DOCTORAL PORTFOLIO

IN COUNSELLING

PSYCHOLOGY

Nazreen Akhtar

A Portfolio Submitted to The University of Wolverhampton for the Practitioner Doctorate, Counselling Psychology Award: D.Couns.Psych

October 2016

DECLARATIONS

This work, or any part thereof, has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or any other purpose (unless otherwise indicated). Other than the expressed acknowledgements, references and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person.

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All work throughout this portfolio has been appropriately anonymised and all identifiable information removed, so no participant can be identified.

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RESEARCH

DOSSIER

The Experiences of Cognitive Behavioural Therapists when delivering Manualised Therapy to Black and Minority Ethnic Clients

Abstract

Rationale: This study was conducted to help improve mental health care for Black and Minority Ethnic (BME) clients as previous research carried out in non-western countries has suggested that western-developed psychotherapies often need to be culturally adapted to become more effective in treating this client group. The aim of this study was to explore how CBT therapists deliver manualised CBT with BME clients and if they make any adaptations, how and to what extent are they implemented.

Method: Interpretative Phenomenological Analysis (IPA) guided the conduct and analysis of one-to-one, semi-structured interviews with six CBT therapists working in an Improving Access to Psychological Therapies (IAPT) service. The inclusion criteria for participants was accreditation with the BABCP, completion of an IAPT programme CBT diploma and to be currently working in an IAPT service, at least two years experience as a CBT therapist and at least four cases of completed therapy with BME clients.

Findings: Four master themes emerged (1) CBT is based on western principles, (2) The complex nature of CBT, (3) Changing practice of manualised CBT and (4) The influence of therapist factors.

Conclusion: The participants experienced many issues in their practice of manualised CBT with BME clients which led them to make changes including adaptations to manualised CBT. They described their current practice as being integrative as they incorporated therapeutic approaches other than pure manualised CBT, making them more flexible and adaptable. The adaptations involved altering the cognitive and behavioural interventions to better suit the individual needs of the client. The adaptations took into account the client's culture, religion, language, psychological mindedness, acculturation to their host country, education and age. The participants' confidence in CBT and their self-identity as therapists also influenced their overall practice of therapy. Recommendations for practice are discussed in relation to therapeutic practice, training of therapists, supervision and policy makers.

Chapter One - Introduction

1.1. An Introduction to the Research Topic

One of the cornerstones of counselling psychology has been examining the utility of the integration of science and practice (Stoltenberg et al., 2000). The scientist-practitioner model is the integration of science, research and evidence, which are key within counselling psychologists' professional competence (Woolfe, Strawbridge, Douglas & Dryden, 2010). It is also an ethical responsibility of practitioners to stay informed of current research, as it relates to theory and clinical practice (Corrie & Callanan, 2000). Counselling psychologists have a dual role both as a reflective practitioner and as a scientist-practitioner.

To demonstrate my scientist-practitioner stance, I conducted research as part of the fulfilment of the doctorate in counselling psychology. The present study is focussed on evidence-based practice and on the Improving Access to Psychological Therapies (IAPT) programme. The IAPT programme was formed from a strong political and economic basis (Layard et al., 2006) and has been adamant on delivering therapies that are scientific and evidence-based, favouring a medical and behavioural model of practice (Woolfe et al., 2010).

The present study is primarily concerned with manualised Cognitive Behavioural Therapy CBT), which is a specific form of CBT that has been utilised by the National Health Service (NICE, 2009; 2011). It consists of a set of manuals or protocols for dealing with specific mental health disorders such as depression and anxiety disorders based on a medicalised or diagnostic stance (Binnie, 2015). It is well suited to the NHS as it is a brief, time-limited form of therapy and it is highly structured so there is a set standard in the delivery of therapy by different practitioners. The National Institute for Health and Care Excellence (NICE) guidelines have recommended CBT as the treatment of choice for common mental health problems such as anxiety and depression. This is based on findings from Randomised Controlled Trials (RCTs) which provided the strongest evidence base for CBT (Butler, Chapman, Forman & Beck, 2006). Following this research supporting the evidence base for CBT, the UK government's commitment to the IAPT programme (Clark, 2011) led to the funding of manualised CBT training since 2006.

There have been challenges to the proposal of CBT as the NICE guideline's treatment of choice, with many critiquing the evidence base of CBT and implying that CBT does not differ from other psychotherapies and all therapies are equally as effective as CBT (Bower et al., 2000; Cape, Whittington, Buszewicz, Wallace & Underwood, 2010; King et al., 2000). Research on CBT (Butler et al., 2006; Chambless & Ollendick, 2011) also states that CBT has a universal application across mental health presentations. The wide application of CBT has also been extended to different cultures, race and ethnicity (Griner & Smith, 2006; Huey & Polo, 2008). However it is important to address that research conducted on psychotherapies, has neglected the issue of culture (Miranda et al., 2005). Hays and Iwamasa (2006) stated that the majority of therapies in existence today were developed from a European-American perspective and empirical research studies on therapies have mainly included Caucasian participants. This does not conclude that psychological therapies are not suitable for clients from a non-western culture. However, further research is required if we are to conclude that CBT does actually meet the needs of clients from non-western cultures.

Considering the biggest mental health programme to be set up in recent years is the IAPT programme, which serves a diverse population throughout the UK. It is questionable how cultural differences are included within the framework of manualised CBT. Culture has many facets (Sue, 1998), which the IAPT programme has recognised, especially in attempting to remove the barriers to accessing psychological services (DH, 2009). To date, there has been no research carried out on the IAPT programme and the suitability of manualised CBT with Black and Minority Ethnic (BME) clients. As the IAPT programme continues to grow there is a need to evaluate the effectiveness of manualised CBT for BME clients to counterbalance the western participants and psychologists that have dominated development and testing of psychological therapies.

The present study explored the experience of CBT therapists when delivering manualised CBT to BME clients, and sought to gain their perspective on whether any adaptations are made to the manualised model of CBT. The literature review that follows from the introduction will outline the extant literature on this topic.

1.2. Structure of Research Dossier

The structure of the thesis is based on the scientist-practitioner model and consists of seven chapters that provide an in-depth understanding of the research conducted. Chapter two is a literature review that will provide a critical and in-depth evaluation of previous research in this area. This will give a basis to this study conducted and include theories, concepts and empirical research studies.

Chapter three, four and five constitute the empirical study which consists of a brief introduction that summarises the literature review and the focus of the research. This is followed by an in-depth methodology and the findings of the study. The sixth chapter is the discussion which reviews the findings and discusses them in relation to the literature review and other empirical studies, allowing a final conclusion to be drawn.

Chapter seven is a critical appraisal of my development as a researcher and practitioner and of the application of the research to clinical practice.

Chapter Two - Literature Review

2.1. Introduction

This literature review will address the use of Cognitive Behavioural Therapy (CBT) with Black and Minority Ethnic (BME) clients. It will explore to what extent CBT is applicable with BME clients and any issues that it poses. This will be followed by discussing culturally sensitive therapy and how adaptations have been made to CBT in order to be used effectively with BME clients. Lastly, therapists experience with therapy manuals will be explored and other psychosocial interventions with BME clients.

A systematized literature review was carried out. To identify relevant literature, the following databases were searched: PsychARTICLES, PsychINFO, ScienceDirect and Psychology and Behavioural Sciences Collection. The search engines Google and Google Scholar were also used. Relevant literature from the reference lists of identified articles were also followed up. The search terms that were included were "black and ethnic minority", "BME", "ethnic minority", "cognitive behavioural therapy", "CBT", "culture", "adaptations", "modification", "manualised treatment", "IAPT", "evidence base", "culturally sensitive CBT", "IPT" and "family therapy". Colleagues and research supervisors were also requested to share any additional publications. Searches were conducted from inception to the conclusion of the study.

2.2. Terminology

Although the terms "race", "ethnicity" and "culture" are frequently used within the research literature, they are not interchangeable. It is therefore, important to clearly define the specific terminology used in this research. Race is viewed in terms of physical characteristic and is not correlated with psychological or behavioural attributes (Helms, Jernigan & Mascher, 2005; Phinney, 1996). Betancourt and Lopez (1993) defined ethnicity as shared nationality, language, similar values, beliefs, and customs of an identifiable group of people. There are many definitions of culture but one that is related to therapy is by Geertz (1973) who defined culture as "an historically transmitted pattern of meanings embodied in symbols; a system of inherited conceptions expressed in

symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and attitudes toward life" (p. 89).

Culture can have a significant impact on how an individual understands psychological issues and the way that they express their issues. Cultural values and beliefs particularly influence the help-seeking behaviours, presentation and reporting of symptoms, as well as the engagement in psychological interventions (Kleinman, 1977; 1988; Zhang, Snowden & Sue, 1998). This would also have an impact on how a therapist practices therapy with the individual.

Black and Minority Ethnic (BME) is a term used in the UK to refer to members of non-white communities in the UK. This group is diverse in terms of the history of migration, culture, language and religion (Gill, Kai, Bhopal & Wild, 2007). Ethnic minority individuals are considered those with a cultural heritage distinct from the majority population (Manthorpe & Hettiaratchy, 1993). As BME clients are not a homogeneous group and migration changes within the UK, it is not easy to categorise the group. However some of the main groups within BME are Asian communities consisting of Indian, Pakistani, Bangladeshi and Chinese as well as African and Caribbean communities' (Gill, Kai, Bhopal & Wild, 2007). The present study chose to focus on BME rather than a specific ethnic group as it is the main ethnic groups in the UK and therefore encountered by mental health services. Also the present study's area of research is new within the UK and the aim was to give an overview of the experience of CBT therapists practice with BME clients, allowing for future research to narrow its focus on specific ethnic groups.

The term western and non-western are also used in relation to countries and culture. Western countries and cultures are defined as from Europe, Americas, South Africa and Oceania. Non-western countries are from Central Asia, Far East, Middle East, Western Asian, North Africa and South Asia. Cultures within these countries are referred to as eastern or non-western cultures (Thompson & Hickey, 2005). The present study focussed on culture and the definitions that will be used are western cultures, non-western cultures and eastern cultures.

2.3. Background

Over the last two decades, England and Wales have become more ethnically diverse. In the 2011 UK Census (ONS, 2011) "the ethnic group population other than White British accounted for 20% (or 11 million) of the population of England and Wales compared with 14% (or 7 million) in 2001" (Jivraj, 2012, p. 1).

The rate of mental health problems varies amongst different ethnic groups. This can be related to their different cultural and socio-economic contexts and their ability to access culturally suitable services (Mental Health Foundation, 2015). Weich et al. (2004) found the prevalence of common mental disorders in England to be significantly higher amongst middle-aged Irish and Pakistani men and older Indian and Pakistani women when compared to White British People. Black African-Caribbeans in the UK are twice as likely as White British people to be diagnosed with a mental health problem and less likely to access treatment (Hill, 2003). They are also more likely to be diagnosed with severe mental health disorders such as schizophrenia and least likely with depression (Mental Health Foundation, 2015). Therefore, it is essential that appropriate and effective mechanisms are in place to oversee the provision of mental health services for these minority groups.

Mental health services within the UK have been developed to meet the needs of the dominant cultural group (Joint Commissioning Panel for Mental Health, 2014). Therefore, ethnic minorities receive a substandard service as their issues may not be identified and assessed (CSJ, 2011). BME groups living in the UK are more likely to be diagnosed with mental health problems, experience poor recovery and are more likely to disengage from mental health services, leading to social exclusion and a worsening of their mental health than non-BME groups (Fernando & Keating, 2009; Mental Health Foundation, 2015).

The differences in mental health with BME communities may be due to a lack of understanding by mental health services of the needs of BME clients and providing services that are not culturally appropriate or accessible to BME communities (Mental Health Foundation, 2015). Mental health services can create a barrier with BME groups accessing their services if their cultural, religious and social differences are not acknowledged and incorporated within the delivery of psychological therapies. Therefore,

it is important that any mental health service delivery reflects culturally responsive services (DH, 2009). The National Service Framework for Mental Health (DH, 1999) outlines that all mental health services must provide a non-discriminatory service. Furthermore, the Race Relations Amendment Act 2000 (HMSO, 2000) imposes a legal requirement on all public authorities to promote race equality. It is important to understand that in regards, to mental health, the Equality Act 2010 (HMSO, 2010) outlines that equality is not about treating everyone the same it is about treating people in such a way that the outcome for each person can be the same which again relates to acknowledging the individual difference.

Psychological therapies are an area of mental health where there is inequality of access for BME communities. BME communities can experience further barriers involving ethnicity, culture, language or faith (DH, 2009). This involves stigma around accessing mental health services, lack of awareness of mental health services and language needs. Knifton et al. (2010) measured the knowledge, attitudes and behavioural intent in BME individuals following mental health awareness workshops. The attitudinal questions found those classified as BME had high scores on stigmatising responses such as not telling anyone about their mental health problems.

In another study by Shefer et al. (2012), a focus group involving BME people was carried out. The thematic analysis found cultural mental health beliefs influenced relationships with family and help-seeking behaviours. The study suggests that stigma needs to be addressed whilst engaging BME communities with mental health. This highlights that changes need to be made to clinical practice, service configuration and the way services are commissioned to meet the needs of BME communities.

2.4. Cognitive Behavioural Therapy

Over the years, the availability of many forms of psychotherapies such as psychodynamic psychotherapy, family/ systemic therapies, cognitive behavioural therapy and humanistic therapies have expanded. However the recommended therapy by the Department of Health and The National Institute for Health and Care Excellence (NICE) for common mental health problems is CBT (NICE, 2009).

CBT was developed over four decades ago and has become a widely used, evidence-based intervention. CBT is an umbrella term and is the integration of behaviour therapy (Bandura, 1977) and cognitive therapy (Beck, 1976). The cognitive model was originally developed following research studies conducted by Beck (Beck, 1963; 1964) to explain the psychological processes in depression (Knapp & Beck, 2008). Beck, Rush, Shaw and Emery (1979) define CBT as "an active, directive, time-limited, structured approach. . . based on an underlying theoretical rationale that an individual's affect and behaviour are largely determined by the way in which he structures the world" (p. 3).

2.4.1. Distinctive Characteristics of CBT

CBT emphasises the use of empirical psychological knowledge and tackling the client's problems in an empirical way. It takes a problem focussed and structured approach with the therapist adhering to an agenda throughout the sessions. Sessions are time limited and brief with six to twenty sessions offered with the onus on the client to complete homework outside of session (Westbrook, Kennerley & Kirk, 2011).

As CBT follows an information-processing approach, the basic premise is that people's emotions, behaviours and physiology are influenced by how they process and perceive events in their environment which are all interconnected (Padesky, 1994). There is an interaction between four systems the cognitive system is what a person thinks, imagines and believes. The behavioural system is what they do or say that can be directly observed by others. The affective system is their emotions and the physiological system is what happens to the body (Westbrook et al., 2011). This is illustrated by Padesky and Greenberger's (1995) five aspects model, which highlights how the problem is maintained.

The focus of CBT is to reframe and correct distorted thoughts and behaviours. CBT is based on a shared model of understanding where the focus is on collaboration between the therapist and client to work through developing shared formulations and self-evaluation. The continuum principle of CBT views psychological problems as extreme versions of normal processes. The here and now principle of CBT is that the initial focus is on the present day issues and what is maintaining the problem, rather than being

concerned with the processes that led to the problem initially developing (Westbrook et al., 2011).

CBT interventions are divided into either cognitive or behavioural interventions. One type of cognitive intervention is guided discovery which uses Socratic questioning to help the client understand the idiosyncratic meaning of situations and to see a different perspective. Behavioural interventions include behavioural activation, graded exposure and behavioural experiments involving real-life in vivo work. Summaries and feedback are frequently used to enable a shared understanding and reduce misunderstanding (Westbrook et al., 2011).

Kuyken, Padesky and Dudley (2008) differentiated between three levels of conceptualisation/ formulation within CBT; the descriptive, cross-sectional and longitudinal. The descriptive level is similar to the generic model of CBT known as the five aspects (Padesky & Mooney, 1990) which breaks the clients' experience into thoughts, emotions, behaviours and physical aspects (Padesky, Kuyken & Dudley, 2011b). The cross-sectional conceptualisation level identifies triggers, responses and maintenance cycles. A longitudinal formulation incorporates both descriptive and cross-sectional levels and more specifically developmental history that link to the presenting issues. This would incorporate core beliefs and dysfunctional assumptions along with early life experiences (Kuyken, Padesky & Dudley, 2008; Padesky, Kuyken & Dudley, 2011a).

2.4.2. Cognitive Model

Beck originally formulated the Beckian cognitive model in the 1960s and 1970s (Beck, 1963; 1964; Beck et al., 1979) to explain the psychological processes in depression (Westbrook et al., 2011). It has now become one of the main psychological approaches used in the UK. The Beckian cognitive model of emotional disorders outlines three levels of cognitions that need to be examined and modified with a person (Neenan & Dryden, 2005). The three levels of cognitions are negative automatic thoughts, dysfunctional assumptions and core beliefs.

Negative automatic thoughts (NATs) were first described by Beck (1967) and refer to thoughts occurring automatically and involuntarily when a person is upset (Gilbert, 2000; Neenan & Dryden, 2005). NATs are specific thoughts about events or situations. They are

the most accessible level of cognition to the conscious than assumptions and core beliefs because of their immediate impact on emotions (Neenan & Dryden, 2005; Sanders & Wills, 2005; Simmons & Griffiths, 2008).

Beck (1967) also outlined cognitive distortions, which are irrational automatic thoughts that occur as a result of faulty information processing. Cognitive distortions lead to interpreting reality inaccurately. There are many types of cognitive distortions from overgeneralisation, emotional reasoning, catastrophising, personalisation and mind reading. An example of mind reading would be assuming someone is reacting negatively towards you but without any evidence (Winterowd, Beck & Gruene, 2003).

Core beliefs are the deepest level of cognition. They manifest as global and absolute beliefs rather than being conditional. They represent fundamental beliefs about self, others and the world that apply in all situations that help us to make sense of our life experiences (Neenan & Dryden, 2005). This would entail having a negative view of one's self (I am worthless), the world (everyone is against me) and other people (No one loves me). They are usually developed early on in life from childhood experiences and become influential in shaping our outlook. Absolute and global negative core beliefs are activated during emotional distress leading to processing information in a biased way, preventing the core belief from being challenged by any contradictory evidence (Neenan & Dryden, 2005; Simmons & Griffiths, 2008; Westbrook et al., 2011).

Dysfunctional assumptions bridge the gap between core beliefs and negative automatic thoughts (Westbrook et al., 2011). Assumptions tend to be called rules of living as they guide our everyday behaviour, set our standards and values. They are not as easy to identify as negative automatic thoughts. They take the form of conditional statements such as 'If ... then ...' propositions or 'should/must ... otherwise ...' statements (Westbrook et al., 2011). Due to dysfunctional assumptions being rigid and inflexible they are easily violated as they trigger negative automatic thoughts. They also reinforce negative core beliefs (Neenan & Dryden, 2005).

Within cognitive behavioural therapy, negative automatic thoughts are addressed first through short-term therapy. Once a client has developed the ability to challenge negative automatic thoughts and there is some symptom-relief then the focus is shifted to

modifying dysfunctional assumptions. Core beliefs are more entrenched as they are considered the underlying cause of the problem and require long-term therapy to reduce the chance of a relapse (Neenan & Dryden, 2005; Simmons & Griffiths, 2008).

2.4.3. Rational Emotive Behavioural Therapy (REBT)

The development of CBT has been significantly influenced by Albert Ellis Rational Emotive Behavioural Therapy (REBT). One of the main contributions of REBT to CBT is in differentiating between rational and irrational beliefs. Rational beliefs are defined as non-absolute and flexible and therefore do not hinder the pursuit of goals and purposes. However, irrational beliefs are considered absolute and ridged in nature. They lead to the experience of negative emotions and dysfunctional behaviours which prevent goals from being achieved (Ellis & Dryden, 1997). Albert Ellis identified twelve irrational beliefs some of which are you should be competent at everything, be loved by every significant person, need someone stronger to rely on and have perfect control over things (McLeod, 2015).

Another major contribution of REBT to CBT is what is defined by Albert Ellis (1957) as the A-B-C model which is considered to be the basis of CBT, where A is the Activating event, B is the Beliefs about the event and C is the Consequences. The A-B-C model helps to analyse beliefs and behaviours. The model outlines that people hold many beliefs, thoughts or ideas about the activating event and these beliefs have a strong influence on the cognitive, emotional and behavioural consequences. The person's beliefs are the main mediator between the activating event and the consequence even though the activating event seems to directly cause the consequence. People interpret or experience the activating event using their own biased beliefs or evaluations (Ellis & Dryden, 1997).

2.5. Evidence Base

CBT has come a long way from initially being only offered for depression (Beck, 1976). It has proven to be effective for various anxiety disorders (Hawton, Salkovskis, Kirk & Clark, 1989; Wells, 1997) and eating disorders (Fairburn, 2008). It is also effective for long-standing disorders as outlined in the multi-axial system known as The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013) such as personality disorders

(Bizzini, 1998; Davidson & Tyrer, 1996) and more severe mental health disorders like psychosis (Turkington, Kingdon & Turner, 2002). This has been based on evidence from empirical studies that CBT has been demonstrated as the most effective therapy for a wide variety of psychological disorders. This evidence has come from Randomised Controlled Trials (RCTs), which are considered the gold standard of clinical research.

Butler et al. (2006) conducted a review of 16 meta-analyses which found support for the efficacy of CBT for a wide range of psychological disorders. The most up-to-date evidence base for the efficacy of CBT comes from Hofmann, Asnaani, Vonk, Sawyer and Fang (2012) who provided a comprehensive survey of all contemporary meta-analyses examining the evidence base for the efficacy of CBT. Importantly for the present study, a limitation found in this review was that meta-analytic studies of CBT did not report on the outcome for specific subgroups, such as ethnic minorities.

2.6. The Improving Access to Psychological Therapies (IAPT) Programme

The most recent development in mental health service delivery has been the formation of the Improving Access to Psychological Therapies (IAPT) programme. Its main initiative was to enable greater access to psychological therapies for the whole community by offering psychological interventions approved by The National Institute for Health and Care Excellence (NICE) for treating people with common mental health problems.

The IAPT programme was set up following Layard et al.'s (2006) report that highlighted the social and economic cost of people suffering from anxiety and depression and advised that evidence-based psychological therapy should be offered. Layard et al. (2006) promoted CBT as the treatment of choice based on the NICE guidelines. With under-resourced mental health services, there were not enough therapists to deliver CBT so the government funded CBT training as part of the IAPT programme.

Since 2006, there have been yearly intakes of trainees onto IAPT developed CBT diploma courses. The CBT courses are specifically developed for the IAPT programme which is far from the CBT developed by Beck (1970) and Ellis (1962). The IAPT programme CBT training is based on a medical model of psychological therapy. Trainees on the course are

taught a prescribed version of CBT which consists of various protocols or manuals in how to treat common mental health problems (Binnie, 2015). A significant part of this training is also treating a client based on a diagnosis followed by applying the relevant protocol for the diagnosis. Another point that Binnie (2015) makes is that the training is overly focussed on cognitive therapy and lacks behavioural therapy. Considering that the courses are only a year long and significant omissions have been made this also raises another issue of whether manualised CBT courses are sufficient for effective practice (Binnie, 2015).

The Revised Cognitive Therapy Scale (CTS-R) (Blackburn et al., 2001) is a significant part of the assessment for the IAPT programme CBT trainees. It is also a framework for how to conduct and structure a CBT session. The CTS-R Scale includes twelve items that a therapist is assessed against and deemed to be a competent practitioner. It focuses on general therapeutic skills such as agenda setting, feedback, understanding, interpersonal effectiveness, collaboration and pacing. Then there are specific cognitive therapy skills that need to be demonstrated such as conceptualisation, guided discovery, eliciting key cognitions, behaviours and emotions, strategy for change, application of cognitive-behavioural techniques and homework (Blackburn et al., 2001; Gordon, 2006). It is unclear whether the CTS-R is the most effective way to deliver CBT and assess CBT competence. Keen and Freeston (2008) assessed CBT trainees' competence in CBT using essays, case studies and videotaped clinical works. They found videotaped assessments using the CTS-R were the least reliable method to assess practical therapeutic skills and essay examination was the most reliable.

Strawbridge and Woolfe (2010) and Binnie (2015) have outlined how therapy becomes diluted when the focus is on diagnosis and the training emphasises techniques and manualised treatments. One of the main issues is that trainees on IAPT courses are not taught the foundations of CBT, instead they are taught a version of CBT that has specifically been developed to be medically orientated and based on manuals. BABCP (2007) has made reference to IAPT courses as feeder courses focussed on specific areas of practice and require practitioners to have further experience in order to be accredited.

There is limited data on BME clients use of IAPT services but the most recent data taken from IAPT quarterly activity data covering quarter two from July to September 2015

shows that 330,318 referrals were received of which 86.7% were non-BME ethnicities and 13.3% of BME ethnicities. The number of clients finishing a course of treatment was 85.1% of non-BME ethnicities in comparison to just 14.9% BME ethnicities (HSCIC, 2016).

2.7. One Size Does Not Fit All: Cultural Considerations

The IAPT programme recognises the need for the cultural competence of its workforce as it utilises the Ten Essential Shared Capabilities Framework (Hope, 2004) and has developed Positive Practice Guidelines for BME clients (DH, 2009) which aim to meet BME communities' specific language, cultural and religious requirements. As well as identifying the barriers for BME clients in accessing psychological services and engaging. However the IAPT service is considered a 'Universalist Service' (Levinson, 2012). This is based on the notion that people's issues can be understood using a standard set of ideas and their similarities are more important (Falicov, 1995). This one size fits all approach would entail everyone being offered the same assessment, protocol driven formulation, prescribed evidence-based treatment plan and number of sessions which is what the IAPT service adheres to (Levinson, 2012).

One of the main areas that the IAPT programme has overlooked is that CBT might not be suitable for BME clients. Firstly the evidence for CBT has come from RCTs which have predominantly been conducted in non-minority populations (Miranda et al., 2005). This suggests they have not controlled for variables such as race, ethnicity and class (Smith, 2008). Participant samples in CBT efficacy studies are composed primarily of Caucasian middle-class participants and there is a need for further research to find out if CBT is as effective for ethnic minority clients. The evidence is also sparse from meta-analytic reviews for other patient characteristics such as psychological mindedness, motivation and capacity to sustain personal relationships, which could have an effect on the outcome of CBT (DH, 2001b; Smith, 2008).

There is a lack of empirically-based studies involving people from BME communities and inadequate evidence that empirically-supported therapies are effective with BME communities (Dryden & Branch, 2012). NICE guidelines and training in CBT do recognise that BME communities have specific needs but do not offer advice or guidance on how to

consult with those communities. Beck et al. (1979) offered guidance to practitioners to only use CBT with the type of clients that research studies have demonstrated as showing effectiveness.

Summerfield and Veale (2008) highlighted another area of contention with the IAPT programme in stating that psychological therapies are grounded in a western version of a person. This is supported by Scorzelli and Reinke-Scorzelli (1994) (as cited in Naeem, 2012, p. 47) who outlined that most current theories of therapy were developed in America or Europe and therefore it is expected that these theories are likely to conflict with the cultural values and beliefs of minority individuals and their suitability to BME people is limited. There is literature available that explores cultural differences such as cultural barriers to engaging in therapies but there is limited research on studies that actually compare different psychotherapies with different ethnic groups. This is further impeded by western psychotherapies not extensively practiced in non-western countries (Naeem, 2010; 2012).

Hays (1995) reviewed the multicultural applications of CBT. Several limitations were identified with using CBT. Firstly CBT takes a scientific stance and is focussed on rational thinking. This particular cognitive style of CBT is known as linear way of thinking which a lot of formulations and interventions are based on and can be suited to more western cultures (Mark, 2010). Whereas Ornstein (1977) hypothesised that eastern cultures have a non-linear cognitive style that is less restrictive and more emotional and intuitive.

CBT originated in America and was pioneered by Beck (1970) and Ellis (1962). One of its fundamental views is that maladaptive cognitions contribute to the maintenance of emotional distress and behavioural problems (Hofmann et al., 2012; Neenan & Dryden, 2005). As CBT was founded by middle-class, educated European-American men this would have been considered the dominant social group. This particular group's social values would have been deemed universal and the norm. These values would be orientated towards personal autonomy, independence, future goals, seeking change and individualism (Hays & Iwamasa, 2006). These values are from a western individualistic culture and contrast to what an eastern collectivist culture encompasses. For example Scorzelli and Reinke-Scorzelli (1994) (as cited in Naeem, 2012, p. 116) conducted a study involving whether CBT conflicted with the religious beliefs and cultural and family

values of graduate Indian psychology students. It was found that 82% experienced the principles underlying CBT approach to counselling conflicted with their values and beliefs. 46% stated that CBT was in conflict with their cultural and/or family values and 40% outlined that CBT conflicted with their religious beliefs. The main reason for this incompatibility as outlined by Naeem, Gobi et al. (2009) was related to their religious beliefs as Hindus believe that humans do not have control over their destiny. The participants also held strong collectivist beliefs which although CBT challenged, it did not change the student's belief in abiding by the rules and the values of their family and community (Naeem et al., 2009; Scorzelli & Reinke-Scorzelli, 1994).

Laungani (2004a) outlined four interrelated core values or factors that discriminate western culture from Asian culture, (a) Individualism and Communalism (collectivism), (b) Cognitivism and Emotionalism, (c) Freewill and Determinism and (d) Materialism and Spiritualism. Rathod, Kingdon, Pinninti, Turkington and Phiri (2015) and Naeem (2012) supported Laungani (2004a) as they found Asian people to be more community orientated. The basis of the CBT approach is on rational reasoning, however Asian people are more likely to believe in a spiritual explanation and ideas of determinism. They also take an emotional approach towards problem-solving and are relationship centred (Pande, 1968).

Personality traits have also shown to be different between western and eastern cultures. Allik and McCrae (2004) looked at worldwide personality traits across 36 cultures using the five-factor model of personality (Digmam, 1990). It was found that people from European and American cultures were higher in individualistic cultural traits such as extraversion, open to new experiences and lower in agreeableness, whereas people from Asian and African cultures had more collectivist traits such as introverted, traditional and compliant. European and American cultures were also lower in power distance and higher in individualism. There is a clear contrast of European and American cultures with Asian and African cultures.

Acculturation has been linked with both mental illness and attitudes towards mental health and psychological therapies (Chang, 2007). Acculturation is defined by Moyerman and Forman (1992) as the process of change over time when individuals encounter a different culture. It can be suggested that acculturation into a western culture may

change someone from a BME background. Atkinson and Gim (1989) carried out a study of 557 Asian-American students involving acculturation and attitudes towards seeking psychological support. The students whose acculturation strategy was host-oriented were most likely to recognise the need for psychological support and were willing to talk to a psychologist as they were most tolerant of mental health stigma (Chang, 2007).

Zhang and Dixon (2003) found a positive relationship between Asian international students' levels of acculturation and their attitudes towards seeking professional psychological help. Asian international students whose acculturation strategy was host-oriented to the American culture were more positive to seeking psychological help and had more confidence in their mental health practitioner as they felt less stigmatised. This supports Atkinson and Gim (1989) that Asian Americans underutilise mental health services as their cultural values conflict with psychological therapy. Acculturation is not only related to help seeking it also impacts the understanding of mental health problems such as their causes. Kung (2004) investigated the causal attributions of schizophrenia by Chinese Americans caregivers. Those participants that had acculturated to their host country identified biological causes of schizophrenia in comparison to those that were least acculturation to their host country who were more likely to believe in supernatural causes (Chang, 2007).

Certain cultural values and norms can hinder cognitive and behavioural change process (Iwamasa, Hsia & Hinton, 2006). These include the concept of self and identity as it can be collectivist in some cultural groups, such as Asian and African groups which place greater value on the family group than the individual. This would have implications in using cognitive interventions, which take an individualistic approach focussing only on the individual cognitions where the individual would not be concerned about what others think. One of the core shared values of people of diverse Asian cultures is that they are governed by a patriarchal authoritarian system with the father making most of the decisions and each family member having a specific role (Barakat, 1993; Iwamasa et al., 2006; Sharabi, 1988). The implications of this are that it may not be possible to put into practice CBT skills as it might conflict with cultural roles. Also, the expectations and involvement of the family are an important consideration in engaging this client group. Dependent patterns of behaviour are common in Asian cultures where there are gender

role expectations of females being dependent on male family members but these behaviours are viewed as dysfunctional from a western perspective (Iwamasa et al., 2006). As mentioned earlier, CBT goals are achieving individuation and autonomy, which are not a key goal in Chinese, Pakistani, Indian or African cultures (Iwamasa et al., 2006; Kelly 2006). In these cultures, a person's sense of self-worth, self-identify and happiness is related to and influenced by their relationship with their family and others.

Tam and Wong (2007) looked into dysfunctional attitudes of depressed Chinese patients. They found ten domains of dysfunctional attitudes which were vulnerability, need for approval, roles of performance within family hierarchy, familial harmony, relational harmony, imperatives, fate, face, fairness and success-perfectionism. However, these ten domains of dysfunctional attitudes were also described as cultural specific themes. So what is considered apparently dysfunctional beliefs in western society may be considered normal beliefs or even possible traits in another culture (Mueller, Kennerley, McManus & Westbrook, 2010). The most dominant themes were vulnerability and the need for approval. These attitudes were actually considered to be normal beliefs in the Chinese culture. This is supported by Sahin and Sahin (1992) that some dysfunctional beliefs are not viewed dysfunctional in another culture.

CBT is also an approach that focuses on the client to become their own therapist. This western concept of psychotherapy of taking responsibility for one's own life experiences can cause conflict with BME clients coming from such a collectivist society. Also, taking responsibility requires a certain understanding of mental health and the nature of psychological therapies. Certain groups of BME clients do not view psychological wellbeing as separate from their physical health and seek a medical cure in the form of medication (Laungani, 2004a). Therefore they view a therapist as an authority figure that is expected to have all the answers giving away any responsibility they have towards change. They present with more somatic complaints that may be psychologically related (Hoge et al., 2006; Palmer & Laungani, 1998). Therefore, the attitudes and beliefs of BME clients can have an impact on the process of therapy. Hamid and Furnham (2013) carried out a study with Arabs living in the UK. They investigated the factors affecting their Attitude Towards Seeking Professional Psychological Help (ATSPPH). Participants completed a questionnaire, which found that Arabs showed significantly less positive ATSPPH. Arabs

also had stronger causal beliefs in supernatural and non-western physiology than White British people. These differences could be due to cultural traditions of describing distress somatically.

Religion and spirituality have an impact on understanding, help-seeking and expression of mental health (Cinnirella, Loewenthal & Miriam, 1999; Loewenthal, 1995; Mayers, Leavey, Vallianatou & Barker, 2007). In some Asian and African cultures, there is a belief that not following a religion can lead to mental health issues (Iwamasa et al., 2006; Kelly, 2006). In the South African community, evil spirits or curses are believed to be the cause of mental illness (Uys & Middleton, 2010). Taylor, Mattis and Chatters (1999) found that African Americans were more likely to turn to religious and spiritual support compared to other ethnic groups.

Traditional healers, herbalists or spiritual healers would be the first people to be contacted for help by those with mental illness with less emphasis placed on seeking medical or psychological help due to the stigma attached (Kelly, 2006). Mental illness is viewed to bring shame on the individual, so openly expressing emotions are discouraged. This then relates to the underutilisation of mental health services by BME people as belief in faith healers is strong and therapy is viewed as a ritual rather than a process to help change (Naeem, 2012; Saeed & Mubbashar, 2000; Shaikh & Hatcher, 2005). Therefore, it is vital to consider the client's expectation from psychological therapy and their understanding.

Similar to Scorzelli and Reinke-Scorzelli (1994), Naeem, Gobbi, Ayub, and Kingdon, (2009) explored Pakistani students' views on whether CBT was compatible with their family, socio-cultural, personal and religious values. The philosophical basis of CBT conflicted with a third of the students' religious, family and cultural values but not with their personal values. Similar findings were found with the concept of assertiveness communication. The last concept discussed was cognitive errors. Apart from a few students, the majority of them did not find it conflicted with any of their values. Overall findings of this study state that on a personal level there was agreement with the concepts of CBT. This can be due to the students being young and having been exposed to a western culture which has influenced their personal values and beliefs. However, the CBT concepts still conflicted with their religious values. Both studies from India (Scorzelli

& Reinke-Scorzelli, 1994) and Pakistan (Naeem, Gobbi et al., 2009) have highlighted the need for therapy to be individualised and to incorporate the client's belief and value system.

Language plays an important role in how an individual views and understands mental health. Psychological concepts can vary significantly from one culture to another, with some psychological concepts and words not existing in some cultures at all (Iwamasa et al., 2006). The DSM classification of depression is not applicable to non-western cultures as it is overly medicalised (Bhugra, 1996; Bhugra & Mastrogianni, 2004; Manson, 1995). Research has also indicated the term depression itself is not present in the languages of eastern cultures (Manson, 1995) as it is construed differently (Abusah, 1993; Bhugra & Mastrogianni, 2004; Lee, 1998). This is evidenced by Hamdi, Yousreya and Abou-Saleh (1997) and Sulaiman, Bhugra and de Silva (2001) who found that people from eastern cultures such as from Arab countries and Dubai described depression with complaints of general ill-health using descriptions such as aches, pains and weakness (Bhugra & Mastrogianni, 2004; Naeem, 2012).

There are various cultural differences to consider with different ethnic community groups that would influence the process of counselling and psychotherapy. As discussed, the most important factors to consider are the influence of religion, family structure and roles, acculturation, language and cognitive styles (Iwamasa et al., 2006).

2.8. Culturally Sensitive Therapy

2.8.1. Culturally Sensitive Frameworks

To overcome the difficulties that CBT has presented, many researchers have tried to adapt CBT to be more suitable for BME clients. They have done this by incorporating culturally sensitive and relevant information (Gielen, Draguns & Fish 2008; Matsumi, 2008). This has led to the development of guidelines for adapting therapy.

The IAPT programme has developed the BME Positive Practice Guide (DH, 2009). This guidance document outlines the steps to understanding the needs of different cultures, removing barriers to access and engaging with BME communities. However, the CBT competencies framework (Roth and Pilling, 2007) and the national curriculum for training

IAPT CBT therapists (DH, 2008) do not specifically address cultural awareness. The findings of Bassey and Melluish (2012) support this position as IAPT CBT therapists did not consider the IAPT CBT diploma to have sufficiently addressed the issue of culture and its influence on the practice of CBT.

As far back as the 90s, guidelines were developed to assist therapists in delivering culturally sensitive therapy. Sue (1990) outlined three main areas that therapists would need to address when working with BME clients; culture-bound communication styles, socio-political facets of non-verbal communication and counselling as a subset of communication style or temporary cultures.

Bernal, Bonilla and Bellido's (1995) work with Hispanics served as a guide for either developing culturally sensitive treatments or adapting existing psychosocial treatments and was based on eight dimensions. These included using culturally appropriate language, having knowledge of cultural values and traditions, the treatment concepts being consistent with culture and context, having consideration of changing context, being aware of the racial similarities and differences between therapist and client and incorporating cultural knowledge into treatment procedure. Although the focus of the study was with Hispanics, the framework can be relevant for other BME groups.

Hwang (2006) developed a more in-depth and systematic framework to guide adaptation of empirically supported treatments based on Chinese clients. The Psychotherapy Adaptation and Modification Framework (PAMF) consists of six therapeutic domains and twenty five therapeutic principles. The domains include: (a) dynamic issues and cultural complexities, (b) orienting clients to psychotherapy and increasing mental health awareness, (c) understanding cultural beliefs about mental illness, its causes, and what constitutes appropriate treatment, (d) improving the client-therapist relationship, (e) understanding cultural differences in the expression and communication of distress, and (f) addressing cultural issues specific to the population.

In comparing this framework with the one proposed by Bernal et al. (1995), numerous similarities can be observed in the dimensions considered for adaptation; language, cultural context and concepts and the therapeutic relationship.

Tseng (2004) proposed three levels of cultural adjustments that needed to be made for therapy to be culturally competent and which incorporated Bernal et al.'s (1995) dimensions and Hwang's (2006) six therapeutic domains. These cultural adjustments are (a) technical: orientating the client to psychotherapy, (b) theoretical: the concept of self and ego boundaries, defence mechanisms and coping and (c) philosophical: re-orientation or re-examination of the client's view of life which would have an effect on the direction and goal of therapy.

Hays (2001) developed the ADDRESSING framework for therapists to become more aware of the cultural identities of their clients. The ADDRESSING acronym summarises various dimensions of cultural influences that have been typically overlooked in psychological research and practice and need to be addressed within therapy. These include Age and generational influences, Developmental and acquired Disabilities, Religion and spirituality, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin and Gender. This framework also allows a therapist to become aware of their own cultural views, biases and areas of inexperience. The ADDRESSING framework also enables the therapist to conceptualise culturally sensitive hypothesis about the client's mental well-being (Matsumi, 2008).

The majority of these studies addressed generic therapeutic difficulties encountered within different therapeutic approaches rather than focussing on specific adaptations related to CBT. Furthermore, these studies have not assessed the efficacy of the adaptations proposed.

2.8.2. Culturally Adapted CBT

One of the first CBT adaptation frameworks based on systematic observations carried out in a developing country was called the Southampton Adaptation Framework for CBT. It was developed by Naeem (2012) and based on three studies. The first covered interviews with six psychologists on their experience of providing CBT to depressed patients (Naeem, Gobbi, Ayub & Kingdon, 2010). In a second study, nine ethnic minority patients with depression were interviewed about their experience of mental health (Naeem, Ayub, Kingdon & Gobbi, 2012). In the third study, thirty four students from a Pakistani university were assessed on their views about the compatibility of CBT with their

personal, social and religious values (Naeem, Gobbi et al., 2009; Naeem, Waheed, Gobbi, Ayub & Kingdon, 2011). Thematic content analysis was carried out on the information from the interviews across the three studies as well as from field and therapy notes. These helped form guidelines to develop an adaptation framework consisting of three themes; culture, capacity and cognitions. Each theme was further divided into seven sub-themes, some of which included religion, family, language, expression of distress, help-seeking behaviours, beliefs about illness and psychotherapy. The Southampton Adaptation Framework was used to develop a culturally sensitive CBT manual for depression.

Naeem et al. (2010) was the first study to explore the experiences of South Asian psychologists in delivering CBT to Pakistani clients living in Pakistan. The aim of the study was to identify the factors which may require modification in delivering CBT. Thematic content analysis was used to analyse the interviews. Four major themes were found; hurdles in therapy, therapy related issues, the involvement of family in therapy and making modifications in therapy. These were related to sub-themes such as a lack of structure in sessions and the preference for an instructional style of therapy rather than collaborative. This could include the cultural view of a person in authority as having the answers to their problems (Iwamasa, 1993). All psychologists agreed that CBT in its current form was not suitable for Pakistani clients and that adaptation was required to meet the needs of the individual.

Problem-solving and coping strategies were the interventions found to be beneficial by Pakistani clients. This was in line with the type of psychological issues commonly found in Pakistan, primarily being related to social and relationship issues (Husain, Creed & Tomenson, 2000). Behavioural interventions were found to be more effective than cognitive interventions which could be due to them being tangible and relying less on language where barriers may present. Also, behavioural interventions offer a practical solution which may be more acceptable from a cultural standpoint, rather than a talking solution.

Naeem et al.'s (2010) study has significant limitations. Firstly, it mainly explored issues that were pre-determined by asking specific questions. Secondly, the psychologists were trained in rational emotive behaviour therapy and not CBT. Thirdly, psychologists were

unable to identify common trends, obvious changes or modifications they made to CBT techniques. Psychologists tried to address the difficulties by doing whatever they felt was suitable based on their own experience. Naeem et al., (2010) recommended that further in-depth research was needed to explore these ideas further.

A RCT by Naeem, Gul et al. (2015) assessed the efficacy of brief Culturally adapted CBT (CaCBT) for depression in Pakistan (Naeem, Ayub, McGuire & Kingdon, 2013). This involved six sessions delivered by a therapist in the participants' native language with a family member also present. Therapists were psychology graduates from the same ethnic background as the participants and were provided training in CaCBT which covered psycho-education, symptoms management, negative thoughts, behavioural activation, problem-solving, relationships and communication skills as well as an additional session with all the family. 137 Pakistani Urdu speaking participants were screened and allocated to either a CaCBT treatment group or a Treatment As Usual (TAU) control group which offered only medication. Participants in the treatment group who had received brief CaCBT showed a statistically significant improvement in depression, anxiety and somatic symptoms when compared with the control group, which was maintained at the nine month follow-up. Due to the differences across Pakistan Naeem, Gul et al. (2015) stated the results might not be generalisable which means individual differences still need to be considered when making adaptations to the CBT model. It cannot be assumed this form of CaCBT is suitable for every person living in Pakistan.

Rathod, Kingdon, Phiri, and Gobbi (2010) extended the development of culturally sensitive CBT to work with BME clients experiencing psychosis in the UK. Individual interviews were carried out to incorporate views on psychosis, its origin and management from schizophrenic patients and focus groups with lay members from African-Caribbean, Black African/Black British and South Asian Muslim communities. This included first generation immigrants and second generation BME clients who spoke English. Focus groups and interviews were also carried out with CBT therapists who were predominantly white and mental health practitioners from varied ethnic communities. The researcher who conducted the interviews was from a BME background.

Rathod et al. (2010) found that CBT would be culturally acceptable for BME psychosis clients if treatment incorporated culturally-based patient health beliefs, attributions

concerning psychosis, attention to help-seeking pathways, barriers to accessing CBT, the role of religion and validation from the therapist. Working culturally with delusions and hallucinations would entail the sensitive evaluation of cognitive biases that may be culturally tuned. The role of the family would need defining and goals of therapy may require adjusting according to family values. The assessment and formulation of psychopathology need to incorporate the cultural understanding of mental illness as well as the spiritual and religious beliefs of the client.

The efficacy of Culturally adapted CBT for psychosis (CaCBTp) was tested by Rathod et al. (2013) in the UK using participants of the same backgrounds as used in Rathod et al. (2010). Those receiving CaCBTp showed statistically significant improvement on positive symptoms, hallucinations and improved insight in comparison to those in the TAU group.

Naeem, Habib et al. (2014) employed a similar methodology to Rathod et al. (2010) in Pakistan in developing guidelines for adapting CBT for treating psychosis patients by incorporating views of clients, their carers and mental health professionals. From the interviews, the areas identified as requiring adaptation taking into consideration culture and religion, addressing barriers in therapy and cognitions and beliefs related to mental illness and its causes and management. This was similar to Rathod et al.'s (2010) findings in the UK and previous guidelines described for delivering culturally adapted CBT (Naeem et al., 2012).

Naeem, Saeed et al. (2015) carried out a RCT in Pakistan to assess the efficacy of a brief version of CaCBTp combined with TAU which was antipsychotic medication in comparison to a TAU only control group. The brief version of CaCBTp involved six sessions delivered in the client's native language of Urdu with the main carer present, plus a session which included the client's family. The therapists were Pakistani psychology graduates from the same ethnic group as the participants, had experience of working in mental health and were trained to deliver CaCBTp. The CaCBTp treatment group showed significantly greater improvements in positive and negative symptoms including hallucinations and delusions compared to TAU.

Naeem, Saeed et al. (2015) study assessed the combined effects of TAU with CaCBTp, so it is unclear how much CaCBTp contributed to the overall effectiveness. The outcome

measures used to assess the efficacy of CaCBT were not culturally sensitive and validated with western populations (Rathod et al., 2013).

Most importantly there has been no comparison study between standard CBT and culturally adapted CBT with South Asian clients. This means these studies have not identified if culturally adapted CBT is significantly more effective than standard CBT interventions. These studies have only indentified that culturally adapted CBT is more effective than treatment as usual.

Kohn, Oden, Munoz, Robinson and Leavitt (2002) adapted manualised cognitive behavioural group therapy interventions for depressed African American women. The women assessed in the study were all middle-aged high school graduates. To make CBT more culturally sensitive, both structural and didactic adaptations were made. Structural changes involved only allowing African American women in the group, keeping the group closed, incorporating meditative exercise and changing CBT terminology. Didactic adaptations incorporated specific content on forming relationships, spirituality, family issues and female identity, which were relevant to American African woman. Participants were allocated to either the adapted or non-adapted CBT group. Participants in the adapted CBT group had a larger drop in depressive symptoms as measured by The Beck Depression Inventory which showed that adapted group CBT was more effective than standard group CBT.

Hwang et al.'s (2015) RCT was one of the first to evaluate the effectiveness of CBT and culturally adapted CBT (CA-CBT) with depressed Chinese American adults. 50 Chinese Americans with major depression were screened and randomly assigned to receive twelve sessions of CBT or CA-CBT. CA-CBT was based on the Psychotherapy Adaptation and Modification Framework (PAMF) and The Formative Method for Adapting Psychotherapy (Hwang, 2009), which was a community-based developmental approach to culturally adapting therapy. Chinese American therapists were recruited who could speak Cantonese, Mandarin or English in order to treat the participants using their preferred language and were also from the same ethnic background. At the end of week twelve severity of depression was comparable for both groups, with the majority of the participants not entering remission. CA-CBT was not more effective than standard CBT in

reducing depression. This suggests Chinese Americans who have major depression may require longer and more intensive treatment.

2.8.3. Culturally Adapted CBT with Refugees

CBT has also been adapted for traumatised refugees (Hinton et al., 2004; 2005; Hinton, Hofmann, Rivera, Otto & Pollack, 2011; Hinton, Rivera, Hofmann, Barlow & Otto, 2012) and it has been acknowledged that they present with many challenges. They may have poor fluency in English, a limited education and live with socio-economic issues. Many have a history of extensive traumas and are dealing with several types of stress (Hinton & Lewis-Fernández, 2011). CBT treatment for Post-traumatic Stress Disorder (PTSD) involves prolonged exposure therapy (Foa & Rothbaum, 1998) which has been demonstrated to worsen symptoms and increase the drop-out from therapy amongst ethnic groups (Lester, Resick, Young-Xu & Artz, 2010). Therefore, there would be limited effectiveness of using traditional CBT PTSD models with ethnic minorities and refugees.

Cultural adaptations of CBT interventions focus specifically on emotions and somatic sensations with refugees and ethnic groups. This would involve targeting somatic sensations first which are particularly prominent amongst many traumatised non-English speaking refugees (Hinton & Lewis-Fernandez, 2011; Hinton & Otto, 2006). Emotional regulation techniques would be utilised from the patient's religious or cultural healing traditions prior to conducting exposure therapy and addressing catastrophic cognitions (Hinton et al., 2012; Markowitz, 2010). Increasing emotional and cognitive flexibility with refugees would also help with the issue of adapting to change.

Hinton, Hofmann, Rivera, Otto and Pollack (2011) assessed the efficacy of culturally adapted CBT (CA-CBT) compared to applied muscle relaxation for Latino refugees with treatment-resistant PTSD. The main treatment barriers identified with Latino refugees was their illiteracy, lack of understanding of therapy, somatic complaints and poor tolerance of traditional exposure therapy. Therefore, the main adaptations to CBT were education about PTSD, positive reframing of trauma cues, teaching emotional regulation techniques, using culturally appropriate analogies and visualisation, interoceptive exposure and modifying catastrophic cognitions. Latino refugees in the CA-CBT condition had large reductions in PTSD symptoms, improving significantly more than in the applied

muscle relaxation condition. The effectiveness of CA-CBT was equivalent to that found in non-ethnic English-speaking populations treated with traditional CBT (Ehlers, Clark, Hackmann, McManus & Fennell, 2005; Van Etten & Taylor, 1998).

This supports previous findings by Hinton et al.'s (2004) who found CA-CBT to be an efficacious treatment for Vietnamese participants with PTSD. A RCT consisting of CA-CBT condition and a waitlist condition also demonstrated the effectiveness of CA-CBT with Cambodian refugees who had PTSD (Hinton et al., 2005). Cambodian refugees improved on all measures including PTSD severity, anxiety and depression related distress. The treatment trials carried out by Hinton et al. (2004; 2005; 2011) were done with non-English speaking or minimal English speaking refugees. The therapist delivering the CA-CBT was either a social worker of the same cultural background as the refugees who acted as a co-leader or the first author who could speak the native language (Hinton et al., 2012).

These studies have attempted to highlight the type of cultural adaptations to CBT that are required with certain BME groups. But they have not clearly identified the specific issues with implementing standard CBT in clinical practice from either the client's or therapist's perspective. Rathod et al.'s. (2010) study developed CaCBTp based on the views of clients and CBT therapists but this study did not go into detail about their experiences of receiving or delivering CBT.

Naeem et al. (2011) based his culturally adapted CBT framework on three studies but none of these studies assessed the experience of South Asian clients receiving standard CBT (Naeem et al., 2012). One of the studies (Naeem et al., 2010) focussed on the experiences of psychologists delivering CBT with Pakistani clients. However, it did not identify the specific issues with CBT or the adaptations that are required to the CBT model. The psychologists acknowledged that CBT in its current format was not suitable; however they only outlined general therapeutic issues in working with South Asian clients which were not solely related to CBT.

An issue found with RCTs that assessed the effectiveness of culturally adapted CBT was that it was uncertain which specific adapted CBT techniques were effective or necessary (Hinton et al., 2004; 2005; 2011; Naeem et al., 2015; Naeem, Gul et al., 2015; Naeem,

Saeed et al., 2015; Rathod et al., 2013). There were factors such as the incorporation of a family member in therapy and client-therapist match in regards to language and ethnicity in most of the studies which could have contributed to the outcome. Another factor is that the therapists or the psychologists in the studies were not qualified CBT therapists (Hinton et al., 2004; 2005; 2011; Naeem et al., 2010; Naeem, Habib et al., 2014). Therefore, it is unclear if some of the issues identified with CBT are related to the lack of experience of the therapist with CBT. Also, most of the studies have been conducted with South Asians and refugees rather than getting an overview of CBT with other BME groups such as African and Caribbean people therefore at present culturally adapted CBT is not generalisable.

Griner and Smith (2006) conducted a comprehensive meta-analysis to review the effectiveness of adapted mental health interventions. They found an effect size of 0.45, which indicated a moderately strong benefit of culturally adapted interventions in comparison to traditional treatment. However, these findings were only based on a small number of 76 studies. This suggests multicultural therapy research is still in the early stages and research on the effectiveness of specific therapies such as culturally adapted CBT is even more limited.

2.9. Therapists' Experience of Delivering Manualised CBT

The research discussed so far has focussed on the perspective of BME clients and culturally adapted CBT. As this research is concerned with the adaptation of manualised therapy, literature on therapists' attitudes towards manuals, and propensity towards adaptation in general will now be reviewed.

Investigating the implementation of CBT protocol, manuals and treatments, Waller (2009) argues that CBT clinicians do not fully apply all treatments and protocols within the CBT approach. It is the lack of practice of CBT that leads CBT clinicians' to drift away from fully practicing CBT. He states this centres on clinicians own cognitive distortions, emotional reactions and use of safety behaviours. He addressed clinicians' own emotions such as anxiety about own performance due to fear of negative evaluation can lead to them not fully implementing CBT manuals. He also highlighted that CBT clinicians fail to implement behaviour change interventions fully such as exposure and behavioural

experiments, these are the most important elements of CBT for change (Bennett-Levy, 2003; Dimidjian et al., 2006).

Becker, Zayfert and Anderson (2004) provided evidence of exposure therapy for PTSD being underutilised. A survey of 852 clinicians was conducted on the attitudes towards and utilisation of exposure therapy for PTSD. The survey found that a large majority of clinicians stated they did not use exposure therapy with PTSD patients. Around half of the clinicians reported some familiarity with exposure for PTSD, yet only a small minority actually used exposure to treat PTSD. Waller (2009) outlined that this can be related to clinicians engaging in safety behaviours by protecting the client and avoiding any emotional distress with using exposure therapy with trauma clients.

Another issue Waller (2009) identified with CBT clinicians' practice was the lack of progress due to focussing on immediate crises and not maintaining a structured CBT approach. CBT clinicians also neglected the physical needs of the client with just focusing on the cognitions, emotions and behaviours. A significant factor in therapist drift is that there is not enough time spent fully utilising CBT techniques. Waller (2009) outlined that CBT clinicians are keener to utilise and integrate third wave CBT therapies such as DBT, schema therapy and mindfulness rather than focus on fully implementing CBT.

Overall Waller's (2009) study has highlighted that a key problem in the effectiveness of CBT manuals is that it might not be properly implemented even by experienced CBT therapists; a suggestion further supported by Brosan et al. (2007). This leads to the question whether CBT ineffectiveness is partly because of therapists' lack of confidence in implementing manualised CBT and losing sight of why specific tasks should be undertaken. These findings are also supported by Naeem et al. (2010) which found psychologists addressed the difficulties they experienced in delivering CBT to South Asian clients by doing whatever they felt were suitable.

Linehan (1993) stated that CBT therapists working with personality disorder clients depart from CBT treatment manuals when clients display therapy interfering behaviours. Thompson-Brenner and Westen (2005) found that CBT therapists displayed therapist drift and in more complex cases, also engaged in psychodynamic methods. Psychodynamic theory is considered a valuable approach in understanding and addressing issues related

to race relations, racism, oppression and discrimination. These are issues which are experienced by and directly affect BME clients (Alleyne, 2009, 2011; Berzoff, 2011). The psychodynamic approach has also formulated "how race, ethnicity and culture may impact internal processes such as sense of self, transference, object relation, internalization and super ego formulation" (Hughes, 2014, p. 37). As BME clients are less aware of psychological therapies, they are more likely to display therapy interfering behaviours which could lead to therapist drift. Beck (1996) and Teasdale (1996) recognised that the beliefs of clinicians about their role and their preconceptions about what should work in therapy can influence their practice of CBT.

Waller, Stringer and Meyer (2012) extended their research to explore the extent to which 80 CBT clinicians drifted from practicing CBT techniques specifically with eating disorder clients. Clinician's outlined the frequency they used different CBT techniques and completed an anxiety scale. Specific CBT techniques were utilised less than protocols actually stated, especially by those clinicians who were most experienced working with eating disorders and those that were prone to anxiety and older. Around 50% of the sample did not use a single core CBT technique routinely and the majority (56.6%) reported using pre-therapy motivational work. This study has shown that clinicians' use of the label CBT does not suggest they are in fact practicing CBT.

This supports a previous finding by Tobin, Banker, Weisberg and Bowers (2007) where only 6% of 256 clinicians reported they adhered closely to CBT treatment manuals and 98% of the clinicians indicated they used both behavioural and dynamically informed interventions working with eating disorders. Even though this research is limited to eating disorders, it demonstrated that few clinicians closely adhere to CBT treatment manuals and that most practice in a way that Waller (2009) outlined, separating the CBT intervention from the cognitive behavioural model which actually informs their use.

Addis, Wade and Hatgis (1999) highlighted some of the practitioner concerns about manual based psychotherapies. These concerns included the therapeutic relationship being compromised, manual treatment ignoring individual client differences and emotions, not meeting the needs of complex clients and restriction of clinical innovation. Addis et al.'s (1999) findings are in contrast to Najavits, Weiss, Shaw and Dierberger, (2000), who found 75% of the 47 CBT therapists they surveyed, viewed manuals highly

positively. Manuals were read regularly as part of the intrinsic motivation to improve skills. Therapists did not believe that manuals were too simplistic nor impeded their development. They did not believe in the uniformity in practicing manuals and that they should be based on empirical evidence. The therapists described their ideal manual as being a problem-solving resource which suggested what to do during sessions, descriptions of specific techniques, highlighting potential problems and having worksheets. However, the study is limited in that it did not look at the relationship between therapists' views of manuals and their actual performance such as process or outcome data.

Addis and Krasnow (2000) address this limitation and carried a national survey of 891 psychologists' attitudes toward psychotherapy treatment manuals. These were psychologists from varying theoretical orientations. Psychologists had a range of attitudes about treatment manuals from negative to positive. They held quite negative process attitudes and viewed treatment manuals as having a dehumanising effect on the therapeutic process supporting Addis et al. (1999). Psychologists also thought that manuals emphasised technique at the expense of flexibility and a strong therapeutic relationship. They held positive outcome attitudes as they viewed manuals as a guide in helping to use empirically supported interventions. Psychologists viewed stress, health problems and anxiety disorders as being the most appropriate disorders for using manuals with but least for personality disorders. It was also highlighted that psychologists had different preconceptions of treatment manuals and also their attitudes towards manuals could be formed through discussion with colleagues and reading literature rather than actually having any direct experience of using treatment manuals.

Godley, White, Diamond, Passetti and Titus (2001) developed this research by describing 19 therapists’ reactions to the use of manual-guided therapies for the treatment of adolescent marijuana users. All therapists interviewed felt that manuals provided a structure and consistency to their therapeutic work, were easy to use to prepare for a session and helped them to focus. The second most common theme was the restrictiveness of working with manual-based therapies. However therapists did incorporate their own personal style and creativity to make the intervention more client-centered as they found flexibility within an intervention. Themes related to deviation from

the manual included serious clinical issues, logistical reasons, uncooperativeness and lack of motivation from the client, inappropriateness of the material because it was too complex and incorporation of a family meeting as the manual did not provide guidance on family involvement. This study helped shed light on both positive and negative aspects of manual-guided therapy from the therapists' direct experience of manual use.

2.10. Psychosocial Interventions with BME Clients

A key argument considered within this review is that both practitioners and clients perceive adapted manualised CBT to be more effective with BME clients than the original versions of the manualised CBT. The evidence above shows that there is a limited success with manualised CBT, and it is therefore worth exploring the efficacy of other psychotherapeutic interventions in BME populations, which are not manualised.

Chui, Safer, Bryson, Agras and Wilson (2007) investigated if white Caucasian and ethnic minority participants with bulimia nervosa differed in their response to treatment. The effectiveness of CBT and Interpersonal Psychotherapy (IPT) was assessed with treating participants with bulimia nervosa. Participants of all ethnicities received treatment from White therapists in English. In comparison to other Caucasian and ethnic groups, Black participants reduced binge eating episodes to a greater degree when psychologically treated with IPT when compared with CBT. Markowitz, Spielman, Sullivan and Fishman (2000) also found IPT to be more effective than CBT in treating depression for Black HIV-positive patients. The potential reason as to why IPT might be more effective with Black ethnic groups is that CBT could be experienced by this particular culture as more probing and confrontational whereas IPT is more focussed on the patient's illness and environmental stressors. Beutler et al. (1991) found patients with internalising coping styles benefitted more with supportive therapy. So people from Black ethnic groups might have an internalising coping style and thus favour IPT. However this possible explanation has not been tested to date.

Studies with adolescent ethnic minorities have suggested that both IPT and CBT are efficacious treatments. Rossello and Bernal (1999) evaluated the effectiveness of CBT and IPT with depressed Puerto Rican adolescents in Puerto Rico. Psychological therapy and outcome measures were delivered in Spanish. Both IPT and CBT showed a greater

reduction in depressive symptoms in comparison to the wait-list condition. Results from clinically significance tests found that 82% of adolescents treated with IPT were functional after treatment in comparison to 59% of those treated with CBT. Highlighting that IPT was again a more favourable treatment choice when compared with CBT.

Family therapy interventions were also briefly reviewed with ethnic minority clients. Xiong et al. (1994) randomised controlled trial examined the efficacy of the family-based intervention for Chinese patients with schizophrenia in China. 63 schizophrenic patients living with family members were either allocated to standard care which was medication or a family-based intervention. Family-based intervention was delivered in Chinese and consisted of monthly counselling sessions focused on the management of social problems, medication, family group meetings and crisis intervention. Results from 6, 12 and 18 month follow-up periods found that patients who received family-based intervention programme were least likely to be admitted to hospital and had shorter hospital admissions (Xiong et al., 1994) when compared with standard care.

Ran et al. (2003) carried out one of the largest RCT studies on the efficacy of psycho-educational family intervention for families experiencing schizophrenia in China. 326 cases were randomised to treatment groups consisting of family intervention and medication, medication alone, and a control. Results indicated those allocated to the family intervention group complied more with treatment, gained knowledge about their condition and had more positive caring attitudes in comparison to the other two groups (Miranda et al., 2005).

Narrative approaches have also been demonstrated to be effective with BME groups. The tree of life framework which is underpinned by narrative therapy has shown to be effective with ethnic minority groups in the UK and abroad. It was originally developed working with children affected by HIV/AIDS in southern Africa (Ncube, 2006). The tree of life framework allows clients to identify their strengths, skills, abilities, values and their roots. The tree of life framework in particular has had a positive effect with African and Caribbean men in the UK who have experienced mental distress (Byrne et al., 2011). This also includes refugees and immigrants such as Liberian refugees in Australia (Schweitzer et al., 2014).

Psychological therapies based on the transpersonal approach are also considered suitable for BME clients. Transpersonal therapies have incorporated spirituality and religion as part of the therapeutic process which is a significant part of eastern cultures (Laungani, 2004a). The aim of therapy is not just to address the symptoms of mental health disorders but to help the client to achieve a higher stage of human development which involves "a deepening and integration of one's sense of connectedness, whether it be with self, community, nature, or the entire cosmos" (Kasprow & Scotton, 1999, p. 13). Spirituality, religion and transpersonal development have been incorporated within psychological treatment for Africans (Boyd-Franklin, 2010; Watlington & Murphy, 2006) and Asians (Walsh & Vaughan, 1993).

IPT, narrative and transpersonal approaches and family therapy interventions have shown to be effective with ethnic groups without any adaptations made to the interventions. This suggests that these approaches are suitable for ethnic minority clients than CBT. There is strength in knowing that some therapies are effective, and so there is some tentative support that other therapies such as CBT might also be effective if they adopt a similar approach. CBT is the NICE guidelines recommended approach which is the main approach utilised by the NHS (NICE, 2009; 2011). Therefore, CBT cannot be disregarded and needs to be worked with. BME clients are presenting at IAPT services; this is front line care, and so needs to accommodate the individuals who turn up. There is not an option to practice eclectically within this service, therefore need to learn what works, and apply it to the existing model, rather than change the model wholesale.

2.11. Overview

There is an ever growing need for psychotherapies for BME communities that are both empirically supported and culturally sensitive (Hall, 2001). Western developed psychotherapies often need to be culturally adapted to become more effective in treating ethnic minorities.

Thus far, CBT adaptation frameworks have been mainly applied in non-western countries. Also, the culturally sensitive adaptations that have been made are with standard CBT and not with manualised CBT which is the main therapy offered in the UK via the IAPT programme. This poses a significant problem as it is not clear whether manualised CBT

meets the needs of BME clients given that there is limited research on how CBT therapists practice manualised CBT in the UK with BME clients and if any adaptations are made.

Therefore, it is essential to find out what the experiences of CBT therapists are in the UK so that we can better describe the present state of service delivery and create targets for the future development of service provisions for this client group.

EMPIRICAL STUDY

Chapter Three – Introduction

3.1. Brief Introduction

Cognitive Behavioural Therapy has a strong evidence base from randomised controlled trials, reviews and meta-analyses (Butler et al., 2006; Chambless & Ollendick, 2011; Tolin, 2010) and it has also been found to be effective for a wide range of disorders (Fairburn, 2008; Turkington et al., 2008; Wells, 1997). Because of this, the NICE guidelines in the UK (NICE, 2009; 2011) and the American Psychiatric Association (APA) in the USA have viewed CBT as the psychotherapeutic treatment of choice.

There are two major issues concerning the practice of CBT in the UK. Firstly, CBT in its pure form without any adaptations is in conflict with the culture, beliefs and values of BME people from non-western cultures as it is based on western ideology (Iwamasa et al., 2006). People in western cultures tend to construct their internal and social worlds along cognitive and rational lines (Laungani, 2004b) whereas people from non-western cultures place a higher priority on cultural norms, family interdependence and faith (Hays & Iwamasa, 2006). Secondly, there is limited evidence to suggest that CBT is effective with BME clients as there is insufficient research that has compared the effectiveness of CBT with this group, as so far practice-orientated research on CBT has focussed primarily on people of European background (Casas, 1988; Miranda et al., 2005; Renfrey, 1992).

3.2. The Gap in Research

A limited number of studies (Naeem et al., 2010; Naeem, Habib et al., 2014; Rathod et al., 2010) have attempted to explore the views and experiences of therapists delivering CBT to BME clients, and in doing so discovered that adaptations were required for certain BME groups. However these studies lack depth and detail as they do not clarify what specific adaptations are made to the CBT model, nor how and why they were made. Most of the studies that developed culturally sensitive CBT frameworks were not carried out in the UK, with the exception of Rathod et al. (2010) which specifically focussed on psychosis. The majority of these studies have also focussed on specific ethnic groups and

have not involved qualified CBT therapists. RCTs which have assessed the effectiveness of culturally adapted CBT did not address which specific CBT adaptations were the most effective and also did not attempt to judge the necessity of each individual adaptation (Hinton et al., 2004; 2005; 2011; Hwang et al., 2015; Kohn et al., 2002; Naeem, Gul et al., 2015; Naeem, Saeed et al., 2015).

The present study will address some of these gaps in the existing literature by being one of the first to carry out research on the experiences of CBT therapists delivering manualised CBT with BME clients within the UK's IAPT service. More specifically, it will do this by recruiting only qualified CBT therapists in order to rule out lack of experience as a factor and by focusing on BME groups as a whole rather than one specific ethnic group. Previous studies have used thematic analysis but the present study will use IPA which is a more in-depth research methodology as it goes beyond just reporting themes within data and tries to understand the experiences of the participants.

Another area of research that the present study will greatly build upon is research within the IAPT service. The IAPT programme is based on the medical model and mainly offers manualised CBT for a wide range of mental health issues. The CBT diploma run by the IAPT programme is focussed on delivering manualised CBT which consists of various protocols or manuals in how to treat common mental health problems (Binnie, 2015). The IAPT service is considered a universal service offering a one-size-fits-all approach which does not entirely accommodate the specific needs and experiences of the client (Levinson, 2012). Considering that the IAPT service is the UK's biggest mental health programme and the UK contains a sizeable BME population, it should be noted that there has been limited research conducted on the suitability and effectiveness of manualised CBT with BME clients.

Research has shown that the attitudes of therapists towards manuals can be quite negative leading them to practice outside of the treatment manuals to varying extents (Beck, 1996; Becker et al., 2004; Brenner & Westen, 2005; Teasdale, 1996; Tobin et al., 2007; Waller, 2009; Waller, Stringer & Meyer, 2012). Therefore it is important at this time to explore the experiences of CBT therapists in delivering manualised CBT with BME clients, and if they make any adaptations, discovering the extent to which they are made,

how and why they are made and what underpins their clinical decision making when adapting manuals for working with BME clients.

3.3. Research Questions

The gap in research led to the following questions which this study attempts to answer:

1) What are the issues encountered in delivering manualised CBT?

The literature review highlighted various issues for therapists practicing CBT. However, little is known if there are any issues specific to the manualised form of CBT that is delivered by the IAPT programme.

2) If CBT therapists deviate from delivering manualised CBT with BME clients how do they?

This question will explore whether any adaptations are made for BME clients and attempt to discover the process involved in making them.

3) To what extent is manualised CBT adapted to be made culturally sensitive?

Studies from outside of the UK have indicated that there are a number of adaptations made to CBT when being applied to clients from non-western cultures. Some are basic adaptations in the therapeutic relationship while others have incorporated culture. This question aims to get clarity on the extent of adaptations made for BME clients in the UK.

4) If CBT therapists do make adaptations, what assists them in doing so?

Currently there is no cultural training for working with BME clients as part of the CBT course run by the IAPT programme. Therefore, if CBT therapists do make adaptations there is uncertainty as to what they are based on. Discovering more about this issue may highlight if there is a need for changes to the training given on the IAPT CBT course.

Chapter Four - Methodology

This chapter will first outline the methodological rationale followed by the method. This will include sampling and recruitment, participant characteristics, interview schedule development and procedure, data analysis, reflexivity, trustworthiness, the researcher's role as an IPA practitioner, ethical considerations and confidentiality.

4.1. Methodological Rationale

The research method chosen for this study was Interpretative Phenomenological Analysis (IPA).

IPA is an approach that is concerned with exploring and understanding personal lived experiences, the meaning participants attach to them and how they make sense of that experience (Smith, 2011; Smith & Osborn, 2008; Smith, Flowers & Larkin, 2009). The theoretical underpinnings of IPA stem from phenomenology (Biggerstaff & Thompson, 2008). "Phenomenology is interested in the world as it is experienced by human beings within particular contexts and at particular times, rather than in abstract statements about the nature of the world in general" (Willig, 2006, p. 51).

The second major theoretical underpinning of IPA is the hermeneutic tradition which is the theory of interpretation (Biggerstaff & Thompson, 2008). Interpretative analysis can offer a perspective on the text through the systematic and detailed analysis of the text and from the connections which emerge through the data set and dialogue with psychological theory (Smith et al., 2009). IPA research incorporates a two-stage interpretation process called double hermeneutics. This involves the participant trying to make sense of their lived experience as well as the researcher trying to make sense of the participants understanding of their world (Smith & Osborn, 2008).

Idiography constitutes the third and final theoretical underpinning of IPA and is the study of the individual in detail to achieve a better understanding of them (Pietkiewicz & Smith, 2014). In line with idiography principles, only small samples are used in IPA studies to enable a highly intensive and detailed analysis of the individual's experiences (Smith & Osborn, 2008; Smith et al., 2009).

Larkin, Watts and Clifton (2006) state that the major strength of the IPA approach is its main focus on generating an insider's perspective which allows the researcher to "think about what it means for the participant to have made these claims, and to have expressed these feelings and concerns in this particular situation" (p. 104). IPA also acknowledges the experiences of the individual participants as it allows effective analysis of single cases by retrieving claims from any individual case and for analysis to move from single cases to more general claims (Smith et al., 2009).

It was highlighted in the literature review that there are currently only a limited number of empirical studies on how CBT therapists apply manualised CBT with BME clients in the UK, and therefore, this study was to be one of the first. As research in this area is still developing and not at a stage where generalisations can be made, a key criterion for choosing the most suitable methodological approach for this study was a form of analysis that would allow an in-depth understanding of CBT therapists experiences. This study closely follows the principles of IPA, in regards to the phenomenology philosophy, it is concerned with exploring and understanding the subjective experiences of CBT therapists and how they make sense of their own experience of applying manualised CBT with BME clients. Secondly, it takes an idiographic mode of inquiry rather than a nomothetic approach (Smith & Osborn, 2008). This study has selected a small sample of six participants in order to gain a detailed analysis of each individual CBT therapist's experience rather than at a group level. Semi-structured interviews were considered the most in-depth data collection method for detailed first person accounts which is also the main method used in IPA (Smith, 2011). Out of all of the methodologies considered, the IPA approach best met this criterion and, therefore, was deemed to be the most suitable research method for this study. The findings generated through IPA could provide new data on the suitability of CBT with BME clients in the UK that has not been discovered thus far.

Other approaches considered for this empirical study were thematic analysis, grounded theory and quantitative research.

Thematic analysis has no pre-existing theoretical framework and the flexibility of thematic analysis makes it difficult to develop specific guidelines for higher-phase analysis, therefore making it difficult to focus on the data (Braun & Clarke, 2006). Thematic

analysis has limited "interpretative power beyond mere description" and is "unable to retain a sense of continuity and contradiction through any one individual account, and these contradictions and consistencies across individual accounts may be revealing" (Braun & Clarke, 2006, p. 27). It would have required a much larger sample of participants than IPA which would not have allowed for a detailed analysis of the individual experiences as was required for this study.

Grounded theory (Glaser & Strauss, 1977) was also considered and rejected as this study did not aim to generate a theoretical level account of a particular phenomenon to explain the experiences of the participants (Smith et al., 2009). Grounded theory looks for a conceptual explanatory level from a larger sample where the focus is on the general experiences of the participants forming a theoretical claim (Smith et al., 2009). IPA offered a more detailed analysis of the experiences of a small sample of participants focussing on the convergence and divergence between the participants (Smith & Osborn, 2008; Smith et al., 2009).

Quantitative research was reviewed for this study but as there is a considerable gap in the literature on how therapists practiced manualised CBT with BME clients the aim is to attend to the experience as a whole which is in contrast to quantitative methods that try to explain associations between events by testing hypotheses and measuring specific variables (Anzul, Margot, Freidman, Garner & McCormack-Steinmetz, 1991; Smith et al., 2009). Quantitative research tends to focus on what happens rather than how people make sense of what happens and the latter was the focus of this study (Smith et al., 2009).

4.1.1. Critique of IPA

IPA presents with some conceptual and practical limitations. IPA does not fully conceptualise the role of the researcher within the research process as it does not theorize reflexivity. IPA acknowledges the researcher's perspective but does not outline how the researchers own conceptions or views should be incorporated into the analysis of the participant's account (Willig, 2008).

As language is the only way for participants to express their experiences within IPA, phenomenological analysis is therefore dependent on the validity of language. Willig

(2008) argued that language constructs rather than describes reality and therefore the interview transcripts "tells us more about the ways in which an individual talks about a particular experience within a particular context than about the experience itself" (p. 67).

The application of IPA could also be limited if participants do not have the capacity to articulate their experience (Brocki & Wearden, 2006). Therefore IPA may not be suitable for participants who are not able to use language to express their thoughts, emotions and perceptions (Willig, 2008).

4.2. Method

4.2.1. Participants

4.2.1.1. Sampling and Recruitment

As Smith et al. (2009) outlines a homogeneous sample was selected to find participants for whom the research questions presented in the introduction was meaningful. Homogeneous sampling gathers participants that share some similarity.

The main focus of IPA is a detailed account of the individual's experience and would therefore, benefit with a small number of cases (Smith et al., 2009). Three to six participants have been considered to be a suitable range of participants within a study. As PhD studies are quite an individual piece of work there is no ideal set of participants, again it is suggested a range between four and ten are adopted (Smith et al., 2009).

For this study, six participants were recruited as this was a novel area of research and the aim was to allow for a richer depth of analysis which would have been limited with a larger sample (Smith et al., 2009). A smaller sample would also allow the researcher to focus more on the individual participant's account allowing for a deeper and interpretative analysis.

Smith and Osborn (2003) and Pietkiewicz and Smith (2014) both outlined the pragmatic restrictions a researcher is working under. Therefore the experience of the researcher needs to be considered when selecting sample sizes. As the researcher was working

under the time constraints of a doctorate course and had no prior experience of IPA a sample of six was considered manageable as it would not overwhelm the researcher.

4.2.1.2. Inclusion/Exclusion Criteria

The following inclusion criteria were applied to help maintain a homogenous sample:

(1) Provisionally or fully accredited by The British Association for Behavioural and Cognitive Psychotherapies (BABCP);
(2) Completed an IAPT programme CBT diploma;
(3) Practiced for a minimum of two years as a Cognitive Behavioural Therapist;
(4) Working in an IAPT service as a CBT therapist;
(5) Have experience of at least four cases of completed therapy with BME clients.

The requirement of accreditation was to ensure that participants had sufficient experience of practicing CBT following the IAPT training. Participants having accreditation also implied that they had been successfully assessed as competent by the BABCP. Together these criteria ensured that all participants were at a similar level with at least two years CBT experience. Participants also must have completed at least four therapy cases with BME clients. This would indicate a higher level of experience with BME clients so only participants with significant experience in this area were recruited. Four completed therapy cases were considered sufficient as BME clients have a high dropout rate from therapy (Rathod, Kingdon, Smith & Turkington, 2005). Participants were also considered suitable for the study if they had another profession such as a psychologist, counsellor, psychotherapist or trainee counselling psychologist but had to be currently employed in an IAPT service as a CBT therapist. As research in the area of manualised CBT with BME communities is limited the inclusion criterion was also set to maintain a level of homogeneity in the participant sample in case a future replication of this study was carried out.

	Gender	Age	Ethnic Group	Job Title	Qualifications	BABCP Accreditation	Years of Practice	Ethnic Client Group Experience	BME Cases
Angela	Female	40	African	High Intensity Psychological Therapist	BSc Mental Health Studies IAPT CBT Diploma Eye Movement Desensitization and Reprocessing (EMDR)	Provisional	4	White English/ Irish Black African/ Caribbean Indian Pakistani	100
Nina	Female	34	Pakistani	Psychological Therapist	BSc Psychology IAPT CBT Diploma	Full	5	White English/ Irish Indian Pakistani Bangladeshi Black African/ Caribbean Iranian Arab	60-70

Sabrina	Female	27	Bangladeshi	Psychological Practitioner	BSc Psychology Psychology Diploma IAPT CBT Diploma	Provisional	3	Bangladeshi Pakistani Arab Black African Chinese Indian	15-20
Emma	Female	60	English	Cognitive Behavioural Therapist	IAPT CBT Diploma MSc Psychological Counselling	Provisional	5	White English Indian Pakistani Bangladeshi Polish Hungarian Russian	20

Yasmin	Female	34	Pakistani	Cognitive Behavioural Therapist	BSc Psychology MSc Health Psychology IAPT CBT Diploma	Provisional	3	White English/ Irish Pakistani Indian Bangladeshi Black African/ Caribbean Polish Chinese	20-40
Mya	Female	33	Indian	Psychological Therapist	BSc Psychology IAPT CBT Diploma	Full	4	Indian Pakistani Greek Bangladeshi Sri Lankan White English	60

Table 4.1. Participant Characteristics

Table 4.1. provides an outline of the participant characteristics such as gender, age, ethnic group, job title, qualifications, accreditation status, the number of years practicing as a CBT therapist, ethnic groups worked with and the number of BME completed cases. Six participants were recruited; all were female and came from the Midlands and London area. There was a variation in age of participants from late twenties to early sixties. The qualifications recorded were those relevant to the participants' role and all participants had completed an IAPT CBT diploma. However, some of the participants had qualifications other than an IAPT CBT diploma. The variation in CBT experience was from three to five years, which is reflected in the participants' level of accreditation. All participants had extensive experience of delivering CBT with various ethnic minorities. The ethnicity of the participants was also diverse with five participants from an ethnic minority them self.

4.2.2. Interview Schedule Development and Procedure

4.2.2.1. Interview Schedule Development

The interview schedule was initially developed based on a review of the current research in the area, personal reflections and the experiences of the main researcher having worked in an IAPT service and also being trained as a CBT therapist. Smith et al.'s (2009) IPA guidelines were also taken into account during the development of the interview schedule. As this was an area of research that was new, questions were developed and reviewed by supervisors and fellow CBT therapists. Some of the interview questions were specifically designed to further the development of clinical practice.

The interview schedule was arranged into five sections, which involved pre-interview questions that focussed on the participant's understanding of the terminology used in the research and completion of a demographic sheet (appendix 1). This was followed by the main interview sections; (1) participant's background and training, (2) general experience of delivering manualised CBT, (3) specific experience of delivering manualised CBT with BME clients and (4) informed practice. Questions on therapists' worldview and awareness were not incorporated in the interview schedule as the focus of the research was on their current practice however if it presented in the interviews it would be explored.

This interview took a semi-structured format and used open-ended questions that were expansive and involved exploring case examples too. The interview schedule can be found in appendix 2.

4.2.2.2. Interview Procedure

A favourable ethical opinion was provided by the University of Wolverhampton Faculty of Education Health and Wellbeing of the study (appendix 3). Then potential participants were recruited through the Midlands IAPT services after making initial contact with the leads of the IAPT services (appendix 4). This was followed by contacting individual managers of teams requesting them to forward an email containing a participant recruitment letter (appendix 5), information sheet (appendix 6) and consent form (appendix 7) to be sent to all CBT therapists in the team. CBT therapists interested in taking part contacted the researcher directly by email.

Recruitment also took place through advertisement on social networking websites such as Twitter, Counselling Psychologists UK Facebook page and professional therapy websites which allowed participant recruitment to extend outside of the Midlands area (appendix 8). A participant information sheet was available through the link on the recruitment post. Anyone interested in taking part in the research contacted the researcher either through email or the social networking websites.

Following contact, a potential participant was screened on the telephone to see if they met the criteria of the study. The information sheet was given again and participants were given the opportunity to ask any questions. A further discussion took place to arrange a convenient date, time and location where confidentiality could be maintained. Options were also given to participants if the interview was more convenient to be conducted over Skype, FaceTime and telephone if there was difficulty in meeting. One interview was conducted through Skype and the rest were face to face.

All interviews were conducted one to one. Interviews times varied from a period of one hour to two hours. An introduction was given at the start of the interview and participants were asked if they had any questions. Consent and confidentiality were verbally re-addressed. Consent was also asked for an audio recording of the interview using a dictaphone. Participants were informed they could end the interview at any time or

request a break during the interview. The interviews were conducted in line with BPS guidelines on Code of Human Research Participants (BPS, 2010) and Code of Ethics and Conduct (BPS, 2009).

At the start of the interview, participants were informed to take their time to answer the questions. They were also informed it was their individual experience that was of interest. The semi-structured interview was conducted in a flexible manner and the schedule was used as a guide but the questions were not asked in the order they were written. Probing and prompts were used to gain depth and detail within the interview especially when participants struggled to answer.

Towards the end of the interview, participants were thanked and debriefed. All participants were given the opportunity to ask any questions. Contact details were taken of participants who were interested in reading the research once completed. As part of maintaining trustworthiness within research, all participants except one agreed to be contacted in the future as part of member checking. This gave participants an opportunity to check and approve particular aspects of the interpretation of the data they provided. Notes were also made after each interview of the researcher's impression of the participant in order to contextualise the interview.

4.2.3. Data Analysis

Interviews were transcribed verbatim and any identifying characteristics and place names were removed. Pseudonyms were given to each participant to protect anonymity. Data analysis followed the guidelines provided by Smith et al. (2009). An ideographic approach was taken which involved analysing each interview in detail in turn. The most detailed interviews that were two hours in length were analysed first because the researcher was inexperienced in IPA and wanted to get to grips with the richer information. The first reading of the transcript entailed listening to the interview and any notes made at this stage were written in a research diary. The next stage of re-reading the transcript entailed adding exploratory commentary involving making initial notes which were broken down into descriptive (describing the content of what was said), linguistic (specific use of language) and conceptual comments which were more interpretative, taking an enquiring form (Smith et al., 2009). Conceptual coding entailed reflections from the researchers

own experiential and professional knowledge. Analysing exploratory comments then lead to identifying emerging themes for that participant. The emergent themes were reviewed in relation to the transcript so that they related closely to the participant's experience.

Once a set of themes had been established they were arranged in the order they appeared in the transcript. The typed list of themes was printed out and individual themes were cut out and arranged to form clusters where themes had a connection or related to one another (Smith et al., 2009). Groups of themes were formed which identified a super-ordinate theme that suggested a hierarchical relationship between them (Biggerstaff & Thompson, 2008). The same process was followed for the rest of the five participants. However adhering to IPA's ideographic commitment, ideas emerging from the analysis of prior interviews was bracketed (Husserl, 1999) off to allow any new themes to emerge with each interview (Biggerstaff & Thompson, 2008; Smith et al., 2009).

The next stage looked for patterns across all six cases. A table was produced that presented all the six participants' individual super-ordinate themes. These super-ordinate themes were compared to find the themes that were recurrent across all six participants. Similar super-ordinate themes that presented across over half of the sample of six participants were identified and from this four master themes emerged. The same super-ordinate theme could look different in how it was evidenced across different participants (Smith et al., 2009). Therefore, notes and emergent themes were reviewed to come up with evidenced master themes. This is shown as each master theme is formed of constituent super-ordinate themes that were present in over fifty percent of the cases which are evidenced by participant quotes (Biggerstaff & Thompson, 2008; Smith et al., 2009). A final analysis table showing four master themes is presented in chapter five findings.

There was inter-rater agreement across the master themes with both research supervisors. An audit trail of the analysis was shared with the research supervisors; this included how transcripts were analysed, transcript commentary, emergent themes, the formation of super-ordinate themes and master themes. The names of some super-ordinate themes were adjusted to remain close to the ideographic experience of the participants.

4.2.4. The Researcher's Role as an IPA Practitioner

To understand the role of an IPA practitioner the researcher first had to learn about the epistemological underpinnings of IPA. Understanding the phenomenological and hermeneutics tradition is integral to the role of an IPA practitioner as it helps develop the researcher's insight into the findings (Gee, 2011).

A phenomenological attitude towards the research was taken as this process is one of the most important dimensions of phenomenological research. This involved empathy, openness and reflexivity from the beginning of the research, during analysis and evaluation (Finlay, 2008). During the interview process, the researcher was fully present to the participant's personal lived experience to allow deeper meanings to emerge and gained an empathic understanding of that experience (Cassidy, Reynolds, Naylor & De Souza, 2011; Finlay, 2008). This was followed by a more critical and deeper interpretative analysis to make sense of the participants experience (Larkin et al., 2006). The researcher was open to emerging themes and questioned findings so that the interpretations were grounded in the data.

Based on the Husserlian philosophy of phenomenology, the method of 'epoché' or 'bracketing' (Smith et al., 2009) was employed in the data collection and interpretation to prevent the influence of any pre-conceptions and was applied to three areas. The first was natural sciences, as scientific research can potentially reduce the field of investigation (Finlay, 2008). This involved the researcher bracketing off their knowledge of any research that explained the phenomena under investigation so that the researcher could focus on the lived experiences of the participant. An example of this type of bracketing involved the researcher bracketing ideas and concepts from the most influential researchers in the field such as Devon Hinton, Pittu Laungani and Farooq Naeem during the interview process and analysis. Bracketing allowed new themes to emerge rather than themes that just confirmed prior research in the field.

The second was of the natural attitude in order to enter a new way of being (Husserl, 1970; Finay, 2008) and was achieved by the researcher setting aside personal beliefs, bias and assumptions. The third and final area was to stand aside from one's own subjective experience (Finay, 2008). The researcher is from a South Asian ethnic

background and has experience working in an IAPT service as a CBT therapist. The researcher was aware that some participants' experience of practicing manualised CBT might relate to the researcher's own personal experience. The researcher bracketed the experience of sameness and did not allow it to influence the direction of the interviews by not asking questions that validated the researcher's own experience. This was also managed by the researcher keeping a reflective diary, carrying out member checks with the participants and maintaining regular supervision of the analysis to minimise the influence. Overall the impact of bracketing gave credibility to the researcher's interpretation of the participants' experience.

4.2.5. Trustworthiness

Trustworthiness of qualitative research is as important as it is in quantitative research but the concepts of validity and reliability are assessed differently (Shenton, 2004). The criteria by Guba (1981) for assessing trustworthiness was used within this study which was maintaining credibility (internal validity), transferability (validity/generalisability), dependability (reliability) and conformability (objectivity).

One of the main criteria is the credibility of the research. This study used IPA which is a highly regarded idiographic approach (Smith et al., 2009; Smith & Osborn, 2008). Selecting homogeneous sampling also prevented researcher bias in the recruitment process as the researcher only included those participants that met the participant inclusion criteria. Regular supervision meetings were maintained with both research supervisors who addressed any research issues or researcher bias. The researcher also engaged in the process of bracketing (Husserl, 1999) and recorded any experiences, assumptions and judgements in a diary in order to focus on what was actually presented in the transcript data (Biggerstaff & Thompson, 2008). This demonstrated the credibility of the data collection and analysis process (Chan, Fung & Chien, 2013). There was verification of the emerging themes as credibility checks relating to the accuracy of the data were done at each stage of the analysis by the research supervisors.

In regards to transferability Shenton (2004) outlined this could not be concluded from a qualitative study due to the small number of participants. However, it is essential to highlight within the study, detailed contextual information for others to discuss its

transferability. Within this study, a detailed methodological account was given such as the participant information and the inclusion criteria.

To assess the dependability of the findings, this study can be repeated. Member checking was also carried out during the analysis stage. Only five participants from the six interviewed agreed to be contacted afterwards of which three were able to give feedback on their transcript. These participants were able to verify the accuracy of individual transcripts and agreed that the emergent themes were congruent with their experiences.

4.2.6. Ethical Considerations

This study was presented to Wolverhampton University Research Ethics Committee and gained approval (appendix 3). It was recognised to carry minimal risk to participant's welfare. BPS guidelines on Code of Human Research Ethics (BPS, 2010) and the BPS Code of Ethics and Conduct (BPS, 2009) were followed whilst conducting the research.

The research study did not involve deception as participants were given full information about the purpose of the research. Prior to consenting participants were given an information sheet (appendix 6) and had time to ask any questions in order to have sufficient information about the research. Participants were informed they were free to withdraw and had the option of their data being destroyed any time before it was analysed. At the end of the interview, appropriate debriefing for participants was provided.

Participants were informed if they disclosed any information that presented a safeguarding risk, then the researcher would have to follow up with a report to the appropriate professional body. This information was provided in the information sheet and verbally confirmed at the start of each interview.

All participants were informed that the research was in no way related to their employer and that their employer could not get access to the interview.

The following measures were taken to guarantee anonymity. Any identifiable information such as name, location, place of work and any other clearly defined information that could have identified the participant were changed at the point of transcription. All participants were allocated a pseudonym name after the analysis was completed.

The participants were informed the research would form as part of a doctoral thesis and would also be written up in a journal article format with the view to be published. A summary of the findings would be provided to those participants who requested it and the completed thesis will be accessible through Wolverhampton University for all who wish to view it.

The ethical implication of being an insider researcher was addressed by considering internal ethical engagement (Floyd & Arthur, 2012). The dual role of the researcher as a CBT therapist was highlighted to all the participants in order to not deceive them or create any conflict in roles. Participants were made aware that the researcher had to adhere to both BABCP Standards of Conduct, Performance and Ethics (BABCP, 2009) and the BPS Code of Ethics and Conduct (BPS, 2009) to help deal with any ethical dilemmas that may occur unexpectedly. Power dynamics was also addressed by stating there was no right or wrong answer to the interview questions so that participants did not feel judged and the researcher did not feel pressured to agree with the participant's answers.

Service anonymity was also maintained by recruiting participants across the UK so that the participants and the IAPT services were not identifiable. The researcher did not have on-going relationships with the participants in order to allow confidentiality to be maintained (Greene, 2014).

4.2.7. Confidentiality

Confidentiality was maintained by not revealing information to other personnel, except for those directly involved in the study, such as the research supervisors.

Participants were informed it may not be possible or ethical to guarantee full confidentiality if a safeguarding issue becomes apparent while collecting data. This was related to participants being professionals and adhering to NHS trust safeguarding policies and BABCP professional practice guidelines (BABCP, 2009). If anything was raised during the interview that indicated that either the participant or someone else was at risk of harm, then these concerns would have to be considered further, or discussed with the research supervisors, and may require the information to be shared with the NHS trust safeguarding team. The need to adhere to professional practice guidelines was discussed and agreed with the participants at the outset.

Data was protected by keeping transcripts and interview recordings on an encrypted dictaphone and password protected memory stick accessible only to the research team. The data from the study would be stored for five years and then destroyed confidentially.

Chapter Five - Findings

5.1. Narrative Summary of Themes

This section will present the master themes that have emerged from the present study and how they relate to the experience of the participants delivering manualised CBT with BME clients. From this analysis, four master themes were identified:

1. CBT is based on western principles
2. The complex nature of CBT
3. Changing practice of manualised CBT
4. The influence of therapist factors

The table below shows the master themes and super-ordinate themes, with illustrative quotes for each super-ordinate theme presented.

Master Themes	**Super-ordinate Themes**	**Participants**	**Quotes**
1. CBT is based on western principles	1.1 Concepts of CBT not understood in non-western cultures	All	*"they really don't think in this way"* (Emma)
	1.2 CBT does not address collectivism	Angela Nina Sabrina Emma Mya	*"It's not accepting that people are different they've got these different backgrounds."* (Angela)
	1.3 Manualised CBT uses a diagnostic / medical model	Angela Nina Sabrina Emma	*"what we did to fit everything into these little boxes, when sometimes they don't fit into boxes."* (Angela)

2.The complex nature of CBT	2.1 Therapists simplify CBT in practice	Angela Nina Sabrina Yasmin Mya	*"break it down to its bare minimum" (*Nina)
	2.2 Clients need to be psychologically minded and educated	Angela Nina Sabrina Yasmin Mya	*"they don't really understand the rationale for it or they don't get it they don't understand how it will work for them."* (Sabrina)
	2.3 Inadequate CBT training	Angela Nina Sabrina Emma	*"training at some of the courses isn't in depth by any means"* (Emma)
3. Changing practice of manualised CBT	3.1 CBT manuals are helpful for structuring and guidance within therapy	Angela Nina Sabrina Emma Mya	*"the beginning of therapy just to put a structure"* (Angela)
	3.2 Consideration of culture and religion within manualised CBT	Nina Sabrina Emma Yasmin	*"how we can take in consideration values, family dynamics um religious beliefs"* (Sabrina)

	3.3 Integrative practice	Angela Nina Sabrina Emma Mya	*"I mix it with other therapies"* (Angela)
4. The influence of therapist factors	4.1 Therapist's confidence in CBT	Nina Sabrina Emma Mya	*"part of the effectiveness of any psychological therapy is the therapist's belief in what they're doing"* (Emma)
	4.2 Self-identity of therapist	Nina Sabrina Emma Yasmin Mya	*"It's been quite hard because at times I think its challenged my own beliefs"* (Sabrina)

Table 5.1. Table of master themes, super-ordinate themes and illustrative quotes

Mater Theme 1: CBT is based on Western Principles

This master theme was a strong theme throughout the interviews, being present across all six cases. Participants held the view that concepts of CBT were not understood in non-western cultures, that manualised CBT does not address collectivism and uses a diagnostic / medical model.

1.1 Concepts of CBT not understood in non-western cultures

All six participants acknowledged that CBT is based on western ideology. In their practice of manualised CBT, participants experienced that BME clients have different ways of understanding and being when compared with those from a western culture. This meant that some of the concepts that are central to CBT were not as easily understood by BME clients and there was a lack of shared language between therapist and client.

"But if you try to explain that to someone from an ethnic minority background, they might not necessarily understand that." (Angela)

The closer the client's culture was to western concepts and beliefs, the more suitable CBT was in practice, and the better the outcome for clients who engaged within manualised CBT.

"Whereas, I think the Black Caribbean it's easier because their perspective is much closer to the western where CBT comes from and was based upon then these other areas. . ." (Nina)

Participants also compared BME clients born in the UK, to those born abroad.

"Umm, when they speak English, and they're British like they're born here, um it's a lot easier. Um, when originally they're from um like India or Pakistan or anywhere else sometimes that can be, that can be a bit more difficult, umm, I found um. But then I suppose that example is more specific to I suppose Indian, Pakistani, Bangladeshis, whereas if I think about people who are Greek, people who are Italian, people who are Spanish, um I don't think that applies to them. I've been able to like deliver manualised CBT, um quite well." (Mya)

Participants experienced BME clients lacked an understanding of CBT concepts and terminology. They also found a lot of the CBT terminology could not be translated into various eastern languages. In some non-western cultures such as African and Pakistani cultures, there is little comparable terminology to draw upon as awareness of mental health is limited. Both Sabrina and Yasmin found it difficult to translate psychological terminology to their mother tongue.

"It might have to do with lots of different words, linguistically lots of words don't always translate into um the language so it's it's difficult you know try un just trying to explain what depression is in one word, depression. You're having to you know spend a good five minutes trying to explain that one word in a different language um same with other, other psychological psychology terms, it's quite hard." (Sabrina)

"So catastrophising um so I could use catastrophe or catastrophising but I don't have to explain catastrophising to a British born person because it's not a word really it's a made up psychological word. . .but to explain it then in Urdu or Punjabi its proven difficult." (Yasmin)

Communication between therapist and client is therefore hampered by the lack of a common language with which to refer to the concepts that are commonly discussed in CBT. The lack of common language leads to difficulties when using interpreters or translating therapy sessions for those who do not speak English. This important point was addressed by Nina.

"could be two therapists myself and someone else for example carrying out therapy in Urdu which I often do in Mirpuri, two of those people will not be doing the same thing. They will not be using the same words in the same way. . . " (Nina)

Additionally, interpreters may not accurately translate CBT concepts or misinterpret CBT themselves. Using an interpreter also posed another issue highlighted by Mya that there is no opportunity for verifying directly from the client that they understand CBT, which can lead to miscommunication and misunderstanding between the therapist and client.

"Um and I suppose when you can speak the language, so when I can speak the language, it's ok because I'm actually verifying with them actually do they understand

this, and things like that so it's not so bad. When you're working with interpreters for example that can be even bit more difficult." (Mya)

"Not being able to speak English, write English, having to use an interpreter. You knowing as a therapist that the interpreter is not interpreting what I just told them, translating it to mean what they want." (Angela)

The participants also highlighted that some BME clients have a lack of understanding of what therapy is which impacted on how they engaged within therapy and limited any progression of manualised CBT. Participants found that BME clients were more likely to use therapy as a process to offload and have a general conversation.

"They sometimes, they um, they kind of like want to be very friendly and want to kind of like got a tendency to offload and talk about you know their problems and find about little about you um I think that's just the general culture." (Mya)

This suggests that the aim of therapy is not understood by BME clients in the same way as western clients, possibly because therapy is not practiced as widely in non-western cultures and they have limited experience of therapy and mental health. A contributor to their lack of experience may have been the stigma associated with mental health. In non-western cultures, therapy would be the least likely intervention accessed with more turning towards spirituality.

"I've had patients who have, kind have you know, come from Europe and they've um you know, they've had therapies in the past and things whereas I've never actually ever seen anyone who may have had a um had therapies from um, from countries like India and Pakistan and... And a lot of it's kind of is to do with the experience I have had is about the kind of like the stigma of talking to somebody, about your problems." (Mya)

"For example in an apostil faith religion in Africa where people pray when they are moving around in the room waving their arms and if they got water they can sprinkle it at the walls and sort of try to get rid of the evil spirits, this is actually acceptable." (Angela)

Limited awareness of mental health issues and therapy, as well as the associated stigma these may attract, means therapists working with BME clients have additional barriers to overcome. This leaves the therapist in a position where they must first explain to the BME

client what therapy is before trying to engage them within the therapeutic process. Engaging clients within therapy would require the therapist to be sensitive to the individual client's beliefs.

1.2 CBT does not address collectivism

Participants reported having encountered more relationship and family issues with BME clients when compared with non-BME clients. They felt unable to address such issues using manualised CBT as its emphasis is on the individuality of the client rather than the collectivist family and relationship issues that were being presented.

"if this was a western Caucasian patient largely this would be about them and how it impacts upon them and their children maybe. But here it wouldn't just be about how her daughter feels, it's about how it would impact on her, how it would impact on her daughters, how it would impact on her in-laws, how her parents and brothers and sisters, how it would impact upon their children so it has some rippling effect. And you have to take that into consideration you know." (Nina)

CBT therapists working with BME clients have to take a collectivist approach as applying CBT interventions is not as straight-forward as working with a client from a non-BME background which would involve only focussing on the client's individual needs. When working with BME clients, therapists need to also consider the consequences of their interventions to the wider family and community around the BME client. This suggests that CBT therapists need to have some understanding of systemic factors working with BME clients.

Most of the participants commented specifically on cognitive techniques. They identified that rationalising and challenging negative thoughts was a cognitive process that BME clients did not identify with. It was believed that culture influenced how a client cognitively processed their experiences and that eastern cultures placed more emphasis on emotionalism.

"the cultures to some extent change thinking and so you know… we learn all of this in under graduate cognitive psychology, don't we?" (Emma)

"CBT comes from a western perspective imposed onto a different way of understanding and being. . ." (Nina)

Cultural differences in cognitive processes were seen as creating barriers to the effectiveness of cognitive interventions. This limited the interventions CBT therapists could use and potentially made them feel quite pessimistic of the outcome of therapy and hesitant to offer the CBT approach.

1.3 Manualised CBT uses a diagnostic / medical model

Participants associated manualised CBT with the medical model of psychiatry and described their training as being heavily influenced by the diagnostic model, such as the DSM-5 (APA, 2013). They also described their training as being disorder-specific in terms of learning specific techniques to solely work with depression and anxiety disorders. The protocols outline the steps in which to apply cognitive and behavioural interventions during the course of therapy.

"So fitting patients into a depression model um anxiety, generalised anxiety disorder model, panic model you know health anxiety, PTSD so all of those. But they were all separate disorder specific models rather than you know actually I'm working with a patient who is depressed and is also anxious. How can I work with that person diagnostically um or even you know somebody who suffers with OCD suffers with another form of anxiety. It was quite difficult to um kind of implement different models together, it was all trying do, try and fit them all in one model." (Sabrina)

"Otherwise we'd probably be doing more harm than good. I think because you're, you're dismissing the individual. It's like one shoe fits all, no it doesn't. Um you don't squeeze you're foot you know if you're a size 7 into a size 4, um you have to change the shoe (laughs)." (Nina)

The negative view of the medical model by participants is related to the struggle to apply it in practice with clients. There is also a sense of apprehension using the medical model and fitting the client into disorder-specific models as it means neglecting the individual needs of the client which many viewed as unethical as it could do more harm than good. Participants also experienced difficulties with working within a medical model

environment. They felt pressured to label the client with a diagnosis which was described as dehumanising and dismissing the client's needs.

"Very much manualised it was all about formulate, um fit the patient into this model." (Sabrina)

The transdiagnostic approach to therapy involves applying the same underlying treatment principles across various mental health disorders, without having a tailored protocol. Sabrina discussed transdiagnostic practice, but described her knowledge as being very limited as manualised CBT training did not place much emphasis on it.

"To be fair to be absolutely honest I don't even understand what transdiagnostic meant at that time. It wasn't, it felt like it was brushed aside." (Sabrina)

This suggests that the participants' practice and the environment they worked in focussed on the medical model. Participants utilised disorder-specific models as this is what the IAPT service they worked for expected of them. This seemed to lead to internal conflict for the participants.

Mater Theme 2: The Complex Nature of CBT

The second master theme that emerged was the complexity of CBT. This covered quite a diverse area from the CBT therapist's application of CBT, the clients understanding of the approach and the inadequate CBT training received.

2.1 Therapists simplify CBT in practice

Simplifying CBT interventions was identified by participants as one of the main adaptations made, in particular for BME clients. Examples of this include changing the CBT terminology used and explanations of the rational into more layman terms as well as simplifying worksheets by adding pictures and scales.

CBT formulations were also kept quite simple by utilising a basic five-area model, rather than a longitudinal model.

"So say for example you're doing a like simple five-areas model." (Mya)

These adaptations were made so that BME clients could apply the CBT principles being discussed more easily, understand the rationale behind them and incorporate them culturally.

"so, for example like panic attacks, so medicalised so they can't understand it. Using more pictures and things like that, um formulations you know sometimes they are really difficult and you just break it down to its bare minimum, you know. Whereas formulation has so many different elements to it and they just break it down into two, three items you know that they can understand. . ." (Nina)

The next stage of adaptations focussed on the CBT interventions. These were separated into cognitive and behavioural interventions. However, at times only the behavioural interventions would be implemented, such as behaviour activation with depressed clients, therefore not completing the full protocol set for the disorder. This is because the behavioural interventions were viewed as the most simplistic interventions.

"I am only doing behavioural interventions with certain patients because that works better for them." (Sabrina)

Cognitive interventions were stated by most participants as being the most complex to apply especially with BME clients who would mainly be offered behavioural interventions to begin with.

"I am probably focussing more on the behavioural on the behavioural aspect more rather than combining it with behavioural and cognitive aspect it's very difficult so um." (Sabrina)

This suggests that the participants feel that BME clients do not always understand cognitive interventions and therefore applying them may not be effective. This would explain why more tangible behavioural interventions are utilised more. Another reason could be because BME clients take an emotional approach over a cognitive one, where the emphasis is on rationality, logic and control.

With regards to complexity issues, there was agreement that manualised CBT was easier to practice with less severe presentations.

"In other situations, it's a simple thing for simple phobias, for simple panics it can work." (Angela)

It was more difficult for participants to apply manualised CBT to client presentations that were not addressed on their course or that they had little experience of working with which put them under a lot of stress and anxiety.

"we're seeing step three point fives and fours. We're seeing people who are perhaps not actively suicidal, um but they've got serious personality issues." (Emma)

During training, the competency of participants was regularly assessed using the Revised Cognitive Therapy Scale (CTS-R) (Blackburn et al., 2001). Part of the assessment process involved participants demonstrating the ability to structure their CBT sessions according to the twelve items on the CTS-R scale, which they recalled being quite a difficult task. Participants continued to find it difficult to implement the CTS-R after the completion of their course and all but one stopped structuring their sessions according to the CTS-R.

"Well, you know there's twelve things we all do in therapy which you've got to do them all at once with the same client in an hour! Which is not just ridiculous it's absurd. Um so, what you end up doing is you end up thinking to yourself now come on client I need you to behave yourself today because I've only got ten shots and you know that's terrible, that's terrible!" (Emma)

This suggests the complex nature of CBT is not only experienced by the clients as all participants who talked about the CTS-R manual in the interview found it difficult to apply in practice.

"I found it very difficult to pass the CTS-R and I thought what more have I got to do?" (Emma)

"I failed quite a few CTS-R. . ." (Sabrina)

The lack of integration of the CTS-R manual by the participants is mainly due to the complexity of it. However, it is also due to it hindering the therapeutic alliance which is a significant part of the current practice of the participants. Participants viewed the therapeutic alliance as more important than strictly adhering to the CTS-R manual.

Because of this participants failed to maintain practice of the full CTS-R manual after completing the course, opting instead to only implement parts of it.

"Rigid structure, especially if you go by the CTS-R and I think the therapeutic relationship is important." (Nina)

2.2 Clients need to be psychologically minded and educated

Psychological mindedness was an emergent theme which the majority of the participants found to be a significant factor in working with clients of all backgrounds.

"well this person really isn't psychologically minded enough if you're still trying to deliver that basic hot cross bun after session six or seven." (Emma)

Participants viewed psychological mindedness as having prior awareness of psychological therapy and the ability to form a therapeutic relationship. This also included having some level of insight and self-awareness into their condition. Given the activity-based nature of CBT, it requires the client to be able to read and write at a proficient level, but more importantly to comprehend session content.

It was highlighted that psychological mindedness was not an issue solely related to working with BME clients. It was experienced by participants across multiple cultures, including western ones.

"It's not even a cultural thing. It's more about psychologically mindedness. If they don't have that anyway then it's difficult." (Mya)

This suggests that culture is not the only factor that should be taken into account when determining whether manualised CBT is suitable for a client and that the psychological mindedness of the client is just as important. Therapists need to be capable of assessing psychological mindedness of clients and whether they would benefit from manualised CBT.

The experience of participants was that manualised CBT was more effective with clients that were educated and had an above average level of literacy. Clients who were well educated engaged better with manualised CBT, took ownership of their recovery and collaborated well during sessions. The majority of BME clients the participants treated had

a lower standard of education and poorer literacy skills when compared to non-BME clients they treated. This may be because those BME clients were born in countries where the standard of education was poor, the opportunities for learning were lacking or having a good education was not seen as being important within their culture.

"Um if there not on benefits they are illiterate and on low paid jobs. Some of them are illiterate but not all of them um yeah so that's the demographics." (Yasmin)

"when you look at the history of CBT or entomology. . .what do you call it? Is that the word, I can never say it properly. It's based on a well-educated, university educated white British white population. Now the population that we're working within inner city (area) does not necessarily fit that model so what do you do then?" (Nina)

A lot of the barriers to practicing manualised CBT that participants experienced were not encountered by the founders of CBT. Participants reported having had little guidance on how to address these barriers which resulted in them questioning their confidence in manualised CBT. In the case of two thirds of the participants, it even led to them holding negative views about CBT. This is likely to have impacted upon their motivation in applying manualised CBT with BME clients, specifically with regards to whether they would apply the full protocol due to them possibly believing in an ineffective outcome at an early stage.

Psychological mindedness can also be used to describe a client's understanding of therapy and their ability to form a therapeutic relationship. Participants found that the help-seeking behaviours of BME clients impeded the therapeutic relationship as they wanted the therapist to 'fix' them. This led to the clients not taking responsibility for their recovery and not maintaining client-therapist boundaries as they viewed the therapist as an authority figure.

"some people that think kind of like give you that responsibility, of you know fixing me . . ." (Mya)

"I think they think she's not my therapist I can just see her as another sister in the community. . ." (Sabrina)

Participants also found that most BME clients expected the use of medication in their mental health recovery and had limited understanding of how psychological therapy works and how it could help them.

"People from the subcontinent who rely on heavily on medications to solve everything, then they're sent to you for therapy. One, first what is therapy? How is talking going to help me? No, but that's the only real thing they think that's going to help is medication." (Nina)

This also meant that the BME clients did not identify the role of the CBT therapist, possibly mistaking them for a medical professional.

"So seeing helping in a very different way um so rather than help yourself some for like. I know it might sound like a bit judgemental um but kind of like not just within like I'll say I will go to the doctor and get medicine and that will help me. Kind of like this fixing mentality, our culture will make to you, you give me something that will make me better . . ." (Mya)

2.3 Inadequate CBT training

Participants described the IAPT CBT course as being an intensive course that had a lot of theory condensed into a year-long course and would have preferred the course to have been more skill-based and longer to have enabled consolidation of learning.

"the disadvantage of that is at least if you have more time . . . you have more time to reflect and think about what you're doing, what you're learning, instead of this almost emotional roller-coaster. . ." (Nina)

At the end of the course some participants did not believe they were competent enough to be practicing as a CBT therapist.

"the end of the training where I was finally getting, getting used to it, getting my, really understanding it that's where I felt that the doors were closed its off you go you're a therapist now that's how it felt." (Sabrina)

This suggests that participants did not feel that their learning needs were being met and that the IAPT CBT course was incomplete.

Some participants believed they had not received adequate CBT training as they had only learnt to treat certain disorders. Manualised CBT was recognised to be a diluted form of CBT, overlooking the foundations of CBT.

"Well the thing is um, of course I was at (university a) for um for a while and the CBT training there was appalling, I had a friend who was doing the CBT training at (university b) and he sent me some of his materials and I just drooled over them and I thought why couldn't we be taught this? You know, and um really once I got to the (university c) um you know the contrast between the way CBT is taught on some of the courses and the way it's actually taught is really quite disgusting. . ." (Emma)

Participants were aware of the lack of training that they had received on the IAPT CBT course which they felt had limited their knowledge and practice. This has had an impact on their confidence and ability to work with presentations that were not taught on the course and those that are more complex. As a way to cope, they became quite cautious in how they worked and engaged with clients with these presentations.

Master Theme 3: Changing Practice of Manualised CBT

This master theme addressed how CBT therapists practice manualised CBT at present.

3.1 CBT manuals are helpful for structuring and guidance within therapy

There was significant change in how participants practiced as trainees compared to the present day. All participants acknowledged aspects of manualised CBT as being helpful and did not completely disregard manualised CBT within their current practice. The use of formulations and theory around psychological disorders was helpful but participants believed that not everyone fitted into the CBT framework.

"Yes, yes I mean after those things, the different formulation, the different ways of working with each of those disorders in fact that was really helpful." (Nina)

"But again having the manuals, having the protocols helped a lot because it gave me a structure to work. It gave me somewhere to be able to start working on. So I wouldn't discount them altogether but I would say they have to accommodate. And it shouldn't be strictly ABC you have to do because it doesn't work that way." (Angela)

Most participants acknowledged the structure and guidance that manualised CBT provided was helpful if they required some direction in working with a client. When working with new or unfamiliar disorders, participants tended to rigidly follow manualised CBT to structure and guide the entire treatment. However, as they gained more experience in treating specific disorders, they reduced how much they incorporated manualised CBT.

"If there's something kind of like that's a bit that I haven't worked with for a while, so could be for example it could be like classic PTSD and it could be something that is traumatic but it's not classic PTSD so then I would kind of go back to actually, what, what is it, what's um you know, does it fit. . ." (Mya)

Participants explained that when they were newly qualified they would practice manualised CBT as they were taught on the course, adhering strictly to the manuals and the CTS-R outline. Use of the CBT manuals allowed the participants to gain some structure, guidance and reassurance in their practice.

However, when treating BME clients, certain aspects of the CTS-R impeded the development of the therapeutic alliance such as when setting the agenda and reviewing the client's homework.

"you know agenda setting it's not always that easy. You know you do have patients that come in are quite distressed, they see that space as their way of letting it all out and that sit down ok wait a minute lets write the agenda, it's still that can be difficult for some patients. Homework is quite a difficult one for a lot of them. They come in probably quite chaotic, distressing environments. It's quite hard for them you know to sit down and do homework. . ." (Sabrina)

Disregarding the CTS-R so early on in their practice may be an attempt to avoid the distress it might cause to the client or the participant's own anxiety in not feeling confident in implementing it correctly.

However, over time as participants gained more experience, there was a clear indication they had increased confidence as therapists and had been able to identify which aspects of CBT work in practice.

"when I have got my confidence up and I have recognised the presentations I start to understand my patients a little bit better. I can start to tailor edit parts . . ." (Sabrina)

3.2 Consideration of culture and religion within manualised CBT

All participants identified religion and culture as two of the main areas that need to be integrated within the practice of manualised CBT with BME clients.

"I think it's taking into consideration the cultural and religious elements to people's psyche which is very important because they have a strong hold from those from the sub-continent. . ." (Nina)

"Rather than values, beliefs, cultures, religions bringing all of that those things in all as well. Where you know from those kind of communities these kind of values come out quite strongly and you need to take those into consideration in therapy." (Sabrina)

Participants also hesitated somewhat in practicing manualised CBT with BME clients as they were concerned by the western principles of CBT going against the belief and value systems of BME clients.

"You have to be very wary of that because getting them to think what could considered in a western way, it's not for her personally we wouldn't have gone down, it would have made her more anxious then she already was, yeah." (Nina)

This suggests that practicing manualised CBT with BME clients could do more harm than good in some cases and therefore could be considered unethical practice.

Five of the six participants stated they received no specific psychological training in working with cultural differences on the IAPT CBT diploma course. The only diversity training they had received was from their NHS trust and was not therapy related. Their lack of cross-cultural therapy training could also help explain their reluctance to practice manualised CBT with BME clients. Nina was the only participant that had received very basic training as part of her IAPT course that lasted a day.

"When I say a session, I probably mean a day on that or something like that. Um… but other than that no I don't really. I think it was just a tick box exercise if I'm honest." (Nina)

Participants recognised that manualised CBT training does not consider the impact of culture on psychological wellbeing or how to address it within a CBT framework, such as the disorder-specific models. This lack of cultural integration within manualised CBT has led participants to do their own research on how to adapt it to incorporate cultural considerations. Participants were aware of the need to apply CBT in a way that was respectful of both the client's culture and beliefs.

"So I have had to really research into certain religions. If not my own you know I had to research certain things about certain religions, certain cultures in order to adapt for them rather than take away and saying no that doesn't matter. . ." (Sabrina)

For participants, ethical practice is central to their way of working, and not acknowledging a client's culture or religion would go against that. Participants realised the need to be sensitive and cautious when applying cognitive interventions as they believe that BME clients have a collective thought process as opposed to an individualistic one. Participants also realised that behavioural interventions such as behavioural activation could be detrimental when applied with BME clients, unless religious and cultural beliefs were acknowledged. Behavioural interventions were adapted by first considering the appropriateness of any behavioural activity within the client's culture.

"Um and for example getting her to go out and socialise, you'd think that would be helpful getting her out but (talks from client's perspective – 'that's not who I am, I like. . . I like the house, I like doing the chores,') other people would think uh how is that helpful? (talks from client's perspective – 'But I like staying indoors, going out with others they seem to think oh my husband just died and I'm going out and doing different stuff, um how are people going to view that?'). So you have to take that into consideration actually there are elements in that society that would look upon that negatively. So ok let's work within that, what can we do that gets the same result but in a different way." (Nina)

With regards to adaptations made with cognitive interventions, the more experienced participants incorporated collectivist viewpoints (such as from the client's family and community) in challenging core beliefs and assumptions by using cultural and religious information. An exception to this was where such beliefs served an important function in

the client's life and attempting to adjust them could cause more harm than good. Adapting interventions by incorporating culture and religion was shown to be effective.

"I had an OCD lady who would worry about whether she'd prayed correctly and it was out of her thoughts it was 'I haven't prayed correctly I have to pray again' and that led to her praying five, six times over and over again and she just did not think she was praying right. So from a religious point of view I actually looked into it. It wasn't about physically what you were doing but about your intentions. So if your intentions was to do that worship a form of worship then your prayer is accepted. Whereas her worry was well my prayer is not accepted because its wrong so it was actually once she was able to recognise and learn that she was able to minimise and start reducing the number of times she prayed because she is now learning from a religious point of view." (Sabrina)

This suggests that directly challenging religious beliefs or values using Socratic questioning is not always the most suitable intervention to use. With religious adaptation of manualised CBT, the therapist must first understand the client's religion in order to challenge the client's distorted religious beliefs. This may require in-depth research on the client's religion by the therapist but could also involve incorporating advice from community faith leaders.

"So helping them to extract that and if they're saying its religious then getting them to speak to someone who knows a little more about it then they would have and get them to read the appropriate materials that would help them." (Nina)

Reading religious scriptures or praying was incorporated in behavioural activation to facilitate relaxation in order to help ease a client's emotional difficulties.

"when we are doing activity planning, trying to active planning rest periods as well so they struggle with that so. Um some of my Muslim clients anyway when they pray for some them that feels like a rest period so that's fine that can be your rest activity too. . ." (Sabrina)

Nina gave a detailed account of how she adapted cognitive interventions to incorporate and respect the client's culture.

"Again as I said before, it's about looking at um…from a collective, cultural point of view um…what I'm trying to say for example, core beliefs ok, most of the core beliefs will tend to centre around what others will think, what the consequences not to them individually will be but to them as a family, as a culture, as an ethnicity or as a religious group would be. Ok, so that's how if you're challenging that you've got to know what it is. If you're helping them to change that, first you have to say is it a negative core belief or a helpful one given the environment that they're in and if it's one that's making them, that's causing them the difficulties in terms of the depression, the anxiety, what is the possible alternative? Working within those remits? Yeah, because for them it's not about you know me, myself and I, it's about other people, others around them, society in general, how they're going to be viewed without taking into consideration, that's going to be probably more detrimental in terms of central experience." (Nina)

This suggests the onus is on the therapist as to whether the interventions they offer are ethically appropriate and will not be detrimental to the client. The knowledge and experience that a therapist has about culture and diversity is one of the most important factors that can help make CBT interventions more effective with BME clients. In practice however, the level of cultural awareness from therapist to therapist can differ significantly. Because of this, therapists from the same culture as the client are more likely to be better at making culturally sensitive adaptations.

In order to address language barriers such as poor literacy, participants simplified CBT worksheets by adapting them to be more pictorial and even using audio recordings as a way of doing CBT homework.

"when we were activity scheduling we'd kind of draw pictures. . ." (Sabrina)

"So what we ended up doing as recording things on their telephones, on their mobile phones so I found that brilliant actually, I thought that was quite good, innovative a lot of people do it but the patient learned definitely realised what they had to do for homework and then they recorded their own voices in terms of what they felt, what they thought, what they did behaviourally, etc at that time so it was good and good way of them to be feed backing to me and for them to take away what they had learnt." (Yasmin)

Overall, participants found behavioural interventions to be more effective with BME clients once adapted to meet their needs.

"Behavioural is definitely a lot more effective than the cognitive." (Sabrina)

Given the lack of training on culture and diversity, participants took it upon themselves to learn about cultural adaptations. This would entail reading up on the culture, speaking to colleagues, utilising supervision and speaking to specific BME organisations. The participant's prior experience with BME communities was rated as being the most helpful with making adaptations. All participants agreed adaptations were crucial in working with BME clients but some only did so if they were still in line with CBT.

"So literature would help and speaking to colleagues would help and speaking to organisations that deal with ethnic minorities. . ." (Angela)

"Um experience is a big thing, if you haven't worked so many years with people from BME communities. . ." (Yasmin)

"if I was a CBT practitioner and umm I'm making adaptations in relation to the CBT model as in its still CBT but its either simplifying it or it's making it so that it fits that particular client group then I can't see a problem." (Mya)

Participants made adaptations based on their own experience. Therefore, there was no consistency in how the adaptations were made and it also suggests that the adaptations were not derived from evidence-based practice.

Some participants did not have an open relationship with their supervisors so some of their adaptations were made without any guidance. The participants who were more experienced mainly based their adaptations on their own experience. This suggests they potentially made more in-depth adaptations and had tested out adaptations to find what was effective.

3.3 Integrative practice

Participants described their current practice of manualised CBT as being individualised to the client's needs. Taking a more flexible and adaptable approach meant making the interventions more accessible to BME clients and allowing them to take ownership. When

deciding which areas of manualised CBT to adapt, participants focussed on the ones that impeded the therapeutic alliance and were difficult to apply in practice. Some of these included structuring sessions, the use of the CTS-R manual, diagnosis, disorder-specific formulations and the adherence to the full application of the CBT manuals.

"But you've got to adapt anything you're doing to the clients idiosyncratic experience. . ." (Emma)

"it's a question of how do I offer it in a way that's slightly more adaptable and flexible to the person. . ." (Nina)

There was a sense that participants valued developing a therapeutic alliance with their clients over and above the adherence to the treatment manual. This may be because they believed the therapeutic alliance to be more crucial to the process of therapy.

Participants found that a stronger therapeutic relationship could be formed if there was a close client-therapist match. BME clients engaged better if they shared language, ethnicity or cultural background with the therapist, as they believed that the therapist could understand and relate to them better.

"And at one point I had a Muslim lady who was wearing hijab and you know she absolutely loved the fact that I could understand her culture and where she was coming from." (Yasmin)

"So they allow me to actually work with people from BME backgrounds and especially if a South Asian language is a need because I mean it might be partly that they're saving money but also partly it is very good actually for therapeutic alliance for some people." (Yasmin)

The opposite of this was also found to be the case where a weak client-therapist match in language, ethnicity and culture hindered the therapeutic relationship between BME clients and their therapist.

"with some Asian cultures, the person man would not want to see me because I am a women." (Angela)

The importance of the client-therapist match was supported by the only non-BME participant in this study who had first-hand experience of BME clients looking for commonalities with her.

"But people from other ethnic groups to me often so of seem to be scanning for what we have in common." (Emma)

All but one of the participants were of a BME background and in cases where the participant's cultural background was similar to, or the same as the client's, it may have influenced how adaptations were implemented.

"I think both African and Asian because with African there's a lot of things similar, if someone comes to my session and realise that I'm African, "Oh thank God at least you understand" and then there's an adaptation I would do with that particular patient." (Angela)

Many of the participants practiced integratively as they were combining other approaches within their practice. This mainly included humanistic and third wave CBT approaches such as mindfulness.

"so, you know I do work integratively and I take ideas from psychodynamic from all over the place and my general demeanour could be described as pretty person-centred and you know at the same time I, you know feel that a lot of the um the things that cognitive behavioural therapy tries to pin point um are useful and helpful to people." (Emma)

Participants assessed a client's ability to process manualised CBT and if they were unable able to do so fully, they took a more integrative approach.

"I'm working in an integrative way so it's not necessarily just, um you know just CBT sometimes it's people who are struggling for example with um you know rationalising thoughts, um I actually use mindfulness with them, so that's worked quite well." (Mya)

From an ethical standpoint, participants felt more comfortable practicing an integrative approach and tailoring their therapy to BME clients, rather than solely practicing manualised CBT as they believed the integrative approach was more suited to the needs of this client group.

"I feel more comfortable switching and kind of mixing it depending on how it works." (Nina)

"integrate, adapt and edit certain types of interventions to work with that patient." (Sabrina)

This suggests that participants are adapting therapy based on how their clients are behaving and responding within sessions. Integrative practice gives participants more versatility in how they practice and therefore it could also be suggested that there is less chance of them feeling limited within therapy.

Participants incorporate skills from the humanistic approach within manualised CBT, making their practice more integrative. They also stated using counselling skills resulting in them being more reflective. This suggests that when participants practice strict manualised CBT, they perhaps think that they are dehumanising their clients, which makes them feel uncomfortable from an ethical standpoint. Therefore, practicing integratively by incorporating humanistic principles can be seen as a means to ease any internal conflict they might be experiencing.

"Well (laughs) I think sometimes I, well not sometimes most times I mix it with other therapies umm its very few times that you do CBT just in the box. In the first instance, the client does not fit into one box and the criteria's that are met. There is no client like that. There is no patient who is like that." (Angela)

"So you know being quite integrative, in quite person centred. So sometimes it may, it may have come across a little bit more counselling then CBT but then just how it fit for the patient at the time. I can't you know be, you can't be fully, you can't do strict CBT all the time either." (Sabrina)

Half of the participants disclosed how they had to keep their integrative practice and adaptations a secret from their colleagues and managers. This was because the participants thought their colleagues would not accept their practice and feared either being cautioned or losing their job. The other half worked in IAPT services which approved of adaptations to manualised CBT and the use of other therapies.

"No I don't, I only talk to people that I trust, my own group of peers. I wouldn't go to someone from the other team and discuss that in front of them but we don't do that. I think it's just fearing that maybe, you'll lose your job or something. . ." (Angela)

"when you're working with therapists there's an understanding, that's what happens. And I think there is for management level but it's always people covering their backs. . ." (Nina)

"we have been told to work individually. In other words, make adaptations where you need to. . ." (Emma)

Participants also disclosed that this secrecy extended to the environment that they worked in. While their colleagues were aware of others not practicing strict manualised CBT, no one openly admitted to doing that.

"Yeah but we don't admit it. Like formally no one would admit it formally but I think if we were asked we would all say we were following the protocol." (Angela)

"I think people don't generally talk about it because I guess they all a little a bit concerned so yeah I'm not quite sure. You generally don't hear. I speak to, I talk about these things a few people who I did the training with that's why it's little bit easier because we are going through it at the same time." (Sabrina)

Some participants have been challenged during supervision in having to justify their adaptations to manualised CBT. One way to defend their integrative practice was to emphasise they were at least incorporating some aspects of CBT within their practice. Two participants reported saying during supervision that they tried to keep adaptations as close to CBT as possible while knowing this statement was not entirely accurate.

"And you stretch it sometimes when you're in supervision saying how does that fit into CBT? You know it doesn't but this is what I did but this is what I needed to do in order to achieve this. It doesn't you know fall nicely into these little boxes and everything but isn't what you achieve at the end of it that counts, surely?" (Nina)

Some participants felt unsupported in the use of adaptations to manualised CBT during supervision. There was also a fear of losing their jobs as they were aware that their

adaptations might not have a strong link to CBT. Because other CBT therapists were secretly implementing adaptations within their practice, the participants may have felt this justified their own practice and conduct during supervision.

"Um not with my supervisor in the trust no because I would feel they may not always agree. . ." (Sabrina)

This suggests a potential dilemma due to the participants not being fully open with their supervisors, resulting in their practice not being effectively monitored. Without professional oversight, the participants were at risk of potentially applying adaptations incorrectly or ineffectively.

Stress could also potentially become an issue for the participants as they attempt to keep the integrative part of their practice hidden from their colleagues and supervisors.

Master Theme 4: The Influence of Therapist Factors

Confidence in CBT and self-identity were critical factors in how the participants practiced manualised CBT.

4.1 Therapist's confidence in CBT

Four out of the six participants held quite negative views about manualised CBT. These participants questioned the suitability of it for use with BME clients because of the numerous difficulties they encountered in applying it with this group. Their opinion was that manualised CBT had to be adapted or integrated with another approach in order to be effective with BME clients.

"I think having a background that isn't just focused on one therapy i.e. It's a more systemic approach, it's probably a little bit, you can draw upon different theories or practise, I think that's helpful as well. . ." (Nina)

Some participants like Emma believed that manualised CBT is a condensed form of CBT.

"if you actually read Beck, you know Beck doesn't actually have a manual for anything um you know he has urm of course his, his major interest has been in depression um, but you know he's interested in everything and you know in his writing um you know it's

actually very, very person centred there's a terrific relationship on the therapy relationship. Um, going with what the client feels is the issue, um and you know he doesn't actually have a manual really!" (Emma)

The participants who perceived CBT in a negative light were the same participants that had difficulty practicing manualised CBT. Due to these difficulties they acknowledged they no longer practiced as pure CBT therapists.

Yasmin and Mya were the only two participants that viewed manualised CBT positively. They were also the participants who experienced the least amount of difficulty in practicing manualised CBT with BME clients. Yasmin in particular disclosed she was still practicing strict manualised CBT as taught on the course and held a strong belief that CBT should be structured and manualised.

"I'm still pretty much sticking to what they've taught us." (Yasmin)

I'm very manualised and very structured and I still write session notes and still have agenda settings and do my help bridge to last session and all of that." (Yasmin)

Her belief in practicing strict manualised CBT could be the reason she experienced fewer difficulties in working with BME clients in comparison to the other participants. She made fewer adaptations to manualised CBT than the other participants and along with Mya, her adaptations were also more faithful to the CBT model. However, unlike Mya, Yasmin did not integrate any other approaches in her practice. It seems then that a therapist's confidence in CBT is directly related to how effective they are at practicing it.

"part of the effectiveness of any psychological therapy is the therapist's belief in what they're doing because that offers hope to other people." (Emma)

4.2 Self-identity of therapist

How a CBT therapist viewed them-self as a practitioner influenced how they practiced manualised CBT. Participants who found that manualised CBT concepts did not integrate well with their own beliefs and values were least likely to practice pure manualised CBT, especially with BME clients.

"So because I'm religiously practicing myself that is something that I wouldn't do be able to do whereas I know that other therapist might be able to challenge that. So it does kind of challenge your own beliefs and values." (Sabrina)

This suggests that adherence to manualised CBT is influenced significantly by how much a therapist can relate to the approach them-self. It could also mean that therapists might assess how similar they are to their client such as in terms of culture, religion and ethnicity, and make decisions about which parts of manualised CBT are suitable for the client based on their own background and experiences. Therefore they may be less likely to implement the full set of CBT protocols.

Following the completion of the IAPT CBT diploma, some participants had opportunities to complete further psychological training. This seemed to have had a significant impact on their practice as it has veered away from being based on pure manualised CBT. It seems their identity as a therapist is still being formed and influenced by further psychological training.

"I suppose back in those days when you were a trainee and even when you were kind of freshly qualified, it was very much just CBT, pure CBT, now it's more, I've just done a mindfulness courses as well so I'll incorporate mindfulness into it. Um, I've done some like short courses on um compassion focussed therapy so I may incorporate a bit of that. So, um, so I think it's a bit more flexible so I'm working in a bit more of a flexible way now." (Mya)

Some participants were not fully committed in practicing pure manualised CBT as they decided to include other approaches and believed you can still be a CBT therapist if you do this. A therapist's identity as a practitioner seems to form over many years and merely completing a course in manualised CBT will in no way guarantee that they will practice CBT as taught.

It is worth bearing in mind that all participants were offered the IAPT CBT course for free, with the majority of them not possessing a passion for it prior to training. Instead, they were primarily looking for an accessible platform to start their career in therapy.

Nina became a CBT therapist after not being able to get onto a professional psychology doctorate course so it ended up being a backup career for her.

"At the time, um which I didn't have to pay for um I wanted to do clinical but then that wasn't happening. . ." (Nina)

Due to the limited interest and motivation of participants for CBT, as well as their reasons for taking the course, they had issues in identifying with the role of a CBT therapist which may also explain why most of them eventually drifted into a more integrative practice.

Yasmin and Mya were the only two participants who stated they viewed themselves as CBT therapists.

"I've started to get to know a lot about neurolinguistic programming which is something else that I am doing. Now I say all of a sudden my knowledge of neurolinguistic programming its useful to have that but saying I started to kind of like applying that more in this role um instead of CBT and making that adaptation. I don't think that's right in relation to my role here because that's what I'm qualified at and offering to the patient." (Mya)

The more experienced participants were the ones that were incorporating more eclectic approaches into their practice of manualised CBT. Mya identified with the CBT therapist role as she stated that was what she was employed to do and it was expected of her. However, this somewhat contradicted her practice as she also stated incorporating mindfulness and compassion-based approach, believing doing so was still in line with CBT. Again this indicates there are so many different views as to what constitutes being a CBT therapist.

Yasmin was a newly qualified CBT therapist and out of all of the participants she had the strongest confidence in CBT. Unlike most of the other participants, she continued to practice manualised CBT with BME clients even after encountering difficulties while implementing it. Yasmin has even gone onto teach on a CBT course, so clearly the level of confidence and motivation in CBT are significant factors in how strictly therapists practice it.

"I haven't diverted away from it but actually I don't think I would if that makes sense because it was meant to be doing CBT and that's what it is about." (Yasmin)

Chapter Six – Discussion

This section provides an overview of the findings which will be discussed in relation to the literature. This will be followed by the clinical implications of the findings, recommendations for practice, strengths and limitations of the study and suggestions for further research that can be conducted.

6.1. Introduction

The present study aimed to explore the experiences of therapists delivering manualised CBT to BME clients. Four research questions were posed to guide the empirical research study and a summary of the findings responding to each question is outlined.

1. What are the issues encountered in delivering manualised CBT?

Some of the main issues encountered in delivering manualised CBT with BME clients were CBT concepts were not understood, CBT terminology was not translatable, BME clients did not identify with cognitive interventions, CBT did not address collectivism, relationship and family issues could not be addressed through CBT, therapists were apprehensive in applying a medical model, the complexity of CBT and inadequate CBT training.

2. If CBT therapists deviate from delivering manualised CBT with BME clients how do they?

Therapists deviated from practicing manualised CBT with BME clients by practicing a less structured approach of manualised CBT and making various adaptations to the CBT model. This was due to manualised CBT being difficult to apply in practice, impeding the therapeutic relationship, going against BME clients' beliefs and value system and BME clients not being able to process CBT.

3. To what extent is manualised CBT adapted to be made culturally sensitive?

Cognitive and behavioural interventions were adapted by incorporating culture, religion and language. Other adaptations involved simplification of CBT techniques in line with the client's level of education and psychological mindedness. This also involved therapists

practicing integratively by incorporating humanistic and third-wave CBT approaches and not utilising the CTS-R manual.

4. If CBT therapists do make adaptations, what assists them in doing so?

Therapists' personal experience and prior experience with BME clients were rated as the most helpful in making adaptations, followed by knowledge of culture and diversity, research, peer support and supervision. Therapists' confidence in CBT and self-identity as a practitioner also assisted them in making adaptations.

The present study has made a significant contribution to the knowledge and practice of psychological therapy with BME clients and the practice of manualised CBT within the IAPT programme. It was the first study to explore the practice of manualised CBT within the IAPT programme and it has given new findings that have not been previously addressed in the UK. It has also built upon previous research in this area that has been carried out in non-western countries.

The present study not only addressed what specific adaptations were made with BME clients but also highlighted some unexpected findings in the participants' practice of manualised CBT with BME and non-BME clients. Participants acknowledged the structure and guidance that manualised CBT provided was helpful and gave reassurance. Participants tended to rigidly follow manualised CBT when working with new disorders. However, as they gained more experience in treating specific disorders, their practice veered away from pure manualised CBT. This suggests that over time as participants have gained more experience and confidence in their role, they have been able to identify what aspects of manualised CBT they found to be a hindrance and adapted their own practice. The lack of integration of the CTS-R manual by the participants is partly due to the complexity of it but also because it hindered the therapeutic alliance. This means that the participants viewed building a therapeutic alliance a more important part of their practice than adhering strictly to the CTS-R manual.

Another important factor described by participants was adapting their practice of manualised CBT to be more integrative and individualised to the client's needs. Exploring this further revealed that participants took more of a flexible and adaptable approach by not adhering strictly to any CBT manual and spending more time in developing a

therapeutic relationship with the client. Practicing as an integrative therapist involved combining other approaches which were mainly humanistic and third-wave CBT approaches.

Third-wave CBT approaches take a holistic approach and focus on changing the function of psychological events that people experience through a range of interventions such as acceptance, cognitive defusion, mindfulness, client's values, relationships and spirituality (Hayes, 2004; Hofmann, Sawyer & Fang, 2010). There are several third-wave CBT approaches such as acceptance and commitment therapy (Hayes, Luoma, Bond, Masuda & Lillis, 2006), metacognitive therapy (Wells, 2011), dialectical behavioural therapy (Linehan, 1993) and mindfulness-based cognitive therapy (Segal, Williams & Teasdale, 2002).

Participants also made greater use of core counselling skills when they felt practicing pure manualised CBT was dehumanising the client. These findings do support Naeem et al. (2010) and Rathod et al. (2010) who highlighted that engagement and therapeutic alliance can be difficult when providing therapy to BME clients and that more emphasis needs to be placed upon building and maintaining a therapeutic alliance.

The more humanistic practice is in line with prior research on culturally sensitive CBT which has highlighted the importance of the therapeutic alliance. Sue (1990) stated that a therapist would need to take more of a counselling approach in their communication when working with BME clients. Both Hwang's (2006) and Tseng's (2004) frameworks for CBT adaptation with Chinese clients emphasised the importance of focussing on and developing the client-therapist relationship.

Manualised CBT is a very goal focussed treatment and can lead to participants focussing more on the problem behaviours than establishing a therapeutic alliance. Sue and Zane (1987) and Rathod et al. (2010) stated it is crucial for ethnic minority clients to establish the credibility of the therapist through a therapeutic alliance so a respectful rapport and trust can be established quickly. Naeem Phiri et al. (2015) also emphasised the importance of establishing a trusting relationship during the first few sessions because ethnic minority clients may view psychological therapy with certain scepticism and view psychological issues in medical terms so tend to see a doctor in the first instance. It is

even more important in this context that ethnic minority clients form a strong alliance and do not turn back to medical doctors or see spiritual healers (Naeem et al., 2010). Other issues faced by ethnic minority clients are stigma around mental health and encountering barriers in accessing psychological help.

The adaptations discussed were broadly developed in response to difficulties related to culture, religion or language when treating BME clients. Other factors were also reviewed such as psychological mindedness, age, education and acculturation.

6.2. Culture and Religion

One of the main issues encountered by all participants was that CBT was not understood by BME clients in terms of its focus on individualism, rationale, cognitive processes and the incorporation of the medical model. This is supported by Kim et al. (1994) who states that psychological theories are based on individualistic values that reflect western cultures. Gilbert (2006) further added that theoretical assumptions underlying psychological therapy are based on models of human nature, emotional distress and recovery that originate from the implicit cultural assumptions about the self within western cultures. As CBT originated in America by Ellis (1962) and Beck (1970), it is based on western values. Personal autonomy, independence, seeking change and separateness are central to western society (Hays, 1995). These western values have been made universal as those in the west believe that the self is mainly individual. Gilbert (2006) argued even though there are different modes of selfhood, individualism is overemphasised. "The development of self is always simultaneously both individual and social" and different cultures can place more or less emphasis on "the individual inner self and the relationship between self and others" (p. 12).

In the experience of the present study's participants, manualised CBT did not address collectivism. Specifically, participants encountered more relationship and family issues with BME clients when compared to non-BME clients. The issues presented which CBT could not address or addressed inadequately were systemic in nature. Participants had no guidance on how to work with these issues as their manualised CBT training did not acknowledge the systemic or interpersonal issues that are common amongst BME clients.

The foundation of psychological well-being in eastern cultures is based on inter-relationships with other people (Gilbert, 2006). There is also emphasis on the collective responsibility and family hierarchy (Laungani, 2004a). CBT constructs depict people as being in control of their environment, both in their internal and external worlds. This is a view consistent with western individuals but not eastern (Lago & Thompson, 1997). Eastern cultures have a strong belief in determinism which limits freedom of choice and taking proactive measures to change. This contradicts the CBT approach, as part of the aim is to seek change. Reality is also internal to the individual and perceived through contemplation and inner reflections, which would make challenging thought processes difficult (Laungani, 2004a).

There is growing evidence that systemic CBT can be suitable for exploring developmental, interpersonal and family issues (Dattilio, 2005; Dummett, 2004; 2006). Systemic cognitive behavioural formulation does have the basis for understanding systemic problems and tailoring therapy to address both individual and systemic factors. However, further research is required to evaluate systemic cognitive-behavioural therapy (Dummett, 2004).

The lack of understanding about mental health and psychological therapies by BME clients can be related to the stigma around mental health which inhibits seeking therapy. There is a notion that talking to someone outside of the family about such issues would lead to social exclusion (Knifton et al., 2010; Fernando, 2010). Participants experienced BME clients defining their psychological symptoms as physically related and overemphasising the use of medication in their recovery, thereby demonstrating their lack of understanding of how psychological therapy could help them. This is related to how BME clients express psychological distress more somatically. Palmer and Laungani (1999) highlighted that in some cultures emotional problems can be highly stigmatising and physical complaints are considered the only legitimate metaphors through which they can be expressed (Fitzpatrick, 1983).

In response to these difficulties, participants made cultural and religious adaptations within their practice of manualised CBT. Religious adaptations entailed incorporating prayer and other religious practices as part of behavioural activity. Incorporating religious beliefs also helped in modifying negative thoughts. The use of religious examples to

challenge negative thoughts was encouraged by Naeem, Phiri et al. (2015) who found it to be effective when working with South Asian clients. Paukert et al. (2009) also supported religious adaptations and found that religious beliefs and scriptures can be helpful in modifying maladaptive thoughts by looking at situations from a different perspective. Self-statements formed of religious connotations were considered to be positive cognitive coping responses. Paukert et al. (2009) suggested adaptation of behavioural interventions to include religious activities as a form of behavioural activation that may increase opportunities for positive reinforcement. This is in line with the adaptations made by the participants of the present study.

Research from studies that incorporated ethnic minorities (Azhar & Varma, 1995; Hadman, 2008; Razali et al., 1998) have found religiously integrated therapies (such as Islamic CBT) and socio-cultural elements in cognitive therapy to be as, or more effective than conventional treatments for depression. The study by Pearce (2015) was the most recent to develop and implement a new religiously integrated adaptation of cognitive behavioural therapy for the treatment of depression. His study supported previous research and adaptations made by participants in the present study. He outlined that religious CBT can use the client's own religious tradition as a foundation to identify and replace negative thoughts to reduce psychological distress. Pearce (2015) made his religiously integrated cognitive behavioural therapy model applicable to Christianity, Judaism, Islam, Buddhism, and Hinduism.

As already discussed, non-BME clients are less likely to present with family and relational issues than clients from BME communities, whom participants struggled to treat with manualised CBT. As psychological wellbeing is found in inter-relationship with others, participants tried to incorporate this within their practice of behavioural and cognitive interventions.

Behavioural interventions were adapted by collaboratively working with BME clients to account for any cultural differences and what was acceptable. The suitability of any behavioural activity was assessed within the client's culture and how others would perceive the behaviour according to the social norms of that culture (Hays, 2009). This is supported by Gilbert (2006) who outlined that from a collectivist society, one's behaviour is determined, dependent on and organised by "what the person perceives to be the

thoughts, feelings and actions of others" (p. 13). Lau and Kinoshita (2006) also emphasised the importance of cultural congruence and client direction being considered when setting behavioural tasks.

Cognitive adaptations entailed adapting cognitive restructuring intervention to challenge negative thoughts and assumptions by incorporating cultural and collectivist views. It also involved exploring the function of any beliefs held amongst the wider family and community and whether adjusting them would be more detrimental to the client. This adaptation involved directly discussing negative thoughts with BME clients. This is supported by Naeem, Phiri et al.'s (2015) research which highlighted exploring the beliefs of family and other community members to assess whether the client's beliefs are acceptable or dysfunctional. Naeem, Gobbi et al. (2009) also highlighted dysfunctional beliefs and cognitive errors vary from culture to culture. This is supported from evidence from Hong Kong (Tam et al., 2007) and Turkey (Sahin & Sahin, 1992). Iwamasa et al. (2006) outlined that clients from eastern cultures emphasise collectivist responsibility. The beliefs of these clients centre on dependence on family, giving up personal needs for the good of the family and the need for acceptance by others (Hays & Iwamasa, 2006; Iwamasa, et al., 2006). Yet these beliefs viewed from an individualist culture can be considered dysfunctional. For this reason, Hays (2009) advised against challenging core cultural beliefs with BME clients unless they agree, and especially if the therapist takes an individualistic dominant cultural orientation.

Overall, adapting interventions by incorporating culture and religion was shown to be effective with BME clients in the present study, especially with adapted behavioural interventions. Cognitive adaptations were not as effective as behavioural adaptations with BME clients as they were difficult to translate and adapt for the client's culture.

6.3. Language

Participants stated that one of the reasons why BME clients did not understand CBT was differences in language. They found that some CBT terminology could not be directly translated into the client's native language. As CBT is based on English, not all BME clients share a common vocabulary. Each language defines things differently and uses its

own unique concepts for making sense of the world. Therefore a client speaks, communicates and thinks within the constraints of their language (Gilbert, 2006).

Fitzpatrick (1983) and Palmer and Laungani (1999) argue that non-western cultures lack the vocabulary to express emotions and mental states. This is in contrast to western languages which are very rich languages for the expression of mood and feeling (d'Ardenne & Mahtani, 1989). Therefore it is expected for there to be miscommunication about how internal emotional states are felt and expressed by BME clients. CBT therapists need to maintain effective communication by understanding the client's use of language within their culture and avoid getting too attached to the language of any theoretical model (Palmer & Laungani, 1999).

The studies that have assessed the effectiveness of culturally adapted CBT delivered therapy to clients in their native language (Hinton et al., 2004; 2005; 2011; Naeem, Gul et al., 2015; Naeem, Saeed et al., 2015; Hwang et al., 2015). However, these studies did not take into account or acknowledge language as a possible influence. Griner and Smith's (2008) meta-analysis found that therapy is twice as effective if delivered in the client's preferred language.

In the present study, bilingual participants found communicating in the client's preferred language (usually their native language) helped them better understand the issues the clients were trying to convey. However, they found using an interpreter to deliver therapy in a client's native language impeded communication. The use of an interpreter means communication is not direct and this can lead to messages being modified through translation. Also, managing a three-way relationship can make communication even more difficult (Lago & Thompson, 1997). This is not to say that direct communication in the client's preferred (non-English) language is without issues of its own. Participants sometimes found it difficult to explain English therapeutic terms in the client's native language, but in these instances it is unlikely a translator would have fared any better. This supports the need for bilingual therapists in order to improve communication with BME clients. While this study found delivering therapy in the client's native language more likely to improve the therapeutic alliance, it was not however able to show that it had an effect on the therapy outcome.

The focus on behavioural interventions is partly as a result of difficulties concerning language. The behavioural methods rely less on language in comparison to cognitive interventions which become less effective with BME clients due to the language barrier. This gives a clear indication that therapists deviate from treating BME clients with manualised CBT by mainly using behavioural interventions and not utilising the full CBT protocol.

Naeem et al. (2010) found similar results with the experiences of psychologists delivering CBT in Pakistan. The technique which clients found most helpful was behavioural interventions. Psychologists in Naeem et al.'s (2010) study stated that clients found behavioural techniques easier to follow. Like the participants in the present study they too used behavioural techniques more often and found they yielded better results with South Asian clients. Naeem et al. (2010) also suggested South Asian clients feel less stigmatised when behavioural interventions are used as they can be integrated within the bounds of their cultural and social practices.

Participants overcame difficulties with language by simplifying CBT terminology and rationale into more layman terms. The simplification of CBT adaptations was in line with previous research with BME clients. Naeem, Phiri et al. (2015) stated therapists need to be careful with terminology and jargon and to use common language whenever possible. In order to address poor literacy, participants in the present study simplified worksheets by adapting them to be more pictorial and even made use of audio recorders in sessions and as part of CBT homework. Similarly, Naeem, Phiri et al. (2015) found audio recorders to be helpful in increasing homework compliance.

In support of previous studies (Naeem, Gul et al., 2015; Naeem, Saeed et al., 2015) the present study found that its participants kept CBT formulations quite simple, utilising a basic five-area model rather than a longitudinal model as BME clients found it difficult to distinguish between thoughts and emotions.

6.4. Psychological Mindedness

There are many definitions and measures of psychological mindedness with most taking a psychodynamic perspective which limits the use of the construct (Grant, 2001). A more suitable definition that was congruent with the participant's experience is outlined by

Baekeland and Lundwall (1975) and Wolitzky and Reuben (1974). They defined psychological mindedness as the ability to view one's self in psychological terms, use psychological constructs and consider psychological causes of symptoms. Overall, participants of the present study found BME clients did not have an understanding about what therapy was and how to engage within the process; tending to use CBT sessions as an opportunity to offload. Participants found that BME clients did not taking responsibility or maintain boundaries as they viewed the therapist as an authority figure. Laungani (2004a) outlined that in eastern cultures, the nature of relationships is based on a vertical structure where the therapist is viewed and accepted to be in a superior position. These issues encountered by the participants are not confined to CBT. BME engagement in psychological therapies is an ongoing difficulty affecting all therapies.

No specific adaptations were made by the participants in relation to the lack of psychological mindedness of BME clients. It is possible that adaptations are less effective if a client is not psychologically minded, therefore CBT therapists need to be capable of assessing the client's level of psychological mindedness and whether they would benefit from therapy. Roth and Fonagy (2005) outline that intrapersonal factors such as lack of hope and psychological mindedness are associated with poor treatment alliance and therapeutic efficacy (Piper, Azim, Joyce & McCallum, 1991; Ryan & Cicchetti, 1985). The Suitability for Short-Term Cognitive Therapy Rating Scale (Safran, Segal, Shaw & Vallis, 1990) can be used to assess the suitability of CBT for use with BME clients. Some of the suitability criteria require clients to accept personal responsibility for change and to have compatibility with the cognitive rationale which has been demonstrated BME clients are unlikely to possess.

6.5. Education and Age

There is limited research concerning the level of education and the suitability of CBT. Wiebe and Greiver (2005) identified lower socio-economic status, lack of education and not being psychologically minded as barriers to offering CBT in primary care whereas it was easier to offer CBT to younger and educated clients. There were more occurrences of participants working with BME clients who had a lower standard of education and poorer

literacy skills which could be related to first generation BME communities being more illiterate (Jayaweera, 2014).

Simplifying CBT techniques was the main type of adaptation made when working with poorly educated BME clients. This involved simplifying worksheets and formulations, not completing the full set of treatment protocols, the use of audio recorders instead of writing and excluding complex cognitive interventions. Behavioural interventions were offered first as they were a lot simpler to explain and implement in comparison to cognitive interventions. Naeem, Phiri et al. (2015) found that behavioural techniques (behavioural activation, experiments) and problem solving were simpler to use and more effective with less educated people. Cognitive interventions require a client to be more rational, analytical and methodical in their way of thinking which is in contrast with the non-linear, holistic way of thinking from eastern cultures (Mark, 2010).

The present study also found older BME clients and those that had recently come from abroad do not relate well to CBT, making it more difficult to implement with them. This could be related to their level of acculturation to their host country (Berry, 1990; Moyerman & Forman, 1992). Cheung, Chudek and Heine's (2011) findings provided evidence for a sensitive period of acculturation. People are more likely to identify with a host culture the longer they have been exposed to it, especially if they have been exposed to it from a young age. This supports the participants of the present study finding it easier to practice manualised CBT with younger BME clients and those born in the UK. Griner and Smith's (2006) meta-analysis found that cultural adaptations were more beneficial for adults with low levels of acculturation to their host country and limited proficiency in English. Burnett-Zeigler, Bohnert and Ilgen (2013) linked acculturation to a change in self-identity by distancing from one's own cultural customs and native language. This suggests that therapists need to assess the client's extent of acculturation to western culture so that different levels of cultural adaptations can be made to achieve a positive outcome (Rathod et al., 2010).

The findings of this research have shown that culture, religion, language, psychological mindedness, acculturation, education and age have a significant influence on how CBT therapists practice manualised CBT with BME clients.

6.6. Implication for Training and Practice

Participants experienced a struggle to apply disorder-specific models in practice as client presentations did not always fit precisely into a model. They were also unwilling to label clients with a diagnosis as it meant neglecting the individual needs of the client which many viewed as unethical. By adhering to the medical model, participants were unable to take a critical perspective. Strawbridge and Woolfe (2010) stated that the categories of illness and disorders such as in the DSM-5 (APA, 2013) have been criticised by many researchers (Bentall, 2003; Cromby et al., 2007; Kutchins & Kirk, 1999).

Participants did not feel like competent CBT practitioners as a result of their training in manualised CBT. They struggled to work with multiple and complex presentations as they had a limited understanding of working transdiagnostically. This supports Binnie's (2015) view that therapists trained in manualised CBT lack the skills to formulate individual case conceptualisation because the IAPT programme medicalises psychological distress and does not give CBT therapists the opportunity to develop an understanding of the problem and the maintaining factors.

The majority of participants agreed adaptations were crucial in working with BME clients; however there was no consistency in how the adaptations were made. Participants did not receive diversity training and most of the cultural and religious adaptations were based on their own research and prior experience. This supports Bassey and Melluish's (2012) findings that personal experience and a motivation to learn about cultural issues are key contributors to cultural competence. However, it is unclear if this also applies to Caucasian therapists.

The studies that explored the effectiveness of adapted CBT also matched the therapist and client on the basis of ethnicity or culture (Hinton et al., 2004; 2005; 2011; Naeem, Gul et al., 2015; Naeem, Saeed et al., 2015; Hwang et al., 2015). As with language, these studies did not acknowledge or assess the possible influence of ethnicity and culture on therapy. In the present study, participants found that BME clients sought out cultural similarities with them to feel better understood, and where a close match existed, it was found to facilitate the therapeutic alliance. It was also found that a close client-therapist match in cultural background could affect how adaptations were implemented,

but it is unknown how, or to what extent this happened. The most recent meta-analysis on ethnic matching of clients and therapists (Cabral & Smith, 2011) found that clients have a strong preference for a therapist of their own ethnicity. However, no benefit was found to treatment outcomes from the ethnic matching of clients with therapists.

Rathod et al. (2010) found Caucasian CBT therapists would follow the same format of delivering CBT for BME clients as for Caucasian clients as they believed cultural adaptations were unnecessary and also believed CBT took into account varying perspectives of clients. Only one of the present study's participants was Caucasian and so it was not possible to reach any conclusions on what effect that has on delivering manualised CBT to BME clients.

The implication on practice for the participants in the present study was that they deviated from pure manualised CBT by incorporating other psychological therapies. Waller's (2009) study outlined that therapists are poor at implementing the full range of CBT tasks that are necessary for CBT to be effective and also do not understand the rationale behind some of the CBT tasks. Participants in the present study stressed that their manualised CBT training was limited and did not prepare them adequately to deal with more complex cases in clinical practice. The manualised CBT training was a year-long course and the foundations of CBT were not covered thoroughly. Participants also stopped using the CTS-R manual immediately after training finished which supports Brosan et al. (2007) in that CBT is not properly implemented and adhered to in so many cases.

Beck (1996) and Teasdale (1996) found the beliefs of therapists about their role and their preconceptions about what should work in therapy, can influence their practice of CBT. This ties into another significant finding in the present study; that the participants' self-identity and confidence in manualised CBT influenced their practice of it. Four out of the six participants did not believe that manualised CBT was an effective treatment. These were also the participants that struggled to apply manualised CBT with BME clients and found that CBT conflicted with their own beliefs and values.

Gluhoski (1994) stated that difficulties can arise with CBT when trainees hold exaggerated views of the differences between CBT and other therapeutic approaches.

Waller (2006) also emphasised the importance of the beliefs therapist hold about CBT, stating that many therapists fail to deliver full CBT if they believe that CBT is not appropriate for their clients and that it is not effective in clinical practice. Owen-Pugh's (2010) study found similar results with psychodynamic counsellors training in CBT who held very negative views of CBT at the start of the training. He argued that negative views of CBT can lead therapists to take defensive positions on CBT training courses which can further exacerbate their resistance to CBT training, and impede their learning. This corresponds with the experience of participants in the present study and their view of their CBT training as being inadequate.

A lack of commitment and motivation by participants were identified as two important factors that had implications on the practice of manualised CBT. There was limited motivation while participants were training in manualised CBT as it was offered as a free course and some of the participants considered it to be a backup career. Rønnestad and Skovholt (2003) found that commitment to a therapeutic approach was an important factor for practicing or integrating other approaches. They argued that a single theoretical approach can be mastered by a trainee if they are motivated. This supports Burke and Hutchins (2007) and Kontoghiorghes (2001) who found that students who were motivated by extrinsic rewards, such as a pay and promotions were less likely to respond to training than those who were motivated by intrinsic rewards.

Waller (2009) suggested that a significant factor in therapists deviating from practicing CBT is that there is not enough time spent fully utilising CBT techniques. Not long after participants in the present study completed their training, most chose to utilise and integrate humanistic and third-wave CBT therapies such as acceptance and commitment therapy, compassion focused therapy, mindfulness and EMDR. Also, some participants were not open and honest with supervisors about their adaptations, therefore their supervisor could not support them fully in utilising manualised CBT.

Rønnestad and Skovholt (2003) outlined a phase model of professional development for a therapist which can explain the change in practice of the participants in the present study. Initially after training, during the novice professional phase, therapists seek validity of their training. A period of disillusionment with professional training can occur if therapists struggle to address professional challenges. Therapists react to this

disillusionment with more intense exploration into their own skills, values and interests. This can involve learning further psychological theory and integrating more personal expression into their practice. Participants in the present study believed that their manualised CBT training was inadequate following issues in implementing it. As a result of struggling to apply manualised CBT, they started to explore other therapeutic approaches that fit well within their practice and their own identity.

The next phase in development is the experienced professional phase, where a therapist's practice is highly congruent with their self-perceptions. Therapeutic techniques are not applied rigidly, there is increased flexibility in the role and there is a strong belief in their own professional judgement. This phase was demonstrated by the most experienced participants as their practice was the most integrative and they were confident in being able to justify their professional decisions in not practicing pure manualised CBT.

6.7. Recommendations for Practice

6.7.1. Therapeutic Practice

The present study recommends that for BME clients to benefit from any psychological therapy, there needs to be more engagement with BME communities and for mental health services to better understand their needs. Services need to acknowledge individual client factors such as culture, religion, language, psychological mindedness, acculturation, education and age as well as the influence of these on the delivery of psychological therapy.

With regards to treating BME clients using manualised CBT, the present study found that it cannot be applied in its entirety. Instead, an integrative approach is more appropriate as it is adaptable to the individual needs of BME clients and is still able to incorporate aspects of manualised CBT that would be beneficial to the client.

There are specific recommendations for the IAPT programme from the findings of this study. IAPT services that serve a predominantly BME population need to become more diverse in the therapies they offer. Individual IAPT services need to cater for the populations that they serve, meaning they can no longer be part of a standardised service. Participants experienced more systemic and relationship issues with BME clients

because of the collectivist culture they come from. Therefore, psychological therapies that are interpersonal or systemic would be more suitable for this client group. This is demonstrated in the present study with participants preferring to practice integratively. This suggests that IAPT services need to offer a variety of psychological therapies, including humanistic, systemic and integrative. As well as therapies based on the transpersonal approach and narrative approach such as the tree of life framework (Ncube, 2006) which has been shown to be effective with ethnic minorities. The IAPT programme does offer other NICE approved (DH, 2001a) therapies that focus more on interpersonal issues such as interpersonal psychotherapy, counselling for depression and dynamic interpersonal therapy. However, these therapies are practiced in a manualised structure.

6.7.2. Training of Therapists

Another recommendation for IAPT services is to adjust their recruitment practices to ensure they have an adequate number of therapists who can speak the various languages of the population they serve and also therapists with experience with BME communities where applicable. The IAPT programme should also work more closely with BME communities, groups and services to help break down barriers for BME people to access psychological support.

The present study advises against the use of manuals with BME clients. It recommends that the IAPT CBT diploma be reviewed and assessed to see how it can meet the needs of CBT therapists working with BME clients. It has been identified that at a minimum, diversity training needs to be incorporated. The training would need to address the difference in beliefs, attitudes and values from individualistic and collectivist cultures (Bassey & Melluish, 2012). Most importantly, the training needs to focus on culturally sensitive CBT adaptations.

Training needs to address how culture can influence the different stages of therapy (Bassey & Melluish, 2012). Therapists should be instructed on how to do more in-depth assessments which take into account the individual cultural differences and various dimensions of culture which can lead to an idiographic formulation being developed (Hays, 2001). Therapists also need to be taught the importance of the therapeutic

relationship when treating BME clients and how to develop it so that it incorporates specific therapeutic principles (Hwang, 2006) that acknowledge the stigma around mental health, orientates the client to therapy and uses culturally appropriate language.

Personal and professional development modules should also be an essential requirement of NHS funded therapy courses. This would provide therapists a space where they can engage in critical evaluation of theory as well as discuss any personal and professional issues they are experiencing in their practice. This can include topics such as the influence of ethnicity, race and culture in the practice of therapy.

The present study found behavioural interventions were utilised more with BME clients than cognitive interventions as they were more effective with BME clients. Therefore, it is recommended that comprehensive training is given in behavioural therapy. Binnie (2015) outlined that the IAPT CBT diploma does not incorporate behavioural theory as much as cognitive theory. Behavioural therapy is not exclusive to psychiatric diagnosis and can be applied to any presentation. From the functional analysis approach, Matsumi, Seiden and Lam (1996) developed the Culturally Informed Functional Assessment interview (CIFA) that offers practical step-by-step guidelines for developing behavioural clinical case formulation for ethnic clients by understanding the specific cultural context in which the client's problems occur (Haynes, Nelson, Thacher & Kaholokula, 2001).

Bassey and Melluish (2012) stated that the IAPT programme should consider Alladin's (2009) Ethno-Biopsychosocial model which this present study also recommends to replace the medical model as it is more suitable for diverse ethnic communities. The model is multi-faceted and incorporates biological, psychological, social and spiritual aspects of functioning, within the context of ethnic and cultural identities.

6.7.3. Supervision

In regards to supervision recommendations, supervisors within an IAPT service need to be able to support therapists on making adaptations with BME clients. Supervisors should be offered training on existing knowledge of adaptations and working with BME groups. The accessibility of a supervisor that is experienced in working with BME clients might not be widespread. Therefore group supervision could be an alternative offered by IAPT services by sourcing an experienced external supervisor. Sourcing an external supervisor

could also allow a therapist to be more open about their practice and ask for help with adaptations without the worry of repercussion.

6.7.4. Policy Makers

The majority of the participants stated that they did not practice pure manualised CBT and described their practice as integrative. Some participants kept their integrative practice a secret from colleagues and management. This has implications for the IAPT programme outcome measures and on the commissioning of future therapy. The Health and Social Care Information Centre (HSCIC, 2016) collects various IAPT data in order to monitor and plan mental health services effectively. The current outcome data is potentially inaccurate as it does not reflect the extent to which integrative practice takes place as CBT therapists are only likely to disclose their integrative practice if it is permitted by their IAPT service. The success of the service is being evaluated based upon the flawed assumption that therapists are practicing in a manualised way. Therefore, the impact of integrative practice and adaptations to CBT are not being taken into account when assessing therapy outcomes. Psychological therapies that are not suitable for BME clients will continue to be commissioned. Now that we know therapists are masking their practice, it may be time to do a professional survey with quantitative analysis to assess the extent to which this is happening.

As a result of this finding a recommendation for policy makers is to consider practice-based research evidence when assessing the effectiveness of psychological therapies as this study has demonstrated the inaccuracy of quantitative data from IAPT services. The existing policy outlining the Positive Practice Guidelines for BME clients (DH, 2009) also needs to be reviewed to ensure it meets the needs of the different BME communities served by the IAPT programme.

The Mental Health Taskforce (2016) published The Five Year Forward View For Mental Health report which has outlined "there has been no improvement in race inequalities relating to mental health care since the end of the 5-year Delivering Race Equality programme (DH, 2005) in 2010" (p. 13). It has recommended that the Department of Health make race equality a priority within mental health services, introduce regulation of psychological therapies and improve data collection on access, quality and outcomes

across mental health service. The findings of this present study support The Mental Health Taskforce (2016) recommendations. This study further recommends that the Department of Health develops a cultural competence framework that can be used to help deliver more suitable mental health services for people of different ethnicities across the UK.

6.8. Implications for Counselling Psychology

There is a considerable lack of practice-based research in UK counselling psychology (Barkham, Hardy & Mello-Clark, 2010). This present study has added to the practice-based research available within counselling psychology which is highly relevant to counselling psychology identity (Henton, 2012).

This present study's findings have direct implications for counselling psychology practice and training. It has highlighted the need to incorporate race, culture and diversity within counselling psychology training. Race, culture and diversity training is limited within counselling psychology courses as there is no requirement to incorporate it into the syllabus. The emergent themes of this study support Black and Asian Counselling Psychologists' Group (BACPG) recent proposal for a module in race, culture and diversity to be incorporated into the counselling psychology syllabus that focuses on theory, research and professional practice relevant to this area (Ade-Serrano, Nkansa-Dwamena & Eleftheriadou, 2015).

The findings of this study also highlight that awareness of culture and diversity is part of good professional and ethical practice as a counselling psychologist. Both HCPC (2012) and BPS (2009) guidelines outline to offer therapy that is beneficial and does not harm clients. Ade-Serrano et al. (2015) further stated counselling psychologists carry the risk of re-traumatising clients due to their lack of knowledge of race, culture and diversity. This is also supported by the emergent themes of this present study as CBT therapists were weary of the detrimental effects of applying a western based therapy with BME clients.

More culturally diverse placements should also be sourced for trainee counselling psychologists who request it (Ade-Serrano et al., 2015). It would also be beneficial on

these placements to have supervisors who would have more extensive experience working with ethnic minority clients and could explore and help built upon trainee counselling psychologists' experience of sameness and difference in therapy.

Self-development is central to counselling psychology practice (Woolfe et al., 2010). The present study has highlighted the importance of counselling psychologists to be aware of how their own attitudes and beliefs about a therapeutic approach can influence how they work therapeutically with diverse clients as well as their own ethnic identity.

6.9. Strengths and Limitations

The present study is one of the first to investigate the practice of manualised CBT with BME clients within the IAPT programme. It has added to existing studies on culturally sensitive CBT by presenting a deeper understanding of the experiences of CBT therapists working with this client group in a western country. By using the qualitative research method IPA, the present study was not only able to clearly identify the specific adaptations participants made to manualised CBT, but also the process involved and what they based their adaptations on.

The present study found certain factors that need to be considered when making adaptations with BME clients that past studies have not acknowledged or gone into any great detail such as the client's level of acculturation to their host country and their psychological mindedness. Another factor overlooked by past studies (Hinton et al., 2004; 2005; 2011; Naeem, Gul et al., 2015; Naeem, Saeed et al., 2015; Hwang et al., 2015) is the influence of the client-therapist match with regards to language, ethnicity and cultural background, which was found to contribute to how BME clients engaged with their therapist.

Aside from the aforementioned client factors, the present study also found that the self-identity of participants and their confidence in manualised CBT influenced their practice of it. A significant finding was that the majority of the participants described their current practice as being integrative rather than being entirely based on manualised CBT which has direct implications on the IAPT programme.

A limitation of the present study is that it did not investigate standard CBT as participant selection was limited to therapists who had only completed an IAPT CBT diploma, which focuses on the manualised form of CBT. Although confidentiality was assured, participants may not have been entirely open and honest in interviews for fear of being reprimanded or losing their job due to their employer finding out that they are not purely practicing manualised CBT. It may have also been the case that they felt the need to impress the researcher, a fellow CBT therapist, by not disclosing everything about their practice which they thought may be viewed negatively. This is supported by some of the participants admitting to not disclosing their integrative practice and use of adaptations to their colleagues and management for fear of the aforementioned consequences.

6.10. Future Research

It cannot be assumed that the difficulties experienced by participants in delivering manualised CBT to BME clients corresponds with the difficulties experienced by the BME clients who were receiving the therapy. Therefore, it is recommended that further research is conducted which includes the experiences of BME clients receiving manualised CBT, following the INVOLVE model of patient engagement in research (Hayes, Buckland & Tarpey, 2012) which is endorsed by the NHS.

The aim of this research was to give an overview of the experience of CBT therapists with BME clients. Future research could narrow the focus by conducting research on specific ethnic groups and identifying any differences amongst them.

The experience of ethnic or cultural sameness between therapist and client was briefly discussed by therapists and identified as an emergent theme. This further needs exploration to identify if it has an influence on the therapeutic process with BME clients as well as therapists' own worldviews.

6.11. Conclusion

The present study investigated the experiences of CBT therapists delivering manualised CBT to BME clients. The participants experienced many issues in their practice which led them to make changes including adaptations to manualised CBT. They described their current practice as being integrative as they incorporated therapeutic approaches other

than pure manualised CBT, making them more flexible and adaptable. Participants made adaptations based primarily on their own experience. These adaptations involved altering the cognitive and behavioural interventions to better suit the individual needs of the client. The adaptations took into account the client's culture, religion, language, psychological mindedness, acculturation to their host country, education and age. The participants' confidence in CBT and their self-identity as therapists also influenced their overall practice of therapy.

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APPENDICES

Appendix 1

Demographic Data Sheet

These questions are intended to be used in relation to the interview.

1. What is your age? _____

2. Sex (please circle) Male Female

3. What is your ethnic group?

Choose one option that best describes your ethnic group or background

White

☐ 1. English / Welsh / Scottish / Northern Irish / British

☐ 2. Irish

☐ 3. Gypsy or Irish Traveller

☐ 4. Any other White background, please describe

_____

Mixed / Multiple ethnic groups

☐ 5. White and Black Caribbean

☐ 6. White and Black African

☐ 7. White and Asian

☐ 8. Any other Mixed / Multiple ethnic background, please describe

_____

Asian / Asian British

☐ 9. Indian

☐ 10. Pakistani

☐ 11. Bangladeshi

☐ 12. Chinese

☐ 13. Any other Asian background, please describe

_____

Black / African / Caribbean / Black British

☐ 14. African

☐ 15. Caribbean

☐ 16. Any other Black / African / Caribbean background, please describe

_____

Other ethnic group

☐ 17. Arab

☐ 18. Any other ethnic group, please describe

_____

4. What is your job title?

_____

5. Please state all relevant professional qualifications for your role including the IAPT CBT course you have completed?

_____

6. What level of accreditation do you have at present with The British Association for Behavioural and Cognitive Psychotherapies (BABCP)?

_____

7. How many years have you been practicing as a Cognitive Behavioural Therapist?

_____

8. Outline the different ethnic groups your service covers, highlighting the main groups?

_____

Appendix 2

Interview Questions

Format of semi-structured interview

Disclaimer: State that professional practice guidelines outline that confidentiality cannot be guaranteed if something is disclosed during the interview that indicates harm or risk to a client.

Pre - questions

- What is your understanding of the term BME?
- Have you had any training in diversity?
- What is your experience of working with BME clients?
- How many completed therapy cases with BME clients?

Section 1: Background and training

1. What led to you becoming a therapist?
What did you do before this role?

2. What made you decide to train in Cognitive Behavioural Therapy (CBT)?

A. Can you describe your experience of CBT training?

B. How would you describe your approach to delivering CBT?
Example of practice.

3. To what extent was manualised CBT part of your training?
Explanation of manualised CBT if participant unclear of the meaning.

A. Was manualised CBT what you expected?

B. How has your practice been informed by manualised CBT over the years?
How important is manualised CBT now in your practice?

Section 2: General experience of delivering manualised CBT

4. What has been your experience of delivering manualised CBT with clients?
Probe some positive experiences of manualised CBT.
Practice example.

5. Have you come across any difficulties in practicing manualised CBT?
What moment in the therapeutic encounter made you realise it was not working?
Practice example.

A. How have you overcome these difficulties?

B. Have you had to make any adaptations to overcome these difficulties?
Do you realise you're making these adaptations consciously or unconsciously?
At what point in the therapeutic process do you realise you had to make these adaptations?

C. Have you had to make adaptations for any particular group of clients?
Whether that is disability, age or culture etc.
What prompted you to make these adaptations?

Section 3: BME specific experience of delivering manualised CBT

6. How would you describe your experience of practicing manualised CBT with people from different ethnic backgrounds?
What have you noticed within the therapeutic alliance?
Have you come across any differences with using manualised CBT between Black, Asian and minority ethnic clients?
Any differences from working with Caucasian clients?

A. Have you come across any difficulties?

B. How have you overcome these difficulties?

C. Have you made any adaptations in your practice of manualised CBT with people from different ethnic backgrounds?
How do adaptations for people from different ethnic groups differ?
Is there any particular ethnic group your practice of manualised CBT has changed more with?
Example of practice.

D. What have you based your adaptations on?
Experience, training, literature or research.
How have you utilised supervision and peer support with making adaptations?
What is your process in making an adaptation?

Section 4: Informed practice

7. How acceptable do you think it is making adaptations to manualised CBT?
What has been your experience with your peers or service in regards to making adaptations?
Has it raised any professional or service issues?

8. How confident would you be in making adaptations in future practice?
Are there any service or professional difficulties you foresee?
What kind of training / support would help your professional development?

9. Is there anything else you want to include?

Appendix 3

Ethical Approval Confirmation Letter

Date 10th March 2015

Nazreen Akhtar
University of Wolverhampton
Faculty of Education, Health & Wellbeing

Dear Nazreen Akhtar

Re: 'Cognitive Behavioural Therapists (CBT) experience of delivering manualised CBT to Black and Minority Ethnic clients' submitted to The Faculty of Education, Health and Wellbeing Ethics Panel (Health Professions, Psychology, Social Work & Social Care)

The Faculty Ethics Panel (Health Professions, Psychology, Social Work & Social Care) has considered and reviewed your submission and can confirm all conditions have been met.

On review your Research Proposal was passed and the Panel believes that the ethical issues inherent in your study have been adequately considered and addressed. Therefore the Panel is giving you full ethical approval for your study (**Code 1 - Approved**). We would like to wish you every success with the project.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – Ethics Panel

D Chadwick
Dr. D. Chadwick PhD, MSc, BA (Hons). PGCE, CPSYCHOL.
Chair – Ethics Panel

Appendix 4

Recruitment Letter to Organisation

Nazreen Akhtar
Doctoral Student in Counselling Psychology
c/o Dr Wendy Nicholls
University of Wolverhampton
Faculty of Health, Education & Wellbeing
Mary Seacole Building
Nursery street
Wolverhampton
WV1 1AD

Email: EMAIL ADDRESS REMOVED

Dear ……

As part of the Doctorate in Counselling Psychology course at the University of Wolverhampton, I am proposing to conduct a qualitative research project into the experience of cognitive behavioural therapists delivering manualised cognitive behavioural therapy to black and minority ethnic clients. To do this I require your support with recruiting suitable cognitive behavioural therapists.

I am therefore writing to seek your permission to conduct this study in (Trust) with the Improving Access to Psychological Therapies Service and enclose a copy of the research protocol for your information.

I look forward to hearing from you.

Yours sincerely

Nazreen Akhtar
Doctoral Student in Counselling Psychology

Appendix 5

Recruitment Letter to Participants

Dear ……

I am writing to invite you to participate in a research project, which I am conducting as part of the Doctorate in Counselling Psychology course at the University of Wolverhampton. I am proposing to conduct a qualitative research project into Cognitive Behavioural Therapists (CBT) experience of delivering manualised CBT to Black and Minority Ethnic clients. The potential benefits of this research include improving the delivering of psychotherapies for black and minority ethnic clients.

If you are interested in taking part, an interview will be carried out that would take between sixty and ninety minutes. Anything you say would be totally confidential and any notes made as a result of the interview would be destroyed afterwards. The interview would take place at a location and time that is convenient to you. A report will be written of the findings and numbers will replace all names so that you cannot be identified. I enclose an information sheet, which further explains the aims of the project and what taking part will involve.

If you feel that you would like to be interviewed please contact me through my email address EMAIL ADDRESS REMOVED

Yours sincerely

Nazreen Akhtar
Doctoral Student in Counselling Psychology

Appendix 6

Participant Information Sheet

Participant Information Sheet (Version I, 10 October 2014)

Study title

The Experiences of Cognitive Behavioural Therapists when delivering Manualised Therapy to Black and Minority Ethnic

Researcher

Nazreen Akhtar
Doctoral Student in Counselling Psychology, University of Wolverhampton

You are being invited to take part in a research study. Before you decide to take part please take time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?

The aim of this research is to find out about cognitive behavioural therapists experience of working with black and minority ethnic clients and how they deliver manualised CBT with these clients. The research will explore if any issues are encountered in delivering manualised CBT and how cognitive behavioural therapists address this.

It is anticipated the findings of the study would help inform practice of professionals working within psychological services. In particular it will help improve the delivery of psychotherapies for black and minority ethnic clients.

Why have I been chosen?

You have been identified as meeting the selection criterion for this study which includes:

- Provisionally or fully accredited with The British Association for Behavioural and Cognitive Psychotherapies.
- Completed an IAPT programme CBT diploma.
- Practiced for a minimum of two years as a cognitive behavioural therapist.
- Working in an Improving Access to Psychological Therapies service.
- Have experience of at least four cases of completed therapy with BME clients.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time before the commencement of the data analysis without giving a reason.

What will happen if I decide to take part?

If you consent to take part in this study you will be contacted to arrange a convenient location and time to conduct the interview. The interview will be audio-recorded and vary from around sixty to ninety minutes. The interview will consist of open-ended questions that will enable you to explore your experience of practicing manualised cognitive behavioural therapy. After the interview has been transcribed it will be analysed using a method known as interpretative phenomenological analysis.

What are the potential benefits and risks of taking part?

It is expected the potential benefits of taking part in this research will help inform clinical practice with black and minority ethnic clients in regards to psychological therapies and further research.

There are no risks to you in taking part outside of those you would experience in everyday life. However, by taking part if you become upset at any point the researcher will ask you if you want to continue to participate in the interview. Any decision you make will be respected.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. The transcription of the interview you participate in will be stored on a password protected computer in a locked office. Only the researchers working on the project will have access to the information. You will not be identifiable in any publication or report as the data will be grouped together and all identifying information will be removed.

However due to trust safeguarding policies and The British Association for Behavioural and Cognitive Psychotherapies professional practice guidelines full confidentiality cannot be maintained if anything is raised during the interview that indicates that either the participant or someone else is at risk of harm, then these concerns will have to be taken further to the research supervisory team and the trust safeguarding team.

What will happen at the end of the research study?

The study will form as part of a doctoral thesis and will also be written up in an article format with the view to be published in an academic journal. A summary of the findings can be provided to those participants who request it and the completed thesis will be accessible through Wolverhampton University for all who request it.

What if I have a problem or concern?

If you have any concerns about this study, you should ask to speak with the researcher who will do their best to answer your questions or contact the research supervisors below.

Dr Wendy Nicholls

EMAIL ADDRESS REMOVED

Dr Caroline Wesson

EMAIL ADDRESS REMOVED

Who has reviewed the study?

Wolverhampton University, Faculty of Education, Health and Wellbeing Research Ethics Committee has reviewed this study and approved it.

How can potential participants get in contact?

Thank you for taking the time to read this and considering taking part in this study. Please feel free to contact the researcher on the email below if you would like to take part or require any further information.

Nazreen Akhtar
Doctoral Student in Counselling Psychology
EMAIL ADDRESS REMOVED

Appendix 7

General Consent Form and Right to Withdraw

CONSENT FORM

Title of Project: The Experiences of Cognitive Behavioural Therapists when delivering Manualised Therapy to Black and Minority Ethnic

Name of Researcher: Nazreen Akhtar

Please initial boxes

1. I confirm that I have read and understand the information sheet, version 1, dated October 10, 2014 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time before the data is analysed, without giving any reason. ☐

3. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication. ☐

4. I understand that the researcher may wish to publish this study and any results found, for which I give my permission. ☐

5. I agree for my interview to be tape recorded and for the data to be used for the purpose of this study. ☐

6. I agree to take part in the above study. ☐

……	……	……
Name	Date	Signature
……	……	……
Name of person taking consent (if different from researcher, state position)	Date	Signature
……	……	……
Researcher	Date	Signature

Appendix 8

Advertisement Text

Twitter Post:

Research recruitment: Interested in CBT therapists' experience of working in IAPT services with Black & Minority Ethnic clients. See attachment for information.

Website Post:

Research

The Experiences of Cognitive Behavioural Therapists when delivering Manualised Therapy to Black and Minority Ethnic.

The Improving Access to Psychological Therapies Programme has continued amongst the many challenges it has faced over the years. One of which has been whether manualised CBT is a model of treatment for mental health problems that can be applied across cultures and contexts. Therefore, it is important to determine whether Cognitive Behavioural Therapists are able to deliver manualised CBT with Black and Minority Ethnic clients and if any modifications are made to meet individual differences.

I am seeking participants who are Cognitive Behavioural Therapists working in Improving Access to Psychological Therapies Service and have experience of using manualised CBT with Black and Minority Ethnic clients.

This research will involve taking part in a confidential interview lasting sixty to ninety minutes at a location and time that is convenient to you.

If you would like to be interviewed, please refer to the attached participant information sheet for further information and contact me through my email address EMAIL ADDRESS REMOVED

Nazreen Akhtar
Doctoral Student in Counselling Psychology
University of Wolverhampton
EMAIL ADDRESS REMOVED