

**EXPLORING ISSUES OF CULTURAL DIFFERENCE FOR PROFESSIONALS
WORKING WITH PSYCHOSIS**

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ABSTRACT

This study aimed to explore professionals' experiences of working with cultural differences within Early Intervention in Psychosis Services (EIPs), to develop insights that will support professionals in working effectively and appropriately with diverse service users experiencing psychosis. Semi-structured interviews were conducted with ten professionals undertaking the role of a Care-Coordinator within EIPs, and thematic analysis was conducted to generate a broad range of themes.

Care-Coordinators experienced cultural factors as both useful and obstructive within their work. It appeared that their efforts to be culturally-competent were constrained by the limits of the service, with regard to the service culture and service demands and priorities. Their own cultural backgrounds also posed challenges for how service users engaged with them, and how they, in turn, engaged with service users. Care-Coordinators experienced a range of communication challenges that impacted on their sense of control and inhibited their ability to assess psychotic symptomology accurately, and therefore their understanding of the service user's presentation. What Care-Coordinators appeared to value was the importance of gaining cultural knowledge and developing links with the community to support them in providing culturally-competent care.

While EIPs are not cultural services, the results have placed an emphasis on the various challenges experienced in working with cultural differences, including challenges in disentangling psychotic symptomology from cultural phenomena. This suggests that culture is not something that simply needs to be attended to, but something that is crucial to the role of Care-Coordinators within EIPs, in supporting their ability to make accurate interpretations of service users' presentations, and support their mental health needs most effectively. The findings highlight a range of suggestions for developing culturally-appropriate practices within EIPs.

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1. INTRODUCTION

1.1 LITERATURE SEARCH STRATEGY

This literature review employed an iterative search strategy, based upon divergent rather than linear methods, which is more ecologically valid (Barroso et al., 2003). This involves beginning with a broader topic and continually developing and modifying new search terms, throughout the process. The initial search strategy was developed following the review of books about culture and mental health; identifying key groupings of words that captured a specific type of relevant research (see *table 1* for an example). A database search was conducted on SCOPUS and PSYCinfo. All journal articles and documents that appeared relevant to the topic of working with cultural difference – in general health settings, within mental health, within psychosis settings, and with regard to service user perspectives– were included, and those that seemed to divert from these topics were excluded. Reference lists and ‘cited by’ options were explored for further relevant research evidence or search terms, and additional search terms were developed and utilised. This occurred several times throughout the process of the literature search.

Table 1

Initial search terms used for the database search. Terms are separated by an “AND” or “OR”.

<u>Group 1</u>	<u>Group 2</u>	<u>Group 3</u>	<u>Group 4</u>
- Culture	- Psychosis	- Staff	- Experience
- Cultural	- Psychotic	- Professional	- Perspective
- Ethnic	- Early	- Care	- View
- Race	Intervention in	Coordinator	- Working with
- Diverse	Psychosis	- Service	- Engaging
- Diversity	- Schizophren*	- Service user	- Communication
		- Patient	

1.2 LITERATURE REVIEW

1.2.1 Definitions and Context

1.2.1.1 'Race', 'Culture' and 'Ethnicity'

To consider the impact of cultural issues on service provision, it is important to consider what 'culture' means. Over time, there has been a shift from thinking about race to thinking about culture. The concept of *race* has historically been associated with lineage and has developed over time into a term that refers to biological origin and physical characteristics, such as skin colour and features (Fernando, 2002; 2009). It is largely viewed as static and unchangeable.

The concept of *culture*, however, has changed over time and often bears multiple meanings. It was originally related to cultivation, representing growth and development, particularly with respect to the arts, and came to be associated with sophistication and civility (Fernando, 2002; 2009; Kirmayer, 2007). Bacteriologists may associate the word with growth of bacteria in a petri dish, following the provision of nourishment (Berger, 2000). Similarly, this metaphor can also be applied to people, needing culture to grow and develop.

Historically, the concept of culture was applied to other non-European groups, but later, the construct of culture came to be applied to all individuals (Fernando, 2002), but also communities and organisations (Kirmayer, 2007). More recently, culture has been associated with non-material aspects that are held commonly within a group from which the individual may belong to; pertaining to a system consisting of shared ideas, beliefs, attitudes, values, rules, meanings and practices (Fernando, 1991; 2002; 2009; Helman, 2007). It is viewed as a lens through which people perceive and interact with the world that is acquired through the membership of groups (Helman, 2007). This view of culture is consistent with current anthropological ideas about culture (Kirmayer, 2007). In contrast to the concept of race, culture has been viewed as fluid and dynamic. As society becomes more multicultural, it becomes more important to think about culture. The term "cultural issue" may be used to refer to a difficulty or a challenge faced when working with people from different cultural backgrounds. However, culture is not just limited to people from 'other' countries. It encompasses a set of ideologies, values and ways of being that are

shaped by a historical context. Not only do people from certain communities have cultures, but organisations can have cultures too.

In contrast, the concept of ethnicity, within the British context, is assumed to draw together aspects of both race and culture, acknowledging some aspects of cultural and historic traditions as well as physical characteristics (Fernando, 2002). This is viewed in relation to how people define themselves relative to a group, and so it is largely self-defined; however categories are constructed based upon the context in which they are developed (Kirmayer, 2007; Fernando, 2002). For example, oppression of black people in America is likely to lead to a sense of belonging and identity as a black person, both based upon physical characteristics of race but also shared cultural and historic traditions. Fernando (2002) highlights the differences between the terms as viewing race as physical, culture as sociological and ethnicity as psychological.

However, there appears to be confusion about the differences between race, culture and ethnicity; and these terms are often used interchangeably. In its use, the distinction between race, ethnicity and culture is not clear-cut (Fernando 2002; 2009), and such terms have led to assumptions of homogeneity being made about large numbers of people who share membership of a group.

This study makes use of the term “culture”, however it is acknowledged that the term lacks clarity. The concept of culture has been associated with multiple meanings and is not consistently used in the same way, nor can it be consistently defined by members of cultural groups because of the variations existing within them (Sewell, 2009). It is often misused or misunderstood, and has led to stereotypical assumptions being made about groups (Helman, 2007; Sewell, 2009). The term Black and Minority Ethnic (BME) will also sometimes be used in reference to research evidence using this term, and for readability purposes; however the limitations of the term are also acknowledged. Terms such as BME are problematic due to it leading to assumptions of homogeneity, for example, grouping a Ghanaian man and a Chinese woman into the same category implies that both could benefit from the same type of service (Sewell, 2009). It also presents culture and race an issue for “other” non-white people.

Nonetheless, while acknowledging the lack of clarity with and problems associated with the terminology, the concept of 'culture' has been used to refer broadly to issues associated with non-material aspects to include beliefs, values and norms. However, due to the complexities and the challenges in delineating the three terms, this may draw on literature that focuses on race and ethnicity as well as culture. However, there will be a particular emphasis on thinking about culture as a non-material concept, while also accepting participants' constructions of culture as appropriate.

1.2.1.2. 'Psychosis'

In Western mental health, a diagnosis of a psychotic disorder is dependent on the presence of one or more of a series of key symptoms, as per according to the Diagnostic and Statistical Manual of Mental Health – 5th edition [DSM-V] (American Psychiatric Association [APA], 2013). These are delusions (fixed beliefs that are not amenable to change even in the presence of contradictory evidence), hallucinations (sensory experiences in the absence of a real life stimulus, for example hearing a voice that no one else can hear), disorganised thinking (often recognised due to disorganised speech, such as switching from topic to topic very quickly in a disorganised fashion), disorganised behaviour (which refers to unusual behaviour), and negative symptoms (which refers to withdrawal behaviours and difficulties with day-to-day functioning).

However, psychiatric diagnosis has been widely criticised, for lacking in reliability and validity (Bentall, 2004; Boyle, 1990), medicalising normal human experiences, individualising problems that are relational and contextual (Rapley, Moncrieff & Dillon, 2011), and for being unable to shift or eliminate once a person is labelled (Goffman, 1963; Read, 2013; Rosenhan, 1973). Diagnosis implies that it is possible to make biological inferences of observed 'abnormal' behaviours, when such behaviours are defined as compared against societal constructions of normality (Read, 2013; Scheff, 1966), yet there is limited attention paid to social factors. Diagnosis has led to an over-medicalisation of problems, focus on symptom reduction (Boyle, 1990) and increased medication use (Moncrieff, 2008), leading to a failure to acknowledge human complexity and contextual factors (Boyle, 1990). This may also have implications with regard to working with people from different cultural backgrounds, who may

adhere to alternative societally-constructed norms. Despite the drawbacks of diagnosis and medical model approach, the use of diagnosis and medical interventions are widespread.

More recently, however, these ideas have shifted to viewing psychotic experiences as existing on a continuum, rather than as an experience that is abnormal (Johns & Van Os, 2001). This was based on research showing that a significant proportion of the population experience psychotic symptoms but do not present to services due to a lack of distress associated with their experiences. This highlighted an idea that psychotic experiences in themselves did not determine 'illness', but that it would only be regarded problematic if the experience interfered with the person's life in some way.

While this approach is regarded as more normalising and positive, it still does not address some of the complications that arise from conceptualising psychosis in this way.

1.2.1.3. Non-Western Cultural Explanations of Psychosis

'Psychosis', as it is understood in the West, is one way of understanding and conceptualising this form of distress. Mental health phenomena are understood and experienced differently across cultures. The concept of 'mental health' itself is eurocentric, with a view that the mind and body are separate entities. In this approach, a specific emphasis is placed on the role of thoughts, symptoms and feelings in a reductionist fashion focusing within the individual (Fernando, 2009; Malik, 2005), and attempts are made to 'treat' problems at an individual level. Generally speaking, other cultures tend to view distress in other ways. South Asian communities may conceptualise distress in more relational ways, considering the mind, body and spirit as one instead of as separate entities (Malik, 2005) including in its expression. For example, distress is conceptualised in a physical sense in Punjabi culture as a "sinking heart" (Krause, 1989). Culture impacts on how an individual constructs meaning in relation to distress and then how in turn that affects their expression of emotion (Malik, 2005). Various communities have a higher tendency to conceptualise distress as something that is of social or supernatural causes, such as Arab (Hamid & Furnham, 2013), various South Asian communities (Jobanputra & Furnham, 2005; McCabe & Priebe, 2004; Sheikh & Furnham, 2000), West

African communities (McCabe & Priebe, 2004), and various Afro-Caribbean communities, for examples associating mental distress to “Obeah” in Jamaican culture, and “Ju-Ju” in the Bahamas (Ellis, 2015). In Chinese culture distress tends to be seen as caused by an imbalance of internal and external causes, for example, excessive emotional expressivity. This idea has influenced medical practices in China (Lin, 1981).

Research conducted with families of British Pakistani service users with psychotic diagnoses showed that they did not use the term ‘psychosis’ or ‘schizophrenia’ to conceptualise their loved one’s difficulties (Penny, Newton & Larkin, 2009). Instead, they either viewed the problem as a social problem caused by social stressors and triggers; or used black magic as an explanation. Research shows that even British Pakistani people tend to conceptualise distress as relational and circumstantial (Malik, 2005). Chinese family members of people with psychotic diagnoses had a tendency to view psychosis as caused by a combination of factors including social, personal, interpersonal, biological, and spiritual, though social factors, such as stress, and personal factors such as personality seem to be the more key causative beliefs (Phillips, Li, Stroup & Xin, 2000).

The difficulty with utilising a western understanding of mental health is that often concepts like ‘psychosis’ do not translate in a helpful way. In the Urdu/Mirpuri language, spoken by some Pakistani people, psychosis is translated into the stigmatising term “pagal” which means lunatic or crazy person (Penny et al., 2009; Wheeler, 1998). An inability to use culturally-appropriate language to describe people’s difficulties can have a significant impact on engagement (Kleinman & Benson, 2006).

In comparison, spiritual and religious beliefs about supernatural causes can be protective and a form of coping (Hussein & Cochrane, 2003; Loewenthal, 1993) which may lead to a greater sense of self-efficacy, and a reduction in self-blame. Religious beliefs can also be viewed as a helpful outlet for managing distress (Johnson, 2000). In some Arab countries, religious care is integrated into psychiatric services (Okasha, 2003).

Therefore, it is clear that cultural understanding impacts on people's explanations of how psychosis is understood and managed, which may then impact on how people may engage with existing services.

1.2.2. Psychosis in a Multi-Cultural Society

1.2.2.1. Rates of Psychosis

According to the Census data for 2011 (Office of National Statistics, 2012), London is the most diverse area in England and Wales, with the highest proportion of people from Black and Minority Ethnic (BME) groups, and the lowest proportion of British White people. London also has the largest proportion of increase in people from BME groups and the largest proportion of decrease in British White people, between 2001 and 2011.

There has been a vast amount of research demonstrating higher rates of psychosis in BME populations in the UK, particularly in people from black Caribbean and black African backgrounds (Coid et al., 2008; Dealberto, 2010; Fearon et al., 2006; Kirkbride et al., 2012); in the South Asian community, particularly Pakistani and Bengali females in London; and among non-British White people in Britain (Kirkbride et al., 2012).

However, studies that merely outline rates of psychosis without attempting to understand the context are problematic. Such studies hold assumptions of homogeneity among ethnic groups which limit attempts to understand the reasons for these figures. The definition of "Schizophrenia" has also been criticised for lacking in cross-cultural validity as it is based upon western understandings of mental health and illness (Bhugra & Bhui, 2010a).

The causes for elevated rates of psychosis in some populations have been implicated to be due to a variety of reasons. Genetic, drug-induced explanations, migration, socioeconomic factors and adversity are a few examples of these (Bhugra & Bhui, 2010a). However, genetic and biological explanations do not account for the differences in rates across cultures, with evidence suggesting higher rates of psychosis in African-Caribbean people living in white populations (Bhugra & Bhui, 2010a), but much lower rates in black majority populations. Much of the studies have highlighted that migration from one country to another is likely to increase the likelihood of the

development of psychosis. However, migration explanations of psychosis are no longer relevant within the British context, as much of the population of young black males are not and do not consider themselves to be migrants (Bhugra & Bhui, 2010b) yet the rates of psychosis among young black males are still elevated in comparison to white British people.

While there is some controversy with regard to why there are higher rates of psychosis in certain populations, what is significant is that psychosis services in the UK are very diverse. Additionally, as London becomes more diverse over time, this highlights a greater need to think about culture and difference. There are various challenges to consider in relation to working with cultural difference, but first, it is important to understand the context of psychosis provision in the UK.

1.2.2.2. Early Intervention in Psychosis Services

Early Intervention in Psychosis services (EIPs) were developed based upon the idea that a delay in treatment, termed 'duration of untreated psychosis' (DUP), leads to poorer outcomes (Crow, Macmillan, Johnson, & Johnstone, 1986; Joseph & Birchwood, 2005). The term 'critical period', which is the first 3-5 years following onset of psychosis, is used to describe a period where psychosis is most amenable to treatment (Shiers & Smith, 2010). Therefore EIPs aim to reduce the DUP, and to detect and treat emerging psychosis earlier in the trajectory to prevent the worsening of psychotic symptoms, aid recovery and improve outcomes in the long-term (Joseph & Birchwood, 2005) and there is evidence to support the effectiveness of early detection and treatment of psychosis (McGorry et al., 2002; Melle et al., 2004; Morrison et al., 2004).

EIPs traditionally work with service users experiencing a first episode of psychosis between the ages of 14-35 (Shiers & Smith, 2010), which coincides with the ages at which people tend to experience a first episode (Kirkbride et al., 2006). EIPs aim to work holistically, using a combination of psychological, medical and social interventions to support service users and family members (Shiers & Smith, 2010), and service users remain in the service for three years. There is evidence to suggest that Early Intervention is more effective than standard community care (Craig et al., 2004).

EIPSSs consist of a multidisciplinary team to include Psychiatry, Psychology, and professionals who undertake a Care-Coordination role, often with backgrounds of nursing, social work and occupational therapy. What is particularly important about the role of the care-coordinator, is their intensive and highly-involved role with their clients. Care-coordinators hold a caseload and are expected to meet with their clients regularly, providing support in a variety of contexts to include the clinic, the family home, at tribunals and in other settings. They provide both individual and family support, taking into consideration a broader perspective in supporting individual recovery, to include supporting their mental health, social integration, and general overall wellbeing. While in comparison, psychologists and psychiatrists may get a more limited experience of service users, with psychologists meeting individual service users in groups or individually on a weekly basis, at most; and psychiatrists meeting with clients even less so. This makes it even more vital for care-coordinators to take into consideration cultural factors within their work with service users.

1.2.2.3. Psychosis, Race and Culture

There are suggestions that people from non-white backgrounds may have longer DUPs than white populations (Islam, Rabiee & Singh, 2015). Despite this, a systematic review of studies showed that there was little evidence of a direct link between race and DUP (Anderson, Flora, Archie, Morgan & McKenzie, 2013). In fact, the construct of race has also been criticised due to its assumptions of homogeneity (Anderson et al., 2013), where emphasis should be placed upon factors such as culture and immigration status instead. Rather, emphasis was placed upon a combination of barriers to accessing mental health support which impact on people's pathways to care (Anderson et al, 2013; Giacco, Matanov & Priebe, 2014; Islam et al, 2015).

A delay in help-seeking may often be mediated by different beliefs and explanatory models, leading to a tendency to seek support elsewhere first. This means that people often access different pathways to care, for example as a result of crisis, which may lead to a mistrust of services due to punitive treatment and negative experiences (Islam et al., 2015; McLean, Campbell & Cornish, 2003). Other factors associated with a delay in accessing services are to do with stigma and shame, lack of professional understanding of their

difficulties and their cultures, (Islam, Rabiee & Singh, 2015) and social exclusion (McLean et al., 2003, Bowl, 2007a; Bowl, 2007b). People's experiences of mental health services may reinforce some of these and impact on their engagement with services and the usefulness of services.

1.2.2.4. Individual Experiences of Services

Research has attempted to explore how people and families from BME backgrounds experience mental health services. Family members of British Pakistani service users in an Early Intervention in Psychosis service (EIPS) were asked about their experiences of the service (Penny et al., 2009). Families felt they were not adequately informed of their loved one's difficulties. They felt that staff did not talk to them in a way that made sense to them and that they did not appear to value their role in the service user's life, as they felt staff only approached them to gather more information, rather than to share information. Irregular use of interpreters may have led to a limited understanding of what was happening. While EIPs are intended to be holistic in their set up (Shiers & Smith, 2010), the families did not always perceive it in this way. For example, they viewed EIPS as a place that only provide medication (Penny et al., 2009).

Another research study sought to explore the experiences of service users in an EIPS (Islam et al., 2015). It was felt that language needs were considered as interpreters were often used, however there were various challenges associated with the quality of the interpreters. People also tended to withhold information due to fears about being judged and information being used as evidence of mental illness. There was also a sense that professionals were lacking in cultural and spiritual understanding, and failed to appropriately distinguish cultural norms from 'psychosis'. There were recommendations for voluntary and community organisations (VCOs) to bridge the gap between services and local communities. Due to the differing treatment pathways, this led to a great mistrust of services. Similarly, another study found that there may be aspects of cultural context, that are not directly linked to culture, that may lead to mistrust of services among Arab people. For example, the concept of confidentiality is non-existent in Arab communities (Hamid & Furnham, 2013), which may lead to mistrust and fears about sharing information with professionals. Without

awareness of such factors, professionals may not be able to effectively engage service users, which may lead to greater frustration.

In another study, service users shared their experiences of mental health services failing to attend to their diverse needs adequately, and associated this with a lack of diversity within service practices (Faulkner, 2014). Service users experienced professionals as oblivious to their cultural needs. Some service users regarded this to be associated with a lack of familiarity with cultural issues within white professionals that meant that their cultural needs were ignored. However, some felt that it was not about the cultural background of the professional. Rather, they linked it to their ability and confidence in attending to cultural needs, highlighting some professionals' tendencies to divert away from discussing issues associated with culture. It was also experienced that faith-related practices were unhelpfully monitored and pathologised by professionals. Furthermore, service users within mental health services found that there was an over-emphasis on medication with services, which were often viewed as problematic. They felt that the outcomes of services often did not match the goals and aspirations of the service user, which were more in line with their cultural values.

McLean et al. (2003) highlighted that negative experiences and expectations of health services were due to social exclusion experienced by African-Caribbean people in the mental health system. They differentiated between three forms of social exclusion. *Cultural exclusion* is based upon an inability of services to be 'culturally competent' or able to understand people and appropriately address problems according to their needs. This could lead to misinterpretation of the service user, and consequently mistrust of services from the service user's perspective. *Institutional exclusion* refers to institutional-level procedures and actions that inherently disadvantage African-Caribbean groups and that are very difficult to change. This is linked to the idea that the standardised treatment available may not be relevant for the African-Caribbean population. *Socioeconomic exclusion* places emphasis on the relationship between poor socioeconomic conditions, experienced by African-Caribbean people, and distress.

Bowl (2007b) explored whether experiences of South Asian service users with psychotic diagnoses map on to the exclusion framework set out by McLean et

al. (2003) and found there were similar experiences for South Asians. For example, many South Asians were able to make links between low socioeconomic status and distress, either viewing socioeconomic factors as causing or maintaining their current distress, such as, the impact of not being able to earn enough money and problems with residency. Unlike experiences of African-Caribbean service users, they did not highlight the direct impact of racism. South Asian service users also shared experiences of cultural exclusion, identifying a lack of being understood by professionals and viewed language as a major barrier, with interpreters often not being used consistently because the person appeared to have 'good enough' English. They also reported that some of the questioning was not relevant to their culture, for example being asked to name the British prime minister as part of the mini mental state examination. They spoke about their cultural and faith-related behaviours being misinterpreted as being unusual. With regard to institutional exclusion, they felt that professionals did not make enough effort to engage South Asian families. They were also not kept informed about things like side effects of medication.

Research focusing on service user's experiences of services highlight the importance of considering the accessibility and relevance of service provision for BME groups; as well as the indirect disadvantages they face. This illustrates a need for professionals to consider the impact of their practice when working with people from various cultural backgrounds.

1.2.3. Professionals, Services and Cultural Difference

1.2.3.1. Cultural Challenges in Healthcare

Research focusing on professionals' experiences of working with people from different cultural backgrounds, in general health settings, have highlighted some key findings. Some studies have demonstrated that professional's anxieties about offending people prevented them from asking important questions and having important conversations, which limited them in their ability to be effective in their practice (Jirwe, Gerrish & Emami, 2010; Kai et al., 2007). Many studies highlight challenges faced in communication with service users from different backgrounds, and its impact on their ability to engage and build a relationship with them (Badger, Clarke, Pumphrey & Clifford, 2012; Jirwe, Gerrish & Emami,

2010). These also highlighted challenges in supporting faith needs such as providing prayer space and having an awareness that certain practices may differ across cultures, such as how people respond to and manage bereavement and death. Much of the research places an emphasis on the importance of individualised care and balancing cultural understanding with knowledge of the individual (Badger et al., 2012; Jirwe et al., 2010; Kai et al., 2007).

Interestingly, one study found that professionals working with service users from other cultural backgrounds in health settings, tended to focus on practical physical health and avoided discussing culture, due to their perceived complexity of cultural factors (Suphanchaimat, Kantamaturapoj, Putthasri, & Prakongsai, 2015). What is particularly different in the case of psychosis, however, is the importance of differentiating between what is culturally 'normal' and what is deemed 'psychosis' (APA, 2013). This may work to increase the complexity of these cultural challenges further.

1.2.3.2. Working with Cultural Difference in Mental Health

With regard to thinking about culture, there is a tendency to view culture as something 'exotic' belonging to 'other' people. Culture is something that exists for everyone and every group in every society (Fernando, 2009). Western ideas about health and illness are just as influenced by historical and cultural processes embedded in Western culture; yet there is a tendency to view Western ideas as objective and scientific and therefore the 'correct' way; completely dismissing the idea that western values and ideas impact on the provision of healthcare in the same way that other people's cultural values and ideas impact on their ideas about health and distress (Kirmayer, 2012; Fernando, 2009; Thomas, Bracken, Shabbir, & Yasmeen, 2010). What this means is that professionals will be applying a particular type of thinking about and addressing distress in their work with service users, despite service users' own beliefs and assumptions about the aetiology of their distress, and the associated correct 'treatment' of it. Mental health services are structured around biomedical ideas about diagnosis and treatment, and therefore aim to address individual pathology by reducing symptoms.

The DSM-V does, however, highlight the importance of administering a culturally-appropriate assessment to avoid misdiagnosing people based upon western standards (APA, 2013). Therefore an understanding and consideration for culture is an integral part of assessing and diagnosing psychosis. For example, believing in a higher being or a God is not deemed to be a psychosis, despite the lack of objective evidence, as many people share this particular belief. Therefore, belief in God does not warrant a diagnosis of psychosis, based on the knowledge that it is a culturally-acceptable belief for that person.

However, in reality, the evidence suggests that people do respond according to their own biases and beliefs without adequately accounting for cultural difference. Research suggests that service pressures lead psychiatrists to prioritise risk and service management over considering religious beliefs as part of their assessment, despite a recognition that certain beliefs are 'normal' within the context of a person's culture (Colgan, 2015). This suggests that cultural factors may not always be accounted for when working with service users within mental health settings. There also exists evidence showing that African-Caribbean men are more likely to be treated punitively in mental health services; three times more likely to be admitted into inpatient settings (Keating, 2007); more likely to be detained under the mental health act (Inyama, 2009; Keating, 2007); more likely to receive medication for their mental health difficulties and less likely to be offered therapy (McKenzie et al., 2001); and tend to be treated with higher dosages of medication than other service users (Inyama, 2009). These ideas are in line with research suggesting that African-Caribbean people's behaviours and actions are at greater risk of being misinterpreted by professionals as dangerous or aggressive, leading to possible misdiagnoses (McClean et al., 2003). It may not be entirely unusual to feel distrustful and fearful within a mental health service that is inherently racist (McKenzie & Bhui, 2007). Further evidence suggests that religious behaviours may also be pathologised in a similar way (Bowl, 2007b).

In response to invitations to tackle institutional racism, institutions often react in ways that may be unhelpful and fail to address these issues (McKenzie & Bhui, 2007). Reactions may include implications that someone is over-stating an issue due to their personal flaws and biases; institutions may respond in a defensive manner; or they may simply ignore serious issues.

There have, however, been some attempts to address these problems. The first attempt at devising a proposal to tackle ethnic disparities and reform service user experiences and outcome in mental health, was made in *Inside Outside: Improving Mental Health Services for BME Communities in England* (DoH, 2003). This raised concerns about the disparities faced by the BME population in mental health services, in relation to institutional racism. *Delivering Race Equality (DRE)* (Department of Health [DoH], 2005) was developed in response to research illustrating the inequalities faced by BME people with regard to access and experiences of mental health services. This was followed up by *Positive Steps: Supporting Race Equality in Mental Healthcare* (DoH, 2007). These highlight a need for more cultural-appropriateness within services, better engagement with the community with an aim to seek support in influencing services, and improved monitoring of ethnicity in relation to service provision. This was partly developed in response to the David Bennett enquiry, presenting the case of an African-Caribbean male service user with a Schizophrenia diagnosis, who was subjected to racial abuse and on one occasion was restrained for 25 minutes by staff, leading to his unfortunate death (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003). However, there are concerns that very little has changed since the recommendations set out in DRE, in terms of improving the cultural-relevance of services (Rights and Wellbeing of Racialised Groups [RAWorg], 2011). However, in the review for DRE (DoH, 2009); it highlights that some changes have since been implemented, however that this is still premature as the recommendations made by DRE have been extensive. As part of the recommendations of DRE, the *Count Me In 2010* (Care Quality Commission, 2011) census data was set out to monitor experiences of services according to ethnicity. Findings suggest that since DRE, rates of admissions and compulsory detention and treatment still remain higher in BME groups than in White British groups.

In response to DRE, one study presented a finding that opposed research showing that African-Caribbean people are more likely to receive medication and less likely to receive therapy (Raleigh et al., 2007). They found few or no differences between the experiences of people of Caribbean origin and White British origin in receiving support from a mental health professional and medication in the past twelve months. However, they do not stipulate type or

relevance of the mental health professional involvement on offer, nor the differences in types of medication people were prescribed, for example antipsychotic or antidepressant; as there is an indication from past research that black African-Caribbean people are more likely to be treated with excessive amounts of antipsychotic medication (Walkup et al., 2000). However, the study did highlight that ethnicity was not directly linked to predictors of patient experience; but rather that various social factors were important and that efforts needed to be made to improve access to services for African-Caribbean people (Raleigh et al., 2007).

Nevertheless, evidence suggests that professionals and services may hold particular biases that impact on their perception of, attitude towards and treatment of service users from other cultural backgrounds. This highlights a potential challenge for professionals and services in adequately attending to cultural factors.

Additionally, practices that are employed within services like the NHS can have detrimental social consequences for people from some communities. In the Pakistani culture, being a mother and a wife are central to the identities of women; and research has suggested that stigma, hospitalisation and medication can impact negatively on their role as mothers and wives (Wheeler, 1998). For example, losing the respect of their children, losing their husbands, and lacking energy to engage in their household duties. Therefore the practices carried out within the NHS, when working with people from BME backgrounds, can have negative effects on a person's mental, social, physical wellbeing and quality of life; which is counterproductive to the aim of services in improving people's wellbeing and quality of life. This leads one to question just how appropriate service provision is for people from various cultural backgrounds.

1.2.3.3. Professionals' Experiences of Working with Cultural Difference in Mental Health

There is limited research about experiences of professionals working with cultural difference in mental health settings, and most of these pertain to working with immigrants. One study conducted focus groups with student nurses to explore experiences of caring for patients from different cultural backgrounds, in the fields of mental health, learning disability and adult nursing;

but did not discuss differences among field of work (McClimens, Brewster & Lewis, 2014). Some of the challenges that were raised for nursing students were with regard to working with cultural diversity in relation to language and communication, diet and gender. Language was regarded a major barrier to building a relationship with people.

Another study explored professionals' experiences of providing mental health support to immigrants across 16 diverse European countries, including the UK (Sandhu et al., 2013). Professionals highlighted a difficulty with determining diagnoses due to language barriers, cultural beliefs and expectations, and difficulties in differentiating traumatic responses from psychotic symptoms. There was a recommendation for well-trained interpreters and cultural awareness training to overcome this challenge. Another challenge highlighted was the difficulties of developing trust, due to service user unfamiliarity with services, and mistrust, which could be linked to previous traumatic experiences. This led to a suggestion that more time would allow the professional to develop trust with the service user. Professionals also highlighted that immigrants faced an increased risk of marginalisation by wider society which further impacts on their ability to engage with service users. They highlighted a need to increase social reintegration. In line with service user perspective research, this study highlighted the challenges professionals face in accurately making inferences about people's behaviours due to language and cultural factors. This is also highlighted in a publication by the British Psychological Society (BPS) Division of Clinical Psychology, titled *Understanding Psychosis and Schizophrenia* (BPS, 2014).

Some research studies made use of different methods of data collection to highlight some of the challenges professionals faced in their interactions with service users from different cultural backgrounds. One study made use of a videotape consultation approach to observe some of these intercultural challenges (Rosenberg, Richard, Lussier, & Abdool, 2006). They found that a lack of cultural knowledge led to misunderstandings about the cultural values and beliefs of the other person; for example in one case, a professional attempted to address a female service user directly, therefore placing a value on her sense of autonomy; however the service user preferred to let her husband speak for her as she felt he could more adequately communicate what

she wanted to convey. This example illustrates a situation in which the professional and service user hold different priorities and values about the relationship, both of which are unaware of the other person's viewpoint. The study concluded that there was a need for professionals to learn about aspects of culture that are likely to interfere with the work; for example communication, social and family organisation, health beliefs and practices and religion and spirituality.

Effective communication seemed to be an area that was highlighted across various studies, as something that was vital for the care of the service user. A systematic review found many factors associated with effective communication for professionals working in mental health; for example verbal and non-verbal skills, recognition of cultural differences, an ability to make use of cultural knowledge and working collaboratively with service users (Logan, Steel & Hunt, 2014). Language was recognised as a major barrier to the process of effective communication.

Additionally, there has been some recognition of the impact of the professionals' own cultural and religious background in their relationship with service users. In working with service users who held religious beliefs, mental health professionals who regarded themselves religious or spiritual felt more able to understand service users and to incorporate religious ideas with their mental health treatment (Pelechova, Wiscarson & Tracy, 2012).

1.2.4. Culturally-Relevant Service Provision

1.2.4.1. DSM and Culture

Bhugra & Bhui (2010c) identify factors professionals must take into consideration when conducting a culturally-sensitive psychiatric assessment. These broadly consider the need to be aware of one's own beliefs, values and biases and ensure these do not impact on the interpretation of the service user's experiences; and to appreciate and assess the service user's perspective of events, understanding of the problem, cultural norms, beliefs and taboos, and the impact of specific life events; for example, migration. They highlight that it is important not to immediately judge or make assumptions, but to clarify ideas and concepts that are unclear. They also emphasise the importance of

addressing specific needs, for example identifying a preferred language; and to communicate total confidentiality.

Due to problems of misdiagnosis, the need to attend to cultural factors was highlighted and an Outline for Cultural Formulation (OCF) was introduced in the DSM-IV (APA, 1994). This was used to take into consideration cultural background, its influence on the experience of distress and its effect on the relationship between the service user and the professional. It highlighted a range of important factors for professionals to consider. One study found that reviewing medical records of people with psychotic diagnoses, retrospectively, based upon the categories within the OCF in the DSM-IV, led to around half of people being re-diagnosed as not having a psychotic disorder (Adeponle, Thombs, Groleau, Jarvis & Kirmayer, 2012). This implies that without an assessment that takes into consideration cultural factors, people are at greater risk of being misdiagnosed.

However, it appears that the OCF has not been implemented in practice (Lewis-Fernández, Aggarwal, & Kirmayer, 2016), which has been suggested to be due to a lack of guidance in how to implement these ideas (Kirmayer, 2016). An attempt to address this issue has been made by the DSM-V with the introduction of the Cultural Formulation Interview (CFI; APA, 2013, pp752-754), as a way of taking cultural factors into consideration within psychiatric assessments. It is a brief, 16-question semi-structured interview designed to guide clinicians in asking questions that will generate information about the impact of cultural factors on the person's experiences. The CFI provides specific questions that clinicians can ask to support them in their assessment. It is useful at an initial assessment, and aims to assess four areas 1) Cultural definitions of the problem, 2) Cultural conceptualisations about cause and sources of support, 3) Cultural factors affecting coping ability and past help-seeking, and 4) Cultural factors affecting current help-seeking. The CFI-Informant version (APA, 2013, pp.755-757) can help clinicians to gain an understanding of the person's cultural context from their family members or friends.

Gaining an insight into cultural factors within psychiatric assessments can be useful as a means of preventing misdiagnosing unfamiliar cultural phenomena,

as well as provide useful clinical information that may improve engagement with and quality of care for service users (APA, 2013)

While the DSM-V attempts to offer a means of incorporating cultural factors into a psychiatric assessment, it does not provide any indication of how to use this information to guide interventions. Another limitation of the CFI is that in order to devise a culturally-relevant psychiatric assessment, the concept of culture has been simplified and reduced to specific aspects in order to make it implementable (Kirmayer, 2016). Additionally, a range of barriers have been identified in its use (Aggarwal, Nicasio, DeSilva, Boiler & Lewis-Fernández, 2013), such as professionals viewing it as lengthy, irrelevant in relation to eliciting cultural factors, irrelevant to diagnosis, repetitive, difficult to adhere to in its entirety due to professional discomfort with some of the questions, and difficult to use with people who are acutely unwell. From a service user point of view, people could not differentiate it from other forms of care, and expressed discomfort with and confusion around some of the questions or found the interview was too rigid.

While the CFI poses some challenges, it is an attempt at incorporating cultural understanding into psychiatric diagnosis. In addition to this, research has attempted to explore and develop ‘culturally-competent’ ways of practising within mental health settings.

1.2.4.2. ‘Cultural-Competence’

There is no single definition of cultural-competence. It has been defined in a number of ways by various theorists. Some have even categorised ethnicity, race and culture competencies as relating to *attitudes*, for example appreciation and respect, *knowledge* of specific ethnic racial and cultural differences and *professional skills*, for example, in how people interact with and incorporate understanding of ethnicity, race and culture in their practice (Sewell, 2009).

There are various different models proposed for cultural-competence. The Campinha-Bacote Model (2002) proposes that cultural-competence is a process consisting of five constructs – cultural awareness, cultural knowledge, cultural skill, cultural encounters and a desire to want to engage in a process of becoming culturally aware. A person must engage with all of these constructs when managing cultural difference in their practice.

The Giger and Davidhizar Transcultural Model (2002) proposes six cultural factors which should be assessed on an individual basis. These are: *Communication* (both verbal and non-verbal), *space* (rules about interpersonal distance), *social organisation* (the way a group organises itself around a family), *time* (whether things are communicated according to past, present or future orientation), *environmental control* (whether people believe they have control over their environments or not) and *biological variations* (biological and genetic differences that exist within groups).

Alternative constructs have been used to address the problems with the construct of “cultural-competence”, for example, the notion of “cultural humility” (Tervalon & Murray-Garcia, 1998) which emphasises the importance of self-reflection and self-critique to ensure positive engagement with service users from other cultural backgrounds; or “cultural sensitivity” which differentiates between the ability to develop interventions that fit both observable and superficial aspects of a culture, such as food and language; as well as broader social, historical and cultural factors that may impact on people’s actions and behaviours (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999). However, much of these terms have been used in various ways and some distinctions between concepts are unclear. This perhaps highlights the complexities of thinking about cultural difference. Cultural sensitivity is more than simply attending to faith needs, such as diet and religious needs; but it is about respecting differences (Thomas et al., 2010). For example, considering the impact of using culturally-appropriate terms is one way of being sensitive to difference (Kleinman & Benson, 2006). Much of the approaches appear to value respect, willingness and interest in engaging with difference. The concept of cultural-competence will be used to refer to professionals’ abilities to engage with culture in their work in the broadest sense of the term, to include various concepts and definitions.

While religion and spirituality are somewhat distinct from culture, there are various cultural groups who may regard their religious and spiritual beliefs as part of their cultural beliefs. It may be relevant to consider these as religious beliefs are often integrated into people’s understanding of the world (Fernando, 1991) and impact on people’s behaviours and outcomes (Whitley, 2012). ‘Religious competence’ may be seen as an extension of cultural-competence.

Religious and spiritual beliefs may play an important role in shaping people's understanding of mental health. Research has attempted to highlight the link between religiosity and improved well-being among people experiencing distress (McKenzie, Serfaty & Crawford, 2003).

Historically, however, religion has been viewed negatively within psychology and psychiatry; which may have influenced how mental health services practice currently (Whitley, 2012). There exists a 'religiosity gap' (Dein, Cook, Powell, & Eagger, 2010) between mental health professionals and service users, which may lead to the unhelpful dismissal of important religious and spiritual factors. Although there is evidence suggesting that integrating religious and spiritual practices with standard psychiatric support may aid recovery and improve overall outcomes for service users, there appears to be a reluctance to develop such ways of working (Chidarikire, 2012). In addition, some service users within community mental health settings would like the opportunity to consider spiritual and religious issues with their psychiatrists and other mental health professionals further highlighting a need to incorporate such understanding with psychiatric support (Mohr & Huguelet, 2014). Some have highlighted the need for religious competence, and for developing mental health practices that are compatible with people who hold religious beliefs (Whitley, 2012).

Kleinman and Benson (2006) propose an alternative to standard cultural-competence models. They recommend training professionals in ethnography, focusing on the practice of engaging with other cultures, rather than following a set of standards or tasks. They criticise the construct of cultural-competence, for its oversimplification of culture, reducing it to a series of tasks or domains which people must do in order to be 'competent'. They also suggest that cultural factors may not always be relevant, and an over-emphasis of culture may lead to unhelpful and stereotypical assumptions being made, instead of attempts to truly understand someone's current situation. Instead, they highlight the usefulness of the Explanatory Models (EM) approach, which is an interview technique people can employ in order to learn about how people's social context impact on their illness and vice versa.

In another study, the Barts Explanatory Model Inventory and Checklist (BEMI) were used for its ease and efficiency (Owiti et al., 2015). This allowed professionals to gain an insight into people's cultural explanations for distress,

and use the cultural knowledge to adapt and shape interventions to match peoples' Explanatory Models, allowing for a person-centred approach that may enhance engagement and improve overall outcomes (Owiti et al., 2015). Evidence suggests that a shared understanding between the professional and service user leads to improved engagement (McCabe & Priebe, 2004) and improved adherence to treatment (Roesch & Weiner, 2001).

1.2.4.3. Supporting Staff in Engaging with Culture

The influence of ethnography and anthropological principles is also evident in the Cultural Consultation Service (CCS) model, which attempts to enhance mental health professionals' cultural-competence and evaluate the impact of this on the care of service users (Owiti et al., 2014; Palinski et al., 2012). The CCS has been implemented in East London and is based on the CCS in Canada (Kirmayer, Groleau, Guzder, Blake & Jarvis, 2003) which led to outcomes of improved accuracy of diagnoses and culturally appropriate interventions within mental health services; and it also highlighted a need for professionals to receive further training in working with interpreters and cultural brokers and implementing cultural formulation.

The CSS was developed as both a clinical and evaluative tool for enhancing cultural competence in mental health settings, and proposes that with every encounter with a service user, an interaction of four factors takes place (Owiti et al., 2014). These are the culture of the service users, the clinician's culture, the healthcare system's culture and sociocultural factors. This emphasises that the most effective way to develop cultural competence is through clinical encounters. This approach has a series of stages to support staff in considering various factors when working with service users from other cultural backgrounds, from referral to follow-up. This includes the involvement of a cultural consultant within team and individual discussions, using the Barts Explanatory Model Interview to elicit patient narratives of their difficulties, followed by narrative analysis, cultural formulation and finally an evaluation of the process. They found that CSS helped clinicians to develop a broader understanding of culture, feel more equipped to deal with complexity, gain a better understanding about assessment and how to ask questions that will be

useful, and gain more knowledge of how to incorporate cultural and social factors into their understanding of service users (Owiti et al., 2014).

The CCS aims to implement change at different levels, supporting individuals, teams and organisations, through training, workshops, reflective practice and outreach support. Following involvement of the CCS in teams and organisations, professionals noticed an improvement in service user functioning, engagement and adherence to treatment, and reported that they gained new insights about the service users under their care (Palinski et al., 2012). This involvement also led to reduced costs for services. The barriers professionals had previously faced to being culturally-appropriate were about lack of time and resources to support them. Based on the referrals to the CCS, the types of recommendations that were made were about minimising miscommunication, providing links with VCOs, increasing choice and autonomy for families, and supporting staff with further assessment of cultural factors, psychological interventions, and ensuring accuracy of diagnosis. Service users highlighted the need for acknowledgement of their culture and for the availability of choices with regard to sources of support. The findings suggested that support should not be a one-off but continual, as a means of scaffolding and supporting people through cultural issues.

1.2.4.4. Language and Communication

Effective communication has been proposed to be a fundamental aspect of effective mental health support with regard to improving assessment, diagnosis, engagement, intervention and overall outcomes for the service user (Bhui et al., 2015a). However, this can be compromised due to cultural and language differences (Giacco et al., 2014; Islam et al., 2015; Logan et al., 2014; Rosenberg et al., 2006; Sandhu et al., 2013). Culture and identity are expressed through language (Thomas et al., 2010; Tribe, 2007). The ability for a professional and a service user to work well together is reliant on the ability of both to be able to communicate and understand one another. The way in which people express emotions, use metaphors and body language, experience, conceptualise and respond to distress, and where people seek support from will vary across cultures. Therefore, this may pose a challenge for professionals in understanding, identifying and empathising with the service user (Bhui &

Bhugra, 2004; Bhui et al., 2015b). One way of addressing these differences is in using an Explanatory Model (EM) framework, which applies anthropological principles clinically, to help professionals gain a better understanding of the service user's perspective and conceptualisations of distress in order to adapt and make interventions relevant for that person. (Bhui & Bhugra, 2004).

Attending to differences in language means understanding that a form of 'treatment' that is an expression of one culture may not be relevant to another (Thomas et al., 2010). For example, Cognitive Therapy is based upon the understanding of the impact of thoughts on a person's wellbeing. This is an expression of Western culture through language. It then may not be appropriate to 'treat' someone with Cognitive Therapy, if the person does not conceptualise their distress or identities in relation to their thinking styles. Psychiatry has its own culture, expressed through a language of deficit and neurotransmitters (Thomas et al., 2010), which may not be aligned with everyone's EM. Taking a different perspectives approach may help professionals to negotiate a range of forms of treatment, taking into consideration the person's beliefs (Bhui & Bhugra, 2004), for example incorporating spiritual practices into the care plan, while also negotiating that the service user takes medication to support the process of spiritual healing. While Western and non-Western approaches to psychosis may be deemed to be contradictory to one another, there is evidence that often people who hold spiritual or social views about psychosis may be accepting of holistic forms of support, which could include medication, in addition to other sources of support (Penny et al., 2009).

It is important to consider the impact of language and communication on the experience of engaging with service users who may use a different language to conceptualise their problems. One method of improving communication between clinicians and non-English speaking service users is to provide interpretative services. Despite this, communication and the challenges of working with interpreters are still highlighted as major barriers and challenges for professionals when attempting to engage with and support service users (Badger et al., 2012; Bowl, 2007b; Islam et al., 2015; Jirwe et al., 2010; McClimens et al., 2014; Penny et al., 2009; Sandhu et al., 2013), and often

professionals experience a loss of power in the relationship as a result of these challenges (Brisset, Leanza, & Laforest, 2013).

Interpreting is a difficult and demanding task, often underestimated or even viewed negatively by clinicians (Raval, 2013; Tribe & Thompson, 2009). It involves attempts to interpret meaning across cultures, rather than merely translate words (Tribe, 2007). The traditional dyadic relationship between the clinician and the service user become triadic when an interpreter is introduced, which could lead to clinician anxieties about the impact of this on the therapeutic relationship (Tribe and Thompson, 2009). It can be helpful to view the interpreter as part of an equal triadic relationship, with more to contribute than merely translation (Raval, 2013), however there can also be challenges to this. Alliances can often be formed between two of the three people, leading to the other feeling excluded (Dearnley, 2000; Miller, Martell, Pazdinek, Carruth & Lopez, 2005); thereby posing additional challenges to the engagement process (Tribe & Thompson, 2009). Service users may also have anxieties about the involvement of interpreters due to fears about confidentiality, shame and stigma (Tribe & Morrissey, 2004)

Recommendations have been made with regard to training clinicians to gain an insight into effective ways of working with interpreters, for example through the phrasing of sentences or questions asked, providing information for interpreters to support them in their role, finding ways of making services more culturally appropriate, and embedding interpretative practices as part of the structure of services (Raval, 2013). There are also suggestions for good practice with regard to working with interpreters (Tribe & Morrissey, 2004). This includes recommendations to request interpreters with mental health training; prepare the interpreter beforehand with regard to mental health terminology or set up of contractual agreements to include a discussion of confidentiality, roles and expectations; aim to elicit relevant cultural knowledge from the interpreter; attend to age, gender and religion-matching where necessary; and ensure consistency by using the same interpreter.

1.2.4.5. Working with Voluntary and Community Organisations

Recent recognition that health services may not be appropriate and relevant for everyone, has led to the development of new ways of working. There is a

commitment from the government to address this issue by developing partnership working between health services and voluntary and community organisations (VCOs), through meaningful engagement (DoH, 2004). Service users have asked for more choices and more autonomy in decisions about their treatment and for services to be more responsive to their cultural needs. The aim of this agenda is to increase choice and enhance service user experience, provide a framework of joint work and means of how to address barriers, allow VCOs to be involved in mainstream service provision as well as influence existing service practices, and to facilitate equity and fair access for all. Partnership working can help to bridge the gap between mental health services and VCOs and provide services that are more appropriate and relevant for everyone (DoH, 2004; 2005; Islam et al., 2015; Lester et al., 2008).

Some of the strengths and barriers of partnership working between EIPs and VCOs have been highlighted (Lester et al., 2008). Partnership working can be facilitated by shared aims and understanding, for example through a focus on social recovery. People also reflected on VCOs and EIPs as being complimentary to one another, allowing for more holistic forms of support. This also meant having increased access to resources which could positively impact on service user's social environment, for example through volunteering and building skills that will help them find work. Sharing knowledge with one another in the form of training was also seen to be a strength of partnership working. However, barriers to partnership working were also identified. Some of these were practical, for example lack of time, lack of resources, and lack of funding as a result of commissioners failing to recognise the benefits of partnership working. They also found that cultural differences between the EIPs and the VCOs to be problematic, for example in the use of stigmatising language used by EIPs. This led to VCOs wanting to distance themselves with EIPs due to fears of being associated with them and thus losing the trust of the service user. People also felt that professionals in VCOs were wrongly viewed as less of an expert than those in EIPs. People felt that attempts to engage and establish links with VCOs were often tokenistic rather than meaningful.

1.2.4.6. Exploring Issues of Cultural Difference for Care-Coordinators Working with Psychosis

This review has highlighted the importance of professionals' abilities to engage with cultural differences when working with psychosis, particularly within London. This particularly emphasised the disparities that BME service users face in mental healthcare, and the need to pay attention to the professionals' role in supporting culturally-competent care.

Little research has attempted to explore professionals' experiences of working with cultural differences in mental health, as much of the focus has been on service users' experiences. Most of the research that has attempted to explore professionals' experiences have tended to focus on their experiences of working with immigrants rather than cultural differences as a whole. Whereas, within the context of London, many service users may not necessarily be immigrants themselves, but may be born into families that are and therefore their cultural backgrounds are influenced by both the western values of living in London and the cultural values acquired from their families. Additionally, much of the evidence has broadly focused on mental health and not psychosis specifically. Furthermore, previous research has not attempted to explore issues of cultural difference with Care-Coordinators in EIPs specifically, as far as is known. This is important as Care-Coordinators undertake a specific role which involves intensive interaction and engagement with service users, aimed at a level that is more extensive than standard community care. In supporting mental wellbeing and recovery, Care-Coordinators also need to attend to a range of factors that impact on a service user's psychological wellbeing; thus requiring attention to various cultural factors in the process.

This study aims to explore Care-Coordinators' experiences and concerns associated with working with cultural differences within EIPs. EIPs were chosen as they are specialist services aimed at engaging people earlier on in the course of their psychosis, at a time that may be most confusing and challenging for individuals and families. Exploring Care-Coordinators' experiences of working with cultural difference within an EIP may highlight potential areas for development in practice when working with people from a range of cultural backgrounds.

The following research questions were identified for this research study:

- What are Care-Coordinators' experiences of managing issues of cultural difference in their work?
- What are the challenges for Care-Coordinators working with cultural differences?
- What has been helpful in managing these challenges?
- What are the learning experiences people have had when working with people of other cultures to them?

2. METHODOLOGY

2.1. DESIGN

The design employed was a cross-sectional qualitative interview study, seeking to explore Care-Coordinators' experiences of working with cultural differences. As qualitative research methods aim to enhance the understanding of human experiences and processes (Harper & Thompson, 2012), this seemed a suitable method to gain an insight into the experiences of Care-Coordinators, highlighting areas of challenge and learning that are experienced by them in their work.

2.2. EPISTEMOLOGY

This research study adopted a critical realist epistemology (Harper, 2012). This means that participants' reflections were based upon actual experienced events; however accounts were constructed in a particular context and recalled in a particular way representing their own subjective perspective of the events. In other words, the ways in which participants were likely to perceive and construct accounts of their experiences, will have been influenced by their personal, social, historical, cultural, professional and other influences. The researcher's position and perspective also further impacts on how the data is analysed and how conclusions are drawn. It is, therefore, not an attempt to discover truths, but both the participant's and researcher's interpretation of events (Willig, 2008).

2.3. PARTICIPANTS

Single semi-structured interviews were conducted with ten professionals working as Care-Coordinators¹ in an Early Intervention in Psychosis Service (EIPS) for at least 2 months, across an East London and a West London NHS

¹ Care-Coordinators form an important part of the Early Intervention in Psychosis structure, taking a leading role in the care of the service users on their caseload. They are typically Community Psychiatric Nurses, Occupational Therapists and Social Workers. Although they may sometimes be expected to perform roles specific to their profession, for example social workers tend to be more involved in conducting Mental Health Act assessments; the role of the care coordinators are similar in that it involves regular contact, both therapeutic and practical, with service users and their families

trust. Participants were recruited from separate services to ensure findings were not service- or location-specific. The participants in this study consisted of Care-Coordinators with core professions of Nursing (6), Occupational Therapy (2) and Social Work (2). From the ten participants, three identified their ethnicities as Black African, and seven identified as White British. Three of the participants were male, and seven were female. Care-Coordinators had a range of between five months and 21 years of psychosis experience; and specifically between two months and seven years of Early Intervention in Psychosis (EIP) experience.

Care coordinators were chosen among other professionals as they play a key role in various aspects of care for the service users on their caseloads. This involves intensive interaction with service users and their families in a variety of settings, including their homes. This means that care coordinators have a diverse range of experiences to draw from when considering their experiences of working with cultural difference.

2.3.1 Inclusion Criteria

People were recruited into this research project if they were currently working as a Care Coordinator within an EIPS, and for a minimum of two months. EIPSs were chosen as they were specialist services targeting individuals and families of people experiencing psychosis. They also support families earlier on, at a time when the service user's presentation may be confusing or terrifying for them and their families. A minimum of two months was specified so that participants had enough experience to reflect on in relation to working with cultural difference within EIPS. Professionals from all cultural backgrounds were invited to participate, as everyone would have been exposed to working with people from different cultural backgrounds to themselves, regardless of what background they were from.

2.3.2. Recruitment

The EIP teams that were approached for the study were chosen due to established links with the services, either from previous employment or through other professionals. Most members of the team known from previous employment, were unknown to the interviewer due to changes in staffing. Managers and Clinical Psychologists from both teams were contacted with

information about the study and an invitation to take part, to which both agreed. A further two teams were contacted within one of the London NHS Trusts, but neither responded to invitations.

Managers from the East and West London teams were contacted to identify recruitment strategies that would be most appropriate for those teams. Both teams identified the delivery of a presentation to orient the team to the research project. Subsequent to gaining NHS permission, teams were contacted to arrange dates for presentations to take place for recruitment purposes. The presentation gave a very brief overview of the background and rationale for the project, along with specific details about what people are to expect if they agree to partake, and the opportunity for questions and concerns to be raised. The same presentation was delivered to both teams (Appendix A). Following this, individual teams decided how to best move forward with recruitment. Members from one team preferred to distribute the information sheet to team members who were unable to attend. Individual team members then sent an email to express an interest in taking part. Clinic rooms were booked in advance by the participants at their place of work. Within the other team, the team administrator coordinated both the dates and times with members of their team, and ensured clinic rooms were booked for the interviews. A copy of the information sheet was distributed to the team via the manager, and people were informed that they could contact the researcher for any questions or concerns.

2.4. ETHICS AND SAFETY

2.4.1 Ethics and Registration

Ethical approval (Appendix B) and registration of the research (Appendix C) was obtained by the University of East London. The HRA tool was used to identify whether NHS ethical approval should be sought (<http://www.hra-decisiontools.org.uk/ethics/index.html>).

As this research was carried out with staff, the HRA tool indicated that this research did not require NHS ethical approval (Appendix D). This research was registered with the associated NHS Trusts for both teams, both of which approved of the research taking place (Appendix E and F).

2.4.2. Ethical Considerations

Although the study was not expected to cause harm, the process of asking professionals to reflect on and share challenges in relation to working with people of other cultural backgrounds, may cause some discomfort. Asking professionals to potentially share negative aspects of their care may be undermining to their role. Therefore, it was important to verbally debrief all participants to acknowledge and address any potential discomfort or distress their recollection of difficult events may have caused.

Professionals were asked to reflect on their experiences with service users and families; therefore those service users and their families did not have the opportunity to voice their perspective of events. Therefore, consideration needs to be made to the results as being reflections of professionals' subjective experiences and not an accurate reflection of events or service users' experiences.

2.4.3. Consent and Confidentiality

All participants were given informed consent prior to taking part in the research study. Confidentiality agreements were stated both verbally and provided in the information sheet (Appendix G) and people conveyed consent to participate using the consent form (Appendix H). As requested by HRA, all confidential information, including audio recordings, and scanned versions of the consent form, were kept securely on university computers, and all anonymised data were kept on a personal password-protected laptop.

Participants were told that their interviews will be audio recorded, and transcribed anonymously, changing or omitting information that will make the data identifiable to them. Participants were informed that all anonymised data will be kept on a password-protected laptop, and that all identifiable data will be kept on the university computers, including scanned copies of consent forms. Participants were informed that their responses will not be shared with the other team members, but that general themes would be generated across interviews. Participants were provided with an opportunity to ask questions and a consent form to read and sign, and a copy of the consent form was provided for the participant's reference.

Names of participants were changed according to English names, to reduce the potential of being identifiable to other team members. These names were used for extracts. However, in some cases, specific extracts were further anonymised as “The Participant” to further protect their anonymity. As the EIPs are small teams, this often meant that teams were aware of who volunteered for the study, and therefore all names were changed to female names to reduce the possibility that other team members would be able to identify them.

2.4.4. Safety and Risk

A risk assessment form was completed at UEL to outline all the possible risks and strategies to managing these risks. This indicated that the overall risk was very low. As recommended by UEL, awareness of local fire evacuation and health and safety procedures at both sites were sought and adhered to. It was ensured that interviews took place in a visible space with staff nearby. Interviews were conducted in clinic rooms at both team sites, during hours where other staff were present.

2.5. MATERIALS AND PROCEDURES

2.5.1. Audio Recording

All interviews were recorded on two audio recording devices to ensure data was not lost due to technological issues. Participants were informed that the interviews will be audio recorded to support the transcription process, and verbal consent was gained prior to interviews taking place.

2.5.2. Interview Schedule

The interview schedule (Appendix I) was developed with reference to cultural staff research, service user experience research, and psychosis-specific literature. In constructing the interview schedule, it was decided not to include a question that asked interviewees to share their understanding of ‘culture’ or ‘cultural differences’ as it was felt that interviewees’ definitions would be theoretical, whereas the ways in which they construct culture would nevertheless be apparent in their overall responses. Additionally, such a

question may be challenging to answer in a theoretical and broad sense, and is likely to be easier to demonstrate through examples of experiences.

The development of the interview schedule was monitored in supervision and through the administration of pilot interviews to ensure the appropriateness and length of the interview. In order to ensure that the questions in the interview schedule were appropriate and realistic in a one hour interview, this was piloted on two people and feedback was sought. Pilot interviews were conducted with an Assistant Psychologist working in an EIPS, and a Trainee Clinical Psychologist. Both found the questions suitable and were able to draw from experiences and challenges they have faced. The questions were deemed to be appropriate and convincing as a tool for generating responses that were relevant to the thesis topic.

The interview schedule was used as a guide rather than a set list of questions, as a means of guiding people to reflect on experiences of cultural difference. Questions were focused on challenges and learning experiences. The questions roughly follow a sequence beginning with a broad, general question and developing into more specific questions. This allows for some initial flexibility in how people choose to interpret the questions. The follow-up questions then helped to re-shape the interview based upon the interviewer's interpretation of the topic.

2.5.4. Semi-Structured Interviewing

Semi-structured interviewing is a qualitative method used to explore a particular topic through questioning, using open questions to facilitate detailed responses leading to 'rich' data (Howitt, 2010). Active listening is an important part of semi-structured interviewing, as interviewers need to be flexible and modify follow-up questions as guided by interviewees' responses. While presented as more naturalistic, interviews are not the same as conversations that occur naturally, which means that often people are more likely to develop ways of speaking that may portray themselves in a positive way. Therefore, it was important to normalise challenges and invite people to be honest in their responses before the interviews took place.

In deciding which qualitative approach to employ, focus groups were considered as an option. Focus groups aim to capture a team construction of a

particular issue, whereas interviews focus on individual experiences (Howitt, 2010) which are in line with the research questions for this thesis. Additionally, a focus group cannot safeguard confidentiality and anonymity among team members as team members jointly construct and reflect on issues. This may limit how able participants feel to share challenging experiences in the presence of colleagues, and participants may further make efforts to present themselves in a positive light. Therefore, interviews were used to allow participants to feel more able to share their challenges in the context of a confidential agreement that stated that responses will not be shared with other members of the team.

2.5.5. Interviewing Participants

The decision to interview ten people was guided by research that recommends between seven and twelve interviews due to data saturation occurring after twelve interviews (Guest, Bunce & Johnson, 2006). Semi-structured interviews were used to guide participants toward thinking about working with cultural difference, but allowed some flexibility for new ideas to emerge in ways that were most relevant and meaningful to participants.

All participants were interviewed in a clinic room within the participant's place of work. A step-by-step plan for the interview process (Appendix J) was used flexibly, to include a verbal overview of the study including the sharing of reflexivity, an opportunity for questions or concerns, an overview of the confidentiality agreement, consent to participate in the different aspects of the study, a semi-structured interview and a debrief. Participants were invited to be as honest as possible.

Upon completion, participants were verbally debriefed. Participants were given the opportunity to share their feelings about completing the interview and to ask questions or raise concerns about the study. Consent sheets were photocopied and a copy was given to participants for their reference.

Interviews took on average approximately 50 minutes. There were minor interruptions in some of the interviews, including being asked to re-locate to another room on one occasion and people knocking or walking in to the room on another. However, efforts were made to ensure the environment was confidential so people could talk more freely and participants were given flexibility in appointment times to facilitate fewer distractions and better

engagement. All interviews were conducted, audio recorded and transcribed by the researcher.

2.6. DATA ANALYSIS

2.6.1. Transcription

Data was transcribed verbatim using a basic transcription format. Identifiable information was removed or changed. As the themes were generated based upon the topics and ideas people shared and not the specific language or mannerisms; it was not necessary for the transcripts to be detailed. Transcripts were edited, to remove words that did not provide anything of meaning or value such as repetitions or false starts, and punctuated to improve readability. Efforts have been made to ensure transcripts do not edit out vital information. Edited transcripts were sent to participants to verify accuracy and to ensure that they represented what the person was trying to articulate. None of the participants raised any concerns about the transcripts. Examples of coded interview transcripts can be found in the appendices (Appendix K)

2.6.2. Thematic Analysis

Data was analysed using thematic analysis, which involves identifying and generating themes or patterns across the data. The process involved in thematic analysis is outlined by Braun and Clarke (2006):

1. Reading and re-reading transcripts to become familiar with the data
2. Generating many initial codes
3. Searching for themes within the codes
4. Reviewing and refining themes and testing them out against the extracts as well as the entire data set
5. Defining and naming themes in a way that captures the 'essence' of it

A 'theme' is a pattern or a topic that serves as a summary of the important aspects of the data that is relevant to the research question (Braun and Clarke, 2006; Joffe, 2012). These can be inductive, which means that they are derived from the data itself' or deductive, which means that themes are pre-determined based upon theory.

Thematic analysis can be applied flexibly in comparison to other qualitative approaches, and so is compatible with both essentialist and constructionist epistemological stances; making it very compatible with a critical realist approach (Braun & Clarke, 2006). As a qualitative method, it is more accessible and therefore does not limit the researcher in their ability to apply it.

Themes were derived directly from the data and not based on pre-determined themes; therefore an inductive method was adopted. However, it is important to acknowledge that the research questions and theoretical underpinnings will undoubtedly position the researcher in a way that will impact upon the ways in which the data is interpreted and analysed. Therefore, the themes were both data-driven and impacted on by the researchers' own understanding, values and beliefs about the topic. Data was analysed mainly at a semantic level, deriving themes directly from explicit information in the data. However, there were times when further interpretation was necessary because challenges were not explicitly stated. This could be associated with the nature of how professionals typically verbalise information, with a tendency to speak formally, positively and practically; rather than to highlight and reflect on challenges, particularly at a more experienced level. This is also in line with ideas of social desirability bias (Eysenck, 2004) which illustrates a tendency for people to respond in ways that will portray them in a favourable way. Following this method, themes or patterns were identified across the interviews.

Both teams that have agreed to take part have requested for the findings to be shared with the team at the end of the research study. Therefore, a brief presentation will be developed to share generic themes with both teams, without sharing any identifiable information or associating a particular theme or idea with any particular person.

2.7. RESEARCH QUALITY AND REFLEXIVITY

2.7.1. Research Quality

The constructs of validity and reliability are not applied within qualitative research in the same way as quantitative research. Validity can be viewed as referring to methodological and interpretive validity, rather than internal validity; due to the nature of interviews and the interpretive nature of qualitative research

(Spencer & Ritchie, 2012). Methodological validity will be maintained through careful documentation of the processes, with an awareness of the rationale and the value of the project; and interpretive validity will be upheld through documentation of how conclusions and findings were formed along with the associated evidence from the data.

The concept of reliability within qualitative research is problematic as qualitative research is not intended to be replicated in the same way that quantitative research is. Instead, the reliability of qualitative research evidence can be viewed through the constructs of reflexivity, auditability and defensibility (Spencer & Ritchie, 2012). Reflexivity is key, as it allows the researcher to reflect on the processes of the research, and to consider the impact of oneself on the research outcome. Auditability involves a clear and careful documenting of decisions made during the entirety of the research project. Defensibility is about having a clear rationale for all aspects of the research. Reflexivity, auditability and defensibility will be upheld throughout the timeline of the research project, and to ensure further reliability.

2.7.2. Reflexivity

Schon (1983) highlights the importance of reflecting-on-action (following an event) and reflecting-in-action (during an event) as a means of revising and adapting responses to improve professional practice. This concept can also be relevant in research to monitor and modify responses and actions to enhance quality and reduce potential biases in the data. The importance of reflexivity within research is suggested by Alvesson and Skoldberg (2000) who highlight the continual and bi-directional influences of the researcher and the participant on the research process. They distinguish between reflexive and reflective research, and argue that reflexive research consists of both interpretation and reflection. The concept of interpretation raises awareness of the importance of assumptions, knowledge and language on the research process. The concept of reflection refers to the researcher developing a self-awareness with regard to the impact of their wider influences; such as research or organisational communities, wider society as a whole, and cultural traditions.

Therefore my views and how I have conducted the research is influenced by my past experiences and my assumptions about psychosis and ways of

working; while also influenced by my wider context and cultural and academic beliefs. Having worked in EIPS in the past, the decision to conduct this research was guided by my experiences of and own beliefs about the importance of attending to cultural needs within this service.

Awareness of my own position on the subject allowed me to be aware of my own influences and attempt to reduce biases in the research study. I held the position that an over-emphasis on medical approaches within the area, and an under-emphasis on developing culturally-appropriate ways of working, is problematic. I am not anti-medication and do not oppose medication as a possible option for service users, but my issue is with its presentation as the main or only option of support. I believe that professionals need to value and develop skills in engaging with culture and allowing this understanding to shape the support they offer people.

At the same time, my own experiences of adhering to and promoting medical model understandings of psychosis in the past, made me sympathetic towards the tendency of the professionals in promoting biological and cognitive explanations of psychosis with service users and families. My use of the term 'sympathy' has more to do with understanding that each person's position will vary according to the influences that they have had. Much in the same way that my own influences have shaped the way that I think about and perceive aspects of my work, I acknowledge that other professionals will have their own influences. Some professionals may not be exposed to alternative approaches or ways of working in their practice. In the past, I was not aware of alternative ways of working or modifying support for people to suit their understanding of the world; and equally, I expect professionals to act on the knowledge and experiences they have gained. Therefore, I conducted the research from a perspective of acknowledging the varied experiences and knowledge base of participants; in order to gain a better understanding of aspects of the work that may challenge, and what may assist in developing more culturally-competent ways of working.

These factors undoubtedly have influenced my decision to conduct this particular research project, in how I developed my literature review, the research I have drawn from, the types of interview questions I have chosen to ask, and how I interpret the data.

Having my own position on the topic meant that it was important to remain reflexive throughout the process to reduce biases as much as possible, especially at the stage of data collection. I kept a reflective diary (Appendix L) which allowed me to reflect on my thoughts and feelings during the interviews, and to ensure I did not respond or react in a way that would bias the data, for example, in the way I asked follow-up questions. I found myself noticing and being very aware of my facial expressions during the interviews. Though it was not possible to wholly separate my own views and biases from the analysis and the interpretation; I was aware of and wanted to avoid asking leading questions that would elicit a preferred answer. I also attempted to distance myself as much as possible from my own opinions, through raising awareness that these opinions are a result of my own background and circumstances, just as participants' opinions are a result of their own; and through reflecting on my earlier experiences of subscribing to medical model ways of working, to empathise with this position.

3. ANALYSIS

3.1 THEMES

Five main themes and eight sub-themes emerged from the analysis, pertaining to experiences for Care-Coordination in working with cultural differences in EIPs.

Figure 1 illustrates an outline of the main themes and sub-themes captured from the interview texts. Themes emerged from topics that were most prominent in the conversations, but efforts were made to focus mainly on challenges and learning experiences.

During the analysis, it appeared that many of the themes that emerged from the data overlapped and related to one another, possibly mirroring the complex nature of managing cultural differences within this setting.

The analysis uncovered some subtle variations in participants' accounts between white and black participants. Across the interviews, most white participants tended to present themselves as culturally-appropriate and aware. In contrast, black participants did not appear as cautious, and were more forthright with regard to their accounts of working with cultural differences. No other variations were noted with regard to core profession, or other demographic differences.

To note, pseudonyms will be provided for each extract; however some extracts will be further anonymised to protect the identity of the interviewee. In such cases, "The Participant" will be used in place of the pseudonym. "XXXXX" will be used in place of service names, locations and people's names. In situations where someone uses their own name in their extract, their pseudonym will be used.

The themes and sub-themes will be further elaborated on within this section.

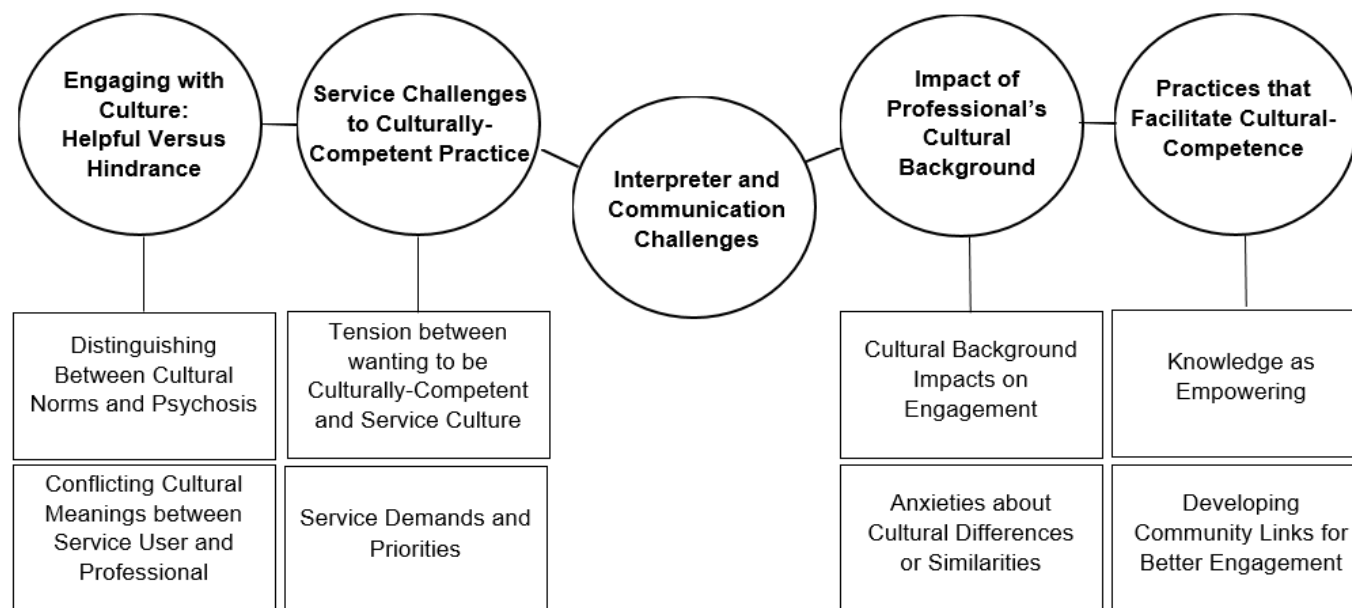


Figure 1 Showing thematic map of Care-Coordinators' experiences of working with cultural differences within EIPs

3.2 THEME ONE: ENGAGING WITH CULTURE - HELPFUL VERSUS HINDRANCE

The first theme pertains to participants' experience of cultural factors being perceived as both helpful and obstructive. On the one hand, participants reflected on the importance of engaging with and understanding culture within their work; however on the other hand, cultural factors were also constructed as a barrier to their ability to work and engage with service users.

3.2.1 Sub-Theme One: Distinguishing Between Cultural Norms and Psychosis

This sub-theme relates to the significance of distinguishing between that which is 'normal' within the service user's cultural context, from that which is symptomatic of a psychosis, which was reflected upon by six participants. There was an emphasis on the distinction being vital to the role of the care-coordinator, due to the potential impact it may have on the person's treatment.

For example, Camilla talked about the need to understand cultural norms in order to define or understand a problem as a psychosis:

It's always quite good to know what's culturally-normal within that specific culture 'cause I guess that's what psychosis is, it's like experiences that do not fit the cultural norm.

Camilla, Lines 619-621.

However, there was also an acknowledgement of the various challenges to the process of distinguishing between cultural norms and psychotic symptomology, highlighting the potential risk of misinterpreting behaviours that are culturally-'normal' as mental health problems. For example, Jenny reflected on an example of a behaviour that she initially viewed as unusual, but that this idea was only challenged or re-considered in light of further cultural information. This was provided to her by the service user himself, in response to her body language:

I have an Afghani man that I'm working with and he talks about things and it's very difficult for me to unpick if that's, kind of, culturally-appropriate or if it's him acting in a way that's bizarre... He wouldn't sleep on the bed. He had a separate mattress and he'd put it up against the wall and I said, this is very odd behaviour and then it actually turned

out that it's because if he had the bed out so he could use it, he didn't have space to pray so, having room for his prayer mat was far more important to him than sleeping on a bed... / Int: Where did you learn that then, that he / He told me. 'Cause I must have pulled some kind of face and he's like, oh yeah that.
Jenny, Lines 144-146... 150-154... 158-159.

Participants were also able to reflect on times that other professionals in the team have misinterpreted culturally-normal behaviours as a psychosis. This suggests that the task of differentiating between that which is culturally-normal and that which is a psychosis, is a complex and challenging one; even though it is deemed vital in the process of appropriately understanding people's behaviours.

For example, Paula talked about the different perspectives of people and the impact this has on how they perceive spiritual beliefs and whether they deem them to be a symptom of psychosis or a cultural norm:

I'm just sort of aware that people are coming from quite opposite sort of views. Some people pathologising people's spiritual beliefs and just assuming that they're psychotic, and then occasionally, you know, I might say something or someone else might be confident enough to sort of challenge that.
Paula, Lines 210-214.

3.2.2 Sub-Theme Two: Conflicting Cultural Meanings between Service User and Professional

In the previous sub-theme, there appeared to be some recognition that cultural meanings and norms needed to be recognised and explored in order to ensure culturally-normal behaviours were not pathologised or viewed as symptoms of psychosis. Despite there being a sense that this task was challenging but vital, many professionals appeared to perceive cultural factors as obstructive in their work with service users.

Eight participants talked about service users' cultural beliefs about psychosis being contradictory to the explanations and treatment offered by the service, posing a challenge as service users deemed the support that was on offer from EIS to be inappropriate:

Some people are very fixed that medication isn't going to fix it and it's definitely a demon or it's definitely a curse or it's definitely God speaking to them or they are definitely [laughs] Lord Sainsbury or Batman or whoever.

Jenny, Lines 315-315.

There appeared to be a marked distinction between the professional's cultural meanings and the service user's understanding of their difficulties. This posed a barrier for professionals, who often viewed difficulties from a medical model understanding, with a focus on symptoms and medication; versus the cultural explanations offered by the service users, centred on spiritual ideas. However, this appeared to be constructed in a manner that positioned the professionals' view as the 'correct' view, and the service users were perceived as people who do not believe or accept the 'truth' of their psychosis.

For example, Stephanie talks about service users who do not engage and do not accept the appropriate treatment as a result of their spiritual beliefs:

It's caused by evil spirits or that psychosis is being controlled by somebody, has got the power to make somebody to be psychotic. And of course with that kind of belief then, which makes them to believe that medication will not help a lot to control the psychosis, they tend to seek for spiritual healing in the churches in order to manage the psychosis. They are the ones that would not take medication that has been prescribed according to the way it's been prescribed, there tends to be a tendency to take it whenever they feel like but not following the regime as we prescribe. That's my experience.

Stephanie, Lines 9-21.

Furthermore, there appeared a greater need to engage family members within EIPs. Participants reflected on the feeling that service users were often ambivalent about whether to engage with services, but that they were being influenced not to engage by family members, who held different cultural meanings about the problem and appropriate solutions:

We're going in kind of prescribing this medication and the parents are saying well you don't need it and then they're influencing over us.

Lisa, Lines 8-9.

Participants reflected on it feeling as though engagement was a lengthy and time-consuming process of having to convince not just service users, but their

families too, about the 'correct', medical model approach, in the hope that they will eventually accept the 'truth'. Two people compared the process to coming to terms with and gaining help for drug addiction; where people are worked with over time and slowly come around to the idea:

I mean like any other type of belief that has been ingrained over time, the person will try to explain to you about why they're believing what they're believing so there will be that non-acceptance of your views initially but then using it depends then on the person who is delivering that psychoeducation and if you sound very convincing and compelling evidence that will start some kind of a process of listening, a process of wanting to believe, a process of [inaudible], a process of increased engagement and then before they perhaps then find out that what you're saying is true, so almost going through some kind of cycle from pre-contemplation to contemplation to wanting to work with you until they find out after they have tested what you're saying, find out that actually this could be real.

Stephanie, Lines 293-303.

Participants felt that as a result of holding different cultural meanings about psychosis, and therefore rejecting the medical approach and need for medication, this led to greater chronicity, poorer outcomes, and delayed engagement. It was felt that service-users engaged only as a last resort, when the situation had become chronic or when families witnessed a positive response to medical treatment.

I think that sometimes, once the child's been in hospital I think that's when they start to clock on that 'maybe my child is unwell', you know it takes something bad to happen sometimes for them to think ah ok maybe my child is unwell

Lisa, Lines 78-81.

I think in the end the family came round to the idea to at least give it a go / Int: Yeah / and take the medication and see if it helps / Int: What helped them to get to, sort of, come around to the idea? / I think unfortunately the fact that she didn't get any better through the religious treatment and that the medication, when she was on the wards, seemed to help

Tina, Lines 147-152.

Participants highlighted that cultural meanings influenced where service users sought support from within their own communities, some of which were perceived by staff to be negative and unhelpful, such as instances where service users have been subject to abuse within their communities. This sometimes led to anxieties about the impact of cultural practices and the

community on the service users. For example, participants held anxieties about families taking service users abroad, what this may involve and whether service users would be harmed by this. These anxieties sometimes led to cultural assumptions being made.

And you're wary of a long holiday abroad because what does that actually entail and is the young person gonna be more traumatised? It has happened in our service that the person's been taken away apparently on a holiday to be seen by a leader and you don't know and you're very fearful of what that would entail and the impact that'll have on their mental health

Claire, Lines 86-90.

We talk about a parent who wants to discharge their child / Int: Mmhmm / And take him back home to India. No not India, Sri Lanka. And they haven't told you that the aim of them discharging their child is to go and marry them off / Int: Okay / But we can tell. We can. It's not good to judge but have to be wise as well. Okay, so the team had to then decide if it's a potential safeguarding issue, because dealing with somebody who is mentally unwell, so they're quite vulnerable.

Sheila, Lines 408-415.

3.3. THEME TWO: SERVICE CHALLENGES TO CULTURALLY-COMPETENT PRACTICE

This theme relates to the challenges and barriers produced at a service-level. This refers to the culture of the service, particularly with regard to it functioning from a medical model perspective; as well as service demands and priorities that pose barriers for culturally-competent practice. This presents a potential incompatibility between the ways in which the service operate and the cultural beliefs and values of the service users.

3.3.1. Sub-Theme One: Tension between wanting to be Culturally-Competent and Service Culture

This sub-theme pertains to the tension that exists for professionals who aspire to practice in a culturally-competent manner; however find that there are limits in their ability to do so. This may be partly influenced by the service culture, which is built upon a medical model understanding of psychosis. There appears a contradiction between the aim of wanting to be culturally-competent and in the way the service operates and the outcomes that exist for people who prescribe to non-Western cultural understandings of their difficulties and associated

solutions. While service users' understanding of their difficulties are regarded important and acceptable, there appear to be paradoxical consequences for them, as a result of their non-acceptance of the 'truth'. This 'truth' being that they are experiencing psychosis and require medication in order to alleviate their symptoms. This places emphasis on the influence the medical model approach has within the culture of the service, which may place a barrier on care-coordinators' abilities to practice in a culturally-competent manner.

Most participants evidenced attempts to be culturally-competent. One prominent example of attempts to do this, regarded using terminology and directing goals that were in line with the service-user's cultural beliefs and values.

I can tell people it doesn't really matter what you call it, you can call it psychosis, you can call it whatever you want to call it, but what I think you need to recognise is there is a problem here. If somebody is not able to achieve their objectives in life, what their goal is, somebody, something, is stopping you from having happiness and completing your studies as it were.
Stephanie, Lines 54-59.

It was discussed by two participants that psychosis as a concept was unclear and that no one truly knew what caused it, suggesting that alternative ideas exist and should be taken seriously:

Just, you know, it's important to be able to be open, to take on board other people's views and, you know, to listen and to share and to do things in a collaborative way / Int: Yeah / rather than telling people what to do or what the problem is, cos you know, do we really know what causes psychosis?
Tina, Lines 72-77.

However, participants also indicated that ultimately there were consequences for people who did not prescribe to the medical model understanding of their experiences, as highlighted by six participants. For example, Camilla shared an experience of someone who had to receive emergency ECT, and would not have had to endure this experience had he accepted that he was ill:

He ended up having, he got so psychotic, he was so unwell, he ended up having to have emergency ECT like / Int: Oh Gosh / electro convulsive therapy, under some obscure section of the mental health act ... you do care about them, and that's really hard to see him go through that and you kind of think urgh if only you just accept that you were, not accept

that you're unwell, that sounds really harsh, but accept that this isn't a spiritual witchcraft thing this is. Or maybe it was, maybe there would have been a better way of working with it
Camilla, Lines 552-556... 561-564.

Lisa shared a similar experience, in which she felt that a poor outcome could have been prevented had the service user accepted that they had psychosis and engaged with services:

Someone was acutely unwell and it warranted a mental health act but that could've been easily prevented, you know they could have gone on to home treatment team, wouldn't have needed to lead to a mental health act if their family, I mean the individual had no insight, no understanding, was paranoid, delusional, really really acutely unwell, needed admission and the family still continued to dismiss it, they could contain it in the family home, they'd be able to deal with it and that's a difficult thing.
Lisa, Lines 151-157.

3.3.2. Sub-Theme Two: Service Demands and Priorities

While the service is guided by a particular culture, with regard to its beliefs about psychosis; there also exists particular practical, legal and other demands and priorities within the service that may place limits on how able professionals feel to attend to people's cultural needs. Five participants made references to these limitations, highlighting an incompatibility between the service structure and the cultural needs of the service users, as the service demands appeared to supersede the cultural preferences and values of the service users.

For example, Camilla reflected on a service-user who was unable to make a decision without her husband and other male members of the family present for cultural reasons. Camilla felt that she could not attend to a service-user's cultural needs due to time limitations and requirements of the service; leading her to make attempts to strike a balance between the service priorities and the service users' cultural needs:

I think the really difficult time was I had to go and do a mental health act tribunal report with her and then there was like legal requirements around that and you have to do it within a certain time and if you don't, you get fined and it's awful so I knew I had to go see this lady and I knew her husband wouldn't be there so it was quite a difficult interview and I said, look, I appreciate this is, and you kind of acknowledge that and you reflect that back and say look I know this isn't ideal I will speak to him, it's

unfortunate that your husband isn't able to be here 'cause he's at work, I am gonna speak to him and I will be taking his views into consideration.
Camilla, Lines 53-61.

There was a sense that within EIPs, mental health is often prioritised at the expense of cultural needs. Therefore, as a result, services are deemed to not be fully equipped to meet the cultural needs of its population. For example, Paula and Gemma discuss the preoccupation with mental health within services, with little attention being paid to cultural needs which are also important:

I think it's partly that I'm not making time to actually cover that area and also it's quite easy to just get side-tracked and preoccupied in terms of the person's psychosis really, but obviously, as I said at the beginning, quite often you know how someone's psychosis presents is influenced by and expressed sort of out of the cultural background that they're from and the beliefs that they hold
Paula, Lines 395-399.

Yeah. I don't think we do that enough here. I don't think we know enough about what the Asian's women's projects are or we don't make enough referrals to culturally-sensitive services, to services that meet client's, you know, diverse needs. I don't think we do enough of that. We make very generic referrals to mental health services, it's almost like they come into us for help, we then refer them to, it's almost like everything's about mental health
Gemma, Lines 561-566.

There was a sense that there were not enough resources available for care-coordinators to seek advice about working with people from cultural backgrounds. For example, Claire reflected on how time-consuming it can be to look for organisations that can support professionals in working with people from other cultural backgrounds. It was felt that if a supportive service was readily available and known, it would be easier to access it:

You could ask for advice from cultural agencies I guess really. I haven't to be honest. I would normally go to my manager and I'd ask safeguarding. 'Cause it's time-consuming as well. Not being rude but it's time consuming to be looking, if it was available then yeah fine, if XXXXX provides a service that you can access instantly, great. They may well do but I haven't found it
Claire, Lines 124-128.

There was a recognition, in both teams, that there was a need to improve the cultural-relevance of services; however some identified that culture was

something that was not viewed as valuable, and any attempts to increase its value or to draw community links were not followed-up due to lack of resources and time. For example, Paula talked about there being a lack of value with regard to culture:

I suppose it would be great if there was a higher profile in terms of the department within the trust. I know that I used to volunteer quite a while ago with the spiritual religious cultural care department in the hospital. I know that they were trying to sort of form links with community teams, but you know, it's all about sort of funding and time and the amount of people that she had on the staff really, and relying on volunteers and so there were attempts to have link people in various wards and try and sort of tentatively have like an interest group, I suppose, and invite people from the community teams to – and nothing's really gotten off the ground as far as I'm aware anyway
Paula, Lines 247-255.

3.4. THEME THREE: INTERPRETER AND COMMUNICATION CHALLENGES

Another theme refers to the challenges associated with communication and working with interpreters, as discussed by six participants. While many professionals reflected on attempts to work effectively with interpreters; many highlighted challenges they faced in doing so. Many of these further interfered with their ability to assess, understand and work with people who may be experiencing psychosis.

Regardless of efforts to reduce barriers associated with using interpreters, for example booking known interpreters or repeating phrases in different ways, participants experienced a lack of control with regard to ensuring information was accurately interpreted. Instead, they could only try to remain optimistic that the interpreter was accurately representing the service user's views, as well as their own:

To be honest, I didn't feel like I really could say anything, and I just had to trust that they were interpreting accurately what the client's family were feeding back to us
Paula, Lines 39-40.

A few participants raised issues about boundaries and confidentiality in the context of working with interpreters within psychosis services, particularly as confidentiality issues may have social consequences for service users within

their community. Jenny specifically discussed facing a dilemma between wanting to ensure confidentiality but also wanting service-users to feel able to adequately communicate and understand information. The solution appeared to be a clinical decision about that particular service user and what would be best for them:

I do spent a lot of time tying myself in knots about what's going to be better for the client, is it better that I bring somebody that they have a shared language with and that they can hopefully get more of what's going on for them across, or is it better that we battle through with, you know, broken English and gesturing because I only speak English unfortunately, and keep it a more confidential conversation
Jenny, Lines 426-431.

Some of the challenges faced when working with interpreters were with regard to practical challenges. For example, Claire discussed the impact of using an interpreter on the length of sessions:

There's too much of a delay, or you're not quite sure. / Int: Yeah, what do you do about that? / Well I ask and I re-ask and I re-word my questioning and I go over the whole thing again and it takes an awful lot of time
Claire, Lines 32-35.

Additionally, the process of understanding and attributing people's experiences to psychosis requires the ability to assess speech and thought content. However, this process seemed to be compromised by communication and language barriers. For example, Claire talked about how using an interpreter made it more difficult to assess symptomology as a result. She also argued for the need for interpreters who have a good understanding of mental health:

It's inevitable that the whole interpreting service and the whole delay really delays and prolongs the progress really and you're getting delayed responses so you're not yourself assessing a patient's quality of speech and their thought content so you really need to have a good interpreter that knows what they're doing
Claire, Lines 50-54.

However, there were also reflections about making use of interpreters as cultural advisors, to make sense of cultural norms and behaviours; in order to aid professionals in their understanding of the service user:

If you had an interpreter specifically for the client, you would ask the interpreter, you know like is that again culturally normal? Did they respond in a way you would expect somebody from your own culture to respond? How were their word finding? You know, what was their kind of educa- you know like with the guy that we were talking about, before he didn't speak any English, he you know like, we'd check with the you know is his words consistent with his presentation? You know cos they can pick up on bits and pieces that we might not be able to and so I think a good interpreter will let you know that
Camilla, Lines 911-918.

3.5. THEME FOUR: IMPACT OF PROFESSIONAL'S CULTURAL BACKGROUND

This theme places emphasis on professionals' own cultural backgrounds and how these contribute to the ways in which service-users relate to them, but also, in turn, how they relate to service users.

3.5.1. Sub-Theme One: Cultural Background Impacts on Engagement

This sub-theme highlights the extent to which professionals' own cultural backgrounds have an influence on how service users relate to and engage with them, which was discussed by seven participants. In some cases, being of a culturally-different background was a barrier to engagement; whereas in other cases this was deemed helpful in the engagement process. Equally, some found that cultural similarities with service users posed challenges for engagement in some instances; however was useful in other instances.

With regard to cultural differences, participants felt that this impacted on service users' sense of feeling understood. For example, Claire reflected on visiting a family from a very different cultural background; and feeling unable to relate with and engage them:

There have been occasions when you wanna attend a house and they look at you like you're an alien because you simply have no understanding of where they're coming from. I'm not just talking about Asian and African cultures, I'm talking about Irish travelling cultures. You know people that have very indoctrinated beliefs and it's very much 'but this is the way that we are. You wouldn't understand it. You have no idea about how we are. This is the way that we live. This is our lifestyle. This is our choice'. And yeah they'll be very clearly saying 'what you're saying is all very well but we think differently'
Claire, Lines 135-142.

In contrast, it was felt that cultural similarity posed a barrier in engagement, due to service users experiencing a lack of trust and fears about being judged by professionals. For example, Gemma shared how her own cultural background influences the ways in which service users from similar cultural backgrounds perceive her. In this example, she described the worries some service-users experience with regard to feeling judged or viewed negatively by her:

I mean I've seen some XXXXX girls where they're doing stuff that's contrary to their own culture, they sometimes don't want to work with you if they're aware of that. They feel like you're going to be judgemental or sometimes they ask you before, 'will you judge me if I tell you that I smoked weed with my friends yesterday?' You're like 'why would I? Why would I judge you?' And sometimes it's [laughs] about showing them that it's very normal and it's as normal as it isn't, it's about showing them actually what you're doing is actually quite normal
Gemma, Lines 324-330.

For those service users who felt unable to work with professionals from similar backgrounds, this meant that cultural differences sometimes aided engagement, as it meant service-users felt less concerned about being judged or felt more able to trust professionals. Vicki gave an example of when her cultural difference aided the engagement process, particularly in relation to working with someone who felt she could not trust other Africans as she feared they would use black magic on her:

She prefers to work with white people and she didn't want to work with any Africans because she didn't trust them because of black magic, so it was it would have been quite difficult I think to get to involve anybody who had maybe a better understanding of that because actually that might have been somebody who she then didn't trust at all
Vicki, Lines 339-344.

However, there were also instances in which cultural similarities aided engagement. Participants reflected on occasions when service users felt a connection with them or felt understood by them due to their cultural similarities. Tina gave an example of this:

She used to get quite angry with the way he was being treated and I remember there was one ward round and she was shouting at all the doctors and everybody saying, 'you lot you don't understand what it's like for us you don't know what it's like for us but Tina does' and that's me
Tina, Lines 163-167.

3.5.2. Sub-Theme Two: Anxieties about Cultural Differences or Similarities

On some occasions, the cultural background of the professional had a direct influence on how service users related to and engaged with them. Conversely, professionals' cultural backgrounds also impacted on their own anxieties about engaging with service users, as discussed by five participants.

As mentioned previously, service users may sometimes disengage from culturally-similar professionals due to fears about trust and judgement. This recognition sometimes appeared to have an impact on participants' anxieties about engaging with those from a culturally-similar background. For example, Sheila reflected on anticipating difficulties when receiving a referral of someone who she identifies as culturally-similar based on their name, which causes her to feel anxious about working with them:

If I have that feeling already, I'm really nervous and apprehensive going in to such situations.
Sheila, Lines 81-82.

Participants talked about the importance of being open and feeling able to ask questions associated with service users' cultural backgrounds. However, participants, from a culturally-different background to service users, felt unable to challenge or question particular ideas of a cultural nature, due to fears about coming across discriminatory. This may potentially limit care-coordinators' understanding of these beliefs, or they may risk missing out on understanding and tackling issues that they may perceive as harmful or unhelpful for the service-user.

For example, Camilla reflected on a challenging situation in which a service user was receiving unhelpful messages from her church, saying that her child's physical illness was a punishment from God. Instead, her focus was to be consistent and have a positive relationship with the service user, without questioning or commenting on the messages she viewed as unhelpful:

You can't say that's nonsense, of course not, because that's not gonna help you work with them.
Camilla, Lines 106-107.

Claire described the need to seek advice in order to be careful not to appear discriminatory. This is in relation to addressing an issue linked to families taking service-users abroad:

You've got to tread very carefully 'cause culturally you don't wanna upset people. You can't be seen as being racist and certainly not discriminatory in anyway, so it becomes a very challenging issue really
Claire, Lines 107-109.

On the other hand, participants, who were from a similar cultural background to the service-user, felt more able to be challenging, making use of cultural knowledge that is available to them. For example, the participant below talked about feeling able to challenge ideas by making use of cultural knowledge available to her:

I do accept this, however even in the Qur'an, even in books that you're reading, it does say that treatment also works but making sure it also works for such disorders, so just that educating them but coming from a cultural perspective. And using their own understanding around that.
The Participant, Lines 66-70.

3.6 THEME FIVE: PRACTICES THAT FACILITATE CULTURAL-COMPETENCE

Participants made reference to practices that helped or could help to facilitate culturally-competent practice. Of the topics discussed, what seemed most pertinent was the value participants placed on the role of cultural knowledge and of developing links with the community, in supporting them to practice in a more culturally-competent manner.

3.6.1 Sub-Theme One: Knowledge as Empowering

The challenges discussed previously have brought to light various factors that may place barriers on culturally-competent practice within EIPs. What may be essential as an underlying factor contributing to some of these challenges may be associated with a lack of cultural knowledge. Participants reflected on there being a need for more knowledge, in a variety of capacities, to improve professionals' understanding and appreciation of cultural differences; reduce the chance of misinterpretations, and reduce anxieties about working with

cultural differences. All participants highlighted the value of cultural knowledge in some form.

While participants valued the knowledge they have gained thus far, there was also an indication that more knowledge was required. For example, Gemma shared that efforts are made by the NHS to ensure services were culturally-adept, through providing interpreters and a diverse workforce; however felt that this was simply not enough and there was a need for training and knowledge to enhance the cultural-competence of the service:

I mean, what they tend to do really, the NHS has this plan of using workers that meet the demographic need of the area, but I don't think that's enough... 'Cause I think we're so engrossed in what we're doing, we don't take time out to think 'ok actually' 'cause you will assume you're meeting the needs by having an interpreter present and I don't think that's enough for people. I don't think there's much training that's been given to us about meeting cultural needs and different cultures.
Gemma, Lines 535-537... 602-606.

Participants valued the training they had received but many participants felt they had more training needs and there were aspects of culture that were neglected, that may interfere with their ability to work with people for whom these issues are important. For example, Claire raised Forced Genital Mutilation (Claire, Line 270) as a potential issue she was not confident in addressing; and Vicki raised black magic as something that “isn't massively one that gets talked about” but that it would be a “useful CPD to have eventually (Vicki, Lines 359-363).

Participants referred to knowledge as something that can be gained from various sources, including training, supervision, the internet, colleagues, the community and service users. For example, Tina talked about using existing support within the community to gain knowledge about cultural treatments and understand how it interacts and interferes with the treatments offered by the service:

We got the Chinese mental health association involved, based in Bethnal Green, and then we had the Vietnamese mental health association I think it's based in South East London they might provide interpreters, not just there for interpreting but for giving us advice about cultural and religion / Int: So is it quite easy to access these kind of things? / Yeah. I remember one person was telling us all about alternative types of medication and herbs and stuff a Vietnamese patient was using, and that was quite useful, cos the doctor wanted to know about that and if it would

clash in any way with the prescribed medication and things like that
Tina, Lines 242-251.

The examples in previous themes demonstrated various challenges professionals faced when working with service users of various cultural backgrounds. Participants talked about the usefulness of gaining knowledge about culture, but also about gaining confidence in and feeling able to engage with culture effectively.

For example, an earlier theme highlighted the challenges of adequately distinguishing between cultural norms and psychosis, which may be associated with a potential lack of knowledge about cultural norms. Participants felt that this knowledge supported them in accurately making inferences about service users' behaviours:

I will often say 'is this the norm?' or 'how is this?' or 'how would this work?' and 'well actually in Africa that does happen' or 'in Bangladesh that would be the norm' because I don't know and I'm the first one to put my hand up and say 'I don't understand, can somebody explain this to me?' / I: Yeah. And does that change how you then work with them? / Yeah absolutely, on advice, because you don't know what's a psychosis, what's an abnormal family relationship and what's actually culture.
Claire, Lines 180-187.

In addition to making use of cultural knowledge to support understanding, it was also highlighted that knowledge can also support professionals' confidence in engaging with culture; for example in helping professionals to feel able to challenge particular cultural ideas or ask particular questions. It was felt that feeling able to engage with culturally-different colleagues allowed professionals to feel more confident in engaging with culturally-different service users:

My young lady from XXXXX was a very devout [Muslim], her fasting is incredibly important to her so we ended up having a really prolonged conversation about medication because she'd become very acutely unwell relatively recently again, and I was like, you know, 'it's not my background and I don't really understand it, but I'd spoken to my colleagues and I understand that you are in a position where you can choose not to fast while you're on this medication and you can make it up late' and you know being able to go to a source to have a bit of knowledge behind it so then you feel comfortable enough to start that conversation
Jenny, Lines 385-392.

These examples also highlight the importance of having a diverse workforce as a source of knowledge to support staff in understanding but also gaining skills in engaging with culture in their work. Moreover, it was recognised that a diverse workforce can also help to keep in mind cultural factors, as these can be missed in a non-diverse team. One team regarded themselves to be culturally-diverse; however the other team did not. It was raised that in a non-diverse team, there was a risk of not attending to particular cultural needs, as the professional cannot relate to and therefore hold in mind these issues. The importance is stressed about the use of a diverse workforce to keep cultural issues in mind:

I'm sure there's lots of stuff I'm thinking of, you know, that I've missed or I haven't been aware of that may well have affected my interactions or my relationships or my care, but as I've not been aware of it, it's just slipped through the net if you know what I mean

Tina, Lines 412-415.

I definitely can sort of forget sometimes a few things that might be important, particularly with regard to religion because I'm not religious and it's not always something that's at kind of the forefront of my mind, unless it's kind of quite obvious or you know someone's talking about it and it's quite overt then I wouldn't always remember to address it

Vicki, Lines 416-421.

3.6.2. Sub-Theme Two: Developing Community Links for Better Engagement

There has been evidence to suggest that developing community links is useful in improving knowledge. Additionally, eight participants highlighted the value of developing links with the community in facilitating the service user's engagement with the EIPS. Although some participants constructed cultural factors as unhelpful and obstructive in the engagement process; there appeared some acknowledgement of the community as a useful resource in supporting service user engagement within EIPSSs.

Some participants were able to reflect on experiences in which members of the cultural community of the service user had been useful in supporting the aims of the service. For example, Sheila reflected on an experience that involved a constant, unsuccessful attempt to convince a service user's mother that the service user was unwell and needed to take medication and therefore could not

fast. This was only resolved when the family went to seek clarification from an imam who was able to provide advice that elicited engagement:

I kept going on over and over and over again and eventually I think he went to see his imam and imam said to him, you can be exempted because you're unwell and then mum agreed that he cannot fast.
Sheila, Lines 317-319.

Tina provided another example, and talked specifically about an experience in the wards, alongside an imam, which allowed for a compromise to be made with the service, to support both the mental health and the cultural needs of the service-user:

Well again the imam would talk to the service users about them being able to take medication if they're not well, during the fasting time, you know, or you might look at people having medication after iftar, so that, you know, having their medication then so that they can fast and take it after they've eaten food.
Tina, Lines 263-266.

There was a recognition that the community were a trusted source from which many service users seek support. For example, Gemma highlighted that service users were more likely to seek support from members of the community than from EIPSSs, and felt it was necessary to utilise this in a way that will improve their engagement with service users:

And it's about having training for the priests and having training for, you know, the leaders of the temple, and those things and just and even having links to them, for example if they're seeing somebody in and they see that this person's in crisis, like the GPs do, they can ring us to say that, you know, 'I've seen this person', 'cause we have to understand that a lot of these people are carers who actually go to these people to get counselling more than they come to us, so it's just about understanding that we're working with those people closely, yeah
Gemma, Lines 591-597.

The value of linking in with the community was not just with regard to directly linking in and making use of community support, but participants also reflected on the need to be aware of local existing community resources that were available for people, to improve the services ability to better attend to cultural needs:

Well I mean there has to be a case for understanding of what is out there, the communities specific to people from a different culture in the work we do.

Stephanie, Lines 482-483.

4. DISCUSSION

4.1 SUMMARY OF FINDINGS

This research study aimed to explore Care-Coordinators' experiences of working with service users and families who come from a different cultural background to their own, within EIPs in London. The aim was to better understand cultural issues that are most pertinent for Care-Coordinators that may significantly impact on their ability to practice in a culturally-competent manner. This is of particular importance due to the complexities in distinguishing between cultural phenomena and culturally-defined psychotic symptomology. The study sought to explore learning experiences and challenges to provide insights into practices that may help to facilitate culturally-competent practice and reduce barriers that may impede on this.

The discussion will be structured according to the themes that emerged from the interviews. While the research questions helped to shape the research, it was felt that structuring the discussion according to the interview questions would prove to be too broad and would not elicit a specific enough focus on the findings that emerged from the data. It was also felt that presenting the discussion in this way would allow for a direct contrast between the specific findings of this research study with existing evidence.

It is important to note that both services appeared to vary in terms of their client demographic and the resources available to them. Equally, the findings may not extrapolate to all EIPs but highlight some potential challenges and learning experiences that may be relevant in other services. Furthermore, much of the existing research that explores professionals' experiences of working with cultural differences are with regard to working with immigrants (Giacco et al., 2014; Sandhu et al., 2013); however, within the context of London, professionals face a rich diversity of service users, some of which may not necessarily be immigrants themselves, however may have been born and bred in London; with both Western and Non-Western influences. The results highlight some key findings, some of which echo the existing research evidence.

In summary, care-coordinators both valued and were challenged by service users' cultural beliefs, values and norms. It was found that cultural factors often led to a challenge in disentangling psychosis symptoms from cultural factors, leading to misinterpretation. While care-coordinators appreciated cultural beliefs, they relied upon the medical model as certainty and so these beliefs were in some ways seen as interfering with the engagement process and with treatment. Attempts to practice in a culturally-competent manner appeared limited by the service culture, which is centred upon medical model understandings of psychosis, and mean that those service users who hold alternative explanatory models of psychosis may experience negative consequences as a result. Further barriers were caused by the demands and priorities of the service which superseded attention to cultural needs. Care-Coordinators experienced challenges in communication and in working with interpreters, which posed further barriers in their understanding and ability to engage with service users. Care-Coordinators also reflected on their own cultural backgrounds as influencing on how service users interact with them, and in turn, how they interact with service users. Enhancing cultural knowledge and developing links with the community were deemed positive in facilitating culturally-competent practice.

4.1.1 Engaging With Culture: Helpful Versus Hindrance

Within the interviews, engaging with and understanding cultural factors were presented as essential and useful in the engagement process, with regard to understanding and ensuring accurate interpretations of service users' behaviours. This reiterates advice given by the DSM-V about the need to conduct a culturally-appropriate assessment of psychosis (APA, 2013). Care-Coordinators experienced a challenge in making a distinction between culturally-normal behaviours and signs of psychosis, mirroring existing research that highlights similar challenges for professionals in the context of working with immigrants experiencing mental health difficulties (Sandhu et al., 2013). Care-Coordinators within this study further highlighted the consequences these challenges may have on how they respond to and work with service users; for example pathologising behaviours that are normal within the cultural context of the service user. This is in line with existing service user perspective research. For example the concept of *Cultural Exclusion*, as highlighted by McClean et al.,

(2003) and supported by Bowl (2007b), illustrates service users' experiences of feeling misunderstood and misinterpreted by professionals, and other research has illustrated that this may lead service users to withhold information due to fears about their cultural beliefs being pathologised (Islam et al., 2015). This has been conceptualised as an issue on the professionals' part in understanding the person and their culture (Islam et al., 2015; McClean et al., 2003; Penny et al., 2009). Evidence suggests that an inadequate culturally-appropriate assessment is likely to produce misdiagnosis (Adeponle et al., 2012). Care-Coordination in this study recognised the impact of this challenge on the risk of making misinterpretations; however, they did not speak directly about misdiagnosis as a consequence.

Furthermore, Care-Coordination discussed the impact of conflicting cultural meanings about psychosis, between themselves and service users, on their ability to engage service users. This mirrors existing research that highlights similar challenges within the immigrant population (Giacco et al., 2014; Sandhu et al., 2013). Psychosis is conceptualised differently across cultures (Ellis, 2015; Jobanputra & Furnham, 2005; Krause, 1989; Lin, 1981; Malik, 2005; McCabe & Priebe, 2004; Penny et al., 2009; Sheikh & Furnham, 2000). Service user research highlights that the meanings service users hold about psychosis may impact on where they seek support from; which may lead to different and often more negative pathways in care (Islam et al., 2015; McClean et al., 2003). Care-Coordination in this study also made reference to this, in the context of viewing these behaviours as obstructive in their practice. Despite viewing the need to understand and engage with culture as vital, what was highlighted as the 'problem' was essentially the service users' cultural beliefs themselves. Professionals viewed the problem as a failure by service users to accept the 'truth' of their difficulties and their need for medication; and portrayed these cultural beliefs, values and norms as leading to poorer outcomes.

The medical view appeared to be constructed as the 'correct' view, highlighting how dominant the role of the medical model is within EIPs, and how incompatible belief systems lead to professionals experiencing the service users' beliefs as problematic. This is consistent with experiences of family members from Pakistani backgrounds who associated EIPs with a place where medication is provided (Penny et al., 2009); despite the claim that EIPs

aim to function holistically (Shiers & Smith, 2010). While evidence suggests that those who hold spiritual views about psychosis, may accept holistic forms of support that include medication in addition to other treatments (Penny et al., 2009), most Care-Coordination did not appear to experience spiritual beliefs in this way and instead experienced them as obstructive.

Care-Coordination shared the feeling that they had to take time to convince service users that they have psychosis, despite evidence suggesting that psychosis as a concept can be problematic and impact negatively on engagement (Kleinman & Benson, 2008; Penny et al., 2009; Wheeler, 1998). In comparison to existing research, the findings highlighted an additional layer of complexity in engaging service users in EIPs due to the additional need to engage family members, and feeling that often service users were influenced by them. Care-Coordination felt they had a role in engaging family members in order to engage the service user. Evidence suggests that families of service users in EIPs do not feel valued by professionals and report that they are not kept informed and involved in their loved one's care (Penny et al., 2009). However care-coordination in this study appeared to disagree as they felt that they made great efforts to engage family members. These differences may be as a result of professionals' perceptions of their efforts being different to the ways in which families experience services. Alternatively, this may highlight that Care-Coordination are engaging in more family-oriented support more recently. Nevertheless, both appear to emphasise the importance of working with families.

4.1.2 Service Challenges to Culturally-Competent Practice

In this study, various service challenges were presented alluding to factors that may restrict professionals' attempts to be culturally-competent. Generally, professionals expressed a desire to practice in a culturally-competent manner. There appeared an intention to use terminology and develop goals that are in accordance with the service users' cultural beliefs and values. This is consistent with research that emphasises the importance of collaborative practices (Logan, Steel & Hunt, 2014) and using culturally-appropriate terminology (Kleinman & Benson, 2006) to aid engagement.

However, ultimately these cultural beliefs were still experienced as 'incorrect', leading to poorer outcomes for service users as a result of 'non-acceptance' of their psychosis. There appeared to be a tension between the service culture, which was centred upon medical model ideas; and the service users' culture which were centred upon spiritual ideas. Therefore, presenting a potential issue in the compatibility of services for service users who hold non-medical cultural views about psychosis.

Wheeler (1998) reflects on a lack of cultural-competence in service provision, in the way that services operate and practice according to Western ideas, and the influence of western ideas on service provision is often not recognised (Fernando 2009; Kirmayer, 2012; Thomas et al., 2010). There appeared to be a strong influence of western ideas within the EIPSSs, and very little recognition of this influence by Care-Coordination who often viewed it as the objective truth. The lack of cultural-relevance in services may limit attendance to cultural needs and may be inherently detrimental for people of non-western backgrounds. As a service that is recovery-focused and aims to improve service users' social situations, it seems contradictory to offer treatment and solutions that may undermine their recovery in the context of their culture. For example, in the situation where a female is unable to attend to her culturally-valued role as a mother due to the side effects of medication or due to being hospitalised. This is in line with the concept of *institutional exclusion*, as highlighted by McClean et al. (2003), suggesting that standardised treatment may not be relevant for the culturally-diverse populations that they serve. This aligns with the idea that the medical culture of EIPSSs pose issues in the compatibility of services for people who hold contradictory meanings about psychosis. In the results, Care-Coordination were able to give examples of detrimental consequences to 'disbelief' in the medical system, for example emergency ECT treatment as a result of not accepting the medical view. This alludes to EIPSSs as an incompatible system for those who hold non-western beliefs.

In addition to the culture of the service, service demands and priorities may place further limits on Care-Coordinator's ability to act in a culturally-competent manner. This is in line with evidence showing that despite acknowledging the need to understand cultural beliefs and norms, professionals may prioritise risk and service demands over cultural-competence (Colgan, 2015). Mental health

taking precedence over cultural needs may be associated with the demands of the service, but may also be associated with it not being deemed “high profile” enough. Notwithstanding the recognition of the significance of understanding and engaging with culture expressed by the Care-Coordination, there appears to be a limit in the value placed on culture by EIPs.

There has been a recognition about the lack of cultural-appropriateness in mental health services, and attempts to identify and address these issues, with some evidence of improvement (DoH 2003; 2005; 2007; 2009; RAWorg, 2011), however further change still needs to occur. Based on the findings of this study, Care-Coordination made efforts to practice in culturally-competent ways, however there appeared to be aspects of the service that placed some limits on their ability to do this, which may suggest that aspects of EIPs may not be culturally-appropriate for service users from various cultural backgrounds. This is in line with existing research that suggests that mental health services often partake in practices and aim for goals that are often not in line with service users’ cultural values and goals (Faulkner, 2014). It is important to note that cultural-appropriateness is not necessarily about providing spiritual treatments; however it is about providing a service that makes use of terminology, and forms of support that are compatible with the beliefs, values and norms of its population; but also consider the benefit of attending to their cultural needs as part of attending to mental health needs.

4.1.3 Interpreter and Communication Challenges

Care-Coordination experienced various communication challenges, particularly with regard to working with interpreters. Interpreter and language barriers are consistently highlighted in research as an area of challenge when working with cultural differences (Badger et al., 2012; Bowl, 2007b; Brisset et al., 2013; Islam et al., 2015; Jirwe et al., 2010; McClimens et al., 2014; Penny et al., 2009; Sandhu et al., 2013). Language constraints are viewed as a major barrier to effective communication (Logan et al., 2014) which is vital for effective care. In fact, language and cultural factors are said to impact on assessment, diagnosis, engagement, intervention and overall outcomes (Giacco et al., 2014; Islam et al., 2015; Logan et al., 2014; Rosenberg et al., 2006; Sandhu et al., 2013).

Similar to existing research highlighting concerns about the quality and reliability of interpreters (Islam et al., 2015; McClimens et al., 2014), care-coordinators spoke about concerns that information was being adapted rather than interpreted directly. This was experienced negatively; rather than as a necessary part of interpreting, as highlighted by existing research (Tribe, 2007). The analysis highlighted some of the ways in which communication and language barriers left Care-Coordination feeling out of control and reliant on hope that information is being interpreted accurately. This has been conceptualised as a sense of loss of power or control that professionals feel when working with interpreters (Brisset et al., 2013). As a result of this loss of control, and inability to assess the quality and accuracy of the interpretation, professionals did not seem aware of some of the challenges that service users may experience in the interpretation. For example, the problems associated with the interpretation of terms such as “psychosis” into stigmatising terms in other languages (Penny et al., 2009; Wheeler, 1998). This may hinder engagement, but its impact may not necessarily be known to the professional. This may further pose challenges for professionals in trying to understand and address potential barriers to the engagement, when they may not be aware of what these barriers are.

Care-Coordination highlighted concerns about confidentiality with regard to using interpreters that may be known to service users within EIPs, which has been highlighted in prior research (Brisset et al., 2013). This has drawn attention to the dilemmas that professionals may face with regard to prioritising confidentiality or communication, which was experienced by Care-Coordination within this study. One participant suggested that interpreter services should ensure interpreters do not work in areas that they live in, to reduce the possibility of the service user being known to them.

Furthermore, language is a means by which people are able to express their culture and identity (Tribe, 2007; Thomas et al., 2010), therefore service users may face difficulties in accurately conveying what they would like to express (Bowl, 2007b). Conversely, Care-Coordination highlighted some of the challenges they face in understanding and making sense of service users’ behaviours. The analysis has shown that professionals’ ability to assess and discriminate between psychological and cultural factors seems to be hindered

by a failure to understand cultural differences. This appears further inhibited by communication and language limitations, that prevent Care-Coordination's abilities to observe signs of psychosis. This is consistent with existing research that highlights the need for effective communication in the diagnosis and treatment of service users experiencing mental health difficulties (Sandhu et al., 2013). If a person is unable to assess speech content and behaviour in the diagnostic process and compare it against the norms of a culture, this may have an impact on the conclusions that professionals draw. Care-coordinators highlighted the importance of working with interpreters who had knowledge of mental health difficulties, but also who were skilled enough to provide cultural information that may aid the care-coordinator's cultural understanding of the service user.

4.1.4 Impact of Professional's Cultural Background

The care-coordinators' own cultural background was deemed to affect the ways in which they interacted with service users, as well the ways in which service users interacted with them.

Previous research has illustrated service users' experiences that many professionals do not understand them (Bowl, 2007b; Faulkner, 2014; Islam et al., 2015; McClean et al, 2003;). Similarly, some care-coordinators reflected on the difficulty they faced in engaging culturally-different service users who perhaps viewed them as someone who did not understand their lifestyle and culture. What was different, however, was that Care-Coordination highlighted the ways in which their cultural difference sometimes aided engagement, in situations where service users did not trust people of their own cultural background. In contrast, those who were culturally-similar experienced this as both helpful and obstructive in their engagement with service users. Culturally-similar service users felt that while some service users felt more understood by them, their similarity also posed a challenge for them, in situations where service users had fears about being judged or harmed by them.

Little research has emphasised the impact of the professionals' cultural background on the engagement process. Evidence suggests that some service users have expressed a preference for mental health professionals who are culturally-similar to them (Faulkner, 2014), however mostly service users

highlight that it is not an issue of the professionals' cultural background, but an issue of whether they feel able to keep in mind cultural, ethnic and racial issues. Perhaps professionals may feel more able to hold these issues in mind when they share those cultural experiences themselves. This is consistent with evidence that found that mental health professionals who are religious, felt better able to work with service users who hold religious views, as well as incorporate their beliefs into the treatment (Pelechova, Wiscarson, & Tracy, 2012).

While cultural differences impacted on the ways in which service users interacted with them, care-coordinators also reflected on the ways this impacted on how they interacted with service users. Again, there is a lack of research focusing on the ways in which professionals' own cultural similarities may impact on how they engage with service users, as far as is known. As a result of cultural similarities posing a barrier in some instances, this led to anxieties for the professional with regard to meeting new culturally-similar clients. In contrast, care-coordinators reflected on anxieties they faced when communicating with service users who were culturally-different. While professionals generally regarded themselves as open to talking about culture, there was still a tendency to be wary in their approach, due to fears about appearing discriminatory or challenging. This is consistent with previous research suggesting that professionals experience anxiety about offending others which may limit their ability to ask important questions and have important conversations about culture, limiting them in their practice (Jirwe et al., 2010; Kai et al., 2007). Similarly, this may lead care-coordinators to shy away from having important conversations, and thus missing vital cultural information that can contribute to the care-coordinator's understanding of the service user, and subsequently the care they receive. Care-Coordinators felt more able to challenge service users' ideas when they were from a similar cultural background to the service user.

4.1.5 Practices that Facilitate Cultural Competence

4.1.5.1 Knowledge as Empowering

The experiences of care-coordinators drew attention to a range of cultural challenges, many of which may be associated with a lack of cultural knowledge and understanding. While many Care-Coordinators were able to recount

learning that they have acquired which have been useful for them, there still appeared some consensus that more cultural knowledge was required. This is consistent with findings from existing research (Logan et al., 2014; Sandhu et al., 2013). Cultural knowledge may support professionals in their understanding, confidence, empathy, engagement, and in developing a more culturally-appropriate service.

Care-Coordination placed a great deal of value on cultural knowledge and establishing community links, as a resource for enhancing culturally-competent practice. There is an extensive list of research that places an emphasis on the need for mental health professionals to gain more knowledge in a variety of forms. Care-Coordination highlighted various sources for gaining knowledge, including the service user, family, members of the community, colleagues and through training, and supervision. They also highlighted the need for a diverse workforce, as a means of providing a rich source of cultural knowledge, which is in line with the NHS agenda to ensure the diverse needs of the population are met by a diverse workforce (DoH, 2005).

Existing research highlights the importance of gaining an understanding of cultural factors to improve care within mental health (Logan et al., 2014; Sandhu et al., 2013;), particularly with regard to gaining cultural knowledge about aspects of culture that are likely to interfere with the work, for example health beliefs and practices (Rosenberg et al., 2006). Equally, Care-Coordination highlighted aspects of culture that are likely to interfere with their engagement with the service and their outcomes. These included:

- Cultural beliefs values and norms and how they differ from psychosis symptomology
- Cultural meanings about psychosis and the need for treatment
- Family structure, lifestyle and preferences
- Professionals' own cultural backgrounds and anxieties
- Religious and spiritual beliefs
- Communication

However in addition to gaining more knowledge about culture, research has highlighted the importance of helping staff to make use of this knowledge in order to modify interventions and make them more relevant (Bhui & Bhugra,

2004), thus emphasising an improvement in the skill of engaging with culture. There have been various attempts to support professionals in enhancing their cultural-appropriateness or supporting their ability to engage with culture in practice (Adenpole et al., 2012; Aggarwal et al., 2013; Fernandez et al 2012; Kirmayer et al., 2003; Kleinman & Benson, 2006; Owiti et al., 2014; Palinski et al., 2012) for example in the use of a cultural consultation model to support staff in managing cultural issues. Equally, care-coordinators gave examples of forms of support that they have found useful or would find useful. For example, an accessible cultural agency within the trust that can be contacted for cultural advice, would be a useful resource.

Several cultural-competence models exist that vary in a number of ways; but what is specifically similar across many are their concern with both knowledge and skill, (Campinha-Bacote, 2002; Giger & Davidhizar, 2002; Sewell, 2009), which in itself can be argued to be a form of knowledge. Similarly, Care-Coordinators spoke about the importance of gaining generic cultural knowledge but also with regard to making use of this knowledge to improve the ways in which they practiced but also their confidence in engaging with cultural differences.

Care-coordinators further highlighted challenges they faced in working with interpreters, emphasising a need for more training in working with interpreters (Raval, 2013), which could perhaps support professionals to gain an understanding of how to work most effectively with interpreters (Raval, 2013; Tribe & Morrissey, 2004; Tribe & Thompson, 2009). Conversely, the findings highlight the need for interpreters to gain more knowledge in mental health.

4.5.1.2 Developing Community Links for better Engagement

The community was viewed as a useful resource with regard to knowledge; but additionally with regard to improving engagement and effectiveness of care for service users. Government recognition of the lack of cultural-relevance of services and their commitment to the development of meaningful partnerships with voluntary and community organisations (VCO) (DoH, 2004) mirror the suggestions made by Care-Coordinators about the need to establish these links. Many Care-Coordinators recognised the value in increasing links with the

community and felt this would benefit their ability to engage service users, and reduce barriers.

Previous research has shown that partnership working can facilitate shared aims, genuine collaboration and holistic practices (Lester et al., 2008), which EIPs claim to engage in (Shiers & Smith, 2010). However, there appeared to be an over-emphasis within EIPs on medical views and practices in the existing EIPs, with a call for more links to improve engagement, but no acknowledgement of the medical culture of the service that may, in part, contribute to the lack of engagement.

Community links can also facilitate better access to resources (Lester et al., 2008), which was raised as a positive outcome of developing these links by Care-Coordination. It was recognised that services need to be better aware of existing community services that can support the wellbeing of their service users. Care-Coordination recognised the practical barriers to linking in with the community, particularly with regard to lack of resources, time and funding, which is in line with existing evidence as a barrier in linking with VCOs (Lester et al., 2008). When demands are high, and resources are low, this may lead services to prioritise according to what services feel are most important; and therefore the need to develop these links may be superseded by other practical demands.

Care-coordination failed to recognise other barriers that may be associated with developing these links, for example, in the incompatibility between cultural differences of EIPs and the VCOs, for example the use of terminology for distress. Research has highlighted that this cultural difference may lead to disengagement by VCOs due to fears about being associated with the stigmatising mental health service (Lester et al., 2008).

4.2 IMPLICATIONS

This study highlights the complexities associated with disentangling cultural phenomena from psychosis, alluding to a major challenge in conducting adequate culturally-appropriate assessments, and understanding and making accurate conclusions about behaviours in its cultural context. There are also systemic barriers that may interfere with professionals' attempts to practice in a

culturally-competent manner. This can have significant consequences for treatment and overall outcomes. The findings suggest important areas to implement change to improve the cultural-appropriateness of EIPs, by supporting staff to:

- Conduct culturally-appropriate assessments, to improve understanding of cultural phenomena and ability to distinguish these from psychosis.
- Enhance their skills in engaging with cultural differences, for example feeling more confident in asking questions and actively making use of cultural knowledge within their work.
- Ensure service practices are in line with the beliefs and values of service users; for example ensuring family are consistently involved, if family is regarded important within the service user's culture.
- Support service users to reach goals that are in line with their beliefs and values, rather than the service's beliefs and values.
- Engage service users by using concepts that are in line with their cultural understanding of the world.
- Improve communication with service users
- Attend to cultural and religious needs

In order to achieve this, the results highlight a range of potential solutions.

4.2.1 More Cultural Knowledge

The findings highlight the empowering influence of gaining cultural knowledge for care-coordinators, to support culturally-appropriate assessments, interpretations, diagnoses and treatments of service users. This knowledge can be in the form of training and teaching, reflective practice, and learning from colleagues, service users and the community.

Knowledge of specific cultural phenomena may help professionals to increase their understanding of cultural norms, values and beliefs; reducing the potential for misinterpreting behaviours. Knowledge about skills in relation to working with cultural factors may increase confidence in asking vital questions, challenging ideas and generally engaging in discussions about culture; but also may increase the cultural-relevance of the service. Gaining more knowledge about working effectively with interpreters may help to reduce the communication barriers that often result in various other problems within EIPs. Gaining

knowledge about alternative treatments may help professionals to better understand how they work, how to incorporate them and make use of them to ensure they are attending to the cultural needs of the service user, and to reduce their anxieties about potential harms that may come about from these treatments. Additionally, a diverse workforce can allow for a richer perspective on culture to exist within a team, provided it allows opportunities for professionals to challenge ideas, and hold in mind cultural issues.

Due to the practical demands and constraints of the service, there is a risk of losing sight of the human being within context. Perhaps staff training needs to consider bringing to life the human being, through focus on a single case in reflective practice, experiential or perspective-taking exercises or through use of audio-visual equipment to link a single person to their context and experience of services. Services will vary with regard to their training needs and it may be helpful for services to assess the need and what opportunities may be available.

4.2.2 Developing Community Links for Better Engagement

The community can provide valuable support for professionals; not only to improve understanding, but to enhance the cultural-relevance of the service and improve engagement with service users. Better links with the community may also reduce anxieties about the risk associated with alternative forms of support. For example, being aware of and having links with trustworthy spiritual healing services may increase confidence that the service user is unlikely to be harmed; in comparison to feeling uncertain about what treatments may involve. This may also lead to a greater sense of autonomy and genuine experience of collaborative practice, allowing VCOs, as well as service users to modify existing practices to enhance the relevance and usefulness of services for them.

Awareness about what services are available in the local community may help professionals to signpost service users to appropriate services that will attend to their cultural needs, which may improve their overall wellbeing and sense of social inclusion.

4.2.3 Culture Shift within Early Intervention in Psychosis

In order to support a culturally-competent service, a culture shift is necessary, to allow services to align their practices with service users' beliefs. Services may need to shift away from their strong medical roots, to allow for other perspectives to coincide in a way that is not tokenistic. Services are at risk of making superficial attempts to be culturally-relevant. A genuine attempt to increase its cultural relevance, through increasing knowledge, improving community links and other means, may help services to better engage and support those from different cultural backgrounds.

As previously mentioned, due to service users' mistrust of mental health services, there is a fear among VCOs about being associated with services (Lester et al., 2008). Therefore, perhaps a culture shift would help to address this issue, allowing for a more culturally-appropriate service that is compatible with VCOs and service users' beliefs.

A culture shift may lead to the development of a service that promotes a consideration of aspects of the service that may be incompatible with service users' cultural beliefs, rather than a one-size-fits-all approach that works for some people, but not others. In order for this to occur, services need to place a greater value in culture, aim to consider aspects of the service that may be incompatible and aim to effect change and modify practices to make EIPs more culturally-adept. These practices need to be embedded within the culture of the service, to support professionals in working in this way, becoming a 'norm'.

This may support engagement, understanding, accurate interpretations of and outcomes for service users from BME backgrounds. This study and existing evidence highlights the complexity associated with the interaction between culture and psychosis, and supports the need to build understanding of culture and how to work with it. A consideration of this evidence would help services to take culture more seriously.

4.2.4 Auditing and Service Evaluation

Despite recommendations set out by Delivering Race Equality (DoH, 2005) about the need for mental health services to become more culturally-relevant,

this appeared to have had very little impact on services (RAWorg, 2011). Equally, this study has illustrated that perhaps there is still far to go for EIPs to develop in their ability to engage with cultural differences and attend to cultural needs. Attention needs to be paid to how to effect and monitor this change, which is in line with the recommendations set out by Delivering Race Equality (DoH, 2005). It may also be helpful for services to conduct evaluations and audit these practices and changes and make sense of how service users experience EIPs with regard to the cultural-competence of the service. Auditing of the recommendations may help to monitor the service's attempts to attend to cultural needs and improve service delivery for service users from diverse cultural backgrounds. To avoid this becoming a tick-box exercise, careful consideration needs to be taken to ensure honest feedback is sought; for example through assuring anonymity.

4.2.5 Interpreter and Language Support

The results highlighted the need for better interpreter services. The way in which words are interpreted is vital to the engagement process and for the service users' ability to convey their experiences in a clear way. However, this is often out of the control of EIPs, and the availability of good interpreters are often location-dependent. Perhaps more efforts should be made by NHS trusts to ensure adequate training is provided for interpreter services, and ensuring interpreters have had training in mental health interpreting. This can help interpreters to be prepared to interpret mental health concepts in a way that will be less stigmatising and more in line with service users' cultural context. Alternatively, there have been suggestions about developing services that have interpreters embedded within the structure of the service (Raval, 2013) which may help to further reduce some of the barriers that professionals may face when working with interpreters in mental health.

Additionally, more opportunities to learn from interpreters may be beneficial. For example, Care-Coordination may benefit from understanding how words are interpreted and how some of the terminology may be stigmatising when translated into the service user's language. As mentioned previously, further training on effective ways of working with interpreters may prove to be useful for staff, in allowing them to make the most of their interactions with service users

alongside interpreters. Similar to training about cultural needs, training can provide professionals the opportunity to take the perspective of the interpreter and gain an understanding of how information needs to be adapted and the challenges interpreters face in doing so. This may help professionals to become more conscious of the words that they use and the ways in which they explain things. Bilingual support workers exist in some teams, which may also be beneficial as they can be embedded within a team and carry both mental health and cultural knowledge which may support the cultural-competence of the service.

4.2.6 Diverse Workforce

A diverse workforce has been highlighted as a resource with regard to providing cultural knowledge and support. Moreover, the existence of culturally-different colleagues gives Care-Coordination the opportunity to gain confidence in asking questions and exploring cultural issues, in a way that enables them to do the same with service users. It also means that cultural issues, that would otherwise not be recognised or considered, may be brought to light and thought about, by colleagues who are able to identify with the cultural experiences of the service users.

Service users have many preferences with regard to whether they would prefer to work with someone who is culturally-similar or different to them. A diverse workforce may allow service users greater choice in who they see, enhancing their potential to engage with their care-coordinator and service.

4.2.7 Service User Involvement

There are various mental health settings that incorporate service user involvement into their service delivery. EIPs may benefit from service user involvement, particularly of people from diverse groups, to support the service in enhancing its cultural-appropriateness. Research has sought to illustrate the disparities faced by service users from BME backgrounds, however it appears that this fails to effect very much change within services. Aims to embed service user involvement within EIPs may ensure that service users' needs are taken seriously, provided that their needs are responded to.

4.2.8 Implications for Clinical Psychology Practice

Clinical Psychologists possess particular skills and knowledge that can help EIPs to modify their practice to ensure services are culturally-competent.

Clinical Psychologists can make use of their membership within a multidisciplinary team to influence team members to hold culture in mind, by initiating discussions about culture within team meetings, facilitating reflective practice sessions, providing teaching and training to the team, and in providing advice to colleagues. This could take a reflective perspective, however can also allow the Clinical Psychologist to draw on the evidence base and share topics from the existing literature. They can also help to establish other opportunities for learning from external sources, for example inviting someone to teach the staff team about working with interpreters.

Clinical Psychologists can also play a role in developing new ideas within the team, to support a shift in the ethos of the service, allowing for a more culturally-adept service to develop. The development of meaningful service evaluation tools, may allow services to develop effective and useful ways of measuring cultural-competence. Clinical Psychologists can play a role in developing these tools but also ensuring this is implemented, evaluated and disseminated. They can also develop formal service user involvement opportunities within services, and ensure this is used meaningfully, aiming to invite people from different cultural backgrounds and perspectives to share their ideas, and ensure their perspectives are taken seriously. Clinical Psychologists can also play a leading role in developing links with communities and other organisations, through the initiation of contact with the community, invitation to share practices and outcomes with one another, exploration of ways to develop partnership working, development of community resource lists for easier access to community resources for professionals within the team, and development of feedback opportunities to measure and develop the partnership working across time.

4.2.9 Considerations of Developing Culturally-Appropriate EIPs

While there is a call for more cultural-relevance within EIPs, there needs to be a consideration of how to develop this culture in the context of a lack of funds and resources. Access to resources may be determined by the location, which may disadvantage service users who live in some areas. In an attempt to

address cultural needs, each service needs to assess what will be most useful for their service in ensuring cultural needs are met. Ultimately, services need to make efforts to effect change, even if this change is small and gradual; with the effort of creating lasting and effective change that will help services become more culturally-competent. However, evidence suggests that putting in place funds for cultural support may be a challenge to resources in the short-term, however may save money in the long-term (Palinski et al., 2012).

While developing a culturally-relevant service is required; attention needs to be paid to ensure a balance between individualised practice and offering a service that is informed by cultural knowledge, as emphasised by existing research (Badger et al., 2012; Jirwe et al., 2010; Kai et al., 2007). There needs to be a balance between allowing for a cultural perspective to exist, and not being overly-challenging or assumptive about service users based on their cultural backgrounds. There still needs to exist an attempt to understand each person as an individual, but within the context of their cultural influences; which may be a challenging balance to maintain.

Another important factor to consider is the impact of exploring culture and spirituality in a service that is already guilty of making inappropriate interpretations of cultural behaviours. As previously shown, service users may withhold information due to fears of misinterpretation (Islam et al., 2015), therefore there needs to be a careful consideration of the application of cultural assessments within services, particularly if this is applied alongside ideas that may be stigmatising and pathologising. This may lead to suspicion within service users who may fear their cultural beliefs will be pathologised, which is understandable given both service users' and professionals accounts of these experiences. It may be useful to consider how to address these fears in a manner that will not pathologise cultural beliefs.

4.2.10 Insights and Challenges

While much of the findings appear to echo the existing research, there are a few aspects of the findings that are striking. This research study helped to strengthen the findings highlighted mainly within service user perspective research, for example the experience that professionals may misinterpret culturally-appropriate behaviours. While this idea has been raised in the existing

research, it did not appear to have a strong influence on the overall findings of existing professional-perspective research. The professionals in this research study highlighted a poignant message of the reality and risks of misinterpreting and misunderstanding service users from different cultural backgrounds to their own. This places a particular emphasis on engaging cultural differences as being more than a challenge to attend to, but a necessity for an adequate and acceptable service. This also draws attention to the idea that professionals, teams and organisations must engage with culture in their work.

Despite this message, challenges still exist as a result of the lack of value placed on culture within organisations. The current NHS context has meant that organisations are tending to operate in a manualised manner, which is likely to further impede on the process of modifying practices to suit people of different cultural backgrounds. The lack of value in culture also means that organisations may turn a blind eye to issues of culture. There has been much research highlighting the need for recognition of cultural factors and culturally-competent practice, yet despite this, little has changed. Many of the findings and recommendations that have been highlighted in this research study echo the existing literature, and the little change that has progressed from this may point to a lack of value placed in culture within this context, but also within a mental health service context as a whole. Perhaps services need to consider the priorities of financial providers of services, and make attempts to investigate and highlight the potential financial benefits of attending to culture (for example, the long-term cost-effectiveness, as highlighted in Palinski et al., 2012). The study also highlighted specific aspects of culture that are likely to present challenges within psychosis services specifically (as highlighted in section 4.1.5.1). This can support services to attend to these area in their attempts to improve culturally-competent care within psychosis services specifically.

4.3 LIMITATIONS OF THE RESEARCH

4.3.1 Broad Area of Research

The topic of working with cultural differences in psychosis services, proved to be extremely broad with a lot of overlap and complexity. While it revealed

interesting findings, it also limited the depth in which particular ideas could be analysed. Further research could help to develop a richer understanding of specific topics within the realms of working with cultural differences in EIPs. For example, with a focus specifically on the impact of conflicting cultural beliefs alone, or on the communication challenges alone. This can help to provide further and richer insights into specific aspects of working with cultural differences in psychosis services.

4.3.2 Limitations of Interviews

While presented as more naturalistic, interviews are not the same as conversations that occur naturally (Howitt, 2010 p62), which means that often people are more likely to develop ways of speaking that may portray themselves in a positive way. Particularly as participants were asked to talk about their work, they may have a tendency for positive self-portrayal. However, different conclusions may be drawn from hearing Care-Coordinators' conversations with colleagues or clients, than in an interview. There may be some inconsistencies between what people say and how they practice.

This was also influenced and challenged by language. People make use of language in different ways. For example, participants from white, middle class backgrounds, tended to make use of language in a way that led to stereotypically positively-framed responses. Problems can arise in the analysis of ideas that pertain to professionals' practice, due to inconsistencies between the two. Therefore it became necessary to further analyse the inconsistencies within interviews, for example in highlighting the contradiction between arguing for an acknowledgement of cultural meanings about distress, and then highlighting the consequences of people 'not accepting' the medical view.

Moreover, some Care-Coordinators appeared to find it difficult to recall specific examples of challenges and learning experiences, despite them often engaging with cultural differences. However, it was decided not to ask participants to reflect on examples before the interviews, as it was felt that being asked questions on the day would trigger aspects of their experiences that were most pertinent to them. Alternatively, it may be useful to devise vignettes and tasks to engage Care-Coordinators in exercises designed to assess how they would

respond to particular cases and issues; rather than relying upon memory or language capacity.

4.3.3 Generalisation of Findings

EIPSSs vary dependent on location and resources available to them, therefore the findings may not extrapolate to the experiences of all care-coordinators or professionals in all EIPSSs. However, there may be similar patterns of themes across EIPSSs, particularly as much of the findings were in line with existing research about professionals' experiences of working with cultural differences. Some of the participants in this study volunteered without fully acknowledging what the research would be about, and did so out of kindness rather than interest in the topic; though were able to provide informed consent prior to the interview taking place. Therefore the results may be less biased towards those who have an interest in the topic, perhaps indicating a broader range of views that may be more representative of Care-Coordination within EIPSSs. However, the research was only conducted across two EIPSS sites, which may limit its generalisability. It may be helpful to access the views and experiences of care-coordinators across a broader range of EIPSSs within London and other diverse areas of the UK.

4.3.4 Researcher Limitations

The data was collected and analysed by the researcher, and therefore influenced by the researcher's own perspective. This is in line with the critical realist (Harper, 2012). perspective that stipulates that the way in which participants recall their experiences are influenced by their own perspective, and the research analysis is further influenced by the researchers' interpretation of the data. Coding, themes and findings were reviewed by the thesis supervisor, and reflections were documented throughout the entire process of the research to reduce the possibility of bias impacting on the findings.

4.3.5 Limitations of Thematic Analysis

Thematic analysis aims to generate an understanding of patterns across data (Braun and Clarke, 2006). Therefore, potentially missing valuable aspects of individuals' experiences and views, that may provide further insights about challenges and effective ways of working. However, the decision to apply

thematic analysis was with the aim of gaining a general understanding of the shared challenges and learning experiences that may be experienced by professionals within EIPs, rather than individual insights. While it may be useful to consider alternative forms of analysis, it was felt that thematic analysis was appropriate in answering the research questions for this study.

4.4 RECOMMENDATIONS FOR FUTURE RESEARCH

4.4.1 Alternative Methods of Exploring Cultural-Competence

It was highlighted that interviews may pose problems as professionals may display a preference for positive self-portrayal. To address the challenges of interviews, it may be useful to record assessment sessions with service users or team meetings and conduct an analysis of these conversations. The limitation would be that it would be difficult to manipulate or control what is talked about; however, it is likely that cultural issues will come to light in talking about service users and families from particular backgrounds; or opportunities for cultural issues may come to light but not be addressed, which would provide useful information with regard to cultural-competence. This would help to gain a more accurate understanding of how care-coordinators engage with culture in practice, which may differ from their accounts about how they practice.

4.4.2 Service User Research to Shape Service Delivery

While there is a great deal of understanding about how service users experience services, there needs to be more research that explores their views about how services can change to make them more culturally-appropriate. Again, as this is a broad topic area, it may be challenging to ask service users directly what methods would help services to become more culturally-relevant. Perhaps making use of methods that will aid them in their responses may be helpful, for example using Q-methodology, drawing ideas from the existing literature and asking service users to decide which factors are most important for them with regard to culturally-competent practice. Results from such studies should help modify current EIPs to develop services that are more culturally-relevant for service users.

4.4.3 Non-English Speaking Service User Experiences of EIPs

Service users from BME backgrounds have raised issues with their experiences of mental health services. These can be further problematic due to professionals feeling less able to communicate with and understand them. It may be helpful to develop insights into how Non-English speaking service users experience EIPs, and what their perceptions of these services are with regard to what they do and whether they are helpful.

4.4.4 More Research on Religion and Spirituality

Previous research suggests there is a reluctance for professionals to consider religion and spirituality within their work (Dein et al., 2010; Chidarikire, 2012), despite there being evidence that service users would like an opportunity to discuss this with professionals (Mohr & Hugulet, 2014), and that it may improve service users' wellbeing (McKenzie et al., 2003; Hussein & Cochrane, 2003; Loewenthal, 1993; Johnson, 2000).

While religion and spirituality were perceived as part of culture, it can also be considered as separate from culture. Care-coordinators had a tendency to experience religion and spirituality as challenging. There also appears to be less knowledge and expertise about religious competence than there is cultural competence. Further research may help to shed light on Care-Coordinators' experiences of working with people who hold religious views; which may include those who may convert into a particular religion and therefore may be viewed very differently to someone who has been born into a particular set of beliefs.

4.4.5 Learning between Services

EIPs vary with regard to the resources available to them. While the findings highlighted common challenges and learning experiences for care-coordinators working across two EIPs, there was little focus on the differences between services. It may be useful to gain an insight into differences across various sites and how these impact on service provision and service users' experience of services. Much of the existing research draws attention to the general experiences of service users and professionals, but there is little indication about how these experiences vary across different services. This could provide insights, both from the perspective of the service user and the professional,

which can help EIPs to effect changes that have been experienced as helpful in other services, to support the improvement of their own.

4.4.6 Monitoring Cultural-Competence over Time

As a result of implementing recommendations, it may be beneficial to measure changes in services over time, for example through quantifying culturally-competent practices and measuring these over time. This may involve quantifying aspects of cultural-competence as suggested from the findings, for example, the extent to which service users think that services are able to align goals and produce outcomes that are in line with their cultural values. These aspects could be developed into a questionnaire that can be completed by service users within EIPs anonymously, and this can be analysed over time.

4.6 CONCLUSIONS

EIPs aim to address the mental health needs of people who experience symptoms of psychosis. They are not cultural services, however, it appears that various cultural challenges exist which impact on the ability of Care-Coordination to understand and interpret service users' presentations, and to engage with and support service users from diverse cultural backgrounds. Furthermore, there is an indication that attending to cultural needs is necessary in order to attend to mental health needs. The challenges highlight that it is not just a matter of attending to needs, but the challenge in disentangling cultural factors from psychosis makes it crucial to consider culture in the work. Challenges in engaging service users may also be associated with the incompatibility of services with service users' beliefs and values, highlighting a need for more cultural-relevance. Undoubtedly, Care-Coordination evidence attempts to engage in culturally-competent practice within their work, but equally are limited in their ability to do so due to the culture of the service and the demands placed on them by the service.

The findings led to recommendations for more cultural knowledge, the development of links with communities, mental health training for interpreters, training for staff in working with interpreters within mental health, ensuring a diverse workforce, service-user involvement and achieving a culture change

within the service. This may help to develop a more culturally-appropriate service that aligns itself with service users' cultural backgrounds, in a manner that is not tokenistic but meaningful. However, similar recommendations have been suggested previously, but do not appear to have been implemented consistently. Thus there is a requirement to ensure auditing, service evaluation and further research can help to support this change to occur and be monitored. Furthermore, a careful assessment of the cultural needs and resources in EIPs need to be conducted to highlight key ways of improving the cultural-competence of EIPs locally.

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APPENDICES

Appendix A

Presentation Slides For Recruitment

Exploring issues of cultural difference for professionals working with psychosis



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Rationale



- ▶ High rates of psychosis in migrant population.
- ▶ A very diverse area of mental health – so important to think of diversity
- ▶ Research looking at professionals working in general health settings highlights key difficulties in working with people of other cultures.
 - ▶ Communication, Faith needs etc.
 - ▶ Professional uncertainties around issues of diversity disempower and limit them in their clinical practice
- ▶ Psychosis as something that is culturally-significant?
- ▶ Cultural beliefs impact on service user engagement – trust of services, who people turn to for support, knowledge and understanding, stigma and shame.

Thesis Project

- ▶ To explore issues of cultural difference for professionals working in psychosis services.
- ▶ **Five Care coordinators** from one team.



- ▶ Any cultural background as will always be working with someone of a different culture to yourself

What will I have to do?

- ▶ Reflect on difficulties and learning experiences of working with people of other cultures (service users and families)
- ▶ Single **semi-structured interview** at **EIP service/other preferred location** lasting about **an hour**. Interviews will be audio recorded.
- ▶ I can be flexible
- ▶ Snacks will be provided!



NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Poul Rohleder **REVIEWER:** Jennie Brown

STUDENT: Roya Afsharzadegan

Title of proposed study: Exploring issues of cultural difference for professionals working with psychosis

Course: Professional Doctorate in Clinical Psychology

DECISION (*Delete as necessary*):

***APPROVED, BUT MINOR CONDITIONS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in

doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required *(for reviewer):*

I suggest you always carry with you 2 audio recorders (or if you have a mobile phone that can make recordings as a back up). I once participated in an interview and the student's recorder broke! I doubt your participants will have time to redo their interviews if this happens!

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students):*

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature)*: Roya Afsharzagdegan

Student number: U1331743

Date: 25/03/2015

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

☐

MEDIUM

☐

LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer (*Typed name to act as signature*): J.Brown

Date: 17/03/15

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: <http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

Appendix C

UEL Registration

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.
UEL.ac.uk/psychology



ROYA AFSHARZADEGAN

Date: 05/05/2015

Student Number: 1331743

Dear Roya,

Registration as a Candidate for the University's Research Degree

I am pleased to inform you that the Research Degrees Subcommittee on behalf of the University Quality and Standards Committee, has registered you for the degree of Professional Doctorate.

Title of Professional Doctorate: Professional Doctorate in Clinical Psychology

Director of Studies: Dr Paul Rohleder

Supervisor/s: Dr Katy Berg

Expected completion: According to your actual date of registration, which is 1st October 2014, the registration period is as follows:

Minimum 18 months maximum 48 months (4 years), according to a full time mode of study.

Your thesis is therefore due to be submitted between:

1st April 2015 and 1st October 2018

I wish you all the best with your intended research degree programme. Please contact me if you have any further queries regarding to this matter.

Yours sincerely,

Dr Kenneth Gannon
School Research Degrees Leader
Direct line: 020 8223 4576
Email: k.n.gannon@uel.ac.uk

Stratford Campus, Water Lane, Stratford, London E15 4LZ
Tel: +44 (0)20 8223 4000 Fax: +44 (0)20 8223 4937
Website: www.uel.ac.uk



Appendix D

HRA Decision Tool Outcome

<http://www.hra-decisiontools.org.uk/ethics/EngresultN1.html>

Your answers to the following questions indicate that **you do not need NHS REC approval for sites in England**. However, **you may need other approvals**.

You have answered **'YES'** to: Is your study research?

You answered **'NO'** to all of these questions:

Question Set 1

- Is your study a clinical trial of an investigational medicinal product?
- Is your study one or more of the following: A non-CE marked medical device, or a device which has been modified or is being used outside of its CE mark intended purpose, and the study is conducted by or with the support of the manufacturer or another commercial company (including university spin-out company) to provide data for CE marking purposes?
- Does your study involve exposure to any ionising radiation?
- Does your study involve the processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers, without consent?
- Is your study a clinical trial involving the participation of practising midwives?

Question Set 2

- Will your study involve research participants identified from, or because of their past or present use of services (adult and children's healthcare within the NHS and adult social care), for which the UK health departments are responsible (including services provided under contract with the private or voluntary sectors), including participants recruited through these services as healthy controls?
- Will your research involve collection of tissue or information from any users of these services (adult and children's healthcare within the NHS and adult social care)? This may include users who have died within the last 100 years.
- Will your research involve the use of previously collected tissue or information from which the research team could identify individual past or present users of these services (adult and children's healthcare within the NHS and adult social care), either directly from that tissue or information, or from its combination with other tissue or information likely to come into their possession?
- Will your research involve research participants identified because of their status as relatives or carers of past or present users of these services (adult and children's healthcare within the NHS and adult social care)?

Question Set 3

- Will your research involve the storage of relevant material from the living or deceased on premises in the UK, but not Scotland, without an appropriate licence from the Human Tissue Authority (HTA)? This includes storage of imported material.
- Will your research involve storage or use of relevant material from the living, collected on or after 1st September 2006, and the research is not within the terms of consent from the donors, and the research does not come under another NHS REC approval?
- Will your research involve the analysis of DNA from bodily material, collected on or after 1st September 2006, and this analysis is not within the terms of consent for research from the donor?

Question Set 4

- Will your research involve at any stage intrusive procedures with adults who lack capacity to consent for themselves, including participants retained in study following the loss of capacity?
- Is your research health-related and involving prisoners?
- Does your research involve xenotransplantation?
- Is your research a social care project funded by the Department of Health?

Appendix E

HRA Staff Research Approval



Miss Roya Afsharzadegan

Email: hra.approval@nhs.net

18 August 2015

Dear Miss Afsharzadegan

Application given HRA Approval

Study title: Exploring issues of cultural difference for professionals working with psychosis
IRAS project ID: 183201

Thank you for your application, which has now been reviewed by an HRA assessor. We are pleased to confirm that the application has been given HRA Approval, on the basis described in the application form, protocol and supporting documentation.

Scope

HRA Approval provides a single approval for research in the NHS in England, consisting of assessments by HRA staff alongside the independent Research Ethics Committee (REC) opinion where required.

HRA Approval applies to all research in England involving NHS patients or staff. Organisations listed in the application are not obliged to undertake this study; arrangements for confirming capacity and capability, where formal confirmation is required, are outlined in the following section of this letter (participating NHS organisations in England). Further information is also provided in appendix B (HRA assessment criteria 4.1, participating NHS organisations and capacity and capability sections).

If there are participating NHS organisations in Northern Ireland, Scotland or Wales, the nation specific processes to approve research applications should be followed.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation as well as seeking Site Specific Approval (SSA) from the REC where necessary.

Participating NHS Organisations in England

The HRA has determined that participating NHS organisations in England do not need to formally confirm their capacity and capability to host this research, because local staff will not be responsible for, or undertake any research activities. It is expected that these organisations will become participating NHS organisations 35 days after submission by the sponsor to the HRA (no later than 9th September 2015) if they have already not confirmed participation, unless justification can be provided to the sponsor and the HRA as to why the organisation cannot participate, or the organisation requires additional time to confirm. Further details are given in appendix B (summary of HRA assessment).

For the avoidance of doubt, working with the participating organisation must involve the local research team and the local research management function supporting that organisation.

For guidance on how you and the sponsor should work with participating NHS organisations in England, please see appendix B (HRA assessment criteria 4.1, participating NHS organisations and capacity and capability sections).

Appendices

The HRA Approval letter contains the following appendices:

- A – List of Approved Documents
- B – Summary of HRA Assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting requirements for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting requirements or procedures.

New Participating Organisations

Plans to include any new participating organisations in the study in addition to those listed in the application should be notified to the HRA as a substantial amendment. The study should not start at the new participating organisation until:

- For CTIMPS, the HRA has acknowledged that the amendment has been received by the Research Ethics Service.
- For NHS organisations in England, the organisation has confirmed capacity and capability in line with guidance provided by the HRA with the acknowledgement of the amendment.
- For NHS organisations in Northern Ireland, Scotland or Wales, management permission has been obtained.
- For non-NHS organisations, management permission has been obtained and SSA has been obtained from the REC where necessary.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Alternatively, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is 183201 Please quote this on all correspondence.

Yours sincerely

Catherine Adams
Senior Assessor

Email: hra.approval@nhs.net

Enclosures: After HRA Approval – guidance for sponsors and investigators

Copy to: Professor Punchard, Sponsor's representative, p.lawson2@uel.ac.uk

Appendix F
NHS Registration

Dear Roya,

Re: 183201 Exploring issues of cultural difference for professionals working with psychosis

Thank you for your application, which has now been reviewed by NOCLOR on behalf of East London Foundation Trust. We are pleased to confirm that **East London NHS Foundation Trust** have the **capacity** and **capability** to host the study at this site. Capacity and Capability to consent is based on the **HRA Approval** on **18th August 2015** and statement of activities signed to confirm this, please find this attached via email. Please also ensure that the office is notified of any changes in status to the project, for example any amendments, if the site should close and recruitment before the stated end date and of any urgent safety measures enacted. Please notify us when the first participant is recruited in the trial. We may contact you to check progress of the study.

Trust/Independent Contractor	Name of PI / LC	Date of Capacity and Capability to Host Study
East London Foundation Trust		23 rd October 2015

We wish you luck with the research and if you have any further queries at any stage please feel free to contact us.

Kind regards,

Stephanie Basset

Noclor Research Support Service

Stephanie Basset

Research Facilitator

1st Floor, Bloomsbury Building, St Pancras Hospital, 4 St Pancras Way, London, NW1 0PE

Tel 020 7685 5949 | Email: stephanie.basset@nhs.net

www.noclor.nhs.uk | twitter.com/NoclorResearch *Promoting the best in research'*

Dear Roya,

Re: 183201 Exploring issues of cultural difference for professionals working with psychosis

Thank you for your application, which has now been reviewed by NOCLOR on behalf of Central and North West London Foundation Trust. We are pleased to confirm that **Central and North West London NHS Foundation Trust** have the **capacity** and **capability** to host the study at this site. Capacity and Capability to consent is based on the **HRA Approval on 18th August 2015**. Please also ensure that the office is notified of any changes in status to the project, for example any amendments, if the site should close and recruitment before the stated end date and of any urgent safety measures enacted. Please notify us when the first participant is recruited in the trial. We may contact you to check progress of the study.

Trust/Independent Contractor	Name of PI / LC	Date of Capacity and Capability to Host Study
Central and North West London NHS Foundation Trust		23 rd October 2015

We wish you luck with the research and if you have any further queries at any stage please feel free to contact us.

Kind regards,

Stephanie Basset

Noclor Research Support Service

Stephanie Basset

Research Facilitator

1st Floor, Bloomsbury Building, St Pancras Hospital, 4 St Pancras Way, London, NW1 0PE

Tel 020 7685 5949 | Email: stephanie.basset@nhs.net

www.noclor.nhs.uk | twitter.com/NoclorResearch *Promoting the best in research*



PARTICIPANT INFORMATION SHEET

Project Title

Exploring Issues of Cultural Difference for Professionals Working with
Psychosis

UNIVERSITY OF EAST LONDON

School of Psychology

Stratford Campus

Water Lane

London E15 4LZ

The Principal Investigator(s)

Roya Afsharzadegan

u1331743@uel.ac.uk

Contact number: x

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in a research study. The study is being conducted as part of my Professional Doctorate in Clinical Psychology degree at the University of East London.

Project Description

Early Intervention in Psychosis services tend to be culturally diverse. This study aims to explore professionals' challenges and experiences of working with cultural difference in this setting.

As part of the project, you will be asked a series of questions about your experiences as a Care Coordinator working with both individuals experiencing psychosis and their families who are culturally different to yourself. This will be completed in a single interview and will be audio recorded to ensure answers are accurately represented. The aim is to identify general themes associated with challenges of and learning experiences gained from working with this group of people.

Remuneration

Light refreshments will be provided

Location

The study will be carried out in your Early Intervention in Psychosis Service/
Other preferred location

Confidentiality of the Data

Interviews will be audio recorded and these recordings will then be transcribed onto a word document and anonymised. This means that any identifiable information, for example your or the service user's name, will be changed or omitted from the transcript. All anonymised transcripts and data will be stored on a personal password-protected laptop and a USB which is kept in a secure cupboard and is only accessible to myself. All signed consent sheets will also be scanned and stored on secure password-protected university computers, along with audio recordings. Audio recordings will be deleted once the thesis grades have been finalised, however anonymised transcripts will be kept for three years and then destroyed. There is scope to submit any relevant findings to a research journal for publication, however these will be general findings and again will abide by the anonymity and confidentiality agreements stated above.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time until the thesis has been submitted in May 2016. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Your responses will not be shared with other members of your team and any identifiable information will be changed in order to ensure that your responses will not be identifiable.

Please feel free to ask me any questions. If you are happy to continue, you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor: Dr. Poul Rohleder, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Telephone: 020 8223 4174. Email: P.A.Rohleder@uel.ac.uk).

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)



PARTICIPANT INFORMATION SHEET

Project Title

Exploring Issues of Cultural Difference for Professionals Working with
Psychosis

UNIVERSITY OF EAST LONDON

School of Psychology

Stratford Campus

Water Lane

London E15 4LZ

The Principal Investigator(s)

Roya Afsharzadegan

u1331743@uel.ac.uk

Contact number: x

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The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in a research study. The study is being conducted as part of my Professional Doctorate in Clinical Psychology degree at the University of East London.

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As part of the project, you will be asked a series of questions about your experiences as a Care Coordinator working with both individuals experiencing psychosis and their families who are culturally different to yourself. This will be completed in a single interview and will be audio recorded to ensure answers are accurately represented. The aim is to identify general themes associated with challenges of and learning experiences gained from working with this group of people.

Remuneration

Light refreshments will be provided

Location

The study will be carried out in your Early Intervention in Psychosis Service/
Other preferred location

Confidentiality of the Data

Interviews will be audio recorded and these recordings will then be transcribed onto a word document and anonymised. This means that any identifiable information, for example your or the service user's name, will be changed or omitted from the transcript. All anonymised transcripts and data will be stored on a personal password-protected laptop and a USB which is kept in a secure cupboard and is only accessible to myself. All signed consent sheets will also be scanned and stored on secure password-protected university computers, along with audio recordings. Audio recordings will be deleted once the thesis grades have been finalised, however anonymised transcripts will be kept for three years and then destroyed. There is scope to submit any relevant findings to a research journal for publication, however these will be general findings and again will abide by the anonymity and confidentiality agreements stated above.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time until the thesis has been submitted in May 2016. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Your responses will not be shared with other members of your team and any identifiable information will be changed in order to ensure that your responses will not be identifiable.

Please feel free to ask me any questions. If you are happy to continue, you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor: Dr. Poul Rohleder, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Telephone: 020 8223 4174. Email: P.A.Rohleder@uel.ac.uk).

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Appendix H

Consent Forms



UNIVERSITY OF EAST LONDON

CONSENT TO PARTICIPATE IN RESEARCH STUDY

Exploring issues of cultural difference for professionals working with psychosis

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

Project ID (183201) - Version 1 – 14/08/2015

You will receive one copy of the signed consent form and I will keep one copy for my records.

UNIVERSITY OF EAST LONDON

CONSENT TO PARTICIPATE IN RESEARCH STUDY

Exploring issues of cultural and religious difference for professionals working with psychosis

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

Project ID (183201) - Version 1 – 14/08/2015

You will receive one copy of the signed consent form and I will keep one copy for my records.

Appendix I
Interview Schedule

Interview Schedule

The following questions are in relation to your experience of working as a Care Coordinator in an Early Intervention in Psychosis Service. I will be asking about your experience of working with cultural difference with both service users and their families. So I'd like you to reflect not on just issues of working with cultural difference, but of doing so in this setting (Early Intervention in Psychosis) in particular.

- 1) What are your experiences of working with service users and their families who come from a different cultural background to your own?
- 2) Tell me about a time when you have faced a difficulty or challenge when working with someone of a different culture to yourself? (What happened? What were the challenges? How did you overcome them? What did you learn?)
- 3) Have there been times when a "cultural issue" made it difficult for you to do your job as a care coordinator? (What happened? What were the challenges? How did you overcome them? What did you learn?)
- 4) Have you ever had to work with a service user or family member who have a different cultural explanation of psychosis to the one you have? What happened? How did you deal with that?
- 5) Have you ever worked with anyone who had or expressed issues with *you* due to your cultural background? (If so, what happened? What did you learn?)
- 6) Are cultural issues discussed as a team? (If so, how are they talked about? What kind of issues have come up for the entire team with regards to culture?)
- 7) Where or to whom do you turn to when faced with any difficulties linked to issues of culture?
- 8) You've highlighted some challenges to working with someone of a different cultural background to yourself in this setting. What do you think can help you to overcome these challenges?
(Is there something the team or someone in the team can do to help overcome some of these challenges?)
- 9) What has been the most helpful learning experience you have had in managing cultural difference in your work as a care coordinator?
- 10) What do you think you need to know more about or need more support with in order to help you to manage these issues in future?
- 11) Is there anything else that you think may be important to talk about in relation to your experience in working with cultural difference in this setting?

Appendix J
Step-By-Step Plan for Interviews

1. Participant Information Sheet

Hand copy of participant information sheet

Summarise everything in the form

Acknowledge own cultural difference, and invite them to be open and honest

Responses not shared with the team, aim to generate themes across interviews

2. Consent to Participate in research study

Hand copy of consent form

Ask them to read through a sign

Give them a copy to keep for their record – ask for direction to photocopier after if necessary.

3. Interview

Are you ready to begin?

Are you happy for me to audio record?

Remind them about the aims of the interview

Complete interview

4. Debrief

Thank you very much.

How did you find that?

What did you think of the questions?

Was there any point of that that felt uncomfortable?

Do you have any questions?

Do you have any comments and general queries?

Anything else?

Thanks again for doing this interview for me today. I really appreciate your help.

5. Photocopy consent for them

Appendix K

Example of Coded Interview Transcripts

Extract 1

84 J: I suppose I've always had this really big thing about being very honest with the
 85 people that I work with. I'm quite blunt and forthright a lot of the time and that I don't
 86 see the point in sort of telling people things that aren't true. If I don't know the
 87 answer, I don't know the answer, and if I think something, then I would want to be
 88 the person saying to somebody 'this is what I think'. So if I'm like going to a tribunal
 89 for somebody or if I'm going to a hearing, I'm gonna say to them before that, actually,
 90 this is what I'm going to say, this is what I think, that's how I practice and it's really
 91 important to me that I'm quite transparent in that way with my clients, and to be in a
 92 situation where, actually, me being that way was actually really detrimental to being
 93 able to work with a family, is a bit of a shock. I think I kind of went with the flow in the
 94 conversation because that was how the daughter was leading it and I'm sort of
 95 picking up queues from her. It's only when I was sort of sitting in the car afterwards
 96 when I was like, oh actually I was making that worse, and trying to be like, really, if
 97 this is what's going on and have you experienced it and it's actually the way that she
 98 did it, and that kind of much more gentle, much more taking it away from the odd
 99 beliefs and making it about how she responded to it, worked much better in that
 100 situation and it's certainly something that I've then taken into other situations where
 101 you know, I certainly don't lie about things, but I'm prepared to not have
 102 conversations if they're not [laughs] not really helpful in that space.

103 I: How do you gage that?

104 J: Mostly from the reaction I'm getting from people. And so what I now do as a result
 105 of that, is kind of ask the person, ask their family what terminology they're using for
 106 it. I mean things like psychosis and depression and mania are all used in everyday
 107 language but actually the meaning of them is very different to each person that says
 108 them. Somebody who tells me they're depressed may actually be psychotic or be,
 109 you know, physically unwell or something, and that's just the word they're using to try
 110 and explain it. And I notice that much more in the communities as a thing that
 111 happens. So kind of getting somebody to say things, you know 'what's your
 112 understanding of what's going on?' and listening to the words that they're using, and
 113 then said, well that that's how they're referring to their symptoms can you can you
 114 tell me a bit more about that and from that being more able to gage, ok is this a good
 115 place to be bringing this conversation? And because it can be, you know, I haven't
 116 really thought about it, but it can be quite confrontational to say to somebody we
 117 think you're psychotic and you need to take some medication and some people
 118 respond really well to that, having a diagnosis understanding where it's coming from
 119 and why they're experiencing what they're experiencing, and some people, it's a
 120 fearful thing to hear. It's, you know, you think of Schizophrenia and you immediately
 121 think of people being beaten and stabbed and all of the horror films and whatever
 122 else and I think I kind of academically understood that but I hadn't really seen that in
 123 practice and that experience with that girl and her mum was like, oh ok, actually, this
 124 is what this looks like, ok no I get the way I'm coming across is quite forcefully and
 125 that's not helpful for them

Hiding truth

Service, user supportive engagement with family

Take focus away from beliefs

Holding back

Modify Practice according to reactions

Engage with their terminology

Assessing appropriateness of mental health term

Exploring culture

Negative connotations of psychosis & meds

Realisation that medical terminology unhelpful

Extract 2

99 I: So tell me about a time when you faced a difficulty or challenge when working with
100 someone of a different culture to yourself?

101 S: Erm

102 I: It could be recent, it could be someone like a family you found difficult to work with,
103 or

104 S: Well I mean it's always a challenge to work with somebody from a different culture
105 for reasons that I've already discussed, but in particular in the early intervention in
106 psychosis team from my experience it seems that by the time we get people from
107 other cultures through denial and through not wanting to ask for help, it seems that
108 the duration of the psychosis is longer which then makes the psychosis to almost be
109 chronic, which then affect the response rate to treatment and that's a challenge. And
110 from my experience working in this team, the majority of people with the longest
111 duration of untreated psychosis tend to come from ethnic minority because they
112 don't accept help or ask for help in a timely manner because of denial and maybe
113 attempt to seek help through other means like spiritual or going through talking to
114 uncle and [inaudible] before you know it the duration of the untreated psychosis is
115 longer than it should be. That's my experience and that can be a challenge

116 I: Yeah

117 S: So that then affects the amount of time they can respond to medication and of
118 course with recent research about the effect of psychosis on the grey matter or that
119 is a traumatic experience in itself, so parts of brain have been affected by the
120 psychotic experience because of the delay in seeking for help

121 I: So you're saying people from ethnic minority backgrounds tend to come to
122 services later

123 S: Later

124 I: and how they have a higher duration of untreated psychosis because they might
125 have a different idea about

126 S: That's right, yeah

127 I: what's going on and seek it elsewhere. So what do you do with that challenge?
128 'Cause that seems like it would be a quite a big challenge.

Culture always
challenging

Denial of
psychosis

Higher DUP
in BME

More chronic

Poorer response
to treatment

Denial /
seeking
help
elsewhere

Poorer response to med

Delay leads
to greater
damage in
brain

Build engagement
with psychoeducation

129 S: Well what you do is that if eventually you have opportunity to work with them, you
130 use something like psychoeducation to tell people about psychosis, the cause of it,
131 and the impact and the importance of seeking help in a timely manner

132 I: Yeah

133 S: and that of course drawing from the experience or from research about what has
134 helped other people and encouraging people to engage and of course, I mean I've
135 spoken more about the Christian faith, but I think we also, in attempt to address the
136 difficulty, appointed somebody, a social worker to build bridges with the imams in the
137 mosque, in order to provide education about psychosis and in doing so increase
138 people's knowledge and understanding about what is psychosis and the impact on
139 the sufferer

Attempts
to build
bridges with
imams

Aim to
educate imams
about mental
health

140 I: How did that come about? That idea.

141 S: It came about the standard period of duration of untreated psychosis within the
142 ethnic minorities group

143 I: Oh ok. So was that attached to this team?

144 S: Yes

145 I: Ok

146 S: Yeah and then he goes to mosque to speak to the imams about psychosis

147 I: Is that happening right now?

148 S: No no no, because the staff has left and we don't have the resource to continue
149 that work

Lack of
resources to
continue/build
bridges with
imams

150 I: Yeah

151 S: But it was with this we devised some kind of a screening tool to say the possible
152 symptoms that manifest as a result of psychosis and when you should start seeing
153 them, this is what you do

Educate imams to
improve understanding
& response to

Appendix L
Reflective Diary Extract

09/11/15 – After interviewing in one team and preparing to interview in another

I was very aware that I was due to interview people from the team that I used to work in. While most of the staff have changed, I was mindful of the medical culture that existed within the team while I was there and wondered if this would still be the case. Perhaps the team has changed since then and has been influenced by the call for a more culturally-appropriate mental health service.

I prepared myself for hearing views that I may perhaps not agree with, myself. In order to do this, I had to reflect carefully on my views about the topic and my experiences of working there. On the one hand, there were aspects of my own practice that I recall feeling uncomfortable about with regard to working with cultural differences, for example imposing medical ideas on to service users. On the other hand, I empathised with this position, as I recall these ideas being the only ones I knew at the time. It was my first Assistant Psychologist post and I did not have access to alternative ideas at the time. In my mind that was the only way to practice. My views were and are a product of my experiences, just as other people's views are a product of theirs. And so I used this understanding to try to create a middle position from which I questioned people. I became very aware of my facial expressions and felt I had to be extra cautious about the follow-up questions that I asked, to ensure that I was not leading questions in any particular way. I was also cautious of not veering the topic away if something was mentioned that made me uncomfortable or that I disagreed with, out of not wanting the participant to come across the wrong way. My natural tendency was to intervene less and let people speak more, to ensure that I was reducing the possibility of biasing their responses.