived experience of mental health practitioners when working with BAME patients are necessary to understand the potential mechanisms that underlie successful psychotherapeutic outcomes. Furthermore, the implications of this research are important for clinicians, researchers, and policymakers who seek to be better informed on culturally appropriate psychological care for BAME populations.

5.1 INTRODUCTION

With established national and BAME mental health prevalence in the UK (Baker, 2020, 2021), the IAPT programme was created by the UK government and has seen the psychological services of the United Kingdom transformed in recent years. The Depression Report published by Layard et al. (2006), led to the inception of the IAPT programme. The report observed significant personal and societal costs due to inadequate access to evidence-based psychological therapies for those suffering from depression or anxiety disorders (Layard et al., 2006). Moreover, patient preference studies suggested that talking therapies were preferred over medication at a ratio 3:1 (Schaik et al., 2004), however, the UK public's preferences were not being met at that time. Mental health patients were not being offered evidence-based psychological therapy and waiting lists were long (Schaik et al., 2004). After pilot testing the IAPT service in two demonstration sites (Doncaster & Newham) from 2006 with encouraging results service attendance and reductions in anxiety and depression (Clark et al., 2009; Parry et al., 2011), the innovative IAPT programme was rolled out nationally across the UK starting in 2008 (Care Services and Improvement Partnership Choice & Access Team, 2008; IAPT, 2008). One of its standout features is that treatments offered are always consistent with National Institute for Health and Care Excellence (NICE) guidelines for depression and anxiety disorders as set forth by Clark (2011).

The NICE advises that stepped-care models, like IAPT, should be the go-to treatment when it comes to mild-moderate depression and anxiety disorders, with the exception of PTSD or social anxiety (Clark, 2011). PTSD and social anxiety often require intensive, invasive and specialised treatments than those offered in the stepped-care model (Clark, 2011). Stepped care is a treatment system, of referral pathways, that ensures people have access to psychological treatments at an intensity level best suited for their needs, with outcome monitoring and regular adjustments (IAPT, 2008). In IAPT services, a large proportion of patients start with brief "low intensity" treatments like guided self-help or psychoeducational classes (known as step 2) (IAPT, 2008). Psychological Wellbeing Practitioners (PWPs) provide 30-to-35-minute sessions typically between six and eight times in total (IAPT, 2008). If a patient does not respond to the lower intensity therapies, they will need to move onto lengthier and tangible face-to-face treatments at step 3 (IAPT, 2008). The intent of up and down referral pathways is to ensure a smooth patient transition between primary and secondary care services, based on the patients' needs and responsiveness to treatment (Care Services and Improvement Partnership Choice & Access Team, 2008). Despite some variations in the IAPT service models (Gyani et al., 2013), many have extended therapy for those with anxiety or depression disorders within both primary care as well as secondary care. Furthermore, since IAPT's inception in 2008 (Care Services and Improvement Partnership Choice & Access Team, 2008; IAPT, 2008) approximately 1-million referrals have been made per annum, with 1.8 million adults referred in 2021/22, 1.6 million adults starting treatment within 6 weeks from referral, 8 session adherence on average, 664,087 referrals completed treatment and approximately 325,000 (around 50%) cases moved to "recovery" (when a case at the beginning of IAPT treatment presented severe anxiety/depression compared to post treatment scores) (NHS, 2022b). Once a patient is moved to “recovery”, they are subject to fewer and shorter sessions (to encourage independence) and the focus of therapy shifts from symptom management to relapse prevention, building resilience alongside developing healthy coping strategies (NHS, 2022b).

Still despite IAPTs outreach and demonstrated track record (NHS, 2022b), BAME populations in England experiencing mental health issues are less likely to access therapeutic services and attain positive outcomes than their white majority peers (Crawford et al., 2016; Mercer et al., 2018). Moreover, BAME service users report more negative experiences during treatment compared to those in the white group (Crawford et al., 2016; Mercer et al., 2018). Despite decades of education and advocacy around the importance of equitable access to care and treatment outcomes (Department of Health, 2005), disparities in health services remain. Additionally, The Health and Social Care Act (2012) and the NHS Constitution (2012) strongly delineate the principles of resolving health service disparities. With that being said, recent evidence from the IAPT programme (Baker, 2021) and "IAPT BAME Service User Guide" (Beck et al., 2019) suggests that compared to those of white backgrounds, individuals within numerous BAME communities are less likely to use IAPT services although 20% of England's population comes from a Black or Minority Ethnic background, only 13% of referrals for these services originate from such populations. Additionally, it is evident that BAME communities have a lower treatment completion rate than their white counterparts (46% of White service users are able to finish the entire course as opposed to 40% of Asian users) (Baker, 2021; Beck et al., 2019). Furthermore, BAME communities are lagging in recovery compared to their white counterparts (66% of white service users improve in psychotherapeutic outcomes while only 61% of Asian service users do; similarly, 50% of White reach full recovery compared to 44 % of Asians reaching the same point) (Baker, 2021; Beck et al., 2019). Although these outcomes are often true for service users from

BAME groups, it does not always apply to all communities (Baker, 2021; Beck et al., 2019). For instance, Chinese service users tend to demonstrate better improvement and recovery rates than white service users (Baker, 2021; Beck et al., 2019). According to the EHRC (2020), mental health services have a clear mandate to ensure equal access for all communities within their jurisdiction. Early studies at IAPT sites indicated decreased uptake of BAME populations compared with white service users (Clark et al., 2009). However once BAME and non-BAME populations engaged in treatment, outcomes are often similar indicating that there may be barriers hindering BAME access to treatment and warrants further improvement (Clark et al., 2009). Although frequent reported factors for reduced treatment success when working with BAME groups has been attributed to social determinants of health, contemporary health inequalities, cultural mental health stigma and historical mistreatment/injustice (Cheng et al., 2018; Codjoe et al., 2019; Memon et al., 2016). Investigation into therapist effects on patient outcomes, including competencies and concerns when working with BAME populations, is a lesser-known field (Naz et al., 2019).

5.1.1 THERAPIST EFFECTS & PATIENT OUTCOMES

Therapist effects can be defined as the influence a therapists individual characteristics and skills have on a patients treatment outcome (Green et al., 2014). Therapist effects, including competencies and concerns when working with BAME populations, is important to unravel as research has indicated that therapist effects explain between 5-9% variance in IAPT patient pre- and post-intervention HADS and GAD scale scores (Lutz et al., 2007; Wampold & Brown, 2005). These findings are further strengthened by Green et al. (2014) who suggests that such explained variance contradicts the concept that protocol-driven treatments, such as IAPT, remain completely pure and unaffected by the abilities of the practitioner administering it. Furthermore, this explained variance introduces the need for therapists to be “culturally competent” (Cronin & Ward, 2004) when working with BAME populations. It also highlights the necessity for allocating adequate training and support for therapists (Naeem et al., 2019) to address repeated concerns when working with “hard-to-reach” populations. By achieving cultural competence and optimised support, case disparities, as indicated in reports by Baker (2021) and Beck et al. (2019), could be reduced.

Research dedicated to studying therapist characteristics has identified a variety of in-session and out-of-therapy factors that have been linked to more efficient practice (Green et al., 2014). Developing more meaningful and intimate relationships (Jennings & Skovholt, 1999), cultivating greater empathy for those in need (Lafferty et al., 1989), creating effective therapeutic alliances (Luborsky et al., 1985) and exhibiting an even higher level of comfort, validation, comprehension and active assistance (Najavits & Strupp, 1994) are all key components of enhanced "in-session" therapist treatment characteristics. According to Weinberger (1993) and Welling (2005), the aforementioned "in-session" characterises are referred to as "common factors" that rely on therapists utilising their intuition. Research into the function and use of clinical intuition is increasing (Green et al., 2014), yet there has not been enough research to determine whether it constitutes an essential component of successful practice (Rea, 2001; Welling, 2005). Despite this, considering the "coaching role" that PWP's frequently take up when delivering guided self-help to their patients (Richards & Whyte, 2009), given the nature and style of delivery, these "common factors" associated with improved treatment (Weinberger, 1993; Welling, 2005) would likely prove useful when working with BAME populations explicitly. For "out-of-therapy" factors associated with enhanced treatment effectiveness, practitioners should exhibit positive emotional adaptation (Luborsky et al., 1985), self-critique of their therapeutic management (Najavits & Strupp, 1994), thoughtful introspection (Jennings & Skovholt, 1999) and a commitment to hard work plus receptiveness towards feedback or commentaries about their practice (Miller et al., 2008). To cultivate an openness to learning, two potential key traits are "ego strength" and "resilience". Ego strength is the capacity to remain in control of yourself when confronted with difficult situations (Markstrom et al., 1997). Resilience entails possessing features that let you adapt during adversity as well as rebound afterwards (Rutter, 1993). Given the demanding workload of a PWP (Weinberger, 1993; Welling, 2005) and other psychological related professions (NHS, 2022b), "ego strength" (Markstrom et al., 1997) and "resilience" (Rutter, 1993) may prove to also be useful for therapists when working with BAME populations as Green et al. (2014) found a positive correlation between increased IAPT therapist resilience and patient outcomes. Nevertheless, it is unclear whether “in-session” characteristics, “out-of-therapy” factors, “ego strength” or “resilience” are of as much utility with BAME populations compared to non-BAME populations as studies that have investigated the preceding variables did not exclusively focus on therapists working with BAME mental health patients.

5.1.2 THERAPIST CONSIDERATIONS & BAME POPULATIONS

Therapist considerations refer to the preconceived thoughts, feelings and actions a practitioner may have towards a patient (Greenwald & Kriege, 2006; Naz et al., 2019). Greenwald and Kriege (2006) and Naz et al. (2019) investigated qualitative aspects for non-BAME therapists to consider when working with BAME populations, in particular implicit biases and prejudices. Suggesting that, it is invaluable for therapists to be conscious of and aware that prejudices and implicit biases do not hamper the therapeutic process when working with service users from a variety of ethnic or cultural backgrounds (Greenwald & Kriege, 2006; Naz et al., 2019). Implicit bias occur unconsciously, outside of conscious control — that facilitates evaluations and assumptions about individuals and circumstances based on therapist personal values, environment, or experiences (Greenwald & Kriege, 2006; Naz et al., 2019). Thus, clinicians should acknowledge and addressed potential implicit biases to mitigate negative effects during the psychotherapeutic process (Naz et al., 2019). With mindful attention and a sense of enthusiasm, therapists can discover how to understand their service user's experiences and identity (Greenwald & Kriege, 2006; Naz et al., 2019). Though having a limited number of sessions may put pressure on the therapist to move quickly, they should be willing to give extra time in every session as this could strengthen the therapeutic relationship as well as foster therapy itself (Greenwald & Kriege, 2006; Naz et al., 2019).

An additional consideration for non-BAME therapists when working with BAME populations is that, when it comes to discussing problems concerning race and racism in therapy, non-BAME therapists may find themselves feeling uneasy due to emotions such as guilt, shame, or anxiety (Brown, 2008). This fear of making mistakes could lead non-BAME therapists to shy away from mentioning topics related to ethnicity, race or culture with people who identify as BAME (Brown, 2008). Consequently, this avoidance behaviour can prevent service users from receiving the help they need (Brown, 2008) and inhibiting progress through the therapeutic pathway (Naz et al., 2019). Furthermore, the counsellor may experience feelings of blame and guilt considering their own racial privilege when compared to their clients (McIntosh, 1990). To effectively support their clients, it is invaluable for non-BAME therapists to hone the capability of using self-CBT techniques to manage uncertainty and pacify themselves in sessions (Mueller et al., 2010). This is especially relevant when they feel overwhelmed by guilt or shame while engaging with a client - at which point they must strive towards cultivating understanding from an empathetic standpoint (Mueller et al., 2010). Due to the sensitive and vulnerable nature of emotions, a secure supervisory relationship must be established between therapist and supervisor for successful learning (Beck, 2016). Such an environment is key in providing safety as well as confidence that their skills are being considered (Beck, 2016). Cultural competence includes having the knowledge, self-awareness, and skills required to establish culturally effective and ethical interactions with individuals from various cultures (Cronin & Ward, 2004; see section 4.1.2). Consequently, culturally competent supervision from senior practitioners can aid therapists in developing culturally competent skills (Beck, 2016, 2019; Naz et al., 2019). Likewise, a safe and non-judgmental learning environment is imperative for practitioners to understand their apprehensions, challenge any biases they may have, and gain invaluable insight from challenging clinical scenarios (Beck, 2016, 2019; Naz et al., 2019).

In conjunction with appropriate support for therapists to enhance cultural competence, research looking at the development of CAP have shown promising results. Mir et al. (2015) investigated how to adjust BA for use with Muslim clients. The study's approach utilised interviews with participants and mental health practitioners on the potential utility of evocative metaphors, language and religious parables in stimulating behaviour change that is rooted in meaningful values (Mir et al., 2015). The study also examined how community expectations can condition the options available to service users seeking relief from depression via engaging activities (Mir et al., 2015) followed by the development of a manual for Islamic service users. Mir et al. (2015) found that Muslim clients accepted the BA approach and alignment with Islamic teachings. Additionally, therapist empathy was valued but that therapists needed continued support, from senior staff and at institution level, to effectively implement the adapted therapy. However, ethnicities who identify as Muslim, or follow the Islamic religion, are not a homogenous group (Mir et al., 2015). Moreover, the study acknowledged a limited sample size from both patients (n = 4) and practitioners (n = 25) suggesting they are not confident that all viewpoints have been identified (Mir et al., 2015). Hinton and Bui (2019) published a book "The Cambridge Handbook for Anxiety and Related Disorders" and highlighted decades of research that has gone into adapting CBT for Cambodian-American service users. This research has indicated that it is possible to make considerable adjustments to core CBT models, as long as there are staff members with a comprehensive understanding of those marginalised communities, plus enough resources available for exploring the cognitive and behavioural mechanisms related to depression and anxiety in such populations (Hinton & Bui, 2019). Additionally, CA-CBT is fundamentally based on CBT and its core tenets, but also comprises significant adjustments that consider the values, customs, beliefs specific to each culture – like health-based convictions (e.g., divine intervention vs medical intervention) which may differ from mainstream Western practice (Hinton & Bui, 2019). Moreover, CA-CBT considers historic occurrences endured by members of a marginalised community (Hinton & Bui, 2019). Likewise, Acarturk et al. (2019) conducted a study of CBT being modified to fit the cultural needs of Turkish adolescents by members belonging to that community. Specifically, the study aimed to examine the effectiveness of CA-CBT to reduce GAD in Turkish adolescents (Acarturk et al., 2019). They found that the CA-CBT group was more effective in reducing GAD compared to the control group (Acarturk et al., 2019). Additionally, this study considers parameters such as somatisation, metaphors and religious convictions to make this treatment model more comprehensible and acceptable for the people from Turkey (Acarturk et al., 2019). In other words, it enables culturally specific versions of mindfulness-based interventions which are tailored exactly for that society's requirements (Acarturk et al., 2019). Both Acarturk et al. (2019) and Hinton and Bui (2019) studies highlighted that more RCT-based studies to validate the utility of their adaptations however, similarities in how their CAP was developed (i.e., with community members) provides a more integrated approach to supporting BAME populations and therapists who work with them.

Although reviews of clinical trials and faith-sensitive therapies provide some evidence to its utility in reducing anxiety and depression for BAME populations (Anderson et al., 2015), more research is needed to understand the impact of therapist characteristics on BAME populations (Beck et al., 2019), specifically when working with African, Caribbean, and Asian populations as requested by the CRED (2021) report. Such studies have been largely inadequate due to a lack of research on minority religious groups (Townsend et al., 2002), poor methodological quality, as well as insufficient details regarding interventions for BAME patients that would allow accurate replication (Anderson et al., 2015; Azhar & Varma, 1995; Walpole et al. 2013). Taking ethnic specific and cultural diversity into account is a critical aspect of interventions and therapeutic processes when working with minority populations (Beck et al., 2019; Mir et al., 2015). This includes an understanding and appreciation for religious teachings, such as Christianity/Islam, that may be culturally influenced (Haque, 2004; Maynard, 2008).

5.1.3 RATIONALE FOR THE PRESENT STUDY

Therapist factors affect BAME mental health patient outcomes, and qualitative exploration into what cultural adaptations health professionals use, if they use and what adaptations they perceive might increase treatment is limited. The present study aimed to explore healthcare professionals' experiences when working with BAME populations and to investigate their views on culturally adapted therapies. This study builds upon the findings from the previous studies (Chapter 3 & 4) in providing insight from the healthcare's perspective into what psychotherapeutic practices (i. e., cultural adaptations), if used, increase treatment acceptability with BAME populations. Additionally, themes that emerged from the previous study (Chapter 4) was used to guide discussions with healthcare professionals to express their views around barriers and mental health stigma. Furthermore, the findings from this study should provide a clearer picture into what the current issues are between both parties (health professionals and BAME populations), and what practices could be put in place to improve psychotherapeutic outcomes.

5.1.4 AIMS & OBJECTIVES

Aim: To explore the experiences that health professionals have regarding health and mental wellbeing practices among BAME patients.

Objectives:

(i) what cultural adaptations health professionals use, if they use any and what adaptations they perceive might increase treatment acceptability.

(ii) to share best practice on methods to engage BAME service users and overcome barriers presented.

(iii) to discuss findings from previous research and potential ways cultural adaptations could improve psychotherapeutic among BAME populations.

5.2 METHODS

5.2.1 STUDY DESIGN

This study was a cross-sectional exploratory qualitative research study.

5.2.2 PARTICIPANTS

The study employed a purposeful sampling plan and acquired 10 participants. This aligns with Pietkiewicz and Smith (2014) and Tracy (2013), who recommended that between 5-8 participants is generally considered appropriate in qualitative research, a larger number often enhancing the depth and diversity of insights. However, the sample size was based on the researcher's judgement and only finished once data saturation was achieved (See section 4.2.2). Participants were recruited via social media (e. g. Facebook, Instagram, Linked-in), email, word of mouth (snowball sampling) through a JISC survey (Appendix 5.1) and were invited to partake as they were male or female, aged 18 and above in addition to being a working member of a National Health Service Mental Health Trust or Primary Care Network (i. e. psychological wellbeing practitioners, assistant psychologists, psychotherapists or equivalent). Anyone who was not a member of a

National Health Service Mental Health Trust or Primary Care Network and younger than 18 years old were not eligible to take part in the study.

5.2.3 PROCEDURE

Following approval from the St. Mary’s Ethics committee, an online, semi-structured, audio/video-recorded, 1-2-1 interview was conducted via Zoom. The interview stance, “deliberate naivete” and type, “narrative interview”, was used to evoke storytelling and discard interviewer bias (Tracy, 2013). Discussions included the main themes and topics revealed from study 2 (Chapter 4) to create a focused narrative. Prior to the 1-2-1 interview, potential participants scanning the QR code on the participant recruitment poster (Appendix 5.3), that was publicised through social media, were signposted to the JISC recruitment survey where individuals had the opportunity to read the participant information sheet (Appendix 5.1) in addition to completing a screening question, the opportunity to give informed consent and sign-up for the online Zoom 1-2-1 interview using their email address. The screening question was used to assess eligibility criteria (Appendix 5.1). All participants that passed the screening question and signed-up for the 1-2-1 interview, were interviewed.

5.2.4 ANALYSIS

To gain a deeper understanding of personal experiences by NHS professionals, IPA was chosen for qualitative analysis (Eatough & Smith, 2008; Pietkiewicz & Smith, 2014). Unlike Ground Theory and Thematic Analyses that prioritise the theoretical background first and speakers' affective, mental, and physical states second, IPA begins by focusing on the person's point of view (Eatough & Smith 2008; Larkin et al., 2006; Pietkiewicz & Smith 2014). Moreover, the IPA method presumes that the researcher's epistemological viewpoint is focused on participants' personal experiences and how they interpret those situations (Larkin et al., 2006). For this study, IPA endeavours to investigate how individuals comprehend BAME mental health concerns, associated with diagnosis, treatment attitudes and share "best treatment practices" for BAME populations to further advance the subject matter of CAP. With its idiographic inclination, this method is especially beneficial to shed light on topics that are convoluted and charged with emotion (Eatough & Smith, 2008; Larkin et al., 2006, 2009; Pietkiewicz & Smith, 2014). Henceforth it proves to be the most appropriate mode of data analysis for the corresponding research question for this study. Larkin et al.'s (2006, 2009) approach guided the analysis process as outlined in Table 4.1 – Chapter 4 (see section 4.2.5 for full procedure).

5.3 FINDINGS

Ten psychological therapists participated in 1-2-1 interviews, of which specific demographic details are presented in Table 5.1. The analysis revealed a network of interrelated themes, with *"stigma in mental health"* emerging as a central challenge for delivering effective psychotherapy, yet also serving as a driving force for enhancing psychological therapy among psychological therapists who have worked with BAME patients (Figure 5.1). Additionally, each subordinate theme is complemented by direct quotes from the transcript to clearly illustrate its purpose (Table 5.2). Further examination of the primary insights of these themes are illustrated below in more detail.

Table 5.1

Demographic characteristics of health professionals (N=10)

Factor	**Total Sample**
Job Title	
Psychological Wellbeing Practitioner	5
Counsellor	1
Clinical Psychologist	1
Cognitive Behaviour Therapist	2
Mental Health Wellbeing Practitioner	1
Gender	
Male	1
Female	9
Race	
Black British	1
White & Asian	3
Pakistani	2
Chinese	1
White British	1
Other	2
Agenda for Change Pay Band	
Band 4	3
Band 5	3
Band 6	3
Band 8a	1

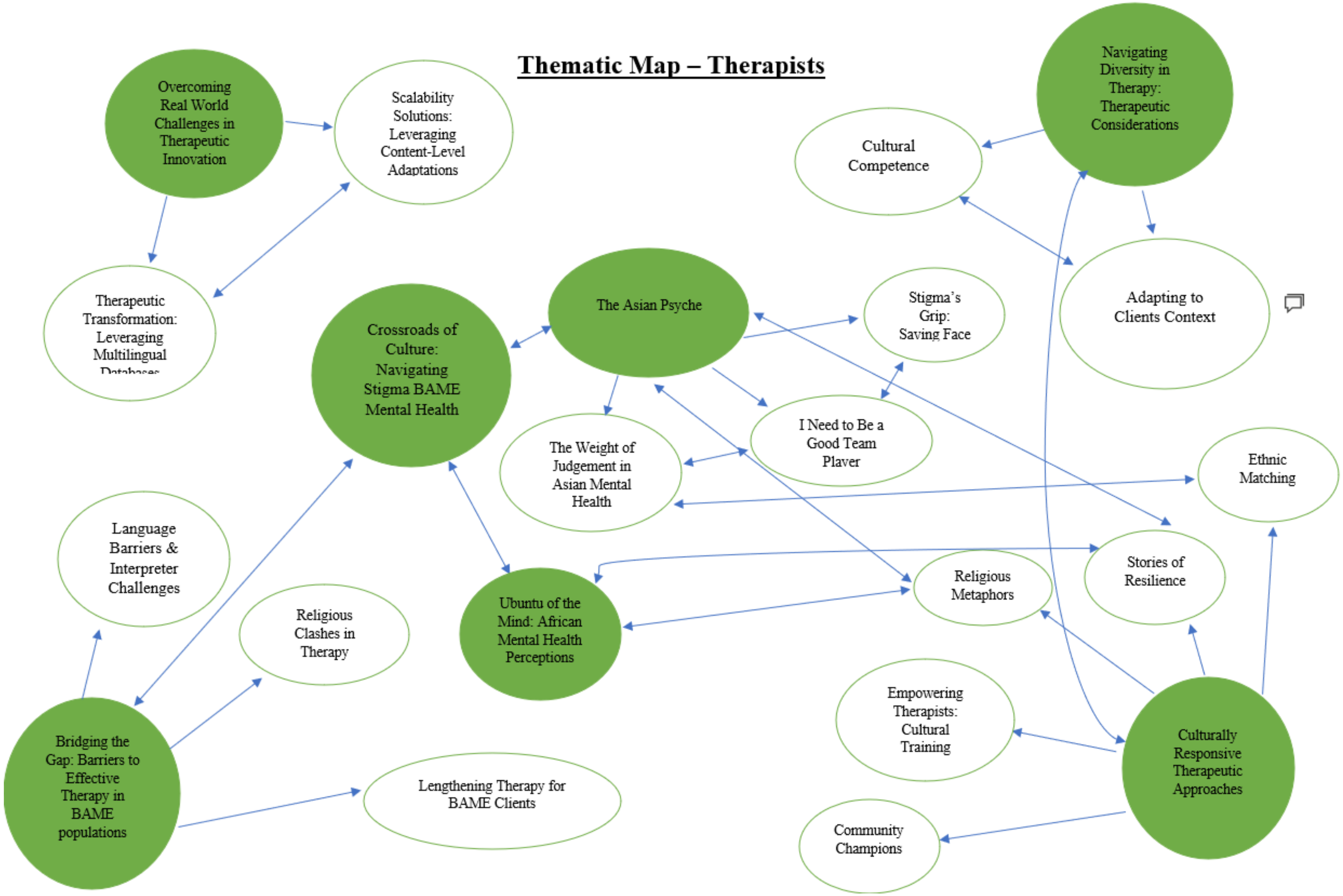
Table 5.2

Superordinate and subordinate themes for psychological therapists

Superordinate	Subordinate
1. Crossroads of Culture: Navigating Stigma in BAME Mental Health	N/A
2. The Asian Psyche: Asian Mental Health Perceptions	2.1. I Need to Be a Good Team Player 2.2. The Weight of Judgement in Asian Mental Health 2.3. Stigma's Grip: Saving Face & Hiding Pain
3. Ubuntu of the Mind: African Mental Health Perceptions	N/A
4. Navigating Diversity in Therapy: Therapeutic Considerations	4.1. Flexibility in Therapy: Adapting to Clients Context 4.2. Embracing Cultural Awareness in Therapy: Cultural Competence
5. Bridging the Gap: Barriers to Effective Therapy in BAME Populations	5.1. Language Barriers & Interpreter Challenges 5.2. Religious Clashes in Therapy 5.3. Time for a Change: Lengthening Therapy for BAME Clients
6. Culturally Responsive Therapeutic Approaches	6.1. Connecting Through Culture: The Role of Ethnic Matching 6.2. Stories of Resilience: Content as Recovery 6.3. Words of Understanding: The Importance of Religious Metaphors 6.4. Cultural Liaisons: The Role of Community Champions in Mental Health 6.5. Empowering Therapists: Cultural Training
7. Overcoming Real World Challenges in Therapeutic Innovation	7.1. Therapeutic Transformation: Leveraging Multilingual Databases 7.2. Scalability Solutions: Leveraging Content-Level Adaptations

Figure 5.1

Thematic Map – Psychological Therapists



5.3.1 QUALITATIVE FINDINGS – THEMES

1. CROSSROAD OF CULTURE: NAVIGATING STIGMA IN BAME MENTAL HEALTH

In this theme, participants illustrated how mental health is perceived across different Eastern vs Western cultures:

> *"They (BAME patients) lack a lot of openness compared to Western cultures who actually like openness. We [Western culture] are all quite open minded in terms of topic of mental health. But for Asian cultures perhaps, we actually need some techniques to help clients cope with the emotions." (Interview 1 – Bradley)*
>
> *"I think in Eastern Cultures, there's a general denial around mental health, ... just like believing that... you know yourself as a person, if you had mental health, you'd be seen as crazy." (Interview 4 – Suki)*

Based on their professional experiences, many participants highlighted that BAME patients hold distinct perceptions of mental health compared to Western culture. Narratives of Eastern vs Western cultural dynamics were, according to participants, attributed to perceptions that are influenced by the presence of stigma in BAME mental health. These stigmatic perceptions, participants explained, affect attitudes and behaviours towards mental health management and the propensity to seek healthcare services. Participants noted that Eastern cultures tend to be more reserved in discussing mental health and emotions, requiring therapists to employ adapted techniques and tools to effectively engage with these patients and achieve positive outcomes.

2. THE ASIAN PSYCHE: CULTURALLY SPECIFIC MENTAL HEALTH PERCEPTIONS

In this theme, participants strived to ascertain the underlying components of how mental health is perceived in Asian culture, the fear of judgment and dismissal commonly associated with the subject matter. Participants illustrated that Asian culture is moulded by "collective thinking" which acts as the fabric for social interaction, behaviour and understanding.

2.1 I NEED TO BE A GOOD TEAM PLAYER

In this theme, participants illustrated a key component in Asian culture that governs mental health perceptions, social and familial dynamics:

> *"Like, Asian patients, feel like they need to be like a good team member in the family compared to just being a good person for themselves. There is a lot of collective thinking. Asian patients see that being a part of something sometimes can be even more important than like, the individual." (Interview 1 – Bradley)*

> *"There is a huge emphasis on family and being a "team player", which is probably the case in many Eastern cultures. But in South Asian cultures in particular, there's an exaggerated emphasis on family. In Pakistan, for example, it's common to have multi-generational homes, and the idea is that you take care of people who are older and younger than you. So, when you're in the prime age range of 20 to 50, you are expected to be the caretaker of everybody. Even if you're not living with your grandparents or parents, there is an expectation that you check in with them and be responsible for them. It can be very hard to find time for self-care in such circumstances. And I think this mentality is deeply ingrained." (Interview 2 – Ted)*

All participants attributed the cultural component of collectivism that shapes familial and social dynamics. Participants noted that Asian patients, typically, view their group membership or identity as being primal and their individual identity secondary. Furthermore, individual action if done in service of their group (e.g. family, work, union, etc.) is perceived by their peers as being ethically "good", and actions done in service of oneself is viewed as ethically "bad". Moreover, many therapists illustrated that Asian patients placed a great deal of important of what their peers thought about themselves, thus conforming to collectivist norms as opposed to individualistic ones.

2.2 THE WEIGHT OF JUDGMENT IN ASIAN MENTAL HEALTH

Participants emphasised how judgment in mental health shaped Asian culture, behaviour and perception:

> *"I would say Asian patients tend to be very secretive and discrete about their mental health due to fear of judgment compared to other groups. Cultural and religious beliefs play a significant role in shaping these beliefs, which can result in vastly different attitudes towards seeking help for mental health issues." (Interview 7 – Daniel)*

> *"But to try and be specific here, with most of my patients with Asian heritage... There is a constant stigma…and strong feeling of prejudice and judgement surrounding anyone who*

> *admits mental illness. Like, this strong fear of being judged by people in their social group. That [stigma] is constantly with them [Asian patients].” (Interview 9 – Ramirez)*

All participants emphasised that Asian patients often experience heightened levels of fear of judgment, leading to secretive behaviours as coping mechanisms for mental health issues in Asian culture. Due to the communal nature of Asian communities, individuals are reluctant to be seen as burdens to the group, fearing ostracization or devaluation. Many Asian patients seek approval from their peers and avoid tarnishing their image with a mental health diagnosis, as it goes against professional, societal, social, and familial norms.

2.3 STIGMA’S GRIP: SAVING FACE & HIDING PAIN

In this theme, participants articulated the influence of shame and dishonour to one’s family, and how these phenomena shape health-seeking behaviour:

> *“Well, this [stigma] can be particularly pronounced in Asian communities, where mental health issues may be viewed as a source of shame or dishonour to the family. As a result, individuals may be hesitant to seek treatment or may delay seeking treatment until their condition has become very severe and this can lead to a significant amount of pressure on individuals to maintain appearances and avoid anything that might bring shame or dishonour to their family, such as “saving face”. Seeking help for mental health issues may be seen as an admission of failure, which can further compound feelings of shame and guilt.” (Interview 6 – Sonia)*

Many participants emphasised that apart from discomfort that Asian patients may feel from being judged, they were also concerned about causing shame and disappointment to their group members, especially family, as a result of their mental health label. These expectations acted as further fuel for patients to delay seeking health treatment and exacerbate self-critical and self-deprecating thoughts. Additionally, Asian patients exhibited a self-sacrificial tendency for the well-being of their group to the point of, at times, sacrificing their own well-being.

3. UBUNTU OF THE MIND: AFRICAN MENTAL HEALTH PERCEPTIONS

In this thematic category, therapists shared their understanding for the underlying components of how mental health is perceived in African culture:

> *"In African culture, certain conditions, such as psychosis or schizophrenia which is often viewed as crazy talk that I see affect my sessions. There seems to be a failure to recognise more severe psychotic conditions as possession of witchcraft that of course, affects how the patient feels during the session. So, there's this idea that witchcraft or possession or evil spirits are taking place." (Interview 6 – Sonia)*

> *"For example, in the African community, mental illness is commonly seen as a consequence of witchcraft or "crazy talk". If you show any traits or psychiatric disorder, even if it's something small, they [African patients] frequently don't accept it as a mental disorder. They just view it as crazy talk and dismiss it [mental illness]." (Interview 9 – Ramirez)*

All participants illustrated a relatively greater openness of African patients to discuss mental health compared to Asian patients. However, this level of openness ceases upon severe mental health conditions such as psychosis or schizophrenia. To African patients, the presents of psychotic disorders were evidence of divine intervention and rather than a scientific explanation. Additionally, being labelled with any association to witchcraft raised the risk of dismissal and rejection among peers.

4. NAVIGATING DIVERSITY IN THERAPY: THERAPEUTIC CONSIDERATIONS

Within this thematic category, participants emphasized the need for therapeutic considerations when working with BAME patients. Specifically, they highlighted the importance of flexibility in tailoring therapy to suit the individual's unique contextual factors and stressed the importance of cultural competence in maintaining a cohesive therapeutic alliance with BAME clients.

4.1 FLEXIBILITY IN THERAPY: ADAPTING TO CLIENTS CONTEXT

In this theme, participants maintained the need for flexibility during the therapeutic process:

> *"As therapists, I think with Asian patients it would be good to focus on trying to break down the fallacy of being weak whilst with African patients, perhaps focusing on building trust to resolve historical mistreatment. If things go wrong during therapy, it could reinforce a client's belief that they are being mistreated because of their cultural*

> *background. Therefore, we need to be mindful of potential triggers and actively work towards creating a safe and supportive environment for our clients." (Interview 5 – Jacob)*

Most participants stressed the need to adapt therapeutic methods to better suit Asian patients by addressing concerns around being perceived as weak. On the other hand, when working with African patients, to the focus should be on building trust due to historical injustices. For Asian patients, it's about easing worries about social judgment, while for African patients, it's about showing reliability to overcome past grievances.

4.2 EMBRACING CULTURAL AWARENESS IN THERAPY: CULTURAL COMPETENCE

In this theme, participants emphasised the gravity of cultural competence in contemporary and future psychological therapists:

> *"I think it's the ability of the therapist to be culturally competent. Being adaptable to the client's culture, demonstrating that understanding, either through training or independent research is essential. I think it's very important to, as with practitioners and stuff, you need to be open and not judgmental, really actively working to understand and acknowledge the patient's perspective." (Interview 4 – Suki)*

> *"Practicing cultural competence and inclusivity starts with asking individuals directly how they prefer their names to be pronounced, or if they have a preferred name. This extends to larger issues such as language barriers where it's essential to find out what the individual feels comfortable with. I've encountered situations where I've struggled with pronouncing people's names correctly and felt that I've lost the opportunity to build rapport with the patients." (Interview 5 – Jacob)*

All participants believed that possessing cultural competence as an intrapersonal skill is vital in fostering a strong therapeutic alliance with BAME mental health patients. Additionally, participants proceeded to illustrate that cultural competence embodies numerous facets of therapeutic adaptability which is important for accommodating the intricate heritage and cultural nuances of BAME patients. Moreover, participants articulated their stance that enhancing one's cultural competence, through training and independent research vicariously amplifies their efficacy as practitioners.

5. BRIDGING THE GAP: BARRIERS TO EFFECTIVE THERAPY IN BAME POPULATIONS

In this theme, participants highlighted various barriers that influence the therapeutic alliance between service users and providers. These barriers encompassed language/interpreter challenges, religious tensions and the need for increased duration and frequency of psychological therapy with BAME patients.

5.1 LANGUAGE BARRIERS & INTERPRETER CHALLENGES

In this theme, participants emphasised the importance of language challenges between service users and providers:

> *"Another challenge is language barriers among BAME adults. Some individuals, despite living in the country for decades, may still struggle with the language. This can lead to difficulties in expressing their emotions and needs."* (Interview 8 – Georgie)

> *"One of the most prevalent challenges I've encountered is the unique linguistic differences of my patients. For instance, the language barrier can be quite difficult with patients whose first language isn't English. Miscommunications can arise, making it difficult to fully understand what the patient is trying to explain."* (Interview 7 – Daniel)

Another aspect contributing to this predicament was the role of interpreters during therapy sessions:

> *"So yeah, ... language barriers could be something relevant for some [BAME] clients, so maybe an interpreter might be involved. But then, that could introduce like extra challenges in terms of like how to the act with the interpreter, and at the same time...not letting the interpreter provide too much input the session or mistranslating something. So that's something I need to pay attention to."* (Interview 1 – Bradley)

> *"Working with interpreters is probably one of the biggest challenges within my role. Some people might be better at it than me, but I have come across lots of miscommunications, interpreters not translating things properly, and not getting everything back translated from the patient. So, there are times when I ask myself, why am I getting three words back when there have been lots of sentences going on?"* (Interview 3 – Hannah)

All participants expressed difficulties with language barriers and more specifically, the limited expression of thoughts and emotions due to this inhibition. This aspect was identified as a specific barrier that could lead to misinterpretation of experiences and feelings during therapy sessions in conjunction to difficulties in understanding therapeutic counsel. Furthermore, all participants indicated the lack of consistent and accurate translation provided by interpreters, which varied from one session to another. This inconsistency was seen as a factor influencing the facilitation, or lack thereof, of the therapeutic alliance.

5.2 RELIGIOUS CLASHES IN THERAPY

In this thematic category, participants highlighted an important point of the role of religion in therapy:

> *"I'm very hesitant to say religion because I'm somebody who... Is religious, but I would say like because I think it's probably like people use religion as an excuse for mental illness. And this may sound bad, but I think, at times religion explains mental health things but poorly and gives a poor understanding or excuse for how mental health illness develops. Then if you try to provide medical treatment, it is met with resistance and the "cure" is seen to act in faith rather than in medicine if that makes sense." (Interview 4 – Suki)*

Participants expressed their challenges with the presence of religion in therapy. Specifically, the tension that exists between scientific and religious interpretations of experience and how this moderates the therapeutic alliance. Many participants when working with both Asian and African patients experienced the explanation of divine intervention as a causal mechanism for various mental illnesses. Additionally, patients who adopted this religious stance were generally more resistant to scientific counsel, assuming this existed in opposition to religious endeavours.

5.3 TIME FOR CHANGE: LENGTHENING THERAPY FOR BAME CLIENTS

In this theme, one participant articulated the potential need for longer therapy sessions for BAME populations:

> *"The standard 10 therapy sessions may not be sufficient for BAME populations, especially considering the complexities and depth of the issues being addressed. The mental health*

> *needs of individuals are often complex and extend beyond just depression. Socioeconomic factors, multiple mental health conditions, and physical health issues all play a role." (Interview 8 – Georgie)*

One participant articulated that due to BAME populations complexity of needs (i.e., low socioeconomic status, low education attainment, unemployment, sub-par living standards, etc.), that therapy acts as one component of a larger multivariate equation that predicts psychotherapeutic success. Therefore, participants request that more sessions are needed to compensate for the complexity of needs and help buttress rapport alongside the therapeutic alliance. To the participants, this was a core structural change to therapy that would facilitate positive changes in BAME patients.

6. CULTURALLY RESPONSIVE THERAPEUTIC APPROACHES

Within this thematic category, participants shared their insight related with the findings from study 2 in Chapter 4. Specifically, they highlighted their stance on ethnic matching, preferred approaches for content related adaptations, importance of integrating religion during therapy, utilisation of community campions and need for cultural training.

6.1 CONNECTING THROUGH CULTURE: THE ROLE OF ETHNIC MATCHING

In this theme, participants illustrated their stance on ethnic matching. Some participants stood on the side of ethnic matching:

> *"Patients engage better when they feel safe, and it's easier to open up to someone from your culture who can understand you. If cultural problems are impacting the patient, a therapist from a different culture may not be able to understand them. That's why when Romanians come to me for therapy, they feel at ease and can talk to me easily. For example, if a Romanian was matched with a British therapist and the difficulties are culturally related, the therapist may not understand the patient's experiences or perceptions. This could hinder the therapy. Whenever I get Romanian patients, they feel really comfortable, because they know I can understand them." (Interview 3 – Hannah)*

Whilst other participants unpacked the potential drawbacks to ethic-matching:

> *"In my experience, therapy matching brings forth its own set of barriers, as I mentioned earlier. Patients often decline to work with a therapist of their own background due to the element of secrecy and stigma. What if the therapist knows someone that they know?" (Interview 2 – Ted)*

> *"Ethnic matching, for example, is a great idea, but the availability of licensed practitioners from specific regions might be a limiting factor. It may be more effective to have specialists who are knowledgeable about particular regions or cultures. So instead of solely relying on ethnic matching, having practitioners who specialize in specific regions, such as South Africa or Southeast Asia, could be a more viable approach." (Interview 9 – Ramirez)*

Ethnic matching created polarization amongst the participants with some advocating for its utility and rapport-building potential whilst other illustrated barriers imposed on the therapeutic alliance and scaling issues. To the therapists who supported ethnic matching, they felt that being of the same heritage promoted shared understanding, empathy, experience and rapport that strengthened the therapeutic alliance, increased reciprocation of counsel facilitates overall more desirable outcomes. Therapists who saw challenges with ethnic matching had two main concerns: (i) patients might feel subjected to the same cultural stereotypes they are trying to escape, and (ii) it could create scalability issues, given the current shortage of therapists, making it difficult to match each patient with a therapist of the same ethnic background.

6.2 STORIES OF RESILIENCE: CONTENT AS RECOVERY

In this theme, participants articulated their stance on content level adaptations:

> *"Many of our self-help books have recovery stories, but they tend to feature Western people dealing with Western issues. For example, a white middle-class elderly woman going through some worrying issues. It's rare to see recovery stories from someone in the black or Asian community going through their type of issues. Therefore, creating recovery stories that better represent diverse communities and their unique challenges is essential. For instance, someone from the black community may face different challenges in dealing with mental health issues than someone from the Asian community. By sharing more diverse recovery stories, we could help patients relate to the content on a more personal level and see that recovery is possible for them too." (Interview 5 – Jacob)*

Participants articulated that content level adaptations could be utilised as a recovery story to facilitate vicarious experience and thus a stronger therapeutic alliance. Additionally, participants saw value in creating recovery stories to match the cultural idiosyncrasies of Asian and African patients. This initiative, according to the participants, could be scaled and be integrated at organisational level in a more sustainable fashion than matching therapists to client ethnicities.

6.3 WORDS OF UNDERSTANDING: THE IMPORTANCE OF RELIGIOUS METAPHORS

In this theme, participants illustrated the utility of religious prompts during therapy:

> *"So, you mentioned the religion bits [use of religious metaphors in therapy], so I guess that could be quite helpful. So…When we explain some concepts to clients, if its' supplied with a religious metaphor or common saying, it can help the client feel heard and understood by the service provider." (Interview 1 – Bradley)*
>
> *Using religion and metaphors can help create a stronger connection with the patient, which can lead to a more effective therapy. (Interview 2 – Ted)*
>
> *"I do think that faith-based questions might be equally as useful with language translations as many clients that are from BAME backgrounds are really spiritual and connected with their faith. (Interview 9 – Ramirez)*

Many participants felt that the use of religious metaphors helped to buttress trust and rapport in therapy. To the participants, BAME populations use faith as their compass for ontology and technical/scientific jargon often gets misunderstood or interpreted as incongruent to religious ideals. Consequently, packaging therapeutic counsel with religious metaphors re-frames guidance through a lens that patients are more likely to understand and meet with acceptance.

6.4 CULTURAL LIAISONS: THE ROLE OF COMMUNITY CHAMPIONS IN MENTAL HEALTH

This theme shed light on the role of community leaders in engaging hard-to-reach groups.

> *"I really liked the idea of community champions, which could work better with African communities given the mistrust we discussed earlier. In some communities, people are more likely to trust someone they know personally, such as a community leader or champion. They may be more comfortable speaking to someone who shares their cultural background and who can understand their experiences." (Interview 5 – Jacob)*

One participant emphasised the potential of community leaders as intermediaries in facilitating rapport building, enhance therapy uptake, improve adherence to therapy, amplify communication and understanding between service providers and BAME communities, ultimately contributing to more effective and culturally sensitive therapeutic outcomes. Additionally, participants emphasised that community champions could take many forms, from pastors in a church, imams in a mosque or community representatives who could act as a liaison between services users and providers.

6.5 EMPOWERING THERAPISTS: CULTURAL TRAINING

In this thematic category, participants highlighted their stance on cultural training:

> *"I believe that cultural training for therapists is essential. Therapists need to undergo cultural sensitivity training to understand the unique experiences and perspectives of different communities. This training can help therapists grasp the contextual factors that shape individuals' problems and view them as part of a larger social picture. For someone like me, who has gone through my own journey and developed an understanding of complexity, I recognize that psychological therapies often operate within a broader social context. Therefore, providing support and training to therapists that emphasizes cultural awareness and sensitivity is crucial for effective therapy with diverse populations. So further training is essential. Therapists need ongoing training to enhance their cultural competence." (Interview 8 – Georgie)*

All participants voiced the importance of implementing cultural training to all therapists to develop cultural competence and thus facilitating a therapeutic alliance. Additionally, participants also illustrated the possible components needed in a cultural training programme for psychological therapists. Specifically, word choice adjustments to avoid fragmenting the therapeutic alliance in the context of what is important in different cultural backgrounds. Furthermore, therapists believed that having cultural training delivered by a BAME representative may provide an insider's perspective for practitioners and ensure that the information being conveyed is reliable and valid to each BAME patient.

6.6 CULTURAL ADAPTATION IN PRACTICE: REAL-WORLD HURDLES

In this theme, participants illustrated various considerations to implementing content, therapist and organisation level adaptations. A specific perspective suggested creating a "worksheet database" to facilitate scaling content-level adaptations to organizational-level implementation.

> *"So, it could be quite helpful in case, like national wide, that we can have a database of the worksheet in different languages because, like the CBT, technically, the therapy only has a few worksheets for me to work from that doesn't allow much room for me to deviate from it or translate it. So, it could be quite helpful in case, like, national wide, that we can have a database of the worksheet in different languages because, , at present when I deliver CBT, I only have a few sheets to work off of." (Interview 1 – Bradley)*

> *"So, the access to a database of worksheets translated in multiple language could help me as a therapist not "deviate" from the therapy but yet still provide that cultural adaptation. Yeah, it [translation of worksheets - database] would be a huge difference [easier for practitioners to modify therapy]. So, in case I had a worksheet in my language [Chinese]. Then I would feel like I could provide better therapy for the patient that I'm being catering for. It's a very different feeling compared to I tell the interpreter…and the interpreter passes the message to the client, and then asks the client to write that, then draw the table on their own. Its a totally different experience, I would say." (Interview 1 – Bradley)*

Another consideration was illustrated around costs. Specifically costs of scaling and pragmatic barriers associated with different approaches.

> *". Maybe it's not possible for the organisation to include certain adaptations due to costs, but it would be perfect if it could. From the organisational point of view, adding ethnicity matching for example could be extra work for them [organisation] to do that may conflict with the existing features of therapy and organisation aims. Logistically, it could be quite tricky, but in terms of the benefits for service users, it's a good thing to have." (Interview 1 – Bradley)*

> *"Ahh, well. One word, costs… If the adaptation costs more for the practice to implement, then it is unlikely to work. Additionally, most therapists are overworked anyway so whatever "training" is put in place as to exist in harmony alongside other therapist commitments." (Interview 6 – Sonia)*

> *“You might call me a hypocrite for asking this question because technically, as a business owner in this field, finding cost-effective solutions is crucial. You want to help as many people as possible, but money is necessary to live. However, I would prioritize implementing adaptations that are cost-effective as my top adaptation, so perhaps content level adaptations. (Interview 7 – Daniel)*

> *“Collaborating with religious establishments and incorporating a mix of religious and scientific support can create a sense of safety and connection for clients who value spirituality. It depends on the individual's level of religiousness, but offering therapy in churches or mosques can provide a secure space where clients can express themselves and receive holistic support. However, there are practical considerations such as transportation and logistics when conducting therapy sessions outside of traditional settings. Arranging for physicians to visit specific religious establishments may require careful planning and coordination. While bringing therapy to religious venues can have advantages, there are challenges related to time and cost, especially if the therapist has to travel across town to different locations.” (Interview 9 – Ramirez)*

One participant did illustrate however that content-level adaptations may be the most “cost-effective” approach to large scale implementation if integrated with technology.

> *“The most cost-effective approach, in my opinion, would be content-level adaptations. There are many things that you can execute quickly and digitally with content. It's easy to share specific adaptations or content tailored to a specific audience, making it very scalable. In comparison, the cost of providing a therapist level adaptation would be much higher. You would have to consider factors such as how much you're going to spend, who you need to speak to, and the limitations associated with environmental factors. With content-level adaptations, there are far fewer limitations when it comes to creativity, making it more cost-effective. Not all adaptations are equal. Providing therapist level adaptation would require a significant investment, whereas content-level adaptations are much more accessible.” (Interview 7 – Daniel)*

7. OVERCOMING REAL WORLD CHALLENGES IN THERAPEUTIC INNOVATION

In this theme, participants illustrated the utility of shared databases of worksheets in multiple languages and that content-level adaptations may be the most cost-effective solutions for policy makers.

7.1 THERAPEUTIC TRANSFORMATION: LEVERAGING MULTILINGUAL DATABASES

In this theme participants suggested creating a "worksheet database" to facilitate scaling content-level adaptations to organizational-level implementation.

> *"So, the access to a database of worksheets translated in multiple language could help me as a therapist not "deviate" from the therapy but yet still provide that cultural adaptation. Yeah, it [translation of worksheets - database] would be a huge difference [easier for practitioners to modify therapy]. So, in case I had a worksheet in my language [Chinese]. Then I would feel like I could provide better therapy for the patient that I'm being catering for. It's a very different feeling compared to I tell the interpreter…and the interpreter passes the message to the client, and then asks the client to write that, then draw the table on their own." (Interview 1 – Bradley)*

Bradley, alongside most other participants, were in favour of leveraging technology to scale worksheets that are used with patients from a diverse range of backgrounds. Many participants articulated that this approach would allow practitioners to invest more time with their patients as opposed to losing time whilst sorting through paper-based worksheets. Furthermore, participants highlighted the value of technological innovation in creating a multilingual worksheet database to address the common language barriers encountered in therapy. Therapists found this strategy would help "cut-out" the need for an interpreter and improve understanding between practitioners and patients.

7.2 SCALABILITY SOLUTIONS: LEVERAGING CONTENT-LEVEL ADAPTATIONS

Closely linked to the previous theme, participants illustrated that content-level adaptations may be the most "cost-effective" approach to large scale implementation if integrated with technology**.**

> *"The most cost-effective approach, in my opinion, would be content-level adaptations. There are many things that you can execute quickly and digitally with content. It's easy to share specific adaptations or content tailored to a specific audience, making it very scalable. In comparison, the cost of providing a therapist level adaptation would be much higher. You would have to consider factors such as how much you're going to spend, who*

> *you need to speak to, and the limitations associated with environmental factors. With content-level adaptations, there are far fewer limitations when it comes to creativity, making it more cost-effective. Not all adaptations are equal. Providing therapist level adaptation would require a significant investment, whereas content-level adaptations are much more accessible." (Interview 7 – Daniel)*

Given the issues around scalability, participants recommended that the use of content level, paperless infrastructure could aid psychological practices in the UK and act as a low-cost but high-quality toolkit for practitioners and patients. Moreover, discussions highlighted that digital systems are easier to updated compared to paper-based procedures that have exist over the last few decades. Furthermore, participants seemed aware that acknowledging cost-effective solutions would not only reduce barriers to implementation, but also satisfy other KPI's (i.e., positive returns on investments) for business growth that many institutions face.

5.4 DISCUSSION

The primary aim of this study was to explore the professional experiences of mental health practitioners when working with BAME patients. This primary aim was underpinned by the following objectives: (i) to ascertain which cultural adaptations are being used, if any, to amplify perceived treatment acceptability, (ii) share strategies for enhancing mental health engagement with BAME populations and (iii) discuss the findings of Chapter 4 on which cultural adaptations may be most effective in improving psychotherapeutic outcomes with BAME populations. The themes found were (i) 'Crossroads of Culture: Navigating Stigma in BAME Mental Health, (ii) ‘The Asian Psyche: Asian Mental Health Perceptions’, (iii) ‘Ubuntu of the Mind: African Mental Health Perceptions’, (iv) ‘'Navigating Diversity in Therapy: Therapeutic Considerations', (v) 'Bridging the Gap: Barriers to Effective Therapy in BAME Populations', (vi) 'Culturally Responsive Therapeutic Approaches’ and (vii) ‘Overcoming Real Word Challenges in Therapy Innovation’. Theme (i) explores the perceptions of mental health service providers regarding BAME service users and examines the differences between Eastern and Western cultural attitudes towards mental health. Theme (ii) and (iii) explores distinct differences in cultural perception towards mental health that practitioners experienced when working with Asian and African patients. Theme (iv) provides insight on what therapeutic considerations are warranted when working with BAME patients. Theme (v) provides a lens into the identification of specific barriers encountered during psychological therapy, as viewed from the perspective of service providers. Theme (vi) was centred around discussions about specific cultural adaptations, meticulously evaluating their advantages and drawbacks for each distinct BAME population (i.e., Asian, African & Caribbean). Theme (vii) highlighted contemporary challenges in scaling adaptations to therapy at institution level alongside potential solutions for future researchers and policy makers. The outcomes arising from this study is in consonance with prior research. Specifically, it corroborates the prevailing notion that mental health is distinctly perceived through a culturally tinted lens among individuals hailing from Asian backgrounds (Algahtani et al., 2019; Hwang, 2006; Hechanova & Waelde, 2017; Hays & Iwamasa, 2006; Jameel et al., 2022; Naeem, et al., 2010; Ng, 1997), as well as those from African/Caribbean origins (Bhui, 2002; Chatters et al., 2011; Hankerson et al., 2015; Rathod et al., 2010; Scott et al., 2019). Furthermore, the findings spotlight the plausible efficacy embedded within diverse cultural adaptations (Arundel et al., 2021). Notably, it underscores that content-related adaptations potentially pose fewer hurdles for implementation, courtesy of their cost-effective integration facilitated by technological innovation and their scalability quotient (Salloum et al., 2022). Further comparisons to research are discussed in the following sections.

5.4.1 UNDERSTANDING CULTURAL PERSPECTIVES ON MENTAL HEALTH

Participants in this study illustrated the landscape of understanding associated with mental health amongst their BAME patients. For instance, practitioners highlighted that Western culture is more open (in discussing mental health) in general compared to Eastern cultures which explains the hesitancy of BAME patients towards mental health discussion with many BAME patients and increased perception of mental health stigma/prejudice. Additionally, practitioners articulated that Asian culture has a strong emphasis of collectivist thinking over individual thinking, that in some cases is pushed to the extreme where individual autonomy is not prioritised. In comparison African culture, where standards of therapy are not met, mistreatment/discrimination may be perceived alongside persistent feelings of witchcraft associated with mental illness.

With regards to the findings of Western vs Eastern culture and perceived mental health stigma, one large scale (n = 11,000) study found similar results (Krendle et al., 2020). Krendle et al. (2020) examined the "Stigma in Global Context-Mental Health" data to analyse two components of stigma, discriminatory potential and prejudice. The study showcased higher levels of perceived stigma and prejudice across Eastern countries compared to Western countries (Krendle et al., 2020). Additionally, concerns about disclosing experiences of prejudice were found to be predictive of the potential for encountering discrimination (measured as social distance) in Eastern cultures, but not in Western cultures (Krendle et al., 2020). This divergence was primarily driven by the heightened emphasis on moral attributions in the context of disclosing experiences of prejudice within Eastern cultures (Krendle et al., 2020). Furthermore, it was revealed that respondents from Western cultures exhibited elevated discrimination directed at individuals with mental illness who belonged to minority groups compared to the majority (Krendle et al., 2020). Conversely, in Eastern countries, this trend was observed concerning schizophrenia, while for depression, a contrary pattern emerged—greater stigma was directed at individuals from the majority group rather than the minority (Krendle et al., 2020). These observations suggest that dissimilarities in the origins of prejudice and attributions concerning the causes of mental illness contribute to the global divergence in the prevalence of stigma in Eastern vs Western cultures (Krendle et al., 2020) with other research identifying similar trends to the dissimilarities in the origins of prejudice (Abdullah & Brown, 2011; Cheon & Chio, 2012; Furnham & Chan, 2004;

Rao et al., 2007). Nevertheless, Krendle et al. (2020) results should be interpreted with caution as the countries included in the study were selected based on their participation in a larger global survey and this selection was not systematic but was dependent on the countries interest and capability to meet the study's inclusion criteria. Additionally, due to the nature of comparing Eastern vs Western countries, specific cultural idioms could not be probed or explored in further detail. Furthermore, other confounding variables may have played a role in influencing the outcome of the results (i.e., country's economic status) however, preceding research investigating international patterns of mental illness suggested that this might not be a major influence (Pescosolido et al., 2015). Moreover, Krendle et al. (2020) suggested that participants seem to recognise depression symptomatology compared to schizophrenia which may have influenced how participants interpret certain item questions and thus, the results. Despite these points, mental health stigma is on average, perceived to be higher amongst Eastern cultures compared to Western countries which exists in consonance with the personal lived experience of mental health professionals that took part in this study. Moreover, it strengthens the notion that due to the different ontological stance between cultures on mental health, psychological therapy may need to be adjusted for such groups (Arundell et al., 2021).

In respect to the findings associated with Asian and African/Caribbean cultural perception on mental health, reluctance to disclose mental health is evident, though driven by different underlying factors. Congruence can be observed with researchers examining Asian culture (Algahtani et al., 2019; Hwang, 2006; Hechanova & Waelde, 2017; Hays & Iwamasa, 2006; Jameel et al., 2022; Naeem, et al., 2010; Ng, 1997) and African/Caribbean culture (Bhui, 2002; Chatters et al., 2011; Hankerson et al., 2015; Rathod et al., 2010; Scott et al., 2019). A closer comparison with preceding research indicates that in Asian and African/Caribbean cultures, individuals with mental health conditions might internalise societal perceptions, resulting in feelings of shame and a tendency to conceal their symptoms. This can lead to diminished self-esteem and a delay in seeking assistance (Corrigan & Penn, 1999; Sussman et al., 1987; Wahl, 1999). Notably, in specific Asian cultures, mental illness carries a particularly strong stigma, as being diagnosed with mental illness is believed to cast a negative light on one's family lineage. This belief could potentially impact the marriage prospects and economic opportunities of other family members (Hechanova & Waelde, 2017; Ng, 1997). Moreover, Asian cultures often emphasise emotional restraint (Tang, 2013, 2015) and collective values, which might contribute to a hesitancy to seek help for mental health concerns due to fears of unfavourable perceptions from the community (Kleinman, 1982; Leung et al., 2012). Conversely, African/Caribbean cultures tend to adopt a more spiritual perspective on mental health, often attributing mental health issues to spiritual or supernatural causes (Abdullah & Brown, 2011; Codjoe et al., 2021). This outlook can contribute to stigmatisation, as individuals with mental health problems might be perceived as being under the influence of malevolent spirits or facing divine retribution (Abdullah & Brown, 2011; Codjoe et al., 2021) which were aspects identified in the present study. Nevertheless, as with all research investigating culture, individual experience and study design limitations can be observed with full critical insight illustrated in Chapter 4 (see section 4.4.1 - Taras et al., 2009).

5.4.2 THERAPEUTIC CONSIDERATIONS FOR BAME POPULATIONS

Study participants emphasised the need for additional considerations when conducting therapy with BAME patients. Considerations were characterised by the capacity of practitioners to tailor therapy to align with the individual client's specific contextual circumstances (i.e., patient-centred). Moreover, participants stressed the importance of practitioners being attuned to the cultural nuances that influence the therapeutic alliance.

Prior studies have examined the connection between patient-centred communication and the therapeutic alliance. Notably, positive correlations have been demonstrated among both adults (Pinto et al., 2012) and adolescents receiving mental health treatment (Murphy & Hutton, 2018). Pinto et al. (2012) carried out a systematic review (n = 12) examining the relationship between therapeutic communication styles and the therapeutic alliance showed large positive correlation coefficients between the two. Specifically, interaction styles, that fall into the categories of patient facilitating, patient involving, and patient supporting, are linked to aspects of therapeutic alliance, as assessed through measures like communicative success, agreement, trust, and rapport; however, due to limitations in available data for many communication factors, a more precise estimation of the strength of this relationship could not be determined through meta-analysis. Nevertheless, Pinto et al. (2012) argues that whilst it is clear that a positive therapeutic alliance predicts better treatment outcomes, the authors argued that when a healthcare provider's manner of interaction encourages the active involvement of the patient during the consultation, including attentive listening and posing inquiries that delve into emotional aspects, it results in the enhancement of the therapeutic alliance with foregoing research supporting this stance (Roberts & Bucksey, 2007). These findings are also echoed by Wolf et al. (2017), a qualitative study that aimed to investigate the realities of patience-centred care between patients (n = 20) and practitioners (n = 16). The study reported that patients appreciated trust and human connection more than formalised aspects of care planning (Wolf et al., 2017). Additionally, both patients and practitioners illustrated that a caring and respectful relationship, underpinned by emotional support, were essential for long-term rapport and successful partnerships. Similarly to the findings of this study, participants emphasised the need for patient-centred counselling through a culturally appropriate lens, aligning with the qualitative argument presented in Pinto et al. (2012) and Wolf et al. (2017). Additionally, what may explain the stance of practitioners in this study and Pinto et al. (2012) outcomes could be found in the self-determination theory (Ryan & Deci, 2000), which suggests an inherent inclination toward psychological development, physical well-being, and social harmony fostered through the fulfilment of fundamental psychological needs for autonomy, competence, and connectedness (Ryan & Deci, 2000). The communication factors illustrated in Pinto et al. (2012) study and the personal lived experience of practitioners in the study resemble the concept of relatedness (Ryan & Deci, 2000) as they encourage favourable motivation among patients who require a sense of connection, genuine care, trust, and rapport - aspects that BAME populations feel little of (Codjoe et al., 2021; Cheng et al., 2018). However, several limitations can be observed in Pinto et al. (2012) review, specifically that there is no agreement on how "communication factors" should be measured nor the tool for measurement. Since most of the studies used various questionnaires and methods to gather and analyse data, direct comparisons are not prudent (Pinto et al., 2012). The review also included studies from a variety of different settings (i.e., online, phone call and in person), on whether it was the patient's first or follow-up visit should be considered and how these factors affect communication between service users/providers and thus, the therapeutic alliance. Murphy and Hutton (2018) conducted a systematic review and meta-analysis on assessing the therapeutic alliance and clinical outcomes in adolescence undergoing psychological therapy. The study revealed that the link between the therapeutic alliance and therapy outcomes is more substantial than previously established (Murphy & Hutton, 2018). Examining 28 studies with a collective participant count of 2,911, the analysis displayed a correlation of 0.29, indicating a notable connection (Murphy & Hutton, 2018). Upon the exclusion of studies involving participants outside the 12 to 19 age range, the correlation strengthened to 0.34, based on 15 studies encompassing 1,797 participants (Murphy & Hutton, 2018). In contrast to research involving adults, the patient-therapist ratio did not moderate this relationship, a finding consistent across both single-predictor and multi-predictor models (Murphy & Hutton, 2018). Nevertheless, irrespective of the limitations associated with predicting the therapeutic alliance, such a cohesive goal is associated with more desirable clinical outcomes in mental health treatment

(Murphy & Hutton, 2018; Pinto et al., 2012) and further strengthens the qualitative claims illustrated in this study around the need to maintain a therapeutic alliance with BAME patients.

Previous research has investigated how therapists understanding cultural subtleties, known as cultural awareness or competence, affects clinical patient outcomes. For instance, Lie et al. (2011) conducted a systematic review involving seven studies to explore the link between cultural competence training and patient outcomes. They suggested that higher cultural competence is linked to better patient outcomes, although the proof isn't consistent or strong enough to firmly support the complete effectiveness of incorporating cultural competence. Despite widely recognised guidelines emphasising the importance of its integration (Ibrahim & Heuer, 2016), many of these studies lack adequate details about the training content, the characteristics of the instructors (like age, gender, ethnicity), the frequency and duration of sessions, or the characteristics of the professionals being trained (Lie et al., 2011). Moreover, it remains uncertain whether solely implementing cultural competence training can significantly enhance patient outcomes. It's likely that cultural competence training is just one factor among many that influence patient outcomes (Lie et al., 2011). In a recent qualitative study, Faheem (2023) conducted a study involving 16 participants, exploring whether IAPT service providers perceive themselves as culturally competent to provide psychological therapy to BAME service users. The present study revealed parallels with the Faheem (2023) insights, as service providers in Faheem (2023) study and the current study emphasised the importance of cultural competence in therapy with BAME individuals and both expressed a lack of adequate training, indicating a need for further support. Additionally, Faheem (2023) identified challenges arising from the interplay between individualistic and collectivist ideologies, which sometimes conflicted with specific therapeutic techniques (Faheem, 2023). This dilemma placed practitioners in situations where they felt they had to choose between respecting cultural backgrounds and adhering to ethical principles of psychological therapy (Faheem, 2023). Another aspect to consider is that, despite the efforts of IAPT therapists to be culturally competent and provide culturally sensitive care, constraints related to session duration, delivery mode, and the increased demands of services (such as meeting key performance indicators) create challenging circumstances for the implementation of culturally inclusive therapy (Bassey & Melluish, 2012). Furthermore, many therapists deal with complex cases where patients present issues beyond the scope of therapy, such as housing or income concerns, which are less influenced by cultural competence training (Naz et al., 2019). Given the complexity of such cases and the often-inadequate treatment outcomes, it becomes essential for psychological therapists to receive regular support and access to culturally competent training to ensure effective support for complex cases whenever possible (Clegg et al., 2016).

5.4.3 BARRIERS TO EFFECTIVE THERAPY

Within theme 4 theme, participants highlighted a range of factors that hinder effective psychological therapy. Specifically, they discussed challenges related to language barriers (limited comprehension), difficulties arising from interpreter variations (different interpreters per session affecting therapeutic alliance), intergenerational differences in mental health perceptions impacting therapeutic alliance, religious tensions during therapy, mental health stigma beliefs, insufficient supporting services beyond psychological therapy, and the perception that the current number of sessions is inadequate for BAME patients due to the intricate nature of their needs.

All the findings have been substantiated by prior research investigating obstacles to effective psychological therapy in BAME patients. For instance, Lowenthal et al. (2012) study aimed to investigate the barriers reported in the IAPT services for BAME populations, focusing on Bengali, Urdu, Tamil and Somali-speaking groups. Through focused group interviews, lack of understanding and interpreter difficulties were highlighted as challenges during the alliance-building process (Lowenthal et al., 2012). Linking Lowenthal et al. (2012) results to the findings of this study, suggests that further support for resolving language barriers, increased training interpreters or policy changes around the existing involvement interpreters have during therapy might need to be revisited. Additionally, Escobar-Galvez et al. (2023) quantitative study aimed to ascertain intergenerational differences in barriers that impede mental health service use among Latino populations in the US. The study discovered intergenerational differences in mental health service usage, with first generational Latinos reporting lower service utilisation and higher levels of perceived stigma compared to latter generational immigrants (Escobar-Galvez et al., 2023). This may suggest that older generations of BAME populations may require further support and outreach to undermine the increased levels of perceived stigma. Nguyen (2020) study aimed to explore the relationship between religion and mental health in older Black and Latino populations. The study reported that religion acts as a source of resilience in later life but that stigma towards seeking mental health aid and resistance to therapy may exist amongst certain subgroups (Nguyen, 2020). This may be as the relationship between religion and mental health varies across ethnicities, ages and genders (Nguyen, 2020). Whilst these dimensions were explored in this study, religion seen as a potential cause for conflict during therapy exists in agreement with Nguyen (2020) findings and warrants further investigation. Memon et al. (2016) and Zhang et al. (2020) investigated the barriers to mental health service utilisation amongst BAME populations. Both studies found mental health stigma beliefs high in BAME populations and for stigma beliefs to be persistent factor in deterring attendance to therapy sessions (Memon et al., 2016; Zhang et al., 2020). In particular, Zhang et al. (2020) illustrated that in Asian cultures, populations diagnosed with mental illness are often avoided due to the perception of aggression, danger and lower status. Whilst these findings were not exactly echoed in this study, similarities can be observed around social status and moral attribution (i.e., social status was deemed important alongside moral judgment). The findings from this study and Zhang et al. (2020) may suggest that social status and moral attributions could be more important factors to consider during therapy when working with distinctly Asian populations versus other distinct Black and minority ethnic populations. Ajayi (2021) also looked at barriers to healthcare services to BAME populations and highlighted a lack of policies and supportive systems, other than therapy, to address inequalities for BAME populations. This is echoed by participants in this study, suggesting that a more robust support network/infrastructure is needed for BAME populations outside of psychological therapy. Faheem (2023) study reported the potential need for an increased number of psychological sessions for BAME patients to allow time for rapport building. This was also supported by participants in this study, which may suggest that more time is needed between practitioners and BAME populations to establish a stronger therapeutic alliance. , Additional research has credited racial discrimination and “racial bias” (Lawton et al., 2021) as the cornerstone for reduced access to mental health services. A recent systematic review (Nwokoroku et al., 2022) illustrated that it is simply the multifaceted phenomenon of “culture”, perceived experience, societal norms, silencing, perceived acceptance and a belief about diagnosis/cause of mental illness to be key factors that moderate the therapeutic alliance, and thus psychological outcomes (Memon et al., 2016). Whilst the landscape of barriers seems inordinate (Memon et al., 2016; Nwokoroku et al., 2022), points of critical consideration surrounding the quality of findings should be heeded. In particular, barriers to psychological therapy are moderated by socio-economic, political and cultural contexts which attenuates applicability (Nwokoroku et al., 2022). Additionally, methodological issues of small sampling, non-randomised methods, and self-reported data undermining the claim to reliability and validity (Cheng et al., 2018). Furthermore, whilst authors provide insight into barriers experienced in BAME individuals (Memon et al., 2016; Lawton et al., 2016) individual experiences may differ thus leaving some perspectives underrepresented. Moreover, selection bias (Lawton et al., 2016) and an overall lack of follow-up longitudinal data (Faheem, 2023) should be noted. Considering these considerations, further research is imperative to determine the prominence of specific barriers and their varying effects across different demographics within BAME populations. This will establish a more solid and validated evidence base, guiding the formulation of precise guidelines to improve psychological therapy outcomes for diverse communities.

5.4.4 THE ROLE OF CULTURAL ADAPTATIONS

In this thematic category, participants shared insights related to the outcomes presented in Chapter 4. They discussed their perspectives on the effectiveness of ethnic matching, strategies for adapting content, the significance of incorporating religion in therapy, the role of community champions, the need for cultural training, and considerations regarding the implementation challenges of scaling adaptations at organisational levels and for broader adoption. Emphasis from the participants centred on the potential benefits of ethnic matching for enhancing the therapeutic alliance alongside the potential stereotypes ethnic matching may bring into therapy. However, considering cost-effectiveness (Salloum et al., 2022), participants indicated that content-level adaptations, such as translating text and incorporating religious metaphors, might be a more viable approach from the perspective of service providers. Additionally, some participants shared that content-level adaptations, like incorporating religious metaphors into workbooks, have been employed in their practice with positive outcomes. These adaptations were particularly useful in aiding patients with limited health literacy to comprehend complex psychological concepts.

Similarly, studies by Algahtani et al. (2019), Naeem et al. (2016a), and Jameel et al. (2022) explored mental health perceptions among BAME individuals (e.g., Saudi Arabian, Pakistani, and Indian participants) and revealed the demand for and perceived value of language translation, ethnic matching, and cultural training by both patients and practitioners. Despite the acknowledged significance of these cultural adaptations in psychological therapy, it remains uncertain which adaptations are most effective for each specific population and the extent of modification required to achieve effectiveness. For instance, as highlighted in Chapter 4, Smith and Cabral's (2011) study involving 53 research works demonstrated a moderate to large effect size in terms of perceived utility for ethnic matching, but only a small effect size in objective client outcomes, indicating limited therapeutic benefits from racially/ethnically matched sessions. Moreover, the prevalent use of content-related adaptations, as observed in Arundell et al.'s (2021) systematic review, might stem from convenience rather than a proven track record of enhanced treatment outcomes (Naeem et al., 2016b). Furthermore, as delineated in Chapter 4, justifications can be presented for tailored adaptations in Asian cultures (Jameel et al., 2022; Naeem et al., 2021), distinct from adaptations for African cultures (Chatters et al., 2011; Hankerson et al., 2015; Rathod et al., 2010), owing to their unique cultural intricacies, ontological perspectives, and mental health perceptions. However, regardless of which adaptation proves therapeutically effective, as illustrated by participants in this study and preceding research (Faheem, 2023), an in-depth critical analysis and economic recommendation is required to understand the costs associated with adaptations for evidence-based practice. If adaptations made to interventions are cost-ineffective, mass adoption and scaling is unlikely to take place due to commonly associated budgeting issues, stakeholder interest, and competing key-performance-indicators (Salloum et al., 2022). For instance, common competing key-performance-indicators are, session quotas versus client needs - balancing session quotas with client needs can lead to fragmented quality of care, as therapists are pressured to meet numerical targets (Geest & Meganck, 2019). Additionally, caseload size versus personalisation - juggling high caseloads and personalisation becomes challenging, as therapists may have limited time to tailor care due to heavy workloads (Tiemens et al., 2019). Furthermore, administrative demands versus client-care - administrative demands, such as documentation and reporting, could divert therapists' time away from meaningful patient interactions, affecting the quality of client care (Cook et al., 2017). Lastly, therapist burn-out versus client care - the risk of therapist burnout increases when high caseloads and lack of allocated self-care time are prevalent, ultimately affecting the quality of care provided to clients (Johnson et al., 2020).

There is an increasingly recognised understanding that cultural modifications in psychological therapy for BAME populations have the potential to enhance care quality (Anik et al., 2021; Arundell et al., 2021; Naeem et al., 2019), with a concurrent emphasis on ensuring their sustained implementation (Salloum et al., 2022). The process for evaluating costs linked to these adaptations typically involves several steps, including stakeholder engagement, gauging the extent of modification needed, organisational evaluations, development of new materials, training staff, implementation, evaluation, and iterative adjustments based on assessment outcomes (Escoffery et al., 2018). Various economic models have been proposed in implementation research to assess intervention costs post adaptations (Mason et al., 2001; Mewes et al., 2017; Sculpher, 2000; Whyte et al., 2016) however it has been argued by Salloum et al. (2022) that these economic models evaluate costs primarily at the patient level, which may not fully inform program-level decisions. Additionally, despite acknowledging implementation gaps, these economic models do not directly address the economic evaluation of adaptations and their consequences (Salloum et al., 2022). In light of this, Stirman et al. (2013) created the “Framework for Reporting Adaptations and Modifications to Evidence-based interventions (FRAME), drawn from a systematic review of adaptations made to evidence-based interventions, for illustrating and measuring adaptations at organisational level with the latest iteration to FRAME embodying 8 domains (Stirman et al., 2019). In particular, (i) timing and methodology of the adaptation; (ii) whether it was planned or reactive; (iii) decision-maker behind the adaptation; (iv) what are the adapted components; (v) level of implementation for the adaptation; (vi) mode of adaptation; (vii) fidelity alignment of the adaptation; and (viii) rationale and objective driving the adaptation (Stirman et al., 2019). All 8 of the FRAME domains could be used to help practitioners scale adaptations in a cost-effective manner (Stirman et al., 2019). In conjunction with the FRAME model, it's crucial to recognize economic considerations before, during, and after implementing the desired adaptation (Stirman et al., 2013, 2019; Salloum et al., 2022). Economic factors related to adaptations can vary based on (i) timing of adaptation; (ii) planned versus unplanned adaptation; (iii) decision-maker identity; (iv) adaptation within intervention or implementation strategy; (v) level of implementation (patient, practice, organisation); (vi) nature of adaptation; (vii) fidelity maintenance; and (viii) rationale for adaptation (Stirman et al., 2013, 2019; Salloum et al., 2022). According to Salloum et al. (2022), it is important to consider the costs associated with the adapted intervention versus costs of the un-adapted/standard evidence-based intervention particularly if large/long-term scaling is the goal. Moreover, practitioners and policy makers considering the incorporation of cultural adaptations into current psychological therapy practices (Arundel et al., 2021) for BAME populations might find it advantageous to begin with relatively "smaller" or more financially feasible adaptations (like content-level adjustments). This approach involves progressively building upon successful outcomes and collective insights about which adaptations contribute to patient-level enhancements before pursuing larger-scale implementation within organisations (Salloum et al., 2022).

Thus, as illustrated by participants in this study and similarly to preceding research (Faheem, 2023), practitioners feel the need for increased cultural training and utilisation of cultural adaptations (Arundell et al., 2021) in psychological therapy however, considerations surrounding costs and implementation are important economic aspects warranted for further consideration (Salloum et al., 2022). Based on the preceding research (Algahtani et al., 2019; Faheem, 2023; Jameel et al., 2022; Rathod et al., 2010) - it seems that it would be prudent to integrate adaptations that are more cost effective such as content level adaptations (Arundell et al., 2021) for organisational scaling alongside the FRAME economic model (Stirman et al., 2013, 2019; Salloum et al., 2022) to aid policy makers and practitioners ascertain costs in a more valid and reliable manner.

5.4.5 REFLEXIVITY

As illustrated in Chapter 4 (heading 4.4.3), two complementary appraisal tools were selected to assess distinct aspects of qualitative research (Leonidaki 2015; Yardley, 2017). In applying Leonidaki's (2015) reflexivity criterion (Section 8; Appendix 5.6–5.7) to this study with health practitioners, the focus shifts to interrogating how my assumptions as a non-clinical researcher influenced interpretations of therapist challenges. My initial outsider status, lacking direct healthcare experience, led me to hypothesise that practitioner difficulties stemmed from individual shortcomings (e.g., cultural ignorance or communication gaps). However, reflexive dialogues with my supervisory team (Arvay, 2003) revealed how systemic constraints (e.g., underfunding, bureaucratic inefficiencies) shaped practitioners' narratives, a dynamic I had initially undervalued. A contemporary reflective journal (Olmos-Vega et al., 2023) could have better documented these evolving realisations in real time. For instance, journal entries might have traced my shift from framing practitioners as agents of care to agents within constrained systems, capturing how interviews exposed tensions between their advocacy for BAME patients and institutional barriers. Yardley's (2017) sensitivity to context (Section 1; Appendix 5.8) proved pivotal in reframing practitioners' accounts. While the study prioritised their voices through conversational interviews (Anyan, 2013), allowing them to foreground structural challenges (e.g., inadequate post-therapy support systems), retrospective application of Yardley's framework highlights missed opportunities to explicitly link these constraints to broader racialised healthcare inequities. For example, practitioners' emphasis on 'complex patient needs' often implicitly referenced systemic failures (e.g., temporary housing), yet the analysis could have more directly connected these to institutional racism or policy gaps. Deepening this structural lens would have strengthened the critique of how practitioners navigate therapy, offering readers a clearer understanding of their (therapists) dual role as both advocates and products of flawed systems.

5.4.6 LIMITATIONS & FUTURE RESEARCH DIRECTIONS

In summary, this research offers new insights into how mental health is perceived in Asian and African/Caribbean communities from the perspective of healthcare practitioners. Additionally, the study suggests using economic models, such as FRAME, to help institutions accurately assess the costs of scaling culturally tailored adaptations for these populations. Furthermore, the present study adds to previous research (Algahtani et al., 2019; Faheem, 2023; Jameel et al., 2022; Memon et al., 2016; Rathod et al., 2010; Zhang et al., 2020) in exploring the personal lived experience of practitioners working with BAME populations, communication styles (Murphy & Hutton, 2018;

Pinto et al., 2012) and which cultural adaptations (Arundell et al., 2021) may serve best to forge the therapeutic alliance between service provider and user however, this study is not without its limitations. Ascertaining specific components of culture and personal lived experience is difficult due to the multidimensional and multifaceted nature of culture (Nwokoroku et al., 2022; Taras et al., 2009). Moreover, as this study was a qualitative study, no causality can be established. Furthermore, generalisability of these findings should be interpreted with caution as despite the researchers' best efforts to include participants from varying levels and psychotherapeutic experience, interpretations of ontology (i.e., what individuals perceive to be true/real - Otoo, 2020) may vary and/or may be underrepresented. Similarly, to Chapter 4, future research would benefit from RCTs comparing different cultural adaptations (Arundell et al., 2021) to specific ethnicities (e.g., Asian vs African) to establish clinical outcomes in conjunction with economic models (Stirman et al., 2013, 2019; Salloum et al., 2022) to aid in predicting future costs associated with each adaptation. Having clinical outcomes and more reliable and valid cost projections can help policy makers move a step closer in effectively carrying out the NHS (2012) constitution that strives to resolve nationwide health disparities experienced in the BAME population.

5.5 CONCLUSION

In conclusion, this study adds to previous literature in investigating the personal lived experience of mental health service providers with BAME service users to establish key differences in ontology between the different cultures, barriers to therapy alongside ascertaining which cultural adaptation may be most effective in therapy. Additionally, this study recommends using economic models for cost projections at the organizational level, aligning with the NHS (2012) constitution's strategy for addressing health disparities. Future research should compare cultural adaptations with different cultures alongside economic models to establish a cogent notion on which cultural adaptations could be most cost effective and clinically effective in reducing mental health outcomes amongst BAME populations. Lastly, future research should aim to provide training related to cultural competence, ascertain the effects this may have on psychotherapy in conjunction with discovering the utility of longer therapy sessions on reducing anxiety and depression in BAME populations.

CHAPTER 6 - GENERAL DISCUSSION

6.1 OVERVIEW OF THESIS FINDINGS

Chapter 6 summarises the key findings of this thesis in association with the aims illustrated in Chapter 1, which were to ascertain effective cultural adaptations to psychological therapy for distinct BAME populations to mitigate widening health disparities compared to non-BAME populations. To answer this, a systematic review (Chapter 2) was carried out to offer a contemporary view of the psychological interventions used in BAME populations, which identified the increased incorporation and effectiveness of CA-CBT indicating utility in addressing cultural barriers to therapy present in BAME populations. Chapter 3 presents findings from a quantitative study that aimed to (i) examine differences in stigma, depression, anxiety and subjective wellbeing between ethnicities and age groups and (ii) asses the relationship between stigma, anxiety, depression, subjective wellbeing and sociodemographic variables. Chapter 3 presented quantitative results from 204 participants and found higher stigma severity in Black African/Caribbean populations and high depression and low subjective well-being levels in Asian or Asian British populations. Chapter 4 presented a qualitative study which explored the perceptions and experiences of mental health and wellbeing, psychotherapeutic practices and healthcare, including any associated stigma, within BAME populations. Chapter 4 highlighted that (i) stigma is prevalent among BAME populations however, Asian participants seem to experience stigma as perceived judgement whilst Black African/Caribbean populations which voiced their perception of stigma as historical injustice, prejudice and mistreatment; (ii) a unanimous warrant for cultural adaptations, in the form of text translations, use of religious metaphors, ethnic-vs-ethnic matching, cultural training for service providers and the use of "community representative" to pioneer the rapport building process with service providers. Chapter 5 presented a qualitative study that explored the experiences of service providers (i.e., psychological wellbeing practitioners, counsellors, clinical psychologists, cognitive behaviour therapist, mental health wellbeing practitioners) with BAME patients. Findings from Chapter 5 highlighted that therapists stressed a challenge between focusing on adaptations that improve therapy outcomes (i.e., ethnic-vs-ethnic matching) vs adaptations that help reduce costs for running the practice and are scalable (content-related adaptations, text translations, religious metaphors).

Lastly, policy recommendations, implications of practice in terms of real-world implications, strengths and limitations of the doctoral thesis are discussed alongside original contributions to the field of health inequalities in BAME populations.

6.2 CONTRIBUTIONS TO KNOWLEDGE - WHAT DOES THIS THESIS ADD?

This thesis contributes to the field of health inequalities in BAME populations by offering a component-by-component analysis of culture between distinct BAME populations and how cultural factors affect psychological therapy outcomes. Whilst previous research, such as that conducted by Anik et al. (2021) and Arundell et al. (2021), has shown the increased utility of CAP (Anik et al., 2021) and cultural adaptations to be used in psychological therapy (Arundell et al., 2021), this study suggests which cultural adaptations may be effective between distinct BAME populations (i.e., scaling content-level adaptations, due to cost-effectiveness, but shaping them to either focus on hierarchical communication patterns [Asian] or mistrust, historical mistreatment and racism [Black African/Caribbean]). Additionally, to our knowledge this is one of the first thesis that used both surveys and interviews with BAME patients and practitioners to ascertain in depth views and experiences of both parties to draw out novelty for the subject matter. By adopting different methodological approaches. this thesis provides new insights into cultural adaptations for BAME populations that were previously unknown or underdeveloped. Specifically, the findings showcased in this thesis address gaps in knowledge on how cultural factors (i.e., social/generational norms, familial dynamics, religious beliefs and langauge) between BAME populations differ and how these cultural idiosyncrasies affect psychological therapy outcomes. In doing so, the thesis addresses how cultural adaptations could be tailored between BAME populations to mitigate cultural barriers and improve psychotherapeutic outcomes.

The systematic review (Chapter 2) revealed that out of the current psychological therapies utilised with BAME populations, both CBT and CA-CBT were found to be the most effective in reducing anxiety and depression in BAME populations, with both modalities demonstrating large positive effect sizes post intervention in favour of the intervention group. It can be argued that if differences in treatment effectiveness are not statistically meaningful between CBT and CA-CBT, then amalgamating cultural adaptations to existing psychological therapy may increase costs, incongruence with the evidence base, attenuate psychotherapeutic fidelity and consequently, intervention effectiveness (Castro et al., 2004; Elliott & Mihalic, 2004; Hall et al., 2016). However, this thesis addresses this counter-argument by emphasising the influence of cultural factors on psychotherapeutic outcomes (Bhugra & Bhui, 1998; Bhui, 2010; Barrera et al., 2013; Edge et al., 2016; Rathod & Kingdon, 2014; Sue et al., 2009) with additional evidence to suggest that CBT does not consider the cultural factors (e.g., societal norms, religious beliefs, language differences) that may influence psychotherapeutic outcomes (Naeem et al., 2015, 2019). By doing so, this thesis acknowledges the limitations and complexities of the field, while demonstrating the validity of the contribution it offers.

Key contributions from Chapter 3, a quantitative study, were that Black African/Caribbean populations presented the highest levels of stigma compared to all ethnic groups and was significantly higher compared to the Asian or Asian British population. Conversely, Asian or Asian British populations presented the highest depression and lowest subject wellbeing levels compared to all other ethnicities, with scores in both constructs being significantly different compared to the Black African/Caribbean population. As noted in Chapter 3, the higher stigma severity scores observed in Black African/Caribbean populations is likely to be a consequence of a complex interplay of sociocultural factors. Additionally, changes in self-identity (viewing oneself as mentally ill may have also partly explained the amplified stigma score. Further explanations to Chapter 3's results could be found in Conner et al. (2010) study which identified myths around seeking mental health aid, seeking psychotherapy as a last resort, historical mistreatment and racism as possible factors explaining the high stigma score. On the other hand, the high depression and low subject wellbeing score in Asian or Asian British populations may be explained common cultural idiosyncrasies such as, collectivism (Codjoe et al., 2021), being overly socio-centric (Bhugra, 2005) and "saving face", which deters help-seeking behaviour (Ryder et al., 2008) risking highted depression and lower subjective wellbeing. Consequently, these differences in stigma, depression and subjective wellbeing between distinct BAME populations advances the macro-argument from the CRED report (2021) that research should focus on distinct BAME populations rather than BAME as a collective group as significant differences across key psychometrics can be observed.

Chapter 4 was a qualitative study that explored the predicament of cultural adaptations for each BAME population including perceived mental health stigma from BAME service users. Key contributions from this study were that (i) Asian participants in this study seemed to associate the acknowledgment of mental health as weakness, flawed characteristics, and as a result being viewed "lower" by members of their social group in a status hierarchy compared to African/Caribbean participants who viewed stigma in mental health to be forged by a combination of social norms, institutional and historical mistrust, mistreatment and racism. Additionally, cultural adaptations for Asian populations may need to focus on addressing family dynamics, social support, and hierarchical communication patterns (Jameel et al., 2022) compared to African/Caribbean populations who may need to prioritise addressing community-level factors, including religiosity/spirituality, social connectedness, racial discrimination (Chatters et al., 2011) alongside content-related adaptations (i., educational content) to tackle mistrust of public services (Rathod et al., 2010) and awareness issues around mental health (Scott et al., 2019). These unique contributions advance the macro argument for how existing cultural adaptations to psychological therapy could be adapted to accommodate cultural needs between BAME populations. However, there is still a need to explore the perceptions of mental health practitioners and their insights into which cultural adaptation may be most effective for the particular ethnicity in question as evidence suggests that therapist characteristics explain 5-9% in IAPT patient pre- and post-intervention HADS and GAD scale scores (Green et al., 2014).

Chapter 5 builds on the findings provided by Chapter 3 and 4, and ascertained that from a service provider standpoint, increased consideration for the associated costs for integrating cultural adaptations in psychological therapy is needed as mass adoption and scaling is unlikely to take place due to commonly associated budgeting issues, stakeholder interest, and competing key-performance-indicators (Salloum et al., 2022). The key contribution from Chapter 5 was that service providers suggested that content-level adaptations may be the most cost-effective adaption (compared to therapist and organisation level adaptations) for scaling to organisation level, making content-level adaptations a more ideal 'starting point' for adapting therapy to distinct BAME populations. Whilst no specific economic model was illustrated by practitioners during the interviews, Chapter 5 goes on to recommend the FRAME economic model (Stirman et al., 2013, 2019). The FRAME model could be used to help service providers in assessing costs at organisational level following culturally adapted interventions in contrast to models which have typically been used to ascertain costs at the patient level (Mason et al., 2001; Mewes et al., 2017; Sculpher, 2000; Whyte et al., 2016). Specifically, the FRAME model can help policy makers and researchers ascertain (i) what changed? (i.e., what changed from the current intervention), (ii) why change? (i.e., provide a rational for why the change to the intervention was made) and (iii) how was it changed? (i.e., documents the process for changes to interventions) (Stirman et al., 2013, 2019). This process allows for accurate documentation for changes to interventions and facilitates easier cost-calculations. Moreover, Chapter 5 further emphasised, as per the service users insights, the proposition that financially feasible adaptations (like content-level adjustments), may be more suitable as a minimal viable product to allow time for understanding which content-level adaptations contribute to patient-level enhancements before pursuing larger-scale implementation within organisations (Salloum et al., 2022).

Overall this thesis aimed to identify effective, culturally tailored interventions to address mental health disparities in BAME communities by developing a taxonomy of psychotherapies, examining differences in stigma and mental health outcomes between BAME groups, explored lived experiences of wellbeing and healthcare access, and proposed policy recommendations to reduce health inequalities. Collectively, the studies presented in this thesis addressed the aims above and found that CA-CBT is growing in utilisation and effectiveness for reducing anxiety and depression in BAME populations (Chapter 2). Additionally, the differences in stigma, depression and subjective wellbeing between BAME populations may present distinct challenges to therapy due to cultural idiosyncrasies (Chapter 3). Furthermore, adaptations that address hierarchical communication patterns may be more effective for Asian or Asian British populations and adaptations that focus on addressing historical mistreatment, mistrust and racism may be more effective for Black African/Caribbean populations (Chapter 4). Moreover, the FRAME economic model could be used to help practitioners learn the projected costs for scaling cultural adaptations to therapy at institutional level (Chapter 5). Whilst these studies offer valuable insights into cultural adaptation to psychological therapy, findings are not meant to provide a comprehensive solution to health inequalities in BAME populations. Rather, findings shed light on a specific aspect of inequality (i.e., disproportionate mental health outcomes in BAME populations) that has been underexplored and merits further investigation.

6.3 POLICY RECOMMENDATIONS

The House of Commons recently published a briefing report with an overview of contemporary mental health policies in the UK (Garratt, 2023). Findings from the present thesis could potentially offer some insight to future mental health policies and address gaps of existing mental health policies in the UK, such as the NHS Long Term Plan - 2019 (NHS, 2019), the Advancing Mental Health Equalities Strategy - 2020 (NHS, 2020b) and (iii) the Suicide Prevention Strategy - 2023 (Department of Health & Social Care, 2023).

The NHS Long Term Plan, published in 2019, is a national level policy that illustrates the priorities for the NHS in the UK till 2024 (NHS, 2019). Specifically, its purpose is to provide guidance on the development and improvement of healthcare services to meet the needs of the ever-changing UK population (NHS, 2019). The NHS Long Term Plan sets out core aims on improving mental health outcomes across various domains such as gambling and rough sleeping (NHS, 2019).

Findings from the present thesis helps to advance the macro arguments of (i) reducing the prevalence of adult mental health illness and (ii) improve mental health inpatient care. At present, point (i) and (ii) is being achieved through redesigning community mental health centres to adhere to the “Community Mental Health Framework for Adults and Older Adults" (National Collaborating Centre for Mental Health [NCCMH], 2019) which is a framework that describes a multi-layered, multi-component approach for patients with differing levels of mental health need to access secondary provisions of support as required. Furthermore, the framework (NCCMH, 2019) allows specialist teams/treatment services to “plug-in” to existing care models from primary care services to support patients with complex needs better (NHS, 2019). However, details beyond simply increasing contact points for patients and improving signposting have not been provided (Garratt, 2023). Thus, the findings in this thesis could provide further transparency about the cultural considerations warranted for distinct BAME populations and to better equip community-led mental health service providers on which adaptations could be applied to psychological therapy when working with patients from BAME backgrounds, who have a well-established complexity of needs profile in mental health (Garratt, 2023).

The Advancing Mental Health Equalities Strategy (NHS, 2020b), published in 2020, is a plan of action aimed to address gaps in mental health services for populations subject to augmented challenges compared to other populations. In particular, the strategy acknowledges that access to and experience with mental health provisions vary amongst populations, thus contributing towards differences in satisfaction and recovery outcomes. The strategy (NHS, 2020b) emphasises three modes of practice to advance its macro argument; (i) “Local Health Systems” - supporting local health systems address inequalities in mental health, (ii) “Data Quality & Flow” - improving data quality and insights amongst multi-disciplinary teams and (iii) “Workforce Diversity” - working in conjunction with healthcare providers to promote a diverse and representative workforce at all levels of a system. To note, whilst the NHS (2020b) have illustrated commitments to improving mental health services, these commitments have been communicated without cogently defining the parameters of achievement of full parity of esteem for mental health services (National Audit Office, 2023). The lack of clarity around definitions attenuates clear direction of resources and efforts that would signify the attainment of equal importance for mental health services in comparison to physical health services (National Audit Office, 2023). Nevertheless, the findings from this thesis may benefit points (i) “*Supporting Local Health Systems*” and (ii) “*Data and Information*” in the Advancing Mental Health Equalities Strategy (NHS, 2020b). Specifically, point (i) can be supported with the increased provision of IAPT positive practice guides geared towards adult BAME service users to buttress cultural understanding and utilisation of psychological techniques used in therapy by mental health service providers. To note, IAPT positive practice guides are at present produced for BAME populations over the age of 65 and not under (NHS, 2020b). Moreover, these IAPT positive practice guides could be further reviewed and developed to target people not just over age of 65, but other ‘at risk’ populations, such as BAME populations who identify as Muslim (Mir et al., 2019) and aiding African and Caribbean men through their mental health recovery process (Southby et al., 2021). Additionally, point (ii) could be improved as per insight from practitioners in Chapter 4, by allowing positive practice guides to be disseminated and stored digitally, and adding to the comprehensive “online library” already set out in the policy (NHS, 2020b). Consequently, delineating IAPT positive practice guides in this fashion could help to manage/reduce costs associated with treatment models in a step-by-step manner as recommended by previous researchers (Stirman et al., 2013, 2019; Salloum et al., 2022).

The Suicide Prevention Strategy for England (Department of Health & Social Care, 2023), published in 2023 and planned till 2028, is a plan of action to tackle prevalent rates of suicide in “at-risk” groups. Specifically, the main ethos is to mitigate suicide rates by providing support to vulnerable groups, including those who have self-harmed and bereaved by suicide (Department of Health & Social Care, 2023). Furthermore, the plan articulates more than 100 strategies with a focus on improving data collection, access to guides/support services and online/in-person support groups among other strategies (Department of Health & Social Care, 2023). Amongst these actions, the Department of Health & Social Care (2023) have illustrated one action which is to:

> *“Collate and promote training and guidance that helps guide constructive conversations and empowers people to check in on those around them. Training and guidance will be available to support people working in environments where effective suicide prevention can be provided. This includes national government, local government and voluntary sector services.”* (Department of Health & Social Care, 2023)

Whilst commitment has been illustrated, the findings of the thesis highlight the need identified by practitioners for additional training which is in line with this policy/action (Department of Health & Social Care, 2023). The contributions from this thesis can offer practical insights to service providers on the personal lived experience of patients from Asian and Black African/Caribbean backgrounds, compared to BAME, to ascertain the cultural idiosyncrasies that may influence psychological therapy outcomes. Additionally, personal accounts from BAME patients (Chapter

3) and service providers (Chapter 5) could be integrated into training guides (e.g., IAPT positive practice guides) to help future service providers buttress their cultural competence and to better navigate the cultural/psychotherapeutic landscape with the BAME patients. Furthermore, these training guides could be tailored further to target education-based interventions for mental health stigma adolescents (Song et al., 2023) and inform school based-interventions for anxiety in children (Hugh-Jones et al., 2021) which are both populations considered ‘vulnerable’ and susceptible to suicide ideation (Office for Health Improvement & Disparities, 2022).

6.4 REFLEXIVITY STATEMENT

During the research journey, my assumptions and understanding around the variables that underpin BAME mental health disparities have evolved. At first, my perspective on the subject matter was shaped by my father’s struggles with suicidal ideation, coupled with the heightened awareness of health inequalities during the COVID-19 pandemic (Otu, 2020). These points informed my initial focus on sociocultural factors that may be central to BAME mental health disparities. Specifically, I assumed that cultural mental health stigma and a distrust towards service providers may be primary drivers for inequalities observed in BAME mental health. Consequently, these assumptions led me to prioritise individual-level narratives, as focal points of my investigation. However, as my research progressed, I became increasingly aware of the broader structural and systemic factors influencing individual experiences. This insight was partly shaped by interviews with service providers, who highlighted that patients often present with a "complexity of needs" that cannot be fully addressed by psychotherapy alone. This realisation marked a shift in my positionality, broadening my lens to consider the intersectionality of ethnicity, culture, and other social dimensions, such as socioeconomic status, discrimination, and access to care, as contributors to mental health disparities in BAME populations.

Olmos-Vega et al. (2023) and Yip (2024) suggest that researchers should practice reflexivity to examine their influence on qualitative research. Thus, I recognise that my initial positionality nested as an outsider to the lived experiences of the populations I studied could have influenced both the data collection and interpretation processes. While I initially viewed this distance as a limitation, it also underscored the importance of exercising heightened sensitivity and caution in framing questions and engaging with participants. Moreover, I acknowledge that my assumptions and perspectives may have shaped what I noticed, emphasised, or overlooked during the research process. For instance, my personal emphasis on evidence-based practices and impartiality might have directed my analysis toward certain themes while inadvertently underemphasisising others. By reflecting critically on my positionality , I aim to buttress the reliability and trustworthiness of my findings to advance understanding in BAME mental health disparities.

6.5 MORE THAN CULTURE & ETHNICITY: THE CONCEPT OF INTERSECTIONALITY

Whilst this thesis approached mental health through individual level-experiences and sought to highlight experiences specific to each group's ethnicity, the author must acknowledge that ethnicity (DaCosta et al., 2021) and culture (Bashir et al., 2019) are deeply interconnected with many social dimensions, such as social rank (Tabassum, 2022), economic status (Iqbal et al., 2021) and gender (Southby et al., 2021; Shundi, 2021). These variables collectively mould the lived experience of the researcher and the participants (Alam et al., 2024). For example, financial struggles can augment cultural stigma associated with mental health by limiting access to education, leading to less health literacy that may otherwise challenge entrenched beliefs. Likewise, gender norms may influence the proclivity for specific communities to seek out mental health aid (Southby et al., 2021; Shundi, 2021). For instance, males may feel subject to social pressures to suppress emotional vulnerability (Southby et al., 2021), whilst women may encounter additional caregiving burdens that impede their ability to prioritise personal mental health (Drake et al,. 2022). Additionally, immigration status presents additional layers of complexity (e.g., discrimination, language barriers, psychological impact of acculturation and being an asylum seeker - as echoed by the service providers in this study) where patients present a complexity of needs that a single-axis framework—focused solely on ethnicity or culture—cannot fully capture (Rowland, 2024). Consequently, these intersectional influences are essential when interpreting the findings of this thesis. For example, in Chapter 3, 37% of participants identified as unemployed, a factor linked to heightened perceived stigma (Brouwers, 2020), suggesting unemployment may partially explain stigma severity scores independently of cultural influences. Thus, unemployment may have contributed to the overall stigma severity score other than culture or stigma (Chapter 3) (Brouwers, 2020). Additionally, the majority of participants in this study (Chapter 3) were female, which may suggest gender-specific factors influencing participation or mental health experiences (DeYoung et al., 2007; Weisterg et al., 2011). Moreover, the lived experiences of BAME participants (Chapter 4) cannot be understood in isolation from the broader systems of intersectionality that frame their lives. For service users, the higher participation of female BAME groups compared to males may have led to the underrepresentation of themes specific to the experiences of male BAME groups. Furthermore, as education attainment and socioeconomic status were not accounted for in the qualitative interviews, it is difficult to ascertain the intersectional positions of the participants at the time of the interviews. These unknown factors may have influenced participants' perceptions of mental health and, consequently, shaped the narratives and themes presented in this thesis.

6.6 DOMINANCE OF CBT IN MENTAL HEALTH & ITS IMPLICATIONS

Despite the cogent presence of CBT in both research and clinical practice (Rowland, 2024), CBT often fails to account for intersectional complexities (Funer, 2023; Rowland, 2024). By predominantly focusing on individual-level change, the CBT approach may overlook the broader structural barriers that perpetuate mental health disparities (Rowland, 2024). For instance, community-based interventions might cohesively tackle cultural stigma, gender norms, improve social connection and overcome economic limitations to foster a more supportive environment conducive to mental health recovery that individual-level change (e.g., CBT) might not account for (Rowland, 2024). Notably, CBT's status as the gold standard in psychotherapy for nearly two decades is bolstered by robust empirical support and sustained investment from both public health systems and private entities, including pharmaceutical companies (Rowland, 2024). However, its dominance raises questions about potential conflicts of interest. Critics argue that heavy reliance on funding sources favouring individual-focused interventions, such as pharmaceutical firms invested in adjunct drug therapies, may inadvertently prioritise CBT's scalability and cost-effectiveness over systemic, equity-driven approaches (Funer, 2023). Furthermore, CBT's evidence base and standardised protocols have historically been developed within Western, educated, industrialised, rich, and democratic contexts, raising concerns about its cultural validity for diverse populations from less prosperous backgrounds (Freeman & Ronen, 2006). Research highlights that CBT's emphasis on cognitive restructuring and behavioural activation may clash with cultural frameworks prioritising collective well-being over individual autonomy, spiritual or somatic expressions of distress, or systemic oppression as a root cause of psychological suffering (Huey et al., 2023). For example, when CBT tries to cognitively restructure perceived 'negative thoughts' in marginalised groups, like racial minorities dealing with racism, CBT might mistake their normal reactions to systemic unfairness (e.g., distrust, anger) as mental health problems, instead of fixing the actual problem: the discrimination they face (Huey et al., 2023; Freeman & Ronen, 2006). While culturally adapted CBT (Naeem et al., 2019) models and complementary therapy (e.g., Mindfulness-Based Therapy and Tai-Chi style therapy) (Ghawadra et al., 2020; Hall et al., 2018; Han et al., 2020; Musa et al., 2021; Yeung et al., 2017) have emerged, they remain understudied and underfunded compared to conventional CBT, despite evidence suggesting improved outcomes when interventions align with clients' cultural values and lived realities (Huey et al., 2023). The author acknowledges that CBT's potential dominance necessitates an awareness towards multifaceted strategies that address these intersecting dimensions (Funer, 2023). Future research should thus integrate an intersectional perspective, heeding how ethnicity and culture interact with other dimensions to shape the mental health trajectories of BAME individuals (Funer, 2023). An intersectional perspective may help to improve existing mental health policy and interventions to consider the unique, multifaceted needs of these BAME populations (Funer, 2023).

6.7 STRENGTHS & LIMITATIONS OF THE THESIS

Despite the contribution of this thesis to the understanding of the impact of health inequalities on mental wellbeing among BAME populations, there are some limitations that need to be acknowledged.

The scope of this thesis is limited to ethic minority groups living in the UK, which means that the findings may not be generalisable to other countries with different healthcare systems, cultural contexts, and social norms. The systematic review conducted in Chapter 2 only included studies published in English, which may have excluded studies published in other languages. A "moderate" risk of bias was observed in the systematic review and thus, study outcomes should be interpreted with caution (Chapter 2). To note, a "moderate" risk of bias was concluded due to bias occurring at various stages of trial conduct (RoB2; Cochrane, 2019) (see section 2.2.3). The systematic review only focused on studies that reported post-intervention effect sizes, which may have resulted in a biased sample. Although the cross-sectional study conducted in Chapter 3 offered novel insights in stigma, depression and subjective wellbeing amongst distinct BAME populations, this study design cannot infer causality (Chapter 3) (Andrade, 2020). The qualitative study in Chapter 4only included Asian, black African, and black Caribbean cohorts, which may have excluded the experiences of other BAME groups. Qualitative research, despite its benefits (Chapter 4 & 5), cannot identify causal variables such as testing a specific cultural adaptation in a randomised controlled trial to observe test scores (e. g. DISC-12, PCQI, HADS, BBC-SWB) pre and post intervention including follow up. Lastly, the results from the qualitative studies (Chapter 3 & 4) focused on a relatively small sample size thus generalisability cannot be inferred (Larkin et al., 2006).

Despite these limitations, the findings of this thesis provide valuable insights into the experiences of BAME populations regarding mental health and wellbeing. Chapter 2 offers a taxonomy and updated conceptual typology of adaptations to existing therapy in BAME populations that researchers can use as a stepping stone for further advancements in the field. Chapter 3 showcased a sample of 204 participants, which is above the > 100 threshold for ensuring reliability of data capture in survey-based interventions (Kotrlik & Higgins, 2001). Additionally, distinct differences across BAME populations were observed in stigma, depression and wellbeing that may offer utility in psychotherapy for future therapists when working with these specific populations (Chapter 3). Chapter 4 and 5 not only provided detailed accounts of lived experience, but also posited these accounts in relation to the broader sociocultural and political domains – a key aim for the 'IPA researcher' as detailed by Larkin et al. (2006). Additionally, the findings of the thesis have important implications for policy makers and practitioners in the UK and potentially other countries with similar healthcare systems and demographics. The limitations identified in this thesis highlight the need for further research to explore the experiences of BAME populations with mental health services and to develop culturally sensitive interventions that can address the mental health disparities that exist between BAME and non-BAME populations.

6.8 RECOMMENDATIONS FOR FUTURE RESEARCH

At present, future research dedicated to health inequalities in BAME populations and mental health, could further add or refine existing conceptual typologies (Arundell et al., 2021) by replicating the systematic review in Chapter 2 and similar reviews (Anik et al., 2021; Arundell et al., 2021) to ensure reliability and validity of the conceptual typology is maintained and expanded/developed across time, with a specific focus on providing conceptual typologies for each ethnic group individually (e.g., a conceptual typology for Asian populations). Additionally, research would benefit from conducting randomised controlled trials, examining which specific cultural adaptation (i.e., content-level adaptations, therapist-level adaptations, organisation-level adaptations) is more effective in eliciting desirable psychotherapeutic outcomes (using HADS;

BBC – SWB or any other well validated wellbeing measure) for BAME populations – again with further research aiming to provide ethnic specific recommendations for adaptations to therapy. Furthermore, it may be useful for future researchers to examine how contextual variables (i.e., education attainment, unemployment, age, gender, socio-economic status, personality, etc) affect treatment acceptability/psychotherapeutic outcomes in distinct ethnic groups as, although a step towards "unpacking" the umbrella term BAME is warranted, distinct ethnic populations are not homogenous (e.g., all Asian individuals do not present the same behaviour and perception tendencies). Moreover, insights from Asian or Asian British and Black African/Caribbean populations (Chapter 4) could (i) inform future policies on mental health in BAME populations and (ii) might have highlighted shortcomings of the existing policies with certain issues, as discussed earlier, needing to be addressed in future plans. Lastly, the insights from Chapter 4 may be used/presented in therapist NHS meetings or IAPT positive practice guides to improve cultural competence beyond generalised 'BAME' counsel.

6.9 CONCLUSION

The thesis set out to investigate an intersection of health inequality and its impact on mental wellbeing in BAME populations. Additionally, the thesis acknowledges the need for targeted approaches geared towards BAME populations due to preexisting disproportionate health outcomes, augmented multi-morbidity and premature mortality. Through a systematic review (Chapter 2), a quantitative study (Chapter 3) and qualitative exploration (Chapter 4 & 5), unique contributions emerged. Chapter 2 of the thesis identified CBT and CA-CBT as the most common and effective interventions in mitigating anxiety and depression in BAME populations. Chapter 3 found that stigma severity scores were high amongst Black African/Caribbean populations compared to Asian or Asian British populations. Conversely, Asian or Asian British populations showcased high anxiety and significantly higher depression, but significantly lower subjective wellbeing scores compared to Black African/Caribbean populations (Chapter 3). Chapter 4 illustrated lived experiences and perspectives of BAME mental health service users, cultural idiosyncrasies and desire for cultural adaptations to therapy. Chapter 5 explored the lived experience of mental health practitioners and the existing tension between balancing effective therapy outcomes versus scalable integrations of cultural adaptations to therapy. The thesis findings contribute towards a better understanding of BAME mental health and underscores the importance of incorporating cultural adaptations to psychological therapy to tackle rising mental ill health, stigma and widening health disparities. Furthermore, the Chapters 2 - 5 contribute to literature offering culturally specific counsel on which cultural adaptation may be effective for different BAME populations (i.e., scaling content-level adaptations, due to cost-effectiveness, but shaping them to either focus on hierarchical communication patterns [Asian] or mistrust, historical mistreatment and racism [Black African/Caribbean]). Chapters 2 – 5 are complimented by Chapter 6, which provides insights into how the thesis contributions could potentially inform future mental health policies in the UK and existing policies, such as the NHS Long Term Plan - 2019 (NHS, 2019), Advancing Mental Health Equalities Strategy - 2020 (NHS, 2020b) and the Suicide Prevention Strategy - 2023 (Department of Health & Social Care, 2023). To further advance the macro arguments of this thesis, future research should examine which cultural adaptation is more effective (i.e., content-level adaptations vs therapist-level adaptations vs organisation-level adaptations) between distinct BAME populations (i.e., Black, African, Caribbean or Black British; Asian or Asian British; Mixed or multiple ethnic groups; Other ethnic group) (PHE, 2020b) to draw insights that moves away from the acronym of "BAME" as per the counsel of the CRED (2021) report. This is due to the notion that each sub-division of ethnicity present their own barriers and facilitators for positive psychotherapeutic outcomes and acceptance of diagnosis (Patel et al., 2017). Consequently, these ethnic specific outcomes could further add or refine existing conceptual typologies (Arundell et al., 2021) and help tailor future mental health policy to more effectively reduce health inequality in BAME populations.

REFERENCES

Abbott, R. A., Ploubidis, G. B., Huppert, F. A., Kuh, D., & Croudace, T. J. (2010). An evaluation of the precision of measurement of Ryff's Psychological Well-Being Scales in a population sample. *Social Indicators Research*, *97*(3), 357–373.

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review*, *31*(6), 934–948.

Abuelgasim, E., Saw, L. J., Shirke, M., Zeinah, M., & Harky, A. (2020). COVID-19: Unique public health issues facing Black, Asian and minority ethnic communities. *Current Problems in Cardiology, 1*, 100–621.

Acarturk, Z. C., Alyanak, B., Cetinkaya, M., Gulen, B., Jalal, B., & Hinton, D. E. (2019). Adaptation of transdiagnostic CBT for Turkish adolescents: Examples from culturally adapted multiplex CBT. *Cognitive and Behavioural Practice*, *26*(4), 688–700.

Afuwape, S. A., Craig, T. K. J., Harris, T., Clarke, M., Flood, A., Olajide, D., Cole, E., Leese, M., McCrone, P., & Thornicroft, G. (2010). The Cares of Life Project (CoLP): An exploratory randomised controlled trial of a community-based intervention for black people with common mental disorder. *Journal of Affective Disorders*, *127*(1–3), 370–374. https://doi.org/10.1016/j.jad.2010.05.017

Agudelo-Suárez, A. A., Ronda-Pérez, E., Gil-González, D., Vives-Cases, C., García, A. M., Ruiz-Frutos, C., & Benavides, F. G. (2011). The effect of perceived discrimination on the health of immigrant workers in Spain. *BMC Public Health*, *11*, 1–9.

Aguilera, A., Bruehlman-Senecal, E., Liu, N., & Bravin, J. (2018). Implementing group CBT for depression among Latinos in a primary care clinic. *Cognitive and Behavioural Practice*, *25*(1), 135–144.

Ahlburg, D. A. (2020). Covid-19 and UK Universities. *The Political Quarterly*, *91*(3), 649–654.

Ahmed, S., Siad, F. M., Manalili, K., Lorenzetti, D. L., Barbosa, T., Lantion, V., & Santana, M. J. (2018). How to measure cultural competence when evaluating patient-centred care: A scoping review. *BMJ Open*, *8*(7), 021525.

Alam, S., O'Halloran, S., & Fowke, A. (2024). What are the barriers to mental health support for racially-minoritised people within the UK? A systematic review and thematic synthesis. *The Cognitive Behaviour Therapist*, *17*, 10.

Alavi, N., & Hirji, A. (2020). The efficacy of PowerPoint-based CBT delivered through email: Breaking the barriers to treatment for generalized anxiety disorder. *Journal of Psychiatric Practice*, *26*(2), 89–100. https://doi.org/10.1097/PRA.0000000000000455

Albert, C., & Davia, M. A. (2011). Education is a key determinant of health in Europe: A comparative analysis of 11 countries. *Health Promotion International*, *26*(2), 163–170.

Aldridge, R. W., Lewer, D., Katikireddi, S. V., Mathur, R., Pathak, N., Burns, R., & Hayward, A. (2020). Black, Asian and Minority Ethnic groups in England are at increased risk of death from COVID-19: Indirect standardisation of NHS mortality data. *Wellcome Open Research*, *5*(88), 88.

Algahtani, H. M. S., Almulhim, A., AlNajjar, F. A., Ali, M. K., Irfan, M., Ayub, M., & Naeem, F. (2019). Cultural adaptation of cognitive behavioural therapy (CBT) for patients with depression and anxiety in Saudi Arabia and Bahrain: A qualitative study exploring views of patients, carers, and mental health professionals. *The Cognitive Behaviour Therapist*, *12*, 44.

Alvarez-Galvez, J., & Salvador-Carulla, L. (2013). Perceived discrimination and self-rated health in Europe: Evidence from the European Social Survey. *PLOS ONE*, *8*(9), 74252.

Alvidrez, J., Snowden, L. R., & Kaiser, D. M. (2008). The experience of stigma among Black mental health consumers. *Journal of Health Care for the Poor and Underserved*, *19*(3), 874–893.

America, M. H. (2021). Black and African American communities and mental health. In *Mental Health America*. https://www.mhanational.org/issues/black-and-african-american-communities-and-mental-health

Anderson, N., Heywood-Everett, S., Siddiqi, N., Wright, J., Meredith, J., & McMillan, D. (2015). Faith-adapted psychological therapies for depression and anxiety: Systematic review and meta-analysis. *Journal of Affective Disorders*, *176*, 183–196.

Andersson, G., Hesser, H., Hummerdal, D., Bergman-Nordgren, L., & Carlbring, P. (2013). A 3.5-year follow-up of Internet-delivered cognitive behavior therapy for major depression. *Journal of Mental Health*, *22*(2), 155–164. https://doi.org/10.3109/09638237.2011.608747

Andrade, C. (2020). The limitations of online surveys. *Indian Journal of Psychological Medicine*, *42*(6), 575–576.

Anglin, D. M., Alberti, P. M., Link, B. G., & Phelan, J. C. (2013). Racial differences in beliefs about the effectiveness and necessity of mental health treatment. *American Journal of Community Psychology*, *52*(3–4), 305–313.

Anik, E., West, R. M., Cardno, A. G., & Mir, G. (2021). Culturally adapted psychotherapies for depressed adults: A systematic review and meta-analysis. *Journal of Affective Disorders*, *1*, 24–53.

Appleby, J., Hemmings, N., Maguire, D., Morris, J., Schlepper, L., & Wellings, D. (2020).

Public satisfaction with the NHS and social care in 2019: Results from the British Social Attitudes survey. *King's Fund*, *8*, 1–36.

Arcaya, M. C., Arcaya, A. L., & Subramanian, S. V. (2015). Inequalities in health: Definitions, concepts, and theories. *Global Health Action*, *8*(1), 27106.

Arvay, M. J. (2003). Doing reflexivity: A collaborative narrative approach. In L. Finlay & B. Gough (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences* (pp. 163–175).

Asad, A. L., & Clair, M. (2018). Racialized legal status as a social determinant of health. *Social Science & Medicine*, *199*, 19–28.

Ashing, K., & Rosales, M. (2014). A telephonic-based trial to reduce depressive symptoms among Latina breast cancer survivors. *Psycho-Oncology*, *23*(5), 507–515. https://doi.org/10.1002/pon.3441

Aspinall, P. J. (2020). Ethnic/racial terminology as a form of representation: A critical review of the lexicon of collective and specific terms in use in Britain. *Genealogy*, *4*(3), 87.

Assari, S., Moazen-Zadeh, E., Caldwell, C. H., & Zimmerman, M. A. (2017). Racial discrimination during adolescence predicts mental health deterioration in adulthood: Gender differences among Blacks. *Frontiers in Public Health*, *5*, 104.

Association, A. P. (2009). *Different approaches to psychotherapy*. https://www.apa.org/topics/therapy/psychotherapy-approaches

Association, A. P. (2017a). *How long will it take for treatment to work?* https://www.apa.org/ptsd-guideline/patients-and-families/length-treatment

Association, A. P. (2017b). *What is cognitive behavioural therapy?* https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral

Association, B. U. P. (2020). *Supporting our BAME colleagues*. https://www.bupa.com/news/stories-and-insights/2020/supporting-our-bame-colleagues

Atkin, K., Ali, N., & Chu, C. E. (2009). The politics of difference? Providing a cancer genetics service in a culturally and linguistically diverse society. *Diversity in Health and Care*, *6*(3), 149–157.

Aube, J., Fichman, L., Saltaris, C., & Koestner, R. (2000). Gender differences in adolescent depressive symptomatology: Towards an integrated social-developmental model. *Journal of Social and Clinical Psychology*, *19*, 297–313.

Azhar, M. Z., & Varma, S. L. (1995). Religious psychotherapy as management of bereavement. *Acta Psychiatrica Scandinavica*, *91*(4), 233–235.

Baena-Díez, J. M., Barroso, M., Cordeiro-Coelho, S. I., Díaz, J. L., & Grau, M. (2020). Impact of COVID-19 outbreak by income: Hitting hardest the most deprived. *Journal of Public Health*, *42*(4), 698–703.

Baker, C. (2020). Mental health statistics for England: Prevalence, services and funding. *House of Commons Library*, *1*, 6988.

Baker, C. (2021). Mental health statistics for England: Prevalence, services and funding. *House of Commons Library*, *1*, 6988.

Baker, C., & Wade, E. K. (2024). Mental health statistics for England: Prevalence services and funding. *House of Commons Library*, *1*, 6988.

Baker, E. H. (2014). Socioeconomic status, definition. In *The Wiley Blackwell encyclopedia of health, illness, behaviour, and society* (Vol. 1, pp. 2210–2214).

Bambra, C., Gibson, M., Sowden, A., Wright, K., Whitehead, M., & Petticrew, M. (2010). Tackling the wider social determinants of health and health inequalities: Evidence from systematic reviews. *Journal of Epidemiology & Community Health*, *64*(4), 284–291.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. Freeman.

Barnes, M., Cullinane, C., Scott, S., & Silvester, S. (2013). *People living in bad housing: Numbers and health impacts*. Shelter.

Barrett, M. S., Chua, W. J., Crits-Christoph, P., Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training*, *45*(2), 247.

Bar-Tal, D. (2017). Self-censorship: The conceptual framework. In *Self-censorship in contexts of conflict: Theory and research* (pp. 1–18).

Bashir, N., Ameyaw, N., Sahota, S., Bajwa, M., & Dayson, C. (2019). *Culture, connection and belonging: A study of addiction and recovery in Nottingham's BAME community*.

Baskin, C., Zijlstra, G., McGrath, M., Lee, C., Duncan, F., Oliver, E., & Gnani, S. (2020). Community interventions improving mental health in minority ethnic adults in the UK: a scoping review. *European Journal of Public Health*, *30*(Supplement_5), 166–1046.

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

Becares, L. (2015). Which ethnic groups have the poorest health. In *Ethnic identity and inequalities in Britain: The dynamics of diversity* (Vol. 1, p. 123).

Beck, A. (2016). *Transcultural cognitive behaviour therapy for anxiety and depression: A practical guide*. Routledge.

Beck, A., Naz, S., Brooks, M., & Jankowska, M. (2019). *Black, Asian and Minority Ethnic* *service user positive practice guide 2019*. https://lewishamtalkingtherapies.nhs.uk/wp-content/uploads/2021/10/IAPT-BAME-PPG-2019.pdf

Beck, A. T. (1993). Cognitive therapy: Past, present, and future. *Journal of Consulting and Clinical Psychology, 61*(2), 194.

Bedoya, C. A., Traeger, L., Trinh, N.-H. T., Chang, T. E., Brill, C. D., Hails, K., Hagan, P. N., Flaherty, K., & Yeung, A. (2014). Impact of a culturally focused psychiatric consultation on depressive symptoms among Latinos in primary care. *Psychiatric Services*, *65*(10), 1256–1262. https://doi.org/10.1176/appi.ps.201300088

Beeber, L. S., Holditch-Davis, D., Perreira, K., Schwartz, T. A., Lewis, V., Blanchard, H., Canuso, R., & Goldman, B. D. (2010). Short-term in-home intervention reduces depressive symptoms in Early Head Start Latina mothers of infants and toddlers. *Research in Nursing & Health*, *33*(1), 60–76. https://doi.org/10.1002/nur.20363

Behtoui, A., & Neergaard, A. (2009). Perceptions of discrimination in recruitment and the workplace. *Journal of Immigrant & Refugee Studies*, *7*(4), 347–369.

Benham-Hutchins, M., Staggers, N., Mackert, M., Johnson, A. H., & DeBronkart, D. (2017). I want to know everything”: A qualitative study of perspectives from patients with chronic diseases on sharing health information during hospitalization. *BMC Health Services Research*, *17*(1), 529.

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

Bennett, S. T., Flett, R. A., & Babbage, D. R. (2014). Culturally adapted cognitive behaviour therapy for Māori with major depression. *The Cognitive Behaviour Therapist*, *7*.

Bergsma, A., Have, M. T., Veenhoven, R., & Graaf, R. D. (2011). Most people with mental disorders are happy: A 3-year follow-up in the Dutch general population. *The Journal of Positive Psychology*, *6*(4), 253–259.

Bert, A. (2018). *3 reasons gender diversity is crucial to science*. Elsevier Connect. https://www.elsevier.com/connect/3-reasons-gender-diversity-is-crucial-to-science

Beukering, I. E., Smits, S. J. C., Janssens, K. M. E., Bogaers, R. I., Joosen, M. C. W., Bakker, M., & Brouwers, E. P. M. (2021). In what ways does health-related stigma affect sustainable employment and well-being at work? A systematic review. *Journal of Occupational Rehabilitation*, 1–15.

Bhugra, D., & Bhui, K. (1998). Psychotherapy for ethnic minorities: Issues, context and practice. *British Journal of Psychotherapy*, *14*(3), 310–326.

Bhui, K. (2002). *Racism and mental health: Prejudice and suffering*. Jessica Kingsley Publishers.

Bhui, K. (2010). Culture and complex interventions: Lessons for evidence, policy and practice. *The British Journal of Psychiatry*, *197*(3), 172–173.

Bhui, K. (2016). Discrimination, poor mental health, and mental illness. *International Review of Psychiatry*, *28*(4), 411–414.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: Systematic review. *The British Journal of Psychiatry*, *182*(2), 105–116.

Bhui, K., Stansfeld, S., McKenzie, K., Karlsen, S., Nazroo, J., & Weich, S. (2005). Racial/ethnic discrimination and common mental disorders among workers: Findings from the EMPIRIC Study of Ethnic Minority Groups in the United Kingdom. *American Journal of Public Health*, *95*(3), 496–501.

Bhuyan, K. K. (2004). Health promotion through self-care and community participation: Elements of a proposed programme in the developing countries. *BMC Public Health*, *4*(1), 11.

Biddle, C., & Schafft, K. (2015). Axiology and anomaly in the practice of mixed methods research: A Kuhnian analysis. *Journal of Mixed Methods Research*, *9*(4), 320–334.

Bignall, T., Jeraj, S., Helsby, E., & Butt, J. (2020). *Racial disparities in mental health: Literature and evidence review* [Mental Health Report v5,]. Racial Equality Foundation.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802–1811.

Boffa, J., Moules, N., Mayan, M., & Cowie, R. L. (2013). More than just great quotes: An introduction to the Canadian Tri-Council’s qualitative requirements. *Canadian Journal of Infectious Diseases and Medical Microbiology*, *24*(2), 103–108.

Bolier, L., Haverman, M., Westerhof, G. J., Riper, H., Smit, F., & Bohlmeijer, E. (2013). Positive psychology interventions: A meta-analysis of randomized controlled studies. *BMC Public Health*, *13*(1), 1–20.

Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P., Speelman, L., Ndogoni, L., & Weissman, M. (2003). Group Interpersonal Psychotherapy for Depression in Rural Uganda: A Randomized Controlled Trial. *JAMA*, *289*(23), 3117. https://doi.org/10.1001/jama.289.23.3117

Boonstra, N., Klaassen, R., Sytema, S., Marshall, M., Haan, L., Wunderink, L., & Wiersma, D.

(2012). Duration of untreated psychosis and negative symptoms—A systematic review and meta-analysis of individual patient data. *Schizophrenia Research*, *142*(1–3), 12–19.

Borrelli, B. (2011). The assessment, monitoring, and enhancement of treatment fidelity in public health clinical trials. *Journal of Public Health Dentistry*, *71*(1), 52–63. https://doi.org/10.1111/j.1752-7325.2011.00233.x

Bradbury, A. (2020). Mental health stigma: The impact of age and gender on attitudes. *Community Mental Health Journal*, *56*(5), 933–938.

Bradbury-Jones, C. (2007). Enhancing rigour in qualitative health research: Exploring subjectivity through Peshkin's I's. *Journal of Advanced Nursing*, *59*(3), 290–298.

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

Bravo, V. N. (2017). Social capital as a determinant of public health. *Revista de Calidad Asistencial: Organo de la Sociedad Española de Calidad Asistencial*, *32*(6), 342.

Brewer, P., & Venaik, S. (2011). Individualism–Collectivism in Hofstede and GLOBE. *Journal of International Business Studies*, *42*(3), 436–445. https://doi.org/10.1057/jibs.2010.62

Brohan, E., Slade, M., Clement, S., Rose, D., Sartorius, N., & Thornicroft, G. (2011). Further development and psychometric validation of the discrimination and stigma scale (DISC-12. *Psychiatrist Praxis*, *38*(S 01), 07 1.

Brooke, M. (2013). Which research paradigm for TESOL? *Theory and Practice in Language Studies*, *3*(3), 430.

Brouwers, E. P. (2020). Social stigma is an underestimated contributing factor to unemployment in people with mental illness or mental health issues: Position paper and future directions. *BMC Psychology*, *8*, 1–7.

Brown, B. (2008). *I thought it was just me (but it isn't): Making the journey from 'What will people think?' to 'I am enough'*. Avery.

Brown, G., Marshall, M., Bower, P., Woodham, A., & Waheed, W. (2014). Barriers to recruiting ethnic minorities to mental health research: A systematic review. *International Journal of Methods in Psychiatric Research*, *23*(1), 36–48.

Bryman, A. (2012). *Social Research Methods* (4th ed.). Oxford University Press.

Burlew, A. K., Weekes, J. C., Montgomery, L. T., Feaster, D. J., Robbins, M. S., Rosa, C. L., & Wu, L. T. (2011). Conducting research with racial/ethnic minorities: Methodological lessons from the NIDA Clinical Trials Network. *The American Journal of Drug and Alcohol Abuse*, *37*(5), 324–332.

Calderón, M., Collado, A., MacPherson, L., & Lejuez, C. (2016). The efficacy of behavioural activation treatment among depressed Spanish-speaking Latinos. *Journal of Consulting and Clinical Psychology*, *84*(7), 651–657. https://doi.org/10.1037/ccp0000103

Caldwell, C. H., Antonakos, C. L., Tsuchiya, K., Assari, S., Loney, D., & Hill, E. (2013). Masculinity as a moderator of discrimination and parenting on depressive symptoms and drinking behaviours among non-resident African-American fathers. *Psychology of Men & Masculinity*, *14*(1), 47.

Cameron, R. (2011). Mixed methods research: The five Ps framework. *Electronic Journal of Business Research Methods*, *9*(2), 96–108.

Canada, P. H. A. (2006). *The human face of mental health and mental illness in canada 2006*. https://www.phac-aspc.gc.ca/publicat/human-humain06/pdf/human_face_e.pdf

Care Services and Improvement Partnership Choice and Access Team. (2008). Department of Health.

Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M. E. D., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual Review of Public Health*, *36*, 375–392.

Castro, F. G., Barrera, M., & Martinez, C. R. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science*, *5*(1), 41–45.

Chapter 3 Mental Health Care for African Americans. (2001). In *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. *Substance Abuse and Mental Health Services Administration (US*. https://www.ncbi.nlm.nih.gov/books/NBK44251/

Chatmon, B. N. (2020). Males and mental health stigma. *American Journal of Men's Health*, *14*(4), 15–22.

Chatters, L. M., Taylor, R. J., Bullard, K. M., & Jackson, J. S. (2011). Race and ethnic differences in religious involvement: African Americans, Caribbean Blacks and non-Hispanic Whites. *Ethnic and Racial Studies*, *34*(3), 411–429. https://doi.org/10.1080/01419870.2010.528889

Chaves, C., Lopez-Gomez, I., Hervas, G., & Vazquez, C. (2017). A Comparative Study on the Efficacy of a Positive Psychology Intervention and a Cognitive Behavioural Therapy for Clinical Depression. *Cognitive Therapy and Research*, *41*(3), 417–433. https://doi.org/10.1007/s10608-016-9778-9

Cheng, H. L., Wang, C., McDermott, R. C., Kridel, M., & Rislin, J. L. (2018). Self-stigma, mental health literacy, and attitudes toward seeking psychological help. *Journal of Counselling & Development*, *96*(1), 64–74.

Cheon, B. K., & Chiao, J. Y. (2012). Cultural variation in implicit mental illness stigma. *Journal of Cross-Cultural Psychology*, *43*(7), 1058–1062.

Chien, W.-T., Leung, S.-F., & Chu, C. S. K. (2012a). A nurse-led, needs-based psycho-education intervention for Chinese patients with first-onset mental illness. *Contemporary Nurse*, *40*(2), 194–209. https://doi.org/10.5172/conu.2012.40.2.194

Chien, W.-T., Leung, S.-F., & Chu, C. S. K. (2012b). A nurse-led, needs-based psycho-education intervention for Chinese patients with first-onset mental illness. *Contemporary Nurse*, *40*(2), 194–209. https://doi.org/10.5172/conu.2012.40.2.194

Choi, I., Zou, J., Titov, N., Dear, B. F., Li, S., Johnston, L., Andrews, G., & Hunt, C. (2012). Culturally attuned Internet treatment for depression amongst Chinese Australians: A randomised controlled trial. *Journal of Affective Disorders*, *136*(3), 459–468. https://doi.org/10.1016/j.jad.2011.11.003

Chowdhary, N., Jotheeswaran, A. T., Nadkarni, A., Hollon, S. D., King, M., Jordans, M. J. D., & Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: A systematic review. *Psychological Medicine*, *44*(6), 1131–1146.

Christiansen, J., Lund, R., Qualter, P., Andersen, C. M., Pedersen, S. S., & Lasgaard, M. (2020). Loneliness, social isolation, and chronic disease outcomes. *European Journal of Public Health*, *30*, 166–1045.

Chubb, J., & Derrick, G. E. (2020). The impact a-gender: Gendered orientations towards research Impact and its evaluation. *Palgrave Communications*, *6*(1). https://doi.org/10.1057/s41599-020-0438-z

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, *23*, 375–384.

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy*, *47*(11), 910–920.

Clayton, J. A., & Tannenbaum, C. (2016). Reporting Sex, Gender, or Both in Clinical Research? *JAMA*, *316*(18), 1863. https://doi.org/10.1001/jama.2016.16405

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

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11–27.

Codjoe, L., Barber, S., Ahuja, S., Thornicroft, G., Henderson, C., Lempp, H., & N'Danga-Koroma, J. (2021). Evidence for interventions to promote mental health and reduce stigma in Black faith communities: Systematic review. *Social Psychiatry and Psychiatric Epidemiology*, *56*(6), 895–911.

Codjoe, L., Barber, S., & Thornicroft, G. (2019). Tackling inequalities: A partnership between mental health services and black faith communities. *Journal of Mental Health*, *28*(3), 225–228.

Cohen, A. K., & Syme, S. L. (2013). Education: A missed opportunity for public health intervention. *American Journal of Public Health*, *103*(6), 997–1001.

Commission, M. H. (2021). *Cognitive Behavioural Therapy for Canadians of South Asian Origin Project Backgrounder*. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-04/CACBT_Project_Backgrounder_eng.pdf

Consortium, C. O. R. (2021). *Recommendations for using outcome measures*. https://www.corc.uk.net/media/1487/corc-approach-v3.pdf

Cook, S. C., Schwartz, A. C., & Kaslow, N. J. (2017). Evidence-based psychotherapy: Advantages and challenges. *Neurotherapeutics*, *14*, 537–545.

Cooper, L. A., Ghods Dinoso, B. K., Ford, D. E., Roter, D. L., Primm, A. B., Larson, S. M., Gill, J. M., Noronha, G. J., Shaya, E. K., & Wang, N.-Y. (2013). Comparative Effectiveness of Standard versus Patient-Centred Collaborative Care Interventions for Depression among African Americans in Primary Care Settings: The BRIDGE Study. *Health Services Research*, *48*(1), 150–174. https://doi.org/10.1111/j.1475-6773.2012.01435.x

Corker, E., Hamilton, S., Henderson, C., Weeks, C., Pinfold, V., Rose, D., & Thornicroft, G. (2013). Experiences of discrimination among people using mental health services in England 2008-2011. *The British Journal of Psychiatry*, *202*(s55), 58–63.

Coronavirus and the social impacts on behaviours during different lockdown periods, great britain: Up to february 2021. (2021). https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/coronavirusandthesocialimpactsonbehavioursduringdifferentlockdownperiodsgreatbritain/uptofebruary2021#well-being-and-mental-health

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services*, *63*(10), 963–973.

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, *54*(9), 765.

Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self–stigma of mental illness: Implications for self–esteem and self–efficacy. *Journal of Social and Clinical Psychology*, *25*(8), 875–884.

Coventry, P. A., Meader, N., Melton, H., Temple, M., Dale, H., Wright, K., & Gilbody, S. (2020). Psychological and pharmacological interventions for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network meta-analysis. *PLoS Medicine*, *17*(8), 1003262.

Coyle, C. E., & Dugan, E. (2012). Social isolation, loneliness and health among older adults. *Journal of Aging and Health*, *24*(8), 1346–1363.

Craig, G., & Walker, R. (2012). Race'on the welfare margins: The UK government's Delivering Race Equality mental health programme. *Community Development Journal*, *47*(4), 491–505.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: The new Medical Research Council guidance. *BMJ*, *337*.

Crawford, M. J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., & Parry, G. D. (2016). Patient experience of negative effects of psychological treatment: Results of a national survey. *The British Journal of Psychiatry*, *208*(3), 260–265.

CREDLibrary. (2014). Monitoring and Reporting Treatment Fidelity. *ASHA Journals Academy*. https://academy.pubs.asha.org/2014/11/monitoring-and-reporting-treatment-fidelity/

Cribb, J., Keiller, A., & Waters, T. (2018). *Living standards, poverty and inequality in the UK: 2018* (Issue 145)) [(IFS Report].

Crockett, K., Zlotnick, C., Davis, M., Payne, N., & Washington, R. (2008). A depression preventive intervention for rural low-income African-American pregnant women at risk for postpartum depression. *Archives of Women's Mental Health*, *11*(5–6), 319–325. https://doi.org/10.1007/s00737-008-0036-3

Crotty, M. J. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage.

Csikszentmihalyi, M., & Seligman, M. E. (2000). Positive psychology: An introduction. *American Psychologist*, *55*(1), 5–14.

Cuijpers, P., Cristea, I. A., Karyotaki, E., Reijnders, M., & Huibers, M. J. (2016). How effective are cognitive behaviour therapies for major depression and anxiety disorders? A meta-analytic update of the evidence. *World Psychiatry*, *15*(3), 245–258.

Culturally responsive cognitive behavioural therapy for ethnically diverse populations. (2023). *Annual Review of Clinical Psychology*, *19*(1), 51–78.

DaCosta, C., Dixon-Smith, S., & Singh, G. (2021). *Beyond BAME: rethinking the politics, construction, application and efficacy of ethnic categorization*. Higher Education Research Action Group (HERAG.

Dattani, S., Ritchie, H., & Roser, M. (2017). *Mental health – our world data*. https://ourworldindata.org/mental-health

David, D., Cristea, I., & Hofmann, S. G. (2018). Why cognitive behavioural therapy is the current gold standard of psychotherapy. *Frontiers in Psychiatry*, *9*, 4.

Davis, K. (2018). Cognitive behavioural therapy: How does CBT work? *Www.Medicalnewstoday.Com*. https://www.medicalnewstoday.com/articles/296579

Dean, K., & Kickbusch, I. (1995). Health related behaviour in health promotion: Utilizing the concept of self-care. *Health Promotion International*, *10*(1), 35–40.

Dell’Osso, B., Glick, I. D., Baldwin, D. S., & Altamura, A. C. (2012). Can long-term outcomes be improved by shortening the duration of untreated illness in psychiatric disorders? A conceptual framework. *Psychopathology*, *46*(1), 14–21.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The Sage handbook of qualitative research*. Sage.

DeVylder, J. E., Narita, Z., Horiguchi, S., Kodaka, M., Schiffman, J., Yang, L. H., & Koyanagi, A. (2020). Stigma associated with the labelling of schizophrenia, depression, and hikikomori in Japan. *Stigma and Health*, *5*(4), 472.

DeYoung, C. G., Quilty, L. C., & Peterson, J. B. (2007). Between facets and domains: 10 aspects of the Big Five. *Journal of Personality and Social Psychology*, *93*(5), 880.

Dhillon, J. K., & Thomas, N. (2019). Ethics of engagement and insider-outsider perspectives: Issues and dilemmas in cross-cultural interpretation. *International Journal of Research & Method in Education*, *42*(4), 442–453.

Diabetes, U. K. (2020a). *Diabetes risk factors*. https://www.diabetes.org.uk/preventing-type-2-diabetes/diabetes-risk-factors

Diabetes, U. K. (2020b). *Diabetes risk factors*. https://www.diabetes.org.uk/preventing-type-2-diabetes/diabetes-risk-factors

Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin*, *125*(2), 276.

Dijk, T. K., Agyemang, C., Wit, M., & Hosper, K. (2011). The relationship between perceived discrimination and depressive symptoms among young Turkish–Dutch and Moroccan–Dutch. *The European Journal of Public Health*, *21*(4), 477–483.

Discrimination and Stigma Scale Version 12. (2013). https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/manual-version3-discrimination-and-stigma-scaledisc-version-12

Djukanovic, I., Carlsson, J., & Årestedt, K. (2017). Is the Hospital Anxiety and Depression Scale (HADS) a valid measure in a general population 65–80 years old? A psychometric evaluation study. *Health and Quality of Life Outcomes*, *15*(1). https://doi.org/10.1186/s12955-017-0759-9

Downe-Wamboldt, B. (1992). Content analysis: Method, applications, and issues. *Health Care for Women International*, *13*(3), 313–321.

Drake, M., Wilson, L., Desai, R., & Atherton, B. (2022). The Experiences of Black, Asian and Minority Ethnic Women of Maternity Services in the UK. *Journal of Medical and Health Studies*, *3*(4), 32–43.

Dwight-Johnson, M., Aisenberg, E., Golinelli, D., Hong, S., O’Brien, M., & Ludman, E. (2011). Telephone-Based Cognitive-Behavioural Therapy for Latino Patients Living in Rural Areas: A Randomized Pilot Study. *Psychiatric Services, 62*(8), 936–942. https://doi.org/10.1176/ps.62.8.pss6208_0936

Eaton, L., & Louw, J. (2000). Culture and self in South Africa: Individualism-collectivism predictions. *The Journal of Social Psychology*, *140*(2), 210–217. https://doi.org/10.1080/00224540009600461

Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In *The Sage handbook of qualitative research in psychology* (pp. 179–194).

Ebrahimi, A., Neshatdoost, H. T., Mousavi, S. G., Asadollahi, G. A., & Nasiri, H. (2013). Controlled randomized clinical trial of spirituality integrated psychotherapy, cognitive-behavioural therapy and medication intervention on depressive symptoms and dysfunctional attitudes in patients with dysthymic disorder. *Advanced Biomedical Research, 2,* 1–3.

Edge, D., Degnan, A., Cotterill, S., Berry, K., Drake, R., Baker, J., & Abel, K. (2016). Culturally-adapted Family Intervention (CaFI) for African-Caribbeans diagnosed with schizophrenia and their families: A feasibility study protocol of implementation and acceptability. *Pilot and Feasibility Studies*, *2*(1), 1–14.

Elliott, D. S., & Mihalic, S. (2004). Issues in disseminating and replicating effective prevention programs. *Prevention Science*, *5*(1), 47–53.

England, N. H. S. C. (2012). *Department of health*. https://www.gov.uk/government/publications/the-nhs-constitution-for-england

England, P. H. (2018a). *Health matters: Reducing health inequalities in mental illness*. https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness

England, P. H. (2018b). *Local action on health inequalities: Understanding and reducing ethnic inequalities in health*. https://assets.publishing.service.gov.uk/media/5b607232e5274a5f6ab8603f/local_action_on_health_inequalities.pdf

England, P. H. (2020a). *List of ethnicities*. https://www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups

England, P. H. (2020b). *Overweight adults*. https://www.ethnicity-facts-figures.service.gov.uk/health/diet-and-exercise/overweight-adults/latest#data-sources

Equality, & Commission, H. R. (2020). *Race discrimination*. https://www.equalityhumanrights.com/en/advice-and-guidance/race-discrimination

Escobar-Galvez, I., Yanouri, L., Herrera, C. N., Callahan, J. L., Ruggero, C. J., & Cicero, D. (2023). Intergenerational differences in barriers that impede mental health service use among Latinos. *Practice Innovations*, *13*(1), 1–21.

Escoffery, C., Lebow-Skelley, E., Haardoerfer, R., Boing, E., Udelson, H., Wood, R., & Mullen, P. D. (2018). A systematic review of adaptations of evidence-based public health interventions globally. *Implementation Science*, *13*(1), 1–21.

EuroQol—A new facility for the measurement of health-related quality of life. (1990). *Health Policy*, *16*(3), 199–208. https://doi.org/10.1016/0168-8510(90)90421-9

Eylem, O., Wit, L., Straten, A., Steubl, L., Melissourgaki, Z., Danışman, G. T., & Cuijpers, P. (2020). Stigma for common mental disorders in racial minorities and majorities a systematic review and meta-analysis. *BMC Public Health*, *20*, 1–20.

Ezenweke, E. O., & Nwadialor, L. K. (2013). Understanding Human Relations in African Traditional Religious Context in the Face of Globalization: Nigerian Perspectives. *American International Journal of Contemporary Research*, *3*(2).

Ezeudu, F. O., Eya, N. M., Nwafor, S. C., & Ogbonna, C. S. (2020). Intervention for depression among chemistry education undergraduates in a Nigerian university. *Journal of International Medical Research*, *48*(1), 030006051986506. https://doi.org/10.1177/0300060519865064

Faheem, A. (2023). It's been quite a poor show'–exploring whether practitioners working for

Improving Access to Psychological Therapies (IAPT) services are culturally competent to deal with the needs of Black. *Asian and Minority Ethnic (BAME) Communities. The Cognitive Behaviour Therapist*, *16*, 6.

Farrelly, S., Clement, S., Gabbidon, J., Jeffery, D., Dockery, L., Lassman, F., & Group, M. I. R. I. A. D. S. (2014). Anticipated and experienced discrimination amongst people with schizophrenia, bipolar disorder and major depressive disorder: A cross-sectional study. *BMC Psychiatry*, *14*, 1–8.

Fazel, M., Stratford, H. J., Rowsell, E., Chan, C., Griffiths, H., & Robjant, K. (2020). Five Applications of Narrative Exposure Therapy for Children and Adolescents Presenting With Post-Traumatic Stress Disorders. *Frontiers in Psychiatry*, *11*. https://doi.org/10.3389/fpsyt.2020.00019

Felez-Nobrega, M., Haro, J. M., & Koyanagi, A. (2022). Multimorbidity, depression with anxiety symptoms, and decrements in health in 47 low-and middle-income countries. *Journal of Affective Disorders*, *317*, 176–184.

Ferreira, F. H., & Peragine, V. (2016). Individual responsibility and equality of opportunity. In *The Oxford Handbook of Well-being and Public Policy* (Vol. 1, pp. 1–12).

Fierros, M., & Smith, C. (2006). The relevance of Hispanic culture to the treatment of a patient with posttraumatic stress disorder (PTSD. *Psychiatry (Edgmont*, *3*(10), 49.

Flick, U. (2006). *An introduction to qualitative research*. Sage Publications.

Flick, U. (2007). *Sampling, selecting and access* (U. Flick, Ed.). SAGE Publications.

Flick, U., Kvale, S., Angrosino, M. V., Barbour, R. S., Banks, M., Gibbs, G., & Rapley, T. (2007). *Designing qualitative research* (Vol. 1). Sage Publications Ltd.

Foley, N. (2020). *Unemployment by ethnic background (House of Commons Library: Briefing Paper Number 6385*. House of Commons Library.

Foundation, J. R. (2017). *Poverty and ethnicity in the labour market*. https://www.jrf.org.uk/report/poverty-ethnicity-labour-market

Freitas, M. A. (2002). Mathematics and its other: Disclosing the feminine. *Gender and Education*, *20*(3), 281–290.

Freud, S., & Chase, H. W. (1925). The origin and development of psychoanalysis. In *Sigmund Freud's lectures at Clark University, 1910*. Clark University.

Fund, T. K. (2021a). *Health inequalities in a nutshell*. https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/health-inequalities

Fund, T. K. (2021b). *Public satisfaction with the NHS and social care in 2021: Results from the british attitudes survey*. https://www.kingsfund.org.uk/publications/public-satisfaction-nhs-social-care-2021

Funer, F. (2023). Admitting the heterogeneity of social inequalities: Intersectionality as a (self-) critical framework and tool within mental health care. *Philosophy, Ethics, and Humanities in Medicine*, *18*(1), 21.

Furnham, A., & Chan, E. (2004). Lay theories of schizophrenia: A cross-cultural comparison of British and Hong Kong Chinese attitudes, attributions and beliefs. *Social Psychiatry and Psychiatric Epidemiology*, *39*, 543–552.

Furnham, A. F. (1984). Personality and values. *Personality and Individual Differences*, *5*(4), 483–485.

Galderisi, S., Rossi, A., Rocca, P., Bertolino, A., Mucci, A., Bucci, P., & Birindelli, N. (2014). The influence of illness-related variables, personal resources and context-related factors on real-life functioning of people with schizophrenia. *World Psychiatry*, *13*(3), 275–287.

Gallagher-Thompson, D., Gray, H. L., Tang, P. C. Y., Pu, C. Y., Leung, L. Y. L., Wang, P.-C., Tse, C., Hsu, S., Kwo, E., Tong, H.-Q., Long, J., & Thompson, L. W. (2007). Impact of In-Home Behavioural Management Versus Telephone Support to Reduce Depressive Symptoms and Perceived Stress in Chinese Caregivers: Results of a Pilot Study. *The American Journal of Geriatric Psychiatry*, *15*(5), 425–434. https://doi.org/10.1097/JGP.0b013e3180312028

Gallimore, J. B., Gonzalez Diaz, K., Gunasinghe, C., Thornicroft, G., Taylor Salisbury, T., & Gronholm, P. C. (2023). Impact of mental health stigma on help-seeking in the Caribbean: Systematic review. *PLoS One*, *18*(9), 0291307.

Gao, L., Xie, W., Yang, X., & Chan, S. W. (2015). Effects of an interpersonal-psychotherapy-oriented postnatal programme for Chinese first-time mothers: A randomized controlled trial. *International Journal of Nursing Studies*, *52*(1), 22–29. https://doi.org/10.1016/j.ijnurstu.2014.06.006

García-Batista, Z. E., Guerra-Peña, K., Cano-Vindel, A., Herrera-Martínez, S., & Medrano, L. A. (2018a). Validity and reliability of the beck depression inventory (BDI-II) in general and hospital population of dominican republic. *PLoS One*, *13*(6). https://doi.org/doi: 1371/journal.pone.0199750

García-Batista, Z. E., Guerra-Peña, K., Cano-Vindel, A., Herrera-Martínez, S. X., & Medrano, L. A. (2018b). Validity and reliability of the Beck Depression Inventory (BDI-II) in general and hospital population of Dominican Republic. *PLOS ONE*, *13*(6), 0199750. https://doi.org/10.1371/journal.pone.0199750

Garratt, K. (2023). *Mental health policy and services in England*. House of Commons Library.

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities.3 Issues in. *Mental Health Nursing*, *26*(10), 979–999. https://doi.org/10.1080/01612840500280638

Gee, G. C., Ro, A., Shariff-Marco, S., & Chae, D. (2009). Racial discrimination and health among Asian Americans: Evidence, assessment, and directions for future research. *Epidemiologic Reviews*, *31*(1), 130–151.

Geest, R. M., & Meganck, R. (2019). How do time limits affect our psychotherapies? A literature review. *Psychologica Belgica*, *59*(1), 206.

Gender differences in personality traits across cultures: Robust and surprising findings. (2001). *Journal of Personality and Social Psychology*, *81*(2), 322.

Ghawadra, S. F., Abdullah, K. L., Choo, W. Y., Danaee, M., & Phang, C. K. (2020). The effect of mindfulness-based training on stress, anxiety, depression and job satisfaction among ward nurses: A randomized control trial. *Journal of Nursing Management*, *28*(5), 1088–1097. https://doi.org/10.1111/jonm.13049

Gialdino, I. V. (2009). Ontological and epistemological foundations of qualitative research. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *10*(2)).

Gilchrist, A., & Kyprianou, P. (2011). *Social networks, poverty and ethnicity (Joseph Rowntree Foundation*. Joseph Rowntree Foundation.

Gill, P. S., Plumridge, G., Khunti, K., & Greenfield, S. (2012). Under-representation of minority ethnic groups in cardiovascular research: A semi-structured interview study. *Family Practice*, *30*(2), 233–241.

Goddard, W., & Melville, S. (2004). *Research methodology: An introduction*. Juta and Company Ltd.

Golinowska, S., Groot, W., Baji, P., & Pavlova, M. (2016). Health promotion targeting older people. *BMC Health Services Research*, *16*, 345.

Graaff, A. M., Cuijpers, P., McDaid, D., Park, A., Woodward, A., Bryant, R. A., Fuhr, D. C., Kieft, B., Minkenberg, E., & Sijbrandij, M. (2020). Peer-provided Problem Management Plus (PM+) for adult Syrian refugees: A pilot randomised controlled trial on effectiveness and cost-effectiveness. *Epidemiology and Psychiatric Sciences*, *29*, 162. https://doi.org/10.1017/S2045796020000724

Graham, H. (2004). Social determinants and their unequal distribution: Clarifying policy understandings. *The Milbank Quarterly*, *82*(1), 101–124.

Graham, H. (2009). *Understanding health inequalities*. McGraw-Hill Education (UK.

Graham, J. R., Sorenson, S., & Hayes-Skelton, S. A. (2013). Enhancing the cultural sensitivity of cognitive behavioural interventions for anxiety in diverse populations. *The Behaviour*

Therapist/AABT, *36*(5), 101.

Green, H., Barkham, M., Kellett, S., & Saxon, D. (2014). Therapist effects and IAPT Psychological Wellbeing Practitioners (PWPs): A multilevel modelling and mixed methods analysis. *Behaviour Research and Therapy*, *63*, 43–54.

Green, J., & Thorogood, N. (2009). *Qualitative Methods for Health Research* (2nd ed.). Sage Publications Ltd.

Greenwald, A. G., & Krieger, L. H. (2006). Implicit bias: Scientific foundations. *California Law Review*, *94*(4), 945–967.

Guidi, J., Brakemeier, E.-L., Bockting, C. L. H., Cosci, F., Cuijpers, P., Jarrett, R. B., Linden, M., Marks, I., Peretti, C. S., Rafanelli, C., Rief, W., Schneider, S., Schnyder, U., Sensky, T., Tomba, E., Vazquez, C., Vieta, E., Zipfel, S., Wright, J. H., & Fava, G. A. (2018). Methodological Recommendations for Trials of Psychological Interventions. *Psychotherapy and Psychosomatics*, *87*(5), 276–284. https://doi.org/10.1159/000490574

Gujral, U. P., Pradeepa, R., Weber, M. B., Narayan, K. V., & Mohan, V. (2013). Type 2 diabetes in South Asians: Similarities and differences with white Caucasian and other populations. *Annals of the New York Academy of Sciences*, *1281*(1), 51.

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

Hahn, R. A., & Truman, B. I. (2015). Education improves public health and promotes health equity. *International Journal of Health Services*, *45*(4), 657–678.

Hall, B. J., Xiong, P., Guo, X., Sou, E. K. L., Chou, U. I., & Shen, Z. (2018). An evaluation of a low intensity mHealth enhanced mindfulness intervention for Chinese university students: A randomized controlled trial. *Psychiatry Research*, *270*, 394–403. https://doi.org/10.1016/j.psychres.2018.09.060

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behaviour Therapy*, *47*(6), 993–1014.

Hamilton, S., Corker, E., Weeks, C., Williams, P., Henderson, C., Pinfold, V., & Thornicroft, G. (2016). Factors associated with experienced discrimination among people using mental health services in England. *Journal of Mental Health*, *25*(4), 350–358.

Hammond, W. P. (2012). Taking it like a man: Masculine role norms as moderators of the racial discrimination–depressive symptoms association among African American men. *American Journal of Public Health*, *102*(2), 232–241.

Han, Y. M. Y., Sze, S. L., Wong, Q. Y., & Chan, A. S. (2020). A mind-body lifestyle intervention enhances emotional control in patients with major depressive disorder: A randomized, controlled study. *Cognitive, Affective, & Behavioural Neuroscience*, *20*(5), 1056–1069. https://doi.org/10.3758/s13415-020-00819-z

Hankerson, S. H., Suite, D., & Bailey, R. K. (2015). Treatment disparities among African American men with depression: Implications for clinical practice. *Journal of Men's Health*, *11*(4), 119–126. https://doi.org/10.1016/j.jomh.2015.08.001

Haque, A. (2004). Religion and mental health: The case of American Muslims. *Journal of Religion and Health*, *43*(1), 45–58.

Harandi, T. F., Taghinasab, M. M., & Nayeri, T. D. (2017). The correlation of social support with mental health: A meta-analysis. *Electronic Physician*, *9*(9), 5212.

Hart, S. L. (1971). Axiology–theory of values. *Philosophy and Phenomenological Research*, *32*(1), 29–41.

Harwood, T. G., & Garry, T. (2003). An overview of content analysis. *The Marketing Review*, *3*(4), 479–498.

Hathcoat, J. D., & Meixner, C. (2017). Pragmatism, factor analysis, and the conditional incompatibility thesis in mixed methods research. *Journal of Mixed Methods Research*, *11*(4), 433–449.

Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health*, *103*(5), 813–821.

Hays, P. A., & Iwamasa, G. Y. (2006). *Culturally responsive cognitive-behavioural therapy: Assessment, practice, and supervision*. American Psychological Association.

Health and Social Care Act 2012. (2012). https://www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets

Health, D. (2005). *Delivering race equality in mental health care*. https://documents.manchester.ac.uk/display.aspx?DocID=54691

Health, D., & Care, S. (2019). *Five year forward view for mental health: A government response*. https://www.gov.uk/government/publications/five-year-forward-view-for-mental-health-government-response

Health, D., & Care, S. (2023). *Suicide prevention strategy for England 2023 to 2028*. https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028

Health, T. L. G. (2020). Mental health matters. *The Lancet. Global Health*, *8*(11), 1352.

Health, T. L. P. (2020). Education: A neglected social determinant of health. *The Lancet. Public Health*, *5*(7), 361.

Hechanova, R., & Waelde, L. (2017). The influence of culture on disaster mental health and psychosocial support interventions in Southeast Asia. *Mental Health, Religion & Culture*, *20*(1), 31–44.

Heikkinen, J., Honkanen, R., Williams, L., Leung, J., Rauma, P., Quirk, S., & Koivumaa-Honkanen, H. (2019). Depressive disorders, anxiety disorders and subjective mental health in common musculoskeletal diseases: A review. *Maturitas*, *127*, 18–25.

Hellawell, D. (2006). Inside–out: Analysis of the insider–outsider concept as a heuristic device to develop reflexivity in students doing qualitative research. *Teaching in Higher Education*, *11*(4), 483–494.

Henderson, C., Corker, E., Hamilton, S., Williams, P., Pinfold, V., Rose, D., & Thornicroft, G. (2014). Viewpoint survey of mental health service users' experiences of discrimination in England 2008–2012. *Social Psychiatry and Psychiatric Epidemiology*, *49*, 1599–1608.

Henderson, C., Potts, L., & Robinson, E. J. (2020). Mental illness stigma after a decade of Time to Change England: Inequalities as targets for further improvement. *European Journal of Public Health*, *30*(3), 497–503.

Henderson, C., & Thornicroft, G. (2009). Stigma and discrimination in mental illness: Time to Change. *The Lancet*, *373*(9679), 1928–1930.

Hendriks, T., Schotanus-Dijkstra, M., Hassankhan, A., Sardjo, W., Graafsma, T., Bohlmeijer, E., & Jong, J. (2020). Resilience and well-being in the Caribbean: Findings from a randomized controlled trial of a culturally adapted multi-component positive psychology intervention. *The Journal of Positive Psychology*, *15*(2), 238–253. https://doi.org/10.1080/17439760.2019.1590624

Hensvik, L., Le Barbanchon, T., & Rathelot, R. (2020). *Which jobs are done from home? Evidence from the American Time Use Survey*.

Hiluy, J. C., Nazar, B. P., Gonçalves, W. S., Coutinho, W., & Appolinario, J. C. (2019). Effectiveness of pharmacologic interventions in the management of weight gain in patients with severe mental illness: A systematic review and meta-analysis. *The Primary Care Companion for CNS Disorders*, *21*(6), 23687.

Hinton, D., & Bui, E. (2019). Cultural Considerations in Anxiety and Related Disorders. In *The Cambridge Handbook of Anxiety and Related Disorders* (pp. 394–418).

Hinton, D. E., Chhean, D., Pich, V., Safren, S. A., Hofmann, S. G., & Pollack, M. H. (2005). A randomized controlled trial of cognitive-behaviour therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: A cross-over design. *Journal of Traumatic Stress*, *18*(6), 617–629. https://doi.org/10.1002/jts.20070

Hinton, D. E., Hofmann, S. G., Rivera, E., Otto, M. W., & Pollack, M. H. (2011). Culturally adapted CBT (CA-CBT) for Latino women with treatment-resistant PTSD: A pilot study comparing CA-CBT to applied muscle relaxation. *Behaviour Research and Therapy, 49*(4), 275–280. https://doi.org/10.1016/j.brat.2011.01.005

Hinton, D. E., Pham, T., Tran, M., Safren, S. A., Otto, M. W., & Pollack, M. H. (2004). CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: A pilot study. *Journal of Traumatic Stress*, *17*(5), 429–433. https://doi.org/10.1023/B:JOTS.0000048956.03529.fa

Hitchcock, G., & Hughes, D. (2002). *Research and the teacher: A qualitative introduction to school-based research*. Routledge.

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioural therapy: A review of meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427–440.

Hofstede, G., & McCrae, R. R. (2004). Personality and culture revisited: Linking traits and dimensions of culture. *Cross-Cultural Research*, *38*(1), 52–88.

Holliday, E., Griffith, K. A., Castro, R., Stewart, A., Ubel, P., & Jagsi, R. (2015). Gender differences in resources and negotiation among highly motivated physician-scientists. *Journal of General Internal Medicine*, *30*, 401–407.

Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science*, *10*(2), 227–237.

Hoopman, R., Terwee, C. B., Muller, M. J., Öry, F. G., & Aaronson, N. K. (2009). Methodological challenges in quality-of-life research among Turkish and Moroccan ethnic minority cancer patients: Translation, recruitment and ethical issues. *Ethnicity & Health*, *14*(3), 237–253.

Huber, M., Knottnerus, J. A., Green, L., Horst, H., Jadad, A. R., Kromhout, D., & Smid, H. (2011). How should we define health? *BMJ, 343*.

Huey, S., & Pan, D. (2006). Culture-responsive one-session treatment for phobic Asian Americans: A pilot study. *Psychotherapy: Theory, Research, Practice, Training*, *43*(4), 549–554. https://doi.org/10.1037/0033-3204.43.4.549

Hugh-Jones, S., Beckett, S., Tumelty, E., & Mallikarjun, P. (2021). Indicated prevention interventions for anxiety in children and adolescents: A review and meta-analysis of school-based programs. *European Child & Adolescent Psychiatry*, *30*(6), 849–860.

Huhn, M., Tardy, M., Spineli, L. M., Kissling, W., Foerstl, H., Pitschel-Walz, G., & Leucht, S. (2014). Efficacy of pharmacotherapy and psychotherapy for adult psychiatric disorders: A systematic overview of meta-analyses. *JAMA Psychiatry*, *71*(6), 706–715.

Hulsley, J., Elliott, K., & Therrien, Z. (2013). *The Efficacy and Effectiveness of Psychological Treatments*. Canadian Psychological Association. https://cpa.ca/docs/File/Practice/TheEfficacyAndEffectivenessOfPsychologicalTreatments_web.pdf

Hwang, W. C. (2006). The psychotherapy adaptation and modification framework: Application to Asian Americans. *American Psychologist*, *61*(7), 702.

Hwang, W.-C., Myers, H. F., Chiu, E., Mak, E., Butner, J. E., Fujimoto, K., Wood, J. J., & Miranda, J. (2015). Culturally Adapted Cognitive-Behavioural Therapy for Chinese Americans With Depression: A Randomized Controlled Trial. *Psychiatric Services*, *66*(10), 1035–1042. https://doi.org/10.1176/appi.ps.201400358

Hyde, J. S., & Mezulis, A. H. (2020). Gender differences in depression: Biological, affective, cognitive, and sociocultural factors. *Harvard Review of Psychiatry*, *28*(1), 4–13.

Hyde, J. S., Mezulis, A. H., & Abramson, L. Y. (2008). The ABCs of depression: Integrating affective, biological, and cognitive models to explain the emergence of the gender difference in depression. *Psychological Review*, *115*(2), 291.

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

Idang, G. E. (2015). African culture and values. *Phronimon*, *16*(2), 97–111.

Idler, E. L. (Ed.). (2014). *Religion as a social determinant of public health*. Oxford University Press.

Ikram, U. Z., Snijder, M. B., Fassaert, T. J., Schene, A. H., Kunst, A. E., & Stronks, K. (2015). The contribution of perceived ethnic discrimination to the prevalence of depression. *The European Journal of Public Health*, *25*(2), 243–248.

Improving Access to Psychological Therapies. (2008). Department of Health.

Improving mental health services for black and minority ethnic communities in England—Social Care Online. (2003). https://www.scie-socialcareonline.org.uk/inside-outside-improving-mental-health-services-for-black-and-minority-ethnic-communities-in-england/r/a11G00000017rChIAI

Institute, D.-F. C. (2005). *Recruiting Diverse Populations in Clinical and Community Research Trials: Guidelines and Recommendations*.

Institute for Race and Relations. (2022). https://irr.org.uk/research/statistics/definitions/

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

Iqbal, H., West, J., Haith-Cooper, M., & McEachan, R. R. (2021). A systematic review to identify research priority setting in Black and minority ethnic health and evaluate their processes. *PLoS One, 16*(5), 0251685.

Islam, M. M. (2019). Social determinants of health and related inequalities: Confusion and implications. *Frontiers in Public Health, 7,* 11.

Jackson-Koku, G. (2016). Questionnaire review beck depression inventory. *Occupational Medicine*, 174–175. https://doi.org/10.1093/occmed/kqv087

Jacob, K. S., Bhugra, D., & Mann, A. H. (2002). A Randomised Controlled Trial of an Educational Intervention for Depression among Asian Women in Primary Care in the United Kingdom. *International Journal of Social Psychiatry*, *48*(2), 139–148. https://doi.org/10.1177/002076402128783190

Jalal, B., Kruger, Q., & Hinton, D. E. (2020). Culturally adapted CBT (CA-CBT) for traumatised indigenous South Africans (Sepedi): A randomised pilot trial comparing CA-CBT to applied muscle relaxation. *Intervention*, *18*(1), 61. https://doi.org/10.4103/INTV.INTV_68_18

Jameel, S., Munivenkatappa, M., Arumugham, S. S., & Thennarasu, K. (2022). *Cultural adaptation of cognitive behaviour therapy for depression: A qualitative study exploring views of patients and practitioners from India.3 the Cognitive Behaviour Therapist* (Vol. 15, p. 16).

Jarolmen, J. (2020). Thoughts on Individualism, Collectivism, and Culture. *REFLECTIONS*, *26*(1), 104–109.

Jennings, L., & Skovholt, T. M. (1999). The cognitive, emotional and relational characteristics of master therapists. *Journal of Counselling Psychology*, *46*, 3–11.

Jesse, D. E., Gaynes, B. N., Feldhousen, E. B., Newton, E. R., Bunch, S., & Hollon, S. D. (2015). Performance of a culturally tailored cognitive-behavioral intervention integrated in a public health setting to reduce risk of antepartum depression: A randomized controlled trial. *Journal of Midwifery & Women's Health*, *60*(5), 578–592.

Johnson, J., Corker, C., & O'connor, D. B. (2020). Burnout in psychological therapists: A cross-sectional study investigating the role of supervisory relationship quality. *Clinical Psychologist*, *24*(3), 223–235.

Johnson, R. B., & Christensen, L. (2019). *Educational research: Quantitative, qualitative, and mixed approaches*. Sage Publications.

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

https://doi.org/10.3102/0013189X033007014

Jones, J., Lee, L., Zigarelli, J., & Nakagawa, Y. (2017). Culturally responsive adaptations in evidence-based treatment: The impact on client satisfaction. *Contemporary School Psychology, 21*(3), 211–222. https://doi.org/10.1007/s40688-016-0118-6

Jones, L. V., & Warner, L. A. (2011). Evaluating Culturally Responsive Group Work with Black Women. *Research on Social Work Practice, 21*(6), 737–746. https://doi.org/10.1177/1049731511411488

Jorm, A. F., & Reavley, N. J. (2013). Depression and stigma: From attitudes to discrimination. *The Lancet*, *381*(9860), 10–11.

Jose, J. P., & Cherayi, S. (2017). Social exclusion of older persons: The role of socio-demographic characteristics. *Ageing International*, *42*(4), 447–465.

Julian, L. J. (2011). Measures of anxiety: State-Trait Anxiety Inventory (STAI), Beck Anxiety Inventory (BAI), and Hospital Anxiety and Depression Scale-Anxiety (HADS-A. *Arthritis Care & Research*, *63*(S11), 467–472. https://doi.org/10.1002/acr.20561

Jung, C. G. (1936). The concept of the collective unconscious. *Collected Works, 9*(1), 99–104.

Jutlla, K., & Raghavan, R. (2017). *Improving the recruitment of Black, Asian and Minority Ethnic (BAME) communities in health and social care research: A review of literature*. De Montford University.

Kalibatseva, Z., & Leong, F. T. (2014). A critical review of culturally sensitive treatments for depression: Recommendations for intervention and research. *Psychological Services*, *11*(4), 433.

Kananian, S., Ayoughi, S., Farugie, A., Hinton, D., & Stangier, U. (2017). Transdiagnostic culturally adapted CBT with farsi-speaking refugees: A pilot study. *European Journal of Psych Traumatology*, *8*. https://doi.org/10.1080/20008198.2017.1390362

Kananian, S., Soltani, Y., Hinton, D., & Stangier, U. (2020). Culturally Adapted Cognitive Behavioural Therapy Plus Problem Management (CA-CBT+) With Afghan Refugees: A Randomized Controlled Pilot Study. *Journal of Traumatic Stress*, *33*(6), 928–938. https://doi.org/10.1002/jts.22615

Kang, K. K., & Moran, N. (2020). Experiences of inpatient staff meeting the religious and cultural needs of BAME informal patients and patients detained under the Mental Health Act 1983. *Mental Health Review Journal*, *25*(2), 1–14.

Kanter, J. W., Santiago-Rivera, A. L., Santos, M. M., Nagy, G., López, M., Hurtado, G. D., & West, P. (2015). A randomized hybrid efficacy and effectiveness trial of behavioural activation for Latinos with depression. *Behaviour Therapy*, *46*(2), 177–192.

Karasz, A., Raghavan, S., Patel, V., Zaman, M., Akhter, L., & Kabita, M. (2015). ASHA: Using Participatory Methods to Develop an Asset-building Mental Health Intervention for Bangladeshi Immigrant Women. *Progress in Community Health Partnerships: Research, Education, and Action*, *9*(4), 501–512. https://doi.org/10.1353/cpr.2015.0080

Karlsen, S., & Nazroo, J. Y. (2002a). Agency and structure: The impact of ethnic identity and racism on the health of ethnic minority people. *Sociology of Health & Illness*, *24*(1), 1–20.

Karlsen, S., & Nazroo, J. Y. (2002b). Relation between racial discrimination, social class, and health among ethnic minority groups. *American Journal of Public Health*, *92*(4), 624–631.

Karlsen, S., Nazroo, J. Y., McKenzie, K., Bhui, K., & Weich, S. (2005). Racism, psychosis and common mental disorder among ethnic minority groups in England. *Psychological Medicine*, *35*(12), 1795-1803 3.

Karnieli-Miller, O., Strier, R., & Pessach, L. (2009). Power relations in qualitative research. *Qualitative Health Research*, *19*(2), 279–289.

Kaur, A., Kallakuri, S., Kohrt, B. A., Heim, E., Gronholm, P. C., Thornicroft, G., & Maulik, P. K. (2021). Systematic review of interventions to reduce mental health stigma in India.4. *Asian Journal of Psychiatry*, *55*, 102466.

Kaur, D. M. W., & Hardeep, D. (2021). *What is Cognitive Behavioural Therapy*. CBT)? Psychology Tools. https://www.psychologytools.com/self-help/what-is-cbt/

Keating, F., Robertson, D., McCulloch, A., & Francis, E. (2002). *Breaking the circles of fear: A review of the relationship between mental health services and African and Caribbean communities*. The Sainsbury Centre for Mental Health.

Kelly, S. (2019). *APA PsycNet*. Psycnet.apa.org. https://psycnet.apa.org/record/2018-55365-005

Keyes, C. L. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American Psychologist*, *62*(2), 95.

Killam, L. (2013). *Research terminology simplified: Paradigms, axiology, ontology, epistemology and methodology*. Laura Killam.

Kim, Y. H., Choi, K. S., Han, K., & Kim, H. W. (2018). A psychological intervention programme for patients with breast cancer under chemotherapy and at a high risk of depression: A randomised clinical trial.5. *Journal of Clinical Nursing*, *27*(3–4), 572–581. https://doi.org/10.1111/jocn.13910

Klein, B., & Richards, J. C. (2001). A brief internet-based treatment for panic disorder. *Behavioural and Cognitive Psychotherapy*, *29*(1), 113–117. https://doi.org/10.1017/S1352465801001138

Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in

China: Report Number One of the University of Washington—Hunan Medical College Collaborative Research Project111222.6 Culture. *Medicine and Psychiatry*, *6*(2), 117–190.

Knaevelsrud, C., Brand, J., Lange, A., Ruwaard, J., & Wagner, B. (2015). Web-Based Psychotherapy for Posttraumatic Stress Disorder in War-Traumatized Arab Patients: Randomized Controlled Trial. *Journal of Medical Internet Research*, *17*(3), 71. https://doi.org/10.2196/jmir.3582

Knifton, L., Gervais, M., Newbigging, K., Mirza, N., Quinn, N., Wilson, N., & Hunkins-Hutchison, E. (2010). Community conversation: Addressing mental health stigma with ethnic minority communities. *Social Psychiatry and Psychiatric Epidemiology*, *45*(4), 497–504. https://doi.org/10.1007/s00127-009-0095-4

Knowledge, H. (2021). Introduction to study designs—Intervention studies and randomised controlled trials. *Health Knowledge*. https://www.healthknowledge.org.uk/e-learning/epidemiology/practitioners/introduction-study-design-is-rct

Kola, L., Kohrt, B. A., Hanlon, C., Naslund, J. A., Sikander, S., Balaji, M., & Patel, V. (2021). COVID-19 mental health impact and responses in low-income and middle-income countries: Reimagining global mental health. *The Lancet Psychiatry*, *8*(6), 535–550.

Kotrlik, J. W. K. J. W., & Higgins, C. C. H. C. C. (2001). Organizational research: Determining appropriate sample size in survey research appropriate sample size in survey research. *Information Technology, Learning, and Performance Journal*, *19*(1), 43.

Kouros, C. D., & Garber, J. (2014). Trajectories of individual depressive symptoms in adolescents: Gender and family relationships as predictors. *Developmental Psychology*, *50*(12), 2633.

Labov, W., & Waletzky, J. (2003). *Narrative analysis: Oral versions of personal experience*. University of Washington Press.

Lafferty, P., Beutler, L. E., & Crago, M. (1989). Differences between more and less effective psychotherapists: A study of select therapist variables. *Journal of Consulting and Clinical Psychology*, *57*(1), 76.

Lane, D., Beevers, D. G., & Lip, G. Y. H. (2002). Ethnic differences in blood pressure and the prevalence of hypertension in England. *Journal of Human Hypertension*, *16*(4), 267–273.

Langella, M., & Manning, A. (2019). *Residential mobility and unemployment in the UK*. Centre for Economic Performance.

Larkin, M., Smith, J. A., & Flower, P. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*(2), 102–120. https://doi.org/10.1191/1478088706qp062oa

Las Nueces, D., Hacker, K., DiGirolamo, A., & Hicks, L. S. (2012). A systematic review of community-based participatory research to enhance clinical trials in racial and ethnic minority groups. *Health Services Research*, *47*(3pt2), 1363–1386.

Lasalvia, A., Zoppei, S., Bortel, T., Bonetto, C., Cristofalo, D., Wahlbeck, K., & Thornicroft, G. (2013). Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: A cross-sectional survey. *The Lancet*, *381*(9860), 55–62.

Latif, Z. (2014). *The maternal mental health of migrant women (Race Equality Foundation*.

Laungani, P. (2004). *Asian perspectives in counselling and psychotherapy*. Routledge.

Law, T. (2020). Women Are Now the Majority of the U.S. Workforce—But Working Women Still Face Serious Challenges. *Time*. https://time.com/5766787/women-workforce/

Lawton, L., McRae, M., & Gordon, L. (2021). Frontline yet at the back of the queue–improving access and adaptations to CBT for Black African and Caribbean communities. *The Cognitive Behaviour Therapist*, *14*, 30.

Layard, R. (2006). *The depression report: A new deal for depression and anxiety disorders* (Issue 15)).

LeBlanc, J. C., Almudevar, A., Brooks, S. J., & Kutcher, S. (2002). Screening for adolescent depression: Comparison of the kutcher adolescent depression scale with the beck depression inventory. *Journal of Child and Adolescent Psychopharmacology*, *12*(2), 113–126. https://doi.org/10.1089/104454602760219153

Lefever, S., Dal, M., & Matthiasdottir, A. (2007). Online data collection in academic research: Advantages and limitations. *British Journal of Educational Technology*, *38*(4), 574–582.

Leonidaki, V. (2015). Critical appraisal in the context of integrations of qualitative evidence in applied psychology: The introduction of a new appraisal tool for interview studies. *Qualitative Research in Psychology*, *12*(4), 435–452.

Leung, P., Cheung, M., & Tsui, V. (2012). Help-seeking behaviours among Chinese Americans with depressive symptoms. *Social Work*, *57*(1), 61–71.

Leung, S. S., Lee, A. M., Chiang, V. C., Lam, S. K., Kuen, Y. W., & Wong, D. F. (2013). Culturally sensitive, preventive antenatal group cognitive–behavioural therapy for Chinese women with depression. *International Journal of Nursing Practice*, *19*, 28–37.

Levin, L. S. (1980). *Self-care oriented health education from the perspective of the WHO role* (Issue HED/80.1)). World Health Organization.

Lewis, C., & Cotterell, N. (2018). *Social Isolation and Older Black, Asian and Minority Ethnic*

People in Greater Manchester. Ambition for Ageing.

Lewis, J. A., Mendenhall, R., Harwood, S. A., & Huntt, M. B. (2013). Coping with gendered racial microaggressions among Black women college students. *Journal of African American Studies*, *17*(1), 51–73.

Li, Y. (2016, October 28). *How to Determine the Validity and Reliability of an Instrument | Discovery Center for Evaluation*. Research, & Professional Learning. A Miami University Blog. https://sites.miamioh.edu/discovery-center/2016/11/how-to-determine-the-validity-and-reliability-of-an-instrument/

Li, Z., Geng, W., Yin, J., & Zhang, J. (2018). Effect of one comprehensive education course to lower anxiety and depression among Chinese breast cancer patients during the postoperative radiotherapy period—One randomized clinical trial. *Radiation Oncology*, *13*(1), 111. https://doi.org/10.1186/s13014-018-1054-6

Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyei, S., & Braddock, C. H. (2011). Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. *Journal of General Internal Medicine*, *26*, 317–325.

Linardon, J., Fitzsimmons-Craft, E. E., Brennan, L., Barillaro, M., & Wilfley, D. E. (2019). Dropout from interpersonal psychotherapy for mental health disorders: A systematic review and meta-analysis. *Psychotherapy Research*, *29*(7), 870–881.

Lindegaard, T., Brohede, D., Koshnaw, K., Osman, S. S., Johansson, R., & Andersson, G. (2019). Internet-based treatment of depressive symptoms in a Kurdish population: A randomized controlled trial.7. *Journal of Clinical Psychology*, *75*(6), 985–998. https://doi.org/10.1002/jclp.22753

Lindegaard, T., Seaton, F., Halaj, A., Berg, M., Kashoush, F., Barchini, R., Ludvigsson, M., Sarkohi, A., & Andersson, G. (2020). Internet-based cognitive behaviour therapy for depression and anxiety among Arabic-speaking individuals in Sweden: A pilot randomized controlled trial. *Cognitive Behaviour Therapy*, *50*(1), 47–66. https://doi.org/10.1080/16506073.2020.1771414

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalised stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, *71*(12), 2150–2161.

Loewenthal, D., Mohamed, A., Mukhopadhyay, S., Ganesh, K., & Thomas, R. (2012). Reducing the barriers to accessing psychological therapies for Bengali, Urdu, Tamil and Somali communities in the UK: some implications for training, policy and practice. *British*

Journal of Guidance & Counselling, *40*(1), 43–66.

Lohse, S. (2017). Pragmatism, ontology, and philosophy of the social sciences in practice. *Philosophy of the Social Sciences*, *47*(1), 3–27.

London, U. C. (2020). *Levels of depression and anxiety higher amongst those from BAME backgrounds during the lockdown*. https://www.ucl.ac.uk/news/2020/jul/levels-depression-and-anxiety-higher-amongst-those-bame-backgrounds-during-lockdown

Longhi, S., Nandi, A., Bryan, M., Connolly, S., & Gedikli, C. (2017). Gender and unemployment. In *Analysis of Understanding Society: The UK Household Longitudinal Survey*.

Loon, A., Schaik, A., Dekker, J., & Beekman, A. (2013). Bridging the gap for ethnic minority adult outpatients with depression and anxiety disorders by culturally adapted treatments. *Journal of Affective Disorders*, *147*(1–3), 9–16.

Luborsky, L., McLellan, A. T., Woody, G. E., O'Brien, C. P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry*, *42*(6), 602–611.

Lupton, D. (1992). Discourse analysis: A new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health*, *16*(2), 145–150.

Luthans, F., Avolio, B. J., Avey, J. B., & Norman, S. M. (2007). Positive psychological capital: Measurement and relationship with performance and satisfaction. *Personnel Psychology*, *60*(3), 541–572.

Lutz, W., Leon, S. C., Martinovich, Z., Lyons, J. S., & Stiles, W. B. (2007). Therapist effects in outpatient psychotherapy: A three-level growth curve approach. *Journal of Counselling Psychology*, *54*(1), 32.

Ma, L. (2012). Some philosophical considerations in using mixed methods in library and information science research. *Journal of the American Society for Information Science and Technology*, *63*(9), 1859–1867.

Maarouf, H. (2019). Pragmatism as a supportive paradigm for the mixed research approach: Conceptualizing the ontological, epistemological, and axiological stances of pragmatism. *International Business Research*, *12*(9), 1–12.

Macías, J., Valero-Aguayo, L., Bond, F. W., & Blanca, M. J. (2019). The efficacy of functional-analytic psychotherapy and acceptance and commitment therapy (FACT) for public employees. *Psicothema*, *31*(1), 24–29.

Mak, W. W., Poon, C. Y., Pun, L. Y., & Cheung, S. F. (2007). Meta-analysis of stigma and mental health. *Social Science & Medicine*, *65*(2), 245–261.

Manduca, R. (2018). Income inequality and the persistence of racial economic disparities.

Sociological Science, *5*, 182.

Mantovani, N., Pizzolati, M., & Edge, D. (2017). Exploring the relationship between stigma and help-seeking for mental illness in African-descended faith communities in the UK. *Health Expectations*, *20*(3), 373–384.

Marcks, B. A., & Woods, D. W. (2005). A comparison of thought suppression to an acceptance-based technique in the management of personal intrusive thoughts: A controlled evaluation. *Behaviour Research and Therapy*, *43*(4), 433–445. https://doi.org/10.1016/j.brat.2004.03.005

Markstrom, C. A., Sabino, V. M., Turner, B. J., & Berman, R. C. (1997). The psychosocial inventory of ego strengths: Development and validation of a new Eriksonian measure. *Journal of Youth and Adolescence*, *26*(6), 705–732.

Marmot, M., Friel, S., Bell, R., Houweling, T. A., & Taylor, S. (2008). & Commission on Social Determinants of Health. *The Lancet*, *372*(9650), 1661–1669.

Martinez, A. B., Co, M., Lau, J., & Brown, J. S. (2020). Filipino help-seeking for mental health problems and associated barriers and facilitators: A systematic review. *Social Psychiatry and Psychiatric Epidemiology*, *55*, 1397–1413.

Mashal, N. M., Beaudreau, S. A., Hernandez, M. A., Duller, R. C., Romaniak, H., Shin, K. E., Paller, K. A., & Zinbarg, R. E. (2020). A Brief Worry Reappraisal Paradigm (REAP) Increases Coping with Worries. *Cognitive Therapy and Research*, *44*(1), 216–228. https://doi.org/10.1007/s10608-019-10053-8

Mason, J. (2002). *Qualitative researching*. Sage Publications Ltd.

Mason, J., Freemantle, N., Nazareth, I., Eccles, M., Haines, A., & Drummond, M. (2001). When is it cost-effective to change the behaviour of health professionals? *JAMA*, *286*(23), 2988–2992.

Mayhew, K., & Anand, P. (2020). COVID-19 and the UK Labour Market. *Oxford Review of Economic Policy*, *36*(1), 215–224.

Maynard, S. (2008). *Muslim mental health: A scoping paper on theoretical models, practice and related mental health concerns in Muslim communities*. Stephen Maynard and Associates.

McCabe, K. O., & Fleeson, W. (2012). What is extraversion for? Integrating trait and motivational perspectives and identifying the purpose of extraversion. *Psychological Science*, *23*(12), 1498–1505.

McIntosh, P. (1990). White privilege: Unpacking the invisible knapsack. *Journal of Mental Health*, *2*, 1–29.

Mclean, C., Campbell, C., & Cornish, F. (2003). African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (re) productive of health inequalities. *Social Science & Medicine*, *56*(3), 657–669.

McManus, S., Meltzer, H., Brugha, T., Bebbington, P. E., & Jenkins, R. (2009). Adult psychiatric morbidity in England: Results of a household survey. *Health and Social Care Information Centre*.

McQuaid, R., Raeside, R., Egdell, V., & Graham, H. (2016). *Multiple scarring effects of youth unemployment in the UK*. Employment Research Institute.

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: A qualitative study in Southeast England. *BMJ Open*, *6*(11), 012337.

Mendes Ferracioli, N. G. (2018). Psychological aspects of aging and psychology's contributions to gerontology: Theoretical and technical interface. *MOJ Gerontology & Geriatrics*, *3*(2). https://doi.org/10.15406/mojgg.2018.03.00101

Mercer, L., Evans, L. J., Turton, R., & Beck, A. (2019). Psychological therapy in secondary mental health care: Access and outcomes by ethnic group. *Journal of Racial and Ethnic Health Disparities*, *6*(2), 419–426.

Mewes, J. C., Steuten, L. M., IJsbrandy, C., IJzerman, M. J., & Harten, W. H. (2017). Value of implementation of strategies to increase the adherence of health professionals and cancer survivors to guideline-based physical exercise. *Value in Health*, *20*(10), 1336–1344.

Mikkonen, J., & Raphael, D. (2010). Social determinants of health. *The Canadian Facts*.

Miller, S. D., Hubble, M., & Duncan, B. (2008). Supershrinks: What is the secret of their success? *Psychotherapy in Australia*, *14*, 14–22.

Milligan, L. (2016). Insider-outsider-inbetweener? Researcher positioning, participative methods and cross-cultural educational research. *Compare: A Journal of Comparative and International Education*, *46*(2), 235–250.

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, *5*(1), 25–35.

Mir, G., Ghani, R., Meer, S., & Hussain, G. (2019). Delivering a culturally adapted therapy for Muslim clients with depression. *The Cognitive Behaviour Therapist*, *12*, 26.

Mir, G., Meer, S., Cottrell, D., McMillan, D., House, A., & Kanter, J. W. (2015). Adapted behavioural activation for the treatment of depression in Muslims. *Journal of Affective Disorders*, *180*, 190–199.

Mir, G., & Tovey, P. (2003). Asian carers' experiences of medical and social care: The case of cerebral palsy. *British Journal of Social Work, 33*(4), 465–479.

Mlinac, M. E., & Schwabenbauer, A. (2018). Psychological resilience. *Resilience in Aging: Concepts, Research, and Outcomes*, 81–104.

Mohr, D. C., Spring, B., Freedland, K. E., Beckner, V., Arean, P., Hollon, S. D., Ockene, J., & Kaplan, R. (2009). The Selection and Design of Control Conditions for Randomized Controlled Trials of Psychological Interventions. *Psychotherapy and Psychosomatics*, *78*(5), 275–284. https://doi.org/10.1159/000228248

Montgomery, P., Grant, S., Mayo-Wilson, E., Macdonald, G., Michie, S., Hopewell, S., & Moher, D. (2018). Reporting randomised trials of social and psychological interventions: The CONSORT-SPI 2018 Extension. *Trials*, *19*(1). https://doi.org/10.1186/s13063-018-2733-1

Monticelli, R. (2022). *Towards a phenomenological axiology: Discovering what matters*. Springer Nature.

Moon, K., & Blackman, D. (2014). A guide to understanding social science research for natural scientists. *Conservation Biology*, *28*(5), 1167–1177.

Morgan, C., Mallett, R., Hutchinson, G., Bagalkote, H., Morgan, K., Fearon, P., & Leff, J. (2005). Pathways to care and ethnicity. 1: Sample characteristics and compulsory admission: Report from the AeSOP study. *The British Journal of Psychiatry*, *186*(4), 281–289.

Morgan, C., Mallett, R., Hutchinson, G., & Leff, J. (2004). Negative pathways to psychiatric care and ethnicity: The bridge between social science and psychiatry. *Social Science & Medicine*, *58*(4), 739–752.

Morgan, D. L. (2007). Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research*, *1*, 48–76. https://doi.org/10.1177/2345678906292462

Morgan, D. L. (2014). Pragmatism as a paradigm for social research. *Qualitative Inquiry*, *20*(8), 1045–1053.

Mueller, M., Kennerley, H., & McManus, F. (2010). *Oxford guide to surviving as a CBT therapist. Oxford Guides to Cognitive Behaviour*. Routledge.

Murphy, B. P., Chung, Y. C., Park, T. W., & McGorry, P. D. (2006). Pharmacological treatment of primary negative symptoms in schizophrenia: A systematic review. *Schizophrenia Research*, *88*(1–3), 5–25.

Murphy, E., Dingwall, R., Greatbatch, D., Parker, S., & Watson, P. (1998). Qualitative research methods in health technology assessment: A review of the literature. *Health Technology*

Assessment (Winchester, England, *2*(16), 274.

Murphy, R., & Hutton, P. (2018). Practitioner review: Therapist variability, patient-reported therapeutic alliance, and clinical outcomes in adolescents undergoing mental health treatment–A systematic review and meta-analysis. *Journal of Child Psychology and Psychiatry*, *59*(1), 5–19.

Musa, Z. A., Soh, K. L., Mukhtar, F., Soh, K. Y., Oladele, T. O., & Soh, K. G. (2021). Effectiveness of mindfulness-based cognitive therapy among depressed individuals with disabilities in Nigeria: A randomized controlled trial. *Psychiatry Research*, *296*, 113680. https://doi.org/10.1016/j.psychres.2020.113680

Muto, T., Hayes, S. C., & Jeffcoat, T. (2011). The Effectiveness of Acceptance and Commitment Therapy Bibliotherapy for Enhancing the Psychological Health of Japanese College Students Living Abroad. *Behaviour Therapy*, *42*(2), 323–335. https://doi.org/10.1016/j.beth.2010.08.009

Naeem, F., Gul, M., Irfan, M., Munshi, T., Asif, A., Rashid, S., Khan, M. N. S., Ghani, S., Malik, A., Aslam, M., Farooq, S., Husain, N., & Ayub, M. (2015). Brief Culturally adapted CBT (CaCBT) for depression: A randomized controlled trial from Pakistan. *Journal of Affective Disorders*, *177*, 101–107. https://doi.org/10.1016/j.jad.2015.02.012

Naeem, F., Habib, N., Gul, M., Khalid, M., Saeed, S., Farooq, S., & Kingdon, D. (2016). A qualitative study to explore patients', carers' and health professionals' views to culturally adapt CBT for psychosis (CBTp) in Pakistan. *Behavioural and Cognitive Psychotherapy*, *44*(1), 43–55.

Naeem, F., Latif, M., Mukhtar, F., Kim, Y. R., Li, W., Butt, M. G., & Ng, R. (2021). Transcultural adaptation of cognitive behavioural therapy (CBT) in Asia. *Asia-Pacific Psychiatry*, *13*(1), 12442.

Naeem, F., Phiri, P., Nasar, A., Munshi, T., Ayub, M., & Rathod, S. (2016). An evidence-based framework for cultural adaptation of cognitive behaviour therapy: Process, methodology and foci of adaptation. *World Cultural Psychiatry Research Review*, *11*, 67–70.

Naeem, F., Phiri, P., Rathod, S., & Ayub, M. (2019). Cultural adaptation of cognitive–behavioural therapy. *BJPsych Advances*, *25*(6), 387–395. https://doi.org/10.1192/bja.2019.15

Naeem, F., Phiri, P., Rathod, S., & Kingdon, D. (2010). Using CBT with diverse patients. Working with South Asian Muslims. In M. Mueller, H. Kennerley, & F. McManus (Eds.), *Oxford guide to surviving as a CBT therapist* (pp. 41–100). Oxford University Press.

Naeem, F., Sarhandi, I., Gul, M., Khalid, M., Aslam, M., Anbrin, A., Saeed, S., Noor, M., Fatima, G., Minhas, F., Husain, N., & Ayub, M. (2014). A multicentre randomised controlled trial of a carer supervised Culturally adapted CBT (CaCBT) based self-help for depression in Pakistan. *Journal of Affective Disorders*, *156*, 224–227. https://doi.org/10.1016/j.jad.2013.10.051

Najavits, L. M., & Strupp, H. H. (1994). Differences in the effectiveness of psychodynamic therapists: A process-outcome study. *Psychotherapy: Theory, Research, Practice, Training*, *31*(1), 114.

Nakao, S., Nakagawa, A., Oguchi, Y., Mitsuda, D., Kato, N., Nakagawa, Y., Tamura, N., Kudo, Y., Abe, T., Hiyama, M., Iwashita, S., Ono, Y., & Mimura, M. (2018). Web-Based Cognitive Behavioural Therapy Blended With Face-to-Face Sessions for Major Depression: Randomized Controlled Trial. *Journal of Medical Internet Research*, *20*(9), 10743. https://doi.org/10.2196/10743

National Collaborating Centre for Mental Health. (2019). https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

National Statistics, O. (2020). *Employment in the UK*. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/employmentintheuk/november2020#unemployment

Naz, S., Gregory, R., & Bahu, M. (2019). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. *The Cognitive Behaviour Therapist*, *12*.

Neter, E., & Brainin, E. (2019). Association between health literacy, ehealth literacy, and health outcomes among patients with long-term conditions. *European Psychologist*, *24*, 68–81.

Network, P. R. (2021). *Self-care and wellbeing for ethnically diverse women*. https://www.bitc.org.uk/toolkit/self-care-and-wellbeing-for-ethnically-diverse-women/

Neuner, F., Onyut, P. L., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T. (2008). Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *76*(4), 686–694. https://doi.org/10.1037/0022-006X.76.4.686

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A Comparison of Narrative Exposure Therapy, Supportive Counselling, and Psychoeducation for Treating Posttraumatic Stress Disorder in an African Refugee Settlement. *Journal of Consulting and Clinical Psychology*, *72*(4), 579–587. https://doi.org/10.1037/0022-006X.72.4.579

Ng, C. H. (1997). The stigma of mental illness in Asian cultures. *Australian & New Zealand Journal of Psychiatry*, *31*(3), 382–390.

Ng, T. K., & Wong, D. F. K. (2017). The efficacy of cognitive behavioural therapy for Chinese people: A meta-analysis. *Australian & New Zealand Journal of Psychiatry, 52*(7), 620–637. https://doi.org/10.1177/0004867417741555

Nguyen, A. W. (2020). Religion and mental health in racial and ethnic minority populations: A review of the literature. *Innovation in Aging*, *4*(5), 035.

Nolen-Hoeksema, S. (1994). An interactive model for the emergence of gender differences in depression in adolescence. *Journal of Research on Adolescence*, *4*, 519–534.

Nordal, K. C. (2012). *Outcomes measurement benefits psychology*. https://www.apa.org/monitor/2012/01/perspectives

Normann, N., & Morina, N. (2018). The efficacy of metacognitive therapy: A systematic review and meta-analysis. *Frontiers in Psychology*, *9*, 2211.

Nosé, M., Barbui, C., & Tansella, M. (2003). How often do patients with psychosis fail to adhere to treatment programmes? A systematic review. *Psychological Medicine, 33*(7), 1149–1160.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1609406917733847.

Nwokoroku, S. C., Neil, B., Dlamini, C., & Osuchukwu, V. C. (2022). A systematic review of the role of culture in the mental health service utilisation among ethnic minority groups in the United Kingdom. *Global Mental, ealth,1*, 1–10.

Office for Health Improvement & Disparities. (2022). https://www.gov.uk/government/publications/vulnerabilities-applying-all-our-health/vulnerabilities-applying-all-our-health

Office, N. A. (2023). *Progress in improving mental health services in england*. https://www.nao.org.uk/reports/progress-in-improving-mental-health-services-in-england/#downloads

Office of National Statistics. (2021). https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity

Okeke, A. (2013). A culture of stigma: Black women and mental health. *Journal of Mental Health*, *1*, 1–3.

Olesen, V. L. (2007). Feminist qualitative research and grounded theory: Complexities, criticisms, and opportunities. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of grounded theory* (pp. 417–436). SAGE Publications.

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2023). A practical guide to reflexivity in qualitative research. *AMEE Guide, 45*(149), 241–251.

Olson, S., & Anderson, K. M. (Eds.). (2013). *Leveraging culture to address health inequalities: Examples from Native communities: Workshop summary*. National Academies Press.

Opara, V., Sealy, R., & Ryan, M. K. (2020). The workplace experiences of BAME professional women: Understanding experiences at the intersection. *Gender, Work & Organization, 27,* 1192–1213.

Oppong, N. Y. (2013). *Towards African Work Orientations: Guide from Hofstede's Cultural Dimensions*. University of Cape Coast. https://www.researchgate.net/publication/315671039_Towards_African_Work_Orientations_Guide_from_Hofstede%27s_Cultural_Dimensions

Organisation, W. H. (1998a). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine*, *28*(3), 551–558.

Organisation, W. H. (1998b). The World Health Organization quality of life assessment (WHOQOL): Development and general psychometric properties. *Social Science & Medicine*, *46*(12), 1569–1585.

Organisation, W. H. (2009). Pharmacological treatment of mental disorders in primary health care. *World Health Organization*.

Organisation, W. H. (2019). *What do we mean by self-care*. https://www.who.int/reproductivehealth/self-care-interventions/definitions/en/

Organisation, W. H. (2020a). *Depression*. https://www.who.int/health-topics/depression#tab=tab_1

Organisation, W. H. (2020b). *Mental health*. https://www.who.int/mental_health/who_urges_investment/en/#:~:text=WHO%2FP.,to%20her%20or%20his%20community.

Otoo, B. K. (2020). Declaring My Ontological and Epistemological Stance: A Reflective Paper. *Journal of Educational Thought/Revue de La Pensée Educative*, *53*(1), 67–88.

Otu, A., Ahinkorah, B. O., Ameyaw, E. K., Seidu, A. A., & Yaya, S. (2020). One country, two crises: What Covid-19 reveals about health inequalities among BAME communities in the United Kingdom and the sustainability of its health system? *International Journal for Equity in Health*, *19*(1), 1–6.

Ozano, K., & Khatri, R. (2018). Reflexivity, positionality and power in cross-cultural participatory action research with research assistants in rural Cambodia. *Educational Action Research*, *26*(2), 190–204.

Padula, C. A. (1992). Self-Care and the Elderly: Review and Implications. *Public Health Nursing*, *9*(1), 22–28.

Pallant, J. (2020). *SPSS survival manual: A step by step guide to data analysis using IBM SPSS*.

Palumbo, D., & Galderisi, S. (2020). Controversial issues in current definitions of mental health. *Archives of Psychiatry and Psychotherapy*, *1*, 7–11.

Pan, D., Huey, S. J., & Hernandez, D. (2011). Culturally adapted versus standard exposure treatment for phobic Asian Americans: Treatment efficacy, moderators, and predictors. *Cultural Diversity and Ethnic Minority Psychology*, *17*(1), 11–22. https://doi.org/10.1037/a0022534

Parry, G., Barkham, M., Brazier, J., Dent-Brown, K., Hardy, G., Kendrick, T., & Lovell, K. (2011). An evaluation of a new service model: Improving Access to Psychological Therapies demonstration sites 2006-2009. *Journal of Consulting and Clinical Psychology*, *60*(1), 100.

Parsons, C. E., Crane, C., Parsons, L. J., Fjorback, L. O., & Kuyken, W. (2017). Home practice in mindfulness-based cognitive therapy and mindfulness-based stress reduction: A systematic review and meta-analysis of participants’ mindfulness practice and its association with outcomes. *Behaviour Research and Therapy*, *95*, 29–41.

Pascoe, E. A., & Smart Richman, L. (2009a). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin*, *135*(4), 531.

Pascoe, E. A., & Smart Richman, L. (2009b). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin*, *135*(4), 531.

Patel, N., Ferrer, H. B., Tyrer, F., Wray, P., Farooqi, A., Davies, M. J., & Khunti, K. (2017). Barriers and facilitators to healthy lifestyle changes in minority ethnic populations in the UK: a narrative review. *Journal of Racial and Ethnic Health Disparities*, *4*(6), 1107–1119.

Patel, V., Chisholm, D., Parikh, R., Charlson, F. J., Degenhardt, L., Dua, T., & Whiteford, H. (2016). Addressing the burden of mental, neurological, and substance use disorders: Key messages from Disease Control Priorities. *The Lancet*, *387*(10028), 1672–1685.

Patterson, G. T., & Graham, W. K. (2018). *Clinical interventions in criminal justice settings: Evidence-based practice*. Academic Press Is An Imprint Of Elsevier. https://www.sciencedirect.com/book/9780128113813/clinical-interventions-in-criminal-justice-settings

Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and* *practice*. Sage publications.

Pederson, A. B., Konadu Fokuo, J., Thornicroft, G., Bamgbose, O., Ogunnubi, O. P., Ogunsola, K., & Oshodi, Y. O. (2023). Perspectives of university health care students on mental health stigma in Nigeria: Qualitative analysis. *Transcultural Psychiatry*, *60*(2), 272–285.

Perera, N., & Agboola, S. (2019). Are formal self-care interventions for healthy people effective? A systematic review of the evidence. *BMJ Global Health*, *4*(Suppl 10), 001415.

Perissinotto, C. M., & Covinsky, K. E. (2014). Living alone, socially isolated or lonely—What are we measuring? *Journal of General Internal Medicine*, *29*, 1429–1431.

Pescosolido, B. A., Halpern-Manners, A., Luo, L., & Perry, B. (2021). Trends in public stigma of mental illness in the US, 1996-2018. *JAMA Network Open*, *4*(12), 2140202–2140202.

Pescosolido, B. A., Martin, J. K., Long, J. S., Olafsdottir, S., Kafadar, K., & Medina, T. R. (2015). The theory of industrial society and cultural schemata: Does the “cultural myth of stigma” underlie the WHO schizophrenia paradox? *American Journal of Sociology*, *121*(3), 783–825.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, *20*(1), 7–14.

Pinto, R. Z., Ferreira, M. L., Oliveira, V. C., Franco, M. R., Adams, R., Maher, C. G., & Ferreira, P. H. (2012). Patient-centred communication is associated with positive therapeutic alliance: A systematic review. *Journal of Physiotherapy*, *58*(2), 77–87.

Pontin, E., Schwannauer, M., Tai, S., & Kinderman, P. (2013). A UK validation of a general measure of subjective well-being: The modified BBC subjective well-being scale (BBC-SWB. *Health and Quality of Life Outcomes*, *11*(1), 1–9.

Pratt, S. (2016). Pragmatism as ontology, not (just) epistemology: Exploring the full horizon of pragmatism as an approach to IR theory. *International Studies Review*, *18*(3), 508–527.

Preferred Reporting Items for Systematic Reviews and Meta-Analyses. (2021). https://www.bmj.com/content/372/bmj.n71

Priest, N., Paradies, Y., Trenerry, B., Truong, M., Karlsen, S., & Kelly, Y. (2013). A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people. *Social Science & Medicine*, *95*, 115–127.

Proto, E., & Quintana-Domeque, C. (2020). COVID-19 and Mental Health Deterioration among BAME Groups in the UK. *CESifo Working Paper*, *1*, 1–56.

Proto, E., & Quintana-Domeque, C. (2021). COVID-19 and mental health deterioration by ethnicity and gender in the UK. *PloS One*, *16*(1), 0244419.

Race, C., & Disparities, E. (2021). *Covid disparities*. https://www.gov.uk/government/organisations/commission-on-race-and-ethnic-disparities

Rachman, S. (2015). The evolution of behaviour therapy and cognitive behaviour therapy. *Behaviour Research and Therapy*, *64*, 1–8.

Raisi-Estabragh, Z., McCracken, C., Bethell, M. S., Cooper, J., Cooper, C., Caulfield, M. J., & Petersen, S. E. (2020). Greater risk of severe COVID-19 in Black, Asian and Minority Ethnic populations is not explained by cardiometabolic, socioeconomic or behavioural factors, or by 25 (OH)-vitamin D status: Study of 1326 cases from the UK Biobank. *Journal of Public Health*, *42*(3), 451–460.

Rao, D., Feinglass, J., & Corrigan, P. (2007). Racial and ethnic disparities in mental illness stigma. *The Journal of Nervous and Mental Disease*, *195*(12), 1020–1023.

Raphael, D. (2006). Social determinants of health: Present status, unanswered questions, and future directions. *International Journal of Health Services*, *36*(4), 651–677.

Rathod, S., & Kingdon, D. (2014). Case for cultural adaptation of psychological interventions for mental healthcare in low and middle income countries. *BMJ*, *349*.

Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behavioural and Cognitive Psychotherapy*, *38*(5), 511–533.

Rawlings, G. H., & Bains, M. (2020). Experiences of depression in older adults from non-white and ethnic minority groups: A thematic synthesis of qualitative studies. *Journal of Affective Disorders*, *266*, 341–348.

Raypole, C. (2018, September 13). *Rational Emotive Behaviour Therapy*. Healthline; Healthline Media. https://www.healthline.com/health/rational-emotive-behavior-therapy

Razali, S. M., Aminah, K., & Khan, U. A. (2002). Religious–Cultural Psychotherapy in the Management of Anxiety Patients. *Transcultural Psychiatry*, *39*(1), 130–136. https://doi.org/10.1177/136346150203900106

Rea, B. (2001). Finding our balance: The investigation and clinical application of intuition. *Psychotherapy: Theory, Research, Practice, Training*, *38*(1), 97.

Reed, M. (2000). The limits of discourse analysis in organizational analysis. *Organization*, *7*(3), 524–530.

Rees, R., Stokes, G., Stansfield, C., Oliver, E., Kneale, D., & Thomas, J. (2016). *Prevalence of mental health disorders in adult minority ethnic populations in England: A systematic review*. UCL/Institute of Education.

Rezvan, S., Baghban, I., Bahrami, F., & Abedi, M. (2008). A comparison of cognitive-behaviour therapy with interpersonal and cognitive behaviour therapy in the treatment of generalized anxiety disorder. *Counselling Psychology Quarterly*, *21*(4), 309–321. https://doi.org/10.1080/09515070802602096

Richards, D., & Whyte, M. (2009). *Reach Out: National programme student materials to support the delivery of training for Psychological Wellbeing Practitioners delivering low intensity interventions* (2nd ed.). Rethink.

Rich-Edwards, J. W., Kaiser, U. B., Chen, G. L., Manson, J. E., & Goldstein, J. M. (2018). Sex and Gender Differences Research Design for Basic, Clinical, and Population Studies: Essentials for Investigators. *Endocrine Reviews*, *39*(4), 424–439. https://doi.org/10.1210/er.2017-00246

Robb, C. E., Jager, C. A., Ahmadi-Abhari, S., Giannakopoulou, P., Udeh-Momoh, C., McKeand, J., & Middleton, L. (2020). *Associations of social isolation with anxiety and depression during the early COVID-19 pandemic: A survey of older adults in*.

Roberts, L., & Bucksey, S. J. (2007). Communicating with patients: What happens in practice? *Physical Therapy*, *87*(5), 586–594.

Robertson, R., Appleby, J., Evans, H., & Hemmings, N. (2019). *Public satisfaction with the NHS and social care in 2018: Results from the British Social Attitudes survey*. King's Fund.

Rogers, C. R. (1986). Carl Rogers on the development of the person-centred approach. *Person-Centred Review*, *1*(3), 257–259.

Rojas-Garcia, A., Ruiz-Perez, I., Rodriguez-Barranco, M., Bradley, D. C. G., Pastor-Moreno, G., & Ricci-Cabello, I. (2015). Healthcare interventions for depression in low socioeconomic status populations: A systematic review and meta-analysis. *Clinical Psychology Review*, *38*, 65–78.

Romaioli, D., & Contarello, A. (2019). Redefining agency in late life: The concept of 'dispensability'. *Ageing & Society*, *39*(1), 194–216.

Rooney, L. K., Bhopal, R., Halani, L., Levy, M. L., Partridge, M. R., Netuveli, G., & Sheikh, A. (2011). Promoting recruitment of minority ethnic groups into research: Qualitative study exploring the views of South Asian people with asthma. *Journal of Public Health*, *33*(4), 604–615.

Rose, D., Willis, R., Brohan, E., Sartorius, N., Villares, C., Wahlbeck, K., & Thornicroft, G. I. N. D. I. G. O. (2011). Reported stigma and discrimination by people with a diagnosis of schizophrenia. *Epidemiology and Psychiatric Sciences*, *20*(2), 193–204.

Rose, G. A., Khaw, K. T., & Marmot, M. (2008). *Rose's strategy of preventive medicine: The complete original text*. Oxford University Press.

Rose, L. (2020). Retirement and health: Evidence from England. *Journal of Health Economics*, *73*, 102352.

Rose, T., Joe, S., & Lindsey, M. (2011). Perceived stigma and depression among black adolescents in outpatient treatment. *Children and Youth Services Review*, *33*(1), 161–166.

Rowland, H. (2024). Unravelling the Dominance: An Exploration of the Relationship Between the Medicalisation of Ordinary Mental Distress, the Primacy of Cognitive Behavioural Therapy, and the Influence of Neoliberal Ideology in the UK Mental Health Economy. *Medical Research Archives*, *12*(5).

Ruhé, H. G., Dekker, J. J., Peen, J., Holman, R., & Jonghe, F. d. (2005). Clinical use of the hamilton depression rating scale: Is increased efficiency possible? A post hoc comparison of hamilton depression rating scale, maier and bech subscales, clinical global impression, and symptom checklist-90 scores. *Comprehensive Psychiatry*, *46*(6), 417–427. https://doi.org/10.1016/j.comppsych.2005.03.001

Rutter, M. (1993). Resilience: Some conceptual considerations. *Journal of Adolescent Health*, *2*(Suppl.), 10–20.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*(1), 68.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, *57*(6), 1069.

Salamanca-Sanabria, A., Richards, D., Timulak, L., Connell, S., Mojica Perilla, M., Parra-Villa, Y., & Castro-Camacho, L. (2020). A Culturally Adapted Cognitive Behavioural Internet-Delivered Intervention for Depressive Symptoms: Randomized Controlled Trial. *JMIR Mental Health*, *7*(1), 13392. https://doi.org/10.2196/13392

Sale, J. E. M., Lohfeld, L. H., & K, B. (2002). *Revisiting the quantitative-qualitative debate: Implications for mixed-methods research* (pp. 43–53).

Salloum, R. G., Wagner, T. H., Midboe, A. M., Daniels, S. I., Quanbeck, A., & Chambers, D. A. (2022). The economics of adaptations to evidence-based practices. *Implementation Science Communications*, *3*(1), 1–13.

Sanetti, L. M. H., Cook, B. G., & Cook, L. (2021). Treatment Fidelity: What It Is and Why It Matters. *Learning Disabilities Research & Practice*, *36*(1), 5–11. https://doi.org/10.1111/ldrp.12238

Santana, M. J., Manalili, K., Zelinsky, S., Brien, S., Gibbons, E., King, J., & Sawatzky, R.

(2020). Improving the quality of person-centred healthcare from the patient perspective: Development of person-centred quality indicators. *BMJ Open, 10*(10), 037323.

Santomauro, D. F., Herrera, A. M. M., Shadid, J., Zheng, P., Ashbaugh, C., Pigott, D. M., & Ferrari, A. J. (2021). Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. *The Lancet, 398*(10312), 1700–1712.

Saunders, M., Lewis, P., & Thornhill, A. (2009). *Research methods for business students*. Pearson education.

Savin-Baden, M., & Major, C. (2023). *Qualitative research: The essential guide to theory and practice*. Routledge.

Schaik, D. J., Klijn, A. F., Hout, H. P., Marwijk, H. W., Beekman, A. T., Haan, M., & Dyck, R. (2004). Patients' preferences in the treatment of depressive disorder in primary care. *General Hospital Psychiatry, 26*(3), 184–189.

Schmidt, C. E. (2018). Values and democracy in East Asia and Europe: A comparison. *Asian Journal of German and European Studies*, *3*(1). https://doi.org/10.1186/s40856-018-0034-9

Schnyder, N., Panczak, R., Groth, N., & Schultze-Lutter, F. (2017). Association between mental health-related stigma and active help-seeking: Systematic review and meta-analysis. *The British Journal of Psychiatry*, *210*(4), 261–268.

Scott, T. N., Gil-Rivas, V., & Cachelin, F. M. (2019). The need for cultural adaptations to health interventions for African American women: A qualitative analysis. *Cultural Diversity and Ethnic Minority Psychology*, *25*(3), 331.

Sculpher, M. (2000). Evaluating the cost-effectiveness of interventions designed to increase the utilization of evidence-based guidelines. *Family Practice, 17*(suppl_1), 26–31.

Seifert, R., & Wang, W. (2018). Race discrimination at work: The moderating role of trade unionism in English local government. *Industrial Relations Journal*, *49*(3), 259–277.

Service, N. H. (2018). *Anxiety*. https://www.nhs.uk/conditions/generalised-anxiety-disorder/

Service N. H. (2019). *NHS long term plan*. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Service, N. H. (2020a). *Advancing mental health equalities strategy*. https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/

Service, N. H. (2020b). *Definitions of health inequalities*. https://www.england.nhs.uk/ltphimenu/definitions-for-health-inequalities/#health-inequalities

Service, N. H. (2022a). *Psychological therapies, annual report on the use of IAPT services, 2021-2022*. https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2021-22

Service, N. H. (2022b). *Types of talking therapy*. https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/types-of-talking-therapies/

Shahsavari, H., Matourypour, P., Ghiyasvandian, S., & Nejad, M. R. G. (2020). Medical Research Council framework for development and evaluation of complex interventions: A comprehensive guidance. *Journal of Education and Health Promotion*, *9*.

Shankar, J., Ip, E., Khalema, E., Couture, J., Tan, S., Zulla, R. T., & Lam, G. (2013). Education as a social determinant of health: Issues facing indigenous and visible minority students in postsecondary education in Western Canada. *International Journal of Environmental Research and Public Health*, *10*(9), 3908–3929.

Shaw, S. A., Ward, K. P., Pillai, V., & Hinton, D. E. (2019). A group mental health randomized controlled trial for female refugees in Malaysia. *American Journal of Orthopsychiatry*, *89*(6), 665–674. https://doi.org/10.1037/ort0000346

Sheikh, A., Halani, L., Bhopal, R., Netuveli, G., Partridge, M. R., Car, J., & Levy, M. (2009). Facilitating the recruitment of minority ethnic people into research: Qualitative case study of South Asians and asthma. *PLoS Medicine*, *6*(10), 1000148.

Shundi, L. (2021). Minority women’s mental health: Black, Asian, and Minority Ethnic (BAME) engagement with mental health services in the UK. In *Mental health, mental illness and migration* (pp. 523–540). Springer Singapore.

Smith, K., Bhui, K., & Cipriani, A. (2020). COVID-19, mental health and ethnic minorities. *British Medical Journal*, *3*(3), 1–2.

Smith, T. B., & Cabral, R. R. (2011). Racial/Ethnic Matching of Clients and Therapists in Mental Health Services: A Meta-Analytic Review of Preferences, Perceptions, and Outcomes. *Journal of Counselling Psychology*, *58*(4), 537–554.

Social inequality in England and Scotland. (2019). https://www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-37/social-inequality-in-england-and-scotland.aspx

Soleimani, M., Mohammadkhani, P., Dolatshahi, B., Alizadeh, H., Overmann, K. A., & Coolidge, F. L. (2015). A Comparative Study of Group Behavioural Activation and Cognitive Therapy in Reducing Subsyndromal Anxiety and Depressive Symptoms. *Iranian Journal of Psychiatry*, *10*(2), 71–78.

Song, N., Hugh-Jones, S., West, R. M., Pickavance, J., & Mir, G. (2023). The effectiveness of anti-stigma interventions for reducing mental health stigma in young people: A systematic review and meta-analysis. *Cambridge Prisms: Global Mental Health, 10,* 39.

Southby, K., Keating, F., & Joseph, S. (2021). The Meanings of Mental Health Recovery for African and Caribbean Men in the UK: An Intersectionality's Approach. *International Journal of Men's Social and Community Health*, *4*(1), 83–95.

Stirman, S. W., Baumann, A. A., & Miller, C. J. (2019). The FRAME: an expanded framework for reporting adaptations and modifications to evidence-based interventions. *Implementation Science*, *14,* 1–10.

Stirman, S. W., Miller, C. J., Toder, K., & Calloway, A. (2013). Development of a framework and coding system for modifications and adaptations of evidence-based interventions. *Implementation Science*, *8*(1), 1–12.

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counselling Psychologist*, *29*(6), 790–821.

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual2 Review of Psychology*, *60,* 525–548.

Sullivan, G. M. (2011). A Primer on the Validity of Assessment Instruments. *Journal of Graduate Medical Education*, *3*(2), 119–120. https://doi.org/10.4300/JGME-D-11-00075.1

Survey, E. H. (2019). *Overcrowded households*. https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/overcrowded-households/latest#download-the-data

Sussman, L. K., Robins, L. N., & Earls, F. (1987). Treatment-seeking for depression by black and white Americans. *Social Science & Medicine*, *24*(3), 187–196.

S.V.R.I. (2021). *Hospital Anxiety and Depression Scale (HADS*. https://www.svri.org/sites/default/files/attachments/2016-01-13/HADS.pdf

Tabassum, U. (2022). *Time to belong: Exploring factors affecting BAME young people's sense of belonging in relation to their school experiences* [(Doctoral dissertation,]. University of Sheffield.

Tang, J. Y., Li, C., Rodgers, R. F., & Ballou, M. (2015). Ethnic differences in the effectiveness of cognitive behavioural therapy combined with medication: Comparing Asian American and white psychiatric patients. *North American Journal of Medicine and Science*, *8*(4), 154–159. https://doi.org/10.7156/najms.2015.0804154

Tang, J. Y.-P. (2013). *Examining cognitive behavioural therapy with Asian American patients in* *acute psychiatric partial hospital setting*. Northeastern University. https://repository.library.northeastern.edu/files/neu:983/fulltext.pdf

Tannenbaum, C., Greaves, L., & Graham, I. D. (2016). Why sex and gender matter in implementation research. *BMC Medical Research Methodology*, *16*(1). https://doi.org/10.1186/s12874-016-0247-7

Taras, V., Rowney, J., & Steel, P. (2009). Half a century of measuring culture: Review of approaches, challenges, and limitations based on the analysis of 121 instruments for quantifying culture. *Journal of International Management*, *15*(4), 357–373.

Taylor, J., Stubbs, B., Hewitt, C., Ajjan, R. A., Alderson, S. L., Gilbody, S., & Siddiqi, N. (2017). The effectiveness of pharmacological and non-pharmacological interventions for improving glycaemic control in adults with severe mental illness: A systematic review and meta-analysis. *PloS One, 12*(1), 0168549.

Temple, J. B., Brijnath, B., Enticott, J., Utomo, A., Williams, R., & Kelaher, M. (2021). Discrimination reported by older adults living with mental health conditions: Types, contexts and association with healthcare barriers. *Social Psychiatry and Psychiatric Epidemiology, 56*, 1003–1014.

Thomas, J., Thirlaway, K., Bowes, N., & Meyers, R. (2020). Effects of combining physical activity with psychotherapy on mental health and well-being: A systematic review. *Journal of Affective Disorders*, *265*, 475–485.

Thomson, P., & Gunter, H. (2011). Inside, outside, upside down: The fluidity of academic researcher ‘identity’ in working with/in school. *International Journal of Research & Method in Education*, *34*(1), 17–30.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., & Leese, M. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey. *The Lancet, 373*(9661), 408–415.

Tiemens, B., Kloos, M., Spijker, J., Ingenhoven, T., Kampman, M., & Hendriks, G. J. (2019). Lower versus higher frequency of sessions in starting outpatient mental health care and the risk of a chronic course; a naturalistic cohort study. *BMC Psychiatry*, *19*(1), 1–12.

Tol, W. A., Leku, M. R., Lakin, D. P., Carswell, K., Augustinavicius, J., Adaku, A., Au, T. M., Brown, F. L., Bryant, R. A., Garcia-Moreno, C., Musci, R. J., Ventevogel, P., White, R. G., & Ommeren, M. (2020). Guided self-help to reduce psychological distress in South Sudanese female refugees in Uganda: A cluster randomised trial. *The Lancet Global Health*, *8*(2), 254–263. https://doi.org/10.1016/S2214-109X(19)30504-2

Toledano-Toledano, & × J. A. C.-Valdez., F. (2018). Validity and reliability of the beck depression inventory II (BDI-II) in family caregivers of children with chronic diseases. *PLoS One*, *13*(11). https://doi.org/10.1371/journal.pone.0206917

Tóth, M. D., Ihionvien, S., Leduc, C., Aust, B., Amann, B. L., Cresswell-Smith, J., & Purebl, G. (2023). Evidence for the effectiveness of interventions to reduce mental health related stigma in the workplace: A systematic review. *BMJ Open*, *13*(2), 067126.

Townsend, M., Kladder, V., Ayele, H., & Mulligan, T. (2002). Systematic review of clinical trials examining the effects of religion on health. *Southern Medical Journal*, *95*(12), 1429–1435.

Tracy, S. J. (2013). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. Wiley-Blackwell.

Triana, M. D. C., Jayasinghe, M., Pieper, J. R., Delgado, D. M., & Li, M. (2019). Perceived workplace gender discrimination and employee consequences: A meta-analysis and complementary studies considering country context. *Journal of Management*, *45*(6), 2419–2447.

Tselebis, A., Pachi, A., Ilias, I., Kosmas, E., Bratis, D., Moussas, G., & Tzanakis, N. (2016). Strategies to improve anxiety and depression in patients with COPD: a mental health perspective. *Neuropsychiatric Disease and Treatment*.

Tummala-Narra, P., Alegria, M., & Chen, C. N. (2012). Perceived discrimination, acculturative stress, and depression among South Asians: Mixed findings. *Asian American Journal of Psychology*, *3*(1), 3.

Turnbull, S., Cabral, C., Hay, A., & Lucas, P. J. (2020). Health equity in the effectiveness of web-based health interventions for the self-care of people with chronic health conditions: Systematic review. *Journal of Medical Internet Research*, *22*(6), 17849.

Turner, J., Hayward, R., Angel, K., Fulford, B., Hall, J., Millard, C., & Thomson, M. (2015). The history of mental health services in modern England: Practitioner memories and the direction of future research. *Medical History*, *59*(4), 599–624.

Twohig, M. P., & Levin, M. E. (2017). Acceptance and commitment therapy as a treatment for anxiety and depression: A review. *Psychiatric Clinics*, *40*(4), 751–770.

Üçok, A., Brohan, E., Rose, D., Sartorius, N., Leese, M., Yoon, C. K., & Group, I. N. D. I. G. O. S. (2012). Anticipated discrimination among people with schizophrenia. *Acta Psychiatrica Scandinavica*, *125*(1), 77–83.

Universities, U. K. (2020). *Achieving stability in the higher education sector following covid-19*. https://universitiesuk.ac.uk/news/Documents/uuk_achieving-stability-higher-education-april-2020.pdf

Vahdaninia, M., Simkhada, B., Teijlingen, E., Blunt, H., & Mercel-Sanca, A. (2020). Mental health services designed for Black, Asian and Minority Ethnics (BAME) in the UK: a scoping review of case studies. *Mental Health and Social Inclusion*, *24*(2), 81–95.

Vance, T. A. (2019, February 8). *Addressing Mental Health in the Black Community*. Columbia University Department of Psychiatry. https://www.columbiapsychiatry.org/news/addressing-mental-health-black-community

Vickers, T., Craig, G., & Atkin, K. (2012). *Research with black and minority ethnic people using social care services (SSCR methods review, 11*. NIHR School for Social Care Research.

Victor, C. R., Burholt, V., & Martin, W. (2012). Loneliness and ethnic minority elders in Great Britain: An exploratory study. *Journal of Cross-Cultural Gerontology*, *27*(1), 65–78.

Vos, T., Lim, S. S., Abbafati, C., Abbas, K. M., Abbasi, M., Abbasifard, M., & Bhutta, Z. A. (2020). Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: A systematic analysis for the Global Burden of Disease Study 2019. *The Lancet*, *396*(10258), 1204–1222.

Waheed, W., Hughes-Morley, A., Woodham, A., Allen, G., & Bower, P. (2015). Overcoming barriers to recruiting ethnic minorities to mental health research: A typology of recruitment strategies. *BMC Psychiatry*, *15*(1), 1–11.

Wahl, O. F. (1999). Mental health consumers’ experience of stigma. *Schizophrenia Bulletin*, *25*(3), 467–478.

Wainwright, J., McKeown, M., & Kinney, M. (2019). In these streets”: The saliency of place in an alternative black mental health resource centre. *International Journal of Human Rights in Healthcare*, *13*, 1–9.

Wallace, D. D., Carlson, R. G., & Ohrt, J. H. (2021). Culturally adapted cognitive-behavioural therapy in the treatment of panic episodes and depression in an african american woman: A clinical case illustration. *Journal of Mental Health Counseling*, *43*(1), 40–58.

Wallace, S., Nazroo, J., & Bécares, L. (2016). Cumulative effect of racial discrimination on the mental health of ethnic minorities in the United Kingdom. *American Journal of Public Health*, *106*(7), 1294–1300.

Walpole, S. C., McMillan, D., House, A., Cottrell, D., & Mir, G. (2013). Interventions for treating depression in Muslim patients: A systematic review. *Journal of Affective Disorders*, *145*(1), 11–20.

Wampold, B. E., & Brown, G. S. J. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and*

Clinical Psychology, *73*(5), 914.

Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., & Wells, J. E. (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *The Lancet, 370*(9590), 841–850.

Ward, E. C., & Brown, R. L. (2015). A culturally adapted depression intervention for African American adults experiencing depression: Oh Happy Day. *American Journal of Orthopsychiatry*, *85*(1), 11–22. https://doi.org/10.1037/ort0000027

Weber, R. (2004). Editor's comments: The rhetoric of positivism versus interpretivism: A personal view. *MIS Quarterly*.

Weich, S., Nazroo, J., Sproston, K., McManus, S., Blanchard, M., Erens, B., & Tyrer, P. (2004). Common mental disorders and ethnicity in England: The EMPIRIC study. *Psychological Medicine*, *34*(8), 1543–1551.

Weinberger, J. (1993). Common factors in psychotherapy. In G. Stricker & J. R. Gold (Eds.), *Comprehensive handbook of psychotherapy integration*. Plenum Press.

Weisberg, Y. J., DeYoung, C. G., & Hirsh, J. B. (2011). Gender differences in personality across the ten aspects of the Big Five. *Frontiers in Psychology*, *2*, 178.

Welling, H. (2005). The intuitive process: The case of psychotherapy. *Journal of Psychotherapy Integration*, *15*(1), 19.

Wenhua, S., Diran, Z., Guoqing, T., Xuezhu, Y. U., Jiancong, L. I. U., Liaohu, Y., & Yanheng, Z. (2016). A Comparative Study of Cognitive-Behavior Therapy and Paroxetine for Minor Depression. *Chinese Journal of Evidence-Based Medicine*, *7*, 711–714.

Whaley, D. E., & Krane, V. (2011). Now that we all agree, let's talk epistemology: A commentary on the invited articles. *Qualitative Research in Sport, Exercise and Health*, *3*(3), 394–403.

Whyte, S., Dixon, S., Faria, R., Walker, S., Palmer, S., Sculpher, M., & Radford, S. (2016). Estimating the cost-effectiveness of implementation: Is sufficient evidence available? *Value in Health*, *19*(2), 138–144.

Wilkinson, R. G., & Marmot, M. (Eds.). (2003). Social determinants of health: The solid facts. *World Health Organization*.

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health*, *93*(2), 200–208.

Wilson, A. C., Mackintosh, K., Power, K., & Chan, S. W. (2019). Effectiveness of self-compassion related therapies: A systematic review and meta-analysis. *Mindfulness*, *10*(6), 979–995.

Wilson, C. J., & Cottone, R. R. (2013). Using cognitive behaviour therapy in clinical work with african american children and adolescents: A review of the literature. *Journal of Multicultural Counselling and Development*, *41*(3), 130–143.

Wilson, W., & Barton, C. (2020). *Overcrowded housing (england*.

Wisdom, D., & Bowie, J. A. (2023). Stigma and Help-Seeking Attitudes: The Moderating Role of Religiousness/Spirituality. *Caribbean Journal of Psychology*, *15*(1).

Wittenberg, E., & Wedegaertner, F. (2021). A return-to-work intervention for prematurely retired depression or anxiety disorder patients. *Frontiers in Psychiatry*, *12*, 662158.

Wohlwill, J. F. (1970). The age variable in psychological research. *Psychological Review*, *77*(1), 49–64. https://doi.org/10.1037/h0028600

Wolf, A., Moore, L., Lydahl, D., Naldemirci, Ö., Elam, M., & Britten, N. (2017). The realities of partnership in person-centred care: A qualitative interview study with patients and professionals. *BMJ Open*, *7*(7), 016491.

Wong, D. F. K. (2008a). Cognitive and Health-Related Outcomes of Group Cognitive Behavioural Treatment for People With Depressive Symptoms in Hong Kong: Randomized Wait-List Control Study. *Australian & New Zealand Journal of Psychiatry*, *42*(8), 702–711. https://doi.org/10.1080/00048670802203418

Wong, D. F. K. (2008b). Cognitive behavioural treatment groups for people with chronic depression in Hong Kong: A randomized wait-list control design. *Depression and Anxiety*, *25*(2), 142–148. https://doi.org/10.1002/da.20286

Woodward, A., & Kawachi, I. (2000). Why reduce health inequalities? *Journal of Epidemiology & Community Health*, *54*(12), 923–929.

Work, D. & Pensions. (2019a). *Households below average income: 1994/95 to 2018/19*. https://www.gov.uk/government/statistics/households-below-average-income-199495-to-201819

Work, D. & Pensions. (2019b). *Households below average income: 1994/95 to 2018/19*. https://www.gov.uk/government/statistics/households-below-average-income-199495-to-2018192

Wright, K. B. (2005). Researching Internet-based populations: Advantages and disadvantages of online survey research, online questionnaire authoring software packages, and web survey services. *Journal of Computer-Mediated Communication*, *10*(3), 1034.

Wu, Y., Levis, B., Sun, Y., He, C., Krishnan, A., Neupane, D., & Thombs, B. D. (2021).

Accuracy of the Hospital Anxiety and Depression Scale Depression subscale (HADS-D) to screen for major depression: Systematic review and individual participant data meta-analysis. *BMJ*, *373*(1), 1–12.

Yardley, L. (2017). Demonstrating the validity of qualitative research. *The Journal of Positive Psychology*, *12*(3), 295–296.

Yeung, A. S., Feng, R., Kim, D. J. H., Wayne, P. M., Yeh, G. Y., Baer, L., Lee, O. E., Denninger, J. W., Benson, H., Fricchione, G. L., Alpert, J., & Fava, M. (2017). A Pilot, Randomized Controlled Study of Tai Chi With Passive and Active Controls in the Treatment of Depressed Chinese Americans. *The Journal of Clinical Psychiatry*, *78*(5), 522–528. https://doi.org/10.4088/JCP.16m10772

Yip, S. Y. (2024). Positionality and reflexivity: Negotiating insider-outsider positions within and across cultures. *International Journal of Research & Method in Education*, *47*(3), 222–232.

Zhang, Z., Sun, K., Jatchavala, C., Koh, J., Chia, Y., Bose, J., & Ho, R. (2020). Overview of stigma against psychiatric illnesses and advancements of anti-stigma activities in six Asian societies. *International Journal of Environmental Research and Public Health*, *17*(1), 280.

Zhao, Y., Munro-Kramer, M. L., Shi, S., Wang, J., & Luo, J. (2017). A randomized controlled trial: Effects of a prenatal depression intervention on perinatal outcomes among Chinese high-risk pregnant women with medically defined complications. *Archives of Women's Mental Health*, *20*(2), 333–344. https://doi.org/10.1007/s00737-016-0712-7

Zu, S., Xiang, Y.-T., Liu, J., Zhang, L., Wang, G., Ma, X., Kilbourne, A. M., Ungvari, G. S., Chiu, H. F. K., Lai, K. Y. C., Wong, S. Y. S., Yu, D. S. F., & Li, Z.-J. (2014). A comparison of cognitive-behavioural therapy, antidepressants, their combination and standard treatment for Chinese patients with moderate–severe major depressive disorders. *Journal of Affective Disorders*, *152–154*, 262–267. https://doi.org/10.1016/j.jad.2013.09.022

Zucker, B. G., Craske, M. G., Blackmore, M. A., & Nitz, A. (2006). A cognitive behavioural workshop for subclinical obsessions and compulsions. *Behaviour Research and Therapy*, *44*(2), 289–304. https://doi.org/10.1016/j.brat.2005.03.015

APPENDICES

APPENDIX 1.1) DECLARATION OF ORIGINALITY

Students are reminded that the work that they submit for assessment must be their own. Please read the following statements and sign and date at the bottom of this form to show that you have complied:

1. This thesis and the work to which it refers are the results of your own efforts. Any ideas, data or text resulting from the work of others (whether published or unpublished) are fully identified as such within the work and attributed to the originator in the text, bibliography or footnotes.

2. This thesis has not been submitted in whole or in part for any other academic degree or professional qualification at this or any other institution.

3. Any chapters that describe the outcomes of joint research should be clearly identified as such with a statement inserted as a footnote on the first page and contributors named. Significant data, images or text resulting from the input of other researchers should be identified as such and attributed to the persons concerned by means of a footnote within the chapter.

4. It is usual to acknowledge the help and guidance of others who have assisted you during your research and preparation of your thesis. Such acknowledgements do not replace or obviate the need for individual attribution as discussed in points 1 and 3.

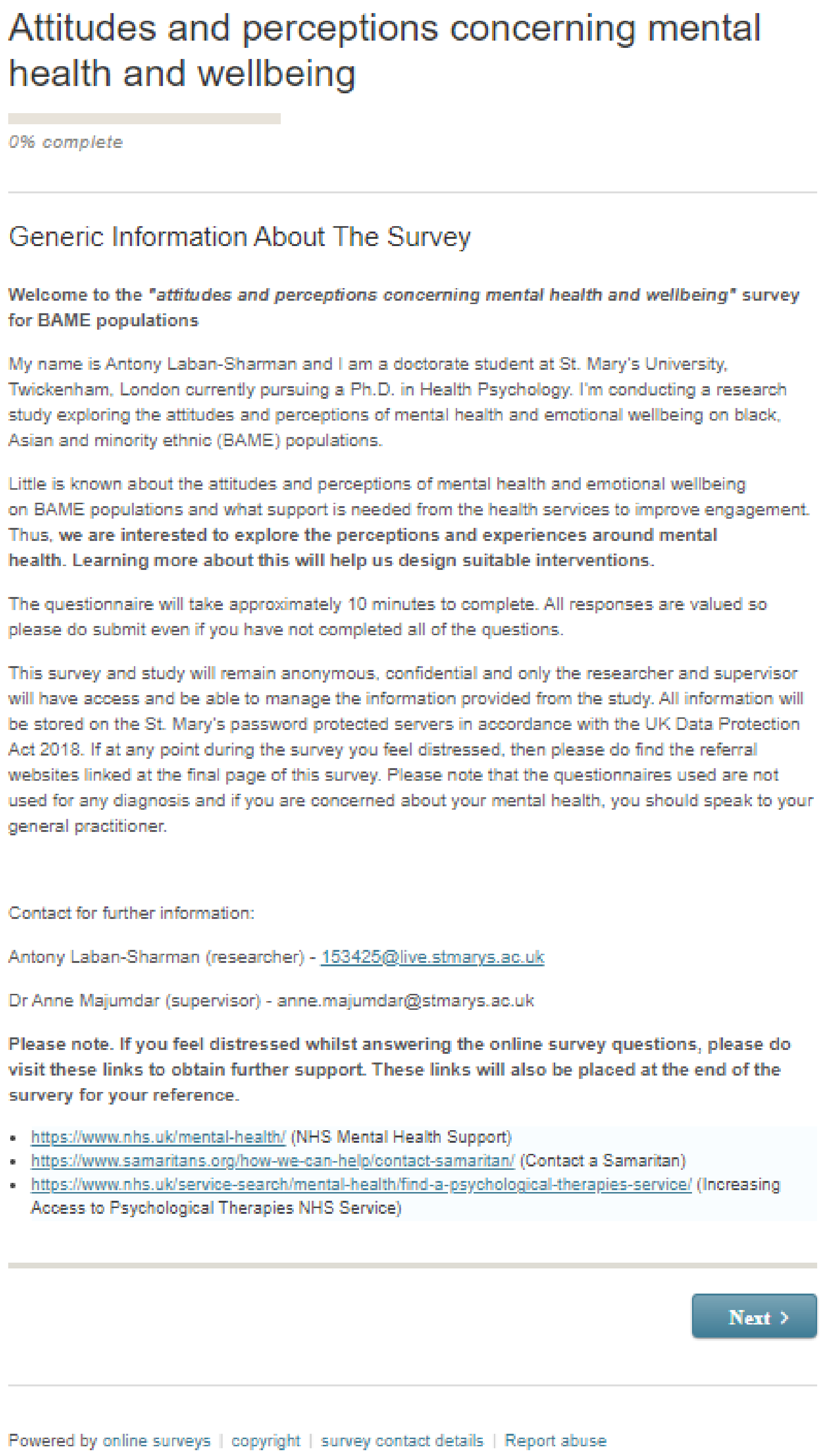
5. The University reserves the right to submit electronic versions of your draft documents for assessment of plagiarism using electronic detection software such as 'Turnitin.' In addition, whether or not drafts have been so assessed, the University reserves the right to require an electronic version of the final document (as submitted) for assessment.

SIGNED: A. Laban-Sharman

PRINT NAME: Antony Laban-Sharman

DATE: 30/09/2024

APPENDIX 3.1) ONLINE SURVEY INCLUDING PARTICIPANT INFORMATION & CONSENT



Attitudes and perceptions concerning mental health and wellbeing

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Generic Information About The Survey

Welcome to the "*attitudes and perceptions concerning mental health and wellbeing*" survey for BAME populations

My name is Antony Laban-Sharman and I am a doctorate student at St. Mary's University, Twickenham, London currently pursuing a Ph.D. in Health Psychology. I'm conducting a research study exploring the attitudes and perceptions of mental health and emotional wellbeing on black, Asian and minority ethnic (BAME) populations.

Little is known about the attitudes and perceptions of mental health and emotional wellbeing on BAME populations and what support is needed from the health services to improve engagement. Thus, **we are interested to explore the perceptions and experiences around mental health. Learning more about this will help us design suitable interventions.**

The questionnaire will take approximately 10 minutes to complete. All responses are valued so please do submit even if you have not completed all of the questions.

This survey and study will remain anonymous, confidential and only the researcher and supervisor will have access and be able to manage the information provided from the study. All information will be stored on the St. Mary's password protected servers in accordance with the UK Data Protection Act 2018. If at any point during the survey you feel distressed, then please do find the referral websites linked at the final page of this survey. Please note that the questionnaires used are not used for any diagnosis and if you are concerned about your mental health, you should speak to your general practitioner.

Contact for further information:

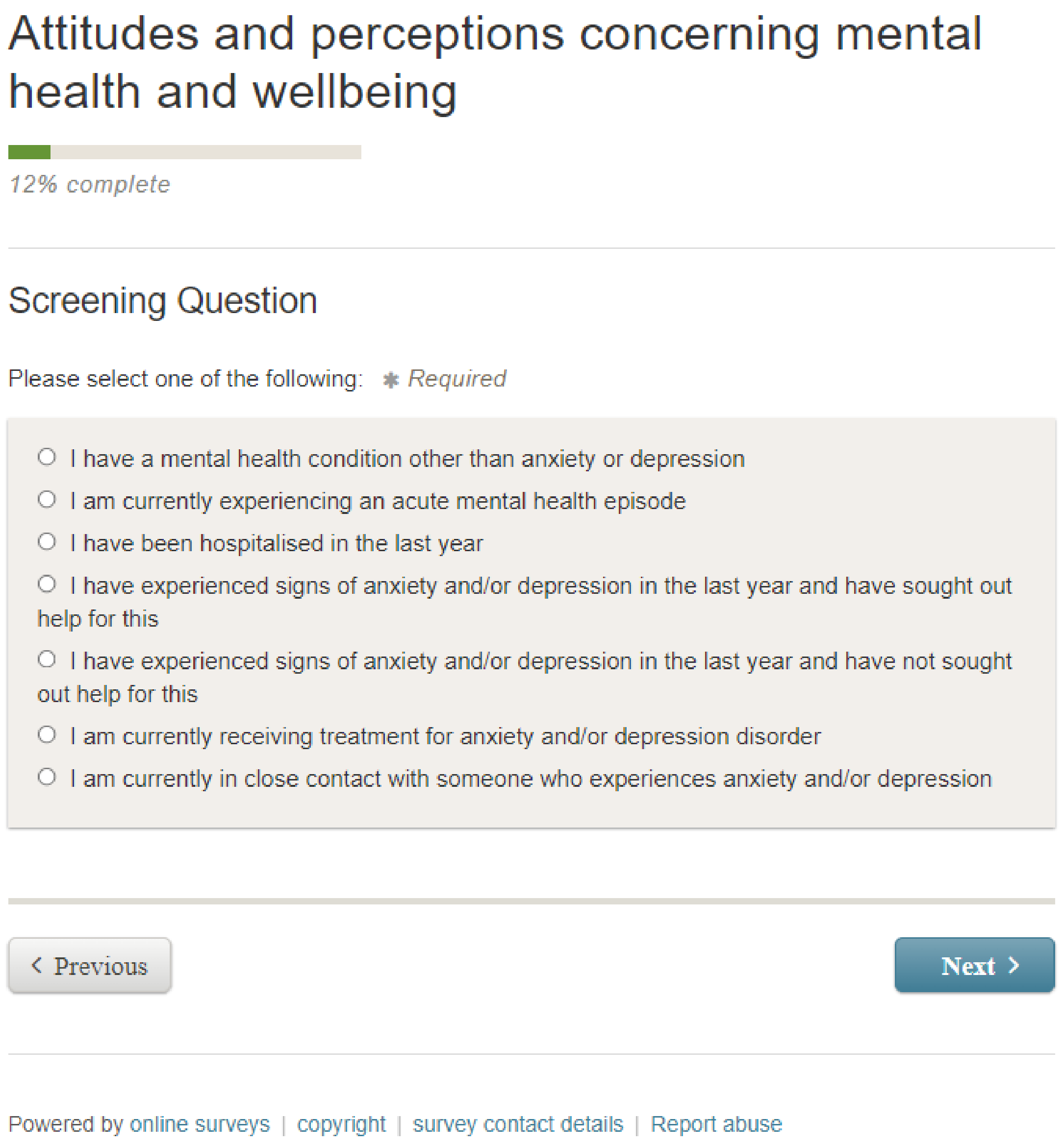
Antony Laban-Sharman (researcher) - 153425@live.stmarys.ac.uk

Dr Anne Majumdar (supervisor) - anne.majumdar@stmarys.ac.uk

Please note. If you feel distressed whilst answering the online survey questions, please do visit these links to obtain further support. These links will also be placed at the end of the survery for your reference.

- https://www.nhs.uk/mental-health/ (NHS Mental Health Support)
- https://www.samaritans.org/how-we-can-help/contact-samaritan/ (Contact a Samaritan)
- https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service/ (Increasing Access to Psychological Therapies NHS Service)

Powered by online surveys | copyright | survey contact details | Report abuse



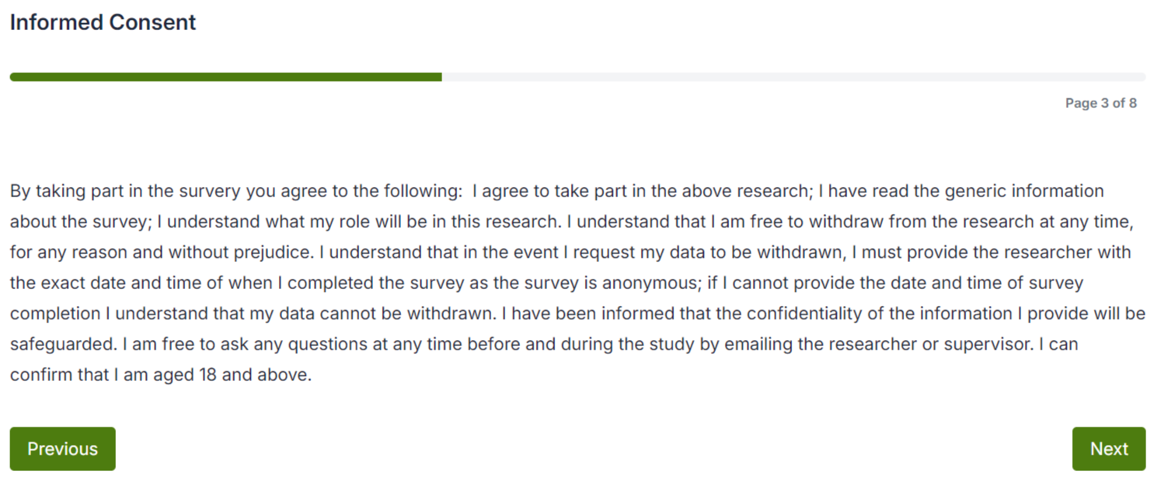
Attitudes and perceptions concerning mental health and wellbeing

Screening Question

Please select one of the following: ✱ *Required*

- ○ I have a mental health condition other than anxiety or depression
- ○ I am currently experiencing an acute mental health episode
- ○ I have been hospitalised in the last year
- ○ I have experienced signs of anxiety and/or depression in the last year and have sought out help for this
- ○ I have experienced signs of anxiety and/or depression in the last year and have not sought out help for this
- ○ I am currently receiving treatment for anxiety and/or depression disorder
- ○ I am currently in close contact with someone who experiences anxiety and/or depression

(Screened message will come up If selected any but “I have experienced anxiety and/or depression in the last year and have sought out help for this”)



Informed Consent

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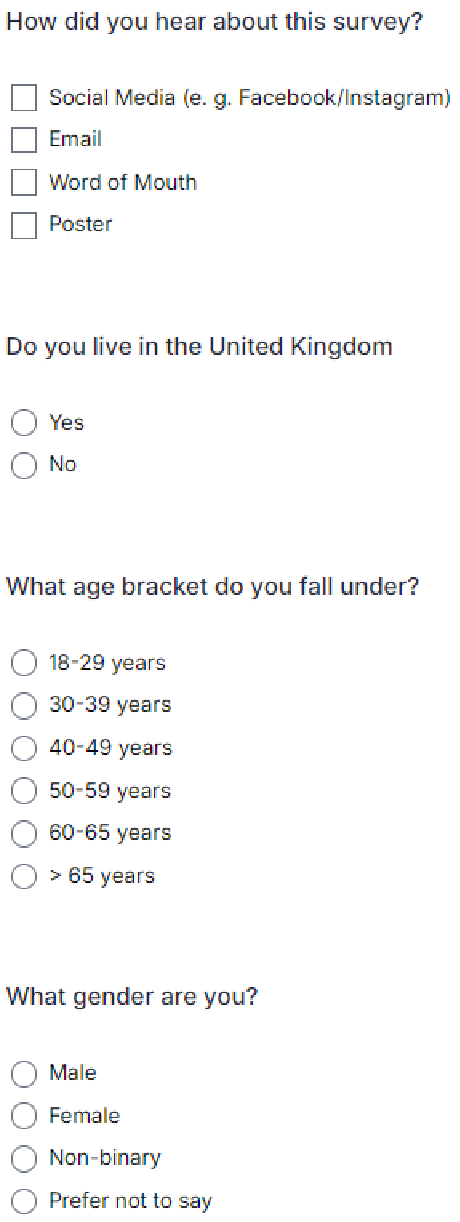
By taking part in the survery you agree to the following: I agree to take part in the above research; I have read the generic information about the survey; I understand what my role will be in this research. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice. I understand that in the event I request my data to be withdrawn, I must provide the researcher with the exact date and time of when I completed the survey as the survey is anonymous; if I cannot provide the date and time of survey completion I understand that my data cannot be withdrawn. I have been informed that the confidentiality of the information I provide will be safeguarded. I am free to ask any questions at any time before and during the study by emailing the researcher or supervisor. I can confirm that I am aged 18 and above.



How did you hear about this survey?

- ☐ Social Media (e. g. Facebook/Instagram)
- ☐ Email
- ☐ Word of Mouth
- ☐ Poster

Do you live in the United Kingdom

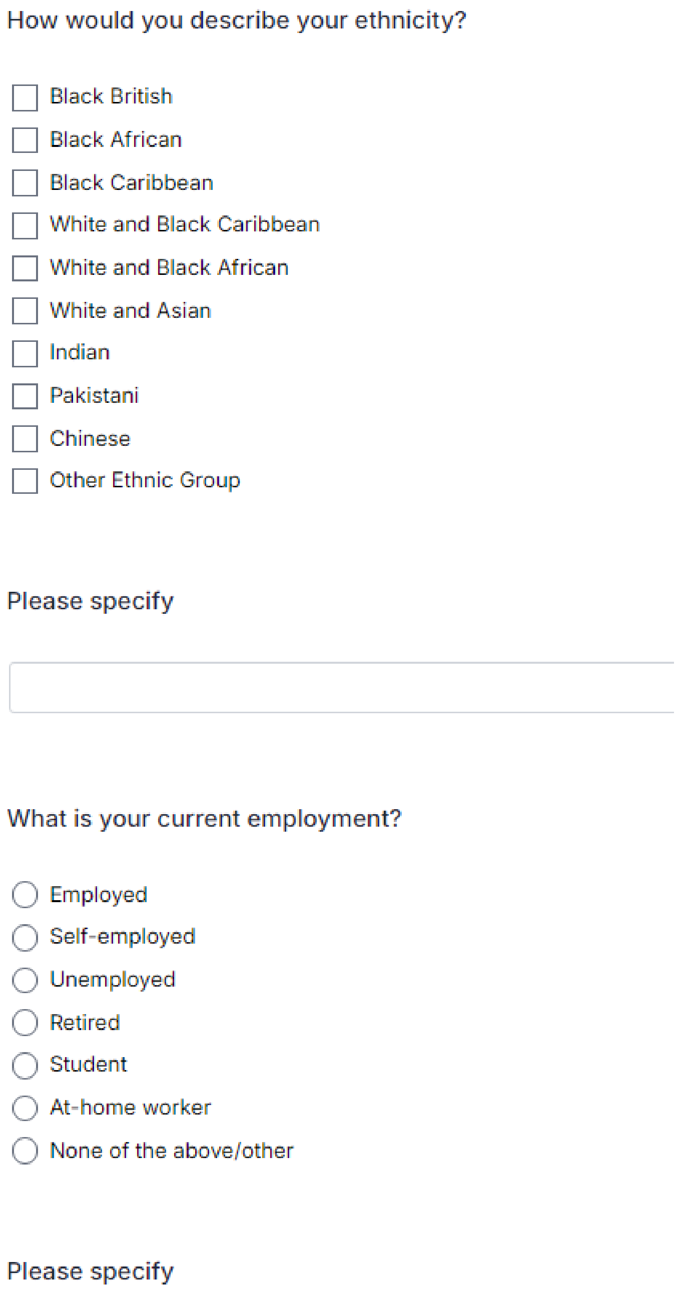
- ○ Yes
- ○ No

What age bracket do you fall under?

- ○ 18-29 years
- ○ 30-39 years
- ○ 40-49 years
- ○ 50-59 years
- ○ 60-65 years
- ○ > 65 years

What gender are you?

- ○ Male
- ○ Female
- ○ Non-binary
- ○ Prefer not to say



How would you describe your ethnicity?

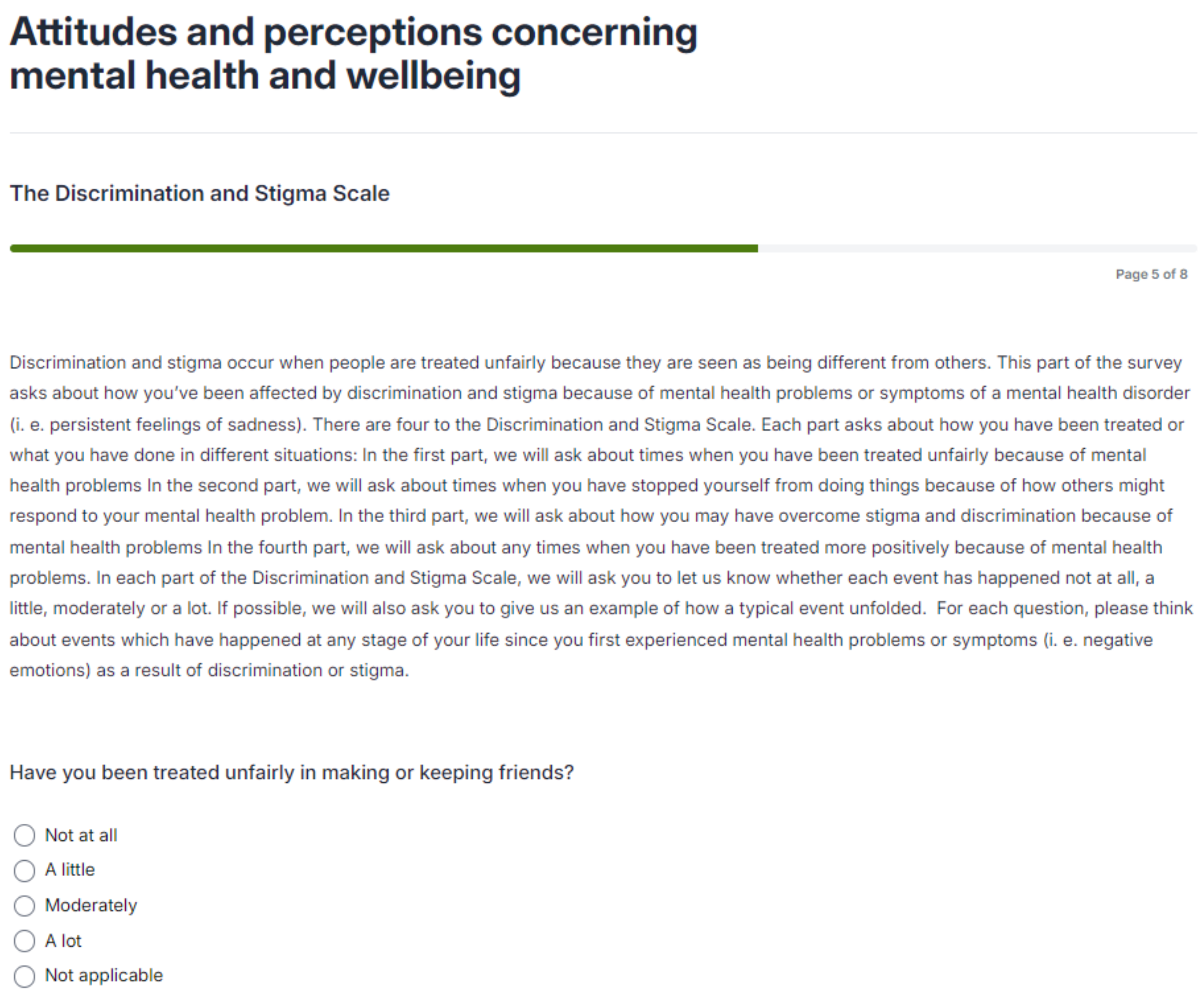
☐ Black British
☐ Black African
☐ Black Caribbean
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Indian
☐ Pakistani
☐ Chinese
☐ Other Ethnic Group

Please specify

What is your current employment?

○ Employed
○ Self-employed
○ Unemployed
○ Retired
○ Student
○ At-home worker
○ None of the above/other

Please specify



Attitudes and perceptions concerning mental health and wellbeing

The Discrimination and Stigma Scale

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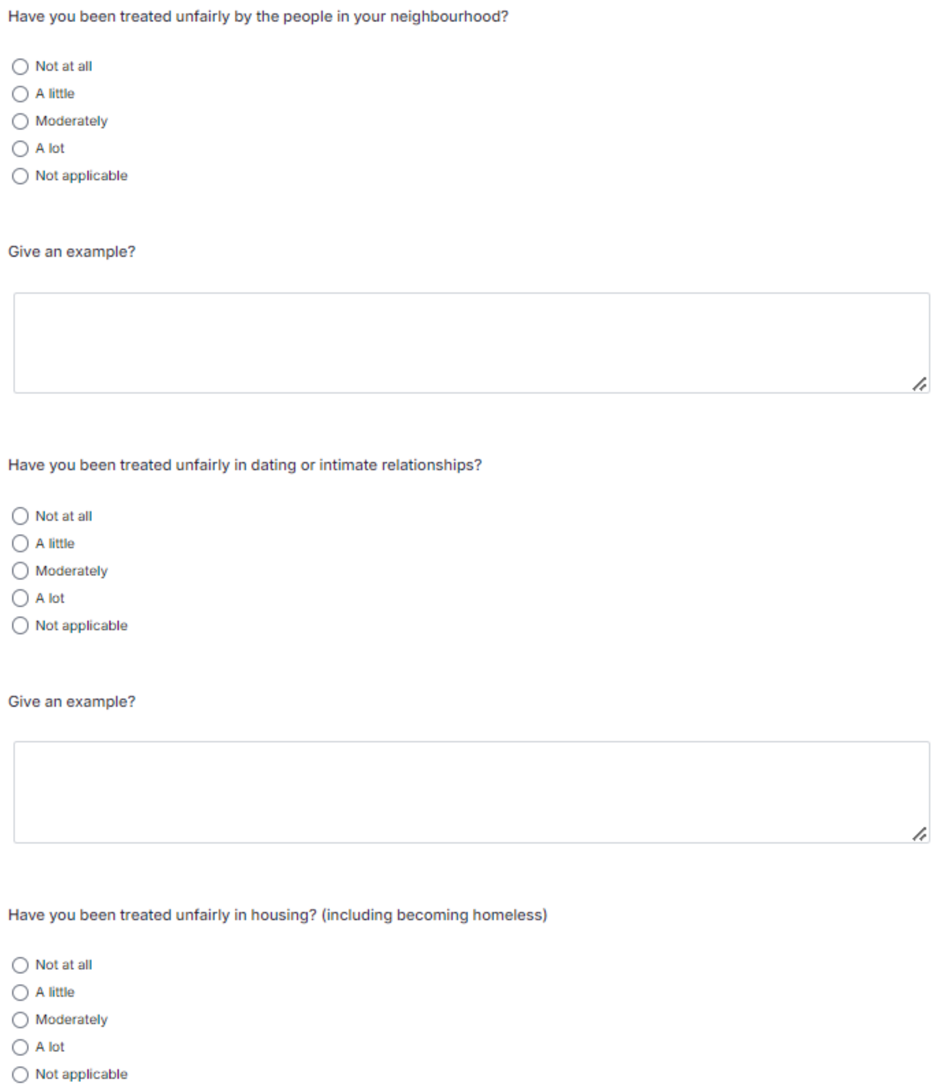
Discrimination and stigma occur when people are treated unfairly because they are seen as being different from others. This part of the survey asks about how you've been affected by discrimination and stigma because of mental health problems or symptoms of a mental health disorder (i. e. persistent feelings of sadness). There are four to the Discrimination and Stigma Scale. Each part asks about how you have been treated or what you have done in different situations: In the first part, we will ask about times when you have been treated unfairly because of mental health problems In the second part, we will ask about times when you have stopped yourself from doing things because of how others might respond to your mental health problem. In the third part, we will ask about how you may have overcome stigma and discrimination because of mental health problems In the fourth part, we will ask about any times when you have been treated more positively because of mental health problems. In each part of the Discrimination and Stigma Scale, we will ask you to let us know whether each event has happened not at all, a little, moderately or a lot. If possible, we will also ask you to give us an example of how a typical event unfolded. For each question, please think about events which have happened at any stage of your life since you first experienced mental health problems or symptoms (i. e. negative emotions) as a result of discrimination or stigma.

Have you been treated unfairly in making or keeping friends?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable



Have you been treated unfairly by the people in your neighbourhood?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable

Give an example?

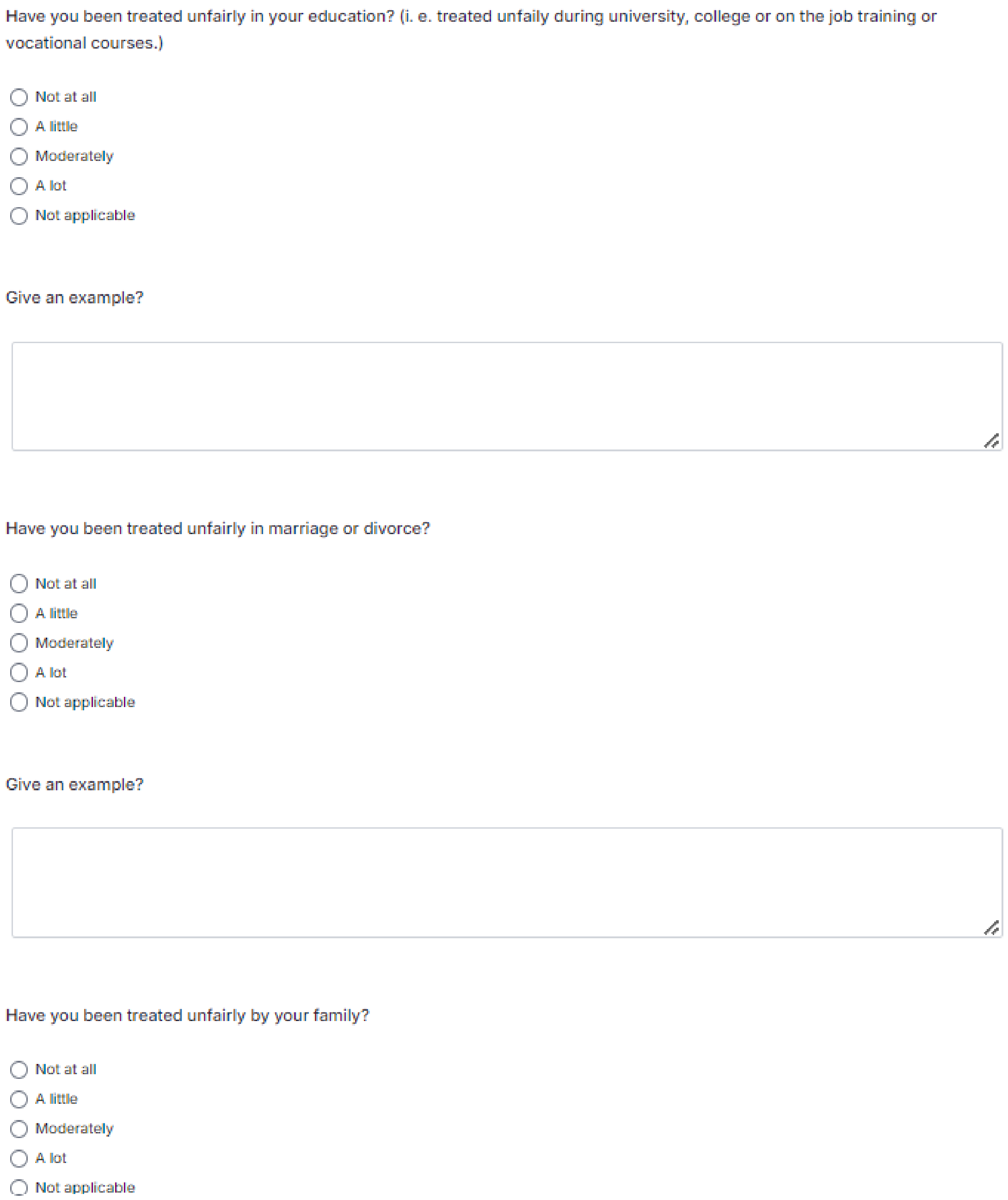
Have you been treated unfairly in dating or intimate relationships?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable

Give an example?

Have you been treated unfairly in housing? (including becoming homeless)

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable



Have you been treated unfairly in your education? (i. e. treated unfaily during university, college or on the job training or vocational courses.)

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

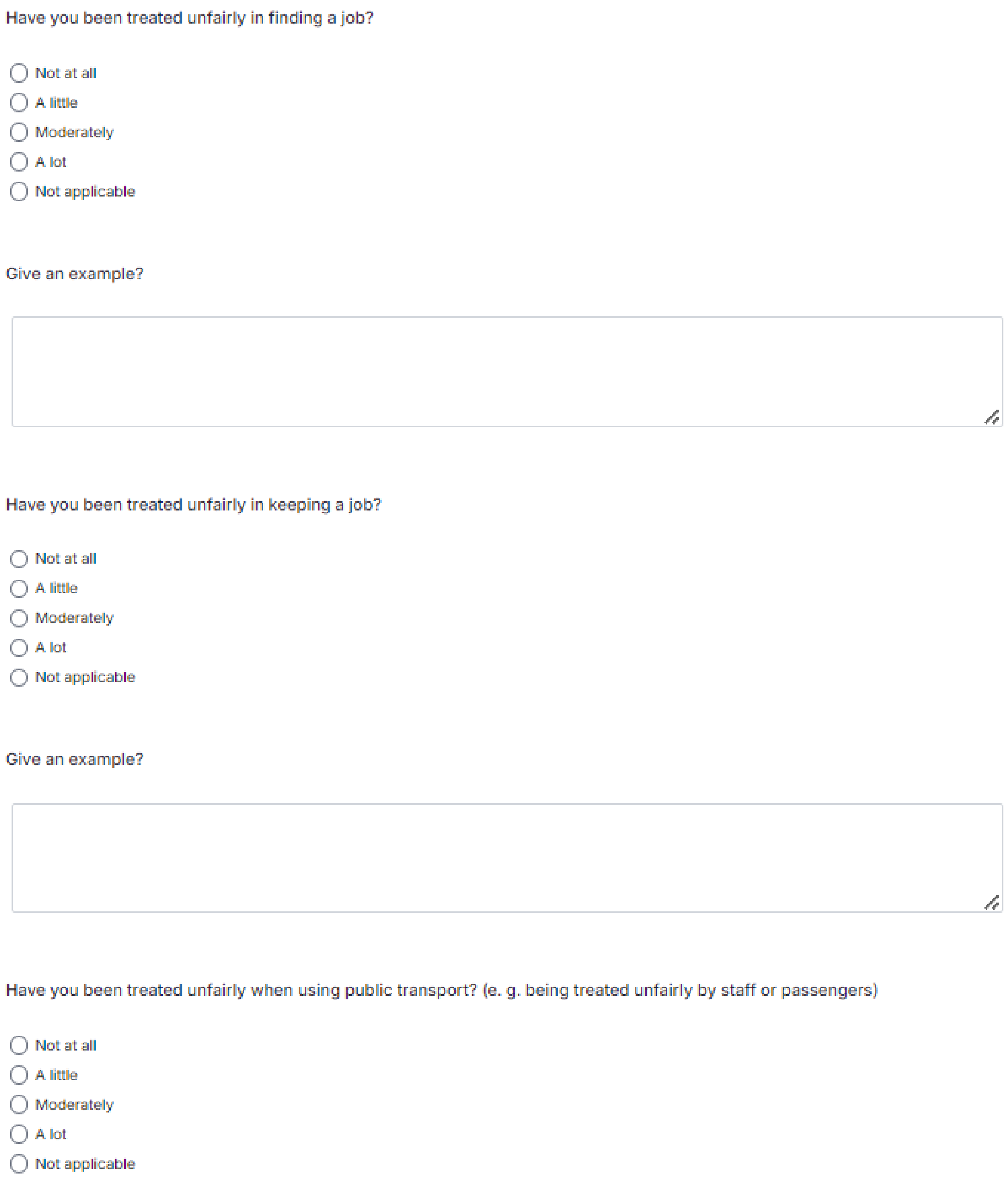
Have you been treated unfairly in marriage or divorce?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

Have you been treated unfairly by your family?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable



Have you been treated unfairly in finding a job?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

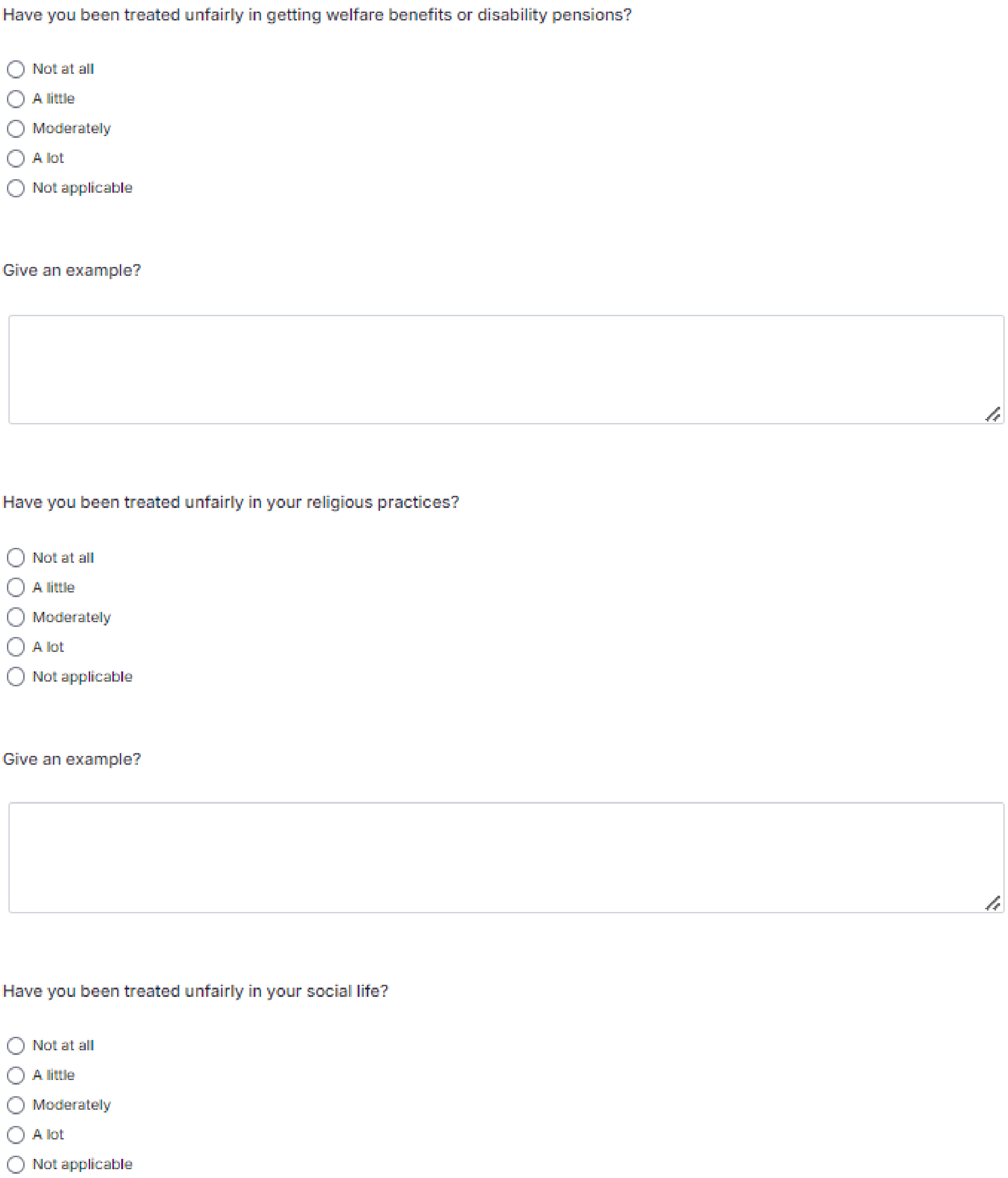
Have you been treated unfairly in keeping a job?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

Have you been treated unfairly when using public transport? (e. g. being treated unfairly by staff or passengers)

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable



Have you been treated unfairly in getting welfare benefits or disability pensions?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable

Give an example?

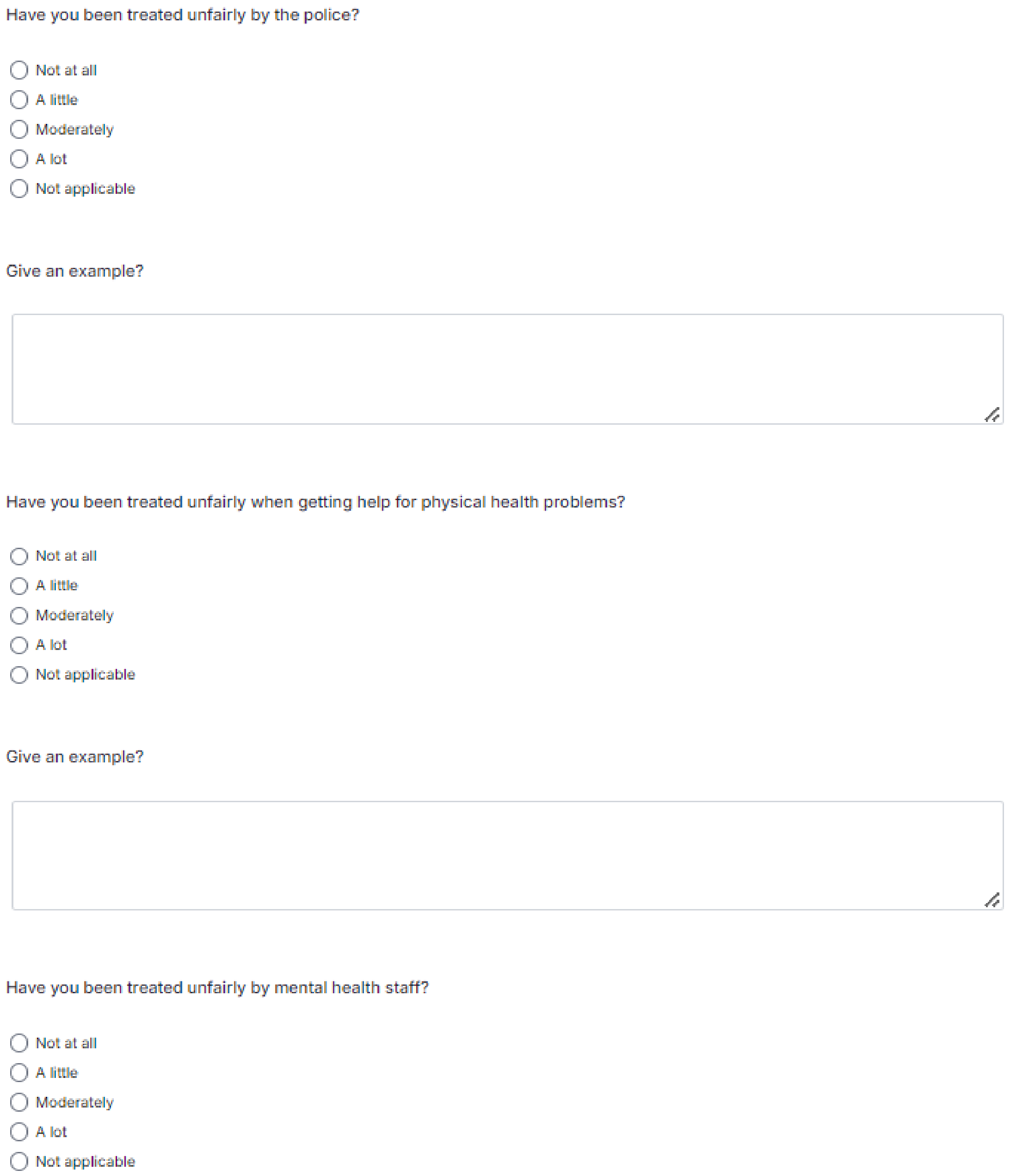
Have you been treated unfairly in your religious practices?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable

Give an example?

Have you been treated unfairly in your social life?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable



Have you been treated unfairly by the police?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

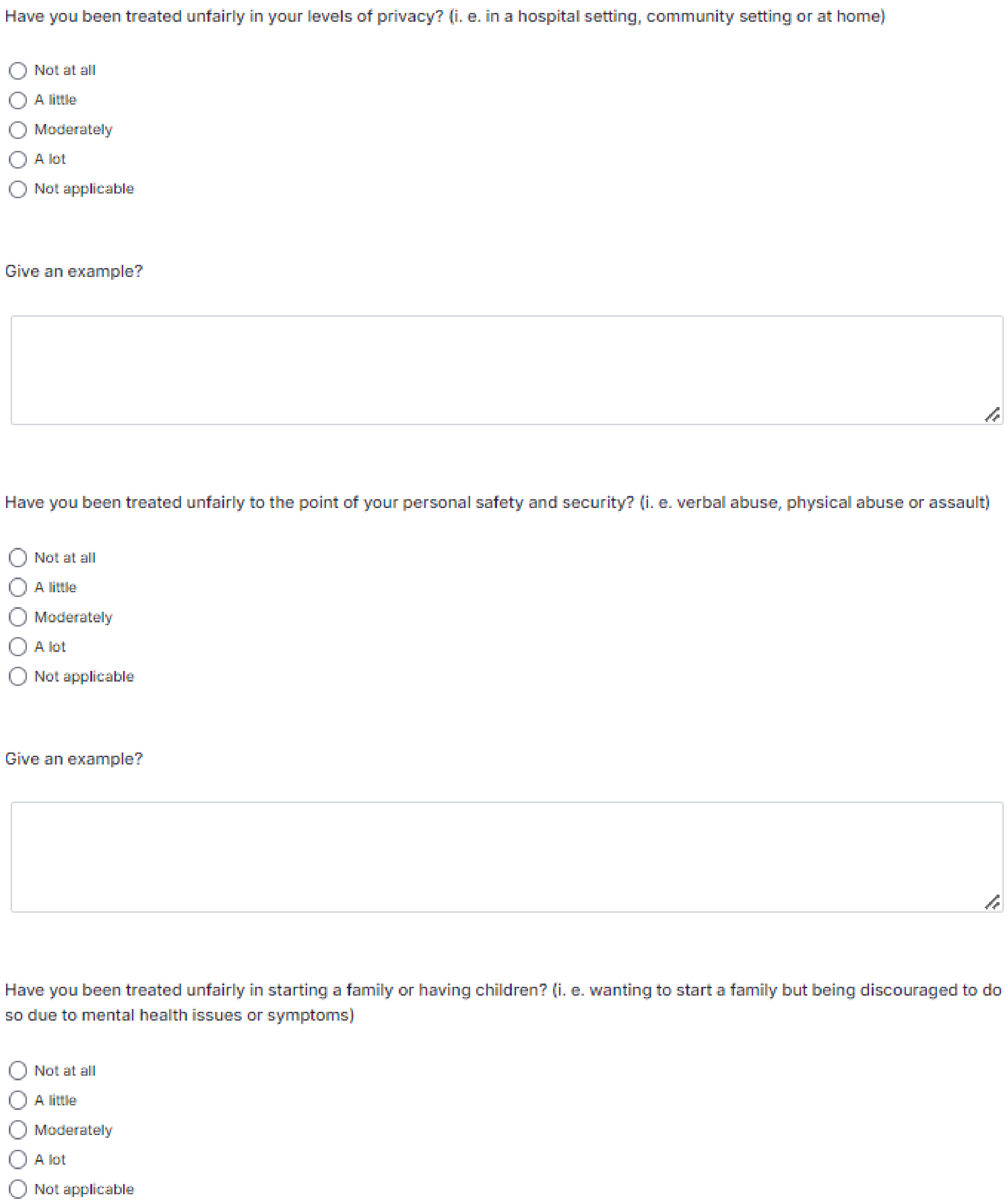
Have you been treated unfairly when getting help for physical health problems?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

Have you been treated unfairly by mental health staff?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable



Have you been treated unfairly in your levels of privacy? (i. e. in a hospital setting, community setting or at home)

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable

Give an example?

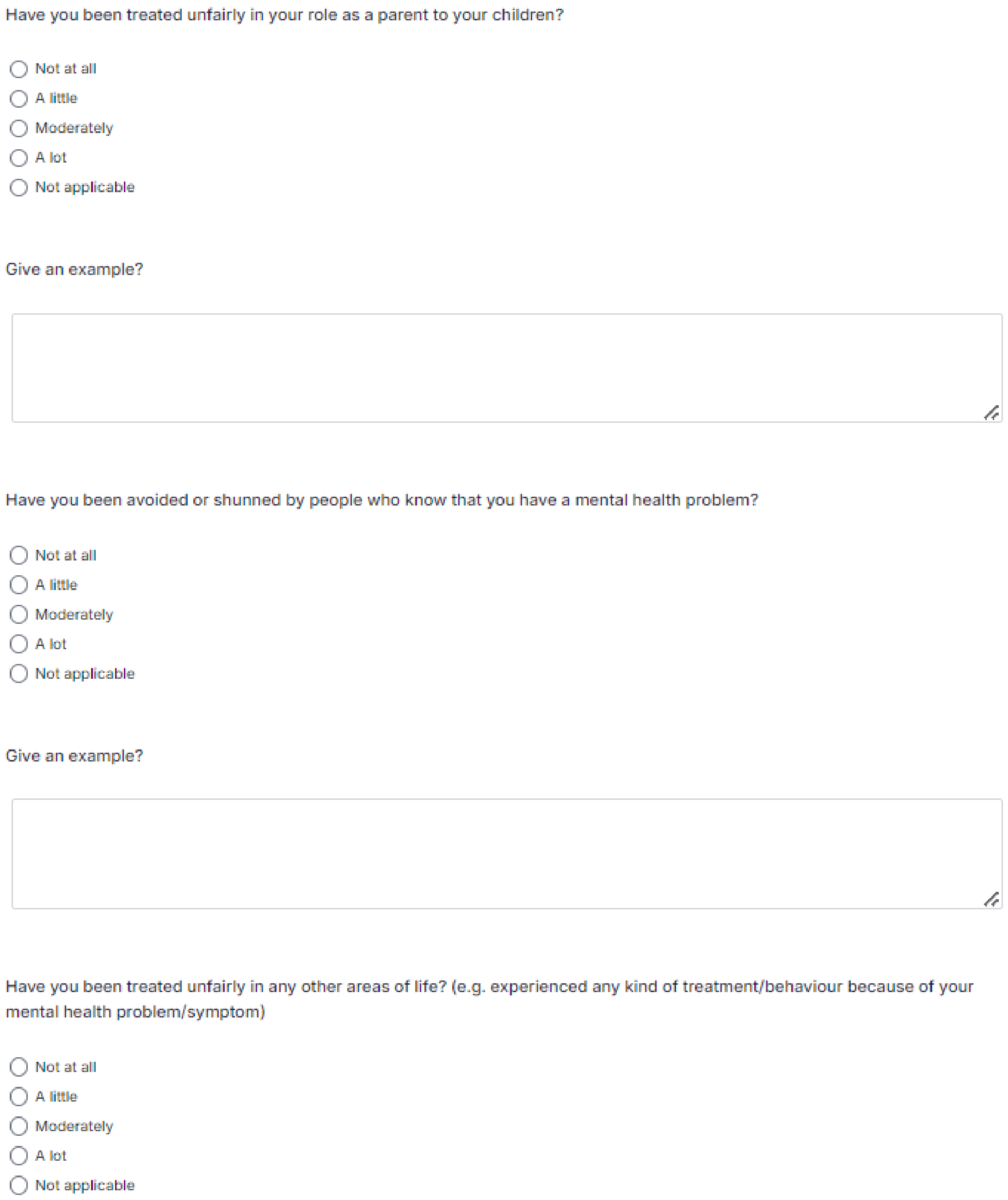
Have you been treated unfairly to the point of your personal safety and security? (i. e. verbal abuse, physical abuse or assault)

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable

Give an example?

Have you been treated unfairly in starting a family or having children? (i. e. wanting to start a family but being discouraged to do so due to mental health issues or symptoms)

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable



Have you been treated unfairly in your role as a parent to your children?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

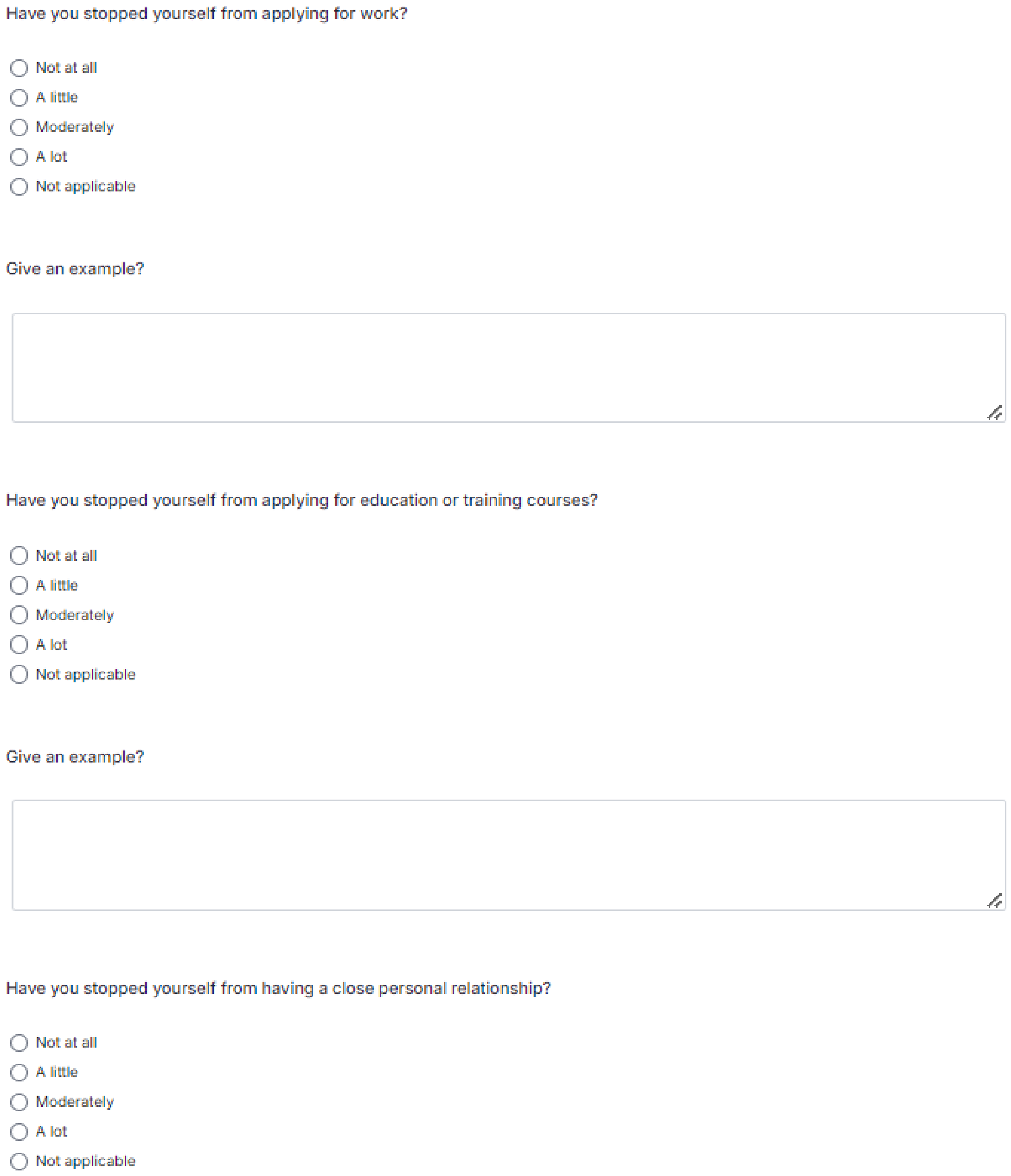
Have you been avoided or shunned by people who know that you have a mental health problem?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

Have you been treated unfairly in any other areas of life? (e.g. experienced any kind of treatment/behaviour because of your mental health problem/symptom)

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable



Have you stopped yourself from applying for work?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable

Give an example?

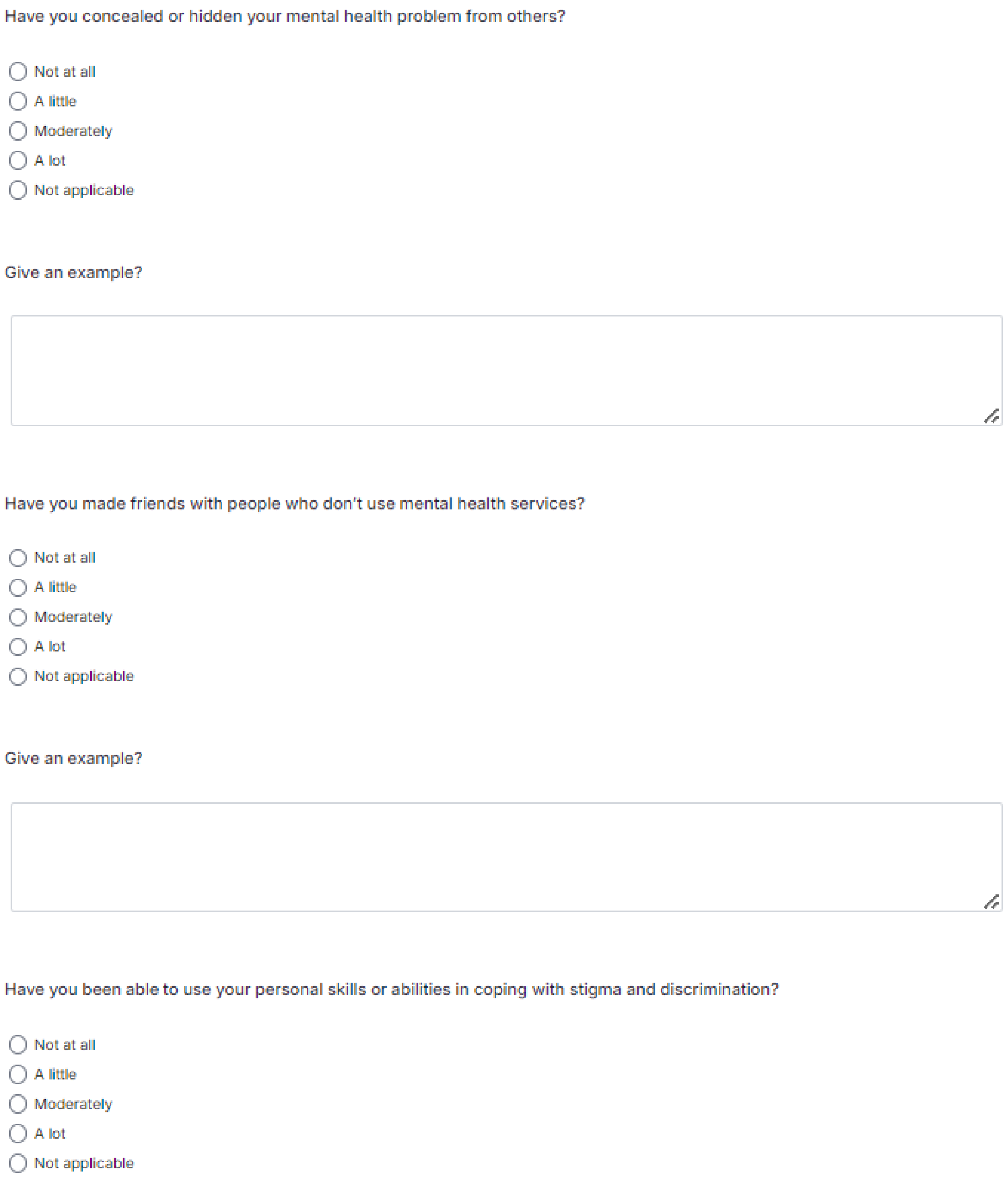
Have you stopped yourself from applying for education or training courses?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable

Give an example?

Have you stopped yourself from having a close personal relationship?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable



Have you concealed or hidden your mental health problem from others?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable

Give an example?

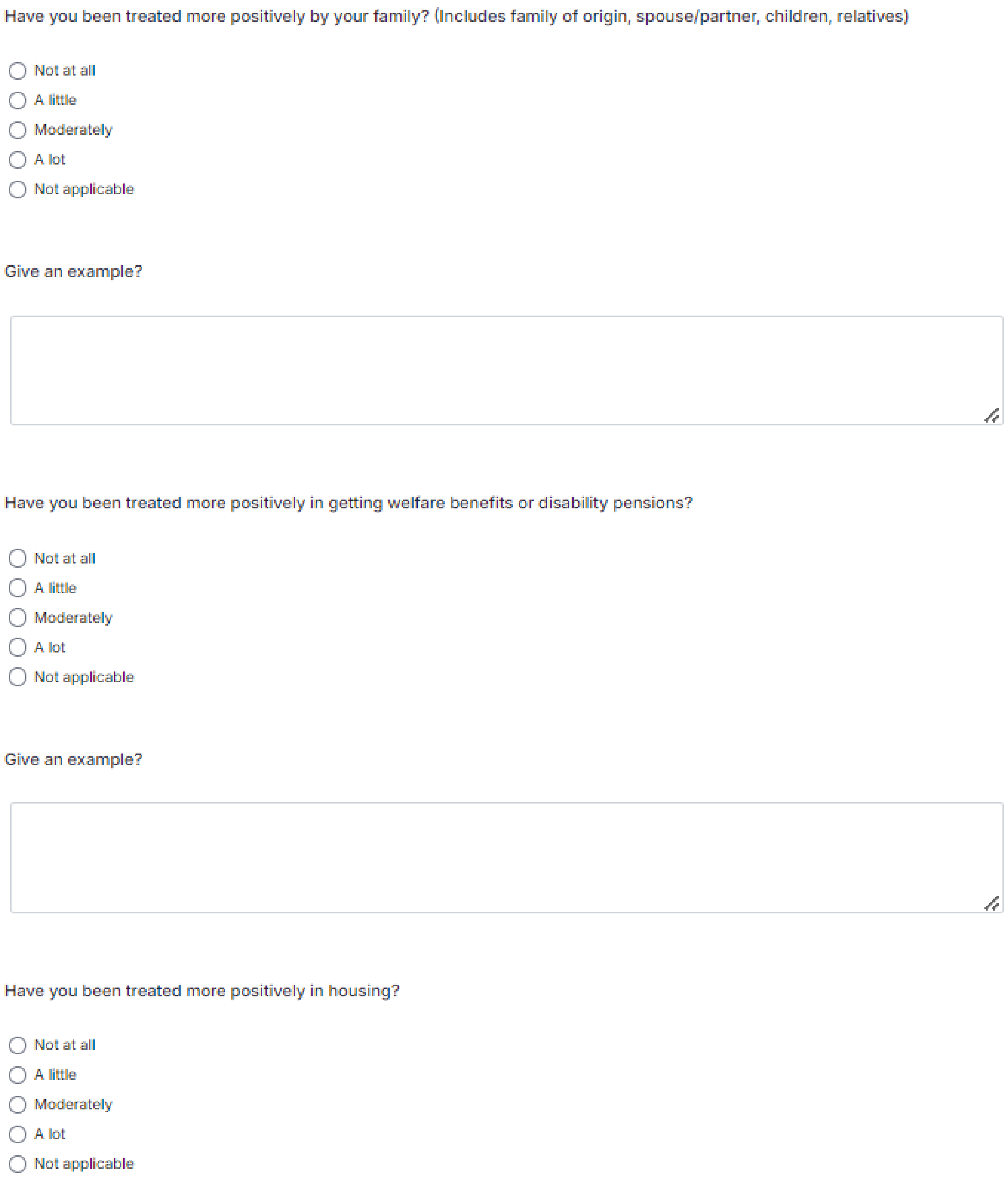
Have you made friends with people who don't use mental health services?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable

Give an example?

Have you been able to use your personal skills or abilities in coping with stigma and discrimination?

- ○ Not at all
- ○ A little
- ○ Moderately
- ○ A lot
- ○ Not applicable



Have you been treated more positively by your family? (Includes family of origin, spouse/partner, children, relatives)

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

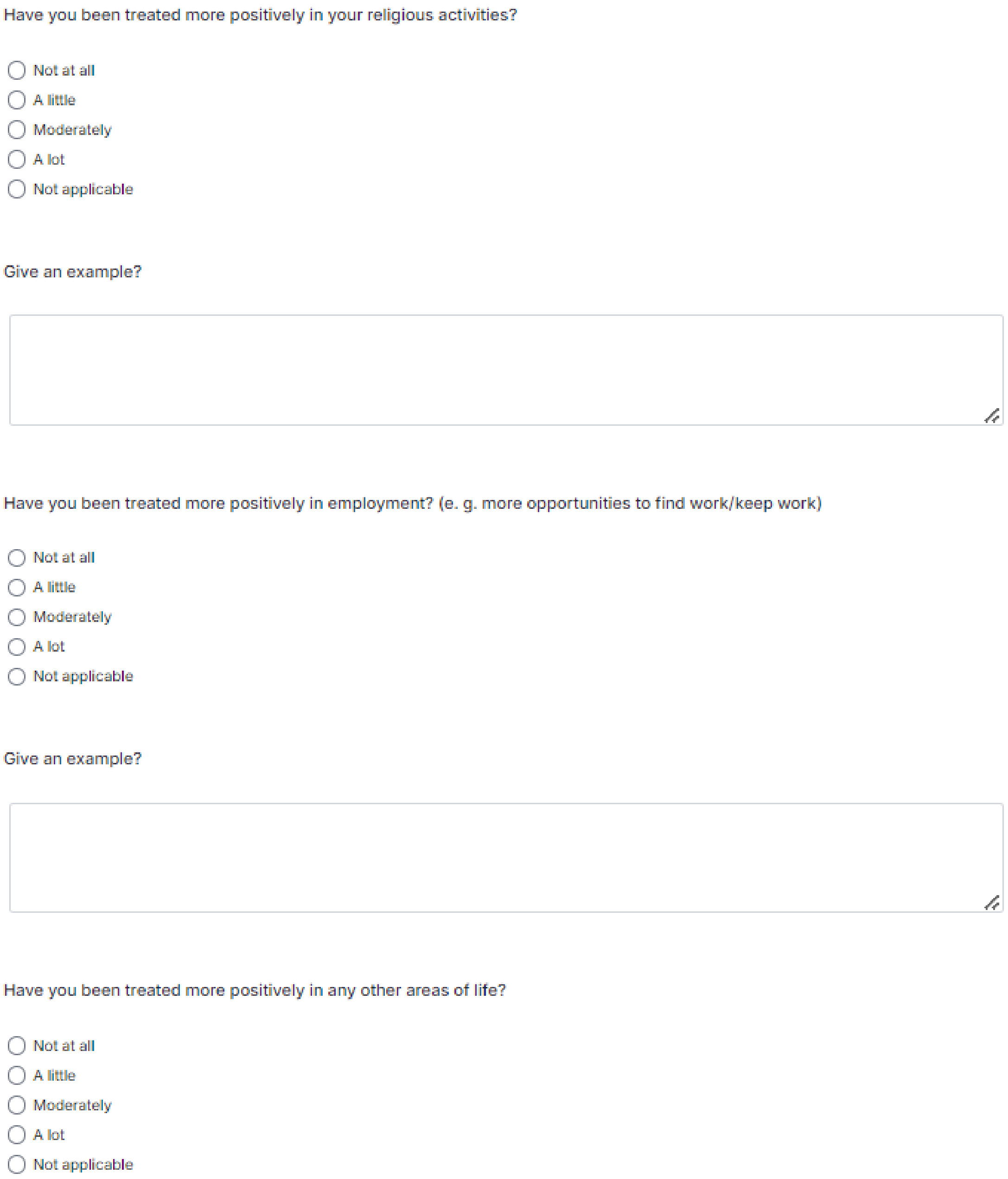
Have you been treated more positively in getting welfare benefits or disability pensions?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

Have you been treated more positively in housing?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable



Have you been treated more positively in your religious activities?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

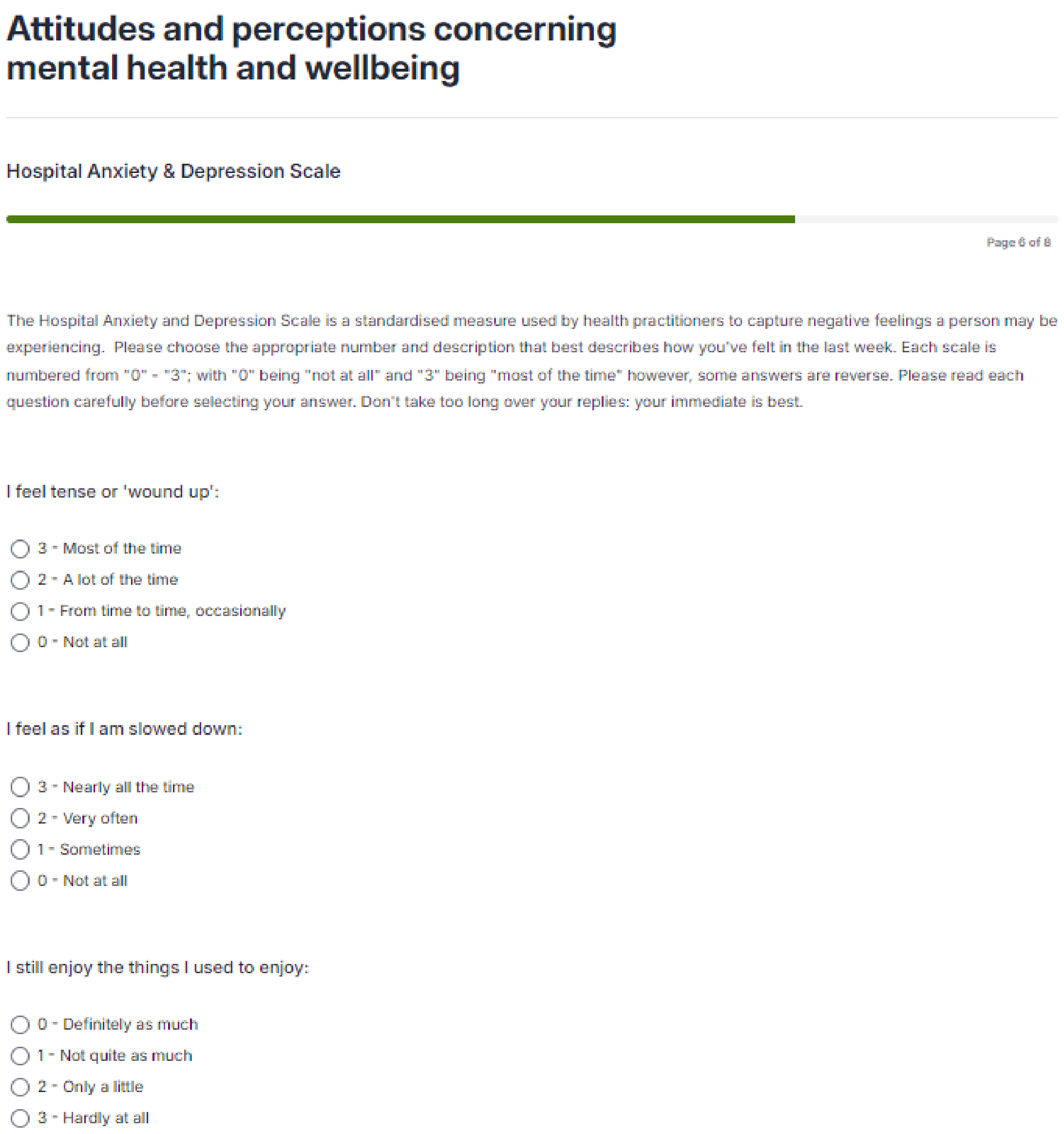
Have you been treated more positively in employment? (e. g. more opportunities to find work/keep work)

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable

Give an example?

Have you been treated more positively in any other areas of life?

○ Not at all
○ A little
○ Moderately
○ A lot
○ Not applicable



Attitudes and perceptions concerning mental health and wellbeing

Hospital Anxiety & Depression Scale

Page 6 of 8

The Hospital Anxiety and Depression Scale is a standardised measure used by health practitioners to capture negative feelings a person may be experiencing. Please choose the appropriate number and description that best describes how you've felt in the last week. Each scale is numbered from "0" - "3"; with "0" being "not at all" and "3" being "most of the time" however, some answers are reverse. Please read each question carefully before selecting your answer. Don't take too long over your replies: your immediate is best.

I feel tense or 'wound up':

○ 3 - Most of the time
○ 2 - A lot of the time
○ 1 - From time to time, occasionally
○ 0 - Not at all

I feel as if I am slowed down:

○ 3 - Nearly all the time
○ 2 - Very often
○ 1 - Sometimes
○ 0 - Not at all

I still enjoy the things I used to enjoy:

○ 0 - Definitely as much
○ 1 - Not quite as much
○ 2 - Only a little
○ 3 - Hardly at all

I get a sort of frightened feeling like 'butterflies' in the stomach:

- ○ 0 - Not at all
- ○ 1 - Occasionally
- ○ 2 - Quite often
- ○ 3 - Very often

I get a sort of frightened feeling as if something awful is about to happen:

- ○ 3 - Very definitely and quite badly
- ○ 2 - Yes, but not too badly
- ○ 1 - A little, but it doesn't worry me
- ○ 0 - Not at all

I have lost interest in my appearance:

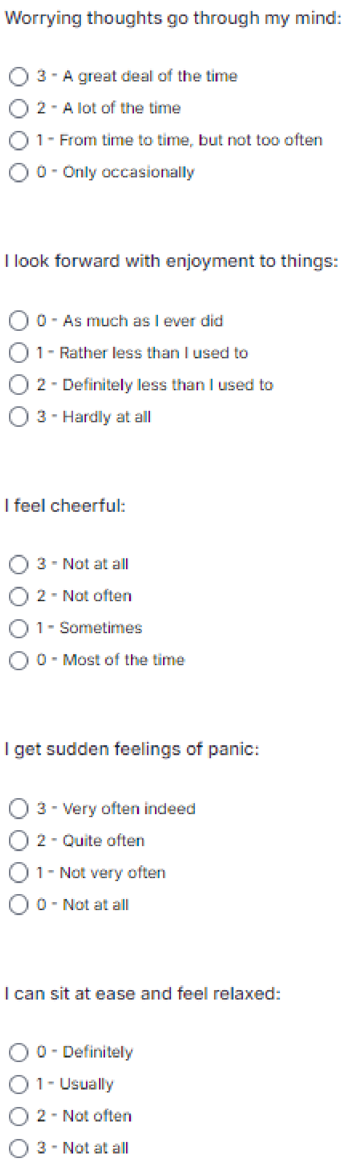
- ○ 3 - Definitely
- ○ 2 - I don't take as much care as I should
- ○ 1 - I may not take quite as much care
- ○ 0 - I take just as much care as ever

I can laugh and see the funny side of things:

- ○ 0 - As much as I always could
- ○ 1 - Not quite so much now
- ○ 2 - Definitely not so much now
- ○ 3 - Not at all

I feel restless as I have to be on the move:

- ○ 3 - Very much indeed
- ○ 2 - Quite a lot
- ○ 1 - Not very much
- ○ 0 - Not at all



Worrying thoughts go through my mind:

○ 3 - A great deal of the time
○ 2 - A lot of the time
○ 1 - From time to time, but not too often
○ 0 - Only occasionally

I look forward with enjoyment to things:

○ 0 - As much as I ever did
○ 1 - Rather less than I used to
○ 2 - Definitely less than I used to
○ 3 - Hardly at all

I feel cheerful:

○ 3 - Not at all
○ 2 - Not often
○ 1 - Sometimes
○ 0 - Most of the time

I get sudden feelings of panic:

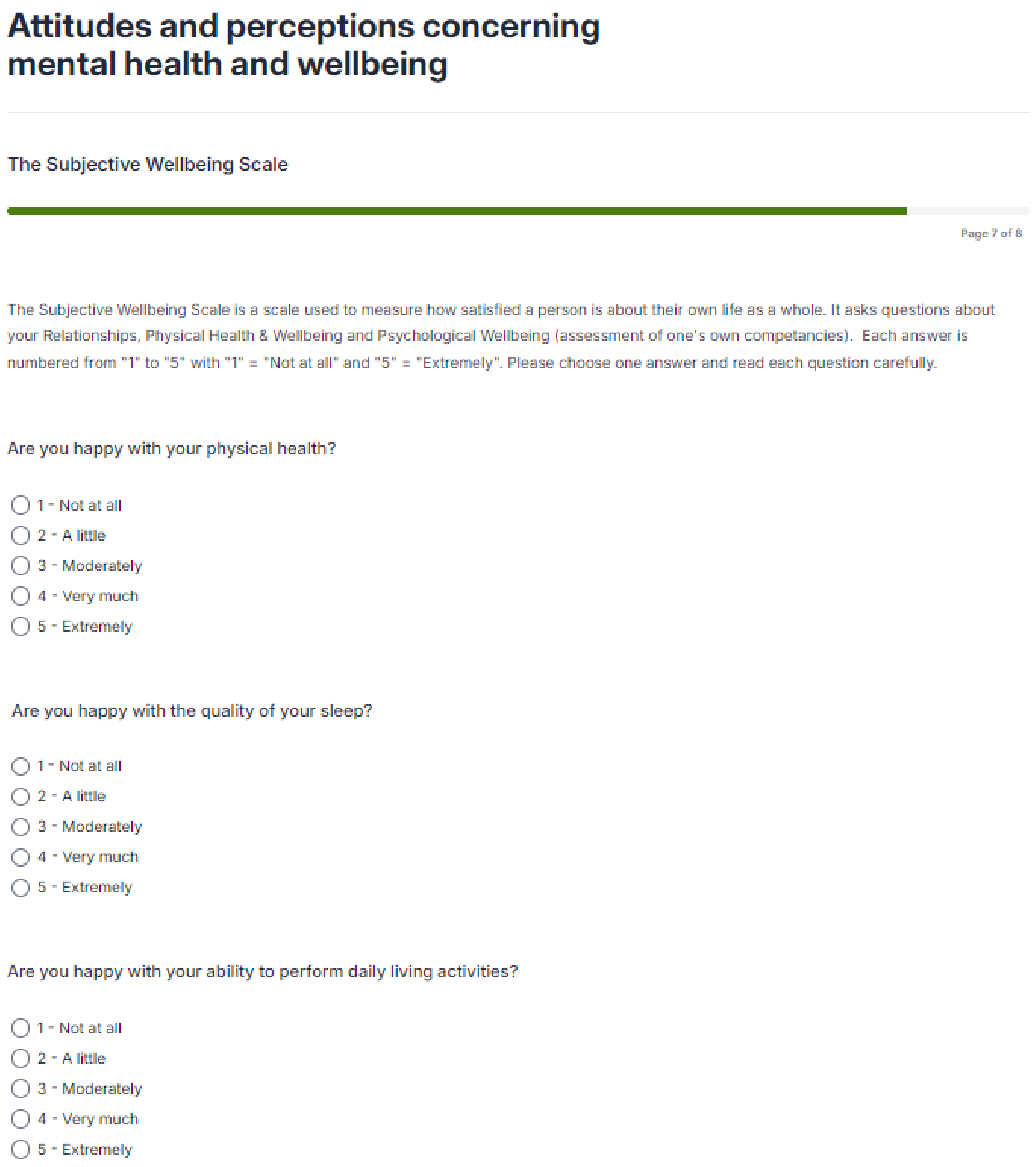
○ 3 - Very often indeed
○ 2 - Quite often
○ 1 - Not very often
○ 0 - Not at all

I can sit at ease and feel relaxed:

○ 0 - Definitely
○ 1 - Usually
○ 2 - Not often
○ 3 - Not at all

I can enjoy a good book or radio or TV program:

○ 0 - Often
○ 1 - Sometimes
○ 2 - Not often
○ 3 - Very seldom



Attitudes and perceptions concerning mental health and wellbeing

The Subjective Wellbeing Scale

The Subjective Wellbeing Scale is a scale used to measure how satisfied a person is about their own life as a whole. It asks questions about your Relationships, Physical Health & Wellbeing and Psychological Wellbeing (assessment of one's own competancies). Each answer is numbered from "1" to "5" with "1" = "Not at all" and "5" = "Extremely". Please choose one answer and read each question carefully.

Are you happy with your physical health?

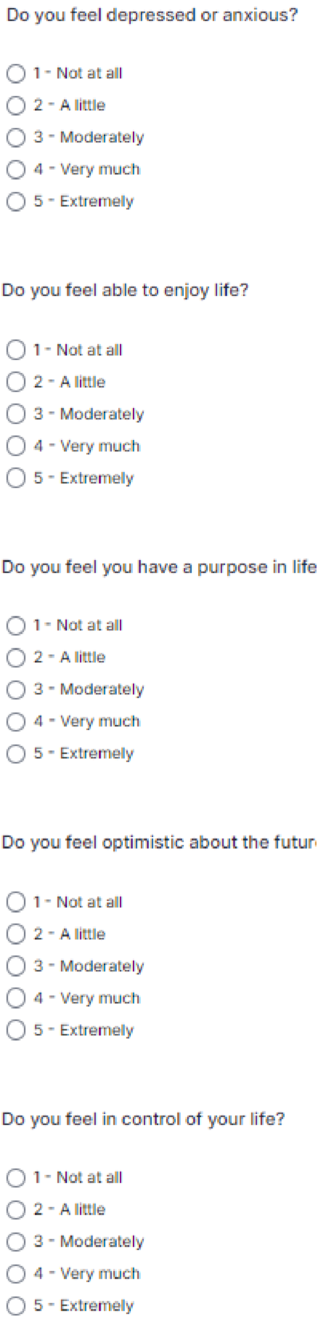
○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
○ 4 - Very much
○ 5 - Extremely

Are you happy with the quality of your sleep?

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
○ 4 - Very much
○ 5 - Extremely

Are you happy with your ability to perform daily living activities?

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
○ 4 - Very much
○ 5 - Extremely



Do you feel depressed or anxious?

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
○ 4 - Very much
○ 5 - Extremely

Do you feel able to enjoy life?

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
○ 4 - Very much
○ 5 - Extremely

Do you feel you have a purpose in life

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
○ 4 - Very much
○ 5 - Extremely

Do you feel optimistic about the futur

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
○ 4 - Very much
○ 5 - Extremely

Do you feel in control of your life?

○ 1 - Not at all
○ 2 - A little
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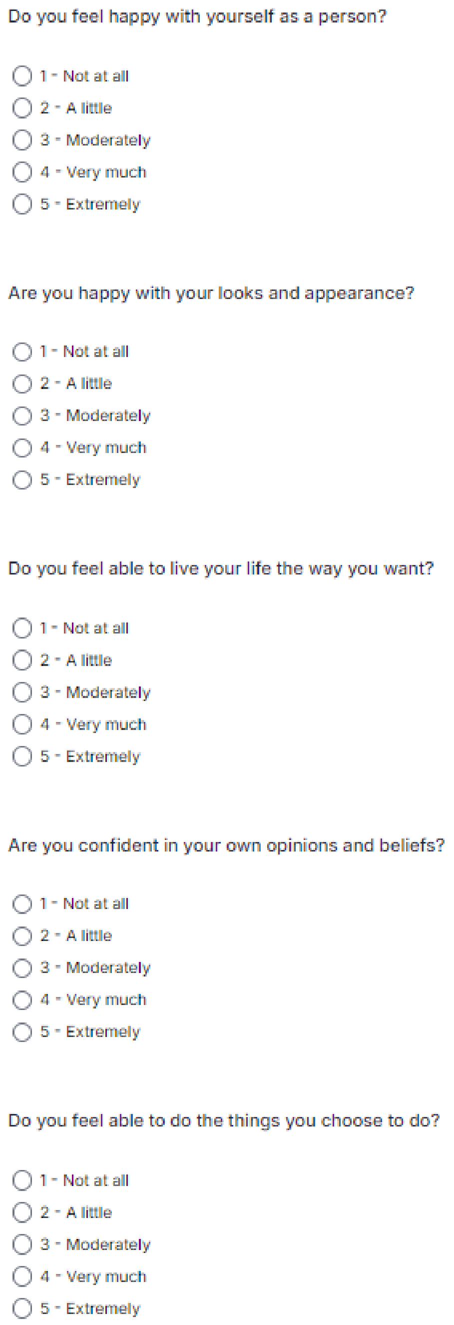

Do you feel happy with yourself as a person?

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
○ 4 - Very much
○ 5 - Extremely

Are you happy with your looks and appearance?

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
○ 4 - Very much
○ 5 - Extremely

Do you feel able to live your life the way you want?

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
○ 4 - Very much
○ 5 - Extremely

Are you confident in your own opinions and beliefs?

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
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Do you feel able to do the things you choose to do?

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
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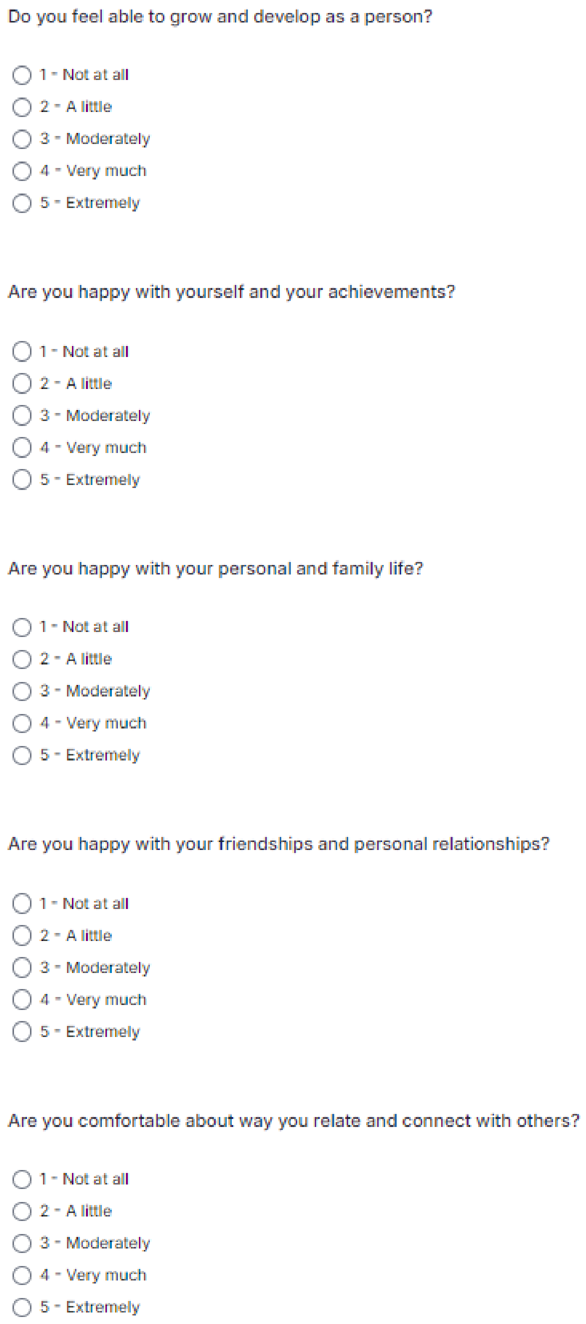

Do you feel able to grow and develop as a person?

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
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Are you happy with yourself and your achievements?

○ 1 - Not at all
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Are you happy with your personal and family life?

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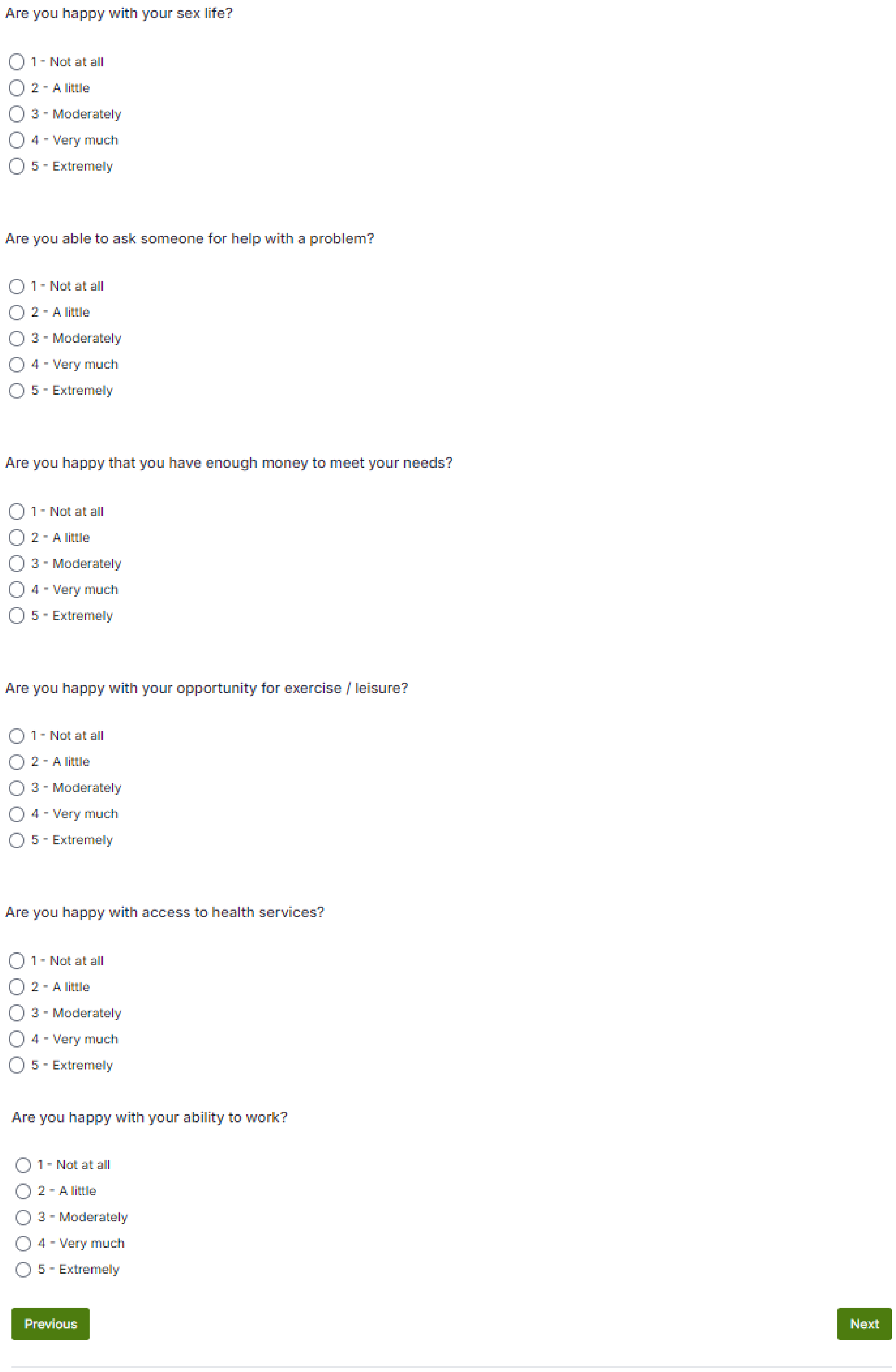

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Are you happy that you have enough money to meet your needs?

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Are you happy with your opportunity for exercise / leisure?

○ 1 - Not at all
○ 2 - A little
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Are you happy with access to health services?

○ 1 - Not at all
○ 2 - A little
○ 3 - Moderately
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○ 5 - Extremely

Are you happy with your ability to work?

○ 1 - Not at all
○ 2 - A little
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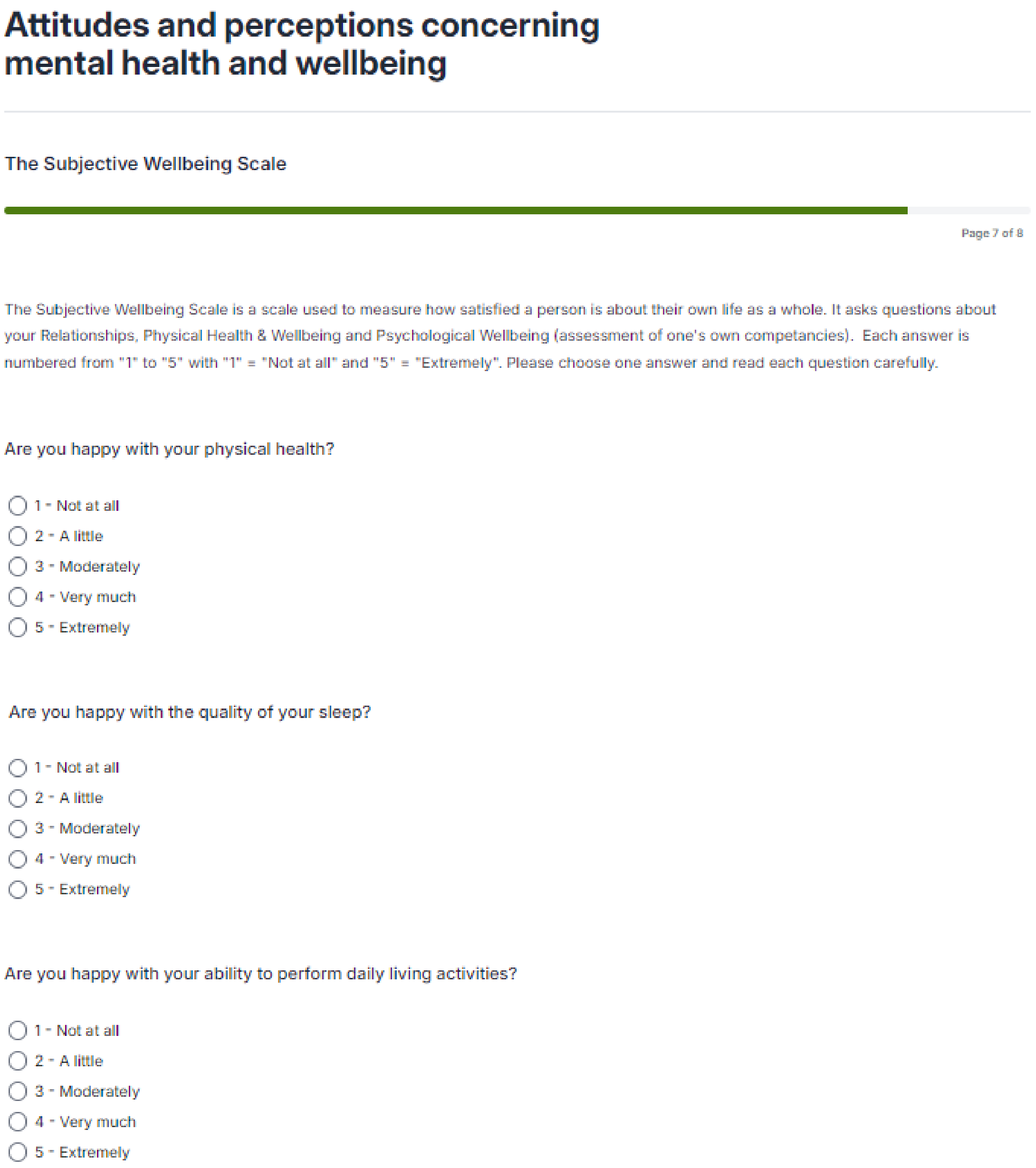

Attitudes and perceptions concerning mental health and wellbeing

The Subjective Wellbeing Scale

Page 7 of 8

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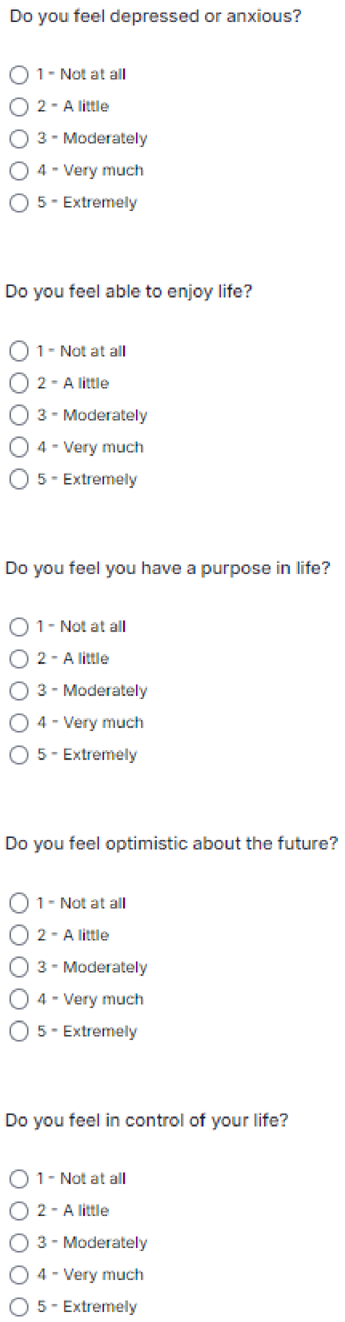

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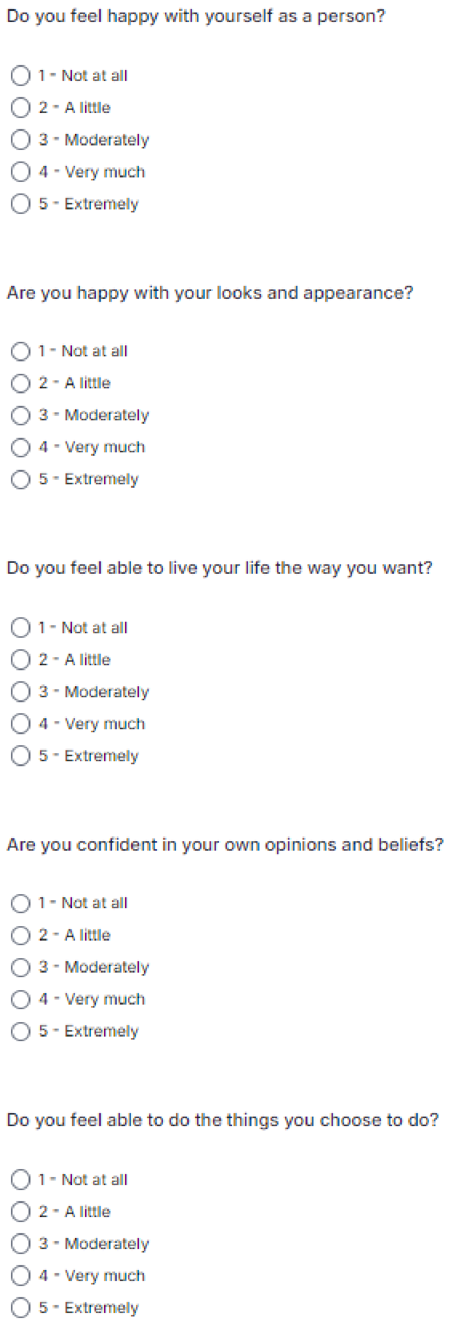

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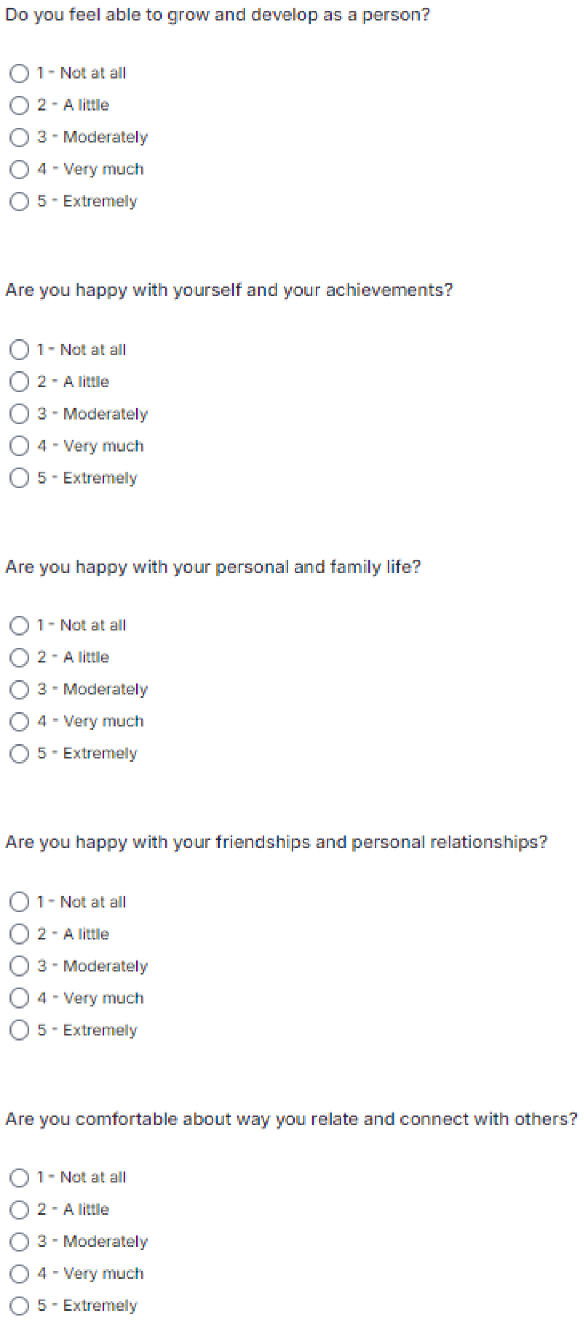

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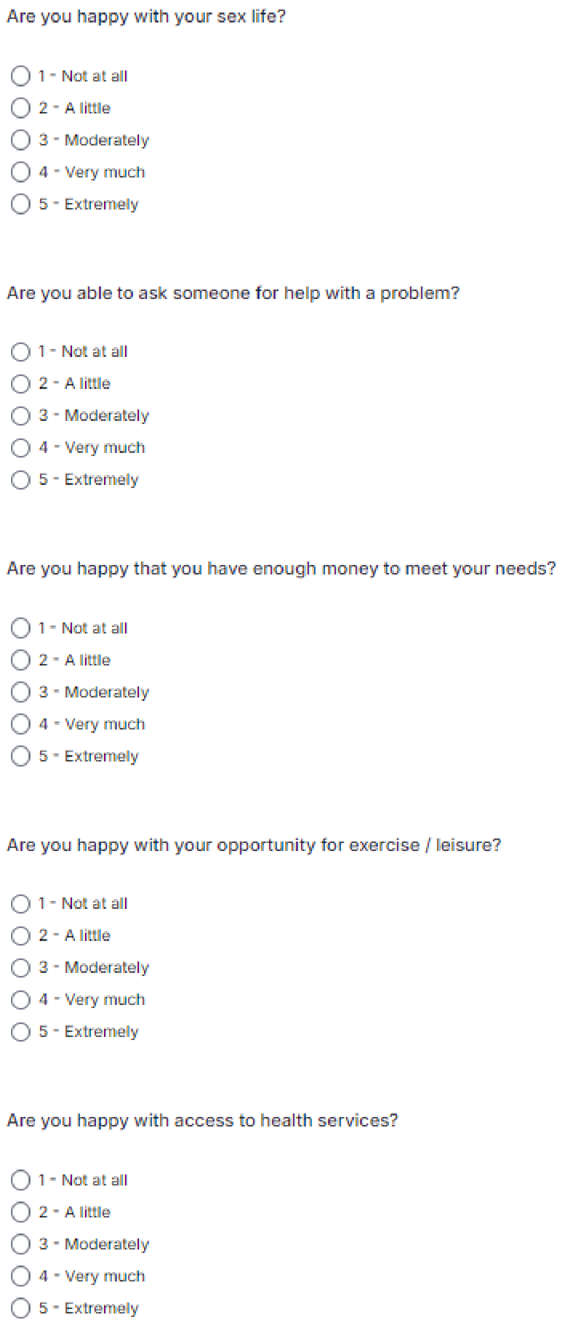

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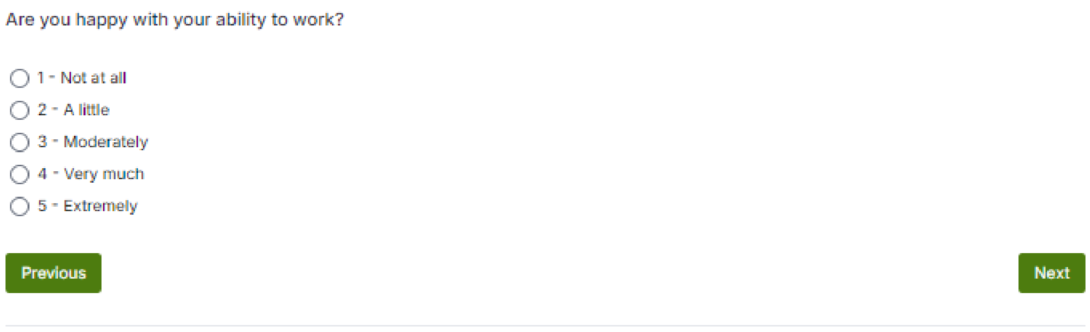

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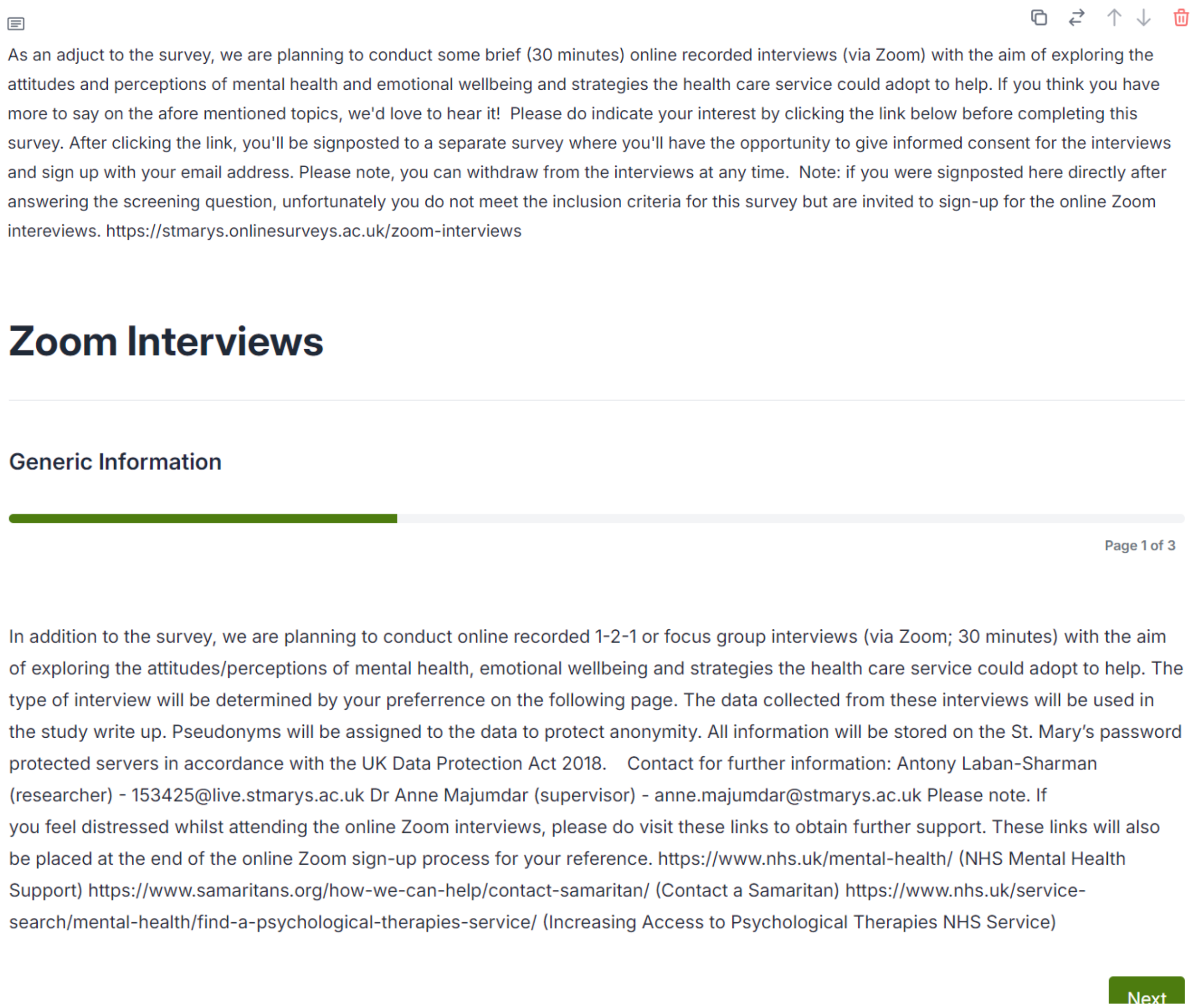


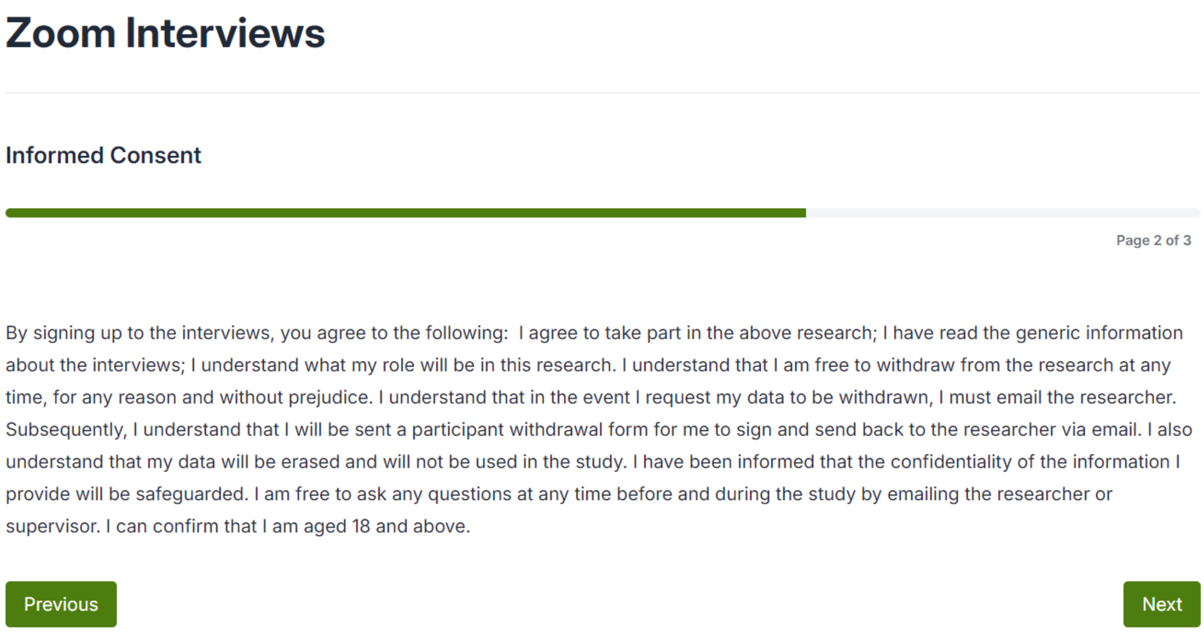
As an adjunct to the survey, we are planning to conduct some brief (30 minutes) online recorded interviews (via Zoom) with the aim of exploring the attitudes and perceptions of mental health and emotional wellbeing and strategies the health care service could adopt to help. If you think you have more to say on the afore mentioned topics, we'd love to hear it! Please do indicate your interest by clicking the link below before completing this survey. After clicking the link, you'll be signposted to a separate survey where you'll have the opportunity to give informed consent for the interviews and sign up with your email address. Please note, you can withdraw from the interviews at any time. Note: if you were signposted here directly after answering the screening question, unfortunately you do not meet the inclusion criteria for this survey but are invited to sign-up for the online Zoom intereviews. https://stmarys.onlinesurveys.ac.uk/zoom-interviews

Zoom Interviews

Generic Information

Page 1 of 3

In addition to the survey, we are planning to conduct online recorded 1-2-1 or focus group interviews (via Zoom; 30 minutes) with the aim of exploring the attitudes/perceptions of mental health, emotional wellbeing and strategies the health care service could adopt to help. The type of interview will be determined by your preferrence on the following page. The data collected from these interviews will be used in the study write up. Pseudonyms will be assigned to the data to protect anonymity. All information will be stored on the St. Mary's password protected servers in accordance with the UK Data Protection Act 2018. Contact for further information: Antony Laban-Sharman (researcher) - 153425@live.stmarys.ac.uk Dr Anne Majumdar (supervisor) - anne.majumdar@stmarys.ac.uk Please note. If you feel distressed whilst attending the online Zoom interviews, please do visit these links to obtain further support. These links will also be placed at the end of the online Zoom sign-up process for your reference. https://www.nhs.uk/mental-health/ (NHS Mental Health Support) https://www.samaritans.org/how-we-can-help/contact-samaritan/ (Contact a Samaritan) https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service/ (Increasing Access to Psychological Therapies NHS Service)

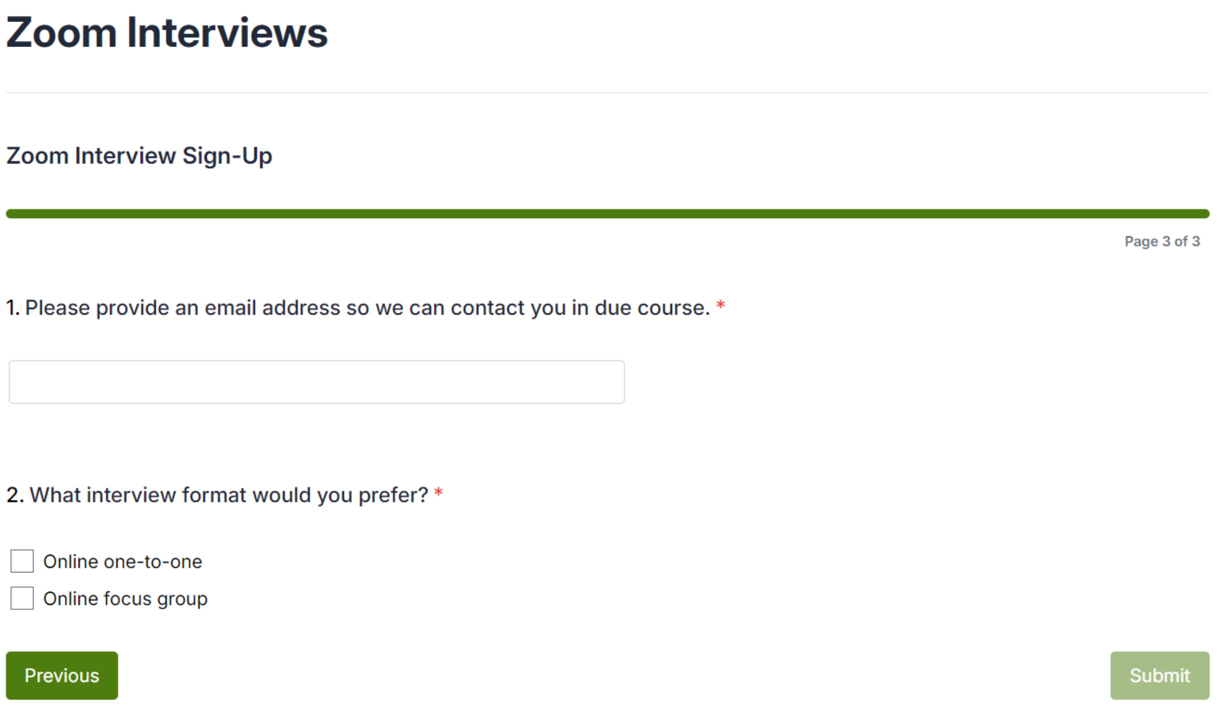


Zoom Interviews

Informed Consent

Page 2 of 3

By signing up to the interviews, you agree to the following: I agree to take part in the above research; I have read the generic information about the interviews; I understand what my role will be in this research. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice. I understand that in the event I request my data to be withdrawn, I must email the researcher. Subsequently, I understand that I will be sent a participant withdrawal form for me to sign and send back to the researcher via email. I also understand that my data will be erased and will not be used in the study. I have been informed that the confidentiality of the information I provide will be safeguarded. I am free to ask any questions at any time before and during the study by emailing the researcher or supervisor. I can confirm that I am aged 18 and above.



Zoom Interviews

Zoom Interview Sign-Up

1. Please provide an email address so we can contact you in due course. *

2. What interview format would you prefer? *

☐ Online one-to-one
☐ Online focus group

APPENDIX 3.2) WRITTEN CONSENT FORM WITH WITHDRAWAL SECTION

Name of Participant: ____

Title of the project: Perceptions and experiences of mental health and wellbeing, psychotherapeutic practices, and healthcare, including any associated stigma, within BAME communities.

Main investigator and contact details: Antony Laban-Sharman - 153425@live.stmarys.ac.uk

Members of the research team:

- Dr Anne Majumdar - anne.majumdar@stmarys.ac.uk; Contact Number – 0208 240 2312
- Dr Kyriaki Myrissa
- Dr Eirini Kelaiditi
- Prof Symeon Dagkas

1. I agree to take part in the above research. I have read the Participant Information Sheet which is attached to this form. I understand what my role will be in this research, and all my questions have been answered to my satisfaction.

2. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice.

3. I have been informed that the confidentiality of the information I provide will be safeguarded.

4. I am free to ask any questions at any time before and during the study.

5. I have been provided with a copy of this form and the Participant Information Sheet.

Data Protection: I agree to the University processing personal data which I have supplied. I agree to the processing of such data for any purposes connected with the Research Project as outlined to me.

Name of participant (print)…………………………………………………………………………..

Signed………………..…………………   Date…………………………..........

If you wish to withdraw from the research, please complete the form below and return to the main investigator named above.

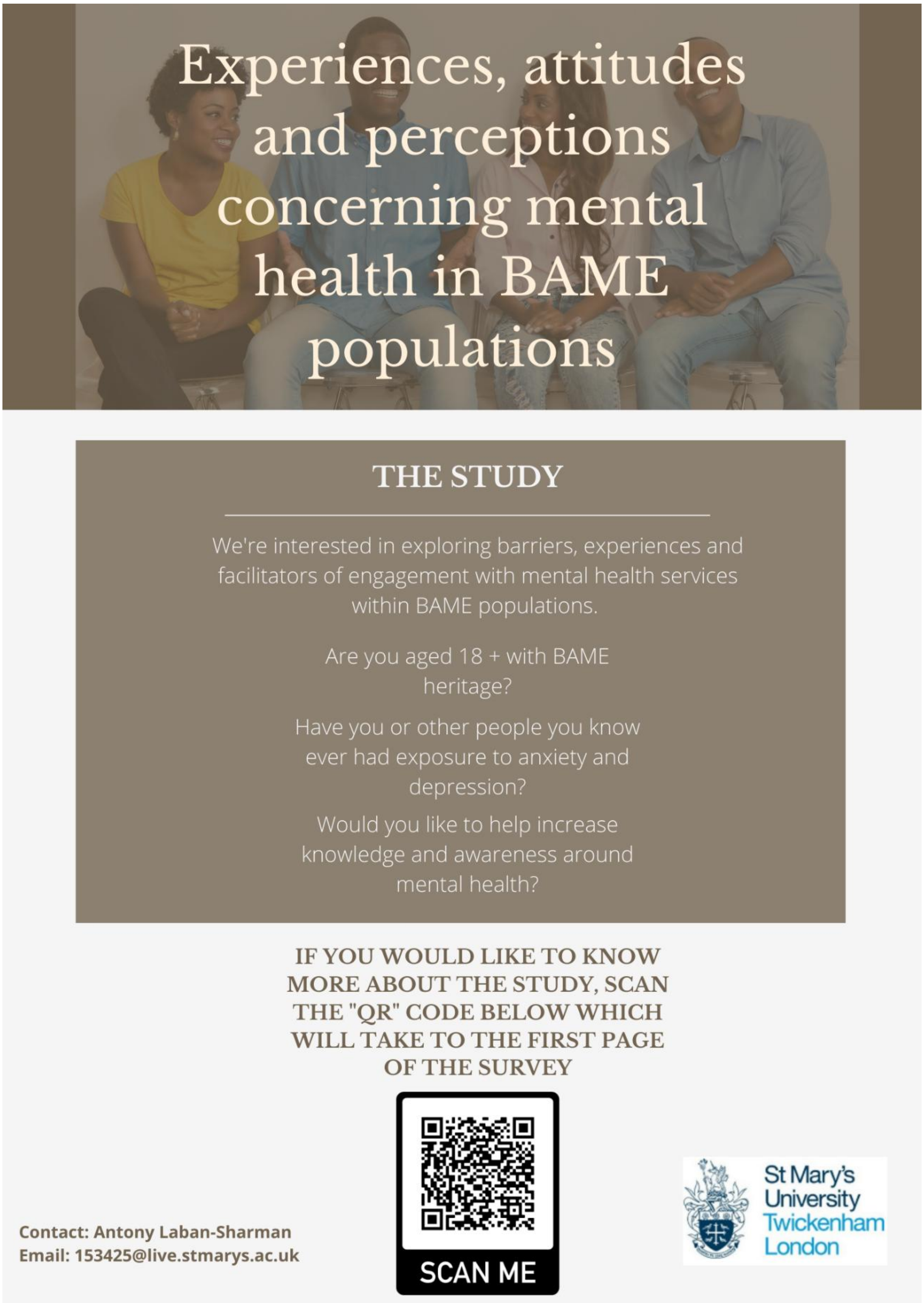
Title of Project: ____

I WISH TO WITHDRAW FROM THIS STUDY

Name: ____

Signed: _________________________________   Date: ____________________

APPENDIX 3.3) PARTICIPANT RECRUITMENT POSTER



Experiences, attitudes and perceptions concerning mental health in BAME populations

THE STUDY

We're interested in exploring barriers, experiences and facilitators of engagement with mental health services within BAME populations.

Are you aged 18 + with BAME heritage?

Have you or other people you know ever had exposure to anxiety and depression?

Would you like to help increase knowledge and awareness around mental health?

IF YOU WOULD LIKE TO KNOW MORE ABOUT THE STUDY, SCAN THE "QR" CODE BELOW WHICH WILL TAKE TO THE FIRST PAGE OF THE SURVEY

SCAN ME

Contact: Antony Laban-Sharman
Email: 153425@live.stmarys.ac.uk

St Mary's University Twickenham London

APPENDIX 3.4) INTERVIEW QUESTIONS

1. Opening Questions

- **Informed consent**

- How are/is everyone doing today?

- I have scheduled us for 30 minutes today, is that still okay with you/everyone?

- Will provide an overview of the interview so that the participants know what to expect.

- Any questions before we begin?

- **Rapport building**

- I will introduce myself and the topic to create rapport, empathy and "set the scene" for open discussion (Smith, 2006)

> *The rationale for the "opening questions" section are that i) the "informed consent" section acts as an opportunity to establish informed consent and ii) the "rapport building" section is nested for the purpose of vicarious sharing of emotion (empathy) (Smith, 2006) to build rapport and reciprocation of information.*

2. Personal Beliefs Towards Mental Health

- Define mental health in its relationship with the participants ethnic community (evidence)

> *Evidence suggest that defining mental health for the appropriate context (i. e. defining it to the* shared heritage of the participants*) is essential to help "set the scene" for the recipient and probe answers that will best answer the research question (Cheng et al., 2018).*

- What does mental health mean to you?

> *This is an attempt to gauge "how mental health is understood" to the participant?*

- How would you describe your feelings about mental health?

- How is mental health understood within your family and friendship circles?

- If you were concerned about the mental health and wellbeing of someone in your family, how might you approach this? How did you reach this conclusion?

> *This is an open-ended question, guided by Tracy (2013), with the aim of encouraging storytelling and narrative. Specifically, the question is asking "How would you describe" probing contemplation and deep thought to extract feelings, thoughts and experiences. Note that the follow-up question is another "How" rather than "why" as asking "why" would likely lead to a short justification of the resolve (Tracy, 2013) however asking*

> *"how" asks the recipient to give the "story" behind the rational thus aiming to extract a deeper level of analyses (Pietkiewicz & Smith, 2014).*

- In your opinion, does the perception of mental health *("how mental health is understood")* within family and close community circles need to be addressed? Are there any aspects that you feel are most important to tackle?

> *As there is an inordinate number of stigma beliefs associated with mental health in BAME populations (Alvidrez et al., 2008; Cheng et al., 2018), this question aims to shift focus to one or two stigma beliefs where future focus can be invested. The rational for this is because the dialogue then has a cogent direction and is easier for the recipient to grasp. Again, the follow-up question is a "how" question to provide the researcher with a deeper level of analysis behind reaching that resolve (i. e. how the person came to the conclusion that one stigma belief is privileged over another).*

- How would you describe the common attitude towards mental health diagnosis, acceptance and management amongst individuals with shared heritage to yours?

- Do you feel that a negative perception of mental health stigma belief/s is common amongst other people from your community? How? [will only ask if stigma manifests from the former]

> *The rational for this question is to provide an opportunity for the participate to contemplate on whether or not the stigma belief/s they chose as being "important" to be common or unique from their own evaluation. Questions that involve individual level and group level analysis are important as providing an opportunity to do so may allow the participant to change or reaffirm their original perception, enhancing trustworthiness of themes (Tracy, 2013).*

- Do you have any thoughts on the origins of negative thoughts and feelings concerning mental health and mental wellbeing?? Why do you think they exist? Why might they be particularly strong within this cultural group? [will only ask if stigma manifests from the former]

> *Naeem et al. (2019) suggests that before comprising a list of initiatives to be nested in a "culturally adapted" component of a pre-existing therapy, the researcher needs full comprehension of how the stigma beliefs were created and why. This is critical as understanding the "story" of how these stigma beliefs manifested allows the researcher to vicariously embody the culture of the participant allowing rapport and empathy to ensue. "Seeing the problem" from the participants lens will allow the researcher to reach a consensus on what probable strategies could be employed to undermine these stigma beliefs.*

- What might help individuals of your heritage to overcome these stigma beliefs? Why do you think this? [will only ask if stigma manifests from the former]

> *This question acts as an adjunct to the previous one where once the "underlying mechanisms" for stigma have been cogently illustrated, the participant can have a clear*

idea on what initiatives could be put in place for future practice to undermine stigma beliefs and improve psychotherapeutic outcomes.

- Would you be comfortable describing your experiences with mental health, if any?

> *As the researcher in this study has chosen the interpretative phenomenological analysis method of analysing the data, this qualitative method assumes an interest in the person and what a particular process, life event, situation, and so on, was/is like for them (Larkin et al., 2006). In this study, an opportunity for the researcher to obtain "shared experience" from the participant will help the researcher "make sense" of the participant trying to "make sense" of their relationship with mental health.*

3. Personal Feelings towards Health Care Services in the UK

- Could you tell me about your experiences with health care services in the UK?

- Do you think your experiences with healthcare services in the UK are common amongst other people with a shared heritage to you?

> *These two questions take a different perspective on the dialogue by asking the participant first about their experiences with healthcare services and then comparing those experiences at the group level. The rational for this "perspective" is because research (Appleby et al., 2020; Codjoe et al., 2019) has emphasised that there is a contemporary theme of "mistrust" nested in BAME communities towards healthcare services due to not feeling prioritised and prolonged hospital waiting times. This "mistrust" towards public services acts as an additional barrier for engagement and access that further exacerbates feelings of mental health stigma. This question is put forward to see if this theme is contemporary amongst this cohort.*

- In your opinion, what do you think holds people from your community back from engaging with health care services? How could health-care services resolve this? (Barrier)

> *This question probes the participant to highlight what issue/s inhibit people with* a shared *heritage to them from engaging with healthcare services. The rational for this is because identification of such barriers will give clarity to how a healthcare service could resolve this issue as "improving relations" between* specific ethnic *populations and healthcare services is a joint venture (Memon et al., 2016).*

4. Personal Beliefs towards Ca-CBT

- Brief overview of what CBT & Ca-CBT are.

> *To combat stereotypes in psychotherapy, "ethno-psychotherapy" is a new concept where "cultural adaptations" are applied to pre-existing therapies to accommodate for the ever-growing diverse population (Naeem et al., 2019). Adjusting the course of discussion in the context is essential to orient participants towards a thought process that'll best answer the research question.*

- Has/Have anyone/you ever heard about CBT and Ca-CBT? Why?

> *"Ethno-psychotherapy" is an initiative that originated in the USA and isn't fully integrated in the UK thus individuals may find the "movement" unbeknownst to them, thus this question needs to be in the interview process.*

- How do you feel about the development of a "Culturally adapted" component added to CBT? Why?

> *It isn't clear whether this initiative would be fully embraced by individuals of the same ethnic background although, literature thus far deems it positive (Naeem et al., 2019). Still, this question needs to be in the interview process to resolve any ambiguity.*

- **Are there any particular features that must be taken into account in order to reach and engage people from XXX culture in such a programme? (Facilitator)**

> *British Social Attitudes Survey (BSAS, 2019) revealed "low levels" of satisfaction and engagement among BAME groups towards the NHS. Thus, the questions aims to uncover if there are any components that should be added into "culturally adapted" programme to improve engagement and long-term adherence.*

- What would healthcare services need to include in this "culturally adapted component" to make it more relatable for individuals with shared heritage to you?

> *A contemporary limitation in research is that it isn't obvious what strategies need to be added into a "culturally adapted component" to improve relatedness between practitioner and recipient (Naeem et al., 2019). Consequently, this question aims to explore the ambiguity underlying culture to precisely define a "list of techniques" that could be useful.*

5. Closing the Interview

- Is there anything we've missed today that you feel needs further discussion?

> *This question is placed strategically for the participant to briefly meditate on whether all important aspects of discussion has been covered. Simultaneously, the researcher can also use this opportunity to contemplate on whether all relevant themes have been explored.*

- What did you feel was the most important thing we've spoken about today? Why?

> *An opportunity to summarise the interview process is recommended with a "summary type" questions (Tracy, 2013). In this instance, the interview is summarised with the participant highlighting what theme was deemed most important to them and why.*

Thank you for your time today.

APPENDIX 3.5) DISCRIMINATION & STIGMA SCALE (DISC-12)

Discrimination and Stigma Scale (DISC-12)

Version 22/04/09

Instructions for interviewer to read to participant

(Note to interviewer: Please use the below paragraph to introduce the scale to the participant, with further explanation if necessary)

"Discrimination and stigma occur when people are treated unfairly because they are seen as being different from others. This interview asks about how you've been affected by discrimination and stigma **because of mental health problems.**

There are four parts to this interview. Each part asks about how you have been treated or what you have done in different situations:

1. In the first part, I will ask about times when you have been treated **unfairly** because of mental health problems
2. In the second part, I will ask about times when you have **stopped yourself** from doing things because of how others might respond to your mental health problem
3. In the third part, I will ask about how you may have **overcome stigma and discrimination** because of mental health problems
4. In the fourth part, I will ask about any times when you have been treated **more positively** because of mental health problems

In each part of the interview, I will ask you to let me know whether each event has happened **not at all, a little, moderately or a lot**. I will also ask you to give me an example of this.

(Note to interviewer: Choose the timeframe for the study and adapt the below paragraph as appropriate)

For each question, please think about events which have happened **at any stage of your life since you first experienced mental health problems/during the last 12 months/during (specify timeframe).**

Here is a card with the choices for each answer for you to use throughout the interview. (Give participant the response choices card).

(Instructions for interviewer to read to participant)

"In this section I would like to ask about times when you have been treated **unfairly because of mental health problems**. There are **22 questions** in this section. Please choose **one** answer for each question"

1.	Have you been treated unfairly in making or keeping friends? Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

2.	Have you been treated unfairly by the people in your neighbourhood? Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

3.	Have you been treated unfairly in dating or intimate relationships? *(excluding treatment by spouse/co-habiting partner as covered by Q6)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

4.	Have you been treated unfairly in housing? *(including becoming homeless)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

5.	Have you been treated unfairly in your education? *(ask about school, college, university and on the job training or vocational courses)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

6.	Have you been treated unfairly in marriage or divorce? *(including co-habiting or civil partnership, ask about ability to find a partner or spouse, problems during the relationship, divorce settlements)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

7.	Have you been treated unfairly by your family? *(ask about family of origin i.e. parents, brothers, sisters and other relations as well as any children. Exclude treatment by spouse / co-habiting partner as covered by Q6)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

8.	Have you been treated unfairly in finding a job? *(this means finding full or part-time, paid work)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

9.	Have you been treated unfairly in keeping a job? Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

10.	Have you been treated unfairly when using public transport? *(ask about using free travel pass, passengers, drivers, etc)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

11.	Have you been treated unfairly in getting welfare benefits or disability pensions? *(ask about applying for benefits (e.g. income support, disability living allowance), level of benefits, support)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

12.	Have you been treated unfairly in your religious practices? *(ask about attending church, other church members, church leaders)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

13.	Have you been treated unfairly in your social life? *(ask about socialising, hobbies, attending events, leisure activities)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

14.	Have you been treated unfairly by the police? *(ask about any contact with police because of mental health problems or any other reasons)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

15.	Have you been treated unfairly when getting help for physical health problems? *(ask about GP, dentist, nurses, emergency treatment including A&E)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐
Give an example:______________________________					
16.	Have you been treated unfairly by mental health staff? (*ask about treatment and behaviour of staff, feeling disrespected or humiliated by contact with mental health staff)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐
Give an example:______________________________					
17.	Have you been treated unfairly in your levels of privacy? *(ask about privacy in hospital and in community settings, e.g. private letters or phone calls, medical records, criminal records bureau check)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐
Give an example:______________________________					
18.	Have you been treated unfairly in your personal safety and security?*(ask about verbal abuse, physical abuse, assault)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐
Give an example:______________________________					

19.	Have you been treated unfairly in starting a family or having children? *(ask about behaviour of health professionals, friends and family, as well as how they or their partner were treated during pregnancy or childbirth)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

20.	Have you been treated unfairly in your role as a parent to your children? *(ask about behaviour of other parents, teachers, family or mental health staff)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

21.	Have you been avoided or shunned by people who know that you have a mental health problem? Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

22.	Have you been treated unfairly in any other areas of life? *(e.g. experienced any kind of treatment/behaviour because of your mental health problem)* Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

(Instructions for interviewer to read to participant)

"In this section I would like to ask about times when you have **stopped yourself from doing things** that are important to you **because of how others might respond to your mental health problem**. There are **4 questions** in this section.
Please choose **one** answer for each question"

23.	Have you stopped yourself from applying for work?	Not at all	A little	Moderately	A lot
	Not applicable ☐	☐	☐	☐	☐
Give an example:______________________________					
24.	Have you stopped yourself from applying for education or training courses?	Not at all	A little	Moderately	A lot
	Not applicable ☐	☐	☐	☐	☐
Give an example:______________________________					
25.	Have you stopped yourself from having a close personal relationship?	Not at all	A little	Moderately	A lot
	Not applicable ☐	☐	☐	☐	☐
Give an example:______________________________					
26.	Have you concealed or hidden your mental health problem from others?	Not at all	A little	Moderately	A lot
	Not applicable ☐	☐	☐	☐	☐
Give an example:______________________________					

(Instructions for interviewer to read to participant)

"In this section I would like to ask you about examples of **overcoming** stigma and discrimination **because of mental health problems**.
There are **2 questions** in this section. Please choose **one** answer for each question"

27.	Have you made friends with people who don't use mental health services? Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

28.	Have you been able to use your personal skills or abilities in coping with stigma and discrimination? Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

(Instructions for interviewer to read to participant)

"In this section I would like to ask about times when you have been treated **more positively** because of **mental health problems**. Being treated "more positively" means any times when you have received special treatment. I would like to know if you have experienced any favorable treatment compared with how you were treated before you developed a mental health problem or compared with how people who don't have a mental health problem are treated.
There are **7 questions** in this section. Please choose **one** answer for each question"

29.	Have you been treated more positively by your family? (Includes family of origin, spouse/partner, children, relatives) Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

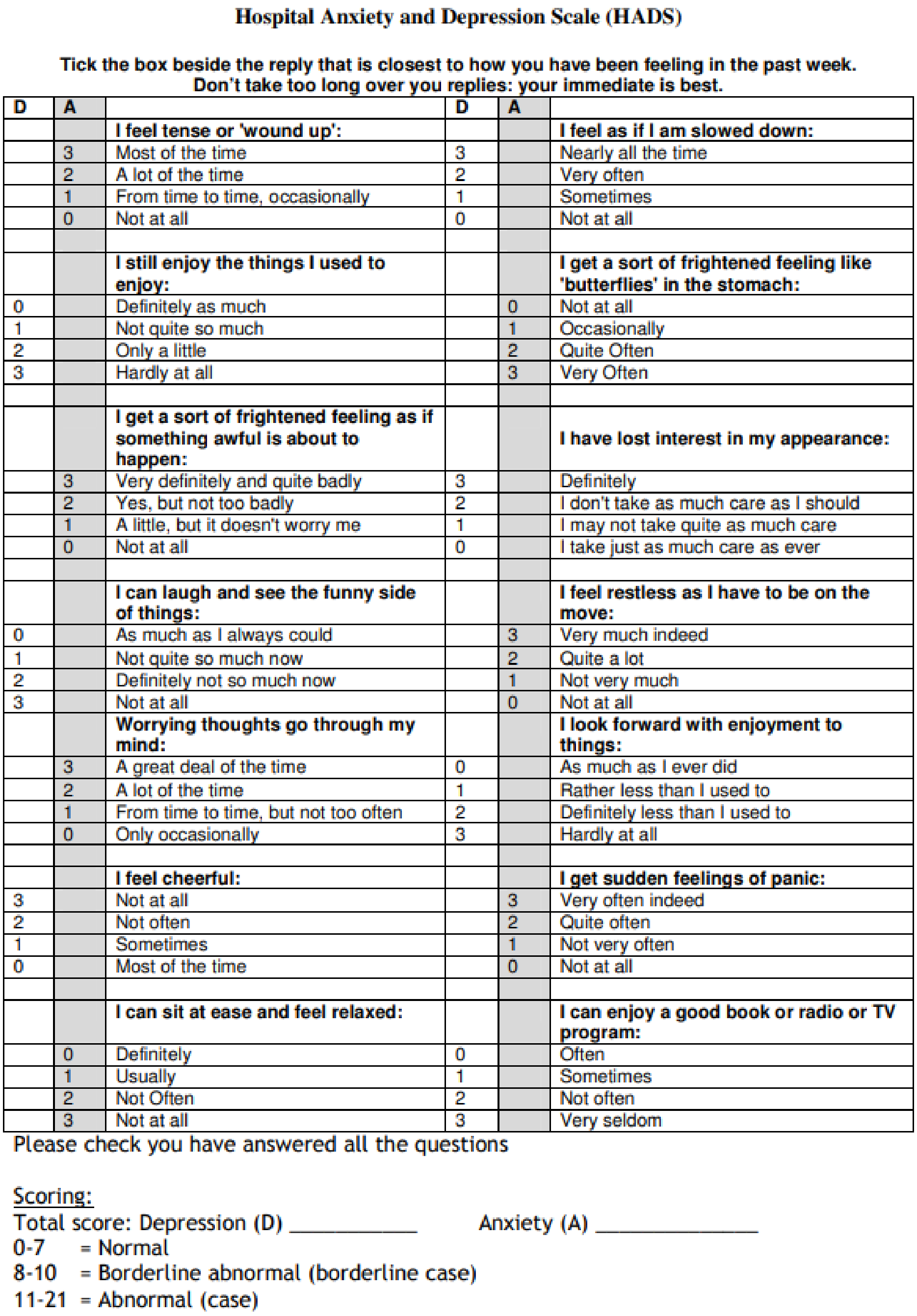
30.	Have you been treated more positively in getting welfare benefits or disability pensions? Not applicable ☐	Not at all	A little	Moderately	A lot
		☐	☐	☐	☐

Give an example:____

____

31.	Have you been treated more positively in housing?	Not at all	A little	Moderately	A lot
	Not applicable ☐	☐	☐	☐	☐
Give an example:________________________________					
32.	Have you been treated more positively in your religious activities?	Not at all	A little	Moderately	A lot
	Not applicable ☐	☐	☐	☐	☐
Give an example:________________________________					
33.	Have you been treated more positively in employment (*ask about finding work, keeping work and adjustments in the workplace*)?	Not at all	A little	Moderately	A lot
	Not applicable ☐	☐	☐	☐	☐
Give an example:________________________________ ____					
34.	Have you been treated more positively in any other areas of life? *(e.g. any kind of support that is not available to other people)*	Not at all	A little	Moderately	A lot
	Not applicable ☐	☐	☐	☐	☐
Give an example:________________________________					

APPENDIX 3.6) HOSPITAL ANXIETY AND DEPRESSION SCALE (HADS)



Hospital Anxiety and Depression Scale (HADS)

Tick the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

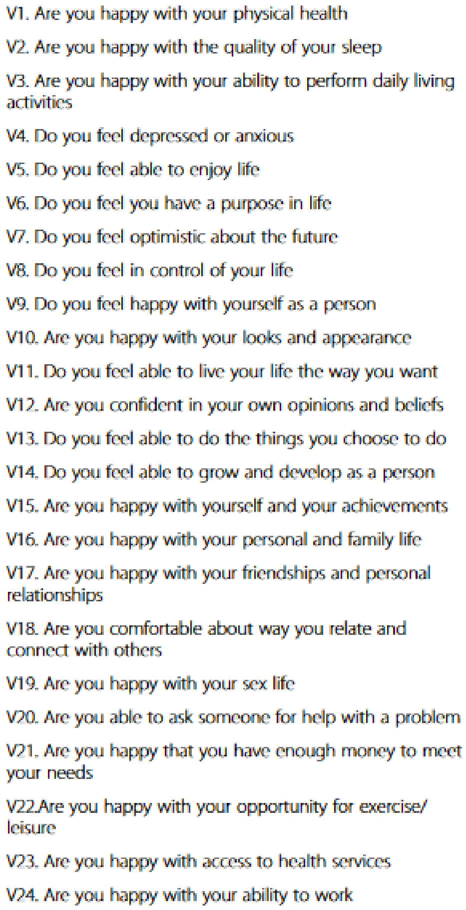
Please check you have answered all the questions

Scoring:

Total score: Depression (D) ___________ Anxiety (A) _____________

0-7 = Normal
8-10 = Borderline abnormal (borderline case)
11-21 = Abnormal (case)

Appendix 3.7) BBC-Subjective Wellbeing Scale (BBC-SWB; Pontin et al., 2013)



V1. Are you happy with your physical health

V2. Are you happy with the quality of your sleep

V3. Are you happy with your ability to perform daily living activities

V4. Do you feel depressed or anxious

V5. Do you feel able to enjoy life

V6. Do you feel you have a purpose in life

V7. Do you feel optimistic about the future

V8. Do you feel in control of your life

V9. Do you feel happy with yourself as a person

V10. Are you happy with your looks and appearance

V11. Do you feel able to live your life the way you want

V12. Are you confident in your own opinions and beliefs

V13. Do you feel able to do the things you choose to do

V14. Do you feel able to grow and develop as a person

V15. Are you happy with yourself and your achievements

V16. Are you happy with your personal and family life

V17. Are you happy with your friendships and personal relationships

V18. Are you comfortable about way you relate and connect with others

V19. Are you happy with your sex life

V20. Are you able to ask someone for help with a problem

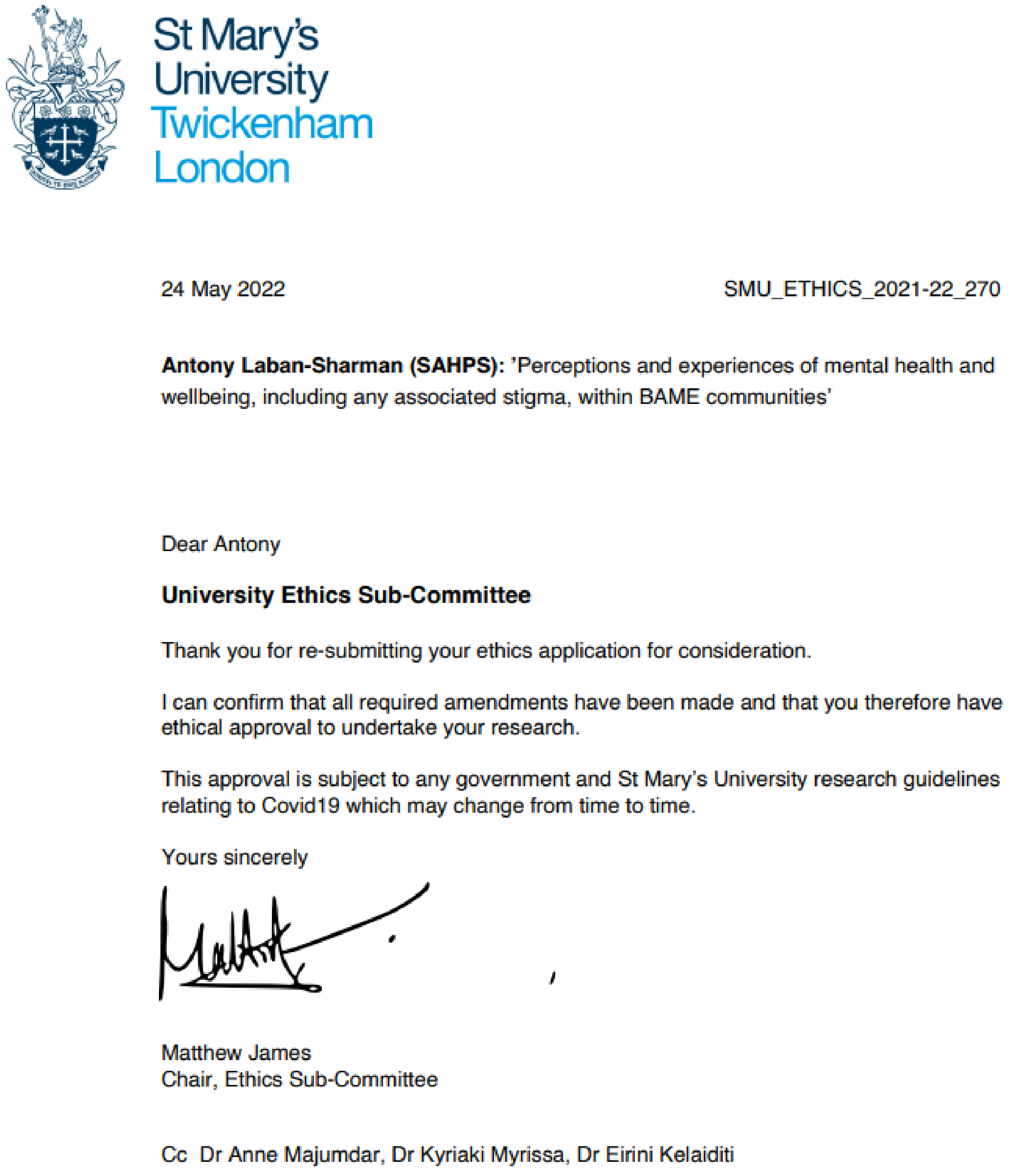
V21. Are you happy that you have enough money to meet your needs

V22.Are you happy with your opportunity for exercise/ leisure

V23. Are you happy with access to health services

V24. Are you happy with your ability to work

APPENDIX 3.8) ST MARY'S UNIVERSITY ETHICS COMMITTEE LEVEL 3 APPROVAL SHEET



St Mary's
University
Twickenham
London

24 May 2022 SMU_ETHICS_2021-22_270

Antony Laban-Sharman (SAHPS): 'Perceptions and experiences of mental health and wellbeing, including any associated stigma, within BAME communities'

Dear Antony

University Ethics Sub-Committee

Thank you for re-submitting your ethics application for consideration.

I can confirm that all required amendments have been made and that you therefore have ethical approval to undertake your research.

This approval is subject to any government and St Mary's University research guidelines relating to Covid19 which may change from time to time.

Yours sincerely

Matthew James
Chair, Ethics Sub-Committee

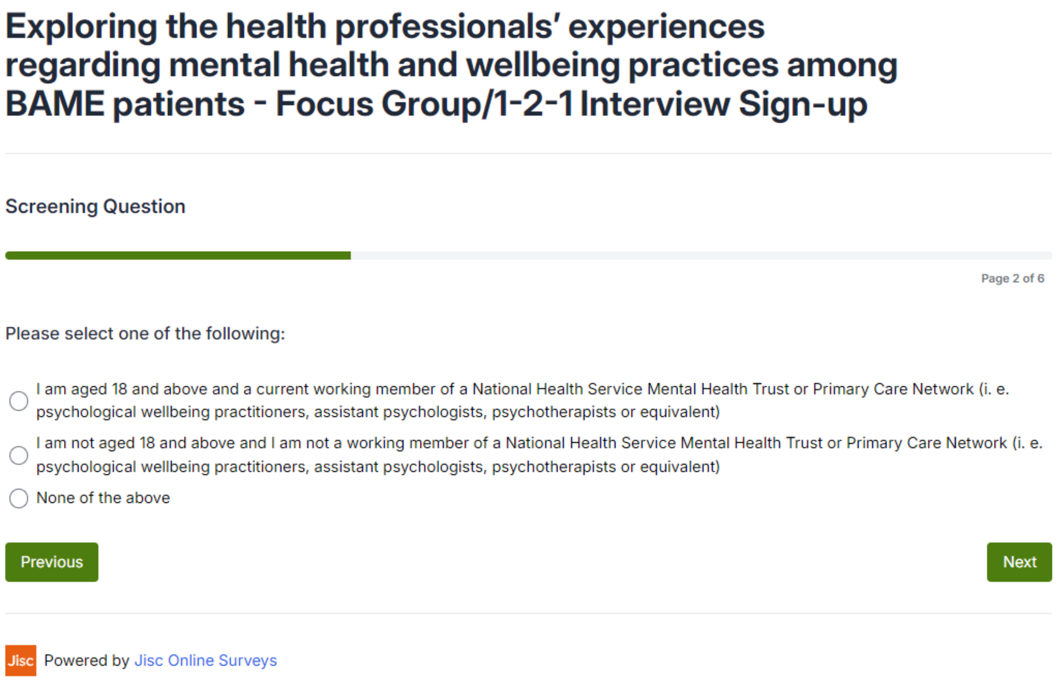
Cc Dr Anne Majumdar, Dr Kyriaki Myrissa, Dr Eirini Kelaiditi

APPENDIX 5.1) ONLINE RECRUITMENT SURVEY, PARTICIPANT INFORMATION & CONSENT

Exploring the health professionals' experiences regarding mental health and wellbeing practices among BAME patients - Focus Group/1-2-1 Interview Sign-up

Generic Information About The Survey & Study

Welcome to the Focus Group/1-2-1 Interview Sign-up for the following study: "Exploring health professionals' experiences regarding mental health and wellbeing practices among BAME patients" My name is Antony Laban-Sharman and I am a doctorate student at St. Mary's University, Twickenham, London currently pursuing a Ph.D. in Health Psychology. I'm conducting a research study exploring health professionals' experiences regarding mental health and wellbeing practices among black, Asian and minority ethnic (BAME) patients. Research has highlighted that BAME populations present augmented rates of mental health conditions with 1 in 5 BAME adults reporting anxiety and depression post Covid-19. Furthermore, traditional therapies to manage mental health in BAME populations do not address stigma and this can affect engagement of BAME groups with mental health services. Research has highlighted that therapist characteristics affect 5-8% of mental health treatment outcomes and thus have the potential to improve psychotherapy outcomes in BAME populations. Thus, we are interested in exploring your professional experiences when working with BAME populations and to provide further comments on existing research findings associated with culturally adapted therapy. Learning more about this will help us design suitable interventions for BAME populations. The sign-up survey will take approximately 5 minutes to complete. All participants that pass the screening question will have the opportunity to sign-up for a focus group or 1-2-1 interview. This survey and study will remain anonymous, confidential and only the researcher and supervisor will have access and be able to manage the information provided from the study. All information will be stored on the St. Mary's password protected servers in accordance with the UK Data Protection Act 2018. Contact for further information: Antony Laban-Sharman (researcher) - 153425@live.stmarys.ac.uk Dr Anne Majumdar (supervisor) - anne.majumdar@stmarys.ac.uk

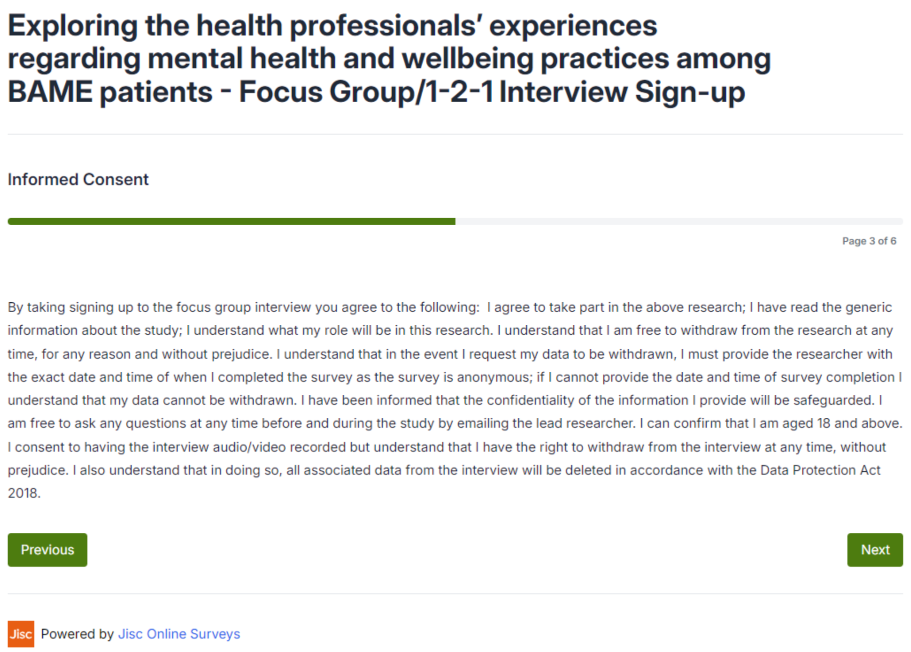


Exploring the health professionals' experiences regarding mental health and wellbeing practices among BAME patients - Focus Group/1-2-1 Interview Sign-up

Screening Question

Please select one of the following:

- ○ I am aged 18 and above and a current working member of a National Health Service Mental Health Trust or Primary Care Network (i. e. psychological wellbeing practitioners, assistant psychologists, psychotherapists or equivalent)
- ○ I am not aged 18 and above and I am not a working member of a National Health Service Mental Health Trust or Primary Care Network (i. e. psychological wellbeing practitioners, assistant psychologists, psychotherapists or equivalent)
- ○ None of the above



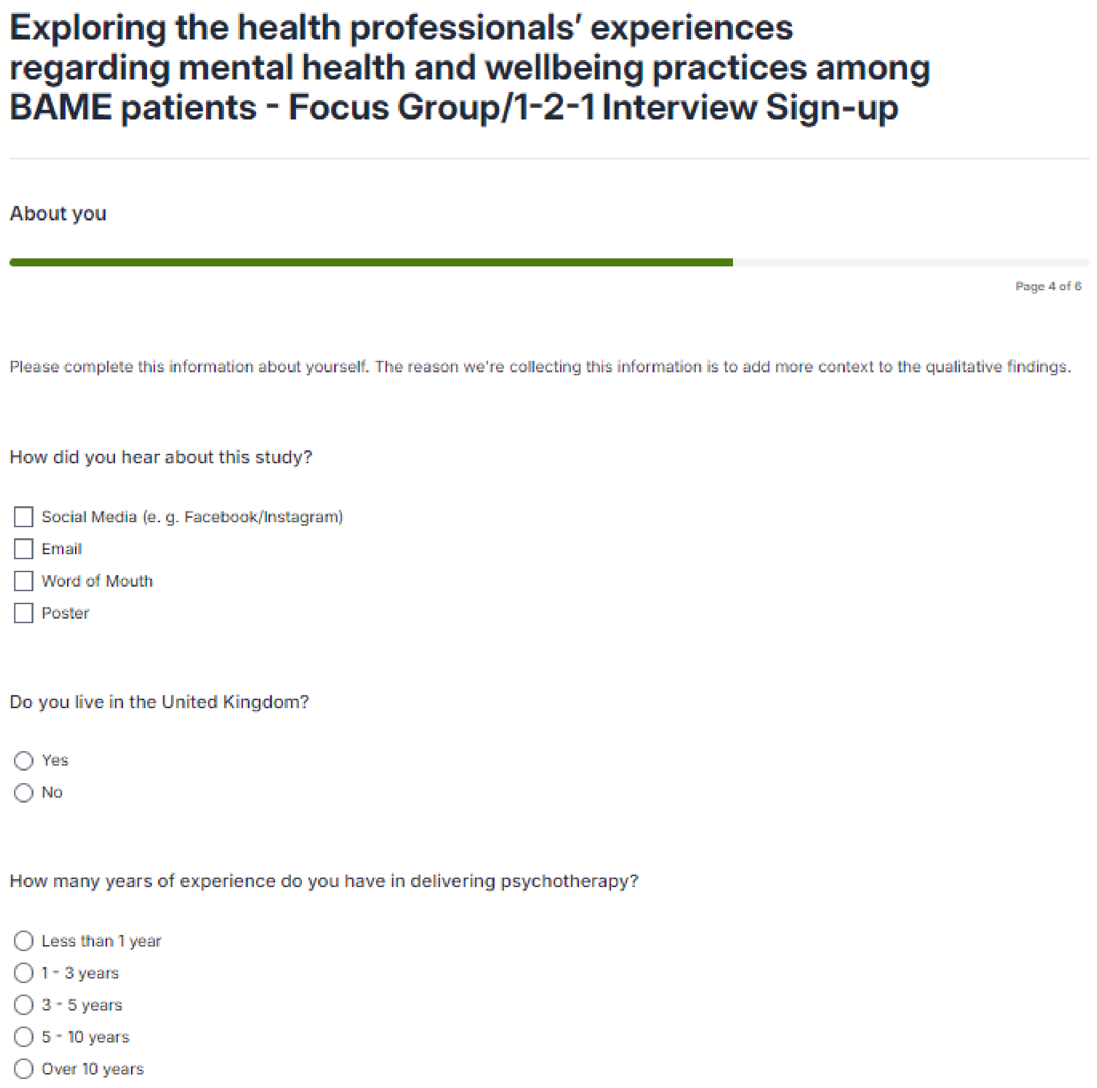
Exploring the health professionals' experiences regarding mental health and wellbeing practices among BAME patients - Focus Group/1-2-1 Interview Sign-up

Informed Consent

Page 3 of 6

By taking signing up to the focus group interview you agree to the following: I agree to take part in the above research; I have read the generic information about the study; I understand what my role will be in this research. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice. I understand that in the event I request my data to be withdrawn, I must provide the researcher with the exact date and time of when I completed the survey as the survey is anonymous; if I cannot provide the date and time of survey completion I understand that my data cannot be withdrawn. I have been informed that the confidentiality of the information I provide will be safeguarded. I am free to ask any questions at any time before and during the study by emailing the lead researcher. I can confirm that I am aged 18 and above. I consent to having the interview audio/video recorded but understand that I have the right to withdraw from the interview at any time, without prejudice. I also understand that in doing so, all associated data from the interview will be deleted in accordance with the Data Protection Act 2018.

Powered by Jisc Online Surveys



Exploring the health professionals' experiences regarding mental health and wellbeing practices among BAME patients - Focus Group/1-2-1 Interview Sign-up

About you

Page 4 of 6

Please complete this information about yourself. The reason we're collecting this information is to add more context to the qualitative findings.

How did you hear about this study?

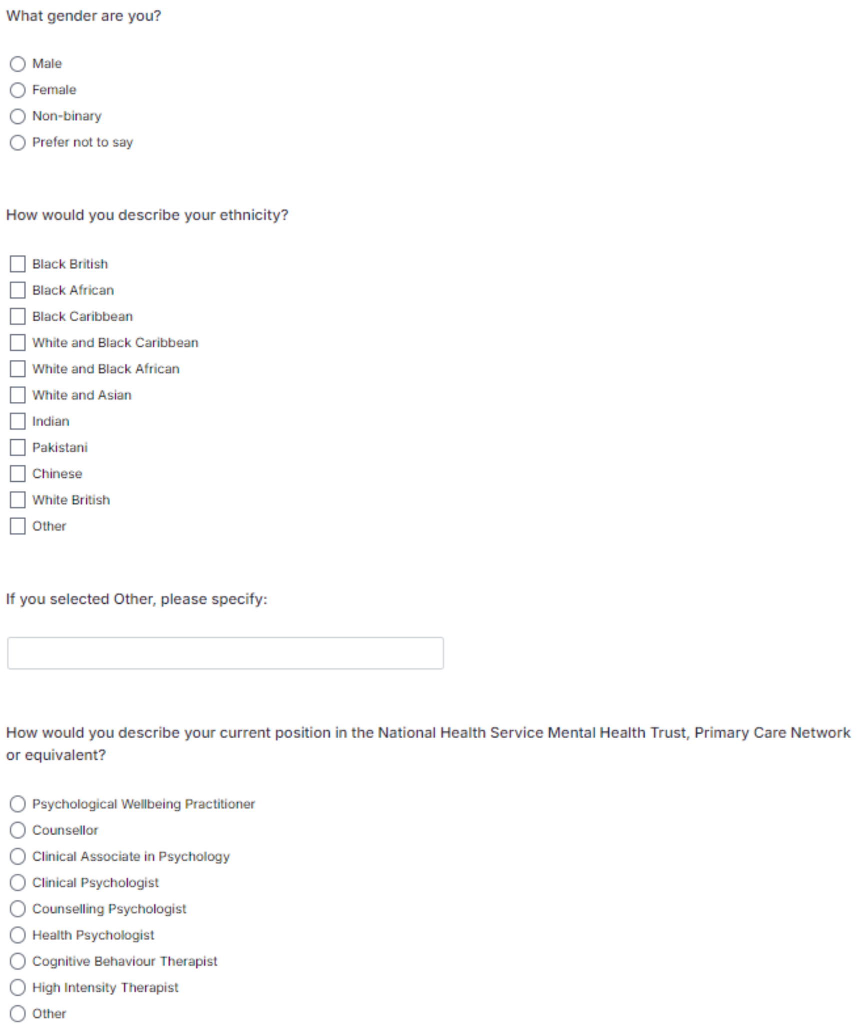
☐ Social Media (e. g. Facebook/Instagram)
☐ Email
☐ Word of Mouth
☐ Poster

Do you live in the United Kingdom?

○ Yes
○ No

How many years of experience do you have in delivering psychotherapy?

○ Less than 1 year
○ 1 - 3 years
○ 3 - 5 years
○ 5 - 10 years
○ Over 10 years



What gender are you?

- ○ Male
- ○ Female
- ○ Non-binary
- ○ Prefer not to say

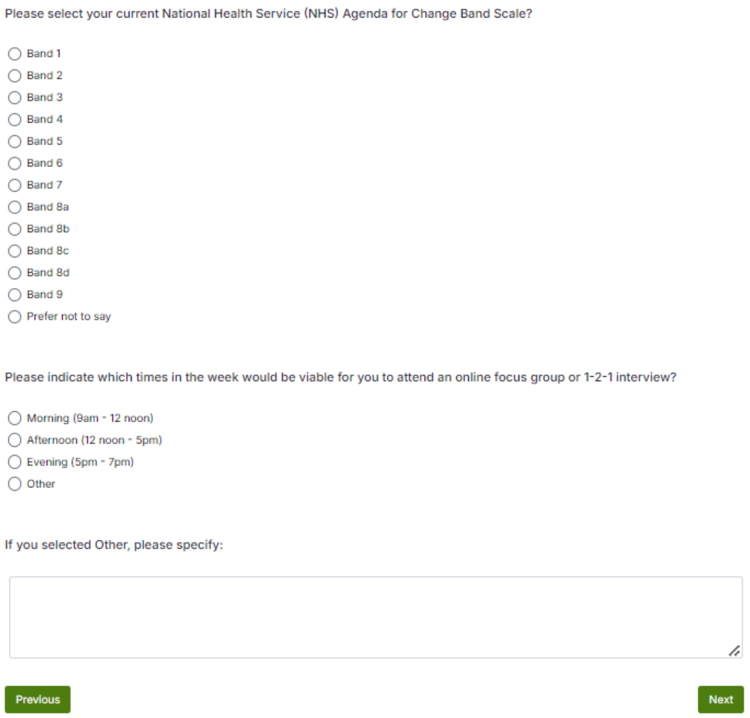
How would you describe your ethnicity?

- ☐ Black British
- ☐ Black African
- ☐ Black Caribbean
- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Indian
- ☐ Pakistani
- ☐ Chinese
- ☐ White British
- ☐ Other

If you selected Other, please specify:

How would you describe your current position in the National Health Service Mental Health Trust, Primary Care Network or equivalent?

- ○ Psychological Wellbeing Practitioner
- ○ Counsellor
- ○ Clinical Associate in Psychology
- ○ Clinical Psychologist
- ○ Counselling Psychologist
- ○ Health Psychologist
- ○ Cognitive Behaviour Therapist
- ○ High Intensity Therapist
- ○ Other



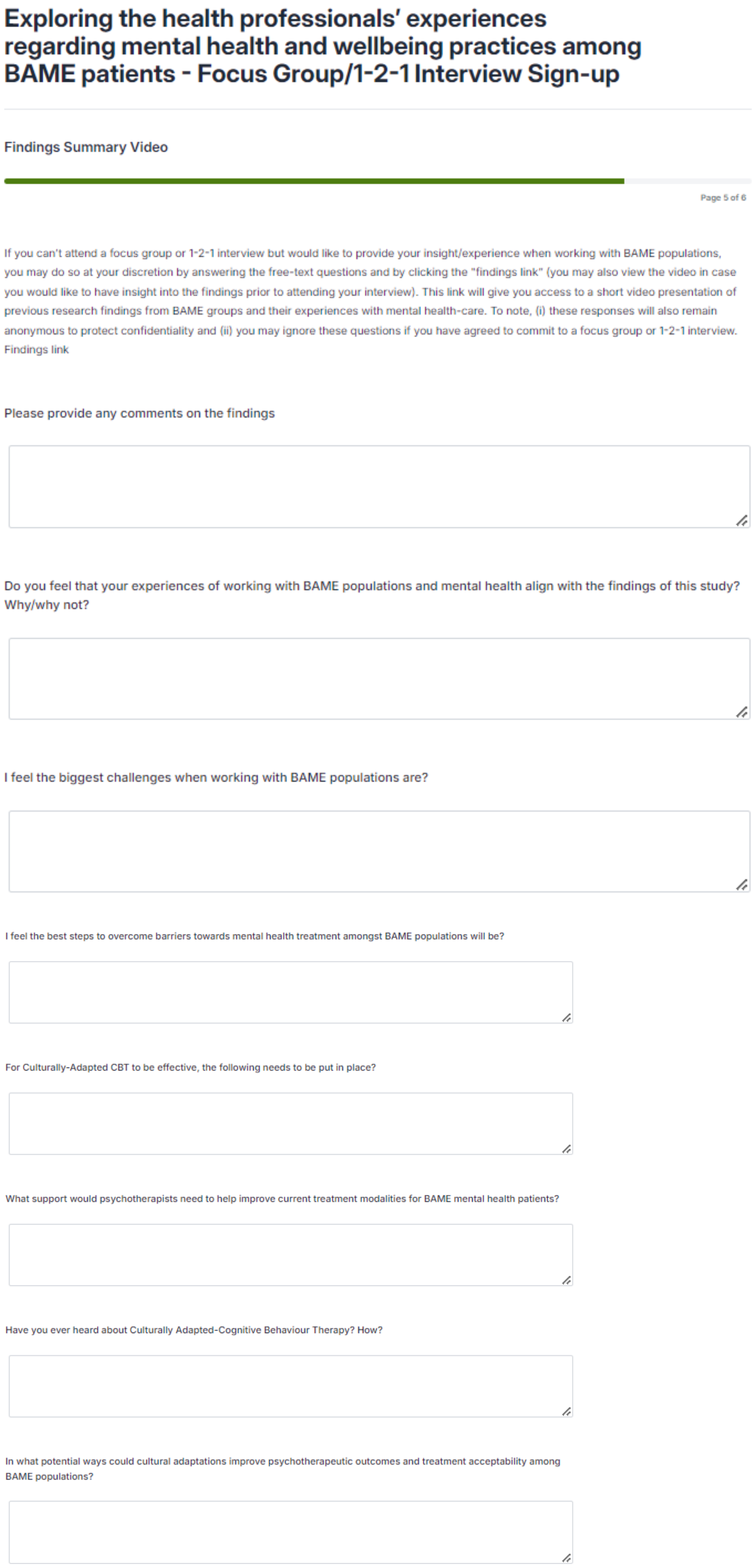
Please select your current National Health Service (NHS) Agenda for Change Band Scale?

- ○ Band 1
- ○ Band 2
- ○ Band 3
- ○ Band 4
- ○ Band 5
- ○ Band 6
- ○ Band 7
- ○ Band 8a
- ○ Band 8b
- ○ Band 8c
- ○ Band 8d
- ○ Band 9
- ○ Prefer not to say

Please indicate which times in the week would be viable for you to attend an online focus group or 1-2-1 interview?

- ○ Morning (9am - 12 noon)
- ○ Afternoon (12 noon - 5pm)
- ○ Evening (5pm - 7pm)
- ○ Other

If you selected Other, please specify:



Exploring the health professionals' experiences regarding mental health and wellbeing practices among BAME patients - Focus Group/1-2-1 Interview Sign-up

Findings Summary Video

Page 5 of 6

If you can't attend a focus group or 1-2-1 interview but would like to provide your insight/experience when working with BAME populations, you may do so at your discretion by answering the free-text questions and by clicking the "findings link" (you may also view the video in case you would like to have insight into the findings prior to attending your interview). This link will give you access to a short video presentation of previous research findings from BAME groups and their experiences with mental health-care. To note, (i) these responses will also remain anonymous to protect confidentiality and (ii) you may ignore these questions if you have agreed to commit to a focus group or 1-2-1 interview.
Findings link

Please provide any comments on the findings

Do you feel that your experiences of working with BAME populations and mental health align with the findings of this study? Why/why not?

I feel the biggest challenges when working with BAME populations are?

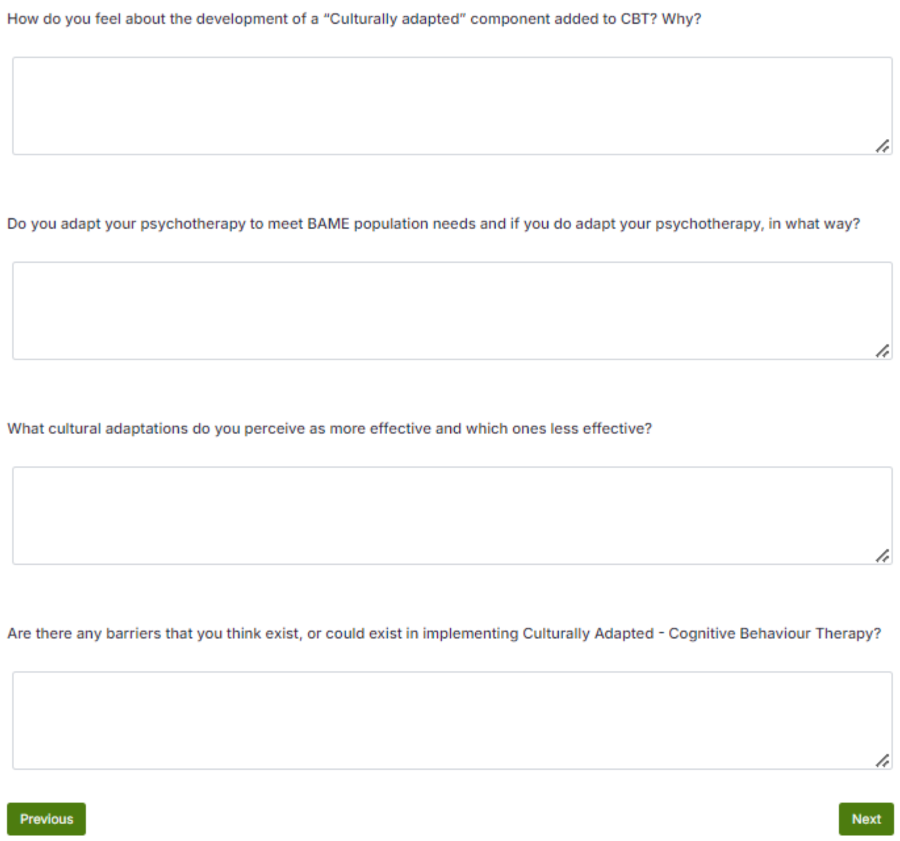
I feel the best steps to overcome barriers towards mental health treatment amongst BAME populations will be?

For Culturally-Adapted CBT to be effective, the following needs to be put in place?

What support would psychotherapists need to help improve current treatment modalities for BAME mental health patients?

Have you ever heard about Culturally Adapted-Cognitive Behaviour Therapy? How?

In what potential ways could cultural adaptations improve psychotherapeutic outcomes and treatment acceptability among BAME populations?

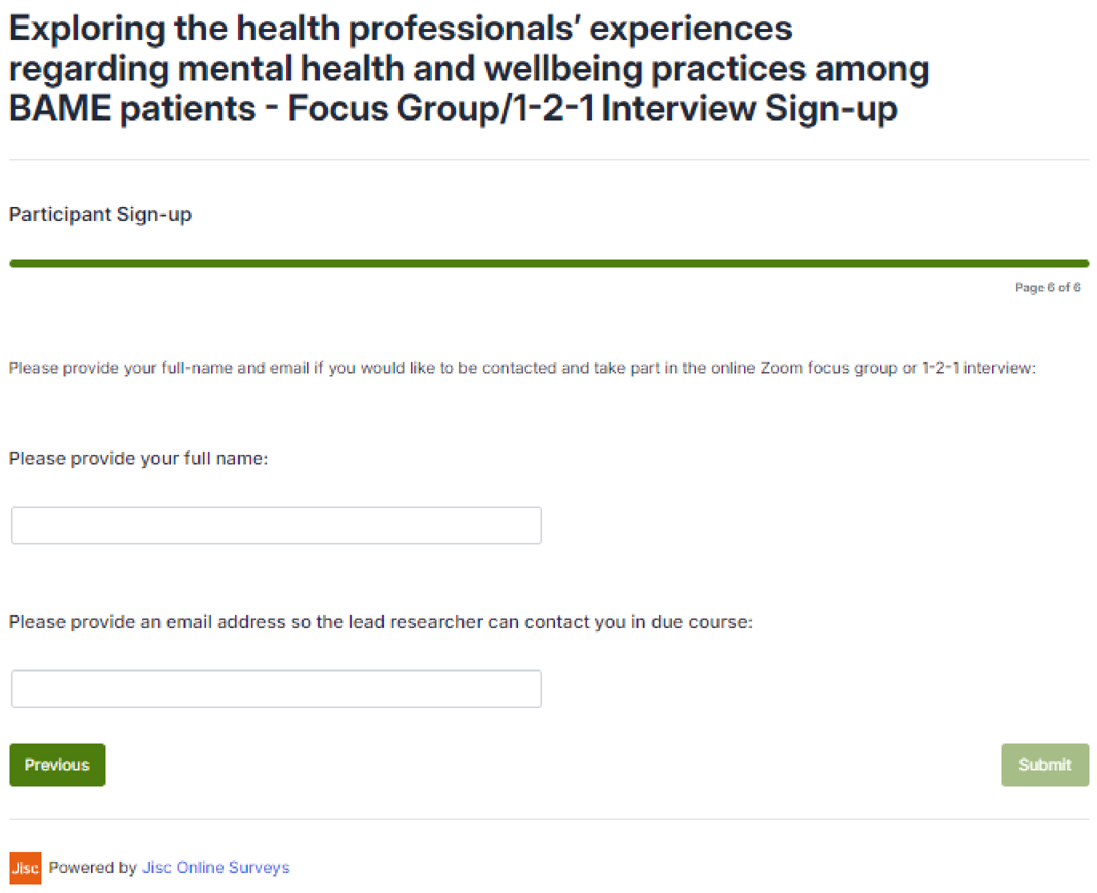


How do you feel about the development of a "Culturally adapted" component added to CBT? Why?

Do you adapt your psychotherapy to meet BAME population needs and if you do adapt your psychotherapy, in what way?

What cultural adaptations do you perceive as more effective and which ones less effective?

Are there any barriers that you think exist, or could exist in implementing Culturally Adapted - Cognitive Behaviour Therapy?



Exploring the health professionals' experiences regarding mental health and wellbeing practices among BAME patients - Focus Group/1-2-1 Interview Sign-up

Participant Sign-up

Page 6 of 6

Please provide your full-name and email if you would like to be contacted and take part in the online Zoom focus group or 1-2-1 interview:

Please provide your full name:

Please provide an email address so the lead researcher can contact you in due course:

APPENDIX 5.2) WRITTEN CONSENT FORM WITH WITHDRAWAL SECTION

Name of Participant: ____

Title of the project: Exploring health professionals' experiences regarding mental health and wellbeing practices among BAME patients

Main investigator and contact details: Antony Laban-Sharman - 153425@live.stmarys.ac.uk

Members of the research team:

- Dr Anne Majumdar - anne.majumdar@stmarys.ac.uk; Contact Number – 0208 240 2312
- Dr Kyriaki Myrissa
- Dr Eirini Kelaiditi
- Prof Symeon Dagkas

1. I agree to take part in the above research. I have read the Participant Information Sheet which is attached to this form. I understand what my role will be in this research, and all my questions have been answered to my satisfaction.

2. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice.

3. I have been informed that the confidentiality of the information I provide will be safeguarded.

4. I am free to ask any questions at any time before and during the study.

5. I have been provided with a copy of this form and the Participant Information Sheet.

Data Protection: I agree to the University processing personal data which I have supplied. I agree to the processing of such data for any purposes connected with the Research Project as outlined to me.

Name of participant (print)………………………………………………………………………..

Signed………………..…………………   Date……………………………........

If you wish to withdraw from the research, please complete the form below and return to the main investigator named above.

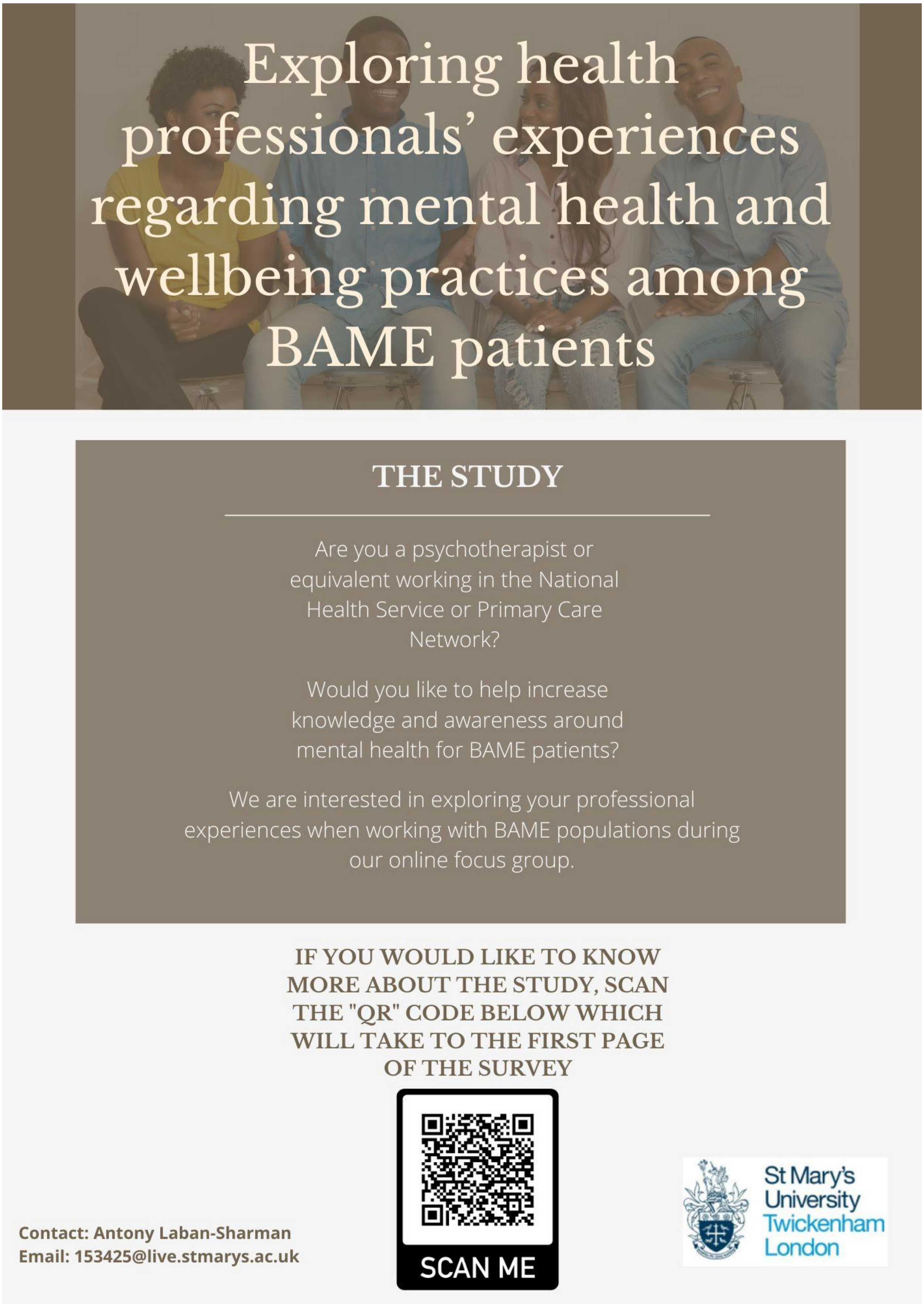
Title of Project: ____

I WISH TO WITHDRAW FROM THIS STUDY

Name: ____

Signed: ____________________________________   Date: _____________________

APPENDIX 5.3) PARTICIPANT RECRUITMENT POSTER



Exploring health professionals' experiences regarding mental health and wellbeing practices among BAME patients

THE STUDY

Are you a psychotherapist or equivalent working in the National Health Service or Primary Care Network?

Would you like to help increase knowledge and awareness around mental health for BAME patients?

We are interested in exploring your professional experiences when working with BAME populations during our online focus group.

IF YOU WOULD LIKE TO KNOW MORE ABOUT THE STUDY, SCAN THE "QR" CODE BELOW WHICH WILL TAKE TO THE FIRST PAGE OF THE SURVEY

SCAN ME

Contact: Antony Laban-Sharman
Email: 153425@live.stmarys.ac.uk

St Mary's University Twickenham London

APPENDIX 5.4) INTERVIEW QUESTIONS

1. Opening Questions

- **Informed consent**

- How are/is everyone doing today?

- I have scheduled us for 30 minutes today, is that still okay with you/everyone?

- Will provide an overview of the interview so that the participants know what to expect.

- Any questions before we begin?

- **Rapport building**

- I will introduce myself and the topic to create rapport, empathy and "set the scene" for open discussion (Smith, 2006)

> *The rationale for the "opening questions" section are that i) the "informed consent" section acts as an opportunity to establish informed consent and ii) the "rapport building" section is nested for the purpose of vicarious sharing of emotion (empathy) (Smith, 2006) to build rapport and reciprocation of information.*

2. Professional experience working with BAME mental health patients

- How would you describe your experiences when working with BAME mental health patients? How did you decide this?

> *This is an open-ended question, guided by Tracy (2013) and Larkin et al. (2006), with the aim of encouraging storytelling and narrative. Specifically, the question is asking "How would you describe" probing contemplation and deep thought to extract feelings, thoughts and experiences. Note that the follow-up question is another "How" rather than "why" as asking "why" would likely lead to a short justification of the resolve (Tracy, 2013) however asking "how" asks the recipient to give the "story" behind the rational thus aiming to extract a deeper level of analyses (Pietkiewicz & Smith, 2014).*

- What challenges do you expect to face as a psychotherapist when working with BAME populations?

> *As there is an inordinate number of challenges when working with BAME populations (Alvidrez et al., 2008), stigma beliefs being one of them (Cheng et al., 2018), this question aims to flesh out the underlying ontological stance of the practitioner in relationship with BAME mental health to assess if such challenges overlap with the Chapter 3 study or if they are idiosyncratic.*

- What in your opinion, is the main challenge when working with BAME mental health patients?

> *This question aims to "narrow down" a singular "challenge" to help "focus" future culturally adapted guidelines (Naeem et al., 2019). Doing so will help complement existing*

conceptual typologies (Arundell et al., 2021) alongside improving psychotherapeutic impact on BAME mental health patients (Green et al., 2014). Additionally, the rational for this is because identification of such barriers will give clarity to how a healthcare service could resolve this issue as "improving relations" between specific ethnic *populations and healthcare services is a joint venture (Memon et al., 2016).*

- What competencies do you think are essential for a psychotherapist to possess when working with BAME populations?

Research has highlighted that psychotherapists characteristics affect 5-8% of MH treatment outcomes (Green et al., 2014) and thus have the potential to improve psychotherapy outcomes in BAME groups (Naeem et al., 2019). With that being said, this question aims to unpack which intrapersonal competencies could completement the psychotherapeutic BAME mental health treatment pathway.

- What support would psychotherapists need to help improve current treatment modalities for BAME mental health patients?

With existing conceptual typologies (Arundell et al., 2021), this question helps guide practitioners on what additional support may be required to improve BAME psychotherapeutic modalities (Naeem et al., 2019).

- What strategies should a psychotherapist use to engage BAME service users and overcome barriers presented?

As there is an inordinate number of challenges when working with BAME populations (Alvidrez et al., 2008), stigma beliefs being one of them (Cheng et al., 2018) including mistrust towards health services (Appleby et al., 2020; Codjoe et al., 2019), this question aims to flesh out what strategies psychotherapist use to help overcome barriers presented and increase psychotherapeutic adherence when working with BAME populations. This question can help refine existing culturally adapted typologies (Arundell et al., 2021) and better shape the surrounding evidence base.

3. Comments on findings associated with Chapter 3

- From watching the short video presentation, could you provide any comments on the findings presented in the previous study? How did you decide this?

Participants in the previous study have "unpacked" three clusters of ethnic specific themes related to their relationship with mental health and their comments on "ethno-psychotherapy". To combat stereotypes in psychotherapy, "ethno-psychotherapy" is a new concept where "cultural adaptations" are applied to pre-existing therapies to accommodate for the ever-growing diverse population (Naeem et al., 2019). Adjusting the *course of discussion in the context is essential to orient participants towards a thought process that'll best answer the research question.*

- How do the themes mentioned in the previous study relate to your professional experience when working with BAME patients?

One of the objectives of this research is to discuss the results from the stage 2 study, and potential ways cultural adaptations could improve psychotherapeutic outcomes and treatment acceptability among BAME populations.

- I feel the biggest challenges when working with BAME populations are?

  Numerous challenges illustrated in the literature (Memon et al., 2016), thus important to know what challenges are psychotherapists most subjected to.

- For Culturally-Adapted CBT to be effective, the following needs to be put in place?

  Unclear which aspects to Ca-CBT would be effective (Naeem et al., 2019), thus this question aims to explain that ambiguity from the practitioner's stance.

- What support would psychotherapists need to help improve current treatment modalities for BAME mental health patients?

  It isn't clear what support psychotherapists need to successful implement CA-CBT (Naeem et al., 2019), thus this question aims to resolve ambiguity and aim in illustrating future policy around psychotherapeutic support.

- Has/Have anyone/you ever heard Culturally Adapted-Cognitive Behaviour Therapy? How?

"Ethno-psychotherapy" is an initiative that originated in the USA and isn't fully integrated in the UK thus individuals may find the "movement" unbeknownst to them, thus this question needs to be in the interview process.

- In what potential ways could cultural adaptations improve psychotherapeutic outcomes and treatment acceptability among BAME populations?

A contemporary limitation in research is that it isn't obvious what strategies need to be added into a "culturally adapted component" to improve relatedness between practitioner and recipient (Naeem et al., 2019). Consequently, this question aims to explore the ambiguity underlying culture to precisely define a "list of techniques" that could be useful.

- How do you feel about the development of a "Culturally adapted" component added to CBT? Why?

It isn't clear whether this initiative would be fully embraced by practitioners (Naeem et al., 2019). Still, this question needs to be in the interview process to resolve any ambiguity.

- Do you adapt your psychotherapy to meet BAME population needs and if you do adapt your psychotherapy, in what way?

It has been hypothesised that treatment characteristics effects 5-8% variance in psychotherapeutic outcomes (Green et al., 2014). Additionally, it is also suggested that therapists, when working with BAME populations may inherently adapt therapy to meet cultural variance. Thus, it is important to know that if this is the case, in what way is therapy adapted for future study replicability.

- What cultural adaptations do you perceive as more effective and which ones less effective?

Despite existing conceptual typology (Arundell et al., 2021), it is not clear which of the different existing cultural adaptations are most effective in mitigating neurotic feelings in BAME populations. This question can help guide future practitioners on which cultural adaptations to include with specific BAME populations and which to exclude.

- Are there any barriers that you think exist, or could exist in implementing Ca-CBT?

Important to understand what barriers exist or could prevent the successful integration of Ca-CBT in psychotherapeutic practice. Understanding barriers can help nest further modification for success delivery, in addition to saving time and cost for the public sector.

5. Closing the Interview

- Is there anything we've missed today that you feel needs further discussion?

This question is placed strategically for the participants to briefly meditate on whether all important aspects of discussion has been covered. Simultaneously, the researcher can also use this opportunity to contemplate on whether all relevant themes have been explored.

- What did you feel was the most important thing we've spoken about today? Why?

An opportunity to summarise the interview process is recommended with a "summary type" questions (Tracy, 2013). In this instance, the interview is summarised with the participant highlighting what theme was deemed most important to them and why.

APPENDIX 5.5) ST MARY'S UNIVERSITY ETHICS COMMITTEE LEVEL 2 APPROVAL SHEET

St Mary's
University
Twickenham
London

Approval Sheet

(This sheet must be signed at all relevant boxes)

Name of proposer(s)	Antony Laban-Sharman
Name of supervisor(s)	Dr Kyriaki Myrissa, Dr Eirini Kelaiditi, Dr Anne Majumdar & Prof Symeon Dagkas
Programme of study	PhD Health Studies
Title of project	Exploring health professionals' experiences regarding mental health and wellbeing practices among BAME patients

Supervisors, please complete section 1. If approved at level 1, please forward a copy of this Approval Sheet to the Faculty Ethics Representative for their records.

SECTION 1: To be completed by supervisor. (for student research projects). PhD/MPhil applications must be referred to and reviewed by an Ethics Representative at Section 2 below.

☐ Approved at Level 1.

☐ Refer to Ethics Representative for consideration.

Name of Supervisor:			
Signature of Supervisor:		Date:	

SECTION 2: To be completed by Ethics Representative.

☐ Approved at Level 1

X☐ Approved at Level 2

☐ Level 3 consideration is required by Ethics Sub-Committee.

Name of Faculty Ethics Representative:	Dr Holly Chinnery		
Signature of Faculty Ethics Representative:		Date:	08/02/2023

APPENDIX 5.6) QUALITATIVE RESEARCH EVALUATION – ASSESSING DATA COLLECTION QUALITY USING LEONIDAKI'S (2015) APPRAISAL TOOL

Leonidaki (2015) provided an appraisal tool (Appendix 5.8) that allows researchers to assess the quality of their research process, and in particular their qualitative findings. The appraisal criteria in Leonidaki's (2015) tool is organised into nine separate sections, with each section containing questions to evaluate the quality of qualitative research across different stages (Leonidaki, 2015). The tool includes 56 items, scored as 0 (No) or 1 (Yes), with the final score calculated by dividing the number of "yes" responses by the total applicable items (excluding "Non Applicable" questions) (Leonidaki, 2015). Scores are categorised as follows: 0–0.45 ("poor quality"), 0.46–0.69 ("fair quality"), and above 0.70 ("high quality") (Leonidaki, 2015). The analysis resulted in a score of 0.88 (i.e., high quality) (Leonidaki, 2015) and is supplemented with qualitative insights by the author for each domain to enhance transparency for the reader.

1. Context and Purpose

In this thesis, I presented a cogent and comprehensive picture of the theoretical and empirical context of health inequalities and mental health care for BAME populations. My goal was to explore the various factors that underpinned the complexities of health inequalities and how these factors influenced the perceptions and experiences of BAME individuals when accessing psychotherapeutic interventions. I aimed to address gaps in understanding by exploring a specific intersection of health inequality in BAME populations, striving to provide both quantitative and qualitative insights for the reader. This aligns with the importance of having a clear purpose and theoretical grounding, as outlined by Leonidaki (2015) criteria.

2. Recruitment

For recruitment, transparency was ensured by providing appropriate information about participants selection, inclusion criteria, recruitment channels and consent procedures. The sample was chosen to reflect the diversity within BAME populations, in consideration to the CRED (2021) report highlighting the necessity for ethnic centred research. However, there could have been further detail potentially for how participants were approached as, all participants who volunteered for the interviews did so via online channels.

3. Situating the Sample

In this thesis, the sample was selected to align with the research objectives. BAME participants were categorised based on the PHE (2020b) “list of ethnicities” report and CRED (2021) report, ensuring ethnic-centred insights and facilitating potential comparisons between ethnic groups. This approach emphasised the importance of a sample closely aligned with the research questions. However, additional details about the interviewer’s experience and the time intervals between interviews and data analysis could have enhanced transparency for the reader.

4. Data Collection

In this thesis, the data collection process was cogent and transparent, with clear reporting of interview questions, participant consent and the disclosure of semi-structured interviews. The researcher adhered to practices for data collection as illustrated by Leonidaki (2015), ensuring the process was coherent and methodologically sound. These measures were designed to align with the study's objective of exploring the perceptions and experiences of psychotherapeutic practices among service users and providers. However, one limitation was that the interviewer was not independent from the intervention which may introduce a need for the reader to consider the findings with caution.

5. Analysis/Findings

The analysis in this thesis was thorough and reflective of the diversity and nuances within participant experiences, aligning with the appraisal criteria outlined by Leonidaki (2015). Detailed data extracts were presented to illustrate the complexities of participant narratives, particularly in relation to their cultural heritage. The researcher focused on how participants interpreted their experiences and how these interpretations shaped their views on mental health and therapeutic interventions. Notably, both divergent and contradictory data were identified. Divergent data emerged as a shared theme—such as mental health stigma—was consistently reported across all BAME participants but perceived differently between ethnic groups. These distinctions challenge prior assumptions in BAME research and underscore the need for an ethnically nuanced approach, as emphasised in the CRED (2021) report.

6. Auditability/Credibility

To ensure credibility, member checking was carried out in both Chapter 4 and 5 to ensure the initial coding reflected the participants' perceptions. This aligns with Leonidaki (2015) criteria for credibility checks. However, articulating an audit trail and regular review of the researchers intervention fidelity (e.g., reviewing the video interviews to ensure the IPA process was respected and adhered to) would have increased the robustness of the findings. Lastly, doing so would have provided additional transparency round the specific steps taken in data coding and theme development.

7. Impact and Value

The thesis findings have an impact for both policy and practice by illustrating how existing policy could be improved and how the qualitative insights can shape mental health interventions that are culturally sensitive and relevant to BAME populations. These points align with Leonidaki (2015) criteria on providing research that has impact and novelty.

8. Reflexivity

Reflexivity is an important aspect of my research; however the author acknowledges that reflexivity could have been better incorporated into the qualitative analysis process more consistently. Whilst I reflected on my positionality and potential biases through dialogue with my supervisor team, I did not consistently document this reflection in a systematic way (e.g., through a reflective journal). Furthermore, whilst I had no relationship with the participants, I could have articulated this boundary clearly to the reader. Consequently, in future research, I plan to use a more structured approach to documenting the qualitative analysis, alongside reflective journaling, to ensure that reflexive practices are consistently applied and reported for the reader.

9. Ethics

The author believes that ethical considerations were embedded throughout the research process. In particular, ethical approval was achieved through the St. Mary’s Ethics Panel, participants were given the opportunity to exercise their autonomy/consent, and their confidentiality was maintained at all times. The author demonstrated cultural sensitivity, recognizing the stigma and challenges BAME patients may face, while fostering a supportive environment for participants to reflect on and share their psychotherapeutic experiences during interviews.

APPENDIX 5.7) LEONIDAKI (2015) EVALUATION TOOL

Evaluation Criteria	**Presence/Applicability (Yes, No, N/A)***
1. **Context & Purpose**	
Does the paper:	
a. Review relevant literature, including previous research studies	Yes
b. Present a rational for the conduct of the study?	Yes
c. State explicitly its focus/aims/research questions?	Yes
2. **Recruitment**	
a. Are the selection criteria, and any deviations from them, described?	N/A
b. Is/are the methods of approaching participants reported?	No
c. Is there any discussion about potential participants who did not finally take part?	N/A
d. Did the selection criteria and recruitment method enable access to a sample that allowed for the aims of the study to be investigated?	Yes
e. Did the selection criteria and recruitment method enable access to a sample that allowed for the aims of the study to be investigated?	Yes
f. Is the sample composition consistent with the methodology used?	Yes
3. **Situation the sample:**	
Does the paper report:	
a. Participants age and gender?	Yes
b. Participants difficulties/presenting issues?	N/A
c. The grade or degree of experience that the therapist/ the professional delivering the intervention had?	No
d. Exactly when during/after participants' therapy/intervention the data was collected, e.g., a month after its completion?	No
e. Any information about the recruitment setting(s)?	Yes
f. The type and duration of the therapy/intervention, e.g., theoretical orientation of therapy, individual or group?	Yes
4. **Data collection**	
a. Is the interview as a method of data collection compatible with the aims of the study?	Yes
b. Does the paper report the questions/domains that guided data collection?	Yes
c. Is the content of the interview questions consistent with the study aims?	Yes
d. Is the degree of the interview structure appropriate to the methodology used?	Yes
e. Does the paper report the exact form of the original data e.g., transcribed interviews, video recording?	Yes

f.	Does the paper report any procedures for refining the data collection method(s), including a pilot study?	Yes
g.	Was the data collection conducted at an optimal time?	Yes
h.	Was the interviewer independent from the delivery of the intervention?	No
i.	Was the data collection setting different from the clinic where the participants received therapy/the intervention ?	Yes
5.	**Analysis/Findings**	
a.	Does the paper report the different stages of the data analysis?	Yes
b.	Is the reported process of analysis consistent with the study methodology?	Yes
c.	Is there sufficient data presented?	Yes
d.	Are the themes well-grounded in the data?	Yes
e.	Are any divergent/contradictory data presented?	Yes
f.	Is the final structure/frame produced by the analysis sufficiently synthesised?	Yes
g.	Does the paper make consistent use of either actual numbers or phrases such as “the majority of the participants” to indicate the prevalence of emerging themes in the sampling corpus?	Yes
6.	**Auditability/Credibility:** Does the paper:	
a.	Mention the use of an audit trail?	No
b.	Use Credibility Checks?	Yes
c.	Check therapist’s/practitioner’s adherence to the therapy modality/intervention delivered?	No
d.	Are the credibility methods used appropriate for the methodology of the study?	Yes
7.	**Impact & Value** Does the paper:	
a.	Does the paper link its findings to its aims/objectives/questions?	Yes
b.	Does the paper link its findings to the existing literature?	Yes
c.	Do clinical, practical or wider implications emerge from the findings?	Yes
d.	Do the findings increase our theoretical knowledge in the field?	Yes
e.	Does the paper identify directions for future research?	Yes
f.	Does the paper discuss its main limitations?	Yes
g.	Is the reported transferability of the findings justifiable by the sample?	Yes
h.	Are the analytic claims consistent to the aims of the methodology used?	Yes
8.	**Reflexivity:** Have the researchers made disclosures regarding their:	

a.	Beliefs/assumptions about the under study phenomenon?	Yes
b.	Professional background/training?	No
c.	Relevant theoretical perspectives?	Yes
d.	Have the researchers reflected on the impact of any of the above on the research process?	Yes
e.	Have the researchers referred to a reflective journal?	No
f.	Have the researchers clarified what is their relationship with the participants (even if there is no relationship)?	No
9.	**Ethics** Has the paper:	
a.	Kept information that could lead to the identification of participants to a minimum?	Yes
b.	Anonymised the service from which the data were collected?	Yes
c.	Reported that approval was granted by an appropriate ethical committee?	Yes
d.	Avoided the use of discriminatory language?	Yes
e.	How they tried to ensure participants' welfare?; e.g., option for debriefing, excluding vulnerable individuals	Yes
f.	How they tried to ensure confidentiality of data?	Yes
g.	Clarified whether informed consent was obtained	Yes

***Yes** = Meets criteria; **No** = Does not meet criteria / Lack of sufficient information; **NA** = Criterion not applicable to the evaluated study

Total Score = Total number of questions marked as "yes" / 56 – (Total number of NA Questions)

APPENDIX 5.8) QUALITATIVE RESEARCH EVALUATION – OVERALL RESEARCH RIGOUR (YARDLEY, 2017)

Whilst Leonidaki's (2015) tool provides a detailed assessment of the data collection process (Appendix 5.6 – 5.7), Yardley (2017) paper outlines broader principles for evaluating research quality: Sensitivity to Context, Commitment and Rigor, Transparency and Coherence, and Impact and Importance. Although the author of this thesis has carried out a qualitative self-assessment (Appendix 5.6) using Leonidaki (2015) tool (Appendix 5.7), additional insights into Yardley (2017) principles have been included to enhance rigor of the thesis.

1. Sensitivity to Context

This thesis demonstrated a consistent sensitivity to the cultural nuances of BAME participants, particularly regarding psychotherapeutic interventions. During data collection and analysis, the author prioritised allowing participants to lead the interviews, providing them ample time to articulate their experiences with mental health in relation to their background, social norms, and ethnic heritage. Additionally, each narrative was carefully compared with others to ensure a data-driven approach. This method aligns with Yardley (2017) recommendation to show sensitivity to context and avoid imposing preconceived beliefs. However, the author acknowledges that greater sensitivity to broader systemic issues could have offered a more comprehensive perspective, enhancing the reader's understanding of how BAME patients navigate and interpret their mental health experiences.

2. Commitment & Rigor

This thesis demonstrates commitment and rigor through an in-depth, ethinc-vs-ethnic comparison of perceptions of mental health psychotherapy within BAME populations. The researcher sought to capture the richness of participants' experiences and iteratively refined themes, incorporating participant feedback where feasible. Additionally, the methodology (IPA) was thoughtfully aligned with the research aim: to help future researchers understand how contemporary BAME patients and service providers perceive and make sense of themselves and their interactions in the context of mental health care.

3. Transparency & Coherence

The author believes that transparency was maintained through the qualitative process by clearly outlining how themes were developed from the data, guided through Larkin et al. (2006, 2009) counsel. Additionally, the author illustrated how each quote corresponded to the theme generated from the IPA analysis. However, the researcher acknowledges, as said earlier, that during the qualitative process, reflexivity was not consistently documented (i.e., through a journal or field notes). Thus, the reader should take this acknowledgment when interpreting the findings with caution.

4. Impact & Importance

Yardley (2017) suggests that “importance refers to the requirement for all research to generate knowledge that is useful – whether in terms of practical utility, generating hypotheses, or even changing how we think about the world”. Based on this criteria, the author has demonstrated how the findings of this thesis enrich understanding into the cultural idiosyncrasies that may present between ethnic groups during therapy. Additionally, by exploring the lived experiences of BAME individuals with mental health services, this research highlights areas where current practices may not be fully inclusive or sensitive to cultural needs. Consequently, the insights generated through this thesis could influence future policy and practice, by informing the design of mental health interventions that are more accessible, relevant, and effective for specific ethnicities within BAME populations.